



HEALTH PROMOTION AND HEALTH CARE OF MIGRANTS AND REFUGEES

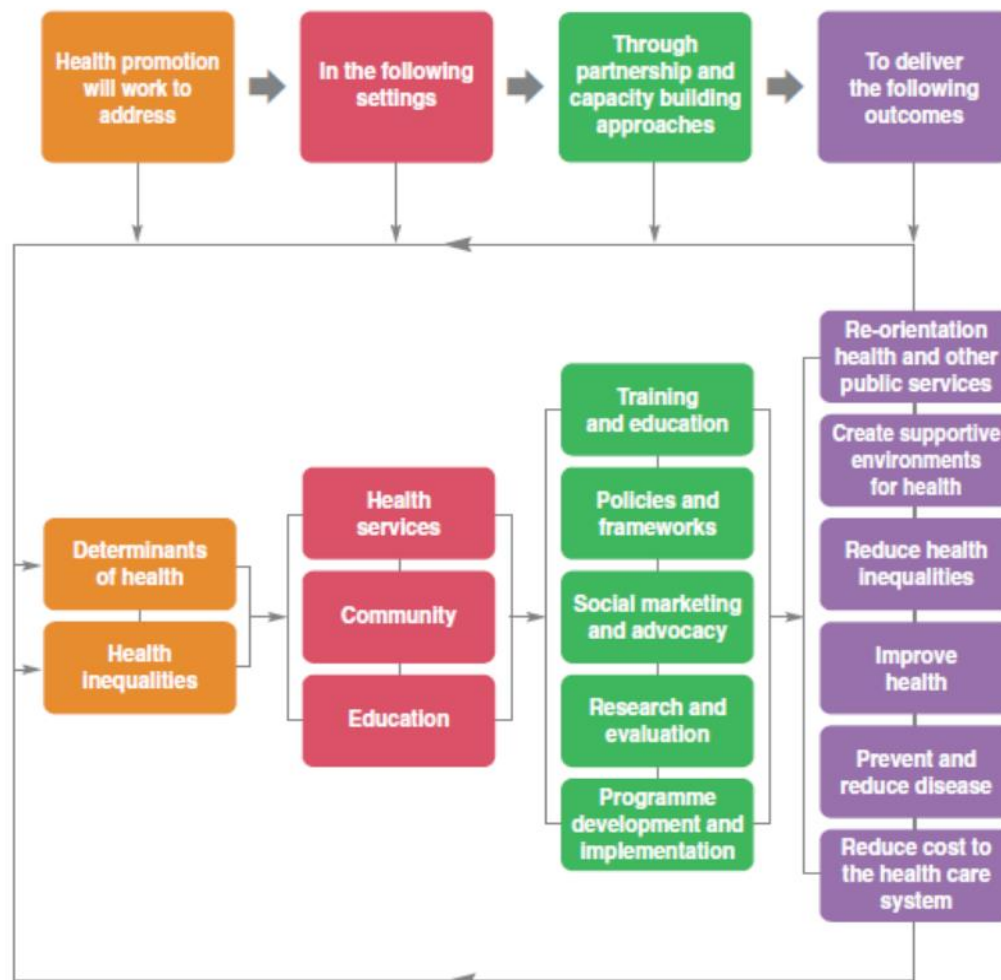


HEALTH AND HEALTH PROMOTION

- WHO: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.
- Health promotion is the process of enabling people to increase control over, and to improve, their health.
 - Building Healthy Public Policy,
 - Creating Supportive Environments,
 - Strengthening Community Action,
 - Developing Personal Skills,
 - Reorienting Health Services



HEALTH PROMOTION

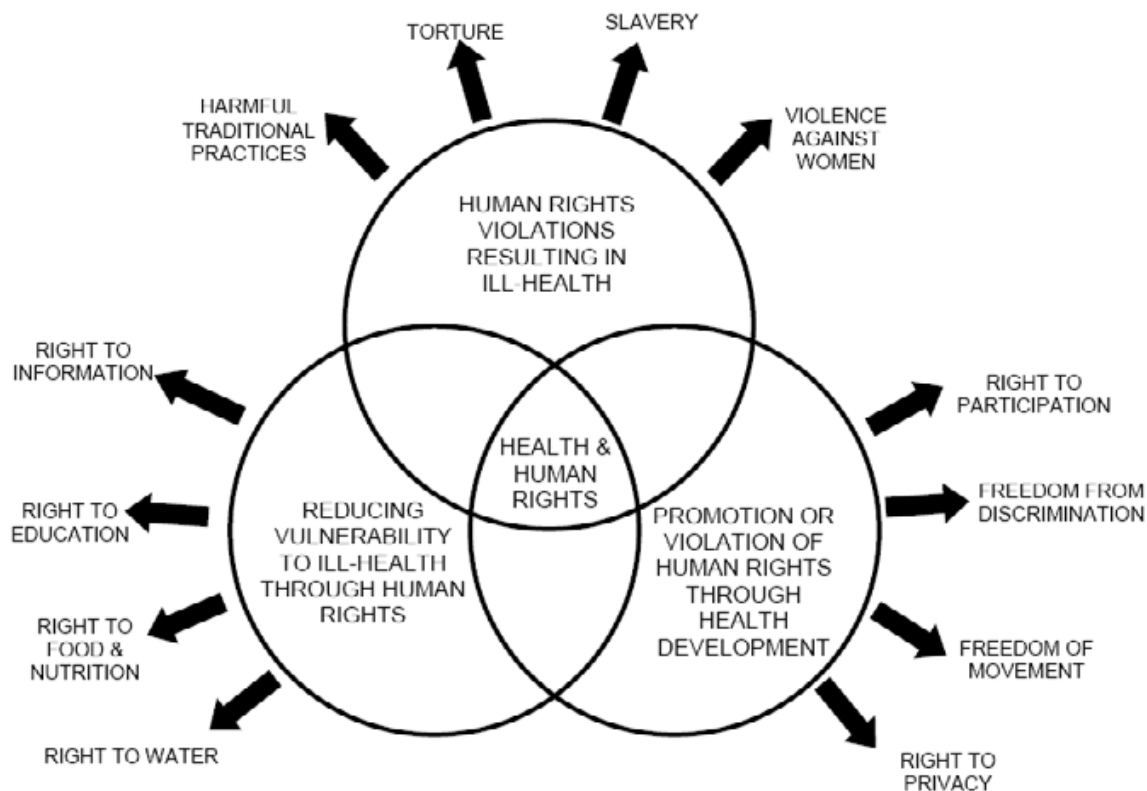




MIGRANTS' RIGHT TO HEALTH

- Health is considered a universal human right.

LINKAGES BETWEEN HEALTH AND HUMAN RIGHTS





THE RIGHT TO HEALTH

- Key aspects of the right to health:
- **Freedom** (the right to consensual and informed medical treatment, diagnosing or participation in medical experiments)
- **Entitlements** (obligation of the state to provide
 - adequate food, drinking water, shelter, sanitation, healthy occupational and environmental conditions;
 - adequate health services of the highest attainable standard and on an equal basis for all;
 - access to information and education about health



PUBLIC HEALTH APPROACH TO MIGRANT HEALTH



WHO. Health of migrants: the way forward – report of a global consultation, Madrid, Spain, 3-5 March 2010. Geneva: WHO, 2010.



MIGRANTS' HEALTH

- Some research suggests that immigrants to Western world are often healthier than the native-born residents of their host countries (**Healthy Migrant Effect**)
- Available morbidity and mortality data often do not include migrants returning home to convalesce and possibly to die (**Salmon bias**)
- Conditions surrounding the migration process can increase vulnerability to ill health (especially for people who migrate involuntarily, flee natural or man-made disasters and human rights violations)
- Other risk factors may include poverty, stigma, discrimination, social exclusion, language and cultural differences, separation from family and socio-cultural norms, administrative hurdles and legal status.
- Over several generations, the health outcomes of immigrant populations converge with those of native-born population (immigrants may adopt the least-healthy lifestyle habits of their host countries, including alcohol, tobacco, and drug use)



MIGRANTS' HEALTH

- Health of migrants is influenced by:
 - environmental, economic, genetic and socio-cultural factors
 - when people migrated, where and how they lived in their original home country, and how and why they migrated
 - postmigration factors involving integration, employment, education and poverty, as well as the accessibility and responsiveness of the health care system of host country to immigrants' health needs



STAGES OF MIGRATION PROCESS AND INFLUENCES ON MIGRANTS' HEALTH

- **Predeparture**

- Pre migratory events, particularly trauma, such as war, human rights violations, torture, sexual violence, especially for forced migration flows;
- Linguistic, cultural and geographic proximity to destination, including health beliefs and behaviours;
- Epidemiological profile and how it compares to the profile at destination;
- “Efficiency of health system in providing preventive and curative health care”.



STAGES OF MIGRATION PROCESS AND INFLUENCES ON MIGRANTS' HEALTH

- **Travel**
 - Travel conditions and mode (perilous, lack of basic health necessities), especially for irregular migration flows;
 - Duration of journey;
 - Traumatic events, abuse, (sexual) violence;
 - Alone or mass movement.



STAGES OF MIGRATION PROCESS AND INFLUENCES ON MIGRANTS' HEALTH

- Host community (countries of transit and destination):
 - Migration related policies/health policies;
 - Inclusion or discrimination;
 - Legal status and access to services;
 - Language and cultural values;
 - Separation from family partner;
 - Duration of stay;
 - Culturally, linguistically, and epidemiologically adjusted services;
 - Abuse, (sexual) violence exploitation, working and living conditions.



STAGES OF MIGRATION PROCESS AND INFLUENCES ON MIGRANTS' HEALTH

- **Return**
 - Level of home community services (possibly destroyed), especially after crises situations: Remaining community ties;
 - Duration of absence;
 - Behavioural and health profile as acquired in host communities.



KEY DETERMINANTS OF HEALTH IN MIGRANTS

- access to minimum essential food, which is nutritionally adequate and safe;
- access to drinking water;
- access to basic shelter;
- access to healthy occupational and environmental conditions;
- education and access to information concerning health;
- access to health care



LEGISLATION OF HEALTH CARE OF MIGRANTS IN HOST COUNTRY

- Example: Slovenia (adapt slide to your country)
 - International protection act (Uradni list RS, št. 22/16)
 - Health care and health insurance act (Uradni list RS, št. 72/06)
- Applicants for international protection have the right to:
 - Emergency medical treatment
 - Women's health care for family planning, pregnancy and birth
 - Children and youth to the full health care
- Migrants with approved status of international protection have covered:
 - Compulsory health insurance (for children and youth it means full health care coverage)



ACCOMODATION OF MIGRANTS IN RECEPTION CENTERS IN HOST COUNTRY

(Adapt slide to situation in your country)

Slovenia:

- **Applicants for asylum** are located in Asylum centre in Ljubljana and its branches (*for 540 migrants*)
(also in some other institutions e.g. Youth crisis centre or in private accomodation)
- **Migrants with approved status of international protection** can be located in two integration houses in Ljubljana and Maribor for one year (*for 60 migrants*) or in private accomodation
- **Migrants with rejected asylum application** are transferred to police and its accommodation center for foreigners in Postojna before leaving Slovenia (*for 350 migrants*)



HEALTH CARE OF MIGRANTS IN SLOVENIA

- Slovenia: (Adapt slide to situation in your country)
 - Asylum center in Ljubljana has its own ambulance with a contracted general practitioner, a doctor from Médecins Sans Frontières (MSF), once per week a psychiatrist for non-urgent situations and nurse 24/7
 - For asylum center branches health care services in the nearby medical institutions are provided
 - Migrants with approved status of international protection have equal access for health care services as local population



INTEGRATION OF MIGRANTS

Slovenia: (Adapt slide to situation in your country)

Migrants with approved status of international protection have the right to:

- Stay in Slovenia;
- One time financial support in amount of basic minimum income;
- Accommodation in accommodation capacities of Ministry of the Interior;
- Financial support for private accommodation;
- Help with integration;
- Information about rights and obligations;
- Education and training.



SOCIAL SUPPORT, EDUCATION AND OCCUPATION RIGHTS OF MIGRANTS

- Slovenia: (Adapt slide to situation in your country)
 - Migrants with approved status of international protection have the same rights to social protection and education as local population;
 - Migrants with approved status of international protection have free access to labour market and they don't need a work permit.



DIFFERENCES IN ACCESSING HEALTH CARE SERVICES IN MIGRANTS

- Compared to non-migrants several studies show:
 - Higher utilization of ER and GPs among migrants;
 - Underutilisation of psychiatric, reproductive health services, prenatal/maternity care, screening programmes and other specialist services and outpatient care

Consequences of poor access to health care:

- Higher rates of maternal mortality and morbidity, infant mortality, unintended pregnancies and induced abortions among migrants
- lower vaccination coverage of migrant children



KEY BARRIERS FOR ACCESS TO HEALTH CARE SERVICES IN MIGRANTS

- **legal status of migrants and legislative barriers**
(emergency treatment before migrant status approved)
- **lack of awareness of their rights and health care system in host country**
- **language barrier**
(postponed visits to the doctor, misdiagnosis, ineffective consultation visits, unnecessary examinations, incorrect treatments)
- **cultural differences**
(health, social, cultural, religious and gender-related issues)



KEY ELEMENTS IN ENSURING HEALTH CARE FOR MIGRANTS

- **Availability:** functioning public health and health facilities, goods, services and programmes in sufficient quantity.
- **Accessibility:** non-discrimination, physical accessibility, economic accessibility (affordability), information accessibility.
- **Acceptability:** respectful of medical ethics and culturally appropriate, sensitive to age and gender.
- **Quality:** scientifically and medically appropriate.



MIGRANTS' LIFESTYLE

- Physical activity and diet:
 - Several studies indicate lower levels of physical activity among adult and children migrants, as compared to the native population
 - Lowest participation rates in sport and physical activity were most evident in people from North Africa and the Middle East (female lowest participation from this group)
 - Physical activity is considered as 'a waste of time' or as a 'luxury' in some minority groups
 - Migrant children are at higher risk for overweight and obesity than their native counterparts



MIGRANTS' LIFESTYLE

- In refugees nutritional deficiencies are common, and are usually due to a chronic lack of essential nutrients
 - vitamin D and/or calcium deficiency
 - vitamin A deficiency in lactating and pregnant women
 - iron deficiency anaemia
- Immigration to high-income European countries may alter lifestyles, such as alterations in physical activity and dietary intake
- Acculturation may result in rapid and unhealthy weight gain:
 - “Western” dietary patterns tend to be high in fat and low in fruits and vegetables
 - barriers in preparing nutritious and culturally-appropriate foods
 - difficulties with transportation
 - lack of familiar equipment for food preparation
 - being unable to find foods that they are comfortable preparing
 - low-cost, high-energy foods due to financial constraints



MIGRANTS' LIFESTYLE

- Smoking: - less economically developed countries at the early phases
 - economically developed countries are at the advanced phases
 - acculturation process after arrival in the host country

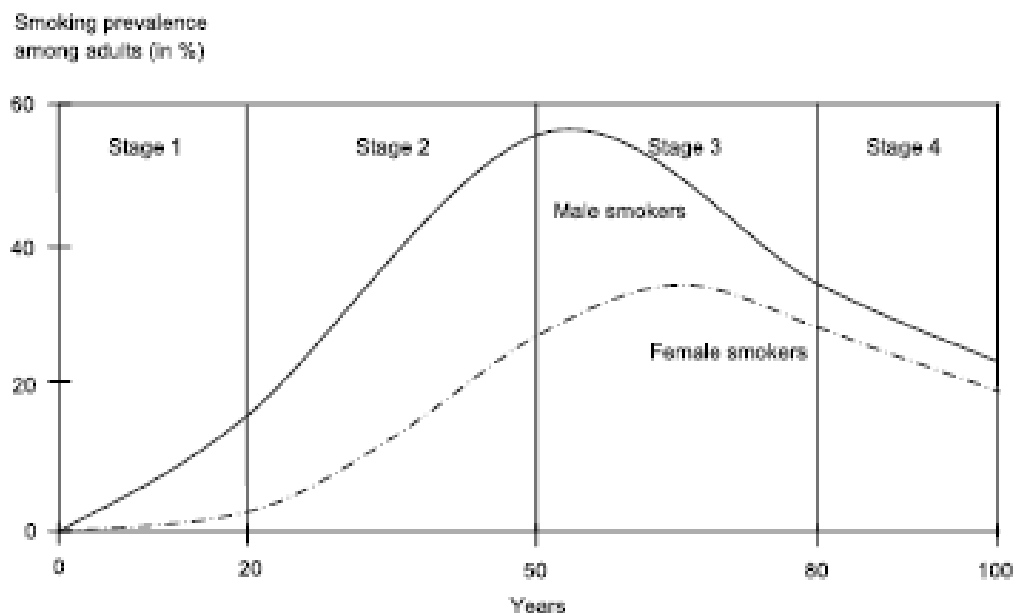


Figure 1 The stages of the 'smoking epidemic' proposed by Lopez et al. in 1994.

- Less developed countries of origin: smoking prevalence among men is higher than in host countries, contrary applies to women
- Immigrant paradox – higher acculturated women more likely unhealthy behaviour



MIGRANTS' LIFESTYLE

- Alcohol consumption:
 - the prevalences of hazardous/harmful and dependent drinking higher in camp settings compared with community settings (camp settings particularly vulnerable risk environment for substance use)
 - Need to integrate substance use prevention and treatment into services offered to forced migrants, particularly in camp settings
 - Increase in the prevalence of lifetime alcohol use among newly-arrived refugees in the US over a 12-month period



HEALTHY LIFESTYLE PROMOTION

- **Smoking:**
 - different strategies for men and women needed;
 - programs for male immigrants should aim to further decrease smoking prevalence;
 - programs addressing immigrant women should aim at preventing smoking initiation;
 - key persons from immigrant communities should be involved in implementing strategies in their communities, settings, and networks.



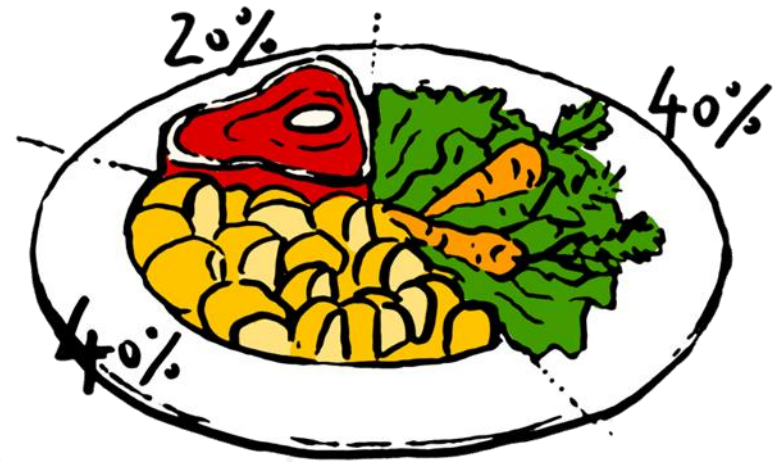
HEALTHY LIFESTYLE PROMOTION

- **Diet:**
 - Health care providers should incorporate a discussion of dietary behaviors into follow-up visits, including an exploration of culturally acceptable and nutritious diets.
 - Encourage migrants to retain healthful eating patterns from their original country or rural area, while adopting the healthy dietary practices of their new environment
 - Partnerships with governmental organizations, resettlement agencies, and other local community groups may enhance healthcare providers' capacity to address this important issue
 - Explain how to read labels and the amount of sugar or 'energy' in fast foods and sugary drinks, as well as the long-term health effects of poor dietary intake
 - Assist families to identify shops and suburbs where they can buy healthy, familiar, traditional foods and ingredients from their country of origin



HEALTHY LIFESTYLE PROMOTION

- Healthy plate:
 - 2/5 carbohydrates
 - 2/5 fruit and vegetables
 - 1/5 protein rich foods



- Ideally 3 - 6 meals evenly spread throughout the day
- 1,5 – 2 l fluids per day



HEALTHY LIFESTYLE PROMOTION

- Physical activity:
 - Physical activity associated with reduction in risks of getting coronary heart disease, obesity, type 2 diabetes, even some cancers and improved mental health and general well being
 - Participation in sports may serve important social functions (social cohesion, expanding social networks and fostering deep cultural meanings and social bonds)
 - Ensure environments that support physical activity (including facilities and outdoor settings)
 - Culturally sensitive programmes are most likely to be successful
 - At least 150 min moderate-intensity aerobic activity per week (e.g. brisk walking)
 - and muscle-strengthening activities on 2 or more days a week that work all major muscle groups (legs, hips, back, abdomen, chest, shoulders, and arms).



MIGRANTS' HEALTH PROMOTION

- Improving migrants' health – selected action points

Monitoring migrant health

- Develop health information systems, collect and disseminate data
- Assess, analyse migrants' health
- Disaggregate information by relevant categories

Policy-legal frameworks

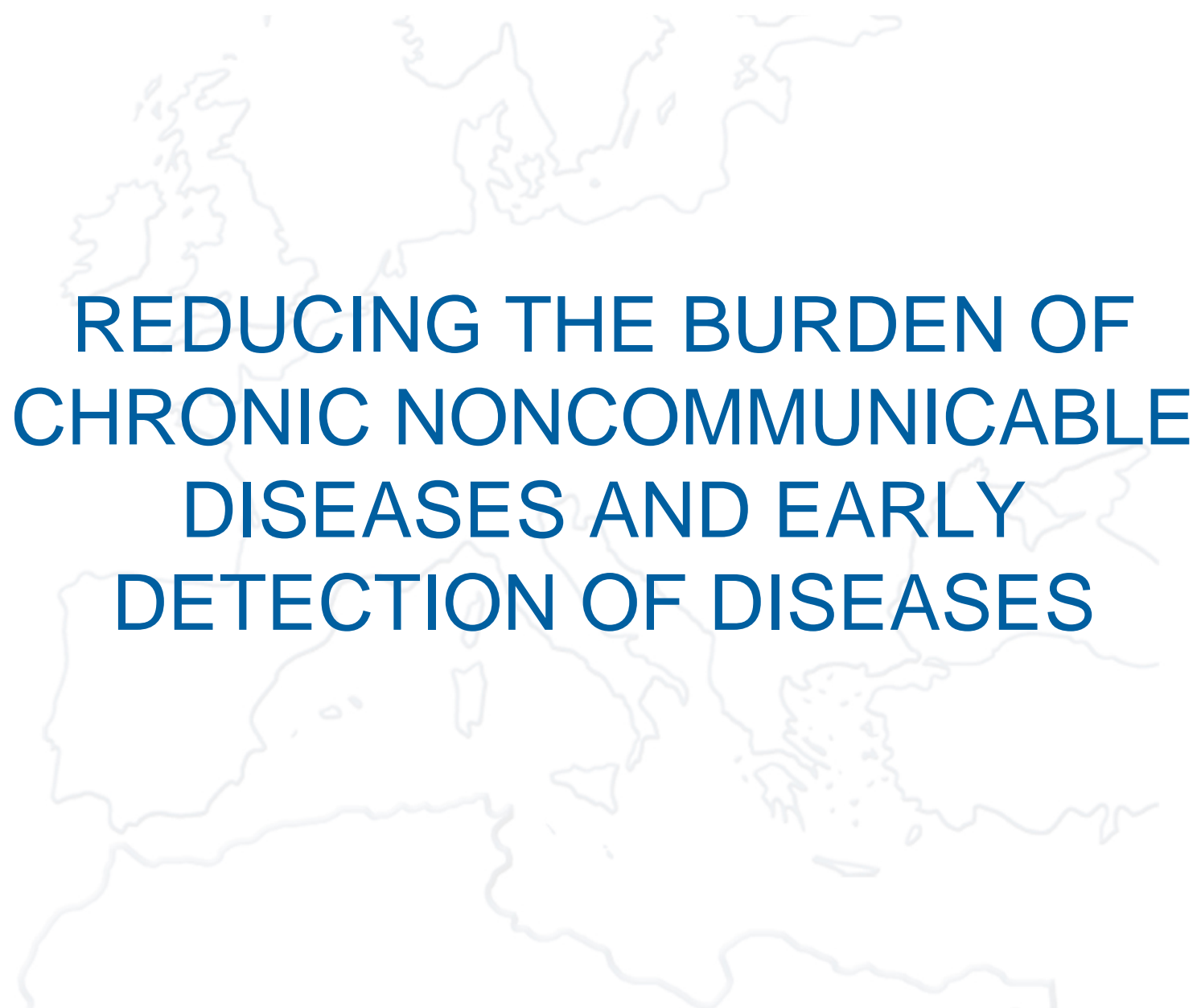
- Promote migrant sensitive health policies
- Include migrant health in regional/national strategies
- Consider impact of policies of other sectors

Migrant sensitive health systems

- Strengthen health systems; fill gaps in health service delivery
- Train health workforce on migrant health issues; raise cultural and gender sensitivities

Partnerships, networks and multi-country frameworks

- Promote dialogue and cooperation among Member States, agencies and regions
- Encourage a multi-sectoral technical network



REDUCING THE BURDEN OF CHRONIC NONCOMMUNICABLE DISEASES AND EARLY DETECTION OF DISEASES



CHARACTERISTICS OF MIGRANTS' HEALTH

- Most migrants are healthy young people and are often healthier than the native-born residents of their host countries (**Healthy Migrant Effect**)
- Some protective factors carry over from countries of origin can insulate migrants and immigrants from the least-healthy lifestyle habits prevalent in their host country (traditional culinary practices, abstention from alcohol, tobacco and drugs)
- Over several generations, the health outcomes of immigrant populations converge with those of native-born population (may adopt the least-healthy lifestyle habits of their host countries, including alcohol, tobacco, and drug use. Their culinary habits may change due to the unavailability of traditional foods or to the overabundance of cheaper food options that may be less healthy overall.
- **The loss of the healthy migrant effect may result in elevated rates of chronic disease or disability in immigrant populations.**



MIGRANTS' HEALTH CONDITIONS

- Migrants can introduce health conditions into host communities and/or can acquire conditions while migrating or residing in host communities;
- Migrants can also introduce acquired conditions while returning home;
- This is of relevance for communicable as well as chronic non-communicable diseases.



MIGRANTS' HEALTH CONDITIONS

- Infectious and parasitic diseases are usually associated with premigration experiences and exposure to risk factors in the country of origin, but also to the conditions during the journey (tuberculosis, malaria, hepatitis, HIV);
- Chronic diseases could be associated with postmigration experiences and exposure to risk factors in the host country (cancer, diabetes, coronary heart disease);
- Psychiatric disorders link pre and postmigration experiences with the experience of migration itself.



CHARACTERISTICS OF MIGRANTS' HEALTH

- Differences and similarities in health problems according to countries of origin (in rescued sea migrants*), population composition and the difficulties of the journey :
 - Most of African migrants are young men. Among them there were more unaccompanied minors and patients with skin diseases, including scabies. Pregnancy-associated conditions were the most common reasons for hospital referral among women.
 - Migrants from the Near East (Syrians, Iraqis and Palestinians) included a large proportion families with children, pregnant women, elderly and disabled people. Among this group there was more acute and chronic vascular disease, diabetes, and health-seeking behavior.
 - Most common health problems in both groups are respiratory and gastrointestinal morbidities as well as traumatic injuries (likely associated with the dangerous journey - overcrowding, poor hygiene conditions, cold and wet climate, scarce and contaminated water and food).

*Trovato A et al. Dangerous crossing: demographic and clinical features of rescued sea migrants seen in 2014 at an outpatient clinic at Augusta Harbor, Italy 2016. Conflict and Health 2016; 10: 1-11.



CHRONIC NONCOMMUNICABLE DISEASES IN MIGRANTS

- The prevalence of chronic non-communicable diseases in refugees' regions of origin is rising;
- Chronic non-communicable diseases (mainly cardiovascular disease, cancer, chronic respiratory diseases, and diabetes) now account for 61% of all deaths and 46% of the burden of disease among low- and middle-income countries*;
- The global rise in chronic NCDs has dramatically increased the likelihood that adults from low- and middle-income nations will arrive in the host country with pre-existing chronic conditions.
- Migrants from poorly developed economic areas can present, on arrival, illnesses in later or more advanced stages, because of limited access to care at their place of origin.



CHRONIC NONCOMMUNICABLE DISEASES IN MIGRANTS

- Acculturation increase the risk of obesity and associated non-communicable diseases such as diabetes and hypertension due to weight gain and environmental and psychological stress;
- Studies have demonstrated significant rates of obesity/overweight (46.8%), hypertension (22.6%), and coronary artery disease and diabetes (3.7% and 3.1% respectively) among different refugee populations*;
- *People of certain ethnic backgrounds (specifically Latin Americans, Africans and South Asians) face a twofold to fourfold higher prevalence of type 2 diabetes mellitus than white people, with earlier onset and poorer outcomes;*
- Among people of African origin hypertension is three-fold to four-fold more prevalent than in the European population.



CHRONIC NONCOMMUNICABLE DISEASES IN MIGRANTS

- Migrant children are at higher risk for overweight and obesity than their native counterparts;
- *Black and Indo-Asian ethnicity is also associated with higher rates of renal failure incidence rates (diabetes and hypertension are important risk factors);*
- U.S. Study (Yun et al, 2012): during their first eight months in the US, half of adults were diagnosed or treated for at least one chronic non-communicable diseases (51.1%), and one in five adults had two or more (the most common being behavioral health diagnoses and hypertension).



CHRONIC NONCOMMUNICABLE DISEASES IN MIGRANTS

- The causal link between migration and chronic diseases has been established through a number of mechanisms that characterize the refugee experience of acculturation:
 - acculturative stress
 - obesity and changes in health-related behaviors such as alcohol use, diet, cigarette smoking
 - lack of access or utilization of modern health services
- Other important factors include poverty, marginalization and lack of adequate living conditions.



ACCULTURATION AND CHRONIC NONCOMMUNICABLE DISEASES

- Evidence from migrant studies consistently indicates that change toward a “Westernized” lifestyle increases risks of several major chronic diseases.
 - Asian-American female migrants who had lived in the West for a decade or longer had an 80% higher risk of breast cancer than more recent immigrants.
 - U.S. born Japanese-American women were found to have significantly higher body fat than immigrant Japanese-American women.



PREVENTION AND EARLY DETECTION OF CHRONIC NONCOMMUNICABLE DISEASES

- **Healthy lifestyle promotion:**
 - Healthy diet
 - Physical activity
 - Reducing and preventing smoking and alcohol and illicit drugs consumption
- **Occupational health promotion**
- **Screening and early detection of chronic noncommunicable diseases, which should be done at the arrival of migrants.**



SCREENING

- Screening is looking for an early stage of a particular disease in apparently healthy population
- Is a secondary preventive intervention: detection of early stages of disease, before symptoms and signs arise and when disease is easier to treat
- Positive result of screening is followed by further diagnostics. The result is early treatment of disease and reduced mortality from the particular disease in population, reduced incidence of severe complications and increase in complete cure of the disease.
- If screening is for abnormalities that precede disease, then also the incidence of the disease can be reduced.

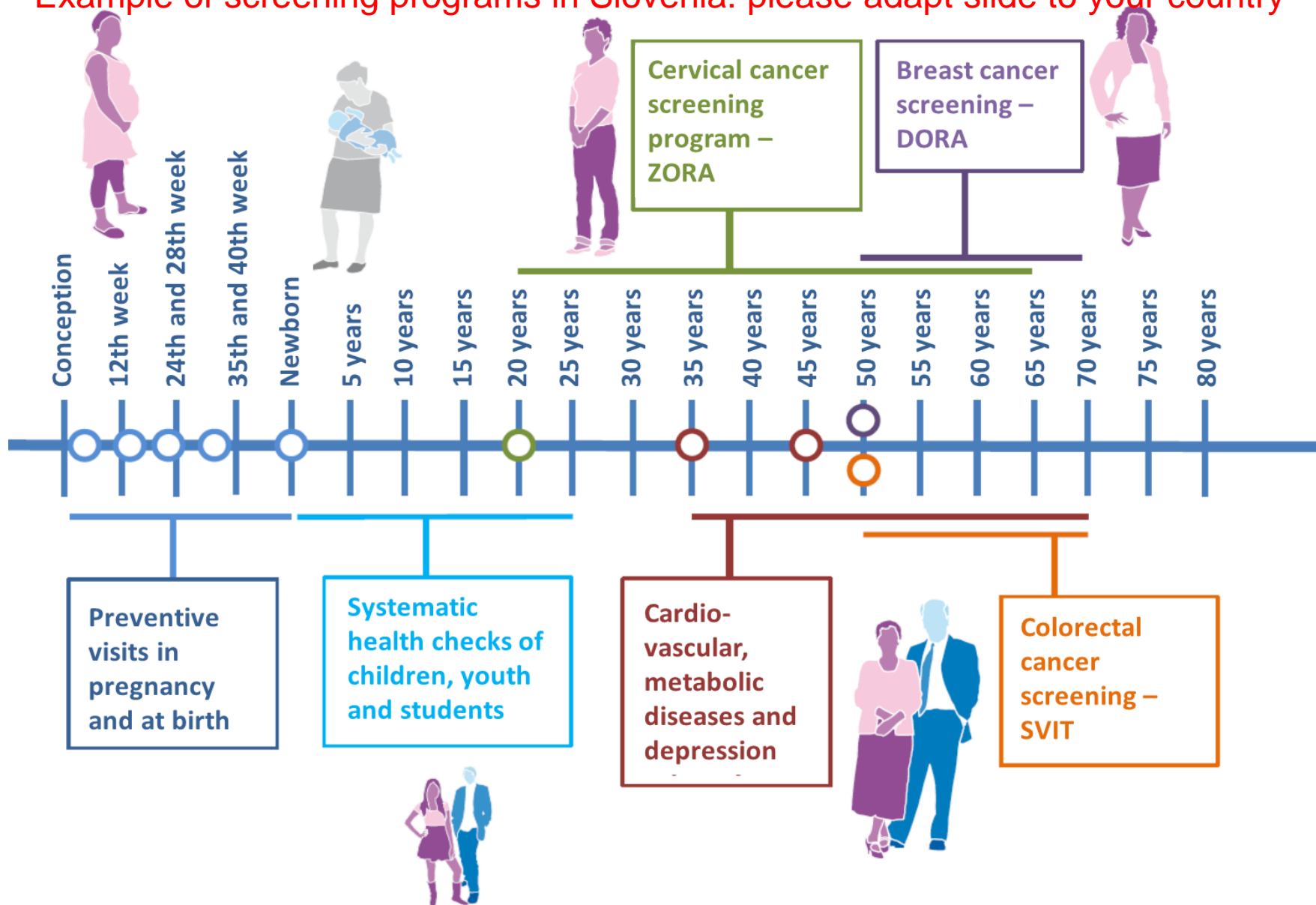


NATIONAL SCREENING PROGRAMS

- **Slovenia: (adapt slide to your country's situation)**
- **Antenatal period:** anemia, blood group and Rh factor, serological screening for toxoplasmosis, syphilis, hepatitis B, asymptomatic bacteriuria, ultrasound fetal morphology, chromosomal abnormalities in the presence of risk factors, risk factors for pre-eclampsia in gestational diabetes,...
- **Neonatal period:** general condition of the newborn, gestational age, clinical and basic neurological examination, prevention of hemorrhagic disease and neonatal (gonorrhoeic) ophthalmia, detection of phenylketonuria and congenital hypothyreosis, hips ultrasound, hearing examination (TEOAE), assessment of the effectiveness of breastfeeding,...
- **Health care of newborns and children up to 6 years old**
- **Health care of school children and youth up to 19 years of age**
- **Health care of students**
- **Health care of sportsmen**
- **Health care of adults:** national program of primary prevention of cardiovascular diseases, diabetes, depression, risky alcohol drinking, smoking, COPD, screening for cervical cancer / breast cancer / cancer of the colon and rectum,...



Example of screening programs in Slovenia: please adapt slide to your country





CANCER SCREENING PROGRAMS

- Slovenia: (adapt slide to your country's situation)
- ZORA:
 - cervical cancer screening program;
 - cervical smear for women 20 - 64 years with basic health insurance at selected gynecologist;
 - every 3 years
- DORA:
 - breast cancer screening program
 - mammography for women 50 – 69 years with permanent residence in Slovenia;
 - every 2 years
- SVIT:
 - colorectal cancer screening program;
 - fecal occult blood test for men and women 50 – 69 years with basic health insurance;
 - every 2 years



NATIONAL PROGRAM FOR PREVENTION OF CARDIOVASCULAR DISEASES

- Slovenia: (adapt slide to your country's situation)
 - for men 35 – 65 years and women 45 – 70 years with basic health insurance at general practitioner
 - questionnaire for cardiovascular disease risk assessment, medical examination, blood tests (glucose, cholesterol)
 - every 5 years (in people with an increased risk more often)
 - Interventions: Treatment or health education for healthier lifestyle



DIABETES MELLITUS

- Type 2 diabetes has long been thought of as a disease of upper income countries, but now affecting all socioeconomic groups and countries everywhere.
- The International Diabetes Federation (IDF) estimates:
 - over 387 million people are now living with diabetes (especially type 2)
 - by 2035 another 205 million people will develop the disease
- Type 2 diabetes is the product of
 - biogenetic (highly present in the Pima Indians in the United States, natives of the islands of the Western Pacific and populations in South-East Asia)
 - socio-behavioural process



DIABETES MELLITUS

- Migrants are significantly more likely to develop type 2 diabetes than non-migrants with earlier onset and poorer outcomes
 - Dutch study (Ujic-Voortman JK et al, 2009): Onset of type 2 diabetes was one and two decades earlier in Turkish and Moroccan migrants, respectively, as compared with the local Dutch populations.
- Risk factors in migrants:
 - chronic stress
 - aculturation with unhealthy diet and less physical activity



DIABETES MELLITUS - RECOMENDATIONS

- Recommendations from the Canadian Collaboration for Immigrant and Refugee Health:
 - screening for type 2 DM in immigrants and refugees > 35 years of age from ethnic groups at high risk for type 2 diabetes (South Asian, Latin American and African) with fasting blood glucose.
- Persons with hypertension and hypercholesterolemia are at high risk for complications from diabetes and have the most to benefit from treatment of obesity, high cholesterol, hypertension and hyperglycemia.
- Culturally appropriate diabetes education and lifestyle interventions are more effective at controlling levels of hemoglobin A1C than standard approaches.
 - A Cochrane review on culturally appropriate health education showed improved glycemic control and diabetic knowledge scores compared with standard diabetic education approaches at 12 months.



CORONARY HEART DISEASE

- Several European studies have found high incidence of and mortality rates from coronary heart disease among South Asians;
- High mortality and incidence stroke rates have been observed for migrants of West African origin;
- Coronary heart disease is the biggest chronic problem facing Europe's ethnic minority populations*;
- Ethnic minority groups develop cardiovascular diseases earlier than European local populations.



CARDIOVASCULAR DISEASES

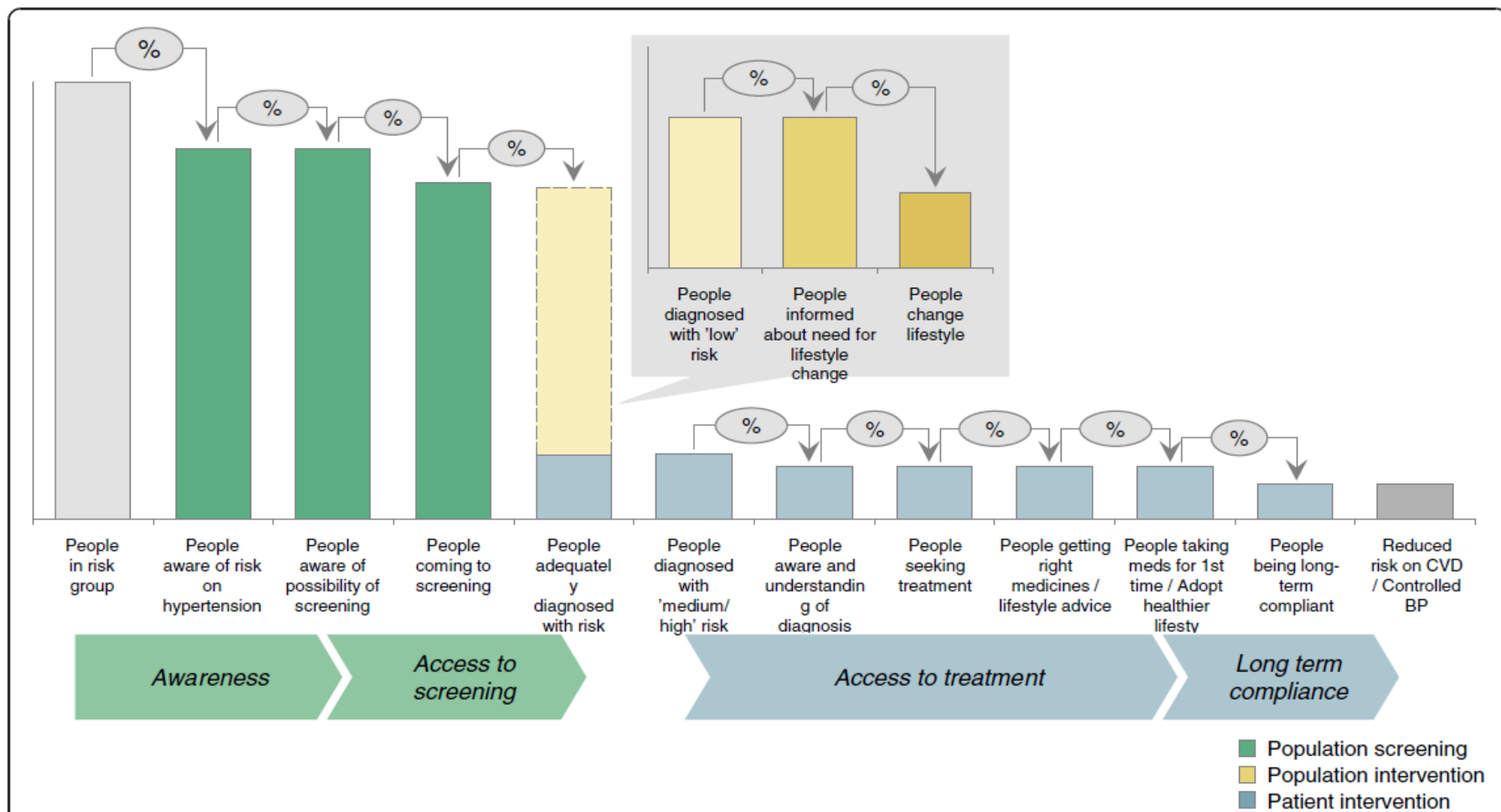


Figure 1 Framework showing steps from awareness of cardiovascular risk factors in risk group towards long term compliance with controlled blood pressure.



CARDIOVASCULAR DISEASES PREVENTION

- Key steps for CVD prevention in migrants:
 - Increasing awareness of CVD risk (tailor the awareness campaign to the local situation; potential entry points churches, local television and radio, community leaders and cultural gatherings);
 - Improving access to screening (screening points in churches and community centers; determine the target age group);
 - Facilitating access to treatment (could include group consultations, financial and non-financial incentives and follow up calls for high risk patients);
 - Adhering to prescribed medication (could include SMS reminders and development of patient support groups).



CANCER

- Cancer mortality is generally lower for the migrant populations, but the pattern varied by cancer site.
 - Oesophagus/oral cavity, colon/rectum, and lung/bronchus cancer mortality was lower in the migrant populations.
 - Liver cancer mortality is higher for those from North Africa, Sub-Saharan Africa, and especially East Asia.
 - Mortality due to stomach cancer is higher among those from North Africa, Caribbean, Eastern Europe and Turkey.



SCREENING IN MIGRANTS

- Many refugees fail to obtain preventive screening procedures because of:
 - limited access to health care and physicians not discussing screening procedures with their patients
 - a lack of familiarity with the procedure and lack of understanding as to its importance
- Education about cancer and its risk factors, smoking cessation, and cancer screening are high priorities for this population.



CERVICAL CANCER

- Cervical cancer is one of the most preventable forms of cancer
- Significantly lower rates of screening among immigrants and refugees
 - Women who have never had cervical screening, or have not had cervical screening in the previous five years, account for 60%–90% of invasive cervical cancers overall.
- Higher mortality rates from cervical cancer in immigrant women
- Infection with HPV is strongly associated with cervical cancer.
 - Prevalence estimates for HPV are particularly high for Africa (22.1%) and Central America (20.4%).
 - Women with HIV and women who have been victims of sexual trauma are at higher risk for HPV infection and cervical cancer.
 - Refugee women in particular are disproportionately victims of sexual and sex-based violence, which can include rape, domestic violence and female genital mutilation.



CERVICAL CANCER

- Cervical cancer screening will be a new concept for many immigrant women.
- Factors that can reduce rates of screening among immigrant women:
 - limited language proficiency
 - little knowledge and many misconceptions about the benefits of screening for cervical cancer
 - transportation and childcare difficulties
 - male physicians (especially for muslim patients) and some women feel uncomfortable undressing in front of a stranger
- Before screening for cervical cancer in women who have been victims of sexual violence, practitioners should develop a process that can take several visits.
- Immigrant community health workers and other community interventions that provide information and offer transport, female physicians and interpreters in informal clinic settings may improve uptake of screening.
- Vaccination against HPV is recommended in immigrant girls



CANCER SCREENING - GOOD PRACTICES

- A program to increase breast and cervical cancer screening for Cambodian women (Kelly AW et al, 1996). The intervention included:
 - community informational programs in the Cambodian language
 - group screening appointments
 - provision of transportation
 - female physicians and interpreters
 - informal clinic setting.

Initial screening rates for Cambodian women were significantly lower than for non-Cambodians. After the intervention, community screening rates were almost five times higher than at baseline.
- Video was a useful medium for cancer education in Cambodian refugees because of low literacy levels and high rates of VCR ownership (Mahloch J, 1999).
- Barriers addressed were:
 - beliefs that traditional postpartum practices protect against cervical cancer
 - Cambodians do not get cervical cancer and screening is unnecessary
 - fear of cancer as well as surgery
 - lack of understanding about preventive concepts and familiarity with the pap test
 - concerns about embarrassment and pain
 - problems with transportation and child care



GOOD PRACTICE

- The San Diego Refugee Health Services Consortium approach to refugee health promotion/disease prevention involved five discrete stages:
 - Stage I - gain the confidence of refugee populations that their health care needs, belief systems, and patterns of health services utilization are understood and respected by the health care system;
 - Stage II - addressing mental health issues to make refugees receptive to health promotion and disease prevention interventions (Posttraumatic stress disorder and depressive disorders are common among migrants and can inhibit their motivation and cognitive ability to understand and adopt these interventions);
 - Stage III - interventions for both immediate and short-term health care needs, most of which are related to infectious disease risks associated with countries of origins, and the long-term health care needs, most of which are related to chronic diseases associated with the host country (nutrition, physical activity, and smoking and alcohol);
 - Stage IV - implementation of interventions in the target communities (e.g., grocery stores instead of doctors' offices);
 - Stage V - evaluation of the process and outcomes.



GOOD PRACTICE

- Programs that facilitate early access to primary care, such as partnerships between refugee service organizations and clinical service providers;
- Multidisciplinary framework (health care providers, social services, religious leaders, cultural interpreters...);
- Culturally effective medical management, health care navigation, and community health worker models may improve access and increase health care efficiency for refugees;
- Tobacco cessation, physical activity, and healthy food preparation and eating habits are important targets for community health education and primary care among recently-arrived refugees;
- Short-term solutions, designed only to address acute communicable diseases, are no longer adequate to meet the needs of this community.



COMMUNICABLE DISEASES

Part one



Communicable Diseases in Migrants and Refugees

- Environmental and socio-economic determinants of communicable diseases in modern society:
 - Microbial adaptation and change
 - Susceptibility to infections – the impact of poverty
 - Change in lifestyle and behaviour
- Challenges of communicable diseases in migrant and local populations – similarities and disparities
- Communicable diseases: surveillance and response in migrants and refugees – for diverse contexts adjusted approaches required



Key determinants of communicable diseases in migrants

- Exhausting journeys
- Undernutrition or malnutrition
- Crowding and poor housing conditions – exposure to hot or cold environment
- Poor hygiene (lack of safe water and food)



Key determinants of communicable diseases in migrants

- Lack of access to medical care
- No vaccination or partial vaccination
- Exploitation of migrants – exhausting work in unsuitable environments
- Coercion of migrants into prostitution or prostitution as the only possible source of income



Special Topics in Communicable Diseases

- **Acute respiratory infections** – a global challenge
- **Food and water borne** communicable diseases – hygiene measures to lower the burden of the disease
- Knowledge, attitude and behavior of migrants and refugees to **sexually transmitted diseases, HIV/AIDS, hepatitis B and C** – differences in incidence depending on the country of origin
- **Vector borne diseases** – specific problems in migrants and refugees
- Reintroduction of **malaria** in suitable environments – early recognition and response
- **Hemorrhagic fevers** – no risk for the local population
- **Skin infections** – detection of common skin infections in a dark-colored skin and recognition of infections that are not common in temperate climate
- **Measures** to reduce the spread of highly resistant microbes (MRSA, VRE, ESBL, etc.) in community and health care environment



ACUTE RESPIRATORY INFECTIONS



ACUTE RESPIRATORY INFECTIONS

- Acute respiratory tract (ARI) infections are very common
- ARI affect all age groups, most commonly young children
- Adults have at least three ARI per year, children app. five or more
- ARI are caused by different viruses (mostly) or bacteria
- Acute respiratory infections are more common in the colder part of the year - the season begins in autumn and ends in spring



ACUTE RESPIRATORY INFECTIONS

ARI can be more or less serious infections depending on:

1. Site of the infection :

- upper respiratory infections (the common cold) feeling unwell for couple days, nasal discharge, self-limiting disease
- Inflammation of the lower respiratory tract (pneumonia) - the patient has a high fever, cough

2. Age – ARI are more serious in very young children and the elderly

3. The presence of chronic diseases (heart disease, lung disease, diabetes)

4. Immunocompromised patient (e.g. a cancer patient on radio- or chemotherapy)

5. Being smoker or having alcohol dependence

6. Malnutrition, exhaustion (migration)



ACUTE RESPIRATORY INFECTIONS

Environmental factors significantly affect the incidence of respiratory infections:

1. **Climatic factors:** the low ambient temperature, humidity, insolation
2. **Air pollution**
3. **Housing conditions:**
 - overcrowding (e.g. the lack of space between the beds)
 - cold, damp rooms
 - inadequate ventilation



ACUTE RESPIRATORY INFECTIONS

How do acute respiratory infection spread among humans?

- Viruses and bacteria are found in respiratory secretions – coughing, sneezing, talking aloud produces droplets that are transferred to the people in the vicinity (distance up to 1 m)
- Contagious respiratory secretions are transferred through the hands to surfaces (switches, handles, table, chair, keyboard, cell phone, bank notes, tap, etc). Viruses remain viable for some time on surfaces depending on the humidity, sunshine, temperature. When an infected person touches contaminated surfaces and fomites, the viruses are transferred to his/hers hands, and from there to the mouth, nose, conjunctiva



ACUTE RESPIRATORY INFECTIONS

Upper respiratory infections

Common cold, sore throat, sinusitis, otitis media

Signs & symptoms

- ✓ moderate malaise
- ✓ low fever
- ✓ runny nose
- ✓ pain when swallowing
- ✓ ear pain

Lower respiratory infections

Bronchitis, bronchiolitis, pneumonia

Signs & symptoms

- ✓ malaise, prostration
- ✓ fever
- ✓ cough
- ✓ rapid, shallow breathing
- ✓ the patients feels that he/she does not have enough air to breath



ACUTE RESPIRATORY INFECTIONS

When the patient have to be refered to medical care?

- Persistent high fever ($\geq 38^{\circ}$ C) without improvement for more than 48 hours
- Prostration
- Vomiting
- The patient declines to drink water or other fluids

The medical personnel will assess the need for antibiotics, hospitalization etc.

In some cases the isolation of the patient is warranted not to pass the infection to others in his/her vicinity



ACUTE RESPIRATORY INFECTIONS

When medical care is urgently needed?

- ✓ The patient is breathing rapidly and shallowly
- ✓ She/he feels the of lack of air
- ✓ The lips are colored blue (oxygen deficiency)
- ✓ Not answering to basic questions in sensible way or even confused
- ✓ The patient is unresponsive

Children are particularly vulnerable to high fever and dehydration - the child's state of health can deteriorate very quickly and become life-threatening



ACUTE RESPIRATORY INFECTIONS

What can we do to prevent the transmission of acute respiratory infection?

1. Hand hygiene - frequent hand washing and/or disinfection
2. Do not touch lips, nose, eyes with the hands
3. If you are in close contact with the person who has common cold, cough, put on protective equipment (facial mask and gloves)
4. If possible, maintain a distance of $\geq 1\text{m}$ (probability of infection is significantly reduced)
5. The mask should be removed and replaced when it feels moist
6. Do not touch the front of the mask with your hands
7. Facial masks have to be removed in the correct way
8. After removing the mask, wash or disinfect your hands carefully
9. Mask and gloves should be disposed directly into the bin to avoid any contamination of surfaces



ACUTE RESPIRATORY INFECTIONS

Being ill with respiratory infection, what you should do to prevent the spread of the infection to the others?

- In principle, patients with acute respiratory infection should remain at home and not go to the work until fever is gone
- Often health care workers and others working in essential services keep on working as there is a lack of work force despite the fact that they have a common cold, are coughing and feel unwell
- If keep on working is unavoidable, reduce the possibility to transmit the infection to co-workers and migrants/refugees:
 - ✓ use mask
 - ✓ sneeze and cough into the sleeve
 - ✓ wash and disinfect your hands
 - ✓ participate in tasks that do not require close contact with people



INFLUENZA

- Influenza is an acute respiratory infection
- Caused by influenza (or flu) viruses
- All age groups can be affected, the highest incidence is in preschool and school children,
- The highest need for hospitalization is in elderly and chronically ill persons



INFLUENZA

- Course of influenza **in children** is usually without complications - a common cold, fever, cough, which lasts a few days
- Course of influenza **in adults** is more serious – starts with abrupt onset of high fever, weakness, cough - resolves within 1 week, cough is present longer
- Course of influenza **in the chronically ill, the elderly** – is the same as in adults, but with more prominent complications with pneumonia, exacerbation of chronic disease and leads to the need for treatment in a hospital

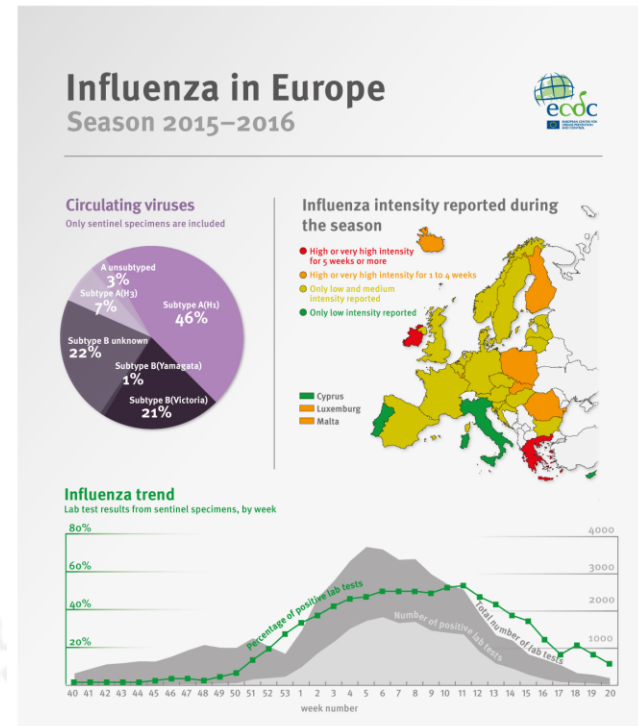


INFLUENZA

There is a pronounced seasonality in influenza – the incidence reaches top in January and February

Influenza spreads as other respiratory infections - through infectious droplets and contaminated surfaces

Influenza is transmitted within families, in workplaces, schools, kindergartens and everywhere where people are close together e.g. refugee camps, asylum seekers centres





INFLUENZA- what can we do to not become infected with the flu?

Everyone who is exposed to flu viruses professionally should get influenza vaccine every year before the start of the season (October, November)

Vaccinated person:

- It is less likely to be sick with the flu (protection is not 100%)
- Vaccinated person is less likely to transfer the virus to her/his colleagues and all others with whom she/he comes in contact in the workplace
- Vaccinated person does not transmit influenza virus to the domestic environment, which is especially important if someone lives together with an infant or the elderly, chronically ill



HOW SAFE IS INFLUENZA VACCINE?

SAFETY CONCERNS:

- Side effects may occur after any vaccine
- It is important how serious they are and how often they occur or whether or not they hinder our daily activities



INFLUENZA VACCINE

local side effects

Very common side effects:

1. Pain at the site of vaccination which lasts one or at maximum two days. The pain does not hamper daily activities and is considered to be expected, not serious side effect
2. Redness and swelling at the vaccination site - much more rare adverse reaction resolves within a few days



INFLUENZA VACCINE

side effects

Rare side effects:

malaise, low grade fever, and pain in muscles and joints

Extremely rare side effects - allergic reaction to the vaccine

A person may have an allergy to component of the vaccine against influenza (extremely rare) or a very serious allergy to egg proteins



INFLUENZA VACCINE EFFECTIVENESS

- The effectiveness of influenza vaccines is not optimal - it is estimated that the protection against the disease is found in approximately half of vaccinated persons - the majority of other vaccines are more effective - almost 100% protective efficacy is expected from e.g. tetanus, yellow fever, hepatitis B vaccine etc.
- Despite vaccination there is a 50 % chance to get the infection but milder course of influenza is expected



CONCLUSION

Acute respiratory infections are normally expected to increase in autumn-winter season with influenza causing the greatest burden of the disease

Hygiene measures (washing hands, social distancing, cough etiquette) and vaccination with flu vaccine can prevent at least a part of infections

Adequate living conditions of migrants and refugees minimise the spread of infections



TUBERCULOSIS



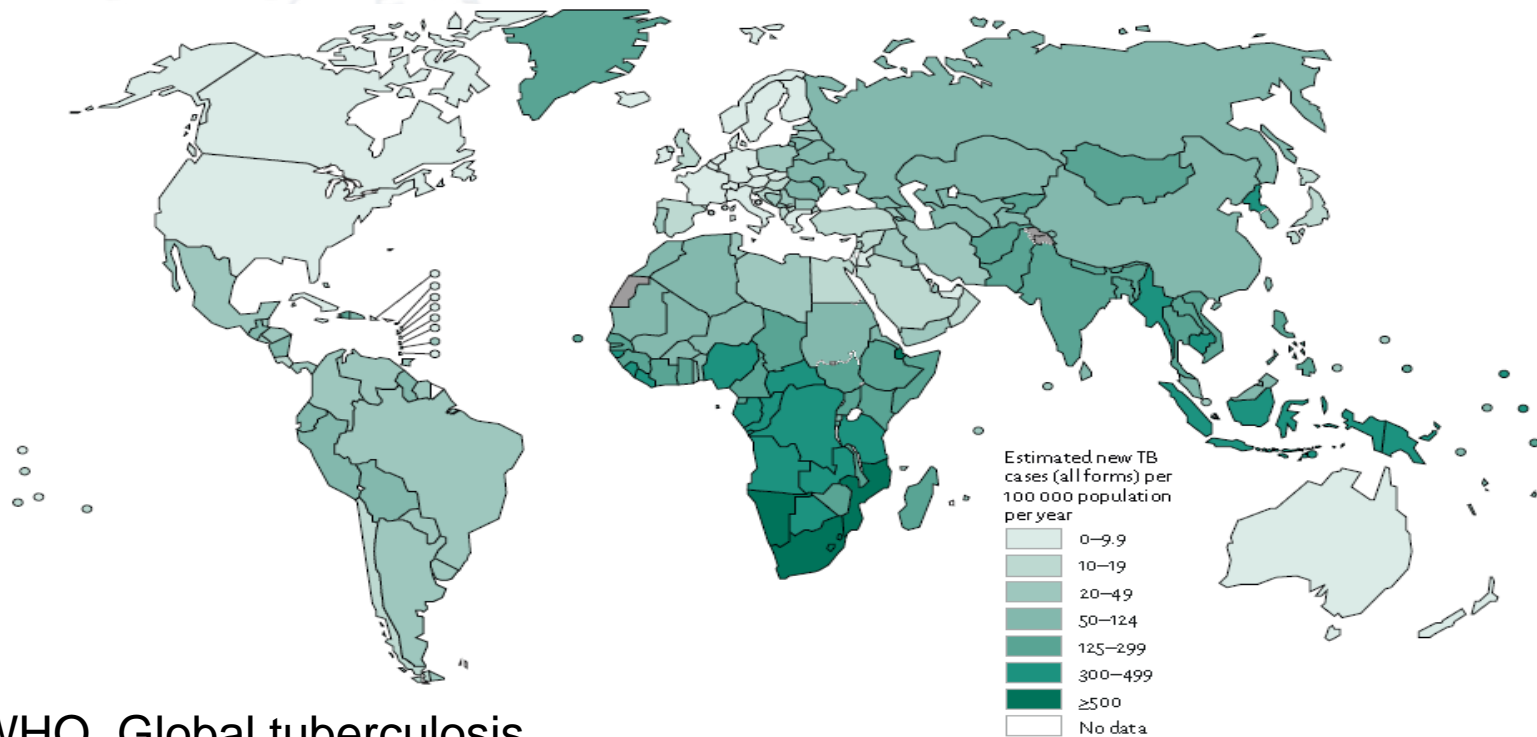


TUBERCULOSIS

- To lower the number of TB patients, procure the treatment and save lives is one of the WHO top priorities
- TB incidence has fallen by an average of 1.5% per year since 2000 and is now 18% lower than the level of 2000
- The TB death rate dropped 47% between 1990 and 2015.
- Future challenge: globally an estimated 480 000 people developed multidrug-resistant TB (MDR-TB).



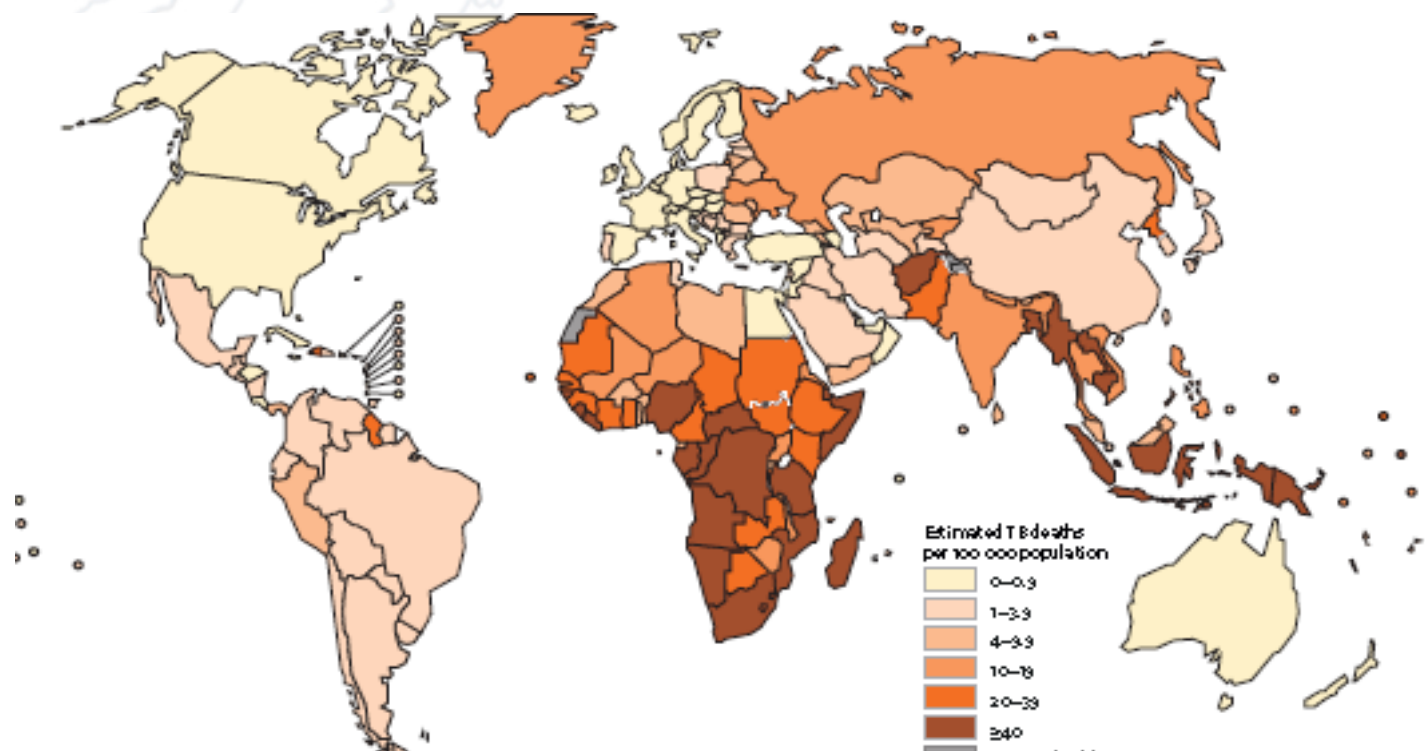
TUBERCULOSIS – worldwide distribution



WHO. Global tuberculosis
report 2015.



TUBERCULOSIS mortality





TUBERCULOSIS

- Tuberculosis (TB) is caused by bacteria (*Mycobacterium tuberculosis*) that most often affect the lungs
- Tuberculosis is curable and preventable
- About one-third of the world's population has latent TB, which means people have been infected by TB bacteria but are not (yet) ill with the disease and cannot transmit the disease
- People infected with TB bacteria have a 10% lifetime risk of falling ill with TB
- There is higher risk for some individual to develop TB after infection



TUBERCULOSIS

Personal factors

- AGE – anyone can get TB, but not all age groups are affected equally
- GENDER – more frequent in male than females
- NUTRITION – negative impact of undernutrition
- HEREDITY – has no impact
- IMMUNITY – humans are not naturally immune against TB

Social and environmental factors

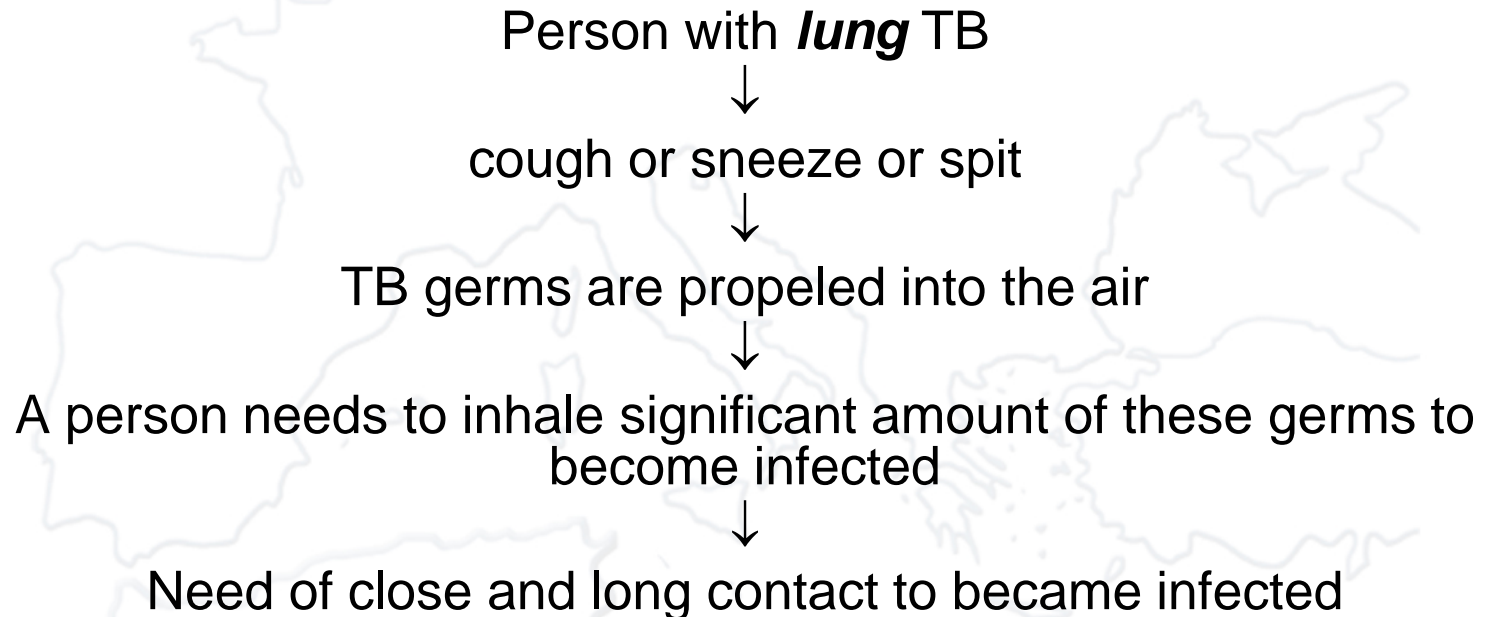
- Poverty
- Unfavorable living conditions
- Overcrowding
- Undernutrition
- Low level of education – low empowerment to cope with the disease



TUBERCULOSIS

mode of transmission

Bacteria (*Mycobacterium tuberculosis*) is spread from person to person through the air.





TUBERCULOSIS

TB is NOT transmitted:

- by shaking hands
- through foods or drinks
- through objects
- towels, toiletries
- touching a door knob, a switch etc.



TUBERCULOSIS

how to recognize a case?

- Common symptoms of active lung TB are cough with sputum and blood, chest pain, weakness, weight loss, fever and night sweats
- The probability to have TB is higher in patients coming from countries with high incidence of TB



TUBERCULOSIS

Cough, pallor and emaciation may result from various diseases and conditions affecting respiratory tract:

- Chronic lung disease
- Lung cancer
- Pneumonia etc.

The patient might look like TB patient but he/she is not!



TUBERCULOSIS protective measures

In case of suspected TB
protective equipment must be
used

Due to the transmission of the
bacillus tuberculosis through the
air, the most important part of
the protection is respirator
which prevents the TB bacillus
to be inhaled into the lungs

PRAVILNA UPORABA MASKE

PREDEN SI NAMESTIMO MASKO, SI RAZKUŽIMO ROKE.

PO NAMESTITVI MASKE SI NADENEMO ROKAVICE.

MASKA MORA POKRIVATI USTA, NOS IN BRADO.



MASKO ZAMENJAMO VSAJ NA 2 URI.

MASKE SE NE SME VEČKRAT UPORABITI.

MASKO ODSTRANIMO TAKO, DA SE
DOTIKAMO LE TRAKOV.

KO ODVRŽEMO MASKO MED ODPADKE, SI
UMIJEMO ALI RAZKUŽIMO ROKE.



TUBERCULOSIS – what to do?

1. An individual with suspected TB needs to wear the appropriate surgical mask covering nose and mouth
2. A suspected case should be accommodated in a separate room
3. The personnel who is in contact with this person should wear PPE
4. The room must be well ventilated from the outside; after the suspected TB case leaves the room, the room has to be ventilated for at least 30 minutes



TUBERCULOSIS – what to do?

- A person with suspected TB should be sent to a healthcare facility to prove or rule out the disease and start the treatment as soon as possible
- In case that pulmonary TB has been confirmed, all persons who did not use adequate protective equipment in contact with TB case should be checked for newly acquired infection approximately 2 months after the last unprotected contact



Acute Respiratory Infections and Tuberculosis

CONCLUSION

- Identification and prevention of seasonal outbreak of influenza in at-risk population (pregnant women, children under the age of 5, people with chronic underlying conditions and the elderly)
- Lower respiratory infections (pneumonia, acute bronchiolitis in children) – early recognition and treatment
- Some respiratory infections can be prevented through vaccination (influenza, pertussis)
- Low risk of emerging infection diseases in migrants and refugees (eg. MERS-CoV)
- TB turns in clinical illness as a result of poor living conditions

A faint, light blue outline map of Europe is visible in the background of the slide.

COMMUNICABLE DISEASES – Part 2



Communicable Diseases in Migrants and Refugees

- Environmental and socio-economic determinants of communicable diseases in modern society:
 - Microbial adaptation and change
 - Susceptibility to infections – the impact of poverty
 - Change in lifestyle and behaviour
- Challenges of communicable diseases in migrant and local populations – similarities and disparities
- Communicable diseases: surveillance and response in migrants and refugees – for diverse contexts adjusted approaches required



Key determinants of communicable diseases in migrants

- Exhausting journeys
- Undernutrition or malnutrition
- Crowding and poor housing conditions – exposure to hot or cold environment
- Poor hygiene (lack of safe water and food)
- Lack of access to medical care
- No vaccination or partial vaccination
- Exploitation of migrants – exhausting work in unsuitable environments
- Coercion of migrants into prostitution or prostitution as the only possible source of income



Objectives and Competences of the Attendant

- Recognition of the basic concepts of communicable diseases' determinants in migrants and refugees
- Recognition of the importance of environmental and socio-economic determinants of health
- Recognition of health indicators and health information sources for surveillance of communicable diseases in migrants
- Recognition of key topics in communicable diseases challenges in migrants and refugees
- Recognition of public health approaches to control major communicable diseases issues in vulnerable population



VECTOR BORNE DISEASES





VECTOR BORNE DISEASES

DEFINITION: communicable diseases which are transmitted through vectors (arthropod borne vectors):

MECHANICAL VECTOR (passive transmission without multiplication within vector):

- flies

BIOLOGICAL VECTOR (pathogen multiplies within vector)

- ticks
- mosquitos
- lice
- fleas
- sand-flies





VECTOR BORNE DISEASES

Vector borne diseases are an emerging issue in the EU countries. The incidence varies greatly between countries and regions depending on:

- environmental factors that allow the vectors to survive and are active (e.g. ticks become active when the ambient temperature exceeds 7°C)
- the presence of a suitable vector (not all mosquitoes overwinter in a cold climate)
- the presence of a suitable reservoir
- the presence of vector borne disease
- sustained contact between vectors and humans



VECTOR BORNE DISEASES – transmission route

Multiplication of
pathogen in a suitable
reservoir

Tick or mosquito takes
a blood meal from
infected mammal

Infected tick or
mosquito bites
susceptible human and
transmits the disease



VECTOR BORNE DISEASES

Vector-borne diseases already present in EU
(occur independently of migrant flows):

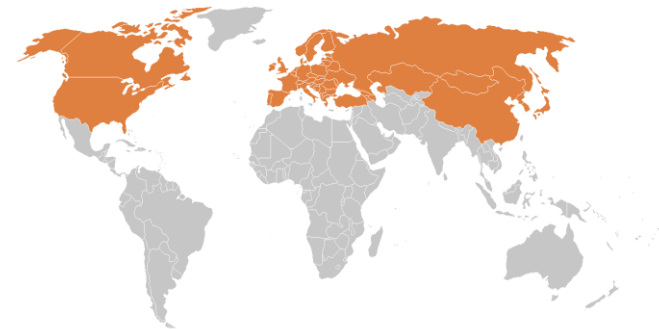
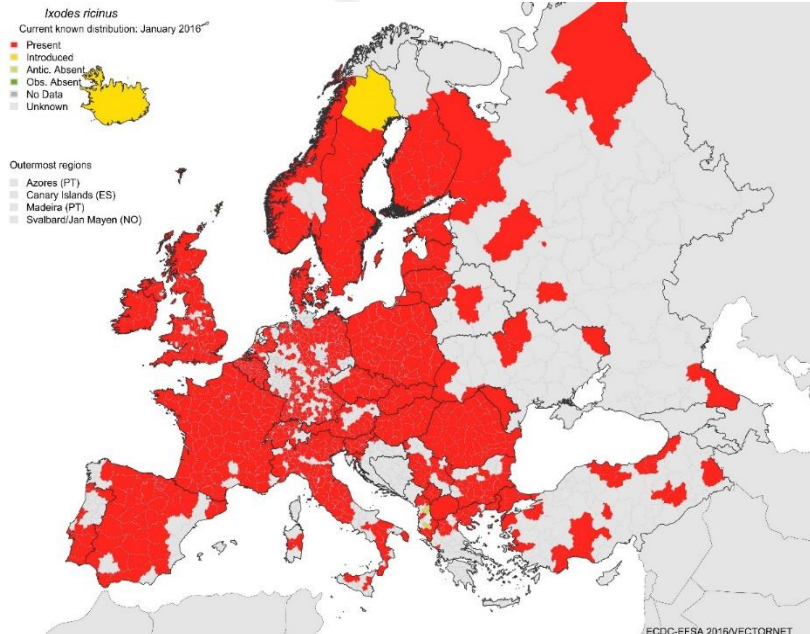
- **Lyme disease (most common and widespread)**
- Tick-borne meningoencephalitis (Baltic states, Eastern EU, Austria, Germany)
- West Nile fever (Southern part of EU, Balkan)
- Tularemia (rare)
- Q fever (often in outbreaks)



TICK BORNE DISEASES in EU

The presence of ticks capable to transmit TBE in LB v EU

LB – widely geographically distributed



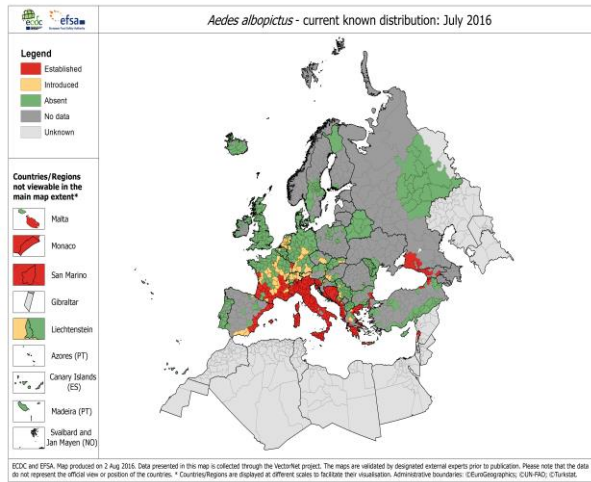
TBE cases in EU



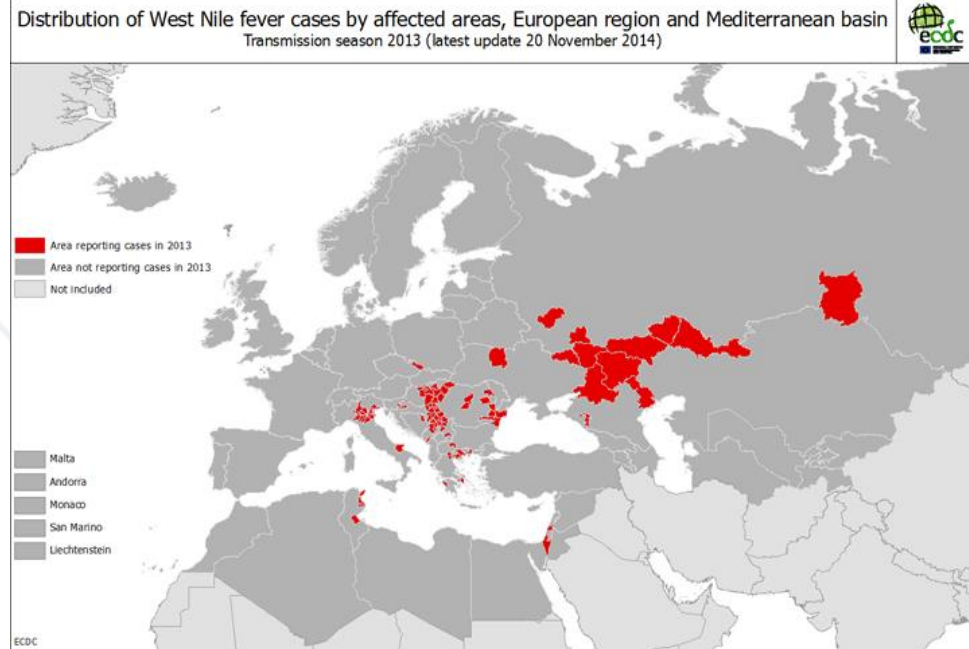


MOSQUITO BORNE DISEASES in EU

The distribution of *Aedes albopictus* (tiger mosquito) – vector of West Nile fever



West Nile fever cases in EU





Important VECTOR BORNE DISEASES – outside EU

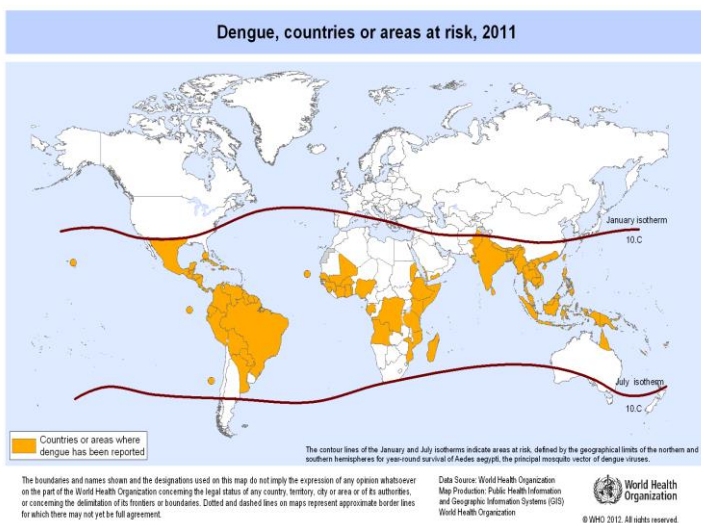
The most important vector borne diseases present in the Middle East, Africa, South East Asia, Americas:

- malaria
- dengue
- chikungunya
- yellow fever
- leishmaniosis
- Zika virus infection



VECTOR BORNE DISEASES – global distribution

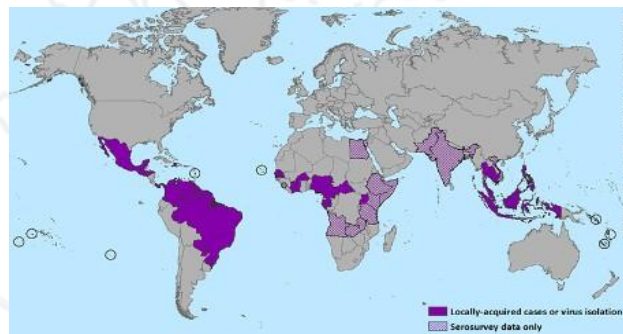
DENGUE



MALARIA



ZIKA virus infection





VECTOR BORNE DISEASES not common in EU

- Where they occur and how they affect human health?
- Can this communicable diseases be contracted in Europe?
- What is the probability to get malaria, dengue, chikungunya, Zika virus infection etc. in Europe?
- Does influx of migrants and refugees increase the possibility that abovementioned vector borne diseases spread throughout Europe?
- Can these diseases spread directly from infected person to a person in vicinity or through casual social contacts?



VECTOR BORNE DISEASES

Can this communicable diseases be contracted in Europe?

- Vector borne disease are transmitted through infected mosquito or tick (or other arthropod) bite
- Local mosquito/tick must acquire the virus through blood meal from a person who has viremia (virus in blood)
- For most vector borne diseases the duration of viremia in humans is short (couple days to week)
- Local mosquitos must be capable of amplification and transmission of the virus to susceptible person



There is a possibility but very low probability



VECTOR BORNE DISEASES

Does the influx of migrants and refugees increase the possibility that the vector borne diseases will spread throughout Europe?

NO, this is highly unlikely. Most of vector borne diseases even if acquired in home country are cured before coming to Europe.

There are some exceptions to the rule (e.g. malaria)

European residents who travel as tourists or do the business trip to areas out of Europe are more likely to return in one day. They may carry a virus in their blood and become ill few days after return.

Teoretically, returning travelers pose greater risk for the introduction of vector borne diseases in home environment

Imported vector borne diseases do happen in EU, but local spread is extremely rare



VECTOR BORNE DISEASES

And malaria?

- Malaria is caused by a parasite which is present in the blood and internal organs for a long time after infection
- The patient/infected person spreads malaria in local environment if only a mosquito that is capable to transmit malaria is present
- Having a direct contact with migrants or refugee infected with malaria parasite does not pose a risk for exposed personnel
- Suitable environment and mosquitos are present in Southern part of EU – migrant workers transmitted malaria parasite to local mosquitos in Greece



HAEMORRHAGIC FEVERS





HAEMORRHAGIC FEVERS

(= fever + bleeding)

- caused by different viruses not present in the EU
- the basic characteristic is fever, damage to the internal organs due to bleeding and visible bleeding in the skin
- haemorrhagic fevers are transmitted by close contact with the patient, especially in risky environments (health facilities)



HAEMORRHAGIC FEVERS

Is it possible to get in contact with migrants or refugees who suffer from haemorrhagic fever?

- Hemorrhagic fevers occur mostly in Sub-Saharan Africa (eg. Ebola, Lassa fever, Marburg)
- Even in this part of the world hemorrhagic fevers are rare and appear in outbreaks
- Mostly, haemorrhagic fevers have a short incubation period (incubation period is defined as the time that elapses between infection and the onset of symptoms)
- The incubation period lasts usually a week, exceptionally 3 weeks
- Migrants are traveling at least 5 days (exceptionally), mainly for longer period of time
- Even if infected migrant or refugee would have fell ill before reaching EU and she/he would not be able to continue the voyage



CONCLUSION

- There is a very low probability (practically nil) to come in contact with migrants or refugees infected with haemorrhagic fever
- A migrant or refugee who at first glance appears to be ill with fever accompanied with other symptoms most probably got infected with one of the infectious diseases which are common in EU but more exotic infections must be kept in mind (e.g. malaria)



COMMUNICABLE DISEASES – Part 3



FEVER WITH RASH

Public health response



FEVER WITH RASH

- **Definition:** the patient has various skin lesions and fever
- What is the cause of fever & rash in migrants and refugees? Does it differ from the local population?
- What needs to be done to prevent the spread of infection in community ?



FEVER WITH RASH

is caused by bacteria or viruses, most often by:

- Varicella (chicken pox) virus
- Bacteria *Streptococcus pyogenes* → scarlet fever
- Measles virus
- Rubella virus
- Enteroviruses (including hand, foot and mouth disease)
- Bacteria *meningococcus*



SCARLET FEVER

- Scarlet fever and angina are caused by the bacteria streptococcus
- Streptococci are spread through infected droplets - respiratory secretions
- The patient has the characteristic changes in the skin, fever
- Scarlet fever is treated with antibiotics
- It occurs throughout the world, mostly in preschool children and schoolchildren
- Migrants and refugees do not pose an additional risk, but the disease can be easily transmitted in overcrowded conditions





MEASLES

- Measles are highly contagious disease, measles virus is transmitted by air - a susceptible person can acquire the virus while staying in the same room with a patient
- Fever, runny nose, sore eyes, cough and skin rash are typical signs & symptoms of measles
- In adults, measles are usually a much more severe disease with multiple complications than in children
- After recovering from measles, the immunity is permanent
- Vaccination with measles vaccine prevents infection (or at least severe infection)
- It is extremely important that a patient with measles is recognized immediately and appropriate actions are taken



MEASLES

- Measles occur in EU countries depending on vaccination coverage
- Migrants and refugees coming from economically deprived countries with inadequate vaccination programmes or coming from war zones may not be vaccinated
- Measles virus can spread rapidly depending on living conditions



COUNTERMEASURES SHOULD BE IMPLEMENTED IMMEDIATELY!



MEASLES - response

- A patient with suspected measles should be kept in isolation (separate room)
- Medical services should be consulted as soon as possible and the territorial epidemiologist informed
- Personnel in contact with the patient with suspected measles should use a respirator (if no respirator available at least a surgical mask) and gloves
- As few persons as possible should be nearby the patient
- If the suspected measles case is verified, all unvaccinated close contact should be identified and offered immunization



RUBELLA

- Rubella is a contagious, generally mild viral infection that occurs most often in children and young adults
- Rubella infection in pregnant women may cause fetal death or congenital defects known as congenital rubella syndrome (CRS)
- The rubella virus is transmitted by airborne droplets when infected people sneeze or cough
- Humans are the only known host for rubella virus
- There is no specific treatment for rubella but the disease is preventable by vaccination.
- **Action: Check immunization and vaccinate all who do not have protection.**
- It is important that a pregnant woman with no protection (naturally acquired or through vaccination) is in contact with the rubella patient





VARICELLA (chickenpox)

- Varicella is an acute, highly contagious disease – the virus is transmitted through the air
- In temperate climates most cases occur before the age of 10 years - most adults are immune and cannot become ill with varicella
- Transmission is via droplets, aerosol or direct contact, or indirectly by touching freshly soiled contaminated items
- Patients are usually contagious from a few days before onset of the rash until the rash has crusted over





VARICELLA

- In children, varicella is generally considered to be a mild disease with typical rash (a small blister filled with fluid) but can be quite complicated in infants and adults - it can affect severely the brain and the lungs

RESPONSE:

- Close contacts of the patient should use a respirator to prevent inhalation of the virus and gloves
- Persons who have no immunity against varicella should not be in contact with a patient
- Varicella outbreak in asylum center can be contained with timely application of varicella vaccine



HAND, FOOT AND MOUTH DISEASE

Hand, foot, and mouth disease is a common viral illness that usually affects infants and children younger than 5 years old

One or two days after the fever starts, painful sores can develop in the mouth (herpangina) and red spots develop over one or two days on the palms of the hands and soles of the feet

HFM is self-limiting

MEASURES

Washing hands often with soap and water

Cleaning and disinfecting frequently touched surfaces and soiled items, including toys

Avoiding close contact such as kissing, hugging, or sharing eating utensils or cups with people with hand, foot, and mouth disease.





MENINGOCOCCAL INFECTION

Meningococcus cause extremely dangerous infections that occurs worldwide

The source of infection are carriers of meningococcus – the bacteria is passed through contaminated droplets to non-immune person

After infection, the bacteria can disseminate through the blood and cause inflammation of the brain, the meninges in cause the damage of internal organs

The patient has a headache, fever, vomits, the typical rash on skin and becomes poorly responsive

Meningococcus is more likely to be spread in overcrowded environments

PUBLIC HEALTH RESPONSE

Wear mask in close contact with patient

Exposed persons should receive antibiotic and in some cases meningococcal vaccine





CONCLUSION

Allergic rash is very similar to rashes caused by infectious diseases

Patients with allergy are without fever or have body temperature slightly above normal

In any case, it is important to use personal protective equipment and hygienic measures to prevent the spread of infectious diseases with rash



A faint, light blue outline map of Europe is visible in the background of the slide.

FOOD BORNE DISEASES



FOOD BORNE DISEASES

Migrants and refugees are more prone to foodborne diseases as they:

- have no basic public services (electricity, water)
- lack of the access to safe water for personal hygiene
- disrupted or uncertain supplies of safe food
- unhealthy living conditions (overcrowding)



FOOD BORNE DISEASES

Refugees and migrants become ill with food borne disease during their journey

Most commonly noticed:

- Norovirus
- **Hepatitis A**
- **Shigellosis**
- Campylobacteriosis
- Salmonellosis



FOOD BORNE DISEASES

The symptoms most commonly found are:

- Nausea
- Vomiting
- Diarrhoea (watery, bloody)

Most food and water borne infection episodes clear up within a few days

Infants and toddlers are prone to dehydrate



Rehydration is the mainstay of therapy



FOOD BORNE DISEASES

During the journey and in the refugee camps the living conditions enable and support rapid development of an outbreak.

Foodborne and waterborne diseases can easily reach epidemic proportions.

Early recognition of an rapidly evolving outbreak and immediate response



FOOD BORNE DISEASES

Hygienic measures are of utmost importance!

Access to safe water and facilities for personal hygiene:

- minimise overcrowding facilities for refugees
- where possible, preventing or minimising overcrowding in reception;
- promote hygiene for migrants and refugee and raise awareness among refugees concerning personal hygiene to prevent the spread of food and water borne pathogens
- enable the hygiene – provide enough and hand washing facilities, soap, paper towels and toilet paper;



FOOD BORNE DISEASES

Safe food

- **Promote hand hygiene** – wash hands before handling food and during food preparation, after going to the toilet
- **Enable safe food** – wash and sanitize surfaces and utensils used for food preparation in the facilities with migrants and refugees
- **Empower** migrants and refugee with knowledge about safe food preparation – separate raw meat, poultry and sea food from other food, cook food throughout, keep food at safe temperature etc.



CONCLUSION

- Food borne diseases outbreaks are expected to evolve in unfavorable hygienic conditions
- The most important counter-measure is to provide adequate living conditions



MENTAL HEALTH OF MIGRANTS AND REFUGEES



Intended Learning Outcomes

- Basic knowledge of mental health determinants in migrant population
- Understanding of the pre- and post-migration risks that can influence mental health
- Knowledge of common mental health problems in migrants and refugees
- Recognition of issues in treatment of mental health problems



Migration, New Cultural Environment and Stress

- Migration is not itself a cause of mental illness,
- Change of **cultural, religious, gender identity** and social role brings stress of acculturation,
- **Stress of migration** and loss; it is a stressful life event and anxiety generator,
- Refugees and asylum-seekers, together with undocumented migrants, are considered to be particularly at risk, due to past and current predicaments,
- There is a **risk of victimization** and acquiring victim identity.



Determinants that Influence Mental Health

Migrant's personal characteristics:

- Gender
- Age
- Education level
- Resources
- Acculturation strategies
- Pre-existing mental health problems

Social support:

- Family
- Community – Diaspora community
- Neighbourhood
- School
- Networks of relatives

Characteristics of the host country:

- Socio-economic framework
- Unemployment levels
- Education programmes
- Health services



Pre and post migration factors

Pre-migration	Reasons (economical, political. Preparation Group or singly Degree of control over migration
Migration	How long ago and why? Age on arrival? Possible return or permanent? Asylum status?
Post-migration	Aspiration/achievement Acculturation and adjustment Attitudes towards new culture Support networks available
Interviewer	Own values Being aware of strenghts of one's own culture and its weaknesses



Common Mental Health Problems

- Depression and grief
- Post-traumatic stress disorder
- Anxiety
- Schizophrenia
- Addiction
- Psychosomatic disorders
- Syndromes linked to culture



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Migrants show **higher levels of depression**.

- This higher risk for depression is not attributable to ethnic minority status but is mainly due to experienced barriers to socioeconomic integration and processes of discrimination
- Depression and generalized anxiety are more prevalent in the migrant populations than in population groups from within the European Union.
- Depression in migrants was characterized by higher comorbidity (mostly somatoform and anxiety disorders), higher severity, and a non-recurrent, chronic course.



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In addition to pre-migratory traumatic exposure, **acculturative stress has an effect on presentation of PTSD and anxiety.**

This effect was only found for some domains of acculturative stress indicating that some post-migratory stressors hinder the recovery from traumatic exposure, suggesting that acculturative stress experienced may be influenced by the social context of the host society, in particular the immigration policies and attitudes of the wider society toward different cultures.



Schizophrenia

- In a Swedish study, refugees were at **increased risk of psychosis** compared with both the Swedish-born population and non-refugee migrants. The increased rate in refugees compared with non-refugee migrants was more pronounced in men and was present for refugees from all regions except sub-Saharan Africa. Both refugees and non-refugee migrants from sub-Saharan Africa had similarly high rates relative to the Swedish-born population.
- African-Caribbean migrants to Europe have 5–10 times higher incidence rate of schizophrenia syndrome than expected, according to multiple studies using various methodologies in the past few decades.



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Migrants from countries in which suicide risks are particularly high, i.e. countries in northern and eastern Europe, experienced higher suicide rates relative to groups without migration background.

Young female migrants from Turkey, East Africa and South Asia are a risk group.

Risk factors:

Psychiatric problem

Mental health problem

Drug or alcohol use

Traumatic experiences in combination with other factors



Addiction

Forced migrants may be at risk for substance use for reasons including coping with traumatic experiences, co-morbid mental health disorders, acculturation challenges and social and economic inequality.

- The stress of the migratory process itself may be implicated in some countries, where asylum seekers and refugees form the largest group of migrants.
- These factors may all interact with genetic vulnerability and substance abuse.



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Male sex, trauma exposure and symptoms of mental illness were commonly identified correlates of substance use.

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- Language difficulties
- Lack of knowledge
- Fear of losing residence rights.
- Cultural understanding of the causes and treatment of addictive behavior



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Treatment approach

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- The results suggest that clinical services should provide holistic interventions within a phased approach when working with refugees and asylum seekers.
- At a policy level, the results suggest the need for asylum policies that reduce post-migration problems and provide support for refugees and asylum seekers



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Cultural awareness, the ability of the psychiatrist to understand and respond to the unique cultural needs of a patient.

The psychiatrist needs to consider the patient's culture as it relates to the presenting symptoms and history, and to help formulate a treatment plan that is mutually agreed upon by the **physician, patient and patient's family**.

Attitudes toward seeking mental health services in migrants have been shown to be affected by cultural and traditional beliefs about mental health, perceived societal stigma, knowledge and familiarity with available services, and the use by patients and families of informal indigenous resources. For example, Muslims in the US and elsewhere often seek guidance for mental health issues from imams.(9)



Religious approach

Mood and anxiety disturbances are addressed rather by family support, religiously based interventions, and indigenous herbal remedies. Those suffering mood disturbance avoid seeking treatment from a doctor or institution for fear of being labeled “insane” and shaming their family.

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MENTAL HEALTH OF MIGRANTS AND REFUGEES



Intended Learning Outcomes

- Basic knowledge of mental health determinants in migrant population
- Understanding of the pre- and post-migration risks that can influence mental health
- Knowledge of common mental health problems in migrants and refugees
- Recognition of issues in treatment of mental health problems



Migration, New Cultural Environment and Stress

- Migration is not itself a cause of mental illness,
- Change of **cultural, religious, gender identity** and social role brings stress of acculturation,
- **Stress of migration** and loss; it is a stressful life event and anxiety generator,
- Refugees and asylum-seekers, together with undocumented migrants, are considered to be particularly at risk, due to past and current predicaments,
- There is a **risk of victimization** and acquiring victim identity.



Determinants that Influence Mental Health

Migrant's personal characteristics:

- Gender
- Age
- Education level
- Resources
- Acculturation strategies
- Pre-existing mental health problems

Social support:

- Family
- Community – Diaspora community
- Neighbourhood
- School
- Networks of relatives

Characteristics of the host country:

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A faint, light blue outline map of Europe is visible in the background of the slide.

CULTURAL CONSTRUCTION OF HEALTH PROBLEMS



Health and Disease

WHO: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.

- “Disease” diagnosed by health professional and “disease” experienced by user may be very different.



Disease/Illness/Sickness

- **Disease**: malfunctioning or maladaptation of biologic and psycho-physiologic processes in the individual (Physician's point of view)
- **Illness**: personal, interpersonal, cultural reactions to disease or discomfort (the personal experience of suffering: Patient's point of view)
- **Sickness**: social and cultural meanings of the individual's experience of suffering/illness; society's response and expectations towards a sick person and how a sick person handles his/her illness (Society's point of view)
 - Biological level; Psychological level; Sociocultural level; Economical level



All human communities have developed their own answers to the occurrence of the “disease”, these are rigidly connected with the beliefs and knowledge held by community members.



- **Diagnosed disease without experienced illness** (If they can't feel it, why treat it? eg. high cholesterol)
- **Experienced illness without diagnosed disease** (Correct but unresponsive health professionals when there are no visible or measurable signs) → user's feelings of illness do not comply with the health professional's perception of their conditions
- **Somatization** ("stigma" attached to the psychosocial distress)



**HEALTH PROBLEM IS A RESULT OF AN
IMBALANCE BETWEEN A PERSON AND
THE WORLD, WHICH CAN BE CAUSED
BY VARIOUS REASONS.**



Culturally Conditioned Understanding of Illness/Disease

- Different perception of pain or illness
- Different description of pain or illness
- Different understanding of the origin of pain or illness
- Different understanding of treatment (way of treatment, length of healing process, etc.)
- Different logical linking of the symptoms and demands for treatment (*'same disease' can be healed differently in a migrant's country of origin*)



Individual's culture can affect his/her beliefs, values and practices in the following areas:

- Perceptions of the body
- Perceptions of health and disease (when a person is sick? what disease is dangerous, etc.)
- The perception of pain and pain behavior
- The importance and role of suffering
- Perception of health institutions, health care workers/providers and other therapists (trust or distrust in instructions)



- The boundaries of privacy, age, sex and relations (eg. touch)
- Success and evaluation of an individual therapy
- Beliefs regarding the daily rhythm and practices that can direct daily activities
- The importance of family and close relations (what constitutes a family, how important is it?)
- Autonomy and self-care
- Ways of communication
- The importance of rituals and traditions



- Power relations (the roles of the patient and the health professional)
 - Decision making and consensus given during treatment: what is patient's role; how much does he/she want to be involved in the healing process (decisions, explanations, etc.)?
 - Health professional is seen as an expert with complete authority; involving the patient and asking for their opinion can be understood as incompetence or lack of knowledge, confidence in his/her treatment



Biomedicine

- Cartesian dualism – body and mind are separate
- Body as a machine (with broken parts)
- What is the disease and what is the formula to 'fix it' (what is the cure)?
- Standardization of care (protocols, rules, formulas, etc.)
- Short-term results (not lifestyle but drugs that do not take much time)
- Authority and responsibility in practitioner/health care professional



Holistic Medicine

- Body/mind – adaptable, flexible, creative, interlinked with other systems → individual's regenerative capacities (*vis mediatrix naturae*)
- Priority: prevention
- Causes are searched for on physical, emotional, spiritual, mental and social level
- Long-term focus on creating and maintaining health and well-being (lifestyle)
- Authority and responsibility inherent in an individual, co-operative partnership
- Bio-Psycho-Social model



Culture, Health and Disease

It is crucial to understand the patient's explanation of health problems, since his/her interpretation affects his/her practices in maintaining health and preventing/treating diseases.

Ignored, overlooked, unheard, misunderstood or underestimated confessions of patients and their explanation as to why the illness occurred, often carry with them the key on the cause of disease and to the key to treatment (eg. lifestyle and personal convictions – healthy diet to somebody who cannot afford it).



Internal Structure of the Body

Functioning of the body:

Different beliefs about the structure of the body and the location of internal organs are very important for successful medical treatment.

However, the behavior of an individual is even more affected by his/her beliefs about how the body works.



The Body

- **Individual body-self** (intuitive sense of embodied self, existing apart from other individual bodies; the constituent parts (mind, matter, psyche, soul, self, etc.) and relations to each other vary)
- **Social body** (representational uses of the body as a natural symbol with which to think about nature, society and culture)
- **Body politics** (regulation, surveillance, control of the bodies (individual and collective))
- **Body/mind dualism** - many non-Western cultures do not differentiate between mind and body



- **Social body –**
- Body as a Symbol
- The perception of the body is socially and culturally conditioned
 - What is appropriate and accepted care for our bodies?
 - What are appropriate dress code, movements and gestures?
 - Controlling the body and bodily functions
 - Changes in body politics through place and time



Body's boundaries:

They extend beyond the actual physical boundaries of an individual and are culturally conditioned. Those boundaries (how close can one stand while communicating, when touch is appropriate, etc.) vary between individuals and between cultures, but also depend on a situation.



Understanding of the anatomy of the body can vary between health professionals and the patient → It requires attention and reflection, since complications and conflicts during treatment may not be the result of deliberate non-cooperation of the user. Often there are just different conceptions of the body or discomfort to openly talk about a specific part of the body (esp. around genitalia) or troubles that is causing.



Touch

- Is a sensory perception that human embryo develops at an early age.
- Is not only very important for perception of the world but also plays a key role in human relationships.
- Social rules (taboos): who, where and how
- When not sure, avoid touching!
- Explain and ask for patient's consent!
- Health professionals take touching patients for granted – without their consent, they (un)consciously express their feeling of superiority.



Pain

- Normal response to certain stimuli, events, developments within us or outside us (biological, physiological, physical and psychological fact)
- An inevitable part of **life** (religious, social, economic, etc.)
- Part of socialization
- An opportunity to reveal personal strength
- Deserved punishment for transgressions and sins
- Type of purification
- Deliverance experience



Pain

- Main feature: inability to describe it to another person – it is impossible to fully experience the pain of others
- For the physician the absence of physiological evidence for the existence of pain = doubt about the reality and seriousness of the problem.
- Stereotypes: absence of pain behavior does not mean the absence of pain → dangers of superficial generalization!



CONFRONTING STEREOTYPES

-
recognition and response



PREJUDICE

POSITIVE FEATURE

- Perception
- Organization
- Comprehension of everyday world

IT IS EXPRESSED THROUGH

- Social interactions
- Everyday speech
- Phrases
- Gestures
- Humor and ambiguities

NEGATIVE FEATURE

- Disrespect
- Intolerance
- Contemptuous attitude
- It proclaims standards of normality; majority; desirability



XENOPHOBIA

FEAR of stranger, foreigner, foreign, different.

Xenophobia is related to our ignorance (lack of knowledge) of surroundings, persons, habits, objects, etc., that are otherwise unknown in our known area.

Xenophobia impedes our professional work and our everyday lives.



STEREOTYPES

Stereotypes are a valuating representation of social phenomena and people. They represent a type of judgement with negative or positive connotations (hidden meanings).

They attribute certain physical, psychological, social, behavioural features to social group or individual.

They compare, judge, evaluate and rank to hierarchy.

An individual from a group we judge to be inferior (substandard), will also be perceived as inferior – bad, dangerous, dirty.

Today they are expressed covertly and symbolically.



Stereotypes are rarely born from a direct, personal experience of an individual.

In reality, they are socially rooted.

Stereotype is not your idea, it is society's idea

—

THINK YOUR OWN THOUGHTS!



INCEPTION OF STEREOTYPES

- They are cognitive structure (way of thinking that helps us make sense of the world)
- Integrative social element (part of a culture that a person internalizes and makes him or her a member of a society)
- They are connected to culture's history (myths and real historic events) → to explain them we need to understand the past



Factors that also influence inception and type of stereotypes

- Culture (fashion, food, religion, language, customs, etc.)
- Family forms of community (monogamy or polygamy)
- Legal system
- Geography
- Physical traits
- Etc.



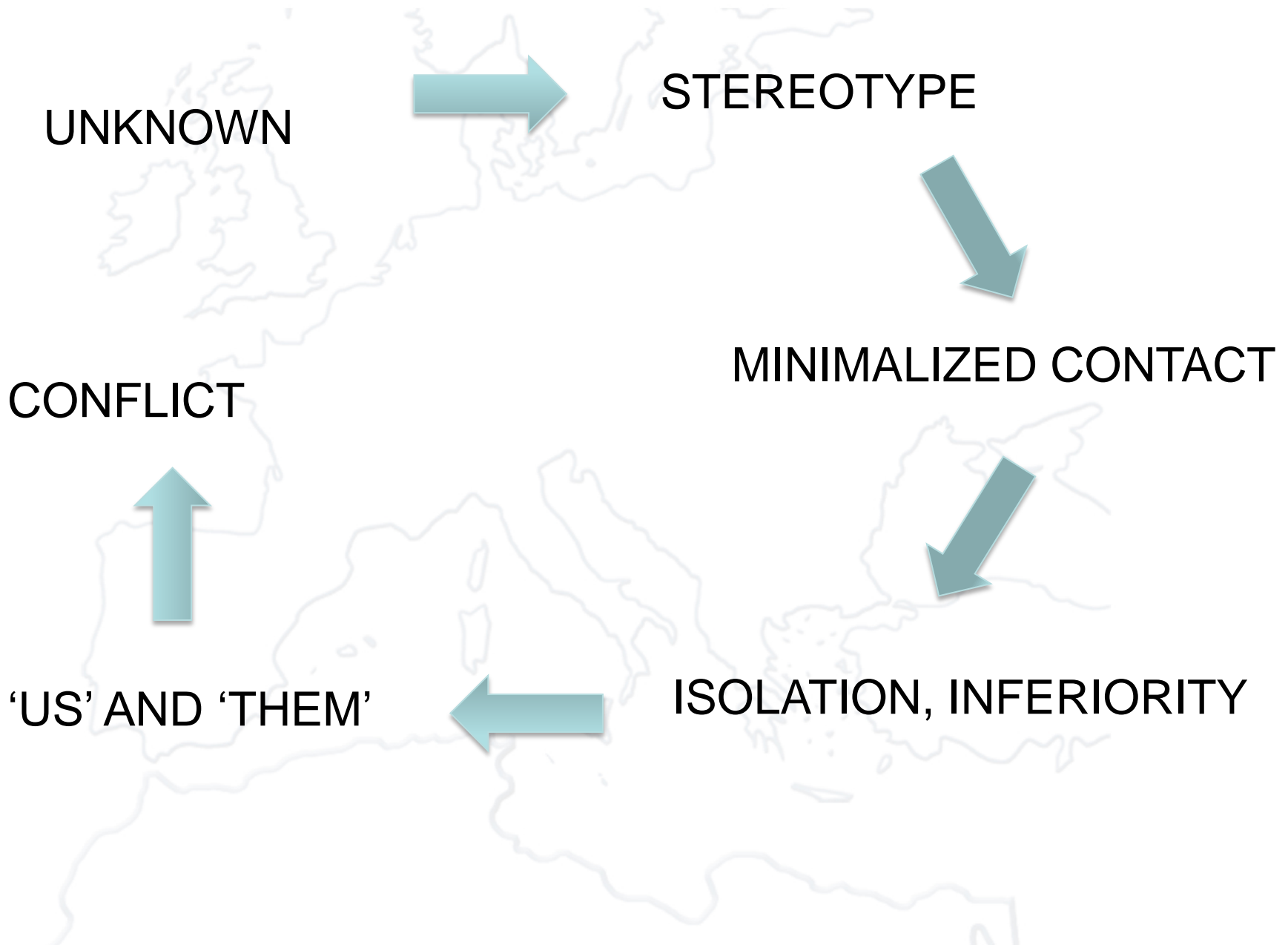
It is interesting how many of the stereotypical idea of 'the other' appear in similar versions, except that they are adapted to the specific circumstances.

(Šabec 2006, 258)



Dangers and failures of incomplete images of others (stereotypes)

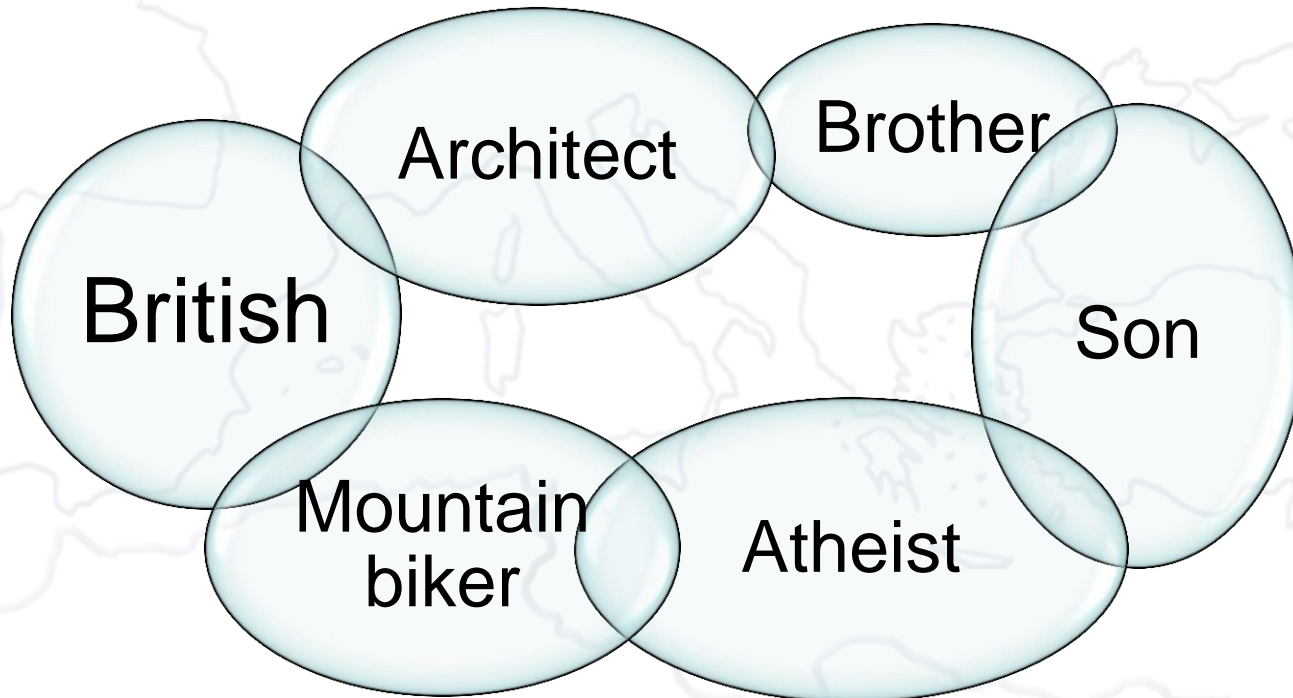
- No person belongs to only one social group, as no groups are completely homogeneous (uniform) → a trait of a group is not necessarily a trait of an individual member
- Emphasizing the differences between two groups; two individuals from two different groups can have more in common that they do with their own groups
- The less we know, the quicker we jump to (incorrect) conclusions





INDIVIDUAL versus UNIT

- An individual belongs to variety of social groups and consequently has more than one clean identity – religion, age, sex, nationality, education, etc.
- Identities and roles change through time and space.





HOW TO RECOGNIZE STEREOTYPES?

- Stereotypes can be found in thoughts, words and action in our everyday lives
- Reflection and self-reflection: observing and understanding of emotions, thoughts, words and actions

GENERALIZATION they are all the same

POLARIZATION ... we are /.../ and they are /.../

APPARENT DENIAL not true, but...

SELECTIVE INFORMATION SHARING

SIMPLIFICATION

REDIRECTED ATTENTION

APPARENT RECOGNITION it is true, however...

COMPARISEMENTS

EXPLANATION it is so, because...

IMPLICIT, UNCLEAR AND INDIRECT STATEMENTS somebody who knows somebody; it has been said,...



NATIONAL STEREOTYPES

- Nationalism and patriotism are two sides to one coin – depends on our point of view (from the outside in or inside out)
- Inclusivity and exclusivity (we belong and others don't)
- Dangers:
 - When someone is treated badly, as inferior only due to being member of a 'foreign' social group
 - When we force our 'patriotism' on others, on those outside our group



- They positively distinguish person's own community from another, especially if there is too much similarity and pronounced tendency for interactions.
- They discriminate against and exclude people and groups who would potentially compromise their own values and habits, such as people of other religions.
- They demonstrate loyalty to certain group.
- They provide a scapegoat to a particular nation, particularly during periods of major economic, political or symbolic crisis.



- National stereotypes are strongest with neighboring nations/states; they are also influenced by world, political and economical powers
- They origin from ethnic folklore and historical circumstances
- The greater the national pride, the greater xenophobia!



Functions of National Stereotypes

Richard Hill – national stereotypes are extremely resistant

- They structure the world outside observer (nation), making use of stereotypes, with already established referenced framework (society says so).
- Emphasise the sense of belonging (so called: 'we-feeling').
- They bring cohesiveness to the community by emphasizing common values and traditions of the community.



National stereotypes look fairly similar since the beginning of development of nationalism (18th century).

A foreigner is always:

- Dirty,
- Cunning,
- Stupid,
- Sexually perverted,
 - Irrational,
 - Uneducated,
- Usually has alcohol problems.

Brands are the same, the only thing that changes are the identities we pin them on.



Securitization Discourse

- Migrants are perceived and spoken of as a (national) threat against which we must protect ourselves.
- It is a discourse of the politicians and the media.
- It reinforces and justifies racism and discrimination.
- Migration is a commonplace occurrence, the numbers of migrants is increasing and it will continue to do so.
- We should condemn situations and circumstances that lead to forced migrations.
- We should draw up programs for successful integration and coexistence of different cultures.



SELF-FULFILLING PROPHECY

- Fulfillment of (incorrect) expectations of others

PROPHET	TARGET PERSON
is acting on the basis of their own thoughts, expectations, stereotypes and prejudices	reacts to prophets behavior and begins to act the way they are expected to

- Psychology – Merton & Rosenthal; 1950
- First experiment: teacher's expectation and its influence on students' results
- There are positive and negative prophecies (expectations); positive expectations have greater influence



- Victims of stereotyping often cling to stereotypes about themselves, even strengthen them, sometimes due to defiance or self-humiliation
- As prophets we can influence the frequency of the realization of the prophecy
 - Level of thinking (building expectations)
 - Level of behavior
- Franzoi's suggestion: when in bad relationship, change your behavior (expectations). Results will follow.



Prophet's Influence

Teachers cultivated positive expectations towards some students and in consequence offered them:

- *environment* (encouraging socio-emotional atmosphere: non-verbal communication, demonstration of emotional support: demonstration of warmth, attention, smiling, approving nodding, maintaining eye contact, etc.),
- *feedback* (common feedback on the students' work, more response, more compliments, more critique – it helps to understanding of what and how to improve)
- *input* (students, towards whom positive expectations were cultivated, were acquainted with more and more complex content)
- *output* (encouragement to posing additional questions, to more frequent and more intense cooperation and response; they were given more time to finish their their tasks correctly)

(Gomboc 2011, 99)



EXCEPTIONS THAT DO NOT PROVE THE RULE

- Even positive stereotypes are still stereotypes – incomplete, faulty and dangerous!
- We need to approach a migrant with calm, rational and with understanding of (self)reflection.

Every individual is a unique person that deserves to introduce themselves, with their own words and their own actions.



FIGHT AGAINST STEREOTYPES

‘By introspection, critical reflection and empathy, the individual will be able to avoid a situation in which the other persons and groups are subjected to stereotyping, but their own stereotypical perception of reality and behavior will not be recognized.’

(Šabec 2006, 21)



- Flexible thinking, search for alternatives and alternative options
- Critical approach towards often heavily biased given information (including from the media)
- Re-questioning and Reflection
- Learning about our own culture, habits, thinking, beliefs, experiences, behavior
- Curiosity and interest in meeting new people
- Searching for identity in somebody we can most connect with
- Keeping a positive and open approach



Above all, stereotypes are a consequence of ignorance – the best weapon against them is knowledge! Every stereotype has an origin and an explanation so -

EXPAND YOUR HORIZONS, MEET NEW PEOPLE, ASK QUESTIONS, BE CURIOUS!



INTERCULTURAL COMPETENCES

-

what are they?



WHAT IS CULTURE?

Culture

It is dynamic unity of cultural practices, knowledge, material and non-material, visible and invisible; ideas, customs, social behaviour. It is learnt, transferred from people to people and modified by each individual through his/her beliefs, behaviours and practices. Therefore, culture is dynamic, not static.



CULTURE AS AN ICEBERG

Language; Customs; Food; Music; Rituals; Literature;
Games; Art; Habits; Dress; Behaviors; Architecture;
Drink

Beliefs; Norms; Assumptions; Expectations; Space
Orientation; Learning Styles; Attitudes; Values;
Prejudices; Notions of Modesty; Attitudes towards Age;
Importance of Time; Notions of 'Self'; Gender Roles; ...

Edward T. Hall, 1976



Cultural Shock

Intercultural communication and exchange can produce discomfort, unfamiliarity feelings, misunderstanding due to cultural diversity.



Categories of Values and People Behaviors

- Personal, which make every one of us different from everybody else and unique even within the same cultural environment (I am an individual, I am not a copy of another member of my group).
- Cultural, which are shared by members of specific cultural backgrounds and are reasons why certain groups of people are different from other groups.
- Universal, which are common to everybody, irrespective of their personal or cultural characteristics (everybody values life, though the idea of life varies, depending on personal and cultural values).



Cultural Differences

- Meaning of rituals and traditions (methods of implementations, importance/significance, relevance of custom, etc.)
- Meaning of daily rhythm and practices that guide daily activities
- Society's structure (organization; class structure, social institutions, social network, norms, etc.)
- Boundaries of privacy, age, sex and relationships (different roles, different rights, duties, values, etc.)



Cultural Differences (2)

- Hierarchy within society
- Social emphasis on individualism versus collectivism (responsibilities and needs of individuals against those of the group)
- Importance of family and important others (what constitutes a family, who constitutes a family (eg. extended family, god-fathers/mothers, etc, who plays a significant role in someone's life)
- Mode of communication (greeting with handshake, kiss on the cheek, looking into one's eyes, etc.)
- Meaning of "body", "health", "disease"



Cultural Differences (3)

- **Eating habits** (tastes, types of food, spiciness, quantity and numbers of meals/servings. Food also has significant – social - role and important than just means of survival)
- **Perception of time** (focus on past or future; perception of time as linear or cyclic, etc.; importance and value of punctuality)
- **Perception of “space”** (intimate space, common space, space among people in private/public contexts)



INTERCULTURAL COMPETENCES

- A set of knowledge and skills useful to interact with other people, necessary to understand and respect those with different cultural patterns.
- Appropriate, tolerant and respectful communication.
- Can improve understanding, sensitivity, accepting, respecting and response of cultural differences and relationships.



INTERCULTURAL COMPETENCES (2)

- Establishment of positive and constructive relationships with other people.
- Awareness of the diversity of cultures and understanding that our culture is 'different' and 'foreign' to somebody else.
- Efficient identification of potentially different conceptions and practices, actual needs and expectations of other people (since culture and practices can be different, other people's needs and solutions to those needs can be different than our own)
- Competences of using various, flexible strategies and ways of empowerment and inclusion.



INTERCULTURAL COMPETENCES (3)

Intercultural competence does not mean a suppression or even denial of our own cultural background and patterns!

Intercultural competence means to be open, curious and interested in other cultures, abilities of understanding and interpreting habits, behaviors, values and other cultural practices.

Intercultural competence is a continuous learning process.



INTERCULTURAL COMPETENCES (4)

Despite the evidence of diversity among the people, only a few are actually able to understand those differences.

Therefore, an intercultural competent person does not evaluate others through the 'glasses' of his/her own culture.



INTERCULTURAL COMPETENCES (5)

- Awareness of integration in our own culture (our beliefs, practices, habits, mindsets all come from our own culture; knowing our own culture can help us see the differences with other cultures).
- Reflecting on our own prejudices, stereotypes and worldview.
- Ability to recognize differences and take them into consideration when interacting with others.



WHY INTERCULTURAL COMPETENCES?

- They contribute to the political, social, cultural and economic integration (culturally different can be someone from the same country but can be of different religion, socioeconomic class, education (type and level), political belief, etc. Intercultural competences integrate our 'national diverse culture').
- They contribute to positive dialogue between different cultures, societies and people.
- They encourage and promote equality, human dignity and sense of common purpose.



WHY INTERCULTURAL COMPETENCES? (2)

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- developing a better and deeper understanding of diverse worldviews and practices,
- increased co-operation and participation,
- personal growth,
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VIOLENCE AGAINST MIGRANTS AND REFUGEES



Definition (World Report on Violence and Health)

‘the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.’



Typology (WRVH)

- Physical Violence
- Sexual Violence
- Psychological Attack
- Deprivation



Sub-types

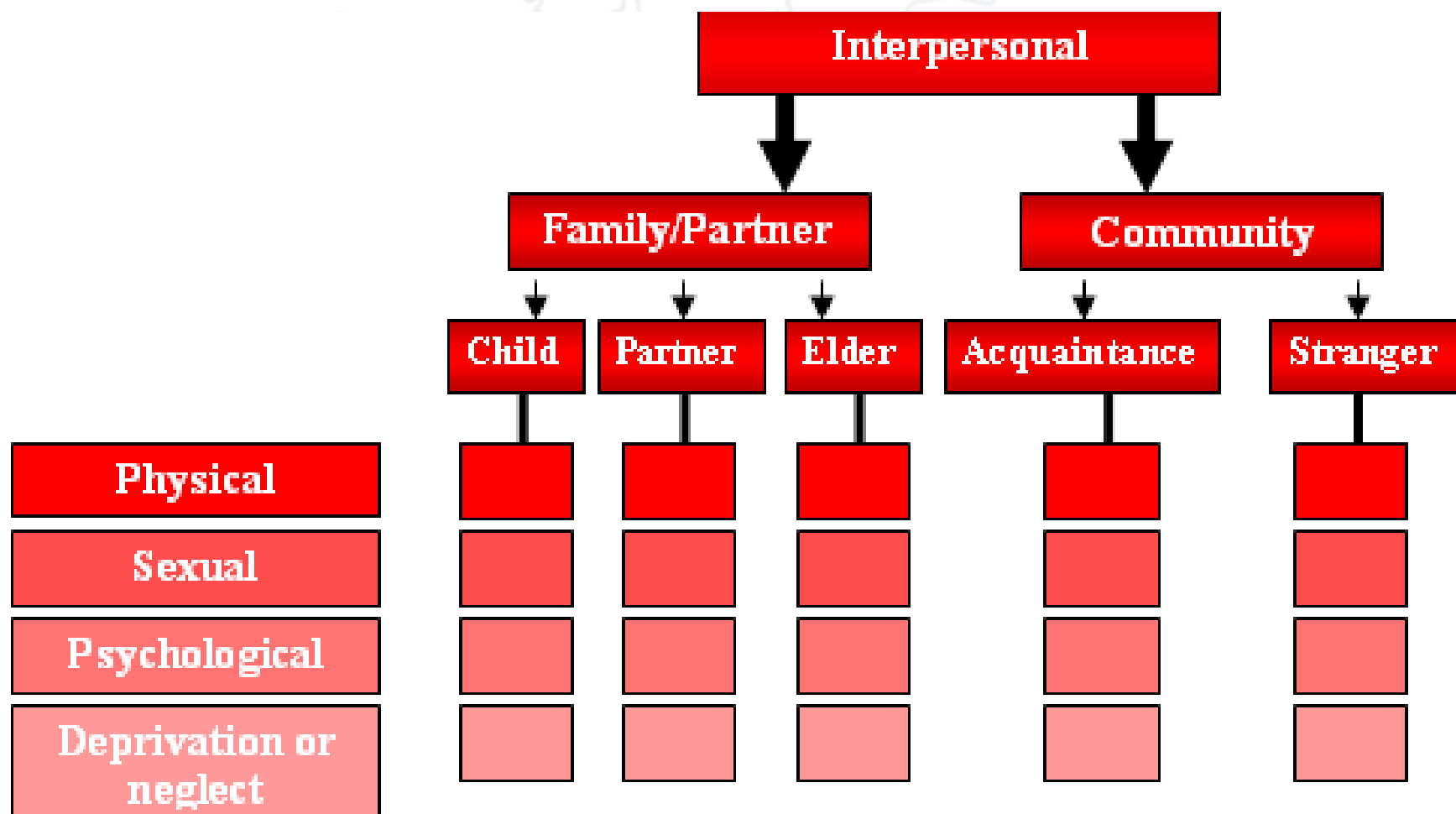
According to the victim-perpetrator

- **Self-directed violence and suicide** (victim and perpetrator are the same individual; self-abuse and suicide)
- **Interpersonal violence** (*next slide*)
- **Collective violence committed by groups of individuals in economic, social and political context** (larger groups of individuals; subdivided into social, political and economic violence)



Interpersonal Violence

- Family and intimate partner violence
 - *Child maltreatment*
 - *Intimate partner violence*
 - *Elder abuse*
- Community violence
 - *Acquaintance violence*
 - *Stranger violence*
 - *Includes: youth violence; assault by strangers; violence related to property crimes; violence in workplaces and other institutions*



Typology of interpersonal violence based on World Report on Violence and Health
<http://www.who.int/violenceprevention/approach/definition/en/>



Youth Violence - Bullying

- Maltreatment and exploitation
- Unwanted aggressive behavior(s) by another youth or group of youths, who are not siblings or current dating partners.
- Involves an observed or perceived power imbalance and is repeated multiple times or is highly likely to be repeated.
- May inflict harm or distress including physical, psychological, social or educational harm.
- A young person can be a perpetrator, a victim, or both.



Violence against Women

- Rape
- Genital mutilation (NB: not the result of religion but culture!!)
- Sexual exploitation
- Physical abuse
- Honor killing



Honor Killings

- Homicide of a member of a family (mostly women) or social group by other members (mostly men), due to belief the victim has brought *dishonor* upon the family or community and with intent of restoring reputation and honor of the family → femicide (killing of women by men) is result of a continuum (a girl killed in honor killing has been mistreated all of her life)
- ‘Crimes of passion’, female infanticide, preadolescent morality of girls and dowry-related death, ‘honor killings’
- Embedded in the culture, religion, tradition – the perpetrator is the victim (of dishonor)



Violence towards and among Migrants

- Collective violence
- Intra-familial violence toward spouses, children, other relatives and elderly
- Maltreatment and exploitation of unaccompanied minor
- Human trafficking and violence
- Maltreatment and exploitation of migrant workers



The Impact of Violence on Human Health

- Physical injury
- Functional impairment
- Mental health problems
- Negative health behaviour
- Chronic conditions
- Reproductive health problems



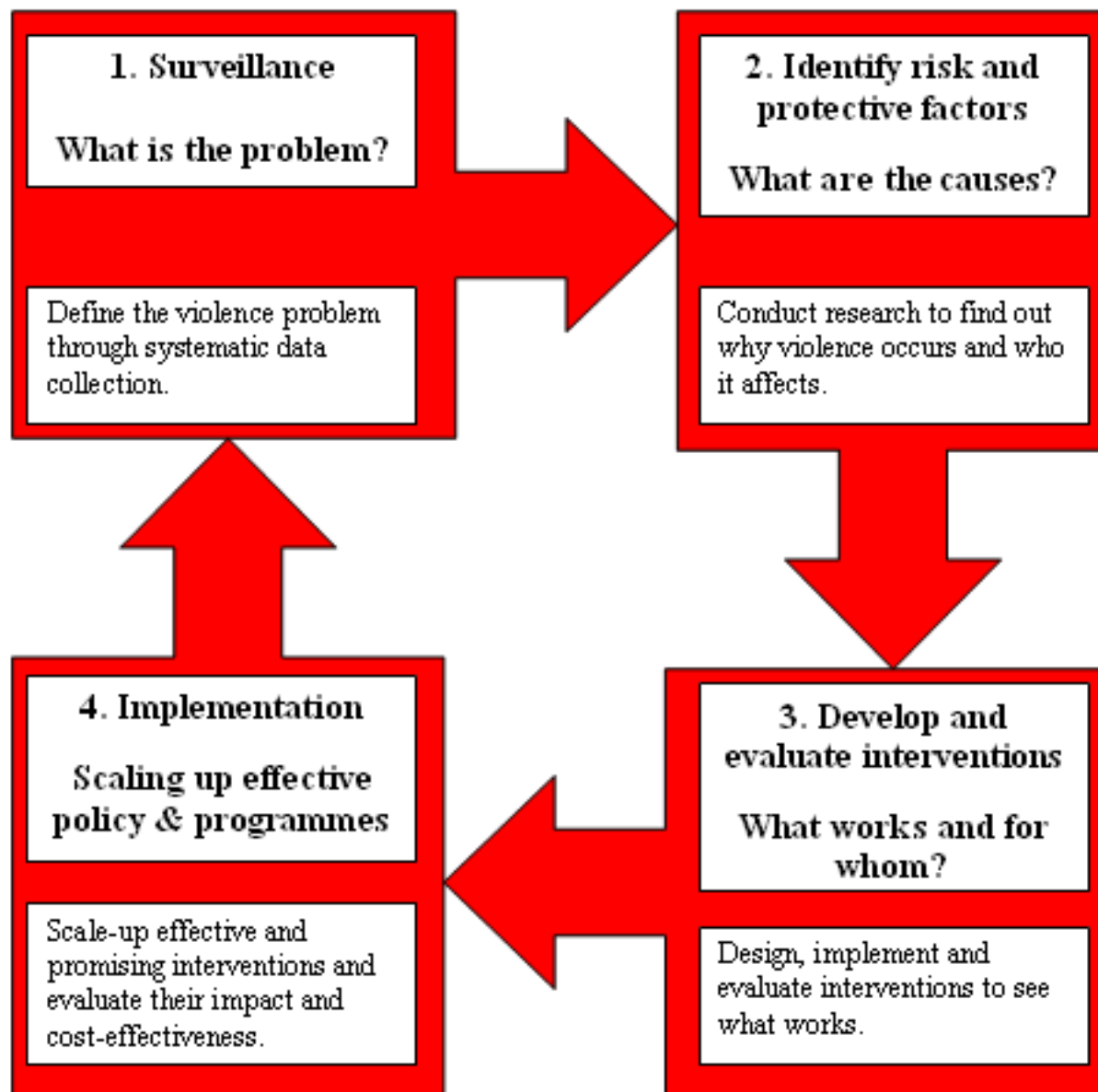
Public Health Approach to Violence Prevention

- Primary prevention – approaches that aim to prevent violence before it occurs.
- Secondary prevention – approaches that focus on the more immediate responses to violence, such as pre-hospital care, emergency services or treatment for sexually transmitted infections following a rape.
- Tertiary prevention – approaches that focus on long-term care in the wake of violence, such as rehabilitation and reintegration, and attempt to lessen trauma or reduce long-term disability associated with violence.



Public Health approach to Prevention (WRVH)

1. To define the problem through the systematic collection of information about the magnitude, scope, characteristics and consequences of violence.
2. To establish why violence occurs using research to determine the causes and correlates of violence, the factors that increase or decrease the risk for violence, and the factors that could be modified through interventions.
3. To find out what works to prevent violence by designing, implementing and evaluating interventions.
4. To implement effective and promising interventions in a wide range of settings. The effects of these interventions on risk factors and the target outcome should be monitored, and their impact and cost-effectiveness should be evaluated.



Public Health Approach, WRVH
http://www.who.int/violenceprevention/approach/public_health/en/



Human Rights Approach to Prevention of Violence

- Obligations of states to respect, protect and fulfill human rights
- Prevent, eradicate and punish violence
- Violence as a violation of many human rights:
 - the rights to life, liberty, autonomy and security of the person;
 - the rights to equality and non-discriminations;
 - the rights to be free from torture and cruel, inhuman and degrading treatment or punishment;
 - the right to privacy;
 - the right to the highest attainable standard of human health



Comprehensive Society Response to Violence Against Migrants and Refugees

- Inter-sectorial cooperation with programmatic, policy and legislative measures to prevent violence
- The role of health policy, health systems and health service providers to recognize and support the victims of violence among migrants and refugees
- Evaluation of health, social and legal services for victims of violence – how to identify gaps and stimulate action to address them



Comprehensive Society Response to Violence Against Migrants and Refugees

- Medical, psychological, social and financial support to maltreated and abused migrants and refugees – the importance of cultural and religious sensitivity
- Opportunities for prevention activities within primary level of health care considering accessibility and acceptability for migrants



Useful Links

- <http://www.who.int/violenceprevention/approach/definition/en/> : WHO, World Report on Violence and Health
- http://www.who.int/violence_injury_prevention/violence/en/ : WHO, Violence and Injury Prevention
- <http://www.vawnet.org> : National Online Resource Center on Violence Against Women (population specific approaches)
- <http://www.cdc.gov/violenceprevention/youthviolence/bullyinresearch/index.html> : CDC, Injury Prevention and Control: Division of Violence Prevention
- <http://www.genevadeclaration.org> : Geneva Declaration on Armed Violence and Development
- <http://www.ohchr.org/EN/Issues/Discrimination/Pages/discrimi>



MIGRATION CLARITY

- streams of people:
who when where why



MIGRATIONS

- There is no one definition, due to the fact that migration is a very complex phenomenon.
- Migrations include economical, political, social, demographic, cultural, ecological, linguistic phenomena and we cannot understand or study migrations without taking into consideration all of these aspects. Very often they mix and intertwine.
- Who migrates? → People, Animals, Objects, Culture, Religion, Habits, Language, Food, etc.
- Migrations became a way of life → technological progress, globalization = distances have disappeared, time travel has shortened



Time-Space MOBILITY

- Time-space mobility can be characterized as a degree of movement or migration within a geographical area by an individual, group or population within a given timeframe. It can be:
 - Routine (repeated)
 - Everyday
 - Occasional
 - Temporary
 - Exceptional
 - Accidental
- Factors can be:
- Cultural
 - Individual
 - Demographic
 - Economic
 - Physical



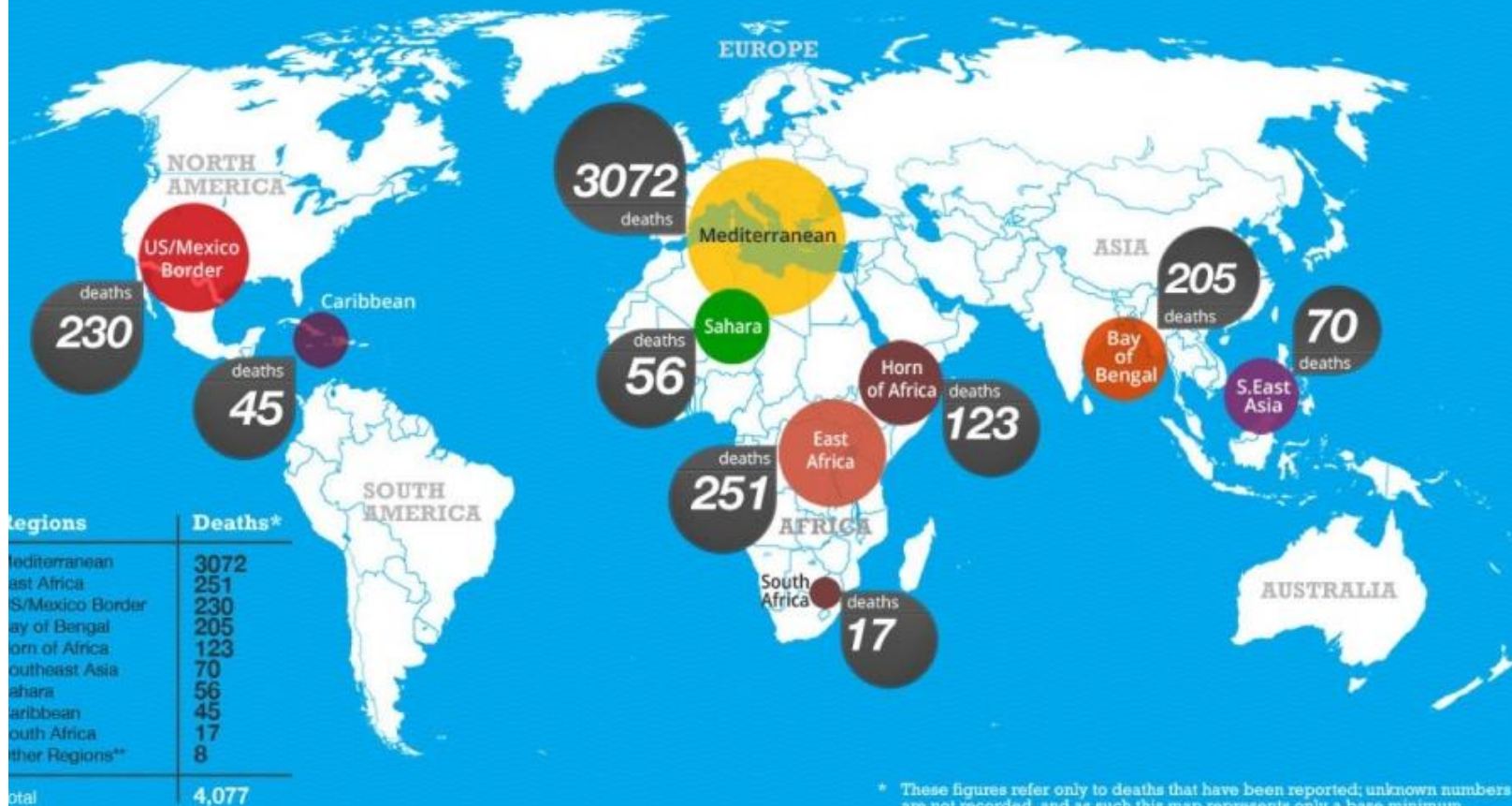
INEQUALITIES

- Not everybody has the same opportunity to be mobile:
 - limitations to modern technology access;
 - not everybody can afford 'leisure time' for 'leisure travel';
 - political and legal roadblocks (eg.: permissions to leave or enter a country)
- Migration can be life-threatening



THE MISSING MIGRANTS PROJECT

Migrant Deaths on World Borders, Jan-Sept 2014



* These figures refer only to deaths that have been reported; unknown numbers are not recorded, and as such this map represents only a base minimum.

** This refers to deaths that occurred in Europe other than the Mediterranean (7) and India (1). Although deaths are occurring in Central America, non-disaggregated data makes it difficult to isolate migration-related deaths.



MODERN MIGRATIONS

- During the World Wars nation states have taken on themselves to regulate, limit and/or direct migrants, making the borders between states very selective (eg.: difficult legal entry into a country).
- Consequences of those limitations, regularities and directions have turned the twentieth (and are turning the twenty-first) century into a century of illegal migrations.



MIGRANTS

IMMIGRANT

Entering a new area (country, city, etc.)

EMIGRANT

Leaving an old area

We are all immigrants and emigrants at the same time, the only difference is the perspective.

AN INTERNATIONAL MIGRANT: definition of an international migrant is a person who lives in a different state than that of his birth or has a nationality of a different state than the one he lives in. Of course, there are always the stateless.



TYPES OF MIGRATIONS

- **Internal** (within an area) / **External migration** (between two different areas; eg.: countries)
- **Permanent** (with no intention to return) / **Temporary migration** (with no intention to stay longer than for a designated period of time)
- → **Return migration** (returnees; designation is 'home')
- **Seasonal migration** ('summer house', seasonal work, etc.)
- **Step migration** (farm-village-town-city)
- **Forced / Voluntary migration** (possibility of choice of whether to travel, when, how, where, etc.)



FORCED MIGRATION (1)

- UNHCR – figures at a glance, as of 20th June, 2016:
<http://www.unhcr.org/figures-at-a-glance.html>
- Forcibly displaced people worldwide (65.3 millions;
34.000 per day)
- Refugees (persons fleeing conflict or persecution (including fear of persecution) due to race, nationality, religion, political opinion or membership in a particular social group (eg.: homosexual) and were given protection in another state → 21.3 million, half of them younger than 18 years)

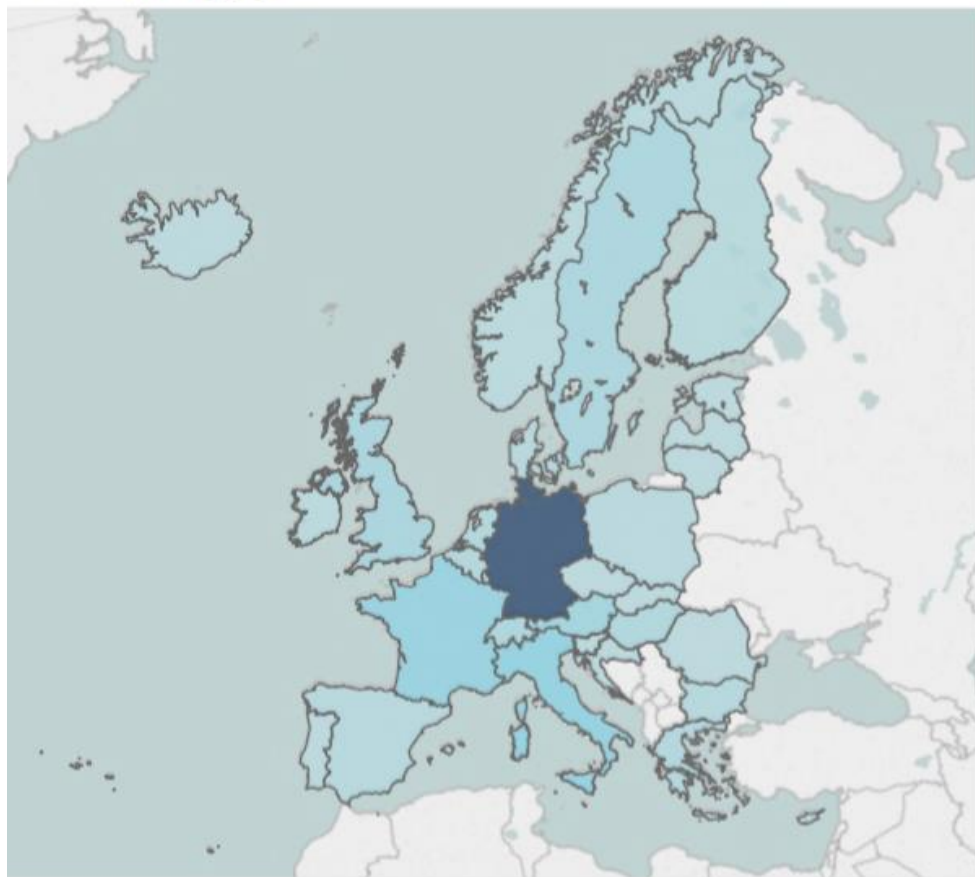


FORCED MIGRATION (2)

- Asylum seekers (an individual seeking international protection)
- Stateless people (persons that do not have citizenship of any of the existing countries, due to different reasons (can be inherited; legally these people do not exist) → 10 million)
- Internally displaced people (forced to flee home and are seeking safety in other parts of their country → 38 millions)
- Returnees (those who are returning to their home country)



Asylum Applications in the EU/EFTA by Country, 2008-2016 (Q1)*



Total asylum applications from all countries in EU/EFTA in 2016: 308,915

Top 10 Countries of Origin in All in 2016

All countries	308,915
Syria	104,300
Afghanistan	37,725
Iraq	36,510
Pakistan	12,085
Unknown	10,180
Iran	10,085
Nigeria	6,825
Albania	6,760
Eritrea	5,405
Russia	4,435

Select Country of Origin
All countries

Year
2016



Migration Policy Institute (MPI) Data Hub
<http://migrationpolicy.org/programs/data-hub>



Asylum Applications in the EU/EFTA by Country, 2008-2016

<http://www.migrationpolicy.org/programs/data-hub/charts/asylum-applications-euefta-country-2008-2016-q1>



REASONS FOR MIGRATION

- Ecological / environmental factors (natural disaster, vacationing)
 - Political (war)
 - Economical (work)
 - Cultural (religion, education, etc.)
- Reasons are most usually intertwined (there is never just one!)



PUSH FACTORS

Come from 'Home'

Natural disaster

Poverty

Hunger

Political disagreements

War

PULL FACTORS

Come from 'Destination'

Better job opportunities

Educational opportunities

Partnerships (love, family, friends, etc.)

Ecological preferences (eg. weather, natural surroundings)



MISCONCEPTIONS ABOUT MIGRANTS

- Biased (subjective and stereotypical) mental picture and expectations about migrants.
- Local's perspective on a migrant can vary, depending on his/her experience, personal beliefs, conviction, up-bringing, etc.
- Misconceptions:
 - Migrants are a homogeneous group!
 - Migrants are terrorists!
- South-East ('dirty' (morally, culturally threatening), dangerous, will steal our jobs, live off of our money, carries infectious diseases, etc.) // North-West (well behaved, clean, smart, educated, etc.)
- **WHAT IS REALITY?**



DANGERS AND DIFFICULTIES

A migrant can meet many dangers and difficulties after reaching his or her destination:

- **Exploitation of workers** (cheap labor force, dangerous and unhealthy work place, etc.)
- **Gaps in legal system** (falling through gaps in legal system can mean difficulties obtaining health insurance, health care, living arrangements, official employment, etc.)
- **Human trafficking**

We should all be aware of dangers and difficulties a migrant can face, when interacting with one, we should ask questions and make sure we help them according to our best abilities.



INTEGRATION PROCESS

There are three steps to integration:

- 'Honey moon phase' (feels like a tourist; everything is new and exciting)
- **Cultural shock** (nothing is the way it should be/the way it normally goes; feelings of discomfort, homelessness & can also be experienced by a local when interacting with a migrant)
- **Acceptance** (acceptance of new ways, new culture, new habits, language; can successfully maneuver through everyday life and activities) → the level of acceptance depends on migrant, his/her culture and local culture



Interactive Maps

World Population Dashboard

- <http://www.unfpa.org/world-population-dashboard>

IOM World Migration

- <https://www.iom.int/world-migration>