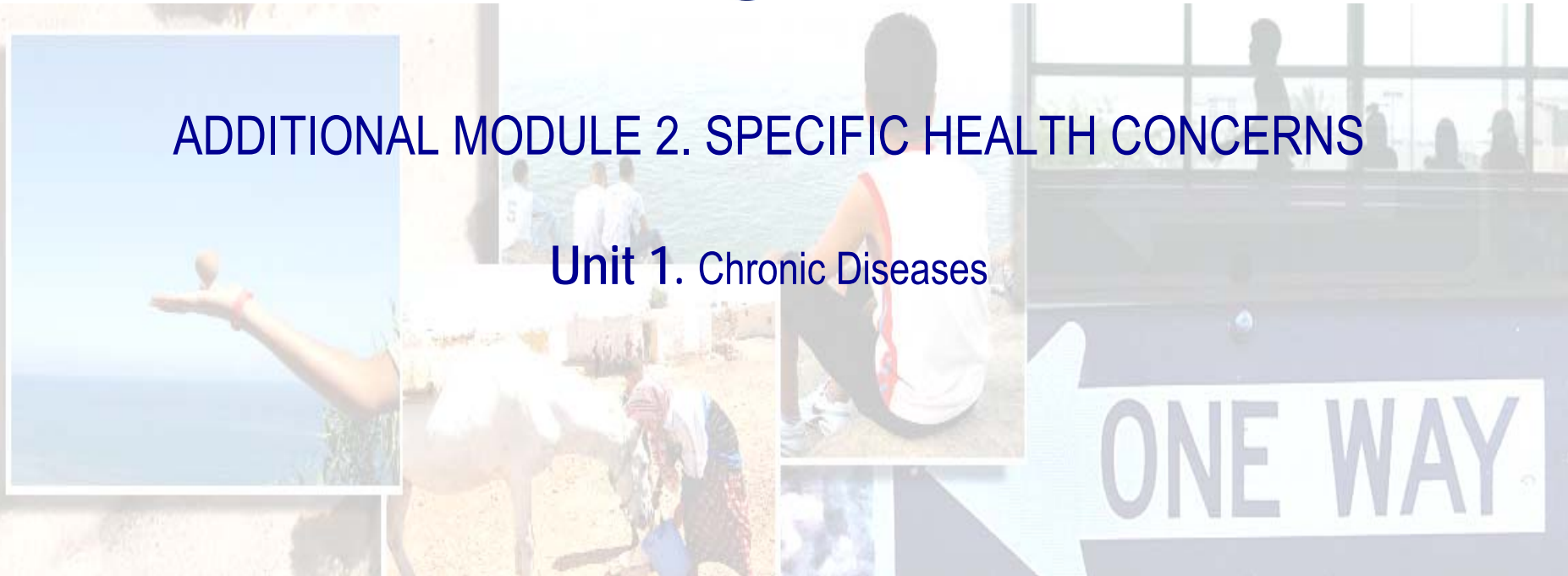




Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma

## ADDITIONAL MODULE 2. SPECIFIC HEALTH CONCERNS

### Unit 1. Chronic Diseases



Elaborated by:  
M<sup>a</sup> Victoria López Ruiz, Andalusian School of Public Health 2015

Mortality issues in migrant

Cardiovascular diseases

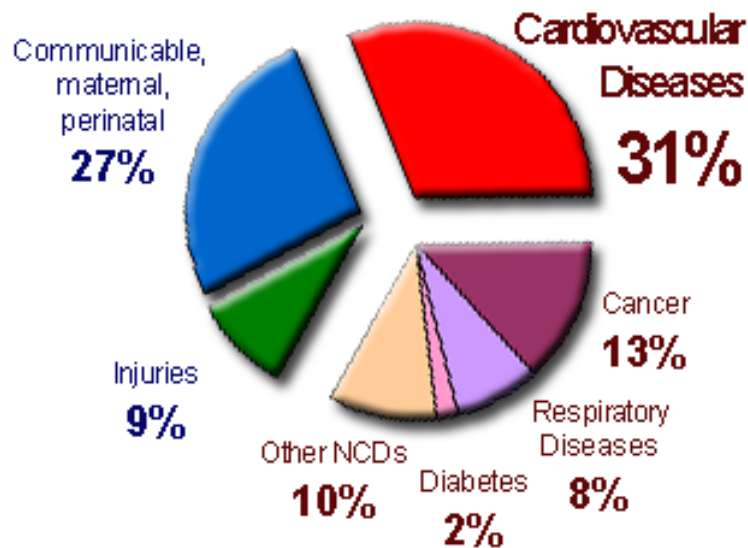
Diabetes

Cancer

Inherited diseases

Transcultural care

## Mortality issues in migrants



Source: World Health Statistics 2014

The health disadvantage appears to be more linked to specific diseases, and life expectancy is not consistently lower than among locally born residents

	<b>Total population</b>			
	Crude		Adjusted	
	RR	95% CI	OR	95% CI
Smoking prevalence	0.62	0.56–0.67	0.50	0.45–0.56
Overweight (BMI $\geq$ 25)	0.91	0.88–0.94	0.77	0.70–0.84
Obesity (BMI $\geq$ 30)	0.68	0.63–0.74	0.58	0.52–0.65
Hypertension	0.67	0.62–0.72	0.71	0.64–0.79
High blood cholesterol	0.83	0.77–0.90	0.88	0.78–0.99
Fair or poor health	0.94	0.87–1.01	0.81	0.74–0.90
Activity imitation	0.51	0.46–0.55	0.41	0.37–0.46
Mean bed disability days	-1.6	-2.6 to -0.7	-1.4	-2.5 to -0.4
Asthma prevalence	0.50	0.44–0.58	0.43	0.37–0.51
Diabetes prevalence	0.78	0.69–0.89	0.94	0.81–1.09
Heart disease prevalence	0.50	0.43–0.57	0.54	0.46–0.63
Lack of health insurance	2.61	2.47–2.75	2.65	2.46–2.87
Pap test use	0.90	0.87–0.92	0.61	0.53–0.69
Mammography use	0.90	0.86–0.95	0.90	0.77–1.07
Prostate cancer screening	0.77	0.67–0.88	0.77	0.61–0.97
Colorectal cancer screening	0.80	0.72–0.89	0.84	0.72–0.99

## Cardiovascular diseases

### CORONARY DISEASE & STROKE

Higher prevalence of coronary disease have been reported for the South Asian and East African born populations

In the case of stroke, consistently higher mortality and incidence rates have been observed for migrants of west African origin

### HTA

There is consensus that among people of African origin, hypertension is three-fold to four-fold more prevalent than the native European population

Both country of origin and acculturation can have a positive or negative effect on CHD mortality.

E.g. migrants from countries with a high CHD mortality, such as Finland and Hungary, have a lower CHD risk in Sweden than in their country of birth. For low-risk countries of southern Europe, the risk was higher in migrants in Sweden than in southern Europe.

- ✓ A paucity of reliable data makes difficult a quantification of the cardiovascular risk factors and their implication in the shortening of life expectancy in **Roma population**.
- ✓ The **Roma population** has higher occurrence of obesity and hypertension, non-related to the region of country
- ✓ Compared with non-Roma, **Roma population** had a much higher prevalence cardiovascular disease, which may contribute to their higher mortality



[http://www.epi.bris.ac.uk/CVDethrisk/CHD\\_CVD\\_form.html](http://www.epi.bris.ac.uk/CVDethrisk/CHD_CVD_form.html)

A modified Framingham CHD and CVD risk calculator for British black and minority ethnic groups

## Possible factor affecting CVD in migrants

- ✓ Complex nature of migration and resettlement and the surrounding social and psychological conditions
  - Poor socioeconomic status
  - Challenging everyday living and working conditions
  - Alterations in family life and chronic stress related to insecurity and homesickness
- ✓ Poor dietary adaptation
- ✓ Poor access to healthcare services and their underutilisation
- ✓ Other diseases and health problems
- ✓ Socioeconomic background



# Diabetes

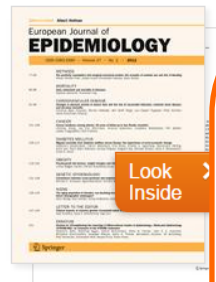
In many parts of the EU the available data suggest that migrants may be more at risk of developing type 2 diabetes than non- migrants and also at greater risk of serious outcomes if and when they do develop the disease.

European Journal of Epidemiology  
February 2012, Volume 27, Issue 2, pp 109-117

Date: 14 Dec 2011

## Migrant mortality from diabetes mellitus across Europe: the importance of socio-economic change

Hadewijch Vandenheede, Patrick Deboosere, Irina Stirbu, Charles O. Agyemang, Seeromanie Harding, Knud Juel, Snorri Björn Rafnsson, Enrique Regidor, Grégoire Rey, Michael Rosato, ...  
[show all 12](#)



Article Metrics

Age-sex standardized prevalence of type 2 DM was 30% in Roma and 10% in non-Roma.

- Mortality rate ratios were highest in migrants from the Caribbean or South Asia.
- MRRs for the migrant population as a whole were 1.9 (95% CI 1.8–2.0) and 2.2 (95% CI 2.1–2.3) for men and women respectively.
- Inverse association between GDP of COB and diabetes mortality

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## RESOURCE

<http://www.migrantclinician.org/issues/diabetes/online-toolkit.html>

Age-sex standardized  
DM was 30% in Gypsies and 10% in non-  
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ratios were highest in  
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migrant population as  
1.9 (95% CI 1.8–2.0)  
and 2.1–2.3) for men  
and women, respectively.

- Inverse association between GDP of COB and diabetes mortality

## Cancer

Migrants from non-western countries showed a more favourable all-cancer morbidity and mortality compared with native populations of European host countries.

Migrants have **20–50% lower incidence and mortality rates**

Migrants were more prone to cancers that are **related to infections** experienced in early life, such as liver, cervical and stomach cancer.

Almost all migrant groups, irrespective of sex, seem to be at **high risk of liver cancer mortality**, especially Bangladeshis and African-Caribbeans.

Roma experience a **greater prevalence** of cancer than non-Roma.

## Inherited diseases



Sickle-cell  
anaemia

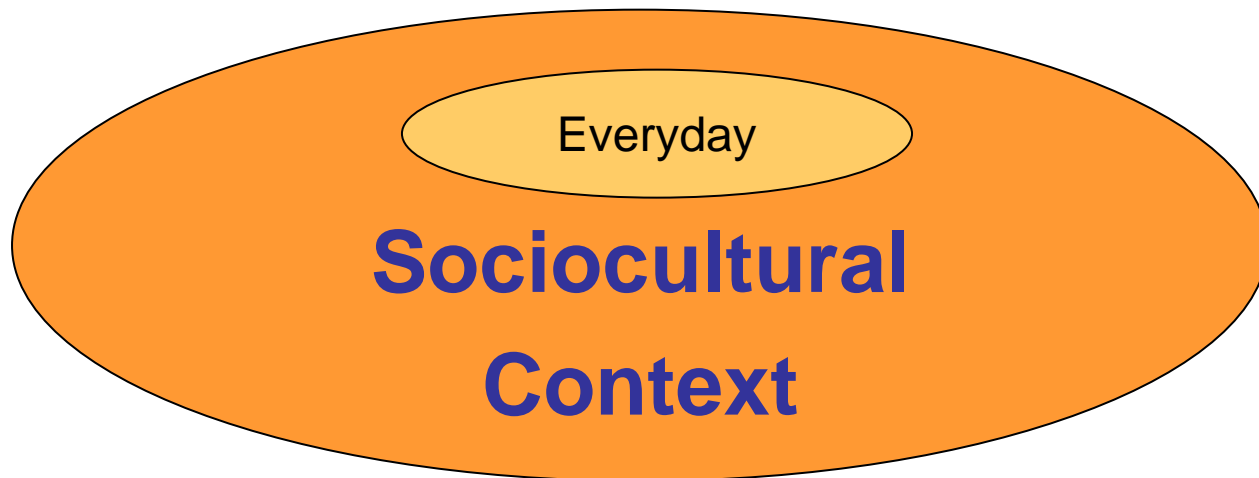
The geographical specificity and hereditary nature of these diseases suggests that both are likely to be present in communities with large numbers of migrants from **the Mediterranean Basin, the Caribbean and Africa**



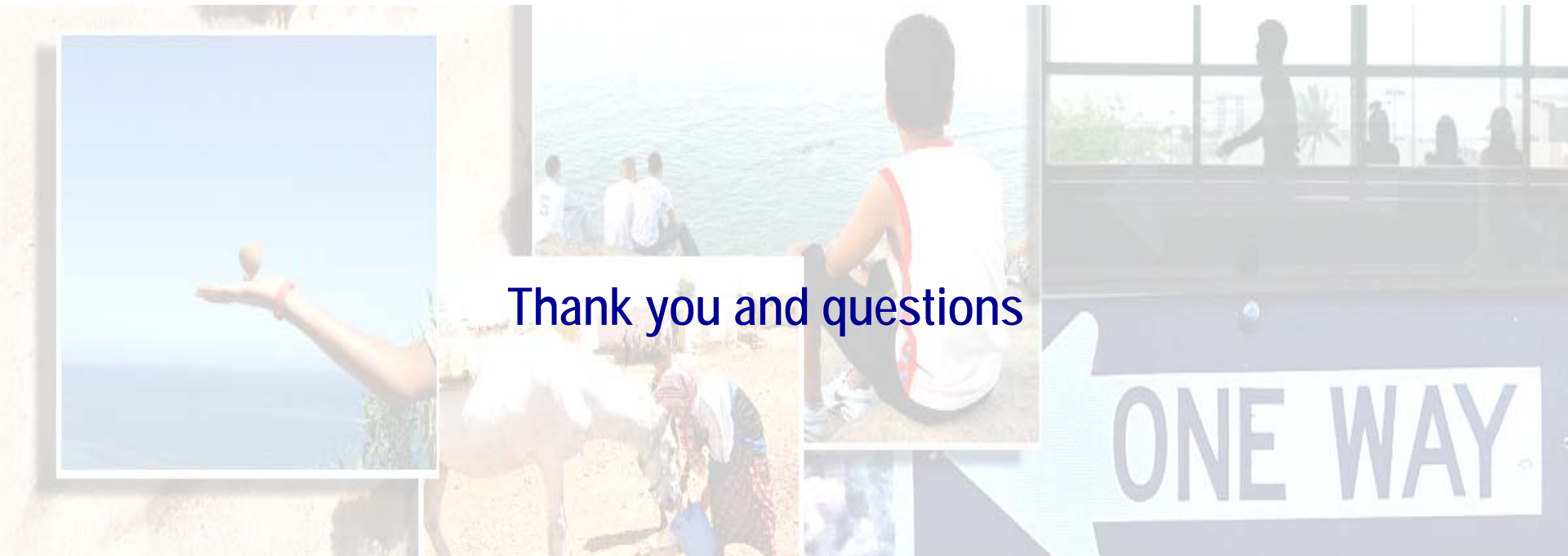
Thalassemia

**Thalassemia**, which is primarily a blood disease found in people in the Mediterranean region, is also being seen in the UK among migrants and ethnic minorities of Middle Eastern and Cypriot origin. There is increasing evidence that it is relatively common among **migrants of Pakistani, Chinese and Bangladeshi origin**

# IMPORTANCE OF TRANSCULTURAL CARES PRACTICES



The pattern of chronic disease varies hugely internationally, and this is now reflected in Europe's multiethnic populations. This is creating challenges for epidemiology, public health and clinical care



Thank you and questions

Pictures: Andalusian Childhood Observatory (OIA, Observatorio de la Infancia de Andalucía) 2014;  
Josefa Marín Vega 2014; Redlsir 2014; Morguefile 2014.

## References

- Modesti PA, Agostoni P, Agyemang C. & cols. Cardiovascular risk assessment in low-resource settings: a consensus document of the European Society of Hypertension Working Group on Hypertension and Cardiovascular Risk in Low Resource Settings. *J Hypertens*. 2014 May; 32(5): 951-60.
- Cappuccio FP, Oakeshott P, Strazzullo P, Kerry SM. Application of Framingham risk estimates to ethnic minorities in United Kingdom and implications for primary prevention of heart disease in general practice: cross sectional population based study. *BMJ*. 2002; 325:1271–1276.
- Mladovsky P. Research Note : Migration and health in the EU. The London School Of Economics And Political Science. European Commission; 2007
- Dobranici M, Buzea A, Popescu R. The cardiovascular risk factors of the Roma (Gypsies) people in Central- Eastern Europe: a review of the published literature. *J Med Life*. 2012; 5(4): 382–9.
- Fernandes A., Pereira J. Health and Migration in the EU: Better health for all in an inclusive society. Instituto Nacional de Saúde Doutor Ricardo Jorge; 2009.
- Vozarova de Courten B, de Courten M, Hanson RL, Zahorakova PH, Vozár J . Higher prevalence of type 2 diabetes, metabolic syndrome and cardiovascular diseases in gypsies than in non-gypsies in Slovakia. *Diabetes Research and Clinical Practice* 2003; 62(2): 95-103.
- Vandenhede H, Deboosere P , Stirbu I , Agyemang CO , S Harding , Juel K , Rafnsson SB , Regidor E , G Rey , Rosato M , Mackenbach JP , Kunst AE. Migrant mortality from diabetes mellitus across Europe: the importance of socio-economic change. *Eur J Epidemiol*. 2012 Feb; 27(2): 109-17.
- Arnold M, Razum O, Coebergh J-W. Cancer risk diversity in non-western migrants to Europe: An overview of the literature. *Eur J Cancer* [Internet]. Elsevier Ltd; 2010 Sep; 46(14): 2647–59.
- Rechel B, Mladovsky P, Devillé W, Rijks B, Petrova-Benedict R, McKee M. Migration and health in the European Union. European Observatory on Health Systems and Policies Series. 2011

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Migrants & Ethnic Minorities  
Training Packages



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