

EDITORIAL

Content

EDITORIAL p1

Written by Prof. Martin McKee

OVERVIEW p3

1) Intersectoral action for migrant health

2) Obstacles to access to care for migrants, children and pregnant women in Europe

NEWS p6

EVENTS p6

OPINION p7

Occupational health aspects of migration

RECOMMENDED READING p9

Prof. Martin McKee,
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The humanitarian crisis in the Mediterranean has provided examples of both the best and the worst in human nature. In April 2015, newspapers published a picture of an off-duty Greek soldier, Antonis Deligiorgis, pulling a young Eritrean woman from the sea (1). Antonis, stationed on the island of Rhodes with the Greek army, was with his wife, having just left their children at school. They stopped at a café but their peace was interrupted by a boat crashing into the rocks. Among its passengers was Wegasi Nebiat, whose family had paid \$10 000 to flee Eritrea. Within minutes the boat broke apart, flinging almost 100 migrants into the water. Antonis single-handedly rescued 20 of them, including Wegasi. Another Eritrean woman he had rescued would soon give birth in a local hospital. In tribute, she named her newborn child after him.

In stark contrast, politicians from several European countries have either done nothing or only the bare minimum to help those drowning in the Mediterranean. In the United Kingdom, the Home Secretary – responsible for immigration and border control – has said that nothing should be done to help migrants, as it “encourages more people to make these perilous journeys”. The United Kingdom, along with some other European governments, has refused to participate in a scheme that would resettle those migrants who have been rescued across Europe.

The EUPHA has called upon European governments to do much more in response to the unfolding humanitarian crisis in the Mediterranean. In April 2015 a statement was issued to this effect, noting that, while southern European countries had been struggling to cope with an influx of migrants for many years, the movement of vast numbers of people in this emerging crisis warrants special attention (2). In the previous month it had been estimated that at least 1700 migrants have drowned in the Mediterranean.

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The reason that so many people are now moving is clear. They are fleeing countries affected by conflict, such as the Syrian Arab Republic, Iraq, and Libya. European countries must accept some responsibility for those ongoing conflicts, having failed to plan for the aftermath of military actions in which they have engaged. Yet, the task of saving drowning migrants has fallen to a few individual countries: namely Italy, Malta and Greece.

For a year the Italian Government maintained a significant naval and air presence in what was termed Operation Mare Nostrum. The scale of the operation was beyond the resources of a single country and could only be temporary. It was replaced by the European Union (EU)'s Operation Triton, which operates with far fewer ships and aircraft. In the face of international criticism, European governments have agreed to increase the funding for Operation Triton, although – as Amnesty International noted – they have provided “a face-saving not a life-saving operation” (3).

The EUPHA is in no doubt that the need exists for a coordinated European response, and one that will treat migrants with dignity. Yet, for those who survived the journey to Europe, their problems are often only beginning. Several European countries – such as Spain and the United Kingdom – have made it increasingly difficult for undocumented migrants to have access to basic health care (4). Purely on the basis of self-interest, this policy is wrong as it risks the spread of infectious disease. However, many of the policy responses to undocumented migrants are wrong on many other levels, whether in international law or in simple humanitarian terms.

The real tragedy of Europe today is the lack of political leadership. Migrants have contributed an enormous amount to making Europe the success that it is, and they continue to do so. At a time of rapidly falling birth rates, they fill a growing shortage of people who will care for older people in years to come. Many of them fill the gaps that result from inadequate investment in training of the health workforce. Quite simply, Europe needs migrants. Yet it would be foolish to ignore just how toxic the issue of migration has become in some European countries, leading to the rise of extreme nationalist – and, in some cases, outright racist – parties.

There is no simple solution to the crisis in the Mediterranean. It requires a coordinated process across governments. This should address pull factors, for example by investing in training for those without skills in the existing European population, thereby reducing the need for migration, as well as implementation of living wages to prevent employers from engaging in a race to the bottom, creating jobs that only migrants will take. It should also address push factors, working with renewed vigour to achieve peace in those war-torn countries – the home from which so many migrants are fleeing – coupled with substantial investment by European development agencies to give people the prospect of a real future in their own countries. Of course, these measures will require money to be spent. Moreover, even if they did not lead to a life of a single migrant being saved, they would be worth doing in their own right. The fact that they offer a realistic prospect of reducing the scale of the carnage in the Mediterranean makes such measures even more important.

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OVERVIEW

Intersectoral action for migrant health

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Migrant child in a temporary camp for refugees in Preševo, Serbia ©WHO/Sara Barragán

There are approximately 215 million international migrants and 740 million internal migrants today worldwide (1). In the WHO European Region, 8% of the population is estimated to be composed of migrants, accounting for a total of 73 million people (2). Human mobility summons an increase in diversity across societies, which requires health systems to be flexible and to adapt to diverse health profiles and needs. The migration phenomenon poses short-, medium- and long-term public health implications, which are different but nonetheless impact all 53 countries of the WHO European Region. Despite the different subregional migration dynamics, there are common public health questions and challenges to be addressed, requiring a cross-regional dialogue in order to ensure coordinated and sustainable public health and health system interventions that improve the health of migrants and the population as a whole. On the first day of the 65th session of the WHO Regional Committee for Europe, to be held in Vilnius, Lithuania on 14–18 September 2015, European Member States will come together to hold a preliminary

discussion on public health and migration with the aim to agree on a common understanding and way forward.

Fostering the health of migrants through governmental joint actions

The migration process – including the conditions which migrants endure at the countries of origin and transit, during the journey, at the destination countries and during the return process – entails exposure to potential health risks that can impact the physical, mental and social well-being of migrants. Even though most of these risk factors lie outside the health care sector, they heavily impact on the health outcomes of this population group. Understanding the possible health hazards that arise through this process and the actors involved at each stage is essential to embark on intersectoral joint actions that intervene on these determinants and address the public health aspects of migration. Therefore, addressing migration and health requires the engagement of a variety of actors, both governmental and nongovernmental, from arenas such as home and foreign affairs, justice, labour, social affairs, education and health, whose policies and interventions have implications across sectors.

Despite the growing evidence in this field, migration is an area in which the health sector has not been actively involved in many European countries, but has rather intervened in a reactive way, responding almost exclusively to potential or ongoing health emergencies. In 2011, given the growing pressure of migration flows to European countries and particularly considering the impact on their health systems, WHO/Europe started working closely with ministries of health through the project Public Health Aspects of Migration in Europe (PHAME).

Issue 6 - July 2015

Adapting the existing WHO *Toolkit for assessing health-system capacity for crisis management (3)* to the specifics of public health and migration, joint assessments have been conducted with the ministries of health of Bulgaria, Cyprus, Greece, Italy, Malta, Portugal, Serbia and Spain. The short-term objective of these exercises is to assess the capacity of the health systems to cope with the public health challenges that sudden and large influxes of migrants pose to transit and destination countries. The medium- and long-term aims include identifying: potential areas in which technical assistance may be provided to strengthen health system preparedness, response and capacity; and best practices in the area of migrant health, in order to facilitate inter-country knowledge exchanges, contributing to a paradigm shift in the way migrant health is managed.

From the governance perspective, this joint process entails two major steps. First, ownership must be reinforced within

the health sector, which is called upon to lead discussions in an area that has been traditionally run by other sectors. Second, and as a result of this renewed leadership, the Ministry of Health must call all key national governmental and non-state actors for an initial meeting of stakeholders, in which cross-sectoral migration policies and interventions are to be revised with the aim of analysing their public health impact. After, field visits are to be organized to those areas in the country most affected by migration inflows, and interviews with local health and non-health professionals conducted. Finally, a debriefing meeting chaired by the Ministry of Health and WHO and again attended by the main national governmental and non-state actors should analyse the preliminary results and possible areas of collaboration. This lengthy practice arises from the acknowledgement of multisectoral, multilevel and transnational approaches as the way forward to allow coordinated, systematic and sustainable change on migrant health.

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Obstacles to access to care for migrants, children and pregnant women in Europe

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Since 2006, the MdM International Network Observatory on access to health care has carried out multicentre European surveys during face-to-face medical and social consultations with people facing multiple vulnerability factors in health (most of them migrants). MdM collects data on social and health characteristics, care needs and barriers to accessing care, in order to raise awareness among stakeholders and bring about positive changes in laws and practices.

An impressive range of international texts and commitments exist to ensure people's basic and universal right to health.

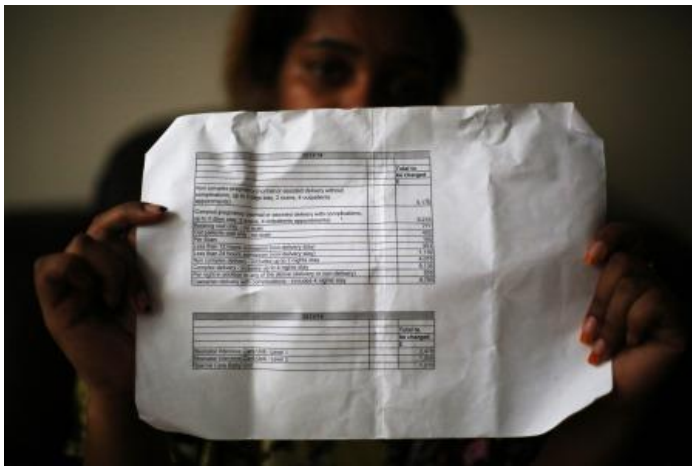
However, many European countries have set legal and administrative barriers to care. Undocumented migrants are hit first, whether they are European Union (EU) migrant citizens or third-country nationals, often along with asylum seekers and destitute nationals. These restrictions on care often also apply to pregnant women and children. Data collected by MdM in 2014 – relating to 23 040 people in 25 cities in Belgium, France, Germany, Greece, the Netherlands, Spain, Sweden, Switzerland, Turkey⁽¹⁾ and the United Kingdom – demonstrate persisting gaps in access to health care (1).

(1) In Istanbul, Turkey, the nongovernmental organization collecting data was L'Association de solidarités et d'entraide aux migrants (ASEM), an MdM partner.

Issue 6 - July 2015

Pregnant women involved in Mdm programmes face multiple vulnerabilities. A large majority had no health care coverage (81.1%); over half of them had not had access to antenatal care prior to engaging with Mdm; 67.8% restricted their movements for fear of arrest (an additional barrier to accessing care); and one third declared that they never or rarely had someone they could rely on in case of need. Personal health reasons for migrating were cited even less frequently than among all Mdm patients (0.8% versus 4.0%), which reflects the absence of any push factor for migration related to their current pregnancy.

Nearly half of pregnant women who had minor children were living apart from one or more of them. They reported considerable emotional strain, including anxiety, guilt and a sense of loss, and they are at greater risk of depression. In addition, an overwhelming majority of patients (84.4%) questioned on violence reported they had suffered at least one violent experience, whether in their country of origin, during their journey or in the host country. These people need care and safe surroundings instead of living, too often, in ditches and slums, in fear of expulsion.



“I am a lesbian. I had a forced marriage which is why I’m pregnant. I had to flee for my life. At the hospital they gave me an estimate for the cost of my delivery of €12 000.”

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Only half of the pregnant women knew their HIV, hepatitis B or hepatitis C status when they arrived under the Mdm programme and, of these, 14.3% were HIV positive, 11.1% tested positive for hepatitis B and 2.8% for hepatitis C. In addition, 67.1% of the women wished to be screened for one or the other of these viruses, but 34.3% did not know where they could go for the test.

Children of asylum seekers and refugees only have the same rights to health care as nationals in six of the surveyed countries. In most countries, children of undocumented migrants face legal barriers to accessing care and vaccination. As a consequence, only 42.5% of the children seen in Mdm consultations were immunized against tetanus and, even worse, only 34.5% against measles, mumps and rubella viruses (that is, far fewer than among the general population).

EU countries and institutions within them must offer universal public health systems built on solidarity, equality and equity (rather than profit-making rationale), open to everyone living in Europe. They should ensure immediately that all children residing in Europe have full access to national immunization programmes and to paediatric care. Similarly, all pregnant women must have access to termination of pregnancy, antenatal and postnatal care and safe delivery.

Almost 100 European-level and national institutions, along with professional and civil society organizations endorsed the Granada Declaration in April 2014 (2), showing their deep attachment to the principles of ethics, human rights, and care for those most in need. They reject all instrumentalization of health care policies in the vain hope of limiting migration and/or public deficits.

Together with the World Medical Association’s Declaration of Lisbon on the rights of the patient (3), Mdm will continue to provide appropriate medical care to all people, without discrimination. Mdm refuses all restrictive legal measures to alter medical ethics and exhorts all health professionals to take care of all patients, whatever their administrative status and existing legal barriers.

NEWS

Italian National Institute of Health. Workshop on screening practices for infectious diseases among newly arrived migrants, 28–29 May 2015, Rome, Italy

http://www.enpi-info.eu/mainmed.php?id_type=1&id=41002&lang_id=450&utm_source=Oempro&utm_medium=Email&utm_content=Subscriber%232080&utm_campaign=Workshop%20on%20screening%20practices%20for%20infectious%20diseases%20among%20newly%20arrived%20migrants%20

The **Deaths at the Borders Database** is the first collection of official evidence on people who died while attempting to reach southern European Union (EU) countries from the Balkans, the Middle East, and North and West Africa, and whose bodies were found in or brought to Europe. It is interactive and covers a 25-year period from 1990 to 2013.

<http://www.borderdeaths.org/>

New report on migration in Italy, presented at the Expo Milano 2015 Conference “Feeding the Planet, Energy for Life”, 4 June 2015, Milan, Italy

<http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/news/news/2015/06/new-report-on-migration-in-italy>

Health a priority for European Development Days. European Development Days forum, 3–4 June 2015, Brussels, Belgium

<http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/news/news/2015/06/health-a-priority-for-european-development-days>

EVENTS

65th session of the WHO Regional Committee for Europe, 14–18 September, Vilnius, Lithuania

<http://www.who.int/mediacentre/events/2015/regional/en/>

8th European Public Health Conference: “Health in Europe – from global to local policies, methods and practices”, 14–17 October 2015, Milan, Italy

<http://ephconference.eu/>

9th Conference of the Hungarian Association of Public Health Training and Research Institutions: “Hungarian Health – European Health”, 26–28 August 2015, Pécs, Hungary

http://nke2015.pte.hu/index2_en.html

Pre-conference meeting of the European Public Health Association (EUPHA) section on Migrant and Ethnic Minority Health, in partnership with the Task Force on Migrant-friendly Hospitals and Health Services, entitled “Public health and human rights: ensuring access to health care for refugees crossing the Mediterranean Sea”, at the 8th European Public Health Conference, 15 October 2015, Milan, Italy

<http://www.ephconference.eu/2015-programme-pre-conferences-196>

OPINION

This article represents the opinion of the author(s) and publications and does not necessarily represent the views of WHO, the University of Pécs or the Editorial Board of this newsletter.

Occupational health aspects of migration

Prof. István Szilárd, Chief Scientific Adviser, Chair of Migration Health, University of Pécs Medical School, Hungary

Current demographic trends are forecasting a significant decrease in the working-age population of the European Union (EU), while the number of individuals of retirement age is growing significantly (see Fig. 1) (1). Naturally, this trend has a serious, unfavourable economic impact as well, and some studies show that low- and semi-skilled sectors or seasonal employment opportunities would probably not survive in the absence of migrants.

Reflecting this, the European Commission has issued a Green Paper (2) that states:

Between 2010 and 2030, at current immigration flows, the decline in the EU-25's working-age population will entail a fall in the number of employed people of some 20 million. Such developments will have a huge impact on overall economic growth, the functioning of the internal market and the competitiveness of EU enterprises.

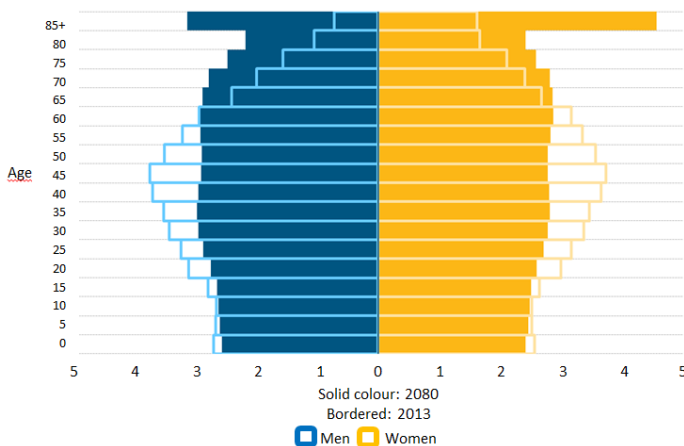


Fig. 1. Demographic forecast for the population of the 28 Member States of the EU, 2013–2080 (1)

It is clear from this statement that the EU is in need of a healthy migrant workforce, for which the health care system should play a decisive role in ensuring their smooth and secure introduction into workplaces, as well as supporting their integration into the host community.

The aim of this opinion-based article is to provide a picture of how current EU policy and bodies are coping with this

challenging task.

On 4 July 2013 the Office of the High Commissioner for Human Rights issued an overview of findings relating to migrant workers' current situation (3).

Many of them find so-called "3 D jobs", dirty dangerous and degrading occupations that leave them exposed to a range of abuses, especially denial of their right to health. Language and cultural differences often exacerbate the risks taken by both regular and irregular migrant workers, so much so that many individuals who left their countries in sound physical and mental health, end up in a debilitated state because of States' failures to provide primary and ongoing care, both physical and mental.

In a report to the Human Rights Council, the Special Rapporteur on the right to health, Anand Grover describes the desperate conditions confronted by many migrant workers who may be "cramped or hidden in boats or trucks... [who] may also face physical and sexual violence during transit... [and] limited or no health care during transit and in transit countries".

In spite of this alarming account, there are only few rigorous studies on the occupation-related health problems of migrants in EU countries. The responsible agency (European Agency for Safety and Health at Work, EU-OSHA) published a literature overview on the subject in 2007 (4). In summary, it states that:

- very few studies exist on the health consequences of work environment and working conditions on migrant workers;
- the reports and studies that do exist are outdated;
- data are scarce on occupational safety and health issues and the health status of migrant seasonal workers.

Some data from the SALTSA project (5) – an EU-level comparative study – are useful to highlight the serious disadvantage that migrant workers face.

- In France, migrant workers were found to be disproportionately represented in industrial accident rates: more than 30% of industrial accidents leading to permanent disability happened to non-French workers (6).
- In Austria, about 30% of migrant workers felt particularly affected by accidents and injury risks in the workplace, compared with only 13% of Austrians.

Issue 6 - July 2015

- In Italy, one accident takes place at work for every 23 people in the total active population; this increases to one in 16 for non-nationals.
- In Ireland, the fatality rate per 100 000 workers is 5.6 among non-nationals, compared with 3.0 per 100 000 for Irish workers (and with a particularly high risk in the construction sector).

Data from Germany also suggest that foreign workers are at a disadvantage in terms of certain occupation-related health problems (7).

- The occupational health condition which most affected Turkish male workers was noise-induced hearing loss (54.2%, compared with 39.2% of Germans), followed by silicosis (18.3% and 14.2%, respectively), tendosynovitis (5.8% and 2.3%), asbestosis (5.6% and 10.4%), and skin diseases (5.0% and 5.4%).
- It was also found that foreign workers suffer from musculoskeletal diseases more than German workers (14.4% and 13.0%, respectively).

A recently published country-specific comparative study of Italian versus Spanish migrants showed higher risks of musculoskeletal problems among migrants compared to the non-migrant population in Italy, with the same trend in respiratory problems in Spain (8).

In contrast, in the United States the occupational health hazard of foreigners is a well-documented research field, focusing mostly on the health of migrant workers in the agricultural

sector (9, 10). The Centers for Disease Control and Prevention publish information on the health problems of migrant workers, highlighting in particular the importance of cultural differences as barriers to safety (11).

One particular area of focus within the migration-related occupational health field is the health hazard(s) faced by law enforcement and health care personnel working with irregular migrants in migrant reception centres. A Hungarian study highlights the need for additional training for these individuals (12).

It is possible to summarize that migrant workers are suffering from a serious disadvantage in terms of occupational health hazards, despite the fact that relevant international legislation and declarations (such as the *International convention on the protection of all migrant workers and members of their families* (13)) protect the human rights of migrant workers at all stages of the migration process. In reality, workplaces and occupational health services in the EU are not prepared to cope with this emerging challenge, both in terms of the human rights issues involved and the associated economic impact. There is also a shortage of much-needed specialist training for health care staff; a need to which the EU higher education institutions are not currently responding, including, unfortunately, EU-OSHA. As discussed in the 1st issue of the WHO Regional Office for Europe PHAME newsletter (14), the University of Pécs Medical School is preparing to launch a Master of Science (MSc) on migration health, which will also cover the required occupational health aspects.

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RECOMMENDED READING

ARTICLES:

Rondet C, Lapostolle A, Soler M, Grillo F, Parizot I, Chauvin P. **Are immigrants and nationals born to immigrants at higher risk for delayed or no lifetime breast and cervical cancer screening? The results from a population-based survey in Paris metropolitan area in 2010.** PLOS One 2014;9(1):e87046. doi: 10.1371/journal.pone.0087046.

(<http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0087046>)

Britz JB, McKee M. **Charging migrants for health care could compromise public health and increase costs for the NHS.** J Pub Health (Oxf). 2015;Apr 22: pii: fdv043

(<http://jpubhealth.oxfordjournals.org/content/early/2015/04/21/pubmed.fdv043.abstract>)

Poduval S, Howard N, Jones L, Murwill P, McKee M, Legido-Quigley H. **Experiences among undocumented migrants accessing primary care in the United Kingdom: a qualitative study.** Int J Health Serv. 2015;45(2):320–333. doi: 10.1177/0020731414568511.

(<http://www.ncbi.nlm.nih.gov/pubmed/25711730>)

Odone A, Tillmann T, Sandgren A, Williams G, Rechel B, Ingleby D et al. **Tuberculosis among migrant populations in the European Union and the European Economic Area.** Eur J Public Health 2015;25(3):506–512. doi: 10.1093/eurpub/cku208.

(<http://www.ncbi.nlm.nih.gov/pubmed/25500265>)

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