Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma
MEM-TP

MODULE 2: KNOWLEDGE ABOUT MIGRANTS, ETHNIC MINORITIES AND THEIR HEALTH
Unit 1: Migrants' and ethnic minorities' health problems and health determinants.

Guidelines

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Migrants & Ethnic Minorities Training Packages

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Unit 1: Migrants' and ethnic minorities' health problems and health determinants

1. Objectives and Methods

1. Objectives and Methods

1.1. Objectives

Objectives of the Presentation:

- To describe basic demographic characteristics of the current migrant population and ethnic minorities.
- To describe basic demographic characteristics of the current migrant population and ethnic minorities.
- To analyse the social determinants of health of migrants and ethnic minorities.
- To identify major trends in the state of health of migrants and ethnic minorities.

Objectives of the Activity:

- To stress previous knowledge and perceptions on health needs among migrants and ethnic minorities
- To analyse the social determinants of health of migrants and ethnic minorities.

1.2. Methods

The estimated time required for Module 2 is 5 hours, approx. 3 hours for Unit 1 and 2 hours for Unit 2. The training materials of each Unit are composed of presentations, activities, videos and recommended lectures.

Data of Unit 1 has to be adapted to specific demographic characteristics of the migrant population and ethnic minorities, the specific health outcomes and morbidity/mortality patterns. As part of the local adaptation contents and activity from Additional Module 2 are to be integrated in this Unit. We suggest the use of a participatory pedagogical approach based on the participants' own experience and knowledge.

Time	Objetives	Activities	Sources
10 minutes	• To describe basic demographic characteristics of the current migrant population and ethnic minorities.	Presentation (slides 1-6) and questions	Projector, laptop, screen.
15 minutes	• To introduce the social determinants of health of migrants and ethnic minorities.	• Video Screening • Group discussion in plenary and Presentation (slides 7-13)	Projector, laptop, screen.
30 minutes	• To identify major trends in the state of health of migrants and ethnic minorities.	Presentation (slides 14-20) and questions	Projector, laptop, screen.

Presentation

Slide 1 *Information for this document was obtained from Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen, 2015.*

Slide 2: Outline of contents

Slide 3: Social context of migrants and ethnic minorities

Global migration is increasing and accelerating. As a result, societies are becoming more and more diverse – culturally, ethnically, and linguistically. Two recent trends in international migration are highly relevant for the issue of migration health:

1. Firstly, there has been an increasing shift toward 'circular' or 'transient' migration1. Circular migration may involve regular trips back and forth between the host country and the home country.
2. The other phenomenon is 'super-diversity'2: in the major capitals of Europe, hundreds of different languages may be spoken. Within each migrant nationality there will also be a great deal of diversity in e.g. educational levels, skills, ages, religions, ethnicities, and many other characteristics that have traditionally been assumed to be homogenous.

At the beginning of 2013, the total of migrant stock in the EU27 was 50.872,674, i.e. 10.1% of the total population[3]. Migration has been strongly affected by geographic proximity, with 30% of the migrants living in the EU originally being from other EU countries[4]. Many European countries have come to rely on migrants to counteract falling birth rates and ageing societies. For sender countries, remittances often make up a large share of their GDP and play a vital role in their development.

Regarding asylum claims, figures from 2013 continued the increase that started in 2010 and reached the highest level in Europe for a decade[5]. The main countries of origin of asylum seekers were Syria, Russian Federation, Afghanistan, Iraq and Serbia/Kosovo. According to UNHCR, six nations on southern Europe (Cyprus, Greece, Italy, Malta, Portugal and Spain) have a sustained increase in the number of asylum claims[6].

Of the estimated 5 to 8 million "irregular" migrants in Europe, most have overstayed their visas or remained in the country after their asylum application failed[7]. Numbers of "irregular"

[1] Newland, K. (2009). Circular Migration and Human Development, Human development research paper 2209/42, UNDP

[2] Vertovec, S. (2010). Towards post-multiculturalism? Changing communities, conditions and contexts of diversity. *International Social Science Journal*, 61: 83–95.

[3] Source: Eurostat [migr_pop3ctb]

[4] IOM (2008) World migration 2008, Managing labour mobility in the evolving global economy. Geneva, IOM.

[5] UNHCR (2014), Asylum Trends 2013. Levels and Trends in Industrialized Countries. New York: United Nations High Commissioner for Refugees.

[6] Gushulak B, Pace P, Weekers J (2010). Migration and health of migrants. In: *Poverty and social exclusion in the WHO European Region: health systems respond.* Copenhagen, WHO Regional Office for Europe.

[7] PICUM Who are Undocumented Migrants. Available at: http://picum.org/en/our-work/who-are-undocumented-migrants/ (retrieved: July 24, 2015)

migrants are intrinsically hard to estimate, but this group is estimated to make up approximately 1% of the population of the EU[8].

Women make up approximately half of the migrants in Europe (50% in 2013 according to Eurostat)[9]. However in some countries, female migrants outnumber males, e.g. Cyprus, Italy, Spain and Ireland. Research has shown that a great number of female migrants are domestic workers or personal care workers, and that these forms of employment often expose the migrants to exploitation and abuse from employers. Therefore, they are more vulnerable to face exclusion from access to health services and other social welfare services[10].

Slide 4 Migrants tend to be younger than the native population and therefore migrants themselves will tend to consume less health care than natives: the highest costs[11] are incurred in early childhood and old age, categories in which migrants are under-represented as shown in **figure 1**.

The term 'ethnic minority' covers a range of disparate groups. *This issue has already been addressed in Module 1. For the purpose of this training package in terms of health trends and needs of ethnic minorities the discussion should be adapted to national contexts. Problems regarding data collection on ethnic minorities are stressed in Module 4*.

Studies across European countries on health issues related to ethnicity are difficult and methodologically challenging due to differences in definitions and available data, as well as variations in the determinants of health across "similar" ethnic groups in different countries and within ethnic groups in each country. Results from such studies show that although country of birth predicts some of the variation in health outcomes, there are important variations between different countries of residence. These may reflect differences in the background characteristics of the ethnic minority populations in each country, their socioeconomic position, and in health policies affecting them. International comparative studies on comparable ethnic groups may produce important new hypotheses on the role of cultural, social and environmental factors and provide insight in the most effective organization and provision of culturally sensitive health care. Confirming hypotheses generated by such research, however, will require more in-depth studies – often based on qualitative methods in local settings[12].

Presentation

Slide 5 The Roma, as Europe's largest ethnic minority of approximately 11 million, experience the highest levels of deprivation in Europe. According to WHO Europe, "*the encompassing term Roma is often used to describe various communities who identify themselves as Sinti, Ashkalia, Egyptians, Roma, gens de voyage, Yenish, Kale, Gypsies and Manouch, among other things, although those identifying themselves as Egyptians explicitly reject that their origin is*

[8] Düvell F (2009). Irregular migration in northern Europe: overview and comparison. Oxford, University of Oxford Centre on Migration, Policy and Society

[9] Flanders, O.A. (2011). Immigration to EU Member States down by 6% and emigration up by 13% in 2008. Eurostat. Available at: http://ec.europa.eu/eurostat/en/web/products-statistics-in-focus/-/KS-SF-11-001 (retrieved: July 24, 2015)

[10] Kouta, C., Kaite, C. (2012). Health issues among female migrant domestic workers.In: Ingleby, D., et al (eds). *Health inequalities and risk factors among migrants and ethnic minorities*, Vol. 1. COST Series on Health and Diversity. Antwerp: Garant Publishers.

[11] Yamamoto, D.H. (2013). *Health Care Costs – From Birth to Death*. Schaumburg, Illinois: Society of Actuaries. Available at: http://www.healthcostinstitute.org/files/Age-Curve-Study_0.pdf (retrieved: July 24, 2015)

[12] Salway, S., *et al* (2011). Contributions and challenges of cross-national comparative research in migration, ethnicity and health: insights from a study of maternity experiences and outcomes. *BMC Public Health,* 11:514.

Indian. Together, they comprise an ethnic population that is made up predominantly of communities of commercial and nomadic groups from India). Because they are thought to share challenges of exclusion and a culture distinguished by nomadism and self-employment, Travellers are often included in policy discussions about Roma. Roma and Sinti are "Often linked together pejoratively under the term Gypsies, alongside ethnically unrelated groups". Others have questioned the homogeneity of experiences of Roma and Travellers. The CE convention uses the term Roma to refer to both Roma and Travellers." [13]

In terms of data collection on Roma communities in Europe some obstacles have been identified:

- Data collection in many countries in Europe does not disaggregate data by ethnicity; in some cases because of historical misuse of data for purposes of persecution and segregation.
- Ethnic minorities may try to hide their ethnicity in order to avoid stigmatisation;
- There is a lack of agreement regarding the terminology and definitions used when referring to Roma minorities[14].

The greatest numbers of Roma live in Central Eastern Europe – Romania, Slovakia, Bulgaria, Hungary, and the former Yugoslavia. Less than 20% of Roma in Europe are nomadic. **Figure 2** shows EU member states with the largest Roma and Traveller populations[15].

There are four countries with migrant Roma populations estimated to be 50.000 or above (United Kingdom, Greece, Germany, and Italy). France has an estimated population of 10.000-15.000 migrant Roma (2010). Roma populations also exist in Belgium, the Czech Republic, Ireland and Spain although no estimates for their size were identified. The largest group appears to be found in the UK, where estimates range between 50,000 and 1 million. Most migrant European Roma come from Eastern EU countries. They can live and work freely in the EU.

Using the average for the EU-27, the European Roma population has an average age of 25.1 in comparison with 40.2 for the non-Roma population. **Figure 3** shows the population pyramids in Europe: Roma community and the European Union[16].

A large proportion of the health disadvantages experienced by migrants and ethnic minorities are related to their generally unfavourable socioeconomic position. On average, the socioeconomic status (SES) of migrants and ethnic minorities is lower and they are in general more likely to live in poverty than non-migrants and the majority population. Migrants and ethnic minorities tend to suffer from multiple forms of disadvantage, and this is a major factor influencing their health. Currently, as a result of 'austerity' policies, the most vulnerable groups in society absorb the main impact of spending cuts and privatisation in the public services sector, in particular when these policy measures limit access to key services such as health care.[17] As restrictions on migration are tightened, the number of "irregular" migrants

[13] Gushulak B, Pace P, Weekers J (2010). Migration and health of migrants. In: *Poverty and social exclusion in the WHO European Region: health systems respond.* Copenhagen, WHO Regional Office for Europe.

[14] Kallayova, D., Bosak, L. (2012) Improvement of health services for Roma communities in Slovakia. In: Ingleby, D. et al (eds.) *Inequalities in Health Care for Migrants and Ethnic Minorities. COST Series on Health and Diversity. Antwerpen:* Garant Publishers.

[15] OSF, 2010. No Data—No Progress. Country Findings. Data Collection in Countries Participating in the Decade of Roma Inclusion, 2005–2015. Available at: http://osf.to/1uyswGX (retrieved: july 24, 2015)

[16] *Roma Health Report*. European Commission, Health and Consumers. http://ec.europa.eu/chafea/documents/health/roma-health-report-2014_en.pdf (accessed on 25th of November, 2014).

[17] Eurofound (2013). *Impacts of the crisis on access to healthcare services in the EU*, Dublin.

goes up. Such migrants, because of the precariousness of their situation as well as the perilous journeys many have made to reach the EU, are often found to be in ill-health.

Slide 6 Evolution of migration trends in Europe are shown in the map of **figure 4**. Countries which experienced rapid economic growth and net immigration in the 1950's and 1960's are shown in red. During the 1980's and 1990's, a new group of European countries (marked in yellow) experienced increasing immigration. Countries which have experienced an increasingly positive migration balance since 2000 are shown in green, while countries whose balance has remained (or become) negative are shown in blue.

Concerning asylum seekers and "irregular" migrants, worsening economic, climatic and political conditions in many non-European countries have led to an increase in recent years. The most conspicuous illustration of this is the large number of 'boat people' crossing the Mediterranean to Southern Europe. At the same time – often in response to measures to deter the boat traffic – migration over land across Europe's Eastern borders has increased. This has presented new challenges to the health systems of the countries involved.

The prolonged economic crisis which hit the EU after 2007 has had far-reaching consequences for the health of migrants. In many countries, policies have been adopted which have simultaneously weakened the social position of migrants and limited their access to health care. Anti-immigration sentiment has increased, health and social services have been cut.

Slide 7 **Social determinants of health relevant for migrants and ethnic minorities**

We recommend introducing this issue with a video screening: "Making the Connections: Our City, Our Society, Our Health": https://www.youtube.com/watch?v=LMpQEMb0Trc

Gaps in the data

Although the amount of information available on the health of migrants and ethnic minorities in Europe has increased considerably in the last decade, this information still has serious limitations. Health statistics are seldom categorized according to the ethnicity or migration status of the people concerned, and often it is not possible to link them with databases that do contain such variables. The availability of data on specific health conditions varies much more between countries[18] and most countries in Europe do not record ethnicity in census or other population registers. Moreover, in the scientific literature, migrants and ethnic minorities as categories to a large extent overlap: much research on ethnicity is at the same time research on migration, because it uses "country of birth" as an indicator of ethnicity.

According to the European Commission's 2014 Report on the implementation of the EU Framework for National Roma Integration Strategies, the lack of systematic data collection on health of Roma compared to the general population continues to be a problem to the monitoring of Roma health and health inequalities.[19]

The relation between poor health and shortcomings in health service provision

[18] Migrant and Ethnic Health Observatory (MEHO). Website: http://www.meho.eu.com/ (temporarily unavailable). See also Nielsen SS, Krasnik A, Rosano A. (2009) Registry data for cross-country comparisons of migrants' healthcare utilization in the EU: A survey study of availability and content. *BMC Health Serv Res*; 9:210.

[19] Report on the implementation of the EU Framework for National Roma Integration Strategies. European Commission, Directorate-General for Justice (2014). Available at: http://ec.europa.eu/justice/discrimination/files/roma_implement_strategies2014_en.pdf (retrieved: February 23, 2015).

It is often argued that shortcomings in health services for migrants and ethnic minorities must be addressed because of the heightened health risks known to affect these groups. Nevertheless, poor access to good-quality care is not only a problem when groups are exposed to heightened health risks. Accidents, infections, complications in childbirth, genetic defects and the natural deterioration of the body in old age can affect anybody.

However, those with the greatest need for good health care are often those who are least able to get it ('Inverse Care Law'[20]). Migrants and ethnic minorities sometimes experience special needs and vulnerabilities, which justify greater attention to the services provided. It is a question of rights: the universal human right to health and the unacceptability of discrimination in service provision between groups.

Health determinants

According to WHO[21] "*Many factors combine together to affect the health of individuals and communities. Whether people are healthy or not, is determined by their circumstances and environment. To a large extent, factors such as where we live, the state of our environment, genetics, our income and education level, and our relationships with friends and family all have considerable impacts on health, whereas the more commonly considered factors such as access and use of health care services often have less of an impact. The determinants of health include:*

- *The social and economic environment,*
- *The physical environment, and*
- *The person's individual characteristics and behaviours.*

The context of people's lives determine their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate. Individuals are unlikely to be able to directly control many of the determinants of health. These determinants—or things that make people healthy or not—include the above factors, and many others:

- *Income and social status - higher income and social status are linked to better health. The greater the gap between the richest and poorest people, the greater the differences in health.*
- *Education – low education levels are linked with poor health, more stress and lower self-confidence.*
- *Physical environment – safe water and clean air, healthy workplaces, safe houses, communities and roads all contribute to good health. Employment and working conditions – people in employment are healthier, particularly those who have more control over their working conditions*
- *Social support networks – greater support from families, friends and communities is linked to better health. Culture - customs and traditions, and the beliefs of the family and community all affect health.*
- *Genetics - inheritance plays a part in determining lifespan, healthiness and the likelihood of developing certain illnesses. Personal behaviour and coping skills – balanced eating,*

[20] Tudor Hart (1971).
[21] WHO. Website: http://www.who.int/hia/evidence/doh/en/ (retrieved: July 24, 2015)

keeping active, smoking, drinking, and how we deal with life's stresses and challenges all affect health.

- *Health services - access and use of services that prevent and treat disease influences health*
- *Gender - Men and women suffer from different types of diseases at different ages."*

Considering migrants, the origin of health problems may lie in the country of origin, the journey, or in the host country[22]. The 'life-course' perspective considers that there may be highly complex interactions between all three factors.

Health inequalities affecting the descendants of migrants

The "second generation" or migrant offspring's tends to be invisible in statistics on health: either by excluding them from studies of migrants, or by lumping together migrants and their offspring born in the host country.

Some of the main findings from available research[23],[24, 25,26] are as follows:

- Blood pressure rose faster over time for ethnic minority children (UK).
- Adolescent boys from ethnic minorities tended to report better mental health despite coming from poorer families and neighbourhoods. Positive factors identified were caring parents, doing things together as a family and having friends from different ethnic groups (UK).
- Experiences of racism had a negative effect on mental health in all ethnicities (UK).
- Second generation of non-Western migrants are more diagnosed as "psychotic" than the majority population (Netherlands)
- Rates of risky behaviour in the second generation not always converge towards the rates found in the majority population. This is the case in alcohol consumption.
- In relation to smoking in men and overweight and physical inactivity in women rates of risky behaviour have converged. Male descendants who reported to be daily smokers were slightly higher than migrants in general, and significantly higher compared to the majority population. In adolescence, girls from some ethnic groups were more likely to be overweight than participants from other ethnic groups. Contributory factors included skipping breakfast, drinking too many carbonated soft drinks and not eating enough fruit and vegetables (UK, Netherlands and Denmark).
- Rates of physical activity were higher among all migrants compared to Danes, and among descendants aged 18-39, rates of physical activity were significantly higher.
- Considering self-perceived health, the older the migrants and their descendants, the greater the differences in perceived health when compared to the majority population (Denmark).

Presentation

Slide 8 The diagram in **figure 5** (adapted from Reeske & Spallek, 2012[27]) illustrates the complexity of these determinants of migrant and ethnic minorities' health. It must also be

[22] Gushulak B, Pace P, Weekers J (2010). Migration and health of migrants. In: *Poverty and social exclusion in the WHO European Region: health systems respond.* Copenhagen, WHO Regional Office for Europe.

[23] DASH Project. Website: http://dash.sphsu.mrc.ac.uk (retrieved: July 24, 2015)

[24] Veling, W., Selten, J. P., Veen, N., Laan, W., Blom, J. D. & Hoek, H. W. (2006). Incidence of schizophrenia among ethnic minorities in the Netherlands: a four-year first-contact study. *Schizophr.Res*, 86, 189-193.

[25] Selten, J. P., Laan, W., Kupka, R., Smeets, H. & van Os, J. (2011). Meer kans op depressie en psychose bij allochtonen. *Ned Tijdschr Geneeskd*, 155.

[26] Singhammer, J. *et al* (2008). Etniske minoriteters sundhed. Partnerskabet for undersøgelse av etniske minoriteters sundhed, Center for Folkesundhed

[27] Reeske, A. and Spallek, J. (2012) Obesity among migrant children and adolescents: a life-course perspective on obesity development. In: Ingleby, D., Krasnik, A., Lorant, V. & Razum, O. (Eds.) *Health inequalities and risk factors*

borne in mind that these factors do not affect health directly, but though various intervening variables and pathways. Many different kinds of factors may underlie the prevalence of disease among migrant groups:

1. Genetic factors

Particular genetic differences may well be the key to understanding differences between population groups in their vulnerability to certain diseases. It has long been known that sickle-cell anaemia occurs predominately in African Americans, while Tay-Sachs disease is mainly found in Ashkenazi Jews. Developments in genetic profiling will undoubtedly discover more such links, though intermarriage and complex interactions with other factors weaken the impact of any such effects.

2. Cultural factors

Differences in lifestyle linked to 'culture' have been a popular type of explanation in the study of migrants' health. Again, some quite strong connections can be found: for example, the difference in smoking habits between men and women in traditional Bangladeshi and Pakistani communities is reflected in marked sex differences in lung cancer incidence.[28] Female genital mutilation is perhaps the most well-known example of a practice that negatively affects health and is linked to traditional cultures. However, as Bhopal points out[29], many cultural traditions (such as prohibitions on alcohol and sexual promiscuity) can have positive influences on health.

However, there are two main problems with explanations in terms of 'culture'. Firstly, the notion that each ethnic group or country of origin is associated with a stable and homogeneous culture has come under fire in recent decades. Secondly, lifestyles are not practised in a vacuum: healthy eating, for example, is not just a personal choice but also depends on the availability and affordability of the right foodstuffs, as well as having the time and facilities to prepare them. Advertising and social pressures are also powerful determinants of behaviour.

3. Health system factors

Health may be impaired by shortcomings of the health system in providing adequate prevention programmes, health education and promotion, or health services that are accessible and of high quality. However, a shift has occurred in *interventions* aimed at improving the health of these groups. The focus has moved influenced by the "social determinants of health" movement associated with the "Marmot Report"[30]. As an example, Early research on Roma also tended to focus on poor access to good quality services as a cause of health problems. By contrast, later projects, such as *Health and the Roma Community* (2007-2009) and *Reports on health status of the Roma population* (2012-2013) placed more emphasis on the need for more epidemiological research into the causes of ill-health, especially the role of social disadvantage.

4. Lifestyle factors

among migrants and ethnic minorities. COST Series on Health and Diversity, Volume I (pp. 237-256). Antwerp/Apeldoorn: Garant

[28] Jack, R.H., Davies, E.A. & 1 Møller, H. (2011) Lung cancer incidence and survival in different ethnic groups in South East England. British Journal of Cancer 105, 1049–1053.

[29] Bhopal, R. (2014) *op cit.*

[30] CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*. *Final report of the Commission on the Social Determinants of Health.* Geneva, World Health Organization

The importance of *prevention* has been widely emphasised since the WHO's 1978 'Declaration of Alma Ata' [31] and even before. Some preventive measures are targeted at individuals and aim to induce *behavioural change.* This can either have the aim of harm reduction or illness prevention. Recently there has been a great increase in attention to behavioural ('lifestyle') factors as determinants of both communicable and non-communicable illnesses.

Slide 9

5. Social determinants

Currently more emphasis is address on the need for more epidemiological research into the causes of ill-health, especially the role of social disadvantage linked to 'social determinants of health'[32]. The 'rainbow diagram' of Dahlgren and Whitehead[33] represents the social determinants of health. As shown in **figure 6**, in the WHO's 2010 *Policy Briefing on migrant and ethnic minority health*[34] this diagram was adapted to show the social determinants of migrant health.

Slide 10

The same information is represented in **figure 7** with the distinction between determinants which specifically affect migrants (direct) and those which affect people in disadvantaged socioeconomic positions (indirect)[35].

Slide 11 Social determinants of health and the influence of Social Economic Status
Image 1 Differences in life expectancy within a small area of London ("*Jubilee line*")

The emphasis on deeper structural determinants of health inequities has mainly been linked to the enormous differences in health and longevity between those at the top and bottom of the socioeconomic ladder. The poverty and social exclusion experienced by most Roma is well documented, and migrant households experience poverty with much greater frequency than native households[36].

Slide 12 According to WHO Europe "*access to employment is a major aspect of social and economic inclusion. Levels of poverty are noted to be higher in the unemployed and other inactive members of society (…) Rates of unemployment vary by country, but there is evidence to indicate that employment income is reduced in migrant populations, particularly those of irregular migrants (...) Working people whose income is less than 60% of the median national income are at greater risk of poverty-associated outcomes (…) Some migrant populations are at particular risk of poverty (…) migrants in an irregular situation; asylum seekers; single-parent migrant families, specifically those headed by women; those traumatized or tortured during the migratory process; and the victims of human trafficking"*[37].

Slide 13 SES is part of the causal chain between migration status or ethnicity and health, if membership of these groups to some extent determines a person's SES. WHO Europe report

[31] WHO (1978). *Declaration of Alma-Ata.* Geneva, World Health Organization.
[32] CSDH (2008). *Op. cit.*
[33] Dahlgren G & Whitehead M (1991) Policies and strategies to promote social equity in health. Institute for Future Studies, Stockholm.
[34] WHO (2010). *Op. cit.*
[35] Ingleby, J.D. (2014) Social determinants of migrants' health. Presentation at workshop entitled "Health Impact Assessment: a tool to support healthier decision-making." EUPHA 5th European Conference on Migrant and Ethnic Minority Health, April 2014
[36] Sainsbury, D. (2012) Welfare States and Immigrant Rights: The Politics of Inclusion and Exclusion. Oxford: *Oxford University Press.*
[37] Gushulak B, Pace P, Weekers J (2010). Migration and health of migrants. *In: Poverty and social exclusion in the WHO European Region: health systems respond.* Copenhagen, WHO Regional Office for Europe

on poverty and social exclusion lists a number of health risks correlated with migrant' and ethnic minorities' social conditions:

- poverty related to social exclusion;
- lack of appropriate housing/accommodation;
- poor diet;
- low level of income associated to low education level or to employments not commensurate with their education.

Some of these factors are shared with other groups affected by poverty and some are specifically associated with the migratory process[38].

In addition, there may be a *direct* relationship between discrimination and poor health.[39] In any case, measures to reduce health inequalities may need to be specially adapted in order to reach migrant and ethnic minority groups effectively.

Slide 14 Needs and frequent types of health problems of migrants and ethnic minorities.

In this area few straightforward generalizations can be made. It depends on the health problems studied, the origin and host countries involved, the sex and age of the migrants in question, as well as their reason for migration, legal status and socioeconomic position (SES). Moreover, the health problems of first-generation migrants may differ from those of their descendants. Where differences are found they are not always in the direction of worse health for migrants[40].

The "healthy migrant effect" as a phenomenon[41] is subject to many factors increasing the risk of ill-health before or during migration, and thus work in the opposite direction. Therefore, migrant status may (statistically speaking) have a positive association with health, but the influence of migration on an individual's health is nevertheless usually negative. Recent literature review[42] gives some examples of the differences found in health outcomes between migrants and host country populations.

General measures of health

Clinical data may suffer from biases because of variations in care utilization and the difficulty of estimating denominators like the proportion of migrants in the underlying population[43]. For these reasons, data relies on variables collected for the population as a whole, such as self-

[38] Gushulak B, Pace P, Weekers J (2010). Migration and health of migrants. *In: Poverty and social exclusion in the WHO European Region: health systems respond.* Copenhagen, WHO Regional Office for Europe

[39] Pascoe EA, Smart Richman L (2009). Perceived discrimination and health: a meta-analytic review. *Psychological Bulletin,* 135:4:531–554.

[40] Bhopal R (2009). Chronic diseases in Europe's migrant and ethnic minorities: challenges, solutions and a vision. *European Journal of Public Health*, 19:2:140–143.

[41] See e.g. Fennelly K (2005). The healthy migrant effect. *University of Minnesota, Healthy Generations Newsletter,* 5:3. Available at: http://www.epi.umn.edu/mch/resources/hg/hg_immi.pdf (retrieved: July 11, 2014). Kennedy S, McDonald JT, Biddle N (2006). The healthy immigrant effect and immigrant selection: evidence from four countries. Hamilton, McMaster University (Social and Economic Dimensions of an Aging Population Research Papers 164; Availablea at: http://ideas.repec.org/p/mcm/sedapp/164.html (retrieved: July 11, 2014).

[42] European overview: ECDC (2014) Assessing the burden of key infectious diseases affecting migrant populations in the EU/EEA. European Centre for Disease Prevention and Control; Rechel, B. et al (eds.) 2011. Migration and health in the European Union. European observatory on health systems and policies. Open University Press.

[43] Ingleby, D. (2009) *European Research on Migration and Health.* Brussels: International Organisation for Migration. http://www.migrant-health-europe.org/background-papers/research-on-migration-health.html (temporarily unavailable)

reported health status, life expectancy or mortality. However, mortality rates may be underestimated because of the tendency of some migrants to return to their country of origin as they become older and less healthy.[44] And self-reported health status is rather an imprecise measure for the cross-cultural differences in the interpretation of wellbeing.[45]

- Mortality and life expectancy

Death certificates are not a reliable indicator of the prevalence of specific illnesses, because the causes of death are often oversimplified.[46] A Dutch study[47] found that life expectancy was longer than for native Dutch in seven out of ten non-Western migrant groups. The authors concluded that *"migrant health could be benefiting from the favourable socioeconomic, public health and health-care conditions in The Netherlands, but not yet be affected by the higher risks of cancer and cardiovascular disease associated with prosperity."* However, there are many studies showing higher mortality rates for migrants and it is clear that no overall generalisations can be made. For example, postpartum maternal mortality rates amongst foreign (sub-Sahara, Asia, North and South America) women in France were twice as high compared to non-foreigners.[48] This study suggests that inferior medical attention may have been a factor in these elevated mortality rates.

These findings were echoed in the UK, where two major triannual studies into maternal mortality showed that women in minority ethnic groups were at significantly greater risk than the majority population[49, 50] . In particular Black African and, to a lesser extent, Black Caribbean women had significantly higher mortality rates than White women. Potential causes for these elevated rates included the later engagement with maternity services, and migration trajectories and circumstances of some Black African women who may have been newly arrived refugees or asylum seekers. Furthermore, many migrant groups experience higher diabetes mortality. The research on migrant mortality from diabetes mellitus in several European countries, conducted by the University of Amsterdam as part of the MEHO project[51], found that rates were particularly high in migrants from North Africa, the Caribbean, the Indian subcontinent and countries with a low gross domestic product (GDP).[52]

- Self-perceived health

This variable is included in the standard data-set for the European Union Statistics on Income and Living Conditions (SILC).[53] Most studies have found that migrants' judgements of their own health tend to be less favourable than those of the host population. A large part of this

[44] Bhopal, R. (2014). *Op. cit*.
[45] Ramírez, M., Ford, M.E., Stewart, A.L. and Teresi, J.A. (2005). Measurement Issues in Health Disparities Research. *Health Services Research*, 40(5), 1640-1657.
[46] Bhopal, R. (2014). *Op. cit*.
[47] Mackenbach, J. P., Bos, V., Garssen, M. J., Kunst, A. E. (2005). Mortality among non-western migrants in The Netherlands. *Nederlands Tijdschrift Geneeskunde*, 149(17):917-23.
[48] Philibert, M., Deneux-Tharaux, C., Bouvier-Colle, M. (2008). Can excess maternal mortality among women of foreign nationality be explained by suboptimal obstetric care? *BJOG* 115:1411–1418.
[49] Ge, L. (2007). Saving mothers' lives: reviewing maternal deaths to make childbirth safer - 2003–2005. London: CEMACH.
[50] Centre for Maternal and Child Enquiries (2011). Saving Mothers' Lives: Reviewing deaths to make motherhood safer: 2006–2008. BJOG, 118(s1):1–203.
[51] Migrant and Ethnic Health Observatory (MEHO). Website: http://www.meho.eu.com/ (temporarily unavailable)
[52] Vandenheede, H. *et al*. (2012). Migrant mortality from diabetes mellitus across Europe: the importance of socio-economic change. *European Journal of Epidemiology* 27, 109–117.
[53] Website: http://ec.europa.eu/eurostat/c/portal/layout?p_l_id=203680&p_v_l_s_g_id=0 (retrieved: July 24, 2015)

difference disappears when socioeconomic differences are controlled for, but in many studies the effect is not entirely removed.[54]

Slide 15 Non-communicable diseases

Several overviews on non-communicable diseases among migrants in Europe are available.[55] The incidence of many of these diseases increases with age, and the growing volume of research on this topic is connected to the increasing numbers of older migrants in Europe.

- Cardiovascular diseases

Cardiovascular diseases (CVD) are one of the major health threats which have been found to be elevated in many (but not all) migrant and ethnic minority groups. The risk of CVD mortality among migrants varies across Europe and according to the migrants' country of origin. Thus, Surinamese and Antilleans have a higher risk of CVD mortality compared to the native population in the host country, while Moroccans have a lower risk[56]. However, differences found depend not only on the country of birth, but also on the destination country; similar findings were reported both in the original MEHO study on CVD[57], and in a later extension of the study[58]. Much research currently focuses on the complex interaction of factors which may underlie the higher risks of CVD among certain migrant and ethnic minority groups[59]

- Diabetes

Age-standardised diabetes prevalence is higher in migrant populations in all the studied reviews, regardless of the country of origin of migrants[60,61]. The European Union is supporting research in this field (Project RODAM and GIFTS) to identify the determinants of such differences.

[54] See e.g. Devillé W et al. (2006). Perceived health and consultation of GPs among ethnic minorities compared to the general population in the Netherlands. In: Westert GP, Jabaaij L, François G, eds. *Morbidity, performance and quality in primary care.* Oxford, Radcliffe Publishing Ltd:85–96.

[55] See e.g. Kunst, A., Stronks, K. and Agyemang, C. (2011) Non-communicable diseases. In: Rechel et al. (2011), *op. cit*., 101-120; Carballo. M. (2009a). Non-communicable diseases. In: Fernandes, A., Pereira Miguel, J., eds. (2009). Health and migration in the European Union: better health for all in an inclusive society. Lisbon, Instituto Nacional de Saúde Doutor Ricardo Jorge:71–81

[56] Ujcic-Voortman, J.K., Baan, C.A., Seidell, J.C., Verhoeff, A.P. (2012). Obesity and cardiovascular disease risk among Turkish and Moroccan migrant groups in Europe: a systematic review. *Obesity Reviews* 13, 2–16.

[57] Bhopal RS, Rafnsson SB, Agyemang C, *et al* . (2011). Mortality from circulatory diseases by specific country of birth across six European countries: test of concept. *Eur J Public Health* 22:353-9.

[58] Rafnsson, S.B., Bhopal, R.S., Agyemang, C., Fagot-Campagna, A., Harding, S., Hammar, N., Kunst, A.E. *et al*. (2013). Sizable variations in circulatory disease mortality by region and country of birth in six European countries. *Eur J Public Health* , 23 (4) 594 - 605.

[59] Bhopal, R. (2014). *Op. Cit.*

[60] Vandenheede, H. et al. (2012). Migrant mortality from diabetes mellitus across Europe: the importance of socio-economic change. *European Journal of Epidemiology* 27, 109–117.

[61] Rechel et al (2011) *Op. cit.*

- Cancer

Cancer risk is often found to be lower in migrant populations[62], reflecting the fact that most types of cancer tend to be less common in many of the developing countries from which many migrants originate. For many types of cancer, incidence rates differ between non-industrialised and industrialised countries: incidence rates among migrants tend to change in the direction of the rate in the country to which they migrate. For example, rates of breast cancer even increase among women migrating from the low-risk south of Italy to the higher-risk north.[63]

Screening programs can play an important role in the detection and early treatment of many types of cancer and it is often reported that migrants' participation in these programs is lower than that of the majority population.[64]

As with all health problems, cancer rates for migrants or ethnic minorities vary by destination country as well as by country of origin, possibly reflecting differences in the accessibility and quality of health services (including screening programs) for such groups. Further research is needed to explore the connections between cancer incidence, migrant status, ethnicity, country of origin, socioeconomic position and the length of stay in the host country.

Slide 16 Communicable diseases

Communicable diseases among migrants have always been a politically sensitive issue. The earliest initiatives on migrant health, such as the screening of US immigrants at Ellis Island from 1891-1930, were motivated by fears that 'import diseases' could infect the host population, while chronically ill or disabled individuals could become a burden on the community. Later in the century, such practices were frequently criticised because of their inaccuracy, lack of respect for human rights and their often dubious scientific basis[65]. At the same time, the success of campaigns to eradicate infectious diseases in the developing world further reduced concern about "import diseases". However, the resurgence of global epidemics (for example of TB, HIV/Aids or hepatitis) toward the end of the 20th century showed this relaxed attitude to be premature.

There is thus a renewed interest in the prevalence of infectious disease among migrants and the potential of screening, early detection and prevention. The European Centre for Disease Prevention and Control (ECDC) recently undertook an extensive overview of this area[66]. Serious and widespread data limitations were noted. Often it was possible to calculate the relative proportions of carriers of a disease who were migrants or non-migrants, but uncertainty about the denominators made it impossible to covert these figures into prevalence rates. Moreover, there is limited information on screening programmes targeted for newly arrived migrants in the EU. At EU level the implementation of screening programmes for communicable diseases varies and the practices are different among countries[67].

[62] *ibid*

[63] Kolonel, L.N. and Wilkens, L.R. (2006), Migrant studies. In: Schottenfeld D, Fraumeni JF Jr (eds) *Cancer epidemiology and prevention,* 3rd edn. Oxford University Press, Inc., New York, pp 189--201

[64] Nørredam, M., Nielsen, S. and Krasnik, A. (2010). Migrants' utilization of somatic healthcare services in Europe – a systematic review. *European Journal of Public Health*, 20(5): 555–63.

[65] Bateman-House, A., Fairchild, A. (2008). Medical Examination of Immigrants at Ellis Island. *Virtual Mentor 10(4), 235-241.*

[66] ECDC (2014). *Op.cit.*

[67] Kärki T, Napoli C, Riccardo F, Fabiani M, Dente MG, Carballo M, Noori T, Declich S. Screening for Infectious Diseases among Newly Arrived Migrants in EU/EEA Countries-Varying Practices but Consensus on the Utility of Screening. Int J Environ Res Public Health. 2014 Oct 21;11(10):11004-14. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4211019/ (retrieved January 23, 2015)

- HIV

Despite the methodological problems just noted, many studies have found that certain groups of migrants have a higher risk of HIV infection. This is often connected with a raised prevalence of HIV in the countries from which migrants originate, but infections may also be contracted in the host country.[68] In fact, the main ways for transmission of HIV in Europe are unsafe sex among men who have sex with men and unsafe injecting drug use. Migrants tend to not be highly represented in either risk group.[69] However, migration remains an influential factor when considering heterosexual transmission: migrants from high HIV prevalence countries accounted for 40% of all cases of transmitted HIV in Western Europe between 2007 and 2011.[70] In those countries with the highest prevalence of migrants among the HIV statistics (Belgium, Cyprus, France, Ireland, Luxembourg, Malta, Sweden and the UK), migrants from Africa (sub-Saharan) seemed to be the group most at risk, and of having acquired the infection in their country of origin.[71] A large study in Spain, found that among migrants with HIV, female sex-workers originating from Latin America were most at risk.[72] In terms of the disease's progression to AIDS, and subsequently potential AIDS mortality, migrants are over-represented, with especially high rates of deaths from AIDS among sub-Saharan Africans. However these rates varied according to EU country: e.g. sub-Saharan Africans in the UK come primarily from Nigeria and Ghana (lower prevalence of HIV), whereas in Portugal they originate mostly from Cape Verde, Mozambique and Angola (higher prevalence of HIV).[73]

- Tuberculosis

Tuberculosis notifications rate are higher in foreign born population than in native born population in Europe. Infected patients are mainly from Asia, Africa and Europe (outside the EU)[74]. In the WHO European countries where TB surveillance data includes information on migrant status of persons with TB, the average percentage of all cases that were found in people of foreign origin in 2008 was over 20%.[75] In some countries this was much higher[76].

- Other infectious diseases

The ECDC report mentioned[77] also concluded that a higher risk of hepatitis B, malaria and Chagas disease may affect certain migrant groups. No increased risks of gonorrhoea and syphilis were found, however, and no reliable evidence was available on measles, rubella and hepatitis C.

The ECDC has looked extensively into the obstacles to MMR (measles, mumps, and rubella) vaccination coverage among hard to reach populations at the European level.[78] They

[68] ECDC (2014), *op.cit.*
[69] Wörmann, T., Krämer, A. (2011). Communicable diseases. In: Rechel, B. et al (eds.). Migration and health in the European Union. European observatory on health systems and policies. Open University Press.
[70] *ECDC (2014a), op cit*
[71] *ibid*
[72] *ibid*
[73] *ibid*
[74] *ibid.*
[75] *ibid*
[76] More information is available in Mock-Muñoz de Luna C, Ingleby D, Graval E, Krasnik A. (2015) Synthesis Report. MEM-TP, Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma. Granada, Copenhagen: Andalusian School of Public Health, University of Copenhagen. Available at: http://www.mem-tp.org/pluginfile.php/619/mod_resource/content/1/MEM-TP_Synthesis_Report.pdf (retrieved: July 24, 2015)
[77] *ibid.*
[78] European Centre for Disease Prevention and Control (2013a). Review of outbreaks and barriers to MMR vaccination coverage among hard-to-reach populations in Europe. Stockholm: ECDC. Available at:

identified the following main barriers: discrimination; administrative and financial problems; language or literacy difficulties; lack of cultural knowledge; lack of information on health and vaccination; religious beliefs; a fatalistic approach to life or a distorted risk perception in relation to vaccines and vaccine-preventable diseases among some individuals and groups.

The EC's **AURORA project**[79] promotes the use of evidence-based prevention for cervical cancer through the exchange of information and expertise at European level. The project evaluated HPV vaccination programmes in five of the participating countries (Italy, Greece, Slovenia, Latvia and Romania) and found that the implementation of a public health education campaign to prepare the population for the vaccination programmes was key to their success or failure.[80]

Other European level projects looking at the vaccination coverage and at the presence of specific programmes or regulations supporting the vaccination coverage of migrants and nomadic groups, include the **EpiSouth Project** and the **Promovax** project:

- **Episouth**[81] found that, of the 26 participating countries in the area of the Mediterranean and the Balkans, 20 had no specific regulations supporting vaccination programmes for migrant and nomadic groups, while 12 countries reported the presence of special programmes promoting vaccination coverage among those groups. Furthermore, findings indicated that even if regular migrants had equal entitlements to vaccines as the general population in 18 of 22 countries that responded, access to vaccines and vaccine uptake was still patchy, especially among some groups, e.g. Roma, irregular migrants. The study's findings include the identification of a number of barriers to vaccination.

- **Promovax's** aims include the improvement of the knowledge base regarding barriers to vaccination coverage, and the development of recommendations for policy makers regarding the vaccination of hard to reach groups, including migrants.[82] A toolkit for health professionals developed as part of the project aims contribute to the wide dissemination of information regarding vaccinations to hard to reach groups, by assisting health professionals to assess the immunisation needs of these groups and thus increase vaccination rates.[83]

According to WHO Europe, *"poverty and socioeconomic exclusion play a great role in the natural history of these infections. Exposure and transmission is accentuated in the poor, those who live in crowded and substandard housing, those with nutritional imbalances and those with limited education or access to preventive measures."*[84]

Slide 17 Mental health

A fundamental issue affecting research on the mental health problems of migrants and ethnic minorities is that cultures vary in the way they conceptualise such problems, the types that

http://ecdc.europa.eu/en/publications/Publications/MMR-vaccination-hard-to-reach-population-review-2013.pdf (retrieved: February 18, 2015).

[79] Website: www.aurora-project.eu (retrieved: January 15, 2015)

[80] *ibid*

[81] EpiSouth Network (2009). EpiSouth Project: Assessment of Countries Migration Status Profile and Vaccination Access of Mobile Population. Available at: http://www.episouth.org/outputs/wp7/WP7_9_Report_Assessment_Countries_Migration.pdf (retrieved: February 18, 2015).

[82] Website: http://www.promovax.eu/index.php/promovax/main (retrieved: February 18, 2015).

[83] Website: http://www.promovax.eu/toolkits/HCW_english_web.pdf (retrieved: February 18, 2015).

[84] Gushulak B, Pace P, Weekers J (2010). Migration and health of migrants. *In: Poverty and social exclusion in the WHO European Region: health systems respond.* Copenhagen, WHO Regional Office for Europe

they recognise and the way distress and disability is expressed[85]. Whereas the presence or absence of physical diseases can be decided on the basis of objective biological indicators, psychiatric diagnosis has to rely on interpretation and judgement[86]. This involves taking into account relevant cross-cultural variations and the evidence base in this area is not well developed.

1. Depression and anxiety disorders

These so-called 'common mental illnesses' are often hard to distinguish from "normal reactions to abnormal situations". It is known that social disadvantage and lower SES are associated with depression, but it is not clear how many of the problems among migrants can be accounted for in such terms. Some studies[87] have shown that perceived discrimination or racism can increase rates of common mental disorders.

2. Schizophrenia and related psychotic disorders

Although the overall prevalence of these disorders is low (around 1%), raised levels are found in some migrant groups. Many studies in the UK, the Netherlands, Sweden and Denmark have shown that young males from non-Western countries are particularly at risk[88].

3. Post-traumatic stress disorder (PTSD) and refugee mental health problems

It is often assumed that the main mental health problems of refugees and asylum seekers are post-traumatic disorders resulting from harrowing experiences in their country of origin. Although a meta-analysis[89] showed a prevalence of 9% among refugees, which is around ten times higher than in the general population, another meta-analysis[90] concluded that rates of depression were twice as high among refugees as among labour migrants (44% versus 20%). The same was true for anxiety disorders (40% versus 21%). Mental health problems among refugees are thus not simply a matter of post-traumatic stress reactions. Moreover, the origin of these problems may lie not in the country of origin, but in experiences endured during the flight and the asylum application procedure[91].

Slide 18 Maternal and child health

Migrant women are exposed to a higher risk of maternal mortality[92], while in many migrant groups worse outcomes are also found in relation to low birth weight, premature birth, perinatal mortality and morbidity and congenital malformations[93,94]. However, rates of stillbirth and neonatal mortality among groups of migrant origin also vary between different

[85] Bhugra, D., Gupta, S. (eds.) (2006). Migration and Mental Health. London and New York: Cambridge University Press

[86] Horwitz, A.V., Wakefield, J.C. (2006). The epidemic in mental illness: clinical fact or survey artifact? *Contexts*, 5(1): 19-23.

[87] *E.g*. Karlsen, S. et al. (2005). Racism, psychosis and common mental disorder among ethnic minority groups in England. *Psychological Medicine,* 35:12:1795–1803

[88] Ingleby, D. (2008). *New perspectives on migration, ethnicity and schizophrenia.* Willy Brandt Series of Working Papers in International Migration and Ethnic Relations 1/08, IMER/MIM, Malmö University, Sweden.

[89] Fazel, M., Wheeler, J., Danesh, J. (2005). Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. *The Lancet,* 365:9467:1309–1314.

[90] Lindert, J. et al. (2009). Depression and anxiety in labor migrants and refugees – a systematic review and meta-analysis. *Social Science & Medicine,* 69:2:246–257.

[91] Ingleby, D. (ed.) (2005) Forced migration and mental health: rethinking the care of refugees and displaced persons. New York: Springer.

[92] Pedersen, G.S., Grøntved, A., Mortensen, L.H., Andersen, A.-M.N., Rich-Edwards, J, (2013). Maternal Mortality among Migrants in Western Europe: A Meta-Analysis*. Matern Child Health* J 1–11.

[93] Bollini, P., Pampallona, S., Wanner, P., Kupelnick, B., (2009). Pregnancy outcome of migrant women and integration policy: A systematic review of the international literature. *Social Science & Medicine* 68, 452–4

[94] Reeske, A., Razum, O. (2011). Maternal and child health – from conception to first birthday. In Rechel et al. (2011), op. cit. , 139-144

countries of destination, which may reflect differences between European countries in the accessibility and quality of health care for pregnant women in those groups.[95] With regard to screening for different types of cancer such as cervical and breast cancer, screening rates among different ethnic minority groups vary significantly.

Poverty often limits access to reproductive health services and health prevention and promotion programs (screening, diagnosis care, prenatal and obstetrical services), and thus increase the risk of adverse outcomes[96].

The obstetric complications associated with female genital mutilation or cutting (FGM) also present challenges to health service providers. They require specialist knowledge about the potential health risks to mother and child, the legal and ethical frameworks surrounding this issue, and the most effective ways of meeting the health needs of the women subjected to or at risk of this procedure. This is in order to ensure qualified and effective preventive measures against FGM, and coping with the effects of the mutilation.

Due to under-reporting and the lack of reliable comparable data, no exact figures exist on the prevalence of FGM in Europe. However, thousands of women and girls in Europe live with the effects of FGM or face the risk of undergoing the procedure in a European country or in Africa or the Middle East.[97] The largest groups of women and girls originating from countries in which the practice of FGM is widespread live in the following EU countries: Austria, Belgium, Denmark, Germany, Spain, Finland, France, Ireland, Italy, the Netherlands, Portugal, Sweden and the United Kingdom.[98] The health impacts of FGM are well documented. Research has linked FGM with an increased risk in complications during childbirth, e.g. prolonged labour, obstetric lacerations, obstetric haemorrhage, and difficult delivery.[99] Midwives especially should be trained in how to prepare for potential delivery complications associated with FGM.

According to WHO Europe: *"Migrant women and girls, particularly those trafficked, forced to flee from conflicts or displaced, are often subject to gender-based violence"*[100]

Occupational health and safety

This is another area in which migrants are exposed to increased health risks. Many migrants work in so-called "3D jobs" – "dirty, demanding and dangerous"[101]. According to a recent overview of the topic[102], migrant workers experience higher rates of industrial accidents, injuries and work-related diseases. Because of their precarious employment conditions and poorer access to health services, many work-related illnesses may go unreported and treated.

[95] Villadsen, S.F., et al (2010). Cross-country variation in stillbirth and neonatal mortality in offspring of Turkish migrants in northern Europe. European Journal of Public Health, 20(5):530–535.

[96] Gushulak B, Pace P, Weekers J (2010). *Migration and health of migrants. In: Poverty and social exclusion in the WHO European Region: health systems respond.* Copenhagen, WHO Regional Office for Europe

[97] Leye, E. (2006). Health care in Europe for women with genital mutilation. *Health Care for Women International*, 27:4. Pg. 362-378.

[98] European Comission. Website: http://ec.europa.eu/justice/gender-equality/gender-violence/eliminating-female-genital-mutilation/index_en.htm (retrieved: February 18, 2015).

[99] Berg, R.C. *et al* (2014). An Updated Systematic Review and Meta-Analysis of the Obstetric Consequences of Female Genital Mutilation/Cutting. *Obstetrics and Gynecology International*, Volume 2014

[100] WHO Regional Office for Europe. *Op. cit.*

[101] McCauley, L.A. (2005) Immigrant workers in the United States: recent trends, vulnerable populations, and challenges for occupational health. *Journal of the American Association of Occupational Health Nurses,* 53(7), 313–19.

[102] Agudelo-Suárez, A.A., Ronda-Pérez, E. & Benavides, F.G. (2011). Occupational health. In: Rechel et al., *op cit.*, 155-168.

The European Agency for Safety and Health at Work (OSHA) explores the challenges faced by migrants, regular and irregular, their employers and co-workers, in the health care sector, and lists the following areas as requiring special health and safety attention: cultural (e.g. language-related) barriers to communication and training in OSH; the high prevalence of overtime work and related risks for accidents and ill health among migrant workers; and cooperation and leadership in multicultural teams and guidance on cultural diversity issues at work.[103]

Slide 19 Needs and frequent types of health problems of ethnic minorities.

Roma have a significantly worse health profile when compared to non-Roma. On average, Roma are estimated to live approximately 10 years less than non-Roma. [104] However, mortality rates and life expectancy estimates vary across and within countries, as well as in different groups within the Roma populations. For example, estimates in Austria suggested mortality rates 14% higher for Roma at the regional level than for the rest of the country. Poorly integrated Roma living in settlements with poor living conditions in Slovakia were found to have a mortality rate twice to three times as high as that of well-integrated Roma, and higher infant mortality rates were found in Bulgaria, Slovakia, Hungary and the Czech Republic.[105]

While genetic or cultural determinants of health and ethnicity may explain some of the inequalities in health compared to non-Roma populations, social and environmental determinants also play a significant role, such as lower income, poor living conditions, discrimination and racism, and barriers to accessing health services.[106,107] On average, Roma are estimated to live approximately 10 years less than non-Roma. [108]

Research on other national ethnic minorities is quite limited, in part due to the fact that many of these minority groups are not recognised and not all groups experience inequalities. The Sami, an indigenous minority group in the north of Norway, Finland and Sweden however, has been the subject of numerous studies. Findings on self-reported health from the **project SAMINOR** (a population-based study of health and living conditions in areas with both Sami and Norwegian inhabitants in Norway) indicated that Sami respondents reported to be in worse health than Norwegian respondents, and Sami women more so than men. Additional findings included experiences of discrimination in encounters with health services (especially reported by Sami women), and language barriers.[109]

Slide 20 Non-communicable diseases

[103] De Jong, *et al* (2014). Current and emerging issues in the healthcare sector, including home and community care. European Agency for Safety and Health at Work. Available at: https://osha.europa.eu/en/publications/reports/current-and-emerging-occupational-safety-and-health-osh-issues-in-the-healthcare-sector-including-home-and-community-care (retrieved: February 18, 2015).

[104] Masseria *et al* (2010). *Op. cit.*

[105] Matrix Consulting (2014). Roma Health Report. European Commission: Consumer, Health and Food Executive Agency. Available at: http://ec.europa.eu/chafea/documents/health/roma-health-report-2014_en.pdf (retrieved: November 25, 2014)

[106] Voko, Z. et al. (2009). Does socioeconomic status fully mediate the effect of ethnicity on the health of Roma people in Hungary*? J Epidemiol Community Health*; 63: 455-460.

[107] Masseria, C., Mladovsky, P., Hernández-Quevedo, C. (2009). The socio-economic determinants of the health status of Roma in comparison with non-Roma in Bulgaria, Hungary and Romania. *European Journal of Public Health,* Vol. 20, No. 5: 549-554.

[108] Masseria et al (2010). *Op. cit.*

[109] Hansen, K., Melhus, M., Lund, E. (2010). Ethnicity, self-reported health, discrimination and socioeconomic status: a study of Sami and non-Sami Norwegian populations. International Journal of Circumpolar Health, North America, 69.

Studies suggest that the prevalence of chronic diseases such as cardiovascular disease, diabetes, obesity, hypertension and asthma is higher in the Roma populations that in the non-Roma.[110,111] Gender and age play an important part, with Roma women experiencing a higher prevalence of some of these health problems than Roma men. UNDP findings reported Roma over the age of 65 suffered a steeper increase in chronic diseases and related problems than non-Roma (70% vs. 56% respectively).[112] In terms of social determinants of health, factors associated with poverty such as poor living conditions, poor diet and malnutrition are listed by the Roma Health Report as potentially leading to chronic conditions such as obesity, hypertension, diabetes and CVD. Factors associated with poor living conditions, such as damp, cold and poor quality housing may contribute to respiratory disease or musculoskeletal diseases, according to the same report. In addition the above listed effects of poverty and poor living conditions, lifestyle related factors such as smoking, drug and alcohol use, and limited physical activity were found to be influential in the development of the health conditions listed above.

Mental illnesses

Links have been suggested between low Socioeconomic Status (SES) of Roma and its negative impact on mental health, as well as the impact of discrimination and racism on mental health.[113] Furthermore, in terms of prevention and care, Roma populations' social representation of mental health and well-being, e.g. the importance of family and social network, are found to be of significance in the development and implementation of interventions.[114,115]

Communicable diseases

Research reports higher rates of infectious diseases such as measles and hepatitis A, as well as a higher risk of outbreaks of infectious diseases, especially amongst Roma living in segregated conditions. Available evidence on vaccination shows that, with the exception of Croatia, Hungary and the Czech Republic, overall rates of childhood vaccination uptake in Europe is lower or much lower in the Roma populations. The limited evidence existing related to rates of HIV/AIDS points to faster disease progression.[116]

More recent research in the area of communicable diseases has explored the health determinants that lead to higher rates of certain communicable diseases in Roma populations. These studies point to factors related to low SES and the living conditions associated with poverty, and other socioeconomic determinants such as access to health services, as possible explanations. [117] Research results strongly recommend the need for targeted preventive and care interventions to decrease the marginalisation that is found to lead to drug use and crime, and to improve the lives and survival rates of those living with infectious diseases.[118],[119]

[110] Zeljko, H.M. *et al* (2013) Age trends in prevalence of cardiovascular risk factors in Roma minority population of Croatia. *Economics and Human Biology* 11: 326-336.
[111] Dobranici *et al* (2012). *Op. cit.*
[112] Matrix Consulting (2014). *Op. cit.*
[113] Skodova, Z. et al (2010) Psychosocial factors of coronary heart disease and quality of life among Roma coronary patients: a study matched by socioeconomic position. *International Journal of Public Health*; 55(5): 373-80
[114] Monteiro, A.P. et al (2013) Promotion of mental health in Roma people: social representations of mental health and wellbeing in a Roma community. *European Psychiatry: Abstracts of the 21th European Congress of Psychiatry.*
[115] Smith, D., Ruston, A. (2013) 'If you feel that nobody wants you you'll withdraw into your own': Gypsies/Travellers, networks and healthcare utilisation. *Sociology of Health and Illness*, Vol. 35; 8:1196-1210.
[116] Matrix Consulting (2014). The Roma Health Report. Consumers, health and food executive agency.
[117] Casals, M. *et al* (2011). Incidence of infectious diseases and survival among Roma population: a longitudinal cohort study. *The European Journal of Public Health*, 1-6.
[118] *Ibid*.
[119] *Ibid*.

According to HCDCP[120] an increased number of hepatitis A cases have been reported among Roma since the beginning of 2013 in Greece. Reported outbreaks and clusters of cases mainly affect camps. The occurrence of new cases among Roma has continued in 2014. Another survey[121] suggests universal vaccination of Roma children and improving conditions at Roma camps as a cost-effective approach to address this issue.

An overview of affected groups by measles transmission in Europe in 2005–2009[122] identifies individuals susceptible to measles as previously uninfected and unvaccinated. The reasons for nonvaccination ranged from lack of information to poor access to health care. Roma and Sinti, Traveller and migrants among other groups have been identified as being particularly at risk. Public settings for transmission included mostly educational and health care facilities. Other research[123] documents the impact of mass immunisation in preventing further measles spread in the Roma community, and the surrounding population.

Figure 8: Recent measles outbreaks among the Roma[124]

Health determinants

According to research, Roma have low levels of education and skills, often leading to long-term unemployment and increasing levels of poverty.[125] Roma generally lack adequate living conditions, with the most severely overcrowded accommodation reported in Slovakia and Hungary.[126] Many Roma are found to live in marginalised communities with limited access to basic services.[127] Roma children especially, face many barriers when trying to access health care.[128] The discrimination, racism and exclusion faced by this community is also a strong determinant of health. Based on these known factors, recommendations have been made for more integrated, multi-sectoral solutions[129],[130].

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For the **Sami**, research has shown, that while their health differs little from that of the majority population, one significant risk factor is their livelihood, namely reindeer herding. This activity can be hazardous and leads to the observed higher rates of injuries from herding accidents.[131] Work towards addressing the social and economic exclusion lived by many ethnic minorities and especially the Roma, has focused on combating discrimination based on gender, racial or ethnic origin, religion or belief, disability, age or sexual orientation (e.g. the **Decade of Roma Inclusion**). Strategies to increase labour market participation and participation in social, cultural and political life are at the centre of European initiatives for social protection and social inclusion (e.g. the Treaty of Lisbon, from 2009, reaffirmed the importance of combating social exclusion and discrimination).

Slide 21: Thank you and questions

Slide 22-26: References.

Reading

Recommended reading:

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