



World Health
Organization

REGIONAL OFFICE FOR

Europe



Report on the **health of refugees and migrants** in the WHO European Region

No PUBLIC HEALTH without REFUGEE and MIGRANT HEALTH

Summary

The World Health Organization was established in 1948 as the specialized agency of the United Nations serving as the directing and coordinating authority for international health matters and public health. One of WHO's constitutional functions is to provide objective and reliable information and advice in the field of human health. It fulfils this responsibility in part through its publications programmes, seeking to help countries to make policies that benefit public health and address their most pressing public health concerns.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health problems of the countries it serves.

The WHO European Region embraces nearly 920 million people living in an area stretching from the Arctic Ocean in the north to the Mediterranean Sea in the south and from the Atlantic Ocean in the west to the Pacific Ocean in the east. Approximately 10% of the population is currently estimated to be migrants (3.9% in 1990). The European programme of WHO supports all countries in the Region in developing and sustaining their own health policies, systems and programmes; preventing and overcoming threats to health; preparing for future health challenges; and advocating and implementing public health activities. According to the universal health coverage approach, WHO is fully committed to leave no one behind. Also for this, there is no public health without refugee and migrant health.

To ensure the widest possible availability of authoritative information and guidance on health matters, WHO secures broad international distribution of its publications and encourages their translation and adaptation. By helping to promote and protect health and prevent and control disease, WHO's books contribute to achieving its principal objective – the attainment by all people of the highest possible level of health.

The Migration and Health programme

The Migration and Health programme, the first fully-fledged programme on migration and health at the WHO Regional Office for Europe, was established to support Member States to strengthen the health sector's capacity to provide evidence-informed responses to the public health challenges of refugee and migrant health. The programme operates under the umbrella of the European health policy framework Health 2020, providing support to Member States under four pillars: technical assistance; health information, research and training; partnership building; and advocacy and communication. The programme promotes a collaborative intercountry approach to migrant health by facilitating cross-country policy dialogue and encouraging homogeneous health interventions along the migration routes to promote the health of refugees and migrants and protect public health in the host community.

National Institute for Health, Migration and Poverty (INMP)

The National Institute for Health, Migration and Poverty is an Italian public institution under the authority of the Ministry of Health. It was established in 2007 to address social and health inequalities affecting vulnerable populations, among which are migrants and poor people. The Institute is the Reference Centre of the National Network for Social and Health Care Issues Related to Migrant Populations and Poverty as well as the National Centre for Transcultural Mediation for the Social and Healthcare Sector. Its mission is to develop and share with the Italian regions innovative models to counteract health inequalities and facilitate access for disadvantaged people to the National Health Service, ensuring them high-quality health care.

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Summary



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Introduction

The movement of people across the planet seeking opportunities or fleeing danger has consistently influenced human activity and has shaped the formation of our societies. This is particularly true for the 53 countries of the WHO European Region, which have a combined population of almost 920 million people, representing nearly a seventh of the world's population. The Region covers a vast geographical area of human mobility and amalgamation that extends from the Atlantic to the Pacific oceans. Almost 10% of the Region's population (90.7 million) are international migrants, accounting for 35% of the global international migrant population (258 million) (1). The proportion of international migrants among the Member States in the Region varies from more than 50% in Andorra and Monaco to less than 2% in Albania, Bosnia and Herzegovina, Poland and Romania. As a consequence, migration-related programme and policy priorities may vary between Member States. Yet, every country today can be an origin, transit or a destination country for refugees and migrants, sometimes acting as more than one of these, and refugee and migrant health has progressively emerged as a theme of common interest for all Member States.

It is estimated that more than 50 000 individuals have lost their lives since the beginning of the millennium in the Mediterranean area (2). Women, young men, adolescents and unaccompanied minors are victims of deceptive recruitment and modern slavery, with grave physical and mental repercussions. The negative health consequences of the displacement and migration process experienced by individual refugees and migrants can also have health repercussions on their families and communities. This has brought observers to consider displacement and migration as a social determinant of health.¹

This is the first report produced by the WHO Regional Office for Europe on refugee and migrant health in the WHO European Region. The report contributes to the evidence base on refugee and migrant health spanning the entire Region by summarizing the latest available evidence and the country initiatives being implemented in the Region.

The acceleration towards creating refugee and migrant-sensitive health systems is indicated by the inclusion of migration-related targets within the 2030 Agenda for Sustainable Development (3), and its resulting 17 Sustainable Development Goals. The Agenda underpins the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region, adopted by its Member States in 2016 (4), and a framework of its principles and priorities is contained in World Health Assembly resolution 70.15 (5) and the Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants of 2017 (6). At both the global and regional levels and in partnership with Member States and partner organizations, the WHO Regional Office for Europe is working towards ensuring a public health-based approach to refugee and migrant health in line with WHO's Thirteenth General Programme of Work (strengthening governance for health and well-being) for 2019–2023 (7) and with universal health coverage objectives.

In addition to providing an evidence base, the report also identifies gaps in existing evidence and seeks to become a tool to support future actions and decisions. At present, there are no global or region-wide indicators or standards for refugee and migrant health, and no global or regional framework is currently implemented for the standardized and routine collection of data. This leads to a shortage of scientifically valid and comparable health data on refugee and migrant populations. Collecting such reliable and comparable records is challenging because of the mobile nature of the population, uncoordinated and/or non-existent information exchange, and administrative and cultural barriers in accessing services and providing information.

While several institutional and non-institutional actors have collected a wealth of both local and national information containing data and evidence on refugee and migrant health in recent years, this information is often not accessible to a wider audience. Available information needs to be collated to get a better understanding of refugee and migrant health in the Region and to inform policies and actions to address their health concerns.

The main source of data for the report was a scoping review of recent literature (more than 13 000 documents) published in English and Russian.

¹ For WHO, social determinants of health are the conditions in which people are born, grow, live, work and age and that are responsible for health inequities – the unfair and avoidable differences in health status seen within and between countries.

Additional targeted literature searches were conducted where there was a dearth of information. The evidence obtained through the scoping review was supplemented by data collected by WHO and provided by collaborators. Member States also contributed documents and data sources for this report.

The report will present the global and regional displacement and migration patterns and policy frameworks, followed by an overview of the health profile of refugees and migrants and the work being done to enable a move towards refugee and migrant-friendly health systems and universal health care, and finishing with a look forward, describing the vision for the health of refugees and migrants in the WHO European Region.

The term refugee is defined precisely in the 1951 Convention relating to the Status of Refugees and the 1967

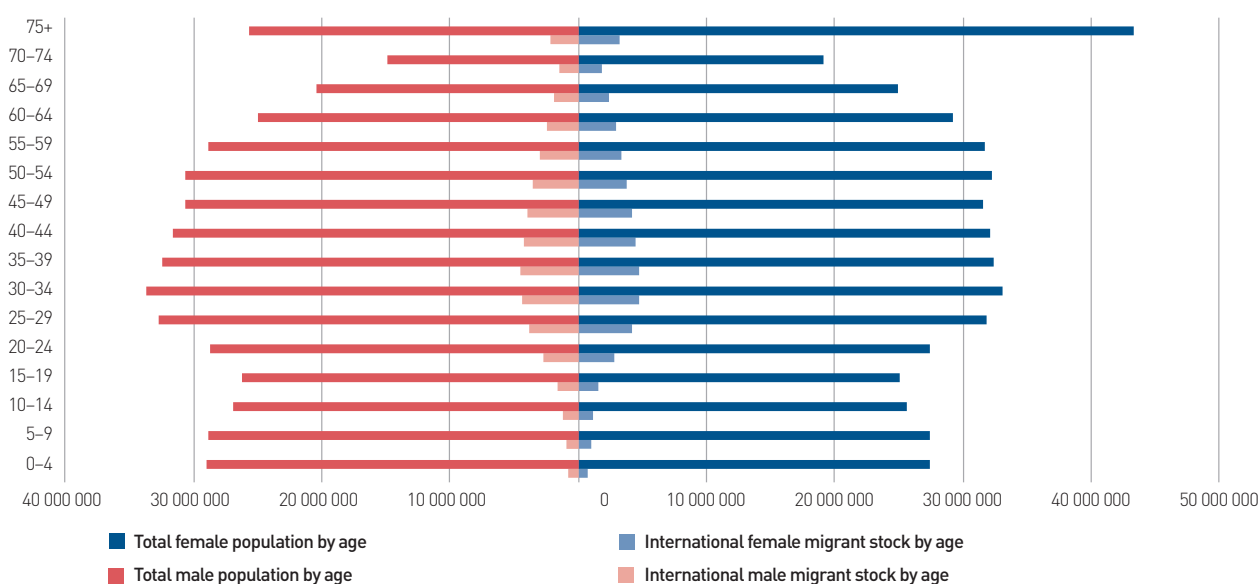
Protocol thereto. Definitions of the term migrant, and of its various subgroups and categories, are diverse and inconsistent across the globe and in the WHO European Region. This implies both political sensitivities and specific challenges, including those related to entitlements and access to health services. Such entitlements are determined most often by migrant legal status and this is regulated by national legislations and the specific international agreements to which each country might have subscribed. Discrepancies in definitions also limit the comparability of data in migrant health information systems across the WHO European Region and beyond. Consequently, it is difficult to harmonize policies and create common monitoring mechanisms towards realizing universal health coverage for these populations. Refugees and migrants are entitled to the same universal human rights and fundamental freedoms as all people, which must always be respected, protected and fulfilled.

Refugees and migrants in the WHO European Region

This report focuses on the health aspects of international migration. However, it is acknowledged that there are aspects associated with internal migration that create common challenges and factors, which would justify an overarching migration health agenda.

The arrival of international migrants is currently one of the main contributors to regional population growth. As shown in Fig. 1, the majority of refugees and migrants coming to the WHO European Region are of working age.

Fig. 1. Total population and total international migrant stock in the WHO European Region stratified by age and sex, 2017



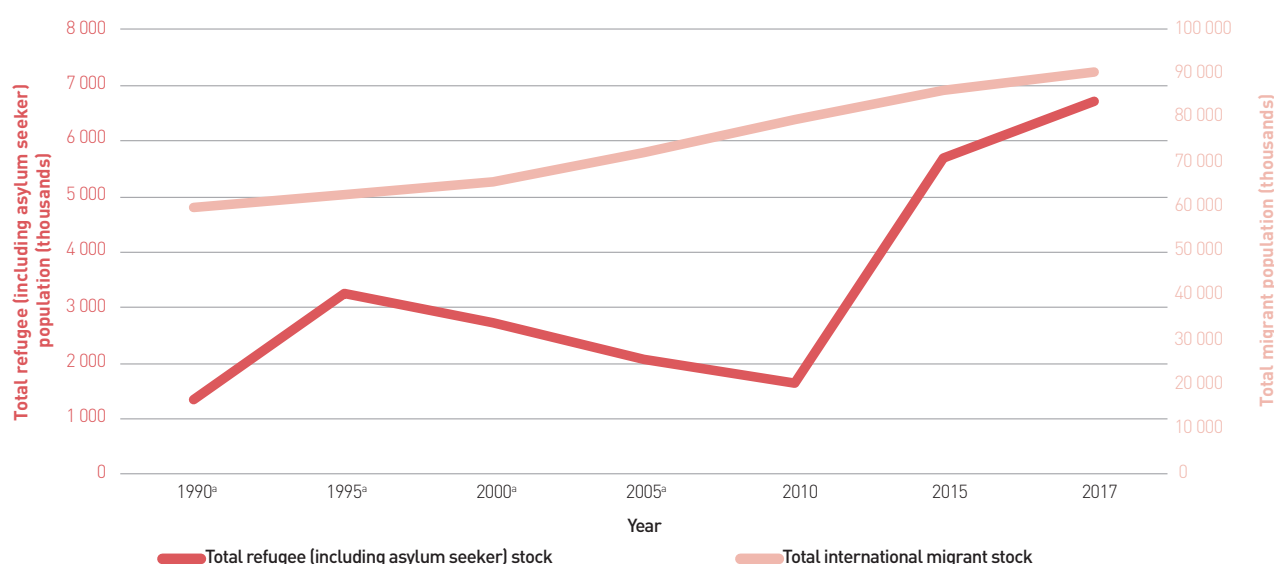
Note: data disaggregated by gender were not available for Andorra, Monaco and San Marino.

Source: United Nations Department of Economic and Social Affairs, 2017 (1).

A very common misperception is that there are too many refugees and migrants, and citizens in some European countries estimate the number of migrants at three or four times more than there actually are (8,9). Yet, the global volume of refugees and migrants as a percentage of the global population has actually remained relatively stable for several decades, at around 3% of the world population (e.g. it was 2.8% in 1990 and 3.3% in 2017 (1)). The proportion of displaced people has grown from around five for every 1000 world population in 1997 to almost nine in every 1000 in 2017. This equates to approximately

68.5 million individuals, with 25.4 million of these crossing international boundaries in search of protection (10). According to the Office of the United Nations High Commissioner for Refugees, and contrary to common perception, 85% of refugees globally are hosted in developing countries. In 2017, Turkey continues to be the country hosting the largest number of refugees in the world (3.5 million). Refugees accounted for less than 7.5% of the total international migrant population in the Region in 2017. Fig. 2 shows the trend in international migrant population in the Region from 2000 to 2017.

Fig. 2. Trends in refugee (including asylum seekers) and total migrant population in the WHO European Region, 2000–2017



^aData are not available for Montenegro.

Source: United Nations Department of Economic and Social Affairs, 2017 (1).

Why is the health of refugees and migrants important?

Refugees and various categories of migrants might face challenges in all five of the areas of access to health care: availability, adequacy, accessibility, affordability and appropriateness. Failure to ensure access to equitable health care for refugees and migrants can have negative public health repercussions for both the refugees and migrants and the host community and can hamper achievement of global health goals. This is why several emerging principles representing key public health arguments for the promotion of refugee and migrant health address the issue of access to health care:

- right to health is a basic human right, regardless of migration status, under the 1966 International Covenant on Economic, Social and Cultural Rights;
- refugees and migrants contribute actively to development of the host society and country of origin;
- the existence of clusters of population with lower health coverage can have negative health outcomes for the whole community;

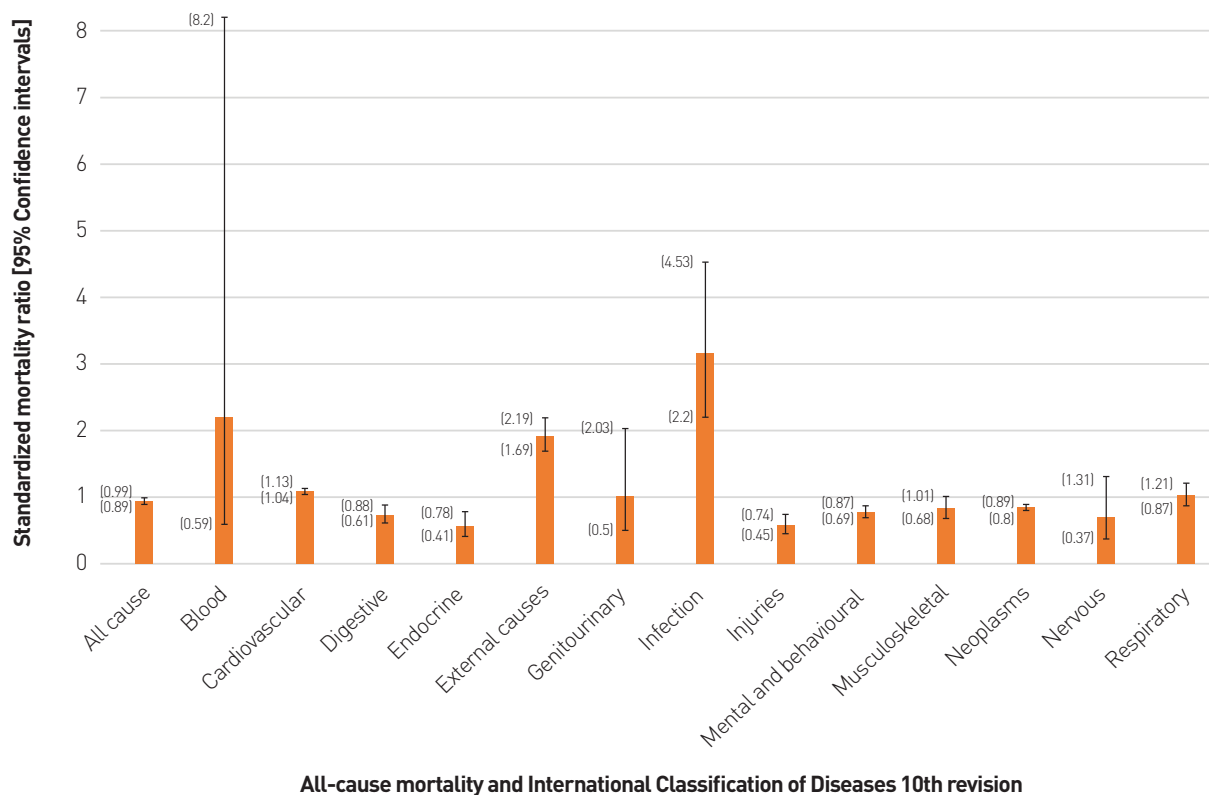
- early diagnosis and treatment save lives and cut treatment costs;
- prioritizing vulnerable populations and individuals most at need in societies is a sound public health strategy;
- migrant and refugee health security is part of global health security; and
- population diversity changes epidemiological profiles.

Health of refugees and migrants in the WHO European Region

The health status of refugees and migrants is generally assessed in relation to either that of the host population in the country of destination or that of the population in the country of origin. Generally, research conducted in the WHO European Region compares refugee and migrant health status with that of the host population in the country of destination.

Mortality estimates tend to be lower in refugees and migrants than in the European host population for all-cause mortality, neoplasms, mental and behavioural conditions, injuries, endocrine disorders and digestive conditions but higher for infections, external causes, diseases of the blood and blood-forming organs and cardiovascular diseases (Fig. 3). Other categories

Fig. 3. Summary standardized mortality ratios for refugees and migrants compared with the host population in the WHO European Region for various mortality causes



Note: Mortality causes are based on the all-cause mortality and International Classification of Diseases 10th Revision; values below 1.0 indicate a mortality advantage for refugees and migrants; standardized mortality ratios were calculated from mortality rates in available in published scientific literature (940 cause-specific estimates) as a subgroup analysis of a global meta-analysis.

Source: Aldridge et al., 2018 (17).

show no evidence of differences. However, contextual factors will have an important influence on health outcomes, for example country of origin or duration and socioeconomic conditions of stay.

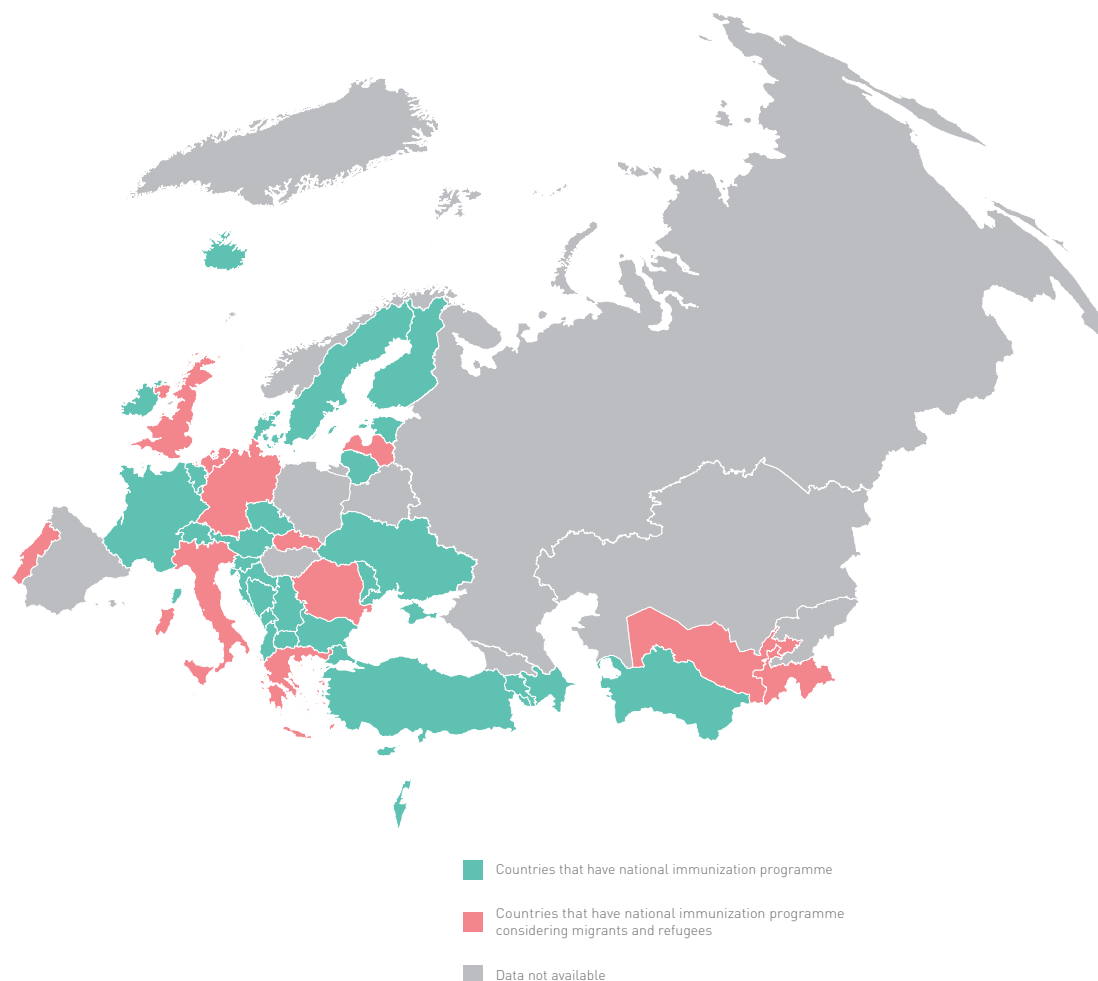
Communicable diseases

There is more research conducted, and hence more evidence available, on communicable diseases than on any other disease group. Breakdown in health systems in the country of origin and living with poor sanitation and contaminated water before or during the migratory journey increase the risk for a variety of infections (bacterial, viral and parasitic) including for vaccine-preventable diseases. Because of the potentially greater health risk that infectious diseases pose for refugees and migrants as a result of conditions in places of origin, transit or destination, it is necessary for them to receive protection against infectious dis-

eases (e.g. tuberculosis, HIV, hepatitis) and for health care workers at the frontline to understand the health risks for this population.

Vaccine-preventable diseases are a risk for those who have not received vaccinations and are exposed to or living in poor conditions. The highest risk group is refugee and migrant children as the process of migration can interrupt their immunization schedule, meaning they might not have received all recommended vaccinations. Similar to the host population, suboptimal vaccination coverage among refugees and migrants can lead to disease outbreaks. It is often seen that language, information, cultural and economic barriers plus factors such as legal right to stay in a region can influence the vulnerability of refugees and migrants to vaccine-preventable diseases. However, only some Member States in the Region have a national immunization programme that considers refugees and migrants (Fig. 4).

Fig. 4. Member States of the WHO European Region with a national immunization programme that includes refugees and migrants



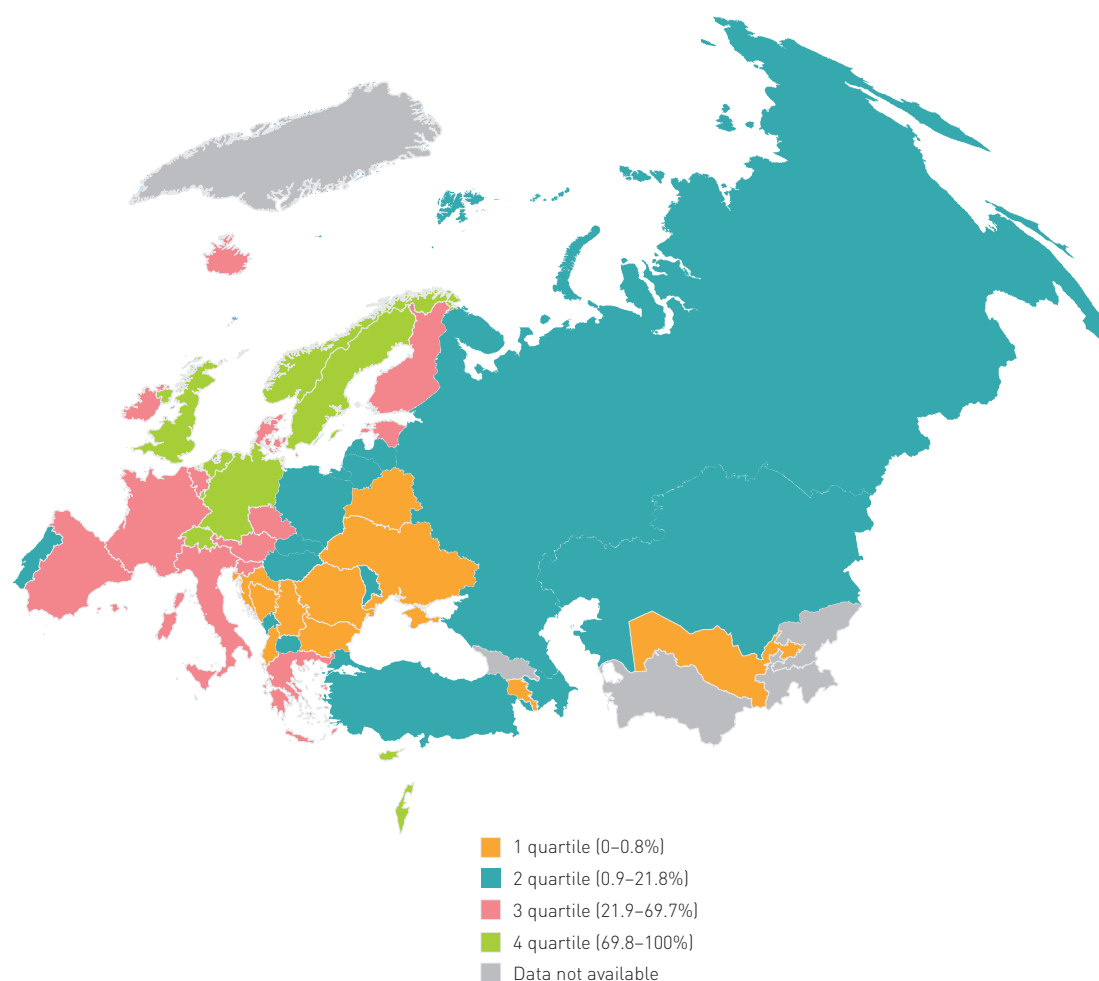
Source: De Vito et al., 2017 (12).

Tuberculosis is not always easy to diagnose and can be latent. Risk of infection is greatest in refugees and migrants arriving from places with a high prevalence of tuberculosis. The epidemiological and health system impact of these refugees and migrants is likely to be less in destination countries with a high domestic prevalence than in destinations of low prevalence. Available evidence indicates that foreign-born individuals make up about 8.2% of all tuberculosis notifications in the WHO European Region, but that the proportion varies geographically (Fig. 5). In Member States of the European Union/European Economic Area, foreign-born individuals make up 32.7% of all tuberculosis notifications and also experience a higher burden of multidrug-resistant tuberculosis.

HIV acquisition is important to understand as it has implications for HIV prevention. It has been estimated that approximately 40% of new HIV diagnoses in the European Union/European Economic Area and 21% in the WHO European Region are reported among people who originate outside of the reporting country. However, there is growing awareness of post-migration acquisition of HIV infection, which is significant for HIV prevention programmes that focus on pre-arrival risks, particularly as some evidence suggests that refugees and migrants are more likely to be diagnosed later in their infections than other risk groups.

Hepatitis B and C viral infections in refugees and migrants vary with the country or region of origin.

Fig. 5. Percentage of cases of foreign origin among total number of diagnoses of tuberculosis in Member States of the WHO European Region



Note: data not available for Georgia, Kyrgyzstan, Monaco, San Marino, Tajikistan and Turkmenistan.

Source: European Centre for Disease Prevention and Control & World Health Organization, 2017 (13).

Evidence from western Europe suggests that refugees and migrants originating from regions of higher hepatitis B prevalence have greater rates of chronic infection in some countries of destination. Prevalence of chronic hepatitis B ranged from 3% to 9% in the 31 reporting countries of the Region.

Noncommunicable diseases

Noncommunicable diseases are the largest contributor to the total burden of disease in the WHO European Region. Generally, data are lacking for refugees and migrants in individual Member States; consequently, it is not possible to draw conclusions on the overall burden of disease within the refugee and migrant population. Some evidence suggests a similar or lower prevalence for many noncommunicable diseases in refugees and migrants when they first arrive, but this begins to converge with the prevalence in the host population with longer duration of stay, particularly for overweight/obesity. Research on cardiovascular diseases indicates that prevalence often depends on the specific disease under observation, and it is difficult to make generalizations for the entire refugee and migrant population.

Risk of developing **diabetes mellitus type 2** appears to be greater in refugees and migrants in the WHO European Region, and this development may occur at an earlier age than in the host population in the country of origin. Moreover, diabetes prevalence is typically higher among female refugees and migrants than male refugees and migrants, depending on the country of origin.

Data on **cardiovascular diseases** among the refugee and migrant populations in the WHO European Region are highly complex as risk factors such as ethnicity and socioeconomic status influence the prevalence and types of cardiovascular disease that affect the population. While results were varied regarding the risks for stroke and ischaemic heart disease among refugees and migrants in western Europe, the general conclusion was that the majority of refugee and migrant groups are at higher risk of ischaemic heart disease and stroke than the host populations. In particular, refugees and migrants originating in south Asia, eastern Europe and the Middle East were at higher risk than the host western European population.

Data on **cancer prevalence** among refugees and migrants in the WHO European Region are limited, making it difficult to draw generalized conclusions. The most significant finding is that cancer is more likely to be diagnosed at an advanced stage among refugees and migrants, which can lead to significantly worse health outcomes compared with host populations. However, refugees and migrants in the Region generally have a lower overall risk of death for all neoplasms, although mortality for cervical cancer is higher.

Mental health

Prevalence of mental disorders in refugees and migrants shows considerable variation depending on the population studied and the methodology of assessment. Post-traumatic stress disorder is indicated to be more prevalent among refugees and asylum seekers than the host population. Depression and anxiety are commonly reported among refugees and migrants, with a lengthy asylum-seeking process and poor socioeconomic conditions, such as unemployment or isolation, associated with increased rates of depression. Evidence is not conclusive and reported ranges vary widely. Overall, drug and alcohol abuse seems to be lower in refugees and migrants compared with host populations, particularly in northern European countries. Evidence shows that post-migration stressors such as length of the asylum application process, unemployment or isolation are usually negatively associated with developing depression and other mental disorders. This underlines the importance of focusing on post-migration stressors.

Maternal health

The risk of adverse perinatal and obstetric outcomes, including mortality, seems to be increased among refugee and migrant women in general, with a large variability depending on the geographical area of origin. The available data indicate that refugees and migrants have an increased risk for low birth weight, and refugees have a higher risk than other migrant groups.

Sexual and reproductive health

Valid and comparable evidence is also limited regarding sexual and reproductive health, with some

studies showing contradictory results. For example, some studies find a higher prevalence of sexually transmitted infections in refugee and migrant women while others find no change from that in non-migrants. Available evidence indicates that knowledge about contraception and family planning is dependent on the country of origin and previous educational attainment.

Female genital mutilation has become a topic of importance for health practitioners since more cases have been observed both through the practice taking place in the WHO European Region and the migration of women who were cut prior to arriving in the Region. Recent evidence indicates that longer duration of stay in a host country is positively associated with opposing the practice.

Both children and adults can experience serious sexual violence during transit and even after their arrival in Europe. It is important to point out that, while both men and women reported sexual violence, the majority of the support services mainly focus on female victims and are often connected to maternal and reproductive health clinics.

Child and adolescent health

Compared with the host population, refugee and migrant children seem to have a higher prevalence of overweight/obesity. However, the evidence on this is inconclusive.

The mental health status of refugee and migrant children is often shown to be lower than that of the host population within the WHO European Region. Some studies indicate that migration status can be postulated as a risk factor for children's mental condition. Generally, these populations are at higher risk for developing nearly all types of mental disorder but predominantly internalized problems (post-traumatic stress disorder, depression and anxiety).

Unaccompanied minors are a group of children at particular risk for both health and social problems: risks for abduction, trafficking for sale and exploitation can be exacerbated if border controls are weak, violations of child's rights already exist and there is easy access to the child. In 2017, unaccompanied minors seeking asylum in the European Union were predominately male. Evidence show high rates of depression and post-traumatic stress disorder among unaccompanied teenage asylum seekers after resettlement.

Health care organization and delivery

Health care organization and delivery play a large part in promoting refugee and migrant health through encompassing a broad range of multilevel policies, programmes, measures and cooperation that varies greatly throughout the Region.

Entitlement to services varies widely among the Member States of the WHO European Region even though the right to health and, therefore, the right to health services should be universal. Consequently, it is difficult to generalize the findings on entitlement to services and also to gauge the unmet needs of the refugee and migrant population. While there has been an increasing acknowledgement of specific health needs for refugees and migrants, there has also been concurrent enforcement of policies restricting their right to health in certain Member States of the Region.

Preventive care for refugees and migrants in the WHO European Region consists of health promotion

strategies and screening, but also social support, training of health care professionals and awareness initiatives targeting minority groups. Health promotion and education are especially important for refugees and migrants because often they are not familiar with the health systems of the country of destination and so lack knowledge of what kind of support is available, whether they are entitled to it and how they can access it. Because of the potential for risk for vaccine-preventable diseases among refugees and migrants, systemized immunization plans for newly arrived refugees and migrants are recommended, based on the national immunization schedule of the host country.

Frontier and border assessment with an initial screening that is not limited to infectious diseases can be an effective public health instrument, but it should be non-discriminatory and non-stigmatizing and carried out to the benefit of the individual and

the public. Such screening should also be linked to accessing treatment, care and support. WHO recommends that all screening should respond to appropriate risk assessments, and its effectiveness should be evaluated, and it should be provided on a voluntary basis and with ethical attention to confidentiality. Screening for newly arrived refugees and migrants usually concentrates on communicable diseases, and on tuberculosis in particular. The WHO European Region has established a minimum package on cross-border tuberculosis control and care based on the Wolfheze workshops (14).

Effective **contingency planning** ensures that a country is prepared for, and is able to respond to, unexpected demands on health care provision. Such unexpected demands with regard to displacement and migration are usually concentrated at borders (land or sea) and include all aspects of providing care (e.g. food, clean

water and sanitation) not just health care (e.g. medical supplies and health assessments). Joint assessments conducted by the WHO Regional Office for Europe with Member States identified that Member States need to strengthen their human and fiscal resources, provision of interpreters and cultural mediators, communications strategy, and immunization guidelines.

Health information systems are essential for delivery of high-quality and appropriate health care to those who need it, which requires accurate and relevant information on the health status and health needs of the population. Data on refugee and migrant health is not routinely collected in most European countries. Key challenges include the heterogeneity, accuracy and reproducibility of data. Gathering and comparing data are made more complex by variations in definitions and the applications of terms in relation to migrant populations in different locations.

Gaps in coverage and discrepancies

Accessibility of health care services varies greatly across the WHO European Region and within the national boundaries of its Member States. While some Member States may have national health strategies, these strategies often do not make any reference to the health of refugees and migrants or the accessibility of health care for them. Generally, when state systems are inaccessible or ineffective, nongovernmental organizations provide the needed resources for communities, and access to these health services by refugees and migrants is high. Depending on the host country, refugees and various groups of migrants can have from full to no access to health care services. Ir-

regular migrants are one group that face restrictions in accessing health care services, often being limited to emergency care services and with no access to antenatal and postnatal health care services.

Detention of migrants, or administrative detention, is known to have negative effects on health, especially for vulnerable groups such as children, and health care in detention is very limited. According to international guidelines, detention should only be used as a last resort. Nevertheless, migration detention is widely practised across the WHO European Region, although alternatives to detention exist.

Culturally sensitive health systems

Across the WHO European Region, Member States are attempting to move away from a “one size fits all” approach to health care service provision, which runs the risk of discriminating against those whose needs differ from the majority. Instead, the importance of intercultural competence and cultural sensitivity in health care systems is being increasingly recognized

as integral to the provision of equitable and adequate health care. Culturally sensitive health care has also been implemented across the Region through the training of health care professionals to carry out their activities in intercultural competent and culturally sensitive ways.

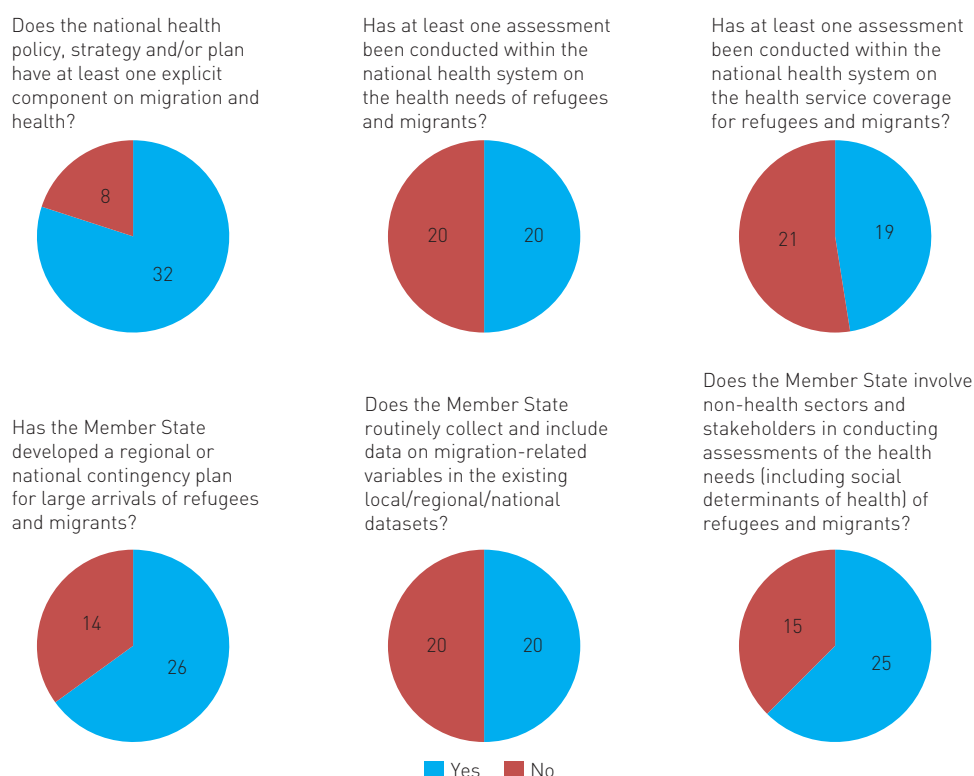
Progress towards a refugee and migrant-friendly health system in the WHO European Region

The Health 2020 policy framework promotes action across governments and society for the health and well-being of all and the reduction of inequalities. It was approved by all 53 Member States of the WHO European Region in 2012 (15). In order to promote the health of refugees and migrants, the WHO Regional Office for Europe established the Migration and Health programme to assist Member States in planning and preparing responses to public health challenges associated with migration, and for protection of the health of refugees, migrants and host populations. The programme provides support to Member States under four pillars: technical assistance; health information, research and training; partnership building; and advocacy and communication. In consultation with Member States and other stakeholders, the Regional Office developed the Regional Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region, which was unanimously endorsed by the WHO Regional Committee for Europe in September 2016 (4). The unfolding situation in the Region was an opportunity not only to address short-term needs but also

to strengthen public health and health systems in the long term. The Regional Office strengthened its Migration and Health programme to better support Member States with implementation of the Strategy and Action Plan. This includes promoting interregional and inter-country collaboration; improving data collection and sharing of practices; producing evidence and research reports; and providing networking platforms, dialogues and knowledge building. One of the main tasks of the Migration and Health programme is to support Member States in the Region to implement the nine strategic areas in the Strategy and Action Plan, and Member States have been working towards implementation in accordance with their national health priorities and policies.

The report outlines the progress made in implementing the nine strategic areas, which was assessed in a survey using five encompassing indicators and to which 40 of the 53 Member States in the Region responded (Fig. 6). The survey will be conducted every two years until 2022.

Fig. 6. Overview of the results from the 40 Member States that responded to the survey



Way forward: a vision for health of refugees and migrants in the WHO European Region

The collaborative work undertaken in the Region and the leadership of some of its Member States have contributed to advancing the implementation of the Strategy and Action Plan for Refugee and Migrant Health in the WHO European Region. Important elements for implementation of the Strategy and Action Plan include:

- strengthening governance at both national and local decentralized levels of the health system to enhance stewardship for implementation of the Strategy and Action Plan;
- strengthening evidence, evaluating coverage, assessing needs and effective communication to provide accurate and reliable information and commonly agreed variables/indicators to support approaches to address refugee and migrant health issues in the face of the complexity and diversity of modern displacement and migration;
- strengthening policy to ensure equity and coverage for refugees and migrants regardless of the definitions used for subgroups;
- strengthening general population-based or disease-specific health policies by including explicit reference to refugees and migrants;
- strengthening grassroots participation and partnership by engaging with local authorities, community health providers, refugee and migrant communities, and sectoral parties such as the labour sector and civil society, plus intercountry collaboration across countries of origin, transit and destination; and
- strengthening national data collection systems by collecting standardized and disaggregated data for all refugees and migrants to support regional and national health policy and planning.

Lastly, it is vital to maintain momentum and enhance political leadership. The international community has now firmly prioritized migration as an essential matter for cooperation, and Member States of the WHO European Region have provided foresight and leadership in setting common goals through a regional strategy. It is essential to use all available platforms to bring migrant and refugee health into mainstream policies and to achieve cumulative and incremental results.

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Report on the health of refugees and migrants in the WHO European Region – no public health without refugee and migrant health

Almost one in 10 people in the WHO European Region is currently an international migrant. Finding work is a major reason why people migrate internationally, although violence, conflict, natural disasters and human rights abuses are also contributors. Migration is a social determinant of health affecting the health of refugees and migrants. The WHO Regional Office for Europe has taken the lead in assisting Member States in promoting refugee and migrant health and addressing the public health aspects of their health. The Regional Office established the Migration and Health programme specifically for this purpose. Gaining an overview of the health status of refugees and migrants and health system response is paramount in achieving the Sustainable Development Goals and in ensuring universal health coverage, and is in line with the Health 2020 framework. This report, the first of its kind, creates an evidence base with the aim of catalysing progress towards developing and promoting migrant-sensitive health systems in the 53 Member States of the WHO European Region and beyond. This report seeks to illuminate the causes, consequences and responses to the health needs and challenges faced by refugees and migrants in the Region, while also providing a snapshot of the progress being made across the Region. Additionally, the report seeks to identify gaps that require further action through collaboration, to improve the collection and availability of high-quality data and to stimulate policy initiatives. The report is a much-needed boost for Member States and other stakeholders to ensure high-quality health care for all.

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THE WHO REGIONAL OFFICE FOR EUROPE

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

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World Health Organization Regional Office for Europe

UN City, Marmorvej 51,
DK-2100, Copenhagen Ø, Denmark
Tel.: +45 45 33 70 00; Fax: +45 45 33 70 01
Email: eurocontact@who.int
Web site: www.euro.who.int

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