European Migrant Crisis: Health and Policy Implications

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Abstract

Over 65 million people are displaced worldwide. Some have migrated to Europe, seeking refuge from wars, conflict and natural disasters. Migration and refugee health have significant repercussions for European governments and the European Union (EU), which were somewhat unprepared to address such issues. The EU proposed Health 2020 as immediate measures to address the health needs of refugees and migrants. The initiative was adopted to improve health for all, and to reduce health inequalities through public policy. However, there are legal restrictions barring irregular migrants from accessing these services. In addition, health service policies for irregular migrants varies in the EU region. There is inadequate response to some diseases affecting migrants from African origin. Consequently, refugee and migrant health is neglected, producing an inequitable situation and unnecessary suffering for the migrants, as well as potential risk to population in their host country.

Keywords: Africa, disease, European agenda, migration, policy, public health

Introduction

More than 65 million people are estimated to be displaced worldwide, (United Nations High Commissioner for Refugees (UNHCR) 2015), with European countries registering over two million asylum applications since January 2015. The number of migrants entering the

European Union (EU) member states has increased steadily since 2008, but reached record highs in 2015. Europe received the largest inflow of refugees and asylum seekers since World War II, fleeing conflicts in Syria, Afghanistan, Iraq, and elsewhere. The International Organization for Migration (IOM) estimates that 1,046,600 migrants arrived in Europe by land and sea. There were almost 4,000 migrant deaths in 2015, nearly four times as many as in 2014 (EYGL 2016; BBC 2016; UNHCR 2016). This situation reportedly "overwhelmed" (Al Jazeera 2016) national authorities and calls for international solutions quickly ensued. International non-governmental organizations were quick to deploy missions at key points along migratory routes, and intergovernmental organizations supported national and regional policies. They also designed interventions on the ground. At the same time, under the auspices of the EU, the continent's leaders met to discuss possible responses to the increased migratory flows, to assign responsibility for the provision of basic services, and to decide on a process for relocating refugees and asylum seekers across the EU's twenty-eight member states. Nevertheless, despite repeated summits and policy declarations, the implementation of agreed actions remained elusive because according to the European Commission in its economic forecast for autumn 2015, three million people could arrive in Europe by the end of 2017 (EYGL 2016; Kenitikelenis and Shriwise 2016).

The trend of increased numbers of refugees and migrants on the Central Mediterranean route continues in 2017. More than 80 percent of all sea arrivals during the first six weeks of the year were registered in Italy (UNICEF 2017). Major risks confronted by refugee and migrant children and women along this route include detention, extortion, gender-based violence, abuse, exploitation and drowning at sea. In January 2017, UNICEF-supported outreach teams identified 1,793 children at risk in Turkey and across Europe, while 739 children, including adolescents,

joined structured education activities in Greece, Bulgaria, Serbia and the former Yugoslav Republic of Macedonia (UNICEF 2017). In addition, 256 babies and infants accessed Infant and Young Child Feeding (IYCF) services, and 1,438 children received culturally appropriate basic supplies in Serbia and Italy. As UNICEF enters its third year of response to the refugee and migrant crisis in Europe, in January it launched its Humanitarian Appeal for 2017 requesting a total of US$ 43,452,000 for continued interventions in response to this complex crisis.

This migrant movement constitutes one of the largest movements of displaced people through European borders since World War II. In 2015, the majority of people leaving by boat from Turkey came from war-torn countries. By mid-December, 57 percent of those who arrived in Greece were from Syria, 24 percent from Afghanistan, 9 percent from Iraq, and 10 percent from other countries (UNHCR 2016). Yet the movement is also becoming increasingly diverse. While 91 percent of those arriving in Greece from Turkey are from the top ten 'refugee-producing' countries, people of other nationalities have increasingly joined the flow. A small but growing number of individuals from South West Asia, North Africa and West Africa are also moving along the same route in an attempt to reach Europe (UNHCR 2016).

This article will address the historical migration trend, migration pressure, European agenda on migration, and health implications of the migration crisis. It will also provide possible recommendations. Migration into and within Europe have implications for public health and public policy. These issues were put on the European agenda during the Portuguese Presidency of the Council of the EU in 2007 (Peiro and Benedict 2010). The conference "Health and migration in the EU: Better health for all in an inclusive society," in Lisbon in June 2007, led to a draft Council Conclusion, adopted by the Council of the EU in December 2007. The draft Council Conclusion highlighted the link between the health of migrants and that of all EU

citizens. According to Peiro and Benedict (2010), the Council Conclusion recommended that the European Commission support action through the Programme of Community Action in the Field of Health 2008–13. It invited the member states to integrate migrant health into national policies and requested that they facilitate access to healthcare for migrants. The Conclusion also called on the European Centre for Disease Prevention and Control (ECDC) to produce a comprehensive report on migration and infectious diseases in the EU. It recommended focusing on tuberculosis (TB), Human Immunodeficiency Virus (HIV) and vaccine-preventable diseases, to inform policy and public health responses (ECDC 2009).

Although certain diseases are associated with the migrant population, Frontières (2016) asserted that final destinations are not always what migrants and refugees expected, and even in Europe, living conditions in the transit camps, where they spend months and even years, often fall well-short of basic humanitarian standards. Preventable, but poor sanitation, overcrowding, and insecurity, which are commonplace among migrant occupation and refugee camps, cause or intensify a large proportion of the health problems being seen in these camps.

Historical Migration Trends

The European continent has been shaped by a long history of internal migration flows (De la Rica et al. 2013). Such flows often occurred in response to the constant shifts of economic and geopolitical power between Europe's constituent nation states. In the aftermath of World War II (WWII), for example, Germany received several million refugees from regions formerly part of Nazi Germany, while large numbers of Finns and Poles had to relocate to the western parts of their countries. According to De la Rica et al. (2013) large-scale immigration into Europe from the rest of the world is a more recent phenomenon. They note that starting in the early 1950s, many European colonial powers (in particular the United Kingdom and France, but

also Belgium, the Netherlands and Portugal), lost their colonies abroad, triggering large population movements toward the metropolitan countries from such diverse regions of the world as Africa, the Caribbean, and South Asia. Countries with no colonies, particularly in Northern and Central Europe, often addressed their severe post-war labor shortages by signing guest-worker agreements. The ensuing immigrant inflows played an important role in the economic expansion in Europe after WWII and turned many ethnically homogeneous countries into multi-ethnic societies. The IOM (2008) estimated an approximate 7.6 percent of the total EU population to be foreign-born, and it was estimated that between 2.6 million and 6.4 million migrants are in irregular status. The recent trends in the inflow of the migrants and refugees into Europe reflect a combination of several factors such as political instability, social unrest, violence, emerging geo-strategic dynamics in the West Asian region, the quest for better political and socio-economic conditions, as well as access to the social security system. Global trends point out that the number of displaced people has been rising. The UNHCR (2015) annual global trends report, "World at War," noted that worldwide displacement was at the "highest level ever recorded."

The movements include men, women, boys and girls; young and old; singles and whole families. Many among those on the move have specific needs that place them at heightened risk (UNHCR 2016). These include unaccompanied or separated children (UASC), single women, pregnant or lactating women, the elderly, people with disabilities, as well as the sick and injured. There is a significant number of children among the population on the move (both unaccompanied or separated and traveling with families) requiring particular attention; with approximately 30 percent of the total movement from Turkey to Greece being children. In total, 250,000 children have needed specific protection and assistance in 2015 alone (UNHCR 2016).

The current migration flow to Europe appears to have caught the international community unprepared. Although efforts were made at the European level in the course of 2015 to manage borders through registration, screening, relocation and return, this has only been partially implemented and often at a very slow pace, according to the Regional Refugee and Migrant Response (RRMR) Plan for the Europe Eastern Mediterranean and Western Balkans Route January-December 2016. While significant achievements have been made by many of the countries involved in terms of humanitarian assistance, the overall response has remained unstructured (RRMR 2016).

Migration Pressure

Over the last two years, Europe has experienced a significant migration and refugee crisis as people have fled conflict and poverty in Syria, Iraq, Afghanistan, Africa, South Asia, and other countries and regions (UN 2017). According to the United Nations, more than 1 million refugees and migrants reached Europe by sea in 2015, and roughly 362,000 did so in 2016 (UN 2017). Greece and Italy have been major arrival and transit points. Many individuals subsequently attempted to travel onward to northern EU member countries, such as Germany and Sweden, where they believed they were more likely to receive asylum and better welfare benefits.

Archicks (2017) analyzing the current EU challenges and future prospects beginning from 2015, argued that various EU initiatives to manage the crisis proved largely unsuccessful. The EU came under criticism for lacking coherent and effective migration and asylum policies, which have long been difficult to forge because of national sovereignty concerns and sensitivities about minorities, integration, and identity. The flows also created deep divisions within the EU. Frontline states: Greece and Italy; and key destination countries farther north, expressed dismay

at the lack of European solidarity. Others charged that traditionally generous asylum policies in countries such as Germany and Sweden were serving as pull factors and exacerbating the flows (Archicks 2017). Some EU governments reportedly viewed with dismay, Germany's announcement in August 2015 that it would no longer apply the EU's "Dublin regulation," (which usually deems the first EU country an asylum-seeker enters as responsible for examining that individual's application). Germany's decision was considered a unilateral move potentially subverting agreed-upon EU asylum procedures, and failing to consider the implications for the wider EU.

Efforts to establish EU redistribution and resettlement programs, in which each EU member state would accept a certain number of asylum-seekers and refugees (in part to relieve the burdens on Greece and Italy), were extremely controversial. Countries in Central and Eastern Europe were particularly vocal opponents. They feared that the newly arrived migrants and refugees, many of whom are Muslim, could alter the primarily Christian identities of their countries and of Europe (Archicks 2017). Although the EU approved a limited but mandatory plan to relocate some asylum-seekers from Greece and Italy in September 2015, this outcome was achieved using the EU's qualified majority voting system rather than consensus. Hungary, the Czech Republic, Slovakia, and Romania voted against the plan, and Finland abstained. Adopting a proposal on such a sensitive issue directly related to a state's sovereignty and territorial integrity by the qualified majority is largely unprecedented in the EU. Many observers viewed the need to hold the vote as a further indication of the profound cleavages within the bloc (Archick 2017).

As the uptick in refugees and migrants arriving in Europe continued unabated in early 2016, the EU began to focus on discouraging people from undertaking the journey in an effort to

stem the flows. In March 2016, EU leaders agreed to end the "wave-through approach" that was allowing individuals from Greece to transit the Western Balkans to seek asylum in other EU countries, and announced a new deal with Turkey. The main provisions of the EU's accord with Turkey centered on Turkey taking back all new "irregular migrants" crossing from Turkey to the Greek islands in exchange for EU resettlement of one Syrian refugee from Turkey for every Syrian returned. The EU also pledged to speed up the disbursement of a previously allocated €3 billion in aid to Turkey and to provide an additional €3 billion in assistance for Syrian refugees in Turkey.

Since these measures took effect, the number of migrants and refugees reaching Europe has decreased substantially. Nevertheless, the EU's deal with Turkey remains controversial and potentially fragile. Most EU leaders maintain that the return measures agreed upon with Turkey are crucial to breaking the business model of migrant smuggling and saving lives. However, some Members of the European Parliament and many human rights advocates are concerned that the agreement violates international law and the rights of refugees. Those of this view also worry that other parts of the accord with Turkey—in which the EU pledged to lift visa requirements for Turkish citizens—and to reenergize Turkish accession negotiations could be seen as rewarding a Turkish government that they view as increasingly authoritarian.

The failed July 2016 coup attempt in Turkey and the subsequent government crackdown has exacerbated tensions between the EU and Turkey. Although Turkey has made progress in meeting most of the EU's requirements for visa-free travel, some issues remain outstanding. In November 2016, the European Parliament approved a nonbinding (although symbolic) resolution calling for Turkey's EU accession negotiations to be suspended until the Turkish government ends its "disproportionate" response to the failed coup. Amid these developments, some

observers suggest that the EU's deal with Turkey on the refugee and migrant flows could be in danger (Nikolaj 2016, 2017).

Although the agreement with Turkey has helped to staunch the migrant flows to Greece, Italy has experienced an uptick in migrant and refugee arrivals since mid-2016. Most of these individuals come from Africa, with Libya being their main point of departure. In early February 2017, the EU announced a plan to help the UN-backed Libyan government curb migration across the Central Mediterranean. Among other measures, the EU will seek to provide increased training and better equipment for the Libyan coast guard, improve conditions at Libyan reception centers, enhance EU cooperation with countries near Libya to slow the inflows, and work with local communities on migration routes and in coastal areas to improve their socioeconomic conditions. As a first step, the EU announced €200 million in funding through 2017 for such migration-related projects. Local Libyan authorities, however, have criticized the plan as likely to worsen the situation on the ground in Libya. Furthermore, refugee advocates worry that the plan does not sufficiently protect human rights, and some analysts suggest that Libya's continued instability casts doubt on the plan's prospects for success (BBC 2017).

The migration and refugee flows continue to have significant repercussions for European governments and the EU. Perhaps most notably, the migratory pressures have severely strained the Schengen system, which largely depends on confidence in the security of the bloc's external borders. This concept has been tested not only by the magnitude of the refugee and migrant flows but also by concerns that some terrorists may have been able to exploit the chaos to slip into Europe. In 2015, several Schengen countries (including Germany, Austria, Denmark, and Sweden) instituted temporary border controls in response to the migratory pressures. These

temporary controls remain in effect, and some experts worry they could become permanent, at least on a de facto basis.

EU officials assert that they remain committed to Schengen and are working to strengthen EU border controls, including by establishing a new European Border and Coast Guard to reinforce national capacities at the EU's external borders through joint operations and rapid border interventions. This new border guard corps became operational in October 2016 (Archick 2017). The European Commission also has been working with Greece to improve the country's border control management, and the EU continues to support "hotspot" facilities in both Greece and Italy to help register and process all refugees and migrants.
The influxes of refugees and migrants have renewed questions about European countries' ability to integrate minorities into European culture and society. Such anxieties have become more pronounced amid reports of criminal activity and sexual assaults allegedly committed by some migrants and asylum-seekers and by revelations that many of the recent terrorist attacks in Europe were carried out by extremists of Muslim background born and/or raised in Europe. At the same time, there are concerns about increasing societal tensions and xenophobia in Europe. Germany, Sweden, and other EU countries have seen an increase in the number of violent incidents against migrants and refugees (Jim 2017).

Debate has also arisen over the economic impact of the migrant and refugee flows. Some leaders and analysts contend that the influxes could be economically beneficial and help to offset unfavorable demographic developments (such as ageing populations and shrinking workforces), thus strengthening EU fiscal sustainability in the longer term. Many experts point out, however, that much will depend on how well migrants and refugees are integrated into the labor market (International Monetary Fund (IMF) 2016). Others worry that the newcomers could take jobs

away or reduce wages, especially in the short term. Some suggest that such fears have helped to further increase support in many EU countries for far-right, anti-immigrant, Eurosceptic political parties.

European Agenda on Migration

On the basis of a Commission Proposal (10-point action plan), on April 23, 2015, the member states undertook to take swift action to save lives and step up the EU's action in the field of migration (WHO 2017). A European Parliament resolution was adopted on April 29, 2015. On May 13, 2015, the Commission published the "European Agenda on Migration." The Agenda proposes immediate measures to cope with the crisis in the Mediterranean and measures to be taken over the next few years to manage all aspects of immigration more effectively. As regards the medium- and long-term, the Commission proposes guidelines in four policy areas: reducing incentives for irregular immigration; border management –saving lives and securing external borders; developing a stronger common asylum policy; and establishing a new policy on regular immigration, modernizing and revising the "Blue Card" system, setting fresh priorities for integration policies and optimizing the benefits of migration policy for the individuals concerned and for countries of origin. The Agenda also launched the idea of setting up EU-wide relocation and resettlement schemes and proposed a possible Common Security and Defence Policy (CSDP) operation in the Mediterranean to dismantle smuggling networks and combat trafficking in persons.

On the basis of this agenda, on April 6, 2016, the Commission published its guidelines on regular immigration in a communication entitled: "Towards a reform of the common European asylum system and enhancing legal avenues to Europe." There are four main strands to the guidelines as regards regular migration policies: revising the Blue Card Directive, attracting

innovative entrepreneurs to the EU, developing a more coherent and effective model for regular immigration in the EU by assessing the existing framework, and strengthening cooperation with the key countries of origin (Fact Sheet 2017).

For many supporters of the European project, the EU has entered uncharted territory. Although most experts consider a complete dissolution of the EU to be likely, the future shape and character of the bloc are being increasingly questioned. In light of the serious internal and external challenges currently facing the EU, especially Brexit, advocates worry that for the first time in EU history, at least some aspects of integration may be stopped or reversed. Others contend that the multiple crises currently facing the EU could produce some beneficial reforms and ultimately transform the bloc into a more effective and cohesive entity.

Following the June 2016 United Kingdom (UK) Brexit vote, many EU leaders acknowledged that it cannot be "business as usual," especially given the extent of public dissatisfaction, both with the EU itself and with Europe's generally pro-EU political establishment. Days after the UK referendum, the leaders of the 27 other member states announced they were launching a "political reflection" to consider further EU reforms and how best to tackle the key security and economic challenges facing the EU (European Council 2016). Germany, France, and Italy are spearheading this effort and likely will be influential in determining the EU's future direction.

In September 2016, the EU-27 leaders (meeting informally) held an initial discussion in Slovakia. The resulting *Bratislava Declaration* asserts that "although one country has decided to leave, the EU remains indispensable for the rest of us." EU leaders also pledged to find "common solutions" to current challenges and to improve communication between the EU and its citizens. The accompanying *Bratislava Roadmap* sets out "concrete measures" for addressing

some aspects of the migration crisis. These include countering terrorism, strengthening EU security and defense cooperation, and improving economic opportunities, especially for young people (European Council 2016). Despite the attempt to demonstrate unity in Bratislava, some EU leaders reportedly were disappointed that measures proposed were not bold enough, did not offer a strategic vision for the EU going forward, and were focused mostly on implementing tactical responses to the various crises or recommitting support to existing initiatives (Herszenhorn and Palmeri 2016).

In early February 2017, the EU-27 leaders held a follow-up discussion to their talks in Bratislava and sought to prepare for the European Council summit at the end of March 2017 in Rome. This was designed to coincide with and honor the 60th anniversary of the *Treaties of Rome.* The EU asserted that the March meeting in Rome would conclude the EU's "reflection process," and the EU-27 leaders were expected to issue a declaration setting out post-Brexit plans for the EU at that time.

Migration Crisis and Health Implications

Migration implies challenges and opportunities (Peiro and Benedict 2010). Health is one major challenge and an essential element for migrants' well-being and contribution to societies. Migrants' health and the implications for their integration, public health and health services in the EU are becoming more important as EU member states experience increases in their foreign-born populations. The health of migrants is seen by many experts and stakeholders as an essential theme in the current EU and member states' health agendas.

The issue of migration and health is high on the EU agenda. EU political commitment is reflected in policy instruments intended to ensure that migrants have access to healthcare and in the *European Commission's 2003– 2008 European Health Programme* and *2008–2013 Second*

Programme of Community Action in the Field of Health. The latter include projects on health inequities, migrant health status and infectious disease burden and models for the provision of health care for undocumented migrants. However, more can be done to improve understanding of the relationship between migration and public health, and to address the health and healthcare needs of migrants.

Migration involves several stages, each of which presents strategic opportunities for prevention and control of infectious diseases. There is a pre-entry phase, where a migrant's health reflects the disease profile of his or her country of origin. There is a transitional phase, where the process of moving, sometimes through intermediate countries, can influence a migrant's health (Ho 2003). Finally, there is a post-entry phase, where the process of adapting to working and living conditions in the host country can also influence a migrant's health.

There are European Union legal references in the field of health. The treaty establishing the European Community states that a high level of human health protection shall be ensured by the Community, with the proviso that Community action, by the subsidiary principle, can only complement national policies, for instance in relation to cross-border health threats, patient mobility and reducing health inequalities. The Council Conclusions on "Health in All Policies" under the Finnish EU Presidency stressed the fact that the impact of health determinants is unequally distributed among population groups, resulting in health inequalities (Council of the European Union (CEU) 2006). These Conclusions also recognized that immigration, integration and social policies could have a positive or negative impact on health determinants. Before the Finnish EU Presidency, the UK EU Presidency in 2005 also devoted attention to health inequalities, notably via a summit on "Tackling Health Inequalities: Governing for Health."

Despite concerns that migrants are responsible for the spread of infectious diseases, most migrants to the EU are healthy (Peiro and Benedict 2010). In population terms, however, migrants bear a disproportionate burden of infectious disease. For example, in the UK, approximately 70 percent of newly diagnosed cases of TB and HIV were in people born outside the UK (Health Protection Agency (HPA) 2006). The ECDC (2015) reported that in Europe, migrants bear the highest burden of infectious diseases, including TB, HIV, and malaria. The risk of outbreaks as a consequence of this burden is, nevertheless, extremely low. Displacement adds a litany of other health challenges, such as intentional and accidental injuries, psychological trauma, sexual abuse, poor nutrition, and exposure to infectious diseases (Uniken Venema and Weirdsma 1992; Selten and Sijben 1994; Karmi 1997).

Socioeconomic, cultural and legal factors, in particular, affect the physical and psychological health of migrant populations. Poor living and working conditions are also critical factors. Migrants often live in poor quality, overcrowded housing, which increases the risk of diseases such as TB. High rates of domestic accidents, including lead poisoning, have been recorded among migrant children living in poor quality housing (de Jong and Wesenbeek 1997). Reports suggest that most migrants and refugees are young and relatively healthy, but this should not eclipse the fact that many are coming from countries whose healthcare systems have broken down, and where protracted conflicts and poverty have long limited people's access to quality health care, including screening and vaccination (Frontières 2016).

Low-skilled migrants tend to do jobs in higher risk occupational sectors. For example, the incidence of occupational accidents and diseases in construction and agriculture is higher than in other sectors (Bollini and Siem 1995; Carballo and Siem 1996). Migrants may be unfamiliar with the safe use of equipment and often receive inadequate training, supervision and protection.

Psychological health may be affected by the process of leaving family and coping with job insecurity, legal problems, unfamiliar language and culture. Stress and anxiety can result in more serious psychological problems (Mirdal 1985; Selten and Sijben, 1994; Liebkind 1996). Limited access to healthcare for migrants is also a critical factor. Policies, laws and regulations governing service delivery, the characteristics of migrant communities, and wider social attitudes can all influence access to, and uptake of services. Legal status, with consequent lack of residence status and health insurance, are often barriers to healthcare. Lack of culturally sensitive information in relevant languages, suitably trained professionals and services tailored to the specific needs of migrants are also barriers. Within migrant communities, culture, religion, beliefs about health, disease prevention and healthcare as well as limited knowledge of available services can prevent uptake of services.

The stigma and discrimination associated with TB and with HIV may be exacerbated in the case of migrants who are already socially isolated, and fear further stigma, discrimination and marginalization. This may deter them from seeking screening, counseling and/or testing. Migrants also tend to be disproportionately represented in prisons in many countries of the EU. Conditions in prisons, such as overcrowding and poor ventilation, can increase the spread of infectious diseases like TB among inmates. Solutions and measures to deal with long-term displaced populations are lacking, with the focus falling on short-term "care and maintenance." Almost half of the refugees under the care of the United Nations High Commissioner for Refugees (UNHCR) in 2014 had been displaced for five years or more. In many countries, the tide of public opinion is turning against migration as negative press coverage and, increasingly, the political discourse focus on security issues, social cohesion and pressure on basic public services, such as healthcare and education.

The 2016 UN high-level Summit for Refugees and Migrants in New York (UN 2016) provided an historic opportunity to engage world leaders in responding to the health dimensions of mass migration. Despite the magnitude of the phenomenon and its potential for changing global as well as national health patterns, the response to date has been, at best, variable (WHO 2015a, 2015b). At worst, it has been an example of benign national and international neglect. The health sector has been especially passive on this issue. At present, most of the health care being provided to refugees and migrants arriving in Europe is by volunteers and non-governmental organizations that do not necessarily have any special training or formal links with the healthcare system, leaving many migrants with variable healthcare quality, and making timely referral to secondary or tertiary institutions difficult (DeLargy 2016).

Public Health Aspect of Migrant and Refugee Health

Refugee and migrant health was probably the basis of the adoption of health 2020 agenda of the World Health Assembly resolution of 2012 (WHO 2012a) which is the improvement of health for all, and the reduction of health inequalities through policies focused on four priority areas (WHO 2018). According to the report, there is investment in health through a life-course approach and empowering people; tackling the region's major health challenges of communicable disease and NCDs; strengthening people-centered health systems, public health capacity and emergency preparedness, surveillance and response; and creating resilient communities and supportive environments. The question is: to what extent have these priorities been followed? The rest of this article will interrogate these priorities as linked to refugee and migrant health.

According to the WHO (2018) report, refugee and migrant health is a highly complex topic because findings cannot be generalized to wider refugee and migrant populations in a

country, region or globally. Hitherto, refuge and migrant health outcomes are a product of different interacting factors such as the migratory process, social determinants of health, the risks of exposure in the country origin, transit or destination environment, interacting with biological and social factors.

Social determinants of health require a general public health approach. As noted in the WHO (2008) article on the need for closing the gap in a generation through health equity and action on social determinants of health, "the condition in which people grow live work and aged have a powerful influence on health, and … avoidable inequality in these conditions could lead to severe inequality in health." Some such conditions are the displacement and migratory trajectories that place individual refugee and migrants at risk for certain diseases (WHO 2018, ECDC 2017). The report affirmed that in 2015 for example, more than one-third of all newly diagnosed HIV cases in the EU/European Economic Area (EEA) were of foreign origin; while in ten EU/EEC countries, more than half of all newly diagnosed HIV cases were also of foreign origin. This is of great importance to public health, and implies the need to attend to the health needs of refugees and migrants in the host countries. A study on mortality from infectious disease among African migrants in Portugal found higher mortality from Acquired Immunodeficiency Syndrome (AIDS) in migrants, than in those born in Portugal (Williamson et al. 2009).

The epidemiology profile of migrants and refugees can impact the epidemiology profile of a country because the descendants of migrants might have genetically related illness and individualized diseases (Hemminki et al. 2015). Moreover, research also confirmed that refugee and migrant communities and their descendants frequently travel with other non-migrant travelers, which may expose them to different travel-related health risks (Piel et al. 2017; Public

Health England 2017). Neglecting refugee and migrant health, therefore, is a potential risk to the host countries.

Healthcare Delivery, Gaps in Coverage, and Discrepancy

There is a high degree of variability in the right to healthcare for irregular migrants in the European region. While healthcare should be available at all levels regardless of the administrative status of the persons seeking treatment, there are frequently legal restrictions barring irregular migrants from enjoying full and effective access to this service (WHO 2018). Generally, there is a lack of healthcare policies at the national level that address the irregular migrant issue (Suess et al. 2014; WHO 2015b). The policies for health services for irregular migrants vary greatly in the region from no access to full access (WHO 2015b). The literature on migrants' health service utilization in Europe shows the underutilization of screening services by migrants and inconsistent primary care (Graetz et al. 2017). Furthermore, information on the immunization status of refugees and migrants is often lacking because they may not be specifically targeted in surveillance programs (Mipatini et al. 2017). Although TB is a vaccine-preventable disease, it is prevalent among refugees and migrants (Dhavan et al. 2017). This is because, according to Dhavan et al. (2017), TB is a disease of poverty, aggravated by social deprivation and substandard living conditions, a condition that is almost ubiquitous among refugees and irregular migrants. There is evidence of higher levels of prevalence of multidrug-resistant TB (MDR-TB) among refugees and migrants in Europe, than in host populations because of failures within the health system. Such failures include poor capacity for detection, late initiation of treatment and incomplete treatment courses (Hargreaves, et al. 2018).

Discrepancy in migrant and refugee health outcomes also occur because a person's migrant status is used to restrict entitlement to national healthcare services. For example,

irregular migrants do not have access to prenatal and postpartum health services, and are often

limited to emergency care services (WHO 2015; IOM 2016; WHO 2018). According to Suk and

Semenza (2011), restricted access to healthcare for refugees and migrants has the potential threat

of causing the emergence and re-emergence of infectious diseases.

According to the European Commission's (2018) report, only four member states

(Austria, Croatia, Germany and Portugal) in the EU at the end of 2017 had defined indicators to

measure the integration of refugees and migrants in the field of health. These were the only states

that also created healthcare frameworks for refugees and migrants. While some member states

may have national health strategies, these strategies often do not make any reference to refugee

and migrant health or accessibility to healthcare for the refugee and migrant population

(European Commissions 2018).

African Refugee and Migrant Disease Burden in Europe

Some diseases are uncommon in the majority of countries of the European region, and

those assessing and providing care for refugees and migrants should be familiar with the

epidemiology and distribution of such diseases (see Table 1). Tropical and parasitic infections

(e.g., schistosomiasis, strongyloidiasis, and Chagas disease) can also be associated with long

periods of latency or chronicity, which can have serious effects on individual health if left

untreated (Monge-Maillo et al. 2015; Olorunlana et al. 2016).

Another tropical disease that is of public health importance is malaria. The risk for re-

emergence of malaria in Europe is attributed to people in transit from sub-Saharan Africa

(Khyatti et al. 2014). A higher prevalence of hepatitis B and C infections (HBV and HCV) were

seen among refugees of North Africa compared with the host population in some countries of the

European region (Khyatti et al. 2014). In another report, evidence from Sweden suggests that

migrants from sub-Saharan Africa are 2.5 times more likely than the host population to develop type 2 diabetes (Bennet et al. 2014).

In the case of stroke, however, records indicate that consistently higher mortality and incidence rates have been observed for migrants of West African origin. In England in 1999–2003, stroke mortality was almost 200 percent higher among male migrants from West Africa (Harding et al. 2009). In a more recent study, the migrant population in Italy was seen to have a higher risk of stroke and hypertension than the host population (Clementi et al. 2016; Fedeli et al. 2016). In addition, rates of cerebrovascular disease, hypertension and heart failure were higher in migrants from Africa than in the general Italian population (Fedeli et al. 2018).

In France, maternal mortality is 2.5 times higher among refugee and migrant women than women born in France, and this rate increases to 3.5 times higher specifically for women from sub-Saharan Africa (Deneux-tharaux and Saucedo 2017; Pedersen et al. 2013). African refugee and migrant mothers in Sweden were found to have 18 times higher risk of neonatal death with potentially avoidable perinatal deaths (Essén et al. 2002; Esscher et al. 2013). The most common factors identified as resulting in potentially avoidable perinatal death were a delay in seeking healthcare, refusal of medical interventions, insufficient surveillance of intrauterine growth restriction, inadequate medication, misinterpretation of cardiograph and interpersonal miscommunication (Essén et al. 2002; Pedersen, et al 2013).

A large cohort study in Sweden indicated an increased risk for psychotic disorders for those who migrated during infancy and a variation in risk by region of origin, with migrants from Africa having an elevated risk for schizophrenia (Dykxhoorn et al. 2017).

Despite the recorded disease burden, the WHO (2018) report suggests that following specific strategies might alleviate the burden of these diseases by improved monitoring, a better

understanding of risk factors, strengthened prevention and testing programs for refugees and migrants, removal of barriers to the provision of healthcare services, and updating services that contribute to strengthened evidence-based care; are all necessary for public health interventions. We assume that the consideration of health issues faced by refugees and migrants provide an opportunity to detect gaps in routine service delivery and finance arrangements. To strengthen universal health coverage however, European countries would need to enact policies that will promote the basic health and well-being of refugees and migrants as the EU follows the WHO strategies and action plans.

Conclusion

The number of displaced people globally influenced the new trend of increased numbers of refugees and migrants, and consequent constructions of crises in the EU in 2015. Although the numbers were technically reduced in 2016 by EU policy, a new trend of migration is in the continuum in 2017. In the modern era, historically, WWII recorded the beginning of significant migrant movement through European borders. Migration into and within Europe has implications for public health, as some specific diseases are associated with the migrant population. Millions of migrants are in irregular status, because a significant number of them fled from conflict and poverty in their countries of origin. The EU is currently facing these challenges amidst the escalation of nativist xenophobic rhetoric. Efforts to establish EU redistribution and resettlement programs, in which each EU member state would accept a certain number of asylum-seekers and refugees are extremely controversial, due to the growing influence of right-wing parties and attendant xenophobia. Nonetheless, the migration and refugee flows will continue to have significant repercussions for European governments and the EU, as well as on the health of the migrants.

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Table 1: Diseases and health condition of Africa refugees and migrants in Europe

S/N	Disease and/or health condition
1	Cerebrovascular disease (hypertension and heart failure)
2	Chagas disease
3	Hepatitis B and C (HBV and HCV)
4	Malaria
5	Risk for Psychotic disorders
6	Risk for Schizophrenia
7	Risk of Neonate death
8	Schistosomiasis
9	Stroke
10	Stroke and Hypertension
11	Strongyloidiasis
12	Type 2 diabetes

Compiled by author, 2019.

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