

MIGRATION AND HEALTH KNOWLEDGE MANAGEMENT (MIHKMA) PROJECT FINAL SUMMARY REPORT

September 2019



© World Health Organization 2019

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.

Migration and Health Knowledge Management (MiHKMA) project final summary report

10/09/2019

1. Introduction

Migration is one of the defining phenomena of today's globalised world, with international migrants accounting for almost 10% of the Region's population in 2017 (1). Since the late 2000s, there has also been a substantial increase in the number and proportion of refugees and asylum seekers (1). Migration brings with it many positive social and economic benefits and opportunities, yet it also brings new challenges for public health systems to adequately respond to meet the diverse health needs of migrants, refugees, and host populations alike, and reduce the health inequalities between them. Refugees and migrants are at higher risk for developing ill-health, and face greater restrictions on access to health care. However, insufficient knowledge and evidence on the health status of these groups, and on effective interventions remains a significant issue. Lack of standardised good practices across countries at the regional level presents additional complexity. Evidently, there is a need to expand, share, and consolidate information on refugee and migrant health, implement coordinated activities, and facilitate exchange of experience.

In collaboration and with financial support of the European Commission Directorate-General for Health and Food Safety, the WHO Regional Office for Europe produced a series of six technical documents to address some of the key public health issues related to migration. Produced in response to requests from Member States for increased guidance to meet the health needs of refugees and migrants in the Region, the series aims to expand knowledge, and support development and uptake of robust, evidence-informed policy and practice in this area. The aim of this paper is to present the main findings and recommendations.

2. Development and methodology

Development of this series was overseen by a steering committee of representatives from United Nations agencies, universities and other institutions with expertise in migration and health. Subject matter experts were engaged to provide specific consultation and feedback on each document.

Regarding research methods, authors reviewed scientific and grey literature to synthesise best available knowledge in each area. Specific search strategies are outlined in the documents respectively.

3. Findings

Health status of refugee and migrants in the Region

Recognising that refugees and migrants are not a homogenous group and there are differences within and between groups, overall, they are likely to have good general health. Many are often healthier than host populations, particularly during the initial period after migration (1) (2) (3). However,

migration and displacement are key social determinants of health, and the circumstances that surround the migratory process can put these populations at increased risk for ill-health (1) (2). These include the conditions experienced during transit and after arrival, their legal status, the policies that grant or deny access to health and social services, and their living and working situations (2). Therefore, while refugees and migrants should not be considered separate to mainstream populations, the risks faced during migration mean they may have some additional and unique needs to which receiving countries need to be cognisant of.

Women's health, and maternal and newborn health

Women are overrepresented in high-risk migrant groups such as those who have been experienced violence or trafficking, and may be exposed to a range of specific dangers and health risks related to these circumstances (4). Concerning maternal health, female refugees and migrants tend to show significantly worse pregnancy-related indicators than female host populations. This includes for maternal mortality and morbidity, and mental ill-health such as post-partum depression (4). There is also a marked trend for worse perinatal and neonatal mortality, including stillbirth, pre-term birth, and congenital anomalies (4).

Child health

Care for chronic disorders and rehabilitation for disabilities are often the most pressing needs of refugee and migrant children, with dental issues the most common need for care (5). Refugee and migrant children have poorer oral health than host populations, with increased rates of dental caries related to inadequate dental care and nutritional deficiencies (1). They may also have increased vulnerability to diet-related health issues (both malnutrition and overweight/obesity), linked to stress and dietary changes including in breastfeeding patterns (5) (6). Additionally, migration is an important risk factor for mental health conditions in children, and unaccompanied minors experience higher rates of depression and symptoms of post-traumatic stress than other refugee and migrant groups (1) (5).

Health of older persons

Patterns of health and morbidity vary greatly within older refugee and migrant populations according to a range of risk factors over the life-course of the individual. However, whereas host populations may benefit from a delayed onset of morbidity to older ages (compression of morbidity), migrant populations may not benefit in the same way, contributing to growing differentials in health between older population groups (3). Self-rated health, wellbeing and mental health status tend to be lower among older refugees and migrants than in host populations with deterioration over time in the host country (3).

Noncommunicable diseases (NCDs)

Noncommunicable diseases, the greatest contributor to mortality and morbidity globally, are an increasing burden among refugees and migrants (7). All migrant groups have higher incidence, prevalence and mortality for diabetes than host populations, and the development of diabetes may occur at an earlier age for refugees and migrants than for both the host populations and the non-migrating population in the country of origin (1) (7) (8) (9). Refugees and migrants also often have higher rates of heart attack, hypertension and stroke, with irregular migrants in particular having a two-fold higher mortality rate from cardiovascular diseases than the general European population (1) (7) (10).

Mental health

Post-traumatic stress disorder (PTSD) and mood disorders such as depression and anxiety are the most frequently reported conditions, mainly for refugees and recently arrived asylum seekers (1). However, PTSD is the only disorder for which substantial and consistent differences in comparative prevalence between populations has been reported, with higher rates among refugee groups (9-36%) than host populations (1-2%) (11) (12) (13) (14). Prevalence of mood disorders does not consistently differ from host populations (11).

4. Areas for intervention

In line with the *Strategy and action plan for refugee and migrant health in the WHO European Region* and other regional and global commitments, this series has adopted a human rights-based approach (15). It reflects that as for all people, refugees and migrants have the right to enjoy the highest attainable standard of health as enshrined in the International Covenant on Economic, Social and Cultural Rights, and without distinction of race, religion, political belief, or economic or social conditions (15). However, achieving such a standard of health cannot be done without addressing the impacts of migration and displacement on an individual's physical, social and mental wellbeing.

Outlined below are some of the key cross-cutting areas for intervention ('best buys') identified in the documents to promote the health of refugees and migrants in the Region. They recognise the permanence of migration to Europe, and the need for long-term solutions. Strategies to address the health needs of refugees and migrants should not be separated from mainstream public health policies and interventions. Rather, existing services should be strengthened to accommodate for the potentially unique needs faced by these groups as a result of the migration process.

5.1. Create healthy public policies

Just as for host populations, the health of refugees and migrants is influenced by numerous overlapping factors (2). Health, disease and mortality are determined by complex interactions of various political, social, economic and environmental conditions, including the process of migration (2). For refugees and migrants, their legal status and the conditions experienced during the different phases of migration are greatly influenced by multiple sectors (e.g. home and foreign affairs, immigration, finance, social affairs, education, labour etc.) which can promote or hinder positive health outcomes (2) (16) (17) (18) (19) (20). Policy-making regarding migration has also typically been siloed within these sectors, often not including the health sector, or considering the health implications of their policies (2) (21). Therefore, there is a need for coordinated, intersectoral, and whole-of-government efforts to create healthy public policies that foster equity and improve health and wellbeing. This can be referred to as a health in all policies (HiAP) approach, and is about healthy public policies rather than merely public health policies (2) (23).

Adopting a HiAP approach has great potential to impact on a number of key issues related to migrant health. For example, education plays a critical role in protecting and promoting the health of refugee and migrant children, and there is need to ensure equal and early access to educational opportunities for migrant children and prioritise educational continuity, including for unaccompanied children in transitory housing (5). Similarly, the role of the financial sector is important in the prevention and control of NCDs among refugees and migrants (7). This is through the use of fiscal policies to minimise demand, access and affordability of tobacco products, alcohol, and unhealthy food and beverages (7).

5.2. Develop supportive environments, and promote social integration

Health is inextricably linked to people's environment, and the conditions in which they are born, grow, live work and age (2). Promoting the health of refugees and migrants, therefore, must

emphasise a socioecological approach, and the importance of safe, stimulating, and satisfying living and working conditions (2). Creating supportive physical and social environments is also fundamental to addressing some of the key social determinants of health for refugees and migrants, and reducing the vulnerabilities and disadvantages that can be experienced during stages of migration, settlement and acculturation (2). In the context of older migrants and refugees for example, supportive environments are important for enabling individuals to live independently in good health, stay engaged in social relationships, uphold social roles important to wellbeing, and reduce social isolation (3).

The availability of supportive environments is also critical for the integration of refugees and migrants in the communities in which they live and fostering positive social interactions and cultural exchange (2). Integration – a dynamic process of mutual accommodation and interaction – is essential for social cohesion, increased individual and community resilience, and improved wellbeing for all (2) (24). Lack of social integration, particularly social isolation and unemployment, is linked to higher prevalence of mental disorders in refugees and migrants, for example (11) (25). While social exclusion is a predictor of mental health difficulties in the general population, refugees and migrants may have a particularly difficult task in integrating into a new country and culture (11). They often face negative attitudes, prejudices, and discrimination which add to this burden (11). Stringent integration policies have also been shown to negatively impact maternal and newborn health whereas strong integration policies are beneficial, likely mediated through increased accessibility of services, reduced language barriers, and reduced stress (4) (26) (27).

5.3. Build people-centred health systems, and provide equal access to quality services

All individuals, irrespective of country of birth or migrant status, should be ensured access to quality health services (including prevention, treatment, rehabilitation, and palliation) without exposure to financial hardship. Across the Region, refugees and migrants face inequities not only in regard to their health, but also the accessibility and quality of health care services available to them. The legal status of migrants is a significant factor, and formal regulations determining entitlement to care vary between countries (18). Irregular or undocumented migrant status is an additional risk factor for negative health outcomes compared with other migrants, with such status significantly associated with low health service utilisation, and tendency to present only when symptoms become acute (7) (28). Undocumented status is also associated with late antenatal care initiation among pregnant women, for example, as well as higher risk for hospitalization for preventable chronic disease complications (4) (7) (10) (29) (30). Even where entitlements exist or there is universal health coverage, access and timeliness is, in practice, often still greatly dependent on socioeconomic or insurance status, as well the organization of health systems (7) (18). Attention must be paid to reducing inequity within health systems and ensure fair access, delivery and financing of health care for all population groups in the Region.

5.4. Promote diversity- and culturally-sensitive approaches to healthcare, and build a culturally competent health workforce

Available health services are only as effective as they are inclusive, diversity-sensitive, and responsive to the particular linguistic and cultural needs of refugees and migrants. Language can be a major barrier for these groups to accessing care, as many have limited host language skills or limited health literacy in the context of the host country's health system (2). Member States should aim to ensure information and support is available and services permeable to all groups through utilisation of bilingual and bicultural health providers, trained interpreters and cultural mediators. This is particularly relevant to newly arrived refugees and vulnerable groups such as unaccompanied minors, though can also be an issue for older migrants who, with age, sometimes experience loss of learned second (host) languages (3) (5).

Effective health systems must be receptive to people's belief systems and culture which influence perceptions of health and illness, as well as health-seeking behaviours (2) (23) (31). Failure to attend to cultural differences increases likelihood for negative and costly health outcomes such as diagnostic errors, inadequate adherence to prescription regimens, and adverse drug reactions (32). For mental health for example, engaging with refugees and migrants in a cross-cultural context is particularly pertinent, where expressions and explanatory models of mental distress can vary depending on cultural background, and specific cultural beliefs about mental phenomena can complicate diagnostic processes (11). Similarly, doctor-patient misunderstandings pertaining to cultural fear of medical intervention during childbirth for some migrant women has been shown to have potentially adverse yet preventable perinatal outcomes (4). Stereotypes and assumptions about cultural differences which can be embedded within health care systems can also lead to marginalisation and lower quality and efficacy of care (2) (23) (31). Diversity-sensitive and culturally competent health care is important both in and of itself, and for its potential to reduce disparities in health between refugee and migrant groups, and mainstream populations.

5.5. Adopt a life-course approach to responding to refugee and migrant health needs

As for the general population, the health status of refugees and migrants can be understood as the result of a lifetime of risks and exposures. However, the health of these groups is also influenced by additional exposures during the life-course which occur during the various stages of migration, not experienced by the majority population (33). A refugee or migrant background is frequently associated with different accumulation patterns and timings of physical or social exposures during critical periods over the lifetime that shape health and disease risks in later life (3) (33). The intersection of the migration experience with different life stages thus may help explain the dynamics of health outcomes for refugees and migrants at different ages, and the health differentials that exist between populations.

In this context, a life-course perspective may be a useful approach to responding to the health needs of refugees and migrants in the Region. However, it takes into consideration not only the impact of migration trajectories and the vast heterogeneities among them, but also how cultural norms and practices and gender dimensions shape one's health and health behaviours (3). This includes with respect to how perceived roles and responsibilities of men and women, as well as the specific risks and resources available to them can influence health into old age (3).

Effective interventions must target key factors as they unfold over the life-course. This begins with making pregnancies safe and with early childhood development, as healthy children become productive adults who can contribute actively in society into older age (20). Children make up a significant number of refugees and migrants in the Region and interventions targeting this group can promote health across their entire lifetime (1). Healthy and active ageing to improve quality of life must also be a policy priority in the context of an increasing ageing demographic in Europe (20).

5.6. Invest in strengthened data collection regarding the health of refugees and migrants, and service utilisation

In order to meet the health needs of refugees and migrants and support good decision-making the European Region, high-quality migrant-specific data is essential. At present, there are almost no Region-wide and comparable indicators on refugee and migrant health, and a general paucity of comprehensive and representative data regarding the health status and service needs of these groups (1) (18). Few Member States routinely collect migration-related data and information is often collected on an ad hoc basis (1) (7). Moreover, there is great heterogeneity in the methods and definition used for capturing information which complicates analysis and comparison of such information, and makes it extremely difficult to coordinate regional strategies, and develop evidence-informed approaches (1).

Member States must work to improve routine collection of standardised and disaggregated migration-related data, including the use of common methods and terminology. This is essential for strengthening the evidence base upon which national and regional policies and interventions can be developed. Availability of large routine datasets for example, may help identify generic or specific factors that could be used to predict mental disorders, better monitor perinatal and maternal health outcomes, or understand factors related to the development of NCDs, among other things (11) (4) (7).

5. Conclusion and future directions

International migration continues to be a permanent fixture of the European landscape as many move to and from the Region, bringing with it great possibilities and opportunities for all. Health systems, however, are not necessarily adequately equipped to cope with the public health challenges it presents. The current situation presents a unique opportunity to act now, both to meet short-term needs following from recent large-scale influxes, and address social determinants and strengthen public health capacity into the long term. Alongside the *Strategy and action plan for refugee and migrant health in the WHO European Region*, and other key regional and global commitments, this series forms a basis for a concerted and consolidated response, based on the principles of solidarity, universality and equity (15). Such coordination is imperative to ensure migrants and refugees are able to realise their right to health, and that all populations can enjoy the positive aspects afforded by migration.

Technical guidance series on improving the health and wellbeing of refugees and migrants in the WHO European Region

[Improving the health care of pregnant refugee and migrant women and newborn children](#)

[Health of refugee and migrant children](#)

[Health of older refugees and migrants](#)

[Mental health promotion and mental health care in refugees and migrants](#)

[Prevention and control of noncommunicable diseases in refugees and migrants](#)

[Health promotion for improved refugee and migrant health](#)

6. References

1. Report on the health of refugees and migrants in the WHO European Region: no public health without refugee and migrant health. Copenhagen: WHO Regional Office for Europe; 2018.
2. Pahlman K. Health promotion for improved refugee and migrant health. Copenhagen: WHO Regional Office for Europe; 2018 (technical guidance).
3. Kristiansen M. Health of older refugees and migrants. Copenhagen: WHO Regional Office for Europe; 2018 (technical guidance).
4. Essén B. Improving the health care of pregnant refugee and migrant women and newborn children. Copenhagen: WHO Regional Office for Europe; 2018 (technical guidance).
5. Hjern A, Kadir A. Health of refugee and migrant children. Copenhagen: WHO Regional Office for Europe; 2018 (technical guidance).
6. Hjern A, Kocturk-Runefors T, Jeppson O, Tegelman R, Hojer B, Adlercreutz H. Health and nutrition in newly resettled refugee children from Chile and the Middle East. *Acta Paediatr Scand.* 1991;80(8-9):859-67.

7. Kumar B, Pahlman K, Severoni S. Prevention and control of noncommunicable diseases in refugees and migrants. Copenhagen: WHO Regional Office for Europe; 2019 (technical guidance).
8. Agyemang C, van den Born B-J. Non-communicable diseases in migrants: an expert review. *J Travel Med.* 2018;107:1-9.
9. Choukem SP, Fabreguettes C, Akwo E, Porcher R, Nguewa JL, Bouche C et al. Influence of migration on characteristics of type 2 diabetes in sub-Saharan Africans. *Diabetes Metab.* 2014;40(1):56-60.
10. Jackson Y, Paignon A, Wolff H, Delicado N. Health of undocumented migrants in primary care in Switzerland. *PLOS One.* 2018;13(7):e0201313.
11. Priebe S, Giacco D. Mental health promotion and mental health care in refugees and migrants. Copenhagen: WHO Regional Office for Europe; 2018 (technical guidance).
12. Priebe S, Giacco D, El-Nagib R. Public health aspects of mental health among migrants and refugees: a review of the evidence on mental health care for refugees, asylum seekers and irregular migrants in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016 (Health Evidence Network 47; http://www.euro.who.int/_data/assets/pdf_file/0003/317622/HEN-synthesis-report-47.pdf?ua=1, accessed 21 March 2019).
13. Fazel M, Wheeler J, Danesh J. Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *Lancet.* 2005;365:1309-14.
14. Close C, Kouvonon A, Bosqui T, Patel K, O'Reilly D, Donnelly M. The mental health and wellbeing of first generation migrants: a systematic-narrative review of reviews. *Glob Health.* 2016;12:47.
15. Strategy and action plan for refugee and migrant health in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2016.
16. De Vito E, de Waure C, Specchia ML, Ricciardi W. Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region. Copenhagen: WHO Regional Office for Europe; 2015 (Health Evidence Network synthesis report 42; http://www.euro.who.int/_data/assets/pdf_file/0004/289255/WHO-HEN-Report-A5-3-Undocumented_FINAL-rev1.pdf?ua=1, accessed 21 March 2019).
17. Simon J, Kiss N, Łaszewska A, Mayer S. Public health aspects of migrant health: a review of the evidence on health status for labour migrants in the European Region. Copenhagen: WHO Regional Office for Europe; 2015 (Health Evidence Network synthesis report 43; http://www.euro.who.int/_data/assets/pdf_file/0003/289245/WHO-HEN-Report-A5-1-Labour-rev1.pdf?ua=1, accessed 21 March 2019).
18. Bradby H, Humphris R, Newall D, Phillimore J. Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. Copenhagen: WHO Regional Office for Europe; 2015 (Health Evidence Network synthesis report 44; http://www.euro.who.int/_data/assets/pdf_file/0004/289246/WHO-HEN-Report-A5-2-Refugees_FINAL.pdf?ua=1, accessed 21 March 2019).
19. Hannigan A, O'Donnell P, O'Keefe M, Macfarlane A. How do variations in definitions of "migrant" and their application influence the access of migrants to health care services? Copenhagen: WHO Regional Office for Europe; 2016 (Health Evidence Network (HEN) synthesis report 46; http://www.euro.who.int/_data/assets/pdf_file/0013/317110/HEN-synthesis-report-46.pdf?ua=1, accessed 21 March 2019).
20. Health 2020: Multisectoral action for the health of migrants. Thematic brief on migration. Copenhagen: WHO Regional Office for Europe; 2016 (http://www.euro.who.int/_data/assets/pdf_file/0006/324627/Health-2020-Multisectoral-action-for-the-health-of-migrants-en.pdf?ua=1, accessed 21 March 2019).
21. Zimmerman C, Kiss L, Hossain M. Migration and health: a framework for 21st century policy-making. *PLOS Med.* 2001;8(5):e1001034.
22. Dodson S, Good S, Osborne R, editors. Health literacy toolkit for low- and middle-income countries: a series of information sheets to empower communities and strengthen health systems. New Delhi: WHO Regional Office for South-East Asia; 2015 (http://apps.searo.who.int/PDS_DOCS/B5148.pdf?ua=1, accessed 21 March 2018).

23. Mohsin Khan M, Kobayashi K. Optimizing health promotion among ethnocultural minority older adults (EMOA). *IJMHS*. 2015;11(4):268-81.
24. Together in the EU: promoting the participation of migrants and their descendants. Vienna: European Union Agency for Fundamental Rights; 2017 (<http://fra.europa.eu/en/publication/2017/migrant-participation>, accessed 21 March 2019).
25. Bogic M, Njoku A, Priebe S. Long-term mental health of war-refugees: a systematic literature review. *BMC Int Health Hum Rights*. 2015;15:29.
26. Bollini P, Pampallona S, Wanner P, Kupelnick B. Pregnancy outcome of migrant women and integration policy: a systematic review of the international literature. *Soc Sci Med*. 2009;68(3):452-61.
27. Malmusi D. Immigrants' health and health inequality by type of integration policies in European countries. *Eur J Public Health*. 2015;25(2):293-9.
28. Castañeda H. Illegality as a risk factor: a survey of unauthorized migrant patients in a Berlin clinic. *Soc Sci Med*. 2009;68(8):1552-60.
29. Almeida LM, Caldas J, Ayres-De-Campos D, Salcedo-Barrientos D, Dias S. Maternal healthcare in migrants: a systematic review. *Matern Child Health J*. 2013;17(8):1346-54.
30. de Jong L, Pavlova M, Winters M, Rechel B. A systematic literature review on the use and outcomes of maternal and child healthcare services by undocumented migrants in Europe. *Eur J Public Health*. 2017;27(6):990-7.
31. Napier AD. Culture matters: using a cultural contexts of health approach to enhance policy-making. Copenhagen: WHO Regional Office for Europe; 2017 (Policy brief 1; <http://www.euro.who.int/en/publications/abstracts/culture-matters-using-a-cultural-contexts-of-health-approach-to-enhance-policy-making-2017>, accessed 21 March 2019).
32. Brach C, Fraser I. Reducing disparities through culturally competent healthcare: an analysis of the business case. *Qual Manag Healthc*. 2002;10(4):15-28.
33. Spallek J, Zeeb H, Razum O. What do we have to know from migrants' past exposures to understand their health status? a life course approach. *Emerg Themes Epidemiol*. 2011;8:6.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czechia
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
North Macedonia
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

World Health Organization Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark

Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01

Email: eurocontact@who.int

Website: www.euro.who.int