



Training packages for health professionals to improve access and quality of health services for migrants and ethnic minorities, including the Roma  
MEM-TP

***ADDITIONAL MODULE 2:***  
***SPECIFIC HEALTH CONCERNS***

***Unit 1: Chronic diseases***

***Guidelines***

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Migrants & Ethnic Minorities  
Training Packages



Escuela Andaluza de Salud Pública  
CONSEJERÍA DE IGUALDAD, SALUD Y POLÍTICAS SOCIALES



SERVIZIO SANITARIO REGIONALE  
EMILIA-ROMAGNA  
Azienda Unità Sanitaria Locale di Reggio Emilia



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## Additional Module 2: Specific Health Concerns

### Unit 1: Chronic Diseases

#### 1. Objectives and Methods

Time	Objectives	Activities	Sources
5 minutes	Explain the objectives of the Unit.	Explanation of the objectives	Projector, laptop, screen.
30 minutes	<ul style="list-style-type: none"> <li>• To explain the general patterns of chronic diseases in migrant and ethnic minority populations, among them the Roma.</li> <li>• To inform about the epidemiology of specific chronic diseases in migrants and ethnic minorities, among them the Roma, in Europe and how EU institutions could address these problems.</li> </ul>	Presentation “Chronic Diseases”	Projector, laptop, screen.

#### 2. Presentation

**Slide 1:** Title page.

**Slide 2:** Summary

**Slide 3:** Morbidity data on heart diseases, cerebrovascular diseases and diabetes among migrant populations and ethnic minorities are currently scarce. There are important differences both among and within countries that limit the comparability of data, such as the way in which disease outcomes are defined and measured<sup>1</sup>. Within European born populations in a country, people in disadvantaged socioeconomic positions run an increased risk of major noncommunicable diseases, with the exception of breast cancer. In contrast, for migrants to European countries, the health disadvantage seems to be more linked to specific

<sup>1</sup> Rafnsson SB, Bhopal RS. Large-scale epidemiological data on cardiovascular diseases and diabetes in migrant and ethnic minority groups in Europe. *Eur J Public Health* 2009; 19(5): 484-91. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/19498046>

diseases, and life expectancy is not always lower than that of the residents born in the country<sup>2</sup>.

**Slide 4:** In this research<sup>3</sup>, nativity differentials in mortality increased over time for major cancers, cardiovascular diseases, diabetes, respiratory diseases, unintentional injuries, and suicide, with immigrants experiencing generally lower mortality than the US-born in 1973-2003. Overall, this study provides evidence that the healthy migrant effect.

**Slide 5:** Cardiovascular diseases are the leading cause of death in Europe. Morbidity data and mortality rates for CVD data vary according to ethnicity, country of origin and country of residence. Thus, the incidence of coronary heart disease is higher in populations of East Africa and South Asia, while in the case of a stroke, it will be higher in populations that come from West Africa<sup>4</sup>. However, other populations such as Maghrebis in the countries of southern Europe will have a lower rate of cardiovascular events than that of the native population.

**Slide 6:** It is unclear why some immigrants but not others experience lower CHD mortality than the general population. One Swedish study has investigated whether rates of CHD mortality persist from the country of birth or are a result of migration. It was found that for countries with high CHD mortality, such as Finland and Hungary, the risk was lower among immigrants in Sweden than in their country of birth. For low-risk countries in southern Europe, the risk was higher in immigrants in Sweden than in southern Europe<sup>5</sup>. This suggests that as well as country of origin, acculturation can have a positive or negative effect on CHD mortality<sup>6</sup>.

**Slide 7:** Dobranici, Buzea and Popescu<sup>7</sup> review the cardiovascular risk factors of the Roma people in Central-Eastern Europe. They concluded that data on Roma population in Europe are few, so studies do not provide conclusive results. However, Roma populations have higher rates of CVD risk factors, as well as cardiovascular disease prevalence, than non-Roma.

Ethrisk is a modified version of the Framingham CVD risk assessment tool. It has been designed for UK ethnic groups. It uses the prevalence ratios for CVD for each ethnic group compared to the general population and adjusts for differences in mean risk factor levels and prevalence of smoking between each ethnic group. The calculator can be applied to people aged 35 to 74 without diabetes or a previous history of CVD.

**Slide 8:** A range of candidate factors merit consideration in this emerging epidemiology of CVD in migrants. First of all, the complex nature of migration and resettlement and the social and

<sup>2</sup> Rechel B, Mladovsky P, Devillé W, Rijks B, Petrova-Benedict R, McKee M. Migration and health in the European Union. 2011. European Observatory on Health Systems and Policies Series. Available from: [http://www.euro.who.int/data/assets/pdf\\_file/0019/161560/e96458.pdf](http://www.euro.who.int/data/assets/pdf_file/0019/161560/e96458.pdf)

<sup>3</sup> Singh GK, Hiatt RA. Trends and disparities in socioeconomic and behavioural characteristics, life expectancy, and cause-specific mortality of native-born and foreign-born populations in the United States, 1979-2003. *Int J Epidemiol.* 2006 Aug; 35(4): 903-19.

<sup>4</sup> Cappuccio FP, Oakshott P, Strazzullo P, Kerry SM. Application of Framingham risk estimates to ethnic minorities in United Kingdom and implications for primary prevention of heart disease in general practice: cross sectional population based study. *BMJ* 2002; 325: 1271-1276. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/12458243>

<sup>5</sup> Newbold, K. Bruce. Chronic conditions and the healthy immigrant effect: evidence from Canadian immigrants. *Journal of Ethnic and Migration Studies* 2006;32(.5): 765-784.

<sup>6</sup> Mladovsky. P. Research Note: Migration and health in the EU. The London School of Economics and Political Science. European Commission. 2007.

Available from: [http://ec.europa.eu/employment\\_social/social\\_situation/docs/rn\\_migration\\_health.pdf](http://ec.europa.eu/employment_social/social_situation/docs/rn_migration_health.pdf)

<sup>7</sup> Dobranici M, Buzea A, Popescu R. The cardiovascular risk factors of the Roma (Gypsies) people in Central- Eastern Europe: a review of the published literature. *J Med Life.* 2012; 5(4): 382-9. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23390466>

psychological conditions surrounding it, such as poor socioeconomic status, challenging everyday living and working conditions, alterations in family life and chronic stress related to insecurity and homesickness, may all be implicated and certainly deserve note. Poor dietary adaptation, including inappropriate use of fast foods and subsequent obesity also need to be taken into account, as does poor access to healthcare services and their under-utilization if and when they are available. Just as is the case in other diseases and health problems, socioeconomic background also plays a key role in determining the success of treatment, as well as the timely diagnosis of CVD, and appears to be a factor in what are generally worse outcomes when CVD incidents do occur in migrants<sup>8</sup>.

**Slide 9-10:** When we talk about diabetes, the rate in migrants with type 2 diabetes mellitus will be higher in migrants than in European natives. Mortality rate ratios were highest in migrants originating from either the Caribbean or South Asia. MRRs for the migrant population as a whole were 1.9 (95% CI 1.8–2.0) and 2.2 (95% CI 2.1–2.3) for men and women respectively<sup>9</sup>. In the Roma population, age-sex standardized prevalence of type 2 DM is 30% in Roma and 10% in non-Roma<sup>10</sup>.

MCN Diabetes Online Toolkit offers a free, central and easily accessible place with information and quality tools and resources around diabetes care for migrants and other mobile underserved individuals.

**Slide 11:** Migrants generally have a lower incidence of cancer than the native population (20-50% less). Nevertheless, there are some types of cancer where the prevalence is higher, such as liver, stomach or cervical cancers (all of them related to infections experienced in early life)<sup>11</sup>. In the Roma population, cancer incidence is higher than in the general population<sup>12</sup>.

**Slide 12:** With regard to congenital conditions, blood diseases should be highlighted such as sickle-cell anemia that is a disease among populations originating in the Mediterranean, Africa or the Caribbean; or the typical Thalassemia of indigenous people from the Mediterranean and, in some cases, from some parts of Asia<sup>2</sup>.

**Slide 13:** Regarding the treatment of chronic diseases, adapting to different cultural beliefs and practices requires flexibility and a respect for others view points. To provide culturally appropriate care we need to know and to understand culturally influenced health behaviors.

**Slide 14:** Thank you and questions.

<sup>8</sup> Fernandes A., Pereira J. Health and Migration in the EU: Better health for all in an inclusive society. 2009. Instituto Nacional de Saúde Doutor Ricardo Jorge.

Available from: <http://www.portaldasauade.pt/NR/rdonlyres/89916BBA-2C9C-48D2-979C-DEA62DA6ABC3/18919/HealthMigrationEU2.pdf>

<sup>9</sup> Vandenheede H, Deboosere P, Stirbu I, Agyemang CO, S Harding, Juel K, Rafnsson SB, Regidor E, G Rey, Rosato M, Mackenbach JP, Kunst AE. Migrant mortality from diabetes mellitus across Europe: the importance of socio-economic change. *Eur J Epidemiol.* 2012 Feb; 27 (2): 109-17. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/22167294>

<sup>10</sup> Vozarova de Courten B, de Courten M, Hanson RL, Zahorakova PH, Vozár J. Higher prevalence of type 2 diabetes, metabolic syndrome and cardiovascular diseases in gypsies than in non-gypsies in Slovakia. *Diabetes Research and Clinical Practice.* 2003;62(2):95-103.

<sup>11</sup> Arnold M, Razum O, Coebergh J-W. Cancer risk diversity in non-western migrants to Europe: An overview of the literature. *Eur J Cancer* [Internet]. Elsevier Ltd; 2010 Sep; 46(14): 2647–59. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/20843493>

<sup>12</sup> Rechel B, Mladovsky P, Devillé W, Rijks B, Petrova-Benedict R, McKee M. Migration and health in the European Union. 2011. European Observatory on Health Systems and Policies Series.

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**Slide 15:** References.

### 3. Readings

#### Recommended readings:

Bhopal R. Chronic diseases in Europe's migrant and ethnic minorities: challenges, solutions and a vision. *Eur J Public Health* [Internet]. 2009 Apr; 19(2): 140–3. Available from:

<http://www.ncbi.nlm.nih.gov/pubmed/19307249>

Carballo M. Chapter 5: Non-communicable diseases. In Fernandes A., Pereira J. *Health and Migration in the EU: Better health for all in an inclusive society*. 2009. Instituto Nacional de Saúde Doutor Ricardo Jorge. Available from:

<http://www.portaldasaude.pt/NR/ronlyres/89916BBA-2C9C-48D2-979C-DEA62DA6ABC3/18919/HealthMigrationEU2.pdf>

Dobranici M, Buzea A, Popescu R. The cardiovascular risk factors of the Roma (Gypsies) people in Central- Eastern Europe: a review of the published literature. *J Med Life*. 2012; 5(4): 382–9. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/23390466>

#### Complementary readings:

Rafnsson SB, Bhopal RS. Large-scale epidemiological data on cardiovascular diseases and diabetes in migrant and ethnic minority groups in Europe. *Eur J Public Health* [Internet]. 2009 Oct [cited 2014 Dec 3]; 19(5): 484–91. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/19498046>

Kunst A, Stronks K, Agyemang C. Non-communicable diseases. In: Rechel B, Mladovsky P, Devillé W, Rijks B, Petrova-Benedict R, McKee M. *Migration and health in the European Union*. 2011. European Observatory on Health Systems and Policies Series. Available from:

[http://www.euro.who.int/\\_data/assets/pdf\\_file/0019/161560/e96458.pdf](http://www.euro.who.int/_data/assets/pdf_file/0019/161560/e96458.pdf)

Cappuccio FP, Oakshott P, Strazzullo P, Kerry SM. Application of Framingham risk estimates to ethnic minorities in United Kingdom and implications for primary prevention of heart disease in general practice: cross sectional population based study. *BMJ* 2002; 325: 1271–1276. Available from:

<http://www.ncbi.nlm.nih.gov/pubmed/12458243>

Vandenheede H, Deboosere P, Stirbu I, Agyemang CO, S Harding, Juel K, Rafnsson SB, Regidor E, G Rey, Rosato M, Mackenbach JP, Kunst AE. Migrant mortality from diabetes mellitus across Europe: the importance of socio-economic change. *Eur J Epidemiol*. 2012 Feb; 27 (2): 109-17. Available from:

<http://www.ncbi.nlm.nih.gov/pubmed/22167294>

Arnold M, Razum O, Coebergh J-W. Cancer risk diversity in non-western migrants to Europe: An overview of the literature. *Eur J Cancer* [Internet]. Elsevier Ltd; 2010 Sep; 46(14): 2647–59. Available from: <http://www.ncbi.nlm.nih.gov/pubmed/20843493>