

MIGRATION AND HEALTH: A FAST CHANGING EUROPEAN SCENARIO

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RESUMEN

La migración está cambiando el desarrollo económico y demográfico de la Unión Europea y de los países de la Asociación del Mercado Libre Europeo y, desde la perspectiva de la salud, está afectando a la epidemiología de la enfermedad.

Los casos de tuberculosis han aumentado con la emigración debido a las pobres condiciones de vida en la que viven y trabajan los inmigrantes. El 50% de nuevos casos relacionados con la hepatitis tienen que ver con los países de origen. La migración está cambiando, también la distribución del HIV. Ciertos inmigrantes en Europa son más vulnerables a las enfermedades cardiovasculares, y las mujeres inmigrantes en Suecia tienen mayor tendencia a la obesidad.

En resumen, es necesario tomar medidas para planificar y proporcionar servicios sanitarios a toda esta nueva población y cambiar el conocimiento y la actitud de los inmigrantes respecto a la sanidad. También se hace imprescindible la formación de personal sanitario que dé respuesta al cambio social, cultural y demográfico de nuestra sociedad actual.

Palabras clave: migración, enfermedad, formación de personal sanitario.

ABSTRACT

Migration is changing the economic and demographic development of the EU and the EFTA countries and from a health care perspective, it is affecting the epidemiology of disease.

Tuberculosis cases have grown in concert with migration due to the poor physical and social conditions immigrants live and work in. 50% of new cases related to hepatitis are thought to involve people from migrant countries. Migration is also influencing the distribution of HIV. Certain immigrants in Europe are more vulnerable to cardiovascular diseases, and migrant women in Sweden have been reported to have a higher tendency to obesity.

In conclusion, it is necessary to take measures in the planning and delivery of health care if health systems want to be efficient in how migrants access health care service and to change migrants' health knowledge and attitudes. Training of health care personnel is also a must in our present, changing social, cultural and demographic environment.

Key words: migration, disease, training health care personnel.

Migration has become a central element in the economic and demographic development of European Union (EU) and European Free Trade Association (EFTA) countries. There is good reason to believe that the pace of migration will grow even more and that Europe will become increasingly complex from a health and health care perspective. As it does, the planning and delivery of health care will have to be guided by how this complexity is affecting the epidemiology of disease, patterns of health care seeking behavior and health management. Health systems that take this evidence into account and respond to it will probably be more successful than others in helping to improve how migrants, and other groups, access health care services. They may also be in a better position to reduce the incidence of diseases that seem to be especially associated with migration and enhance the efficacy of treatment outcomes among migrants.

1. CHANGING DEMOGRAPHICS

Patterns of health and healthcare delivery in the European Union (EU) and the European Free Trade Association (EFTA) are changing rapidly. One of the reasons for this is the growing pace of migration within and into the EU. In countries such as Luxembourg, Switzerland and Germany, migrants constitute about 37%, 25% and 12% of the national populations(1, 2) and if to this is added the number of undocumented migrants into the EU/EFTA region, the proportion is far higher. During the first weekend of September 2006, more than 1,300 illegal migrants arrived in the Spanish Canary Islands and estimates

suggest that between 50,000 and 70,000 people enter the EU unofficially through Spain every year.

The challenge to health is linked to the fact that migrants into the EU/EFTA region are arriving from an increasingly wide set of countries and—like anyone else—are bringing with them their medical histories and “health prints” that reflect different socio-economic backgrounds and culturally defined beliefs and attitudes to health and health care. Of equal importance is the fact that the health of migrants is also being influenced by the social conditions they are moving into and working in.

2. TUBERCULOSIS AND HIV

Among the diseases historically associated with migration, tuberculosis (TB) continues to be a concern. In a Europe in which the incidence of new cases fell in the course of the 20th century, the arrival of people from disadvantaged socio-economic backgrounds in South East Asia, Latin America and Eastern Europe is helping to change the epidemiology of the disease. In what had become low-TB incidence countries, the proportion of new cases of TB has grown in concert with migration, is occurring in younger people than before and is associated with higher treatment default rates and poor outcomes. Migrant TB, however, may not all be imported; there is evidence that some migrants are placed at risk of exposure to, and reactivation of, TB by the poor physical and social conditions they live and work in. There is little evidence of TB transmission from migrants to local host communities, and this suggests that their patterns of social networking do not typically extend beyond their own groups.

Migration is also influencing the distribution of HIV. In 2005, almost half (46%) of all heterosexually acquired HIV infections (over 50% of all newly reported infections) in Western Europe involved people coming from countries with a high prevalence of HIV. In the UK, where about 70 percent of new cases of HIV are estimated to involve foreign-born people, and 85 percent of them involved infection prior to arrival in the UK. A similar picture is emerging in other parts of the Europe such as Luxembourg and Belgium, France, the Netherlands, Germany, Sweden, Ireland, Spain, and Italy. Migrants may also be taking newly acquired HIV back to low prevalence countries.

3. HEPATITIS

Migration may be increasing the burden of hepatitis A and B (and possibly C) in some countries. Hepatitis A in low prevalence areas of Hungary has been linked to people arriving from China and former Yugoslavia and in the Netherlands, infection of children who had gone back to visit family in HAV endemic countries such as Morocco and Turkey has been reported. High rates of HAV infection have also been found among children of Moroccan migrants in Spain who had returned to Morocco on holiday. In the UK where the number of infected people with HBV is thought to have doubled in the past five years, 50% of new cases are thought to involve people from Africa, Asia, China, Russia and new EU countries.

Where universal vaccination programs have been started and where there has been a targeting of high risk groups, the incidence of hepatitis in children has dropped significantly but programs that target the children of migrants have at times been met with suspicion by parents unfamiliar with the concept of vaccination[18]. In some cases migrant attitudes to vaccination appear to vary according to the vaccination in question, their country of origin and how long ago they arrived but in general in a region where vaccination of children remains far from optimal it is even less so in the case of the children of migrants and some religious minorities.

4. CARDIOVASCULAR DISEASE

Patterns of infectious diseases are not the only ones influenced by migration. In many parts of the EU cardio-vascular diseases (CVD) account for almost 50% of reported deaths and 33% of disabilities, but migrants from some countries appear to be especially vulnerable. Turkish migrants are reported to have very high rates of ischemic heart disease in Europe despite the fact that Mediterranean populations – of which they are one, tend to have a low incidence of the disease. In the Netherlands, Turkish male migrants have a higher risk of fatal stroke incidents than Dutch males, and in Sweden male migrants irrespective of origin are at greater risk of CHD than Swedish-born men. Patterns of CVD among South Asian and southern European migrants suggest that they too are now beginning to be at higher risk than Swedes. In the UK people of Caribbean origin are more likely than their “white” host counterparts population to suffer from stroke, and people of South Asian origin, including men in low age groups, appear to be more prone to coronary heart disease than the host population, with 36% (men) and 46% (women) higher

coronary heart disease mortality rates than British men and women of European and other backgrounds. A range of candidate factors merit consideration in this emerging epidemiology of CVD in migrants. The complex nature of migration and resettlement and the psychosocial conditions surrounding it present serious challenges to everyday life and work and poor dietary adaptation, and obesity also need to be taken into consideration. In Sweden, migrant women have been reported to have a higher tendency to obesity than non-migrant women, and possibly for many of the same reasons, especially poor dietary adaptation and stress, Type 2 diabetes is also emerging as a disease that some migrants groups are especially at risk of[26]. In the Netherlands migrants of Turkish and Surinamese Indo-Asian origin are far more likely to develop the disease than the general population and in Norway Type 2 diabetes among South Asian women and men is almost nine and three times respectively, higher than among their “western” counterparts. A similar picture is also emerging in the UK. Patterns of diagnosis and treatment, especially the capacity for self care, vary considerably and migrants may be less able to manage their diabetes than others are.

5. OVERCOMING BARRIERS

To date, most EU and EFTA countries have taken a fairly passive approach to the issue of migration and have assumed that either migrants will choose not to stay for prolonged periods, or that they share the same health profiles and needs of their hosts. The emerging picture suggests this is far from being the case and that the mono-cultural epidemiological models used in much of health planning in the region have not kept pace with the implications of today’s changing social, cultural and demographic environment. The health and health care needs of migrants now call for new disease prevention and health protection strategies that take into account the epidemiological profile of the countries migrants are coming from, the conditions under which they are moving and the conditions in which they are living and working in once they arrive. They will also have to address the many linguistic and cultural features that characterize migrants’ knowledge and attitudes to health and health care. Training of health care personnel in what has become known as cultural competency is also long overdue.

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