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La santé des migrants

Bibliographie thématique

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Sommaire

En guise d'introduction : un domaine de recherche complexe

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L'étude de la santé des migrants est intéressante à plusieurs titres. En épidémiologie descriptive, elle relève d'une démarche d'investigation utilisée autrefois pour apprécier la part de l'environnement dans la genèse des maladies chronique. En santé publique, elle entre dans le champ de l'examen des populations vulnérables. Mais il s'avère très difficile d'avoir une vision globale de l'état de santé des migrants, d'une part pour des raisons idéologiques, d'autre part du fait de la diversité des populations, des biais de déclaration dans les enquêtes ou de la sous-estimation des données de mortalité, car les migrants gravement malades retournent souvent dans leur pays d'origine.

En France, la santé des migrants a émergé comme domaine de recherche à partir des années 1990 sous l'angle de la mesure des disparités en matière de mortalité et de morbidité entre groupes de population. Si dans les années 1980 et 1990, l'état de santé des immigrés semblait meilleur que celui des non-immigrés, des travaux menés, dans les années 2000, à partir de *l'Enquête décennale santé*, ont montré que les immigrés se déclarent plutôt en moins bonne santé que le reste de la population, un constat qui résulte notamment de conditions de vie souvent plus précaires.

Une évolution similaire semble s'observer dans les autres grands pays d'immigration. Des travaux réalisés aux Etats-Unis, au Canada, en Australie et dans certains pays méditerranéens ont révélé l'existence d'un effet sélectif de l'état de santé sur la migration « healthy migrant effect » ou « immigrant en bonne santé » : ne migrent que les personnes en bon état de santé, mais une fois sur le territoire du pays d'accueil, leur santé se dégrade plus vite du fait de moins bonnes conditions de vie et d'une sous-utilisation des dispositifs de santé.[1]

Cette tendance s'accentue à l'époque actuelle du fait de la crise économique, des conditions de vie plus précaires des immigrés et de l'affaiblissement des appuis familiaux et sociaux faisant suite au déracinement. L'arrivée massive de réfugiés dans les pays de l'Union européenne, ces dernières années, va, par ailleurs, l'intensifier. Et une étude récente de *Santé publique France*, ciblant plus particulièrement les immigrés nouvellement arrivés sur le sol français, démontre que ces derniers ont des conditions d'accès aux soins très dégradées[2].

Quel est aujourd'hui l'état de santé des personnes résidant en France ou à l'étranger ayant vécu une migration ? Quels sont leurs modes d'accès aux soins et à la prévention, quel est leur comportement de santé ?

L'objectif de cette bibliographie est de recenser des sources d'information (ouvrages, rapports, articles scientifiques, littérature grise, sites institutionnels…) sur l'ensemble de cette problématique.
Le périmètre géographique étudié concerne la France, les pays de l'Union européenne, les États-Unis, le Canada et l'Australie.
Les recherches bibliographiques ont été réalisées sur les bases suivantes : Base bibliographique de l'Irdes, Banque de données santé publique (BDSP), Cairn, Medline et Econlit.

[1] Hamel, Moisy (2012)
[2] Lot, Quelet (2017)

Les critères retenus sont les suivants :

- Période : 2008-2022/07 avec des études antérieures pour la France ou des articles fondateurs pour l'étranger ;
- Concepts : état de santé (global et quelques pathologies spécifiques comme la santé mentale, le sida, la tuberculose, le diabète et le cancer, le covid-19…) ;
- Aspects : recours aux soins (soins primaires, hôpital), comportement et prévention de santé, en relation avec la discrimination selon les races et les nationalités, l'assimilation et l'acculturation, enfin la couverture maladie.

Les études comparées ou internationales, les revues de la littérature ou scoping review sont privilégiées. Les références sont présentées par thématique, puis par ordre alphabétique des auteurs et/ou des titres. Des définitions et données démographiques sur les populations migrantes figurent aussi dans cette bibliographie.

Récapitulatif des documents sur lesquels s'appuient les focus

(1) Hamel, C., et Moisy, M. (2012). "Migrations, conditions de vie et santé en France à partir de l'enquête Trajectoires et origines, 2008." Bulletin Epidemiologique Hebdomadaire(2-3-4): 21-24.

(2) Lot, F., Quelet, S. (coor.) (2017). La santé et l'accès aux soins des migrants : un enjeu de santé publique. Bulletin Epidemiologique Hebdomadaire(19-20) : 371-436.
(3) Dourgon, P., Jusot, F., Sermet, C., Silva, J. (2009). «Le recours aux soins de ville des immigrés en France ». Questions d'Economie de la Santé (Irdes)(146) : 6

(4) Berchet, C., Jusot, F."Etat de santé et recours aux soins des immigrés en France : une revue de la littérature." Bulletin Epidemiologique Hebdomadaire(2-3-4) : 17-20.
(5) Lert, F., et al. (2006). Comment caractériser l'ethnicité dans les travaux épidémiologiques en France : approche exploratoire à partir de l'étude Insee-Histoire de vie. Épidémiologie sociale et inégalités de santé, colloque thématique de l'Adelf, 2006.

(6) Wluczka, M., et al. (2008). La santé des primo-migrants en 2007 : Etude réalisée à partir des enquêtes "semaine données". Paris : Anaem **:** 19.

(7) Veïsse, A., et al. (2012). "Santé mentale des migrants/étrangers : mieux caractériser pour mieux soigner." Bulletin Epidemiologique Hebdomadaire(2-3-4) : 36-40.
(8) (2015). Observatoire de l'accès aux soins de la mission France de Médecins du Monde : rapport 2014. Paris Médecins du Monde **:** 83p.

(9) Berchet, C. et Jusot, F. (2012). "Etat de santé et recours aux soins des immigrés : une synthèse des travaux français." Questions d'Economie De La Sante (Irdes)(172): 8.

(10) Boisguerin, B., et Haury B. (2008). « Les bénéficiaires de l'AME en contact avec le système de soins ». Etudes et Résultats (645) : 6p.

(11) Berchet, C. et Jusot, F. (2012). "Etat de santé et recours aux soins des immigrés : une synthèse des travaux français." Questions D'economie De La Sante (Irdes)(172): 8.

(12) Abraido-Lanza, et al. (1999). The Latino mortality paradox: a test of the "salmon biais" and healthy migrant hypothses. Am J Public Health 89(10): 1543-8

(13) Klat, M., Darmon, N. Is there a Mediterranean migrants mortality paradox in Europe? Int J Epidemiol 32(6): 1115-8

(14) Veïsse, A., et al. (2012). "Santé mentale des migrants/étrangers : mieux caractériser pour mieux soigner." Bulletin Epidemiologique Hebdomadaire(2-3-4): 36-40.

(15) Drouot, N., et al. (2012). "L'accès aux soins des migrants en situation précaire, à partir des données de l'Observatoire de Médecins du Monde : constats en 2010 et tendances principales depuis 2000." Bulletin Epidemiologique Hebdomadaire(2-3-4): 41-44.

(16) Berchet, C. et Jusot, F. (2012). "Etat de santé et recours aux soins des immigrés en France : une revue de la littérature." Bulletin Epidemiologique Hebdomadaire(2-3-4): 17-20.

(17)(18) Stanojevitch, A.E. « Repères sur la santé des migrants ». Santé de l'homme, n° 392, 2007

(19) (2016). "Migrations internationales : Etat des lieux. Extrait de : Perspectives des migrations internationales 2015 (OCDE)." Problèmes Economiques(3124): 5-16, tab., graph.
(20) Abraido-Lanza, A. B. et al. (1999)'"The Latino mortality paradox: a test of the 'salmon-bias' and healthy migrant hypotheses ". American Journal of Public Health **89** : 543-48.

(21) Khlat, M. et Darmon, N. (2003). "Is there a Mediterranean migrants mortality paradox in Europe?" Int J Epidemiol **32**(6): 1115-1118.

(22) Moullan, Y. et Jusot, F. (2014). "Why is the healthy immigrant effect different between european countries ?" Eur J Public Health **24**(suppl. 1) : 80-86.

(23) OMS, Bureau régional de l'Europe. (2010). How health systems can address inequities linked to migration and ethnicity.

(24) Derose, K. P., et al. (2009). "Review: immigrants and health care access, quality, and cost." Med Care Res Rev **66**(4): 355-408.

(25) Chen, J., et al. (2016). "Racial and Ethnic Disparities in Health Care Access and Utilization Under the Affordable Care Act." Medical Care **54**(2): 140-146.

(25bis) Clemans-Cope, L., et al. (2012). "The Affordable Care Act's coverage expansions will reduce differences in uninsurance rates by race and ethnicity." Health Aff.(Millwood.) **31**(5): 920-930.

(26) Ahmed, S., et al. (2015). "Barriers to Access of Primary Healthcare by Immigrant Populations in Canada: A Literature Review." J Immigr Minor Health.

(27) Mahmoud, I. et Hou, X. Y. (2012). "Immigrants and the utilization of hospital emergency departments." World J Emerg Med **3**(4): 245-250.

Les migrants en France : un état de santé qui se dégrade et un accès aux soins semé d'obstacles

L'état de santé des immigrés est considéré comme un véritable enjeu de santé publique en raison de la fragilisation économique et sociale que peuvent connaître certains d'entre eux, et qui participe à la détérioration de leur état de santé. Le bilan des études françaises sur l'état de santé et l'accès aux soins des immigrés suggère l'existence d'inégalités de santé liées à la migration et de disparités selon le pays d'origine. En outre, l'ensemble des études s'accorde sur le moindre recours aux soins de la population immigrée, révélant des difficultés d'accès à la médecine de ville[3]. Enfin, la situation économique et sociale plus défavorisée des immigrés, leur moindre accès à la complémentaire santé et leur moindre intégration sociale sont les principaux facteurs expliquant ces inégalités de santé et d'accès aux soins. Les travaux appellent à une modification des politiques sanitaires et sociales visant à améliorer l'état de santé et l'accès aux soins des populations d'origine étrangère.[4]

En termes de morbidité, les données épidémiologiques caractérisant les migrants sont rares. Pourtant, le recensement de " l'origine " des individus est autorisé dès lors que celle-ci est définie par des variables sociodémographiques classiques (lieu de naissance, nationalité, nationalité des parents, etc.). Ce sont surtout des réticences culturelles et politiques à voir ce champ de la santé investi par la recherche et les pouvoirs publics[5] qui expliquent l'insuffisance des études représentatives.

S'agissant des maladies infectieuses, les études de Santé publique France permettent d'observer des taux de prévalence significativement plus importants dans certaines populations étrangères que dans le reste de la population, en particulier pour le VIH, les hépatites virales chroniques et la tuberculose. Une approche " par conglomérats " faisant la somme de travaux et rapports réalisés sur des échantillons restreints de migrants permet également d'établir un certain nombre d'hypothèses sérieuses sur la santé des migrants. Selon le rapport de l'Anaem[6], réalisé à partir des résultats de 8 086 visites médicales obligatoires en mai et novembre 2005, l'obésité, les maladies cardio-vasculaires et le diabète sont les principaux pourvoyeurs de maladies chroniques des étrangers bénéficiaires d'une carte de résident. Les résultats des bilans de santé proposés par le Comede à vingt mille patients exilés, suivis entre 2000 et 2006, mettent en évidence trois principaux groupes de pathologies : psycho-traumatismes, maladies infectieuses (dont le diagnostic est effectué en France dans 94 % des cas) et maladies chroniques. [7]

Si on se réfère au rapport 2014 de l'Observatoire de Médecins du Monde, 95 % de personnes recourant à ces centres de santé sont des migrants. L'afflux des immigrés complique gravement l'accès aux soins, et donc l'état de santé. Des troubles d'ordre psychologique ont été repérés pour 12 % des consultants des Caso. Les syndromes anxieux, le stress, les troubles psychosomatiques sont les plus fréquents. On constate une majoration de ces troubles pour les demandeurs d'asile et les personnes ayant déclaré avoir été exposées à des situations de violences. La précarité sociale et administrative ainsi que la barrière de la langue auxquelles sont confrontés les migrants précaires constituent des obstacles importants à une prise en charge en santé mentale.[8] Enfin, le rapport 2015 souligne que l'année a été marquée par de nombreuses réformes (loi de santé, loi immigration, loi asile, réforme PUMa....) qui sont venues modifier en profondeur le contexte législatif français en matière d'accueil et d'intégration des étrangers en particulier et qui ont fortement mobilisé les équipes de Médecins du Monde.

[3] Dourgon, Jusot, Sermet, et al. (2009)
[4] Berchet, Jusot, BEH (2012/01/17)
[5] Lert (2006)
[6] Wluczka, *La santé des primo-migrants en 2005.*
[7] Comede, La santé des exiles (2013)
[8] Observatoire de Médecins du Monde (2015)

QUELQUES ELEMENTS DE CADRAGE

Un essai de définition

La définition ou le comptage et la catégorisation des migrants en France sont l'objet de nombreux débats où l'on distingue les migrants (personnes nées à l'étranger et vivant sur le sol français, y compris des nationaux), les étrangers (non nationaux) et les Français. Mais d'autres classifications juridiques opposent les migrations de travail aux migrations de familles et de réfugiés, que l'on ne peut pas interdire en vertu de principes constitutionnels, les migrations volontaires et les migrations forcées (personnes déplacées contre leur gré), les migrations selon l'âge, le sexe, la qualification (mobilité des cerveaux). On assiste aujourd'hui à un brouillage des catégorisations de la migration, car beaucoup de migrants appartiennent à la fois à l'une ou l'autre de ces catégories (migrant de travail et d'asile, par exemple, ou migrant de travail venu dans le cadre du regroupement familial) ou entrent successivement dans celles-ci au cours de leur vie, ce qui n'était pas le cas dans le passé où les catégorisations étaient beaucoup plus étanches.[9] Dans le champ de la santé publique, le terme « migrant » est davantage utilisé que le terme « immigré ».

Selon la définition adoptée par le Haut Conseil à l'Intégration et repris par l'Insee pour le recensement démographique, **un immigré** est une personne née étrangère à l'étranger et résidant en France. Les personnes nées françaises à l'étranger et vivant en France ne sont donc pas comptabilisées. À l'inverse, certains immigrés ont pu devenir français, les autres restant étrangers. Les populations étrangère et immigrée ne se confondent pas totalement : un immigré n'est pas nécessairement étranger et réciproquement, certains étrangers sont nés en France (essentiellement des mineurs). La qualité d'immigré est permanente : un individu continue à appartenir à la population immigrée même s'il devient français par acquisition. C'est le pays de naissance, et non la nationalité à la naissance, qui définit l'origine géographique d'un immigré[10].

Terminologie

Le terme **« immigré"** désigne une personne ayant vécu à l'étranger et résidant désormais en France. Dans le champ de la santé publique, le terme « **migrant** » est davantage utilisé.

Un étranger est une personne qui n'a pas la nationalité française, terme utilisé par les autorités de police et les associations de soutien juridique. L'expression " étranger malade " correspond à la transposition administrative du droit au séjour pour raison médicale.

Un exilé est une personne contrainte de vivre hors de son pays d'origine, terme évoquant notamment les conséquences psychologiques des migrations forcées. **Un demandeur d'asile** est une personne ayant demandé le statut de réfugié au titre de la Convention de Genève de 1951.

Un réfugié est une personne ayant obtenu le statut de réfugié ou la protection subsidiaire accordés par l'Ofpra (Office français de protection des réfugiés et apatrides) ou la Commission des recours des réfugiés.

Un sans-papiers ou **clandestin** est un étranger en séjour irrégulier, termes destinés par leurs utilisateurs à souligner le caractère légitime (attaches en France du " sans-papiers ") ou illégitime (situation irrégulière du " clandestin ") de la présence de la personne.

Voir aussi : IOM (2019). Glossary of migration. Genève : IOM

[10] Organisation de Coopération et de Développement Economiques

Des indicateurs démographiques et socio-économiques

D'après le « Portait social de l'Insee : édition 2021 », 6,7 millions d'immigrés vivent en France hors Mayotte en 2020, soit 10,1 % de la population. L'immigration en France est un phénomène ancien : en 1911, les immigrés sont 1,1 million en France métropolitaine, puis 2,3 millions en 1954 et 3,9 millions en 1975. Leur nombre croît modérément de 1975 à 1999, leur part dans la population restant stable (7,3 % en 1999), mais augmente à nouveau depuis 1999. En 2020, 36 % des immigrés possèdent la nationalité française.

Depuis 1975, les origines géographiques des immigrés présents en France se diversifient. En 2020, 47 % des immigrés sont nés en Afrique. 30 % sont originaires du Maghreb, une proportion stable depuis les années 1980. En dix ans, le nombre d'immigrés originaires d'Afrique a progressé de 2,9 % par an en moyenne (4,8 % pour l'Afrique hors Maghreb). 33 % des immigrés viennent d'Europe, contre 66 % en 1975. Les origines européennes sont de plus en plus variées : les immigrés venus d'Espagne, d'Italie et du Portugal sont moins nombreux, en raison des décès et des retours au pays, tandis que les effectifs venus des autres pays d'Europe continuent de croître, en particulier hors Union européenne (+ 2,5 % par an en moyenne). Enfin, 15 % des immigrés sont originaires d'Asie. La migration en provenance de Chine, ainsi que des pays du Moyen-Orient s'est accrue au cours des dix dernières années.

Site de l'Insee
- Etrangers et immigrés en 2019
- Répartition des immigrés par pays de naissance

Site de Vie publique
- L'immigration en chiffres pour 2021

Attias, Donfut, C. et Gallou, R. (2006). "L'impact des cultures d'origine sur les pratiques d'entraide familiale : représentation de la solidarité familiale par les immigrés âgés." Informations Sociales(134): 86-97, graph, tabl.

[BDSP. Notice produite par APHPDOC NR0x1DIm. Diffusion soumise à autorisation]. Qui doit s'occuper des parents âgés et comment ? Cette question est ici envisagée du point de vue des immigrés (parents et enfants) qui vivent en France. Les opinions se construisent autour de différents critères qui prennent en compte l'âge de l'enquêté, le moment de son arrivée en France, la durée de son séjour, son pays d'origine, sa religion... Au centre de la réponse se trouvent les femmes, les "aidantes".

Attias-Donfut, C. et Delacroix, C. (2004). "Femmes immigrées face à la retraite." Retraite Et Societe(43): 137-163, graph., tabl.

[BDSP. Notice produite par FNG Ov0R0xsa. Diffusion soumise à autorisation]. L'objet de ce travail est de décrire, sur la base des premiers résultats d'une récente enquête nationale sur le passage à la retraite des immigrées au seuil de la vieillesse, selon leur statut par rapport au monde du travail et à la retraite. Nous aborderons leur insertion dans la société française à travers ce qu'elles en pensent ou ressentent, la façon dont elles perçoivent leur trajectoire personnelle, familiale ou professionnelle. Nous mettons en rapport les conditions objectives et les évaluations subjectives de leurs propres parcours, pour nous interroger sur la capacité des interprétations théoriques courantes - en termes de domination ou d'exploitation - à rendre compte de la réalité vécue par les femmes immigrées.

Attias-Donfut, C., et al. (2005). "Démographie des immigrés de 45 à 70 ans." Retraite Et Societe(45): 116-155, graph., tabl.

[BDSP. Notice produite par FNG jthR0xUd. Diffusion soumise à autorisation]. L'article décrit la population immigrée, de toute origine, vivant et vieillissant en France, sur la base des données d'une enquête réalisée en 2003 auprès d'un échantillon de 6211 immigrés âgés de 45 à 70 ans. La description de générations d'immigrés dans leur diverses composantes montre que les situations de

vie restent fortement marquées par les conditions de l'émigration, par la situation précédant l'arrivée en France ainsi que par les traditions culturelles qui façonnent profondément leur vie familiale.

Attias-Donfut, C., et al. (2005). "Les immigrés au temps de la retraite." Retraite Et Societe(44): 12-47.

[BDSP. Notice produite par FNG E7UR0xom. Diffusion soumise à autorisation]. Avec le vieillissement de la population immigrée, le nombre de retraités est en constante augmentation. Dans quelles conditions, objectives et subjectives, les immigrés vivent-ils leur retraite ? Comment celle-ci se situe-t-elle dans le processus d'intégration ? L'objet de ce travail est d'apporter des éléments de réponse à ces questions, en étudiant les modes de vie et les formes d'intégration des retraités immigrés et leur double rapport au pays d'origine et à la France. Cette analyse s'appuie sur les résultats d'une récente enquête réalisée par la CNAV en collaboration avec l'INSEE, sur un échantillon de 6211 immigrés âgés de 45 à 70 ans (enquête PRI, Passage à la Retraite des Immigrés). Elle montre que, loin d'être ressenti comme "illégitime", rester en France au temps de la retraite est au contraire signe et facteur d'une bonne intégration. Le rapport à la vie de retraite est conditionné en priorité par l'état de santé et le niveau du revenu, ce qui est le cas de tout retraité, immigré ou non. L'ancrage en France se combine, pour une grande partie des immigrés d'Europe, du Maghreb et d'Afrique, avec le maintien de liens importants avec le pays d'origine. Il reste que c'est parmi les retraités (comparés aux actifs) que l'on observe la plus forte adhésion identitaire à la France. (Résumé de l'auteur.).

Attias-Donfut, C., et al. (2006). "Les transferts intergénérationnels des migrants âgés." Economie Et Statistique(390): 3-23, 11 tabl., 21 graph.

Basée sur une enquête réalisée en 2003 Passage à la retraite des immigrés (PRI), cette étude de l'Insee montre l'existence d'une spécificité et d'une diversification des comportements de transferts monétaires des immigrés. Ces transferts se font surtout dans le cadre familial (inter ou intragénérationnel) et les destinataires sont différents (parents ou enfants) en fonction de la culture des migrants. A noter aussi les transferts effectués pour eux-mêmes par les immigrés à destination de leur pays d'origine.

Auriol, E. et Rapoport, H. (2021). "L'immigration qualifiée : un visa pour la croissance." Notes du conseil d'analyse économique **67**(3): 1-12.
https://www.cairn.info/revue-notes-du-conseil-d-analyse-economique-2021-3-page-1.htm

Baccaini, B. (2001). "Les migrations en France entre 1990 et 1999. Les régions de l'Ouest de plus en plus attractives." Insee Premiere(758): 4 , 2 tabl., 3 carte, 3 graph.

Entre 1990 et 1999 une personne sur deux a déménagé. Cependant la mobilité résidentielle baisse régulièrement depuis 1975. Les jeunes de moins de 30 ans restent les plus mobiles mais ils le sont de moins en moins. Les personnes qui quittent l'Ile-de-France, ou s'y installent, représentent 42% de l'ensemble des migrants : la moindre attractivité de cette région explique donc en grande partie la baisse générale de la mobilité. Le déficit migratoire de l'Ile-de-France s'est accentué depuis les années 80 essentiellement parce que les jeunes adultes sont de moins en moins nombreux à s'y établir. De même les régions du Sud sont moins attractives que par le passé, alors que l'Ouest et le Sud-Ouest se révèlent de plus en plus dynamiques.

Baptista Mendes, A. (2021). "Histoire et expérimentation d'un dispositif innovant au service des migrants. Le STADA Corot." Sociographe **76**(5): 93-111.
https://www.cairn.info/revue-sociographe-2021-5-page-93.htm

Le STADA Corot 3 rend compte de la démarche d'accompagnement de jeunes migrants accueillis au sein du dispositif géré par les professionnels de La Sauvegarde du Nord. À travers les témoignages des directeurs, chef de service et éducateurs, cette étude de cas permet de nourrir la réflexion sur la question de l'accueil des demandeurs d'asile et réfugiés et tente de mettre à jour les leviers de réussite et d'amélioration des parcours d'insertion.

Barou, J. et Gallou, R. (2011). "Vieillir et mourir en Afrique ou en France ? Regards croisés de deux générations d'immigrés subsahariens." Gerontologie Et Societe(139): 117-145.

> [BDSP. Notice produite par FNG oGR0x978. Diffusion soumise à autorisation]. L'enquête réalisée auprès de soixante personnes originaires d'Afrique subsaharienne explore les représentations de la vieillesse de parents nés et socialisés en Afrique et de leurs enfants, nés et élevés en France. Pour les premiers, vieillir en Afrique reste positif car c'est acquérir un statut privilégié. La vieillesse en France est au contraire perçue comme un univers de solitude et de déconsidération. Les enfants qui ont une vision idéalisée de la vieillesse en Afrique, n'imaginent ni le retour des parents au pays, ni leur placement en institution. Ils entrevoient déjà les difficultés d'une nouvelle cohabitation. Reste l'éthique du devoir qui unit les deux générations : de solidarité vis-à-vis du pays des ancêtres d'un côté et de gratitude des enfants envers leurs parents de l'autre. (R.A.).

Beauchemin, J., et al. (2013). "Les immigrés en France : en majorité des femmes." Population Et Societes(502): 4 , fig.

> La population immigrée comprend 51 % de femmes en France métropolitaine en 2008. Comme le montre l'enquête Trajectoires et Origines (TeO), la féminisation de la population immigrée ne vient pas seulement du regroupement familial. Les courants migratoires les plus féminisés sont en fait ceux dans lesquels les femmes célibataires ou pionnières (qui devancent leur conjoint en migration) sont les plus nombreuses. Rejoindre un conjoint en France n'est plus réservé aux femmes : les hommes forment après 1998 le tiers des personnes regroupées et progressent également parmi les conjoints de Français. En définitive, sans atteindre un équilibre parfait entre hommes et femmes, les comportements migratoires des deux sexes se rapprochent fortement. (résumé de l'éditeur).

Beauchemin, C., Caron, L., Haddad, M., et al. (2021). "Migrations internationales : ce que l'on mesure (ou pas)." Population & Sociétés(594): 4.

> Parmi les événements qui contribuent à la dynamique démographique, les migrations sont les plus difficiles à appréhender. Au contraire des naissances ou des décès, elles font l'objet de définitions variables selon les pays et de mesures beaucoup moins standardisées, deux facteurs de confusion dans les débats publics. Cet article fait le point sur le sujet et situe la France par rapport à ses voisins européens.

Beauchemin, C., Ichou, M. et Simon, P. (2022). "Familles immigrées : le niveau d'éducation progresse sur trois générations mais les inégalités sociales persistent." Population & Societes(602): 4.
https://www.ined.fr/fr/publications/editions/population-et-societes/familles-immigrees-le-niveau-d-education-progresse-sur-trois-generations-mais-les-inegalites-sociales-persistent/

> Le niveau d'éducation augmente d'une génération à l'autre ; progresse-t-il autant dans les familles issues de l'immigration que dans les autres ? Cette étude examine la question en s'appuyant sur la deuxième édition de l'enquête Trajectoires et Origines (TeO2) et analysent les différences de progression au sein des familles selon leur origine géographique et le sexe des enfants.

Bellot, C. (2008). Enquête sur les immigrés vieillissants. Paris Comité National des Retraites et Personnes Agées**:** 31.

> Cette enquête fait suite à la commande de la Direction Générale de l'Action Sociale (DGAS) qui souhaitait que les Comités Départementaux des Retraités et Personnes Agées (CODERPA) soient interrogés par le Comité National des Retraités et Personnes Agées (CNRPA) pour connaître les actions menées localement par les départements en faveur des immigrés vieillissants. Ce terme d'immigrés vieillissants recouvre les personnes nées étrangères à l?étranger, vivant en France principalement en foyer de travailleurs migrants ou en habitat diffus, en situation régulière et issues des vagues d?immigration de travail des ? trente glorieuses ?.Une enquête en deux parties : la première vise une meilleure connaissance de cette population, la deuxième porte sur les objectifs ou actions du schéma

gérontologique ou du schéma départemental des établissements et services sociaux et médico-sociaux.

Beque, M. (2005). "Le vécu des attitudes intolérantes ou discriminatoires par les personnes immigrées et issues de l'immigration." Etudes Et Resultats(424): 8 , 2 graph., 5 tabl., 1 ann.

L'enquête Histoire de vie permet d'appréhender les attitudes négatives, voire intolérantes ou discriminatoires, que signalent avoir vécues les personnes enquêtées et les motifs qui s'y rapportent. Les personnes immigrées et issues de l'immigration déclarent davantage avoir été en butte à de telles attitudes négatives que l'ensemble de la population. La seconde génération, plus jeune, est notamment plus sensible à ce type d'évènements mais ils revêtent un caractère de gravité souvent plus marqué pour les immigrés de la première génération, généralement plus âgés. Des comportements intolérants à connotation " raciste " sont plus spécifiquement cités par un quart des immigrés et des personnes issues de l'immigration, contre 14 % de l'ensemble de la population. Pour les personnes issues de l'immigration, comme pour l'ensemble de la population, près de la moitié des attitudes négatives à leur égard se sont déroulées à l'école, alors que les immigrés évoquent dans 41 % des cas leur milieu professionnel. Le sentiment de discrimination est plus marqué lorsque les personnes immigrées sont arrivées en France avant l'âge adulte, se rapprochant ainsi du vécu exprimé par la seconde génération. La sensibilité aux manifestations d'intolérance est aussi plus forte, pour cette dernière, chez les diplômés ainsi que chez les personnes immigrées vivant en couple mixte. Avoir eu un père au chômage ou avoir vécu dans une cité accroît par ailleurs l'exposition aux comportements intolérants. Enfin, des facteurs plus subjectifs (attachement au pays d'origine ou degré de satisfaction concernant la vie en France) semblent également liés au ressenti d'attitudes intolérantes.

Beque, M. (2007). "Qui sont les nouveaux bénéficiaires d'un titre de séjour en France ?" Etudes Et Resultats (Drees)(612): 8.

[BDSP. Notice produite par MIN-SANTE BR0xjCL4. Diffusion soumise à autorisation]. L'ensemble des nouveaux bénéficiaires d'un titre de séjour d'au moins un an en France représente 120 000 personnes en 2006. Cette population se compose essentiellement d'étrangers arrivés au titre de conjoints de Français, dans le cadre du regroupement familial, de réfugiés et de personnes régularisées pour résidence de plus de dix ans en France ou pour liens personnels et familiaux. Près de la moitié d'entre eux sont originaires des pays du Maghreb (21% pour l'Algérie, 15% pour le Maroc et 7% pour la Tunisie). Plus du quart sont nés dans un autre pays d'Afrique. Les "nouveaux migrants" sont plutôt jeunes et majoritairement des femmes. L'accès à l'emploi des nouveaux migrants est étroitement lié à la maîtrise du français, l'expérience professionnelle, le réseau relationnel ou encore à l'origine géographique.

Blanpain, N. et Papon, S. (2021). Décès en 2020 et début 2021 : pas tous égaux face à la pandémie de Covid-19. France, portrait social. Edition 2021., Paris : Insee**:** 11-26, tabl., fig.
https://www.insee.fr/fr/statistiques/5435421

En raison de l'épidémie de Covid-19, le nombre de décès en France s'est fortement accru en 2020 et au premier semestre 2021 : + 9,1 % toutes causes confondues en 2020 et + 7,3 % au premier semestre 2021 par rapport aux périodes équivalentes de 2019. Les risques de décéder ont augmenté dès 35 ans pour les hommes et 55 ans pour les femmes, tandis que la mortalité des plus jeunes, surtout celle des hommes, a baissé compte tenu de l'effet « protecteur » des confinements. L'espérance de vie à la naissance a reculé de 0,5 an pour les femmes et 0,6 an pour les hommes en 2020, essentiellement du fait de la hausse de la mortalité des personnes de 70 ans ou plus. La perte d'espérance de vie en 2020 affecte en particulier les régions les plus touchées par les deux premières vagues de l'épidémie : Île-de-France, Grand Est, Auvergne-Rhône-Alpes, Bourgogne-Franche-Comté et Hauts-de-France, mais aussi Mayotte, qui a cumulé épidémies de Covid-19 et de dengue. La pandémie a été plus meurtrière pour les personnes nées à l'étranger, en particulier celles nées en Afrique ou en Asie. Celles-ci résident en effet plus souvent dans les régions les plus touchées par l'épidémie et dans des communes à l'habitat dense, facteur associé à des risques de décès plus forts en 2020.

Blavier, P. et Perdoncin, A. (2020). "Trajectoires d'activité d'immigrés : une approche sociohistorique, 1968-2008." Population **75**(1): 39-70, tab., annexes.

> Les immigrés sont souvent considérés, dans le débat public, comme s'ils formaient un ensemble homogène et indifférencié. Cet article vise à contribuer, dans la lignée d'autres travaux historiques ou sociodémographiques, à une meilleure compréhension de la diversité de leurs trajectoires en France. Pour cela, il étudie les trajectoires d'activité d'individus arrivés en France après 1968, en s'appuyant sur l'enquête Trajectoires et origines (TeO) conduite par l'Ined et l'Insee en 2008, en particulier sur son calendrier rétrospectif. La méthode d'appariement optimal, couplée à une modélisation des probabilités de transition entre divers états des trajectoires d'activité, permet de construire et de qualifier sociologiquement des types de trajectoires, mais aussi d'expliquer les transitions les plus structurantes au sein de la population entre études et non-emploi, emploi et chômage, inactivité au foyer et salariat. Les trajectoires d'activité ainsi analysées sont déterminées par le sexe, les expériences professionnelles éventuelles avant la migration, ainsi que par le pays d'origine et l'âge à la migration. Sur le plan historique, les années 1970 reconfigurent les modalités d'entrée dans un monde du travail plus précaire, plus fréquemment marqué par des moments hors salariat.

Bodier, M. et Chambaz, C. (1995). "La difficile maîtrise de la langue française." Insee Premiere(385): 4 , 6 tabl.

> Les résultats, issus de l'enquête "Etude et Conditions de vie de 1994 et de l'enquête" Efforts d'évaluation des familles "de 1992, permettent d'évaluer la maîtrise de la langue française parmi la population résidant en France, et de connaître les caractéristiques des personnes ayant des difficultés à parler, lire, écrire ou maîtriser le français dans la vie courante.

Boeldieu, J. et Borrel, C. (2000). "La proportion d'immigrés est stable depuis 25 ans. Recensement de la population 1999." Insee Premiere(748): 4, 4 graph., 1 enc.

> En mars 1999, 4 310 000 immigrés résidaient en France métropolitaine, soit 7,4 % de la population, proportion constante depuis 1975. Leurs origines géographiques sont de plus en plus diversifiées et lointaines. Le nombre des immigrés natifs de pays d'Europe diminue, celui des originaires du Maghreb augmente légèrement. Les immigrés vivent surtout dans les grandes villes et en région parisienne. Par rapport à 1990, la population immigrée a vieilli mais elle comprend plus de jeunes adultes que le reste de la population. Elle compte désormais autant de femmes que d'hommes. Les immigrés français par acquisition sont plus souvent des femmes et sont plus âgés que ceux restés étrangers. Plus d'un immigré sur trois est de nationalité française.

Boeldieu, J. et Thave, S. (2000). "Le logement des immigrés en 1996." Insee Premiere(730): 4, 4 graph.

> Les conditions de logement des ménages immigrés sont très différentes de celles des autres ménages. Moins souvent propriétaires de leur logement, ils sont plus présents dans le secteur locatif social, et notamment HLM. Les caractéristiques de ce parc correspondent particulièrement au profil social et familial de la population immigrée, composée en grande partie de familles nombreuses aux faibles revenus. Les HLM accueillent ainsi près de la moitié des ménages immigrés locataires, en particulier dans les logements les plus anciens. Et ceux qui sont en attente d'un logement HLM depuis au moins trois ans sont deux fois plus nombreux que la moyenne.

Boisguerin, B. (2011). "Insertion socio-professionnelle, état de santé et recours aux soins des bénéficiaires de l'AME : le rôle des réseaux d'entraide." Dossiers Solidarite Et Sante (Drees)(19): 14.

> [BDSP. Notice produite par MIN-SANTE 7mAR0xEq. Diffusion soumise à autorisation]. Fin 2010,230 000 personnes bénéficient de l'aide médicale d'État (AME), un dispositif permettant de prendre en charge les dépenses de santé des étrangers en situation irrégulière. À partir d'une enquête réalisée en 2007 par la DREES, cette étude se penche sur le soutien éventuellement mobilisable par cette population, selon la provenance de l'aide (familiale, amicale, associative, sociale) et sa nature (matérielle ou financière, pour trouver un logement, du travail, effectuer des démarches). Il s'agit

également d'observer si ce réseau d'entraide a une influence sur les conditions de logement, l'insertion professionnelle et l'état de santé perçu. Le réseau d'entraide sur lequel peuvent s'appuyer les bénéficiaires de l'AME conditionne directement leurs modalités d'existence : en particulier, l'insertion dans un réseau familial et amical améliore les conditions de logement et facilite l'accès à l'emploi. L'état de santé des bénéficiaires de l'AME apparaît également lié à leur capacité à mobiliser un soutien : deux personnes sur dix se déclarent en mauvaise santé et quatre sur dix indiquent souffrir d'une ou plusieurs maladies chroniques. Ce sentiment est renforcé chez les personnes qui ne peuvent s'appuyer sur la famille ou les amis. Enfin, les bénéficiaires de l'AME recourent davantage aux soins quand ils peuvent être épaulés à la fois par l'entourage familial et le milieu associatif pour effectuer des démarches et formalités.

Boissard, S. c. (2006). Besoins de main-d'oeuvre et politique migratoire. Paris la Documentation française**:** 120, ann., tabl.

Selon le présent document, bien que le taux de fécondité soit en France un des plus élevés d'Europe, le vieillissement de la population se fait ressentir et induira, à moyen terme des besoins de main d'oeuvre "ciblés". Ce rapport s'interroge sur l'opportunité d'opérer des migrations de remplacement pour mettre un frein au problème du vieillissement démographique qui risque d'accroître les difficultés de recrutement dans certains secteurs d'activité. Il étudie les relations entre immigration et marché du travail et analyse l'impact de l'immigration sur l'emploi et la croissance. Il se penche sur l'accès des étrangers au marché du travail français, à la fois dans ses aspects juridiques et politiques. Il donne, enfin, des orientations pour la politique migratoire de la France (opportunité du recours à la main-d'oeuvre immigrée, intégration de celle-ci sur le marché du travail, gestion des migrations du travail).

Bornia, L., et al.(2011). "Vieillissement et migrations." Gerontologie Et Societe(139): 204. https://www.cairn.info/revue-gerontologie-et-societe1-2011-4.htm

[BDSP. Notice produite par FNG R0x9nkkl. Diffusion soumise à autorisation]. Longtemps associées au développement industriel des pays riches, les migrations humaines ont changé de visages au cours des trois dernières décennies. Tout d'abord les déplacements de population, subis ou désirés par les migrants, ne se font plus seulement dans le sens Sud-Nord, mais aussi Est-Ouest et Sud-Sud. Ils se sont mondialisés. Ensuite, l'allongement de la durée de la vie et le vieillissement démographique des pays développés entraînent un flux migratoire nouveau dont les impacts économiques et sociaux sont de plus en plus forts dans les pays d'origine des migrants. (extraits 4e de couv.).

Borrel, C. (2004). "Les limites de l'approche statistique des circulations migratoires. Le système statistique français." Revue Francaise Des Affaires Sociales(2): 73-85, graph., tabl.

[BDSP. Notice produite par ORSIF R0xJWB1f. Diffusion soumise à autorisation]. La question de la maîtrise des flux, celle des prévisions de population à vingt ou trente ans demande des données statistiques pour asseoir les décisions politiques. Face à ces besoins, le système statistique français apparaît encore rudimentaire. Les statistiques sur l'attribution des titres de séjour permettent une estimation du flux d'entrées des étrangers non communautaires. Pour les autres éléments utiles au débat, sorties d'étrangers du territoire, mouvements migratoires de Français, les démographes et les statisticiens doivent faire appel à des enquêtes, à des estimations ponctuelles, mais en aucun cas à une production régulière du système statistique. Le nouveau recensement, avec une collecte chaque année auprès de plus de huit millions de personnes, permettra un enrichissement de la connaissance statistique des migrations : estimation des flux d'entrées comprenant les ressortissants communautaires et du solde migratoire.

Borrel, C. (2006). "Enquêtes annuelles de recensement 2004 et 2005 : près de 5 millions d'immigrés à la mi-2004." Insee Premiere(1098): 4 , 5 graph.

A la mi-2004, 4,9 millions d'immigrés résident en France métropolitaine ; ils représentent 8,1 % de la population. Les immigrés originaires d'Afrique et d'Asie sont plus nombreux sur le territoire qu'en

1999 ; c'est l'inverse pour ceux issus des anciens courants migratoires, d'Espagne et d'Italie. Dans la population immigrée, hommes et femmes sont désormais aussi nombreux : l'immigration à dominante féminine liée au regroupement familial a succédé après 1974 à l'immigration de main-d'oeuvre à majorité masculine. Grâce aux nouveaux arrivants, la population immigrée n'a pas vieilli entre 1999 et 2004-2005, contrairement aux non-immigrés. Le niveau de formation s'est élevé nettement pour les immigrés, tout comme pour l'ensemble de la population. En particulier, par rapport à 1982, quatre fois plus d'immigrés détiennent un diplôme de l'enseignement supérieur. Quatre immigrés sur dix résident en Île-de-France, un sur dix en Rhône-Alpes et un sur dix en Provence -Alpes -Côte d'Azur.

Borrel, C. et Boeldieu, J. (2001). "De plus en plus de femmes immigrées sur le marché du travail. Recensement de la population 1999." Insee Premiere(791): 4 , 2 tabl., 3 graph.

En 1999, 2,3 millions d'immigrés actifs résidaient en France, soit 8,6% de la population active. Les femmes sont maintenant aussi nombreuses que les hommes dans la population immigrée mais elles ont, traditionnellement, un taux d'activité bien inférieur. Cependant elles ont de plus en plus tendance à suivre le modèle français d'activité féminine. Ainsi, le taux d'activité des femmes âgées de 15 à 64 ans est passé de 41 % en 1982 à 57 % en 1999. Les immigrés sont davantage affectés par le chômage que le reste de la population, les femmes encore plus que les hommes. De plus ils occupent plus fréquemment que les autres des emplois temporaires ou à temps partiel. La plupart des immigrés actifs sont ouvriers ou employés. Les hommes sont sur-représentés dans le secteur de la construction et les femmes dans celui des services aux particuliers (résumé d'auteur).

Borrel, C., et al. (2012). Immigrés et descendants d'immigrés en France. Edition 2012. Collection Insee Références. Paris INSEE**:** 266, tabl., graph.

Cette première édition des « Immigrés et descendants d'immigrés en France », réalisée conjointement avec le Département des statistiques, des études et de la documentation du Secrétariat général à l'immigration et à l'intégration apporte un éclairage particulier sur la dynamique d'intégration des bénéficiaires d'un Contrat d'accueil et d'intégration, les parcours scolaires des enfants d'immigrés, l'accès à l'emploi des descendants d'immigrés à la sortie du système éducatif et leur place dans la fonction publique. La vue d'ensemble et les fiches thématiques font le point sur l'immigration en matière de démographie, de santé et de recours aux soins, de flux migratoires, d'éducation, d'emploi et de conditions de vie.

Borrel, C. et Lhommeau, B. (2010). "Etre né en France d'un parent immigré." Insee Premiere(1287): 4 , 3 graph., 1 tabl.

En 2008, 3,1 millions de personnes âgées de 18 à 50 ans, nées en France métropolitaine, sont enfants d'immigrés. La moitié d'entre elles ont moins de 30 ans. 50 % ont deux parents immigrés, 20 % sont descendants d'immigrés uniquement par leur mère et 30 % uniquement par leur père. La moitié des descendants directs ont un parent immigré né en Europe et quatre sur dix sur le continent africain, essentiellement au Maghreb. Les descendants les plus jeunes ont des parents d'origines plus variées et plus lointaines. Les enfants d'immigrés de 18 à 30 ans ont une fois sur deux une ascendance africaine. La répartition régionale des descendants s'écarte peu de celle des immigrés. Ainsi, un tiers des descendants âgés de 18 à 50 ans sont franciliens. Près du quart des descendants ayant la nationalité française ont au moins une autre nationalité. Pour la grande majorité des descendants, la langue française a été transmise dans leur enfance par au moins un de leurs parents. À la génération suivante, les descendants devenus eux-mêmes parents parlent français avec leurs enfants vivant en France, dans 99 % des cas (résumé d'auteur

Boubtane, E. (2010). "Immigration et âge de départ à la retraite." Revue Economique **61**(5): 917-932.

Cet article étudie l'effet d'une politique d'immigration sur le choix de l'âge de départ à la retraite. Dans le cadre d'un modèle à générations imbriquées avec un système de retraite par répartition où les individus sont hétérogènes, il montre que l'admission de travailleurs peu qualifiés peut inciter les seniors qualifiés à reporter leur départ à la retraite et prolonger leur activité. Le modèle prend en

compte l'impact de l'immigration sur les pensions de retraite, sur les rémunérations des travailleurs et sur le choix de retraite des seniors. Il permet de mettre en évidence que l'arrivée d'immigrés peu qualifiés, via son impact sur les salaires et sur les pensions de retraite, affecte le choix de la durée d'activité des seniors qualifiés. Ces derniers reportent leur départ à la retraite pour profiter plus longtemps de la hausse de leur salaire en fin de carrière.

Breton, D., Belliot, N., Barbieri, M., et al. (2021). "L'évolution démographique récente de la France : Moins de naissances, de mariages et de migrations, plus de décès... la Covid-19 bouleverse la dynamique de la population française." Population **76**(4): 68.
https://www.ined.fr/fichier/s_rubrique/32331/conjoncture.2021.population.4.fr.pdf

Le 1er janvier 2021, la France comptait 67,4 millions d'habitants soit 120 000 de plus qu'au 1er janvier 2020. Contrairement à de nombreux pays européens, la population de la France n'a pas diminué, mais marque un très fort ralentissement, du fait principalement de la crise sanitaire engendrée par la pandémie de Covid qui a eu des effets sur toutes les composantes démographiques. L'année 2020 devrait voir diminuer le nombre de titres de séjour d'au moins un an délivrés à des personnes des pays tiers (– 10 000), notamment ceux en provenance de pays d'Afrique et ceux pour causes « familiale » et « humanitaire ». Le nombre de naissances a également fortement baissé, particulièrement 9 mois après le confinement. Cette baisse s'explique par une diminution du nombre de conceptions et non une augmentation des interruptions volontaires de grossesses qui sont en recul, notamment les mois suivant le premier confinement. Mais les deux phénomènes les plus fortement affectés sont, d'une part, les mariages rendus impossibles du fait des règles sanitaires (– 70 000) et, comme on pouvait s'y attendre, la mortalité avec une diminution de l'espérance de vie de 0,56 an pour les hommes et 0,45 an pour les femmes, soit un retour au niveau de mortalité observé 6 ans auparavant.

Brutel, C. (2017). "Être né en France d'un parent immigré. Une population diverse reflétant l'histoire des flux migratoires." Insee Premiere(1634): 4 , 6 graph.
https://www.insee.fr/fr/statistiques/2575541

En 2015, 7,3 millions de personnes nées en France ont au moins un parent immigré, soit 11 % de la population. L'origine des descendants d'immigrés est le reflet des flux d'immigration qu'a connus la France depuis plus d'un siècle. Les descendants d'immigrés sont dans leur ensemble plus jeunes que l'ensemble de la population résidant en France ; c'est notamment le cas de ceux d'origine africaine. La moitié des descendants d'immigrés ont un seul parent immigré. Lorsque les deux parents sont immigrés, ils viennent presque toujours du même pays. Entre 18 et 24 ans, les descendants d'immigrés partent plus tardivement du foyer familial que les autres jeunes. C'est surtout le cas pour ceux dont les deux parents sont immigrés : le comportement de décohabitation des jeunes issus de couples mixtes est plus proche de celui de l'ensemble de la population. Deux tiers des descendants d'immigrés de 25 ans ou plus vivant en couple ont choisi un conjoint sans lien direct avec l'immigration. La localisation géographique des descendants est proche de celle des immigrés, même si elle est un peu moins concentrée dans l'unité urbaine de Paris (résumé d'auteur).

Brutel, C. (2014). "Les immigrés récemment arrivés en France. Une immigration de plus en plus européenne." Insee Premiere(1524): 4, 6 tabl.

De 2004 à 2012, 200 000 immigrés sont entrés chaque année, en moyenne, sur le territoire français. Compte tenu des décès et des départs, la population immigrée a crû en moyenne de 90 000 personnes par an. Début 2013, elle représente 8,8 % de la population française. De 2004 à 2009, les entrées en France sont restées stables, puis ont augmenté, de 2009 à 2012, en raison essentiellement de l'afflux d'Européens. Le profil des immigrés qui entrent chaque année en France évolue au cours de la dernière décennie. La part des femmes continue d'augmenter, dans la lignée d'un mouvement datant du milieu des années 1970. Celle des personnes originaires d'Europe se renforce : près de la moitié des immigrés entrés en France en 2012 sont nés dans le continent contre un tiers dix ans auparavant. L'immigration d'origine européenne est majoritairement portugaise, britannique, espagnole, italienne ou allemande. Depuis 2008, malgré la hausse du niveau de diplôme, la part des immigrés déclarant occuper un emploi l'année de leur arrivée en France est stable. Elle varie toutefois fortement selon le

pays d'origine. Six nouveaux migrants sur dix vivent en famille l'année de leur arrivée en France, qu'ils aient migré ensemble ou rejoint un membre de leur famille précédemment installé (résumé auteur).

Brutel, C. (2015). "L'analyse des flux migratoires entre la France et l'étranger entre 2006 et 2013 : un accroissement des mobilités." Insee Analyses(22): 4, tabl., graph., fig.

Selon le dernier bilan démographique (publié en janvier 2015), le solde migratoire de la France s'établit à + 33 000 personnes en 2013. Il était de + 112 000 en 2006. Ce solde résulte de mouvements migratoires entre la France et l'étranger de trois catégories de personnes qui vivent en France : celles qui sont nées en France, les immigrés et les personnes nées françaises à l'étranger. Les travaux présentés ici visent à quantifier l'ensemble de ces mouvements sur la période 2006 à 2013. Outre l'analyse du solde migratoire, réalisée habituellement par le rapprochement des données du recensement et des données de l'état civil, cette méthode présente une exploitation nouvelle des recensements successifs pour estimer les flux d'entrées sur le territoire et par déduction les flux des sorties. Les départs vers l'étranger des personnes nées en France se sont amplifiés depuis 2006, alors que leurs retours, moins nombreux, ont peu varié sur la période. Leur solde migratoire est ainsi négatif et a doublé sur la période : il est estimé à – 120 000 personnes en 2013 contre – 60 000 en 2006. Dans le même temps, le nombre d'entrées d'immigrés a progressé, mais à un rythme plus faible que leurs sorties du territoire, si bien que le solde migratoire des personnes immigrées, estimé à + 140 000 personnes en 2013, s'inscrit en léger recul par rapport à 2006 (+ 164 000). Enfin, les flux d'entrées et de sorties des personnes nées françaises à l'étranger sont plus faibles ; leur solde migratoire s'élève à + 13 000 en 2013. L'augmentation récente des sorties de personnes nées en France vient gonfler la présence française à l'étranger : en 2013, un peu moins de 3 millions et demi de personnes nées en France vivraient à l'étranger.

Brutel, C. (2015). "Populations française, étrangère et immigrée en France depuis 2006 et L'analyse des flux migratoires entre la France et l'étranger entre 2006 et 2013." Insee Focus(38): 1, tabl., graph., fig.

Au 1er janvier 2014, la France compte 65,8 millions d'habitants hors Mayotte : 11,6 % d'entre eux sont nés à l'étranger, 8,9 % sont immigrés et 6,4 % sont de nationalité étrangère. Au cours des années 2006 à 2013, l'ensemble de la population résidant en France a augmenté de 2,6 millions de personnes, celle de nationalité française de 2,1 millions. Les immigrés, qui ne sont pas tous de nationalité étrangère, comptent 700 000 personnes en plus. Leur part dans la population s'est accrue de 0,8 point entre 2006 et 2014.

Carde, E. (2009). "Les restrictions apportées au droit aux soins des étrangers sont-elle discriminatoires ? La loi et l'illégitime." Sante Publique **21**(3): 331-337.

[BDSP. Notice produite par EHESP IHnR0xA9. Diffusion soumise à autorisation]. L'auteur présente tout d'abord le raisonnement juridique qui peut être mis en oeuvre pour évaluer l'aspect éventuellement discriminatoire d'une loi définissant l'accès aux soins des étrangers. Elle examine plus particulièrement le raisonnement suivi par le Conseil Constitutionnel dans une décision datée du 13 août 1993, décision qui met en tension deux enjeux : la protection de l'intérêt général et celle des droits fondamentaux. Puis, dans un second temps, l'auteur s'interroge sur les fondements de ce raisonnement mettant en avant l'importance des choix politiques et sociaux utilisés pour justifier des traitements différentiels opérés à l'encontre des étrangers en situation irrégulière.

Caron, R. (2019). "Santé, immigration, avenir : comment les territoires influencent l'opinion des Français." Etudes Et Resultats(1106): 6.
https://drees.solidarites-sante.gouv.fr/IMG/pdf/er1106.pdf

Les opinions des Français sont parfois très marquées par leur appartenance à un territoire. Les données du Baromètre d'opinion de la DREES 2017, qui interroge 3 000 personnes, laissent apparaître certains de ces contrastes. Pour les mettre en évidence, une typologie des communes françaises ad hoc a été élaborée : elle montre qu'en 2017, huit habitants des grands centres urbains sur dix estiment que notre système de sécurité sociale apporte un niveau de protection suffisant, contre deux

tiers de ceux des campagnes isolées. Les opinions relatives à l'accès aux soins ou à l'intégration des étrangers divergent aussi entre les grands centres et les territoires qui en sont les plus éloignés. Les trois quarts des habitants des campagnes isolées estiment que le nombre de médecins spécialistes à proximité de chez eux est insuffisant, contre un tiers dans les grands centres. Six personnes sur dix des campagnes isolées ou des petits centres urbains déclarent qu'il y aurait trop de travailleurs immigrés en France, contre quatre sur dix dans les grands centres. Les habitants des « banlieues », qu'elles soient plutôt favorisées ou défavorisées, se distinguent par une vision plus optimiste de leur propre situation.

Charbit, C. (2018). Working Together for Local Integration of Migrants and Refugees in Paris. Paris OCDE**:** 108 , tab., graph., fig.
https://www.oecd-ilibrary.org/social-issues-migration-health/working-together-for-local-integration-of-migrants-and-refugees-in-paris_9789264305861-en

Of the requests for asylum in France made in 2016, more than 10 000 applications were made by people in Paris and were made in the context of a rising number of refugees and asylum seekers since 2015. This increase has stirred a debate in France around its "universal" migrant integration model, which aspires to equal treatment for all and for which the main tool has been "Integration Contract" for migrants. At all levels of government, measures are now being designed for "reinforced" support for migrants, helping them to better integrate socially and to better access the job market; these measures are tailored for all persons with a residency permit, in particular for refugees. This case study examines the City of Paris and its ambitions to successfully integrate its new inhabitants. The municipality sets aside dedicated resources for this and actively involves French citizens in implementing activities to foster social cohesion. The city is still attracting new migrants while socio-economic disparities and segregation remain marked in Paris and its region, in a context of limited emergency accommodation facilities for migrants and a tight housing market. More can be done to improve coherence across levels of government and among partners, in order to prevent fragmented service delivery and to improve how the impact of integration programmes is measured.

Chojnicki, X. et Ragot, L. (2016). "L'incidence fiscale de l'immigration." Informations Sociales **194**(3): 38-48.
https://www.cairn.info/revue-informations-sociales-2016-3-page-38.htm

L'immigration est souvent perçue comme étant coûteuse pour les finances publiques. Et pourtant, les études menées en France et dans les autres pays développés concluent en général à un impact extrêmement modéré. Dans le cas de la France, celui-ci varie entre plus et moins 0,2 % de PIB selon l'année considérée. Ce résultat s'explique pour l'essentiel par une structure par âge favorable de la population immigrée, caractérisée par une surreprésentation de celle-ci dans les catégories d'âge actif, alors même que sa contribution nette individuelle aux finances publiques est relativement dégradée comparativement aux natifs. Toutefois, une modification de la politique migratoire (portant sur la taille ou la structure des flux) ne saurait constituer une solution au fardeau fiscal du vieillissement de la population française.

Colin, J. P. (1999). "Culture et émigration : l'indispensable aller et retour." Gerontologie Et Societe(91): 93-97.

[BDSP. Notice produite par FNG eaJ5R0xl. Diffusion soumise à autorisation]. Si bien des travailleurs migrants sont partis sans esprit de retour au XIXème siècle et dans la première partie du XXème siècle, cela n'a plus été le cas par la suite, en particulier dès lors que les Maghrébins ou les Africains venaient de civilisations très éloignées de l'Europe. Ayant pourtant fait des efforts pour mieux s'intégrer, ayant fait venir leurs familles, la plupart d'entre eux vieilliront ici, parmi leurs enfants et leurs petits-enfants, même s'ils souhaitent - comme c'est désormais possible - retourner régulièrement au pays sans perdre leurs droits. Leur présence parmi nous devrait être très positive ; ils permettront à leurs petits-enfants de garder leur héritage culturel, condition paradoxale d'une intégration réussie ; ils transmettront à notre société l'image de systèmes sociaux où les vieux ne sont pas mis à l'écart, cantonnés dans des institutions spécialisées, mais où ils restent dans leur famille, dans leur quartier, continuant à jouer un rôle social jugé essentiel.

Cornuau, F. et Dunezat, X. (2008). "L'immigration en France : concepts, contours et politiques." Espace Populations Societes(2): 159-172, tabl., fig.

> Cet article présente l'immigration en France. Il existe un certain nombre de prénotions- en tête desquelles l'idée selon laquelle la France serait un pays d'immigration massive qui semblent liées à trois grandes causes qui vont être développée dans ce dossier. La première est le flou sémantique et statistique qui entoure la question de l'immigration. La deuxième cause est la politisation de cette question. Enfin, la troisième cause est la méconnaissance à la fois qualitative et quantitative de l'immigration dite irrégulière.

Cour des Comptes (2020). L'entrée, le séjour et le premier accueil des personnes étrangères. Paris Cour des comptes**:** 178.
https://www.ccomptes.fr/fr/publications/lentree-le-sejour-et-le-premier-accueil-des-personnes-etrangeres

> En 2019, la France a délivré 276 576 premiers titres de séjour à des ressortissants non européens. En augmentation de plus de 30 % depuis le début de la décennie, ces chiffres placent toutefois notre pays parmi les plus restrictifs en termes de séjour (3,72 titres accordés pour 1 000 habitants en 2016, contre 12,18 en Allemagne ou 7,65 en Espagne). À l'inverse, 154 620 demandes d'asile ont été enregistrées, plaçant la France dans la fourchette haute des pays de l'Union européenne et son système d'asile sous forte tension. La moitié des titres de séjour attribués et la totalité des demandes d'asile reposent sur des procédures relevant de droits individuels protégés par la Constitution et les conventions internationales ratifiées par la France, comme celui de déposer une demande d'asile à son arrivée sur le territoire. L'État, qui ne peut donc pas les limiter quantitativement, dispose d'un pouvoir de sélection restreint. À défaut de maîtriser les entrées, il a durci le régime du séjour en imposant le renouvellement fréquent d'une majorité de titres courts. Les relations entre l'administration et les usagers, qui n'ont pas fait l'objet d'une modernisation suffisante, en sont d'autant plus difficiles. Enfin, le dispositif de premier accueil apparaît sous-dimensionné au regard des ambitions affichées en matière d'intégration

D'Albis, H. et Boubtane, E. (2018). "L'admission au séjour des demandeurs d'asile en France depuis 2000." Population Et Societes(552): 4 , fig.

> Les demandes d'asiles ont augmenté ces dernières années en France, tout en représentant une part décroissante du total des demandes adressées aux pays de l'Union européenne. L'afflux récent de demandeurs d'asile a en effet beaucoup moins concerné la France que certains de ses voisins européens. Environ un quart des demandeurs qui s'adressent à la France obtiennent sa protection. La proportion varie de 18 % à 32 % selon l'année de dépôt. Plus d'un quart ne l'obtiennent pas mais sont finalement admis au séjour pour un autre motif (études, famille, travail) souvent de nombreuses années après. Parmi les personnes ayant déposé une demande en 2000, près de 60 % ont été admises au séjour au 31 décembre 2016, un tiers d'entre elles au titre de l'asile (comme réfugié, apatride ou bénéficiaire de la protection subsidiaire), et un peu plus de la moitié pour motif familial.

Dayan, J. L., et al. (1995). "La vie professionnelle des immigrés : les marques de l'histoire." Insee Premiere(369): 4 , 3 tabl., 2 graph.

> L'aspect de l'enquête "Mobilité géographique et insertion sociale" de 1992 étudié dans ce numéro est le par cours professionnel des immigrés (hommes et femmes), selon leur origine géographique et l'époque de leur arrivée en France.

De, Almeid, A. A. (1999). "Le vieillissement des Portugais en France : choix et perspectives." Gerontologie Et Societe(91): 115-125.

> [BDSP. Notice produite par FNG R0x23Q0c. Diffusion soumise à autorisation]. La vague migratoire des Portugais vers la France remonte aux années soixante. Ils sont plus de 700 000 en 1975, dont plus de la moitié ayant entre 15 et 35 ans. Parmi cette population, le nombre de retraités va augmenter

progressivement au cours des vingt prochaines années : ils seront certainement plus de 350 000 dans dix ans. Quel sera l'avenir de ces retraités qui, pour la plupart, auront des pensions assez faibles ? Resteront-ils en France ou profiteront-ils de la fin de la vie active pour réaliser le rêve du retour au pays d'origine ? Que faut-il faire pour répondre de forme adéquate aux problèmes et aux besoins spécifiques de cette population pour améliorer la qualité de leur vie et leur offrir un environnement agréable pendant les dernières années de leurs existences, souvent très pénibles ?

Diop, A. M. (1999). "Préretraités et retraités ouest-africains en Ile de France." Gerontologie Et Societe(91): 127-135.

[BDSP. Notice produite par FNG R0xPFJ0C. Diffusion soumise à autorisation]. L'immigration africaine défraie souvent la chronique, génère des fantasmes, et des interrogations sur "l'étrangeté de l'Autre", sur des pratiques traditionnelles d'un autre âge. A cette réalité visible, il en est d'autres, moins connus, et plutôt relativement partagées, à un moment donné de la vie par tous les corps sociaux. Les Africains eux aussi vieillissent dans une société où la population âgée est souvent circonscrite dans le domaine de la pathologie. L'article, après une esquisse de la présence africaine en France, s'intéresse aux questions vécues par une catégorie de préretraités et retraités, vivant dans la région parisienne.

Docquier, F., et al. (2016). "Les effets des migrants sur le marché du travail. Extrait d'une étude britannique de VoxEU.org et Cepr." Problemes Economiques(3124): 17-23, tab., graph.

En Europe, le stéréotype le plus répandu concernant le profil des immigrants est qu'ils sont en général pauvres et peu qualifiés. Les études portant sur les récentes migrations internationales montrent tout d'abord qu'une part importante des flux migratoires de main-d'oeuvre provient des pays de l'Organisation de coopération et de développement économiques (OCDE) à destination d'autres pays de l'OCDE. Elles révèlent ensuite que les travailleurs ayant eu accès à une formation supérieure sont beaucoup plus mobiles que les travailleurs les moins éduqués et qu'ils se déplacent vers les pays où ils sont les mieux payés. L'immigration tend à réduire les différences salariales dans les pays d'accueil entre les travailleurs les mieux rémunérés et ceux qui le sont le moins.

Dourlens (2005). "L'accueil des demandeurs d'asile dans les structures d'urgence." 4.

Cette étude décrit les modalités d'accès des demandeurs d'asile aux dispositifs d'urgence sociale. Elle met en évidence les difficultés rencontrées par ces personnes pour s'orienter au sein d'un maillage complexe de structures dont les conditions d'admission sont très hétérogènes et rarement clairement énoncées. Elle montre aussi que si la question de l'asile acquiert ainsi une certaine visibilité, c'est au prix d'une certaine perte de consistance de cette question. Moins arcboutée à une définition strictement juridique, la dénomination de demandeur d'asile s'élargit considérablement. Les ambiguïtés qui marquent les significations attachées au droit d'asile se manifestent au sein même des structures d'urgence, dont les principes d'action sont très largement perturbés par l'accueil de ce nouveau public.

Dumont, G. F. (2008). "Immigration étrangère et développement local en France." Futuribles(343): 5-20, tabl., graph.

La dynamique démographique en France résulte aujourd'hui, pour une grande part, des flux migratoires qui traversent le pays. Mais ces flux migratoires ne sont pas les mêmes sur tout le territoire national : certaines régions accueillent davantage de populations immigrées que la moyenne quand d'autres sont à peine concernées, et l'impact de ces flux migratoires sur le développement local n'est pas non plus uniforme. Après un bref rappel des deux approches principales en matière d'analyse de l'immigration étrangère et de ses conséquences sur le développement territorial (source de richesse vs. fardeau budgétaire), l'auteur propose une analyse détaillée de l'immigration étrangère en France selon les régions : part dans les migrations régionales, renouvellement des flux, poids dans la population active et taux de chômage des actifs étrangers, rôle pivot de l'Île-de-France... Il analyse également les effets économiques, très variables, de la présence de cette population étrangère, considérant deux angles distincts - le critère juridique (nationalité) et le critère géographique (origine

des immigrés, qu'ils aient acquis ou non la nationalité française), et étudie de plus près les relations entre immigration et chômage (distinguant ici « quatre France »). Autant d'éléments montrant que les effets de l'immigration sur le développement local varient en fonction de deux critères géographiques différents : l'origine géographique des individus et le territoire particulier où ils s'installent.

Fédération des Acteurs de la Solidarité (2022). L'accompagnement social des personnes étrangères en situation administrative précaire. Paris Fédération des Acteurs de la Solidarité**:** 32.
https://www.federationsolidarite.org/wp-content/uploads/2022/07/202112_Etude-Accompagnement-social-personnes-etrangeres-situation-administrative-precaire-002.pdf

La Fédération des acteurs de la solidarité s'engage pour la défense des droits fondamentaux de toute personne en situation de pauvreté et d'exclusion. Parmi elles, les personnes étrangères en situation administrative précaire - c'est-à-dire qui ne disposent que d'un titre de séjour de courte durée et dont le renouvellement est incertain ou qui ne disposent pas d'un droit au séjour sur le territoire au regard de la règlementation en vigueur - voient leurs droits particulièrement remis en question. Or, si leur accès à certains droits sociaux est limité de fait par leur situation administrative, il n'en demeure pas moins que ces personnes devraient, d'après la loi nationale et les engagements internationaux de la France, pouvoir accéder de manière effective à des droits essentiels. Il en va ainsi de l'accueil inconditionnel à l'hébergement pour toute personne en situation de détresse, de la possibilité de bénéficier d'une prise en charge médicale ou encore de voir des besoins de première nécessité satisfaits, tels que l'accès à l'eau ou à l'alimentation .Les résultats présentés dans cette publication sont les fruits d'une enquête menée auprès des professionnels intervenant en structures d'hébergement, accueils de jours, plateformes d'accompagnement social à l'hôtel, dispositifs d'accompagnement et/ou d'hébergement spécifiques ainsi qu'avec quelques personnes accompagnées. Les professionnels rencontrés étaient pour une partie importante des travailleurs sociaux, issues de toutes formations, ainsi que des directions de structures. Au total, vingt-six structures ou dispositifs, ainsi que quatre personnes accompagnées ont constitué

Fromentin, J. et Pistre, P. (2021). "L'immigration dans les campagnes françaises : des effectifs limités mais des effectifs qui ne cessent de se diversifier." Population & Sociétés(591): 4.

Que représente aujourd'hui l'immigration dans les campagnes françaises ? Comment se répartit-elle sur le territoire national et quelles sont ses caractéristiques ? Exploitant les recensements de population, Julie Fromentin et Pierre Pistre examinent comment la population immigrée a évolué dans les campagnes françaises depuis les années 1970, à la fois en nombre, en part de la population, et dans ses origines.

Gallou, R. (2005). "Les immigrés isolés : la spécificité des résidants en foyer." Retraite Et Societe(44): 108-147.

[BDSP. Notice produite par FNG WqSoR0xB. Diffusion soumise à autorisation]. Cet article a pour objectif d'exposer les caractéristiques des hommes immigrés vivant seuls, en relation avec leur univers résidentiel : foyer, parc diffus, logement classique. L'auteur met particulièrement l'accent sur les résidants en foyer dont les spécificités se dégagent de la comparaison avec les occupants des deux autres types d'habitat. Cette population de résidants s'est constituée rapidement au cours des années soixante et soixante dix. Plus âgés que les autres au moment de la migration, ils étaient souvent déjà mariés et pères en arrivant en France. On retrouve par conséquent aujourd'hui, dans leurs actes et leurs discours, une véritable dualité : la conservation de contacts très étroits avec le pays d'origine et un attachement profond à la France.

Gallou, R. (2009). "Vieillir loin de ses racines. Le choix irrésolu des immigrés résidant en foyer." Cadrage(6): 1-6.

Les immigrés vieillissant dans les foyers de travailleurs vivent dans des conditions précaires, ce qui, à l'âge de la retraite, ne les empêche pas de se maintenir dans ce lieu de vie habituel. un paradoxe apparent qu'ils résolvent par le va-et-vient entre la France et leur pays d'origine.

Gentilini, M. et Kerouedan, D. (2020). L'immigration en France : situation sanitaire et sociale. Paris Académie nationale de médecine**:** 40.
http://www.academie-medecine.fr/limmigration-en-france-situation-sanitaire-et-sociale/

> La situation sanitaire et sociale des demandeurs d'asile et des migrants en général est insuffisamment documentée en France, notamment en ce qui concerne les femmes enceintes, les enfants et les mineurs non accompagnés. Les personnes auditionnées ont conforté l'attention de l'Académie sur le retentissement sanitaire et social des souffrances traversées dans le pays d'origine, du déracinement tout au long du parcours migratoire, ainsi que sur les questions sanitaires et éthiques relatives à l'accueil sur le territoire français. Les problèmes de santé mentale figurent au premier plan des motifs de consultation. L'Académie formule huit recommandations à l'attention des pouvoirs publics.

Gosselin, A., et al. (2016). "Migrants subsahariens : combien de temps leur faut-il pour s'installer en France ?" Population & Sociétés(533): 4p.

> Alors que l'accueil des réfugiés devient un enjeu crucial en Europe, on est peu renseigné sur le processus d'installation des migrants. Utilisant l'enquête Parcours, Anne Gosselin et ses collègues ont estimé le temps nécessaire aux migrants originaires d'Afrique subsaharienne pour obtenir un titre de séjour, trouver un logement et avoir un travail une fois arrivés en France.

Heran, F. (2002). Immigration, marché du travail, intégration. Paris La documentation française**:** 230.
http://www.ladocumentationfrancaise.fr/brp/notices/024000590.shtml

> La France a une longue tradition d'immigration. Pourtant, l'immigration a souvent suscité des polémiques et continue de poser de nombreuses questions. Comment les immigrés s'insèrent-ils dans la société française, notamment dans l'emploi ? Leur arrivée pèse-t-elle sur les salaires ou le chômage ? Sont-ils victimes de pratiques discriminatoires pénalisantes ? Les difficultés de recrutement de certaines entreprises appellent-elles la relance d'une politique d'immigration de main-d'oeuvre ? L'immigration est-elle une réponse à l'avenir de nos retraites ? Quels effets l'intégration européenne a-t-elle sur nos politiques nationales ? Ces questions ont été abordées dans le cadre du séminaire de recherche organisé par le Commissariat Général du Plan en 2001. Le rapport qui en résulte présente des synthèses thématiques et une quinzaine d'articles originaux. Il est consultable sur le site de la documentation française à l'adresse :

Guilyardi, C. et Simon, P. (2020). "Comment l'enquête Trajectoires et Origines a changé la donne sur les statistiques ethniques en France." De Facto **21**.

> Alors que la polémique a repris en juin 2020 autour de statistiques « ethniques » qu'il faudrait interdire ou permettre, un retour sur la mise en place de l'enquête Trajectoires et Origines (TeO) dans les années 2000 permet d'illustrer toute la complexité de ce « débat » trop souvent polarisé. Dans ce numéro d'été de De facto, Catherine Guilyardi, journaliste, nous éclaire sur la genèse et la réception de cette enquête qui a donné lieu à de vifs débats non seulement entre chercheurs mais aussi entre les chercheurs et certaines associations anti-racistes.

Heran, F. (2004). "Cinq idées reçues sur l'immigration." Population Et Societes(397): 4 , fig.

Heran, F., et al. "Deux enfants par femme dans la France de 2006 : la faute aux immigrées ?" Population Et Societes(432): 4, fig., tabl.

> [BDSP. Notice produite par ORSLR yR0x02yF. Diffusion soumise à autorisation]. Les étrangères contribuent aux naissances de la France dans une proportion de 12% et les immigrées, qui incluent les étrangères devenues françaises, dans une proportion de 15%. La fécondité des étrangères est plus élevée que celle des Françaises (3,3 enfants contre 1,8 en 2004), mais comme ce surcroît ne concerne qu'une minorité au sein de la population, il relève seulement de 0,1 enfant le taux de fécondité de la métropole, qui passe ainsi de 1,8 à 1,9 enfant par femme en 2004. Immigration ou pas, la fécondité de la France reste l'une des plus élevées d'Europe.

Ichou, M. et Goujon, A. (2017). "Le niveau d'instruction des immigrés : varié et souvent plus élevé que dans les pays d'origine." Population Et Societes(541): 4 , fig.

> Les immigrés vivant en France et les réfugiés arrivés en Autriche sont plus instruits que la plupart des personnes restées dans leur pays de naissance. Par comparaison à la population de leur pays d'accueil, leur niveau d'instruction est varié : certains groupes comme les immigrés portugais vivant en France sont relativement peu instruits alors que d'autres, comme les immigrés roumains, sont plus souvent diplômés de l'enseignement supérieur que les personnes nées en France.

Institut National de la Statistique et des Etudes (2019). Répartition des étrangers immigrés par groupe de nationalités en 2018 : données annuelles de 2010 à 2018, Paris : Insee

> Cette rubrique présente des chiffres détaillés sur la répartition des étrangers en France selon la nationalité en 2018. Elle comprend aussi des données d'évolution sur la période 2010-2018.

Institut National de la Statistique et des Etudes Economiques (2022). Etrangers et immigrés en 2019, Paris : Insee https://www.insee.fr/fr/statistiques/6478362

> Cette rubrique présente des chiffres détaillés sur la répartition des étrangers en France selon la nationalité en 2019. Elle comprend aussi des séries longues depuis 1968.

Institut National de la Statistique et des Etudes Economiques (2016/04). La localisation géographique des immigrés : une forte concentration dans l'aire urbaine de Paris. Insee Première (1591)

Institut National de la Statistique et des Etudes Economiques (1997). Les immigrés en France. Contours et caractères. Paris Insee **:** 140, tabl., graph.

> Qui sont les immigrés ? Quelle est la part des réfugiés parmi eux ? Que sait-on sur les mariages mixtes, les enfants des immigrés à l'école ? Quelle est leur pratique du Français ? Qu'en est-il de l'emploi, du chômage, des trajectoires professionnelles des immigrés ? Comment vivent-ils au quotidien ? Les réponses à ces questions et de nombreuses autres indications figurent dans cet ouvrage qui rassemble toute l'information actuellement disponible et dresse le portrait social de la population des immigrés en 46 fiches thématiques, chacune comportent des tableaux de données et une analyse.

Institut National de la Statistique et des Etudes Economiques (2011). "Population immigrée - Population étrangère - Exploitation complémentaire du recensement de la population 1999 en France métropolitaine." Insee Resultats : Societe(121): tabl.

> Ces données sont relatives à l'exploitation complémentaire du recensement de la population 1999 qui permet d'obtenir des informations détaillées sur les structures des ménages et des familles, sur l'emploi (activité économique, catégorie socioprofessionnelle...)... Cet Insee Résultats présente les caractéristiques de la population immigrée et de la population étrangère résidant en France métropolitaine. En mars 1999, 4 310 000 immigrés ont été recensés, soit 7,4 % de la population métropolitaine. Entre 1990 et 1999, le nombre d'immigrés a augmenté de 145 000 (+ 3,4 %), au même rythme que l'ensemble de la population. La part des immigrés dans la population est stable depuis 1975. En 1999, les immigrés ayant acquis la nationalité française sont 1,56 million. Leur nombre a augmenté de 250 000 (+ 19 %) depuis 1990. Par contre celui des immigrés étrangers a baissé de 105 000 (- 4 %) et atteint 2,75 millions. Plus d'un immigré sur trois (36 %) est français.

Institut National d'Etudes Démographiques (2016). Trajectoires et origines : enquête sur la diversité des populations en France. Paris Ined**:** 623 , tab., graph., fig.

> L'enquête TeO vise à identifier l'impact des origines sur les conditions de vie et les trajectoires sociales, tout en prenant en considération les autres caractéristiques sociodémographiques que sont le milieu social, le quartier, l'âge, la génération, le sexe, le niveau d'études. Les questions d'intégration

et de discrimination occupent une place importante dans les débats publics. Mais aujourd'hui la France manque encore de statistiques nationales permettant d'étudier ces phénomènes. L'enquête TeO est conçue pour combler ces lacunes. TeO s'intéresse à toutes les populations vivant en France métropolitaine, à leurs conditions de vie actuelles et à leurs parcours. L'enquête porte cependant un intérêt particulier aux populations qui peuvent rencontrer des obstacles dans leurs trajectoires du fait de leur origine ou de leur apparence physique (immigrés, descendants d'immigrés, personnes originaires des DOM et leurs descendants). L'enquête TeO a été réalisée conjointement par l'INED et l'INSEE. Elle a été rigoureusement contrôlée par les organismes qui encadrent la statistique publique (CNIS ; CNIL). Elle respecte scrupuleusement le droit des enquêtés : les personnes ont été enquêtées de manière volontaire et anonyme.

Jacquat, D. et Bachelay, A. (2013). Rapport d'information sur les immigrés âgés. Rapport d'information ; 1214. Paris Assemblée nationale**:** 613, annexes.

Ce rapport est le fruit des travaux d'une mission parlementaire qui s'est donné pour objectif d'analyser la situation des populations immigrées aujourd'hui âgées. De façon consensuelle, la mission a fait le choix de centrer ses travaux sur les immigrés âgés de plus de cinquante-cinq ans originaires d'États tiers à l'Union européenne, en raison de la spécificité de leur situation, de la singularité de leur histoire et de leur parcours migratoire, ainsi que de la précarité des conditions de vie d'une part importante d'entre eux. Ce rapport émet 82 propositions destinées à améliorer la situation des quelque 800.000 immigrés de plus de 55 ans vivant en France, dont 350.000 âgés de plus de 65 ans.

Jugnot, S. (2016). Les débats français sur les statistiques « ethniques » : une histoire sans fin ? Document de travail; 01.2016. Noisy-le-Grand IRES**:** 49 , annexes.
http://www.ires.fr/publications/documents-de-travail/712-rapport03-2016-projets-2016-de-l-agence-d-objectifs

Depuis près de vingt ans, les statistiques "ethniques" sont l'objet de controverses publiques. D'abord cantonnés à la sphère « scientifique », les acteurs et les enjeux se sont ensuite élargis jusqu'à un paroxysme en 2007, lorsque la volonté de l'Ined de demander la couleur de peau dans une enquête de l'Insee s'accompagne d'un amendement à la loi Informatique et Libertés destiné à faciliter la collecte de ce type d'informations. Cette disposition est finalement jugée contraire à la constitution. Un certain flou sur les catégories mobilisées, les objectifs poursuivis et le cadre juridique se maintient dans les débats. Il conduit à une confusion entre la mesure des inégalités et celle des discriminations, entre l'outillage de la connaissance et celle d'une politique de quotas. Cette contribution propose donc une clarification en retraçant les grandes étapes des controverses récentes.

Kohler, C. et Thave, S. (1997). "La population active immigrée en 1982 et 1990." Insee Resultats : Demographie Societe(61): 138, graph., tabl.

Cet ouvrage présente des données sur la population active immigrée en 1982 et en 1990 tirées des deux recensements décennaux de la population vivant en France métropolitaine. Est considérée comme immigrée toute personne née étrangère dans un pays étranger qui vit en France. Elle peut avoir gardé sa nationalité d'origine ou être devenue française. Ces tableaux de statistiques nous renseignent sur les caractéristiques professionnelles et sociodémographiques des immigrés actifs ou des personnes actives vivant dans un ménage d'immigré.

Kohler, C. et Thave, S. (1997). "Les immigrés et leur famille au recensement de 1990." Insee Resultats : Demographie Societe(56-57): 210 , tabl., carte, graph.

Le recensement de 1990 n'a pas fini de livrer ses richesses. Le présent ouvrage apporte des informations inédites sur les ménages d'immigrés et plus simplement sur les familles où l'homme ou la femme est immigré. Est immigrée toute personne née étrangère dans un pays étranger, qui vit en France. Elle peut avoir gardé sa nationalité d'origine ou être devenue française. En 1990, les immigrés représentent 7% de la population de la France, soit 4 166 000 individus. Leur part dans la population est stable depuis le recensement de 1975. En 1990, les deux tiers des immigrés ont gardé leur

nationalité d'origine, un tiers est devenu français par acquisition. Les originaires d'Europe sont les plus nombreux. Les immigrés forment une population plutôt jeune et les hommes y sont majoritaires.

Le, J. (2019). "En 2017, la moitié des personnes arrivées en France sont nées en Europe." Insee Focus(145): https //www.insee.fr/fr/statistiques/3716876?pk_campaign=avis-parution. https://www.insee.fr/fr/statistiques/3716876

En France, entre 2006 et 2016, la population a augmenté de 3,2 millions de personnes, dont un tiers d'immigrés. En 2015, le solde migratoire de la France s'établit à + 41 000 personnes. Les entrées d'immigrés (253 000) sont plus nombreuses que les sorties (66 000). Leur solde migratoire est ainsi positif (+ 188 000). À l'inverse, ce solde est négatif pour les personnes non immigrées (- 147 000). Stables aux environs de 300 000 jusqu'en 2010, les arrivées en France progressent depuis et atteignent 378 000 en 2016. Celles de 2017 sont également connues (370 000) ; 70 % d'entre elles concernent des immigrés. Parmi les personnes arrivées en 2017, une sur deux est née en France ou ailleurs en Europe.

Lefran, C. et Thave, S. (1995). "Les enfants d'immigrés : émancipation familiale et professionnelle." Insee Premiere(368): 4 , 2 graph., 2 tabl.

Tirés de l'enquête "Mobilité géographique et insertion sociale" de 1992, ces résultats fournissent des informations sur l'émancipation familiale et professionnelle des enfants d'immigrés en France selon l'origine géographique des parents, et sont rapprochés du modèle national.

Legros, F. (2003). "La fécondité des étrangères en France : une stabilisation entre 1990 et 1999." Insee Premiere(898): 4, 5 graph., 2 tabl.

L'auteur de ce document analyse et compare la fécondité des étrangères en France de 1990 à 1999 : nombre d'enfants selon la nationalité ; âge moyen de maternité, comportement des étrangères par rapport aux françaises selon l'ancienneté de l'immigration ; taux de fécondité par âge, fréquence des naissance hors mariage?

Leridon, H. (2000). "Vieillissement démographique et migrations : quand les Nations unies veulent remplir le tonneau des Danaïdes." Population Et Societes(358): 4 , 2 fig.

Le rapport sur les « migrations de remplacement » publié par les Nations unies en mars 2000 n'est pas passé inaperçu. Constatant que l'évolution démographique probable des pays développés, notamment européens, conduira dans la plupart d'entre eux à un excédent des décès sur les naissances, à terme plus ou moins rapproché (parfois déjà atteint), ainsi qu'à un vieillissement accentué de la population, les experts des Nations unies se sont demandé si l'on pouvait compter sur l'immigration pour combler ces déficits et rééquilibrer la pyramide des âges. La population de l'ensemble de l'Union européenne, par exemple, devrait commencer à diminuer avant 2010 et revenir en 2050 au niveau qui était celui du même ensemble de pays en 1965 ; quant à la part des personnes âgées de 65 ans et plus, elle devrait passer de 16 % actuellement à 29 % dans cinquante ans. De telles perspectives invitent indiscutablement à la réflexion. (Résumé d'auteur).

Lollivier, S. (2005). Les immigrés en France. Insee références. Paris Inn see **:** 161 , tabl., graph.

Cette édition sur les immigrés en France vient actualiser et enrichir les recueils publiés par l'INSEE en 1986 et 1997. L'ouvrage contient une soixantaine de fiches thématiques qui s'organisent autour de cinq grands domaines : la population immigrée, les flux d'immigration, l'éducation et la maîtrise de la langue, la situation sur le marché du travail et les conditions de vie.

Malinvaud, E. (1995). Les étrangers en France, Paris : Insee.

Ce document présente en vingt sept rubriques et quarante neuf tableaux un portrait acceptable des étrangers en France : dénombrement, histoire de l'immigration, structures par âge, sexe et P.C.S., lieu de résidence, mouvement de la population, condition de vie, scolarisation, etc.

Mathieu, B. (2016). "L'immigration : une chance pour l'économie. Débat entre Hippolyte d'Albis et Jean-Thomas Lesueur (L'Expansion)." Problemes Economiques(3124): 24-29, tab., graph.

Ministère chargé de l'économie et des finances (2006). Immigration sélective et besoins de l'économie française. Paris Minefi**:** 59 , 23 tabl., 53 fig., 57 ann.

Ce rapport a pour objet d'étudier les effets de l'immigration et de l'immigration qualifiée sur une économie et d'identifier les métiers et les secteurs pour lesquels l'immigration serait une réponse soit aux besoins d'innovation, soit aux besoins à terme de l'économie française, soit aux difficultés de recrutement des entreprises. Partant de la composition de l'immigration en France au début des années 2000, le rapport pointe notamment la faiblesse des flux d'entrée de travailleurs qualifiés. Il aborde les principales caractéristiques des immigrés sur le marché du travail et note que les universités françaises attirent de plus en plus d'étudiants étrangers. Il étudie, dans une deuxième partie, les effets de l'immigration sur différents indicateurs macroéconomiques, la répartition des revenus ainsi que sur les finances publiques. Sur la base d'enquêtes et de travaux de prospectives (Unedic, ANPE, Commissariat général du plan, Dares), la troisième partie a pour objectif d'identifier les métiers et les secteurs qui bénéficieraient d'une immigration qualifiée. Enfin, le quatrième chapitre propose des pistes pour la mise en place d'une politique d'immigration de travailleurs qualifiés.

Mizrahi, A. (2018). "Paradoxe dans l'enquête de victimisation : racisme perçu et racisme actif." 11 , tab., graph., fig.

Les immigrés et les enfants d'immigrés se déclarent plus souvent discriminés que les Français, peut-on en déduire que les Français manifestent plus fréquemment du racisme que les immigrés ? Différents paramètres interfèrent dans ces relations : importance relative de chacun des groupes, (environ 20 % d'immigrés ou d'enfants d'immigrés), discriminations d'un groupe à l'autre ou aussi à l'intérieur des deux groupes qui sont hétérogènes, nombre de discriminations subies par personne ou exercées par raciste. Le problème est abordé à partir des données fournies par l'enquête TeO, « Trajectoires et Origines, Enquête sur la diversité des populations », dans laquelle 35,8 % des immigrés ou enfants d'immigrés déclarent avoir été discriminés et 18,6 % des Français. A partir d'un modèle très simple, où chaque personne discriminée l'a été une fois et une seule, et chaque personne discriminant l'a fait une fois et une seule, les taux de racistes seraient respectivement de 77,3 parmi les immigrés et de 8,7 % parmi les Français. On approche la stabilité de ces résultats, en faisant varier la proportion de personnes d'un groupe n'ayant jamais rencontré de personnes de l'autre groupe. Un modèle dual à partir des personnes déclarant ne pas avoir été discriminées, conforte ces premiers résultats. On introduit ensuite différents paramètres de manière à se rapprocher de la réalité et on montre que dans chacun des cas de figure, le taux de racistes (discriminateurs) est plus important parmi les immigrés que parmi les Français.

Monso, O. et Gleizes, F. (2009). "Langue, diplômes : des enjeux pour l'accès des immigrés au marché du travail." Insee Premiere(1262): 4 , 3 tabl., 2 graph.

Les immigrés sont plus exposés au chômage que le reste de la population, les femmes immigrées étant en outre moins souvent présentes sur le marché du travail. Ceci est en partie dû à un manque de qualifications. Toutefois, des écarts subsistent à niveau de diplôme équivalent. Ils sont plus marqués pour les diplômés du supérieur. Les qualifications des immigrés, lorsqu'elles existent, bénéficient rarement d'une reconnaissance formelle en France, sauf pour les diplômés du supérieur. Les immigrés éprouvent souvent des difficultés avec la langue française, même si cela ne constitue pas forcément une gêne pour travailler. Les immigrés ayant un emploi se sont souvent appuyés, pour le trouver, sur leur réseau relationnel. Une minorité d'entre eux fait état de discriminations d'ordre professionnel. Ce ressenti est plus fréquent pour ceux qui sont originaires d'Afrique subsaharienne. Cette publication donne également des éléments sur les formations suivies par les immigrés à leur arrivée. Ces

formations sont de plus en plus fréquentes au fil des vagues migratoires, ce qui peut s'interpréter en partie à travers le développement des formations linguistiques sur fonds publics. Enfin, des données sont disponibles sur la répartition géographique des immigrés ainsi que sur les motifs de migration. Pour ces derniers, il s'agit des motifs déclarés comme tels par les immigrés et non des motifs administratifs.

Monso, O. et Saint, Paul, T. (2006). "L'origine géographique des individus dans les recensements de la population en France." Courrier Des Statistiques(117-119): 33-42.

En France, au XIXe siècle, des critères sont mis en place, sur le plan politique et juridique, permettant de dire qui appartient ou pas à la communauté nationale. Apparaissent alors plusieurs questions sur les origines géographiques dans les listes nominatives et les bulletins individuels des recensements français. À la fin du XIXe siècle, tandis que se fondent la carte européenne et les États-nations, dans un cadre d'immigration croissante, le souci n'est plus seulement de dénombrer la population, mais aussi d'opérer une distinction statistique entre résidents français et étrangers d'une part, entre Français de naissance et Français par acquisition de l'autre. Au cours de la seconde moitié du XXe siècle, enfin, la demande d'informations sur les origines s'accroît de la part des statisticiens : ces informations doivent désormais également porter sur les parcours de ces individus qui intègrent la communauté nationale. Après un panorama historique, cet article étudie la question des origines dans les recensements généraux de la population en France au regard d'exemples étrangers. Les auteurs mettent ainsi au jour le particularisme français, qui tient notamment aux rôles de la citoyenneté d'État et du mode d'acquisition de la nationalité comme critères distinctifs.

Pan, K. Eshon, J.L. (2011). "La ségrégation des immigrés en France : état des lieux." Population Et Societes(477): 4, fig.

[BDSP. Notice produite par ORSLR pR0xlkrk. Diffusion soumise à autorisation]. En France, les Maghrébins, les Africains subsahariens, les Turcs et les Asiatiques représentent les populations immigrées faisant l'objet d'une ségrégation spatiale importante. Entre 1990 et 1999, cette situation s'accentue pour les Turcs, les Algériens et les Marocains, mais s'amenuise pour les Tunisiens et stagne pour les Africains subsahariens. Sur une période plus longue (1968-1999), la ségrégation diminue pour tous. Comme le montre l'enquête Trajectoires et origines (TeO) effectuée par l'Ined en 2008,42% des immigrés d'Afrique, du Maghreb et de Turquie se situent dans les 10% des quartiers où le taux de chômage est le plus élevé, et constituent 28% de la population des "quartiers sensibles". Les fils et filles de ces immigrés sont toutefois moins concentrés dans les quartiers défavorisés, montrant ainsi une dynamique d'intégration résidentielle.

Papon, S. et Robert-Bobee, I. (2020). "Une hausse des décès deux fois plus forte pour les personnes nées à l'étranger que pour celles nées en France en mars-avril 2020." Insee Focus(198): html. https://www.insee.fr/fr/statistiques/4627049?pk_campaign=avis-parution

Cette étude de l'Insee pointe les inégalités sociales face au nouveau coronavirus. Pendant les deux mois de surmortalité liée à l'épidémie en mars-avril, les décès ont deux fois plus augmenté chez les personnes nées à l'étranger (+48%) que chez celles nées en France (+22%) par rapport à la même période de 2019. Les décès ont en particulier crû de 54% pour les personnes nées au Maghreb (8.300), de 91% pour l'Asie (1.600), de 114% pour l'Afrique noire (2.000).

Pison, G. (2019). "Le nombre et la part des immigrés dans la population : comparaisons internationales." Population Et Societes(563): 4.

La proportion d'immigrés varie beaucoup d'un pays à l'autre, dépassant la moitié de la population dans certains pays, alors qu'elle est inférieure à 0,1 % dans d'autres. Dans quels pays les immigrés sont-ils les plus nombreux ? De quels pays sont-ils issus ? De façon plus générale, comment les immigrés se répartissent-ils à l'échelle de la planète ? Cet article dresse ici un panorama du nombre et de la part des immigrés dans les différents pays du monde.

Pison, G. et Dauphin, S. (2020). Enjeux et perspectives démographiques en France 2020-2050. Un état des connaissances. Document de travail; 259**:** 59 , tabl., fig.
https://www.ined.fr/fr/publications/editions/document-travail/enjeux-et-perspectives-demographiques-en-france-2020-2050/

Ce document présente une synthèse sur les perspectives démographiques en France d'ici 2050. La situation et les évolutions françaises sont replacées dans un cadre plus général au moyen de comparaisons internationales et européennes. Le document se compose de cinq parties abordant chacune un thème de la démographie. La première porte sur la croissance de la population mondiale, européenne et française. La deuxième traite des spécificités de la démographie française au sein de l'Union européenne. La troisième examine l'évolution des naissances et de la fécondité en France. La quatrième s'interroge sur les perspectives d'allongement de la vie et le vieillissement démographique. Enfin, la cinquième porte sur les migrations et étudie leur contribution à la population française hier, aujourd'hui et demain.

Renaut, S. (2006). "D'un recensement à l'autre : 1990-1999. La population immigrée en foyer de travailleurs." Retraite Et Societe(47): 170-192, tabl., fig.

[BDSP. Notice produite par FNG 2myQR0xQ. Diffusion soumise à autorisation]. Cet article fait le point sur l'évolution des caractéristiques de la population immigrée vivant en foyers de travailleurs à partir des résultats des recensements de 1990 et 1999.

Rosental, P.-A. (2016). "La valeur des migrants. Protection et utilité (XVIIIe-XXIe s.)." Informations Sociales **194**(3): 14-26.
https://www.cairn.info/revue-informations-sociales-2016-3-page-14.htm

Jusqu'au XIXe siècle, les droits socio-économiques des migrants sont ancrés localement et balancés entre leur commune d'origine et leur commune d'installation, selon leur capacité contributive. Autour de 1900 se marque un tournant : passage d'un contrôle ex post à un contrôle ex ante, nationalisation des droits sociaux. La fin du XXe siècle marque moins l'émergence des droits humains des migrants – ainsi le regroupement familial – que leur autonomisation par rapport aux critères utilitaristes et aux droits sociaux.

Rouault, D. et Thave, S. (1997). "L'estimation du nombre d'immigrés et d'enfants d'immigrés." Insee Methodes(66): 80, tabl., graph.

La nationalité fait l'objet d'une question dans les recensements de la population. Elle sert à distinguer les résidents français des autres résidents. Depuis peu, une autre distinction a pris de l'importance : celle qui consiste à délimiter au sein de la population le groupe des immigrés, c'est-à-dire des personnes nées étrangères à l'étranger et vivant en France. Cet Insee méthodes interroge les outils statistiques disponibles sur la signification de ce concept d'immigrés, et propose quelques repères et pistes de réflexion. Sont ainsi présentées dans ce volume une étude sur l'estimation des vagues d'arrivée des immigrés entre deux recensements, et une évaluation d'une population de référence concernant les jeunes étrangers nés en France susceptibles d'acquérir la nationalité française par manifestation de leur volonté de devenir français.

Samaoli, O. (1991). "Les immigrés dans la vieillesse." Gerontologie Et Societe(56): 167-173.

De plus en plus d'immigrés maghrébins arrivent aujourd'hui à l'âge de la retraite. Ces personnes rencontrent de nombreuses difficultés. Bon nombre d'entre elles sont restées célibataires contrairement à la tradition maghrébine. Le logement est souvent un problème : les plus âgés et les plus vulnérables vont devoir entrer en institution. Pour la plupart, c'est une blessure. La tradition maghrébine concernant la mort est, elle, une notion complètement inexistante dans l'immigration.

Samaoli, O. (1999). "Considérations gérontologiques autour de l'immigration en France." Gerontologie Et Societe (91): 79-92, phot.

[BDSP. Notice produite par FNG sR0xS4zF. Diffusion soumise à autorisation]. Alors qu'elle ne devait être que foncièrement provisoire, l'immigration de travail s'avère aussi concernée par des préoccupations gérontologiques. Cette permanence dans l'immigration soulève des préoccupations nouvelles que la société d'accueil n'avait pas pris l'habitude de prendre en compte : accès aux droits et aux services ; prise en charge institutionnelle ; insertion ou intégration urbaine harmonieuse, et somme toute des préoccupations, qui jugées à l'aune de la vieillesse et du vieillissement, concernent autant ces anciens que nos concitoyens autochtones. Sensibiliser la population et l'informer, aider dans leur vieillesse ces cohortes d'hommes et de femmes s'imposent à nous aujourd'hui comme une nouvelle préoccupation gérontologique et impliquent la mise en oeuvre d'une politique d'intégration solidaire.

Samaoli, O. (2011). "Vieillesse des immigrés : quelques interrogations d'actualité." Gerontologie Et Societe(139): 67-75.

[BDSP. Notice produite par FNG kIR0xJnq. Diffusion soumise à autorisation]. Considérée longtemps comme un phénomène marginal ou ne concernant qu'une frange particulière de la population immigrée, la question de la vieillesse des immigrés se révèle de plus en plus dans une autre complexité avec des ramifications qui dépassent de loin la seule réglementation sur le séjour. Les questions juridiques, éthiques et socio-sanitaires que soulève cette présence aujourd'hui en France, sont des révélateurs des déficits, des dysfonctionnements ou de l'absence d'intérêt des politiques publiques à l'endroit de ces personnes âgées. (R.A.).

Schor, R. (2018). "Héran François, Avec l'immigration. Mesurer, débattre, agir." Revue Européenne des Migrations Internationales **34**(4): 233-234.
https://www.cairn.info/revue-europeenne-des-migrations-internationales-2018-4-page-233.htm

Dans un contexte de migrations juvéniles en pleine évolution, ce dossier de la Revue européenne des migrations internationales vise à interroger les dynamiques participant à la construction des expériences scolaires des enfants et des jeunes migrants. Inscrit dans une optique pluridisciplinaire, il est composé de travaux de sociologues, de géographes et de juristes. Différentes échelles d'analyse sont mobilisées et visent à analyser notamment les politiques publiques, les réalités et pratiques institutionnelles ou leurs effets sur les parcours sociaux d'enfants et de jeunes migrants à l'école ou au collège. C'est ainsi que les différentes contributions proposent, d'une part, des pistes d'analyses juridiques et sociodémographiques, macro sociales. D'autre part, elles offrent des clés de réflexion quant aux modalités concrètes d'agencement des situations socio-scolaires dans différents contextes. Elles portent également une attention spécifique aux manières d'enquêter sur les mineurs, dans et hors l'école, d'un point de vue qualitatif. A ce titre, les enquêtes auprès d'enfants et de jeunes migrants posent la question épistémologique et éthique de la place du chercheur, mais aussi celle des modalités de recueil des données, situation toujours liminaire qui nécessite des formes méthodologiques contingentes et hybrides.

Simon, P. (1995). "Le logement des immigrés." Population Et Societes(303): 4 , 2 tabl.

L'enquête "Mobilité Géographique et Insertion des Immigrés (MGIS)" réalisée en 1992 a donné lieu à différentes publications. Sont présentés dans ce document les premiers résultats sur les conditions d'habitat des groupes immigrés couverts par l'enquête (personnes d'origine espagnole, portugaise, algérienne, marocaine, turque, d'Afrique Noire et d'Asie du Sud-Est) : évolution des conditions d'acquisition d'un logement, conditions du logement, discriminations subies.

Simon, P. (2012). "Les revirements de la politique d'immigration." Cahiers Francais(369): 86-91.

La politique d'immigration de la France depuis les années 2000 témoigne d'une volonté de rendre plus efficace la restriction des entrées et les mesures d'éloignement des étrangers en situation irrégulière. Or les marges de manoeuvre de cette politique publique sont réduites par le contexte européen et mondial dans lequel elle s'inscrit et par l'inertie des flux d'immigration. Par-delà leur évaluation,

l'auteur de cet article montre que ces politiques témoignent d'une représentation négative d'une immigration pourtant vectrice de richesse économique, sociale et culturelle pour le pays d'accueil dans un contexte mondialisé.

Solignac, M. (2018). "L'émigration des immigrés, une dimension oubliée de la mobilité géographique." Population **73**(4): 693 , tabl., fig., annexes.

Cet article analyse la mobilité géographique des immigrés par rapport à celle des natifs en tenant compte des départs du pays d'accueil. Alors que la mobilité résidentielle de la plupart des natifs s'effectue au sein du territoire national, une proportion importante d'immigré le quitte pour leur pays de naissance ou un pays tiers. Mais ces flux d'immigration sont souvent occultés, tant par l'approche rétrospective habituellement adoptée pour l'étude de la mobilité résidentielle, qu'en raison du manque de données adaptées pour mesurer les sorties du territoire. Ce travail se distingue en proposant une analyse du taux de départ des communes françaises, quelque soit la destination. Dépassant la dichotomie entre migration interne et migration internationale, cette approche intégralement fondée sur sur un suivi individuel offre une mesure générale de la mobilité incluant l'émigration. Ce travail est mené à partir de l'exploitation d'un large panel administratif constitué de recensements exhaustifs et de l'état civil. Représentatif de la population, il permet un suivi systématique des trajectoires individuelles sur le territoire métropolitain français entre 1968 et 1999, tout en demeurant représentatif de l'ensemble de la population. La mobilité des immigrés se révèle nettement plus élevée que celle mesurée de façon rétrospective : elle est de 30 % à 50 % supérieur à celle des natifs. Un quart à un tiers des immigrés observé à un recensement donné ont quitté le territoire français au bout de 7 à 9 ans (résumé éditeur).

Tavan, C. (2005). "Les immigrés en France : une situation qui évolue." Insee Premiere(1042): 4 , tabl., graph.

Depuis 1975, la part des immigrés dans la population est restée stable, mais l'immigration a beaucoup changé : les entrées pour motif familial ont augmenté, la population immigrée s'est féminisée et les immigrés proviennent de pays de plus en plus lointains. Les immigrés vivent plus souvent que le reste de la population en couple, notamment avec enfants. Plus de la moitié des couples composés d'au moins un immigré sont des couples mixtes. Du fait de la taille de leur famille, de la faiblesse de leurs revenus et de leur concentration dans les grandes villes, les immigrés sont plus souvent locataires du secteur social. Les immigrés sont davantage affectés par le chômage. Ils occupent plus souvent des postes d'ouvriers ou d'employés, notamment non qualifiés. Leur sur-représentation dans l'industrie et la construction s'atténue. Les personnes nées en France ayant deux parents immigrés représentent 5 % des moins de 66 ans. Les enfants d'immigrés sont souvent en difficulté scolaire, mais pas plus que les autres enfants ayant les mêmes caractéristiques sociales. À origine sociale donnée, les descendants de migrants ont le même destin social que les autres.

Thave, S. (1999). "Les étrangers et leurs logements." Insee Premiere(689): 4 , 2 tabl., 4 graph.

Selon l'enquête Logement de fin 1996, le nombre de ménages étrangers était à cette date de 1,3 million, soit 5,7 % de l'ensemble des ménages. Cette part est légèrement en baisse par rapport aux enquêtes précédentes. Parmi les ménages étrangers, 44 % viennent de l'Union européenne et 35 % du Maghreb. (Algérie, Maroc, Tunisie). Entre 1992 et 1996, les ménages étrangers ont déménagé plus souvent que les ménages français. Ils cherchent en premier à accroître le confort ou la taille de leur logement, en second à devenir propriétaires ; les Français le font aussi, plus que les étrangers, pour des raisons professionnelles, ou pour améliorer leur environnement.

Thave, S. (1999). "Les immigrés de 60 ans ou plus. Quelques chiffres." Gerontologie Et Societe(91): 11-18, graph.

[BDSP. Notice produite par FNG RnK3R0xX. Diffusion soumise à autorisation]. Au recensement de 1990,932 000 immigrés présents en France, soit 22% des immigrés recensés, sont âgés de 60 ans ou plus. Ce sont pour la plupart les représentants des vagues migratoires de l'entre-deux-guerres : 27% sont nés en Italie, 18% en Espagne. Répondant à des appels de main-d'oeuvre, 60% des hommes ont

travaillé ou travaillent encore comme ouvriers, alors que peu de femmes ont été actives : 25% ont travaillé ou travaillent encore comme employées. Le mode de vie des hommes reste très familial, sauf évidemment pour ceux qui, bien que mariés, vivent leur retraite dans des foyers de travailleurs. Les femmes quant à elles sont plus nombreuses à vivre seules en raison de leur plus grande longévité.

Thave, S., et al.(1999). "Regards sur l'immigration depuis 1945." Syntheses(30): 64 , tabl., graph. https://www.epsilon.insee.fr/jspui/handle/1/15790

Ce fascicule sur l'immigration présente cinq études qui éclairent quelques aspects de ces mouvements migratoires successifs. La première étude de cet ouvrage analyse l'évolution des entrées d'étrangers par la procédure du regroupement familial enregistrée par l'Office des Migrations Internationales (OMI) de 1945 à nos jours. La deuxième étude offre un éclairage sur l'évolution du nombre de réfugiés en se fondant sur la demande d'asile et sur le taux de reconnaissance du statut de réfugié depuis 1973. La troisième analyse se centre sur 62000 personnes qui ont reçu un titre de séjour suite à l'application de la loi dite "Chevènement". Enfin, ce dossier propose également deux analyses quantitatives des populations qui sortent de la population étrangère ou immigrée résidant en France. La quatrième étude présentée dans ce document propose une interprétation de l'évolution des acquisitions de nationalité à partir des statistiques d'acquisitions enregistrées à la Sous-direction de naturalisations depuis 1945. Le dernier texte donne pour la première fois une estimation des taux de sortie des immigrés en fonction de leur période d'arrivée en France.

Thierry, X. (2001). "Les entrées d'étrangers en France de 1994 à 1999." Population **56**(3): 423-449, 421 ann., 423 graph., 410 tabl.

En prenant pour principale unité de mesure de l'immigration en France le nombre d'étrangers obtenant pour la première fois un titre de séjour d'une durée de validité d'au moins un an, 145 000 admissions au séjour ont été enregistrées en 1999, contre 156 000 en 1998. Ce recul s'explique par l'épuisement des effets de la circulaire de régularisation exceptionnelle de juin 1997. Néanmoins, divers indicateurs révèlent une augmentation de l'apport migratoire depuis 1997. L'augmentation des entrées est surtout le fait des membres de famille de Français et d'étrangers, notamment originaires du Maghreb. Le flux d'étudiants s'accroît également et représente toujours le principal motif de venue en France. L'immigration en provenance d'Afrique sub-saharienne progresse, tandis que la part relative des entrées de ressortissants de l'Espace économique européen diminue. De nouvelles investigations concernant l'opération de régularisation de 1997-1998 révèlent que la quasi-totalité (90 %) des postulants n'avaient jamais été en situation régulière avant la circulaire, ceci expliquant l'importance de son impact sur le nombre d'étrangers admis pour la première fois au séjour. Elles montrent également qu'une part significative d'entre eux (23 %) étaient d'anciens demandeurs d'asile déboutés. Enfin, elles mettent en évidence que les demandeurs ont globalement obtenu satisfaction dans des proportions comparables selon leur nationalité (environ les deux tiers) (Résumé d'auteur).

Thierry, X. (2004). "Evolution récente de l'immigration en France et éléments de comparaison avec le Royaume-Uni." Population **59**(5): 725-764, 723 ann., 722 enc., 725 graph., 710 tabl.

Les flux d'immigration en France, qui sont pour l'essentiel mesurés sur la base du nombre d'étrangers obtenant, pour la première fois, un titre de séjour d'une durée de validité d'au moins un an, ont augmenté depuis la fin des années 1990 : le nombre d'admissions au séjour régulier est passé de 145 000 en 1999 à 206 000 en 2002. Grâce aux informations contenues dans les fichiers relatifs aux titres de séjour délivrés par le ministère de l'Intérieur, l'article précise les caractéristiques des immigrants (sexe, âge, nationalité, etc.). Il apporte également un éclairage sur les parcours des étrangers, reconstituant les étapes préalables à l'obtention du premier titre (notamment la durée écoulée entre l'arrivée en France et l'admission légale) et celles qui l'ont suivi (proportion de titres renouvelés). Parmi les ressortissants d'un pays tiers admis au séjour à la fin des années 1990, un peu plus de 10 % auraient vécu au moins une année en séjour irrégulier auparavant et plus de 80 % ont prolongé leur séjour à l'expiration du premier titre d'un an. Grâce à des données inédites fournies par l'office statistique du Royaume-Uni, l'article compare ensuite les flux d'immigration sur la période récente en France et au Royaume-Uni. L'immigration est plus importante outre-Manche, mais les caractéristiques

des immigrants sont assez semblables dans les deux pays. Ainsi, comme en France, le travail constitue le premier motif d'immigration en Grande-Bretagne (31 %), suivi des études (28 %), puis des raisons familiales (21 %) (Résumé d'auteur).

Toulemon, L. (2004). "La fécondité des immigrées : nouvelles données, nouvelle approche." Population Et Societes(400): 4, fig., tabl.

[BDSP. Notice produite par ORSLR rd4R0xoA. Diffusion soumise à autorisation]. Au recensement de 1999, on comptait 4 310 000 immigrés, dont 1 560 000 (soit 36%) étaient devenus français. D'après l'étude de l'histoire familiale, vaste enquête réalisée par l'Insee et l'Ined dans le cadre du recensement de 1999, les naissances d'au moins un parent immigré représentent 17,1% des naissances de 1991-1998, la moitié des enfants d'immigrés sont issus d'un couple mixte, la fécondité des immigrées en approche classique est de 2,5 enfants par femme en 1991-1998. Cette étude révèle également que les immigrées entrées très jeunes en France, ont à peine plus d'enfants que les femmes nées en métropole. A l'opposé, si elles sont entrées vers 25 ou 30 ans, leur fécondité est très supérieure à celle des autres femmes, avec toutefois un profil très particulier : elles avaient en moyenne, au moment d'entrer en France, moins d'enfants que les femmes de leur âge natives de France. Alors que la fécondité des femmes immigrées était estimée à 2,50 enfants à partir des seuls taux par âge, elle recule à 2,16 si l'on tient compte de la répartition des immigrées selon l'âge d'arrivée. Du coup, le surcroît de fécondité des immigrées par rapport aux femmes nées en France se réduit.

Tribalat, M. (1994). "Chiffres-clés à propos de l'immigration : mise au point." Population Et Societes(291): 4.

Tribalat, M. (1995). "Les immigrés et leurs enfants." Population Et Societes(300): 4 , 1 tabl.

L'enquête Mobilité Géographique et Insertion Sociale (M.G.I.S.), réalisée par l'Institut National des Etudes Démographiques (INED), en 1992-1993, permet de décrire l'évolution des comportements des immigrés au cours de leur vie et de mesurer les changements intervenus, de leur génération à celle de leurs enfants. Les résultats fournissent des informations sur l'âge de l'entrée en France selon l'origine géographique des immigrés, l'évolution de leur niveau scolaire, et plus particulièrement celui de leur femme, les courants migratoires qui ont eu lieu selon les éthnies, les changements de leurs pratiques matrimoniales, le degré de pratique religieuse islamique et l'insertion scolaire et professionnelle des jeunes algériennes nées en France.

Tribalat, M. (1997). "Chronique de l'immigration." Population **52**(1): 163-219, tabl., graph.

Tribalat, M. (2004). "Une estimation des populations d'origine étrangère en France en 1999." Population **59**(1): 51-82, 51 enc., 51 graph., 10 tabl.

Avec une ampleur certes variable, l'immigration n'a pratiquement pas cessé en France depuis au moins un siècle et demi. Aujourd'hui comme hier, on en voit les traces dans la composition de sa population. En 1999, la population résidant en France d'origine étrangère ou partiellement étrangère (immigrés ou nés en France ayant au moins un parent ou un grand-parent immigré) représentait autour de 13,5 millions de personnes soit entre un quart et un cinquième de la population totale. Ce résultat, obtenu par Michèle Tribatalat à partir du dernier recensement et, en particulier, de l'enquête Etude de l'histoire familiale (EHF) qui lui était associée, est très proche de celui que la même auteure avait estimé en 1986, à partir de l'état civil. Mais l'emploi de l'EHF lui permet cette fois-ci d'aller plus loin et d'estimer les effectifs selon le pays d'origine, en excluant les descendants des rapatriés provenant des anciennes colonies et notamment de l'Algérie. Ce raffinement, qui nécessite un certain nombre d'hypothèses, s'avère finalement très utile lorsqu'on veut prendre la mesure des effets discriminatoires dont souffrent certaines de ces populations dans des domaines essentiels, à l'instar de l'emploi, pris ici comme exemple par l'auteure (Résumé d'auteur).

Tribalat, M., et al. (1996). De l'immigration à l'assimilation : enquête sur les populations d'origine étrangère en France, Paris : INED ; Editions de la Découverte

Cet ouvrage présente les résultats détaillés de la première enquête d'envergure auprès d'un large échantillon d'immigrés et de jeunes d'origine étrangère en France, menée en 1992 par l'Institut National d'Etudes Démographiques (INED) et l'Institut National de la Statistique et des Etudes Economiques (INSEE) - enquête dont une première synthèse avait été proposée par l'auteur, chercheur à l'INED, dans Faire France (La Découverte, 1995). Conduite sans a priori, cette enquête s'est intéressée aux aspects essentiels qui déterminent les rapports des populations d'origine étrangère à la société française : apprentissage du français, regroupement familial, abandon ou maintien des pratiques traditionnelles en matière matrimoniale ou religieuse, exercice de la citoyenneté, etc.

Tucci, I. (2011). "Immigration, intégration et diversité en France et en Allemagne." Informations Sociales(163): 116-123.

[BDSP. Notice produite par APHPDOC pR0xkC78. Diffusion soumise à autorisation]. Depuis deux ou trois décennies, la question de l'intégration des immigrés et de leurs descendants est devenue prioritaire en France et en Allemagne. Ainsi, ces deux pays ont mis en place des politiques d'immigration et d'intégration et des institutions spécifiques chargées de l'intégration. Cela n'empêche pas que l'existence de fortes inégalités sociales et de discriminations à l'encontre des immigrés et de leurs descendants, qu'ils soient devenus ou non citoyens du pays d'accueil, compromette leur intégration. (R.A.).

Ukrayinchuk, N. et Chojnicki, X. (2020). "Le rôle du capital humain prémigratoire dans l'intégration économique des immigrés en France : compétences métier vs compétences transversales." Population **75**(2): 325-357. https://www.cairn.info/revue-population-2020-2-page-325.htm

L'objectif de cet article est de différencier le rôle joué par les compétences transversales et les compétences métier accumulées à l'étranger, sur les chances d'accéder à un emploi en France, ainsi que sur l'adéquation de cet emploi et du niveau de salaire avec les compétences prémigratoires. Pour quantifier l'impact de la transférabilité du capital humain, les données de l'enquête Trajectoires et Origines (2008) sont utilisées. Le capital humain prémigratoire joue un rôle important aussi bien sur les chances d'accès à un emploi, que pour le maintien ou la progression de la position socioprofessionnelle, ainsi que pour la rémunération des immigrés. En utilisant plusieurs indicateurs d'intégration des immigrés, quantitatifs et qualitatifs, on s'aperçoit qu'à l'exception des compétences linguistiques, les autres compétences transversales ne jouent pas le rôle attendu en tant que vecteur d'intégration. À l'inverse, les compétences métier permettent une meilleure intégration économique. Par ailleurs, les effets négatifs d'un faible niveau de transférabilité des compétences métier sur l'intégration économique se maintiennent.

Volant, S., Pison, G. et Heran, F. (2019). "La France a la plus forte fécondité d'Europe. Est-ce dû aux immigrées ?" Population Et Societes(568): 4.

Les immigrées contribuent aux naissances en France dans une proportion de 19 %. L'indicateur conjoncturel de fécondité des immigrées est plus élevé que celui des natives (2,6 enfants contre 1,8 en 2017), mais comme ce surcroît ne concerne qu'une minorité au sein de la population, il relève seulement de 0,1 enfant le taux de fécondité national, qui passe ainsi de 1,8 à 1,9 enfant par femme en 2017. Immigration ou pas, la fécondité de la France reste l'une des plus élevées d'Europe.

Wolf, M. (2016). "Migrations : un équilibre difficile à trouver (d'après un article du Financial Times)." Problemes Economiques(3124): 30-35, tab., graph.

UNE PRESENTATION DES SOURCES D'INFORMATION

Les principales sources d'information sur la santé de migrants en France sont les suivantes :

- Enquête Téo de l'Ined : https://www.ined.fr/fichier/s_rubrique/19558/dt168_teo.fr.pdf .

- Enquête décennale Santé et soins médicaux : 1980, 1991, 2002-2003 ;
- Enquête ESPS (Santé, soins, protection sociale) de l'Irdes :: 2000-2002, 2006-2008
- Enquête Premiers Pas de l'Irdes : 2018-2019.
- Enquête européenne Share ;
- Enquête sur les personnes défavorisés (Irdes) : 1999-2000 ;
- Données de soins de centres de santé (ONG tels Comède, Médecins du Monde).

➢ Pour une présentation plus complète des sources d'information sur les migrants et immigrés (enquêtes, réseaux, projets…), se reporter à la bibliographie thématique : « *Les enquêtes auprès des migrants* » sur le site de l'Irdes à la rubrique « Ressources documentaires, synthèses et bibliographies thématiques ».

LA PLACE DE L'IRDES DANS CETTE PROBLEMATIQUE

La problématique des migrants s'inscrit dans un courant de recherche déjà ancien à l'Irdes, emprunté par Andrée et Arié Mizrahi ainsi que Thérèse Lecomte dans les années 90, puis par Paul Dourgnon, Florence Jusot, Catherine Sermet et Georges Menahem dans les années 2000. Entre 2011 et 2015, l'Irdes s'investit dans cette problématique via le projet EUNAM (Union européenne et migrants d'origine nord-africaine).

En France, le sujet a longtemps soulevé des réticences sur le plan scientifique en raison des statistiques ethniques, ce qui n'est pas le cas dans les pays anglo-saxons. L'enquête menée en 2007 par la Drees [11]sur l'Aide médicale d'Etat a produit quelques résultats restés sous exploités.

En collaboration avec d'autres organismes[12], l'Irdes a mené en 2018-2019 une enquête intitulée « Premiers pas : trajectoires de soins et de droits des immigrants illégaux à leur arrivée en France », qui comporte deux volets : un volet administratif et une enquête de terrain (bénéficiaires éligibles à l'AME en cours, éligibles non en cours et non éligibles). Il s'agit d'un partenariat avec Médecins du Monde et d'autres partenaires académiques. Il est indispensable de travailler avec les associations sur ces thématiques afin de récupérer les informations sur les personnes non éligibles.

Les problématiques liées à l'accès à l'assurance et au recours aux soins des migrants sont amenées à prendre une importance croissante et justifient l'investissement de l'Irdes dans ce champ. Elles doivent être abordées hors du champ politique.

Berchet, C. (2013). "[Health care utilisation in France: an analysis of the main drivers of health care use inequalities related to migration]." Rev Epidemiol Sante Publique **61 Suppl 2**: S69-79.

> In using a general health survey representative of the French population, the 2006 and 2008 French Health, health care and insurance survey, this study explores inequalities in health care utilization between immigrants and natives. Our objective is to highlight the most important factors generating health care use inequalities relating to immigration in using non-linear decomposition. Estimation results reveal that for equivalent health care needs, immigrants present a lower demand for GP and specialist care than the French population. The implementation of non-linear decompositions suggests that health care use inequalities between French and immigrant populations are for the most part attributable to differences in the distribution of observable characteristics between both populations. In particular, immigrant lower health coverage represents the first factor generating inequalities in the propensity to contact a GP while education and income are the most important drivers of inequalities in the propensity to contact a specialist.

Berchet, C. (2013). "Le recours aux soins en France : une analyse des mécanismes qui génèrent les inégalités de recours aux soins liées à l'immigration." Rev Epidemiol Sante Publique **61S**(3): 209-213, tabl.

[11] Boisguerin, et Haury (2008)
[12] Enquête Premiers Pas. Site de l'Irdes

À partir des données de l'Enquête sur la santé et la protection sociale (ESPS) réalisée en 2006 et 2008, cette étude s'intéresse aux disparités de recours aux soins entre la population immigrée et la population française. Nous cherchons à mettre en évidence les mécanismes qui génèrent les inégalités de recours aux soins liées à l'immigration en utilisant des techniques de décomposition non linéaire. Les résultats des estimations montrent que les immigrés présentent, à besoins de santé équivalents, un plus faible recours aux médecins généralistes et spécialistes que la population française. L'application des techniques de décomposition non linéaire révèle que la majeure partie du différentiel de recours aux soins entre les immigrés et les Français est liée à une différence de distribution des caractéristiques observables entre les deux populations. En particulier, les inégalités de recours aux généralistes semblent être en premier lieu expliquées par la plus faible couverture santé des immigrés, tandis que leur niveau d'études et de revenu sont les principaux facteurs générant les inégalités de recours aux spécialistes.

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Berchet, C. et Jusot, F. (2009). "Inégalités de santé liées à l'immigration et capital social : une analyse en décomposition." Economie Publique(24-25): 73-100.

Cet article étudie la contribution du capital social à l'explication des différences d?état de santé entre la population immigrée et la population native en France à partir des données de l?Enquête santé protection sociale (ESPS) menée en 2006 et 2008. L'utilisation de la méthode de décomposition proposée par Fairlie montre que 38,7 % des différences d?état de santé entre les deux populations sont liées à une différence de distribution des caractéristiques observables. Alors que l?âge contribue négativement aux disparités de santé, les résultats indiquent que le capital social présente la contribution la plus importante (53,9 %) devant le revenu (42,5 %) et la Profession et catégorie socioprofessionnelle (PCS) (16 %).

Berchet, C. et Jusot, F. (2010). "Inégalités de santé liées à l'immigration et capital social : une analyse en décomposition." Revue D'economie Publique(24-25): 73-100.

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Berchet, C. et Jusot, F. (2010). "L'état de santé des migrants de première et de seconde génération en France. Une analyse selon le genre et l'origine." Revue Economique **61**(6): 1075-1098.

À partir de l'enquête française Santé Protection Sociale menée en 2006, cette étude analyse les inégalités de santé liées à la migration. Les résultats suggèrent des disparités d'état de santé entre la population immigrée et la population française particulièrement marquées chez les émigrés d'Afrique du Nord. L'ampleur de ces inégalités est plus élevée chez les immigrés de première génération que chez les immigrés de seconde génération. Elles sont également plus notables chez les femmes que les hommes. Le mauvais état de santé des hommes immigrés est principalement expliqué par leur situation économique et sociale, leur intégration sociale et par leur hygiène de vie, alors que chez les femmes la migration constitue un risque spécifique.

Berchet, C. et Jusot, F. (2012). "Etat de santé et recours aux soins des immigrés : une synthèse des travaux français." Questions D'economie De La Sante (Irdes)(172): 8.

Cette étude propose une synthèse des travaux français portant sur l'état de santé et le recours aux soins des migrants depuis une trentaine d'années. Malgré la divergence des résultats de la littérature - due notamment à la diversité des indicateurs utilisés et des périodes considérées -, cette synthèse souligne l'existence de disparités entre les populations française et immigrée. De meilleur, l'état de santé des immigrés est devenu moins bon que celui des Français de naissance. Ces différences sont plus marquées chez les immigrés de première génération, les femmes, et varient selon le pays d'origine. Un moindre recours aux soins de ville et à la prévention a également été constaté. Si des phénomènes de sélection liés à la migration permettent d'expliquer le meilleur état de santé initial des immigrés, leur situation économique fragilisée dans le pays d'accueil ainsi que la détérioration du lien social contribuent notamment à la dégradation de leur état de santé et à leur moindre recours aux soins. Ce constat appelle la mise en œuvre de politiques de santé publique adaptées visant à améliorer l'état de santé et l'accès aux soins des populations d'origine étrangère, notamment à travers la prévention, le développement d'actions de proximité et de simplification de l'accès à certains droits et dispositifs tels que la Couverture maladie universelle ou l?Aide médicale d'État.

Berchet, C. et Jusot, F. (2012). "Etat de santé et recours aux soins des immigrés en France : une revue de la littérature." Bulletin Epidemiologique Hebdomadaire(2-3-4): 17-20.

Ce bilan des études françaises sur l'état de santé et l'accès aux soins des immigrés suggère l'existence d'inégalités de santé liées à la migration et de disparités selon le pays d'origine. En outre, l'ensemble des études s'accorde sur le moindre recours aux soins de la population immigrée, révélant des difficultés d'accès à la médecine de ville. Enfin, la situation économique et sociale plus défavorisée des immigrés, leur moindre accès à la complémentaire santé et leur moindre intégration sociale sont les principaux facteurs expliquant ces inégalités de santé et d'accès aux soins.

Beynet, A. and G. Menahem (2002). Problèmes dentaires et précarité. Rapport Credes. Paris CREDES**:** 139 , 111 graph., 157 tabl., enc., ann.

Ce rapport a été réalisée par le Centre de Recherche - d'Etude et de Documentation en Economie de la Santé (CREDES) à la suite d'une enquête auprès de 590 consultants dans 80 centres de soins gratuits en France, entre fin 1999 et mai 2000. A partir des déclarations des personnes enquêtées et d'un examen dentaire, cette étude avance des éléments de réponse à ces questions. Après une présentation de la méthode et des différentes situations de précarité, l'étude compare l'état bucco-dentaire et le recours ou le non-recours au dentiste des personnes démunies aux résultats recueillis en population générale. Elle montre en quoi le besoin de soins dentaires révélé par l'examen médical affecte davantage les hommes et les personnes âgées. Enfin, elle examine pourquoi les situations de précarité affectent moins l'état dentaire des consultants de nationalité étrangère que celui des Français et propose des hypothèses permettant de rendre compte de ce constat.
Voitr aussi le Questions d'Economie de la Santé, n° 48, 2002

Collet, M., et al. (2003). "Précarité, risque et santé. Enquête menée auprès des consultants de centres de soins gratuits." Questions D'economie De La Sante (Credes)(63): 6 , graph.

Le CREDES a réalisé de septembre 1999 à mai 2000 une enquête sur l'état de santé et les logiques de recours aux soins des consultants de centres de soins gratuits en France. Cette enquête a été effectuée dans le cadre de l'appel d'offre « Précarité, précarisation et santé » de l'INSERM. Ce document constitue, après « Précarité et problèmes dentaires », le deuxième volet d'une série qui portera ensuite sur les profils des consultants de soins gratuits, les motifs de recours et les logiques de recours aux soins. Cette étude prolonge des recherches que le CREDES mène depuis plus de vingt ans sur les consommations de soins et l'état de santé des populations en situation de précarité.

Cong, H. Q., et al. (1992). Recours aux soins et morbidité des défavorisés 1988-1989-1990 : l'expérience de six centres associatifs de soins gratuits. Rapport Credes. Paris C.redes **:** 63 , tabl., grah.

Analyse des caractéristiques de 5575 patients ayant consulté pour la première fois en 1990 dans six centres de soins gratuits à Paris, Marseille, Lille, Lyon appartenant à l'association R.E.M.E.D.E. et à M.S.F. (Médecin sans frontière - Mission Solidarité France). Réalisé par une équipe regroupant des chercheurs, des médecins et des travailleurs sociaux, ce travail prolonge deux observations effectuées en 1988 et 1989. Il fait une étude des patients par nationalité, statut, niveau de scolarité, âge et sexe.

Dourgnon, P., et al. (2007). Etat de santé des populations immigrées en France : une approche multiniveaux http://www.ces-asso.org/docs/JESF_2007/dourgnon.pdf

Cette communication a été présentée à l'occasion des 29èmes Journées des Economistes de la Santé Français qui se sont déroulées à Lille en décembre 2007. En s'appuyant sur l'Enquête santé de l'Insee, les auteurs explorent les liens existants entre nationalité, immigration et état de santé.

Dourgnon, P., et al. (2008). "La santé perçue des immigrés en France. Une exploitation de l'Enquête décennale santé 2002-2003." Questions D'economie De La Sante (Irdes)(133): 1-6.

Selon les données de l'enquête décennale santé menée par l'INSEE en 2002- 2003, les personnes d'origine étrangère vivant en France se déclarent en moins bon état de santé que les Français nés en France. Les conditions socioéconomiques dégradées de ces populations expliquent en partie leur plus mauvaise santé perçue. Mais on observe également des différences d'état de santé selon les pays d'origine, liées au niveau de développement de ces derniers. Ainsi, les personnes originaires des pays les plus riches déclarent un meilleur état de santé que les personnes originaires des pays de niveau de développement moyen, suggérant un effet à long terme de la situation sociale et sanitaire du pays de naissance sur l'état de santé. Les personnes originaires des pays les plus pauvres déclarent également un meilleur état de santé que les personnes originaires des pays de niveau de développement moyen, ce qui peut s'expliquer par une sélection à la migration plus marquée dans ces pays. Enfin, il ne semble pas y avoir de différence d'état de santé entre les immigrés étrangers et ceux ayant été naturalisés.

Dourgnon, P., et al. (2009). Etat de santé et recours aux soins des populations immigrées en France. Rapport final : Volume 1 : Etat de santé des populations immigrées en France. Paris IRDES**:** 156 , tabl.

Cette recherche a été réalisée dans le cadre de l'appel à projets de recherche DREES/MIRE « Analyses secondaires de l'enquête décennale de l'Insee sur la santé et les soins médicaux ». Cette analyse repose sur des analyses descriptives et multi varié de l'état de santé d'une part et du recours aux services de santé d'autre part selon le statut migratoire : personne de nationalité française née en France, personne de nationalité française née à l'étranger, personne de nationalité étrangère. Le rapport final de cette étude est présenté en deux volumes, l'un consacré à l'état de santé et le deuxième au recours aux soins. Ce premier volume rassemble des réalisations sur l'état de santé des immigrés en France.

Dourgnon, P., et al. (2009). Etat de santé et recours aux soins des populations immigrées en France. Rapport final : Volume 2 : Recours aux soins des populations immigrées en France. Paris IRDES**:** 65 , tabl.

Cette recherche a été réalisée dans le cadre de l'appel à projets de recherche DREES / MIRE « Analyses secondaires de l'enquête décennale de l'Insee sur la santé et les soins médicaux ». Cette analyse

repose sur des analyses descriptives et multi varié de l'état de santé d'une part et du recours aux services de santé d'autre part selon le statut migratoire : personne de nationalité française née en France, personne de nationalité française née à l'étranger, personne de nationalité étrangère. Le rapport final de cette étude est présenté en deux volumes, l'un consacré à l'état de santé et le deuxième au recours aux soins. Ce second volume rassemble des réalisations sur le recours aux soins des immigrés en France.

Dourgnon, P., et al. (2009). "Le recours aux soins de ville des immigrés en France." Questions D'economie De La Sante (Irdes)(146): 6.

Les personnes immigrées ont un taux de recours à la médecine de ville, au généraliste comme au spécialiste, plus bas que le reste de la population française. Ceci s'explique davantage par la situation sociale défavorisée des immigrés que par des différences d'âge, de sexe ou d'état de santé entre ces deux populations. Cette analyse reste valable quelle que soit la région d'origine des personnes immigrées, à l'exception de celles originaires du Maghreb, plus nombreuses à consulter un généraliste. Le constat est plus contrasté pour les soins préventifs, les immigrés se déclarant plus souvent vaccinés que les Français mais recourant moins fréquemment aux tests de dépistage.

Dourgnon, P. et Moullan, Y. (2015). Social determinants of overweight among immigrants in Spain and France. The IMI Working Papers Series ; 116. Oxford Université d'Oxford**:** 49, tabl. http://www.imi.ox.ac.uk/publications/new-imi-working-paper-on-the-differences-of-overweight-between-immigrants-and-natives-in-france-and-spain

This study addresses immigrant health from the point of view of social health inequalities research. We study differences in overweight between immigrants and natives in two countries, France and Spain. Controlling for socioeconomic characteristics, we focus on effects that pertain to the country of origin and to the country of arrival in explaining overweight prevalence. We first estimate and compare between France and Spain, in women and men, the effect of immigration status on overweight when controlled for age, socioeconomic status (SES), and country of origin. We study the role of length of stay as proxied by naturalisation status and according to country of origin. We investigate the role of GDP, HDI and obesity prevalence in the country of origin. We then estimate how differences in population compositions and differences in estimated coefficients contribute to observed differences in overweight between natives and migrants for each country.

Dourgnon, P., Guillaume, S., Jusot, F., et al. (2019). "Étudier l'accès à l'Aide médicale de l'État des personnes sans titre de séjour. L'enquête Premiers pas." Questions D'economie De La Sante (Irdes)(244): 8. https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/244-etudier-l-acces-a-l-aide-medicale-de-l-etat-des-personnes-sans-titre-de-sejour.pdf

L'Aide médicale de l'État (AME), l'assurance maladie destinée aux personnes étrangères en situation irrégulière en France, reste très mal connue. Quelles sont les caractéristiques sociales, économiques et sanitaires des personnes étrangères en situation irrégulière bénéficiant de l'AME ? Qui sont celles qui ne recourent pas au dispositif ? Pour quelles raisons ? Quels sont les recours aux soins et à l'assurance santé des personnes étrangères en situation irrégulière ? L'AME permet-elle à ses assurés d'accéder aux services de santé ? Les récents débats portant sur une possible réforme de l'AME n'ont pu s'appuyer que sur des informations éparses et incomplètes. L'enquête Premier pas vise à apporter de premières réponses à ces questions. Elle a été menée en 2019 auprès de 1 223 étrangers sans titre de séjour dans 63 lieux et structures, à Paris intra-muros et dans l'agglomération de Bordeaux. Après une description du protocole, de l'organisation de la collecte et du bilan statistique de l'enquête, nous présentons la structure de l'échantillon. Ce deuxième Questions d'économie de la santé sur l'accès à l'AME des personnes étrangères en situation irrégulière à partir de l'enquête Premiers pas s'inscrit dans une série. Le premier revenait sur l'histoire des droits de cette population en France et dressait un état des lieux des connaissances et ignorances concernant le dispositif de l'AME. Le troisième sera consacré à l'analyse de l'accès à l'AME.

Dourgnon, P., Jusot, F., Marsaudon, A., et al. (2022). "Non, l'Aide médicale d'État n'encourage pas les migrations pour raisons de santé." De Facto(31): 30-33.
https://www.icmigrations.cnrs.fr/wp-content/uploads/2022/03/DF31-Dourgnon-et-al.pdf

L'AME est une assurance publique donnant accès aux étrangers en situation irrégulière (ESI) à la plupart des services de santé sans restes à charge. Elle suscite des débats clivants. Un argument fréquemment soulevé par ses opposants est que « les sans-papiers viennent en France pour profiter du système de santé ». Les résultats de l'enquête Premiers Pas, réalisée en 2019 auprès d'un échantillon représentatif d'ESI montrent une tout autre réalité. Tout d'abord, seuls 9,5 % d'entre eux évoquent la santé comme motif de venue en France. De plus, seuls 51 % des ESI éligibles sont couverts par l'AME. Le principal facteur explicatif du recours à l'AME n'est pas l'état de santé ni le motif de venue en France, mais la durée de séjour sur le territoire. Si l'accès à l'AME est croissant avec la durée de séjour, même après 5 ans en France, 34,6 % des ESI restent non couverts.

Dourgnon, P., Jusot, F. et Marsaudon, A. (2022). "Just a question of time? Explaining non-take-up of a public health insurance program designed for undocumented immigrants living in France." Journal of Health Economics Policy and Law: 1-17.

State Medical Aid is a public health insurance program that allows undocumented immigrants with low financial resources to access health care services for free. However, the low take-up rate of this program might threaten its efficiency. The purpose of this study is therefore to provide the determinants of such a low take-up rate. To this end, we rely on the Premier Pas survey. This is an original representative sample of undocumented immigrants attending places of assistance to vulnerable populations in France. Determinants of State Medical Aid take-up are analyzed through probit and Cox modeling. The results show that only 51% of those who are eligible for the State Medical Aid program are actually covered, and this proportion is higher among women than among men. The length of stay in France is the most important determinant of take-up. It is worth noting that State Medical Aid take-up is not associated with chronic diseases or functional limitations and is negatively associated with poor mental health. There is, therefore, mixed evidence of health selection into the program. Informational barriers and vulnerabilities experienced by undocumented immigrants are likely to explain this low take-up.

Vignier, N., Moussaoui, S., Marsaudon, A., et al. (2022). "Burden of infectious diseases among undocumented migrants in France: Results of the Premiers Pas survey." Front Public Health **10**: 934050.

INTRODUCTION: An increase in migration rates to the European Union has been observed over the last few years. Part of these migrants is undocumented. This work aimed to describe the reported frequency of infectious diseases and their associated factors among unselected samples of undocumented migrants in France. METHODOLOGY: The Premier Pas survey is a cross-sectional epidemiological survey of a random sample (two-stage sample design) conducted among undocumented migrants recruited in Paris and the Bordeaux region, in places and facilities likely to be frequented by undocumented migrants. The percentages were weighted. The analysis was performed using Stata 15.1 software. RESULTS: A total of 1,223 undocumented migrants were recruited from 63 places and facilities, with a participation rate of 50%. Most of them were between 30 and 40 years of age (36%), 69% were men, aged mainly 30-40 (36%) years old, from sub-Saharan Africa (60%) or North Africa (25%), and 60% had arrived <3 years earlier. Among the participants, 24.8% declared a poor perceived health status and 33.5% a chronic health condition. Dental infections concerned 43.2% of the participants. Apart from dental issues, 12.9% reported suffering from at least one infectious disease: HIV infection (3.5%), chronic hepatitis B virus infection (3.1%), upper respiratory tract infection (1.7%), skin mycosis (1.2%), skin and soft tissue infection (0.8%), chronic hepatitis C infection (0.8%), urinary tract infection (0.7%), lower respiratory tract infection (0.7%), scabies (0.3%), tuberculosis disease (0.2%), vaginal mycosis (0.6%), and herpes (0.1%). Regarding HIV, HBV, and HCV infections, 56, 71, and 89%, respectively, were diagnosed after their arrival. Chronic viral infections were more often reported by undocumented migrants from sub-Saharan Africa and Latin America. In multivariate analysis, a higher risk of reporting chronic viral infection was observed among people food insecure. CONCLUSION: This original study on a large random sample confirms the frequency of

infectious diseases among undocumented migrants in France and the importance of integrating their screening during a health Rendezvous and their management into early access to care and inclusive medico-psycho-social management.

Jusot, F., et al. (2008). Etat de santé des populations immigrés en France. Document de travail Irdes ; 14. Paris Irdes**:** 20.
http://www.irdes.fr/EspaceRecherche/DocumentsDeTravail/DT14EtatSantePopuImmigrFrance.pdf

Ce document étudie les liens existant entre nationalité, migration et état de santé à partir des données de l'Enquête décennale Santé menée en 2002-2003 en France. Les résultats montrent l'existence d'inégalités face à la santé des personnes d'origine étrangère, liées à l'existence d'un effet de sélection à la migration compensé à long terme par un effet délétère de la migration, expliqué en partie seulement par la situation sociale difficile des immigrés. Cette analyse suggère également un effet non négligeable à long terme des caractéristiques économiques et sanitaires du pays de naissance, propre à expliquer les disparités d'état de santé observées au sein de la population immigrée.

Jusot, F., et al. (2009). "Inégalités de santé liées à l'immigration en France. Effet des conditions de vie ou sélection à la migration ?" Revue Economique **60**(2): 385-412.

Cet article étudie les liens existant entre nationalité, migration et état de santé à partir des données de l'enquête décennale Santé menée en 2002-2003 en France. Les résultats montrent l'existence d'inégalités face à la santé des personnes d'origine étrangère, liées à l'existence d'un effet de sélection à la migration compensé à long terme par un effet délétère de la migration, expliqué en partie seulement par la situation sociale difficile des immigrés en France. Cette analyse suggère également un effet non négligeable à long terme des caractéristiques économiques et sanitaires du pays de naissance, propre à expliquer les disparités d'état de santé observées au sein de la population immigrée.

Jusot, F., Dourgnon, P., Guillaume, S., et al. (2019). "Le recours à l'Aide médicale de l'État des personnes en situation irrégulière en France : premiers enseignements de l'enquête Premiers pas." Questions D'economie De La Sante (Irdes)(245): 8.
https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/245-le-recours-a-l-aide-medicale-de-l-etat-des-personnes-en-situation-irreguliere-en-france-enquete-premiers-pas.pdf

La France a choisi de longue date de garantir l'accès aux soins des étrangers en situation irrégulière avec l'Aide médicale gratuite puis, depuis 2000, l'Aide médicale de l'Etat (AME). L'existence d'un tel dispositif ne garantit pas, à elle seule, que l'ensemble des personnes éligibles y accèdent ni en fassent usage. Nous étudions ici le recours à l'AME et ses déterminants à partir des données de l'enquête Premiers pas, réalisée en 2019 auprès d'un échantillon de personnes étrangères sans titre de séjour. Seules 51 % des personnes qui y sont éligibles bénéficient de l'AME. Près de la moitié des personnes sans titre de séjour déclarant souffrir de pathologies nécessitant des soins, comme le diabète ou les maladies infectieuses, ne sont dans les faits pas assurées pour la santé, ni par l'AME, ni par l'assurance maladie de droit commun. Le recours à l'AME est un peu plus important chez les 10 % ayant cité la santé parmi leurs motifs de migration. Il est cependant assez peu corrélé aux problèmes de santé, en dehors des troubles musculo-squelettiques. Le recours à l'AME augmente avant tout avec la durée de séjour sur le territoire. Ces résultats suggèrent que la plupart des migrants ont peu de connaissances de l'AME et n'ont pas tous la capacité à se saisir d'un dispositif complexe. Même après cinq années ou plus de résidence en France, 35 % des personnes sans titre de séjour n'ont pas l'AME. Ce troisième Questions d'économie de la santé sur l'accès à l'Aide médicale de l'Etat des personnes étrangères en situation irrégulière s'inscrit dans une série. Le premier rappelle l'histoire des droits de cette population en France et dresse un état des lieux des connaissances sur le dispositif de l'AME. Le deuxième présente l'enquête Premiers pas.

Khlat, M., et al. (1998). "La morbidité dans les ménages originaires du Maghreb : sur la base de l'enquête santé de l'INSEE, 1991-1992." Population **53**(6): 1155-1184, 1158 tabl.

Mizrahi, A. et Mizrahi, A. (2008). "Morbidité et soins médicaux aux personnes nées à l'étranger." Journal D'economie Medicale **26**(3): 159-176, tabl., graph.

> [BDSP. Notice produite par ORSRA BIFDR0xD. Diffusion soumise à autorisation]. Peu de données nationales sont disponibles sur la situation sanitaire et médicale des étrangers en France : les auteurs ont cherché à regrouper les informations mobilisables sur ce thème. Les données utilisées proviennent de trois sources nationales : l'enquête décennale auprès des ménages sur la santé et les soins médicaux - ESSM (2003, et 1970,1980,1991), l'enquête permanente auprès des ménages sur les soins et la protection sociale - ESPS (2000 et 2002 regroupées), l'enquête sur les hospitalisés (EH) de 1991. Sont analysés quelques résultats sur la morbidité des étrangers comparée à celle des Français, puis la couverture maladie, et enfin la consommation médicale (médecine de ville et hospitalisation).

Marsaudon, A., Dourgnon, P., Jusot, F., et al. (2020). "Anticiper les conséquences de l'épidémie de la Covid-19 et des politiques de confinement pour les personnes sans titre de séjour." Questions D'economie De La Sante (Irdes)(253): 6.
https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/253-anticiper-les-consequences-de-l-epidemie-covid-19-et-des-politiques-de-confinement-pour-les-personnes-sans-titre-de-sejour.pdf

> À partir des données de l'enquête Premiers pas, réalisée en 2019 auprès de personnes étrangères sans titre de séjour et de structures leur proposant de l'assistance, cette étude éclaire les risques encourus par cette population du fait de l'épidémie et des confinements successifs. La vulnérabilité des personnes sans titre de séjour aux facteurs de risque médicaux, leur situation économique ainsi que leurs problèmes de santé mentale les rendent plus fragiles aux conséquences de la mise en quarantaine. Alors qu'un second confinement est en place, il est important d'en anticiper les conséquences sur une population mal connue. Ce Questions d'économie de la santé s'inscrit dans la suite des travaux menés à partir de l'enquête Premiers pas sur la santé et l'accès aux soins des personnes étrangères sans titre de séjour en France. Il vient compléter trois autres Questions d'économie de la santé. Le premier revenait sur l'histoire des droits des personnes étrangères sans titre de séjour en France et dressait un état des lieux des connaissances concernant l'Aide médicale de l'État (AME). Le second présentait la méthodologie de l'enquête et le troisième était consacré à l'analyse de l'accès à l'AME.

Mizrahi, A. et Mizrahi, A. (2006). "Morbidité et soins médicaux aux personnes nées à l'étranger." Bibliographie Argses(41): 23, graph.

> Peu de données nationales sont disponibles sur la situation sanitaire et médicale des étrangers en France ; cet article cherche à regrouper les informations qui pourraient très mobilisées sur ce thème. Au cours des dernières décennies, le groupe des personnes étrangères en France, s'est renouvelé, certains rentrant chez eux ou acquérant la nationalité française, de nouveaux venus rejoignant cette population. Les données disponibles proviennent essentiellement d'enquêtes effectuées auprès des ménages ou relevées dans les dossiers de Sécurité sociale. Ces données sont éloignées dans le temps (1970, 1980, 1991, 2003) et, sur de si longs intervalles, l'origine géographique des étrangers s'est modifiée : les changements observés résultent simultanément de ces modifications et des évolutions de la situation sanitaire de chacun des groupes qui constituent la population des étrangers. En dépit des marges d'incertitude des conclusions qu'on peut tirer d'enquêtes, soit par l'insuffisante représentativité des échantillons, soit par les lacunes des données relevées, on peut penser que globalement, l'état de santé des étrangers ne se distingue pas de manière importante de celle des Français. Cependant ils souffrent un peu plus souvent que les Français de maladies longues et coûteuses, d'accidents et maladies professionnelles et d'invalidité. Un tiers d'entre eux ne sont pas protégés par une couverture complémentaire. Leur consommation médicale est surtout caractérisée par un faible appel aux soins dentaires et un grand recours à hospitalisation.

Mizrahi, A., et al. (1993). Accès aux soins et état de santé des populations immigrées en France. Rapport Credes. Paris CREDES**:** 62 , tabl., graph.

> Deux sources de données complémentaires, l'Enquête Santé et Protection Sociale (ESPS 1988-1991) et l'étude de clientèle des Centres de Soins Gratuits (CSG 1990-1991) ont permis d'étudier la différence

entre l'état de santé et l'accès aux soins des étrangers et des Français favorisés ou non. La première enquête apporte des informations sur l'état de santé, la protection complémentaire maladie et la consommation médicale des ménages dont un membre au moins était assuré au Régime général. La seconde étudie une population défavorisée, ou plus exactement, les nouveaux patients de centres de soins gratuits. Les informations recueillies permettent de mieux appréhender les motifs de consultation et le type de protection sociale de cette population.

Moullan, Y. et Jusot, F. (2014). "Why is the healthy immigrant effect different between european countries ?" Eur J Public Health **24**(suppl. 1): 80-86.

Même si l'état de santé des immigrants constitue un important problème de santé publique, la littérature donne des résultats contradictoires sur l'existence d'un effet de «migrant en bonne santé» en Europe. Cette étude se propose d'explorer l'hétérogénéité de l'écart de l'état de santé entre les migrants et les autochtones dans quatre pays européens (Belgique, France, Espagne et Italie).

Prieur, C., Dourgnon, P., Jusot, F., et al. (2022). "Une personne sans titre de séjour sur six souffre de troubles de stress post-traumatique en France." Questions D'economie De La Sante (Irdes)(266): 8. https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/266-une-personne-sans-titre-de-sejour-sur-six-souffre-de-troubles-de-stress-post-traumatique-en-france.pdf

Les Troubles de stress post-traumatique (TSPT) sont des troubles psychiatriques qui surviennent après un événement traumatisant. Ils se traduisent par une souffrance morale et des complications physiques qui altèrent profondément la vie personnelle, sociale et professionnelle. Ces troubles nécessitent une prise en charge spécialisée. Pour les personnes sans titre de séjour, la migration peut avoir donné lieu à des expériences traumatiques sur le parcours migratoire ou dans le pays d'accueil, qui peuvent s'ajouter à des traumatismes plus anciens survenus dans le pays d'origine, alors que les conditions de vie sur le sol français sont susceptibles de favoriser le développement de TSPT. Quelle est la prévalence des troubles de stress post-traumatique au sein de cette population encore mal connue ? Comment les conditions de migration et les conditions de vie dans le pays d'accueil jouent-elles sur leur prévalence ? Quel est l'accès à l'Aide médicale de l'Etat (AME) des personnes qui en souffrent ?

UN ETAT DE SANTE SOUVENT PRECAIRE

Une revue de la littérature existante en France [13]révèle des résultats contradictoires : de meilleur que celui des non-immigrés dans les années 1980 et 1990, l'état de santé des immigrés semble devenir moins bon dans les années 2000. Une évolution similaire a été décrite dans d'autres grands pays d'immigration. Dans la littérature internationale, l'effet « immigrant en bonne santé » (healthy *migrant effect*), très net pour les migrations de travail, a été observé pour le taux de mortalité, la santé perçue et la prévalence de certaines maladies chroniques. Cette différence en faveur des migrants a longtemps été interprétée comme le reflet des facteurs sélectifs, tenant à la fois au filtre des procédures d'immigration et à un processus d'auto-sélection ; de certaines habitudes de vie, notamment alimentaires, plus favorables. Les femmes migrantes arrivées dans le cadre du regroupement familial ne semblaient pas bénéficier de cet effet, qui a été documenté aux États-Unis (où il existe toute une littérature épidémiologique sur *le Latino mortality paradox*[14], au Canada, en Australie et dans certains pays d'Europe[15]. Mais cet avantage s'estompe au fur et à mesure que la durée de résidence dans le pays d'accueil s'allonge, jusqu'à se retourner en désavantage par rapport à la population du pays d'accueil [4]. Ce « paradoxe de l'assimilation » est attribué en grande partie à l'adoption progressive par les migrants d'habitudes de vie moins favorables à la santé, engendrant une exposition croissante aux facteurs de risque des maladies de civilisation (alcool, tabac, obésité). Pour la France, l'explication réside sans doute aussi dans une évolution des profils de migrants. À ces effets de composition s'ajoutent un effet d'usure lié à la pénibilité des

[13] Berchet, Jusot (2012)
[14] Abraído-Lanza AF, et al. (1999)
[15] Khlat M, Darmon N. (2003)

emplois et une fragilité particulière par rapport à la crise et à la montée de la précarité, alors que les appuis familiaux et sociaux sont affaiblis en raison du déracinement.

Une vue d'ensemble

(2010). "Santé des étrangers : l'autre double peine." Plein Droit : La Revue Du Gisti(86): 1-20. http://www.gisti.org/spip.php?article2072

> Quels impacts les discriminations ont-elles sur la santé ? Les études révèlent que les personnes en situation de précarité sont particulièrement vulnérables et leurs difficultés d'accès aux soins bien réelles. Parmi elles, les étrangers, parce qu'ils cumulent certains « facteurs à risque » sont en première ligne en matière d'inégalité sanitaire. Leurs difficultés d'accès au logement les conduisent parfois à vivre dans des logements insalubres, non adaptés, surpeuplés. Or le mal-logement et a fortiori l'absence de logement affectent directement leur état de santé. Les conditions de travail des étrangers, particulièrement pénibles, et leur exposition aux risques liés au travail - accidents, cancers, troubles musculo-squelettiques - particulièrement forte, ne peuvent qu'aggraver les choses. Si on ajoute un environnement social dégradé et une précarité administrative qui rendent plus difficile leur accès aux soins, on peut se demander si en matière de santé aussi, les populations étrangères ne sont pas victimes de la double peine (Résumé de l'éditeur).

Adam, C. d., et al. (2017). La santé des populations vulnérables, Paris : Ellipses

> « Les hommes naissent et demeurent libres et égaux en droits. Les distinctions sociales ne peuvent être fondées que sur l'utilité commune. » L'article 1er de la Déclaration des droits de l'homme et du citoyen du 26 août 1789 a ensuite été placé en 1791 en tête de la Constitution de la République française. Cependant, depuis la naissance d'un individu, se développent de manifestes inégalités face à la santé et à la maladie qui impactent directement l'espérance de vie, notamment au détriment des personnes aux revenus les plus faibles. La mortalité prématurée évitable touche de façon très discriminante les différentes catégories sociales. Pour les professionnels concernés, agir à cet égard ne relève pas d'une charité où la bonne volonté se substituerait à la compétence. Des savoirs, des savoir-faire et des savoir-être sont indispensables. Ils résultent de nécessaires processus d'apprentissage enrichis par l'expérience.

Andre, J. M. et Fassin, D. p. (2019). La santé des migrants en question(s), Paris : Éditions Hygée https://www.presses.ehesp.fr/produit/sante-migrants-questions/

> Depuis 2015, l'arrivée de populations d'Afrique et du Moyen-Orient en Europe a cristallisé les tensions politiques entre pays membres, divisés face à la « crise migratoire ». Mais, au-delà des discours alarmistes et/ou extrémistes, il apparaît que cette « crise » est moins liée au flux migratoire qu'à la gestion des conditions d'accueil. Quel est l'état de santé des migrants ? Comment accèdent-ils aux soins ? Quel est le rôle et le quotidien des professionnels de santé et acteurs de la solidarité ? À travers ces thématiques, des experts répondent, études et chiffres à l'appui, à certaines idées reçues sur les migrants (porteurs de maladies transmissibles, profitant du système de protection sociale français…) et décrivent les insuffisances des conditions d'accueil.

Andro, A., Scodellaro, C., Eberhard, M., et al. (2019). "Parcours migratoire, violences déclarées et santé perçue des femmes migrantes hébergées en hôtel en Île-de-France. Enquête Dsafhir." Bull Epidemiol Hebd(17-18): 334-341.

> La « mise à l'abri » à l'hôtel est une forme particulièrement précaire d'hébergement d'urgence. Les femmes migrantes hébergées à l'hôtel cumulent des facteurs de vulnérabilité face aux violences. Ce contexte a un effet délétère sur leur état de santé et renforce leurs difficultés d'accès aux soins de santé. L'enquête Droits, santé et accès aux soins des femmes hébergées immigrées et réfugiées en Île-de-France (Dsafhir), menée auprès de 469 femmes migrantes vivant à l'hôtel en 2017, permet notamment de décrire l'état de santé perçu de ces femmes et la diversité des formes de violence qu'elles ont subies (physiques, psychologiques, sexuelles, économiques et administratives), les liens

qui les unissent (ou les unissaient) aux auteurs des violences (conjoint, membre de la famille, représentant de l'autorité, etc.), ainsi que la temporalité des actes incriminés (violences survenant avant la migration, pendant le trajet migratoire, en France). En mobilisant les données quantitatives (n=469) et qualitatives (n=30) de cette enquête, cet article décrit les états de santé et les violences auxquelles ont été exposées les femmes migrantes mises à l'abri en les caractérisant (types de violence, lien avec l'auteur) et en les plaçant dans la temporalité des parcours migratoires. Les violences sexuelles font l'objet d'une attention spécifique. Les résultats montrent que ces femmes sont particulièrement exposées au fait de subir des violences au cours de leur vie. Les grandes enquêtes statistiques sur les violences, parce qu'elles interrogent des répondants dans des « ménages ordinaires », sous-représentent largement cette population de femmes marginalisées. En outre, elles sont rarement prises en charge, sur le plan médico-psycho-social, alors que ces expériences ont un impact négatif avéré sur leur état de santé.

Attias-Donfut, C. and P. Tessier (2005). "Santé et vieillissement des immigrés." Retraite Et Societe(46): 89-129, tabl., graph.
http://www.cairn.info/revue-retraite-et-societe-2005-3-page-89.htm

[BDSP. Notice produite par FNG xwR0x3dJ. Diffusion soumise à autorisation]. L'étude sur la santé des immigrés âgés, présentée ici, est fondée sur les données de l'enquête "Passage à la retraite des immigrés", réalisée par la CNAV, avec la collaboration de l'INSEE en 2002-2003. L'objectif de l'article est double. Les déterminants de la santé des enquêtés sont analysés afin de mettre en évidence le rôle éventuel de facteurs spécifiques au phénomène migratoire, à savoir la durée de résidence en France et la région d'émigration. Dans un second temps, les besoins évalués à partir de déficiences de santé sont confrontés aux aides reçues de la part de l'entourage ou de l'aide professionnel.

Barda, L., et al. (2016). Les conditions d'hébergement des personnes en situation de grande précarité. Une enquête auprès des patients rencontrés. Paris MDM**:** 27.

Ce rapport présente les résultats d'une enquête menée dans les centres d'accueil, de soins et d'orientation (Caso) de Médecins du Monde en Île-de-France (Paris et Saint-Denis) auprès de 192 patients identifiés comme vulnérables et sans solution fixe d'hébergement. Il permet de mettre en lumière les très difficiles démarches entreprises par ces personnes pour trouver une solution notamment auprès du 115, et leurs conditions de vie dans des lieux improvisés pour pallier l'absence de prise en charge, aggravant leur précarité et mettant en danger leur santé.

Bouchaud, O. (2019). "Santé des migrants (I) : données générales et accès aux soins." Revue Du Praticien **69**(5): 545-572.

Bouchaud, O. (2019). "Santé des migrants (II) : situations de vulnérabilité." Revue Du Praticien **69**(6): 667-686.

Bourdillon, F., et al. (1991). "La santé des populations d'origine étrangère en France." Social Science & Medicine **32**(11): 1219-1227, 1213 tabl.

Comède (2017). La santé des exilés : rapport d'activité et d'observation 2017. Le Kremlin Bicêtre Comité médical pour les exilés **: 52**, tab., graph.
http://www.comede.org/rapport-dactivite/

Comme chaque année depuis plus de 30 ans, le Comité médical pour les exilés (Comede) analyse les statistiques d'accueil des patients accueillis dans ces centres de santé : description des populations, état de santé, accès aux soins et accès aux droits.

Comiti, V. P. and J. Patureau (2005). "La santé des migrants en France : spécificités, dispositifs et politiques sanitaires." Sante Societe Et Solidarite : Revue De L'observatoire Franco-Quebecois(1): 129-137.

Afin de présenter l'état de santé des migrants en France, les spécificités et les dispositifs qui y sont consacrés, l'auteur étudie tour à tour la précarité comme déterminant principal des problèmes de

santé et comme obstacle réel à l'accès aux soins, les pathologies prédominantes et la politique sanitaire mise en oeuvre.

Desgrees-Dulou, A. et Lert, F. (2017). Parcours de vie et santé des Africains immigrés en France, Paris : Editions de la Découverte

Pourquoi et comment l'infection VIH percute-t-elle la vie des immigrés d'Afrique subsaharienne en France ? Première étude quantitative d'ampleur menée par des chercheurs et des associations au sein de cette population particulièrement touchée par le virus, l'enquête ANRS Parcours a retracé en 2012-2013 les trajectoires migratoires, sociales, administratives et de santé de ces immigrés. Elle met en relief les difficultés d'installation, les bouleversements familiaux et professionnels à l'arrivée en France, et leurs conséquences en termes de santé.

Fleurel, S., et al. (2011). Santé, bien-être et population immigrée en France et en Grande-Bretagne : groupe de travail franco-britannique sur les migrations, la santé et le bien-être. Santé et géographie : nouveaux regards., Paris : Economica**:** 127-152.

Ce chapitre propose un état de l'art sur les principaux thèmes qui entrent dans l'étude des liens entre migrations et santé, tels qu'ils ont été abordés et discutés lors d'une série de séminaires pluridisciplinaires en 2006-2007 (Programme : Migration, health and wellbeing : comparative perspectives from Britain and France.

Gauld, C. (2019). "Précarité de la migration : autour des notions de santé et de capacités." Seve : Les Tribunes De La Sante(61): 89-93.

En se plaçant dans un cadre particulier de la philosophie de la médecine, qui considère la santé selon une approche dit "holistique" et globale, la maladie peut être conçue comme une perte de capacités "de second ordre". Celles-ci correspondent à la faculté d'acquérir la faculté d'agir fonctionnellement dans le monde physique et social. Le migrant précaire, lorsqu'il met le pied sur le territoire d'accueil, ne semble pas avoir accès à ces capacités particulières. Or cette perte permet de distinguer ce qui discerne la maladie de la santé : est considéré comme malade le sujet qui ne peut exprimer ses capacités de second ordre. Cette distinction peut être comprise en terme de handicap psychique. Mais le migrant en situation de précarité en est-il malade pour autant, d'un point de vue normativiste ? Cette approche de la santé conçue en terme de capacité sera discutée dans cet article. Elle sera mise en lumière par la condition du migrant en situation de précarité. Cette vision ne pourrait-elle pas constituer le socle d'une lutte pour la reconnaissance de sa situation ? (résumé de l'auteur).

Ginot, L., Laconde, C. et Rousseau, A. (2019). "Santé des personnes migrantes, parcours d'exils, violences subies : un enjeu pour l'ensemble du système de santé [Éditorial]." Bull Epidemiol Hebd(17-18): 310-311.

Gosselin, A. (2019). "Santé des immigrés : quand les difficultés d'installation détériorent l'état de santé. Exemple de la population immigrée d'Afrique subsaharienne." Sepidemio.
https://soepidemio.com/2019/09/11/sante-des-immigres-quand-les-difficultes-dinstallation-deteriorent-letat-de-sante-exemple-de-la-population-immigree-dafrique-subsaharienne/

Alors que l'accueil des réfugiés devient un enjeu crucial en Europe depuis la dite « crise migratoire » de l'été 2015, le processus d'installation des immigrés est peu renseigné, notamment parce qu'on manque de données longitudinales sur cette question. Les études disponibles portent soit sur la thématique de l'intégration sur le marché du travail ou sur des sous-groupes de population (par exemple bénéficiaires d'un titre de séjour, cf. par exemple l'enquête ELIPA). A partir des données de l'enquête ANRS Parcours, nous avons pu observer le processus d'installation des immigrés d'Afrique subsaharienne à leur arrivée et le mettre en lien avec leur état de santé.

Halle des Fontaines, V. et Kerouedan, D. (2020). "Santé des migrants." Actualite Et Dossier En Sante Publique(111).
https://www.hcsp.fr/explore.cgi/adsp?clef=1172#82

Ce dossier a pour objectif de dresser un bilan de la santé des migrants en France sous divers aspects : définition et état de santé, santé des femmes et des enfants, dispositifs d'accueil et de prise en charge, modes de couverture sociale et problèmes spécifiques de santé mentale.

Hamel, C. et Moisy, M. (2013). Immigrés et descendants d'immigrés face à la santé. Document de travail ; 190. Paris INED**:** 50 , tabl., fig.
http://www.ined.fr/fr/ressources_documentation/publications/documents_travail/bdd/publication/1625/

Basée sur les données de l'enquête « Trajectoires et Origines, enquête sur la diversité des populations en France » (TeO), ce rapport est structuré en trois grandes parties qui abordent le rapport des immigrés et des natifs d'un DOM à leur santé et au système de soins avant de s'intéresser à la santé des enfants d'immigrés, nés en France et devenus aujourd'hui adultes. La première partie propose de décrire et d'analyser la perception que les hommes et les femmes enquêtés ont de leur état de santé en fonction de leur origine, de leur âge et de leurs conditions de vie actuelles et passées, mais aussi selon leur âge à l'arrivée sur le territoire métropolitain et la durée de résidence en France. La deuxième partie explore ce qu'il en est du non recours et du renoncement aux soins, particulièrement pour les immigrés qui déclarent un besoin de soins, soit parce qu'ils se sont déclarés en mauvaise santé, soit parce qu'ils évoquent des limitations fonctionnelles et nous examinons ces résultats au regard de leur couverture médicale et en les mettant en perspective avec la déclaration d'un traitement différencié en raison de l'origine par le personnel médical. Dans la dernière partie, il s'agit d'observer si parmi les personnes ayant grandi en France, les filles et fils d'immigrés ainsi que les enfants des descendants des DOM ont un rapport à leur santé et au système de soins comparable à celui des enquêtés de la population majoritaire ou si des différences persistent malgré une socialisation en France et une familiarisation avec le corps médical et les messages de prévention depuis le plus jeune âge

Hamel, C. and M. Moisy (2012). "Migrations, conditions de vie et santé en France à partir de l'enquête Trajectoires et origines, 2008." Bulletin Epidemiologique Hebdomadaire(2-3-4): 21-24.

[BDSP. Notice produite par InVS qR0xI9s8. Diffusion soumise à autorisation]. Les immigrés âgés de 18-60 ans se déclarent globalement en plus mauvaise santé que les personnes sans ascendance migratoire depuis au moins deux générations. Toutefois, la catégorie "immigrés" revêt des réalités différentes en fonction de l'origine, des parcours migratoires et des conditions de vie passées et actuelles sur le territoire métropolitain. Les immigrés originaires de Turquie et du Portugal sont ceux qui se déclarent le plus en mauvaise santé. Pour les premiers, un cumul de précarité sur le territoire métropolitain explique cette sur-déclaration d'une mauvaise santé malgré une structure de population très jeune ; pour les seconds, les facteurs explicatifs relèvent davantage d'événements vécus pendant l'enfance et de faibles niveaux de qualification, qui, s'ils ne les empêchent pas d'être sur le marché du travail, les exposent à des conditions de travail pénibles. (R.A.).

Hamel, E., Veisse, A. et Kotobi, L. (2021). "Migrants en situation de vulnérabilité et santé : dossier." Sante En Action (La)(455): 60.
https://creaiors-occitanie.fr/?mailpoet_router&endpoint=track&action=click&data=WyI0OTYwIiwib296ZzRqbHlkams4bzBrZ2N3YzhjbzQ0OHdzc3M0Z3ciLCI5MiIsImYwMWZiNjFkNzhkYiIsZmFsc2Vd

La santé des exilés, qu'ils soient immigrés, réfugiés, demandeurs d'asile ou étrangers en situation irrégulière, est généralement meilleure, à leur arrivée, que celle des nationaux des pays dits d'accueil, mais elle se dégrade rapidement dans ces derniers, résultante non seulement des difficultés d'accès aux soins, mais aussi et surtout du traitement qui leur est fait par la société où ils espéraient fonder une nouvelle vie. Tel est le constat dressé en ouverture de ce dossier central par Didier Fassin, médecin, sociologue et anthropologue, titulaire de la chaire Santé publique au Collège de France.

HCSP (2019). Avis relatif au bilan de santé des enfants étrangers isolés. Paris HCSP**:** 82 , annexes.
https://www.hcsp.fr/explore.cgi/avisrapportsdomaine?clefr=753

Un rendez-vous santé initial est recommandé pour la population vulnérable des enfants étrangers isolés. Ce rendez-vous santé n'a pas pour objet de déterminer l'âge de l'enfant. Il est à dissocier de la procédure d'évaluation sociale. Le HCSP rappelle que ces enfants ont les mêmes droits à la santé et aux soins que tout autre enfant sur le territoire (priorité de l'intérêt de l'enfant, soins complets et gratuits, protection socioéducative). Ce rendez-vous santé, si possible organisé en deux étapes, peut être assuré par un personnel infirmier par délégation de compétence d'un médecin référent, avec l'aide d'un interprète professionnel si besoin et l'articulation avec un réseau de soins spécialisé incluant des soins psychiques, lorsque nécessaire. Il s'agit du premier temps de la mise en place d'un parcours de soins et de l'ouverture de droits à l'assurance maladie. L'enfant étranger isolé doit donner son consentement pour chaque soin, notamment pour les procédures de dépistage et de rattrapage vaccinal. L'enfant, accompagné par un adulte en qui il a confiance, est adressé aux différentes structures de soins préalablement identifiées. Le HCSP décline ses recommandations en termes de prise en charge des soins, continuité du parcours de soins adapté aux pathologies somatiques et/ou psychiques identifiées, organisation au sein et entre les départements et propose une trame de guide d'entretien et de prise en charge initiale pour ce rendez-vous santé ainsi qu'un livret de santé.

Hourdel, A., Reinier, M., Van Destee, G. F., et al. (2020). "État de santé des patients se déclarant mineurs non accompagnés et non reconnus mineurs: enquête rétrospective au sein de la Permanence d'accès aux soins de santé de l'Hôtel-Dieu." Bulletin Epidemiologique Hebdomadaire (BEH)(27): 531-537. http://beh.santepubliquefrance.fr/beh/2020/27/2020_27_2.html

Le nombre de mineurs non accompagnés (MNA) a augmenté de façon exponentielle ces dernières années. Après une première évaluation de la minorité au sein du Dispositif national de mise à l'abri, d'évaluation et d'orientation des mineurs isolés étrangers (Demie), on estime à 57% le nombre de jeunes non reconnus mineurs. Le cadre juridictionnel autour de ce statut reste flou et l'accès aux soins est entravé. Une étude rétrospective a été menée afin d'évaluer l'état de santé de cette population. Le recueil a été effectué de manière rétrospective à partir du dossier médical Orbis®. Les patients inclus étaient ceux se déclarant MNA mais non reconnus mineurs par le Demie lors de la consultation à la Permanence d'accès aux soins de santé de l'Hôtel-Dieu (Paris). Ont été recueillis?: les données démographiques, les diagnostics de consultation, la prévalence de pathologies cibles, les hospitalisations et les correspondants associatifs. Entre le 1er janvier 2019 et le 9 octobre 2019, 301 patients ont été inclus et un total de 1 035 consultations ont été analysées. La proportion d'homme était de 95% et l'âge moyen déclaré de 16,2 ans. La prévalence des psychotraumatismes était de 27,7% et des infections chroniques par le virus de l'hépatite B (VHB) de 12,8%. Les principaux diagnostics de consultation concernaient l'appareil locomoteur, la dermatologie et la gastro-entérologie. Le taux d'hospitalisation suite à la consultation était de 6%. Il s'agit d'une population fragile et isolée. Les prévalences des pathologies graves et le taux d'hospitalisation sont plus élevés qu'attendus. L'adhésion à la prise en charge au sein de la structure est bonne. La population des MNA non reconnus mineurs est une population à risque pour laquelle l'accès aux soins doit être facilité et amélioré.

Kaoutar, B., et al. (2012). "[Health of immigrant population of consultants at the Baudelaire outpatient clinic in Saint-Antoine hospital in Paris, France]." Bull Soc Pathol Exot **105**(2): 86-94.

Social and health data on the immigrant population remain scarce in France, especially concerning those in irregular situation. The Baudelaire outpatient clinic in Saint- Antoine hospital in Paris (PASS, i.e. specific free medicosocial care for the poor, the uninsured or the undocumented patients) treats a majority of immigrants, a lot of them being in an irregular residence status. The objectives of this study were to describe the social and health status of the immigrant consultants, to compare regular and undocumented migrants and to describe their main reasons for migration. A cross-sectional, descriptive, survey among the immigrant consultants has been performed among this outpatient clinic in April and May 2009. In total, 536 patients were included. Their age mean was 45 years, 62% are male, 49% are in an irregular situation and they have been in France for 12 years in average (19 years for the regular immigrants and 5 years for the undocumented). More than 20% had no health insurance. A majority (55%) of patients were suffering from a chronic disease. The more frequent ones

were hypertension (20%), type 2 diabetes (11.6%), chronic infectious diseases - HIV, HBV, HCV - (7%). Reasons for immigration were mostly economical (39%), family (19%) and political (17%). Health reasons were at the 4th rank and concerned 9% of the patients. The main chronic diseases observed among this population are similar to those of the general population of consultants in primary health care, except for the chronic infectious diseases, which are more frequent. Immigration for health reasons represents only a small proportion of all immigration reasons. For this population, free clinics like the one investigated here constitute unique, irreplaceable, access points in the French healthcare system.

Kaoutar, B., et al. (2014). "[Socio-demographic characteristics and health status of patients at a free-of-charge outpatient clinic in Paris]." Rev Med Interne **35**(11): 709-714.

PURPOSE: In the context of the French National Health Service, a free access to healthcare facilities (the PASS: "permanence d'acces aux soins de sante") has been implanted in 2000 for patients without health insurance or those dealing with financial hardship. There is few data about socio-demographic characteristics of the patients using these services. The objective of this study was to provide descriptive data about socio-demographic characteristics and motivation of those patients who use these clinics. METHODS: This descriptive cross-sectional study was conducted between April an May 2008, in 5 PASS clinics from academic tertiary hospitals in Paris. Descriptive data on patient were collected by general practitioners at the end of their consultations. RESULTS: This study included 581 patients. The mean age was 42 years, and 65% of patients were males. Only 50.9% declared a salary income and 38.5% had a health insurance. Half of the patients were homeless, and 80% were migrants. The main reasons to visit these health facilities were direct access (no appointment needed), being in financial difficulty and having a medical record in the same hospital. Half of the patients had one chronic disease at least, while only a third of them saw regularly a physician. A total of 834 diseases were found among the 581 patients, including 411 chronic diseases, and 17% of the patients had a psychologic or a psychiatric disorder. Prognosis was divided in three grades: good, low and poor. Almost a half of the patients were considered by the doctor as having a low or a poor prognosis if they would not receive a therapy. CONCLUSIONS: The findings of this study suggest that the PASS carry out their mission: most of the patients frequenting these facilities live under poor conditions and are in poor health status compared to the patients having access to conventional outpatient services.

Khlat, M., et al. (1998). "La morbidité dans les ménages originaires du Maghreb : sur la base de l'enquête santé de l'INSEE, 1991-1992." Population **53**(6): 1155-1184, 1158 tabl.

Lombrail, P. (1999). "A propos des liens entre santé et migration." Sciences Sociales Et Sante **17**(4): 37-44.

Mouden, M. E. (2020). "[Health of migrants in Calais]." Soins **65**(843-844): 54-55.

Health care is provided to migrant patients in Calais (62) in a specific context: influx and mixing of populations from all four corners of the world, requirement for urgent care, adaptability of the care provision and facilities, pathologies dominated by physical and mental illness. PASS, a unit offering continuous access to health care in Calais (North), receives these patients. Their health care needs are numerous and complex, and require team work and the participation of networks and associations.

Office des Migrations Internationales (2004). La santé des primo-migrants enquête semaine donnée n°2. Année 2003 documents et commentaires. Paris, OMI

L'enquête a été réalisée pendant la semaine du 17 au 21 novembre 2003 inclus. Elle a concerné. L'ensemble des délégations et missions de l'OMI, dotées d'un service assurant les visites médicales dans le cadre de l'arrêté du 6 juillet 1999. Une partie du recueil de données a été effectuée sur la base de fiches de saisies qui ont été transmises soit à la délégation régionale, soit au siège de l'OMI, soit, pour la plus grande partie réalisée en DR et en mission grâce au programme informatique sur base "Access" dont les médecins coordinateurs ont maintenant une excellente maîtrise. Dans ce cas, le raccourcissement des délais de réalisation et de transmission est considérable puisque l'étape fastidieuse de la saisie est soit "sautée" soit largement répartie. A l'exception des données de la DR de

Marseille qui n'ont pu être recueillies en exhaustivité, l'enquête est nettement plus représentative que la N°1 de 2003, qui, il faut le rappeler avait été fortement perturbée par les mouvements sociaux survenus au moment de sa réalisation.

Ouanhnon, L., Astruc, P., Freyens, A., et al. (2022). "Women's health in migrant populations: a qualitative study in France."

BACKGROUND: In 2019, there are 6.5 million migrants living in France. Numerous quantitative studies show inequalities in access and quality of care, in particular in women's health. This study aimed to explore migrant women's experience of gynaecological care. METHODS: We conducted 17 semi-structured in-depth interviews with migrant women in Toulouse (France). We used a Grounded Theory approach to perform the analysis. RESULTS: Although migrant women were generally satisfied with the gynaecological care received, they also reported dysfunctions. Positive elements were the French health insurance system, the human qualities of the healthcare providers and the performance of the health system. Although reassuring, the structured framework was perceived to have little flexibility. This was sometimes felt as oppressive, paternalistic or discriminatory. These obstacles, amplified by the women's lifestyle instability and precariousness, the language barrier and the difficulty to understand a totally new healthcare system, made women's health care and, especially, preventive care, a difficult-to-achieve and low-priority objective for the women. CONCLUSIONS: Migrant women's overall satisfaction with the healthcare system contrasted with the known health inequalities in these populations. This is a good example of the concept of acculturation. Healthcare professionals need to make an introspective effort to prevent the emergence of stereotypes and of discriminatory and paternalistic behaviours. A better understanding and respect of the other person's culture is an indispensable condition for intercultural medicine, and thus for reducing the health inequalities that migrant women experience.

Pedrero, C. (2021). "Santé, vieillissement et foyers de travailleurs migrants à Nanterre : la fabrique de territoires." Revue Francaise Des Affaires Sociales(3): 275-292.
https://www.cairn.info/revue-francaise-des-affaires-sociales-2021-3-page-275.htm

Cet article explore les inégalités de santé au sein de la population immigrée vieillissante résidant en foyer de travailleurs migrants. Le propos se focalise sur cette population afin de saisir les spécificités du foyer comme lieu de vie, ses effets sur l'état de santé et le recours aux soins des travailleurs immigrés âgés. On observe des indicateurs plus défavorables dans la population vivant en foyer au regard de celle résidant en habitat classique : couverture de santé moins étendue, recours moindre aux médecins spécialistes, plus forte proportion de personnes précaires, etc. Cet état des lieux relevant de constructions sociales et territoriales ne donne pas les mêmes chances de vieillir en bonne santé aux immigrés résidant en foyer. On note particulièrement l'influence de facteurs comme le cadre social et spatial du lieu d'habitation, le réseau social, le rapport à la ville, les politiques communales, etc. La santé est un révélateur du quotidien vécu par cette population, mais également de leur intégration par les pouvoirs publics dans la société française. L'analyse géographique proposée, par l'étude des interactions respectives entre espace, société et santé, présente ainsi l'intérêt de révéler des mécanismes d'exclusion sociale.

Petruzzi, M., Veïsse, A., Wolmark, L., et al. (2019). "Impact des violences de genre sur la santé des exilé(e)s." Bull Epidemiol Hebd(17-18): 327-333.

Objectifs et méthodes : cette étude a pour but d'évaluer la fréquence des violences fondées sur le genre parmi les personnes exilées suivies au Comité pour la santé des exilés (Comede), les caractéristiques des victimes, ainsi que l'impact de ces violences sur la santé. Elle se fonde sur des données recueillies auprès des 2 065 femmes, dont 449 femmes enceintes, et 3 816 hommes ayant bénéficié d'un bilan de santé et d'un suivi médical au Centre de santé du Comede entre 2012 et 2017, ainsi que des personnes suivies en psychothérapie. Résultats et discussion : entre 2012 et 2017 au Comede, des antécédents de violences de genre ont été retrouvés chez 30% des femmes et 4% des hommes. Ces violences sont plus fréquentes chez les jeunes et chez les exilés originaires d'Afrique subsaharienne. Elles sont très liées à la situation de vulnérabilité sociale, en particulier une partie des

viols subis par les femmes ayant lieu en France. Les troubles psychiques graves sont particulièrement fréquents parmi les victimes (59% des femmes et 84,9% des hommes) et sévères sur le plan clinique, plus des trois quarts des patients concernés souffrant de syndromes psychotraumatiques et de traumas complexes. Les victimes de violence fondées sur le genre sont également plus souvent atteintes d'infection par le VIH et relèvent plus souvent d'une prise en charge pluridisciplinaire, incluant des soins ostéopathiques. Ces résultats corroborent en partie d'autres travaux réalisés sur le sujet, ces violences apparaissant notamment plus fréquentes parmi les femmes et plus sévères parmi les hommes exilés. Conclusion : cette étude met en lumière l'impact des violences de genre dans un contexte de multiples facteurs de vulnérabilité pour la santé, la perpétuation de certaines violences en France signant l'insuffisance ou la défaillance des dispositifs de protection théoriquement prévus. Les actions de prévention et de soins reposent sur la création d'espaces de parole rassurants, individuels et collectifs, dans un cadre pluridisciplinaire intégrant la nécessité de la « mise à l'abri » des personnes exilées.

Pursch, B., Tate, A., Legido-Quigley, H., et al. (2020). "Health for all? A qualitative study of NGO support to migrants affected by structural violence in northern France." Social Science & Medicine **248**: 112838.

Spira, A. (2017). Précarité, pauvreté et santé. Paris Académie Nationale de Médecine**:** 24. http://www.academie-medecine.fr/articles-du-bulletin/publication/?idpublication=100733

Dans un contexte général d'amélioration de la santé, plus de 5 millions de personnes ne disposent pas de la totalité de leurs droits à la santé en France en 2017. L'espérance de vie à 35 ans des plus pauvres est diminuée de plusieurs années, de nombreuses pathologies sont fortement augmentées parmi eux, en particulier le risque de dépression, de maladies métaboliques et de maladies cardio-vasculaires. Ce rapport a pour but de proposer des dispositifs spécifiques et coordonnés qui pourraient améliorer, pour les personnes pauvres et précaires, l'accès aux droits en santé, le recours au système de soins et la prévention des maladies.

Spira, A., Gallois, L., Kerouedan, D., et al. (2019). "La santé des migrants : dossier." Bulletin De L'academie Nationale De Medecine **203**(1-2): 9-41.

Après un aperçu statistique sur la population migrante dans le monde, ce dossier rassemble une série d'articles sur l'état de santé et le recours aux soins des migrants en France et sur la crise de solidarité actuelle existant dans l'ensemble des pays européens.

Stanojevich, E. A. and A. Weïsse (2007). "La santé des migrants." Santé de l'homme(392): 21-24.

Vaillant, N. and F. C. Wolff (2010). "Origin differences in self-reported health among older migrants living in France." Public Health **124**(2): 90-98.

OBJECTIVES: Little is known about the health status of older migrants living in Europe. Using detailed data collected in 2003, this study investigated differences in health status by country of origin within the older immigrant population living in France using a self-rated health measure. STUDY DESIGN: The database used in this research was the Passage a la Retraite des Immigres survey, conducted from November 2002 to February 2003 on a sample of 6211 migrants aged 45-70 years and living in France at the time of the survey. METHODS: A difficulty with a self-rated outcome is that it may not be comparable between different origin groups, particularly because of cultural and linguistic differences. Therefore, generalized ordered Probit models were estimated, and an indicator of health, net of cross-cultural effects was constructed for each respondent. RESULTS: This study found that male immigrants from southern Africa and Asia, and female immigrants from northern Europe, southern Africa and Asia are more likely to be in good health, while the health status is lower among immigrants from Eastern Europe living in France. CONCLUSION: The diversity in health status within the immigrant population is large in France. These results are helpful in order to target the more disadvantaged origin groups and to adjust the provision of health care.

Wluczka, M., et al. (2008). La santé des primo-migrants en 2007 : Etude réalisée à partir des enquêtes "semaine

données". Paris ANAEM**:** 19.
http://www.anaem.fr/IMG/pdf/la_sante_des_primo-migrants_en_2007_.pdf

Aux mois de mai et novembre 2007, les équipes médicales des Délégations de l'ANAEM ont participé à un recueil exhaustif de données à partir des fiches médicales révisées "semaine données". Ce recueil a permis de dresser une synthèse de l'état de santé des primo-migrants vus par le service médical dans des conditions de représentativité satisfaisante, la cohorte ainsi enregistrée représente 8119 dossiers. La limite de représentativité de l'enquête repose sur les paramètres suivants : - La motivation inégale des équipes médicales et des médecins chargés du recueil : plus les équipes sont nombreuses, plus les médecins travaillent à temps plus complet pour l'ANAEM et meilleure est la collecte des données, que ce soit sur le plan quantitatif ou qualitatif. - Des efforts ont été particulièrement fait en 2007 pour améliorer le recueil de ces données, et cela se remarque pour la majorité pathologies relevées, mais il reste encore des points faibles sur lesquels nous travaillons. (Introd.).

L'émergence de certaines pathologies : diabète, sida, hépatite, tuberculose…

Antoine, D., et al. (2014). "Les cas de tuberculose déclarés en France en 2012." Bulletin Epidemiologique Hebdomadaire(20): 352-359.

Les données présentées dans cet article concernent les cas de tuberculose maladie déclarés en France au cours de l'année 2012. Le nombre de cas de tuberculose maladie déclarés était de 4 975 en 2012 en France, soit 7,6 cas pour 100 000 habitants. Le nombre de cas est resté stable comparé à 2011 (4 991 cas, soit - 0,3%). Les données épidémiologiques montrent que, malgré une incidence nationale faible et en baisse depuis plusieurs décennies, la tuberculose n'est pas encore maîtrisée partout en France. Comme les années précédentes, les taux de déclaration de la maladie restent plus élevés en Île-de-France, en Guyane et à Mayotte et dans certains groupes de population, particulièrement les personnes nées à l'étranger arrivées récemment en France. Cet élément souligne l'importance de ne pas relâcher la vigilance en matière de maîtrise de la tuberculose, particulièrement pour ces populations, afin de garantir une bonne prise en charge des cas et limiter les résistances aux antituberculeux. Enfin, entre 2000 et 2012, le taux de déclaration de tuberculose a augmenté en France métropolitaine hors Île-de-France parmi les moins de 5 ans. Cette situation nécessite donc une attention particulière, notamment dans le contexte d'une couverture vaccinale BCG insuffisante, en particulier hors Île-de-France, et doit inciter à poursuivre les efforts d'information et de sensibilisation des médecins à l'intérêt et à la pratique de la vaccination par le BCG. (R.A.).

Antoun, F., et al. (2003). "Epidémie de tuberculose dans un foyer de migrants à Paris en 2002." Bulletin Epidemiologique Hebdomadaire(10-11): 58-60, graph., tabl.

[BDSP. Notice produite par ORSRA 2wR0x4hV. Diffusion soumise à autorisation]. Au cours d'un dépistage dans un foyer en mars 2002, où précédemment une tuberculose était diagnostiquée chaque année, 13 cas de tuberculose ont été identifiés dont 2 bacilifères à l'examen microscopique. Deux autres sessions de dépistage ont été organisées en juin et en septembre 2002. Au total 34 diagnostics de tuberculose ont été posés. Les caractéristiques de ces cas sont analysées.

Brouard, C., Vau, S. (coor.) (2017). Hépatites B et C en populations spécifiques. Bulletin Épidémiologique Hebdomadaire(14-15° / 251-290.
http://invs.santepubliquefrance.fr/beh/2017/14-15/pdf/2017_14-15.pdf

Caumes, E. and G. Brucker (1995). "Epidémiologie des infections rencontrées chez les migrants." Revue Du Praticien (La)(45): 1445-1448, 1443 tabl.

Che, D. and D. Antoine (2011). "[Epidemiology of tuberculosis in France in 2008]." Med Mal Infect **41**(7): 372-378.

A total of 5,758 tuberculosis cases were notified in France in 2008, giving a rate of nine cases per

100,000 inhabitants. The median age was 45 years and 59% of cases were male patients. Ile-de-France (Paris and greater Paris area) and French Guiana had the highest notification rate in 2008 (17.9/10(5) and 22.6/10(5) respectively). The rate of tuberculosis was higher in individuals born abroad (43.2/10(5) vs. 5.0/10(5) for individuals born in France), especially those recently arrived in France. Pulmonary tuberculosis accounted for 72% of notified cases, 76% of which were potentially contagious (positive sputum smear, or culture). Compared to 2007, the number of notified tuberculosis cases increased by 3.3% in 2008. This increase was not accompanied by a rise of severe cases (meningitis and miliary TB); this seemed to be due partly to improvement in identification and notification of cases. However this trend could require specific monitoring in future years. A national tuberculosis control program was launched in France in 2007, aiming at reducing epidemiological disparities. Clinical and public health expertise needs to be maintained on all the territory to ensure that implemented measures can have the expected impact on the epidemiology of the disease.

Che, D., et al. (2004). "Les cas de tuberculose déclarés en France en 2002." Bulletin Epidemiologique Hebdomadaire(4): 13-16, 13 fig., 12 tabl.

[BDSP. Notice produite par INVS NoT1LR0x. Diffusion soumise à autorisation]. Les données recueillies sur la tuberculose par la déclaration obligatoire mise en place depuis 1964, montrent que l'épidémiologie de cette maladie est en progressive mutation en France. Chaque année, l'incidence de la tuberculose décroît pour les sujets de nationalité française alors qu'elle augmente très fortement dans la population de nationalité étrangère, particulièrement pour les sujets d'origine subsaharienne, avec des taux d'incidence similaires à ceux retrouvés dans les pays d'origine. Les groupes de population les plus à risques ont été régulièrement identifiés par la surveillance épidémiologique : migrants en provenance de pays à forte prévalence et notamment les sujets jeunes d'Afrique subsaharienne, sans domicile fixe, personnes en situation de précarité économique et sociale. De la même manière, les aires géographiques regroupant le plus grand nombre de nouveaux cas de tuberculose sont bien définies et l'Ile-de-France représente toujours la région de plus forte incidence. Cependant, la description de la situation épidémiologique n'a pas été suivie de mesures spécifiques vis-à-vis des populations les plus à risques. Dans ce contexte évolutif, cet article décrit les données issues de la déclaration obligatoire de la tuberculose pour l'année 2002.

Choukem, S. P., et al. (2014). "Influence of migration on characteristics of type 2 diabetes in sub-Saharan Africans." Diabetes Metab **40**(1): 56-60.

AIM: This study compared the clinical and biochemical characteristics and microvascular complications found in three groups of type 2 diabetes (T2D) patients: Africans living in Africa; African immigrants living in France; and Caucasians living in France. METHODS: Diagnosed T2D Africans living in Cameroon (n=100) were compared with 98 African migrants diagnosed with T2D after having moved to France, and a group of 199 T2D Caucasian patients living in France. All underwent clinical and biochemical evaluations, and all were assessed for microvascular complications. RESULTS: The median duration of stay of the migrants in France was 15years before being diagnosed with diabetes. Despite similar durations of diagnosis, they were 8.9years younger at the time of diagnosis than Africans living in Cameroon (P<0.001). Caucasians and African immigrants in France had lower HbA1c values than Africans in Cameroon (P<0.001); they were also more aggressively treated for hypertension and dyslipidaemia and, therefore, had significantly lower blood pressure levels and better lipid profiles. Diabetic nephropathy and retinopathy rates were higher in Cameroon than in the two other groups. After adjusting for age, diabetes duration, HbA1c, hypertension and other covariates, only the prevalence of diabetic nephropathy (OR: 5.61, 95% CI: 2.32-13.53; P<0.0001) was higher in Cameroon compared with those living in France. CONCLUSION: Our results suggest that Africans who emigrate to France may develop diabetes earlier than those staying in their home country. However, the latter may be a reflection of late diagnosis of diabetes. Also, the less adequate diabetes and hypertension control in the latter would explain their higher rates of nephropathy. Large-scale cohorts are now warranted to substantiate these observations.

Deneux, T. Haraux, C., et al. (2009). "Surmortalité maternelle des femmes de nationalité étrangère en France et qualité des soins obstétricaux : étude nationale 1996-2001." Bulletin Epidemiologique

Hebdomadaire(9): 77-80.
http://www.invs.sante.fr/beh/2009/09/beh_09_2009.pdf

[BDSP. Notice produite par InVS srHnR0x8. Diffusion soumise à autorisation]. Objectif - Comparer le risque de décès maternel des femmes de nationalité étrangère à celui des femmes françaises et examiner si la qualité des soins reçus par les femmes décédées diffère selon la nationalité. Méthode - Étude cas-témoins nationale en France. Les 267 cas étaient les décès maternels identifiés par l'Enquête confidentielle sur les morts maternelles pour 1996-2001. Les 13 186 témoins provenaient de l'Enquête nationale périnatale de 1998. Résultats - Après prise en compte des facteurs de confusion, le risque de décès maternel était 2 fois plus important pour les femmes de nationalité étrangère : OR 2,0 (1,4-2,8). Après ajustement sur l'âge, l'OR était de 5,5 (3,3-9,0) pour les femmes de nationalité d'Afrique subsaharienne, et de 3,3 (1,7-6,5) pour les femmes des pays d'Asie et d'Amérique. Le risque de décès maternel par complications de l'hypertension et par infection était multiplié par 4 chez les femmes de nationalité étrangère. Parmi les décès, les soins prodigués étaient plus souvent non optimaux chez les femmes de nationalité étrangère (78% vs 57%). Conclusion - La nationalité étrangère est associée à un sur-risque de décès maternel, qui est particulièrement important pour certaines nationalités et causes de décès. Parmi les décès maternels, la nationalité étrangère est associée à une moindre qualité des soins, suggérant que le sur-risque de décès maternel pourrait être en partie expliqué par des facteurs liés aux soins. (R.A.).

Desgrees, et al. (2015). "Migrants subsahariens suivis pour le VIH en France : combien ont été infectés après la migration ? Estimation dans l'Étude ANRS-Parcours." Bulletin Epidemiologique Hebdomadaire(40-41): 752-758.
http://www.invs.sante.fr/Publications-et-outils/BEH-Bulletin-epidemiologique-hebdomadaire/Archives/2015/BEH-n-40-41-2015

[BDSP. Notice produite par InVS R0xqH9oJ. Diffusion soumise à autorisation]. Contexte : les données épidémiologiques disponibles suggèrent qu'une part non négligeable des migrants d'Afrique subsaharienne qui vivent avec le VIH en Europe ont été infectés après leur arrivée, sans que cette proportion soit précisément connue. Matériel et méthodes : nous avons estimé la proportion de migrants subsahariens qui ont acquis le VIH après leur arrivée en France, en combinant les données biographiques et cliniques recueillies au sein d'un échantillon représentatif de patients nés en Afrique subsaharienne et suivis pour une infection à VIH dans les hôpitaux d'Île-de-France. L'infection était considérée comme acquise en France si l'un des critères biographiques suivants était rempli : 1) une durée de séjour en France avant le diagnostic d'au moins 11 ans, 2) un test VIH négatif après l'arrivée en France, 3) le premier rapport sexuel après l'arrivée en France. Lorsqu'aucun de ces critères n'était rempli, nous avons estimé la durée depuis la contamination à partir de la première mesure des CD4 en utilisant un modèle statistique de déclin des CD4. Cette durée a été estimée 500 fois pour chaque enquêté. Nous avons considéré que la contamination était survenue en France si au moins 50% (en scénario médian) ou au moins 95% (en scénario conservateur) des 500 durées estimées étaient inférieures à la durée de vie en France. Résultats : parmi 898 adultes infectés par le VIH nés dans un pays d'Afrique subsaharienne, nous avons estimé que 49% [IC95% : 45-53] d'entre eux en scénario médian et 35% [31-39] en scénario conservateur ont acquis le VIH après leur arrivée en France. Cette proportion était plus basse pour les femmes que pour les hommes (30% [25-35] vs. 44% [37-51] dans le scénario conservateur) et augmentait avec la durée du séjour en France. Conclusion : au vu de cette proportion importante de migrants d'Afrique subsaharienne infectés par le VIH après la migration, il apparaît nécessaire d'améliorer la prévention dans ce groupe de population et, pour cela, de mieux comprendre les déterminants de ces infections survenues en France.

D'Hermies, F. and H. de Champs-Leger (2015). "[Ophthalmology and urban underprivileged. Experience of 150 patients]." J Fr Ophtalmol **38**(1): 1-6.

INTRODUCTION: An ophthalmology consultation was carried out at the Hotel-Dieu to facilitate eye care in underprivileged patients referred by the general medicine PASS (socialized health care) of the same hospital. MATERIALS AND METHODS: The files of 150 consecutive patients examined by a single ophthalmologist between January 2012 and June 2013 were reviewed. A standard examination was

performed in these patients, sent with a consult sheet, to which a response was sent to PASS. As necessary, prescriptions were also written for the patients. RESULTS: Most patients (89/150) were immigrants from sub-Saharan Africa. Additionally, there were 25 Europeans with only 5 French, and 17 Asians. The mean age was 41 years with 90 men (mean age 43) and 60 women (mean age 36). The most common systemic diseases observed were hypertension, (13), diabetes (6), and hepatitis (6). The mean best-corrected visual acuity (129 patients) was a slightly more than 8/10 (16/20) (measurable in 143 patients). Refractive state (measured in 129 patients) was myopia (46), hyperopia (41), presbyopia (isolated in 12 cases), astigmatism (26), and emmetropia (28). Optical correction was prescribed in 87 patients. The main pathological conditions included pingueculae (19), cataracts (19), trauma (13) of which 4 patients were monocular, and pterygia (9). DISCUSSION AND CONCLUSION: Refractive errors were the main abnormality observed in these underprivileged patients. Apart from cataract as a pathologic condition observed in the general population, more characteristic of this sub-Saharan population were pinguecula, pterygium and trauma. This study highlights the more general question of access to eye care for all underprivileged patients.

Dourgnon, P. and Y. Moullan (2015). Social determinants of overweight among immigrants in Spain and France. The IMI Working Papers Series ; 116. Oxford Université d'Oxford**:** 49 , tabl.
http://www.imi.ox.ac.uk/publications/new-imi-working-paper-on-the-differences-of-overweight-between-immigrants-and-natives-in-france-and-spain

This study addresses immigrant health from the point of view of social health inequalities research. We study differences in overweight between immigrants and natives in two countries, France and Spain. Controlling for socioeconomic characteristics, we focus on effects that pertain to the country of origin and to the country of arrival in explaining overweight prevalence. We first estimate and compare between France and Spain, in women and men, the effect of immigration status on overweight when controlled for age, socioeconomic status (SES), and country of origin. We study the role of length of stay as proxied by naturalisation status and according to country of origin. We investigate the role of GDP, HDI and obesity prevalence in the country of origin. We then estimate how differences in population compositions and differences in estimated coefficients contribute to observed differences in overweight between natives and migrants for each country.

Dray, Spira R., et al. (2015). "Caractéristiques des personnes originaires d'Afrique subsaharienne suivies pour une hépatite B chronique en Île-de-France en 2012-2013. Données de l'enquête ANRS-Parcours." Bulletin Epidemiologique Hebdomadaire(19-20): 339-347.

[BDSP. Notice produite par InVS ClkHAR0x. Diffusion soumise à autorisation]. En France, les migrants originaires d'Afrique subsaharienne sont particulièrement touchés par l'hépatite B chronique. Cependant, les caractéristiques des personnes originaires d'Afrique subsaharienne porteuses d'une hépatite B chronique et leurs spécificités sur le plan sociodémographique, épidémiologique et clinique ne sont pas bien connues. Cet article décrit les caractéristiques des personnes originaires de cette région suivies pour une hépatite B chronique en Île-de-France à partir des données de l'enquête ANRS-Parcours, menée en 2012-2013 auprès d'un échantillon aléatoire de 778 consultants dans 20 structures de soins. Les résultats indiquent que les personnes originaires d'Afrique subsaharienne suivies pour une hépatite B chronique constituent une population relativement jeune (âge médian : 39 ans), installée en France de façon durable (depuis 10 ans en médiane). Les situations de précarité sociale et/ou administrative sont fréquentes (12,1% de personnes sans logement stable, 32,1% sans emploi, 25,8% sans couverture santé ou couvertes par l'aide médicale d'État), tout particulièrement parmi les femmes et les personnes suivies dans d'autres structures que les services experts en hépatologie. Le maintien du secret sur le statut VHB vis-à-vis de l'entourage est fréquent, en particulier chez les hommes (23,9%). Le diagnostic d'hépatite B chronique n'a été établi qu'après l'arrivée en France dans l'immense majorité des cas, après un délai de 3 ans en médiane et dans des circonstances variées. Si le dépistage systématique occupe une place prépondérante parmi les femmes, il n'est à l'origine que de moins d'un tiers des diagnostics chez les hommes, parmi lesquels le diagnostic survient dans un délai plus long après l'arrivée en France et plus souvent lors d'une phase active de la maladie. Les caractéristiques de l'hépatite B chronique et de sa prise en charge n'apparaissent pas différentes selon que les personnes sont suivies dans des services experts en

hépatologie ou dans d'autres structures de soins. Ces résultats fournissent des informations utiles pour contribuer à améliorer le dépistage, la prévention de la transmission et la prise en charge de l'hépatite B parmi les personnes originaires d'Afrique subsaharienne.

Durieux, P. (1992). "Epidémiologie des infections rencontrées chez les migrants et leur famille." Revue Du Praticien (La) **42**(2): 259-261, 252 tabl.

Fosse-Edorh, S., et al. (2014). "Type 2 diabetes prevalence, health status and quality of care among the North African immigrant population living in France." Diabetes Metab **40**(2): 143-150.

AIM: This report is an overview of type 2 diabetes (DT2) in the North African immigrant population living in France. METHODS: Data were collected in two separate cross-sectional national surveys. DT2 prevalence was estimated using a population-based survey involving 13 959 people aged >/= 45 years (EDS), while health status and quality of care were evaluated using a sample of 3894 DT2 patients (ENTRED). RESULTS: Prevalence of DT2 and obesity was 14.0% [CI 95%: 9.9; 18.0] and 20.5% [15.7; 25.3], respectively, in participants born in North Africa (BNA) and 7.5% [7.0; 8.0] and 15.8% [14.7; 16.8], respectively, in those born in France (BIF). DT2 was associated with region of birth in women after adjusting for age, body mass index and income or occupation, but not after adjusting for education level. In men, DT2 was not associated with region of birth. BNA and BIF patients with diabetes frequently benefited from free medical coverage (88% vs. 84%, respectively), although BNA diabetic patients visited a general practitioner less frequently than BIF (8.5 vs. 9.0 visits/year, respectively). The percentage of BNA vs. BIF diabetes patients tested three times a year for HbA1c was lower (39% vs. 44%), while HbA1c was higher in BNA vs. BIF diabetics (> 8%: 30% vs. 15%). Ophthalmological complications were also more frequent in BNA vs. BIF patients with diabetes (25% vs. 18%, respectively). CONCLUSION: The greater prevalence of DT2 in BNA women and the poorer glycaemic control observed in the BNA population overall both probably contribute to disparity in diabetes mortality compared with BIF diabetics, a fact that has been observed in previous studies.

Genty, S., et al. (2006). "Problèmes de santé des migrants africains qui voyagent au pays." Bulletin Epidemiologique Hebdomadaire(23-24): 168-170, 162 fig.

[BDSP. Notice produite par InVS R0xD60d0. Diffusion soumise à autorisation]. La médecine des voyages est une discipline récente dont les principaux objectifs sont d'informer les voyageurs sur les risques de problèmes de santé pendant les séjours à l'étranger, principalement en zones tropicales, d'en assurer la prévention et de les prendre en charge au retour. Le choix des moyens préventifs, pour certains onéreux et à la charge des voyageurs, repose principalement sur l'évaluation du risque. Or nous ne disposons que de très peu d'études sur ce sujet, notamment chez certaines populations particulièrement à risque comme les migrants (personnes issues de pays en développement et vivant dans un pays industrialisé) qui représentent pourtant une part importante des voyageurs internationaux (entre 20 et 40%). C'est la raison pour laquelle nous avons débuté dans le centre de conseils aux voyageurs de trois hôpitaux du nord de Paris une étude dont les objectifs principaux étaient de décrire les principaux problèmes de santé rencontrés par des migrants africains retournant dans leur pays d'origine en Afrique subsaharienne pour des vacances et les moyens préventifs utilisés. (Introduction).

Girard, S., Barbe, A., Vareilles, G., et al. (2021). "Données rétrospectives du dépistage radiologique et du suivi de la tuberculose maladie auprès de la population étrangère primo-arrivante, recueillies par le Centre de lutte antituberculeuse de l'Isère en 2018." Bulletin Epidemiologique Hebdomadaire (BEH)(12): 7. http://beh.santepubliquefrance.fr/beh/2021/12/2021_12_1.html

En 2018 le centre de lutte antituberculeuse de l'Isère (Clat 38) a renforcé la stratégie de dépistage et de prise en charge de la tuberculose maladie (TM) auprès de la population étrangère primo-arrivante. Cet article présente les résultats du dépistage radiologique et suivi des TM auprès de cette population en 2018. Cette étude rétrospective concerne les adultes, foyers familiaux ou jeunes mineurs non accompagnés (JMNA), arrivés en France depuis moins de deux ans et ayant eu une radiographie pulmonaire (RP) de dépistage ou diagnostiqués pour une TM en Isère en 2018.

Guthman, J. P. c. (2020). "La tuberculose en France : une maladie des populations les plus vulnérables." Bulletin Epidemiologique Hebdomadaire (BEH)(10-11): 39.
http://beh.santepubliquefrance.fr/beh/2020/10-11/index.html

La maîtrise de la tuberculose passe donc par des solutions adaptées aux populations les plus exposées. L'article de C. Fac et coll. sur le dépistage de la tuberculose en prison montre l'importance de pouvoir assurer le lien avec le système de soins extérieur à la prison, afin de permettre une prise en charge ou une continuité des soins après la sortie de prison, pour une population souvent en situation de précarité et marginalisée. En Seine-Saint-Denis, comme en témoigne l'article de A. Castro et coll., l'incidence de tuberculose est quatre fois supérieure au niveau national, avec une répartition de la maladie similaire à celle des indicateurs de défavorisation sociale. Les auteurs indiquent donc la nécessité de développer des actions de prévention et de prise en charge de la tuberculose, en allant de façon active vers les populations les plus exposé.

Kern, T., et al. (2005). "Tuberculose chez les sans domicile fixe à Paris : mise en oeuvre de la stratégie DOT, Directly Observed Therapy." Bulletin Epidemiologique Hebdomadaire(17-18): 73-74, 71 tabl.

[BDSP. Notice produite par INVS tAR0xNwa. Diffusion soumise à autorisation]. Paris est la ville ayant le taux d'incidence de la tuberculose le plus élevé en France en 2002, 54,1 cas pour 100 000, soit 5 fois le taux national. Des taux élevés sont retrouvés dans les grandes agglomérations de nombreux pays de l'Ouest de l'Europe où l'incidence de la tuberculose est faible. Ces taux élevés s'expliquent par la concentration de personnes à risque de tuberculose : les migrants en provenance de pays à forte prévalence, les personnes infectées par le VIH, les personnes sans domicile fixe. Entre juin 1999 et mai 2000, un dépistage radiologique systématique de la tuberculose a été réalisé dans les centres d'hébergement du Samusocial de Paris avec l'aide de la Direction de l'action sociale, de l'enfance et de la santé (Dases). Il a porté sur 663 personnes et permis de détecter 9 tuberculoses contagieuses (1,4%). Par ailleurs, durant la même période 28 cas de tuberculose ont été diagnostiqués chez des personnes présentant des symptômes. Les difficultés de prise en charge thérapeutique de ces 37 patients (taux d'échec voisin de 50%), ont conduit à formaliser les principes et les modalités d'action d'une équipe dédiée à cette tâche. Fin 2000, une équipe mobile de lutte contre la tuberculose (EMLT) a été mise en place avec pour objectif le suivi thérapeutique des personnes sans domicile dans le cadre d'un travail en réseau (R.A.).

Kehr, J. (2021). Spectres de la tuberculose. Une maladie du passé au temps présent, Rennes : Presses universitaires de Rennes

À partir d'une enquête ethnographique sur la tuberculose, l'une des maladies infectieuses les plus meurtrières, ce livre dévoile les pratiques ordinaires de lutte contre cette affection en France et en Allemagne. La tuberculose est une maladie sociale qui prospère en notre période de précarité croissante. Elle est vue comme une maladie du passé dans un monde tourné vers l'avenir et comme une maladie des immigrés dans un monde pétri de frontières nouvelles et anciennes. En joignant une sensibilité historique à une ethnographie fine de la lutte contre la tuberculose dans des institutions de soin et de prévention, l'ouvrage éclaire les hantises du passé et les paradoxes médicaux, politiques et sociaux qui informent la pratique clinique et la santé publique au quotidien.

Klat, M., Legleye, S. et Bricard, D. (2020). "Gender Patterns in Immigrants' Health Profiles in France: Tobacco, Alcohol, Obesity and Self-Reported Health." Int J Environ Res Public Health **17**(23): 1-10.
https://www.mdpi.com/1660-4601/17/23/8759

To date, little attention has been given to gender differences in the health of migrants relative to native-born. In this study, we examine the health profile of the largest immigrant groups in metropolitan France, considering several health indicators and with a special interest in the gendered patterns.

Lapostolle, A., et al. (2011). "Time since the last HIV test and migration origin in the Paris metropolitan area, France." AIDS Care **23**(9): 1117-1127.

> In France, the newly diagnosed infection rate was 372/100,000 for African immigrants versus 6/100,000 for the French-born population in 2008. In addition, people from sub-Saharan countries were at higher risk for late diagnosis than native-born French despite their more frequent use of HIV testing. The purpose of this study was to compare the mean time since the last HIV test according to migration origin. This study used data from the SIRS (a French acronym for health, inequalities, and social ruptures) cohort, which, in 2005, included 3023 households representative of the greater Paris area. HIV testing uptake and the time since the last test were studied in relation to socio-economic factors, psychosocial characteristics, and migration origin. Multivariate ANOVA analyses were performed using Stata 10. People from sub-Saharan Africa were more likely to have been tested in their lifetime (78.51%) than those of French (56.19%) or Maghreb (39.74%) origin (p<0.0000). The mean time, in years, since the last HIV test was shorter among sub-Saharan immigrants and Maghreb immigrants (2.15 and 2.53 years, respectively) than among native-born French (4.84 years) (F=12.67; p<0.0000). These differences remained significant even after adjusting for gender, age, number of steady relationships, time lived in France, and difficulty reading and/or writing French (F=5.73; p=0.0007). A gender analysis revealed the same pattern for both sexes, with greater differences in the mean duration by migration origin for women. These results and recent epidemiological data seem to show that since the early 2000s, measures aimed at increasing HIV testing and decreasing late diagnosis in sub-Saharan immigrants have been effective.

Lebouche, B., et al. (2006). "Incidence rate and risk factors for loss to follow-up in a French clinical cohort of HIV-infected patients from January 1985 to January 1998." HIV Med **7**(3): 140-145.

> OBJECTIVES: To determine the incidence rate and risk factors for loss to follow-up (LFU) in HIV-infected individuals. METHODS: We estimated the incidence rate of LFU in 1756 HIV-infected patients enrolled in the Tourcoing Clinical Cohort from January 1985 to January 1998. We then investigated potential LFU risk factors at inclusion through a case-control study. Cases were 209 patients who had attended neither our clinic nor another HIV clinic for at least 1 year. Controls were 209 patients randomly selected from the group of HIV-infected patients followed up regularly. RESULTS: The incidence of LFU was estimated at 4.3 per 100 person-years [95% confidence interval (CI) 3.7-4.9]. Independent risk factors for LFU were (i) year of enrolment before 1993 [odds ratio (OR) 6.7; 95% CI 2.7-16.5 versus after 1997]; (ii) year of enrolment between 1993 and 1997 (OR 5.1; 95% CI 2.0-13.0 versus after 1997); (iii) age<30 years (OR 1.8; 95% CI 1.0-3.5 versus >40 years); (iv) injecting drug use (OR 5.3; 95% CI 2.7-10.5 versus men who have sex with men); (v) homelessness and/or illegal immigrant status (OR 2.2; 95% CI 1.0-4.9); and (vi) lack of a primary care provider (OR 6.0; 95% CI 2.4-15.1). A history of an AIDS-defining illness (OR 0.3; 95% CI 0.2-0.6) and a history of psychiatric disease (OR 0.4; 95% CI 0.3-0.8) were both associated with a decreased risk of LFU. CONCLUSIONS: This study assessed the sociodemographic, clinical and behavioural characteristics associated with LFU in HIV-infected patients. The findings of this study may allow clinicians to identify patients at risk of LFU, so that appropriate interventions may be initiated.

Lebrun, C., et al. (2008). "Impact of disease-modifying treatments in North African migrants with multiple sclerosis in France." Mult Scler **14**(7): 933-939.

> BACKGROUND: Multiple Sclerosis in North African migrants (MS-NA) is more aggressive with mostly primary progressive forms and cerebellar symptoms. Despite an earlier onset in NA patients, the disease progresses more rapidly, with a higher proportion showing incomplete recovery from the first relapse, a shorter time between the first two relapses, a higher number of relapses in the first 5 years, and a shorter time to reach an EDSS of 4.0 and 6.0. We collected data and studied the impact of disease-modifying therapies (DMT) in NA patients with MS, among the 4144 MS patients treated in our MS clinics. METHODS: We performed a descriptive population-based study of MS-NA patients. Data were crossed with expected age- and gender-matched characteristics available in our EDMUS databases for the period 1995-2007. RESULTS: A total of 133 patients, representing 66% of the MS-NA patients included in the database were identified: mean age at the first documented symptom: 29.7 years; mean time from diagnosis to the beginning of DMT: 1.2 years. 40% of MS-NA patients had an EDSS >3 at the beginning of treatment (vs. 25%; P=0.002). A majority of patients were treated initially

with immunomodulatory drugs (MS-NA: 48% vs. CT: 51%, P=0.8). NA patients were treated earlier after diagnosis (1.3 years vs. 4.5 years, P=0.003), with the frequent use of immunosuppressive drugs: for remitting forms, mitoxantrone (18.5% vs. 7.8%, P=0.0001) and for progressive forms, cyclophosphamide (38% vs. 28%, P=0.003). CONCLUSIONS: Considering EDSS follow-up during DMT, MS-NA patients appear as responsive as other MS patients to treatment, despite the earlier treatment prescription and the more frequent use of immunosuppressors.

Le, Bihan. S., et al. (1993). "Les accidents de la vie courante chez les enfants appartenant à des familles d'origine étrangère." Bloc-Notes Statistique(63): 36 , tabl.

Cette étude constitue une première tentative pour décrire les accidents de la vie courante qui touchent les enfants appartenant à des familles d'origine étrangère. Les informations traitées ont été recueillies à partir des enquêtes réalisées entre 1987 et 1990 par un certain nombre de Caisses Primaires d'Assurance Maladie, auprès des assurés sociaux du régime général.

Lert, F., et al. (2007). "Functional limitations and overweight among migrants in the Histoire de Vie study (Insee, 2003)." Rev Epidemiol Sante Publique **55**(6): 391-400, tabl., graph.

[BDSP. Notice produite par ORSLR kD9eR0xd. Diffusion soumise à autorisation]. En France, les données épidémiologiques sur la population immigrée sont d'autant plus limitées que la caractérisation des immigrés est considérée comme un enjeu très sensible. L'enquête Histoire de Vie permet de décrire plusieurs caractéristiques de la notion d'immigration et leur association avec deux indicateurs de santé. Les limitations dans la réalisation des activités quotidiennes pour raison de santé et le surpoids (indice de masse corporelle BMI=25 kg/m2) ont été étudiés parmi les 18-64 ans par une standardisation indirecte sur l'âge. Quatre catégorisations ont été effectuées pour rendre compte de la situation d'immigration : ces définitions ont trait à la notion de parcours migratoire de l'interviewé et de ses parents, de nationalité, d'origine géographique, de langue (s) parlée (s) en famille. Les analyses ont été réalisées par sexe, sur l'ensemble de l'échantillon et séparément par catégorie socioprofessionnelle (PCS) (élevées et basses). L'analyse des limitations d'activité a été répétée en excluant les personnes dont la limitation est survenue avant 19 ans, âge moyen de l'immigration, pour examiner l'hypothèse d'un effet de sélection à l'émigration. Concernant les limitations d'activité, on observe un excès de risque chez les hommes nés en/ou ayant au moins un parent né en Europe (SMR : 1,4 ; IC 95% : 1,06-1,81), et un risque réduit chez les personnes nées/ou ayant au moins un parent né hors d'Europe (SMR : 0,63 ; IC 95% : 0,46-0,86), différences qui se maintiennent lorsque le statut social est pris en compte. Chez les femmes, on observe une tendance en faveur d'un moindre risque dans les PCS faibles pour les femmes immigrées à l'âge adulte, les étrangères, les non européennes. Les résultats sur la population sans limitation d'activité à 19 ans ne suggèrent pas de biais de sélection. La fréquence d'un BMI supérieur ou égal à 25 kg/m2 ne diffère pas entre les hommes français et ceux nés à l'étranger, tandis que le risque de surpoids est majoré chez les femmes nées à l'étranger, arrivées à l'âge adulte, en particulier celles de faible statut social, à l'exception des femmes arrivées en France dans l'enfance ou des filles de la deuxième génération. Les résultats témoignent d'une hétérogénéité de l'association entre immigration et santé qui recouvrent des processus multiples et différents selon le sexe ; la deuxième génération semble avoir pour les indicateurs étudiés des résultats proches de ceux des français nés de parents eux-mêmes nés en France. D'autres études sont nécessaires pour élargir l'éventail des indicateurs de santé. · l'avenir, les études de santé en population devraient recueillir les informations nécessaires pour permettre une bonne caractérisation de la population immigrée (Résumé d'auteur.)

Lot, F., Comité Médical pour les Exilés . Le Kremlin Bicêtre (2006). "Place des étrangers dans l'épidémie de VIH-sida en France." Dossier : migrants, étrangers et exilés face au VIH-sida.(17): 1-3.

La proportion importante de nouveaux cas de VIH-sida parmi les personnes de nationalité étrangère en France a conduit les politiques de santé publique à prendre en compte la vulnérabilité particulière de ces populations. Conduite par l'InVS, l'observation épidémiologique a permis de caractériser les groupes les plus vulnérables parmi les étrangers, principalement les Africaines en métropole et les Caribéens dans les Départements français d'Amérique.

Lot, F., et al. (2012). "Trois pathologies infectieuses fréquemment rencontrées chez les migrants en France : le VIH, la tuberculose et l'hépatite B." Bulletin Epidemiologique Hebdomadaire(2-3-4): 25-30.

[BDSP. Notice produite par InVS FHmm7R0x. Diffusion soumise à autorisation]. La prévalence du VIH, de la tuberculose et de l'hépatite B est élevée dans certaines régions du monde, notamment en Afrique subsaharienne et en Asie. L'objectif de cet article est de décrire le poids de ces pathologies dans la population migrante vivant en France. Parmi les 6 700 découvertes de séropositivité à VIH et les 5 276 cas de tuberculose maladie déclarés en 2009, environ la moitié concernait des migrants. Parmi les 1 715 patients pris en charge pour une hépatite B chronique (HBC) en 2008-2009, les trois-quarts étaient migrants. La part de l'Afrique subsaharienne était importante, puisque 70% des migrants découvrant leur séropositivité VIH, 54% de ceux pris en charge pour une HBC et un tiers de ceux déclarés pour une tuberculose étaient nés dans cette partie du monde. Les taux de découvertes de séropositivité VIH et de déclarations de tuberculose étaient en 2009 respectivement 10 et 8 fois plus élevés chez les migrants que chez les non-migrants. Le recours au dépistage du VIH était beaucoup trop tardif chez les migrants nés en Asie ou en Afrique du Nord, ce qui n'était pas observé chez ceux nés en Afrique subsaharienne. La prise en charge après un diagnostic d'HBC chez les migrants nés en Asie ou en zone de moyenne endémicité était également souvent tardive, alors que celle des migrants d'Afrique subsaharienne était l'une des plus rapides. Parallèlement aux actions de prévention, il est donc indispensable de renforcer les stratégies de dépistage du VIH, de l'hépatite B et de la tuberculose dans toutes les populations migrantes. Il est également nécessaire que leur accès au système de soins soit facilité, afin de permettre une prise en charge précoce et un suivi régulier, ceci dans le but de réduire les disparités observées. (R.A.).

Martin-Fernandez, J., et al. (2012). "Overweight according to geographical origin and time spent in France: a cross sectional study in the Paris metropolitan area." BMC Public Health **12**: 937.

BACKGROUND: For the first time in France in a population-based survey, this study sought to investigate the potential impact of migration origin and the proportion of lifetime spent in mainland France on body mass index (BMI) and overweight in adults living in the Paris metropolitan area. METHODS: A representative, population-based, random sample of the adult, French speaking population of the Paris metropolitan area was interviewed in 2005. Self-reported BMI (BMI = weight/height(2)) and overweight (BMI >/= 25) were our 2 outcomes of interest. Two variables were constructed to estimate individuals' migration origin: parental nationality and the proportion of lifetime spent in mainland France, as declared by the participants. We performed multilevel regression models among different gender and age groups, adjusted for demographics and socioeconomic status. RESULTS: In women, a parental origin in the Middle East or North Africa (MENA) was associated with a higher risk of being overweight (especially before the age of 55) and a higher BMI (between 35 and 54 years of age), and so were women of Sub-Sahara African parental origin in the middle age category. Only in the youngest men (< 35 years of age) did we observe any association with parental nationality, with a higher BMI when having a MENA parentage. Regarding the association between the proportion of lifetime spent in France and overweight, we observed that, in women, a proportion of 50% to 99% appeared to be associated with overweight, especially after the age of 35. In men, having spent more than half of one's lifetime in France was associated with a higher risk of overweight among oldest men. CONCLUSIONS: Our results plea for potential cultural determinants of overweight in the migrant and migrants-born populations in the French context of the capital region. Taking into account the people' family and personal migration histories may be an important issue in public health research and policies on overweight and obesity prevention.

Meffre, C., et al. (2006). Prévalence des hépatites B et C en France en 2004. Décembre 2006. Saint-Maurice, Institut de Veille Sanitaire**:** 176p.

Philibert, M., et al. (2008). "Can excess maternal mortality among women of foreign nationality be explained by suboptimal obstetric care?" Bjog **115**(11): 1411-1418.

OBJECTIVES: To test the hypothesis that the risk of postpartum maternal death in France remains

significantly higher for women of foreign nationality after individual characteristics are taken into account and to examine whether the quality of care received by the women who died differs according to nationality. DESIGN: A national case-control study. SETTING: Metropolitan France. POPULATION: A total of 267 women who died of maternal death from 1996 to 2001 as cases and a representative sample (n = 13 186) of women who gave birth in 1998 as controls. METHODS: Crude and adjusted odd ratios were calculated with multivariate logistic regression, and the quality of care for cases was compared according to nationality with chi-square tests or Fisher's exact tests. MAIN OUTCOME MEASURES: Odd ratio for postpartum maternal death associated with nationality and quality of care. RESULTS: After taking individual characteristics into account, the risk of postpartum maternal death was twice as high for foreign women. The odds ratio was 5.5 (95% CI: 3.3-9.0) for women from sub-Saharan Africa and 3.3 (95% CI: 1.7-6.5) for those from Asia, North and South America. There was no significant excess risk of postpartum maternal death for the other European and North Africa women. The risk of dying from hypertensive disorder or infection was four times higher for foreign women. Among women who died, care was more often considered not optimal for foreign women (78 versus 57%). CONCLUSIONS: The excess risk of postpartum maternal death persisted for foreign women after individual characteristics were taken into account and was especially important for some nationalities and for some causes of death, primarily hypertensive disorders. These results point to an immediate need to pay special attention to early enrollment in prenatal care, screening and prenatal management of hypertension, especially in women of sub-Saharan African nationality.

Pistone, T., et al. (2014). "Epidemiology of imported malaria give support to the hypothesis of 'long-term' semi-immunity to malaria in sub-Saharan African migrants living in France." Travel Med Infect Dis **12**(1): 48-53.

BACKGROUND: Short-term semi-immunity to malaria in sub-Saharan African migrants who have recently arrived in non-endemic countries results in less severe imported malaria. Our aim was to investigate the factors associated with imported malaria that would favour the hypothesis of a 'long-term' semi-immunity to malaria in adult travellers of sub-Saharan origin living in France and visiting family or relatives in their country of origin (VFR group). METHOD: The epidemiological, clinical and biological characteristics of imported Plasmodium falciparum malaria in VFR were compared with those of travellers of European origin (TEO). Newly arrived African migrants and European expatriates were excluded. RESULTS: This retrospective study included 106 adult VFR (30%) and 240 adult TEO (70%) with imported P. falciparum malaria treated at the University Hospital Center of Bordeaux between 2000 and 2007. The main regions visited were West Africa (58%) and Central Africa (34%). P. falciparum was associated with severe malaria in 8% of patients (VFR 3% vs. TEO 11%), of which two TEO died. In univariate analysis, the factors associated with P. falciparum malaria in VFR vs. TEO were: female sex, younger age, less frequent use of mosquito nets, poor compliance with chemoprophylaxis, less severe malaria without death, less severe thrombocytopenia and a tendency towards a lower level of parasitaemia and higher haemoglobinaemia. In multivariate analysis, the only factor to be independently associated with P. falciparum malaria in VFR compared to TEO was less frequent severe malaria. CONCLUSIONS: Our results give support to the hypothesis of 'long-term' semi-immunity to malaria in VFR living in France.

Revault, P., et al. (2017). "Infections par le VHB et le VHC chez les personnes migrantes, en situation de vulnérabilité, reçues au COMEDE entre 2007 et 2016." Bulletin Epidemiologique Hebdomadaire(14-15): 271-276.

[BDSP. Notice produite par SANTE-PUBLIQUE-FRANCE A8lR0x9o. Diffusion soumise à autorisation]. Le centre de santé du Comede à l'hôpital Bicêtre reçoit en consultation de médecine un public migrant vivant en Île-de-France, récemment arrivé en France, particulièrement vulnérable. Un bilan de santé est systématiquement proposé, comportant en particulier le dépistage des infections par le VHB et le VHC et réalisé par 96% des consultants. Les résultats sont documentés en continu par les soignants dans une base de données et dans un dossier médical papier. Les prévalences des personnes chroniquement infectées par le VHB et le VHC, parmi 16 095 personnes accueillies en consultation de médecine générale au centre de santé entre 2007 et 2016, sont de 6,8% pour le VHB et de 1,8% pour le VHC. Seules 8% des personnes infectées par le VHB et 15% de celles infectées par le VHC connaissaient déjà leur statut

sérologique. Parmi les personnes accueillies en 2014,6% étaient vaccinées contre le VHB et 45% nécessitaient un rattrapage vaccinal. Un cumul de vulnérabilités plus important est retrouvé chez les personnes infectées par le VHC, qui sont plus âgées. Ces résultats sont en faveur d'une proposition de dépistage au moyen des trois marqueurs du VHB et des anticorps du VHC, complété si besoin par un rattrapage vaccinal ou une orientation pour un suivi et un traitement. De façon plus générale, il s'agit d'améliorer l'accès aux soins et à la prévention chez les migrants cumulant des facteurs de vulnérabilité.

Roville-Sausse, F et al. (2001). "Gain de poids maternel durant la grossesse dans certaines communautés vivant en France." Rev Epidemiol Sante Publique **49**(5): 439-447.

[BDSP. Notice produite par INIST-CNRS R0x7oH0H. Diffusion soumise à autorisation]. Position du problème : L'objectif de cette étude est d'évaluer la situation des femmes enceintes immigrées en région parisienne, à partir des gains de poids moyens durant la grossesse et du poids de naissance des enfants, en fonction de l'origine géographique des futures mères et de leur vécu socio-culturel. Méthodes : L'étude a été réalisée à partir de l'analyse de 559 dossiers de grossesse de femmes venues en consultation prénatale à l'Hôpital Lariboisière (Paris) en 1997 et ayant accouché dans cet hôpital. Les mères étaient originaires du Maghreb, d'Afrique sub-saharienne, de Turquie, du Sri Lanka, de Chine et de France métropolitaine. Les indices de masse corporelle successifs ont été calculés pour chaque sujet, ainsi que les augmentations de cet indice durant le premier semestre de gestation, le troisième trimestre et la grossesse complète. Les moyennes dans chaque communauté étudiées ont été comparées à celles de la population d'origine non immigrée du même service hospitalier. Les poids de naissance des enfants des différentes communautés ont été comparés à ceux des enfants d'origine non immigrée. Résultats : Les femmes des différentes communautés étudiées (sauf les Turques) ont un gain de poids gestationnel moyen inférieur à celui des Françaises non immigrées. Indépendamment du poids prégestationnel, le gain de poids pendant la grossesse représente 20% du poids initial chez les Maghrébines, les Turques et les Chinoises qui mettent au monde des enfants de poids de naissance non différent de celui des Français non immigrés. Le gain de poids moyen représente 15,8% du poids pré-gestationnel des Africaines subsahariennes. Le gain de poids gestationnel représente 18% du poids initial des Sri-Lankaises. Les poids de naissance des enfants dans ces deux communautés sont significativement inférieurs aux moyennes françaises de référence. Par rapport aux pays d'origine, la fréquence des petits poids de naissance est inférieure et le poids de naissance moyen est supérieur. Conclusion : Les femmes originaires d'Afrique du Nord, d'Afrique subsaharienne et d'Asie, récemment immigrées en France, donnent naissance à des enfants de poids moyen satisfaisant. Le nombre de petits poids de naissance est réduit par rapport aux fréquences que l'on observe dans le pays d'origine. Quelles que soient les raisons de leur immigration et quel que soit le statut socio-économique des familles immigrées qui vivent en France, les nouveau-nés ont un poids de naissance moyen suffisant pour permettre une bonne croissance staturo-pondérale ultérieure.

Wanner, P., et al. (1995). "La mortalité par cancer chez les migrants suisses en France." Rev Epidemiol Sante Publique **43**(1): 26-36, tabl.

[BDSP. Notice produite par ENSP idS2R0xr. Diffusion soumise à autorisation]. A partir des données françaises de mortalité de 1979 à 1985, les risques de décès par cancer chez les migrants suisses ont été calculés par rapport aux natifs. En l'absence de données de population valides pour les migrants suisses, les risques ont été estimés par une approche cas-témoins en considérant comme cas les décès par un cancer spécifique et comme témoins l'ensemble des autres décès. Afin d'évaluer le changement des risques après migration, les risques de décès en Suisse par rapport aux natifs de la France ont été calculés par une régression de Poisson. Pour la plupart des décès par cancer, le risque chez les migrants suisses se situe entre celui du pays d'origine et celui du pays d'accueil. Les migrants suisses gardent toutefois un risque significativement plus élevé que celui des natifs pour le cancer du poumon, de la vessie et le mélanome chez l'homme, pour le cancer du sein chez la femme et pour les lymphomes non hodgkiniens pour les deux sexes. En revanche, le risque est significativement plus faible chez les migrants suisses masculins pour le cancer du foie. (résumé d'auteur).

Zeitlin, J., et al. (2011). "Neighbourhood socio-economic characteristics and the risk of preterm birth for migrant and non-migrant women: a study in a French district." Paediatr Perinat Epidemiol **25**(4): 347-

356.

Neighbourhood-level deprivation is associated with preterm birth; preterm birth rates are also higher for some, but not all migrant groups. We studied the impact of neighbourhood characteristics (a deprivation score and the proportion of foreign-born residents) on singleton preterm birth in the French district of Seine-Saint-Denis for women born in France, North Africa, sub-Saharan Africa and other countries. Multilevel logistic regression models were adjusted for maternal demographic and health care characteristics. For women born in France, the preterm birth rate rose with neighbourhood deprivation quintile (3.8% in the first to 5.7% in the fifth, adjusted odds ratio: 1.40 [95% confidence interval 1.14, 1.72]) and with increasing proportions of foreign-born residents. Preterm birth rates were not higher in more deprived neighbourhoods for women born outside of France and were lower in neighbourhoods with more foreign-born residents; in multilevel models, the inverse association with deprivation remained significant for women from sub-Saharan Africa. Area-based deprivation measures should be used with caution in populations with large numbers of migrants. These results raise questions about the health benefits of clustering for migrant communities as well as the negative consequences of acculturation.

Une mortalité sous-estimée

Boulogne, R., et al. (2012). "Mortality differences between the foreign-born and locally-born population in France (2004-2007)." Soc Sci Med **74**(8): 1213-1223.

In contrast to the situation in many European countries, the mortality of immigrants in France has been little studied. The main reasons for the lack of studies are based on ethical and ideological considerations. The objective of this study is to explore mortality by country of birth in Metropolitan (i.e. 'mainland') France. Complete mortality data were used to study the relative risks of mortality of the foreign- and locally-born populations by gender, age and cause of death for the period 2004-2007 in Metropolitan France. Analyses were conducted by countries of birth grouped into geographic areas and by the Human Development Index (HDI). The differentials in mortality between foreign-born and locally-born populations were not homogeneous. The figures varied by age (higher foreign-born mortality for the young; lower mortality for migrants aged 15-64 years), gender (female migrants more frequently had higher relative mortality than men migrants), country of birth (Eastern European-born migrants had higher mortality, while those born in Morocco, Central Asia, 'other Asian countries' and America had lower mortality) and cause of death (migrant mortality was higher overall for deaths caused by infectious diseases and diabetes, and lower for violent death and neoplasm). Moreover, mortality relative risks for male, violent deaths and cancer were positively associated with country-of-birth HDI, while female mortality and infectious disease mortality were negatively associated with country-of-birth HDI. Some important caveats have to be considered because the study did not control for individuals socioeconomic position in France, or length of residence in the host country. A strong healthy migrant effect was suggested and its intensity varies with age and gender (which may reflect different reasons for migration). For some specific causes of death, a lifestyle effect seems to explain mortality differentials. The associations between HDI and mortality show that mortality trends are partly related to the educational, sanitary and economic conditions of the country of birth. Further studies would enrich the differential analysis of mortality by country of birth by contributing additional detailed data on socioeconomic and living conditions in the host country as well as in the country of origin.

Guillot, M., Khlat, M. et Wallace, M. (2019). "Adult mortality among second-generation immigrants in France: Results from a nationally representative record linkage study." Demogr Res **40**(54): 1603-1644. https://www.demographic-research.org/volumes/vol40/54/

Background : France has a large population of second-generation immigrants (i.e., native-born children of immigrants) who are known to experience important socioeconomic disparities by country of origin. The extent to which they also experience disparities in mortality, however, has not been previously examined. We used a nationally representative sample of individuals 18 to 64 years old in

1999 with mortality follow-up via linked death records until 2010. We compared mortality levels for second-generation immigrants with their first-generation counterparts and with the reference (neither first- nor second-generation) population using mortality hazard ratios as well as probabilities of dying between age 18 and 65. We also adjusted hazard ratios using educational attainment reported at baseline. We found a large amount of excess mortality among second-generation males of North African origin compared to the reference population with no migrant background. This excess mortality was not present among second-generation males of southern European origin, for whom we instead found a mortality advantage, nor among North African–origin males of the first-generation. This excess mortality remained large and significant after adjusting for educational attainment. In these first estimates of mortality among second-generation immigrants in France, males of North African origin stood out as a subgroup experiencing a large amount of excess mortality. This finding adds a public health dimension to the various disadvantages already documented for this subgroup. Overall, our results highlight the importance of second-generation status as a significant and previously unknown source of health disparity in France.

Khlat, M. et Guillot, M. (2017). Health and Mortality Patterns Among Migrants in France., University of Pennsylvania**:** 35p.
http://repository.upenn.edu/psc_publications/8/

Research on migrants' health and mortality has been lagging in France, by comparison with other European countries with shorter immigration histories. This lag has been related to the predominance in France of the modèle d'intégration républicaine (republican model of integration), according to which the state disregards criteria such as race, ethnicity or religion when interacting with individuals, in order to guarantee equal treatment for all (Oberti, 2008). Given the strong links between the state and the statistical system, the dividing line has long been limited to the basic distinction between foreigners and French citizens (Safi, 2007).

Wanner, P., et al. (1997). "Causes de décès des immigrés en France 1979-1985." Migrations Sante(91): 9-34.

La comparaison des risques de décès selon la cause parmi les groupes d'immigrés apporte de riches informations sur leur santé. La présente étude analyse de manière systématique les risques de décès entre 1979 et 1985 en France pour 34 pays ou régions de provenance, et les compare avec les risques des natifs. Les résultats sont ensuite discutés en fonction des connaissances étiologiques et des autres études sur les migrants. Dans l'ensemble, les immigrés en France sont protégés pour la plupart des causes de décès. Cependant, des risques augmentés sont associés au comportement et à l'exposition professionnelle (chez les immigrés européens), et probablement aussi à des facteurs génétiques ou des pathologies importées (chez les immigrés africains notamment). Le présent travail pourrait permettre l'isolation de groupes à risques et la définition de priorités d'actions de la part des spécialistes de la santé des immigrés.

L'effet « immigration en bonne santé » dans la santé perçue

Berchet, C. and F. Jusot (2009). "Inégalités de santé liées à l'immigration et capital social : une analyse en décomposition." Economie Publique(24-25): 73-100.
http://economiepublique.revues.org/8476

Cet article étudie la contribution du capital social à l'explication des différences d?état de santé entre la population immigrée et la population native en France à partir des données de l?Enquête santé protection sociale (ESPS) menée en 2006 et 2008. L'utilisation de la méthode de décomposition proposée par Fairlie montre que 38,7 % des différences d?état de santé entre les deux populations sont liées à une différence de distribution des caractéristiques observables. Alors que l?âge contribue négativement aux disparités de santé, les résultats indiquent que le capital social présente la contribution la plus importante (53,9 %) devant le revenu (42,5 %) et la Profession et catégorie socioprofessionnelle (PCS) (16 %).

Berchet, C. and F. Jusot (2010). "Inégalités de santé liées à l'immigration et capital social : une analyse en décomposition." Revue D'economie Publique(24-25): 73-100.

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Dourgnon, P., et al. (2008). "La santé perçue des immigrés en France. Une exploitation de l'Enquête décennale santé 2002-2003." Questions D'economie De La Sante (Irdes)(133): 1-6.
http://www.irdes.fr/Publications/Qes/Qes133.pdf

Selon les données de l'enquête décennale santé menée par l'INSEE en 2002- 2003, les personnes d'origine étrangère vivant en France se déclarent en moins bon état de santé que les Français nés en France. Les conditions socioéconomiques dégradées de ces populations expliquent en partie leur plus mauvaise santé perçue. Mais on observe également des différences d'état de santé selon les pays d'origine, liées au niveau de développement de ces derniers. Ainsi, les personnes originaires des pays les plus riches déclarent un meilleur état de santé que les personnes originaires des pays de niveau de développement moyen, suggérant un effet à long terme de la situation sociale et sanitaire du pays de naissance sur l'état de santé. Les personnes originaires des pays les plus pauvres déclarent également un meilleur état de santé que les personnes originaires des pays de niveau de développement moyen, ce qui peut s'expliquer par une sélection à la migration plus marquée dans ces pays. Enfin, il ne semble pas y avoir de différence d'état de santé entre les immigrés étrangers et ceux ayant été naturalisés.

Jusot, F., et al. (2009). "Inégalités de santé liées à l'immigration en France. Effet des conditions de vie ou sélection à la migration ?" Revue Economique **60**(2): 385-412.
http://www.cairn.info/resume.php?ID_ARTICLE=RECO_602_0385

Cet article étudie les liens existant entre nationalité, migration et état de santé à partir des données de l'enquête décennale Santé menée en 2002-2003 en France. Les résultats montrent l'existence d'inégalités face à la santé des personnes d'origine étrangère, liées à l'existence d'un effet de sélection à la migration compensé à long terme par un effet délétère de la migration, expliqué en partie seulement par la situation sociale difficile des immigrés en France. Cette analyse suggère également un effet non négligeable à long terme des caractéristiques économiques et sanitaires du pays de naissance, propre à expliquer les disparités d'état de santé observées au sein de la population immigrée.

Molines, C., et al. (2000). "Santé perçue et migration : une nouvelle approche pour l'intégration sanitaire ?" Rev Epidemiol Sante Publique **48**(2): 145-155.

[BDSP. Notice produite par INIST tdR0xFFJ. Diffusion soumise à autorisation]. Position du problème : Il y a peu de données sanitaires récentes concernant les 6% de la population française d'origine étrangère. Ce constat est pour partie lié aux difficultés de mise en oeuvre d'études de l'état de santé de cette population. L'objectif était de montrer que l'état de santé perçue au sein d'une même communauté, dans son pays d'origine et dans son pays d'accueil, variait à niveau comparable d'état de santé diagnostiquée par le système de soins. L'objectif secondaire était d'étudier, au sein de la population émigrée, les variations de l'état de santé ressentie en fonction de l'état de santé diagnostiquée. Méthodes : Deux études transversales ont été réalisées auprès des femmes d'une même communauté aux Comores et à Marseille. La santé perçue était mesurée par un questionnaire générique validé en français : le Profil de Santé de Duke (PSD) ; la santé diagnostiquée par le questionnaire Ridit, un questionnaire proposé dans les enquêtes en population générale au niveau international. Les comparaisons des communautés autochtone versus émigrée prenaient en compte

les principaux facteurs de confusion. Résultats : Les femmes émigrées présentent un meilleur état de santé perçue pour les principales dimensions du PSD : physique (71,0 ± 23,8 vs. 55,9 ± 23,0), mentale (74,6 ± 19,3 vs. 50,0 ± 18,5), santé générale (68,3 ± 16,3 vs. 61,4 ± 12,7) et santé perçue (62,7 ± 32,9 vs. 57,1 ± 48,2). Seule la santé sociale (59,2 ± 21,8 vs. (...)

Moullan, Y. and F. Jusot (2014). "Why is the healthy immigrant effect different between european countries ?" Eur J Public Health **24**(suppl. 1): 80-86.
http://eurpub.oxfordjournals.org/content/eurpub/24/suppl_1/80.full.pdf

CONTEXTE: Même si l'état de santé des immigrants constitue un important problème de santé publique, la littérature donne des résultats contradictoires sur l'existence d'un effet de «migrant en bonne santé» en Europe. Cette étude se propose d'explorer l'hétérogénéité de l'écart de santé entre les migrants et les autochtones dans quatre pays européens. DONNÉES ET MÉTHODES: Sur la base de plusieurs enquêtes sur la santé nationale harmonisées, l'association entre le statut migratoire et la santé de l'auto-évaluation a été tout d'abord exploré séparément en Belgique, en France, en Espagne et en Italie. Pour déterminer si les différences dans écart de santé entre les pays reflètent les différences dans l'état de santé des immigrants entre les pays d'accueil ou si elles sont en raison des différences dans l'état de santé des autochtones entre les pays d'accueil, l'association entre le pays et la santé hôte a été d'autre part analysé séparément au sein d'un pool échantillon d'immigrants et un des indigènes, le contrôle de la situation socio-économique et le pays d'origine. RÉSULTATS: Après avoir contrôlé le statut socio-économique, les immigrants font état d'un mauvais état de santé que les natifs en France, en Belgique et en Espagne, alors qu'ils déclarent un meilleur état de santé que les natifs en Italie, tant chez les femmes et les hommes. Un gradient Nord-Sud dans l'état de santé des immigrants apparaît: leur état de santé est meilleur en Italie et en Espagne qu'en France et en Belgique. A l'inverse, l'état de santé des autochtones est plus pauvre en Italie et en Belgique qu'en France et en Espagne. CONCLUSION: Les différences dans les écarts de santé reflètent les différences dans l'état de santé des indigènes et des immigrants entre les pays d'accueil. Cela suggère des différences dans la sélection de la santé à la migration et à l'intégration des immigrants entre les pays européens.

Vaillant, N. et Wolff, F. C. (2010). Origin differences in self-reported health among older migrants living in France. Working Paper. Nantes Université de Nantes. Laboratoire d?Economie et de Management Nantes-Atlantique**:** 19 , tabl.

Little is known about the health status of older migrants living in Europe. Using detailed data collected in 2003, we investigate differences in health status by origin country within the older immigrant population living in France using a self-rated health measure. The database used in this research is the ?Passage à la Retraite des Immigrés' survey, conducted from November 2002 to February 2003 on a sample of 6,211 migrants aged 45 to 70 and living in France at the time of survey. A difficulty with the self-rated outcome is that it may not be comparable between different origin groups, in particular because of cultural and linguistic differences. We thus estimate generalized ordered Probit models and construct for each respondent an indicator of health net of cross-cultural effects. Male immigrants from Southern Africa and Asia and female immigrants from Northern Europe, Southern Africa and Asia are more likely to be in good health, while the health status is lower among immigrants from Eastern Europe living in France. The diversity in health status within the immigrant population is large in France. These results are helpful in order to target the more disadvantaged origin groups and to adjust the provision of health care.

DES TROUBLES PSYCHO-PATHOLOGIQUES SPECIFIQUES

Les pathologies psychiques représentent l'un des enjeux majeurs de santé chez les migrants/étrangers en France, mais ceux-ci sont souvent ignorés dans les études en population générale[16]. Les données recueillies au sein des dispositifs de soin du Comede (Comité médical pour les exilés) ont permis de décrire les psychotraumatismes dans une population d'exilés marquée par des antécédents de violence, la précarité du statut administratif et des difficultés de communication pour les personnes non francophones. Entre 2004 et 2010, parmi les 17 836 personnes ayant consulté un médecin dans les centres de santé du Comede, plus de 60 % avaient subi des violences dans leur pays d'origine, et près d'un quart la torture. Le taux de prévalence des psychotraumatismes à la première consultation était de 112 ‰. Il était le plus élevé chez les personnes âgées de 29 à 49 ans, chez les femmes, et variait selon la nationalité. Ces résultats montrent une forte prévalence des syndromes psychotraumatiques dans cette population, plus élevée que la prévalence des pathologies psychiques rapportée dans les études en population générale. La fréquence et les caractéristiques des maladies psychiques chez les migrants/étrangers en situation de vulnérabilité nécessitent de développer la recherche associant enquêtes épidémiologiques et études qualitatives, et de faire évoluer les catégories diagnostiques utilisées.

Amad, A., et al. (2013). "Increased prevalence of psychotic disorders among third-generation migrants: results from the French Mental Health in General Population survey." Schizophr Res **147**(1): 193-195.

> There is very strong evidence that the prevalence of psychosis is elevated in migrant populations and that this risk persists into the second generation. However, these results have not been replicated in France, and the prevalence of psychotic disorders in the third generation of migrants remains unknown. Based on the Mental Health in General Population survey (n=37063), we report for the first time the increased prevalence of psychotic disorders in migrants in France, which persists into the second generation for a single psychotic episode (SPE) (OR=1.43, 95% CI [1.02-2.03], p<0.03) and into the third generation for recurrent psychotic disorder (RPD) (OR=1.78, 95% CI [1.45-2.18], p<0.0001) after adjustment for age, sex, level of education and cannabis use. Complementary statistical analyses of our sample showed a significantly higher risk of SPE in migrants from the French West Indies and Africa (chi(2)=17.70, p<0.01). These results are consistent with the socio-developmental model and the psychosis continuum hypothesis.

Chambon, N. et Le Goff, G. (2016). "Enjeux et controverses de la prise en charge des migrants précaires en psychiatrie." Revue Francaise Des Affaires Sociales **6**(2): 123-140.
http://www.cairn.info/revue-francaise-des-affaires-sociales-2016-2-page-123.htm

> Cet article présente les problématiques d'accès au soin en santé mentale des migrants en situation de précarité. La psychiatrie est interpellée sur les questions où sont entremêlées des problématiques médicales, juridiques, administratives et politiques. La question de la légitimité de ces demandes est régulièrement interrogée, d'autant plus dans un contexte où les politiques dénoncent régulièrement le coût de l'aide médicale d'État. Les individus sont donc considérés comme des étrangers avant d'être des sujets malades ou en souffrance. Après avoir exposé trois typologies – l'immigré, l'exilé, et le migrant précaire – à travers une lecture sociohistorique et leur appréhension en psychiatrie, les auteurs interrogent les demandes de soin en santé mentale des migrants aujourd'hui. La diversité des demandes met en difficultés les professionnels et les institutions de droit commun. Pour les auteurs, il y a alors un enjeu de santé publique à penser le recalibrage de l'action publique afin de répondre aux problématiques de santé mentale des migrants en situation de précarité.

Gosselin, A., Malroux, I., Desprat, D., et al. (2022). "Prévalence des risques psychosociaux au travail et santé mentale parmi les immigrés et descendants d'immigrés: résultats de l'enquête nationale Conditions de Travail-Risques psychosociaux 2016." Bulletin Epidemiologique Hebdomadaire (BEH)(7): 141-149.
http://beh.santepubliquefrance.fr/beh/2022/7/2022_7_2.html

> Peu d'études se sont penchées sur les risques psychosociaux parmi les immigrés et les descendants d'immigrés et leur association avec la santé mentale. Notre étude a pour objectif: 1) de décrire la

[16] Veisse A., BEH (2012/01/17)

prévalence de deux indicateurs qui recouvrent les dimensions d'exigence psychologique, de latitude décisionnelle et d'isolement au travail: le job strain (tension au travail: faible latitude/forte demande) et l'iso-strain (combinaison d'une situation de job strain et d'un faible soutien social) selon le statut migratoire et modéliser la probabilité d'être exposé ; 2) vérifier que les associations entre le job strain, l'iso-strain et l'anxiété sont similaires pour tous les groupes (immigrés, descendants d'immigrés

Kammogne, C. L. et Marchand, A. (2021). "Ethnicité et statut d'immigrant : quelle association avec le travail et les symptômes dépressifs ?" Rev Epidemiol Sante Publique **69**(3): 145-153.
https://doi.org/10.1016/j.banm.2021.07.008

Résumé Position du problème Cette recherche tente de déterminer si les traits d'identité culturelle, et en particulier l'ethnicité et le statut d'immigrant, modifient la façon dont le travail est associé aux symptômes dépressifs dans la main-d'œuvre canadienne. Méthode Les données proviennent des neuf cycles de l'Enquête nationale sur la santé de la population (ENSP) de Statistique Canada, contenant un échantillon de 6477 personnes en emploi. Des analyses de régressions multiples multiniveaux ont été estimées en effectuant des ajustements sur les facteurs liés à la famille, le soutien social hors travail et les caractéristiques personnelles. Résultats Une fois prises en compte, les variables potentiellement confondantes, l'ethnicité et les facteurs liés au travail semblent être associés de façon distincte et directe aux symptômes dépressifs. Les travailleurs issus des minorités visibles semblent avoir significativement moins de symptômes dépressifs en comparaison aux travailleurs caucasiens. Toutefois, contrairement aux caucasiens, ils sont plus surqualifiés, utilisent moins leurs compétences, et ont moins d'autorité décisionnelle. Toutes les analyses menées sur le statut d'immigrant se sont avérées non concluantes. Conclusion L'ethnicité semble jouer un rôle dans la façon dont le travail est associé aux symptômes dépressifs. Il pourrait être bénéfique de mener des interventions ciblées sur l'amélioration des conditions de travail en fonction de l'ethnicité et en particulier les situations de surqualification professionnelle.

Le Ferrand, P. (2017). "La santé mentale des migrants : le syndrome d'Ulysse." Medecine : De La Medecine Factuelle a Nos Pratiques **13**(9): 409-417.

Lorsque les médecins sont amenés à rencontrer des migrants en consultation, la demande se fait le plus souvent sur des plaintes somatiques multiples et diffuses et sur une profonde souffrance psychique qu'ils associent à l'état de stress post-traumatique (ESPT). Pourtant le diagnostic de syndrome post-traumatique ne correspond pas toujours aux troubles observés. Dans de très nombreux cas, il s'agit en réalité d'un épuisement psychique ressemblant à une forme de burnout que certains cliniciens ont dénommé « syndrome d'Ulysse ».

Médecins du Monde (2018). La souffrance psychique des exilés. Une urgence de santé publique. Paris Médecins du Monde, Paris Centre Primo Levi **:** 34 , ill.
https://www.primolevi.org/wp-content/themes/primo-levi/La%20souffrance%20psychique%20des%20exil%C3%A9s_Rapport%20pages.pdf

La santé mentale, et plus largement la souffrance psychique, se situe dans l'exact angle mort des politiques publiques concernant les personnes exilées, encore majoritairement orientées vers le soin des maladies infectieuses et la prise en charge des urgences médicales. Elle constitue pourtant une urgence sanitaire et un enjeu de santé publique majeur. Le Centre Primo Levi et Médecins du Monde, tous deux engagés dans l'accueil et le soin des personnes exilées, réunissent leurs constats dans ce rapport. Ils dressent un tableau sans concession de la situation et mettent en avant des propositions afin que soit enfin élaborée, au niveau national, une réponse de santé publique adaptée à l'enjeu majeur que représente la santé mentale de ces personnes.

Osario, R., et al. (2016). Recommandations pour la prise en charge efficiente de la santé mentale des demandeurs d'asile. Paris SomaPsy Network**:** 44 , tab., graph., fig.
http://somapsy.org/fr/publications-reseau-somapsy/

Ce document est conçu comme un outil destiné aux professionnels de santé pour offrir des soins de santé mentale efficients aux demandeurs d'asile qui arrivent en Europe. Il s'agit d'un modèle avec quatre recommandations majeures pour gérer de façon plus efficiente la prise en charge de ce type de population et pour agir sur des aspects tels que l'accès aux services de santé, la prise en charge intégrée

des problèmes de santé, le suivi des traitements et l'amélioration de la communication entre professionnels de santé et patients.

Philibert, M., et al. (2008). "Can excess maternal mortality among women of foreign nationality be explained by suboptimal obstetric care?" Bjog **115**(11): 1411-1418.

OBJECTIVES: To test the hypothesis that the risk of postpartum maternal death in France remains significantly higher for women of foreign nationality after individual characteristics are taken into account and to examine whether the quality of care received by the women who died differs according to nationality. DESIGN: A national case-control study. SETTING: Metropolitan France. POPULATION: A total of 267 women who died of maternal death from 1996 to 2001 as cases and a representative sample (n = 13 186) of women who gave birth in 1998 as controls. METHODS: Crude and adjusted odd ratios were calculated with multivariate logistic regression, and the quality of care for cases was compared according to nationality with chi-square tests or Fisher's exact tests. MAIN OUTCOME MEASURES: Odd ratio for postpartum maternal death associated with nationality and quality of care. RESULTS: After taking individual characteristics into account, the risk of postpartum maternal death was twice as high for foreign women. The odds ratio was 5.5 (95% CI: 3.3-9.0) for women from sub-Saharan Africa and 3.3 (95% CI: 1.7-6.5) for those from Asia, North and South America. There was no significant excess risk of postpartum maternal death for the other European and North Africa women. The risk of dying from hypertensive disorder or infection was four times higher for foreign women. Among women who died, care was more often considered not optimal for foreign women (78 versus 57%). CONCLUSIONS: The excess risk of postpartum maternal death persisted for foreign women after individual characteristics were taken into account and was especially important for some nationalities and for some causes of death, primarily hypertensive disorders. These results point to an immediate need to pay special attention to early enrollment in prenatal care, screening and prenatal management of hypertension, especially in women of sub-Saharan African nationality.

Prieur, C., Dourgnon, P., Jusot, F., et al. (2022). "Une personne sans titre de séjour sur six souffre de troubles de stress post-traumatique en France." Questions D'economie De La Sante (Irdes)(266): 8. https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/266-une-personne-sans-titre-de-sejour-sur-six-souffre-de-troubles-de-stress-post-traumatique-en-france.pdf

Les Troubles de stress post-traumatique (TSPT) sont des troubles psychiatriques qui surviennent après un événement traumatisant. Ils se traduisent par une souffrance morale et des complications physiques qui altèrent profondément la vie personnelle, sociale et professionnelle. Ces troubles nécessitent une prise en charge spécialisée. Pour les personnes sans titre de séjour, la migration peut avoir donné lieu à des expériences traumatiques sur le parcours migratoire ou dans le pays d'accueil, qui peuvent s'ajouter à des traumatismes plus anciens survenus dans le pays d'origine, alors que les conditions de vie sur le sol français sont susceptibles de favoriser le développement de TSPT. Quelle est la prévalence des troubles de stress post-traumatique au sein de cette population encore mal connue ? Comment les conditions de migration et les conditions de vie dans le pays d'accueil jouent-elles sur leur prévalence ? Quel est l'accès à l'Aide médicale de l'Etat (AME) des personnes qui en souffrent ?

Rondet, C., et al. (2013). "Depression prevalence and primary care among vulnerable patients at a free outpatient clinic in Paris, France, in 2010: results of a cross-sectional survey." BMC Fam Pract **14**: 151.

BACKGROUND: Data on the prevalence of depression and on how a depressive episode prompts the sufferer to seek primary care are not scarce, but the available evidence on the prevalence of depression among immigrants and poor people who frequent general practice facilities is scarce. The Baudelaire Outpatient Clinic at the Saint-Antoine Hospital in Paris provides free medical and social assistance to the poor and/or uninsured. The goal of our study was to estimate the prevalence of depression among these outpatients, to characterize this depressed population, and to analyze its demand for primary care for depressive episodes. METHODS: From September to December 2010, we conducted a cross-sectional, observational survey among users of the Baudelaire Outpatient Clinic. French-speaking patients attending the clinic between September 15 and December 30, 2010 who agreed to answer a questionnaire administered face-to-face before their consultation were included in

the study. The chi-squared test (or Fisher's exact test for small samples) was used for the comparisons of proportions. Logistic regression models were estimated, along with the odds ratios (OR) and their 95% confidence intervals (95% CIs), for the multivariate analysis of factors associated with depression and healthcare-seeking. Models were estimated separately for men and women, since sex was an interaction factor. The statistical analyses were performed using Stata v. 10 software (StataCorp LP, College Station, Texas, USA). RESULTS: Of the 250 patients included (mean age: 45 years), 52.0% were men and 52.4% were immigrants. Close to 40% of them reported having no supplemental health insurance. The estimated prevalence of depression in this population was 56.7%. Depression was more prevalent among the women, immigrants, and people from the poorer socioeconomic groups. Only half of these depressed patients, mostly women, reported having discussed their depression with a physician. French nationality and complete health insurance coverage were associated with more-frequent healthcare-seeking. Few patients reported having been asked about their morale by the physician they consulted, and almost 80% would have liked to be asked about this more often. CONCLUSION: Depression is a real public health problem, particularly among people from disadvantaged backgrounds, and should be included in their overall management.

Tortelli, A., Perquier, F., Melchior, M., et al. (2020). "Mental Health and Service Use of Migrants in Contact with the Public Psychiatry System in Paris." Int J Environ Res Public Health **17**(24).

BACKGROUND: Migrants, and particularly asylum seekers, are at increased risk of psychiatric disorders in comparison with natives. At the same time, inequalities in access to mental health care are observed. METHODS: In order to evaluate whether the Parisian public psychiatric system is optimally structured to meet the needs of this population, we examined data on mental health and service use considering three different levels: the global system treatment level, a psychiatric reception center, and mobile teams specializing in access to psychiatric care for asylum seekers. RESULTS: We found higher treatment rates among migrants than among natives ($p < 0.001$) but inequalities in pathways to care: more mandatory admissions (OR = 1.36, 95% CI: 1.02-1.80) and fewer specialized consultations (OR = 0.56, 95% CI: 0.38-0.81). We observed a mismatch between increased need and provision of care among migrants without stable housing or seeking asylum. CONCLUSIONS: Inequalities in the provision of care for migrants are observed in the Parisian public psychiatric system, particularly for those experiencing poor social and economic conditions. There is a need to facilitate access to mental health care and develop more tailored interventions to reduce discontinuity of care.

Tortelli, A., et al. (2014). "Different rates of first admissions for psychosis in migrant groups in Paris." Soc Psychiatry Psychiatr Epidemiol **49**(7): 1103-1109.

PURPOSE: The association between migration and psychosis has been reported in the past decades in many European countries. Despite large-scale migration into France, epidemiological data on the incidence of psychosis in this population are lacking. In this study, we compare the incidence rates of first admission for psychosis among natives and first generation migrants. METHODS: Two-hundred and fifty-eight patients aged 15+ with first admission for psychosis were identified in the catchment area of the 20th district of Paris between 2005 and 2009. Standardised incidence rates and incidence rate ratios were calculated for migrant and native groups. RESULTS: We found higher rates of admissions for psychosis in the migrant group (IRR 2.9, 95 % CI 0.9-9.8) compared to individuals born in France. Among migrants, incidence was higher in individuals from Sub-Saharan Africa compared to natives (IRR 7.1, CI 95 % 2.3-21.8), whereas the incidence was similar for those from Europe (IRR 1.2, CI 95 % 0.3-5.1) and from North Africa (IRR 1.4, CI 95 % 0.4-5.6). CONCLUSIONS: Our findings suggest that Sub-Saharan migrants were identified as the most vulnerable migrant group for developing psychosis in France, but additional work is warranted to confirm these trends.

Veïsse, A., et al. (2012). "Santé mentale des migrants/étrangers : mieux caractériser pour mieux soigner." Bulletin Epidemiologique Hebdomadaire(2-3-4): 36-40.

[BDSP. Notice produite par InVS oFR0xqpA. Diffusion soumise à autorisation]. Introduction - Les pathologies psychiques représentent l'un des enjeux majeurs de santé chez les migrants/étrangers en France, mais ceux-ci sont souvent ignorés dans les études en population générale. Matériel et

méthode - Les données recueillies au sein des dispositifs de soins du Comede (Comité médical pour les exilés) ont permis de décrire les psychotraumatismes dans une population d'exilés marquée par des antécédents de violence, la précarité du statut administratif et des difficultés de communication pour les personnes non francophones. Résultats - Entre 2004 et 2010, parmi les 17 836 personnes ayant consulté un médecin dans les centres de santé du Comede, plus de 60% avaient subi des violences dans leur pays d'origine, et près d'un quart la torture. Le taux de prévalence des psychotraumatismes à la première consultation était de 112 pour mille. Il était le plus élevé chez les personnes âgées de 29 à 49 ans, chez les femmes, et variait selon la nationalité. Ces résultats montrent une forte prévalence des syndromes psychotraumatiques dans cette population, plus élevée que la prévalence des pathologies psychiques rapportée dans les études en population générale. Conclusion - La fréquence et les caractéristiques des maladies psychiques chez les migrants/étrangers en situation de vulnérabilité nécessitent de développer la recherche associant enquêtes épidémiologiques et études qualitatives et de faire évoluer les catégories diagnostiques utilisées. (R.A.).

DES BARRIERES DANS L'ACCES ET LE RECOURS AUX SOINS

L'état de santé des migrants est aggravé par les difficultés d'accès aux soins. D'après les indicateurs du MIPEX, la France se place parmi les pays où les droits accordés aux migrants semblent les plus avantageux, et pourtant les barrières administratives et juridiques figurent paradoxalement parmi les premiers obstacles : complexité du droit en matière d'immigration et succession de réformes et de nouveaux textes de loi ; complexité des situations par rapport au droit de l'assurance maladie (N. Drouot et coll.)[17]. À ceci s'ajoutent des difficultés de communication relevant à la fois des registres linguistique et culturel (C. Berchet et coll.)[18], sans compter les problèmes de discrimination à l'égard des migrants. S'il est impératif de simplifier l'accès aux soins pour ces populations, il existe également une marge d'action importante en matière de prévention. La question de la santé des migrants relève pleinement de la problématique des inégalités sociales de santé, sans y être réductible. Ce courant de recherches doit se développer pour une meilleure connaissance des spécificités des populations migrantes dans leur diversité, en élaborant des approches générationnelles pour éclairer la situation des descendants d'immigrés, nés en France. Les avancées dans ce domaine pourront alimenter très utilement la réflexion sur les politiques publiques et les programmes en direction des migrants, à une époque où les enjeux de santé publique associés aux phénomènes migratoires font l'objet d'un intérêt croissant dans le monde.

En France, l'accès aux soins est organisé selon le dispositif suivant :

Sécurité sociale de base (dont couverture maladie universelle - CMU - de base, puis Puma) : protection maladie pour la prise en charge des frais médicaux, droit pour toute personne vivant en France en situation régulière et depuis au moins trois mois (sauf pour les demandeurs d'asile, qui sont dispensés de cette dernière condition). La **PUMA** (Protection Universelle Maladie)[19][20], mise en place au 1er janvier 2016 en remplacement de la Cmu de base, complique, pour l'instant, l'accès des immigrés à la couverture maladie, car ce droit s'interrompt à chaque expiration du titre de séjour. Des décrets pour améliorer ce dispositif sont à l'étude[21][22].

Complémentaire santé solidaire (CSS) : les personnes qui ont de faibles ressources (et ne peuvent donc pas à souscrire une mutuelle ou une assurance complémentaire privée) peuvent bénéficier de la CSS; elle permet au patient de se faire soigner sans débourser d'argent pour les consultations (à l'hôpital et chez le médecin), les examens de laboratoire et les médicaments.

Aide médicale de l'État (AME) : dispositif de protection maladie destiné aux personnes qui n'ont pas de titre de séjour et qui disposent de faibles ressources.

Permanences d'accès aux soins de santé (Pass) : sans argent et sans protection maladie, seules ces permanences de l'hôpital public peuvent délivrer les soins nécessaires.

Mais ces dispositifs sont souvent très opaques pour les populations migrantes et les complexités administratives sont des obstacles à l'accès aux soins[23].

(2019). "Populations migrantes : violences subies et accès aux soins." Bull Epidemiol Hebd(17-18): 52 p.

[17] Drouot, et al, BEH (2012/01/17)
[18] Berchet, Jusot, BEH (2012/01/17)
[19] Article L160-1 du code de la sécurité sociale modifié par la loi n°2016-1827 du 23 décembre 2016 - art. 64 (V)
[20] Voir aussi le site d'Ameli pour l'attribution des droits à la PUMA
[21] (2021). "Malades étrangers en France : recul du droit de séjour après la loi de 2016." Revue Prescrire **41**(447): 60-64.
[22] La Cimade (2018). Personnes étanagères malades : soigner ou suspecter ? Paris : La Cimade**:** 19p.
[23] Dourgnon, P., Guillaume, S., Jusot, F., et al. (2019). "Étudier l'accès à l'Aide médicale de l'État des personnes sans titre de séjour. L'enquête Premiers pas." Questions D'economie De La Sante (Irdes)(244)

(2021). "Malades étrangers en France : recul du droit de séjour après la loi de 2016." Revue Prescrire **41**(447): 60-64.

Depuis le 1er janvier 2017, en France, les médecins de l'Office français de l'immigration et de l'intégration sont chargés de l'évaluation médicale des demandes de "titres de séjour pour raisons médicales. Cette évaluation était assurée jusqu'alors par les médecins des agences régionales de santé (ARS). Et cet article analyse les multiples raisons qui ont entraîné une baisse des titres de séjour pour raisons médicales.

(2016). "Accès à l'assurance maladie obligatoire en France : importants changements en 2016." Revue Prescrire **36**: 940-941.

Depuis le 1er janvier 2016, les démarches d'accès à l'assurance maladie sont simplifiées pour bon nombre de personnes, notamment en cas de changement de situation personnelle ou professionnelle. Mais il existe un risque de rupture de droits pour les personnes étrangères en situation irrégulière, ou régulière quand leur titre de séjour est de courte durée ou arrive à échéance.

(2016). La protection sociale des étrangers en France, Paris : Unafo
http://ressources-professionnelles.unafo.org/index.php?alias=home&oidart=ARTICLES:2g257bqgoqnd&function=detailArticle&insidefile=fiche-article.html&ye

Le premier semestre 2016 aura été marqué par des modifications législatives importantes en matière de droit à la protection sociale et de droit spécifique applicable aux étrangers en France. Dans la continuité de son travail mené en partenariat avec l'ODTI, depuis plusieurs années, autour de l'élaboration et la diffusion du guide du retraité étranger, l'Unafo rassemble dans ce cahier juridique les nouvelles modifications législatives dans les domaines suivants : Protections maladie et familiale, accès aux minima sociaux, aides sociales aux personnes âgées, droit au séjour et à la nationalité française.

(2016). Les droits fondamentaux des étrangers en France. Paris Le Défenseur des Droits **:** 304, fig.

Ce rapport pointe l'ensemble des obstacles qui entravent l'accès des étrangers aux droits fondamentaux, en prenant appui sur les décisions de l'Institution mais en identifiant aussi de nouveaux problèmes juridiques et les pratiques illégales. Une partie est notamment consacrée aux droits à la protection de la santé (AME, PUMa, refus de soins discriminatoires), à la protection sociale (discriminations légales à l'accès aux prestations sociales des étrangers en situation régulière, accès aux prestations familiales, aux minima sociaux), au droit du travail, au droit au séjour des étrangers pour soins.

Aeberhard, P., et al. (2011). L'accès aux soins des migrants, des sans-papiers et des personnes précaires, Bordeaux : Les Etudes Hospitalières

L'accès aux soins et à la santé des migrants, des sans papiers et des personnes précaires est au coeur de la santé publique et des droits de la personne. Pour remporter les défis juridiques et économiques à venir, il importe de continuer d'améliorer la politique de santé publique en faveur des migrants et du droit des « malades sans frontières » pour un droit universel aux soins. Pour cela, il convient de prendre en compte tous les témoignages des acteurs de terrain, des experts et scientifiques qui prennent en charge ces populations très hétérogènes. Cet ouvrage collectif réunit une quinzaine d'acteurs de la prise en charge des personnes migrantes ou précaires autour de Patrick Aeberhard, professeur associé à l'université Paris-8, et Jacques Lebas, professeur associé au CNAM, afin de développer les moyens politiques d'accès aux soins en France. Il se veut scientifique et pédagogique pour encourager ceux qui voudraient mettre en oeuvre une action ou participer à l'évolution législative en faveur d'un droit universel aux soins. Traitant d?abord de « la santé et les droits de l'homme », il apporte les données sociales, juridiques et médicales utiles pour appréhender les enjeux

de l'accès aux soins des migrants, sans-papiers, puis précise les moyens que souhaitent les associations pour qui le droit universel aux soins constitue une priorité, ce que semblaient pouvoir permettre, ces dernières années, le revenu minimum d'insertion, la couverture médicale universelle, l'aide médicale d'État. Ce livre, qui décrit les droits des personnes les plus exclues , est enfin un cri d'alarme pour nos sociétés confrontées à des remises en cause sans précédent et un appel à la construction d'un édifice juridique conforme à nos principes fondamentaux. « Il s'agit de construire une société d'ouverture et de respect, un État de droit et de sécurité pour tous » (Résumé de l'éditeur).

Ancora, A., et al. (2015). "Migrants. Dossier. 3ème partie." Information Psychiatrique (L') **91**(3): 203-254.

[BDSP. Notice produite par EHESP 7s7R0xnr. Diffusion soumise à autorisation]. Cette troisième et dernière partie d'un dossier consacré à la psychopathologie du migrant aborde les points suivants : réalités et controverses de la situation actuelle des migrations internationales, l'expérience singulière du voyage retour des adoptés dans leur pays de naissance, le repérage de la souffrance psychique des patients migrants primo-arrivants en consultation de médecine générale, l'accompagnement de femmes migrantes dans une unité mère bébé, le mutisme extra-familial chez les enfants de migrants.

André, J.-M. et Azzedine, F. (2016). "Access to healthcare for undocumented migrants in France: a critical examination of State Medical Assistance." Public Health Reviews **37**(1): 5. https://doi.org/10.1186/s40985-016-0017-4

In France in 2012, of the total population of 65.2 million, 8.7 % were migrants. After being the third principal host country, France is now the 6th highest host country in the OECD. Since the 1980's numerous Acts have been passed by parliament on immigration issues.

Appay, B., et al. (2001). Précarisation, risque et santé. Questions en santé publique. Paris INSERM**:** 474 , tabl.

Les personnes les plus pauvres sont aussi les plus vulnérables face à la maladie. Permettre à tous les actifs réguliers et à leurs proches d'accéder à la prévention et aux soins (couverture sociale) aurait dû remédier à cette situation et réduire les inégalités. Cet ouvrage, consacré à l'analyse des liens entre précarité, risque et santé, montre clairement que d'autres facteurs interviennent. Cet ouvrage rassemble les contributions de différents d'experts d'horizon différent : épidémiologistes, anthropologues, sociologues, psychologues, médecins... Il tente d'évaluer les interactions entre les évolutions sociales et économiques et la santé, et d'indiquer comment des actions mieux adaptées pourraient être développées, quitte à remettre en cause certains aspects de l'organisation des soins.

Azoulay, J., et al. (2007). Rapport sur la gestion de l'aide médicale d'Etat : Mission d'audit de modernisation. Paris IGS, IGAS**:** 45, ann.

Le présent rapport fait partie de la cinquième vague d'audits de modernisation lancés en octobre 2005 dans le cadre de la loi organique relative aux lois de finances (LOLF) qui introduit une démarche de performance, visant à faire passer l'Etat d'une "logique de moyens" à une "logique de résultats". Les audits sont réalisés sous la co-maîtrise d'ouvrage du ministère intéressé (qui s'appuie sur le secrétaire général et ses équipes de modernisation) et du ministère chargé du budget et de la réforme de l'Etat (qui s'appuie notamment sur la direction générale de la modernisation de l'Etat).

Begues, S. et Toullier, A. (2005). "L'accès des étrangers aux prestations servies par les caisses d'allocations familiales." Droit Social(6): 665-671.

Après un aperçu historique sur l'accès des étrangers aux prestations familiales en France depuis les années 1945, cet article tente à démontrer que la politique familiale à l'égard des étrangers est de plus en plus subordonnée à la politique de l'immigration.

Berchet, C. (2013). "[Health care utilisation in France: an analysis of the main drivers of health care use inequalities related to migration]." Rev Epidemiol Sante Publique **61 Suppl 2**: S69-79.

In using a general health survey representative of the French population, the 2006 and 2008 French Health, health care and insurance survey, this study explores inequalities in health care utilization between immigrants and natives. Our objective is to highlight the most important factors generating health care use inequalities relating to immigration in using non-linear decomposition. Estimation results reveal that for equivalent health care needs, immigrants present a lower demand for GP and specialist care than the French population. The implementation of non-linear decompositions suggests that health care use inequalities between French and immigrant populations are for the most part attributable to differences in the distribution of observable characteristics between both populations. In particular, immigrant lower health coverage represents the first factor generating inequalities in the propensity to contact a GP while education and income are the most important drivers of inequalities in the propensity to contact a specialist.

Berchet, C. (2013). "Le recours aux soins en France : une analyse des mécanismes qui génèrent les inégalités de recours aux soins liées à l'immigration." Rev Epidemiol Sante Publique **61S**(3): 209-213, tabl.

À partir des données de l'Enquête sur la santé et la protection sociale (ESPS) réalisée en 2006 et 2008, cette étude s'intéresse aux disparités de recours aux soins entre la population immigrée et la population française. Nous cherchons à mettre en évidence les mécanismes qui génèrent les inégalités de recours aux soins liées à l'immigration en utilisant des techniques de décomposition non linéaire. Les résultats des estimations montrent que les immigrés présentent, à besoins de santé équivalents, un plus faible recours aux médecins généralistes et spécialistes que la population française. L'application des techniques de décomposition non linéaire révèle que la majeure partie du différentiel de recours aux soins entre les immigrés et les Français est liée à une différence de distribution des caractéristiques observables entre les deux populations. En particulier, les inégalités de recours aux généralistes semblent être en premier lieu expliquées par la plus faible couverture santé des immigrés, tandis que leur niveau d'études et de revenu sont les principaux facteurs générant les inégalités de recours aux spécialistes.

Berchet, C. et Jusot, F. (2012). "Etat de santé et recours aux soins des immigrés : une synthèse des travaux français." Questions D'economie De La Sante (Irdes)(172): 8.

Cette étude propose une synthèse des travaux français portant sur l'état de santé et le recours aux soins des migrants depuis une trentaine d'années. Malgré la divergence des résultats de la littérature - due notamment à la diversité des indicateurs utilisés et des périodes considérées -, cette synthèse souligne l'existence de disparités entre les populations française et immigrée. De meilleur, l'état de santé des immigrés est devenu moins bon que celui des Français de naissance. Ces différences sont plus marquées chez les immigrés de première génération, les femmes, et varient selon le pays d'origine. Un moindre recours aux soins de ville et à la prévention a également été constaté. Si des phénomènes de sélection liés à la migration permettent d'expliquer le meilleur état de santé initial des immigrés, leur situation économique fragilisée dans le pays d'accueil ainsi que la détérioration du lien social contribuent notamment à la dégradation de leur état de santé et à leur moindre recours aux soins. Ce constat appelle la mise en œuvre de politiques de santé publique adaptées visant à améliorer l'état de santé et l'accès aux soins des populations d'origine étrangère, notamment à travers la prévention, le développement d'actions de proximité et de simplification de l'accès à certains droits et dispositifs tels que la Couverture maladie universelle ou l?Aide médicale d'État.

Berchet, C. et Jusot, F. (2012). "Etat de santé et recours aux soins des immigrés en France : une revue de la littérature." Bulletin Epidemiologique Hebdomadaire(2-3-4): 17-20.

Ce bilan des études françaises sur l'état de santé et l'accès aux soins des immigrés suggère l'existence d'inégalités de santé liées à la migration et de disparités selon le pays d'origine. En outre, l'ensemble des études s'accorde sur le moindre recours aux soins de la population immigrée, révélant des difficultés d'accès à la médecine de ville. Enfin, la situation économique et sociale plus défavorisée des immigrés, leur moindre accès à la complémentaire santé et leur moindre intégration sociale sont les principaux facteurs expliquant ces inégalités de santé et d?accès aux soins.

Blanpain, N. et Pankeshon, J. L. (1997). "L'assurance complémentaire maladie : une diffusion encore inégale." Insee Premiere(523): 4 , 3 tabl., 2 graph.

La plupart des Français (84%) sont couverts par une assurance complémentaire maladie. Les personnes les moins protégées se trouvent parmi les jeunes qui ne sont plus couverts par l'assurance complémentaire de leurs parents et qui ne sont pas encore insérés dans le marché du travail. Les chômeurs ou les étrangers sont aussi parmi les personnes les moins protégées. Les contrats de groupe souscrits par l'intermédiaire de l'employeur offrent des prestations qui semblent plus avantageuses que les assurances personnelles ; 96% des salariés ayant la possibilité de contracter une assurance complémentaire maladie par leur entreprise sont couverts contre 78% des salariés ne possédant pas cet avantage.

Boisguerin, B. (2011). "Insertion socio-professionnelle, état de santé et recours aux soins des bénéficiaires de l'AME : le rôle des réseaux d'entraide." Dossiers Solidarite Et Sante (Drees)(19): 14.

[BDSP. Notice produite par MIN-SANTE 7mAR0xEq. Diffusion soumise à autorisation]. Fin 2010,230 000 personnes bénéficient de l'aide médicale d'État (AME), un dispositif permettant de prendre en charge les dépenses de santé des étrangers en situation irrégulière. À partir d'une enquête réalisée en 2007 par la DREES, cette étude se penche sur le soutien éventuellement mobilisable par cette population, selon la provenance de l'aide (familiale, amicale, associative, sociale) et sa nature (matérielle ou financière, pour trouver un logement, du travail, effectuer des démarches). Il s'agit également d'observer si ce réseau d'entraide a une influence sur les conditions de logement, l'insertion professionnelle et l'état de santé perçu. Le réseau d'entraide sur lequel peuvent s'appuyer les bénéficiaires de l'AME conditionne directement leurs modalités d'existence : en particulier, l'insertion dans un réseau familial et amical améliore les conditions de logement et facilite l'accès à l'emploi. L'état de santé des bénéficiaires de l'AME apparaît également lié à leur capacité à mobiliser un soutien : deux personnes sur dix se déclarent en mauvaise santé et quatre sur dix indiquent souffrir d'une ou plusieurs maladies chroniques. Ce sentiment est renforcé chez les personnes qui ne peuvent s'appuyer sur la famille ou les amis. Enfin, les bénéficiaires de l'AME recourent davantage aux soins quand ils peuvent être épaulés à la fois par l'entourage familial et le milieu associatif pour effectuer des démarches et formalités.

Boisguerin, B. et Haury, B. (2008). "Les bénéficiaires de l'AME en contact avec le système de soins." Etudes Et Resultats(645): 8p.

L'enquête effectuée au premier trimestre 2007 en Île-de-France fournit des éléments de connaissance sur les conditions d'existence, l'état de santé et le recours aux soins des bénéficiaires de l'aide médicale de l'État (AME) en contact avec le système de soins. Il s'agit d'une population composée à 70% de jeunes adultes âgés de 20 à 39 ans, ayant un niveau scolaire élevé et dont la majorité réside en France depuis moins de cinq ans. Soumis à des conditions d'existence précaires, les bénéficiaires de l'AME sont nombreux à percevoir leur état de santé comme dégradé.

Bories, C. (2021). "Catégorisation juridique des étrangers et inégalités sociales de santé : quelles sont les règles du jeu ?" Revue Francaise Des Affaires Sociales(3): 205-224.
https://www.cairn.info/revue-francaise-des-affaires-sociales-2021-3-page-205.htm

En matière d'accès aux soins, tous les étrangers ne sont pas égaux : certains malades étrangers rencontrent des difficultés faisant de l'accès aux soins un véritable « parcours du combattant » quand d'autres se voient accorder d'importantes facilités. Triste réalité. Cette différenciation est liée, principalement, à l'attribution de prérogatives de santé aux étrangers à travers le prisme des catégories juridiques, lesquelles deviennent le socle d'un traitement volontairement différencié entre les étrangers. Si chères aux juristes, ces catégories représentent, dans le domaine de l'accès aux soins, un matériel de jeu privilégié dont l'édification répond à une rationalité certaine. À travers l'amusante métaphore du jeu de société, il s'agira de mettre en lumière la manière dont le travail de catégorisation, appliqué aux étrangers, participe à la fabrique des inégalités sociales de santé entre les

éléments catégorisés. Les étrangers seront les joueurs du jeu de l'accès aux soins, les catégories juridiques leurs équipes de jeu et les autorités nationales les « maîtresses du jeu ».

Bourdillon, F., et al. (2017/09). "La santé et l'accès aux soins des migrants : un enjeu de santé publique." Bulletin Epidemiologique Hebdomadaire (BEH)(19).
http://invs.santepubliquefrance.fr/beh/2017/19-20/pdf/2017_19-20.pdf

La situation sanitaire des personnes précaires est un sujet de préoccupation, un enjeu de société. Dans un rapport très récent, publié le 20 juin 2017 sous le titre « Précarité, pauvreté et santé », l'Académie de médecine fait un état des lieux et des propositions : les migrants y sont identifiés comme l'une des populations qui, parce qu'elles présentent de nombreux facteurs de vulnérabilité et de précarité, nécessitent q u'« elles bénéficient d'une attention particulière du point de vue médical ». Ce numéro spécial du BEH, principalement consacré à la santé des migrants les plus précaires, pour la plupart récemment arrivés sur le sol français, vient apporter des éclairages supplémentaires émanant de diverses structures amenées à les prendre en charge.

Boyer, J. B., De Beco, A., Champs-Leger, H., et al. (2018). "Les consultations au sein d'une permanence d'accès aux soins de santé." Medecine : De La Medecine Factuelle a Nos Pratiques **14**(2): 76-80.

Créée par la loi du 29 juillet 1998, la Permanence d'Accès aux Soins de Santé (PASS) a pour mission de lutter contre l'exclusion en favorisant l'accès aux soins des personnes les plus démunies. Elle s'insère dans un dispositif plus large de lutte contre la pauvreté. Les PASS travaillent en étroite collaboration avec les intervenants sanitaires, sociaux ou agissant dans le domaine de la précarité au sens large. L'activité peut se réduire à des consultations de médecine générale ou d'autres spécialités, mais aussi se déployer de façon plus transversale en intégrant des services sociaux afin de répondre aux besoins plus globaux de ses usagers.

Calvez, M., et al. (2006). "Les personnes originaires d'Afrique subsaharienne en accès tardif aux soins pour le VIH : données de l'enquête Retard, France, novembre 2003-août 2004." Bulletin Epidemiologique Hebdomadaire(31): 227-229, 223 tabl.

[BDSP. Notice produite par InVS 7pR0xGpw. Diffusion soumise à autorisation]. Les données récentes sur les nouveaux diagnostics de VIH-sida mettent en évidence le poids grandissant des personnes originaires d'Afrique subsaharienne. L'enquête ANRS-Vespa réalisée auprès d'un échantillon statistiquement représentatif des personnes vivant avec le VIH souligne également l'importance de la population d'origine étrangère et, parmi elle, des personnes originaires d'Afrique subsaharienne. Alors que l'effort de recherche s'est largement porté sur d'autres groupes touchés par le VIH, cette population n'a pas encore reçu une attention comparable de la recherche en sciences sociales et en santé publique. L'enquête Retard, réalisée dans le cadre des programmes de l'ANRS (Agence nationale de recherches sur le sida et les hépatites virales), fournit des informations sur les personnes originaires d'Afrique subsaharienne qui sont en accès tardif aux soins. En reliant cet accès tardif à leur mode de vie, elle met l'accent sur les situations de précarité qui les caractérisent. (Introduction).

Carde, E. et Université Paris 11. Faculté de médecine de Paris-Sud. Kremlin-Bicêtre. (2006). Les discriminations selon l'origine dans l'accès aux soins : étude en France métropolitaine et en Guyane française. Thèse pour l'obtention du doctorat d'université. Santé publique, sociologie **:** 539p.

Comité Médical pour les Exilés. (2016). La protection sociale des étrangers par les textes internationaux, Paris : Comède

Les normes de la protection sociale des étrangers sont notamment issues d'accords que la France a conclus avec d'autres États. Parmi eux, on distingue les traités adoptés sous l'égide d'une organisation internationale (l'ONU, l'OIT, le Conseil de l'Europe ou l'Union européenne) et les conventions ou les accords bilatéraux portant sur les droits sociaux. Ces textes sont importants parce qu'ils priment sur le droit interne et qu'ils sont souvent porteurs de droits et de garanties supérieurs à ceux prévus en France. L'ambition de ce cahier juridique est d'inciter ceux qui œuvrent pour les droits sociaux des

étrangers à s'appuyer sur ce droit international et de leur en donner les moyens. Après un bref rappel des principes qui régissent l'application des textes internationaux, cette publication présente un inventaire des textes internationaux applicables dans la sphère sociale, accompagné d'une analyse concrète des dispositions qui peuvent être invoquées à l'appui de recours contentieux. En annexe figurent des tableaux indiquant quels textes sont applicables à des étrangers en France selon leur situation et des extraits des textes les plus pertinents.

Comité Médical pour les Exilés. (2017). Rapport 2017 du Comède : activité 2016. Kremlin Bicêtre Comité médical pour les exilés **:** 55, tabl., graph.

Dans un contexte de crise de la protection des exilés, les actions du Comede ont poursuivi leur progression en 2016 dans l'ensemble des dispositifs (augmentation globale soit +15%. Au total, l'équipe du Comede a effectué 18 100 consultations et appels téléphoniques pour 6 365 personnes, et développé ses activités de formation et publications destinées aux acteurs et décideurs. Ce rapport décrit et analyse l'ensemble de leurs activités pour 2016.

Cong, H. Q., et al. (1992). Recours aux soins et morbidité des défavorisés 1988-1989-1990 : l'expérience de six centres associatifs de soins gratuits. Rapport Credes. Paris Credes **:** 63 , tabl., grah.

Analyse des caractéristiques de 5575 patients ayant consulté pour la première fois en 1990 dans six centres de soins gratuits à Paris, Marseille, Lille, Lyon appartenant à l'association R.E.M.E.D.E. et à M.S.F. (Médecin sans frontière - Mission Solidarité France). Réalisé par une équipe regroupant des chercheurs, des médecins et des travailleurs sociaux, ce travail prolonge deux observations effectuées en 1988 et 1989. Il fait une étude des patients par nationalité, statut, niveau de scolarité, âge et sexe.

Cordier, A. et Salas, F. (2010). Analyse de l'évolution des dépenses au titre de l'aide médicale d'état. Paris IGF ; Paris Igas**:** 24, 13 ann.

L'aide médicale de l'Etat (AME) est un dispositif de prise en charge des soins pour les étrangers en situation irrégulière résidant en France de manière ininterrompue depuis plus de trois mois et disposant de ressources inférieures à un plafond identique à celui exigé pour bénéficier de la CMUC (634 euros mensuels pour une personne seule, 951 euros pour deux personnes). Depuis sa création dans la continuité de l'aide médicale départementale, l'AME a fait l'objet de plusieurs rapports. Le rapport ci-joint s'inscrit dans le prolongement du rapport IGF/IGAS de mai 2007 (http://www.ladocumentationfrancaise.fr/rapports-publics/074000345/index.shtml). Une forte augmentation des dépenses d'AME (droit commun) a été observée en 2009 (+13,3%) pour atteindre 540 millions d'euros, largement supérieure au rythme de progression des dépenses d'assurance maladie. Cette progression s'est à peine ralentie au premier semestre 2010 (+12,3%). Les ministres commanditaires ont demandé à la mission d'analyser les causes d'une telle évolution, et de proposer toutes solutions utiles pour améliorer la fiabilité des prévisions budgétaires (au sein du programme 183 « protection maladie »), voire pour renforcer la maîtrise du dispositif. A leur demande, la mission devait également examiner les modalités de mise en place d'une contribution forfaitaire des bénéficiaires de l'AME sous forme d'un droit d'entrée dans le dispositif, et en évaluer le bénéfice-coût.

Dauvrin, M., Heymans, S., Lievens, C. M., et al. (2020). "La santé des migrants - Ancrer le soin dans un séjour précaire." Santé conjuguée(90).
www.maisonmedicale.org/-La-sante-des-migrants-Ancrer-le-soin-dans-un-sejour-precaire-.html

Face à l'arrivée de migrants et au durcissement des conditions de séjour, une partie de la population s'est mobilisée pour offrir un accueil alternatif. Un accueil qui ramène un peu d'humanité là où l'état s'est retiré. sans moyens supplémentaires, le monde associatif est venu lui aussi remplir les trous en mobilisant le réseau formel et informel, en apportant soutien et réconfort à ces laissés-pour-compte. Ce dossier met l'accent sur ces initiatives de l'ombre et en particulier celles qui touchent à la santé et aux soins. Il entrouvre les portes de lieux où l'on pénètre peu, à moins d'y être tenu : les centres d'accueil, les centres fermés, les cabinets médicaux ou de kinésithérapie, les consultations

psychologiques et de gynécologie... Il nous éclairera aussi sur les procédures, souvent longues et vaines, de régularisation.

de Celeyran, F. T., et al. (2013). "Health-care access for migrants in France." Lancet **382**(9906): 1704.

de Waure, C., et al. (2015). "Health inequalities: an analysis of hospitalizations with respect to migrant status, gender and geographical area." BMC Int Health Hum Rights **15**: 2.

BACKGROUND: The quality of care includes several aspects which may be influenced by social-economic status. This study analyzes hospitalizations for several conditions, such as chronic diseases, cancer and appendectomy, in Italians and immigrant people living in Italy with the aim to evaluate possible inequalities in the quality of health care services due to migrant status, gender and geographical macro-areas (Northern, Central, Southern Italy). METHODS: The data source of hospital discharges for stroke, myocardial infarction, chronic liver disease, cervical cancer, mastectomy and appendectomy was the Ministry of Health. ICD 9 codes were used for data collection. Crude and standardized hospitalization rates per 100.000 were calculated. Italian resident population and an estimate of immigrants living in Italy were used as denominators while standardization was done with respect to the European population. The data we used covers the 2006-2008 period. RESULTS: Immigrants showed significantly higher hospitalization rates for stroke, cervical cancer and appendectomy and significantly lower hospitalization rates for chronic liver diseases and mastectomy. Males showed significantly higher hospitalization rates than females for myocardial infarction, chronic liver diseases and appendectomy. Notwithstanding, differences related to migrant status and gender varied according to geographical macro-area. With respect to that, Southern Italy showed significantly higher hospitalization rates for stroke, myocardial infarction and chronic liver diseases and significantly lower hospitalization rates for mastectomy and appendectomy. CONCLUSIONS: The results of this study may reflect inequalities in the quality of health care, in particular in primary and secondary prevention, access to specialized care and inappropriateness, due to migrant status and gender. Also, differences between macro-areas suggest heterogeneities in the integration policies and the promotion of immigrants' health. Research should be endorsed in this field in order to further describe inequalities and their reasons and in the light of supporting policies development.

Deniaud, F., et al. (2008). "Dépistage ciblés proposés dans 6 foyers de migrants à Paris en 2005 : étude de faisabilité et d'impact." Sante Publique **20**(6): 547-559.

[BDSP. Notice produite par EHESP R0xlJIC7. Diffusion soumise à autorisation]. Dans le cadre de visites organisées par le service de dépistage radiologique itinérant de la tuberculose à Paris, une permanence médicale s'est tenue dans six foyers de migrants pour proposer, en plus du dépistage radiologique, un recueil d'urines pour le dépistage de la bilharziose ; et dans un second temps, une consultation gratuite de diagnostic et d'orientation dans un centre médico-social proche du foyer visité. L'objectif de cette étude est d'évaluer la faisabilité et l'impact de dépistages effectués sur site et en consultation. Sur les 97 personnes ayant bénéficié d'un entretien individuel en foyer, 52 ont fait la dépistage de la bilharziose urinaire te 3 cas ont été détectés (5,7%). En consultation 57 personnes sont venues sur 75 rendez-vous proposés. A l'issue de l'action, 33 pathologies ont été détectées chez 24 patients : infection à VHB (7 cas), bilharziose urinaire (9 cas), parasitoses intestinales (5 cas), infections sexuellement transmissible (2 cas), infection à VIH2 (1 cas) et des pathologies non infectieuses en moindre nombre. Les sujets détectés avec une pathologie curable ont été traités. Aller au devant des personnes dans les foyers de migrants entraîne un bénéfice général pour le dépistage de la bilharziose urinaire, cependant moins performant sur site qu'à l'issue des consultations, et de l'infection à VHB. Cette prise de contact personnalisée au foyer aide le migrant à venir consulter dans un CMS voisin et à rencontrer un travailleur social. En revanche, le suivi des affections chroniques détectées est incertain et coûteux pour les patients sans couverture complémentaire. La poursuite des permanences médicales sur site et l'initiative d'actions de prévention sont recommandées dans ces établissements.

Desgrees-Dulou et Lert, F. (2017). Un système de protection sociale universaliste, mais dea barrières à l'accès aux soins encore trop nombreuses. Parcours de vie et santé des Africains immigrés en France., Paris : Editions de la Découverte**:** 113-135, tab., grph., fig.

Bien que les données sur l'état de santé des immigrés en France soient rares et parfois divergentes, ces drniers seraient particulièrement exposés à certains problèmes de santé, dont les maladies infectieuses, les maladies cardiovasculaires et les pathologies psychiatriques. Leur prévention primaire et secondaire et leur prise en charge passent par une possibilité d'accès aux soins, mais peu de données sont disponibles sur cet accès, et quand elles existent, elles soulignent une inégalité dans cet accès. Ce chapitre en fait une analyse détaillée.

Desgrees Dulou, A. (2018). "Migrations et santé : des (nouvelles) questions de santé publique au coeur des enjeux sociétaux." Questions De Sante Publique(34): 8 , tab., graph., fig.

Les migrations constituent un des moteurs majeurs des dynamiques des populations. Elles sont pourtant encore trop peu étudiées sous l'angle de la santé publique, bien que celle-ci s'intéresse à tout ce qui est en lien avec le bien-être et la santé des populations. En France, cela vient en partie de notre modèle d'intégration républicaine, qui ne distingue pas les individus ou les groupes selon des critères d'origine ethnique ou de religion. Cependant, certaines maladies comme le VIH/sida ont montré qu'il pouvait être nécessaire de prendre en compte l'origine des personnes pour améliorer la prévention et l'accès aux soins. Améliorer l'accueil et la prise en charge des immigrés dans le système de santé français passe en effet par une meilleure connaissance de leurs besoins spécifiques.

Despres, C., et al. (2017). Des pratiques médicales et dentaires, entre différenciation et discrimination : une analyse de discours de médecins et dentistes. Paris Défenseur des Droits ; Paris Fonds CMU**:** 248 , tab., graph., fig. http://www.defenseurdesdroits.fr/sites/default/files/atoms/files/2017_03_27_rapport_final_medecins_et_patients_precaires.pdf

Cette recherche répond à une demande du Fonds de financement de la CMU et du Défenseur des Droits . Elle visait à analyser le refus de soins à l'égard des bénéficiaires de la CMU, de l'ACS et de l'AME et plus largement, à explorer d'autres formes de discrimination à l'encontre de Patients, qui vivent des situations de pauvreté et/ou de précarité. En effet, la discrimination peut s'exprimer sous des formes multiples, parfois plus insidieuses, dissimulées sous des formes variables de prise en charge, le refus de soins n'en étant que la forme la plus extrême et la plus visible. Elle a été réalisée au sein du laboratoire LEPS de l'université Paris XIII.

Diederichs, O., et al. (2013). Rapport sur l'admission au séjour des étrangers malades. Rapport IGAS ; 2013 041. Paris La documentation française**:** 126.

[BDSP. Notice produite par MIN-SANTE pFR0xCs8. Diffusion soumise à autorisation]. L'inspection générale des affaires sociales et l'inspection générale de l'administration ont été conjointement chargées d'une mission sur "l'admission au séjour des étrangers malades - évaluation de l'application de l'article L. 313-11 du code de l'entrée et du séjour des étrangers". Cette demande portait essentiellement sur l'élaboration d'un bilan de la loi du 16 juin 2011, tant en matière d'organisation administrative que d'efficience de la prise en charge sanitaire des intéressés, en dégageant, le cas échéant, des voies d'amélioration. Elle mettait notamment l'accent sur la diversité d'interprétation de la condition relative à l'accès au traitement dans le pays d'origine, sur les conditions dans lesquelles les médecins des agences régionales de santé émettent leur avis, l'existence de facteurs de fraude, les risques d'utilisation purement dilatoire de la procédure et enfin la validité de la notion de circonstances humanitaires exceptionnelles (article L 313-11 et L 511-4,10° et L 521-3,5° du CESEDA). La mission devait également analyser la situation de personnes en rétention ou en détention au regard de la protection contre l'éloignement découlant du recours à la procédure "Etrangers Malades" pendant leur rétention ou leur détention. D'un point de vue plus général, la mission était enfin invitée à faciliter, grâce à ses travaux, l'établissement ultérieur d'un "diagnostic partagé" entre le ministère des affaires sociales et de la santé et le ministère de l'intérieur.

Douai, C., et al. (2013). Observatoire de l'accès aux soins de la mission France de Médecins du Monde : rapport 2012. Paris Médecins du Monde**:** 210, annexes.

A l'occasion du 17 octobre, Journée internationale du refus de la misère, Médecins du Monde publie son rapport annuel sur l'accès aux soins des plus démunis en France. En 2012, en France, les conséquences de la crise économique sur la santé et l'accès aux soins sont prégnantes. Les inégalités sociales de santé s'accentuent chez les plus démunis. À cela s'ajoutent des réponses publiques souvent plus sécuritaires que sociales, notamment envers les migrants, les personnes se prostituant et les usagers de drogues. Ces personnes accèdent de plus en plus difficilement au système de soins, avec pour conséquence une détérioration de leur état de santé.

Dourgnon, P., et al. (2009). Etat de santé et recours aux soins des populations immigrées en France. Rapport final : Volume 1 : Etat de santé des populations immigrées en France. Paris IRDES**:** 156, tabl.

Cette recherche a été réalisée dans le cadre de l'appel à projets de recherche DREES/MIRE « Analyses secondaires de l'enquête décennale de l'Insee sur la santé et les soins médicaux ». Cette analyse repose sur des analyses descriptives et multi varié de l'état de santé d'une part et du recours aux services de santé d'autre part selon le statut migratoire : personne de nationalité française née en France, personne de nationalité française née à l'étranger, personne de nationalité étrangère. Le rapport final de cette étude est présenté en deux volumes, l'un consacré à l'état de santé et le deuxième au recours aux soins. Ce premier volume rassemble des réalisations sur l'état de santé des immigrés en France.

Dourgnon, P., et al. (2009). Etat de santé et recours aux soins des populations immigrées en France. Rapport final : Volume 2 : Recours aux soins des populations immigrées en France. Paris IRDES**:** 65, tabl.

Cette recherche a été réalisée dans le cadre de l'appel à projets de recherche DREES / MIRE « Analyses secondaires de l'enquête décennale de l'Insee sur la santé et les soins médicaux ». Cette analyse repose sur des analyses descriptives et multi varié de l'état de santé d'une part et du recours aux services de santé d'autre part selon le statut migratoire : personne de nationalité française née en France, personne de nationalité française née à l'étranger, personne de nationalité étrangère. Le rapport final de cette étude est présenté en deux volumes, l'un consacré à l'état de santé et le deuxième au recours aux soins. Ce second volume rassemble des réalisations sur le recours aux soins des immigrés en France.

Dourgnon, P., et al. (2009). "Le recours aux soins de ville des immigrés en France." Questions D'economie De La Sante (Irdes)(146): 6.

Les personnes immigrées ont un taux de recours à la médecine de ville, au généraliste comme au spécialiste, plus bas que le reste de la population française. Ceci s'explique davantage par la situation sociale défavorisée des immigrés que par des différences d'âge, de sexe ou d'état de santé entre ces deux populations. Cette analyse reste valable quelle que soit la région d'origine des personnes immigrées, à l'exception de celles originaires du Maghreb, plus nombreuses à consulter un généraliste. Le constat est plus contrasté pour les soins préventifs, les immigrés se déclarant plus souvent vaccinés que les Français mais recourant moins fréquemment aux tests de dépistage.

Dourgnon, P., Guillaume, S., Jusot, F., et al. (2019). "Étudier l'accès à l'Aide médicale de l'État des personnes sans titre de séjour. L'enquête Premiers pas." Questions D'economie De La Sante (Irdes)(244): 8. https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/244-etudier-l-acces-a-l-aide-medicale-de-l-etat-des-personnes-sans-titre-de-sejour.pdf

L'Aide médicale de l'État (AME), l'assurance maladie destinée aux personnes étrangères en situation irrégulière en France, reste très mal connue. Quelles sont les caractéristiques sociales, économiques et sanitaires des personnes étrangères en situation irrégulière bénéficiant de l'AME ? Qui sont celles qui ne recourent pas au dispositif ? Pour quelles raisons ? Quels sont les recours aux soins et à l'assurance santé des personnes étrangères en situation irrégulière ? L'AME permet-elle à ses assurés d'accéder aux services de santé ? Les récents débats portant sur une possible réforme de l'AME n'ont pu s'appuyer que sur des informations éparses et incomplètes. L'enquête Premier pas vise à apporter de premières réponses à ces questions. Elle a été menée en 2019 auprès de 1 223 étrangers sans titre de

séjour dans 63 lieux et structures, à Paris intra-muros et dans l'agglomération de Bordeaux. Après une description du protocole, de l'organisation de la collecte et du bilan statistique de l'enquête, nous présentons la structure de l'échantillon. Ce deuxième Questions d'économie de la santé sur l'accès à l'AME des personnes étrangères en situation irrégulière à partir de l'enquête Premiers pas s'inscrit dans une série. Le premier revenait sur l'histoire des droits de cette population en France et dressait un état des lieux des connaissances et ignorances concernant le dispositif de l'AME. Le troisième sera consacré à l'analyse de l'accès à l'AME.

Dourgnon, P., Jusot, F. et Marsaudon, A. (2022). "Just a question of time? Explaining non-take-up of a public health insurance program designed for undocumented immigrants living in France." Journal of Health Economics Policy and Law: 1-17.

State Medical Aid is a public health insurance program that allows undocumented immigrants with low financial resources to access health care services for free. However, the low take-up rate of this program might threaten its efficiency. The purpose of this study is therefore to provide the determinants of such a low take-up rate. To this end, we rely on the Premier Pas survey. This is an original representative sample of undocumented immigrants attending places of assistance to vulnerable populations in France. Determinants of State Medical Aid take-up are analyzed through probit and Cox modeling. The results show that only 51% of those who are eligible for the State Medical Aid program are actually covered, and this proportion is higher among women than among men. The length of stay in France is the most important determinant of take-up. It is worth noting that State Medical Aid take-up is not associated with chronic diseases or functional limitations and is negatively associated with poor mental health. There is, therefore, mixed evidence of health selection into the program. Informational barriers and vulnerabilities experienced by undocumented immigrants are likely to explain this low take-up.

Dourgnon, P., Jusot, F., Marsaudon, A., et al. (2022). "Non, l'Aide médicale d'État n'encourage pas les migrations pour raisons de santé." De Facto(31): 30-33.
https://www.icmigrations.cnrs.fr/wp-content/uploads/2022/03/DF31-Dourgnon-et-al.pdf

L'AME est une assurance publique donnant accès aux étrangers en situation irrégulière (ESI) à la plupart des services de santé sans restes à charge. Elle suscite des débats clivants. Un argument fréquemment soulevé par ses opposants est que « les sans-papiers viennent en France pour profiter du système de santé ». Les résultats de l'enquête Premiers Pas, réalisée en 2019 auprès d'un échantillon représentatif d'ESI montrent une tout autre réalité. Tout d'abord, seuls 9,5 % d'entre eux évoquent la santé comme motif de venue en France. De plus, seuls 51 % des ESI éligibles sont couverts par l'AME. Le principal facteur explicatif du recours à l'AME n'est pas l'état de santé ni le motif de venue en France, mais la durée de séjour sur le territoire. Si l'accès à l'AME est croissant avec la durée de séjour, même après 5 ans en France, 34,6 % des ESI restent non couverts.

Drouot, N., et al. (2012). "L'accès aux soins des migrants en situation précaire, à partir des données de l'Observatoire de Médecins du Monde : constats en 2010 et tendances principales depuis 2000." Bulletin Epidemiologique Hebdomadaire(2-3-4): 41-44.

[BDSP. Notice produite par InVS Fpss8R0x. Diffusion soumise à autorisation]. Médecins du Monde (MdM) agit en France dans 30 villes et mène 103 programmes de promotion de la santé en centres fixes ou unités mobiles, auprès de populations fragiles en difficulté d'accès à la prévention et aux soins. Pour décrire le profil des publics reçus, témoigner des obstacles à l'accès aux soins et en mesurer les évolutions, MdM a mis en place, depuis 2000, un Observatoire de l'accès aux soins. Les centres fixes utilisent à cet effet un recueil de données commun renseigné pour chaque personne rencontrée. En 2010, les centres ont accueilli 28 160 personnes, et des données ont été recueillies pour 21 710 d'entre elles. Il y avait 92% d'étrangers et 12% de mineurs. Leur profil socioéconomique est marqué par l'absence ou la précarité du logement, la grande faiblesse des ressources et une situation administrative précaire. Les trois-quarts peuvent en théorie disposer d'une couverture maladie, dont la moitié de l'Aide médicale de l'État (AME) réservée aux étrangers en situation irrégulière. Parmi les obstacles à l'accès aux soins principalement repérés : une méconnaissance des

droits, la barrière linguistique, des difficultés administratives, des difficultés financières mais aussi la peur des arrestations. L'analyse des données met en évidence les besoins de suivi médical, alors qu'il s'agit de personnes dépourvues de couverture maladie. Les mineurs et les femmes enceintes ne sont pas épargnés. La complexité des dispositifs administratifs limitent l'accès aux soins. Aussi, dans un objectif de simplification, une fusion de l'AME et la CMU (Couverture maladie universelle) en un seul dispositif pour toutes les personnes résidant sur le territoire et vivant sous le seuil de pauvreté, a été proposée. Mais certaines politiques de sécurité et de lutte contre l'immigration clandestine, par la peur des arrestations qu'elles engendrent, éloignent les personnes des structures de santé et entravent le travail de prévention, de réduction des risques et d'accès aux soins. Ces contradictions devraient être levées dans l'intérêt individuel des personnes et collectif de santé publique. (R.A.).

Duguet, A. M. et Beviere, B. (2011). "Access to health care for illegal immigrants: a specific organisation in France." Eur J Health Law **18**(1): 27-35.

Health care is a fundamental human right in Europe, and all Member States recognise everyone's right to the access to preventive healthcare and to receive medical care in the event of sickness or pregnancy. Nevertheless, this right is focused on citizens and the application to migrants, particularly undocumented migrants, varies widely in the EU. The French legislation is organized with a humanitarian approach. In this article, the authors present the French system of social protection, the "Couvernture medicale universelle" or CMU, which provides the same protection to asylum seekers and documented immigrants as to nationals, and the "Aide medicale d'etat" or AME, that is open to every person who does not fulfil the legal conditions to obtain the CMU, such as illegal immigrants. Created in 1995, recently access to the AME has been restricted. A claim of discrimination has been rejected by the Conseil d'Etat and 215,000 persons received the AME in 2009. The expenses incurred by the AME increased by 17% in 2010, and there is a debate in Parliament to limit care and to ask the recipient for a financial contribution.

Dupont, E. (2019). "Accès aux soins primaires des mineurs isolés étrangers dits "mineurs non accompagnés"." Medecine : De La Medecine Factuelle a Nos Pratiques **15**(10): 445-451.

Les mineurs non accompagnés (MNA) constituent un groupe vulnérable significatif. Ils nécessitent un accompagnement médical individualisé prenant en compte leur parcours et leur environnement : les médecins généralistes pourraient être des interlocuteurs privilégiés. Cependant, la complexité de leurs parcours et la situation administrative inhabituelle dans laquelle ils se trouvent peuvent être à l'origine d'inquiétudes chez les médecins. Un bilan de santé est recommandé dès l'étape d'évaluation de leur minorité effectuée par les conseils départementaux. Se pose alors la question de la possibilité de ces soins sans le consentement des titulaires de l'autorité parentale ou d'un représentant légal.

Fahet, G., et al. (2012). Observatoire de l'accès aux soins de la mission France de Médecins du Monde : rapport 2011. Paris Médecins du Monde**:** 215, annexes.

Ce rapport constitue le baromètre annuel de Médecins du Monde sur l'accès aux soins des plus démunis en France. Il souligne l'importante détérioration des conditions d'accès aux soins des populations précaires en France : Plus d'un tiers des patients vient se soigner tardivement par rapport aux soins qu'imposent leurs pathologies. 45% des femmes enceintes ont un retard dans leur suivi de grossesse ; 2 800 mineurs ont été accueillis dans les centres MdM en 2011 : leur nombre a augmenté de 48% depuis 2008; 72% des patients déclarent vivre à la rue ou dans un logement précaire. Une dégradation inquiétante des conditions de vie qui ont un impact sur la santé des plus démunis; Plus de 98% des personnes reçues vivent sous le seuil de pauvreté.

Fahet, G., et al. (2009). "Défaut de soins, refus de soins : l'expérience d'une association." Problemes Politiques Et Sociaux(960): 68-70, tabl., graph.

Fassin, D., et al. (2001). Un traitement inégal : les discriminations dans l'accès aux soins. Rapport d'étude ; 5. Bobigny CRESP**:** 270 , ann.

Faire respecter la réglementation en vigueur, faire prévaloir le principe de prise en charge médicale avant la régularisation administrative, renforcer le dispositif favorisant l'égalité en matière de soins sont quelques-unes des recommandations de ce rapport portant sur les discriminations dans l'accès aux soins. Réalisé par l'équipe de Didier Fassin, directeur du Centre de Recherche sur les Enjeux Contemporains en Santé Publique, ce rapport remis à la Direction de la Population et des Migrations du Ministère chargé de la Santé se base sur les résultats d'une enquête, la première sur ce thème en France.

Gabarro, C., Dourgnon, P., Jusot, F., et al. (2022). "L'aide médicale d'Etat, la fabrique d'un faux problème." De Facto(31): 74.
https://www.icmigrations.cnrs.fr/defacto/defacto-031/

Dans le contexte des élections présidentielles à l'issue de deux années de pandémie, l'aide médicale d'État (AME) est une fois de plus dans le viseur de certain.e.s candidat.e.s. Croisant expertises scientifiques et expériences professionnelles, ce numéro de De facto répond à l'actualité électorale par les faits. Contre la rhétorique de l'effet d'« appel d'air » de l'AME, Céline Gabarro documente la détérioration des conditions d'obtention. En chiffres, Paul Dourgnon, Florence Jusot, Antoine Marsaudon et Jérôme Wittwer démontrent la sous-utilisation du dispositif. Quant au coût économique de l'AME, Nicolas Vignier le relativise en soulignant l'importance des conséquences sanitaires et budgétaires qu'entraînerait sa suppression. À la lumière de vingt années de débat, Caroline Izambert pointe le décalage patent entre discours politique et expertise scientifique. La remise en cause de l'accès aux soins des étrangers est un phénomène qui touche d'autres pays européens. En Italie, Roberta Perna relate comment l'extrême-droite s'attaque au caractère universel et inclusif du système de santé avec en ligne de mire les migrant.e.s. En Grèce, Christiane Vollaire et Phillippe Bazin reviennent en images sur l'« archipel de solidarités » qui se développe en résistance face à l'effondrement du système de santé pour venir en aide aux populations autochtones comme migrantes. Enfin, en Allemagne, Jérémy Geereart explique le rôle du milieu associatif qui se bat pour faire évoluer les lois et améliorer l'accès aux soins pour les étrangers.

Gabarro, C. (2012). "Les demandeurs de l'aide médicale d'État préisentre productivisme et gestion spécifique." Revue Ruopeenne Des Migrations Internaionales **28**(2): 35-56.

En 2000 est créée l'aide médicale d'État (AME), une couverture maladie réservée aux personnes en situation irrégulière. Dans cet article, nous nous intéressons aux conséquences de cette spécificité sur l'accès aux soins de ces personnes dans trois champs : le droit, l'organisation des caisses d'assurance maladie et les pratiques des agents de ces caisses (aussi bien les agents d'accueil qui reçoivent les demandeurs, que les agents du service AME qui instruisent les dossiers). La combinaison de ces trois angles d'approche donnera ainsi à voir du parcours effectué par les personnes en situation irrégulière et des embûches rencontrées. Nous verrons que cantonner les personnes en situation irrégulière au sein d'une prestation qui leur est propre crée un système de santé à plusieurs vitesses, favorisant la réception de ce public dans des lieux distincts ou de manières différenciées et limitant son accès aux soins et aux structures. Nous serons particulièrement attentive à l'impact de la gestion productiviste sur l'accueil de ces personnes et le traitement de leur dossier : les rendements imposés aux agents des caisses et leur manque de formation les poussent à réclamer aux demandeurs plus de justificatifs, différant toujours plus leur accès aux soins.

Gastaut, J.-A. (2001). "La prise en charge des migrants atteints par le VIH." Impact Medecin(547): 7.

[BDSP. Notice produite par ENSP YoR0xs5X. Diffusion soumise à autorisation]. Aujourd'hui, en France, l'infection VIH se singularise par sa fréquence chez les personnes les plus précarisées et notamment chez les étrangers. Leur prise en charge globale doit être améliorée par la conjonction de différentes dispositions concernant aussi bien les aspects médicaux que psychologiques, sociaux, économiques, juridiques. Il faut réduire le risque de contamination tout en facilitant l'accès au conseil, au dépistage, aux soins et à l'accompagnement social. L'information-prévention spécifiquement adaptée aux populations étrangères doit être renforcée.

Gayral-Taminh, M., et al. (1997). "Situations sociales et besoins de santé des populations étrangères immigrées en France au cours des 5 dernières décennies." Sante Publique(1): 5-18.

L'objectif de cet étude est d'identifier, chez les étrangers immigrés en France au cours des 5 dernières décennies, d'éventuelles spécificités de besoins de santé dont la nature et la gravité justifieraient la mise en place de systèmes d'intervention adaptés. En dépit d'une apparente proximité de besoins partagés entre nationaux et étrangers appartenant à des catégories socio-économiques équivalentes, l'immigration introduit des facteurs de risques originaux. La spécificité des besoins en relation avec l'expression coutumière de la maladie et la rupture culturelle liée à "l'exil" nécessite un traitement médical et social adapté.

Gayral-Taminh, M., et al. (1995). "Protection sociale et situation administrative des étrangers immigrés en France (1990-1994)." Sante Publique(1): 5-18, fig.

[BDSP. Notice produite par ENSP R0xuP4uJ. Diffusion soumise à autorisation]. L'accès aux soins, à la protection sociale et l'avenir des étrangers immigrés en France sont inégaux : ils dépendent de leur statut administratif qui peut évoluer avec le temps. La politique de l'immigration du gouvernement Balladur (1993-1994) poursuit celle menée depuis 10 ans. Cependant, les nouvelles mesures, plus sélectives et restrictives à l'entrée et au séjour des étrangers, accentuent la disparité des réponses économiques et sociales apportées à "la demande d'asile". Elles concourent au clivage de cette population étrangère entre, d'une part les groupes pour lesquels leur installation dans la sécurité est favorisée par le libre accès au travail et l'assurance d'une protection sociale, et d'autre part les groupes pour lesquels la situation d'illégalité définitive et de précarité économique et sociale absolue sont une incitation à retourner dans leur pays d'origine. (R.A.).

Goasguen, C. et Sirugue, C. (2011). L'évaluation de l'aide médicale d'Etat : rapport d'information. Paris Assemblée nationale**:** 159, tabl., ann.

Ce rapport confirme l'intérêt de l'Aide médicale d'Etat (AME), qui a fait l'objet de nombreuses polémiques et de récentes réformes législatives très controversées. Cette prise de position en faveur de l'AME rejoint en beaucoup de points celle de l'Inspection générale des affaires sociales (IGAS) et de l'Inspection générale des finances (IGF) dans leur rapport de mission rendu public en décembre dernier. Le sujet est en effet polémique. Pendant un an, ils ont procédé à une dizaine d'auditions, à des déplacements (deux hôpitaux d'Île-de-France et deux caisses d'assurance maladie) et ont interrogé au moyen de questionnaires toutes les Caisses primaires d'assurance maladie (CPAM). Le rapport constate qu'il n'y a pas d'"explosion" de la consommation de soins par les bénéficiaires de cette prestation. Comme les enquêtes précédentes, les rapporteurs confirment également que les fraudes supposées n'ont rien à voir avec l'envolée des dépenses d'AME. La Caisse nationale d'assurance maladie (CNAMTS) les évalue en effet à moins de 0,3 % du montant des prestations. Le fantasme des innombrables ayants droit d'un même bénéficiaire est également mis à mal par les deux rapporteurs, qui rappellent que 81 % des bénéficiaires de l'AME sont des personnes isolées et que seuls 5 % ont deux ayants droit ou davantage. La forte croissance est liée à l'envolée du nombre d'étrangers concernés et à la forte hausse des coûts des séjours hospitaliers (même constat que l'IGAS). On assiste également à une sous-estimation chronique des crédits à allouer. Mais si les députés estiment que le dispositif doit être maintenu, car il répond, selon eux, aux impératifs humanitaires et de santé publique, ils préconisent néanmoins de réformer sa gestion. Les deux députés, bien que divisés sur l'efficacité de l'introduction d'un ticket d'entrée de 30 euros, sont en revanche convaincus que ce timbre coûtera plus cher qu'il ne rapportera. Ils font un certain nombre de recommandations, pas toujours partagées, pour améliorer les modalités de gestion de l'AME. Ils suggèrent ainsi d'appliquer pour les séjours hospitaliers une tarification de droit commun par groupe homogène de séjour (GHS) et de mettre en place un suivi médical en aval efficace et une première visite de prévention lors de la première année. Côté divergences, le député UMP se dit favorable à un transfert de la gestion de l'AME à un organisme d'assurance privé, préconise une enveloppe limitative annuelle et se montre ouvert à l'idée de niveaux de protection gradués. Son collègue socialiste plaide en revanche pour un assouplissement de la procédure de domiciliation des demandeurs - avec l'introduction d'une domiciliation par des tiers - et préconise l'amélioration de la couverture

territoriale des lieux d'instruction des dossiers.

Goasguen, C. et Sirugue, C. (2012). L'aide médicale de l'État : mieux gérer un dispositif nécessaire. Suivi du rapport de 2011 sur l'évaluation de l'aide médicale de l'État : rapport d'information. Paris Assemblée nationale**:** 24, tabl., ann.

Ce rapport de suivi sur l'évaluation de l'aide médicale de l'État établit un bilan du fonctionnement du dispositif en mettant en évidence son intérêt en termes de santé publique mais en s'interrogeant sur les moyens de mieux connaître et de maîtriser l'origine des variations des dépenses afférentes. Les conclusions du document mettent en relief la nécessité d'une adaptation et d'une modernisation de sa gestion, notamment en ce qui concerne les modalités de tarification des soins hospitaliers. Parmi les points positifs relevés par le rapport de suivi, on retiendra l'application rapide de la recommandation d'abandonner progressivement le tarif journalier de prestation (TJP) afin d'adopter la tarification de droit commun par groupe homogène de séjour (GHS), le TJP étant devenu une variable d'ajustement des recettes de l'hôpital. Cette recommandation a été adoptée à l'été 2011, dans le cadre du premier projet de loi de finances rectificative pour 2011. La réforme vise une tarification modifiée à partir du 1er décembre 2011 et complètement en vigueur en 2013. Il s'agit d'un système reposant sur la T2A (le tarif sera équivalent à 80 % du tarif « de droit commun »), mais modulée par deux coefficients correcteurs afin de prendre en compte les spécificités de ces patients et les difficultés des hôpitaux lors de la transition. Cette réforme ne s'applique pas aux soins assurés dans le cadre de la procédure des soins urgents. Autre point positif, la revalorisation significative de la dotation initiale en 2011, alors que jusqu'alors les dotations étaient systématiquement et très largement sous-évalués. Ce qui n'a pas empêché une ouverture supplémentaire de crédits de 35 millions d'euros en fin d'année, les réformes engagées au cours de l'année 2011 n'ayant sans doute pas porté encore tous leurs effets. Les autres propositions du rapport de juin 2011 ont connu des fortunes diverses. La proposition d'une visite de prévention à tout nouveau bénéficiaire de l'AME est encore au stade de l'expérimentation, réalisée sur trois centres de santé seulement. La rédaction d'un arrêté qui prolongerait la conservation des données issues de la base de l'assurance maladie Érasme se heurterait aux réticences de la CNIL. S'agissant de l'amélioration des conditions de gestion, la CNAMTS développe actuellement un nouvel outil de gestion, en cours d'expérimentation dans certaines caisses. De plus, elle effectue depuis juillet dernier un rapport mensuel (et non trimestriel) des dépenses, ce qui devrait améliorer la prévision budgétaire. Enfin, l'application du droit de timbre oblige certaines familles, en raison du coût du timbre, de choisir le membre de la famille bénéficiaire. Le nombre de droits de timbre de 30 euros acquittés au 15 décembre dernier était de 88 086. Quant au nombre de bénéficiaires de l'AME en 2011, il semble avoir diminué par rapport à 2010, notamment en raison de la suppression de la possibilité d'instruire les demandes par les associations.

Grillo, F., et al. (2012). "L'absence de dépistage du cancer du col de l'utérus en fonction des caractéristiques migratoires chez les femmes de l'agglomération parisienne en 2010." Bulletin Epidemiologique Hebdomadaire(2-3-4): 45-47.

[BDSP. Notice produite par InVS R0xoAnmI. Diffusion soumise à autorisation]. Objectifs - L'objectif de cette étude était de comparer les pratiques de dépistage du cancer du col utérin par frottis (FCU) entre femmes françaises nées de deux parents français (FPF), françaises nées d'au moins un parent étranger (FPE), et étrangères dans l'agglomération parisienne. Méthodes - Il s'agit des données de la seconde vague d'enquête de la cohorte "Santé, inégalités, ruptures sociales" (SIRS), conduite en 2010 auprès d'un échantillon représentatif des adultes francophones de l'agglomération parisienne (1 724 femmes). Des modèles de régressions logistiques ont analysé les caractéristiques démographiques, socioéconomiques, d'insertion sociale et de santé associées à l'absence de FCU au cours de la vie. Résultats - Parmi les femmes âgées de 25 ans ou plus, 91,2% avaient déjà eu au moins un FCU au cours de leur vie. Une fois ajusté sur l'âge, les femmes FPE avaient 2 fois plus de risque de n'avoir jamais été dépistées que les femmes FPF (OR=2,46 ; IC95% [1,60-3,77]), et ce risque redoublait pour les femmes étrangères (OR=5,27 ; IC95% [3,41-8,15]). La proportion de vie passée en France métropolitaine diminuait le risque de non dépistage pour les femmes étrangères, mais les différences entre les FPF et les FPE ou les étrangères persistaient, même lorsque toutes les autres caractéristiques étaient prises en compte. Conclusion - Des actions spécifiques doivent être entreprises pour réduire les inégalités

relatives à l'immigration dans le domaine du dépistage du cancer du col utérin. (R.A.).

Grognet, F., et al. (2009). "Santé et droits des étrangers : réalités et enjeux." Hommes & Migrations(1282): 210.

Les articles de ce dossier montrent comment le corps malade ou souffrant des migrants peut leur permettre de revendiquer des droits en bénéficiant de la législation française en matière d'immigration et d'asile. Ils décrivent également comment les professionnels de santé interviennent aux côtés des réseaux associatifs dans la protection des droits des étrangers et l'accès aux soins.

Guillon, M., et al. (2015). Cost-effectiveness analysis of early access to medical and social care for migrants living with HIV in France. Working Paper ; 2015–06. Paris Ecole d'Economie**:** 19 , tab., graph., fig.

Background In 2011, migrants accounted for 47% of newly diagnosed cases of HIV infection in France, including 70% from Sub-Saharan Africa. These populations meet with speci_c obstacles leading to late diagnosis and access to medical and social care. Reducing these delays has a proven benefit to patients' health and contributes to a better control of the epidemic by preventing secondary infections. Methods The objective of this study is to assess the cost-effectiveness impact of an early access to care (ATC) for migrant people living with HIV (PLHIV) in France. The model compares \early" vs. \late" ATC for migrant PLHIV in France, defined by an entry into care with a CD4 cell count of 350 and 100/mm3 respectively, and integrate the positive externality of treatment on prevention. To evaluate the cost-effectiveness of \early" ATC, incidence and hidden prevalence among migrants in France were estimated. Findings Early ATC strategy proved cost-saving, or cost-effective in the worst case scenario. In the most favorable scenario, early ATC generated an average net saving of €198,000 per patient, and prevented 0.542 secondary infection. In the worst case scenario, early ATC strategy generated an average cost of €28,000, a cost-effectiveness ratio of €133,000 per averted infection and prevented 0.211 secondary infection. Interpretation In addition to individual health benefit, improving early ATC for migrant PLHIV proves an efficient strategy in terms of public health and economics. These results stress out the benefit of ensuring ATC for all individuals living with HIV in France.

Guillou, A. Y. (2009). "Immigration thérapeutique, immigration pathogène. Abandonner le parcours thérapeutique pour l'expérience migratoire. Commentaire." Sciences Sociales Et Sante **27**(1): 63-71.

Halley, E., Giai, J., Chappuis, M., et al. (2021). "Health Profile of Precarious Migrants Attending the Médecins Du Monde's Health and Social Care Centres in France: a Cross-Sectional Study." Trop Med Int Health **66**: 602394.

Objective: The present study aimed to compare the precarious migrants' health problems managed in Médecins du Monde's health and social care centres (CASO) with those of patients attending general practice in France. Methods: We compared the most frequent health problems managed in the 19 CASO in metropolitan France with those of a national sample of usual general practice consultations, after standardisation for age and sex. Results: Precarious migrants had fewer health problems managed per consultation than other patients (mean: 1.31 vs. 2.16), and these corresponded less frequently to chronic conditions (21.3% vs. 46.8%). The overrepresented health problems among CASO consultations were mainly headache (1.11% vs. 0.45%), viral hepatitis (1.05% vs. 0.20%), type 1 diabetes (1.01% vs. 0.50%) and teeth/gum disease (1.01% vs. 0.23%). Their underrepresented health problems were mainly lipid disorder (0.39% vs. 8.20%), depressive disorder (1.36% vs. 5.28%) and hypothyroidism (0.50% vs. 3.08%). Prevention issues were nominal in precarious migrants (0.16%). Conclusion: Both chronic somatic and mental conditions of precarious migrants are presumably underdiagnosed. Their screening should be improved in primary care.

Hamadache, N. (1999). "L'accès des immigrés âgés aux droits et prestations sociales. Un combat juridique mené au niveau associatif." Gerontologie Et Societe(91): 65-77.

[BDSP. Notice produite par FNG eF8yR0xM. Diffusion soumise à autorisation]. Depuis plusieurs années, l'ODTI (Office Dauphinois des Travailleurs Immigrés), association loi 1901 créée en 1970, lutte pour l'égalité de traitement entre populations immigrées ou issues de l'immigration et nationaux. Ce combat se traduit par des actions dans le domaine du logement, du Droit, de la santé, de l'accès à

l'emploi et de la culture. En matière d'accès aux droits, notre objectif a toujours été de conduire les organismes sociaux à respecter les dispositions légales nationales ou européennes pour lesquelles la France s'est engagée. Cependant, il n'en demeure pas moins que les règles de lois restent encore insuffisantes à garantir une réelle égalité d'accès aux droits aux populations immigrées vieillissantes tant les modalités d'accès à ces droits dépendent, en grande partie, de la façon dont cette accession se déroule dans le quotidien.

Hamel, C. et Moisy, M. (2010). L'expérience de la migration, santé perçue et renoncement aux soins. Trajectoires et Origines, enquête sur la diversité des populations en France. Premiers Résultats., Paris : Ined**:** 77-84, tabl., fig.

Si les dimensions du genre et des inégalités de revenu sont de plus en plus systématiquement prises en compte dans les études récentes sur la santé des immigrés, les critères de nationalité, pays de naissance et origine apparaissent souvent manquants, qu'ils soient indisponibles ou non présentés. L'enquête Trajectoires et Origines, de par son objectif premier d'étudier la diversité des populations en France, de par les données quelle renseigne sur le parcours migratoire et les conditions de vie actuelles dans différentes sphères du quotidien et de par la taille de son échantillon, permet d'apporter un éclairage sur la santé des immigrés et natifs d'un DOM. Ce chapitre présente les premiers résultats sur la santé perçue des immigrés et natifs d'un DOM, âgés de 18 à 60 ans, en France. Les natifs d'un DOM sont intégrés aux analyses multivariées au titre de leur expérience d'une grande mobilité géographique et de ses effets possibles sur la santé perçue, à âge identique, les hommes immigrés ont une probabilité supérieure de 30 % de déclarer un état de santé altéré comparés aux hommes de la population majoritaire. Pour les femmes immigrées, cette probabilité s'accroit de 80 %. Être chômeur ou inactif, disposer de faibles revenus et d'un niveau d'études inférieur au baccalauréat apparaissent parmi les facteurs explicatifs les plus significatifs pour expliquer les différences de perception de santé entre immigrés et population majoritaire. Si l'on prend en compte le pays d'origine, ce sont les immigrés de Turquie, du Maghreb et du Portugal qui se déclarent le plus souvent en mauvaise santé. À âge et caractéristiques socio-économiques identiques, les hommes et les femmes immigrés présents sur le territoire métropolitain depuis plus de trente ans se déclarent également en plus mauvaise santé ce qui est compatible avec l'hypothèse souvent émise de l'effet d'une dégradation de l'état de santé sur la terre d'accueil due à une situation sociale plus défavorable.

Hoyez, A.C. (2011). « Accès aux soins des migrants en France et la culture de l'initiative locale » Espace, Société, Territoire (566)

Jolivet, A., et al. (2012). "Migration, santé et soins en Guyane (France), 2009." Numéro thématique. Santé et recours aux soins des migrants en France.(2-3-4): 48-51.

Objectifs - Les objectifs de ce travail étaient 1) estimer le poids des déterminants sanitaires dans l'ensemble des déterminants de la migration vers la Guyane ; 2) comparer l'état de santé des populations vivant en Guyane en fonction de leur statut migratoire ; 3) décrire et estimer les migrations pendulaires pour soins à l'hôpital de Saint-Laurent du Maroni (SLM). Méthodes - Une première enquête en population a été conduite sur un échantillon aléatoire de 1 027 résidents de Cayenne et SLM âgés de 18 ans ou plus. Des modèles de régression logistique ont permis de comparer trois indicateurs de santé (santé perçue, maladies chroniques, limitations fonctionnelles) en fonction des statuts migratoires. Les enquêtes à l'hôpital de SLM s'appuyaient sur un échantillon aléatoire de patients consultant le service des urgences (n=286) et sur un échantillon consécutif de femmes accouchant à la maternité de l'hôpital (n=264). Les migrants pendulaires ont été définis comme ceux ayant déclaré leur résidence principale au Suriname. Ces enquêtes ont été conduites entre février et avril 2009. Résultats - Les immigrés représentaient 40,6% de la population adulte à Cayenne et 57,8% à SLM. Parmi ceux-ci, 3,1% ont déclaré avoir migré et/ou s'être installés en Guyane pour une raison de santé. Les personnes en situation irrégulière présentaient les plus mauvais indicateurs sanitaires. À l'hôpital de SLM, les migrants pendulaires représentaient 4,6% des consultants aux urgences et 12,5% des accouchements à la maternité. Conclusion - Les migrations pour soins ne représentaient qu'une minorité des mouvements migratoires vers la Guyane. À SLM, les migrations pendulaires pour soins

étaient limitées et avant tout le reflet de disparités dans l'offre de soins entre la Guyane et le Suriname. (R.A.).

Jusot, F., Dourgnon, P., Guillaume, S., et al. (2019). "Le recours à l'Aide médicale de l'État des personnes en situation irrégulière en France : premiers enseignements de l'enquête Premiers pas." Questions D'economie De La Sante (Irdes)(245): 8.
https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/245-le-recours-a-l-aide-medicale-de-l-etat-des-personnes-en-situation-irreguliere-en-france-enquete-premiers-pas.pdf

La France a choisi de longue date de garantir l'accès aux soins des étrangers en situation irrégulière avec l'Aide médicale gratuite puis, depuis 2000, l'Aide médicale de l'Etat (AME). L'existence d'un tel dispositif ne garantit pas, à elle seule, que l'ensemble des personnes éligibles y accèdent ni en fassent usage. Nous étudions ici le recours à l'AME et ses déterminants à partir des données de l'enquête Premiers pas, réalisée en 2019 auprès d'un échantillon de personnes étrangères sans titre de séjour. Seules 51 % des personnes qui y sont éligibles bénéficient de l'AME. Près de la moitié des personnes sans titre de séjour déclarant souffrir de pathologies nécessitant des soins, comme le diabète ou les maladies infectieuses, ne sont dans les faits pas assurées pour la santé, ni par l'AME, ni par l'assurance maladie de droit commun. Le recours à l'AME est un peu plus important chez les 10 % ayant cité la santé parmi leurs motifs de migration. Il est cependant assez peu corrélé aux problèmes de santé, en dehors des troubles musculo-squelettiques. Le recours à l'AME augmente avant tout avec la durée de séjour sur le territoire. Ces résultats suggèrent que la plupart des migrants ont peu de connaissances de l'AME et n'ont pas tous la capacité à se saisir d'un dispositif complexe. Même après cinq années ou plus de résidence en France, 35 % des personnes sans titre de séjour n'ont pas l'AME. Ce troisième Questions d'économie de la santé sur l'accès à l'Aide médicale de l'Etat des personnes étrangères en situation irrégulière s'inscrit dans une série. Le premier rappelle l'histoire des droits de cette population en France et dresse un état des lieux des connaissances sur le dispositif de l'AME. Le deuxième présente l'enquête Premiers pas.

Isidro, L. (2016). "La protection sociale des personnes étrangères. Pour un nouveau critère d'accès aux prestations sociales." Informations Sociales **194**(3): 106-116.
https://www.cairn.info/revue-informations-sociales-2016-3-page-106.htm

L'État social est né dans le giron de l'État-Nation. En tant que non national, l'étranger, à moins d'être rattaché à la collectivité des travailleurs, a de ce fait longtemps été l'objet de discrimination dans le domaine de la protection sociale. La construction européenne et la montée en puissance des droits de l'Homme ont toutefois contribué à délégitimer la condition de nationalité. La voie s'est alors ouverte pour que se concrétise le projet d'une protection sociale universelle, c'est-à-dire applicable à toutes les personnes en tant que membres de la société. Dans l'ordre juridique interne, les préoccupations relatives à la maîtrise de l'immigration ont conduit à conditionner la protection sociale de l'étranger à l'exigence de régularité du séjour. Plus libéral, un tel régime conserve néanmoins l'empreinte de la nationalité. La jurisprudence de la Cour de justice de l'Union européenne fondée sur le concept d'intégration incite cependant à dessiner les traits d'un critère universel d'accès à la protection sociale, moins organisé autour du lien à l'État qu'à la société, un lien non plus de nationalité mais d'intégration.

La Cimade (2018). Personnes étanagères malades : soigner ou suspecter ? Paris : La Cimade**:** 19p.
https://www.lacimade.org/wp-content/uploads/2018/06/La_Cimade_Soigner_Suspecter.pdf

La loi du 7 mars 2016 représente une large réforme du dispositif de protection médicale devant permettre aux personnes étrangères malades ne pouvant se soigner dans leur pays d'origine d'obtenir un titre de séjour pour soins. Dans un récent rapport, la Cimade analyse les effets de cette loi qui est entrée en vigueur au début de l'année 2018. L'Association dénonce que de plus en plus d'étrangers gravement malades, notamment séropositifs, sont visées par des décisions d'expulsion. Concrètement, en 2017, le nombre de titres de séjour délivrés pour raisons médicales a chuté de 37 %. La nouvelle procédure imposées aux personnes malades est bien plus complexe, et laisse les demandeurs sous la menace de l'expulsion. Détaillant tous les obstacles jalonnant la procédure, le rapport s'appuie sur les constats de bénévoles de l'association ainsi que sur divers témoignages. La

Cimade examine de plus comment la loi du 7 mars donne l'ascendant aux préfets sur les médecins, certains malades se voyant refuser un titre de séjour pour soins alors que le médecin leur avait remis un avis favorable. Elle pointe aussi du doigt le manque de transparence s'agissant des critères utilisés pour établir l'avis médical.

La Ruche, G. et Brunet, B. (2006). "Demandes de séjour pour raison médicale des malades étrangers dans le département du Val-d'Oise de 1999 à 2003." Sante Publique **18**(1): 119-130.

[BDSP. Notice produite par ENSP 75wR0xrH. Diffusion soumise à autorisation]. Les demandes de séjour pour raison médicale des malades étrangers sont soumises pour avis aux médecins inspecteurs de santé publique. L'article rapporte l'évolution quantitative et qualitative de ces demandes dans un département d'Ile-de-France. Ces demandes ont considérablement augmenté, passant de 152 en 1999 à 1 823 en 2003. Les demandeurs étaient majoritairement des femmes et des personnes originaires d'Afrique Sub-Saharienne. L'infection à VIH était le motif le plus fréquent des demandes même si son importance relative a diminué au cours du temps, passant de 25% en 1999 à 15% en 2003, suivie du diabète (8% des demandeurs), de l'hypertension artérielle (5%) et de la tuberculose (4%). L'avis a été favorable dans 74% des cas. L'analyse des autorisations de séjour pour raison médicale est un angle d'approche permettant d'appréhender la santé des étrangers en situation irrégulière.

Laforgerie, F. (2020). "Santé des étrangers-ères : la dégradation en marche. Épisode 2 : on rentre dans le dur !" Cahier Gingembre : Remaides N° 111(42): 16.
https://www.aides.org/sites/default/files/Aides/bloc_telechargement/gingembre_42.pdf

De loi sur l'immigration en loi sur l'immigration (on en compte plus de 100 en 75 ans, en France, les conditions d'accès à la santé des personnes étrangères, dont celles malades, n'ont cessé de se dégrader. Le phénomène est net, ces dernières années. Il s'est même emballé, ces récents mois. Sur cette période, les projets gouvernementaux, les protestations des ONG, la radicalisation du discours politique et les conséquences concrètes pour les personnes concernées, autant de sujets sur lesquels, Gingembre revient dans un feuilleton en deux parties : « Le temps des menaces » et « On rentre dans le dur ». Cette publication constitue la deuxième partie de l'étude. La première partie est accessible à cette adresse : https://www.aides.org/sites/default/files/Aides/bloc_telechargement/gingembre_41.pdf.

Larchanche, S. (2012). "Intangible obstacles: health implications of stigmatization, structural violence, and fear among undocumented immigrants in France." Soc Sci Med **74**(6): 858-863.

This study identifies undocumented immigrants' obstacles to realizing their health care rights in France. The ethnographic fieldwork informing this study was carried out in Paris from March 2007 to July 2008. Research findings are based on (1) participant observation carried out in two grassroots health associations catering to undocumented immigrants in Paris (one providing legal and medical aid to undocumented immigrants from sub-Saharan Africa, and another focused specifically on assisting undocumented individuals seeking a visa for medical reasons, as well as women victims of domestic violence); (2) a review of legislative debates on the issue of healthcare access for undocumented immigrants in France, and (3) recently published reports on healthcare access for the undocumented in Europe. The paper analyzes how interaction among intangible factors - namely social stigmatization, precarious living conditions, and the climate of fear and suspicion generated by increasingly restrictive immigration policies - hinders undocumented immigrants' access to health care rights and, furthermore, minimizes immigrants' sense of entitlement to such rights in this European context. Intangible factors such as fear and suspicion have powerful "subjectivation" effects, which influence how both undocumented immigrants and their interlocutors (i.e., healthcare providers) think about "deservingness." Medical anthropology is in a unique position to demonstrate and theorize these factors and effects, which inform contemporary debates about migration and "health ethics."

Laude, A. (2011). "Le droit à l'accès aux soins des étrangers : réforme de l'aide médicale d'Etat." Seve : Les Tribunes De La Sante **54**(30): 17-19.

Cet article présente la réforme de l'aide médicale d?Etat (AME) destinée à tous les étrangers séjournant en France depuis plus de trois mois dans le cadre de la loi de finances pour 2011 (loi 2010-1657 du 29 décembre 2010) et actée par le décret n° 2011-273 du 15 mars 2011. Cette réforme introduit, entre autre, un droit de timbre de 30 euros.

Launay, D. (2000). "Accueil et prise en charge des patients d'origine étrangère aux hôpitaux de Saint-Denis." Revue Hospitaliere De France(1): 29-32.

[BDSP. Notice produite par ENSP dPR0xEg9. Diffusion soumise à autorisation]. Dans un département qui compte une forte proportion d'étrangers (18,9% au dernier recensement de 1990,30% à Saint-Denis) les indicateurs de précarité sont nombreux, tant en termes de revenus et d'emploi que de santé. L'accès de cette population aux soins, et plus particulièrement aux soins hospitaliers, a fait l'objet d'un mémoire de fin d'études à travers l'exemple des hôpitaux de Saint-Denis. La RHF en publie ici la synthèse faite par son auteur, Delphine Launay. Par delà le problème de réduction des créances irrécouvrables, celle-ci s'attache à la question des relations et de la communication entre le personnel hospitalier et les patients. Résultats d'enquêtes et proposition de pistes composent les points forts de ce document, rédigé avant le vote de la loi sur la CMU.

Le, Vu, S., et al. (2005). "Les migrants africains au sein du dépistage anonyme du VIH, 2004." Bulletin Epidemiologique Hebdomadaire(46-47): 233-235.

[BDSP. Notice produite par InVS 5j4AwR0x. Diffusion soumise à autorisation]. Après deux précédents en 1999 et 2000, une enquête nationale s'adressant aux candidats à un test VIH dans les Centres de dépistage anonymes et gratuits (CDAG) a été réalisée en octobre 2004. Son objectif était de décrire la population recourant au dépistage anonyme du VIH en France. L'analyse consiste ici à décrire les consultants originaires d'ASS et de comparer leurs caractéristiques à celles des autres consultants. (Extrait introduction).

Le Défenseur de sDroits (2019). Personnes malades étrangères : des droits fragilisés, des protections à renforcer. Paris Le Défenseur des Droits **:** 76.
https://www.defenseurdesdroits.fr/sites/default/files/atoms/files/rap-etrangmalad-num-07.05.19_0.pdf

Le Défenseur des droits est chargé par l'article 71 de la Constitution de veiller au respect des droits et des libertés. A la suite d'une forte augmentation des réclamations qui lui sont adressées en matière de défense des droits des personnes malades étrangères, il dresse, dans ce nouveau rapport un bilan de son action et présente ses recommandations.

Le Vu, S. et Lydie, N. (2008). "Pratiques de dépistage du VIH chez les personnes originaires d'Afrique subsaharienne en Île-de-France, 2005." Bulletin Epidemiologique Hebdomadaire(7-8): 52-55.

[BDSP. Notice produite par GRPS JBHR0xk9. Diffusion soumise à autorisation]. Dans le cadre de l'enquête sur les connaissances, attitudes, croyances et comportements face au VIH/sida réalisée en 2005 par l'Institut national de prévention et d'éducation pour la santé (Inpes), 1 874 personnes originaires d'Afrique subsaharienne et résidant en Île-de-France ont été interrogées dans des lieux publics sur le dépistage du VIH. Les personnes originaires d'Afrique subsaharienne déclaraient à 64,9% avoir déjà été testées au cours de la vie et 34,2% déclaraient avoir été testées plusieurs fois. Le dépistage était plus courant parmi les personnes de nationalité française ou les étrangers en situation stable. Comparé à la population générale, le dernier dépistage avait plus fréquemment été réalisé à l'hôpital (30,4%), et avait été plus souvent (61,2%) initié par un médecin lors d'un bilan de santé ou dans le cadre d'un protocole de dépistage (examen prénatal ou prénuptial). Très peu de tests avaient été réalisés suite à une prise de risque. Finalement, les populations originaires d'Afrique subsaharienne ont un niveau de recours au test relativement élevé, et ce malgré les freins que représente une situation administrative précaire. (R.A.).

Lebrun, C., et al. (2008). "Impact of disease-modifying treatments in North African migrants with multiple sclerosis in France." Mult Scler **14**(7): 933-939.

BACKGROUND: Multiple Sclerosis in North African migrants (MS-NA) is more aggressive with mostly primary progressive forms and cerebellar symptoms. Despite an earlier onset in NA patients, the disease progresses more rapidly, with a higher proportion showing incomplete recovery from the first relapse, a shorter time between the first two relapses, a higher number of relapses in the first 5 years, and a shorter time to reach an EDSS of 4.0 and 6.0. We collected data and studied the impact of disease-modifying therapies (DMT) in NA patients with MS, among the 4144 MS patients treated in our MS clinics. METHODS: We performed a descriptive population-based study of MS-NA patients. Data were crossed with expected age- and gender-matched characteristics available in our EDMUS databases for the period 1995-2007. RESULTS: A total of 133 patients, representing 66% of the MS-NA patients included in the database were identified: mean age at the first documented symptom: 29.7 years; mean time from diagnosis to the beginning of DMT: 1.2 years. 40% of MS-NA patients had an EDSS >3 at the beginning of treatment (vs. 25%; P=0.002). A majority of patients were treated initially with immunomodulatory drugs (MS-NA: 48% vs. CT: 51%, P=0.8). NA patients were treated earlier after diagnosis (1.3 years vs. 4.5 years, P=0.003), with the frequent use of immunosuppressive drugs: for remitting forms, mitoxantrone (18.5% vs. 7.8%, P=0.0001) and for progressive forms, cyclophosphamide (38% vs. 28%, P=0.003). CONCLUSIONS: Considering EDSS follow-up during DMT, MS-NA patients appear as responsive as other MS patients to treatment, despite the earlier treatment prescription and the more frequent use of immunosuppressors.

Ledesert, B., et al. (2006). Etat de santé et accès aux soins des migrants en France : analyse et synthèse bibliographique. Montpellier ORSLR**:** 75, 72 tabl.

Ce document, réalisé par l'Observatoire Régional de la Santé du Languedoc Roussillon (ORS), propose une synthèse bibliographique de l'état de santé et de l'accès aux soins des migrants en France.

Lert, F., et al. (2002). Sida, immigration et inégalités. Nouvelles réalités, nouveaux enjeux, Paris : ANRS

Cet ouvrage est composé d'articles issues des recherches financées par l'Agence Nationale de Recherches sur le Sida (ANRS) sur le thème de l'immigration et des inégalités. Il fait le bilan de trois grands thèmes : les catégories de l'immigration et l'épidémie de sida ; les discriminations ; la politique d'immigration la vie familiale et sexuelle.

Lot, F., et al. (2004). "Parcours sociomédical des personnes originaires d'Afrique subsaharienne atteintes par le VIH, prises en charge dans les hôpitaux d'Ile-de-France, 2002." Bulletin Epidemiologique Hebdomadaire(5): 17-20, 14 tabl., 12 fig.

[BDSP. Notice produite par INVS 0aMR0xco. Diffusion soumise à autorisation]. L'incidence du sida a considérablement diminué en France à partir de 1996, puis plus faiblement ensuite, grâce aux nouvelles stratégies thérapeutiques. Cette diminution a été moins marquée chez les personnes de nationalité d'un pays d'Afrique subsaharienne, chez qui on note même, à partir de 1999, une augmentation du nombre de nouveaux cas de sida (+72% entre 1998 et 2001). Cette augmentation a essentiellement concerné des personnes domiciliées en Ile-de-France et plus les femmes (+143%) que les hommes (+32%). Afin de comprendre les raisons de l'augmentation récente des cas de sida dans cette population et de mieux adapter les actions de prévention, de dépistage et de prise en charge en direction de ces personnes, l'Institut de veille sanitaire (InVS) a réalisé une étude descriptive auprès de patients originaires d'Afrique subsaharienne atteints par le VIH, pris en charge dans les hôpitaux d'Ile-de-France. L'article présente la méthode, les résultats avec une caractérisation sociodémographique des personnes contaminées par le VIH.

Lukombo, S., et al. (2006). "Service d'accueil des urgences au CHU Avicenne. Profil socio-épidémiologique des migrants originaires d'Afrique subsaharienne." Gestions Hospitalieres(454): 205-206.

[BDSP. Notice produite par ENSP 8btR0x2n. Diffusion soumise à autorisation]. Parmi la population immigrée fréquentant les services d'accueil des urgences (SAU), on compte une part importante de populations originaires d'Afrique du Sud du Sahara. Il n'existe pas de données actuellement

disponibles et aucune étude n'a encore été menée sur cette population fréquentant les SAU des hôpitaux de France. L'objectif principal de cette étude est de connaître les motivations et les trajectoires de recours au SAU des populations originaires d'Afrique subsaharienne au centre hospitalier universitaire Avicenne et de dresser leur profil sociologique.

Marical, F. et Saint-,Polt, T. (2007). "La complémentaire santé : une généralisation qui n'efface pas les inégalités." Insee Premiere(1142): 4 , 4 graph.

Neuf personnes sur dix disposent en 2003 d?une couverture maladie complémentaire contre sept sur dix en 1981. En 2003, les plus pauvres et les étrangers restent moins couverts. Les ménages sans enfant ont une probabilité plus élevée que les autres de ne pas être couverts par une complémentaire. Les chômeurs aussi. Le statut professionnel joue également un rôle important : pour près d?un assuré social sur quatre ayant une complémentaire, cette adhésion était rendue obligatoire par son entreprise. Ces différences ne sont pas sans lien avec le recours aux soins : les individus non couverts sont deux fois plus nombreux à ne pas avoir consulté de médecin au cours des douze derniers mois.

May, E. (2020). "Accès à la santé des immigrés : le rôle des centres de santé." Cahiers De Sante Publique Et De Protection Sociale (Les)(35): 4.
https://cahiersdesante.fr/editions/novembre-2020/acces-a-la-sante-des-immigres-le-role-des-centres-de-sante/

La question de l’accès à la santé des immigrés, et plus précisément, celle de leur accès au système de soins et de protection sociale réapparaissent régulièrement dans le débat public en France. Elles sont portées idéologiquement de façon accusatrice par le camp des droites les plus extrêmes mais aussi par les femmes et hommes politiques qui ont besoin d’occuper le terrain médiatique et qui pensent flatter – et séduire – une partie de l’électorat : la droite dénonce ainsi depuis longtemps son coût et l’appel d’air que constituerait le modèle social et sanitaire français trop généreux. Les débats fumeux s’appuient souvent sur des données fausses, mal expliquées et en fait ignorent tout simplement la réalité, le vécu des personnes immigrées et de leurs soignants.

Mbaye, E. M. (2009). "Sida et immigration thérapeutique en France : mythes et réalités." Sciences Sociales Et Sante **27**(1): 43-61.

Le modèle d'unité républicaine, l'approche culturaliste, le choix des catégories publiques, le choix des catégories statistiques ont principalement retardé l'inscription sur l'agenda public et la prise en charge politique du problème des immigrés malades du sida. Ce n'est que vingt ans après la découverte du sida, suite à l'arrivée des trithérapies, qu'est mis en place, dans un contexte politique et sanitaire favorable, l'ouverture des droits de séjour et à la prise en charge des immigrés atteints par le VIH/sida en France. Cet accès aux soins et ces droits n'ont pas empêché l'augmentation du nombre de cas de sida chez les étrangers, particulièrement chez ceux originaires d'Afrique subsaharienne. Cette situation a entraîné une controverse politique sur l'existence d'une immigration thérapeutique. La lutte contre ce phénomène a motivé certains projets de restriction des droits des étrangers. Cependant, grâce à l'action de certains acteurs associatifs et médicaux, le droit aux soins et au séjour des étrangers resiste encore aux multiples réformes en matière d'immigration et à la naissance d'un nouveau paradigme de lutte contre "l'immigration subie".

Mechali, D. et Bouchaud, O. (2008). "[Should there be a specific management for HIV infected-immigrants in France?]." Med Mal Infect **38**(8): 438-442.

Immigrants living in France account for one third of new cases of infection and are a target population for prevention. Care givers should adapt their management practice, taking into account this population's specificities which are not restricted to cultural differences but include major socioeconomic factors. In addition to training on alien rights and basic sociocultural knowledge, care-givers (especially clinicians) must spend more time with the patient (especially at the beginning of the relationship) and accept sharing the "medical power" with other people with a better knowledge of other aspects of the patients' life in addition to the medical one. As in other chronic diseases,

mediation is one of the available tools with evident benefits for any patient. Assuming compliance is the same for migrants as for other patients, using this mediation will warrant therapeutic success.

Médecins du Monde (2020). Observatoire de l'accès aux droits et aux soins dans les programmes de Médecins du Monde en France : rapport 2019. Paris Médecins du Monde**:** 128.
https://www.medecinsdumonde.org/fr/actualites/publications/2020/10/14/observatoire-de-lacces-aux-droits-et-aux-soins-2019

En 2019, Médecins du Monde (MdM) compte 59 programmes en France dans plus d'une trentaine de villes auprès des personnes en situation de grande précarité et/ou d'exclusion. L'objectif est de promouvoir ou faciliter leur accès aux droits et aux soins. Ses équipes constatent au quotidien les difficultés auxquelles sont confrontées ces populations et s'attachent à faire valoir leurs droits, en assurer la continuité dans le temps et leur faciliter un accès aux soins. Le rapport 2019 se penche sur les conditions de vie des personnes reçues dans les centres d'accueil, de soins et d'orientation (CASO), les problèmes de santé associés : santé mentale, santé des femmes, dépistage et la prévention des maladies infectieuses, l'accès aux droits et aux soins.

Mizrahi, A., et al. (1993). Accés aux soins et état de santé des populations immigrées en France. Rapport Credes. Paris Credes**:** 62, tabl., graph.

Deux sources de données complémentaires, l'Enquête Santé et Protection Sociale (ESPS 1988-1991) et l'étude de clientèle des Centres de Soins Gratuits (CSG 1990-1991) ont permis d'étudier la différence entre l'état de santé et l'accès aux soins des étrangers et des Français favorisés ou non. La première enquête apporte des informations sur l'état de santé, la protection complémentaire maladie et la consommation médicale des ménages dont un membre au moins était assuré au Régime général. La seconde étudie une population défavorisée, ou plus exactement, les nouveaux patients de centres de soins gratuits. Les informations recueillies permettent de mieux appréhender les motifs de consultation et le type de protection sociale de cette population.

Mizrahi, A. et Mizrahi, A. (2008). "Morbidité et soins médicaux aux personnes nées à l'étranger." Journal D'economie Medicale **26**(3): 159-176, tabl., graph.

[BDSP. Notice produite par ORSRA BIFDR0xD. Diffusion soumise à autorisation]. Peu de données nationales sont disponibles sur la situation sanitaire et médicale des étrangers en France : les auteurs ont cherché à regrouper les informations mobilisables sur ce thème. Les données utilisées proviennent de trois sources nationales : l'enquête décennale auprès des ménages sur la santé et les soins médicaux - ESSM (2003, et 1970,1980,1991), l'enquête permanente auprès des ménages sur les soins et la protection sociale - ESPS (2000 et 2002 regroupées), l'enquête sur les hospitalisés (EH) de 1991. Sont analysés quelques résultats sur la morbidité des étrangers comparée à celle des Français, puis la couverture maladie, et enfin la consommation médicale (médecine de ville et hospitalisation).

ODSE (2022). Étrangers malades résidant en France : Démarches préfectorales et accès aux droits, Paris : ODSE
https://www.odse.eu.org/spip.php?article238

Les lois du 7 mars 2016 et du 10 septembre 2018 sur l'immigration et leurs textes d'application ont modifié les conditions et les procédures pour l'admission au séjour et la protection contre l'expulsion des personnes étrangères gravement malades résidant en France. Ces changements nécessitent une actualisation des connaissances et une modification des démarches à entreprendre par les étrangers-es malades et les personnes et professionnels qui les accompagnent. Cette brochure est spécifiquement à destination des étrangers-es malades et des personnes qui les accompagnent (travailleurs-ses sociaux-les, associations, soignants-es, etc.)

Petregne, F., et al. (2014). "Le médecin généraliste et la barrière linguistique : utilisation d'outils d'aide à la consultation en médecine générale." Medecine : De La Medecine Factuelle a Nos Pratiques **10**(8): 372-375.

L'Organisation des Nations Unies estimait en 2005 à plus de 200 millions le nombre de migrants chaque année, dont 30 à 40 millions de clandestins. La France a connu, comme de nombreux pays européens, une forte augmentation du nombre d'immigrés depuis 2005. En 2010, ils sont estimés à 6,7 millions en France. S'y ajoutent chaque année plus de 68 millions de touristes étrangers. Les différentes initiatives déployées par l'Union européenne témoignent de la volonté des États membres de mettre en perspective la situation des immigrés en matière de santé [4]. La littérature montre que la plupart des études réalisées concerne plutôt l'accès aux soins, mais peu la qualité du service médical rendu. Ainsi, la barrière linguistique peut limiter le recours aux soins adaptés et la sensation de santé perçue, favoriser les complications liées aux traitements, et rendre la prévention plus aléatoire. Plusieurs études mettent en relief le handicap que représente la barrière linguistique dans l'accès aux soins et à leur qualité. En 2008, environ 6 % de la population d'Aquitaine était constituée d'immigrés, avec un pourcentage atteignant les 8 % pour la tranche d'âge 25 à 54 ans. Cette étude a eu pour objectif principal d'identifier les outils à disposition des médecins généralistes pour franchir la barrière linguistique. Notre objectif secondaire était d'identifier les difficultés qu'elle peut induire dans la relation médecin malade.

Rey, J. L. et Fillon, J. C. (1999). "L'assurance maladie des immigrés retraités." Gerontologie Et Societe(91): 57-63.

[BDSP. Notice produite par FNG N8IR0x8d. Diffusion soumise à autorisation]. Les règles d'assurance maladie applicables aux immigrés retraités sont complexes. Elles varient selon la nationalité de l'intéressé - ressortissant ou non d'un Etat-membre de l'Union européenne ou de l'Espace économique européen - selon son lieu de résidence ou de séjour et selon l'existence - et le contenu - d'une convention bilatérale de sécurité sociale liant la France avec son Etat d'origine. Suivant la nationalité des intéressés, les règles correspondant aux quatre principales situations suivantes sont successivement présentées : celle du retraité résidant en France, celle du retraité résidant en France et effectuant un séjour dans son Etat d'origine, celle du retraité retourné s'installer dans son Etat d'origine, enfin, celle du retraité résidant dans son Etat d'origine et effectuant des séjours en France.

Romby, A., et al. (2013). "Migrants en situation de vulnérabilité et tuberculose, suivi et dépistages autour des cas. Enquête au centre de santé du Comede, France, 2009-2011." Bulletin Epidemiologique Hebdomadaire(28-29): 348-353.

[BDSP. Notice produite par InVS qDl9R0xl. Diffusion soumise à autorisation]. Introduction - Le traitement et le suivi de la tuberculose chez les migrants/étrangers en situation de vulnérabilité représentent un enjeu majeur de santé publique. Le Comité médical pour les exilés (Comede) s'intéresse au suivi des patients qui ont consulté dans la structure et aux enquêtes de dépistage dans leur entourage. Méthode - Une étude rétrospective des cas de tuberculose chez les patients suivis entre 2009 et 2011 a été menée. Les données sociodémographiques et d'issues de traitement, le vécu de la maladie et les données de dépistage autour de ces cas ont été recueillis. Résultats - Sur 13 patients, un a arrêté le traitement. Trois enquêtes n'ont pas pu être réalisées et deux n'ont pas identifié de sujets contact. Seules trois enquêtes ont donné lieu au dépistage des sujets contact identifiés. Des difficultés de communication entre patients et soignants ainsi qu'entre professionnels ont été identifiées. Conclusion - Les données de suivi de traitement et d'enquêtes sont semblables à celles retrouvées en population générale. L'étude des cas ayant posé un problème de suivi ou de dépistage a permis d'identifier des pistes d'amélioration. La création d'un réseau régional de prise en charge des patients migrants/précaires souffrant de tuberculose, formant un maillage entre les équipes des centres hospitaliers, des associations et des Centres de lutte antituberculeuse, permettrait d'apporter des réponses mieux adaptées aux problèmes de compréhension et d'exclusion des personnes, et de pallier les difficultés de coordination entre professionnels. (R.A.).

Rondet, C., et al. (2014). "Are immigrants and nationals born to immigrants at higher risk for delayed or no lifetime breast and cervical cancer screening? The results from a population-based survey in Paris metropolitan area in 2010." PLoS One **9**(1): e87046.

OBJECTIVES: This study aims to compare breast cancer screening (BCS) and cervical cancer screening

(CCS) practices of French women born to French parents with those of immigrants and nationals born to immigrants, taking their socioeconomic status into account. METHODS: The study is based on data collected in 2010 in the Paris metropolitan area among a representative sample of 3000 French-speaking adults. For women with no history of breast or cervical cancer, multivariate logistic regressions and structural equation models were used to investigate the factors associated with never having undergone BCS or CCS. RESULTS: We confirmed the existence of a strong gradient, with respect to migration origin, for delaying or never having undergone BCS or CCS. Thus, being a foreign immigrant or being French of immigrant parentage were risk factors for delayed and no lifetime screening. Interestingly, we found that this gradient persisted (at least partially) after adjusting for the women's socioeconomic characteristics. Only the level of income seemed to play a mediating role, but only partially. We observed differences between BCS and CCS which suggest that organized CCS could be effective in reducing socioeconomic and/or ethnic inequities. CONCLUSION: Socioeconomic status partially explained the screening nonparticipation on the part of French women of immigrant origin and foreign immigrants. This was more so the case with CCS than with BCS, which suggests that organized prevention programs might reduce social inequalities.

Roudot, T. Horaval, F., et al. (2017). "Prise en charge des populations précaires fréquentant les permanences d'accès aux soins de santé, atteintes d'hépatites et ayant bénéficié d'une proposition systématique de dépistage : étude Précavir 2007-2015." Bulletin Epidemiologique Hebdomadaire(14-15): 263-270.

[BDSP. Notice produite par SANTE-PUBLIQUE-FRANCE DqR0xCr8. Diffusion soumise à autorisation]. Chez les personnes en situation de précarité, la prévalence des hépatites est plus élevée que dans la population générale. Nous rapportons notre expérience du dépistage systématique du VHB et du VHC dans deux permanences d'accès aux soins de santé (PASS) et de la prise en charge des personnes dépistées positives. De mai 2007 à décembre 2015, un dépistage a été proposé à 3 540 sujets et effectué chez 2 870 d'entre eux (81%), plus souvent en cas de prélèvement immédiat sur site. Il s'agissait de migrants dans 94% des cas, majoritairement originaires d'Afrique subsaharienne (66%) ; 78% étaient demandeurs d'asile ou en séjour irrégulier. Une sérologie d'hépatite positive était observée chez 292 consultants (10,2%) : l'antigène HBs était positif chez 211 (7,4%) et les anticorps anti-VHC positifs chez 88 (3,1%). Seuls 21 patients connaissaient au préalable leur infection. L'accès à une consultation spécialisée et à un bilan virologique a été possible dans 90% des cas. Une évaluation de la fibrose a été effectuée chez 102 patients VHB et 31 des 42 patients ARN VHC positifs. Un traitement a été institué chez 32 des 39 patients VHB le justifiant et chez 22 des patients VHC. À deux ans, 59% et 65% respectivement des patients VHB et VHC étaient toujours suivis. Le dépistage systématique des virus des hépatites en soins primaires des populations précaires est possible et efficace. Sa mise en oeuvre devrait être encouragée auprès des professionnels en proposant, dans la mesure du possible, un prélèvement immédiat. Une amélioration du suivi à long terme reste souhaitable.

Saurel Cubizolles, M. J., et al. (2012). "Santé périnatale des femmes étrangères en France." Numéro Sargent, C. et Kotobi, L. (2017). "Austerity and its implications for immigrant health in France." Soc Sci Med **187**: 259-267.

The ongoing economic crisis in France increasingly has affected immigrant rights, including access to health care. Consistent with a 2014 League Against Cancer survey, we identify the ways in which sickness produces a "double penalty" for immigrants with serious illness. Immigrants with chronic illnesses such as cancer, diabetes, and other debilitating conditions divert vital funds from daily needs to deal with sickness and loss of work while at the same time national austerity measures shred the state's traditional safety net of social services and support. We examine how immigrants strategize to manage financial exigencies, therapeutic itineraries and social relations in the face of these converging pressures. We base our findings on two studies related by this theme: an investigation of health inequalities in the Medoc region, in which 88 women, 44 of North African and Eastern European origin, were interviewed over a three-year period (2010-2013); and a three-year study (2014-2017) of West African immigrant women with breast cancer seeking treatment in the greater Paris region, 70 members of immigrant associations, and clinical personnel in three hospitals.

Sargent, C. et Kotobi, L. (2017). "Austerity and its implications for immigrant health in France." Soc Sci Med **187**: 259-267.

The ongoing economic crisis in France increasingly has affected immigrant rights, including access to health care. Consistent with a 2014 League Against Cancer survey, we identify the ways in which sickness produces a "double penalty" for immigrants with serious illness. Immigrants with chronic illnesses such as cancer, diabetes, and other debilitating conditions divert vital funds from daily needs to deal with sickness and loss of work while at the same time national austerity measures shred the state's traditional safety net of social services and support. We examine how immigrants strategize to manage financial exigencies, therapeutic itineraries and social relations in the face of these converging pressures. We base our findings on two studies related by this theme: an investigation of health inequalities in the Medoc region, in which 88 women, 44 of North African and Eastern European origin, were interviewed over a three-year period (2010-2013); and a three-year study (2014-2017) of West African immigrant women with breast cancer seeking treatment in the greater Paris region, 70 members of immigrant associations, and clinical personnel in three hospitals.

Thayer, C. (1994). "Prise en charge de la santé des populations immigrées : étude comparative en France et en Angleterre." Sante Publique(3): 283-299.

Si la politique française de santé met l'accent à tous les niveaux sur l'insertion des populations marginalisées et sur la limitation de situations d'exclusion, au Royaume-Uni, par contre, la préoccupation du gouvernement concerne surtout la défaillance des services existants relatifs aux groupes visés, et les modalités à préconiser pour combler ces lacunes. Localement, des actions ponctuelles sont menées dans certains hôpitaux parisiens, mais sans être intégrées dans une politique bien définie. Au Royaume-Uni les autorités sanitaires locales ont adopté des politiques spécifiques en la matière, et développé une gamme d'actions concrètes en faveur des minorités. Les différentes organisations associatives britanniques ont une possibilité d'influencer la politique sanitaire locale qui semble échapper à leurs homologues français.

Tuppin, P. et Blotiere, P. O. (2012). "[Hospitalization rates for immigrant-related illness among individuals with low income and full health insurance coverage in France, 2009]." Bull Soc Pathol Exot **105**(2): 79-85.

Complementary Universal Health Insurance (CMUC) which provides free access to health care has been available in France since 2000 for people with an annual income less than 60% of the poverty threshold. Hospitalization rates in 2009 for common diseases among immigrants were compared between beneficiaries of the general scheme under the age of 60 years with (4.5 millions) or without CMUC (34.1 millions) in 2008 and still alive at the end of the year. Data were derived from the French national health insurance reimbursements and short-stay hospital discharge databases. Age - and sex-adjusted hospitalization rates and relative risk significantly greater overall hospitalization rates (17.5% vs 13.2%) (males RR= 2.0, female RR 2.3) and each parasitic diseases (RR = 2.1), which include viral diseases and fevers of unknown origin (1.1/1000, RR =1.6), septicaemia (0.4/1000, RR = 2.2), HIV infection (0.7/1000, RR = 3.5), other infectious and parasitic diseases (0.7/1000, RR= 2.5) and, more precisely, measles (2.7/1000, RR = 5.0). Hospitalization for sickle cell disease (3%, RR = 4.5) were also more frequent as also for lead poisoning (0.12/1000, RR = 5.2). In this low-income population with free access to health care, hospitalizations were higher for many diseases that are targets for prevention and screening actions. This is tha case for immigrant with CMUC coverage arriving in France and when they travel to their country of origin.

Vasseur, P. (2016). "Établir une relation de soins entre migrantes et professionnels de santé." Sante En Action (La)(437): 24-25.

[BDSP. Notice produite par SANTE-PUBLIQUE-FRANCE n97R0xCB. Diffusion soumise à autorisation]. Sage-femme, Patricia Vasseur a consacré sa thèse d'anthropologie aux conditions de prise en charge des femmes migrantes d'Afrique de l'Ouest installées en France et qui accouchent en Seine-Saint-Denis. Conditions qui ont un impact sur l'enfant. Elle décrit les termes de la rencontre entre ces femmes et les professionnels, les ajustements qui s'opèrent pour s'entendre lorsque l'on ne se comprend pas toujours et pour prendre l'autre en compte. Morceaux choisis.

Vignier, N., et al. (2017). "Accès aux soins des personnes originaires d'Afrique subsaharienne vivant avec une hépatite B chronique." Sante Publique **30**(3): 361-370.

[BDSP. Notice produite par EHESP mo8R0x8A. Diffusion soumise à autorisation]. Objectif : L'objectif de cette étude est d'analyser l'accès aux soins des personnes originaires d'Afrique subsaharienne (ASS) vivant avec une hépatite B chronique (HBC) en France. Méthodes : L'enquête ANRS-Parcours est une étude biographique réalisée en 2012-2013 auprès de personnes originaires d'ASS recrutées dans des services de prise en charge de l'HBC en Ile-de-France. Les données ont été recueillies en face-à-face à l'aide d'une grille biographique et d'un questionnaire standardisé. Résultats : Parmi les 619 participants, 96,4% ont une couverture maladie de base dont 18,6% la Couverture maladie universelle (CMU) et 23,4% l'Aide médicale d'état (AME). Un tiers des bénéficiaires de l'Assurance maladie n'ont pas de complémentaire santé et 75,7% sont couverts au titre d'une Affection longue durée. L'obtention d'une couverture maladie après l'arrivée en France a lieu en médiane la première année. Parmi les participants, 22,0% rapportent avoir renoncé aux soins pour raisons financières depuis l'arrivée en France et 9,7% avoir vécu un refus de soins le plus souvent par refus de la CMU ou l'AME. Une fois diagnostiqué, l'entrée en soins a lieu en médiane l'année-même du diagnostic. Le retard à l'entrée en soins est plus fréquent chez les personnes sans couverture maladie l'année du diagnostic. Les ruptures de suivi de plus de 12 mois sont rares. Conclusion : Les personnes originaires d'ASS vivant avec une HBC accèdent rapidement à une couverture maladie et aux soins. Cependant, des obstacles à l'accès aux soins persistent pour certaines du fait notamment de l'absence ou de l'incomplétude d'une couverture maladie et des refus de soins aux bénéficiaires de l'AME ou de la CMU.

Wittwer, J., Raynaud, D., Dourgnon, P., et al. (2019). "Protéger la santé des personnes étrangères en situation irrégulière en France. L'Aide médicale de l'État, une politique d'accès aux soins mal connue." Questions D'economie De La Sante (Irdes)(243): 8.
https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/243-proteger-la-sante-des-personnes-etrangeres-en-situation-irreguliere-en-france.pdf

Depuis sa création en 2000, l'Aide médicale de l'État (AME), assurance publique permettant aux personnes étrangères en situation irrégulière d'accéder à des services de santé, polarise le débat. Quand certains rappellent le devoir de protection d'une population vulnérable et l'universalité du droit à la protection de la santé en France, d'autres suspectent un dévoiement du système qui favoriserait l'immigration irrégulière. Dans un contexte de fortes contraintes financières pour le système de santé, les questions de légitimité, de coût et d'efficacité de l'AME sont posées de façons plus aiguës. Pour autant, les informations sur les personnes sans-papiers comme sur ce dispositif sont longtemps restées très lacunaires. Le projet Premier pas, mené par l'université de Bordeaux et l'Irdes se fonde sur ce constat et vise à étudier l'accès à l'AME et le recours aux services de santé des personnes en situation irrégulière en France. Trois Questions d'économie de la santé proposent : de décrire le contexte et la problématique de la protection des personnes en situation irrégulière en France ; puis une présentation de l'enquête Premier pas recueillie auprès des personnes éligibles à l'AME ; enfin les premiers résultats de l'enquête sur l'accès à l'AME de ces personnes. Ce premier article revient sur l'histoire des droits à la santé des personnes étrangères en situation irrégulière en France et dresse un état des lieux des connaissances, comme des besoins de connaissances sur le dispositif.

PREVENTION ET COMPORTEMENT DE SANTE : LA SPECIFICITE DES MIGRANTS A PRENDRE EN COMPTE

Évolution des politiques de prévention : l'exemple du VIH

La prise en compte de la spécificité des migrants dans les politiques publiques est au cœur des débats sur la prévention. Comme pour l'accès aux soins et à la protection maladie, les programmes de lutte contre le VIH ont joué un rôle majeur dans l'identification des populations particulièrement vulnérables, au premier rang desquelles figurent les migrants originaires d'Afrique subsaharienne. [24]La caractérisation d'attitudes, croyances et comportements fréquents dans ces populations a conduit les acteurs de terrain puis les pouvoirs publics à

[24] Stanojevitch, A.E., (2007)

adapter et affiner leur approche. À la suite de l'alerte épidémiologique lancée par l'InVS à la fin des années 1990, l'État a ainsi mis en place un programme spécifique de lutte contre le VIH en direction des migrants, en renforçant significativement sa politique de prévention. Outre le financement d'études et de recherches, la mise à disposition gratuite de matériel de prévention et le soutien aux acteurs de terrain, un dispositif de communication en direction des Africains émerge en 2002, avec la diffusion d'une campagne télévisée sur les antennes nationales. Fortes du constat que les migrants subsahariens ne se sentaient pas destinataires des messages adressés au grand public, les stratégies de communication vont dès lors privilégier une approche ciblée, en dépit de la crainte de stigmatisation qui avait longtemps inquiété les acteurs de prévention. Car, si le risque existe de stigmatiser ces populations en s'adressant spécifiquement à elles dans les médias à forte visibilité, l'expérience a désormais montré qu'il pouvait être évalué et limité progressivement, la lutte contre le VIH a ainsi battu en brèche les tabous liés à la prise en compte de l'étranger dans les politiques de santé publique. Aujourd'hui, les pouvoirs publics en charge de la prévention, dont l'INPES, s'engagent sur la voie d'une approche spécifique étendue à d'autres pathologies auxquelles les migrants sont particulièrement exposés, afin de mieux prendre en compte les multiples facteurs de vulnérabilité de ces populations.[25]

Antoun, F., et al. (1995). "Dépistage de la tuberculose dans les foyers de migrants à Paris." Bulletin Epidemiologique Hebdomadaire(12): 54-55, tabl.

> [BDSP. Notice produite par ENSP hR0x1ioN. Diffusion soumise à autorisation]. Entre le 31 janvier et le 30 juin 1994,19 foyers de travailleurs migrants ont bénéficié du dépistage itinérant concernant la tuberculose. Cette action menée par une équipe de la Direction de l'Action Sociale de l'Enfance et de la Santé de la mairie de Paris a permis une action de santé publique : sensibilisation au dépistage de la tuberculose, réponse à divers besoins de santé des travailleurs migrants. Le taux de tuberculose mis en évidence par la radiographie systématique est de 826/100000 radiophotographies.

Cazein, F., et al. (2012). "Dépistage de l'infection par le VIH en France, 2003-2011." Numéro thématique. VIH/sida en France : données de surveillance et études.(46-47): 529-533.

> En France, 15 000 à 30 000 personnes seraient infectées par le VIH mais non diagnostiquées, et la moitié des diagnostics d'infection VIH sont tardifs, à moins de 350 CD4/mm3. Cet article présente des données sur l'activité de dépistage du VIH en France de 2003 à 2011, à partir de l'enquête LaboVIH. En 2011, 5,2 millions (IC95% : [5,12-5,24]) de sérologies VIH ont été réalisées en France, soit une augmentation significative de+4% par rapport à 2010. Le nombre de sérologies a augmenté dans les départements d'outremer (DOM) et en métropole, hors Île-de-France, alors qu'il est stable en Île-de-France. Environ 10 517 (IC95% : [10 276-10 758]) sérologies ont été confirmées positives en 2011, nombre stable depuis 2007 à l'échelle nationale. Le nombre de sérologies positives augmente depuis 2007 en métropole hors Île-de-France, alors qu'il diminue en Île-de-France et dans les DOM. En 2011,7% des sérologies VIH étaient réalisées dans un cadre anonyme et gratuit, et la proportion de sérologies positives était plus élevée parmi les sérologies anonymes que parmi les sérologies non anonymes (3,2 versus 1,9/1 000 tests). Ces données permettent de constater que, dans l'année qui a suivi la publication des recommandations d'élargissement du dépistage, le nombre de sérologies réalisées a augmenté, sans accroissement du nombre de sérologies positives. Un recul plus important est nécessaire pour déterminer si cet élargissement permet un diagnostic plus précoce et une diminution de la prévalence des personnes infectées par le VIH mais non diagnostiquées. (R.A.).

Darmon, N. et Khlat, M. (2001). "An overview of the health status of migrants in France, in relation to their dietary practices." Public Health Nutrition **4**(2): 163-172, tabl.

> This article review studies on the morbidity, mortality and nutrition of migrant populations in France. A systematic search of the bibliographic database Medline, and direct contact with associations and institutions concerned with migrants' health was conducted. In France, as in other host countries, migrants belong to the lowest socio-economic strata. They have on average better health and lower

[25] *Stanojevitch, A.E., (2007)*

mortality than the local-born population. Health benefits are particularly noticeable in Mediterranean men, especially for affluence-related diseases such as cancer and cardiovascular diseases. North African men smoke as heavily as the local-born of the same occupational categories, and yet their mortality rates from lung cancer are notably lower. Such a paradox may be the result of a synergy between different phenomena such as the selection of the fittest applicants for immigration and the maintenance of healthy lifestyles from the countries of origin. In contrast, migrant women do not enjoy the same health advantages, possibly because they are less likely to be selected on the basis of their health and because they are often non-working. Adult migrants from southern Europe and North Africa report dietary practices consistent with the typical Mediterranean diet, which is renowned for its positive effects on health. The diet of Mediterranean adults living in France may partly explain the low rates of chronic diseases and high adult life expectancy observed in migrant men from northern Africa. Information about their diets might provide clues for the design of nutritional education campaigns aimed at low-income people

Deniaud, F., et al. (2008). "Dépistage ciblés proposés dans 6 foyers de migrants à Paris en 2005 : étude de faisabilité et d'impact." Sante Publique **20**(6): 547-559.

[BDSP. Notice produite par EHESP R0xIJIC7. Diffusion soumise à autorisation]. Dans le cadre de visites organisées par le service de dépistage radiologique itinérant de la tuberculose à Paris, une permanence médicale s'est tenue dans six foyers de migrants pour proposer, en plus du dépistage radiologique, un recueil d'urines pour le dépistage de la bilharziose ; et dans un second temps, une consultation gratuite de diagnostic et d'orientation dans un centre médico-social proche du foyer visité. L'objectif de cette étude est d'évaluer la faisabilité et l'impact de dépistages effectués sur site et en consultation. Sur les 97 personnes ayant bénéficié d'un entretien individuel en foyer, 52 ont fait la dépistage de la bilharziose urinaire te 3 cas ont été détectés (5,7%). En consultation 57 personnes sont venues sur 75 rendez-vous proposés. A l'issue de l'action, 33 pathologies ont été détectées chez 24 patients : infection à VHB (7 cas), bilharziose urinaire (9 cas), parasitoses intestinales (5 cas), infections sexuellement transmissible (2 cas), infection à VIH2 (1 cas) et des pathologies non infectieuses en moindre nombre. Les sujets détectés avec une pathologie curable ont été traités. Aller au devant des personnes dans les foyers de migrants entraîne un bénéfice général pour le dépistage de la bilharziose urinaire, cependant moins performant sur site qu'à l'issue des consultations, et de l'infection à VHB. Cette prise de contact personnalisée au foyer aide le migrant à venir consulter dans un CMS voisin et à rencontrer un travailleur social. En revanche, le suivi des affections chroniques détectées est incertain et coûteux pour les patients sans couverture complémentaire. La poursuite des permanences médicales sur site et l'initiative d'actions de prévention sont recommandées dans ces établissements.

Enel, C., et al. (2012). "[Health professionals' perceptions and screening for hepatitis B and C among migrants: a qualitative study in Cote-d'Or, France]." Sante Publique **24**(4): 303-315.

Hepatitis B and C continue to be major public health problems in France, particularly among migrants. The fact of being born in hepatitis B and C-endemic countries or of being a long-term resident of these countries are common risk factors, especially in the case of hepatitis B. Screening for both types of infection remains low among migrants. The main purpose of this study was to examine perceptions of the risk of viral hepatitis B and C in migrants among health professionals in Cote-d'Or (Burgundy, France) and to understand the factors promoting or hindering screening. The paper presents the results of a qualitative study based on face-to-face interviews with 23 healthcare providers and 8 social workers. The participating health professionals were interviewed about their involvement in the fight against hepatitis B and C and their perceptions of the risk of infection among migrants. The interviews conducted with social workers focused mostly on the conditions of social and health support provided to migrants. The study found that hepatitis B and C screening among migrants was associated with HIV screening. Screening was found to be associated with formalities relating to the legal and administrative status of migrants, the type of accommodation or housing, health professionals' knowledge of the risk factors associated with the epidemiological and social/health context in the countries of origin, and their own involvement in humanitarian aid. Migrants seeking political asylum and living in reception centers were found to be more likely to undergo screening. The findings suggest that awareness of the importance of systematic screening for hepatitis B and C in migrants from hepatitis B and C-endemic areas needs to be

promoted among social workers and health professionals, as recommended by the National Prevention and Control Program (2009-2012).

Fassin, D. (1999). "L'indicible et l'impensé : la "question immigrée" dans les politiques du sida." Sciences Sociales Et Sante **17**(4): 5-34.

[BDSP. Notice produite par APHPDOC kYR0x4GJ. Diffusion soumise à autorisation]. La relation entre sida et immigration a été entourée, depuis le début de l'épidémie, d'un silence embarrassé de la part des pouvoirs publics. La production des statistiques épidémiologiques en porte la trace, associant un déploiement de tactiques multiples d'évitement et une surdétermination par le mode supposé de transmission. Ce non-dit trouve sa justification à la fois dans le danger potentiel de stigmatisation de certaines catégories d'étrangers et dans le refus de substantialiser l'origine en la présentant comme une variable explicative. Quelque légitime que soit cet argumentaire, il n'en traduit pas moins la difficulté à penser "la question immigrée" dans une double perspective, scientifique et politique, permettant de dépasser les apories actuelles dont les effets ne portent pas seulement sur la connaissance, mais aussi sur l'action. (R.A.).

Hadj, L., et al. (2017). "Acceptabilité et freins chez les populations africaines et caribéennes vivant en Île-de-France d'une nouvelle offre de prévention du VIH : le Truvada® en prophylaxie pré-exposition (PrEP). Une enquête exploratoire." Bulletin Epidemiologique Hebdomadaire(6): 110-114.
http://invs.santepubliquefrance.fr/beh/2017/6/

[BDSP. Notice produite par SANTE-PUBLIQUE-FRANCE 8R0xCrq9. Diffusion soumise à autorisation]. Objectifs : identifier les connaissances autour de la prophylaxie pré-exposition du VIH (PrEP) et l'acceptabilité de ce nouveau mode de prévention auprès de personnes africaines et caribéennes rencontrées dans le cadre d'actions de prévention menées en Île-de-France. Méthode : une enquête exploratoire qualitative a été conduite au sein de deux associations engagées dans la prévention du VIH/sida, avec observations participantes et groupes de discussion. Les actions de sensibilisation auprès des populations africaines et caribéennes ont servi de sites clés pour évaluer les enjeux et les défis de la prévention auprès de ces populations et aborder la connaissance et l'acceptabilité de la PrEP. Résultats : les personnes rencontrées originaires de pays endémiques ont bien été sensibilisées à la prévention du VIH, mais n'ont le plus souvent pas encore entendu parler de la PrEP. Une fois expliquée, la PrEP a été considérée comme une nouvelle stratégie de prévention acceptable. Les informateurs ont identifié en particulier deux situations pour lesquelles la PrEP offrirait une valeur ajoutée aux efforts actuels de prévention : pour les hommes ayant des partenaires multiples et pour les femmes qui soupçonnent leur partenaire d'infidélité. Conclusion : la PrEP parait acceptable chez les Africains et les Caribéens en Île-de-France quand elle est combinée à d'autres stratégies de prévention incluant le préservatif et le dépistage. Les efforts de sensibilisation sur la PrEP devront prendre en considération les préoccupations soulevées par cette population et participer à une approche globale et coordonnée de la santé sexuelle et de la promotion de la santé.

Kehr, J. (2012). "Blind spots and adverse conditions of care: screening migrants for tuberculosis in France and Germany." Sociol Health Illn **34**(2): 251-265.

Tuberculosis (TB) is an infectious disease that declined significantly throughout the 20(th) century. Large-scale TB screening of entire populations in France and Germany has thus been replaced by active screening of risk-groups, particularly migrants. The article engages with its problems and practices on three levels: by looking at the way information on migrants as an at-risk group is produced through disease surveillance data; by analysing how such at-risk group data influence local screening practices; and by showing which political and medical problems arise in the field. I overturn the discussion about screening and surveillance of migrants as a risk-group by showing that it is not the stigmatisation of migrants through disease risk that is most at stake, but the invisibility of the most vulnerable among them in disease surveillance data and the way restrictive national immigration policies interfere with and subvert local screening and treatment practices targeting them. The aim of my article is to promote a pragmatic sociology of screening, while paying attention to the practical complexities, political conditions and medical ambivalences of screening and follow-up care, especially when the migrant groups concerned are socially, politically and medically vulnerable.

Khlat, M., Legleye, S. et Bricard, D. (2020). "Gender Patterns in Immigrants' Health Profiles in France: Tobacco, Alcohol, Obesity and Self-Reported Health." Int J Environ Res Public Health **17**(23): 8759. https://doi.org/doi:10.3390/ijerph17238759

Khlat, M., Legleye, S. et Bricard, D. (2018). "Migration-related changes in smoking among non-Western immigrants in France." Eur J Public Health(On line): 1-5. https://academic.oup.com/eurpub/advance-article/doi/10.1093/eurpub/cky230/5161110

> Migrants make up a growing share of European populations, and very little is known about the impact of migration on their smoking patterns. We develop a longitudinal analysis of smoking prevalence among native-born and immigrants in France based on retrospective data collected in the 2010 national Baromètre santé health survey.

Klat, M., Bricard, D. et Legleye, S. (2018). "Smoking among immigrant groups in metropolitan France: prevalence levels, male-to-female ratios and educational gradients." BMC Public Health **18**(479): 1-9. https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-018-5379-8

> Although the French population comprises large and diverse immigrant groups, there is little research on smoking disparities by geographical origin. The aim of this study is to investigate in this country smoking among immigrants born in either north Africa, sub-Saharan Africa or French overseas "départements".

Lert, F., et al. (2006). Comment caractériser l'ethnicité dans les travaux épidémiologiques en France : approche exploratoire à partir de l'étude Insee-Histoire de vie. Épidémiologie sociale et inégalités de santé, colloque thématique de l'Adelf, 2006.

Masse, R. (1995). Culture et Santé publique, Paris : Gaëtan Morin

> Les rapports entre la culture, la santé et la maladie sont au coeur des débats contemporains en santé publique. On reconnaît que les croyances, les valeurs ou les représentations de la santé et de la maladie ont une incidence sur les comportements à risque, les pratiques préventives et les attitudes des populations face aux services de santé. L'intérêt pour ces facteurs culturels est toutefois freiné par une méconnaissance des concepts et modèles qui permettent d'en faire un usage judicieux dans les recherches et les pratiques professionnelles. Le présent ouvrage vise donc à initier les professionnels de la santé, les intervenants de la santé publique et les étudiants universitaires aux contributions faites par les sciences sociales, et tout particulièrement par l'anthropologie, à l'analyse des rapports existant entre santé et culture.

Mejean, C., et al. (2007). "Diet quality of North African migrants in France partly explains their lower prevalence of diet-related chronic conditions relative to their native French peers." J Nutr **137**(9): 2106-2113.

> Mediterranean migrant men living in France have lower mortality and morbidity than local-born populations for nutrition-related noncommunicable diseases (NR-NCD). We studied diet quality and its influence on NR-NCD in Tunisian migrants compared with 2 nonmigrant male groups: local-born French and nonmigrant Tunisians, using a retrospective cohort study. We performed quota sampling (n = 147) based on age and place of residence. Using logistic regression models, components of the Diet Quality Index-International (DQI-I) were tested as potential mediators for the effect of migration on overweight, hypertension, hypercholesterolemia, type-2 diabetes, and cardiovascular diseases (CVD). The total DQI-I score revealed good overall diet quality (approximately 60/100) for all groups. Migrants scored higher than the French in variety, adequacy, and moderation and lower than Tunisians in overall balance. Migrants displayed a lower prevalence of overweight than French, lower prevalence of diabetes and CVD than Tunisians, and lower prevalence of hypertension and hypercholesterolemia than the 2 nonmigrant groups. No mediator was found for overweight. Diet adequacy, fruits, and vitamin C were mediators of the difference in hypercholesterolemia between migrants and French and the effect on hypertension was mediated by diet adequacy and fiber. Compared with Tunisians, the effect of migration on hypercholesterolemia was mediated by saturated fat. No mediator was found for hypertension, diabetes, or CVD. Despite increasing NR-NCD levels in

both France and Tunisia, migrants appear to have conserved some healthy dietary characteristics that partly explain their difference in NR-NCD with local-born French, but other lifestyle factors may contribute to the favorable effect of migration.

Pauti, M. D., et al. (2009). "[Development of actions for the prevention of HIV, hepatitis and sexually transmitted infections among immigrants consulting in the doctors of the world "Missions France"]." Med Mal Infect **39**(3): 191-195.

The mission France of Doctors of the World has for objective to facilitate the access to care and to rights in the common law system for vulnerable populations and to bring testimonies out. The objective of the project is to ensure daily actions of prevention: to bring people to screen for HIV and hepatitis as well as obtaining full access to treatment for populations consulting in the Reception centers for Care and Orientation (RCCO). The screening is proposed systematically to all new patients (90% of them are immigrants) after a medical consultation or a special prevention consultation. The prevalence of HIV, hepatitis B and C was respectively 15, 10.5, and 7 times higher than the national average among patients screened in 2007, The centers of Doctors of the World are privileged places to inform, prevent, offer screening, and bring healthcare to this population particularly exposed to risks.

Pauti, M.D., et al. (2016). « Limiter les opportunités manquées de dépistage des hépatites B et C chez les migrants en situation de précarité : le programme de Médecins du Monde ». Bulletin Epidémiologique (13-14)

La Mission France de Médecins du Monde a pour objectif de faciliter l'accès aux soins et aux droits des populations vulnérables dans le système de droit commun, et de témoigner de leur situation. La population reçue dans ses Centres d'accueil, de soins et d'orientation (CASO), à 94,5% étrangère, vit dans des conditions précaires et est particulièrement touchée par les hépatites B et C.

Rondet, C., et al. (2014). "Are immigrants and nationals born to immigrants at higher risk for delayed or no lifetime breast and cervical cancer screening? The results from a population-based survey in Paris metropolitan area in 2010." PLoS One **9**(1): e87046.

OBJECTIVES: This study aims to compare breast cancer screening (BCS) and cervical cancer screening (CCS) practices of French women born to French parents with those of immigrants and nationals born to immigrants, taking their socioeconomic status into account. METHODS: The study is based on data collected in 2010 in the Paris metropolitan area among a representative sample of 3000 French-speaking adults. For women with no history of breast or cervical cancer, multivariate logistic regressions and structural equation models were used to investigate the factors associated with never having undergone BCS or CCS. RESULTS: We confirmed the existence of a strong gradient, with respect to migration origin, for delaying or never having undergone BCS or CCS. Thus, being a foreign immigrant or being French of immigrant parentage were risk factors for delayed and no lifetime screening. Interestingly, we found that this gradient persisted (at least partially) after adjusting for the women's socioeconomic characteristics. Only the level of income seemed to play a mediating role, but only partially. We observed differences between BCS and CCS which suggest that organized CCS could be effective in reducing socioeconomic and/or ethnic inequities. CONCLUSION: Socioeconomic status partially explained the screening nonparticipation on the part of French women of immigrant origin and foreign immigrants. This was more so the case with CCS than with BCS, which suggests that organized prevention programs might reduce social inequalities.

Vallee, J., et al. (2010). "The combined effects of activity space and neighbourhood of residence on participation in preventive health-care activities: The case of cervical screening in the Paris metropolitan area (France)." Health Place **16**(5): 838-852.

Estimates from multilevel regression of 1768 women living in the Paris metropolitan area showed that women who reported concentrating their daily activities in their perceived neighbourhood of residence had a statistically greater likelihood of not having undergone cervical screening during the previous 2 years. Furthermore, the characteristics of the administrative neighbourhood of residence (such as the practitioner density or the proportion of residents with a recent preventive consultation) had a statistically greater impact in terms of delayed cervical screening on women who concentrated

the vast majority of their daily activities within their perceived neighbourhood of residence than among those who did not. The residential environment might promote or damage, to a greater extent, the health behaviour of people whose daily activities are concentrated within their perceived neighbourhood, since we can assume that their exposure to their neighbourhood characteristics is stronger. It could thus be useful to study more often the combined effects of activity space and neighbourhood of residence on participation in preventive health-care activities.

Wanner, P., et al. (1995). "Habitudes de vie et comportements en matière de santé des immigrés de l'Europe du Sud et du Maghreb en France." Rev Epidemiol Sante Publique **43**(6): 548-559, 549 tabl.

A partir d'une enquête nationale française, les comportements de prévention et les habitudes de consommation alimentaire, d'alcool et de tabac de trois groupes d'immigrés (Italie, Espagne et Portugal, Maghreb) ont été comparés à ceux des Français. Des odds-ratios ont été calculés par une régression logistique après ajustement sur l'âge, la catégorie socio-professionnelle et la région de résidence. Des comportements différents ont été observés, notamment, des pratiques de prévention primaire et secondaire moins fréquentes, une consommation plus faible en viandes et produits laitiers et plus riche en féculents et en légumes secs, une consommation plus faible en alcool et plus forte de tabac chez les immigrés Maghrébins. Les différences observées sont discutées en fonction des autres données disponibles en France. Par rapport à d'autres études, elle confirme des habitudes alimentaires importées et une perception plus faible des messages préventifs.

Les migrants à l'étranger : une meilleure intégration dans les pays nordiques, le Canada, les Etats-Unis et l'Australie

Le MIPEX réalisé par des experts internationaux du domaince de la recherche est un outil qui mesure la politique d'intégration des migrants dans les pays de l'Union européenne et d'autres pays industrialisés comme l'Australie, le Japon, les États-Unis et le Canada… au moyen de plus de 167 indicateurs: emploi, santé, éducation, regroupement familial, etc. Son outil cartographique permet de visualiser les résultats en fonction des différents indicateurs sélectionnés. Les indicateurs choisis pour la thématique santé sont les suivants : droits, accès aux soins, réactivité des services aux besoins des migrants et politique de santé.
Les pays qui offrent une meilleure intégration aux migrants sont d'abord les pays nordiques (78 %), puis le Canada (68 %), l'Australie 66 %), les États-Unis (63 %), enfin l'Allemagne (61 %) et l'Espagne (60 %). Le taux d'intégration en France se situe aux alentours de 54 %.

- Voir aussi : le Rapport d'état sur la migration 2011 (OMI)

QUELQUES DONNEES DEMOGRAPHIQUES

Dans la plupart des pays de l'OCDE, les flux migratoires sont en hausse. Pour la première fois depuis 2007, les flux de migrations permanentes vers les pays de l'OCDE ont fortement augmenté en 2014 et ont retrouvé leur niveau d'avant la crise. Les migrations pour raisons familiales représentent plus du tiers de l'ensemble des entrées et celles relatives à la libre circulation 30 %. L'Allemagne est un des principaux pays d'immigration, deuxième derrière les États-Unis en nombre de migrants accueillis. Les demandes d'asile dans la zone Euro ont crû de 46 % en 2014, dépassant 800 000 pour la première fois depuis le début des années 1990. Dans un contexte géopolitique marqué par des conflits aux portes de l'Europe, un million de migrants ont rejoint l'Europe en 2015.[26]

Alesina, A., Miano, A. et Stantcheva, S. (2018). Immigration and Redistribution. NBER Working Paper Series ; n° 24733. Cambridge NBER**:** 48 ,tabl., fig.+annexes.

[26] Problèmes économiques, n° 3124, 2016

http://www.nber.org/papers/w24733

We design and conduct large-scale surveys and experiments in six countries to investigate how natives' perceptions of immigrants influence their preferences for redistribution. We find strikingly large biases in natives' perceptions of the number and characteristics of immigrants: in all countries, respondents greatly overestimate the total number of immigrants, think immigrants are culturally and religiously more distant from them, and are economically weaker – less educated, more unemployed, poorer, and more reliant on government transfers – than is the case. While all respondents have misperceptions, those with the largest ones are systematically the right-wing, the non college-educated, and the low-educated working in immigration-intensive sectors. Support for redistribution is strongly correlated with the perceived composition of immigrants – their origin and economic contribution – rather than with the perceived share of immigrants per se. Given the very negative baseline views that respondents have of immigrants, simply making them think about immigration in a randomized manner makes them support less redistribution, including actual donations to charities. We also experimentally show respondents information about the true i) number, ii) origin, and iii) "hard work" of immigrants in their country. On its own, information on the "hard work" of immigrants generates more support for redistribution. However, if people are also prompted to think in detail about immigrants' characteristics, then none of these favorable information treatments manages to counteract their negative priors that generate lower support for redistribution.

Amer, A. A., Go, D. S. et Willenbockel, D. A. (2016). Global migration revisited : short-term pains, long-term gains, and the potential of south-south migration. Policy Research Working Paper ; 7628. Washington World Bank Group**:** 33 , tab., graph., fig.
http://www-wds.worldbank.org/external/default/WDSContentServer/WDSP/IB/2016/04/11/090224b084280dcd/1_0/Rendered/PDF/Global0migrati0outh0south0migration.pdf

This paper re-examines the development implications of international migration focusing on two issues: how the costs and benefits of migration change over time, and the significance of South-South migration for development. First, the analysis finds that although greater migration could push down the wages of native workers of advanced countries in the short run, these wages eventually recover. This pattern would be mostly caused by the beneficial effect of additional labor on the real returns on capital and fostering faster capital formation. Additional South-North migration could favor capital income recipients and reduces labor income in host regions in the short run. In contrast, in sending countries, capital owners could experience lower incomes while wages rise. Globally, the welfare gains of new migrants could be expected to exceed the losses of old migrants by a wide margin. The remaining natives in sending countries could enjoy a net increase in remittances as well as an increase in labor income, although income from capital might decline. Second, in a hypothetical scenario with lower South-South migration, the implied losses of remittance income could lead to substantially lower welfare in developing countries. Although the wage differentials among developing countries tend to be smaller relative to their wage differentials with high-income countries, South-South migrants make substantial contributions to remittances.

Andersen, T. M. et Migali, S. (2016). Migrant Workers and the Welfare State. IZA Discussion Paper ; 9940. Bonn IZA**:** 44 , tabl., fig.
http://ftp.iza.org/dp9940.pdf

There is wide concern that migration flows may undermine the financial viability of generous welfare arrangements. The discussion focuses on welfare arrangements as attractors of migrants, suggesting that the issue does not pertain to migrant workers. However, this overlooks how welfare arrangements affect return-migration in case of social events like job loss. Importantly, migrants are shown to be self-selected in a way affecting both migration and return-migration. Two migration regimes prevail. In one, with relatively low benefits, unemployed workers return, while in the other some stay. Importantly, the stay or return migration decision is more sensitive to welfare generosity than the migration decision.

Anthony, E., Rafot, L., Rapoport, H., et al. (2020). An Introduction to the Economics of Immigration in OECD Countries. IZA Discussion Paper ; 13755. Bonn Iza**:** 35.

https://econpapers.repec.org/paper/izaizadps/dp13755.htm

> The share of the foreign-born in OECD countries is increasing, and this article summarizes economics research on the effects of immigration in those nations. Four broad topics are addressed: labor market issues, fiscal questions, the political economy of immigration, and productivity/international trade. Extreme concerns about deleterious labour market and fiscal impacts following from new immigrants are not found to be warranted. However, it is also clear that government policies and practices regarding the selection and integration of new migrants affect labour market, fiscal and social/cultural outcomes. Policies that are well informed, well crafted, and well executed beneficially improve population welfare.

Barrera, O., Bensidoun, I. et Edo, A. (2022). Second-generation immigrants and native attitudes toward immigrants in Europe. Working Paper Cepii ; 2022-03. Paris Cepii**:** 54.
http://d.repec.org/n?u=RePEc:cii:cepidt:2022-03&r=

> This paper investigates the role played by immigrants and their children in shaping native attitudes toward immigrants in the European Union. By exploiting the 2017 Special Eurobarometer on immigrant integration, we show that countries with a relatively high share of immigrants are more likely to believe that immigrants are a burden on the welfare system and worsen crime. In contrast, native opinions on the impact of immigration on culture and the labor market are unrelated to the presence of immigrants. We also find that the effects of second-generation immigrants on pro-immigrant attitudes toward security and fiscal concerns are positive (as opposed to first-generation immigrants). Finally, we find no impact of the immigrant share on the attitudes of natives supporting far-left or left political parties, while it is the most negative among respondents affiliated with far-right parties.

Borjas, G. J. (2019). Immigration and Economic Growth. NBER Working Paper ; 25836. Cambridge NBER**:** 51.
https://www.nber.org/papers/w25836

> Immigration is sometimes claimed to be a key contributor to economic growth. Few academic studies, however, examine the direct link between immigration and growth. And the evidence on the outcomes that the literature does examine (such as the impact on wages or government receipts and expenditures) is far too mixed to allow unequivocal inferences. This paper surveys what we know about the relationship between immigration and growth. The canonical Solow model implies that a one-time supply shock will not have any impact on steady-state per-capita income, while a continuous supply shock will permanently reduce per-capita income. The observed relationship between immigration and growth obviously depends on many variables, including the skill composition of immigrants, the rate of assimilation, the distributional labor market consequences, the size of the immigration surplus, the potential human capital externalities, and the long-term fiscal impact. Despite the methodological disagreements about how to measure all of these effects, there is a consensus on one important point: Immigration has a more beneficial impact on growth when the immigrant flow is composed of high-skill workers.

Cavalerri, M. C., Luu, N. et Causa, O. (2021). Migration, housing and regional disparities: A gravity model of inter-regional migration with an application to selected OECD countries. OECD Economics Department Working Papers ; 1691. Paris OCDE**:** 59.
http://d.repec.org/n?u=RePEc:oec:ecoaaa:1691-en&r=&r=lab

> Inter-regional migration – the movements of the population from one region to another within the same country – can be an important mechanism of spatial economic adjustment, affecting regional demographic and growth patterns. This paper examines the economic and housing-related factors that affect the decision of people to migrate to another region within the same country, drawing empirical evidence from country-specific gravity models of inter-regional migration for 14 OECD countries. The results suggest that inter-regional migrants move in search of higher income and better employment opportunities, but are discouraged by high housing costs. In particular, house prices are found to be an important barrier to migration, especially in countries having experienced strong increases in the level and cross-regional dispersion of house prices. There is however large heterogeneity across countries in terms of what factors matter the most and in terms of the magnitude of the migration response.

Cevat Giray, A. et Poutvaara, P. (2019). Refugees' and Irregular Migrants' Self-Selection into Europe: Who Migrates Where? IZA Discussion Paper Series ; 12800. Bonn Iza**:** 80.
https://ecoftp.iza.org/dp12800.pdf

> We analyze self-selection of refugees and irregular migrants and test our theory in the context of the European refugee crisis. Using unique datasets from the International Organization for Migration and Gallup World Polls, we provide the first large-scale evidence on reasons to emigrate, and the self-selection and sorting of refugees and irregular migrants. Refugees and female irregular migrants are positively self-selected with respect to human capital, while male irregular migrants are negatively self-selected. These patterns are similar when analyzing individually stated main reason to emigrate, country-level conflict intensity, and sub-regional conflict intensity. Migrants respond to economic incentives and border policies.

D'Aiglepierre, R., David, A., Levionnois, C., et al. (2020). A global profile of emigrants to OECD countries. Younger and more skilled migrants from more diverse countries. OECD Social - Employment and Migration Working Papers ; 239. Paris OCDE**:** 239 , tabl., fig.
https://doi.org/10.1787/0cb305d3-en

> This paper presents new findings on the main characteristics of immigrants living in OECD countries by country of origin, drawing from the updated Database on Immigrants in OECD Countries (DIOC) 2015/16. It describes migrant populations by country of destination and country of origin in 2015/16, as well as the dynamics of international migration to OECD countries since 2000/01. It also presents evidence on overall emigration rates and emigration rates of the highly educated at the regional and country levels. Finally, the paper looks at age patterns in immigrant populations. Ce document présente de nouveaux résultats sur les principales caractéristiques des immigrants vivant dans les pays de l'OCDE par pays d'origine, à partir de la Base de données sur les immigrés dans les pays de l'OCDE (DIOC) 2015/16. Il décrit les populations immigrées par pays de destination et pays d'origine en 2015/16, ainsi que la dynamique des migrations internationales vers les pays de l'OCDE depuis 2000/01. Il présente également des données sur les taux d'émigration globaux et les taux d'émigration des personnes diplômées de l'enseignement supérieur aux niveaux régional et national. Enfin, ce document examine les profils par âge des populations immigrées.

Docquier, F., et al. (2016). "Les effets des migrants sur le marché du travail. Extrait d'une étude britannique de VoxEU.org et Cepr." Problemes Economiques(3124): 17-23, tab., graph.

> En Europe, le stéréotype le plus répandu concernant le profil des immigrants est qu'ils sont en général pauvres et peu qualifiés. Les études portant sur les récentes migrations internationales montrent tout d'abord qu'une part importante des flux migratoires de main-d'oeuvre provient des pays de l'Organisation de coopération et de développement économiques (OCDE) à destination d'autres pays de l'OCDE. Elles révèlent ensuite que les travailleurs ayant eu accès à une formation supérieure sont beaucoup plus mobiles que les travailleurs les moins éduqués et qu'ils se déplacent vers les pays où ils sont les mieux payés. L'immigration tend à réduire les différences salariales dans les pays d'accueil entre les travailleurs les mieux rémunérés et ceux qui le sont le moins.

Fargues, P. (2016). "Un million de migrants arrivés sans visa en Europe en 2015 : Qui sont-ils?" Population Et Societes(532): 4 , fig.

> La Méditerranée est devenue la route migratoire la plus létale au monde depuis le début du XXIe siècle, le risque de décès pendant le voyage y est en moyenne de 15 pour mille entre 2000 et 2015. Les réfugiés représentent la majorité des flux les plus récents. Leur proportion est passée de 33 % à 76 % parmi les migrants entrés irrégulièrement en Italie et en Grèce au cours des cinq dernières années. La « crise des réfugiés » se déroule parallèlement à une crise de dépopulation qui menace l'Europe. Les migrations de remplacement pourraient donc faire partie des réponses de l'Europe à sa situation démographique.

Ferruccio, P .(éd), et Ponzo, I. (éd.) (2016). Inter-group Relations and Migrant Integration in European Cities, sl : Springer Open

http://link.springer.com/book/10.1007/978-3-319-23096-2

> This book presents a comparative analysis of intergroup relations and migrant integration at the neighbourhood level in Europe. Featuring a unique collection of portraits of urban relations between the majority population and immigrant minorities, it examines how relations are structured and evolve in different and increasingly diverse local societies. Inside, readers will find a coordinated set of ethnographic studies conducted in eleven neighbourhoods of five European cities: London, Barcelona, Budapest, Nuremberg, and Turin. The wide-ranging coverage encompasses post-industrial districts struggling to counter decline, vibrant super-diverse areas, and everything in between. Featuring highly contextualised, cross-disciplinary explorations presented within a solid comparative framework, this book considers such questions as: Why does the native-immigrant split become a tense boundary in some neighbourhoods of some European cities but not in others? To what extent are ethnically framed conflicts driven by site-specific factors or instead by broader, exogenous ones? How much does the structure of urban spaces count in fuelling inter-ethnic tensions and what can local policy communities do to prevent this? The answers it provides are based on a multi-layer approach which combines in-depth analysis of intergroup relations with a strong attention towards everyday categorization processes, media representations, and narratives on which local policies are based. Even though the relations between the majority and migrant minorities are a central topic, the volume also offers readers a broader perspective of social and urban transformation in contemporary urban settings. It provides insightful research on migration and urban studies as well as social dynamics that scholars and students around the world will find relevant. In addition, policy makers will find evidence-based and practically relevant lessons for the governance of increasingly diverse and mobile societies (résumé de l'éditeur).

Héran, F. (2017). De la "crise des migrants" à la crise de l'Europe : un éclairage démographique. Migrations, réfugiés, exil. Boucheron, P. Paris : Odile Jacob**:** 239-260.

> « Il n'est qu'une seule espèce humaine sur la Terre, et cette espèce est migrante. Depuis le début de l'histoire, nous sommes embarqués. Et, aujourd'hui, nous sommes écrasés sous le poids de notre fardeau, celui de notre responsabilité face à l'histoire : car nous savons que nous serons jugés sur notre capacité à affronter la situation des migrants. Ce livre est un appel au calme, un effort de description réaliste. On estime qu'il y a actuellement dans le monde 244 millions de migrants, dont 100 millions sont des migrants forcés. L'Europe est un continent d'immigration au même titre que les États-Unis. Telle est la réalité. On oppose généralement les beaux principes aux dures réalités. Mais nous sommes bien, avec le présent ouvrage, dans le réel. Ce qu'il réclame de nous ? De la considération. »

Kassar, H. et Dourgnon, P. (2014). "The big crossing: illegal boat migrants in the Mediterranean." Eur J Public Health **24 Suppl 1**: 11-15.

> This article explores illegal migration routes and groups across North Africa to Europe. We describe sub-Saharan and cross-Mediterranean routes, and how they changed during the years. We propose an analytical framework for the main factors for these migrations, from local to international and regulatory context. We then describe sea-migrants' nationalities and socio-economic and demographic characteristics, from studies undertook in Tunisia and Morocco. While boat migration represents only a fraction of illegal migration to Europe, it raises humanitarian as well as ethical issues for European and North African (NA) countries, as a non-negligible amount of them end up in death tolls of shipwrecks in the Mediterranean Sea. Moreover, existing statistics show that illegal trans-Mediterranean migration is growing exponentially. Ongoing crises in Africa and the Middle East are likely to prompt even larger outflows of refugees in the near future. This should induce NA countries to share closer public policy concerns with European countries

Lessault, D. et Beauchemin, C. (2009). "Les migrations d'Afrique subsaharienne en Europe : un essor encore limité." Population Et Societes(452): 4 , fig., tabl.

> [BDSP. Notice produite par ORSLR FR0x99HI. Diffusion soumise à autorisation]. Les immigrés originaires d'Afrique subsaharienne n'étaient que 20 000 en France au moment du recensement de 1962, contre 570 000 en 2004, soit une multiplication par 27 en un peu plus de 40 ans. L'augmentation est certes importante, mais on partait de très bas, si bien qu'en 2004 les Subsahariens ne représentent

qu'un peu plus d'un dixième de l'ensemble des immigrés en France (12%). La prise en compte des migrants irréguliers ne modifie pas ce constat : les inclure fait, au maximum, passer la part des Subsahariens de 9 à 11% de l'ensemble de la population immigrée en France en 1999. Par ailleurs, minoritaires en France, les Subsahariens le sont aussi dans les autres grands pays d'immigration. En 2000, ils forment seulement 4% des immigrés installés dans les pays de l'OCDE. Et même dans les nouvelles destinations européennes que sont l'Espagne ou l'Italie, ils ne représentent que moins de 10% de la population immigrée irréguliers compris (4% en Espagne et 8% en Italie en 2006). En réalité, les Africains migrent peu en dehors de l'Afrique. Neuf réfugiés subsahariens sur dix restent sur le continent et s'installent dans un pays voisin du leur. Presque à égalité avec l'Asie, l'Afrique subsaharienne est le continent où la propension à émigrer vers les pays de l'OCDE est, de loin, la plus faible du monde (en 2000, moins d'une personne née en Afrique subsaharienne sur 100 vit dans un pays de l'OCDE). (R.A.).

Lopez, M. J. et Slavov, S. (2019). Do Immigrants Delay Retirement and Social Security Claiming? NBER Working Paper Series ; 25518. Cambridge NBER**:** 48 ,tabl., fig.,annexes.
http://papers.nber.org/papers/W25518

As the share of older immigrants residing in the U.S. begins to rise, it is important to understand how immigrants' retirement behavior and security compare to that of natives. This question has implications for the impact of immigration on government finances and for the retirement security of immigrants. We use data from the Health and Retirement Study (HRS) to examine how immigrants' retirement and Social Security claiming patterns compare to those of natives. We find that immigrants are significantly less likely than natives to retire or claim Social Security in their early 60s. We do not find heterogeneous effects by ethnicity or age of arrival to the U.S. We also find no evidence that immigrants exit the survey at higher rates than U.S. natives in their late 50s through 60s, a finding that is consistent with immigrants retiring in the U.S. rather than abroad.

Organisation de Coopération et de Développement Economiques (2016). Making Integration Work : Refugees and others in need of protection. Paris OCDE**:** 69 , tabl.
http://www.oecd-ilibrary.org/social-issues-migration-health/making-integration-work-humanitarian-migrants_9789264251236-en

The OECD series Making Integration Work draws on key lessons from the OECD's work on integration, particularly the Jobs for Immigrants country reviews series. The objective is to summarise in a non-technical way the main challenges and good policy practices to support the lasting integration of immigrants and their children for selected key groups and domains of integration. Each volume presents ten lessons and examples of good practice, complemented by synthetic comparisons of the integration policy frameworks in OECD countries. This first volume deals with refugees and others in need of protection, referred to as humanitarian migrant.

Organisation de Coopération et de Développement Economiques (2020). Perspectives des migrations internationales 2020. Paris OCDE**:** 388.
www.oecd-ilibrary.org/fr/social-issues-migration-health/perspectives-des-migrations-internationales-2020_6b4c9dfc-fr

L'édition 2020 des Perspectives des migrations internationales analyse les évolutions récentes des mouvements et des politiques migratoires dans les pays de l'OCDE et dans quelques pays non-OCDE et observe l'évolution de la situation des immigrés sur le marché du travail dans les pays de l'OCDE. Le rapport comprend également un chapitre spécial sur l'impact de la migration sur la composition structurelle de l'économie. Il comprend comme chaque année des notes par pays et une annexe statistique.

Rochford, L. (2016). "Contrepoint - Femmes migrantes : plus visibles mais toujours stéréotypées." Informations Sociales **194**(3): 37-37.
https://www.cairn.info/revue-informations-sociales-2016-3-page-37.htm

Les migrations constituent un enjeu essentiel pour la protection sociale, quelle que soit l'échelle spatiale concernée. Au sein de l'Union européenne (UE), un espace en partie fédéral, tout citoyen d'un État membre peut bénéficier de la protection sociale dans le pays où il travaille. Ces droits sociaux constituent l'un des piliers de l'intégration du continent. Ils ont facilité la libre circulation des personnes, au point que les pays de l'UE les plus touchés par la crise débutée en 2008 sont devenus ou redevenus des terres d'émigration. Au-delà de ses frontières, l'UE exerce un fort pouvoir d'attraction pour des populations souffrant de la pauvreté et de l'instabilité politique, voire contraintes à l'exil. Les travailleurs migrants sont souvent les plus touchés par la pauvreté. Et avec l'intensification de la crise, ils sont parmi les plus vulnérables à l'égard d'un chômage endémique. Ce numéro examine dans un premier temps la manière dont les travailleurs migrants ont été traités par la protection sociale, aux différentes étapes historiques de sa construction en France et en Europe, et analyse en particulier les liens entre statut des migrants, droit social et droits fondamentaux (première partie). Compte tenu des difficultés financières qui pèsent sur les États européens, les migrations sont souvent mises en avant comme une contrainte pour la protection sociale, bien que ce constat soit discuté par l'analyse économique (deuxième partie). L'analyse des règles et les conditions d'accès des migrants aux prestations et aux services sociaux se révèle donc essentielle pour comprendre les enjeux de leur intégration, en France comme au sein de l'UE (troisième partie).

Spielvogel, G. et Meghnagi, M. (2018). Assessing the role of migration in European labour force growth by 2030. OECD Social, Employment and Migration Working Papers ; 204. Paris OCDE**:** 38 , tab., graph., fig. http://dx.doi.org/10.1787/6953a8ba-en

This paper presents the methodology as well as the results of the joint OECD-European Commission project Migration-Demography Database: A monitoring system of the demographic impact of migration and mobility. The objective of the project is to evaluate the contribution of migration to past and future labour market dynamics across EU and OECD countries. After assessing the role of migration over the last five to 10 years in shaping the occupational and educational composition of the labour force, this project looks at the potential contribution of migration to the labour force in a range of alternative scenarios. This paper presents the results from the second part of the project: it focuses on projections over the period 2015-2030, and aims at identifying the drivers of changes in working-age population and active population in European countries, and in particular the role of migration flows.

Thierry, X. (2008). "Les migrations internationales en Europe : vers l'harmonisation des statistiques." Population Et Societes(442): 1-4, fig., tabl.

[BDSP. Notice produite par ORSLR rC8R0xsn. Diffusion soumise à autorisation]. Les statistiques d'entrées et de sorties de migrants sont peu comparables entre les divers pays de l'Union européenne. La définition du migrant international n'est souvent pas la même, certains pays comptant par exemple les demandeurs d'asile ou les étudiants, d'autres, non. La durée de séjour minimal varie également, allant de quelques jours seulement en Allemagne et en Espagne à un an au Royaume-Uni et en Suède. Enfin, les sources d'informations ne sont pas les mêmes, les pays ayant des registres de population se fondant principalement sur eux alors que ceux n'en ayant pas se tournent vers d'autres sources (enquête aux frontières au Royaume-Uni, fichiers administratifs de visites médicales ou de titres de séjour en France). Pour améliorer la comparabilité des statistiques, l'Union européenne a adopté un règlement enjoignant les pays à compter tous les mouvements d'une durée de séjour d'au moins un an, quel que soit le motif. (R.A.).

Thierry, X. (2008). "Migration : le défi statistique européen." Futuribles(343): 61-77, tabl., graph.

L'Union européenne a adopté, en juillet 2007, un règlement visant à harmoniser les statistiques européennes relatives aux migrations internationales. Comme le montre ici Xavier Thierry, le défi statistique est de taille et il est urgent de le relever : dans 7 des 27 États membres (dont la France), on ignore le volume d'entrées et de sorties du territoire, et dans les autres pays, quand les chiffres existent, ils n'ont pas la même fiabilité et ne sont pas forcément comparables. Après avoir rappelé les sources d'information existant en Europe sur les migrations internationales (registres de population, enquêtes diverses, fichiers de titres de séjour), l'auteur revient sur la définition des « migrants internationaux », avant de s'intéresser de plus près à la mesure des flux de migrations internationales

propres à la France et à la manière de l'améliorer. Il propose ensuite des éléments de comparaison entre pays de l'Union, en tenant compte des difficultés liées aux instruments de mesure existants. Enfin, il s'intéresse au cas particulier des statistiques de titres de séjour, qui constituent un outil intéressant en matière d'évaluation des politiques migratoires, mais dont le mode de calcul en France se révèle quelque peu étonnant dans le cadre de la nouvelle politique d'immigration affichée par le gouvernement, et pas forcément cohérente avec les principes adoptés à l'échelle européenne.

University of Lugano (2009). Eldery Migrants in Europe: an overview of trends, policies and practices. Lugano University of Lugano**:** 32 , tab., graph., fig.
http://www.cermes.info/upload/docs/Elderly_migrants_in_Europe_paolo_ruspini_14_07_10.pdf

Purpose of this report is to shed a preliminary light on elderly migrants and to analyze the available policy solutions and NGOs practices adopted in a sample of European countries. These policy and practices will then be compared and the resulting policy symmetries/asymmetries will be measured to the needs of the target group of elderly migrants. At last, the proposition of selected recommendations will complete the analysis. Our attention will focus on 'elderly migrants' who have grown old in their host countries and those who are already elderly when they emigrate to rejoin their family or return to their country of origin. Elderly migrants forced to emigrate or displaced for humanitarian reasons as well as those with immigrant background (second and third generation) will also be taken into consideration (COE, 2008). Vulnerability of this elderly category of migrant people is the common dimension for investigation. The lack of information concerning this growing elderly sample calls inevitably for further empirical research. This tendency is reflected by the methodology of this article which gives notice of the available research works through an extensive literature review, collection of best practices and, where possible, contacts with key-informants.

Wihtol de Wenden, C. (2016). "Panorama des migrations à l'échelle mondiale." Informations Sociales **194**(3): 10-13.
https://www.cairn.info/revue-informations-sociales-2016-3-page-10.htm

Les migrations constituent un enjeu essentiel pour la protection sociale, quelle que soit l'échelle spatiale concernée. Au sein de l'Union européenne (UE), un espace en partie fédéral, tout citoyen d'un État membre peut bénéficier de la protection sociale dans le pays où il travaille. Ces droits sociaux constituent l'un des piliers de l'intégration du continent. Ils ont facilité la libre circulation des personnes, au point que les pays de l'UE les plus touchés par la crise débutée en 2008 sont devenus ou redevenus des terres d'émigration. Au-delà de ses frontières, l'UE exerce un fort pouvoir d'attraction pour des populations souffrant de la pauvreté et de l'instabilité politique, voire contraintes à l'exil. Les travailleurs migrants sont souvent les plus touchés par la pauvreté. Et avec l'intensification de la crise, ils sont parmi les plus vulnérables à l'égard d'un chômage endémique. Ce numéro examine dans un premier temps la manière dont les travailleurs migrants ont été traités par la protection sociale, aux différentes étapes historiques de sa construction en France et en Europe, et analyse en particulier les liens entre statut des migrants, droit social et droits fondamentaux (première partie). Compte tenu des difficultés financières qui pèsent sur les États européens, les migrations sont souvent mises en avant comme une contrainte pour la protection sociale, bien que ce constat soit discuté par l'analyse économique (deuxième partie). L'analyse des règles et les conditions d'accès des migrants aux prestations et aux services sociaux se révèle donc essentielle pour comprendre les enjeux de leur intégration, en France comme au sein de l'UE (troisième partie).

Wilson, T. et Raymer, J. (2017). "Les immigrés en Australie : une population croissante et de plus en plus diverse." Population Et Societes(545): 4 , fig.

En Australie, le nombre d'immigrés et leur proportion dans l'ensemble de la population ont augmenté de façon notable entre 1981 et 2011. Alors qu'en début de période ils étaient majoritairement nés en Europe, leurs origines se sont diversifiées en faveur des autres régions du monde. La population immigrée a aussi vieilli, et elle se modifie sous l'effet non seulement des flux d'entrées mais aussi des flux de sorties. Certains immigrés retournent dans leur pays d'origine ou partent ailleurs. Depuis les années 1990, les immigrés temporaires (étudiants, détenteurs de visa d'affaires, vacanciers-travailleurs) représentent une part croissante de l'ensemble des immigrés.

Wolf, M. (2016). "Migrations : un équilibre difficile à trouver (d'après un article du Financial Times)." Problemes Economiques(3124): 30-35, tab., graph.

Wolf, M. (2016). "Quelle réponse apporter à la crise des réfugiés ? Entretien avec François Héran (d'après un article des Echos)." Problemes Economiques(3124): 36-40, tab., graph.

> Le nombre de demandeurs d'asile connaît une augmentation historique en Europe. Face à cette crise, la Commission européenne a proposé en mai un agenda européen pour la migration souhaitant apporter une réponse commune et solidaire. Les Etats membres cherchent depuis avec difficulté à s'entendre sur des mécanismes et des critères de répartition des réfugiés. Francois Héran, ancien directeur de l'Ined, éclaire le débat replaçant dans une perspective historique et économique cette crise migratoire et humanitaire à laquelle l'Europe fait face aujourd'hui.

FOCUS : POUR UN COUP D'ŒIL RAPIDE, QUELQUES REVUES DE LA LITTERATURE

Alidu, L. et Grunfeld, E. A. (2018). "A systematic review of acculturation, obesity and health behaviours among migrants to high-income countries." Psychol Health **33**(6): 724-745.
https://www.ncbi.nlm.nih.gov/pubmed/29172700

> Objective There is extensive evidence for weight gain among people migrating from low/middle-income to high-income countries, which may be due, in part, to acculturation factors. This review aimed to identify associations between acculturation and body weight among immigrants to high-income countries and identify if studies accounted for the role played by health behaviours. Methods A systematic literature search using keywords was performed with three databases (Medline, PsychINFO and EMBASE). The 35 studies were included that utilised quantitative methodology and presented empirical findings focused on acculturation and body weight among adult immigrants. Findings There was evidence presented across multiple studies for an association between acculturation (measured with standard measures or as duration of stay) and obesity. Most studies were cross sectional, which did not allow the exploration of drivers of change in health behaviours and weight gain. Conclusion This is the first review to examine associations between acculturation and body weight among migrants utilising both acculturation scales and proxy measures of acculturation and to examine the role of health behaviours. Evidence from this review suggests that health interventions should target first generation migrants to promote retention of their original healthy behaviours. Recent migrant groups report healthier behaviours than comparative host country populations, and therefore interventions should be promoted at the initial stages following migration to avoid uptake of unhealthy behaviours.

Bajgain, B. B. et Bajgain, K. T. (2020). "Patient-Reported Experiences in Accessing Primary Healthcare among Immigrant Population in Canada: A Rapid Literature Review." **17**(23).

> (1) Background: Immigrants represent around 21.9% of the total population in Canada and encounter multifaceted obstacles in accessing and receiving primary healthcare. This literature review explores patient experiences in primary care from the perspective of immigrants and identifies areas for further research and improvement. (2) Methods: A comprehensive search was performed on PubMed, MEDLINE, Embase, SCOPUS, and Google scholar to identify studies published from 2010 to July 2020. Relevant articles were peer-reviewed, in English language, and reported patient experiences in primary healthcare in Canada. (3) Results: Of the 1566 searched articles, 19 articles were included in this review. Overall, the finding from articles were summarized into four major themes: cultural and linguistic differences; socioeconomic challenges; health system factors; patient-provider relationship. (4) Conclusion: Understanding the gaps to accessing and receiving appropriate healthcare is important to shape policies, enhance the quality of services, and deliver more equitable healthcare services. It is therefore pertinent that primary healthcare providers play an active role in bridging these gaps with strong support from policymakers. Understanding and respecting diversity in culture, language, experiences, and

systems is crucial in reducing health inequalities and improving access to quality care in a respectful and responsive manner.

Bas-Sarmiento, P., et al. (2017). "Mental Health in Immigrants Versus Native Population: A Systematic Review of the Literature." Arch Psychiatr Nurs **31**(1): 111-121.

The relationship between psychopathology and migration presents unresolved questions. OBJECTIVES: To determine whether there is a higher incidence of mental illness among immigrants, to describe the nosologic differences between immigrant and native populations, and to identify the risk factors involved of immigration. METHODS: A systematic review was conducted using the PubMed, Science Direct, ISI, Scopus, Psycinfo, Cochrane, and Cuiden databases. The search strategy was conducted using the MeSH thesaurus for the controlled terms "mental disorders," "mental health," "transients and migrants," "immigrants," and "epidemiology." The quality of the articles was analyzed by using the Equator Guidelines, following checklists according to the methodological design of the studies by two independent reviewers. RESULTS: From a total of 817 studies found, 21 met the inclusion criteria. Out of the 21 studies selected, 13 showed a higher prevalence of mental illness. CONCLUSIONS: Migration represents a major challenge, but it does not lead exclusively to mental distress. Immigrants experience more problems in depression, anxiety, and somatic disorders, pathologies related directly to the migration process and stress suffered. Resources should be oriented to primary and community care.

Credé, S. H., Such, E. et Mason, S. (2018). "International migrants' use of emergency departments in Europe compared with non-migrants' use: a systematic review." Eur J Public Health **28**(1): 61-73.

BACKGROUND: International migration across Europe is increasing. High rates of net migration may be expected to increase pressure on healthcare services, including emergency services. However, the extent to which immigration creates additional pressure on emergency departments (EDs) is widely debated. This review synthesizes the evidence relating to international migrants' use of EDs in European Economic Area (EEA) countries as compared with that of non-migrants. METHODS: MEDLINE, EMBASE, CINAHL, The Cochrane Library and The Web of Science were searched for the years 2000-16. Studies reporting on ED service utilization by international immigrants, as compared with non-migrants, were eligible for inclusion. Included studies were restricted to those conducted in EEA countries and English language publications only. RESULTS: Twenty-two articles (from six host countries) were included. Thirteen of 18 articles reported higher volume of ED service use by immigrants, or some immigrant sub-groups. Migrants were seen to be significantly more likely to present to the ED during unsocial hours and more likely than non-migrants to use the ED for low-acuity presentations. Differences in presenting conditions were seen in 4/7 articles; notably a higher rate of obstetric and gynaecology presentations among migrant women. CONCLUSIONS: The principal finding of this review is that migrants utilize the ED more, and differently, to the native populations in EEA countries. The higher use of the ED for low-acuity presentations and the use of the ED during unsocial hours suggest that barriers to primary healthcare may be driving the higher use of these emergency services although further research is needed.

Chiesa, V., Chiarenza, A., Mosca, D., et al. (2019). "Health records for migrants and refugees: A systematic review." Health Policy **123**(9): 888-900.
http://www.ncbi.nlm.nih.gov/pubmed/31439455

INTRODUCTION: One of the challenges facing migrants and refugees is access to medical records. The aim of this study was to identify Health Records (HRs) developed specifically for migrants and refugees, describe their characteristics, and discuss their reported strengths and weaknesses. MATERIALS AND METHODS: A systematic review of articles focusing on HRs implemented exclusively for migrants and refugees was undertaken. Publications were identified by searching the scientific databases Embase, Medline, Scopus and Cochrane, the grey literature and by checking the reference lists of articles. RESULTS: The literature search yielded an initial list of 1432 records, with 58 articles remaining after screening of title and abstract. Following full-text screening, 33 articles were retained. Among the 33 articles reviewed, 20 different HRs were identified. DISCUSSION: Our findings suggest

that HRs, especially electronic ones, might be efficient and effective tools for registering, monitoring and improving the health of migrants and refugees. However, some of the evidence base is narrative or institutional and needs to be backed up by scientific studies. CONCLUSIONS: Health records, implemented specifically for migrants and refugees, seem to have the potential to address some of the challenges that they face in accessing health care, in particular in strategic hotspots, cross-border settings and for migrants on the move.

de Jong, L., Pavlova, M., Winters, M., et al. (2017). "A systematic literature review on the use and outcomes of maternal and child healthcare services by undocumented migrants in Europe." Eur J Public Health.

Background: Undocumented migrants, in particular pregnant women and their newborns, constitute a particularly vulnerable group of migrants. The aim of this study was to systematically review the academic literature on the use and outcomes of maternal and child healthcare by undocumented migrants in the European Union (EU) and European Free Trade Association (EFTA) countries. Methods: The databases, MEDLINE, Embase, CINAHL Plus, Global Health and Popline were searched for the period 2007 to 2017. Two independent reviewers judged the eligibility of studies. The final number of included studies was 33. Results: The results of quantitative, qualitative and mixed methods studies were analysed separately due to their differences in study design, sample size and quality. Overall, the quantitative studies found that undocumented women underutilised essential maternal and child healthcare services, and experienced worse health outcomes. Qualitative studies supported these results, indicating that undocumented migrants were hesitant to use services due to a lack of knowledge and fear of deportation. Studies included in the review covered 10 of 32 EU or EFTA countries, making a European comparison impossible. Conclusions: Despite major methodological differences between included studies, the results of this review indicate that the status of undocumented migrants exacerbates known health risks and hampers service use.

Diaz, E., et al. (2017). "Interventions to improve immigrant health. A scoping review." Eur J Public Health **27**(3): 433-439.

Background: : Disparities in health between immigrants and their host populations have been described across countries and continents. Hence, interventions for improving health targeting general populations are not necessarily effective for immigrants. To conduct a systematic search of the literature evaluating health interventions for immigrants; to map the characteristics of identified studies including range of interventions, immigrant populations and their host countries, clinical areas targeted and reported evaluations, challenges and limitations of the interventions identified. Following the results, to develop recommendations for research in the field. A scoping review approach was chosen to provide an overview of the type, extent and quantity of research available. Studies were included if they empirically evaluated health interventions targeting immigrants and/or their descendants, included a control group, and were published in English (PubMed and Embase from 1990 to 2015). Most of the 83 studies included were conducted in the USA, encompassed few immigrant groups and used a randomized controlled trial (RCT) or cluster RCT design. Most interventions addressed chronic and non-communicable diseases and attendance at cancer screening services, used individual targeted approaches, targeted adult women and recruited participants from health centres. Outcome measures were often subjective, with the exception of interventions for cardiovascular risk and diabetes. Generally, authors claimed that interventions were beneficial, despite a number of reported limitations. Recommendations for enhancing interventions to improve immigrant health are provided to help researchers, funders and health care commissioners when deciding upon the scope, nature and design of future research in this area.

Economou, C., Mladovsky, P., Siskou, O., et al. (2021). "Migrants' involvement in health policy, service development and research in the WHO European Region: A narrative review of policy and practice." Int J Health Serv **26**(10): 1164-1176.

OBJECTIVES: The involvement of individuals and communities in health decision-making is enshrined in WHO policies. However, migrant groups are under-represented in health decision-making processes.

Our aim was to explore migrants' involvement in health policy, service development and research in the WHO European Region to identify levers for inclusive and meaningful practice. METHODS: We conducted a narrative review of grey literature and peer-reviewed research on migrants' involvement in health decision-making across the 53 countries in WHO Europe. We searched for articles published in English between 2010 and the present in two electronic databases (PubMed, Scopus), IOM MIPEX Health Strand country reports, the EU SOPHIE project and using a Google advanced search. Findings were analysed descriptively and using Normalisation Process Theory to investigate levers and barriers to implementation of policy into practice. RESULTS: Of 1,444 articles retrieved, 79 met the inclusion criteria. We identified 20 policies promoting migrants' involvement, but national-level policies were present in only two countries. We identified 59 examples of migrants' involvement in practice from half of the WHO Europe countries (n = 27). Our Normalisation Process Theory (NPT) analysis of 14 peer-reviewed empirical papers found that participatory research approaches are a lever to putting policy into practice in a meaningful way. CONCLUSIONS: Migrants' involvement in health decision-making requires explicit national policies that are implemented evenly across policymaking, service provider and research activities in all countries in the WHO European Region. Participatory approaches to involvement activities are encouraged because they are a lever to perceived barriers to migrants' involvement.

Fair, F. (2020). "Migrant women's experiences of pregnancy, childbirth and maternity care in European countries: A systematic review." BMC Womens Health **15**(2): e0228378.

BACKGROUND: Across Europe there are increasing numbers of migrant women who are of childbearing age. Migrant women are at risk of poorer pregnancy outcomes. Models of maternity care need to be designed to meet the needs of all women in society to ensure equitable access to services and to address health inequalities. OBJECTIVE: To provide up-to-date systematic evidence on migrant women's experiences of pregnancy, childbirth and maternity care in their destination European country. SEARCH STRATEGY: CINAHL, MEDLINE, PubMed, PsycINFO and Scopus were searched for peer-reviewed articles published between 2007 and 2017. SELECTION CRITERIA: Qualitative and mixed-methods studies with a relevant qualitative component were considered for inclusion if they explored any aspect of migrant women's experiences of maternity care in Europe. DATA COLLECTION AND ANALYSIS: Qualitative data were extracted and analysed using thematic synthesis. RESULTS: The search identified 7472 articles, of which 51 were eligible and included. Studies were conducted in 14 European countries and focused on women described as migrants, refugees or asylum seekers. Four overarching themes emerged: 'Finding the way-the experience of navigating the system in a new place', 'We don't understand each other', 'The way you treat me matters', and 'My needs go beyond being pregnant'. CONCLUSIONS: Migrant women need culturally-competent healthcare providers who provide equitable, high quality and trauma-informed maternity care, undergirded by interdisciplinary and cross-agency team-working and continuity of care. New models of maternity care are needed which go beyond clinical care and address migrant women's unique socioeconomic and psychosocial needs.

George, U., et al. (2015). "Immigrant Mental Health, A Public Health Issue: Looking Back and Moving Forward." Int J Environ Res Public Health **12**(10): 13624-13648.

The Mental Health Commission of Canada's (MHCC) strategy calls for promoting the health and wellbeing of all Canadians and to improve mental health outcomes. Each year, one in every five Canadians experiences one or more mental health problems, creating a significant cost to the health system. Mental health is pivotal to holistic health and wellbeing. This paper presents the key findings of a comprehensive literature review of Canadian research on the relationship between settlement experiences and the mental health and well-being of immigrants and refugees. A scoping review was conducted following a framework provided by Arskey and O'Malley (Int J Soc Res Methodol 8:19-32, 2005). Over two decades of relevant literature on immigrants' health in Canada was searched. These included English language peer-reviewed publications from relevant online databases Medline, Embase, PsycInfo, Healthstar, ERIC and CINAHL between 1990 and 2015. The findings revealed three important ways in which settlement affects the mental health of immigrants and refugees: through

acculturation related stressors, economic uncertainty and ethnic discrimination. The recommendations for public health practice and policy are discussed.

Gieles, N. C., Tankink, J. B., van Midde, M., et al. (2019). "Maternal and perinatal outcomes of asylum seekers and undocumented migrants in Europe: a systematic review." Eur J Public Health **29**(4): 714-723.

BACKGROUND: Asylum seekers (AS) and undocumented migrants (UM) are at risk of adverse pregnancy outcomes due to adverse health determinants and compromised maternal healthcare access and service quality. Considering recent migratory patterns and the absence of a robust overview, a systematic review was conducted on maternal and perinatal outcomes in AS and UM in Europe. METHODS: Systematic literature searches were performed in MEDLINE and EMBASE (until 1 May 2017), complemented by a grey literature search (until 1 June 2017). Primary research articles reporting on any maternal or perinatal outcome, published between 2007 and 2017 in English/Dutch were eligible for inclusion. Review protocols were registered on Prospero: CRD42017062375 and CRD42017062477. Due to heterogeneity in study populations and outcomes, results were synthesized narratively. RESULTS: Of 4652 peer-reviewed articles and 145 grey literature sources screened, 11 were included from 4 European countries. Several studies reported adverse outcomes including higher maternal mortality (AS), severe acute maternal morbidity (AS), preterm birth (UM) and low birthweight (UM). Risk of bias was generally acceptable, although the limited number and quality of some studies preclude definite conclusions. CONCLUSION: Limited evidence is available on pregnancy outcomes in AS and UM in Europe. The adverse outcomes reported imply that removing barriers to high-quality maternal care should be a priority. More research focussing on migrant subpopulations, considering potential risk factors such as ethnicity and legal status, is needed to guide policy and optimize care.

Grabovschi, C., et al. (2013). "Mapping the concept of vulnerability related to health care disparities: a scoping review." BMC Health Serv Res **13**: 94.

BACKGROUND: The aim of this paper is to share the results of a scoping review that examined the relationship between health care disparities and the multiplicity of vulnerability factors that are often clustered together. METHODS: The conceptual framework used was an innovative dynamic model that we developed to analyze the co-existence of multiple vulnerability factors (multi-vulnerability) related to the phenomenon of the 'Inverse Care Law'. A total of 759 candidate references were identified through a literature search, of which 23 publications were deemed relevant to our scoping review. RESULTS: The review confirmed our hypothesis of a direct correlation between co-existing vulnerability factors and health care disparities. Several gaps in the literature were identified, such as a lack of research on vulnerable populations' perception of their own vulnerability and on multimorbidity and immigrant status as aspects of vulnerability. CONCLUSIONS: Future research addressing the revealed gaps would help foster primary care interventions that are responsive to the needs of vulnerable people and, eventually, contribute to the reduction of health care disparities in society.

Grosser, A., et al. (2016). "Inclusion of migrants and ethnic minorities in European birth cohort studies-a scoping review." Eur J Public Health **26**(6): 984-991.

BACKGROUND: Migrant and ethnic minority groups constitute substantial parts of European populations. They frequently experience health disadvantages relative to the respective majority populations. Birth cohort studies can help to disentangle social and biological factors producing these health inequalities over the life course. We investigated whether birth cohorts in European countries (i) assess migration history and ethnicity in the study design; and (ii) use this information in data analyses. METHODS: A scoping review was performed in which European birth cohort studies were identified using dedicated web-based registries, MEDLINE and EMBASE. Two reviewers systematically assessed all identified birth cohorts and selected those fulfilling defined inclusion criteria (e.g. enrolment after 1980). Publications and websites were screened for information on the inclusion of migrants and ethnic minorities. To obtain more detailed information, researchers of enrolled birth cohorts were contacted individually. RESULTS: Eighty-eight birth cohorts were identified in 20

European countries, with more than 486 250 children enrolled in total. Sixty-two studies (70.5%) reported collecting data about migration history or ethnic background. Twenty-three studies (26%) used information on migration history or ethnicity for data analyses or plan to do so in future. CONCLUSION: The majority of European birth cohorts assessed participants' migration history or ethnic background; however, this information was seldom used for comparative analyses in trying to disentangle reasons for health inequalities. Also, heterogeneous indicators were used. Better use of data already available, as well as harmonization of data collection on migration history and ethnicity, could yield interesting insights into the production of health inequalities.

Herold, R., Wuchenauer, F., Kandler, A., et al. (2022). "Association of cultural origin and migration status with work-related mental health of migrants and refugees in Europe: a systematic review protocol." BMJ Open **12**(1): e052395.

IntroductionMigrants make up a significant proportion of the European working population. Previous studies have already shown that migrants and refugees often suffer from poor work-related conditions in the host country, which might have an impact on mental health. Thus, the main objective of this systematic review is to analyse and summarise existing research on work-related conditions of migrants and refugees in Europe and to investigate the relationship of these conditions with their mental health. METHODS AND ANALYSIS: Three electronic databases (PubMed/MEDLINE, PsycINFO and CINAHL) will be systematically searched for eligible articles using quantitative study designs (randomised controlled trials, cohort, case-control and cross-sectional studies with and without control groups) written in English, German, French, Italian, Polish, Spanish or Turkish and published from 1st January 2016 onwards. The primary health outcomes will be diagnosed psychiatric and psychological disorders, suicide and suicide attempts, psychiatric and psychological symptoms, and perceived distress. The secondary health outcomes will be more general concepts of mental health such as well-being, life satisfaction and quality of life. Outcome measures must have been assessed by validated questionnaires. Screening of all articles, reference lists of included studies and relevant reviews as well as data extraction will be performed independently by two review authors. Methodological quality of primary studies will be assessed and discussed. The results of the primary studies will be summarised descriptively. Migrants and natives, migrants and refugees, migrants of different cultural backgrounds and migrants living in different host countries will be compared in terms of the association between their work-related conditions and their mental health. ETHICS AND DISSEMINATION: This systematic review is excluded from ethical approval because it will use previously approved published data from primary studies.

Hilario, C. T., et al. (2015). "Migration and young people's mental health in Canada: A scoping review." J Ment Health **24**(6): 414-422.

BACKGROUND: Young people's mental health is a public health priority. Given the influences of migration and resettlement on mental health, synthesis of current research with young people from migrant backgrounds can help inform mental health promotion initiatives that account for and are responsive to their needs. AIMS: This article distils the results of a review of published literature on the mental health of adolescent immigrants (ages 10-19) living in Canada. METHOD: Scoping review methods were used to define inclusion and exclusion criteria; inform the search strategies; and extract and synthesize key findings. RESULTS: Fourteen articles met criteria for inclusion. Analysis of the studies indicate diversity in mental health indicators, e.g., mental distress, emotional problems and behavioral problems, as well as a wide range of influences on mental health from age at migration and length of stay to place of residence, income and discrimination. CONCLUSIONS: Findings support the need to account for the array of influences on young people's mental health in relation to migration and to augment initiatives beyond the level of individual intervention.

Jackson, J., Santana, M. J., Ferdous, M., et al. (2018). "Barriers to cervical cancer screening faced by immigrant women in Canada: a systematic scoping review." Int J Environ Res Public Health **18**(1): 165.

BACKGROUND: The objective of this scoping study is to review the published literature and summarize findings related to barriers experienced by immigrant women in Canada while accessing cervical

cancer screening. METHODS: Electronic databases of peer-reviewed articles and grey literature were searched using comprehensive sets of keywords, without restricting the time period or language. Articles were selected based on the following criteria: (a) the study population consisted of Canadian immigrant women and healthcare providers and other stakeholders serving immigrant women, (b) the research focused on the barriers to accessing cervical cancer screening, and (c) the study was conducted in Canada. RESULTS: Extracted data were grouped and analyzed, resulting in barriers comprised of six themes: economic barriers, cultural barriers, language barriers, healthcare system-related barriers, knowledge-related barriers, and individual-level barriers. Lack of education, low income, preference for a female physician, lack of knowledge, lack of effective communication, and embarrassment were some of the most common barriers mentioned. CONCLUSIONS: Immigrant access to health services, including cervical cancer screening, is a complex issue concerning a wide range of barriers. Our findings offer insights into barriers to cervical cancer screening in immigrant communities in Canada that can be used to assist policymakers, healthcare providers, and researchers enhance the health and well-being of these populations by mitigating barriers and improving screening.

Khanlou, N., et al. (2017). "Scoping Review on Maternal Health among Immigrant and Refugee Women in Canada: Prenatal, Intrapartum, and Postnatal Care." J Pregnancy **2017**: 8783294.

The last fifteen years have seen a dramatic increase in both the childbearing age and diversity of women migrating to Canada. The resulting health impact underscores the need to explore access to health services and the related maternal health outcome. This article reports on the results of a scoping review focused on migrant maternal health within the context of accessible and effective health services during pregnancy and following delivery. One hundred and twenty-six articles published between 2000 and 2016 that met our inclusion criteria and related to this group of migrant women, with pregnancy/motherhood status, who were living in Canada, were identified. This review points at complex health outcomes among immigrant and refugee women that occur within the compelling gaps in our knowledge of maternal health during all phases of maternity. Throughout the prenatal, intrapartum, and postnatal periods of maternity, barriers to accessing healthcare services were found to disadvantage immigrant and refugee women putting them at risk for challenging maternal health outcomes. Interactions between the uptake of health information and factors related to the process of immigrant settlement were identified as major barriers. Availability of appropriate services in a country that provides universal healthcare is discussed.

Klein, J. et von dem Knesebeck, O. (2018). "Inequalities in health care utilization among migrants and non-migrants in Germany: a systematic review." Int J Equity Health **17**(1): 160.

BACKGROUND: Despite the growing number of people with migrant background in Germany, a systematic review about their utilization of health care and differences to the non-migrant population is lacking. By covering various sectors of health care and migrant populations, the review aimed at giving a general overview and identifying special areas of potential intervention. METHODS: A systematic review was conducted in PubMed database including records that were published until 1st of June 2017. Further criteria for eligibility were a publication in a peer-reviewed journal written in English or German language. The studies have to report quantitative and original data of a population residing in Germany. The appropriateness of the studies was judged by both authors. Studies were excluded if native controls were not originated from the same sample. Moreover, indicators of health care utilization have to assess individual behaviour like consultation or participation rates. 63 studies met the inclusion criteria for a qualitative synthesis of the findings. RESULTS: The overall findings indicate a lower utilization among migrants, although the results vary in terms of health care sector, indicator of health care utilization and migrant population. For specialist care, medication use, therapist consultations and counselling, rehabilitation as well as disease prevention (early cancer detection, prevention programs for children and oral health check-ups) a lower utilization among people with migrant background was found. The lower usage was particularly shown for migrants of the 1st generation, people with two-sided migrant background, children/adolescents and women. Due to the methodological heterogeneity a meta-analysis was not feasible. As most of the studies were cross-sectional, no causal interpretations could be drawn. CONCLUSIONS: The inequalities in utilization could not substantially be explained by differences in the socioeconomic status. Other reasons of

lower utilization could be due to differences in need, preferences, information, language and formal access barriers (e.g. charges, waiting times, travel distances or lost wages). Different migrant-specific and migrant-sensitive strategies are relevant to address the problem for certain health care sectors and migrant populations. TRIAL REGISTRATION: The review protocol was registered on PROSPERO (CRD42014015162).

Kocot, E. et Szetela, A. (2020). "Assessing health systems' preparedness for providing care for refugees, asylum seekers and migrants: a scoping review." Eur J Public Health **30**(6): 1157-1163.

BACKGROUND: Health care systems and care professionals often face the challenge of providing adequate health care for migrant groups. The objective of this study is to answer the question of whether and how meeting the special health system requirements regarding refugees (R), asylum seekers (AS) and migrants (M) (RASM) is checked and evaluated. METHODS: A scoping review was used as a methodology of the research, with four electronic databases, websites of relevant organizations and European projects searched, using a strictly defined search strategy. Finally, 66 studies were included in the analysis. RESULTS: The included studies presented assessment of different types, aspects and facilities of health care, as well as various methods of analysis. In the vast majority of the studies (n = 52, 78%) interviews or questionnaires were used to collect data. The studies were mostly declared to be qualitative. The main issues assessed in the studies can be categorized into three groups: (i) legal aspects, (ii) before receiving health care and (iii) during health care usage. CONCLUSIONS: RASM inflow is a big challenge for health care system in many countries. The first step to guarantee adequate health care for RASM is assessing how the system is functioning. This makes it possible to find gaps, indicate the directions of activities needed and monitor progress. Further work on the development of a comprehensive tool, checked in terms of validity and reliability assessment, and enabling examination of many aspects of health care for RASM should be carried out.

Lebano, A., Hamed, S., Bradby, H., et al. (2020). "Migrants' and refugees' health status and healthcare in Europe: a scoping literature review." BMC Public Health **20**(1): 1039.

BACKGROUND: There is increasing attention paid to the arrival of migrants from outwith the EU region to the European countries. Healthcare that is universally and equably accessible needs to be provided for these migrants throughout the range of national contexts and in response to complex and evolving individual needs. It is important to look at the evidence available on provision and access to healthcare for migrants to identify barriers to accessing healthcare and better plan necessary changes. METHODS: This review scoped 77 papers from nine European countries (Austria, Cyprus, France, Germany, Greece, Italy, Malta, Spain, and Sweden) in English and in country-specific languages in order to provide an overview of migrants' access to healthcare. The review aims at identifying what is known about access to healthcare as well as healthcare use of migrants and refugees in the EU member states. The evidence included documents from 2011 onwards. RESULTS: The literature reviewed confirms that despite the aspiration to ensure equality of access to healthcare, there is evidence of persistent inequalities between migrants and non-migrants in access to healthcare services. The evidence shows unmet healthcare needs, especially when it comes to mental and dental health as well as the existence of legal barriers in accessing healthcare. Language and communication barriers, overuse of emergency services and underuse of primary healthcare services as well as discrimination are described. CONCLUSIONS: The European situation concerning migrants' and refugees' health status and access to healthcare is heterogeneous and it is difficult to compare and draw any firm conclusions due to the scant evidence. Different diseases are prioritised by different countries, although these priorities do not always correspond to the expressed needs or priorities of the migrants. Mental healthcare, preventive care (immunization) and long-term care in the presence of a growing migrant older population are identified as priorities that deserve greater attention. There is a need to improve the existing data on migrants' health status, needs and access to healthcare to be able to tailor care to the needs of migrants. To conduct research that highlights migrants' own views on their health and barriers to access to healthcare is key.

Lommel, L. L. et Chen, J. L. (2016). "The Relationship Between Self-Rated Health and Acculturation in Hispanic and Asian Adult Immigrants: A Systematic Review." J Immigr Minor Health **18**(2): 468-478.

We systematically reviewed studies to identify the association between acculturation and self-rated health (SRH) and the impact of nativity and language use in Asian and Hispanic adult immigrants. Six electronic databases were searched. Data on nativity and limited English proficiency (LEP) was extracted and analyzed. Nine studies met review criteria. A positive association between acculturation and fair/poor SRH among Asians and Hispanics was found. For both Asians and Hispanics, six out of eight studies showed nativity and all three studies reporting LEP were associated with worse SRH compared to whites. Nativity and LEP were found to be risk factors for reporting worse SRH in Hispanics compared to Asians. The degree of association between nativity and LEP and worse SRH was found to vary by Asian and Hispanic subgroup. Further studies are needed to accurately assess the health status of these populations, which will be essential to eliminating disparities.

Lu, J., Jamani, S., Benjamen, J., et al. (2020). "Global Mental Health and Services for Migrants in Primary Care Settings in High-Income Countries: A Scoping Review." Int J Environ Res Public Health **17**(22).

Migrants are at a higher risk for common mental health problems than the general population but are less likely to seek care. To improve access, the World Health Organization (WHO) recommends the integration of mental health services into primary care. This scoping review aims to provide an overview of the types and characteristics of mental health services provided to migrants in primary care following resettlement in high-income countries. We systematically searched MEDLINE, EMBASE, PsycInfo, Global Health, and other databases from 1 January 2000 to 15 April 2020. The inclusion criteria consisted of all studies published in English, reporting mental health services and practices for refugee, asylum seeker, or undocumented migrant populations, and were conducted in primary care following resettlement in high-income countries. The search identified 1627 citations and we included 19 studies. The majority of the included studies were conducted in North America. Two randomized controlled trials (RCTs) assessed technology-assisted mental health screening, and one assessed integrating intensive psychotherapy and case management in primary care. There was a paucity of studies considering gender, children, seniors, and in European settings. More equity-focused research is required to improve primary mental health care in the context of global mental health.

Malmusi, D. et Ortiz-Barreda, G. (2014). "[Health inequalities in immigrant populations in Spain: a scoping review]." Rev Esp Salud Publica **88**(6): 687-701.

BACKGROUND: Health differences between immigrants and natives should be analyzed from an equity perspective due to socioeconomic inequality between them. The aim of this study is to Know the influence of social determinants of health in the immigrant population in Spain and/or inequalities compared with the Spanish population. METHODS: SA scoping review of the literature published in the period 1998-2012 was performed. The literature search was conducted on Medline and MEDES-MEDicina databases. All studies that include the participation of immigrant population from areas such as Latin America, Africa, Asia and Eastern Europe and performed in Spain were selected. RESULTS: A 27 articles were included. Most of the studies were published in the year 2009 (n=11). Twelve used population health surveys at national (n=6) and autonomous (n = 6) level. A total of 23 studies focused on adult population over 15 years. The most frequently studied indicators were self-rated health (n=9) and mental health (n=7). CONCLUSION: The immigrant population is exposed to lower socioeconomic status than natives and, despite a lower prevalence of chronic diseases, it appears to experience more mental health problems and worse self-rated health, especially in women and with longer stay.

Martin, F. et Sashidharan, S. P. (2022). "The Mental Health of Adult Irregular Migrants to Europe: A Systematic Review." J Immigr Minor Health.

The aim of this systematic review is to summarise the existing evidence on the mental health outcomes of adult irregular immigrants (IMs) to Europe. Database (MEDLINE, EMBASE, CINAHL, PsychINFO) searches were conducted according to PRISMA. The risk of bias was assessed using the Appraisal tool for Cross-Sectional Studies. The database searches yielded 2982 results. Eight cross-sectional studies from Western Europe were included, with 1201 participants. The prevalence of

mental disorders varied between studies: depression from 8 to 86%; anxiety from 3.1 to 81%; and post-traumatic stress disorder (PTSD) from 3.4 to 57.6%. The studies had methodological flaws; in particular a risk of unrepresentative samples. There was methodological heterogeneity, therefore pooling of data, and direct comparisons were not possible. The majority of studies found higher rates of depression, anxiety and PTSD than previous estimates for the general population, and higher rates of depression and anxiety than previous estimates for other migrant groups.

Martinez, O., et al. (2015). "Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review." J Immigr Minor Health **17**(3): 947-970.

Over the past two decades, new anti-immigration policies and laws have emerged to address the migration of undocumented immigrants. A systematic review of the literature was conducted to assess and understand how these immigration policies and laws may affect both access to health services and health outcomes among undocumented immigrants. Eight databases were used to conduct this review, which returned 325 papers that were assessed for validity based on specified inclusion criteria. Forty critically appraised articles were selected for analysis; thirty articles related to access to health services, and ten related to health outcomes. The articles showed a direct relationship between anti-immigration policies and their effects on access to health services. In addition, as a result of these policies, undocumented immigrants were impacted by mental health outcomes, including depression, anxiety, and post-traumatic stress disorder. Action items were presented, including the promotion of cultural diversity training and the development of innovative strategies to support safety-net health care facilities serving vulnerable populations.

Monge, S., et al. (2015). "[Methodological limitations and recommendations in publications on migrant population health in Spain]." Gac Sanit **29**(6): 461-463.

Our objective was to describe the methodological limitations and recommendations identified by authors of original articles on immigration and health in Spain. A literature review was conducted of original articles published in Spanish or English between 1998 and 2012 combining keywords on immigration and health. A total of 311 articles were included; of these, 176 (56.6%) mentioned limitations, and 15 (4.8%) made recommendations. The most frequently mentioned limitations included the following: reduced sample sizes; internal validity and sample representativeness issues, with under- or overrepresentation of specific groups; problems of validity of the collected information and missing data mostly related to measurement tools; and absence of key variables for adjustment or stratification. Based on these results, a series of recommendations are proposed to minimise common limitations and advance the quality of scientific production on immigration and health in our setting.

Papatheodoridis, G. V., et al. (2014). "Barriers to care and treatment for patients with chronic viral hepatitis in Europe: a systematic review." Liver Int **34**(10): 1452-1463.

BACKGROUND & AIMS: Despite the availability of effective therapies for hepatitis B (HBV) and C virus (HCV), only a minority of these patients receive treatment. We systematically reviewed published data on barriers to management for chronic HBV/HCV patients in Europe. METHODS: Literature search to identify studies including adult patients with chronic HBV/HCV infection from European countries and data on barriers to treatment. RESULTS: Twenty-five studies including 6253 chronic HBV and 19,014 HCV patients were identified, of which only two were from Eastern Europe. The mean rate of no treatment in HBV patients was 42% being higher in North-Western European countries than Italy (56% vs. 39%, P < 0.001). Immigrants represented the most common barrier to HBV treatment. The mean rate of no treatment in HCV RNA-positive patients was 57%, being highest in Romania (89%), intermediate in France (79%) and lower though still high in other European countries (52%, P < 0.001). The predominant barriers to HCV treatment were lack of financial resources in Romania and direct/indirect limitations of interferon-alfa and/or parenteral drug and alcohol abuse in other countries. The mean rate of no treatment was highest in HCV RNA-positive parenteral drug users (72%) and intermediate in those with HCV-HIV co-infection (64%). CONCLUSIONS: A substantial proportion of diagnosed chronic HBV and the majority of diagnosed HCV patients remain untreated. The rates and most importantly the reasons of barriers to treatment in chronic HBV/HCV patients vary

widely among European countries supporting the need for country-specific national strategies, resource allocation and implementation of global management policies.

Peñuela-O'Brien, E., Wan, M. W., Edge, D., et al. (2022). "Health professionals' experiences of and attitudes towards mental healthcare for migrants and refugees in Europe: A qualitative systematic review." Transcult Psychiatry: 13634615211067360.

Migrants living in Europe constitute over half of the world's international migrants and are at higher risk of poor mental health than non-migrants, yet also face more barriers in accessing and engaging with services. Furthermore, the quality of care received is shaped by the experiences and attitudes of health professionals. The aim of this review was to identify professionals' attitudes towards migrants receiving mental healthcare and their perceptions of barriers and facilitators to service provision. Four electronic databases were searched, and 23 studies met the inclusion criteria. Using thematic synthesis, we identified three themes: 1) the management of multifaceted and complex challenges associated with the migrant status; 2) professionals' emotional responses to working with migrants; and 3) delivering care in the context of cultural difference. Professionals employed multiple strategies to overcome challenges in providing care yet attitudes towards this patient group were polarized. Professionals described mental health issues as being inseparable from material and social disadvantage, highlighting a need for effective collaboration between health services and voluntary organizations, and partnerships with migrant communities. Specialist supervision, reflective practice, increased training for professionals, and the adoption of a person-centered approach are also needed to overcome the current challenges in meeting migrants' needs. The challenges experienced by health professionals in attempting to meet migrant needs reflect frustrations in being part of a system with insufficient resources and without universal access to care that effectively stigmatizes the migrant status.

Phung, V. H., Asghar, Z., Matiti, M., et al. (2020). "Understanding how Eastern European migrants use and experience UK health services: a systematic scoping review." BMC Health Serv Res **20**(1): 173.

BACKGROUND: The UK has experienced significant immigration from Eastern Europe following European Union (EU) expansion in 2004, which raises the importance of equity and equality for the recent immigrants. Previous research on ethnic health inequalities focused on established minority ethnic groups, whereas Eastern European migrants are a growing, but relatively under-researched group. We aimed to conduct a systematic scoping review of published literature on Eastern European migrants' use and experiences of UK health services. METHODS: An initial search of nine databases produced 5997 relevant publications. Removing duplicates reduced the figure to 2198. Title and abstract screening left 73 publications. Full-text screening narrowed this down further to 10 articles, with three more from these publications to leave 13 included publications. We assessed publications for quality, extracted data and undertook a narrative synthesis. RESULTS: The included publications most commonly studied sexual health and family planning services. For Eastern European migrants in the UK, the most commonly cited barriers to accessing and using healthcare were limited understanding of how the system worked and language difficulties. It was also common for migrants to return to their home country to a healthcare system they were familiar with, free from language barriers. Familial and social networks were valuable for patients with a limited command of English in the absence of suitable and available interpreting and translating services. CONCLUSIONS: To address limited understanding of the healthcare system and the English language, the NHS could produce information in all the Eastern European languages about how it operates. Adding nationality to the Electronic Patient Report Form (EPRF) may reveal the demand for interpretation and translation services. Eastern European migrants need to be encouraged to register with GPs to reduce A&E attendance for primary care conditions. Many of the issues raised will be relevant to other European countries since the long-term outcomes from Brexit are likely to influence the level of Eastern European and non-Eastern European migration across the continent, not just the UK.

Pulver, A., et al. (2016). "A scoping review of female disadvantage in health care use among very young children of immigrant families." Soc Sci Med **152**: 50-60.

Preference for sons culminates in higher mortality and inadequate immunizations and health care visits for girls compared to boys in several countries. It is unknown if the negative consequences of son-preference persist among those who immigrate to Western, high-income countries. To review the literature regarding gender inequities in health care use among children of parents who migrate to Western, high-income countries, we completed a scoping literature review using Medline, Embase, PsycINFO and Scopus databases. We identified studies reporting gender-specific health care use by children aged 5 years and younger whose parents had migrated to a Western country. Two independent reviewers conducted data extraction and a quality assessment tool was applied to each included study. We retrieved 1547 titles, of which 103 were reviewed in detail and 12 met our inclusion criteria. Studies originated from the United States and Europe, using cross-sectional or registry-based designs. Five studies examined gender differences in health care use within immigrant groups, and only one study explored the female health disadvantage hypothesis. No consistent gender differences were observed for routine primary care visits however immunizations and prescriptions were elevated for boys. Greater use of acute health services, namely emergency department visits and hospitalizations, was observed for boys over girls in several studies. Studies did not formally complete gender-based analyses or assess for acculturation factors. Health care use among children in immigrant families may differ between boys and girls, but the reasons for why this is so are largely unexplored. Further gender-based research with attention paid to the diversity of immigrant populations may help health care providers identify children with unmet health care needs.

Ramraj, C., et al. (2015). "Intergenerational transmission of the healthy immigrant effect (HIE) through birth weight: A systematic review and meta-analysis." Soc Sci Med **146**: 29-40.

This review examines intergenerational differences in birth weight among children born to first-generation and second-generation immigrant mothers and the extent to which they vary by country of origin and receiving country. We searched MEDLINE, EMBASE, Web of Science, PubMed, and ProQuest from inception to October 2014 for articles that recorded the mean birth weight (in grams) or odds of low birth weight (LBW) of children born to immigrant mothers and one subsequent generation. Studies were analyzed descriptively and meta-analyzed using Review Manager 5.3 software. We identified 10 studies (8 retrospective cohort and 2 cross-sectional studies) including 158,843 first and second-generation immigrant women. The United States and the United Kingdom represented the receiving countries with the majority of immigrants originating from Mexico and South Asia. Six studies were meta-analyzed for mean birth weight and seven for low birth weight. Across all studies, there was found to be no statistically significant difference in mean birth weight between first and second-generation children. However, the odds of being LBW were 1.21 [95% CI, 1.15, 1.27] times greater among second-generation children. Second-generation children of Mexican descent in particular were at increased odds of LBW (OR = 1.47 [95% CI, 1.28, 1.69]). In the United States, second-generation children were at 34% higher odds of being LBW (OR = 1.34 [95% CI, 1.13, 1.58]) when compared to their first-generation counterparts. This effect was slightly smaller in the United Kingdom (OR = 1.18 [95% CI, 1.13, 1.23]). In conclusion, immigration to a new country may differentially influence low birth weight over generations, depending on the mother's nativity and the country she immigrates to.

Rodriguez-Sales, V., et al. (2014). "[Scoping review on cancer prevention in immigrants living in Spain]." Rev Esp Salud Publica **88**(6): 735-743.

BACKGROUND: Secondary prevention of breast cancer, cervix and colon is performed by screening. Spain in the last decade has presented a major wave of migration; it is known that immigrants have more inequalities in access to health services compared to the native population. The objective is to review the published studies and identify gaps in research on cancer prevention among immigrants living in Spain. METHODS: We have conducted a scoping review. The sources of information were the databases Medline (Pubmed) and MEDES - medicine in Spanish (1998-2012). We used three thematic filters: concerning to Cancer, immigration and geographic. Inclusion criteria were studies of cancer prevention and health of immigrants from Latin America, Africa, Asia and Eastern Europe and developed in Spain. We developed an ad hoc data collection protocol. RESULTS: We included five studies of 237 reviewed. The included studies are written in English and published in journals with

impact factor. Most studies have used country of origin as the immigration variable 80 % of the studies conducted cross-sectional surveys. Immigrant population had a lower participation of early detection of breast and cervical cancer. Women reported to be sex workers were more likely to be human papillomavirus positive for high risk types. CONCLUSION: There is little information on cancer prevention through screening programs in the immigrant population. It is important to evaluate and improve the screening circuits and registries to implement programs to better identify the most vulnerable population groups.

Ronda-Perez, E., et al. (2014). "[General characteristics of the original articles included in the scoping review on health and immigration in Spain]." Rev Esp Salud Publica **88**(6): 675-685.

BACKGROUND: The new socio-demographic reality that came about with the incorporation of the immigrant population in Spain requires an analysis of the needs and priorities generated by this situation in all areas, including research in health. The objective of this study is to determine the general characteristics of a group of articles included in a literature review on the subject, carried out within the framework of the CIBERSP Subprogram on Migration and Health. METHODS: Scoping Review of the literature published in the period 1998-2012. Articles in Spanish or English developed in Spain and that fulfil the definition of immigrant from the International Organization for Migration were selected. The literature search was performed in Medline and MEDES. The temporal distribution of the production and main characteristics of the articles are described trough absolute and relative frequencies. RESULTS: The initial search identified 2.625 articles (Medline 2434; 191 Medes-MEDicina) 311 were including finally. Most epidemiological studies are cross-sectional design with primary data. 69% compared with native population. The main theme has been associated with infectious diseases (n=217, 70%). The period of maximum production is between 2004 and 2011(n=256, 82%). The country of origin is the most common way of classifying immigrants (n=220, 71%). CONCLUSIONS: The epidemiology of infectious prevails as the main theme of the studies performed in Spain about the health of the immigrant population. Most of the studies include native population as a comparison group.

Rustage, K., Crawshaw, A., Majeed-Hajaj, S., et al. (2021). "Participatory approaches in the development of health interventions for migrants: a systematic review." BMJ Open **11**(10): e053678.

OBJECTIVE: Analysis of participatory approaches to developing health interventions for migrants and how approaches embody core participatory principles of inclusivity and democracy. DESIGN: A systematic review of original articles. Electronic searches within the databases MEDLINE, Embase, Global Health and PsychINFO (from inception-November 2020). ELIGIBILITY CRITERIA FOR STUDY SELECTION: Original peer-reviewed articles reporting research to develop and implement a health intervention for migrants, incorporating participatory approaches. We defined migrants as foreign-born individuals. Only articles reporting the full research cycle (inception, design, implementation, analysis, evaluation, dissemination) were included. DATA EXTRACTION: We extracted information related to who was involved in research (migrants or other non-academic stakeholders), the research stage at which they were involved (inception, design, implementation, analysis, evaluation, dissemination), the method of their involvement and how this aligned with the core principles of participatory research-categorising studies as exhibiting active or pseudo (including proxy and indirect) participation. RESULTS: 1793 publications were screened, of which 28 were included in our analysis. We found substantial variation in the application of participatory approaches in designing health interventions targeting migrants: across 168 individual research stages analysed across the 28 studies, we recorded 46 instances of active participation of migrants, 30 instances of proxy participation and 24 instances of indirect participation. All studies involved non-academic stakeholders in at least one stage of the research, only two studies exhibited evidence of active participation of migrants across all research stages. Evidence is limited due to the variability of terms and approaches used. CONCLUSIONS: Important shortfalls in the meaningful inclusion of migrants in developing health interventions exist, suggesting a more rigorous and standardised approach is warranted to better define and deliver participatory research and improve quality. REGISTRATION: This review followed Preferred Reporting Items for Systematic Review and Meta-Analysis guidelines and is registered on the Open Science Framework (osf.io/2bnz5).

Skovdal, M., Derluyn, I. et Pabbla, A. (2021). "Oral Health Status, Oral Health Behaviours and Oral Health Care Utilisation Among Migrants Residing in Europe: A Systematic Review." Int J Environ Res Public Health **23**(2): 373-388.

> As the reported data on oral health status among the migrants in Europe is fragmented, we systematically reviewed the published literature on the oral health status, behaviours and care utilisation among migrants residing in Europe. For this, we retrieved publications from PubMed and EMBASE, supplemented by manual citation screening and grey literature search on Google scholars. Two independent reviewers screened the studies, extracted data and critically appraised the publications. A total of 69 studies included showed higher dental caries among migrant children. But some studies on adolescents and adults reported similar or even better oral health among migrants compared to the host population, while other reported the opposite. Poor oral health behaviours were generally reported among the migrants and they frequently made use of emergency service utilisation compared to the host population. We shed light on the gaps in dental literature and make some recommendations for the future.

Sohail, Q. Z., et al. (2015). "The Risk of Ischemic Heart Disease and Stroke Among Immigrant Populations: A Systematic Review." Can J Cardiol **31**(9): 1160-1168.

> BACKGROUND: The increasing frequency of global migration to Canada and other high-income countries has highlighted the need for information on the risk of ischemic heart disease (IHD) and stroke among migrant populations. METHODS: Using the MEDLINE and EMBASE databases, we conducted an English-language literature review of articles published from 2000 to 2014 to study patterns in the incidence of IHD or stroke in migrant populations to high-income countries. Our search revealed 17 articles of interest. All studies stratified immigrants according to country or region of birth, except 2 from Canada and 1 from Denmark, in which all immigrant groups were analyzed together. RESULTS: The risk of IHD or stroke varied by country of origin, country of destination, and duration of residence. In our review we found that most migrant groups to Western Europe were at a similar or higher risk of IHD and stroke compared with the host population. Those at a higher risk included many Eastern European, Middle-Eastern, and South Asian immigrants. When duration of residence was considered, it appeared that in most migrants the risk of IHD worsened over time. In contrast, immigrants overall were at lower risk of myocardial infarction and stroke in Ontario compared with long-term residents of Canada. CONCLUSIONS: The risks of IHD and stroke vary widely in immigrant populations in Western Europe. Detailed studies of immigrants to Canada according to country of birth and duration of residence should be undertaken to guide future cardiovascular health promotion initiatives.

Suphanchaimat, R., et al. (2015). "Challenges in the provision of healthcare services for migrants: a systematic review through providers' lens." BMC Health Serv Res **15**(1): 390.

> BACKGROUND: In recent years, cross-border migration has gained significant attention in high-level policy dialogues in numerous countries. While there exists some literature describing the health status of migrants, and exploring migrants' perceptions of service utilisation in receiving countries, there is still little evidence that examines the issue of health services for migrants through the lens of providers. This study therefore aims to systematically review the latest literature, which investigated perceptions and attitudes of healthcare providers in managing care for migrants, as well as examining the challenges and barriers faced in their practices. METHODS: A systematic review was performed by gathering evidence from three main online databases: Medline, Embase and Scopus, plus a purposive search from the World Health Organization's website and grey literature sources. The articles, published in English since 2000, were reviewed according to the following topics: (1) how healthcare providers interacted with individual migrant patients, (2) how workplace factors shaped services for migrants, and (3) how the external environment, specifically laws and professional norms influenced their practices. Key message of the articles were analysed by thematic analysis. RESULTS: Thirty seven articles were recruited for the final review. Key findings of the selected articles were synthesised and presented in the data extraction form. Quality of retrieved articles varied substantially. Almost all the

selected articles had congruent findings regarding language andcultural challenges, and a lack of knowledge of a host country's health system amongst migrant patients. Most respondents expressed concerns over in-house constraints resulting from heavy workloads and the inadequacy of human resources. Professional norms strongly influenced the behaviours and attitudes of healthcare providers despite conflicting with laws that limited right to health services access for illegal migrants. DISCUSSION: The perceptions, attitudes and practices of practitioners in the provision of healthcare services for migrants were mainly influenced by: (1) diverse cultural beliefs and language differences, (2) limited institutional capacity, in terms of time and/or resource constraints, (3) the contradiction between professional ethics and laws that limited migrants' right to health care. Nevertheless, healthcare providers addressedsuch problems by partially ignoring the immigrants'precarious legal status, and using numerous tactics, including seeking help from civil society groups, to support their clinical practice. CONCLUSION: It was evident that healthcare providers faced several challenges in managing care for migrants, which included not only language and cultural barriers, but also resource constraints within their workplaces, and disharmony between the law and their professional norms. Further studies, which explore health care management for migrants in countries with different health insurance models, are recommended.

Woodward, A., et al. (2014). "Health and access to care for undocumented migrants living in the European Union: a scoping review." Health Policy Plan **29**(7): 818-830.

BACKGROUND: Literature on health and access to care of undocumented migrants in the European Union (EU) is limited and heterogeneous in focus and quality. Authors conducted a scoping review to identify the extent, nature and distribution of existing primary research (1990-2012), thus clarifying what is known, key gaps, and potential next steps. METHODS: Authors used Arksey and O'Malley's six-stage scoping framework, with Levac, Colquhoun and O'Brien's revisions, to review identified sources. Findings were summarized thematically: (i) physical, mental and social health issues, (ii) access and barriers to care, (iii) vulnerable groups and (iv) policy and rights. RESULTS: Fifty-four sources were included of 598 identified, with 93% (50/54) published during 2005-2012. EU member states from Eastern Europe were under-represented, particularly in single-country studies. Most study designs (52%) were qualitative. Sampling descriptions were generally poor, and sampling purposeful, with only four studies using any randomization. Demographic descriptions were far from uniform and only two studies focused on undocumented children and youth. Most (80%) included findings on health-care access, with obstacles reported at primary, secondary and tertiary levels. Major access barriers included fear, lack of awareness of rights, socioeconomics. Mental disorders appeared widespread, while obstetric needs and injuries were key reasons for seeking care. Pregnant women, children and detainees appeared most vulnerable. While EU policy supports health-care access for undocumented migrants, practices remain haphazard, with studies reporting differing interpretation and implementation of rights at regional, institutional and individual levels. CONCLUSIONS: This scoping review is an initial attempt to describe available primary evidence on health and access to care for undocumented migrants in the European Union. It underlines the need for more and better-quality research, increased co-operation between gatekeepers, providers, researchers and policy makers, and reduced ambiguities in health-care rights and obligations for undocumented migrants

ACCULTURATION, ASSIMILATION : UN FACTEUR IMPORTANT DANS L'AMELIORATION DE LA SANTE

Ahlmark, N., et al. (2015). "Survey nonresponse among ethnic minorities in a national health survey - a mixed-method study of participation, barriers, and potentials." Ethn Health **20**(6): 611-632.

OBJECTIVES: The participation rate in the Danish National Health Survey (DNHS) 2010 was significantly lower among ethnic minorities than ethnic Danes. The purpose was to characterize nonresponse among ethnic minorities in DNHS, analyze variations in item nonresponse, and investigate barriers and incentives to participation. DESIGN: This was a mixed-method study. Logistic regression was used to analyze nonresponse using data from DNHS (N = 177,639 and chi-square tests in item nonresponse analyses. We explored barriers and incentives regarding participation through focus groups and cognitive interviews. Informants included immigrants and their descendants of both sexes, with and

without higher education. RESULTS: The highest nonresponse rate was for non-Western descendants (80.0%) and immigrants 25 (72.3%) with basic education. Immigrants and descendants had higher odds ratios (OR = 3.07 and OR = 3.35, respectively) for nonresponse than ethnic Danes when adjusted for sex, age, marital status, and education. Non-Western immigrants had higher item nonresponse in several question categories. Barriers to non-participation related to the content, language, format, and layout of both the questionnaire and the cover letter. The sender and setting in which to receive the questionnaire also influenced answering incentives. We observed differences in barriers and incentives between immigrants and descendants. CONCLUSIONS: Nonresponse appears related to linguistic and/or educational limitations, to alienation generated by the questions' focus on disease and cultural assumptions, or mistrust regarding anonymity. Ethnic minorities seem particularly affected by such barriers. To increase survey participation, questions could be sensitized to reflect multicultural traditions, and the impact of sender and setting considered.

Allen, J. D., et al. (2014). "Pathways between acculturation and health behaviors among residents of low-income housing: the mediating role of social and contextual factors." Soc Sci Med **123**: 26-36.

Acculturation may influence health behaviors, yet mechanisms underlying its effect are not well understood. In this study, we describe relationships between acculturation and health behaviors among low-income housing residents, and examine whether these relationships are mediated by social and contextual factors. Residents of 20 low-income housing sites in the Boston metropolitan area completed surveys that assessed acculturative characteristics, social/contextual factors, and health behaviors. A composite acculturation scale was developed using latent class analysis, resulting in four distinct acculturative groups. Path analysis was used to examine interrelationships between acculturation, health behaviors, and social/contextual factors, specifically self-reported social ties, social support, stress, material hardship, and discrimination. Of the 828 respondents, 69% were born outside of the U.S. Less acculturated groups exhibited healthier dietary practices and were less likely to smoke than more acculturated groups. Acculturation had a direct effect on diet and smoking, but not physical activity. Acculturation also showed an indirect effect on diet through its relationship with material hardship. Our finding that material hardship mediated the relationship between acculturation and diet suggests the need to explicate the significant role of financial resources in interventions seeking to promote healthy diets among low-income immigrant groups. Future research should examine these social and contextual mediators using larger, population-based samples, preferably with longitudinal data.

Amer, M. M. et Hovey, J. D. (2007). "Socio-demographic differences in acculturation and mental health for a sample of 2nd generation/early immigrant Arab Americans." J Immigr Minor Health **9**(4): 335-347.

This study examined socio-demographic differences in acculturation patterns among early immigrant and second-generation Arab Americans, using data from 120 participants who completed a Web-based study. Although sex, age, education, and income did not significantly relate to the acculturation process, respondents who were female and those who were married reported greater Arab ethnic identity and religiosity. Striking differences were found based on religious affiliation. Christian patterns of acculturation and mental health were consistent with acculturation theory. For Muslims, however, integration was not associated with better mental health, and religiosity was predictive of better family functioning and less depression. The results of this study suggest unique acculturation patterns for Christian and Muslim subgroups that can better inform future research and mental health service.

Antecol, H. et Bedard, K. (2006). "Unhealthy assimilation: why do immigrants converge to American health status levels?" Demography **43**(2): 337-360.

It is well documented that immigrants are in better health upon arrival in the United States than their American counterparts but that this health advantage erodes over time. We study the potential determinants of this "healthy immigrant effect, " with a particular focus on the tendency of immigrants to converge to unhealthy American BMI levels. Using data from the National Health Interview Survey, we find that average female and male immigrants enter the United States with BMIs that are approximately two and five percentage points lower than native-born women and men,

respectively. Consistent with the declining health status of immigrants the longer they remain in the United States, we also find that female immigrants almost completely converge to American BMIs within 10 years of arrival, and men close a third of the gap within 15 years.

Antman, F. M., Duncan, B. et Trejo, S. J. (2020). Ethnic Attrition, Assimilation, and the Measured Health Outcomes of Mexican Americans. NBER Working Paper Series ; 26742. Cambridge NBER**:** 40 , tabl., fig., annexes.
https://www.nber.org/papers/w26742

The literature on immigrant assimilation and intergenerational progress has sometimes reached surprising conclusions, such as the puzzle of immigrant advantage which finds that Hispanic immigrants sometimes have better health than U.S.-born Hispanics. While numerous studies have attempted to explain these patterns, almost all studies rely on subjective measures of ethnic self-identification to identify immigrants' descendants. This can lead to bias due to "ethnic attrition," which occurs whenever a U.S.-born descendant of a Hispanic immigrant fails to self-identify as Hispanic. In this paper, we exploit information on parents' and grandparents' place of birth to show that Mexican ethnic attrition, operating through intermarriage, is sizable and selective on health, making subsequent generations of Mexican immigrants appear less healthy than they actually are. Consequently, conventional estimates of health disparities between Mexican Americans and non-Hispanic whites as well as those between Mexican Americans and recent Mexican immigrants have been significantly overstated.

Avila, R. M. et Bramlett, M. D. (2013). "Language and immigrant status effects on disparities in Hispanic children's health status and access to health care." Matern Child Health J **17**(3): 415-423.

The objective of this study is to estimate Hispanic/non-Hispanic (nH)-white health disparities and assess the extent to which disparities can be explained by immigrant status and household primary language. The 2007 National Survey of Children's Health was funded by the Maternal and Child Health Bureau, and conducted by Centers for Disease Control and Prevention's National Center for Health Statistics as a module of the State and Local Area Integrated Telephone Survey. We calculated disparities for various health indicators between Hispanic and nH-white children, and used logistic regression to adjust them for socio-economic and demographic characteristics, primary language spoken in the household, and the child's immigrant status. Controlling for language and immigrant status greatly reduces health disparities, although it does not completely eliminate all disparities showing poorer outcomes for Hispanic children. English-speaking and nonimmigrant Hispanic children are more similar to nH-white children than are Hispanic children in non-English speaking households or immigrant children. Hispanic/nH-white health disparities among children are largely driven by that portion of the Hispanic population that is either newly-arrived to this country or does not speak primarily English in the household.

Becerra, D., et al. (2015). "Linguistic acculturation and perceptions of quality, access, and discrimination in health care among latinos in the United States." Soc Work Health Care **54**(2): 134-157.

This study examined the relationship between acculturation and Latinos' perceptions of health care treatment quality, discrimination, and access to health information. The results of this study indicated that participants who had lower levels of acculturation perceived: 1) greater discrimination in health care treatment; 2) a lower quality of health care treatment; 3) less confidence filling out health related forms; and 4) greater challenges understanding written information about their medical conditions. Participants who identified as immigrants also perceived that their poor quality of medical care was due to their inability to pay and to their race/ethnicity.

Bleakley, H. et Chin, A. (2008). "What Holds Back the Second Generation? The Intergenerational Transmission of Language Human Capital Among Immigrants." J Hum Resour **43**(2): 267-298.

In 2000 Census microdata, various outcomes of second-generation immigrants are related to their parents' age at arrival to the United States, and in particular whether that age fell within the "critical period" of language acquisition. We interpret this as an effect of the parent's English-language skills

and construct an instrumental variable for parental English proficiency. Estimates of the effect of parent's English-speaking proficiency using two-stage least squares yield significant, positive results for children's English-speaking proficiency and preschool attendance, and significant, negative results for dropping out of high school and being below age-appropriate grade. (JEL J13, J24, J62).

Bos, V., et al. (2007). "Duration of residence was not consistently related to immigrant mortality." J Clin Epidemiol **60**(6): 585-592.

OBJECTIVE: This paper aimed to examine immigrant mortality according to duration of residence in the Netherlands and to compare duration-specific mortality levels to levels of mortality in the native Dutch population. STUDY DESIGN AND SETTING: For the years 1995-2000, we linked the national cause of death register, that contains information on deaths of legal residents, to the municipal population register, that contains information on all legal residents. We studied mortality in relation to period of immigration by means of directly standardized mortality rates and Poisson regression. RESULTS: All cause mortality was not related to year of immigration among Turkish and Moroccan men and women, and among Surinamese women. Among Surinamese men and among Antilleans/Aruban men and women, mortality was higher in more recent immigrants. Part of their excess mortality was due to their relatively low socioeconomic status. For most specific causes of death, no consistent relation with duration of residence was observed. CONCLUSION: A consistent relation between duration of residence and immigrant mortality was only observed in some immigrant groups. The results suggest that the healthy migrant effect or adaptation of health-related behaviors were no predominant determinants of immigrant mortality in the Netherlands.

Carballo, M., et al. (1996). "Women and migration: a public health issue." World Health Stat Q **49**(2): 158-164.

The need to migrate is usually a function of the complex interaction of economic, social, familial and political factors. Among the most important, however, are the denial of access to education, employment, goods and services and the lack of respect for basic human rights. Because in many societies women are marginalized from these rights, migration to more economically and educationally open societies can often help improve their personal situation and their professional opportunities. On the other hand, because the status of women is usually linked to their role and status within the family and is defined in relationship to their male partners, migration can place women in situations where they experience stress and anxiety due to the loss of their traditional social entourage and environment. Their social integration in new settings may be equally limited by their initial lack of education and occupational experience. The higher vulnerability of women to sexual abuse and violence also places them at risk of STDs, including HIV, and a range of post-traumatic stress disorders associated with sexual violence. Their reproductive health needs often go unnoticed and unprotected even in well organized refugee and migrant situations, and the insensitivity of health staff to the needs of women is often more pronounced in refugee and migrant contexts than it is in general. Health monitoring of women in all migration-related situations has to be given greater priority. Similarly, much more attention at a health policy level is called for if the rights of women refugees and migrants are to be protected, and their contribution to health and social development is to be acknowledged and promoted.

Castro, F. G., et al. (2010). "Issues and challenges in the design of culturally adapted evidence-based interventions." Annu Rev Clin Psychol **6**: 213-239.

This article examines issues and challenges in the design of cultural adaptations that are developed from an original evidence-based intervention (EBI). Recently emerging multistep frameworks or stage models are examined, as these can systematically guide the development of culturally adapted EBIs. Critical issues are also presented regarding whether and how such adaptations may be conducted, and empirical evidence is presented regarding the effectiveness of such cultural adaptations. Recent evidence suggests that these cultural adaptations are effective when applied with certain subcultural groups, although they are less effective when applied with other subcultural groups. Generally, current evidence regarding the effectiveness of cultural adaptations is promising but mixed. Further research is needed to obtain more definitive conclusions regarding the efficacy and effectiveness of culturally adapted EBIs. Directions for

future research and recommendations are presented to guide the development of a new generation of culturally adapted EBIs.

Clarke, A. I. et Isphording, I. E. (2017). "Language Barriers and Immigrant Health." Health Economics **26**(6): 765-778.
http://ejournals.ebsco.com/direct.asp?ArticleID=438E9F3238734022EA6E

We study the impact of language deficiency on the health status of childhood migrants to Australia. Our identification strategy relies on a quasi-experiment comparing immigrants arriving at different ages and from different linguistic origins. In the presence of considerable non-classical measurement error in self-reported language proficiency, our results provide lower and upper bounds for a strong negative effect of English deficiency on health of between one half and a full standard deviation in the health score. Copyright © 2016 John Wiley & Sons, Ltd.

Costa-Font, J. et Sato, K. (2016). Cultural Persistence of Health Capital: Evidence from European Migrants. Cesinfo Working Paper; 5964. Munich Center for Economic Studies**:** 25 , tabl.+annexes.
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2814466

Culture is an under-studied determinant of health production and seldom measured. This paper empirically examines the persistence and association of health capital assessments of first and second-generation migrants with that of their ancestral countries. We draw on European data from 30 countries, including over 90 countries of birth and control for timing of migration, selective migration and other controls including citizenship and cultural proxies. Our results show robust evidence of cultural persistence of health assessments. Culture persists, rather than fades, and further, appears to strengthen over generations. We estimate a one standard deviation increase in ancestral health assessment increases first generation migrant's health assessments by an average of 16%, and that of second generation migrants between 11% and 25%. Estimates are heterogeneous by gender (larger for males) and lineage (larger for paternal lineage).

Creighton, M. J., Goldman, N., Pebley, A. R., et al. (2012). "Durational and generational differences in Mexican immigrant obesity: is acculturation the explanation?" Soc Sci Med **75**(2): 300-310.
https://www.ncbi.nlm.nih.gov/pubmed/22575698

Using the Los Angeles Family and Neighborhood Survey (L.A.FANS-2; n = 1610), we explore the link between Mexican immigrant acculturation, diet, exercise and obesity. We distinguish Mexican immigrants and 2nd generation Mexicans from 3rd+ generation whites, blacks and Mexicans. First, we examine variation in social and linguistic measures by race/ethnicity, duration of residence and immigrant generation. Second, we consider the association between acculturation, diet and exercise. Third, we evaluate the degree to which acculturation, diet, exercise, and socioeconomic status explain the association between race/ethnicity, immigrant exposure to the US (duration since immigration/generation), and adult obesity. Among immigrants, we find a clear relationship between acculturation measures, exposure to the US, and obesity-related behaviors (diet and exercise). However, the acculturation measures do not clearly account for the link between adult obesity, immigrant duration and generation, and race/ethnicity

Cristancho, S., et al. (2014). "Health information preferences among Hispanic/Latino immigrants in the U.S. rural Midwest." Glob Health Promot **21**(1): 40-49.

We investigated whether length of residence and other socio-demographic factors affect how rural Hispanic/Latino immigrants in the U.S. prefer to receive general health information. As part of a federally-funded participatory research project, we surveyed 894 adult Hispanics who were recruited through schools, community-based organizations (CBO) and faith-based organizations (FBO) in six rural communities of Illinois. Data suggest that workshops in Spanish at community settings are the most preferred health information strategy and home visits the least. Preference for these two strategies decreased significantly in the second generation, while preference for mailed printed materials increased. We further explored the role of length of residence in the U.S. on 'in-person' and 'impersonal' health information preferences controlling for other relevant socio-demographic factors

finding that first generation and less educated Hispanic immigrants' prefer 'in-person' strategies. These findings suggest that rural health organizations and practitioners should implement not only culturally-appropriate but also acculturation-sensitive approaches to address Hispanic/Latino immigrants' specific health information needs.

de Figueiredo, J. M. (2014). "Explaining the 'immigration advantage' and the 'biculturalism paradox': an application of the theory of demoralization." Int J Soc Psychiatry **60**(2): 175-177.

BACKGROUND: Recent immigrants have better mental health than the natives ('immigration advantage'). Biculturals have better mental health than the monoculturals ('biculturalism paradox'). MATERIAL: Mexican immigrants have lower rates of psychopathology than the U.S. population. This is less true for Cubans and not true for Puerto Ricans. The 'advantage' also occurs in other groups. Biculturals have better mental health and endorse both cultures. DISCUSSION: The theory of demoralization predicts that borrowing values from both cultures and applying them judiciously are more conducive to mental health than indiscriminately subscribing to either culture. CONCLUSION: The findings are consistent with the theory of demoralization.

Falla, A. M., et al. (2017). "Language support for linguistic minority chronic hepatitis B/C patients: an exploratory study of availability and clinicians' perceptions of language barriers in six European countries." BMC Health Serv Res **17**(1): 150.

BACKGROUND: Language support for linguistic minorities can improve patient safety, clinical outcomes and the quality of health care. Most chronic hepatitis B/C infections in Europe are detected among people born in endemic countries mostly in Africa, Asia and Central/Eastern Europe, groups that may experience language barriers when accessing health care services in their host countries. We investigated availability of interpreters and translated materials for linguistic minority hepatitis B/C patients. We also investigated clinicians' agreement that language barriers are explanations of three scenarios: the low screening uptake of hepatitis B/C screening, the lack of screening in primary care, and why cases do not reach specialist care. METHODS: An online survey was developed, translated and sent to experts in five health care services involved in screening or treating viral hepatitis in six European countries: Germany, Hungary, Italy, the Netherlands, Spain and the United Kingdom (UK). The five areas of health care were: general practice/family medicine, antenatal care, health care for asylum seekers, sexual health and specialist secondary care. We measured availability using a three-point ordinal scale ('very common', 'variable or not routine' and 'rarely or never'). We measured agreement using a five-point Likert scale. RESULTS: We received 238 responses (23% response rate, N = 1026) from representatives in each health care field in each country. Interpreters are common in the UK, the Netherlands and Spain but variable or rare in Germany, Hungary and Italy. Translated materials are rarely/never available in Hungary, Italy and Spain but commonly or variably available in the Netherlands, Germany and the UK. Differing levels of agreement that language barriers explain the three scenarios are seen across the countries. Professionals in countries with most infrequent availability (Hungary and Italy) disagree strongest that language barriers are explanations. CONCLUSIONS: Our findings show pronounced differences between countries in availability of interpreters, differences that mirror socio-cultural value systems of 'difference-sensitive' and 'difference-blindness'. Improved language support is needed given the complex natural history of hepatitis B/C, the recognised barriers to screening and care, and the large undiagnosed burden among (potentially) linguistic minority migrant groups.

Fassaert, T., et al. (2009). "Acculturation and use of health care services by Turkish and Moroccan migrants: a cross-sectional population-based study." BMC Public Health **9**: 332.

BACKGROUND: There is insufficient empirical evidence which shows if and how there is an interrelation between acculturation and health care utilisation. The present study seeks to establish this evidence within first generation Turkish and Moroccan migrants, two of the largest migrant groups in present-day Western Europe. METHODS: Data were derived from the Amsterdam Health Monitor 2004, and were complete for 358 Turkish and 288 Moroccan foreign-born migrants. Use of health services (general practitioner, outpatient specialist and health care for mental health problems) was measured by means of self-report. Acculturation was measured by a structured questionnaire grading (i) ethnic self-identification, (ii) social interaction with ethnic Dutch, (iii) communication in

Dutch within one's private social network, (iv) emancipation, and (v) cultural orientation towards the public domain. RESULTS: Acculturation was hardly associated with the use of general practitioner care. However, in case of higher adaptation to the host culture there was less uptake of outpatient specialist care among Turkish respondents (odds ratio [OR] = 0.90, 95% confidence interval [CI] = 0.82-0.99) and Moroccan male respondents (OR = 0.81, 95% CI = 0.71-0.93). Conversely, there was a higher uptake of mental health care among Turkish men (OR = 0.81, 95% CI = 0.71-0.93) and women (OR = 0.81, 95% CI = 0.71-0.93). Uptake of mental health care among Moroccan respondents again appeared lower (OR = 0.74, 95% CI = 0.55-0.99). Language ability appeared to play a central role in the uptake of health care. CONCLUSION: Some results were in accordance with the popular view that an increased participation in the host society is concomitant to an increased use of health services. However, there was heterogeneity across ethnic and gender groups, and across the domains of acculturation. Language ability appeared to play a central role. Further research needs to explore this heterogeneity into more detail. Also, other cultural and/or contextual aspects that influence the use of health services require further identification.

Ferruccio, P. é. et Ponzo, I. é. (2016). Inter-group Relations and Migrant Integration in European Cities, sl : Springer Open
http://link.springer.com/book/10.1007/978-3-319-23096-2

This book presents a comparative analysis of intergroup relations and migrant integration at the neighbourhood level in Europe. Featuring a unique collection of portraits of urban relations between the majority population and immigrant minorities, it examines how relations are structured and evolve in different and increasingly diverse local societies. Inside, readers will find a coordinated set of ethnographic studies conducted in eleven neighbourhoods of five European cities: London, Barcelona, Budapest, Nuremberg, and Turin. The wide-ranging coverage encompasses post-industrial districts struggling to counter decline, vibrant super-diverse areas, and everything in between. Featuring highly contextualised, cross-disciplinary explorations presented within a solid comparative framework, this book considers such questions as: Why does the native-immigrant split become a tense boundary in some neighbourhoods of some European cities but not in others? To what extent are ethnically framed conflicts driven by site-specific factors or instead by broader, exogenous ones? How much does the structure of urban spaces count in fuelling inter-ethnic tensions and what can local policy communities do to prevent this? The answers it provides are based on a multi-layer approach which combines in-depth analysis of intergroup relations with a strong attention towards everyday categorization processes, media representations, and narratives on which local policies are based. Even though the relations between the majority and migrant minorities are a central topic, the volume also offers readers a broader perspective of social and urban transformation in contemporary urban settings. It provides insightful research on migration and urban studies as well as social dynamics that scholars and students around the world will find relevant. In addition, policy makers will find evidence-based and practically relevant lessons for the governance of increasingly diverse and mobile societies (résumé de l'éditeur).

Fisher, T. L., et al. (2007). "Cultural leverage: interventions using culture to narrow racial disparities in health care." Med Care Res Rev **64**(5 Suppl): 243s-282s.

The authors reviewed interventions using cultural leverage to narrow racial disparities in health care. Thirty-eight interventions of three types were identified: interventions that modified the health behaviors of individual patients of color, that increased the access of communities of color to the existing health care system, and that modified the health care system to better serve patients of color and their communities. Individual-level interventions typically tapped community members' expertise to shape programs. Access interventions largely involved screening programs, incorporating patient navigators and lay educators. Health care interventions focused on the roles of nurses, counselors, and community health workers to deliver culturally tailored health information. These interventions increased patients' knowledge for self-care, decreased barriers to access, and improved providers' cultural competence. The delivery of processes of care or intermediate health outcomes was significantly improved in 23 interventions. Interventions using cultural leverage show tremendous promise in reducing health disparities, but more research is needed to understand their health effects in combination with other interventions.

Friedberg, R. M. (2000). "You Can't Take It with You? Immigrant Assimilation and the Portability of Human Capital." Journal of Labor Economics **18**(2): 221-251.

Gao, X. L. et McGrath, C. (2011). "A review on the oral health impacts of acculturation." J Immigr Minor Health **13**(2): 202-213.

The impact of acculturation on systemic health has been extensively investigated and is regarded as an important explanatory factor for health disparity. However, information is limited and fragmented on the oral health implications of acculturation. This study aimed to review the current evidence on the oral health impact of acculturation. Papers were retrieved from five electronic databases. Twenty-seven studies were included in this review. Their scientific quality was rated and key findings were summarized. Seventeen studies investigated the impacts of acculturation on the utilization of dental services; among them, 16 reported positive associations between at least one acculturation indicator and use of dental services. All 15 studies relating acculturation to oral diseases (dental caries and periodontal disease) suggested better oral health among acculturated individuals. Evidence is lacking to support that better oral health of acculturated immigrants is attributable to their improved dental attendance. Further researches involving other oral health behaviors and diseases and incorporating refined acculturation scales are needed. Prospective studies will facilitate the understanding on the trajectory of immigrants' oral health along the acculturation continuum.

Giannoni, M., et al. (2016). "Migrant integration policies and health inequalities in Europe." BMC Public Health **16**(1): 1-14.
http://dx.doi.org/10.1186/s12889-016-3095-9

Research on socio-economic determinants of migrant health inequalities has produced a large body of evidence. There is lack of evidence on the influence of structural factors on lives of fragile groups, frequently exposed to health inequalities. The role of poor socio-economic status and country level structural factors, such as migrant integration policies, in explaining migrant health inequalities is unclear. The objective of this paper is to examine the role of migrant socio-economic status and the impact of migrant integration policies on health inequalities during the recent economic crisis in Europe.

Gonzalez-Rabago, Y., et al. (2014). "[Participation and representation of the immigrant population in the Spanish National Health Survey 2011-2012]." Gac Sanit **28**(4): 281-286.

OBJECTIVE: Population health surveys have been the main data source for analysis of immigrants' health status in Spain. The aim of this study was to analyze the representation of this population in the Spanish National Health Survey (SNHS) 2011-2012. METHODS: We analyzed methodological publications and data from the SNHS 2011-2012 and the population registry. Differences in the participation rate between the national and foreign populations and the causes for these differences were analyzed, as well as the representation of 11 countries of birth in the survey with respect to the general population, with and without weighting. RESULTS: Households with any foreign person had a lower participation rate, either due to a higher error in the sampling frame or to a higher non-response rate. In each country of birth, the sample was smaller than would be expected according to the population registry, especially among the Chinese population. When we applied the sample weights to the 11 countries of birth, the estimated population volume was closer to the estimated volume of the population registry for all the countries considered, although globally both the underrepresentation and the intranational bias remained. CONCLUSIONS: The lower participation of the immigrant population and differences in participation depending on the country of origin suggest the existence of a potential bias in the SNHS, which should be taken into account in studies analyzing the health of this population. The lower participation rate should be studied in greater depth in order to take appropriate measures to increase the representativeness of health surveys.

Goodall, K. T., et al. (2014). "Improving access to health information for older migrants by using grounded theory and social network analysis to understand their information behaviour and digital technology use." Eur J Cancer Care (Engl) **23**(6): 728-738.

Migrant well-being can be strongly influenced by the migration experience and subsequent degree of mainstream language acquisition. There is little research on how older Culturally And Linguistically Diverse (CALD) migrants who have 'aged in place' find health information, and the role which digital technology plays in this. Although the research for this paper was not focused on cancer, we draw out implications for providing cancer-related information to this group. We interviewed 54 participants (14 men and 40 women) aged 63-94 years, who were born in Italy or Greece, and who migrated to Australia mostly as young adults after World War II. Constructivist grounded theory and social network analysis were used for data analysis. Participants identified doctors, adult children, local television, spouse, local newspaper and radio as the most important information sources. They did not generally use computers, the Internet or mobile phones to access information. Literacy in their birth language, and the degree of proficiency in understanding and using English, influenced the range of information sources accessed and the means used. The ways in which older CALD migrants seek and access information has important implications for how professionals and policymakers deliver relevant information to them about cancer prevention, screening, support and treatment, particularly as information and resources are moved online as part of e-health.

Haderxhanaj, L. T., et al. (2014). "Acculturation, sexual behaviors, and health care access among Hispanic and non-Hispanic white adolescents and young adults in the United States, 2006-2010." J Adolesc Health **55**(5): 716-719.

PURPOSE: To examine national estimates of sexual behaviors and health care access by acculturation among adolescents. METHODS: Using the 2006-2010 National Survey of Family Growth, four acculturation groups of Hispanic and non-Hispanic whites aged 15-24 years were analyzed by sexual behaviors and health care access. RESULTS: In analyses adjusted for demographics, English-speaking immigrants, Hispanic natives, and non-Hispanic white youth were less likely to have a partner age difference of >/=6 years (adjusted odds ratio [AOR], .28; 95% confidence interval [CI], .13-.60; AOR, .13; 95% CI, .07-.26; AOR, .16; 95% CI, .08-.32, respectively) and more likely to use a condom at the first vaginal sex (AOR, 1.99; 95% CI, 1.10-3.61; AOR, 2.10; 95% CI, 1.33-3.31; AOR, 2.39; 95% CI, 1.53-3.74, respectively) than Spanish-speaking immigrants. Non-Hispanic white youth and Hispanic natives were more likely to have a regular place for medical care (AOR, 2.07; 95% CI, 1.36-3.16; AOR, 3.66; 95% CI, 2.36-5.68, respectively) and a chlamydia test in the past 12 months (AOR, 3.62; 95% CI, 1.52-8.60; AOR, 2.94; 95% CI, 1.32-6.54) than Spanish-speaking immigrants. CONCLUSIONS: Interventions to reduce risk and increase health care access are needed for immigrant Hispanic youth, particularly Spanish-speaking immigrants.

Hakonsen, H., et al. (2014). "Cultural barriers encountered by Norwegian community pharmacists in providing service to non-Western immigrant patients." Int J Clin Pharm **36**(6): 1144-1151.

BACKGROUND: Western societies' need for knowledge about how to meet the challenges in health care following increased immigration has emerged as studies have showed that non-Western immigrants tend to experience more obstacles to drug use and poorer communication with health professionals. OBJECTIVES: To identify the cultural barriers encountered by Norwegian community pharmacists in providing service to non-Western immigrant patients and to outline how they are being addressed. SETTING: Community pharmacies in Oslo, Norway. METHODS: A qualitative study consisting of four focus groups was conducted. In total 19 ethnic Norwegian pharmacists (17 female and 2 male; mean age: 40.6 years) participated. They were recruited from 13 pharmacies situated in areas of Oslo densely populated by non-Western immigrants. The audio-records of the focus group discussions were transcribed verbatim. A thematic content analysis was conducted. Main outcome measure Cultural barriers identified by Norwegian community pharmacists in the encounter with non-Western immigrants. RESULTS: All the pharmacists were in contact with non-Western immigrant patients on a daily basis. They said that they found it challenging to provide adequate service to these patients, and that the presence of language as well as other cultural barriers not only affected what the patients got out of the available information, but also to a great extent what kind of and how much information was provided. Although the pharmacists felt that immigrant patients were in great need of drug counselling, there were large disparities in how much effort was exerted in order to provide this service. They were all uncomfortable with situations where family or friends acted as interpreters, especially children. Otherwise, cultural barriers were related to differences in body language and clothing which they thought distracted the communication. All the

pharmacists stated that they had patients asking about the content of pork gelatin in medicines, but few said that they habitually notified the patients of this unless they were asked directly. Ramadan fasting was not identified as a subject during drug counselling. CONCLUSION: This focus group study shows that language and other cultural barriers, including differences in body language, non-Western gender roles, and all-covering garments, are of great concern for ethnic Norwegian community pharmacists in the encounter with non-Western immigrant patients. Although the pharmacists recognise their role as drug information providers for immigrant patients, large disparities were detected with respect to kind of and amount of information provided to these patients.

Hunt, L. M., et al. (2004). "Should "acculturation" be a variable in health research? A critical review of research on US Hispanics." Soc Sci Med **59**(5): 973-986.

Acculturation has become a popular variable in research on health disparities among certain ethnic minorities, in the absence of serious reflection about its central concepts and assumptions. Key constructs such as what constitutes a culture, which traits pertain to the ethnic versus "mainstream" culture, and what cultural adaptation entails have not been carefully defined. Using examples from a systematic review of recent articles, this paper critically reviews the development and application of the concept of acculturation in US health research on Hispanics. Multiple misconceptions and errors in the central assumptions underlying the concept of acculturation are examined, and it is concluded that acculturation as a variable in health research may be based more on ethnic stereotyping than on objective representations of cultural difference.

Ho, G. W. (2014). "Acculturation and its implications on parenting for Chinese immigrants: a systematic review." J Transcult Nurs **25**(2): 145-158.

PURPOSE: To systematically review and synthesize existing findings on acculturation and its implications on parenting for Chinese immigrants. METHOD: Three electronic databases were searched for original research articles that examined acculturation and its influence on parenting in Chinese immigrants. RESULTS: Twenty-two studies were included. Findings suggest that acculturation influences parenting beliefs, attitudes, and practices, as well as parent-child relationships among Chinese immigrants. Acculturation discrepancies between parents and children are associated with negative child outcomes. DISCUSSION AND CONCLUSIONS: Further research is needed to better understand the relationships among acculturation and parenting perceptions, parent-child relationships, and parent-child acculturation discrepancies and associated child outcomes. In particular, longitudinal studies with larger samples and multiple methods are needed to suggest causal inferences and validate these relationships. IMPLICATIONS FOR PRACTICE: Nurses are at the unique junction to identify these problems through interacting with individuals and families at the clinical and mental/community health levels.

Horn, A., et al. (2015). "[Strengthening health literacy of people with migration background: results of a qualitative evaluation]." Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz **58**(6): 577-583.

The concept of "health literacy", which has gained attention in English-speaking countries during the last decade, is becoming increasingly popular in Germany. While studies on an international level indicate that people with migration background are often limited in their health literacy, there is a lack of empirical data on that topic in Germany. However, it is well known that they are exposed to health-related risks and problems comparatively often whereas they use health care services less frequently. This article focuses on the native speaking counseling services of the Independent Patient Counseling Germany (UPD gGmbH) as an example of good practice and introduces the results of the evaluation of this counseling service. Qualitative interviews were conducted with UPD-consultants as well as with users of the services. It became apparent that Turkish and Russian-speaking immigrants often have limited health-related literacy. Therefore, support and counseling services should focus not only on issues concerning language and cultural aspects. Furthermore, strategies strengthening the health literacy of persons with migration background are required. Therefore, instruments and strategies will be developed in cooperation with the UPD which aim to improve such skills of the UPD-consultants.

Kim, J., et al. (2014). "The Exploration of Acculturation and Health Among Immigrants From Non-Eastern Cultures." Qual Health Res **24**(8): 1138-1149.

> Literature on acculturation has been mainly focused on how acculturation influences the perception of health and well-being among immigrants from non-Western cultures. Conversely, we sought to explore immigration experiences associated with health and well-being among immigrants from non-Eastern cultures during their acculturation process. With a sample of 9 participants, we identified two major themes as outcomes of acculturation: psychological well-being and social benefits. We found that during acculturation, Western immigrants improved their sense of happiness, experienced reduced stress, and discovered meaning through activities, and that overall, acculturation facilitated personal growth. In addition, they developed a sense of cross-group friendships with Korean people and facilitated group cohesion within their own ethnic group. Further implications and future research avenues are discussed.

Iversen, T., Ma, C. T. et Meyer, H. E. (2013). "Immigrants' acculturation and changes in Body Mass Index." Econ Hum Biol **11**(1): 1-7.
https://www.ncbi.nlm.nih.gov/pubmed/22425439

> We study Body Mass Index (BMI) changes among immigrants from Iran, Pakistan, Sri Lanka, Turkey, and Vietnam relative to native Norwegians in Oslo. We assess the effect of acculturation on BMI changes. We hypothesize that acculturation reduces the gap of BMIs between natives and immigrants. Acculturation is measured by immigrants' language skills. Our data come from two surveys in Oslo 2000-2002. Weights and heights were measured at the surveys; participants were asked to recall weights when they were 25 years old. Norwegian language skills and socio-economic data were collected. Our findings support our hypothesis. Acculturation, as measured by proficiency in the Norwegian language, has the predicted effects on BMI changes. We do not find any effect of immigrants' time of residency on BMI changes.

Lara, M., et al. (2005). "Acculturation and Latino health in the United States: a review of the literature and its sociopolitical context." Annu Rev Public Health **26**: 367-397.

> This chapter provides an overview of the concept of acculturation and reviews existing evidence about the possible relationships between acculturation and selected health and behavioral outcomes among Latinos. The effect of acculturation on Latino health is complex and not well understood. In certain areas-substance abuse, dietary practices, and birth outcomes-there is evidence that acculturation has a negative effect and that it is associated with worse health outcomes, behaviors, or perceptions. In others-health care use and self-perceptions of health-the effect is mostly in the positive direction. Although the literature, to date, on acculturation lacks some breadth and methodological rigor, the public health significance of findings in areas in which there is enough evidence justifies public health action. We conclude with a set of general recommendations in two areas-public health practice and research-targeted to public health personnel in academia, community-based settings, and government agencies.

Lee, S., et al. (2013). "A cluster analytic examination of acculturation and health status among Asian Americans in the Washington DC metropolitan area, United States." Soc Sci Med **96**: 17-23.

> Previous studies reported mixed findings on the relationship between acculturation and health status among Asian Americans due to different types of acculturation measures used or different Asian subgroups involved in various studies. We aim to fill the gap by applying multiple measures of acculturation in a diverse sample of Asian subgroups. A cross sectional study was conducted among Chinese, Korean and Vietnamese Americans in Washington D.C. Metropolitan Area to examine the association between health status and acculturation using multiple measures including the Suinn-Lew Asian Self-Identity Acculturation (SL-ASIA) scale, clusters based on responses to SL-ASIA, language preference, length of stay, age at arrival in the United Sates and self-identity. Three clusters (Asian (31%); Bicultural (47%); and American (22%)) were created by using a two-step hierarchical method and Bayesian Information Criterion values. Across all the measures, more acculturated individuals

were significantly more likely to report good health than those who were less acculturated after adjusting for covariates. Specifically, those in the American cluster were 3.8 times (95% Confidence Interval (CI): 2.2, 6.6) more likely and those in the Bicultural cluster were 1.7 times more likely (95% CI: 1.1, 2.4) to report good health as compared to those in the Asian cluster. When the conventional standardized SL-ASIA summary score (range:-1.4 to 1.4) was used, a one point increase was associated with 2.2 times greater odds of reporting good health (95% CI: 1.5, 3.2). However, the interpretation may be challenging due to uncertainty surrounding the meaning of a one point increase in SL-ASIA summary score. Among all the measures used, acculturation clusters better approximated the acculturation process and provided us with a more accurate test of the association in the population. Variables included in this measure were more relevant for our study sample and may have worked together to capture the multifaceted acculturation process

Leung, A. Y., et al. (2014). "Health literacy issues in the care of Chinese American immigrants with diabetes: a qualitative study." BMJ Open **4**(11): e005294.

OBJECTIVES: To investigate why first-generation Chinese immigrants with diabetes have difficulty obtaining, processing and understanding diabetes related information despite the existence of translated materials and translators. DESIGN: This qualitative study employed purposive sampling. Six focus groups and two individual interviews were conducted. Each group discussion lasted approximately 90 min and was guided by semistructured and open-ended questions. SETTING: Data were collected in two community health centres and one elderly retirement village in Los Angeles, California. PARTICIPANTS: 29 Chinese immigrants aged >/=45 years and diagnosed with type 2 diabetes for at least 1 year. RESULTS: Eight key themes were found to potentially affect Chinese immigrants' capacity to obtain, communicate, process and understand diabetes related health information and consequently alter their decision making in self-care. Among the themes, three major categories emerged: cultural factors, structural barriers, and personal barriers. CONCLUSIONS: Findings highlight the importance of cultural sensitivity when working with first-generation Chinese immigrants with diabetes. Implications for health professionals, local community centres and other potential service providers are discussed.

Leung, L. A. (2014). "Healthy and unhealthy assimilation: country of origin and smoking behavior among immigrants." Health Econ **23**(12): 1411-1429.

Smoking rates in the country of origin were used to empirically examine whether immigrants converge toward natives' level of smoking prevalence with assimilation. Results show that assimilation is associated with a lower likelihood of ever quitting smoking for immigrants from countries with lower smoking rates relative to the USA and a higher likelihood for immigrants from countries with higher smoking rates, but for current or ever smoking, the estimated effects of assimilation are statistically insignificant. Although these findings demonstrate that health assimilation depends on the country of origin, the extent to which this pattern of assimilation is due to peer influence, differences in responsiveness to anti-smoking interventions such as taxes or smoke-free air restrictions, and/or other factors remains unclear because of the limitations of this study.

Lionis, C., et al. (2016). "Engaging migrants and other stakeholders to improve communication in cross-cultural consultation in primary care: a theoretically informed participatory study." BMJ Open **6**(7). http://bmjopen.bmj.com/content/6/7/e010822.abstract

Objectives Guidelines and training initiatives (G/TIs) are available to support communication in cross-cultural consultations but are rarely implemented in routine practice in primary care. As part of the European Union RESTORE project, our objective was to explore whether the available G/TIs make sense to migrants and other key stakeholders and whether they could collectively choose G/TIs and engage in their implementation in primary care settings.Setting As part of a comparative analysis of 5 linked qualitative case studies, we used purposeful and snowball sampling to recruit migrants and other key stakeholders in primary care settings in Austria, England, Greece, Ireland and the Netherlands.Participants A total of 78 stakeholders participated in the study (Austria 15, England 9, Ireland 11, Greece 16, Netherlands 27), covering a range of groups (migrants, general practitioners, nurses, administrative staff,

interpreters, health service planners).Primary and secondary outcome measures We combined Normalisation Process Theory (NPT) and Participatory Learning and Action (PLA) research to conduct a series of PLA style focus groups. Using a standardised protocol, stakeholders' discussions about a set of G/TIs were recorded on PLA commentary charts and their selection process was recorded through a PLA direct-ranking technique. We performed inductive and deductive thematic analysis to investigate sensemaking and engagement with the G/TIs.Results The need for new ways of working was strongly endorsed by most stakeholders. Stakeholders considered that they were the right people to drive the work forward and were keen to enrol others to support the implementation work. This was evidenced by the democratic selection by stakeholders in each setting of one G/TI as a local implementation project.Conclusions This theoretically informed participatory approach used across 5 countries with diverse healthcare systems could be used in other settings to establish positive conditions for the start of implementation journeys for G/TIs to improve healthcare for migrants.

Maleku, A. et Aguirre, R. T. (2014). "Culturally competent health care from the immigrant lens: a qualitative interpretive meta-synthesis (QIMS)." Soc Work Public Health **29**(6): 561-580.

Immigrant groups comprise a large segment of ethnic minorities in the United States. Although the literature is rich with strategies to deliver culturally and linguistically appropriate services to eliminate health inequities, studies addressing cultural competence from the immigrant's perspective are limited. Further research is needed to build knowledge of the predictors and needs of this population, and to influence health care policy and practice. Using qualitative interpretive meta-synthesis, this study describes the lived experience of immigrants accessing health care to understand the essence of cultural competence in health care through their lens. Findings provide insight on expanding the definition of culturally competent health care beyond language, behaviors, attitudes, and policies.

Ngwakongnwi, E. (2015). "Canadian Health Measures Survey: A tool for immigrant health research?" Health Rep **26**(3): 3-9.

BACKGROUND: The Canadian Health Measures Survey (CHMS) fills important health information gaps, but the feasibility of using it for immigrant research is unknown. DATA AND METHODS: Weighted estimates of socio-demographic variables by immigrant status from the combined cycles 1 and 2 of the CHMS (2007 to 2009 and 2009 to 2011) were compared with distributions from the 2006 Census and the 2011 National Household Survey (NHS). Weighted CHMS estimates of selected self-reported health indicators among immigrants were compared with corresponding data from the 2009/2010 Canadian Community Health Survey (CCHS) by age group, sex, broad world region of origin, and period of arrival. Z-scores were used to detect statistical significance between the CHMS and CCHS estimates. RESULTS: The CHMS immigrant sample is generally similar to the average of 2006 Census/2011 NHS samples, but it contains higher percentages of recent immigrants, 30- to 49-year-olds, and immigrants from South/Central America. Estimates of selected self-reported health and health behaviour variables from the CHMS and the CCHS were similar overall, with minor differences at subgroup levels, and some inconclusive results due to high variability. INTERPRETATION: The combined CHMS immigrant sample can be used for health research. However, it is necessary to ensure that variables of interest meet sample size and prevalence requirements, especially at the subgroup level.

Ngwakongnwi, E., et al. (2012). "Experiences of French speaking immigrants and non-immigrants accessing health care services in a large Canadian city." Int J Environ Res Public Health **9**(10): 3755-3768.

French speakers residing in predominantly English-speaking communities have been linked to difficulties accessing health care. This study examined health care access experiences of immigrants and non-immigrants who self-identify as Francophone or French speakers in a mainly English speaking province of Canada. We used semi-structured interviews to gather opinions of recent users of physician and hospital services (N = 26). Language barriers and difficulties finding family doctors were experienced by both French speaking immigrants and non-immigrants alike. This was exacerbated by a general preference for health services in French and less interest in using language interpreters during a medical consultation. Some participants experienced emotional distress, were discontent with care received, often delayed seeking care due to language barriers. Recent immigrants identified lack of

insurance coverage for drugs, transportation difficulties and limited knowledge of the healthcare system as major detractors to achieving health. This study provided the groundwork for future research on health issues of official language minorities in Canada.

Okafor, M. T., et al. (2014). "Greater dietary acculturation (dietary change) is associated with poorer current self-rated health among African immigrant adults." J Nutr Educ Behav **46**(4): 226-235.

OBJECTIVE: Investigate the relationship between dietary acculturation and current self-rated health (SRH) among African immigrants, by country or region of origin. DESIGN: Cross-sectional, mixed-methods design using baseline data from longitudinal study of immigrants granted legal permanent residence May to November, 2003, and interviewed June, 2003 to June, 2004. SETTING: 2003 New Immigrant Survey. PARTICIPANTS: African immigrants from a nationally representative sample (n = 763) averaged 34.7 years of age and 5.5 years' US residency; 56.6% were male, 54.1% were married, 26.1% were Ethiopian, and 22.5% were Nigerian. MAIN OUTCOME MEASURE(S): Current SRH (dependent variable) was measured using 5-point Likert scale questions; dietary acculturation (independent variable) was assessed using a quantitative dietary change scale. ANALYSIS: Multivariate logistic regression tested the relationship of dietary acculturation with current SRH (alpha = .05; P < .05 considered significant); exploratory qualitative subset dietary analysis (n = 60) examined food/beverages consumed pre-/post-migration. RESULTS: African immigrants reporting moderate dietary change since arrival in the US had higher odds of poorer SRH status than immigrants reporting low dietary change (odds ratio, 1.903; 95% confidence interval, 1.143-3.170; P = .01). Among most dietary change groups, there was an increase in fast food consumption and decrease in fruit and vegetable consumption. CONCLUSIONS AND IMPLICATIONS: Nutrition educators and public health practitioners should develop targeted nutrition education for African immigrants who are older, less educated, and at increased health risk.

Puthoopparambil, S. J., Phelan, M. et MacFarlane, A. (2021). "Migrant health and language barriers: Uncovering macro level influences on the implementation of trained interpreters in healthcare settings." Health Policy. https://doi.org/10.1016/j.healthpol.2021.05.018

There is a knowledge translation gap between policies promoting equitable access to healthcare and person-centred care, and the use of untrained interpreters in cross-cultural consultations leading to disparities in health outcomes. An 11 member inter-sectoral working group met at four workshops to discuss and agree on levers and barriers to the provision of trained interpreters in healthcare settings in Ireland. The process was informed by Participatory Learning and Action (PLA) research to support inter-stakeholder dialogue and learning. Normalisation Process Theory (NPT) was used as a conceptual framework to analyse levers and barriers. The NPT analysis explored sense-making, engagement and enactment and found challenges with sense-making and engagement in senior level service planners, managers and governmental offices. This had negative impacts on other key actors, including healthcare providers, medical students and interpreters. This also meant that the enactment of interpreted consultations in practice settings was replete with barriers, most notably a lack of resources, training and supportive organisational structures. The emergent action plan focused on improving sense-making and engagement through inter-sectoral awareness raising, designed to stimulate a series of complementary levers for implementation. Combining PLA and NPT provided new insights into macro level influences on implementation work at the level of a national healthcare system. The approaches used in this study are applicable in other fields.

Schaeffer, D., et al. (2017). "Health Literacy in the German Population: Results of a Representative Survey." Dtsch Arztebl International **114**(4): 53-60. http://www.aerzteblatt.de/int/article.asp?id=185758

Background: Persons with low health literacy have difficulty dealing with the health care system and understanding health-related information. Studies from multiple countries have shown that low health literacy negatively affects health, health-related and illness-related behavior, and the utilization of health care resources. The data available till now on health literacy in Germany have been sparse. The goal of this study is to acquire representative data on the health literacy of the German population.Methods: In a

cross-sectional study, we collected data from a representative group of 2000 persons over age 15 in Germany by means of computer-assisted personal interviews (CAPI) that were based on the long version of the questionnaire used in the European Health Literacy Survey (HLS-EU-Q47). Sociodemographic data were also collected.Results: The respondents were a representative sample of the German population. 54.3% of them were found to have limited health literacy. Multiple logistic regression revealed associations of limited health literacy with advanced age (odds ratio [OR] 1.83, 95% confidence interval [CI] [1.36; 2.48]), an immigrant background (OR 1.87 [1.27; 2.75]), low self-assessed social status (OR 5.25 [3.57; 7.72]), and low functional literacy (OR 1.94 [1.49; 2.52]).Conclusion: The low health literacy of many Germans can impair communication between doctors and patients and exacerbate existing problems in health policy. In the future, greater effort will have to be made to foster health literacy, make health-related information for patients easier to understand, and intensify research in the field of health literacy.

Smith, N. R., Kelly, Y. J. et Nazroo, J. Y. (2012). "The effects of acculturation on obesity rates in ethnic minorities in England: evidence from the Health Survey for England." Eur J Public Health **22**(4): 508-513. https://www.ncbi.nlm.nih.gov/pubmed/21697245

OBJECTIVES: To investigate the extent of generational differences in adult health-related lifestyles and socio-economic circumstances, and explore whether these differences might explain changing patterns of obesity in ethnic minorities in England. METHODS: Seven ethnic minority groups were selected from the ethnically boosted 1999 and 2004 Health Survey for England (Indian n = 1580; Pakistani n = 1858; Bangladeshi n = 1549; Black Caribbean n = 1472; Black African n = 587; Chinese n = 1559; and Irish n = 889). Age and sex adjusted odds of being obese in the second generation when compared with the first were estimated before and after adjusting for generational differences in health-related behaviours (snacking, eating cakes and fried foods, low levels of physical exercise, any drinking, current smoker, etc.) and socio-economic factors (social class, equivalized income and highest qualification). RESULTS: Indian [OR: 1.76 (1.14-2.71)] and Chinese [OR: 3.65 (1.37-9.78)] groups were more likely to be obese in the second generation than the first after adjusting for age and sex, with no significant differences observed in all other groups. However, the risk of obesity in all groups converged between generations to the risk observed in the White reference group, with exception to the Black Caribbean group. Adjusting independently for the mixed patterns of acculturative changes and the uniform upward social mobility in all groups increased the risk of obesity in the second generation. CONCLUSIONS: Obesity converged to the risk in the majority population following acculturation. Future research needs to consider generation and trans-cultural identities as a fundamental variable in determining the causes of ethnic health inequalities.

Tran, D. T., et al. (2015). "Effects of acculturation on lifestyle and health status among older Vietnam-born Australians." Asia Pac J Public Health **27**(2): Np2259-2274.

Vietnamese immigrants represent a substantial culturally and linguistically diverse population of Australia, but little is known about the health-related effects of acculturation in this population. This study investigated the relationship between measures of acculturation and lifestyle behaviors and health status among 797 older Vietnam-born Australians who participated in the 45 and Up Study (www.45andup.org.au). The findings suggested that higher degrees of acculturation were associated with increased consumption of red meat, white meat, and seafood; higher levels of physical activities; and lower prevalence of overweight and obesity, type 2 diabetes, and smoking (in men). Targeted health messages could emphasize eating more vegetables, avoiding smoking and alcohol drinking, and increasing levels of physical activity.

Tsai, T. I. et Lee, S. Y. (2015). "Health literacy as the missing link in the provision of immigrant health care: A qualitative study of Southeast Asian immigrant women in Taiwan." Int J Nurs Stud.

OBJECTIVES: Language and communication barrier are main contributors to poor health outcomes and improper use of health care among immigrants. The purpose of this study was to explore and understand specific language and communication problems experiences by Southeast Asian immigrant women in Taiwan. DESIGN: This qualitative study used focus groups and in-depth interviews to uncover the experiences of immigrant women regarding their access to and utilization of health care in Taiwan. PARTICIPANTS: Eight focus groups were conducted with 62 Southeast Asian immigrant

women and 23 individual in-depth interviews with a wide range of stakeholders who had diverse background and intimate knowledge of immigrant-relating health care issues were performed. RESULTS: Directed content analysis was applied and identified four major themes concerning conditions that influenced immigrant women's use of health information and services: (1) gaining access to health information, (2) navigating in health care delivery system, (3) interactions during health care encounters, and (4) capability of using health information and services. Findings from this study suggest that, without basic language and literate skills, the majority of immigrant women had inadequate health literacy to manage health information and navigate the Taiwan health care system. Interpersonal communication gap between immigrant women and health care providers exists because of lack of health literacy in addition al language and cultural barriers. CONCLUSION: With limited language and health literacy skills, immigrant women face numerous challenges in navigating the health care system, interacting with health care providers, and gaining access to proper health care. Future efforts are necessary to enhance individual's health literacy and establish health literate environment.

Viruell-Fuentes, E. A., et al. (2012). "More than culture: structural racism, intersectionality theory, and immigrant health." Soc Sci.Med **75**(12): 2099-2106.

Explanations for immigrant health outcomes often invoke culture through the use of the concept of acculturation. The over reliance on cultural explanations for immigrant health outcomes has been the topic of growing debate, with the critics' main concern being that such explanations obscure the impact of structural factors on immigrant health disparities. In this paper, we highlight the shortcomings of cultural explanations as currently employed in the health literature, and argue for a shift from individual culture-based frameworks, to perspectives that address how multiple dimensions of inequality intersect to impact health outcomes. Based on our review of the literature, we suggest specific lines of inquiry regarding immigrants' experiences with day-to-day discrimination, as well as on the roles that place and immigration policies play in shaping immigrant health outcomes. The paper concludes with suggestions for integrating intersectionality theory in future research on immigrant health

Zeh, P., et al. (2012). "The impact of culturally competent diabetes care interventions for improving diabetes-related outcomes in ethnic minority groups: a systematic review." Diabet Med **29**(10): 1237-1252.

AIM: To examine the evidence on culturally competent interventions tailored to the needs of people with diabetes from ethnic minority groups. METHODS: MEDLINE (NHS Evidence), CINAHL and reference lists of retrieved papers were searched from inception to September 2011; two National Health Service specialist libraries were also searched. Google, Cochrane and DARE databases were interrogated and experts consulted. Studies were included if they reported primary research on the impact of culturally competent interventions on outcome measures of any ethnic minority group with diabetes. Paper selection and appraisal were conducted independently by two reviewers. The heterogeneity of the studies required narrative analysis. A novel culturally competent assessment tool was used to systematically assess the cultural competency of each intervention. RESULTS: Three hundred and twenty papers were retrieved and 11 included. Study designs varied with a diverse range of service providers. Of the interventions, 64% were found to be highly culturally competent (scoring 90-100%) and 36% moderately culturally competent (70-89%). Data were collected from 2616 participants on 22 patient-reported outcome measures. A consistent finding from 10 of the studies was that any structured intervention, tailored to ethnic minority groups by integrating elements of culture, language, religion and health literacy skills, produced a positive impact on a range of patient-important outcomes. CONCLUSIONS: Benefits in using culturally competent interventions with ethnic minority groups with diabetes were identified. The majority of interventions described as culturally competent were confirmed as so, when assessed using the culturally competent assessment tool. Further good quality research is required to determine effectiveness and cost-effectiveness of culturally competent interventions to influence diabetes service commissioners.

ETAT DE SANTE : L'« EFFET IMMIGRANT EN BONNE SANTE » TEND A S'ESTOMPER

A propos du « Healthy immigrant effect »

L'existence d'un effet de « l'immigrant en bonne santé » - où les immigrants sont en moyenne en meilleure santé que la population autochtone - est maintenant un phénomène bien accepté. Plusieurs explications concurrentes ont été avancées pour expliquer ce phénomène, comme l'existence de programmes de dépistage systématique dans les pays d'accueil, de saines habitudes de vie avant la migration suivie de l'adoption progressive des nouveaux comportements (moins) sains du pays d'accueil, et l'autosélection des immigrants où les personnes en meilleure santé et en moyenne plus riches tendent davantage à devenir des migrants. Cet effet a été étudié au départ aux États-Unis, au Canada et en Australie (*le latino paradox*)[27], puis dans les pays méditerranéens.[28] Des études montrent que cet effet tend actuellement à s'estomper.

Par ailleurs, la littérature donne des résultats contradictoires sur l'existence d'un « effet de immigrant en bonne santé » en Europe. Une étude récente[29] explore l'hétérogénéité de l'écart de santé entre les migrants et les autochtones dans quatre pays européens, à partir des données de plusieurs enquêtes nationales de santé harmonisées. L'objectif est de déterminer si les différences de santé entre les pays reflètent les différences dans l'état de santé des immigrants entre les pays d'accueil ou si elles proviennent des différences dans l'état de santé des autochtones entre les pays d'accueil - l'association entre le pays et la santé hôte a été analysé séparément au sein d'un pool échantillons d'immigrants et d'indigènes. Les résultats obtenus sont les suivants : après avoir contrôlé le statut socio-économique, les immigrants présentent un plus mauvais état de santé que les natifs en France, en Belgique et en Espagne, alors qu'ils déclarent un meilleur état de santé que les natifs en Italie, tant chez les femmes et les hommes. Un gradient Nord-Sud dans l'état de santé des immigrants apparaît : leur état de santé est meilleur en Italie et en Espagne qu'en France et en Belgique. À l'inverse, l'état de santé des autochtones est plus bas en Italie et en Belgique qu'en France et en Espagne. Les différences dans les écarts de santé reflètent les différences dans l'état de santé des ndigènes et des immigrants entre les pays d'accueil. Cela suggère des différences dans la sélection de la santé à la migration et à l'intégration des immigrants entre les pays européens.

Abraido-Lanza, A. B. et al. (1999)'"The Latino mortality paradox: a test of the 'salmon-bias' and healthy migrant hypotheses ". American Journal of Public Health **89** : 543-48.

Abuelezam, N. N., El-Sayed, A. M. et Galea, S. (2019). "Relevance of the "Immigrant Health Paradox" for the Health of Arab Americans in California." American Journal of Public Health **109**(12): 1733-1738. https://doi.org/10.2105/AJPH.2019.305308

The aim of this paper is to assess the validity of the immigrant health paradox among Arab Americans in California. We used data from the 2003 to 2017 California Health Interview Survey (n = 1425). We used survey-weighted χ2 and logistic regression analyses to compare Arabs by immigrant generation on socioeconomic indicators, health behaviors, and health outcomes. Second-generation Arab Americans had higher odds of binge drinking (adjusted odds ratio [AOR] = 3.26; 95% confidence interval [CI] = 1.53, 6.94) in the past year than did first-generation Arab Americans. Third-generation Arab Americans had greater odds of receiving the influenza vaccine in the past year (AOR = 3.29; 95% CI = 1.09, 9.98) than did second-generation Arab Americans. Third-generation Arab Americans had increased odds of being overweight or obese when compared with first- (AOR = 2.59; 95% CI = 1.02, 6.58) and second-generation Arab Americans (AOR = 3.22; 95% CI = 1.25, 8.29), respectively. Alcohol use increased across immigrant generations, and we observed no differences in health outcomes, other than obesity. The immigrant health paradox does not appear to apply to Arab Americans in California; mechanisms that generate health in this population should be studied further. First-generation immigrants to the United States—those born in another country who immigrate to the

[27] Abraido-Lanza, et al. (1999)
[28] Khlat, M. et Darmon, N. (2003)
[29] Moullan (2014)

United States—have generally been shown to have better health outcomes and behaviors than second-generation (born in the United States to immigrant parents) and third-generation (born in the United States to US-born parents with immigrant heritage) counterparts of the same ethnic background.1,2 This phenomenon has been termed the “immigrant health paradox” or the “healthy immigrant paradox.”

Aglipay, M., et al. (2013). "Does the healthy immigrant effect extend to anxiety disorders? Evidence from a nationally representative study." J Immigr Minor Health **15**(5): 851-857.

It is currently unknown whether the healthy immigrant effect applies to anxiety disorders. To assess the association between immigrant identity and anxiety disorders, data from 116,796 adults who participated in the nationally representative 2007-2008 Canadian Community Health Survey were analyzed and potential confounders were controlled by using logistic regression models. Compared to the Canadian-born, recent immigrants had a reduced odds of anxiety disorders in the 18-39 year age group (adjusted odds ratio (aOR) = 0.19, 95 % confidence interval (CI) 0.13, 0.26) and the 40-59 year age group (aOR = 0.26, 95 % CI 0.17, 0.40). Immigrants arriving 10 or more years ago also had a reduced odds of anxiety disorders compared with native born Canadians, but to a lesser extent (18-39: aOR = 0.41, 95 % CI 0.32, 0.53; 40-59: aOR = 0.76, 95 % CI 0.64, 0.90). There was a healthy immigrant effect on anxiety disorders among working age Canadians.

Blair, A. H. et Schneeberg, A. (2014). "Changes in the 'healthy migrant effect' in Canada: are recent immigrants healthier than they were a decade ago?" J Immigr Minor Health **16**(1): 136-142.

This study sought to assess whether the health of recent immigrants to Canada has changed in the past decade. Using the Canadian Community Health Survey this study examined changes in self-perceived health of 5,757 recent immigrants over a decade. Multivariable ordinal logistic regressions were conducted to calculate odds ratios (OR) and 95% confidence intervals (CI) for the association between time and self-perceived health. Bivariable analysis showed recent immigrants more likely to report better health. After adjustment, reported health did not change over time (OR 0.97; CI 0.91-1.04). However, being female, increased age, life stress, and smoking all remained associated with higher odds of reporting worse health in both adjusted and unajdusted models. Despite global shifts in health burdens, the health of recent immigrants to Canada does not seem to have changed in the past decade. This suggests they now inhabit an ever more elite health demographic.

Barbieri, P. N. (2016). The heterogeneity in immigrants unhealthy assimilation. Munich MPRA**:** 16 , tabl. https://mpra.ub.uni-muenchen.de/71560/

Immigrants upon their arrival in the United States are in better health condition with respect to their American counterpart however such advantage erodes over time. In this paper, we study the heterogeneity of such unhealthy behaviours assimilation among different arrival cohorts. We focus our analysis on binge drinking and cigarette consumption as a proxy for unhealthy behaviour assimilation by immigrants. Regarding binge drinking we show that more recent immigrant cohorts arrive with a higher probability of being binge drinker and experience a faster "unhealthy assimilation" in terms of increased consumption of alcohol and an increase in the probability of starting to drink over guideline on a daily basis. Such assimilation is less pronounced for smoking habits, in fact both earlier and later arrival cohorts report lower smoking rates. However, such health advantage is decreasing with time spent in the US.

Bostean, G. (2013). "Does selective migration explain the Hispanic paradox? A comparative analysis of Mexicans in the U.S. and Mexico." J Immigr Minor Health **15**(3): 624-635.

Latino immigrants, particularly Mexican, have some health advantages over U.S.-born Mexicans and Whites. Because of their lower socioeconomic status, this phenomenon has been called the epidemiologic "Hispanic Paradox." While cultural theories have dominated explanations for the Paradox, the role of selective migration has been inadequately addressed. This study is among the few to combine Mexican and U.S. data to examine health selectivity in activity limitation, self-rated health, and chronic conditions among Mexican immigrants, ages 18 and over. Drawing on theories of selective migration,

this study tested the "healthy migrant" and "salmon-bias" hypotheses by comparing the health of Mexican immigrants in the U.S. to non-migrants in Mexico, and to return migrants in Mexico. Results suggest that there are both healthy migrant and salmon-bias effects in activity limitation, but not other health aspects. In fact, consistent with prior research, immigrants are negatively selected on self-rated health. Future research should consider the complexities of migrants' health profiles and examine selection mechanisms alongside other factors such as acculturation.

Bousmah, M.-a.-Q., Combes, J.-B. S. et Abu-Zaineh, M. (2018). "Health differentials between citizens and immigrants in Europe: A heterogeneous convergence." Health Policy.
http://www.sciencedirect.com/science/article/pii/S0168851018306833

The literature on immigration and health has provided mixed evidence on the health differentials between immigrants and citizens, while a growing body of evidence alludes to the unhealthy assimilation of immigrants. Relying on five different health measures, the present paper investigates the heterogeneity in health patterns between immigrants and citizens, and also between immigrants depending on their country of origin. We use panel data on more than 100,000 older adults living in nineteen European countries. Our panel data methodology allows for unobserved heterogeneity. We document the existence of a healthy immigrant effect, of an unhealthy convergence, and of a reversal of the health differentials between citizens and immigrants over time. We are able to estimate the time threshold after which immigrants' health becomes worse than that of citizens. We further document some heterogeneity in the convergence of health differentials between immigrants and citizens in Europe. Namely, the unhealthy convergence is more pronounced in terms of chronic conditions for immigrants from low-HDI countries, and in terms of self-assessed health and body-mass index for immigrants from medium- and high-HDI countries.

Constant, A. F., García-Muñoz, T., Neuman, S., et al. (2018). "A "healthy immigrant effect" or a "sick immigrant effect"? Selection and policies matter." The European Journal of Health Economics **19**(1): 103-121.
https://doi.org/10.1007/s10198-017-0870-1

Previous literature on a variety of countries has documented a "healthy immigrant effect" (HIE). Accordingly, immigrants arriving in the host country are, on average, healthier than comparable natives. However, their health status dissipates with additional years in the country. HIE is explained through the positive self-selection of healthy immigrants as well as the positive selection, screening and discrimination applied by host countries. In this article we study the health trajectories of immigrants within the context of selection and migration policies. Using SHARE data we examine the HIE, comparing Israel and 16 European countries that have fundamentally different migration policies. Israel has virtually unrestricted open gates for Jewish people around the world, who in turn have ideological rather than economic considerations to move. European countries have selective policies with regards to the health, education and wealth of migrants, who also self-select themselves. Our results provide evidence that (1) immigrants who move to Israel have compromised health and are significantly less healthy than comparable natives. Their health disadvantage persists for up to 20 years of living in Israel, after which they become similar to natives; (2) immigrants who move to Europe have significantly better health than comparable natives. Their health advantage remains positive for many years. Even though during some time lapses they are not significantly different from natives, their health status never becomes worse than that of natives. Our results are important for migration policy and relevant for domestic health policy.

Constant, A., et al. (2016). A 'healthy immigrant effect' or a 'sick immigrant effect'? Selection and policies matter. Maastricht UNU-MERIT**:** 30 , tab., graph., fig.
http://d.repec.org/n?u=RePEc:unm:unumer:2016051&r=hea

Previous literature in a variety of countries has documented a "healthy immigrant effect" (HIE). Accordingly, immigrants arriving in the host country are, on average, healthier than comparable natives. However, their health status dissipates with additional years in the country. HIE is explained through the positive self-selection of the healthy immigrants as well as the positive selection, screening and discrimination applied by host countries. In this paper we study the health of immigrants within the

context of selection and migration policies. Using SHARE data we examine the HIE comparing Israel and sixteen countries in Europe that have fundamentally different migration policies. Israel has virtually unrestricted open gates for Jewish people around the world, who in turn have ideological rather than economic considerations to move. European countries have selective policies with regards to the health, education and wealth of migrants, who also self-select themselves. Our results provide evidence that a) immigrants to Israel have compromised health and suffer from many health ailments, making them less healthy than comparable natives. Their health does not improve for up to 20 years of living in Israel, after which they become similar to natives; b) immigrants to Europe have better health than natives and their health advantage persists up to six years from their arrival, after which they are not significantly different than natives except in one case in which the health of immigrants became worse than that of natives after 21 years. Our results are important for migration policy and relevant for domestic health policy.

Constant, A. F. (2017). The healthy immigrant paradox and health convergence. Maastricht UNU-MERIT**:** 19 , fig. https://www.merit.unu.edu/publications/wppdf/2017/wp2017-044.pdf

The health status of people is a precious commodity and central to economic, socio-political, and environmental dimensions of any country. Yet it is often the missing statistic in all general statistics, demographics, and presentations about the portrait of immigrants and natives. In this paper we are concerned with international migration and health outcomes in the host countries. Through a general literature review and examination of specific immigration countries, we provide insights into the Healthy Immigrant Paradox and the health assimilation of immigrants as we also elucidate selection and measurement challenges. While health is part of human capital, health assimilation is the mirror image of earnings assimilation. Namely, immigrants arrive with better health compared to natives and their health deteriorates with longer residence in the host country, converging to the health of natives or becoming even worse. A deeper understanding of immigrant health trajectories, and disparities with natives and other immigrants is of great value to societies and policymakers, who can design appropriate policy frameworks that address public health challenges, and prevent the health deterioration of immigrants.

Farré, L. (2016). "New evidence on the healthy immigrant effect." Journal of Population Economics **29**(2): 365-394. http://dx.doi.org/10.1007/s00148-015-0578-4

This paper presents new evidence that immigrants have better health than natives upon arrival to their destination. It analyzes a very interesting episode in international migration, namely the exodus of Ecuadorians in the aftermath of the economic collapse in the late 1990s. More than 600,000 Ecuadorians from 1999 to 2005 left their homeland, most relocating in Spain. Using information from the birth certificate data, the paper compares the birth outcomes of immigrant women in Spain not only to that of natives at destination, but to that of natives in Ecuador and immigrants from other nationalities in Spain. These comparisons suggest that the better health at birth of children born to immigrants from Ecuador partly responds to the selection of healthier women into migration.

Fennelly, K. (2007). "The "healthy migrant" effect." Minn Med **90**(3): 51-53.

In many ways, first-generation immigrants to the United States are healthier than people of similar ethnic backgrounds who were born in this country. However, overtime, the newcomers' health advantages diminish dramatically. This article discusses factors that contribute to the deterioration of immigrants' health: poverty, living in substandard housing, not having access to medical care, adoption of an American diet, smoking, and substance abuse.

Fidalgo, A., et al. (2016). A nonparametric analysis of the healthy immigrant effect. IRENE Working paper ; 16-15. Neuchatel University of Neuchatel**:** 22 , tab., graph., fig. https://www.unine.ch/files/live/sites/irene/files/shared/documents/Publications/Working%20papers/2016/WP_16-15.pdf

This paper uses data from the Swiss Labour Force Survey to evaluate the existence of the healthy immigrant effect (HIE) which would translate in i. a health advantage of immigrants upon their arrival in Switzerland compared to individuals with similar characteristics but Swiss-born and ii. an erosion of that advantage over the time of residence until convergence in the levels of health between these two

groups. This original contribution is to address this issue by taking a nonparametric approach in order overcome any potential danger of misspecification that would preclude valid inference. The study finds little empirical support for the HIE: i. no initial advantage and ii. no convergence but the health status of immigrants is shown to deteriorate more than Swiss-born individuals with similar characteristics. Significant differences appear when disaggregating among immigrants' country of origin. Interestingly, it shows that a standard parametric approach, in contrast to these findings, would fully confirm the existence of the HIE with the same data set.

Fuller-Thomson, E., et al. (2016). "An investigation of the healthy migrant hypothesis: Pre-emigration characteristics of those in the British 1946 birth cohort study." Can J Public Health **106**(8): e502-508.

OBJECTIVES: The finding that migrants to high-income countries have lower rates of morbidity and mortality than non-migrants, controlling for socioeconomic position, is often attributed to the "healthy migrant" hypothesis, which suggests that only the healthiest individuals choose to migrate. This prospective study investigates the healthy migrant hypothesis in a cohort of British emigrants using pre-migration health indicators. We also investigate how early-life health characteristics relate to age at emigration and whether or not the emigrant returned home. METHODS: Data are from the Medical Research Council National Survey of Health and Development, a nationally representative cohort study of people born in England, Scotland or Wales in March 1946. Childhood socio-economic position, health and cognitive ability were compared between 4,378 non-emigrants and 984 emigrants. Of the emigrants, 427 emigrated before age 20 and 557 after that age; 602 emigrants remained abroad and 382 returned home. RESULTS: Emigrants had better childhood health (especially greater height), higher childhood socio-economic position and better childhood cognitive ability at age 8 than non-emigrants. Return emigrants were very similar to emigrants who remained abroad. CONCLUSIONS: We found support for the healthy migrant hypothesis in a cohort of British emigrants. Our findings improve an understanding of how health is distributed within and across nations.

García-Pérez, M. (2016). "Converging to American: Healthy Immigrant Effect in Children of Immigrants." American Economic Review **106**(5): 461-466.

We analyze children of immigrants' healthy immigrant effect using parental year of arrival and region of birth. Using data from Integrated National Health Interview Survey 2008-2014, we evaluate children of immigrants' health status by using obesity rates and the number of visits to the doctor versus their native counterparts. Consistent with their parents, children of immigrants' health status declines the longer their parents, remain in the United States. Meanwhile, there is an increase in the number of visits to the doctor the more years their parents, have resided in the country. The convergence rate differs by immigrant group.

Gimeno-Feliu, L. A., et al. (2015). "The healthy migrant effect in primary care." Gac Sanit **29**(1): 15-20.

OBJECTIVE: To compare the morbidity burden of immigrants and natives residing in Aragon, Spain, based on patient registries in primary care, which represents individuals' first contact with the health system. METHODS: A retrospective observational study was carried out, based on linking electronic primary care medical records to patients' health insurance cards. The study population consisted of the entire population assigned to general practices in Aragon, Spain (1,251,540 individuals, of whom 12% were immigrants). We studied the morbidity profiles of both the immigrant and native populations using the Adjusted Clinical Group System. Logistic regressions were conducted to compare the morbidity burden of immigrants and natives after adjustment for age and gender. RESULTS: Our study confirmed the "healthy immigrant effect", particularly for immigrant men. Relative to the native population, the prevalence rates of the most frequent diseases were lower among immigrants. The percentage of the population showing a moderate to very high morbidity burden was higher among natives (52%) than among Latin Americans (33%), Africans (29%), western Europeans (27%), eastern Europeans and North Americans (26%) and/or Asians (20%). Differences were smaller for immigrants who had lived in the country for 5 years or longer. CONCLUSION: Length of stay in the host country had a decisive influence on the morbidity burden represented by immigrants, although the health status of both men and women worsened with longer stay in the host country.

Ginsburg, C., et al. (2016). "Healthy or unhealthy migrants? Identifying internal migration effects on mortality in Africa using health and demographic surveillance systems of the INDEPTH network." Social Science & Medicine **164**: 59-73.
http://www.sciencedirect.com/science/article/pii/S0277953616303252

> Migration has been hypothesised to be selective on health but this healthy migrant hypothesis has generally been tested at destinations, and for only one type of flow, from deprived to better-off areas. The circulatory nature of migration is rarely accounted for. This study examines the relationship between different types of internal migration and adult mortality in Health and Demographic Surveillance System (HDSS) populations in West, East, and Southern Africa, and asks how the processes of selection, adaptation and propagation explain the migration-mortality relationship experienced in these contexts. The paper uses longitudinal data representing approximately 900 000 adults living in nine sub-Saharan African HDSS sites of the INDEPTH Network. Event History Analysis techniques are employed to examine the relationship between all-cause mortality and migration status, over periods ranging from 3 to 14 years for a total of nearly 4.5 million person-years. The study confirms the importance of migration in explaining variation in mortality, and the diversity of the migration-mortality relationship over a range of rural and urban local areas in the three African regions. The results confirm that the pattern of migration-mortality relationship is not exclusively explained by selection but also by propagation and adaptation. Consequences for public health policy are drawn.

Giuntella, O. et Stella, L. (2016). "The Acceleration of Immigrant Unhealthy Assimilation." Health Economics: Ahead of print

> It is well known that immigrants tend to be healthier than US natives and that this advantage erodes with time spent in the USA. However, we know less about the heterogeneity of these trajectories among arrival cohorts. Recent studies have shown that later arrival cohorts of immigrants have lower entry wages and experience less economic assimilation. In this paper, we investigate whether similar cohort effects can be observed in the weight assimilation of immigrants in the USA. Focusing on obesity, we show that more recent immigrant cohorts arrive with higher obesity rates and experience a faster 'unhealthy assimilation' in terms of weight gain. Copyright © 2016 John Wiley & Sons, Ltd.

Gotsens, M., et al. (2015). "Health inequality between immigrants and natives in Spain: the loss of the healthy immigrant effect in times of economic crisis." Eur J Public Health **25**(6): 923-929.

> BACKGROUND: The immigrant population living in Spain grew exponentially in the early 2000s but has been particularly affected by the economic crisis. This study aims to analyse health inequalities between immigrants born in middle- or low-income countries and natives in Spain, in 2006 and 2012, taking into account gender, year of arrival and socioeconomic exposures. METHODS: Study of trends using two cross-sections, the 2006 and 2012 editions of the Spanish National Health Survey, including residents in Spain aged 15-64 years (20 810 natives and 2950 immigrants in 2006, 14 291 natives and 2448 immigrants in 2012). Fair/poor self-rated health, poor mental health (GHQ-12 > 2), chronic activity limitation and use of psychotropic drugs were compared between natives and immigrants who arrived in Spain before 2006, adjusting robust Poisson regression models for age and socioeconomic variables to obtain prevalence ratios (PR) and 95% confidence interval (CI). RESULTS: Inequalities in poor self-rated health between immigrants and natives tend to increase among women (age-adjusted PR2006 = 1.39; 95% CI: 1.24-1.56, PR2012 = 1.56; 95% CI: 1.33-1.82). Among men, there is a new onset of inequalities in poor mental health (PR2006 = 1.10; 95% CI: 0.86-1.40, PR2012 = 1.34; 95% CI: 1.06-1.69) and an equalization of the previously lower use of psychotropic drugs (PR2006 = 0.22; 95% CI: 0.11-0.43, PR2012 = 1.20; 95% CI: 0.73-2.01). CONCLUSIONS: Between 2006 and 2012, immigrants who arrived in Spain before 2006 appeared to worsen their health status when compared with natives. The loss of the healthy immigrant effect in the context of a worse impact of the economic crisis on immigrants appears as potential explanation. Employment, social protection and re-universalization of healthcare would prevent further deterioration of immigrants' health status.

Gubernskaya, Z. (2015). "Age at migration and self-rated health trajectories after age 50: understanding the older immigrant health paradox." J Gerontol B Psychol Sci Soc Sci **70**(2): 279-290.

OBJECTIVES: This research contributes to the "immigrant health paradox" debate by testing the hypothesis that older age at migration is associated with the increased risk of poor health in later life. METHOD: Using the 1992-2008 Health and Retirement Study, I construct linear random-intercept models to estimate self-rated health (SRH) trajectories after age 50 for the native and foreign born by age at migration. RESULTS: At age 50, both Hispanic and non-Hispanic foreign born report better SRH compared with their native-born counterparts, net of race, gender, and education. Non-Hispanic foreign born who migrated after age 35 and Hispanic foreign born who migrated after age 18, however, experience steeper decline in SRH after age 50, which results in a health disadvantage vis-a-vis the native born in old age. Education has a smaller protective effect on SRH for the foreign born, especially those who migrated as adults. DISCUSSION: Age at migration is an important factor for understanding health status of older immigrants. Steeper health decline in later life of the foreign born who migrated in advanced ages may be related to longer exposure to unfavorable conditions in home countries and limited opportunities for incorporation in the United States.

Hamilton, T. G. (2015). "The healthy immigrant (migrant) effect: In search of a better native-born comparison group." Soc Sci Res **54**: 353-365.

This paper evaluates whether immigrants' initial health advantage over their U.S.-born counterparts results primarily from characteristics correlated with their birth countries (e.g., immigrant culture) or from selective migration (e.g., unobserved characteristics such as motivation and ambition) by comparing recent immigrants' health to that of recent U.S.-born interstate migrants ("U.S.-born movers"). Using data from the 1999-2013 waves of the March Current Population Survey, I find that, relative to U.S.-born adults (collectively), recent immigrants have a 6.1 percentage point lower probability of reporting their health as fair or poor. Changing the reference group to U.S.-born movers, however, reduces the recent immigrant health advantage by 28%. Similar reductions in the immigrant health advantage occurs in models estimated separately by either race/ethnicity or education level. Models that examine health differences between recent immigrants and U.S.-born movers who both moved for a new job-a primary motivation behind moving for both immigrants and the U.S.-born-show that such immigrants have only a 1.9 percentage point lower probability of reporting their health as fair or poor. Together, the findings suggest that changing the reference group from U.S.-born adults collectively to U.S.-born movers reduces the identified immigrant health advantage, indicating that selective migration plays a significant role in explaining the initial health advantage of immigrants in the United States.

Hill, T. D., et al. (2012). "Immigrant status and cognitive functioning in late-life: an examination of gender variations in the healthy immigrant effect." Soc Sci.Med **75**(12): 2076-2084.

Although some research suggests that the healthy immigrant effect extends to cognitive functioning, it is unclear whether this general pattern varies according to gender. We use six waves of data collected from the original cohort of the Hispanic Established Populations for the Epidemiologic Study of the Elderly to estimate a series of linear growth curve models to assess variations in cognitive functioning trajectories by nativity status and age at migration to the U.S.A. among women and men. Our results show, among women and men, no differences in baseline cognitive status (intercepts) between early- (before age 20) and late-life (50 and older) immigrants and U.S.-born individuals of Mexican-origin. We also find, among women and men, that middle-life (between the ages of 20 and 49) immigrants tend to exhibit higher levels of baseline cognitive functioning than the U.S.-born. Our growth curve analyses suggest that the cognitive functioning trajectories (slopes) of women do not vary according to nativity status and age at migration. The cognitive functioning trajectories of early- and late-life immigrant men are also similar to those of U.S.-born men; however, those men who migrated in middle-life tend to exhibit slower rates of cognitive decline. A statistically significant interaction term suggests that the pattern for middle-life migration is more pronounced for men (or attenuated for women). In other words, although women and men who migrated in middle-life exhibit higher levels of baseline cognitive functioning, immigrant men tend to maintain this advantage for a longer period of time. Taken together, these patterns confirm that gender is an important conditioning factor in the association between immigrant status and cognitive functioning

Ichou, M. et Wallace, M. (2019). "The Healthy Immigrant Effect: The role of educational selectivity in the good health of migrants." Demogr Res **40**(4): 61-94.
https://www.demographic-research.org/volumes/vol40/4/default.htm

The Healthy Immigrant Effect (HIE) refers to the fact that recent migrants are in better health than the nonmigrant population in the host country. Central to explaining the HIE is the idea that migrants are positively selected in terms of their socioeconomic and health characteristics when compared to nonmigrants in their country of origin. However, due to a lack of reliable and comparable data, most existing studies rely on socioeconomic and health measures as collected in the host country after migration and do not actually measure selection. We directly test selection as an explanation of the HIE among migrants living in France.Using the French Trajectories and Origins (TeO) survey and Barro?Lee dataset, we construct a direct measure of migrants' educational selectivity. We then test its effect on health differences between migrants and nonmigrants using measures self-rated health, health limitations, and chronic illnesses, by fitting logistic regression and Karlson?Holm?Breen (KHB) decompositions. After demonstrating that migrants in France experience an HIE, especially males, we also show that educational level as measured in the host country cannot account for the HIE. By contrast, we provide important evidence that educational selectivity constitutes a significant factor in explaining health disparities between migrant and nonmigrant populations. Capitalizing on a novel measure of migrants' educational selectivity, we give credit to the oft-cited but rarely tested theory that the HIE is a consequence of migrants' positive selection.

Kennedy, S., et al. (2006). The Healthy Immigrant Effect and Immigrant Selection: Evidence from Four Countries. SEDAP Research Paper ; 16. Hamilton McMaster University**:** 56 , tab., graph., fig.

The existence of a healthy immigrant effect – where immigrants are on average healthier than the native-born – is now a well accepted phenomenon. There are many competing explanations for this phenomenon including health screening by recipient countries, healthy behaviour prior to migration followed by the steady adoption of new country (less) healthy behaviours, and immigrant self-selection where healthier and wealthier people tend to be migrants. We explore the last two of these explanations for the healthy immigrant effect by examining the health outcomes, health behaviours, and socio-economic characteristics of immigrants from a range of source countries in the US, Canada, UK and Australia. We find evidence of strong positive selection effects for immigrants from all regions of origin in terms of education. However, we also find evidence that self-selection in terms of unobservable factors is an important determinant of the better health of recent immigrants.

Khlat, M. et Darmon, N. (2003). "Is there a Mediterranean migrants mortality paradox in Europe?" Int J Epidemiol **32**(6): 1115-1118.

Kim, Y. A., et al. (2014). "Neighborhood context and the Hispanic health paradox: differential effects of immigrant density on childrens wheezing by poverty, nativity and medical history." Health Place **27**: 1-8.

Prior research suggests that immigrant enclaves provide respiratory health benefits for US Hispanic residents. We test if immigrant enclaves provide differential respiratory health benefits for Hispanic children in El Paso (Texas) based on individual-level factors. Results reveal that higher neighborhood immigrant density is associated with reduced odds of wheezing, but that the protective immigrant enclave effect is modified by poverty, general health status, body mass index (BMI), and caretaker nativity. Higher immigrant density is significantly more protective for poor children and those with foreign-born caretakers; conversely, it is significantly less protective for children in worse health and those with higher BMI. These findings foster a novel understanding of how immigrant enclaves may be differentially protective for Hispanic children based on individual-level factors.

Kwak, K. (2016). "An evaluation of the healthy immigrant effect with adolescents in Canada: Examinations of gender and length of residence." Soc Sci Med **157**: 87-95.

BACKGROUND: The healthy immigrant effect, HIE, is the finding that immigrants initially arrive in the settlement society in the same or better health than their native-born counterparts, yet this advantage is lost as their length of residence increases. This phenomenon has been found among adult populations. OBJECTIVE: The present study sought to extend the premise of HIE to adolescents in Canada. METHODS: Utilizing national data sets of three years (Canadian Community Health Survey 2007, 2009, 2011; Statistics Canada), adolescents (aged 12-19), foreign-born immigrants (N = 2919) and native-born non-immigrants (N = 39,083), were compared for their perceived general health and mental health as well as diagnosed chronic illnesses and psychological illnesses. Multiple imputations were first carried out for the degrees of missing values, and multivariate analyses were conducted to find differences between non-immigrants and immigrants, and between recent and long-term immigrants to verify (1) whether immigrant adolescents show better health than their non-immigrant peers, (2) whether the health of immigrant adolescents vary with length of residence and gender, and (3) whether persistent trends would be shown across the three survey years. RESULTS: After adjusting for age, visible minority status, household income and household size as covariates, immigrant adolescents indeed reported better health in all four measures in each survey year. Girls experienced more health problems regardless of immigrant status, especially for chronic and psychological illnesses. However, only in 2009 the long-term immigrant adolescents reported less favorite health than recent immigrants, and length of residence influenced boys' and girls' mental health in different directions. CONCLUSIONS: The HIE was confirmed with national community population samples of adolescents in Canada: foreign-born immigrant adolescents experience better health than their native-born peers. However, understanding of the HIE needs to be further extended to encompass the influence of societal contexts and their impact on various segments of populations.

Lu, Y. et Qin, L. (2014). "Healthy migrant and salmon bias hypotheses: a study of health and internal migration in China." Soc Sci Med **102**: 41-48.

The existing literature has often underscored the "healthy migrant" effect and the "salmon bias" in understanding the health of migrants. Nevertheless, direct evidence for these two hypotheses, particularly the "salmon bias," is limited. Using data from a national longitudinal survey conducted between 2003 and 2007 in China, we provide tests of these hypotheses in the case of internal migration in China. To examine the healthy migrant effect, we study how pre-migration self-reported health is associated with an individual's decision to migrate and the distance of migration. To test the salmon bias hypothesis, we compare the self-reported health of migrants who stay in destinations and who return or move closer to home villages. The results provide support for both hypotheses. Specifically, healthier individuals are more likely to migrate and to move further away from home. Among migrants, those with poorer health are more likely to return or to move closer to their origin communities.

Lu, Y., Kaushal, N., Denier, N., et al. (2017). "Health of newly arrived immigrants in Canada and the United States: Differential selection on health." Health Place **48**: 1-10.

Canada and the U.S. are two major immigrant-receiving countries characterized by different immigration policies and health care systems. The present study examines whether immigrant health selection, or the "healthy immigrant effect", differs by destination and what factors may account for differences in immigrant health selection. We use 12 years of U.S. National Health Interview Survey and Canadian Community Health Survey data to compare the risks of overweight/obesity and chronic health conditions among new immigrants in the two countries. Results suggest a more positive health selection of immigrants to Canada than the U.S. Specifically, newly arrived U.S. immigrants are more likely to be overweight or obese and have serious chronic health conditions than their Canadian counterparts. The difference in overweight/obesity was explained by differences in source regions and educational levels of immigrants across the two countries. But this is not the case for serious chronic conditions. These results suggest that immigration-related policies can potentially shape immigrant health selection.

McDonald, J. T. et Kennedy, S. (2004). "Insights into the 'healthy immigrant effect': health status and health service use of immigrants to Canada." Soc Sci Med **59**(8): 1613-1627.

This paper combines multiple cross-sections of data drawn from the National Population Health Survey and Canadian Community Health Survey to confirm the existence of the 'healthy immigrant effect', specifically that immigrants are in relatively better health on arrival in Canada compared to native-born Canadians, and that immigrant health converges with years in Canada to native-born levels. The paper finds robust evidence that the healthy immigrant effect is present for the incidence of chronic conditions for both men and women, and results in relatively slow convergence to native-born levels. There is only weak evidence in terms of self-assessed health status. The inclusion of controls for region of origin and year of arrival does not account for the observed effects, although region of origin is an important determinants of immigrant health. The paper then considers some alternative explanations for the observed differences, and support is found for the idea that the healthy immigrant effect reflects convergence in physical health rather than convergence in screening and detection of existing health problems.

Moullan, Y. et Jusot, F. (2014). "Why is the 'healthy immigrant effect' different between European countries?" Eur J Public Health **24 Suppl 1**: 80-86.

BACKGROUND: : Even if health status of immigrants constitutes an important public health issue, the literature provides contradictory results on the existence of a 'healthy migrant' effect in Europe. This study proposes to explore the heterogeneity of the health gap between migrants and natives across four European countries. DATA AND METHODS: : Based on several harmonized national health interview surveys, the association between migratory status and self-assessed health was firstly explored separately in Belgium, France, Spain and Italy. To explore whether differences in health gap between countries reflect differences in health status of immigrants between host countries or whether they are because of differences in health status of natives between host countries, the association between the host country and health was secondly analysed separately among a pooled sample of immigrants and one of natives, controlling for socio-economic status and country of origin. RESULTS: : After controlling for socio-economic status, immigrants report a poorer health status than natives in France, Belgium and Spain, whereas they report a better health status than natives in Italy, among both women and men. A North-South gradient in immigrants' health status appears: their health status is better in Italy and in Spain than in France and Belgium. Conversely, health status of natives is poorer in Italy and in Belgium than in France and in Spain. CONCLUSION: : Differences in health gap reflect differences in health status of both natives and immigrants between host countries. This suggests differences in health selection at migration and in immigrants' integration between European countries

Ng, E., et al. (2011). "Official language proficiency and self-reported health among immigrants to Canada." Health Rep **22**(4): 15-23.

BACKGROUND: New immigrants to Canada initially report better health than does the Canadian-born population. With time, this "healthy immigrant effect" appears to diminish. Limited ability to speak English or French has been identified as a possible factor in poor health. This analysis explored the relationship between self-reported official language proficiency and transitions to poor self-reported health. DATA AND METHODS: Statistics Canada's Longitudinal Survey of Immigrants to Canada tracked a sample of the 2001 immigrant cohort for four years (6, 24 and 48 months after arrival). Data from each of the three survey waves were available for 7,716 respondents. Bivariate and multivariate analysis were used to examine associations between official language proficiency and self-reported health, by sex, controlling for selected pre-migration and post-migration factors. The prevalence of poor health among immigrants was compared with rates among the Canadian-born population, based on data from the Canadian Community Health Survey. RESULTS: Among a representative sample of recent immigrants, the prevalence of poor self-reported health had risen substantially, especially among women, after four years in Canada. Prolonged limited official language proficiency was strongly associated with a transition to poor health among male and female immigrants who had earlier reported good health. Other factors significantly associated with an increase in the prevalence of poor self-reported health differed by sex. Refugee status, self-reported discrimination, and living in Vancouver were significant for men. Age, health care access problems, and limited friendliness of neighbours were significant for women.

Nolan, A. (2011). "The 'healthy immigrant' effect: initial evidence for Ireland." Health Econ Policy Law: 1-20.

The period from 1996 to 2008 was one of rapid economic and social change in Ireland, with one of the most significant changes being the transition from a situation of net emigration to one of substantial net immigration. Although research on the impact of immigration on Irish society, as well as the labour market characteristics and experiences of immigrants in Ireland has increased in recent years, comparatively little is known about the health status of immigrants to Ireland. An extensive international literature has documented a ahealthy immigranta effect for large immigrant-receiving countries such as the United States, Canada and Australia, whereby the health status of immigrants is better than comparable native-born individuals. There is also evidence to suggest that immigrantsa health status deteriorates with time spent in the host country. However, the Irish immigration experience differs considerably from that of countries that have been the focus of research on the healthy immigrant effect. Using microdata from a nationally representative survey of the population in 2007, this paper finds only limited evidence in favour of a ahealthy immigrant effect for Ireland, although the distinctive features of the Irish immigrant population, and the nature of the data available, may partly explain the results

Norredam, M., et al. (2014). "Duration of residence and disease occurrence among refugees and family reunited immigrants: test of the 'healthy migrant effect' hypothesis." Trop Med Int Health **19**(8): 958-967.

OBJECTIVES: The 'healthy migrant effect' (HME) hypothesis postulates that health selection has a positive effect on migrants' health outcomes, especially in the first years after migration. We examined the potential role of the HME by assessing the association between residence duration and disease occurrence. METHODS: We performed a historical prospective cohort study. We included migrants who obtained residence permits in Denmark between 1 January 1993 and 31 December 2010 (n = 114,331). Occurrence of severe conditions was identified through linkage to the Danish National Patient Register. Hazard Ratios (HRs) were modelled for disease incidence by residence duration since arrival (0-5 years; 0-10 years; 0-18 years) adjusting for age and sex. RESULTS: Compared with Danish-born individuals, refugees and family reunited immigrants had lower HRs of stroke and breast cancer within 5 years after arrival; however, HRs increased at longer follow-up. For example, HRs of stroke among refugees increased from 0.77 (95% CI: 0.66; 0.91) to 0.96 (95% CI: 0.88; 1.05). For ischaemic heart disease (IHD) and diabetes, refugees and family reunited migrants had higher HRs within 5 years after arrival, and most HRs had increased by end of follow-up. For example, HRs of IHD among family reunited migrants increased from 1.29 (95% CI: 1.17; 1.42) to 1.43 (95% CI: 1.39; 1.52). In contrast, HRs for TB and HIV/AIDS showed a consistent decrease over time. CONCLUSION: Our analyses of the effect of duration of residence on disease occurrence among migrants imply that, when explaining migrants' advantageous health outcomes, the ruling theory of the HME should be used with caution, and other explanatory models should be included.

Regidor, E., et al. (2011). "Healthy and unhealthy migrant effect on the mortality of immigrants from wealthy countries residing in Spain." Eur J Epidemiol **26**(4): 265-273.

This study attempts to identify the possible existence of a healthy migrant effect and an unhealthy migrant effect on the mortality of immigrants from wealthy countries who move to Spain. Immigrants aged 35-64 years from France, Germany, Great Britain and 16 other wealthy OECD countries who resided in Spain were compared with respect to: (1) mortality from cancer, cardiovascular disease, and all other diseases and (2) employment status, duration of residence, and educational level, in two geographic areas: the "preferred destination area"-the Mediterranean coast, Balearic Islands and Canary Islands-and the rest of Spain. In general, cancer mortality was lower and mortality from cardiovascular disease was higher in immigrants who resided in the preferred destination area than in their countries of origin and than in immigrants who resided in the rest of Spain. Immigrants in the preferred destination area had a higher percentage of retired persons, longer time of residence and a lower percentage of persons with university education. The largest differences between the two areas in cardiovascular and all-disease mortality and in the frequency of the aforementioned sociodemographic characteristics were observed in British immigrants and those from the 16 OECD countries. Possible explanations for these findings are suggested which are compatible with the

presence of an unhealthy and/or healthy immigrant bias in the two areas.

Rivera, B., et al. (2015). "The Healthy Immigrant Effect on Mental Health: Determinants and Implications for Mental Health Policy in Spain." Adm Policy Ment Health.

Since the mid-1990s, Spain has started to receive a great number of migrant populations. The migration process can have a significantly negative impact on mental health of immigrant population and, consequently, generate implications for the delivery of mental health services. The aim of this article is to provide empirical evidence to demonstrate that the mental health of immigrants in Spain deteriorates the longer they are resident in the country. An empirical approach to this relationship is carried out with data from the National Survey of Health of Spain 2011-2012 and poisson and negative binomial models. Results show that immigrants who reside <10 years in Spain appear to be in a better state of mental health than that observed for the national population. Studying health disparities in the foreign population and its evolution are relevant to ensure the population's access to health services and care. The need for further research is especially true in the case of the immigrant population's mental health in Spain because there is scant evidence available on their situation.

Rubalcava, L. N., et al. (2008). "The healthy migrant effect: new findings from the Mexican Family Life Survey." Am J Public Health **98**(1): 78-84.

OBJECTIVES: We used nationally representative longitudinal data from the Mexican Family Life Survey to determine whether recent migrants from Mexico to the United States are healthier than other Mexicans. Previous research has provided little scientific evidence that tests the "healthy migrant" hypothesis. METHODS: Estimates were derived from logistic regressions of whether respondents moved to the United States between surveys in 2002 and 2005, by gender and urban versus rural residence. Covariates included physical health measurements, self-reported health, and education measured in 2002. Our primary sample comprised 6446 respondents aged 15 to 29 years. RESULTS: Health significantly predicted subsequent migration among females and rural males. However, the associations were weak, few health indicators were statistically significant, and there was substantial variation in the estimates between males and females and between urban and rural dwellers. CONCLUSIONS: On the basis of recent data for Mexico, the largest source of migrants to the United States, we found generally weak support for the healthy migrant hypothesis.

Ruhnke, S. A., Reynolds, M. M., Wilson, F. A., et al. (2022). "A healthy migrant effect? Estimating health outcomes of the undocumented immigrant population in the United States using machine learning." Social Science & Medicine **307**: 115177.
https://www.sciencedirect.com/science/article/pii/S027795362200483X

This paper investigated whether the commonly observed immigrant health advantage persists among undocumented immigrants in the U.S. and provides nationally representative evidence on the health of this vulnerable population. Data were derived from pooled cross-sections of the National Health Interview Survey (NHIS, 2000–2018). The legal status of foreign-born NHIS respondents is imputed using a non-parametric machine learning model built based on information from the 2004, 2008 and 2014 cohorts of the Survey of Income and Program Participation (SIPP). Multivariate logistic regression analysis indicated that, despite exposure to numerous additional risk factors, the undocumented population experienced a more pronounced Healthy Migrant Effect, with lower odds of reporting fair or poor self-rated health, any physician-diagnosed chronic conditions or being obese. The observed patterns in undocumented health outcomes may be related to the additional challenges and exclusionary policies associated with undocumented migration that could in turn lead to a more pronounced selection of healthy and resilient individuals.

Stipkova, M. (2016). "Immigrant disadvantage or the healthy immigrant effect? Evidence about low birth weight differences in the Czech Republic." Eur J Public Health **26**(4): 662-666.

BACKGROUND: Most of the research about immigrants' birth outcomes comes from countries with high numbers of immigrants. This article provides evidence from the Czech Republic, a country with a short

immigration history and a small immigrant population. Two hypotheses are tested: the immigrant disadvantage hypothesis and the healthy immigrant hypothesis. METHODS: Live singleton births in 2013-14 from the national birth register are analysed. The odds of low birth weight (LBW) among the native population and five immigrant groups are compared using logistic regression. Control variables include maternal age, parity, education and marital status, paternal immigrant status, age and education. RESULTS: All immigrant groups, except for Slovaks, showed smaller odds of LBW than native mothers. Adjusted odds ratios for non-Slovak immigrants range between 0.52 and 0.65. Furthermore, maternal immigrant status interacts with education. There is a wide educational gradient in LBW among Czech and Slovak mothers with low education representing a large disadvantage. Such pattern is not present among other ethnic groups. This makes the outcomes of Czech and Slovak mothers less favourable. Native mothers and immigrants with higher level of education show more similar outcomes. Paternal immigrant status does not have a net effect on LBW when maternal ethnicity is taken into account. CONCLUSIONS: Results provide evidence for the healthy immigrant effect. The favourable outcomes of non-Slovak immigrants seem to result from a combination of two factors, health selection of immigrants and relatively high prevalence of LBW in the native population caused by adverse outcomes of mothers with low education.

Thomson, E. F., et al. (2013). "The Hispanic Paradox and older adults' disabilities: is there a healthy migrant effect?" Int J Environ Res Public Health **10**(5): 1786-1814.

The "Hispanic Paradox" suggests that despite rates of poverty similar to African Americans, Hispanics have far better health and mortality outcomes, more comparable to non-Hispanic White Americans. Three prominent possible explanations for the Hispanic Paradox have emerged. The "Healthy Migrant Effect" suggests a health selection effect due to the demands of migration. The Hispanic lifestyle hypothesis focuses on Hispanics' strong social ties and better health behaviors. The reverse migration argument suggests that the morbidity profile in the USA is affected when many Hispanic immigrants return to their native countries after developing a serious illness. We analyzed data from respondents aged 55 and over from the nationally representative 2006 American Community Survey including Mexican Americans (13,167 U.S. born; 11,378 immigrants), Cuban Americans (314 U.S. born; 3,730 immigrants), and non-Hispanic White Americans (629,341 U.S. born; 31,164 immigrants). The healthy migrant effect was supported with SES-adjusted disability comparable between Mexican, Cuban and non-Hispanic Whites born in the USA and all immigrants having lower adjusted odds of functional limitations than U.S. born non-Hispanic Whites. The reverse migration hypothesis was partially supported, with citizenship and longer duration in the USA associated with higher rates of SES-adjusted disability for Mexican Americans. The Hispanic healthy life-style explanation had little support in this study. Our findings underline the importance of considering nativity when planning for health interventions to address the needs of the growing Hispanic American older adult population.

Vang, Z., et al. (2013). The Healthy Immigrant Effect in Canada: A Systematic Review. Document de travail ; Vol. 3: Iss. 1, Article 4. Montréal McGill University**:** 56 , tab., graph., fig.

Many studies show that immigrants are typically healthier than the native -born population, at least initially upon arrival in their new country. Immigrants are also heal thier than non -migrants in the countries of origin. This foreign -born health advantage (also known as the “healthy immigrant effect”) has been documented among immigrants in Europe (Bollini & Siem, 1995), the United States (Cunningham, Ruben, & Narayan, 2008) and Canada (Beiser, 2005). In Canada, much of what we know about the healthy immigrant effect is based on studies of adult migrants. Thus, it remains unclear whether immigrants’ health advantage extends to foreign -born children and older adults. Moreover, with the exception of a few publications (Beiser, 2005; Hyman & Jackson, 2010; Ng, 2010), there has not been an attempt to systematically document the extent of the healthy immigrant effect in Canada across multiple health indicators and life -course stages. The current report fills this lacuna.

Wang, L. et Hu, W. (2013). "Immigrant health, place effect and regional disparities in Canada." Soc Sci Med **98**: 8-17.

The paper addresses a critically important area in Canadian immigration and health from both a social and a spatial perspective. It employs multilevel and contextual approaches to examine the social

determinants of immigrant health as well as the place effects on self-reported health at a regional and neighborhood scale. The data come from the raw microdata file of the 2005-10 Canadian Community Health Survey (a random national health survey) and the publicly available Canadian Marginalization index based on the 2006 Census. Three populations are compared: Canadian-born, overall foreign-born, and Chinese immigrants. The results suggest various degrees of association between self-reported health, individual and lifestyle behavioral characteristics, and neighborhood material deprivation and ethnic concentration in census tracts. These factors contribute differently to the reported health of Chinese immigrants, Canada's largest recent immigrant group. A healthy immigrant effect is partially evident in the overall foreign-born population, but appears to be relatively weak in Chinese immigrants. For all groups, neighborhood deprivation moderately increases the likelihood of reporting poor health. Ethnic concentration negatively affects self-rated health, with the exception of the slight protective effect of Chinese-specific ethnic density in census tracts. The multilevel models reveal significant area inequalities across Census Metropolitan Areas/Census Agglomerations in risk of reporting unhealthy status, with greater magnitude in the foreign-born population. The vast regional variations in health among Chinese immigrants should be interpreted carefully due to the group's heavy concentration in large cities. The study contributes to the literature on ethnicity and health by systematically incorporating neighborhood contextual effects in modeling the social determinants of immigrant health status. It fills a gap in the literature on neighborhoods and health by focusing on ethnically disparate groups rather than on the general population. By revealing regional disparities in health, the paper adds a spatial perspective to the work on immigrant health.

Des études comparées en Europe et dans les pays industralisés

Arnold, M., et al. (2010). "Cancer risk diversity in non-western migrants to Europe: An overview of the literature." Eur J Cancer **46**(14): 2647-2659.

BACKGROUND: Cancer risk varies geographically and across ethnic groups that can be monitored in cancer control to respond to observed trends as well as ensure appropriate health care. The study of cancer risk in immigrant populations has great potential to contribute new insights into aetiology, diagnosis and treatment of cancer. Disparities in cancer risk patterns between immigrant and autochthonous populations have been reported many times, but up to now studies have been heterogeneous and may be discordant in their findings. The aim of this overview was to compile and compare studies on cancer occurrence in migrant populations from non-western countries residing in Western Europe in order to reflect current knowledge in this field and to appeal for further research and culturally sensitive prevention strategies. METHODS: We included 37 studies published in the English language between 1990 and April 2010 focussing on cancer in adult migrants from non-western countries, living in the industrialised countries of the European Union. Migrants were defined based on their country of birth, ethnicity and name-based approaches. We conducted a between-country comparison of age-adjusted cancer incidence and mortality in immigrant populations with those in autochthonous populations. FINDINGS: Across the board migrants from non-western countries showed a more favourable all-cancer morbidity and mortality compared with native populations of European host countries, but with considerable site-specific risk diversity: Migrants from non-western countries were more prone to cancers that are related to infections experienced in early life, such as liver, cervical and stomach cancer. In contrast, migrants of non-western origin were less likely to suffer from cancers related to a western lifestyle, e.g. colorectal, breast and prostate cancer. DISCUSSION: Confirming the great cancer risk diversity in non-western migrants in and between different European countries, this overview reaffirms the importance of exposures experienced during life course (before, during and after migration) for carcinogenesis. Culturally sensitive cancer prevention programmes should focus on individual risk patterns and specific health care needs. Therefore, continuously changing environments and subsequently changing risks in both migrant and autochthonous populations need to be observed carefully in the future.

Bollini, P. et Siem, H. (1995). "No real progress towards equity: health of migrants and ethnic minorities on the eve of the year 2000." Soc Sci Med **41**(6): 819-828.

The paper reviews the available evidence on access to health care and two health outcomes, perinatal

mortality and accident/disability, for migrant and ethnic minorities in selected receiving industrialized countries. The health of these communities is analyzed using the entitlement approach, which considers health as the product of both the individual's private endowments and the social environment he or she faces. Migrants, especially first and second generations, and ethnic minorities often have reduced entitlements in receiving societies. Not only are they exposed to poor working and living conditions, which are per se determinants of poor health, but they also have reduced access to health care for a number of political, administrative and cultural reasons which are not necessarily present for the native population. The paper argues that the higher rates of perinatal mortality and accidents/disability observed in many migrant groups compared to the native population are linked to their lower entitlements in the receiving societies. Policies aimed at reducing such health gaps need to be accompanied by a more general effort to reduce inequalities and to promote full participation of these groups in the mainstream of society.

Borrell, C., et al. (2015). "Perceived Discrimination and Health among Immigrants in Europe According to National Integration Policies." Int J Environ Res Public Health **12**(9): 10687-10699.

BACKGROUND: Discrimination harms immigrants' health. The objective of this study was to analyze the association between perceived discrimination and health outcomes among first and second generation immigrants from low-income countries living in Europe, while accounting for sex and the national policy on immigration. METHODS: Cross-sectional study including immigrants from low-income countries aged >/=15 years in 18 European countries (European Social Survey, 2012) (sample of 1271 men and 1335 women). The dependent variables were self-reported health, symptoms of depression, and limitation of activity. The independent variables were perceived group discrimination, immigrant background and national immigrant integration policy. We tested for association between perceived group discrimination and health outcomes by fitting robust Poisson regression models. RESULTS: We only observed significant associations between perceived group discrimination and health outcomes in first generation immigrants. For example, depression was associated with discrimination among both men and women (Prevalence Ratio-, 1.55 (95% CI: 1.16-2.07) and 1.47 (95% CI: 1.15-1.89) in the multivariate model, respectively), and mainly in countries with assimilationist immigrant integration policies. CONCLUSION: Perceived group discrimination is associated with poor health outcomes in first generation immigrants from low-income countries who live in European countries, but not among their descendants. These associations are more important in assimilationist countries.

Briebe, S., et al. (2016). Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. Health Evidence Network synthesis report ; 47. Copenhague OMS**:** 71 , tab., graph., fig.
http://www.euro.who.int/__data/assets/pdf_file/0003/317622/HEN-synthesis-report-47.pdf?ua=1

The increasing number of refugees, asylum seekers and irregular migrants poses a challenge for mental health services in Europe. This review found that these groups are exposed to risk factors for mental disorders before, during and after migration. The prevalence of psychotic, mood and substance-use disorders in these groups varies but overall resembles that in the host populations. Refugees and asylum seekers, however, have higher rates of post-traumatic stress disorder. Poor socioeconomic conditions are associated with increased rates of depression five years after resettlement.

Bozorgmehr, K., Biddle, L., Rohleder, S., et al. (2019). What is the evidence on availability and integration of refugee and migrant health data in health information systems in the WHO European Region?, Copenhague: OMS
http://www.euro.who.int/en/publications/abstracts/what-is-the-evidence-on-availability-and-integration-of-refugee-and-migrant-health-data-in-health-information-systems-in-the-who-european-region-2019

L’augmentation rapide et récente des mouvements transfrontaliers de population met en avant l’importance de disposer de données fiables sur la santé des réfugiés et des migrants pour la planification de la santé publique. Ce rapport exploratoire examine les bases factuelles sur la

disponibilité et l'intégration des données relatives à la santé des réfugiés et des migrants dans les systèmes d'information sanitaire de la Région européenne de l'OMS. Si ces données sont disponibles dans 25 des 53 États membres de la Région, on observe des différences quant à la disponibilité, aux types de données et aux principales sources de collecte de données. À l'exception des pays disposant de registres de la population, les principales sources de données sont les dossiers médicaux, les dossiers spécifiques aux maladies et les données de notification. L'intégration des données est souvent limitée, et les enquêtes de suivi sanitaire et les méthodes de mise en relation des données sont insuffisamment utilisées. On mentionnera parmi les considérations politiques l'harmonisation des définitions des migrants, la promotion de la coordination/gouvernance de la collecte de données, le suivi de la performance des systèmes d'information sanitaire, la promotion de l'échange de données d'expérience entre les pays, l'exploitation de la mise en relation des données, le développement de la surveillance sanitaire existante, la réduction des obstacles aux soins de santé, ainsi que le renforcement des systèmes généraux d'information sanitaire.

Brothers, T. D., et al. (2014). "Frailty and migration in middle-aged and older Europeans." Arch Gerontol Geriatr **58**(1): 63-68.

We evaluated life course influences on health by investigating potential differences in levels of frailty between middle-aged and older European immigrants born in low- and middle-income countries (LMICs), immigrants born in high income countries (HICs), and their native-born European peers. Using data from the Survey of Health, Ageing, and Retirement in Europe (SHARE), we constructed a frailty index from 70 age-related health measures for 33,745 participants aged 50+ (mean=64.9 +/- 10.2 years; 54% women) in 14 European countries. Participants were grouped as native-born or as immigrants born in LMICs or in HICs, and further by current residence in Northern/Western or Southern/Eastern Europe. Seven percent of participants (n=2369) were immigrants (mean=64.4 +/- 10.2 years; 56% women; LMIC-born=3.4%, HIC-born=3.6%). In Northern/Western Europe, after adjustment for age, gender, and education, LMIC-born immigrants demonstrated higher frailty index scores (mean=0.18, 95% confidence interval=0.17-0.19) than both HIC-born immigrants (0.16, 0.16-0.17) and native-born participants (0.15, 0.14-0.15 both p<0.001). In Southern/Eastern Europe, frailty index scores did not differ between groups (p=0.2). Time since migration explained significant variance in frailty index scores only in HIC-born immigrants to Southern/Eastern Europe (4.3%, p=0.03). Despite differences in frailty, survival did not differ between groups (p=0.2). LMIC-born immigrants demonstrated higher levels of frailty in Northern/Western Europe, but not Southern/Eastern Europe. Country of birth and current country of residence were each associated with frailty. Life course influences are demonstrable, but complex.

Di Thiene, D., et al. (2009). "[What do we talk about when we talk about immigrant's health in Europe? Considerations from the 2nd Conference of Migrant Health in Europe]." Ann Ig **21**(4): 365-369.

The present contribution aims to highlight the trends in current research at a European level with regard to immigrant's health. With this aim we analyzed the Abstract Book contributions of the "2nd Conference of Migrant Health in Europe" organized in Malmo, Sweden (May 2008), by the 'Migrant Health' section of the European Public Health Association (EUPHA). The analysis of these abstracts permitted to identify the major tipping points and challenges connected with immigration phenomenon in health care systems in hosts countries. In the 141 abstracts, the most discussed issues were: 'Inequalities' (22.6%), 'Maternal child and sexual reproductive health' (14.5%), 'Mental health' (11.3%) and 'Life style and chronic diseases' (10.9%). Further analysis of Inequalities category shows that the most discussed level was maternal-child, with particular reference to pre-birth child health among immigrants and mixed relationship. These studies confirmed inequalities in most cases (68%). Health inequalities between immigrant and native population in maternal child field appeared to be the most discussed issue with regard to immigrant's health in Europe. Juridical differences related to the possibility of obtaining citizenship between ius soli (in force in the majority of European countries) and ius sanguinis (in force in Italy), could probably explain the importance of this research-line.

Dourgnon, P. et Kassar, H. (2014). "Refugees in and out North Africa: a study of the Choucha refugee camp in Tunisia." Eur J Public Health **24 Suppl 1**: 6-10.

In recent years, North African (NA) countries ceased to be emigration-only countries and are now on the verge of becoming immigration as well as transit countries for economic migrants and refugees. Contextual as well as structural long-term factors are driving these changes. The ongoing crises in Africa and the Middle East are prompting strong outflows of refugees, which are likely to induce NA countries to share some common public policy and public health concerns with European countries in a near future. This article highlights some aspects of these changes, from the study of the consequences of the 2011 Libyan crisis in Tunisia. It addresses individual trajectories and health concerns of refugees in and out North Africa from a study of the Choucha camp in Tunisia. The camp opened to immigrants from Libya during the 2011 crisis and accommodated the bulk of the refugees flow to Tunisia until July 2012. The study includes a monographic approach and a qualitative survey in the Choucha camp refugees. We describe the crisis history and the health response with a focus on the camp. We then address refugees' trajectories, and health needs and concerns from the interviews we collected in the camp in April 2012

Escarce, J. J. et Rocco, L. (2018). Immigration and the Health of Older Natives in Western Europe. GLO Discussion Paper, No. 228. sl Global Labor Organization**:** 47 , tabl., carte.
https://www.econstor.eu/bitstream/10419/180225/1/GLO-DP-0228.pdf

Previous research has found that immigration benefits the health of working-age natives, an effect mediated through the labor market. We use the Study of Health, Ageing and Retirement in Europe (SHARE) to investigate whether immigration also affects the health of natives 65-80 years old. Immigration may increase the supply and lower the price of personal and household services, a term that refers to care services and non-care services such as cleaning, meal preparation, and domestic chores. Higher consumption of personal and household services by older natives may help maintain health through a variety of pathways. Using a shift-share IV, we find pervasive beneficial effects of immigration on the physical and mental health of older natives. We also find evidence for the hypothesized pathways, especially for an effect of immigration in increasing social integration (e.g., institutional connections, social participation). However, our ability to test mechanisms is limited in our data.

Exadaktylos, A., Srivastava, D., Keidar, O., et al. (2019). "Refugee, Migrant and Ethnic Minority Health." Int J Environ Res Public Health(Numéro spécial).
https://www.mdpi.com/books/pdfview/book/1653

Les migrations internationales, notamment en Europe, ont considérablement augmenté ces dernières années et rendent la recherche primordiale dans cette problématique. Après une définition des différents concepts, ce numéro spécial porte sur la santé des réfugiés, des migrants et des minorités ethniques. Il rassemble 37 articles dont 28 portent sur l'Europe et abordent la santé sous différents aspects.

Frederiksen, H. W., et al. (2013). "Health-reception of newly arrived documented migrants in Europe. why, whom, what and how?" The European Journal of Public Health **23**(5): 725-726.

Furtado, D. et Theodoropoulos, N. (2013). "SSI for Disabled Immigrants: Why Do Ethnic Networks Matter." The American Economic Review **103**(3): 462-466.

AbstractImmigrants residing among many coethnics are especially likely to receive SSI for a disability when they belong to high SSI take-up immigrant groups. After showing that this relationship cannot be fully explained by differences in health, we consider the likely sources of these network effects by separately examining their role in the decision to apply for SSI and, conditional on applying, their role in determining who ultimately receives benefits. Our results suggest that networks may increase the probability of applying for SSI despite minor disabilities, but it is unlikely that network effects are driven by egregious lies on applications

Gerritsen, A., et al. (2013). "Health and demographic surveillance systems: contributing to an understanding of

the dynamics in migration and health." Glob Health Action **6**: 21496.

BACKGROUND: Migration is difficult to measure because it is highly repeatable. Health and Demographic Surveillance Systems (HDSSs) provide a unique opportunity to study migration as multiple episodes of migration are captured over time. A conceptual framework is needed to show the public health implications of migration. OBJECTIVE/DESIGN: Research conducted in seven HDSS centres [International Network for the Demographic Evaluation of Populations and Their Health (INDEPTH) Network], published in a peer-reviewed volume in 2009, is summarised focussing on the age-sex profile of migrants, the relation between migration and livelihoods, and the impact of migration on health. This illustrates the conceptual structure of the implications of migration. The next phase is described, the Multi-centre Analysis of the Dynamics In Migration And Health (MADIMAH) project, consisting of workshops focussed on preparing data and conducting the analyses for comparative studies amongst HDSS centres in Africa and Asia. The focus here is on the (standardisation of) determinants of migration and the impact of migration on adult mortality. RESULTS: The findings in the volume showed a relatively regular age structure for migration among all HDSS centres. Furthermore, migration generally contributes to improved living conditions at the place of origin. However, there are potential negative consequences of migration on health. It was concluded that there is a need to compare results from multiple centres using uniform covariate definitions as well as longitudinal analysis techniques. This was the starting point for the on-going MADIMAH initiative, which has increased capacity at the participating HDSS centres to produce the required datasets and conduct the analyses. CONCLUSIONS: HDSS centres brought together within INDEPTH Network have already provided strong evidence of the potential negative consequences of migration on health, which contrast with the beneficial impacts of migration on livelihoods. Future comparative evidence using standardised tools will help design policies for mitigating the negative effects, and enhancing the positive effects, of migration on health.

Giannoni, M., et al. (2016). "Migrant integration policies and health inequalities in Europe." BMC Public Health **16**(1): 1-14.
http://dx.doi.org/10.1186/s12889-016-3095-9

Research on socio-economic determinants of migrant health inequalities has produced a large body of evidence. There is lack of evidence on the influence of structural factors on lives of fragile groups, frequently exposed to health inequalities. The role of poor socio-economic status and country level structural factors, such as migrant integration policies, in explaining migrant health inequalities is unclear. The objective of this paper is to examine the role of migrant socio-economic status and the impact of migrant integration policies on health inequalities during the recent economic crisis in Europe.

Gimeno-Feliu, L. A., et al. (2017). "Multimorbidity and immigrant status: associations with area of origin and length of residence in host country." Fam Pract **34**(6): 662-666.
http://dx.doi.org/10.1093/fampra/cmx048

AimMultimorbidity is a growing phenomenon in primary care, and knowledge of the influence of social determinants on its evolution is vital. The aim of this study was to understand the relationship between multimorbidity and immigration, taking into account length of residence in the host country and area of origin of the immigrant population.MethodsCross-sectional retrospective study of all adult patients registered within the public health service of Aragon, Spain (N = 1092279; 144238 were foreign-born), based on data from the EpiChron Cohort. Age-standardized prevalence rates of multimorbidity were calculated. Different models of binary logistic regressions were conducted to study the association between multimorbidity, immigrant status and length of residence in the host country.ResultsThe risk of multimorbidity in foreign-borns was lower than that of native-borns [odds ratio (OR): 0.54, 95% confidence interval (CI): 0.53–0.55]. The probability of experiencing multimorbidity was lowest for Asians (OR: 0.34, 95% CI: 0.31–0.37) and Eastern Europeans (OR: 0.42, 95% CI: 0.40–0.43), and highest for Latin Americans (OR: 0.70, 95% CI: 0.68–0.72). Foreign-born immigrants residing in Aragon for ≥5 years had a higher multimorbidity risk than those residing for <5 years (OR: 2.3, 95% CI: 2.2–2.4).ConclusionPrevalence of multimorbidity is lower among foreign-

borns as compared with native-borns, but increases rapidly with length of residence in the host country. However, the progressive development of multimorbidity among immigrants varies widely depending on area of origin. These findings provide important insight into the health care needs of specific population groups and may help minimize the negative impact of multimorbidity among the most vulnerable groups.

Gkiouleka, A. et Huijts, T. (2020). "Intersectional migration-related health inequalities in Europe: Exploring the role of migrant generation, occupational status & gender." Social Science & Medicine **267**: 113218. https://doi.org/10.1016/j.socscimed.2020.113218

Integrating intersectionality theory and employing a quantitative design, the current study explores how migration-related health inequalities in Europe interact with migrant generation, occupational status and gender. Multilevel logistic regression analyses are conducted using pooled data from six waves of the European Social Survey (2004–2014), from 27 countries for two subjective health measures (general self-reported health and hampering conditions). The results reveal multiple relationships of health inequality that operate simultaneously and the complexity through which the combination of social privilege and disadvantage can have a particularly negative impact on individual health. The 'healthy migrant effect' seems to apply particularly for first-generation immigrants working as manual employees, and within occupational categories, in certain cases non-migrant women are more susceptible to poor health than migrant men. This evidence highlights how the health impact of migration is subject to additional dimensions of social positioning as well as the importance of an intersectional perspective for the monitoring of health inequalities in Europe.

Giannoni, M., Franzini, L. et Masiero, G. (2016). "Migrant integration policies and health inequalities in Europe." BMC Public Health **16**(1): 1-14. http://dx.doi.org/10.1186/s12889-016-3095-9

Research on socio-economic determinants of migrant health inequalities has produced a large body of evidence. There is lack of evidence on the influence of structural factors on lives of fragile groups, frequently exposed to health inequalities. The role of poor socio-economic status and country level structural factors, such as migrant integration policies, in explaining migrant health inequalities is unclear. The objective of this paper is to examine the role of migrant socio-economic status and the impact of migrant integration policies on health inequalities during the recent economic crisis in Europe.

Gray, B. H. et Van, G. E. (2012). "Health Care for Undocumented Migrants: European Approaches." Issues in International Health Policy: 12p.

European countries have smaller shares of undocumented migrants than does the United States, but these individuals have substantial needs for medical care and present difficult policy challenges even in countries with universal health insurance systems. Recent European studies show that policies in most countries provide for no more than emergency services for undocumented migrants. Smaller numbers of countries provide more services or allow undocumented migrants who meet certain requirements access to the same range of services as nationals. These experiences show it is possible to improve access to care for undocumented migrants. Strategies vary along three dimensions: 1) focusing on segments of the population, like children or pregnant women; 2) focusing on types of services, like preventive services or treatment of infectious diseases; or 3) using specific funding policies, like allowing undocumented migrants to purchase insurance

Hemminki, K. (2014). "Immigrant health, our health." Eur J Public Health **24 Suppl 1**: 92-95.

This final chapter reviews the main conclusions reached by the Special Issue articles in the areas of EUNAM (EU and North African Migrants: Health and Health Systems) activities, covering well-being, health status, disease panorama and use of health services of immigrants to the EU. The reviewed chapters show that immigrants are a vulnerable population experiencing, in some aspects, discrimination and hardship similar to the socially weakest national population groups. Immigration

has changed the disease spectrum, particularly in infectious diseases and recessive conditions such as sickle cell disease and familial Mediterranean fever. Importantly, health questions of immigrants cannot be separated from those of any human health issues. An imminent new immigrant question for the EU will be the massive internal migration. Although the overall disease spectrum may not be vastly different between EU countries, the internal migrants will be exposed to lifestyle-dependent ill health and diseases probably in a similar way as did migrants from outside Europe. Migrant health research requires dedicated funding, which needs to come from central EU sources because multiple nationalities are involved. This funding should be able to project the course of health from the country of origin to the country of destination and back again, which was one of guidelines in the funding that initiated EUNAM.

Hjern, A. et Kadir, A. (2018). Health of refugee and migrant children. Technical guidance, Copenhague : OMS Bureau régional de l'Europe
http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/publications/2018/health-of-older-refugees-and-migrants-2018

Entre 2015 et 2017, près d'un million d'enfants demandeurs d'asile ont été enregistrés dans l'Union européenne, et 200 000 d'entre eux sont arrivés sans être accompagnés d'un adulte. Ces enfants courent des risques spécifiques, notamment la discrimination, la marginalisation, le placement en institution et l'exclusion. Lorsque l'on examine la mise en œuvre d'interventions dans le domaine de la santé et des soins de santé, il importe d'accorder une attention particulière à certains facteurs comme leurs origines diverses, le fait qu'ils soient non accompagnés et séparés de leur famille, qu'ils soient victimes de la traite, voire qu'il s'agisse d'enfants abandonnés et laissés seuls. Parmi les considérations politiques à cet égard, il convient de mentionner l'adoption d'une approche intersectorielle visant à promouvoir, chez les enfants migrants, la bonne santé et le bien-être (en particulier la santé mentale) en ciblant les facteurs de risque aux niveaux individuel, familial et communautaire. Il est notamment tenu compte du rôle important joué par les autorités nationales et locales qui contribuent à favoriser ou à compromettre les conditions de vie des enfants réfugiés et migrants à plusieurs égards (logement, services de soins de santé et éducation).

Ikram, U. Z., et al. (2015). "All-cause and cause-specific mortality of different migrant populations in Europe." Eur J Epidemiol.

This study aimed to examine differences in all-cause mortality and main causes of death across different migrant and local-born populations living in six European countries. We used data from population and mortality registers from Denmark, England & Wales, France, Netherlands, Scotland, and Spain. We calculated age-standardized mortality rates for men and women aged 0-69 years. Country-specific data were pooled to assess weighted mortality rate ratios (MRRs) using Poisson regression. Analyses were stratified by age group, country of destination, and main cause of death. In six countries combined, all-cause mortality was lower for men and women from East Asia (MRRs 0.66; 95 % confidence interval 0.62-0.71 and 0.76; 0.69-0.82, respectively), and Other Latin America (0.44; 0.42-0.46 and 0.56; 0.54-0.59, respectively) than local-born populations. Mortality rates were similar for those from Turkey. All-cause mortality was higher in men and women from North Africa (1.09; 1.08-1.11 and 1.19; 1.17-1.22, respectively) and Eastern Europe (1.30; 1.27-1.33 and 1.05; 1.01-1.08, respectively), and women from Sub-Saharan Africa (1.34; 1.30-1.38). The pattern differed by age group and country of destination. Most migrants had higher mortality due to infectious diseases and homicide while cancer mortality and suicide were lower. CVD mortality differed by migrant population. To conclude, mortality patterns varied across migrant populations in European countries. Future research should focus both on migrant populations with favourable and less favourable mortality pattern, in order to understand this heterogeneity and to drive policy at the European level.

Kentikelenis, A., et al. (2015). "How do economic crises affect migrants' risk of infectious disease? A systematic-narrative review." Eur J Public Health **25**(6): 937-944.

BACKGROUND: It is not well understood how economic crises affect infectious disease incidence and prevalence, particularly among vulnerable groups. Using a susceptible-infected-recovered framework,

we systematically reviewed literature on the impact of the economic crises on infectious disease risks in migrants in Europe, focusing principally on HIV, TB, hepatitis and other STIs. METHODS: We conducted two searches in PubMed/Medline, Web of Science, Cochrane Library, Google Scholar, websites of key organizations and grey literature to identify how economic changes affect migrant populations and infectious disease. We perform a narrative synthesis in order to map critical pathways and identify hypotheses for subsequent research. RESULTS: The systematic review on links between economic crises and migrant health identified 653 studies through database searching; only seven met the inclusion criteria. Fourteen items were identified through further searches. The systematic review on links between economic crises and infectious disease identified 480 studies through database searching; 19 met the inclusion criteria. Eight items were identified through further searches. The reviews show that migrant populations in Europe appear disproportionately at risk of specific infectious diseases, and that economic crises and subsequent responses have tended to exacerbate such risks. Recessions lead to unemployment, impoverishment and other risk factors that can be linked to the transmissibility of disease among migrants. Austerity measures that lead to cuts in prevention and treatment programmes further exacerbate infectious disease risks among migrants. Non-governmental health service providers occasionally stepped in to cater to specific populations that include migrants. CONCLUSIONS: There is evidence that migrants are especially vulnerable to infectious disease during economic crises. Ring-fenced funding of prevention programs, including screening and treatment, is important for addressing this vulnerability.

Kontunen, K., et al. (2014). "Ensuring health equity of marginalized populations: experiences from mainstreaming the health of migrants." Health Promot Int **29 Suppl 1**: i121-129.

Migrants around the world significantly contribute to the economies of countries of origin and destination alike. Despite the growing number of migrants in today's globalized world, the conditions in which migrants travel, live and work can carry exceptional risks to their physical and mental well-being. These risks are often linked to restrictive immigration and employment policies, economic and social factors and dominant anti-migrant sentiments in societies, and are often referred to as the social determinants of migrants' health. These social determinants need to be addressed in order for migrants to attain their development potential and to concurrently contribute to sustainable development, while reducing the health costs of migration for both migrants and societies of origin and destination. A multi-sectoral approach is required to effectively address the social determinants of migrants' health, as many of the solutions to improving migrants' health lie not only in the health sector but in other sectors, such as labour and immigration. This requires collaboration across the different sectors and integrating migrants' health issues in different sectoral policies to avoid marginalization and exclusion of migrants and ensure positive health outcomes for migrants and their families. The paper will discuss a 'Health in All Policies' (HiAP) approach to migrants' health as, to date, there has not been much discussion on framing migrants' health within an HiAP approach. The paper will also present some examples from countries who have addressed different aspects of migrants' health in line with the recommendations of the 61st World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants (2008).

Kristiansen, M. (2018). Health of older refugees and migrants. Technical guidance, Copenhague : OMS Bureau régional de l'Europe
http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/publications/2018/health-of-older-refugees-and-migrants-2018

Population ageing caused by consistently low birth rates and increased life expectancy represents a major current social trend across Europe. This technical guidance aims to inform policy and practice development specifically related to improving the health of older refugees and migrants within the European Union and the larger WHO European Region. Both ageing and migration are in themselves complex multidimensional processes shaped by a range of factors at the micro, meso and macro levels over the life-course of the individual, but also with intertwined trajectories. Responding to the needs of older refugees and migrants, therefore, must be integrated into all dimensions of ageing policies and practices across Europe. Relevant areas for policy-making include healthy ageing over the life-course, supportive environments, people-centred health and long-term care services, and

strengthening the evidence base and research. Le vieillissement de la population, dû à des taux de natalité toujours faibles et à l'allongement de l'espérance de vie, constitue actuellement une importante tendance sociale en Europe. Ces recommandations techniques visent à éclairer l'élaboration de politiques et de pratiques spécifiquement liées à l'amélioration de la santé des réfugiés et des migrants âgés dans l'Union européenne et dans la Région européenne de l'OMS dans son ensemble. Le vieillissement et la migration constituent en eux-mêmes des processus multidimensionnels complexes déterminés par une série de facteurs intervenant aux niveaux micro, méso et macro pendant les différents stades de l'existence, mais aussi caractérisés par des trajectoires étroitement liées. Les pratiques et les politiques relatives au vieillissement en Europe doivent donc tenir compte des besoins des réfugiés et migrants âgés et ce, dans tous leurs aspects. Parmi les domaines pertinents pour l'élaboration de politiques, il convient de mentionner le vieillissement en bonne santé tout au long de la vie, l'instauration d'environnements favorables, la prestation de services de santé et de soins de longue durée centrés sur la personne et adaptés à des populations vieillissantes, ainsi que le renforcement des bases factuelles et de la recherche.

Ljunge, M. (2016). Migrants, Health, and Happiness: Evidence that Health Assessments Travel with Migrants and Predict Well-Being. IFN Working Paper ; 1112. Stochkolm IFN**:** 35 , tab., graph., fig. http://www.ifn.se/wfiles/wp/wp1112.pdf

Health assessments correlate with health outcomes and subjective well-being. Immigrants offer an opportunity to study persistent social influences on health where the social conditions are not endogenous to individual outcomes. This approach provides a clear direction of causality from social conditions to health, and in a second stage to well-being. Natives and immigrants from across the world residing in 30 European countries are studied using survey data. The paper applies within country analysis using both linear regressions and two stage least squares. Natives' and immigrants' individual characteristics have similar predictive power for health, except Muslim immigrants who experience a sizeable health penalty. Average health reports in the immigrant's birth country have a significant association with the immigrant's current health. Almost a quarter of the birth country health variation is brought by the immigrants, while conditioning on socioeconomic characteristics. There is no evidence of the birth country predictive power declining neither as the immigrant spends more time in the residence country nor over the life course. The second stage estimates indicate that a one standard deviation improvement in health predicts higher happiness by 1.72 point or 0.82 of a standard deviation, more than four times the happiness difference of changing employment status from unemployed to employed. Studying life satisfaction yields similar results. Health improvements predict substantial increases in individual happiness.

Llácer, A., et al. (2007). "The contribution of a gender perspective to the understanding of migrants' health." J Epidemiol Community Health **61**(Suppl 2): ii4-ii10. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2465778/

In 2005 women represented approximately half of all 190 million international migrants worldwide. This paper addresses the need to integrate a gender perspective into epidemiological studies on migration and health, outlines conceptual gaps and discusses some methodological problems. We mainly consider the international voluntary migrant. Women may emigrate as wives or as workers in a labour market in which they face double segregation, both as migrants and as women. We highlight migrant women's heightened vulnerability to situations of violence, as well as important gaps in our knowledge of the possible differential health effects of factors such as poverty, unemployment, social networks and support, discrimination, health behaviours and use of services. We provide an overview of the problems of characterising migrant populations in the health information systems, and of possible biases in the health effects caused by failure to take the triple dimension of gender, social class and ethnicity into account.

Lamkaddem, M., et al. (2015). "Health changes of refugees from Afghanistan, Iran and Somalia: the role of residence status and experienced living difficulties in the resettlement process." Eur J Public Health **25**(6): 917-922.

INTRODUCTION: Worldwide, refugees show a poorer mental and physical health than the populations among which they resettle. Little is known about the factors influencing health after resettlement. We examined the development of mental and physical health of refugees. As experienced living difficulties might decrease with obtaining a residence permit, we expected this to play a central role in health improvement after resettlement. METHODS: A two-wave study conducted in the Netherlands among a cohort of 172 recent (n = 68) and longstanding (n = 104) permit holders from Afghanistan, Iran and Somalia between 2003 and 2011. Multivariate mediation analyses were conducted for the effect of changes in living difficulties on the association between change in status and changes in health. Health outcomes were self-reported general health, number of chronic conditions, PTSD and anxiety/depression. RESULTS: Recent permit holders had larger decreases in PTSD score (-0.402, CI -0.612; -0.192) and anxiety/depression score (-0.298, CI -0.464; -0.132), and larger improvements in self-rated general health between T1 and T2 (0.566, CI 0.183; 0.949) than longstanding permit holders. This association was not significant for changes in number of chronic conditions. Mediation analyses showed that the effect of getting a residence permit on health improvements transited through an improvement in living conditions, in particular employment and the presence of family/social support. CONCLUSION: These results suggest that change in residence permit is beneficial for health mainly because of the change in living difficulties. These results add up to the evidence on the role of social circumstances for refugees upon resettlement, and point at labour participation and social support as key mechanisms for health improvements.

Lanari, D., et al. (2015). "Self-perceived health among Eastern European immigrants over 50 living in Western Europe." Int J Public Health **60**(1): 21-31.

OBJECTIVES: This paper examines whether Eastern European immigrants aged 50 and over living in Northern and Western Europe face a health disadvantage in terms of self-perceived health, with respect to the native-born. We also examined health changes over time (2004-2006-2010) through the probabilities of transition among self-perceived health states, and how they vary according to nativity status and age group. METHODS: Data were obtained from the Survey of Health, Ageing and Retirement in Europe (SHARE). Logistic regressions and probabilities of transition were used. RESULTS: Results emphasise the health disadvantage of Eastern European immigrants living in Germany, France and Sweden with respect to the native-born, even after controlling for socio-economic status. Probabilities of transition also evidenced that people born in Eastern Europe were more likely to experience worsening health and less likely to recover from sickness. CONCLUSIONS: This paper suggests that health inequalities do not affect immigrant groups in equal measure and confirm the poorer and more steeply deteriorating health status of Eastern European immigrants.

Lassetter, J. H. et Callister, L. C. (2009). "The impact of migration on the health of voluntary migrants in western societies." J Transcult Nurs **20**(1): 93-104.

The authors reviewed literature on the health of voluntary migrants to Western societies and factors affecting their health. Health indicators include mortality rates and life expectancy, birth outcomes, risk of illness, patterns of deteriorating health, cardiovascular disease, body mass index, hypertension, and depression. Multiple factors explain variability, including length of residence and acculturation, disease exposure, life style and living conditions, risky behaviors, healthy habits, social support networks, cultural and linguistic barriers, experiences with racism, and levels of awareness of cultural health practices among health care providers. Evidence exists for superior health among many migrants to Western countries relative to native-born persons, but the differential disappears over time. Migration is a dynamic, extended process with effects occurring years after physical relocation. Systemic change is required, including health policies that ensure equity for migrants, culturally appropriate health promotion, and routine assessment of migration history, cultural health practices, and disease exposure.

Lee, H., et al. (2016). "Is There Disparity in Cardiovascular Health Between Migrant Workers and Native Workers?" Workplace Health Saf.

The purpose of this study was to identify the probability of developing cardiovascular disease (CVD)

and its association with metabolic syndrome (MS) risk factors among middle-aged Korean Chinese (KC) migrant women workers compared to comparable native Korean (NK) women workers. Using matched samples based on the propensity score matching method, 10-year CVD risk was calculated and MS risk factors identified. Logistic regression and classification and regression tree (CART) analysis were conducted. The probability of KC migrants' 10-year CVD risk was significantly lower (6.4%) than NK women risk (7.8%, t = 1.99, p = .048). Blood pressure of 130/85 mmHg or higher was found to be a significant risk factor for 10-year CVD risk in both groups. The findings support existing knowledge about the healthy immigrant effect on CVD and MS risk factors. The findings could be the basis for occupational health professionals to pursue policy initiatives and public health and occupational health interventions to improve CVD outcomes among migrant women workers including KC migrants.

Legido-Quigley, H. et McKee, M. (2012). "Health and social fields in the context of lifestyle migration." Health Place **18**(6): 1209-1216.

Migrants occupy different social fields encompassing both their origin and their destination. Much previous work on interactions within these fields has focused on economic migrants. In this paper we seek to understand the social fields occupied by British pensioners who have moved to Spain and how these interact with their health and their experience of the healthcare system. We explore the links between health, social fields, healthcare, place and social relationships. We use in-depth interviews conducted among those living in a variety of settings. We draw upon Bourdieu's concept of habitus and social fields and differentiate, between ways of being and ways of belonging in the fields. We identified three social fields. The first embraced interviewees' social networks back in the UK where implicit comparisons of healthcare were made. The second embraced their expatriate social networks in Spain which includes their conceptualization of a "healthy life", while the third included the interaction with Spanish institutions, including the healthcare system. This conceptual framework provides new insights for those considering retirement abroad, and those that want to understand how lifestyles and navigating distinct social fields influence health and the healthcare experience

Ljunge, M. (2016). Migrants, Health, and Happiness: Evidence that Health Assessments Travel with Migrants and Predict Well-Being. IFN Working Paper ; 1112. Stochkolm IFN**:** 35 , tab., graph., fig. http://www.ifn.se/wfiles/wp/wp1112.pdf

Health assessments correlate with health outcomes and subjective well-being. Immigrants offer an opportunity to study persistent social influences on health where the social conditions are not endogenous to individual outcomes. This approach provides a clear direction of causality from social conditions to health, and in a second stage to well-being. Natives and immigrants from across the world residing in 30 European countries are studied using survey data. The paper applies within country analysis using both linear regressions and two stage least squares. Natives' and immigrants' individual characteristics have similar predictive power for health, except Muslim immigrants who experience a sizeable health penalty. Average health reports in the immigrant's birth country have a significant association with the immigrant's current health. Almost a quarter of the birth country health variation is brought by the immigrants, while conditioning on socioeconomic characteristics. There is no evidence of the birth country predictive power declining neither as the immigrant spends more time in the residence country nor over the life course. The second stage estimates indicate that a one standard deviation improvement in health predicts higher happiness by 1.72 point or 0.82 of a standard deviation, more than four times the happiness difference of changing employment status from unemployed to employed. Studying life satisfaction yields similar results. Health improvements predict substantial increases in individual happiness.

Ljunge, M. (2014). "Social capital and health: evidence that ancestral trust promotes health among children of immigrants." Econ Hum Biol **15**: 165-186.

This paper presents evidence that generalized trust promotes health. Children of immigrants in a broad set of European countries with ancestry from across the world are studied. Individuals are examined within country of residence using variation in trust across countries of ancestry. The approach addresses reverse causality and concerns that the trust measure picks up institutional factors in the individual's contextual setting. There is a significant positive estimate of ancestral trust

in explaining self-assessed health. The finding is robust to accounting for individual, parental, and extensive ancestral country characteristics. Individuals with higher ancestral trust are also less likely to be hampered by health problems in their daily life, providing evidence of trust influencing real life outcomes. Individuals with high trust feel and act healthier, enabling a more productive life.

Lu, Y., et al. (2017). "Health of newly arrived immigrants in Canada and the United States: Differential selection on health." Health Place **48**: 1-10.

Canada and the U.S. are two major immigrant-receiving countries characterized by different immigration policies and health care systems. The present study examines whether immigrant health selection, or the "healthy immigrant effect", differs by destination and what factors may account for differences in immigrant health selection. We use 12 years of U.S. National Health Interview Survey and Canadian Community Health Survey data to compare the risks of overweight/obesity and chronic health conditions among new immigrants in the two countries. Results suggest a more positive health selection of immigrants to Canada than the U.S. Specifically, newly arrived U.S. immigrants are more likely to be overweight or obese and have serious chronic health conditions than their Canadian counterparts. The difference in overweight/obesity was explained by differences in source regions and educational levels of immigrants across the two countries. But this is not the case for serious chronic conditions. These results suggest that immigration-related policies can potentially shape immigrant health selection.

Makarova, N., et al. (2015). "Applications and limitations of the concept of 'avoidable mortality' among immigrant groups in Europe: a scoping review." Public Health **129**(4): 342-350.

OBJECTIVES: Avoidable mortality is often used as a key indicator of broader health inequalities. Health inequalities refer to unfair differences in the quality of health and wellbeing, and health care across different populations. This includes differences in the presence of disease, health outcomes, or access to health care. Migrants represent a disadvantaged and growing demographic with special health risks. This study analyses the usages of the concept of avoidable mortality as applied in studies on migrants in Europe. In doing so, the study aims to identify the strengths and limitations of the concept of avoidable mortality for comparative work. STUDY DESIGN: A scoping review was conducted for the period of 1990-2011. METHODS: Publications were identified by a systematic search of PUBMED and WEB OF SCIENCE. An additional five publications were found through the search via references. A total number of 37 publications from 10 European countries were included in the analysis. RESULTS: The authors divided studies according to direct versus indirect usage of the concept. Studies with direct usage of the concept established a correlation between patterns of avoidable mortality and health care system performance. Additionally, they searched studies which indirectly used avoidable mortality to examine further evidence for the strengths and weaknesses of the concept. These studies used indicators of amenable mortality (at times alongside other mortality indicators) without making direct reference to the concept. Findings using both approaches identified a similar trend in principal causes of premature death. The difference between the two types of studies concerned the more detailed analysis of the causes of death in studies with direct usage categorising into treatable versus preventable causes of death, or health policy versus medical intervention. CONCLUSIONS: The results of this article highlight the role of health care systems in contributing to migrant health outcomes: whereas mixed outcomes across a number of indicators of avoidable mortality used indirectly do arise, the large number of studies - especially those using the concept directly - evidence a higher share of premature mortality for migrants compared to host populations. These findings can provide policy makers with important insights into targeted ways of improving the access and quality of health services for marginalised populations. However, the strength and depth of such insights stand to improve, as current research on avoidable mortality is often indirect (rather than overt and systematic), thereby limiting the potential for cross-national comparison, as well as a clearer understanding of the links between health outcomes and health care system performance for a disadvantaged group.

Malmusi, D. (2015). "Immigrants' health and health inequality by type of integration policies in European countries." Eur J Public Health **25**(2): 293-299.

BACKGROUND: Recent efforts to characterize integration policy towards immigrants and to compare immigrants' health across countries have rarely been combined so far. This study explores the relationship of country-level integration policy with immigrants' health status in Europe. METHODS: Cross-sectional study with data from the 2011 European Union Survey on Income and Living Conditions. Fourteen countries were grouped according to a typology of integration policies based on the Migrant Integration Policy Index: 'multicultural' (highest scores: UK, Italy, Spain, Netherlands, Sweden, Belgium, Portugal, Norway, Finland), 'exclusionist' (lowest scores: Austria, Denmark) and 'assimilationist' (high or low depending on the dimension: France, Switzerland, Luxembourg). People born in the country (natives, n = 177 300) or outside the European Union with >10 years of residence (immigrants, n = 7088) were included. Prevalence ratios (PR) of fair/poor self-rated health between immigrants in each country cluster, and for immigrants versus natives within each, were computed adjusting by age, education, occupation and socio-economic conditions. RESULTS: Compared with multicultural countries, immigrants report worse health in exclusionist countries (age-adjusted PR, 95% CI: men 1.78, 1.49-2.12; women 1.58, 1.37-1.82; fully adjusted, men 1.78, 1.50-2.11; women 1.47, 1.26-1.70) and assimilationist countries (age-adjusted, men 1.21, 1.03-1.41; women 1.21, 1.06-1.39; fully adjusted, men 1.19, 1.02-1.40; women 1.22, 1.07-1.40). Health inequalities between immigrants and natives were also highest in exclusionist countries, where they persisted even after adjusting for differences in socio-economic situation. CONCLUSION: Immigrants in 'exclusionist' countries experience poorer socio-economic and health outcomes. Future studies should confirm whether and how integration policy models could make a difference on migrants' health.

Martinez, O., et al. (2015). "Evaluating the impact of immigration policies on health status among undocumented immigrants: a systematic review." J Immigr Minor Health **17**(3): 947-970.

Over the past two decades, new anti-immigration policies and laws have emerged to address the migration of undocumented immigrants. A systematic review of the literature was conducted to assess and understand how these immigration policies and laws may affect both access to health services and health outcomes among undocumented immigrants. Eight databases were used to conduct this review, which returned 325 papers that were assessed for validity based on specified inclusion criteria. Forty critically appraised articles were selected for analysis; thirty articles related to access to health services, and ten related to health outcomes. The articles showed a direct relationship between anti-immigration policies and their effects on access to health services. In addition, as a result of these policies, undocumented immigrants were impacted by mental health outcomes, including depression, anxiety, and post-traumatic stress disorder. Action items were presented, including the promotion of cultural diversity training and the development of innovative strategies to support safety-net health care facilities serving vulnerable populations.

Nielsen, S. S. et Krasnik, A. (2010). "Poorer self-perceived health among migrants and ethnic minorities versus the majority population in Europe: a systematic review." Int J Public Health **55**(5): 357-371.

OBJECTIVES: Knowledge about self-perceived health can help us understand the health status and needs among migrants and ethnic minorities in the European Union (EU) which is essential to improve equity and integration. The objective was to examine and compare self-perceived health among migrant and ethnic minority groups in the EU countries. METHODS: Publications were ascertained by a systematic search of PUBMED and EMBASE. Eligibility of studies was based on the abstracts and the full texts. Additional articles were identified via the references. The final number of studies included was 17. RESULTS: Publications were identified in 5 out of the 27 EU countries. In regard to self-perceived health, most migrants and ethnic minority groups appeared to be disadvantaged as compared to the majority population even after controlling for age, gender, and socioeconomic factors. Only limited cross-country comparisons could be carried out, still they revealed a parallel pattern of self-perceived health among similar migrant/ethnic minority groups. CONCLUSIONS: Policies to improve social and health status, contextual factors, and access to healthcare among migrants and ethnic minorities are essential to reduce ethnic inequalities in health.

Noymer, A. et Lee, R. (2013). "Immigrant health around the world: evidence from the World Values Survey." J Immigr Minor Health **15**(3): 614-623.

We describe the relationship between immigrant status and self-rated health around the world, both in raw descriptive statistics and in models controlling for individual characteristics. Using the World Values Survey (1981-2005), we analyze data from 32 different countries worldwide. We estimate four regression models per country. The basic model tests mean differences in self-rated health. Additional models add demographic and social class controls. Introduction of control variables (most particularly, age) changes the results dramatically. In the final model, net of controls, only two countries show poorer immigrant health and three countries show better immigrant health. The multivariate regression models net of controls show few differences in health status between immigrants and the native born. The age structure of immigrant populations is an important mediator of differences in health status compared to the native-born population.

O'Donnell, C. A., et al. (2016). "Reducing the health care burden for marginalised migrants: The potential role for primary care in Europe." Health Policy **120**(5): 495-508.
http://dx.doi.org/10.1016/j.healthpol.2016.03.012

Increasing diversity and numbers of marginalised migrants a feature across Europe. Entitlement to care, access and use of co-payments add to their care seeking burden.?Strong primary care systems may mitigate that burden. External forces, such as austerity, must not be allowed to reduce migrant's access to primary care. Policies improving entitlement and reducing the impact of financial burdens could improve access to primary care for migrants.

Organisation Mondiale de la Santé (2022). World report on the health of refugees and migrants: Health for all, including refugees and migrants: Time to act, Genève : OMS
https://www.who.int/publications/i/item/9789240054462

Worldwide, more people are on the move now than ever before, yet many refugees and migrants face poorer health outcomes than the host populations. Addressing their health needs is, therefore, a global health priority and integral to the principle of the right to health for all. The key is to strengthen and maintain health systems by ensuring that they are refugee- and migrant-sensitive and inclusive.Health outcomes are influenced by a whole host of determinants. However, refugees and migrants face additional determinants such as precarious legal status; discrimination; social, cultural, linguistic, administrative and financial barriers; lack of information about health entitlements; low health literacy; and fear of detention and deportation. This groundbreaking publication outlines current and future opportunities and challenges and provides several strategies to improve the health and well-being of refugees and migrants. It is an advocacy tool for national and international policy-makers involved in health and migration. Evidence on the health of refugees and migrants remains fragmented – comparable data across countries and over time are urgently needed to track progress towards the health-related United Nations Sustainable Development Goals. With only 8 years until the 2030 target date to transform our world, the time to act is now.

Organisation Mondiale de la Santé (2018). Report on the health of refugees and migrants in the WHO European Region: no public health without refugee and migrant health, Copenhague : OMS Bureau régional de l'Europe
http://www.euro.who.int/en/publications/abstracts/report-on-the-health-of-refugees-and-migrants-in-the-who-european-region-no-public-health-without-refugee-and-migrant-health-2018

À l'heure actuelle, les migrants internationaux représentent près d'un dixième de la population de la Région européenne de l'OMS. La recherche d'un emploi constitue l'une des principales raisons pour lesquelles l'on décide d'émigrer à l'étranger, bien que la violence, les conflits, les catastrophes naturelles et les violations des droits de l'homme y contribuent également. La migration et le déplacement sont des déterminants sociaux qui influent sur la santé des réfugiés et des migrants. Le Bureau régional de l'OMS pour l'Europe a pris l'initiative d'aider les États membres à promouvoir la santé des réfugiés et des migrants, et à traiter les aspects de la santé de ces populations qui relèvent de la santé publique. Il a institué le programme Migration et santé spécialement à cette fin. Afin

d'atteindre les objectifs de développement durable et de parvenir à la couverture sanitaire universelle, il importe d'acquérir une vue d'ensemble de l'état de santé des réfugiés et des migrants et des interventions menées par les systèmes de santé. En outre, cette initiative est conforme au cadre Santé 2020. Ce rapport, le premier du genre, constitue une base de données factuelles dont le but est de catalyser la mise en place et la promotion de systèmes de santé tenant compte des besoins des migrants dans les 53 États membres de la Région européenne de l'OMS et au-delà. Le présent rapport vise à mettre en lumière les causes et les conséquences des besoins sanitaires des réfugiés et des migrants de la Région ainsi que les défis auxquels ils sont confrontés, tout en présentant un aperçu des progrès réalisés. Il cherche également à recenser les lacunes nécessitant la prise d'autres mesures en collaboration, à améliorer la collecte et la disponibilité de données de qualité, et à favoriser les initiatives politiques.

Razum, O. et Stronks, K. (2014). "The health of migrants and ethnic minorities in Europe: where do we go from here?" Eur J Public Health **24**(5): 701-702.

Rafnsson, S. B., et al. (2013). "Sizable variations in circulatory disease mortality by region and country of birth in six European countries." Eur J Public Health **23**(4): 594-605.

BACKGROUND: Circulatory disease mortality inequalities by country of birth (COB) have been demonstrated for some EU countries but pan-European analyses are lacking. We examine inequalities in circulatory mortality by geographical region/COB for six EU countries. METHODS: We obtained national death and population data from Denmark, England and Wales, France, the Netherlands, Scotland and Sweden. Mortality rate ratios (MRRs) were constructed to examine differences in circulatory, ischaemic heart disease (IHD) and cerebrovascular disease mortality by geographical region/COB in 35-74 years old men and women. RESULTS: South Asians in Denmark, England and Wales and France experienced excess circulatory disease mortality (MRRs 1.37-1.91). Similar results were seen for Eastern Europeans in these countries as well as in Sweden (MRRs 1.05-1.51), for those of Middle Eastern origin in Denmark (MRR = 1.49) and France (MRR = 1.15), and for East and West sub-Saharan Africans in England and Wales (MRRs 1.28 and 1.39) and France (MRRs 1.24 and 1.22). Low ratios were observed for East Asians in France, Scotland and Sweden (MRRs 0.64-0.50). Sex-specific analyses showed results of similar direction but different effect sizes. The pattern for IHD mortality was similar to that for circulatory disease mortality. Two- to three-fold excess cerebrovascular disease mortality was found for several foreign-born groups compared with the local-born populations in some countries. CONCLUSIONS: Circulatory disease mortality varies by geographical region/COB within six EU countries. Excess mortality was observed for some migrant populations, less for others. Reliable pan-European data are needed for monitoring and understanding mortality inequalities in Europe's multiethnic populations.

Rechel, B., Mladovsky, P., Ingleby, D., et al. (2013). "Migration and health in an increasingly diverse Europe." Lancet **381**.
http://dx.doi.org/10.1016/S0140-6736(12)62086-8

Rechel, B., et al. (2012). "Monitoring migrant health in Europe: a narrative review of data collection practices." Health Policy **105**(1): 10-16.

BACKGROUND: Data on the health of migrants, including on health determinants and access to health services, are an essential pre-condition for providing appropriate and accessible health services to this population group. This article reviews how far current data collection systems in the European Union (EU) allow to monitor migrant health. METHODS: We searched the academic literature using PubMed and reviewed the results of recent EU-funded research projects on migrant health. RESULTS: Most EU member states lack information on the health of migrants, limiting the possibility for monitoring and improving migrant health. National death registers allow for disaggregation according to migrant status in 24 of 27 EU member states. Registry data on health care utilization by migrant status are available in only 11 of 27 member states, although in most cases this only covers secondary and not primary care. Only few countries collect large-scale survey data on migrant health and health care utilization. CONCLUSION: Many EU countries need to step up their organizational and regulatory efforts to monitor migrant health if the current lack of data on migrant health should be overcome. This could be done through the inclusion of improved questions on migration in existing data

collection processes.

Sole-Auro, A., et al. (2008). Health of Immigrants in European countries. Barcelone, RIAC**:** 23p.

The health of older immigrants can have important consequences for needed social support and demands placed on health systems. This paper examines health differences between immigrants and the native born populations aged 50 years and older in 11 European countries. We examine differences in functional ability, disability, disease presence and behavioral risk factors, for immigrants and non-immigrants using data from the Survey of Health, Aging and Retirement in Europe (SHARE) database. Among the 11 European countries, migrants generally have worse health than the native population. In these countries, there is a little evidence of the "healthy migrant" at ages 50 years and over. In general, it appears that growing numbers of immigrants may portend more health problems in the population in subsequent years.

Spallek, J., et al. (2015). "Suicide among immigrants in Europe--a systematic literature review." Eur J Public Health **25**(1): 63-71.

BACKGROUND: Concerns about increased suicide risk among immigrants to European countries have been raised. We review the scientific literature on differences in suicide among immigrants compared with the majority populations in Europe's major immigration countries. METHODS: We searched the databases PubMed and PsycINFO for peer-reviewed epidemiological studies published in 1990-2011, which compared suicide risks of adult immigrant groups with the risks of the majority population in European countries. Hits were screened by two researchers. RESULTS: We included 24 studies in the review. No generalizable pattern of suicide among immigrants was found. Immigrants 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. Gender and age differences were observed. Young female immigrants from Turkey, East Africa and South Asia are a risk group. CONCLUSION: Immigrants 'bring along' their suicide risk, at least for the initial period they spend in the immigration country. Health-care planners and providers need to be aware of this 'imported risks'. However, most immigrant groups do not have an increased suicide risk relative to the local-born population; some may even experience substantially lower risks.

Sze, M., et al. (2015). "Migrant health in cancer: outcome disparities and the determinant role of migrant-specific variables." Oncologist **20**(5): 523-531.

BACKGROUND: Multiethnic societies face challenges in delivering evidence-based culturally competent health care. This study compared health-related quality of life and psychological morbidity in a hospital-based sample of first-generation migrants and Australian-born Anglo cancer patients, controlling for potential confounders related to migrant status. Further, it explored the relative contribution of ethnicity versus migrant-related variables. METHODS: Eligible participants, recruited via 16 oncology clinics in Australia, included those over the age of 18, diagnosed with cancer (any type or stage) within the previous 12 months and having commenced treatment at least 1 month previously. RESULTS: In total, 571 migrant patients (comprising 145 Arabic, 248 Chinese, and 178 Greek) and a control group of 274 Anglo-Australian patients participated. In multiple linear regression models adjusted for age, sex, education, marital status, socioeconomic status, time since diagnosis, and type of cancer, migrants had clinically significantly worse health-related quality of life (HRQL; 3.6-7.3 points on FACT-G, $p < .0001$), higher depression and anxiety (both $p < .0001$), and higher incidence of clinical depression ($p < .0001$) and anxiety ($p = .003$) than Anglo-Australians. Understanding the health system ($p < .0001$ for each outcome) and difficulty communicating with the doctor ($p = .04$ to .0001) partially mediated the impact of migrancy. In migrant-only analyses, migrant-related variables (language difficulty and poor understanding of the health system), not ethnicity, predicted outcomes. CONCLUSION: Migrants who develop cancer have worse psychological and HRQL outcomes than Anglo-Australians. Potential targets for intervention include assistance in navigating the health system, translated information, and cultural competency training for health professionals.

Urquia, M. L., et al. (2014). "Disparities in pre-eclampsia and eclampsia among immigrant women giving birth in

six industrialised countries." Bjog **121**(12): 1492-1500.

OBJECTIVE: To assess disparities in pre-eclampsia and eclampsia among immigrant women from various world regions giving birth in six industrialised countries. DESIGN: Cross-country comparative study of linked population-based databases. SETTING: Provincial or regional obstetric delivery data from Australia, Canada, Spain and the USA and national data from Denmark and Sweden. POPULATION: All immigrant and non-immigrant women delivering in the six industrialised countries within the most recent 10-year period available to each participating centre (1995-2010). METHODS: Data was collected using standardised definitions of the outcomes and maternal regions of birth. Pooled data were analysed with multilevel models. Within-country analyses used stratified logistic regression to obtain odds ratios (OR) with 95% confidence intervals (95% CI). MAIN OUTCOME MEASURES: Pre-eclampsia, eclampsia and pre-eclampsia with prolonged hospitalisation (cases per 1000 deliveries). RESULTS: There were 9,028,802 deliveries (3,031,399 to immigrant women). Compared with immigrants from Western Europe, immigrants from Sub-Saharan Africa and Latin America & the Caribbean were at higher risk of pre-eclampsia (OR: 1.72; 95% CI: 1.63, 1.80 and 1.63; 95% CI: 1.57, 1.69) and eclampsia (OR: 2.12; 95% CI: 1.61, 2.79 and 1.55; 95% CI: 1.26, 1. 91), respectively, after adjustment for parity, maternal age and destination country. Compared with native-born women, European and East Asian immigrants were at lower risk in most industrialised countries. Spain exhibited the largest disparities and Australia the smallest. CONCLUSION: Immigrant women from Sub-Saharan Africa and Latin America & the Caribbean require increased surveillance due to a consistently high risk of pre-eclampsia and eclampsia.

Villalonga-Olives, E. et Kawachi, I. (2014). "The changing health status of economic migrants to the European Union in the aftermath of the economic crisis." J Epidemiol Community Health **68**(9): 801-803.

Vollset, S. E., Goren, E., Yuan, C.-W., et al. (2020). "Fertility, mortality, migration, and population scenarios for 195 countries and territories from 2017 to 2100: a forecasting analysis for the Global Burden of Disease Study." The Lancet(Ahead of pub).
https://doi.org/10.1016/S0140-6736(20)30677-2

Understanding potential patterns in future population levels is crucial for anticipating and planning for changing age structures, resource and health-care needs, and environmental and economic landscapes. Future fertility patterns are a key input to estimation of future population size, but they are surrounded by substantial uncertainty and diverging methodologies of estimation and forecasting, leading to important differences in global population projections. Changing population size and age structure might have profound economic, social, and geopolitical impacts in many countries. In this study, we developed novel methods for forecasting mortality, fertility, migration, and population. We also assessed potential economic and geopolitical effects of future demographic shifts.

White, K., et al. (2012). "Elucidating the role of place in health care disparities: the example of racial/ethnic residential segregation." Health Serv.Res. **47**(3 Pt 2): 1278-1299.

OBJECTIVE: To develop a conceptual framework for investigating the role of racial/ethnic residential segregation on health care disparities. DATA SOURCES AND SETTINGS: Review of the MEDLINE and the Web of Science databases for articles published from 1998 to 2011. STUDY DESIGN: The extant research was evaluated to describe mechanisms that shape health care access, utilization, and quality of preventive, diagnostic, therapeutic, and end-of-life services across the life course. PRINCIPAL FINDINGS: The framework describes the influence of racial/ethnic segregation operating through neighborhood-, health care system-, provider-, and individual-level factors. Conceptual and methodological issues arising from limitations of the research and complex relationships between various levels were identified. CONCLUSIONS: Increasing evidence indicates that racial/ethnic residential segregation is a key factor driving place-based health care inequalities. Closer attention to address research gaps has implications for advancing and strengthening the literature to better inform effective interventions and policy-based solutions

Williams, F. (2012). "Converging variations in migrant care work in Europe." Journal of European Social Policy

22(4): 363-376.

While the employment of migrant women as care workers in European welfare states is increasing, the rate, extent and nature of this increase vary. The article draws on empirical research on migrant care work to develop links between three levels of analysis ƒ_" micro, meso and macro. The main aim is to progress analysis of the meso level by developing indicators attached to three sets of regimes ƒ_" care regimes, migration regimes and employment regimes. It is argued that variations emerge in the ways these three regimes intersect within any one country. These intersections allow us to look across different sites, markets and sectors of care work and, in so doing, reveal a degree of growing convergence across Europe in the employment of migrant care labour. This convergence contributes, at the macro level, to a transnational political economy of care

Un coup d'œil par pays

Allemagne

Buchcik, J., Borutta, J., Nickel, S., et al. (2021). "Health-related quality of life among migrants and natives in Hamburg, Germany: An observational study." BMC Psychiatry **3**: 100045.

PURPOSE: The aim of this observational study was firstly, to assess the Health-related Quality of Life (HrQoL) among migrants and German natives in Hamburg, Germany, using the SF-12 mental and physical summary scores and secondly, to evaluate the contribution of selected sociodemographic and socioeconomic variables to explain the variance in mental and physical HrQoL separately for migrants and natives. METHODS: Face-to-face interviews were conducted with n=809 participants between May 2018 and July 2019 in six randomly selected statistical districts of Hamburg grouped into four levels of socioeconomic status (SES). The SF-12 questionnaire was used to measure the HrQoL. Socioeconomic (school education, income) and sociodemographic (age, gender, marital status, children) data was recorded, too. RESULTS: Migrants and natives scored higher in mental (migrants: M=45.77, SD=7.66; natives: M=47.60, SD=6.14) than in physical HrQoL (migrants: M=42.55, SD=5.55; natives: M=42.03, SD=4.71). Natives had a significantly higher (p<0.001) SF-12 mental summary score than migrants. There was a positive association between education and mental HrQoL (β=0.248, p=2.308) in the migrant but not in the native group. Due to limitations of the study the results of the impact of migration on the HrQoL require interpretation. CONCLUSION: Differences between migrants and German natives in HrQoL were partially confirmed. Future research should differentiate more strongly between migration contexts as well as other determinants of health (e.g. early life, social support, unemployment) and their policy implications according to the WHO.

Giuntella, O. et Mazzonna, F. (2015). "Do immigrants improve the health of natives?" J Health Econ **43**: 140-153.

This paper studies the effects of immigration on health. Specifically, we merge information on individual characteristics from the German Socio-Economic Panel (1984-2009) with detailed local labour market characteristics, and we then exploit the longitudinal component of the data to determine how immigration affects the health of both immigrants and natives over time. We find that immigrants to Germany are healthier than natives upon their arrival (the healthy immigrant effect) but that immigrants' health deteriorates over time. We show that the convergence in health is heterogeneous across immigrants and occurs more rapidly among those working in more physically demanding jobs. Because immigrants are significantly more likely to work in strenuous occupations, we investigate whether changes in the spatial concentration of immigrants affect the health of the native population. Our results suggest that immigration reduces the likelihood that residents will report negative health outcomes. We show that these effects are concentrated in blue-collar occupations and are stronger among low-educated natives. Improvements in natives' average working conditions and workloads help explain the positive effects of immigration on the health of the native population.

Glaesmer, H., et al. (2011). "Health care utilization among first and second generation immigrants and native-born Germans: a population-based study in Germany." Int J Public Health **56**(5): 541-548.

OBJECTIVES: There are contradictory findings on health care utilization (HCU) of immigrants compared to native-born populations. Our study focuses on this topic using a population-based approach and differentiates generational cohorts of immigrants. METHODS: In a representative population survey in Germany (N = 2,510), immigrant background/generational cohort and HCU in the preceding 12 months were screened by means of self-rating instruments. RESULTS: 11.1% (7.0% first and 4.1% second generation) of the sample are immigrants. No differences have been detect with regard to subjective state of health, satisfaction with life and with health and functional disabilities. First generation immigrants contacted a medical specialist less likely, but they more frequently use general practitioners (GPs) than the native-born Germans and the second generation immigrants. CONCLUSIONS: First generation immigrants show remarkable differences in HCU compared to the native-born Germans and the second generation immigrants. Their HCU seems to be focused on primary care, and access to secondary care might be complicated. It seems relevant to especially pay attention to HCU of first generation immigrants and to support equal access to care for this subgroup.

Kohls, M. (2015). "[Mortality risks of migrants: Analysis of the healthy-migrant-effect after the 2011 German Census]." Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz **58**(6): 519-526.

In Germany there are 16 million people with a migration background, one in five of the total population. There are relatively few migrant mortality studies in Germany, which is primarily due to the restricted quantity and quality of existing data. The official migrant death statistics for Germany suffer from incomplete migrant population stock data due to non-registered remigration events. After the German census in 2011 especially the migrant stock data was adjusted downwards, and therefore realistic estimates of the migrant mortality risk and the healthy-migrant-effect are possible. Between 2010 and 2013 mortality risks of foreigners rose strongly due to the census corrections of the migrant population. However, the risks for adults and pensioners still lie below the risks for Germans in the same age groups. The lower risks indicate a healthy-migrant-effect, whicht was primarily effective shortly after the immigration event. Analysis based on data from the Statutory Pension Insurance (GRV) shows higher migrant mortality risks in the age group from 65 to 84. In that age group there are supposedly a lot of people, who immigrated to Germany in the context of the guest worker recruitment in the 1950s to 1970s and who had hard working conditions in their lifetimes. Their mortality risk, therefore, increased in the long-term perspective. In the future the lack of data in the migrant population will again rise due to unregistered remigration. Alternative databases need to be used for migrant mortality analyses.

Kuehne, A., et al. (2015). "Subjective health of undocumented migrants in Germany - a mixed methods approach." BMC Public Health **15**(1): 926.

BACKGROUND: Health of migrants is known to be above-average in the beginning of the migration trajectory. At the same time reports from non-government organisations (NGOs) suggest that undocumented migrants in Germany tend to present late and in poor health at healthcare facilities. In this paper, we explore the health status of undocumented migrants with a mixed method approach including complementary qualitative and quantitative datasets. METHODS: Undocumented migrants attending a NGO based in Hamburg, Germany, were asked to fill in the SF-12v2, a standardized questionnaire measuring health-related quality of life (HRQOL). The SF-12v2 was analyzed in comparison to the U.S. American norm sample and a representative German sample. Differences in mean scores for HRQOL were evaluated with a t-test and with a generalized linear model analyzing the impact of living without legal status on HRQOL. The quantitative research was complemented by a qualitative ethnographic study on undocumented migration and health in Berlin, Germany. The study included semi-structured interviews, informal conversations and participant observation with Latin American migrants over the course of three years. The study focused on subjective experiences of illness and health and the impact of illegality on migrants' health and access to health care. RESULTS: HRQOL was significantly worse in the sample of undocumented migrants (n = 96) as compared to the U.S. American sample ($p < 0.005$). Living without legal status displayed a significant negative effect on

subjective mental and physical health (p </= 0.003) in the generalized linear model when adjusted for age and gender compared to the representative German population sample. The ethnographic study, which included 35 migrants, identified socio-economic conditions, the subjective experiences of criminalization, and late presentation at healthcare-facilities as the three main factors impacting on health from migrant perspective. DISCUSSION: The present research suggests a high morbidity and mortality in this comparatively young population. The ethnographic research confirms negative impacts on health of social determinants in general and stressassociated with living without legal status in particular, both are further aggravated by exclusion from health care services. In addition to the provision of health care it appears to be important to structurally tackle the underlying social conditions which affect undocumented migrants' health. CONCLUSIONS: Living without legal status has a negative impact on health and well-being. Limited access to care may further exacerbate physical and mental illness. Possibilities to claim basic rights and protection as well as access to care without legal status appear to be important measures to improve health and well-being.

Lotty, E. Y., et al. (2015). "[Health Status of Persons without Health Insurance and of Undocumented Migrants: Analysis of Data from the Malteser Migranten Medizin (MMM) in Munich, Germany]." Gesundheitswesen **77**(6): e143-152.

INTRODUCTION: It is estimated that more than 100,000 persons are without health insurance in Germany. The number of undocumented migrants is roughly estimated to be about 40,000. There are hardly any empirical studies looking at health care provision for these population groups, it is even rarely stressed that more empirical studies are needed. There seems to be a major gap concerning perception and research. The present study aims at promoting this discussion by presenting analyses based on data from an institution providing health care for these population groups, i. e., the Malteser Migranten Medizin (MMM) in Munich. METHODS: Data were available from all patients coming to MMM between January 2009 and October 2012 (i. e., from 2,352 visits altogether). The following information is available for each visit: date, sex, age group, country of origin, residence permit status (3 groups), diagnosis (ICD-10 chapter), type of health care (4 broad groups). Multivariate analyses have been conducted for simultaneous control of these variables. In order to compare these data with information from the general population, data from a large statutory sickness fund have been included as well. RESULTS: Focusing first on the MMM patients, the analyses showed large differences concerning diagnoses by country of origin and by residence permit status. We were not able, however, to confirm the hypothesis that mental health problems are especially common among undocumented migrants. The comparison with the general population indicated, surprisingly, that MMM patients showed a very similar spectrum of diagnoses as compared with the general population. CONCLUSION: The data from MMM do not allow a precise assessment of health care need, they still indicate, though, how different the patients are who seek help. MMM offers a broad range of health care, but it is hardly possible to meet the manifold demands of all the patients; there is no psychotherapist, for example. The resources available at MMM will always just allow a very limited provision of health care. It would be important to promote the integration of persons without health insurance and for undocumented migrants into the general system of statutory sickness funds.

Morawa, E. et Erim, Y. (2015). "Health-related quality of life and sense of coherence among Polish immigrants in Germany and indigenous Poles." Transcult Psychiatry **52**(3): 376-395.

Immigrants are faced with several impediments in the host country that may affect their quality of life (QoL), but little is known about the impact of these stressors as well as about the protective role of sense of coherence (SoC) in the context of Polish immigration to Germany. Health Related QoL (Short Form Health Survey SF-36) and SoC (Sense of Coherence Scale SOC-29) were assessed in a total sample consisting of 511 participants aged between 18 and 84 years (260 Polish immigrants in Germany and 251 indigenous Poles). Polish immigrants reported a significantly lower mental and physical health-related QoL than the German norm population, but they were comparable to native Poles. This result remained the same when the model was adjusted for age but physical health status was better for immigrants compared with indigenous Poles. Both groups scored significantly lower for SoC than Germans, but did not differ from each other. The main differences concerning the examined variables were with respect to the German norm population and are putatively shaped by culture.

Nesterko, Y., Turrion, C. M., Friedrich, M., et al. (2019). "Trajectories of health-related quality of life in immigrants and non-immigrants in Germany: a population-based longitudinal study." Int J Public Health **64**(1): 49-58.

OBJECTIVES: Due to a lack of longitudinal studies on health in immigrants, the purpose of the present study is to investigate trajectories of health-related quality of life (HRQoL) in immigrants and non-immigrants in Germany by considering the impact of immigration-related factors. METHODS: Based on longitudinal SOEP data from 2002 to 2012, the trajectories of the mental (MCS) and physical component (PCS) of HRQoL (assessed with SF-12v2) were analyzed in 8546 subjects, including 1064 immigrants by conducting hierarchical linear models. RESULTS: MCS remains stable over time, whereas PCS shows a decrease, influenced by increasing age. There were no differences between immigrants and non-immigrants concerning PCS trajectories as well as no influence of immigration-related factors on it. In contrast, MCS trajectories were influenced by immigration-related factors: 2nd-generation immigrants, participants from Turkey or Southern Europe and those who immigrated at young age show a slight decrease in MCS over time. CONCLUSIONS: The results show negative association between MCS and time in different groups of immigrants. Future research is needed for better conceptualization of the complex interplay between health and migration over time to identify subgroups at greater risk for mental distress.

Schlopker, K., et al. (2009). "[Unresolved problems of undocumented migrants in Germany: an analysis of medical consultations in Berlin, Cologne and Bonn]." Gesundheitswesen **71**(12): 839-844.

INTRODUCTION: Little is known about health related problems of undocumented migrants in Germany. Patterns for medical consultations and socio-demographic characteristics are only available in isolated reports. This article identifies and compares empirical data from non-governmental organisations (NGOs) who provide medical care for unregistered migrants. METHODS: Annual reports of 2006 and 2007 of the Malteser Migranten Medizin (Berlin, Cologne) and the MediNetz Bonn were selected for this document analysis. RESULTS: We identified similarities and differences in the socio-demographic background and patterns of medical consultations between the explored regions. The number of documented migrants without medical insurance increased during the observed period. DISCUSSION: The patterns of health-care utilisation for undocumented immigrants changed in the observed period which might be caused by the EU enlargement to the East. The heterogeneous quality of the annual reports and the lack of information about the use of alternative health-care facilities limit the results of this analysis.

Schunck, R., et al. (2015). "Pathways between perceived discrimination and health among immigrants: evidence from a large national panel survey in Germany." Ethn Health **20**(5): 493-510.

OBJECTIVE: Discrimination is an important determinant of health, and its experience may contribute to the emergence of health inequalities between immigrants and nonimmigrants. We examine pathways between perceived discrimination and health among immigrants in Germany: (1) whether perceptions of discrimination predict self-reported mental and physical health (SF-12), or (2) whether poor mental and physical health predict perceptions of discrimination, and (3) whether discrimination affects physical health via mental health. DESIGN: Data on immigrants come from the German Socio-Economic Panel (SOEP) from the years 2002 to 2010 (N = 8,307), a large national panel survey. Random and fixed effects regression models have been estimated. RESULTS: Perceptions of discrimination affect mental and physical health. The effect of perceived discrimination on physical health is mediated by its effect on mental health. Our analyses do not support the notion that mental and physical health predict the subsequent reporting of discrimination. Different immigrant groups are differentially exposed to perceived discrimination. CONCLUSION: In spite of anti-discrimination laws, the health of immigrants in Germany is negatively affected by perceived discrimination. Differential exposure to perceived discrimination may be seen as a mechanism contributing to the emergence of health inequalities in Germany.

Waller, H. (2008). "[Health problems and health-care among unregistered migrants: a comparison between

Germany and Italy]." Gesundheitswesen **70**(1): 4-8.

Public health aspects concerning health and health-care of unregistered migrants have been rarely investigated. This article aims at providing some empirical data which are derived from the documentation and annual reports of two health-care institutions specialised in health-care for unregistered migrants in Germany and Italy taking into account the different legal regulations between Germany and Italy for the health-care of irregular migrants. The data show that the patients in both institutions are rather young and immigrated often from East Europe and the former Soviet Union. Their main diseases did not differ much from the average spectrum except for showing a higher prevalence of "poverty-related illnesses" like infectious and skin diseases.

Vandenheede, H., et al. (2015). "Mortality in adult immigrants in the 2000s in Belgium: a test of the 'healthy-migrant' and the 'migration-as-rapid-health-transition' hypotheses." Trop Med Int Health **20**(12): 1832-1845.

OBJECTIVE: Firstly, to map out and compare all-cause and cause-specific mortality patterns by migrant background in Belgium; and secondly, to probe into explanations for the observed patterns, more specifically into the healthy-migrant, acculturation and the migration-as-rapid-health-transition theories. METHODS: Data comprise individually linked Belgian census-mortality follow-up data for the period 2001-2011. All official inhabitants aged 25-54 at time of the census were included. To delve into the different explanations, differences in all-cause and chronic- and infectious-disease mortality were estimated using Poisson regression models, adjusted for age, socioeconomic position and urbanicity. RESULTS: First-generation immigrants have lower all-cause and chronic-disease mortality than the host population. This mortality advantage wears off with length of stay and is more marked among non-Western than Western first-generation immigrants. For example, Western and non-Western male immigrants residing 10 years or more in Belgium have a mortality rate ratio for cardiovascular disease of 0.72 (95% CI 0.66-0.78) and 0.59 (95% CI 0.53-0.66), respectively (vs host population). The pattern of infectious-disease mortality in migrants is slightly different, with rather high.

Yaman, F. et Cubi-Molla, P. (2017). Why Do Immigrants Report Lower Life Satisfaction? Research Paper ; 17-05. Londres OHE**:** 30 , tab., graph., fig.
https://www.ohe.org/publications/why-do-immigrants-report-lower-life-satisfaction

This study explores changes in the reporting behaviour of immigrants in Germany 1984-2010, in questions related to life satisfaction. Previous literature suggests that immigrants' happiness tends to decrease over time compared to the natives'. The authors firstly explore the robustness and origin of this finding, and then propose a model that has the potential to decompose the effect of the number of years since migration into a true change in life satisfaction and a simple change in reporting behaviour. The model suggests that the existence and size of the reporting bias depend on how accurately individuals remember their past life satisfaction.

Australie

Benza, S. et Liamputtong, P. (2014). "Pregnancy, childbirth and motherhood: a meta-synthesis of the lived experiences of immigrant women." Midwifery **30**(6): 575-584.

INTRODUCTION: pregnancy, childbirth and motherhood are natural processes that bring joy to individual women and families. However, for many migrant women, becoming a mother while attempting to settle in a new country where the culture is different, can be a challenge for them. AIM: to identify and synthesise qualitative research studies that explore the perceptions of pregnancy, childbirth and motherhood, and lived experiences of migrant women in their new home country. METHODS: the seven steps of Noblit and Hares meta-ethnography was used to conduct the meta-synthesis. Searches for literature of qualitative studies were conducted in May and June 2013 using PubMed, CINAHL, Google Scholar and La Trobe University databases. Studies published in English addressing pregnancy, childbirth and motherhood experiences of women from immigrant backgrounds met the inclusion criteria. FINDINGS: 15 studies published between 2003 and 2013

related to the pregnancy, childbirth and motherhood experiences for women from migrant backgrounds were eligible for the meta-synthesis. Four major themes were identified as common in all the qualitative studies: expectations of pregnancy and childbirth; experiences of motherhood; encountering confusion and conflict with beliefs; and dealing with migration challenges. CONCLUSIONS: migrant womens pregnancy, childbirth and motherhood experiences are influenced by societal and cultural values, and they vary depending on the adjustment process in the new home country. The provision of culturally sensitive maternal health services enhances positive outcomes of a healthy mother and healthy infant. Supportive structures that address the issue of language and cultural barriers seem to promote antenatal clinic attendance, prevent pregnancy and childbirth complications, and enhance their positive motherhood experiences. IMPLICATIONS: women from immigrant backgrounds have the right to receive adequate and sensitive health care during the childbearing and childrearing times regardless of their migrant status.

Riggs, E., et al. (2015). "Breaking down the barriers: a qualitative study to understand child oral health in refugee and migrant communities in Australia." Ethn Health **20**(3): 241-257.

OBJECTIVE: Australia is an increasingly multicultural nation. Never before has the dental workforce been exposed to such language, cultural, religious and ethnic diversity. There is evidence that refugee and migrant children experience significantly poorer oral health than the nonmigrant population. However, little is known about the oral health knowledge, practices and beliefs of parents with young children from refugee and migrant backgrounds. The aim of this study was to identify the sociocultural influences on child oral health in these communities. DESIGN: Participatory and qualitative research methods were utilised. Partnerships were established with community agencies representing migrants from Iraq, Lebanon and Pakistan. Focus group discussions and semi-structured interviews were conducted with community members. Qualitative data were analysed thematically, combining focus group and interview data. RESULTS: Over 100 women participated in focus groups (n = 11) and semi-structured interviews (n = 7). Key findings included the knowledge, beliefs and practices concerning: caries risk factors, oral health practices and oral health literacy. Despite mothers' knowledge of the major causes of poor oral health - dietary changes, confusion about child oral hygiene practices and limited oral health literacy all influenced child oral health outcomes. CONCLUSION: This culturally competent qualitative study explores the sociocultural factors influencing child oral health in refugee and migrant communities. Understanding and acknowledging these factors are a prerequisite to determining where and how to intervene to improve oral health. Furthermore, it has implications for both dental and non-dental health professionals working to reduce health inequalities within such communities.

Stubbe Ostergaard, L., et al. (2017). "Restricted health care entitlements for child migrants in Europe and Australia." Eur J Public Health **27**(5): 869-873.

Background: More than 300 000 asylum seeking children were registered in Europe alone during 2015. In this study, we examined entitlements for health care for these and other migrant children in Europe and Australia in a framework based on United Nations Convention of the Rights of the Child (UNCRC). Methods: Survey to child health professionals, NGO's and European Ombudspersons for Children in 30 EU/EEA countries and Australia, supplemented by desktop research of official documents. Migrant children were categorised as asylum seekers and irregular/undocumented migrants. Results: Five countries (France, Italy, Norway, Portugal and Spain) explicitly entitle all migrant children, irrespective of legal status, to receive equal health care to that of its nationals. Sweden and Belgium entitle equal care to asylum seekers and irregular non-EU migrants, while entitlements for EU migrants are unclear. Twelve European countries have limited entitlements to health care for asylum seeking children, including Germany that stands out as the country with the most restrictive health care policy for migrant children. In Australia entitlements for health care are restricted for asylum seeking children in detention and for irregular migrants. The needs of irregular migrants from other EU countries are often overlooked in European health care policy. Conclusion: Putting pressure on governments to honour the obligations of the UNCRC and explicitly entitle all children equal rights to health care can be an important way of advocating for better access to primary and preventive care for asylum seeking and undocumented children in Australia and the EU.

Belgique

Reus-Pons, M., et al. (2016). "Differences in mortality between groups of older migrants and older non-migrants in Belgium, 2001-09." Eur J Public Health **26**(6): 992-1000.

BACKGROUND: European societies are rapidly ageing and becoming multicultural. We studied differences in overall and cause-specific mortality between migrants and non-migrants in Belgium specifically focusing on the older population. METHODS: We performed a mortality follow-up until 2009 of the population aged 50 and over living in Flanders and the Brussels-Capital Region by linking the 2001 census data with the population and mortality registers. Overall mortality differences were analysed via directly age-standardized mortality rates. Cause-specific mortality differences between non-migrants and various western and non-western migrant groups were analysed using Poisson regression models, controlling for age (model 1) and additionally controlling for socio-economic status and urban typology (model 2). RESULTS: At older ages, most migrants had an overall mortality advantage relative to non-migrants, regardless of a lower socio-economic status. Specific migrant groups (e.g. Turkish migrants, French and eastern European male migrants and German female migrants) had an overall mortality disadvantage, which was, at least partially, attributable to a lower socio-economic status. Despite the general overall mortality advantage, migrants experienced higher mortality from infectious diseases, diabetes-related causes, respiratory diseases (western migrants), cardiovascular diseases (non-western female migrants) and lung cancer (western female migrants). CONCLUSION: Mortality differences between older migrants and non-migrants depend on cause of death, age, sex, migrant origin and socio-economic status. These differences can be related to lifestyle, social networks and health care use. Policies aimed at reducing mortality inequalities between older migrants and non-migrants should address the specific health needs of the various migrant groups, as well as socio-economic disparities.

Canada

Ali, J. S., et al. (2004). "Recent research on immigrant health from statistics Canada's population surveys." Can J Public Health **95**(3): I9-13.

This paper reviews recent research using Statistics Canada data to compare immigrant health with that of the Canadian-born. A number of Statistics Canada studies have been used for such comparisons, including the National Population Health Survey and the Canadian Community Health Survey. Across the range of indicators studied, compared to the Canadian-born, immigrants are generally in as good or better health, have similar or better health behaviours, and similar or less frequent health service use (the "healthy immigrant effect"). These indications appear to be strongest among recent and non-European immigrants. These studies have established baseline patterns and identified that important distinctions exist among immigrant subgroups. Future research on more detailed subgroups that uses longitudinal data and cross-culturally validated instruments is needed.

Beiser, M. (2005). "The health of immigrants and refugees in Canada." Can J Public Health **96 Suppl 2**: S30-44.

Canada admits between more than 200,000 immigrants every year. National policy emphasizes rigorous selection to ensure that Canada admits healthy immigrants. However, remarkably little policy is directed to ensuring that they stay healthy. This neglect is wrong-headed: keeping new settlers healthy is just, humane, and consistent with national self-interest. By identifying personal vulnerabilities, salient resettlement stressors that act alone or interact with predisposition in order to create health risk, and the personal and social resources that reduce risk and promote well-being, health research can enlighten policy and practice. However, the paradigms that have dominated immigrant health research over the past 100 years--the "sick" and "healthy immigrant," respectively--have been inadequate. Part of the problem is that socio-political controversy has influenced the questions asked about immigrant health, and the manner of their investigation. Beginning with a review of studies that point out the shortcomings of the sick immigrant and healthy immigrant paradigms, this article argues that an interaction model that takes into account both predisposition

and socio-environmental factors, provides the best explanatory framework for extant findings, and the best guide for future research. Finally, the article argues that forging stronger links between research, policy and the delivery of services will not only help make resettlement a more humane process, it will help ensure that Canada benefits from the human capital that its newest settlers bring with them.

Calvasina, P., et al. (2015). "The deterioration of Canadian immigrants' oral health: analysis of the Longitudinal Survey of Immigrants to Canada." Community Dent Oral Epidemiol **43**(5): 424-432.

OBJECTIVE: To examine the effect of immigration on the self-reported oral health of immigrants to Canada over a 4-year period. METHODS: The study used Statistics Canada's Longitudinal Survey of Immigrants to Canada (LSIC 2001-2005). The target population comprised 3976 non-refugee immigrants to Canada. The dependent variable was self-reported dental problems. The independent variables were as follows: age, sex, ethnicity, income, education, perceived discrimination, history of social assistance, social support, and official language proficiency. A generalized estimation equation approach was used to assess the association between dependent and independent variables. RESULTS: After 2 years, the proportion of immigrants reporting dental problems more than tripled (32.6%) and remained approximately the same at 4 years after immigrating (33.3%). Over time, immigrants were more likely to report dental problems (OR = 2.77; 95% CI 2.55-3.02). An increase in self-reported dental problems over time was associated with sex, history of social assistance, total household income, and self-perceived discrimination. CONCLUSION: An increased likelihood of reporting dental problems occurred over time. Immigrants should arguably constitute an important focus of public policy and programmes aimed at improving their oral health and access to dental care in Canada.

De Maio, F. G. et Kemp, E. (2010). "The deterioration of health status among immigrants to Canada." Glob Public Health **5**(5): 462-478.

A growing body of literature suggests that immigrants to Canada experience deterioration in their health status after settling in the country. While self-selection processes and Canadian immigration policy ensure that, at the time of arrival, immigrants are healthier than the Canadian-born population, this health advantage does not persist over time. This study uses new data from the Longitudinal Survey of Immigrants to Canada (N=7720) to examine how health transitions vary among immigrants. Logistic regression analyses indicate that visible minorities and immigrants who experienced discrimination or unfair treatment are most likely to experience a decline in self-reported health status. The results also confirm a clear inverse socioeconomic gradient with respect to increasing levels of feelings of sadness, depression and loneliness. These findings reflect important dimensions driving population health patterns in Canada, a country with a highly lauded health care system based on the principles of universality and comprehensiveness. Our findings suggest that discrimination and inequality partly drive the health transitions of immigrants. These factors, which largely operate outside of the formal health care system, need to be understood and addressed if health inequities are to be reduced.

Dunn, J. R. et Dyck, I. (2000). "Social determinants of health in Canada's immigrant population: results from the National Population Health Survey." Soc Sci Med **51**(11): 1573-1593.

As part of the Metropolis project--a large-scale investigation of immigration and integration, including well-being of immigrants in a number of areas of social life--in this paper we investigate the social determinants of health in Canada's immigrant population using Canada's National Population Health Survey (NPHS). Specifically, we examine differences in health status and health care utilization between immigrants and non-immigrants, immigrants of European and non-European origin, and immigrants of < 10 years and > 10 years' residence in Canada. We also examine social determinants of health care utilization and health status in immigrants and non-immigrants, and evaluate the utility of large-scale, national databases for these purposes. Our conceptual approach draws upon a 'population health' perspective, which suggests that the most important antecedents of human health status are not medical care inputs and health behaviours (smoking, diet, exercise, etc.), but rather social and economic characteristics of individuals and populations. We find no obvious, consistent pattern of

association between socio-economic characteristics and immigration characteristics on the one hand, and health status on the other, in the NPHS data. This does not mean that socio-economic factors in Canada are not influential in shaping immigrants' health status. In fact, the results of the logistic regression models calculated for immigrants and non-immigrants on four outcome variables in this study suggest that socio-economic factors are more important for immigrants than non-immigrants, although in ways that defy a simple explanation. The complexity of immigrants' experiences, combined with the inherent limitations of cross-sectional survey data are discussed as major limitations to this kind of research.

Edge, S. et Newbold, B. (2013). "Discrimination and the health of immigrants and refugees: exploring Canada's evidence base and directions for future research in newcomer receiving countries." J Immigr Minor Health **15**(1): 141-148.

Research and practice increasingly suggests discrimination compromises health. Yet the unique experiences and effects facing immigrant and refugee populations remain poorly understood in Canada and abroad. We review current knowledge on discrimination against newcomers in Canada, emphasizing impacts upon health status and service access to identify gaps and research needs. Existing knowledge centers around experiences within health-care settings, differences in perception and coping, mental health impacts, and debates about "non-discriminatory" health-care. There is need for comparative analyses within and across ethno-cultural groups and newcomer classes to better understand factors shaping how discrimination and its health effects are differentially experienced. Women receive greater attention in the literature given their compounded vulnerability. While this must continue, little is known about the experiences of youth and men. Governance and policy discourse analyses would elucidate how norms, institutions and practices shape discriminatory attitudes and responses. Finally, "non-discriminatory health-care" interventions require critical evaluation to determine their effectiveness.

Fuller-Thomson, E., et al. (2011). "Health decline among recent immigrants to Canada: findings from a nationally-representative longitudinal survey." Can J Public Health **102**(4): 273-280.

OBJECTIVE: The healthy immigrant effect suggests new immigrants to Canada enjoy better health, on average, than those born in Canada, yet cross-sectional data suggest that immigrants who have been in Canada for decades have comparable health to their native-born peers. We analyzed prospective cohort data to identify the factors associated with health decline among new immigrants. METHODS: The Longitudinal Survey of Immigrants to Canada was conducted by Statistics Canada and Citizenship and Immigration Canada between April 2001 and November 2005. A probability sample of 7,716 recent immigrants from abroad was interviewed three times: at six months, two years and four years after arrival in Canada. Logistic regression was used to model predictors of a two-step decline in self-reported health (e.g., from excellent to good or from very good to fair). RESULTS: Among recent immigrants, 15% reported a two-step decline in health in the first four years after arrival in Canada. In comparison, only 6% of non-immigrants from a similar age cohort reported a two-step decline in health during the same time period. The characteristics associated with an increased likelihood of health decline among recent immigrants include initial health status, age, gender, marital status, language skills and place/region of birth. Experience of discrimination was also associated with health decline. One in four immigrants who experienced a health decline reported problems accessing Canadian health services. CONCLUSIONS: The process of immigration is associated with health decline for some recent immigrants. These findings support Health Canada's identification of immigration as a determinant of health. Strategies need to be developed to improve access to health care among new immigrants.

George, M. A. et Bassani, C. (2015). "The health of immigrant children who live in areas with high immigrant concentration." Ethn Health: 1-13.

OBJECTIVES: Our objective is to contribute to the literature regarding the association between immigrant children's health, their ethnicity and their living in neighbourhoods with a high ethnic concentration of one's own ethnicity. Using data from families from five ethnic groups who all

immigrated to Vancouver metropolitan region in Canada, our research question asks: How ethnicity, ethnic concentration and living in a neighbourhood with others of the same ethnic background contribute to the health of immigrant children? DESIGN: Two data sets are integrated in our study. The first is the New Canadian Children and Youth Study, which collected original data from five ethnic groups who immigrated to metropolitan Vancouver. The second data set, from which we derived neighbourhood data, is the Canadian census. The dependent variable is health status as reported by the parent. Independent variables are at both the individual and neighbourhood levels, including ethnicity, sex and the percentage of people living in the neighbourhood of the same ethnic background. Analysis was completed using hierarchical linear modelling. RESULTS: Children (n = 759) from 24 neighbourhoods were included in the analyses. Health status varied by ethnicity and ethnic concentration, indicating the heterogeneity of immigrant populations. CONCLUSION: With the lack of research on the health of immigrant children and youth living in ethnic concentrations, our findings make an important contribution to understanding the influences on the well-being of immigrant populations.

Gushulak, B. D., et al. (2011). "Migration and health in Canada: health in the global village." Cmaj **183**(12): E952-958.

BACKGROUND: Immigration has been and remains an important force shaping Canadian demography and identity. Health characteristics associated with the movement of large numbers of people have current and future implications for migrants, health practitioners and health systems. We aimed to identify demographics and health status data for migrant populations in Canada. METHODS: We systematically searched Ovid MEDLINE (1996-2009) and other relevant web-based databases to examine immigrant selection processes, demographic statistics, health status from population studies and health service implications associated with migration to Canada. Studies and data were selected based on relevance, use of recent data and quality. RESULTS: Currently, immigration represents two-thirds of Canada's population growth, and immigrants make up more than 20% of the nation's population. Both of these metrics are expected to increase. In general, newly arriving immigrants are healthier than the Canadian population, but over time there is a decline in this healthy immigrant effect. Immigrants and children born to new immigrants represent growing cohorts; in some metropolitan regions of Canada, they represent the majority of the patient population. Access to health services and health conditions of some migrant populations differ from patterns among Canadian-born patients, and these disparities have implications for preventive care and provision of health services. INTERPRETATION: Because the health characteristics of some migrant populations vary according to their origin and experience, improved understanding of the scope and nature of the immigration process will help practitioners who will be increasingly involved in the care of immigrant populations, including prevention, early detection of disease and treatment.

Hien, A. et Lafontant, J. (2013). "[Inequities in health in minority communities: diagnosis of the situation among the Francophone immigrants of Sudbury]." Can J Public Health **104**(6 Suppl 1): S75-78.

OBJECTIVES: This article aims to uncover health inequities related not only to living in a linguistic minority, but also to being an immigrant and living in a new environment with a cultural background different from that of the host community. METHODS: This qualitative study presents the personal experiences of many Francophone immigrants in relation to services and health care in Sudbury and their perception about the quality and accessibility of these services and health care. Seventy-two (72) respondents aged between 18 and 65 years (45 men and 27 women) participated in this research through individual interviews and focus groups. RESULTS: The results show, among other things, that being immigrant and Francophone limits access to health services, affects the quality of these services and hinders being well supported when encountering health problems. Thus some individuals are not even able to give informed consent when making important decisions about their own health. CONCLUSION: The article makes recommendations that would allow access to better services and health care for immigrants, and would contribute to improving the health of the Canadian population of which they are an integral part.

Kim, I. H., et al. (2013). "Ethnicity and Postmigration Health Trajectory in New Immigrants to Canada."

American Journal of Public Health **103**(4): e96-e104.

Objectives. In this prospective cohort study, we examined the trajectory of general health during the first 4 years after new immigrants? arrival in Canada. We focused on the change in self-rated health trajectories and their gender and ethnic disparities. Methods. Data were derived from the Longitudinal Survey of Immigrants to Canada and were collected between April 2001 and November 2005 by Statistics Canada. We used weighted samples of 3309 men and 3351 women aged between 20 and 59 years. Results. At arrival, only 3.5% of new immigrants rated their general health as poor. Significant and steady increases in poor health were revealed during the following 4 years, especially among ethnic minorities and women. Specifically, we found a higher risk of poor health among West Asian and Chinese men and among South Asian and Chinese women than among their European counterparts. Conclusions. Newly arrived immigrants are extremely healthy, but the health advantage dissipates rapidly during the initial years of settlement in Canada. Women and minority ethnic groups may be more vulnerable to social changes and postmigration settlement Objectives. In this prospective cohort study, we examined the trajectory of general health during the first 4 years after new immigrants? arrival in Canada. We focused on the change in self-rated health trajectories and their gender and ethnic disparities. Methods. Data were derived from the Longitudinal Survey of Immigrants to Canada and were collected between April 2001 and November 2005 by Statistics Canada. We used weighted samples of 3309 men and 3351 women aged between 20 and 59 years. Results. At arrival, only 3.5% of new immigrants rated their general health as poor. Significant and steady increases in poor health were revealed during the following 4 years, especially among ethnic minorities and women. Specifically, we found a higher risk of poor health among West Asian and Chinese men and among South Asian and Chinese women than among their European counterparts. Conclusions. Newly arrived immigrants are extremely healthy, but the health advantage dissipates rapidly during the initial years of settlement in Canada. Women and minority ethnic groups may be more vulnerable to social changes and postmigration settlement

Lebihan, L., Mao Takongmoc, O. et McKellips, F. (2018). Health Disparities for Immigrants: Theory and Evidence from Canada. MPRA Paper : 87375. Munich MPRA**:** 20 , tabl.
https://mpra.ub.uni-muenchen.de/87375/

Few empirical studies have been conducted to analyse the disparities in health variables affecting immigrants in a given country. To our knowledge, no theoretical analysis has been conducted to explain health disparities for immigrants between regions in the same country that differs in term of languages spoken and income. In this paper, we use the Canadian Community Health Survey (CCHS) to compare multiple health measures among immigrants in Quebec, immigrants in the rest of Canada and Canadian-born individuals. We propose a simple structural model and conduct an empirical analysis in order to assess possible channels that can explain the health disparities for immigrants between two regions of the same country. Our results show that well-being and health indicators worsen significantly for immigrants in Quebec, compared to their counterparts in the rest of Canada and Canadian-born individuals. Additional econometric analysis also shows that life satisfaction is statistically and significantly associated with health outcomes. The proposed structural model predicts that, when the decision to migrate to a particular area is based on income alone, and if the fixed costs associated with the language barrier are large, immigrants may face health issues.

Newbold, B. (2005). "Health status and health care of immigrants in Canada: a longitudinal analysis." J Health Serv Res Policy **10**(2): 77-83.

OBJECTIVES: This paper focuses upon health status, need for care, and use of health care from 1994/95 to 2000/01 in the Canadian foreign-born population. METHODS: Using Statistics Canada's longitudinal National Population Health Survey, descriptive and survival analyses are used to explore immigrant health status and health care. RESULTS: The health status of immigrants quickly declines after arrival, with a concomitant increase in use of health care services. However, survival analysis of the risk of a change to poor health indicates no difference between immigrants and the native-born. Similarly, there is no difference in the risk of hospital use between the two populations. CONCLUSIONS: The health status of recent immigrant arrivals is observed to decline towards that of

the native-born population, while health care utilization increases. However, increased use may not be sufficient to offset declines in health, meaning that need for health care within the immigrant population may be unmet.

Newbold, K. B. et Danforth, J. (2003). "Health status and Canada's immigrant population." Soc Sci Med **57**(10): 1981-1995.

Given the framework of the 1984 Canada Health Act, the health status of immigrants should be similar to average levels within whole of Canada. Yet, assuming equality of health status between immigrant and non-immigrants, or between immigrant groups is likely an unrealistic and simplistic assumption, given unseen barriers affecting accessibility, the restructuring of the Canadian health care system, and problems with the provision of health care resources to the immigrant population. Using the National Population Health Survey, this paper focuses upon the health status of the immigrant population relative to that of non-immigrants within Canada, with reference to diagnosed conditions, self-assessed health, and the Health Utilities Index Mark 3. Findings indicate that, with the exception of the most recent arrivals, immigrants experience worse health status across most dimensions relative to non-immigrants. Multivariate analysis reveals that age, income adequacy, gender, and home ownership are dimensions upon which health status differs between the two groups.

Newbold, K. B. et Simone, D. (2015). "Comparing disability amongst immigrants and native-born in Canada." Soc Sci Med **145**: 53-62.

Given high levels of immigration into Canada and the associated requirement to understand the health needs of new arrivals, an extensive literature has developed over the past decade that has explored immigrant health issues, including the 'healthy immigrant effect'. Surprisingly, however, issues of disability within the immigrant population have received much less attention. Using data from Statistics Canada, 2006a, 2006b Participation and Activity Limitation Survey (PALS), this paper examines disability and its covariates amongst immigrants relative to non-immigrants in Canada. Compared with their native-born counterparts, recent immigrant arrivals (within the past 10 years) were less likely to report disability and less likely to report a severe disability than the native-born. However, differences in the rates and covariates of disabilities between males and female immigrants were observed, which are partially explained by socioeconomic and sociodemographic effects. The conclusion explores potential reasons why differentials in disability rates are observed, and points to future research directions.

Ng, E., Pottie, K. et Spitzer, D. (2011). "Official language proficiency and self-reported health among immigrants to Canada." Health Rep **22**(4): 15-23.

BACKGROUND: New immigrants to Canada initially report better health than does the Canadian-born population. With time, this "healthy immigrant effect" appears to diminish. Limited ability to speak English or French has been identified as a possible factor in poor health. This analysis explored the relationship between self-reported official language proficiency and transitions to poor self-reported health. DATA AND METHODS: Statistics Canada's Longitudinal Survey of Immigrants to Canada tracked a sample of the 2001 immigrant cohort for four years (6, 24 and 48 months after arrival). Data from each of the three survey waves were available for 7,716 respondents. Bivariate and multivariate analysis were used to examine associations between official language proficiency and self-reported health, by sex, controlling for selected pre-migration and post-migration factors. The prevalence of poor health among immigrants was compared with rates among the Canadian-born population, based on data from the Canadian Community Health Survey. RESULTS: Among a representative sample of recent immigrants, the prevalence of poor self-reported health had risen substantially, especially among women, after four years in Canada. Prolonged limited official language proficiency was strongly associated with a transition to poor health among male and female immigrants who had earlier reported good health. Other factors significantly associated with an increase in the prevalence of poor self-reported health differed by sex. Refugee status, self-reported discrimination, and living in Vancouver were significant for men. Age, health care access problems, and limited friendliness of neighbours were significant for women

Subedi, R. P. et Rosenberg, M. W. (2014). "Determinants of the variations in self-reported health status among recent and more established immigrants in Canada." Soc Sci Med **115**: 103-110.

Studies have shown that immigrants are normally in better health on arrival compared to their Canadian-born counterparts. However, the health conditions of new immigrants deteriorate after a few years of their arrival in Canada. This phenomenon is popularly termed the "healthy immigrant effect" (HIE) in the immigrant health literature. Although different hypotheses have been proposed to understand HIE, the causes are subject to ongoing discussion. Unlike previous studies, this study explored the possible causes behind the variations in the health status of recent and more established immigrants comparing 2001 and 2010 Canadian Community Health Surveys (CCHS). Four different hypotheses - namely lifestyle change, barriers to health care services, poor social determinants of health, and work related stress - were tested to understand variations in health status. The study concludes that there is a statistically significant difference in the socioeconomic characteristics and health outcomes of immigrants having less than and more than 10 years of residency in Canada. Logistic regression models show that the health conditions of immigrants are associated with age, sex, ethnic origin, smoking habit, Body Mass Index (BMI), total household income, number of consultations made with a family doctor per year and work related stress.

Wang, L. et Hu, W. (2013). "Immigrant health, place effect and regional disparities in Canada." Social Science & Medicine **98**(0): 8-17.

Abstract The paper addresses a critically important area in Canadian immigration and health from both a social and a spatial perspective. It employs multilevel and contextual approaches to examine the social determinants of immigrant health as well as the place effects on self-reported health at a regional and neighborhood scale. The data come from the raw microdata file of the 2005â€“10 Canadian Community Health Survey (a random national health survey) and the publicly available Canadian Marginalization index based on the 2006 Census. Three populations are compared: Canadian-born, overall foreign-born, and Chinese immigrants. The results suggest various degrees of association between self-reported health, individual and lifestyle behavioral characteristics, and neighborhood material deprivation and ethnic concentration in census tracts. These factors contribute differently to the reported health of Chinese immigrants, Canada's largest recent immigrant group. A healthy immigrant effect is partially evident in the overall foreign-born population, but appears to be relatively weak in Chinese immigrants. For all groups, neighborhood deprivation moderately increases the likelihood of reporting poor health. Ethnic concentration negatively affects self-rated health, with the exception of the slight protective effect of Chinese-specific ethnic density in census tracts. The multilevel models reveal significant area inequalities across Census Metropolitan Areas/Census Agglomerations in risk of reporting unhealthy status, with greater magnitude in the foreign-born population. The vast regional variations in health among Chinese immigrants should be interpreted carefully due to the group's heavy concentration in large cities. The study contributes to the literature on ethnicity and health by systematically incorporating neighborhood contextual effects in modeling the social determinants of immigrant health status. It fills a gap in the literature on neighborhoods and health by focusing on ethnically disparate groups rather than on the general population. By revealing regional disparities in health, the paper adds a spatial perspective to the work on immigrant health

Wang, L. et Hu, W. (2013). "Immigrant health, place effect and regional disparities in Canada." Soc Sci Med **98**: 8-17.

The paper addresses a critically important area in Canadian immigration and health from both a social and a spatial perspective. It employs multilevel and contextual approaches to examine the social determinants of immigrant health as well as the place effects on self-reported health at a regional and neighborhood scale. The data come from the raw microdata file of the 2005-10 Canadian Community Health Survey (a random national health survey) and the publicly available Canadian Marginalization index based on the 2006 Census. Three populations are compared: Canadian-born, overall foreign-born, and Chinese immigrants. The results suggest various degrees of association between self-reported health, individual and lifestyle behavioral characteristics, and neighborhood material

deprivation and ethnic concentration in census tracts. These factors contribute differently to the reported health of Chinese immigrants, Canada's largest recent immigrant group. A healthy immigrant effect is partially evident in the overall foreign-born population, but appears to be relatively weak in Chinese immigrants. For all groups, neighborhood deprivation moderately increases the likelihood of reporting poor health. Ethnic concentration negatively affects self-rated health, with the exception of the slight protective effect of Chinese-specific ethnic density in census tracts. The multilevel models reveal significant area inequalities across Census Metropolitan Areas/Census Agglomerations in risk of reporting unhealthy status, with greater magnitude in the foreign-born population. The vast regional variations in health among Chinese immigrants should be interpreted carefully due to the group's heavy concentration in large cities. The study contributes to the literature on ethnicity and health by systematically incorporating neighborhood contextual effects in modeling the social determinants of immigrant health status. It fills a gap in the literature on neighborhoods and health by focusing on ethnically disparate groups rather than on the general population. By revealing regional disparities in health, the paper adds a spatial perspective to the work on immigrant health.

Danemark

Norredam, M., et al. (2014). "Cancer mortality does not differ between migrants and Danish-born patients." Dan Med J **61**(6): A4848.

INTRODUCTION: The aim of this study was to compare cancer mortality among migrant patients with cancer mortality in Danish-born patients. MATERIAL AND METHODS: This was a historical prospective cohort study. All non-Western migrants (n = 56,273) who were granted a right to residency in Denmark between 1 January 1993 and 31 December 1999 were included and matched 1:4 on age and sex with Danish-born patients. Cancer patients in the cohort were identified through the Danish Cancer Registry and deaths and emigrations through the Central Population Register. Using a Cox regression model, mean sex-specific hazard ratio (HR) for all-cause mortality were estimated by ethnicity; adjusting for age, income, co-morbidity and disease stage. RESULTS: No significant differences were observed in mortality for gynaecological cancers between migrant women (HR = 1.12; 95% confidence interval (CI): 0.70-1.80) and Danish-born women. Correspondingly, migrant women (HR = 0.76; 95% CI: 0.49-1.17) showed no significant differences in breast cancer mortality compared with Danish-born women. Regarding lung cancer, neither migrant women (HR = 0.79; 95% CI: 0.45-1.40) nor men (HR = 0.73; 95% CI: 0.53-1.14) presented statistical variances in mortality rates compared with Danish-born patients. Similarly, for colorectal cancer, migrant women (HR = 0.64; 95% CI: 0.27-1.55) and men (HR = 1.58; 95% CI: 0.75-3.36) displayed no significant differences compared with Danish-born patients. CONCLUSION: Different trends were observed according to cancer type, but cancer mortality did not differ significantly between migrants and Danish-born patients. This may imply that the Danish health-care system provides equity in cancer care. FUNDING: The study was funded by the University of Copenhagen and Danielsens Fond. TRIAL REGISTRATION: not relevant.

Espagne

Cimas, M., et al. (2016). "Healthcare coverage for undocumented migrants in Spain: Regional differences after Royal Decree Law 16/2012." Health Policy **120**(4): 384-395.
http://dx.doi.org/10.1016/j.healthpol.2016.02.005
http://www.healthpolicyjrnl.com/article/S0168-8510(16)30023-9/abstract

The implementation of the Spanish RDL 16/2012 which took away healthcare coverage for undocumented migrant arose huge differences among regions. In decentralized health systems, within-country differences in access and/or entitlement can be as relevant as those reported among countries. Central controversial regulations, such as policies of healthcare exclusion, may be useless if regional authorities have power to overcome them.

Gil-Gonzalez, D., et al. (2014). "Racism, other discriminations and effects on health." J Immigr Minor Health

16(2): 301-309.

We study the probability of perceived racism/other forms of discrimination on immigrant and Spanish populations within different public spheres and show their effect on the health of immigrants using a cross-sectional design (ENS-06). VARIABLES: perceived racism/other forms of discrimination (exposure), socio-demographic (explicative), health indicators (dependent). Frequencies, prevalences, and bivariate/multivariate analysis were conducted separately for men (M) and women (W). We estimated the health problems attributable to racism through the population attributable proportion (PAP). Immigrants perceived more racism than Spaniards in workplace (ORM = 48.1; 95% CI 28.2-82.2), and receiving health care (ORW = 48.3; 95% CI 24.7-94.4). Racism and other forms of discrimination were associated with poor mental health (ORM = 5.6; 95% CI 3.9-8.2; ORW = 7.3; 95% CI 4.1-13.0) and injury (ORW = 30.6; 95% CI 13.6-68.7). It is attributed to perceived racism the 80.1% of consumption of psychotropics (M), and to racism with other forms of discrimination the 52.3% of cases of injury (W). Racism plays a role as a health determinant.

Malmusi, D., et al. (2010). "Migration-related health inequalities: showing the complex interactions between gender, social class and place of origin." Soc Sci Med **71**(9): 1610-1619.

In this paper, we briefly review theories and findings on migration and health from the health equity perspective, and then analyse migration-related health inequalities taking into account gender, social class and migration characteristics in the adult population aged 25-64 living in Catalonia, Spain. On the basis of the characterisation of migration types derived from the review, we distinguished between immigrants from other regions of Spain and those from other countries, and within each group, those from richer or poorer areas; foreign immigrants from low-income countries were also distinguished according to duration of residence. Further stratification by sex and social class was applied. Groups were compared in relation to self-assessed health in two cross-sectional population-based surveys, and in relation to indicators of socio-economic conditions (individual income, an index of material and financial assets, and an index of employment precariousness) in one survey. Social class and gender inequalities were evident in both health and socio-economic conditions, and within both the native and immigrant subgroups. Migration-related health inequalities affected both internal and international immigrants, but were mainly limited to those from poor areas, were generally consistent with their socio-economic deprivation, and apparently more pronounced in manual social classes and especially for women. Foreign immigrants from poor countries had the poorest socio-economic situation but relatively better health (especially men with shorter length of residence). Our findings on immigrants from Spain highlight the transitory nature of the 'healthy immigrant effect', and that action on inequality in socio-economic determinants affecting migrant groups should not be deferred.

Perez Ramirez, F., et al. (2013). "The migration process as a stress factor in pregnant immigrant women in Spain." J Transcult Nurs **24**(4): 348-354.

Spain has seen a significant increase of the immigrant population in the past two decades. There are 5.6 million registered immigrants in this country, and 63% of them range in age between 16 and 41 years; 47% of the immigrant population are women. This situation requires additional health care, particularly as it pertains to the sexual and reproductive health of female immigrants. The objective of our study was to determine if there were differences between women of Spanish origin and immigrant women in terms of obstetric outcomes (obstetric history, gestational age at end of gestation, and at delivery) and various psychological variables during the immediate postpartum period. This was a cross-sectional study-we evaluated 30 women of Spanish origin and 30 immigrant women during the immediate postpartum period. During the 4 months after delivery, we proceeded to gather perinatal data for the study participants from their health records, partograms, and nursing assessment notes. Additionally, and following the immediate postpartum period, participants filled out the Stress Perception and Stress Vulnerability Questionnaires, as well as the Optimism Scale. Immigrant women have greater perception of stress (p = .00) and vulnerability to stress (p = .001) than do Spanish women. However, no group differences were found in obstetric variables.

Reher, D. et Requena, M. L. (2009). "The National Immigrant Survey of Spain: A new data source for migration studies in Europe." Demogr Res **20**(12): 28 , tab., graph., fig.
http://www.demographic-research.org/Volumes/Vol20/12/

Spain has recently become the destination for large numbers of international migrants and now ranks as a key focal point for international migration in Europe. Currently, approximately one in ten residents in Spain are foreigners, up more than tenfold from figures existing at the outset of this century. Migration has now become a major social and political issue in the country. In order to provide reliable data about migrants in Spain for researchers and policy makers, acting on a proposal of a research team working within the context of the Population and Society Research Network (GEPS), the Spanish Statistical Office has recently carried out an extremely ambitious survey of foreign-born persons currently living in Spain. In the course of the survey, nearly 15,500 persons were interviewed regarding a large array of issues pertaining to their migration experience. Important documentation, including the project report, the methodological specifications of the survey, and the anonymized micro data have recently been made available to the scientific community and to policy makers at the website of the Instituto Nacional de Estadística. The purpose of this paper is to describe this data source, its content, its methodological underpinnings, and the way the fieldwork and data cleaning were carried out. Examples of preliminary results will be presented so as to underscore the potential this survey affords for researchers everywhere.

Rodriguez Alvarez, E., et al. (2014). "[Immigration and health: Social inequalities between native and immigrant populations in the Basque Country (Spain)]." Gac Sanit **28**(4): 274-280.

OBJECTIVE: To analyze health inequalities between native and immigrant populations in the Basque Country (Spain) and the role of several mediating determinants in explaining these differences. METHODS: A cross-sectional study was performed in the population aged 18 to 64 years in the Basque Country. We used data from the Basque Health Survey 2007 (n=4,270) and the Basque Health Survey for Immigrants 2009 (n=745). We calculated differences in health inequalities in poor perceived health between the native population and immigrant populations from distinct regions (China, Latin America, the Maghreb and Senegal). To measure the association between poor perceived health and place of origin, and to adjust this association by several mediating variables, odds ratios (OR) were calculated through logistic regression models. RESULTS: Immigrants had poorer perceived health than natives in the Basque Country, regardless of age. These differences could be explained by the lower educational level, worse employment status, lower social support, and perceived discrimination among immigrants, both in men and women. After adjustment was performed for all the variables, health status was better among men from China (OR: 0.18; 95% confidence interval [CI95%]: 0.04-0.91) and Maghreb (OR: 0.26; 95% CI: 0.08-0.91) and among Latin American women (OR: 0.36; 95% CI: 0.14-0.92) than in the native population. CONCLUSIONS: These results show the need to continue to monitor social and health inequalities between the native and immigrant populations, as well as to support the policies that improve the socioeconomic conditions of immigrants.

Salinero-Fort, M. A., et al. (2015). "Health-related quality of life of latin-american immigrants and spanish-born attended in spanish primary health care: socio-demographic and psychosocial factors." PLoS One **10**(4): e0122318.

BACKGROUND: This study compares the health-related quality of life of Spanish-born and Latin American-born individuals settled in Spain. Socio-demographic and psychosocial factors associated with health-related quality of life are analyzed. METHODS: A cross-sectional Primary Health Care multi center-based study of Latin American-born (n = 691) and Spanish-born (n = 903) outpatients from 15 Primary Health Care Centers (Madrid, Spain). The Medical Outcomes Study 36-Item Short Form Health Survey (SF-36) was used to assess health-related quality of life. Socio-demographic, psychosocial, and specific migration data were also collected. RESULTS: Compared to Spanish-born participants, Latin American-born participants reported higher health-related quality of life in the physical functioning and vitality dimensions. Across the entire sample, Latin American-born participants, younger participants, men and those with high social support reported significantly higher levels of physical health. Men with higher social support and a higher income reported significantly higher mental

health. When stratified by gender, data show that for men physical health was only positively associated with younger age. For women, in addition to age, social support and marital status were significantly related. Both men and women with higher social support and income had significantly better mental health. Finally, for immigrants, the physical and mental health components of health-related quality of life were not found to be significantly associated with any of the pre-migration factors or conditions of migration. Only the variable "exposure to political violence" was significantly associated with the mental health component (p = 0.014). CONCLUSIONS: The key factors to understanding HRQoL among Latin American-born immigrants settled in Spain are age, sex and social support. Therefore, strategies to maintain optimal health outcomes in these immigrant communities should include public policies on social inclusion in the host society and focus on improving social support networks in order to foster and maintain the health and HRQoL of this group.

Salinero-Fort, M. A., et al. (2012). "Self-reported health status in primary health care: the influence of immigration and other associated factors." PLoS One **7**(6): e38462.

OBJECTIVE: The aims of this study are to compare self-reported health status between Spanish-born and Latin American-born Spanish residents, adjusted by length of residence in the host country; and additionally, to analyse sociodemographic and psychosocial variables associated with a better health status. DESIGN: This is a cross-sectional population based study of Latin American-born (n = 691) and Spanish-born (n = 903) in 15 urban primary health care centres in Madrid (Spain), carried out between 2007 and 2009. The participants provided information, through an interview, about self-reported health status, socioeconomic characteristics, psychosocial factors and migration conditions. Descriptive and multiple logistic regression analyses were conducted. RESULTS: The Spanish-born participants reported a better health status than the Latin America-born participants (79.8% versus 69.3%, p<0.001). Different patterns of self-reported health status were observed depending on the length of residence in the host country. The proportion of immigrants with a better health status is greater in those who have been in Spain for less than five years compared to those who have stayed longer. Better health status is significantly associated with being men, under 34 years old, being Spanish-born, having a monthly incomes of over 1000 euros, and having considerable social support and low stress. CONCLUSIONS: Better self-reported health status is associated with being Spanish-born, men, under 34 years old, having an uppermiddle-socioeconomic status, adequate social support, and low stress. Additionally, length of residence in the host country is seen as a related factor in the self-reported health status of immigrants.

Sousa, E., et al. (2010). "Immigration, work and health in Spain: the influence of legal status and employment contract on reported health indicators." Int J Public Health **55**(5): 443-451.

OBJECTIVE: To analyze the relationship of legal status and employment conditions with health indicators in foreign-born and Spanish-born workers in Spain. METHODS: Cross-sectional study of 1,849 foreign-born and 509 Spanish-born workers (2008-2009, ITSAL Project). Considered employment conditions: permanent, temporary and no contract (foreign-born and Spanish-born); considered legal statuses: documented and undocumented (foreign-born). Joint relationships with self-rated health (SRH) and mental health (MH) were analyzed via logistical regression. RESULTS: When compared with male permanently contracted Spanish-born workers, worse health is seen in undocumented foreign-born, time in Spain </=3 years (SRH aOR 2.68, 95% CI 1.09-6.56; MH aOR 2.26, 95% CI 1.15-4.42); in Spanish-born, temporary contracts (SRH aOR 2.40, 95% CI 1.04-5.53); and in foreign-born, temporary contracts, time in Spain >3 years (MH: aOR 1.96, 95% CI 1.13-3.38). In females, highest self-rated health risks are in foreign-born, temporary contracts (aOR 2.36, 95% CI 1.13-4.91) and without contracts, time in Spain >3 years (aOR 4.63, 95% CI 1.95-10.97). CONCLUSIONS: Contract type is a health determinant in both foreign-born and Spanish-born workers. This study offers an uncommon exploration of undocumented migration and raises methodological issues to consider in future research.

Vazquez, M. L., et al. (2014). "[The impact of the economic crisis on the health and healthcare of the immigrant population. SESPAS report 2014]." Gac Sanit **28 Suppl 1**: 142-146.

Despite the economic crisis, the immigrant population of Spain continues to be high, with 5.7 million

persons (11.4%). This population, whose health needs are similar to those of the general population, is more vulnerable due to their exposure to worse social determinants (living and working conditions together with a higher risk of exclusion from social services). In this article, we analyze how the economic crisis affects or can affect the health of the immigrant population in Spain by examining distinct population-specific or institutional factors that influence the effects of the crisis and the available data. The available evidence is limited, but several effects can be identified: firstly, some social determinants, such as higher unemployment rates and worse working conditions, have deteriorated, which can be expected to lead to a worsening of health status. These consequences have already been described for mental health or have been estimated for infectious diseases. Secondly, political decisions have had a direct impact, excluding-with some exceptions-undocumented immigrants from the right to health care. Finally, the lower priority given to adapting health services to the specific characteristics of the immigrant population (most of whom are documented) together with the introduction of new barriers, has hampered or will hamper access to health care. As a result, the economic crisis can be expected to have a greater impact on the immigrant population.

Villarroel, N. et Artazcoz, L. (2012). "Heterogeneous patterns of health status among immigrants in Spain." Health Place **18**(6): 1282-1291.

OBJECTIVES: (1) To analyse differences in the self-perceived health and mental health status between the Spanish population and immigrants from the seven leading countries in terms of number of immigrants; (2) to examine whether differences are accounted for by socio-economic characteristics, and (3) to determine whether the patterns of associations differ by gender. METHODS: Data come from the 2006 Spanish National Health Survey. The sample was composed of all 20-64 year old Spaniards and immigrants from the seven countries with most immigrants in Spain (Argentina, Bolivia, Colombia, Ecuador, Peru, Romania and Morocco) [n=20,731]. RESULTS: In both sexes, people from Bolivia had poorer health outcomes, above all Bolivian males. Conversely, people from Argentina and Colombia had the best health outcomes. For the rest of the countries varied results depending on gender, country and health indicator were found. CONCLUSIONS: Differences in health status between people born in Spain and foreign-born people depend on relationships between country of birth, characteristics of the migration process, gender, ethnicity and the health outcome analyzed

Etats-Unis

Aguila, E. et Zissimopoulos, J. (2013). "Retirement and health benefits for Mexican migrant workers returning from the United States." Int Soc Secur Rev **66**(2): 101-125.

In the absence of a bilateral agreement for the portability and totalization of social security contributions between the United States and Mexico, this article examines the access to pension and health insurance benefits and employment status of older Mexican return migrants. We find that return migrants who have spent less than a year in the United States have a similar level of access to social security benefits as non-migrants. Return migrants who have spent at least a year in the United States are less likely to have public health insurance or social security benefits, and could be more vulnerable to poverty in old age. These results inform the debate on a bilateral social security agreement between the United States and Mexico to improve return migrants' social security.

Alcantara, C., et al. (2014). "Do post-migration perceptions of social mobility matter for Latino immigrant health?" Soc Sci Med **101**: 94-106.

Latino immigrants exhibit health declines with increasing duration in the United States, which some attribute to a loss in social status after migration or downward social mobility. Yet, research into the distribution of perceived social mobility and patterned associations to Latino health is sparse, despite extensive research to show that economic and social advancement is a key driver of voluntary migration. We investigated Latino immigrant sub-ethnic group variation in the distribution of perceived social mobility, defined as the difference between respondents' perceived social status of origin had they remained in their country of origin and their current social status in the U.S. We also

examined the association between perceived social mobility and past-year major depressive episode (MDE) and self-rated fair/poor physical health, and whether Latino sub-ethnicity moderated these associations. We computed weighted logistic regression analyses using the Latino immigrant subsample (N=1561) of the National Latino and Asian American Study. Puerto Rican migrants were more likely to perceive downward social mobility relative to Mexican and Cuban immigrants who were more likely to perceive upward social mobility. Perceived downward social mobility was associated with increased odds of fair/poor physical health and MDE. Latino sub-ethnicity was a statistically significant moderator, such that perceived downward social mobility was associated with higher odds of MDE only among Puerto Rican and Other Latino immigrants. In contrast, perceived upward social mobility was not associated with self-rated fair/poor physical health. Our findings suggest that perceived downward social mobility might be an independent correlate of health among Latino immigrants, and might help explain Latino sub-ethnic group differences in mental health status. Future studies on Latino immigrant health should use prospective designs to examine the physiological and psychological costs associated with perceived changes in social status with integration into the U.S. mainland.

Arenas, E., et al. (2015). "Return Migration to Mexico: Does Health Matter?" Demography.

We use data from three rounds of the Mexican Family Life Survey to examine whether migrants in the United States returning to Mexico in the period 2005-2012 have worse health than those remaining in the United States. Despite extensive interest by demographers in health-related selection, this has been a neglected area of study in the literature on U.S.-Mexico migration, and the few results to date have been contradictory and inconclusive. Using five self-reported health variables collected while migrants resided in the United States and subsequent migration history, we find direct evidence of higher probabilities of return migration for Mexican migrants in poor health as well as lower probabilities of return for migrants with improving health. These findings are robust to the inclusion of potential confounders reflecting the migrants' demographic characteristics, economic situation, family ties, and origin and destination characteristics. We anticipate that in the coming decade, health may become an even more salient issue in migrants' decisions about returning to Mexico, given the recent expansion in access to health insurance in Mexico.

Argeseanu Cunningham, S., et al. (2008). "Health of foreign-born people in the United States: a review." Health Place **14**(4): 623-635.

This paper identifies the overarching patterns of immigrant health in the US. Most studies indicate that foreign-born individuals are in better health than native-born Americans, including individuals of the same race/ethnicity. They tend to have lower mortality rates and are less likely to suffer from circulatory diseases, overweight/obesity, and some cancers. However, many foreign-born groups have higher rates of diabetes, some infections, and occupational injuries. There is heterogeneity in health among immigrants, whose health increasingly resembles that of natives with duration of US residence. Prospective studies are needed to better understand migrant health and inform interventions for migrant health maintenance.

Bennett, G. G., Wolin, K. Y., Askew, S., et al. (2007). "Immigration and obesity among lower income blacks." Obesity (Silver Spring) **15**(6): 1391-1394.

OBJECTIVE: Our objective was to examine the associations of nativity, immigrant generation, and language acculturation with obesity among lower income black adult men and women. RESEARCH METHODS AND PROCEDURES: Data from 551 black adult men and women were collected from participants in the Healthy Directions-Health Centers Study. Race/ethnicity and nativity were self-reported. Language acculturation was defined using participants' first language, preferred reading language, and language spoken at home. Mixed model logistic regression models were estimated to account for within-health center clustering. RESULTS: Foreign-born blacks had a lower obesity risk, compared with all U.S.-born participants, in multivariable analyses [odds ratio (OR) = 0.57, 95% confidence interval (CI), 0.38, 0.84]. Among U.S.-born participants, those with foreign-born parents were significantly less likely to be obese than individuals with U.S.-born parents (OR = 0.54; 95% CI,

0.37, 0.80). Low-moderate language acculturation also decreased the odds of being obese (OR = 0.45; 95% CI, 0.23, 0.88). DISCUSSION: Our findings suggest a protective effect of foreign-born status and low-moderate language acculturation on obesity risk among lower income black immigrants. These data highlight the importance of more frequently examining nativity in obesity-related research conducted among blacks.

Borjas, G. J. et Slusky, D. (2018). Health, Employment, and Disability: Implications from the Undocumented Population. NBER Working Paper Series ; n° 24504. Cambridge NBER**:** 54 , tabl., fig., annexes. http://papers.nber.org/papers/W24504

Disability benefit recipients in the United States have nearly doubled in the past two decades, growing substantially faster than the population. It is difficult to estimate how much of this increase is explained by changes in population health, as we often lack a valid counterfactual. We propose using undocumented immigrants as the counterfactual, as they cannot currently claim benefits. Using NHIS microdata, we estimate models of disability as a function of medical conditions for both the legal and undocumented populations. The relationship between health and disability is far stronger for those with legal status than it is for those who are undocumented. We find that almost all of the difference in disability trends between the two populations can be explained by different responses to underlying health impairments.

Bjornstrom, E. E. et Kuhl, D. C. (2014). "A different look at the epidemiological paradox: self-rated health, perceived social cohesion, and neighborhood immigrant context." Soc Sci Med **120**: 118-125.

We use data from Waves 1 and 2 of the Los Angeles Family and Neighborhood Survey to examine the effects of neighborhood immigrant concentration, race-ethnicity, nativity, and perceived cohesion on self-rated physical health. We limit our sample to adults whose addresses do not change between waves in order to explore neighborhood effects. Foreign-born Latinos were significantly less likely to report fair or poor health than African Americans and U.S.-born whites, but did not differ from U.S.-born Latinos. The main effect of immigrant concentration was not significant, but it interacted with nativity status to predict health: U.S.-born Latinos benefited more from neighborhood immigrant concentration than foreign-born Latinos. Perceived cohesion predicted health but immigrant concentration did not moderate the effect. Finally, U.S.-born Latinos differed from others in the way cohesion is associated with their health. Results are discussed within the framework of the epidemiological paradox.

Bradby, H. (2012). "Race, ethnicity and health: The costs and benefits of conceptualising racism and ethnicity." Soc Sci.Med **75**(6): 955-958.

Chatterji, P., et al. (2012). "Beware of being unaware: racial/ethnic disparities in chronic illness in the USA." Health Econ **21**(9): 1040-1060.

We study racial/ethnic disparities in awareness of chronic diseases using biomarker data from the 2006 Health and Retirement Study. We explore two alternative definitions of awareness and estimate a trivariate probit model with selection, which accounts for common, unmeasured factors underlying the following: (1) self-reporting chronic disease; (2) participating in biomarker collection; and (3) having disease, conditional on participating in biomarker collection. Our findings suggest that current estimates of racial/ethnic disparities in chronic disease are sensitive to selection, and also to the definition of disease awareness used. We find that African-Americans are less likely to be unaware of having hypertension than non-Latino whites, but the magnitude of this effect falls appreciably after we account for selection. Accounting for selection, we find that African-Americans and Latinos are more likely to be unaware of having diabetes compared to non-Latino whites. These findings are based on a widely used definition of awareness - the likelihood of self-reporting disease among those who have disease. When we use an alternative definition of awareness, which considers an individual to be unaware if he or she actually has the disease conditional on self-reporting not having it, we find higher levels of unawareness among racial/ethnic minorities versus non-Latino whites for both hypertension and diabetes. Copyright (c) 2012 John Wiley & Sons, Ltd

Chaumba, J. (2011). "Health status, use of health care resources, and treatment strategies of Ethiopian and Nigerian immigrants in the United States." Soc Work Health Care **50**(6): 466-481.

Although different health risks and behaviors displayed by contemporary U.S. immigrants create challenges for health care providers, knowledge on the health of and variations among African immigrant groups in the United States lags behind. This study compared health status, use of health care resources, and treatment strategies of 362 Ethiopian and Nigerian immigrants. The results indicated that mental health and English-speaking ability varied by country of birth. Furthermore, the study sample reported a low use of health care resources. These results suggest the existence of potential health issues among subsections of the African immigrant population that may threaten the maintenance of good health.

Diaz, C. J. et Niño, M. (2019). "Familism and the Hispanic Health Advantage: The Role of Immigrant Status." J Health Soc Behav **60**(3): 274-290.

Furtado, D., Papps, K. L. et Theodoropoulos, N. (2020). Who Goes on Disability when Times are Tough? The Role of Work Norms among Immigrants. GLO Discussion Paper ; 590**:** 53.
http://d.repec.org/n?u=RePEc:zbw:glodps:590&r=lab

We examine how work norms affect Social Security Disability Insurance (SSDI) take-up rates in response to worsening economic conditions. By focusing on immigrants in the US, we can consider the influence of work norms in a person's home country, which we argue are exogenous to labor market prospects in the US. We find that the probability of receiving SSDI is more sensitive to economic downturns among immigrants from countries where people place less importance on work. We also provide evidence that this result is not driven by differential sensitivities to the business cycle or differences in SSDI eligibility.

Gee, G. C. et Ford, C. L. (2011). "STRUCTURAL RACISM AND HEALTH INEQUITIES: Old Issues, New Directions." Du Bois Rev **8**(1): 115-132.

Racial minorities bear a disproportionate burden of morbidity and mortality. These inequities might be explained by racism, given the fact that racism has restricted the lives of racial minorities and immigrants throughout history. Recent studies have documented that individuals who report experiencing racism have greater rates of illnesses. While this body of research has been invaluable in advancing knowledge on health inequities, it still locates the experiences of racism at the individual level. Yet, the health of social groups is likely most strongly affected by structural, rather than individual, phenomena. The structural forms of racism and their relationship to health inequities remain under-studied. This article reviews several ways of conceptualizing structural racism, with a focus on social segregation, immigration policy, and intergenerational effects. Studies of disparities should more seriously consider the multiple dimensions of structural racism as fundamental causes of health disparities.

Gubernskaya, Z., et al. (2013). "(Un)Healthy immigrant citizens: naturalization and activity limitations in older age." J Health Soc Behav **54**(4): 427-443.

This research argues that immigrants' political, social, and economic incorporation experiences, which are embedded in individual life course trajectories and heavily influenced by governmental policies, play an important role in producing diverse health outcomes among older U.S. foreign-born persons. Using data from the 2008-2010 American Community Survey and 1998-2010 Integrated Health Interview Series, we demonstrate how naturalization, a key indicator of social and political inclusion, is related to functional health in midlife and older age. Consistent with the theoretical framework, we find that among those foreign-born who immigrated as children and young adults, naturalized citizens show better health at older ages compared with noncitizens, although this relationship is partly mediated by education. But among those older foreign-born who immigrated at middle and older ages, naturalized citizens report worse health compared with noncitizens. Moreover, this negative

health selection into naturalization becomes stronger for those naturalizing after the 1996 Welfare Reform Act.

Giuntella, O. (2017). "Why does the health of Mexican immigrants deteriorate? New evidence from linked birth records." J Health Econ **54**(1): 1-16.
http://ejournals.ebsco.com/direct.asp?ArticleID=4F378900B2D4F2FB4123

This study uses a unique dataset linking the birth records of two generations of children born in California and Florida (1970–2009) to analyze the mechanisms behind the generational decline observed in birth outcomes of children of Mexican origin. Calibrating a simple model of intergenerational transmission of birth weight, I show that modest positive selection on health at the time of migration can account for the initial advantage in birth outcomes of second-generation Mexicans. Moreover, accounting for the socioeconomic differences between second-generation Mexicans and white natives and the observed intergenerational correlation in birth weight, the model predicts a greater deterioration than that observed in the data. Using a subset of siblings and holding constant grandmother quasi-fixed effects, I show that the persistence of healthier behaviors among second-generation Mexican mothers can explain more than half of the difference between the model prediction and the observed birth outcomes of third-generation Mexicans.

Giuntella, O. et Stella, L. (2016). The Acceleration of Immigrant Unhealthy Assimilation. IZA Discussion Paper ; 9664. Bonn IZA**:** 12 , tabl., fig.
http://ftp.iza.org/dp9664.pdf

It is well-known that immigrants tend to be healthier than US natives and that this advantage erodes with time spent in the US. However, we know less about the heterogeneity of these trajectories among arrival cohorts. Recent studies have shown that later arrival cohorts of immigrants have lower entry wages and experience less economic assimilation. In this paper, we investigate whether similar cohort effects can be observed in the weight assimilation of immigrants in the US. Focusing on obesity, we show that more recent immigrant cohorts arrive with higher obesity rates and experience a faster "unhealthy assimilation" in terms of weight gain.

Giuntella, O. et Stella, L. (2016). "The Acceleration of Immigrant Unhealthy Assimilation." Health Economics: n/a-n/a.
http://dx.doi.org/10.1002/hec.3331

It is well known that immigrants tend to be healthier than US natives and that this advantage erodes with time spent in the USA. However, we know less about the heterogeneity of these trajectories among arrival cohorts. Recent studies have shown that later arrival cohorts of immigrants have lower entry wages and experience less economic assimilation. In this paper, we investigate whether similar cohort effects can be observed in the weight assimilation of immigrants in the USA. Focusing on obesity, we show that more recent immigrant cohorts arrive with higher obesity rates and experience a faster 'unhealthy assimilation' in terms of weight gain. Copyright © 2016 John Wiley & Sons, Ltd.

Hamilton, T. G. et Kawachi, I. (2013). "Changes in income inequality and the health of immigrants." Social Science & Medicine **80**(0): 57-66.

Research suggests that income inequality is inversely associated with health. This association has been documented in studies that utilize variation in income inequality across countries or across time from a single country. The primary criticism of these approaches is their inability to account for potential confounders that are associated with income inequality. This paper uses variation in individual experiences of income inequality among immigrants within the United States (U.S.) to evaluate whether individuals who moved from countries with greater income inequality than the U.S. have better health than those who migrated from countries with less income in equality than the U.S. Utilizing individual-level (March Current Population Survey) and country-level data (the United Nations Human Development Reports), we show that among immigrants who have resided in the U.S. between 6 and 20 years, self-reported health is more favorable for the immigrants in the former category (i.e., greater income inequality) than those in the latter (i.e., lower income inequality).

Results also show that self-reported health is better among immigrants from more developed countries and those who have more years of education, are male, and are married

Hilfinger Messias, D. K., et al. (2015). "The impact and implications of undocumented immigration on individual and collective health in the United States." Nurs Outlook **63**(1): 86-94.

A nation of immigrants, the United States currently has more foreign-born residents than any other country; approximately 28% of these foreign-born residents are undocumented immigrants--individuals who either entered or are currently residing in the country without valid immigration or residency documents. The complex and constantly changing social, political, and economic context of undocumented migration has profound effects on individuals, families, and communities. The lack of demographic and epidemiologic data on undocumented immigrants is a major public health challenge. In this article, we identify multiple dimensions of vulnerability among undocumented persons; examine how undocumentedness impacts health and health care access and utilization; and consider the professional, practice, and policy issues and implications for nurses.

Hummer, R. A. et Hayward, M. D. (2015). "Hispanic Older Adult Health & Longevity in the United States: Current Patterns & Concerns for the Future." Daedalus **144**(2): 20-30.

The Hispanic population aged sixty-five and over - the most socioeconomically disadvantaged subset of America's elderly - is projected to quintuple between 2012 and 2050. While current longevity patterns for Hispanics relative to whites are favorable, old-age functioning and disability patterns for Hispanics are unfavorable and have serious implications for caregivers; families; and local, state, and federal governments. Troubling signs for the future Hispanic population (which are shared to varying degrees with other vulnerable groups) include the unresolved legal status of unauthorized immigrants, continued low levels of insurance coverage even after health care reform, some unfavorable trends in health behaviors, and continued disadvantages in educational attainment and income relative to whites. We urge policy-makers to deal with these potentially problematic health and well-being issues. Not doing so could have detrimental consequences for the future of the Hispanic population as well as other at-risk groups and, by extension, the U.S. elderly population as a whole.

Janevic, T., et al. (2011). "Maternal education and adverse birth outcomes among immigrant women to the United States from Eastern Europe: a test of the healthy migrant hypothesis." Soc Sci Med **73**(3): 429-435.

Immigrant women to the U.S. often have more favorable birth outcomes than their native-born counterparts, including lower rates of preterm birth and low birth weight, a phenomenon commonly attributed to a healthy migrant effect. However, this effect varies by ethnicity and country of origin. No previous study has examined birth outcomes among immigrants from the post-Communist countries of Eastern Europe, a group which includes both economic migrants and conflict refugees. Using data on 253,363 singletons births from New York City during 1995-2003 we examined the risk of preterm birth (PTB) (<37 weeks) or delivering a term small-for-gestational-age (SGA) infant among immigrants from Russia and Ukraine (RU), Poland, and former Yugoslavia Republics (FYR) relative to US-born non-Hispanic whites (NHW). Women in all three Eastern European groups had significantly later entry into prenatal care, were more likely to be Medicaid recipients, and had lower educational attainment than US-born NHW. In binomial regression analyses adjusting for age, education, parity, and pre-pregnancy weight, women from RU and FYR had lower risk of PTB than US-born NHW, whereas women from Poland had similar risk. Lower SGA risk was found among women from Poland and FYR, but not RU. When stratified by education, women with <12 years of education from all Eastern European groups had a reduced risk of PTB relative to US-born NHW. An educational gradient in PTB and SGA risk was less pronounced in all Eastern European groups compared to US-born NHW. The healthy migrant effect is present among immigrants from Eastern Europe to the U.S., especially among women with less education and those from the former Yugoslavia, a group that included many conflict refugees.

Kirby, J. B., et al. (2012). "Race, place, and obesity: the complex relationships among community racial/ethnic

composition, individual race/ethnicity, and obesity in the United States." Am J Public Health **102**(8): 1572-1578.

Objectives. We explored the association between community racial/ethnic composition and obesity risk. Methods. In this cross-sectional study, we used nationally representative data from the Medical Expenditure Panel Survey linked to geographic data from the US Decennial Census and Census Business Pattern data. Results. Living in communities with a high Hispanic concentration (>/= 25%) was associated with a 0.55 and 0.42 increase in body mass index (BMI; defined as weight in kilograms divided by the square of height in meters) and 21% and 23% higher odds for obesity for Hispanics and non-Hispanic Whites, respectively. Living in a community with a high non-Hispanic Asian concentration (>/= 25%) was associated with a 0.68 decrease in BMI and 28% lower odds for obesity for non-Hispanic Whites. We controlled for individual- and community-level social, economic, and demographic variables. Conclusions. Community racial/ethnic composition is an important correlate of obesity risk, but the relationship differs greatly by individual race/ethnicity. To better understand the obesity epidemic and related racial/ethnic disparities, more must be learned about community-level risk factors, especially how built environment and social norms operate within communities and across racial/ethnic groups

Krieger, N. (2014). "Discrimination and Health Inequities." International Journal of Health Services **44**(4): 643-710.

In 1999, only 20 studies in the public health literature employed instruments to measure self-reported experiences of discrimination. Fifteen years later, the number of empirical investigations on discrimination and health easily exceeds 500, with these studies increasingly global in scope and focused on major types of discrimination variously involving race/ethnicity, indigenous status, immigrant status, gender, sexuality, disability, and age, separately and in combination. And yet, as I also document, even as the number of investigations has dramatically expanded, the scope remains narrow: studies remain focused primarily on interpersonal discrimination, and scant research investigates the health impacts of structural discrimination, a gap consonant with the limited epidemiologic research on political systems and population health. Accordingly, to help advance the state of the field, this updated review article: (a) briefly reviews definitions of discrimination, illustrated with examples from the United States; (b) discusses theoretical insights useful for conceptualizing how discrimination can become embodied and produce health inequities, including via distortion of scientific knowledge; (c) concisely summarizes extant evidence—both robust and inconsistent—linking discrimination and health; and (d) addresses several key methodological controversies and challenges, including the need for careful attention to domains, pathways, level, and spatiotemporal scale, in historical context.

Mehta, N. K., et al. (2013). "Child health in the United States: Recent trends in racial/ethnic disparities." Social Science & Medicine **95**(0): 6-15.

In the United States, race and ethnicity are considered key social determinants of health because of their enduring association with social and economic opportunities and resources. An important policy and research concern is whether the U.S. is making progress toward reducing racial/ethnic inequalities in health. While race/ethnic disparities in infant and adult outcomes are well documented, less is known about patterns and trends by race/ethnicity among children. Our objective was to determine the patterns of and progress toward reducing racial/ethnic disparities in child health. Using nationally representative data from 1998 to 2009, we assessed 17 indicators of child health, including overall health status, disability, measures of specific illnesses, and indicators of the social and economic consequences of illnesses. We examined disparities across five race/ethnic groups (non-Hispanic white, non-Hispanic black, Hispanic, non-Hispanic Asian, and non-Hispanic other). We found important racial/ethnic disparities across nearly all of the indicators of health we examined, adjusting for socioeconomic status, nativity, and access to health care. Importantly, we found little evidence that racial/ethnic disparities in child health have changed over time. In fact, for certain illnesses such as asthma, blackf_"white disparities grew significantly larger over time. In general, black children had the highest reported prevalence across the health indicators and Asian children had the lowest reported

prevalence. Hispanic children tended to be more similar to whites compared to the other race/ethnic groups, but there was considerable variability in their relative standing

Mendoza, F. S. (2009). "Health disparities and children in immigrant families: a research agenda." Pediatrics **124 Suppl 3**: S187-195.

Children in immigrant families now comprise 1 in 5 children in the United States. Eighty percent of them are US citizens, and 53% live in mixed-citizenship families. Their families are among the poorest, least educated, least insured, and least able to access health care. Nonetheless, these children demonstrate better-than-expected health status, a finding termed "the immigrant paradox" and one suggesting that cultural health behaviors among immigrant families might be protective in some areas of health. In this article the strength of the immigrant paradox, the effect of acculturation on health, and the relationships of acculturation, enculturation, language, and literacy skills to health disparities are reviewed. The current public policy issues that affect the health disparities of children of immigrant families are presented, and a research agenda for improving our knowledge about children in immigrant families to develop effective interventions and public policies that will reduce their health disparities is set forth.

Panikkar, B., et al. (2014). "Characterizing the low wage immigrant workforce: a comparative analysis of the health disparities among selected occupations in Somerville, Massachusetts." Am J Ind Med **57**(5): 516-526.

BACKGROUND: This study estimates job-related risks among common low wage occupations (cleaning, construction, food service, cashier/baggers, and factory workers) held by predominantly Haitian, El Salvadorian, and Brazilian immigrants living or working in Somerville, Massachusetts. METHODS: A community-based cross-sectional survey on immigrant occupational health was conducted between 2006 and 2009 and logistic regression was used to assess the job-related risks among the most common low wage occupations. RESULTS: Construction workers reported significantly higher health risks, and lower access to occupational health services than the other occupations. Compared to cashier/baggers, the reference population in this study, cleaners reported significantly lower access to health and safety and work training and no knowledge of workers' compensation. Factory workers reported significantly lower work training compared to cashier/baggers. Food service workers reported the least access to doctors compared to the other occupations. CONCLUSION: We found significant variability in risks among different low wage immigrant occupations. The type of occupation independently contributed to varying levels of risks among these jobs. We believe our findings to be conservative and recommend additional inquiry aimed at assuring the representativeness of our findings.

Prus, S. G., et al. (2010). "Comparing racial and immigrant health status and health care access in later life in Canada and the United States." Can J Aging **29**(3): 383-395.

Little comparative research exists on health experiences and conditions of minority groups in Canada and the United States, despite both countries having a racially diverse population with a significant proportion of immigrants. This article explores race and immigrant disparities in health and health care access across the two countries. The study focus was on middle and old age given the change and increasing diversity in health and health care policy, such as Medicare. Logistic regression analysis of data from the 2002-2003 Joint Canada/United States Survey of Health shows that the joint effect of race and nativity on health outcomes - health differences between native and foreign-born Whites and non-Whites - is largely insignificant in Canada but considerable in the U.S. Non-White native and foreign-born Americans within both 45-to-64 and 65-and-over age groups experience significant disadvantage in health status and access to care, irrespective of health insurance coverage, demographic, socio-economic, and lifestyle factors.

Rew, K. T., et al. (2014). "Immigrant and refugee health: cross-cultural communication." FP Essent **423**: 30-39.

Physicians in the United States increasingly care for culturally, linguistically, and educationally diverse

immigrants with limited English proficiency. Language barriers contribute significantly to the health disparities experienced by patients with limited English proficiency. Qualified professional interpreters should be used instead of ad hoc interpreters, such as a patient's friend or family member, an untrained bilingual staff member, or a bilingual stranger. Children should not be used as interpreters. Physicians and other health care professionals must be fluent to communicate with patients in another language. Use of electronic translation systems should be avoided. Cultural competence refers to the attitudes, knowledge, and skills needed to work well in cross-cultural situations and effectively provide care to diverse populations. Stereotypes are perpetuated when members of a group are assumed to share cultural values, beliefs, or attitudes. Attempting to memorize a list of what to do and what to avoid when working with any particular group is ineffective. Every patient's culture is multidimensional and dynamic and is not defined by race or language group.

Ro, A., et al. (2016). "An examination of health selection among U.S. immigrants using multi-national data." Soc Sci Med **158**: 114-121.

While migrants are widely believed to be positively selected on health, there has been very little empirical exploration of the actual health differential between migrants and non-migrants. This paper explored: 1) the extent of health selection by comparing US immigrants from 19 sending countries to their non-migrating counterparts still residing in the countries of origin; 2) country-level correlates of health selection; and 3) whether country-level health selection accounted for differences in self-rated health between immigrants and US-born Whites. We combined nationally-representative international data with data from US immigrants from the 2003-2007 Current Population Survey. The health selectivity measure was the Net Difference Index (NDI), which compares the distribution of self-rated health between migrants and non-migrants. We calculated Spearman correlation and bivariate regression coefficients between the NDI and economic, health, distance, and migration characteristics of the sending countries. We used generalized estimating equation models to examine the association between country-level health selection and immigrants' current self-rated health. We found immigrants from South America to show the most positive health selection. Health selection was significantly correlated with visa mode of entry, where family networks decrease, but work-related networks increase health selection. There was little evidence that country-level health selection explained differences in the self-rated health of US immigrants relative to US-born Whites. Our findings do not support the idea that country-level health selection underlies the "healthy immigrant effect".

Ro, A. et Bostean, G. (2015). "Duration of U.S. stay and body mass index among Latino and Asian immigrants: A test of theoretical pathways." Soc Sci Med **144**: 39-47.

Studies find that longer-term immigrants have higher body mass index (BMI) than their more recently arrived counterparts. Most interpretations of these health patterns by duration of U.S. residence rely on theories of immigrant integration; they posit that with increasing time in the United States, immigrants incorporate economically, socially, and culturally into aspects of U.S. society, and that these changes impact health. Few studies empirically examine whether these aspects of integration are indeed mediators of the association between duration of U.S. stay and BMI, and if their patterns differ across immigrant subgroups. This study examines data from the National Latino and Asian American Survey, using path analytic methods to simultaneously test six hypothesized mediators between duration and BMI: household income, English language ability, ethnic identity, family cohesion, acculturative stress and discrimination for both Latino and Asian immigrants, stratified by gender. We find little evidence for an association between duration and BMI for either Latino or Asian men. For women, duration and BMI have a significant and positive relationship, although the pathways differ between the two ethnic groups. For Latina women, household income and acculturative stress are significant indirect pathways, although they work in opposing directions. For Asian women, English proficiency and discrimination are significant indirect pathways. Our findings reveal complex pathways between duration and BMI that vary by ethnicity and gender and highlight limitations in the negative acculturation theory, which suggests that exposure to the United States should have a net negative impact on health. In contrast, our findings suggest that not all groups show declining health with longer duration, as measured by BMI, and that integration processes do not always translate into health differences in the expected directions. Future research on duration patterns may need to consider alternative explanations beyond incorporation-based processes, such

as cross-national health theories or age, period, cohort effects.

Ullmann, S. H., Goldman, N. et Pebley, A. R. (2013). "Contextual factors and weight change over time: a comparison between U.S. Hispanics and other population sub-groups." Soc Sci Med **90**: 40-48. https://www.ncbi.nlm.nih.gov/pubmed/23746607

In recent decades there has been an increasing interest in understanding the role of social and physical contexts in influencing health behaviors and outcomes. This is especially true for weight, which is considered to be highly dependent on environmental factors. The evidence linking neighborhood characteristics to weight in the United States, however, is mixed. Many studies in this area are hampered by cross sectional designs and a limited scope, insofar as they investigate only one dimension of neighborhood context. It is also unclear to what extent neighborhood characteristics account for racial/ethnic disparities in weight. Using longitudinal data from the Los Angeles Family and Neighborhood Survey (L.A. FANS), we compare patterns of weight change between Hispanics and other racial and ethnic groups in order to evaluate whether we observe a pattern of unhealthy assimilation in weight among Hispanic immigrants and to identify differences in the rate at which different groups gain weight over time. We also explore the extent to which patterns of weight change are related to a wider range of community characteristics. We find that weight increases across all groups between the two study waves of L.A. FANS and that the increases are significant except for Asians/Pacific Islanders. With respect to differences in the pace of weight change, second and higher generation Hispanic women and black men gain weight more rapidly than their first generation Hispanic counterparts. Although the evidence presented indicates that first generation Hispanics gain weight, we do not find evidence for convergence in weight since the U.S.-born gain weight at a more rapid rate. The inclusion of community-level variables does not alter the relationships between the race, ethnicity, and immigrant generation categories and weight change. Of the six types of community characteristics considered, only collective efficacy is consistently and significantly associated with weight change, although the protective effect of neighborhood collective efficacy is seen only among women.

Wen, M. et Maloney, T. N. (2014). "Neighborhood socioeconomic status and BMI differences by immigrant and legal status: evidence from Utah." Econ Hum Biol **12**: 120-131.

We build on recent work examining the BMI patterns of immigrants in the US by distinguishing between legal and undocumented immigrants. We find that undocumented women have relative odds of obesity that are about 10 percentage points higher than for legal immigrant women, and their relative odds of being overweight are about 40 percentage points higher. We also find that the odds of obesity and overweight status vary less across neighborhoods for undocumented women than for legal immigrant women. These patterns are not found among immigrant men: undocumented men have lower rates of obesity (by about 6 percentage points in terms of relative odds) and overweight (by about 12 percentage points) than do legal immigrant men, and there is little variation in the impact of neighborhood context across groups of men. We interpret these findings in terms of processes of acculturation among immigrant men and women.

Finlande

Loi, S., Pitkanen, J. et Moustgaard, H. (2019). Health of immigrant children: the role of immigrant generation, exogamous family setting, and family material and social resources. MPIDR Working Papers WP-2019-009. Rostock Max Planck Institute for Demographic Research**:** 36 , tabl. https://ideas.repec.org/p/dem/wpaper/wp-2019-009.html

Children of first-generation immigrants tend to have better health than the native population, but over generations, the health advantage of immigrant children deteriorates. It is, however, poorly understood how family resources can explain health assimilation, whether the process of assimilation varies across health conditions, and where on the generational health assimilation spectrum children with one immigrant and one native parent (exogamous families) lie. We seek to extend our

understanding of the process of health assimilation by analyzing the physical and mental health of immigrant generations, assessing the role of exogamous family arrangements, and testing the contribution of family material and social resources on the offspring's outcomes. We use register-based longitudinal data from a 20% random sample of Finnish households with children born in years 1986-2000, free of reporting bias and loss to follow-up. We estimate the risk of being hospitalized for somatic conditions, psychopathological disorders, and injuries by immigrant generation status. Our results show a negative health assimilation process with higher prevalence of physical and, in particular, mental health problems among second-generation immigrant children than among native children, and to first-generation immigrant children, that is only partially explained by family resources. We find that the children of exogamous families are at especially high risk of developing psychopathological disorders. These results provide strong support for the hypothesis that children of exogamous families constitute a specific health risk group, especially for psychopathological disorders, and that the role of the family seems to be is secondary to other unobserved factors.

Skogberg, N., et al. (2016). "Cardiovascular risk factors among Russian, Somali and Kurdish migrants in comparison with the general Finnish population." The European Journal of Public Health **26**(4): 667-673.

Background: There is limited information on cardiovascular risk among migrants. We compared cardiovascular risk factors among three major migrant groups in Finland with the general population. Methods: Cross-sectional data from 30- to 64-year-old health examination participants (n = 921) of the Migrant Health and Wellbeing Study (2010–12) were used. Data for comparison with the general Finnish population were obtained from the Health 2011 Study (n = 892). Results: Russian men had a similar risk profile to that of the reference group. Kurdish men had lower prevalence of hypertension [prevalence ratio (PR) 0.55, 95% confidence interval (CI) 0.39–0.79] but higher prevalence of dyslipidaemia (PR: 1.12, 95% CI: 1.02–1.24) and hyperglycaemia (PR: 2.61, 95% CI: 1.88–3.64) compared with the reference group. Somali men had lower prevalence of smoking (PR: 0.18, 95% CI: 0.08–0.44), hypertension (PR: 0.55, 95% CI: 0.32–0.97)) and obesity (PR: 0.35, 95% CI: 0.17–0.71) but higher prevalence of hyperglycaemia (PR: 2.59, 95% CI: 1.73–3.86) compared with the reference group. Similar patterns were observed for women, except for higher prevalence of hyperglycaemia among Russian women (PR: 1.95, 95% CI: 1.26–3.01) and obesity among Kurdish and Somali women (PR: 1.41, 95% CI: 1.15–1.72 and PR: 1.68, 95% CI: 1.40–2.03, respectively) compared with the reference group. All migrant women had significantly lower prevalence of smoking than the reference group. Conclusions: There were significant variations in cardiovascular risk profiles of Kurdish and Somali migrants compared with the general population. Differences in cardiovascular risk factors by migrant group need to be taken into account in planning and implementing health promotion strategies.%U http://eurpub.oxfordjournals.org/content/eurpub/26/4/667.full.pdf

Italie

Alacevich, C. et Nicodemo, C. (2019). Immigration and Work-Related Injuries: Evidence from Italian Administrative Data. IZA Discussion Paper; 12510. Bonn IZA**:** 17 , tabl., fig.+annexes. http://ftp.iza.org/dp12510.pdf

There is growing evidence that foreign-born workers are over represented in physically demanding and dangerous jobs with relatively higher injury hazard rates. Given this pattern, do increasing inflows of foreign-born workers alleviate native workers' exposure to injuries? This paper provides evidence of the effects of immigration on the incidence and severity of workrelated accidents. We combine administrative data on work-place accidents in Italy with the Labour Force Survey from 2009 to 2017. Our approach exploits spatial and temporal variation in the distribution of foreign-born residents across provinces. Using province fixed-effects and an instrumental variable specification based on historical settlements of immigrants, we show that inflows of foreign-born residents drive reductions in the injury rate, paid sick leave, and severity of impairment for natives. Next, we investigate potential underlying mechanisms that could drive this effect, such as increased unemployment and selection of the workforce, and the sorting of native workers into less physically demanding jobs. Our results rule out that decreased injuries are driven by higher native unemployment. We find that employment rates are positively associated with immigration, in particular for workers with higher

education. While not statistically significant at conventional levels, we also find that average occupational physical intensity for natives is lower in provinces that receive larger foreign-born inflows.

Atella, V., et al. (2017). The "Double Expansion of Morbidity" Hypothesis: Evidence from Italy. CEIS Research papers; 396. Rome Centre For Economic and International Studies**:** 23 , tabl. https://papers.ssrn.com/sol3/papers2.cfm?abstract_id=2911054

The gains in life expectancy (LE) experienced over the last decades have been accompanied by the increases in the number of years lived in bad health, lending support to the "expansion of morbidity" hypothesis. In this paper we revise this theory and propose the "Double Expansion of Morbidity" (DEM) hypothesis, arguing that not only have life expectancy gains been transformed into years lived in bad health, but also, due to anticipated onset of chronic diseases, the number of years spent in "good health" is actually reducing. Limited to the Italian case, we present and discuss a set of empirical evidence confirming the DEM hypothesis. In particular, we find that from 2000 to 2014 the average number of years spent with chronic conditions in Italy has increased by 6.4 years, of which 3.4 years due to the increase in LE and 3 years due to the reduction in the onset age of chronic conditions. Compared to the year 2000, in 2014 this phenomenon has generated an extra public health expenditure of 8.7 billion euros. We discuss the policy implications of these findings.

Fedeli, U., et al. (2015). "Prevalence of diabetes across different immigrant groups in North-eastern Italy." Nutr Metab Cardiovasc Dis **25**(10): 924-930.

BACKGROUND AND AIMS: Type 2 diabetes, one of the most important non-communicable diseases, represents a major health problem worldwide. Immigrants may contribute relevantly to the increase in diabetes. The aim of the study was to investigate variability in diabetes prevalence across different immigrant groups in the Veneto Region (northeastern Italy). METHODS AND RESULTS: Diabetic subjects on January 2013 were identified by record linkage of hospital discharge records, drug prescriptions, and exemptions from medical charges for diabetes. Immigrant groups were identified based on citizenship. Age-standardized prevalence rates were obtained for residents aged 20-59 years by the direct method, taking the whole regional population as reference. Prevalence rate ratios (RR) with 95% Confidence Intervals (CI) were computed with respect to Italian citizens. Among residents aged 20-59 years, 45280 Italian and 7782 foreign subjects affected by diabetes were identified. Prevalence rates were highest among immigrants from South-East Asia, RR 4.9 (CI 4.7-5.1) among males, and 7.6 (7.2-8.1) among females, followed by residents from both North and Sub-Saharan Africa. Citizens from Eastern Europe (the largest immigrant group) showed rates similar to Italians. Most South-Asian patients aged 20-39 years were not insulin-treated, suggesting a very high risk of early onset type 2 diabetes in this ethnic group. CONCLUSION: Large variations in diabetes prevalence by ethnicity should prompt tailored strategies for primary prevention, diabetes screening, and disease control. An increased demand for prevention and health care in selected population groups should guide appropriate resource allocation.

Carvalho, A. C. C., et al. (2005). "Completion of screening for latent tuberculosis infection among immigrants." Epidemiology and Infection **133**(1): 179-185. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2870236/

The objective of our study was to evaluate the sociodemographic factors associated with completion of screening for latent tuberculosis infection (LTBI) among undocumented immigrants in Brescia, Italy. Screening for LTBI was offered to 649 immigrants; 213 (33%) immigrants completed the first step of screening; only 44% (55/124) of individuals with a positive tuberculin skin test result started treatment for LTBI. The univariate analysis showed that being unmarried, of Senegalese nationality and being interviewed by a health-care worker with the same native language as the immigrant were significantly associated with completion of screening for LTBI. In the multiple logistic regression, being interviewed in the native language of the health-care worker (OR 2.5, 95% CI 1.3-4.8, P = 0.004) and being of Senegalese origin (OR 2.3, 95% CI 1.4-3.6, P = 0.0005) were independently associated with adherence to LTBI screening. Our results suggest that knowledge of the sociodemographic characteristics of

immigrants, and the participation of health-care workers of the same cultural origin as the immigrant during the visits, can be an important tool to improve completion of screening for LTBI.

Firenze, A., et al. (2014). "[Health status of immigrants arrived to Italian coast]." Epidemiol Prev **38**(6 Suppl 2): 78-82.

OBJECTIVE: To analyze the factors involved in access to Emergency Department (ED) of undocumented immigrants in Lampedusa according to the country of origin. DESIGN: This is a retrospective observational study, carried out on newly arrived undocumented immigrants transferred to ED. SETTING AND PARTICIPANTS: Data were collected from medical records of Lampedusa ED between January 2012 and May 2013 on 326 undocumented immigrants. MAIN OUTCOME MEASURES: The outcomes evaluated are demographics characteristics and health condition of undocumented immigrants. RESULTS: In multivariate analysis associated factors to ED visits are: other pathologies rather than traumatic diseases (OR 0.22; p <0.001), younger age (OR 0.9; p <0.001) and female sex (OR 12.49; p=0.017) for Somalis; gastroenterological diseases (OR 2.55; p=0.026) and older age (OR 1.6; p=0.004) for Eritrean; neurological disease (OR 5.33; p=0.048) and male sex (OR 5.45; p=0.032) for Tunisian. CONCLUSION: This analysis shows that undocumented immigrants cannot be considered as a single population, because they generate a diversified set of pathological conditions.

Gualdi-Russo, E., et al. (2009). "Migration and health in Italy: a multiethnic adult sample." J Travel Med **16**(2): 88-95.

BACKGROUND: Immigration to Italy has increased drastically, but there is a paucity of data on the health of these immigrant populations and the need to improve their health care. Therefore, we analyzed a multiethnic immigrant population in Bologna (northern Italy) to identify the risk factors for health. This anthropometric study was part of a multiregional project "Health Assistance and Monitoring for Indigent Italian Citizens and Immigrants" funded by the Italian Ministry of Health. METHODS: The sample consisted of 401 adult immigrants from southeastern Europe (Kosovars, Gypsies, or Roma) and four extra European countries (Senegalese, Moroccans, Tunisians, and Pakistanis). Ethnic ancestry was self-reported. Anthropometric (height, weight, and waist circumference) and blood pressure data were collected during the survey. RESULTS: The prevalence of overweight (and obesity) exceeded 50% in Moroccans and Kosovars of both sexes and in male Roma. The ethnic heterogeneity was associated with different patterns of obesity: the highest prevalence of abdominal obesity was in Moroccan and Kosovar women and in male Kosovars and Gypsies. The highest prevalence of hypertension (more than 20%) was in Senegalese, Kosovar, and Gypsy males. CONCLUSIONS: Some of the immigrant subsamples had a high prevalence of obesity, which is associated with morbidity. Our findings on the relationships between the anthropometric traits and the blood pressure suggest different cardiovascular disease risk profiles in the ethnic groups (higher for Kosovars and Roma) and an urgent need for preventive measures.

Pullini, A. (2011). "[Immigration and health: social inequalities in health disparities in the health system, in welfare and work]." G Ital Med Lav Ergon **33**(2 Suppl): 7-9.

Within the analysis of the socio-economic context and the data from hospital discharges, the themes of social inequalities, health disparities, determinants of health care are discussed. Regular immigrants versus irregular, wealthy people versus those in poverty, they have access to and receive different health treatments, besides presenting risk conditions significantly different in relation to their social situation. Through the analysis of hospital discharge records as well as data from injuries at work, besides underestimations in foreign people and the greater risk of injuries for immigrants, it is evident how the aspects of inequalities connected to socioeconomic determinants and the different access to health services are pivotal for our health and welfare and that a profound change is required to tackle them properly, focusing on intervention on health care system, according to models which take into account not only evidence based medicine, but also narrative medicine, not only health protection, but also health promotion, so that equity and quality of health care is warranted for everyone.

Norvège

Diaz, E., et al. (2015). "Multimorbidity among registered immigrants in Norway: the role of reason for migration and length of stay." Trop Med Int Health.

OBJECTIVES: International migration is rapidly increasing worldwide. However, health status of migrants differs across groups. Information regarding health at arrival and subsequent periodic follow up in the host country is necessary to develop equitable health care to immigrants. The objective of this study was to determine the impact of the length of stay in Norway and other sociodemographic variables on the prevalence of multimorbidity across immigrant groups (refugees, labour immigrants, family reunification immigrants and education immigrants). METHODS: This is a register-based study merging data from the National Population Register and the Norwegian Health Economics Administration database. Sociodemographic variables and multimorbidity across the immigrant groups were compared using Persons' chi-square and ANOVA as appropriate. Several binary logistic regression models were conducted. RESULTS: Multimorbidity was significantly lower among labour immigrants (OR (95%CI) 0.23 (0.21-0.26) and 0.45 (0.40-0.50) for men and women respectively) and education immigrants (OR (95%CI) 0.40 (0.32-0.50) and 0.38 (0.33-0.43)) and higher among refugees (OR (95%CI) 1.67 (1.57-1.78) and 1.83 (1.75-1.92)), compared to family reunification immigrants. For all groups, multimorbidity doubled after a five-year stay in Norway. Effect modifications between multimorbidity and sociodemographic characteristics across the different reasons for migration were observed. CONCLUSIONS: Multimorbidity was highest among refugees at arrival but increased quicker among labour immigrants, especially females. Health providers need to ensure tailormade preventive and management strategies that take into account pre-migration and post-migration experiences for immigrants in order to address their needs.

Pays-Bas

Agyemang, C., et al. (2006). "Validity of the single-item question on self-rated health status in first generation Turkish and Moroccans versus native Dutch in the Netherlands." Public Health **120**(6): 543-550.

BACKGROUND: The single-item question on self-rated health has been used in many studies as a global measure of general health. It is unclear whether ethnic minority groups in the Netherlands attach the same meaning to the single-item question as the native Dutch people do. OBJECTIVE: To assess the validity of using the single-item question on self-rated health in comparing health status in native Dutch with first generation Turkish and Moroccan ethnic groups in the Netherlands. METHODS: The associations between self-reported chronic illnesses and self-rated health were used to examine convergent validity, and self-rated health and health care use for predictive validity using logistic regression analysis. RESULTS: In general, chronic illnesses were associated with fair health and poor health ratings in all the ethnic groups but there were important differences in associations between the groups. There were significant interactions between ethnicity and chronic illnesses on fair health, and poor health, independent of socio-demographical factors. There was also significant interaction between ethnicity and self-rated health on health care uses. These findings indicate that the meaning(s) attached to the single-item question differ between these ethnic groups. CONCLUSION: The study findings suggest that the use of the single-item question on self-rated health to compare native Dutch with the first generation Turkish and Moroccan ethnic groups is not valid. These findings imply that researchers need to be cautious about the interpretation of self-rated health ratings when comparing different ethnic groups. A qualitative research is needed to find out more about how these single-item ratings are being interpreted by Turkish and Moroccan elderly in the Netherlands.

Bos, V., et al. (2005). "Socioeconomic inequalities in mortality within ethnic groups in the Netherlands, 1995-2000." J Epidemiol Community Health **59**(4): 329-335.

STUDY OBJECTIVE: To analyse socioeconomic inequalities in mortality in Dutch, Turkish, Moroccans, Surinamese, and Antillean/Aruban men and women living in the Netherlands and to assess the contribution of specific causes of death to these inequalities. DESIGN: Open cohort design using data from the Municipal Population Registers and cause of death registry. SETTING: the Netherlands from

1995 through 2000. PARTICIPANTS: All inhabitants of the Netherlands. MAIN OUTCOME MEASURES: This study calculated directly standardised mortality rates by mean neighbourhood income and estimated relative mortality ratios comparing the two lowest socioeconomic groups with the two highest socioeconomic groups for all and cause specific mortality by country of origin and sex. MAIN RESULTS: Socioeconomic differences in total mortality were comparatively large in Dutch, (RR = 1.49, CI = 1.46 to 1.52), Surinamese (1.32, 1.19 to 1.46), and Antillean/Aruban men (1.56, 1.29 to 1.89) and in Dutch (1.39, 135 to 1.42) and Surinamese women (1.27, 1.11 to 1.46). They were comparatively small among Turkish (1.10, 0.99 to 1.23) and Moroccan men (1.10, 0.97 to 1.26) and among Turkish (1.13, 0.97 to 1.33), Moroccan (1.12, 0.93 to 1.35) and Antillean/Aruban women (1.03, 0.80 to 1.33). The mortality differences among the Dutch were partly attributable to inequalities in mortality from cardiovascular diseases, whereas among Antillean/Aruban men external causes strongly contributed to the mortality differences. The small differences among Turkish and Moroccan men were due to a lack of inequalities for cardiovascular diseases and small inequalities for the other causes. CONCLUSIONS: The impact of socioeconomic status on mortality differed between ethnic groups living in the Netherlands. Maintaining small socioeconomic inequalities in mortality among Turkish and Moroccans men and women and among Antillean/Aruban women could prevent future increases in overall mortality in these groups.

Dijkstra, A., et al. (2015). "Can selective migration explain why health is worse in regions with population decline? : A study on migration and self-rated health in the Netherlands." Eur J Public Health **25**(6): 944-950.

BACKGROUND: Health disparities between population declining and non-declining areas have received little attention, even though population decline is an established phenomenon in Europe. Selective migration, in which healthier people move out of deprived areas, can possibly explain worse health in declining regions. We assessed whether selective migration can explain the observed worse average health in declining regions as compared with non-declining regions in the Netherlands. METHODS: Combining data from the Dutch Housing and Living Survey held in 2002 and 2006 with Dutch registry data, we studied the relation between health status and migration in a 5-year period at the individual level by applying logistic regression. In our sample of 130 600 participants, we compared health status, demographic and socioeconomic factors of movers and stayers from declining and non-declining regions. RESULTS: People in the Netherlands who migrated are healthier than those staying behind [odds ratio (OR): 1.80]. This effect is larger for persons moving out of declining regions (OR: 1.76) than those moving into declining regions (OR: 1.47). When controlled for demographic and socioeconomic characteristics, these effects are not significant. Moreover, only a small part of the population migrates out of (0.29%) or into (0.25%) declining regions in the course of 5 years. CONCLUSION: Despite the relation between health and migration, the effect of selective migration on health differences between declining and non-declining regions in the Netherlands is small. Both health and migration are complexly linked with socioeconomic and demographic factors.

van de Sande, J. S. O. et van den Muijsenbergh, M. E. T. C. (2017). "Undocumented and documented migrants with chronic diseases in Family Practice in the Netherlands." Fam Pract **34**(6): 649-655. http://dx.doi.org/10.1093/fampra/cmx032

BackgroundUndocumented migrants (UM) face many barriers in accessing healthcare. It is unknown how these affect the care of UM with chronic diseases in general practices. In the Netherlands, a General practitioner (GP) is the gatekeeper to the healthcare system and primary care provider for UM.ObjectiveTo get insight into GP care for chronic diseases in UM compared with documented migrants (DM).MethodsA survey study of medical records of UM and DM in five general practices in the Netherlands with extensive experience in caring for UM. UM and DM were matched for gender, age and region of origin. Consultation rates, values of HbA1C, blood pressure, spirometry, number of referrals and medicine prescriptions were compared in all people with cardiovascular disease, diabetes or asthma/ COPD.ResultsIn overall, 729 migrants were included (407 UM and 322 DM). UM consulted their GP significantly less often than DM (3.24 versus 5.04 times a year). UM with cardiovascular disease had a slightly higher blood pressure (148.1 versus 140.8 mmHg), and UM with diabetes had their blood pressure checked less frequently (0.70 versus 1.95 times a year). Overall

however, the differences between UM and DM with chronic diseases were small.ConclusionUndocumented migrants with chronic diseases in general practices in the Netherlands that are experienced in caring for UM receive to a large extent equitable care compared to documented migrants.

Venema, H. P. U., et al. (1995). "Health of migrant and migratn health policy, the Netherlands as an example." SOCIAL SCIENCE AND MEDICINE **41**(6): 809-818.

In The Netherlands, as in many other countries, many studies have addressed the health situation of migrant groups. After a discussion on methodological pitfalls in migrant studies, the article reviews the most important results. The data show that there are differences in the health status and mortality patterns between migrant groups and the indigenous population. Most, but not all, of the differences are in disfavour of ethnic groups. Possible determinants of these differences are evident in socio/cultural, genetic and socio-economic factors. A model is presented that demonstrates the relation between these factors and health and disease. Implications for research and for health policy are discussed.

Nouvelle-Zélande

Birukila, G., et al. (2013). "HIV-related risk factors among black African migrants and refugees in Christchurch, New Zealand: results from the Mayisha-NZ survey." N Z Med J **126**(1376): 19-27.

AIM: To describe the demographic characteristics of, and HIV-related risk behaviours among, black African migrants and refugees in Christchurch. METHODS: A cross-sectional survey of black African migrants and refugees in Christchurch was carried out. Ten trained African community researchers recruited study participants in social venues and events frequented by Africans. A short self-completed questionnaire collected data on demographic characteristics, previous HIV testing, HIV risk perception, previous STI diagnosis, utilization of health services and sexual behaviours. RESULTS: Valid questionnaires were obtained from 245 respondents (150 men and 95 women) with a mean age of 28 years (range 16 to 58). Participants came from 13 different African countries. Risk factors for HIV identified in this study included: low condom use, low HIV risk perception, having more than one sexual partner, previous STI diagnosis and lack of voluntary testing for HIV. CONCLUSIONS: Our findings justify the need for developing an HIV prevention strategy for black Africans in New Zealand that is informed by local evidence. This strategy should also address sexual health needs of Africans including barriers to condom use, the availability of HIV/STI screening services and targeting sexual behaviours that increase vulnerability to HIV infection.

Royaume-Uni

Baker, J., et al. (2013). "Cross-sectional study of ethnic differences in the utility of area deprivation measures to target socioeconomically deprived individuals." Soc Sci.Med **85**: 27-31.

Area deprivation measures provide a pragmatic tool for targeting public health interventions at socioeconomically deprived individuals. Ethnic minority groups in the UK experience higher levels of socioeconomic deprivation and certain associated diseases than the White population. The aim of this study was to explore ethnic differences in the utility of area deprivation measures as a tool for targeting socioeconomically deprived individuals. We carried out a cross-sectional study using the Health Survey for England 2004. 7208 participants aged 16-64 years from the four largest ethnic groups in England (White, Indian, Pakistani and Black Caribbean) were included. The main outcome measures were percentage agreement, sensitivity and positive predictive value (PPV) of area deprivation, measured using Index of Multiple Deprivation 2004, in relation to individual socioeconomic position (measured by education, occupation, income, housing tenure and car access). We found that levels of both area and individual deprivation were higher in the Pakistani and Black Caribbean groups compared to the White group. Across all measures, agreement was lower in the

Pakistani (50.9-63.4%) and Black Caribbean (61.0-70.1%) groups than the White (67.2-82.4%) group. However, sensitivity was higher in the Pakistani (0.56-0.64) and Black Caribbean (0.59-0.66) groups compared to the White group (0.24-0.38) and PPV was at least as high. The results for the Indian group were intermediate. We conclude that, in spite of lower agreement, area deprivation is better at identifying individual deprivation in ethnic minority groups. There was no evidence that area based targeting of public health interventions will disadvantage ethnic minority groups

Becares, L., et al. (2012). "Ethnic density effects on health and experienced racism among Caribbean people in the US and England: a cross-national comparison." Soc Sci.Med **75**(12): 2107-2115.

Studies indicate an ethnic density effect, whereby an increase in the proportion of racial/ethnic minority people in an area is associated with reduced morbidity among its residents, though evidence is varied. Discrepancies may arise due to differences in the reasons for and periods of migration, and socioeconomic profiles of the racial/ethnic groups and the places where they live. It is important to increase our understanding of how these factors might promote or mitigate ethnic density effects. Cross-national comparative analyses might help in this respect, as they provide greater heterogeneity in historical and contemporary characteristics in the populations of interest, and it is when we consider this heterogeneity in the contexts of peoples' lives that we can more fully understand how social conditions and neighbourhood environments influence the health of migrant and racial/ethnic minority populations. This study analysed two cross-sectional nationally representative surveys, in the US and in England, to explore and contrast the association between two ethnic density measures (black and Caribbean ethnic density) and health and experienced racism among Caribbean people. Results of multilevel logistic regressions show that nominally similar measures of ethnic density perform differently across health outcomes and measures of experienced racism in the two countries. In the US, increased Caribbean ethnic density was associated with improved health and decreased experienced racism, but the opposite was observed in England. On the other hand, increased black ethnic density was associated with improved health and decreased experienced racism of Caribbean English (results not statistically significant), but not of Caribbean Americans. By comparing mutually adjusted Caribbean and black ethnic density effects in the US and England, this study examined the social construction of race and ethnicity as it depends on the racialised and stigmatised meaning attributed to it, and the association that these different racialised identities have on health

Chandola, T. et Jenkinson, C. (2000). "Validating self-rated health in different ethnic groups." Ethn Health **5**(2): 151-159.

BACKGROUND: Subjective accounts of health status are increasingly utilized in social surveys and medical research to assess functioning and well-being. Despite the fact that substantial research evidence suggests that self-rated health is meaningful and provides valid and reliable data, some authors have raised concerns that different social groups may interpret the notion of health in different ways, and hence complete health measures in systematically different ways. This study evaluates the validity of using self-rated health status to measure health status in different ethnic groups. METHODS: Logistic regression models were used to examine the association of self-rated health with more objective measures of morbidity in different ethnic groups. SAMPLE: Two sources of data were used--the Health Survey for England (HSE) 1991-96 combined file and the Fourth National Survey of Ethnic Minorities (Ethmins4). MEASURES OF HEALTH: Hypertension, presence of cardiovascular disease or diabetes, limiting health and number of visits to a doctor. Self-rated health was measured on 5-point scale ranging from excellent to very poor. RESULTS: Poorer self-rated health was associated with greater morbidity within each ethnic group. Furthermore, there was little evidence that the association of self-rated health with more objective measures of morbidity differed between ethnic groups. CONCLUSION: The evidence reported here suggests that the use of a single item measure of self-rated health to measure health status in different ethnic groups is valid. Further research might usefully explore the validity of using more comprehensive profile measures of health status in different ethnic groups.

Vedio, A. B., et al. (2013). "Hepatitis B: report of prevalence and access to healthcare among Chinese residents in Sheffield UK." J Infect Public Health **6**(6): 448-455.

Overall prevalence of hepatitis B (HBV) in the UK is low. However, among migrants from endemic areas, prevalence has been shown to be high. Furthermore, timely diagnosis and/or referral are required prevent serious health consequences through early institution of treatment. METHODS: We identified locations that would be familiar to Chinese members of the community with the objective of facilitating testing. Dried blood spot samples were collected from 229 Chinese subjects and tested for HBV and also for hepatitis C virus (HCV) infection--offering complete chronic viral hepatitis screening. RESULTS: HBsAg was positive in 20/229 (8.7%) participants, (10 F, 10 M). Five women and one man were aware of their condition, but only one man and none of the women were under specialist care. The average length of residence in the UK for positive patients was 15 years (range 2-40). Evidence of HBV past infection, HBcAb(+)/HBsAg(-), was seen in 28/229 participants (12.2%). HCV antibody testing produced negative results in all participants. The methodology of testing was well accepted, 139/144 (95%) responded to a feedback questionnaire declaring no discomfort and 100% finding the information session useful. CONCLUSION: This model of outreach testing is helpful for addressing health inequalities afflicting the UK's Chinese community.

Wallace, M. et Kulu, H. (2015). "Mortality among immigrants in England and Wales by major causes of death, 1971-2012: A longitudinal analysis of register-based data." Soc Sci Med **147**: 209-221.

Recent research has found a migrant mortality advantage among immigrants relative to the UK-born population living in England and Wales. However, while all-cause mortality is useful to show differences in mortality between immigrants and the host population, it can mask variation in mortality patterns from specific causes of death. This study analyses differences in the causes of death among immigrants living in England and Wales. We extend previous research by applying competing-risks survival analysis to study a large-scale longitudinal dataset from 1971 to 2012 to directly compare causes of death. We confirm low all-cause mortality among nearly all immigrants, except immigrants from Scotland, Northern Ireland and the Republic of Ireland (who have high mortality). In most cases, low all-cause mortality among immigrants is driven by lower mortality from chronic diseases (in nearly all cases by lower cancer mortality and in some cases by lower mortality from cardiovascular diseases (CVD)). This low all-cause mortality often coexists with low respiratory disease mortality and among non-western immigrants, coexists with high mortality from infectious diseases; however, these two causes of death contribute little to mortality among immigrants. For men, CVD is the leading cause of death (particularly among South Asians). For women, cancer is the leading cause of death (except among South Asians, for whom CVD is also the leading cause). Differences in CVD mortality over time remain constant between immigrants relative to UK-born, but immigrant cancer patterns shows signs of some convergence to the cancer mortality among the UK-born (though cancer mortality is still low among immigrants by age 80). The study provides the most up-to-date, reliable UK-based analysis of immigrant mortality.

Suisse

Bischoff, A. et Wanner, P. (2008). "The self-reported health of immigrant groups in Switzerland." J Immigr Minor Health **10**(4): 325-335.

BACKGROUND: More than 20% of people living in Switzerland are immigrants, defined as people with foreign nationality. This study examines health disparities between the main immigrant groups in Switzerland and the majority Swiss population. METHODS: Epidemiological analysis of the 2002 Swiss Health Survey (SHS): the SHS contains health-related information about 19,706 people who were randomly sampled from among people living in Switzerland. Bi-variate and multivariate analyses of six variables on self-reported health were performed. FINDINGS: The data from the 2002 Swiss Health Survey provide some evidence of health disparities between Swiss people and immigrants. Although the self-reported health of "Northern immigrants" (people from Germany and France) does not differ significantly from that of the majority Swiss population, "Southern immigrants" (people from Italy, Former Yugoslavia, Portugal, Spain and Turkey) report lower levels of health in several areas. Lower levels of health are particularly likely to be reported by Italian men and women. CONCLUSION: The

self-reported health of immigrants is currently inferior to that of the Swiss. If it is the position of the Swiss health care system to ensure equal health provision for all Swiss residents, including immigrant groups, and to strive for equal health outcomes for all, self-reported ill health among immigrants is a useful basis for health policy and planning.

Rellstab, S., et al. (2016). The Migrant Health Gap and the Role of Labour Market Status: Evidence from Switzerland. IRENE Working paper ; 16-14. Neuchatel University of Neuchatel**:** 25 , tab., graph., fig. http://www.unine.ch/files/live/sites/irene/files/shared/documents/Publications/Working%20papers/2016/WP_16-14.pdf

With more than a fifth of the population being foreign citizens, Switzerland offers an ideal case to study the migrant health gap and the role of labour market status on the migrants' health. This paper examines the potential health gaps between Swiss nationals and different migrant groups (from the permanent foreign resident population), and how alternative types of labour market status affect health among each selected groups. Using a sample of working-age males from the Swiss Labour Force Survey for the years 2003-2009, we estimate a model with a dichotomic dependent variable and test the potential endogeneity of labour market status. Our empirical strategy avoids inconsistencies incurred by unobserved heterogeneity and simultaneity of the choice of labour market status. We observe a health gap in terms of chronic illness between Swiss nationals and all considered migrant groups. Compared to the Swiss, nationals from former Yugoslavia and Turkey have a worse health status whereas Germans have a lower prevalence of chronic illness. Our findings show a negative influence of part-time work, unemployment, and inactivity on health for all groups under study. Labour market status and standard individual characteristics (human capital, demographic attributes, etc.) explain the health disadvantage for migrants from Italy and Portugal/Spain entirely, whereas it does not for migrants from Turkey and former Yugoslavia. We provide insights on the unconditional health gap between migrants and Swiss nationals and estimate the causal effect of labour market status on chronic illness for different groups of the permanent resident population in Switzerland. The results show a negative correlation between non-employment (i.e. unemployment and inactivity) and health but this effect is reduced when taking into account the endogeneity of this variable. The same conclusion applies when labour market status is subdivided into three types: part-time work, unemployment, and inactivity.

Tarnutzer, S. et Bopp, M. (2012). "Healthy migrants but unhealthy offspring? A retrospective cohort study among Italians in Switzerland." BMC Public Health **12**: 1104.

BACKGROUND: In many countries, migrants from Italy form a substantial, well-defined group with distinct lifestyle and dietary habits. There is, however, hardly any information about all-cause mortality patterns among Italian migrants and their offspring. In this paper, we compare Italian migrants, their offspring and Swiss nationals. METHODS: We compared age-specific and age-standardized mortality rates and hazard ratios (adjusted for education, marital status, language region and period) for Swiss and Italian nationals registered in the Swiss National Cohort (SNC), living in the German- or French-speaking part of Switzerland and falling into the age range 40-89 during the observation period 1990-2008. Overall, 3,175,288 native Swiss (48% male) and 224,372 individuals with an Italian migration background (57% male) accumulated 698,779 deaths and 44,836,189 person-years. Individuals with Italian background were categorized by nationality, country of birth and language. RESULTS: First-generation Italians had lower mortality risks than native Swiss (reference group), but second-generation Italians demonstrated higher mortality risks. Among first-generation Italians, predominantly Italian-speaking men and women had hazard ratios (HRs) of 0.89 (95% CI: 0.88-0.91) and 0.90 (0.87-0.92), respectively, while men and women having adopted the regional language had HRs of 0.93 (0.88-0.98) and 0.96 (0.88-1.04), respectively. Among second-generation Italians, the respective HRs were 1.16 (1.03-1.31), 1.06 (0.89-1.26), 1.10 (1.05-1.16) and 0.97 (0.89-1.05). The mortality advantage of first-generation Italians decreased with age. CONCLUSIONS: The mortality risks of first- and second-generation Italians vary substantially. The healthy migrant effect and health disadvantage among second-generation Italians show characteristic age/sex patterns. Future investigation of health behavior and cause-specific mortality is needed to better understand different mortality risks. Such insights will facilitate adequate prevention and health promotion efforts.

Suède

Andersson, L., Ascher, H. et Hjern, A. (2018). "Living conditions and self- rated health among undocumented migrants in Sweden." Eur J Public Health **28**(Suppl. 1): 22-23.

Hjelm, K. et Bard, K. (2013). "Beliefs about health and illness in latin-american migrants with diabetes living in sweden." Open Nurs J **7**: 57-65.

The study explored beliefs about health and illness in Latin American migrants diagnosed with diabetes mellitus (DM) living in Sweden, and investigated the influence on health-related behavior including self-care and care-seeking behavior. Migrants are particularly affected in the diabetes pandemia. Beliefs about health and illness determine health-related behaviour and health but no studies have been found on Latin American migrants with DM. An explorative study design with focus-group interviews of nine persons aged 36-77 years from a diabetes clinic was used. Health was described from a pathogenetic or a salutogenetic perspective: 'freedom from disease or feeling of well-being', and being autonomous and able to work. Economic hardship due to expenses for medications and food for DM affected health. Individual factors such as diet, exercise and compliance with advice, and social factors with good social relations and avoidance of stress, often caused by having experienced severe events related to migrational experiences, were considered important for maintaining health and could cause DM. Disturbed relations to others (social factors), punishment by God or Fate (supernatural factors), intake of diuretics and imbalance between warmth and cold (natural factors) were also perceived as causes. A mix of biomedical and traditional explanations and active self-care behaviour with frequent use of herbs was found. It is important to assess the individual's beliefs, and health professionals, particularly nurses, should incorporate discussions of alternative treatments and other components of explanatory models and co-operate with social workers to consider influence of finances and migrational experiences on health.

Leao, T. S., et al. (2009). "The influence of age at migration and length of residence on self-rated health among Swedish immigrants: a cross-sectional study." Ethn Health **14**(1): 93-105.

OBJECTIVE: Increasing global migration has led to profound demographic changes in most industrialised countries. A growing body of research has investigated various health aspects among immigrant groups and found that some immigrant groups have poorer health than the majority population. It has been suggested that poor acculturation in the host country could lie behind the increased risk of worsened health among certain immigrant groups. The aim was to investigate the cross-sectional association between acculturation, measured as age at migration or length of residence, and self-rated health among young immigrants. DESIGN: The simple, random samples of 7137 women and 7415 men aged 16-34 years were based on pooled, independent data collected during the period 1992-1999 obtained from the Swedish Annual Level of Living Survey (SALLS). Logistic regression was applied in the estimation of odds ratios (OR) for poor self-rated health, after accounting for age, sex, socioeconomic status (SES) and social networks. The non-response rate varied between 23.6 and 28.3% in the different immigrant groups. RESULTS: The odds of poor self-rated health increased with increasing age at migration to Sweden among first-generation immigrants. For those who had resided in Sweden less than 15 years the odds of poor self-rated health were significantly increased. In addition, most of the immigrant groups had higher odds of poor self-rated health than the reference group. CONCLUSIONS: Health care workers and policy makers need to be aware that immigrants who arrive in the host country at higher ages and/or have lived in the host country for a shorter period of time might need special attention as they are more likely to suffer from poor self-rated health, a valid health status indicator that can be used in population health monitoring.

Lofvander, M., et al. (2014). "A case-control study of self-reported health, quality-of-life and general functioning among recent immigrants and age- and sex-matched Swedish-born controls." Scand J Public Health **42**(8): 734-742.

AIM: To examine whether new immigrants had inferior quality-of-life, well-being and general functioning compared with Swedish age- and sex-matched controls. METHODS: A prospective case-

control study was designed including immigrants from non-European countries, 18-65 years of age, with recent Permanent Permits to Stay (PPS) in Sweden, and age- and sex-matched Swedish-born (SB) persons from the general population in Vastmanland County, Sweden. The General Health Questionnaire (GHQ-12), the brief version of the World Health Organization Quality-of-Life (WHOQOL-BREF) Scale and the General Activity Functioning Assessment Scale (GAF) from DSM-IV were posted (SB), or applied in personal interviews (PPS) with interpreters. Differences between the PPS and SB groups were measured using McNemar's test and Wilcoxon signed-rank test conducted separately for observations at baseline, 6- and 12-month follow-up. RESULTS: There were 93 pairs (mean age 36 years). Persons from Somalia (67%) and Iraq (27%) dominated the PPS group. The differences between the groups were statistically significant for all time points for the Psychological health and Social relationship domains of WHOQOL-BREF, and for the baseline and 6-month follow-up time points of GHQ-12 where the PPS-group had a higher degree of well-being, health and quality-of-life than the SB. This tendency applied for both sexes in the immigrant group. CONCLUSIONS: These new immigrants did not have inferior physical or psychological health, quality-of-life, well-being or social functioning compared with their age- and sex-matched Swedish born pairs during a 1-year follow-up. Thus, there is reason to advocate immigrants' fast integration into society.

Mulinari, S., et al. (2015). "Questioning the discriminatory accuracy of broad migrant categories in public health: self-rated health in Sweden." Eur J Public Health **25**(6): 911-917.

BACKGROUND: Differences between natives and migrants in average risk for poor self-rated health (SRH) are well documented, which has lent support to proposals for interventions targeting disadvantaged minority groups. However, such proposals are based on measures of association that neglect individual heterogeneity around group averages and thereby the discriminatory accuracy (DA) of the categories used (i.e. their ability to discriminate the individuals with poor and good SRH, respectively). Therefore, applying DA measures rather than only measures of association our study revisits the value of broad native and migrant categorizations for predicting SRH. DESIGN, SETTING AND PARTICIPANTS: We analyzed 27 723 individuals aged 18-80 who responded to a 2008 Swedish public health survey. We performed logistic regressions to estimate odds ratios (ORs), predicted risks and the area under the receiver operating characteristic curve (AU-ROC) as a measure of epidemiological DA. RESULTS: Being born abroad was associated with higher odds of poor SRH (OR = 1.75), but the AU-ROC of this variable only added 0.02 units to the AU-ROC for age alone (from 0.53 to 0.55). The AU-ROC increased, but remained unsatisfactorily low (0.62), when available social and demographic variables were included. CONCLUSIONS: Our results question the use of broad native/migrant categorizations as instruments for forecasting individual SRH. Such simple categorizations have a very low DA and should be abandoned in public health practice. Measures of association and DA should be reported together whenever an intervention is being considered, especially in the area of ethnicity, migration and health.

Oksuzyan, A., Mussino, E. et Drefahl, S. (2019). "Sex differences in mortality in migrants and the Swedish-born population: Is there a double survival advantage for immigrant women?" Int J Public Health **64**(3): 377-386.
https://doi.org/10.1007/s00038-019-01208-1

In the present study, we examine whether the relationships between country of origin or reason for migration and mortality differ between men and women.

Wahlberg, A., et al. (2014). "Causes of death among undocumented migrants in Sweden, 1997-2010." Glob Health Action **7**: 24464.

BACKGROUND: Undocumented migrants are one of the most vulnerable groups in Swedish society, where they generally suffer from poor health and limited health care access. Due to their irregular status, such migrants are an under-researched group and are not included in the country's Cause of Death Register (CDR). OBJECTIVE: To determine the causes of death among undocumented migrants in Sweden and to ascertain whether there are patterns in causes of death that differ between residents and undocumented migrants. DESIGN: This is a cross-sectional study of death certificates issued from

1997 to 2010 but never included in the CDR from which we established our study sample of undocumented migrants. As age adjustments could not be performed due to lack of data, comparisons between residents and undocumented migrants were made at specific age intervals, based on the study sample's mean age at death+/-a half standard deviation. RESULTS: Out of 7,925 individuals surveyed, 860 were classified as likely to have been undocumented migrants. External causes (49.8%) were the most frequent cause of death, followed by circulatory system diseases, and then neoplasms. Undocumented migrants had a statistically significant increased risk of dying from external causes (odds ratio [OR] 3.57, 95% confidence interval [CI]: 2.83-4.52) and circulatory system diseases (OR 2.20, 95% CI: 1.73-2.82) compared to residents, and a lower risk of dying from neoplasms (OR 0.07, 95% CI: 0.04-0.14). CONCLUSIONS: We believe our study is the first to determine national figures on causes of death of undocumented migrants. We found inequity in health as substantial differences in causes of death between undocumented migrants and residents were seen. Legal ambiguities regarding health care provision must be addressed if equity in health is to be achieved in a country otherwise known for its universal health coverage.

SANTE MENTALE : UNE PREVALENCE DE DEPRESSION ET DE TROUBLES PSYCHOTIQUES

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Ce dossier thématique « Migrations, vulnérabilités et santé mentale » vient d'être actualisé (décembre 2019). On y trouve de nombreuses références bibliographiques et un éventail d'outils pédagogiques qui permettront d'approfondir le sujet, de questionner les pratiques et d'accompagner au mieux les personnes migrantes. Les ressources documentaires sont complétées par une présentation de structures-ressources et une sitographie. La question des vulnérabilités et de la santé mentale des personnes migrantes, les représentations et les pratiques en œuvre, sont au cœur de ce dossier thématique. La démarche de promotion de la santé qui guide la réalisation de ce dossier thématique donne par ailleurs toute sa place aux déterminants sociaux, culturels, environnementaux et politiques qui influencent la santé des personnes et donc leur santé mentale.

Ai, A. L., et al. (2015). "Risk and protective factors for three major mental health problems among Latino American men nationwide." Am J Mens Health **9**(1): 64-75.

The present study investigated psychosocial predictors for major depressive disorder (MDD), general anxiety disorder (GAD), and suicidal ideation (SI) of Latino American men identified in the first national mental health epidemiological survey of Latinos. Three separate sets of logistic regression analyses were performed for 1,127 Latinos, following preplanned two steps (Model 1--Known Demographic and Acculturation Predictors as controls, Model 2--Psychosocial Risk and Protective Factors). Results show that Negative Interactions with family members significantly predicted the likelihood of both MDD and SI, while SI was also associated with Discrimination. Acculturation Stress was associated with that of GAD (alongside more Income, Education of 12 years, and Years in the United States for less than 11 years). Other potential protective factors (social support, racial/ethnic identity, religious involvement) were not influential. The differential predictors for mental health issues among Latino men imply that assessment and intervention for them may need certain gender-specific foci in order to improve mental health disparities in this population.

Amad, A., et al. (2013). "Increased prevalence of psychotic disorders among third-generation migrants: results from the French Mental Health in General Population survey." Schizophr Res **147**(1): 193-195.

There is very strong evidence that the prevalence of psychosis is elevated in migrant populations and that this risk persists into the second generation. However, these results have not been replicated in France, and the prevalence of psychotic disorders in the third generation of migrants remains unknown. Based on the Mental Health in General Population survey (n=37063), we report for the first time the increased prevalence of psychotic disorders in migrants in France, which persists into the

second generation for a single psychotic episode (SPE) (OR=1.43, 95% CI [1.02-2.03], p<0.03) and into the third generation for recurrent psychotic disorder (RPD) (OR=1.78, 95% CI [1.45-2.18], p<0.0001) after adjustment for age, sex, level of education and cannabis use. Complementary statistical analyses of our sample showed a significantly higher risk of SPE in migrants from the French West Indies and Africa (chi(2)=17.70, p<0.01). These results are consistent with the socio-developmental model and the psychosis continuum hypothesis.

Amer, M. M. et Hovey, J. D. (2007). "Socio-demographic differences in acculturation and mental health for a sample of 2nd generation/early immigrant Arab Americans." J Immigr Minor Health **9**(4): 335-347.

This study examined socio-demographic differences in acculturation patterns among early immigrant and second-generation Arab Americans, using data from 120 participants who completed a Web-based study. Although sex, age, education, and income did not significantly relate to the acculturation process, respondents who were female and those who were married reported greater Arab ethnic identity and religiosity. Striking differences were found based on religious affiliation. Christian patterns of acculturation and mental health were consistent with acculturation theory. For Muslims, however, integration was not associated with better mental health, and religiosity was predictive of better family functioning and less depression. The results of this study suggest unique acculturation patterns for Christian and Muslim subgroups that can better inform future research and mental health service.

Arevalo, S. P., et al. (2015). "Beyond cultural factors to understand immigrant mental health: Neighborhood ethnic density and the moderating role of pre-migration and post-migration factors." Soc Sci Med **138**: 91-100.

Pre-migration and post-migration factors may influence the health of immigrants. Using a cross-national framework that considers the effects of the sending and receiving social contexts, we examined the extent to which pre-migration and post-migration factors, including individual and neighborhood level factors, influence depressive symptoms at a 2-year follow-up time point. Data come from the Boston Puerto Rican Health Study, a population-based prospective cohort of Puerto Ricans between the ages of 45 and 75 y. The association of neighborhood ethnic density with depressive symptomatology at follow-up was significantly modified by sex and level of language acculturation. Men, but not women, experienced protective effects of ethnic density. The interaction of neighborhood ethnic density with language acculturation had a non-linear effect on depressive symptomatology, with lowest depressive symptomatology in the second highest quartile of language acculturation, relative to the lowest and top two quartiles among residents of high ethnic density neighborhoods. Results from this study highlight the complexity, and interplay, of a number of factors that influence the health of immigrants, and emphasize the significance of moving beyond cultural variables to better understand why the health of some immigrant groups deteriorates at faster rates overtime.

Balkir, N., et al. (2013). "Exploring the relevance of autonomy and relatedness for mental health in healthy and depressed women from two different cultures: when does culture matter?" Int J Soc Psychiatry **59**(5): 482-492.

BACKGROUND: It is well known that the absence of both autonomy and social support (relatedness) are two important etiologic pathways to major depressive disorder (MDD). However, cross-cultural researchers state that the implications of autonomy and relatedness for mental health vary across cultures. AIM: To test these assumptions, the current study investigated the relevance of autonomy and relatedness for mental health in healthy and depressed women from two different cultures (Germans and Turkish immigrants in Germany). METHODS: One hundred and eight (108) women were evaluated for their levels of autonomy/relatedness satisfaction, for overall psychopathological complaints including depression, for affectivity and for perceived loneliness through self-report measures. RESULTS: Among healthy groups, relatedness satisfaction predicted better mental health in Turkish women, whereas in German women, autonomy satisfaction was the better mental health predictor. Within depressed groups however, cultural differences in mental health outcomes regarding autonomy were no longer evident. Autonomy was associated with higher levels of mental health in Turkish as well as in German patients. CONCLUSIONS: Our findings indicate that the relationship between autonomy and mental health is culture-specific in healthy women, but

disappears in depressed women. These findings are discussed with consideration of clinical implications and an outlook regarding further research.

Bermejo, I., et al. (2012). "[Health care utilisation of migrants with mental disorders compared with Germans]." Psychiatr Prax **39**(2): 64-70.

OBJECTIVE: Analysis of the health care utilisation of migrants with mental disorders compared to Germans with mental disorders under consideration of migration-related and socio-economic factors. METHODS: Reanalysis of the supplement survey "Mental Disorders" of the "German Health Survey" 1998 with a matched sample of migrants (n = 151) and Germans (n = 151) with a positive 12-month prevalence of mental disorders. RESULTS: Regarding the prevalence rates for mental disorders and health care utilisation no differences in the sample between Germans and migrants could be found. CONCLUSIONS: The migration background alone does not explain the differences in health care utilisation which are found in many studies. It is assumed, that differences arise multifactorial, and can be explained through migration-related factors but especially through socio-economic factors. To provide a better understanding of health care utilisation of migrants it might be necessary to set the focus on socio-economic factors. In addition a differentiated measurement of cultural and migration-related factors is needed in future studies.

Bhugra, D., et al. (2014). "EPA guidance mental health care of migrants." Eur Psychiatry **29**(2): 107-115.

Migration is an increasingly commonplace phenomenon for a number of reasons. People migrate from rural to urban areas or across borders for reasons including economic, educational or political. There is increasing recent research evidence from many countries in Europe that indicates that migrants are more prone to certain psychiatric disorders. Because of their experiences of migration and settling down in the new countries, they may also have special needs such as lack of linguistic abilities which must be taken into account using a number of strategies at individual, local and national policy levels. In this guidance document, we briefly present the evidence and propose that specific measures must be taken to improve and manage psychiatric disorders experienced by migrants and their descendants. This improvement requires involvement at the highest level in governments. This is a guidance document and not a systematic review.

Budhwani, H., et al. (2015). "Depression in Racial and Ethnic Minorities: the Impact of Nativity and Discrimination." J Racial Ethn Health Disparities **2**(1): 34-42.

This research examines factors associated with lifetime major depressive disorder in racial and ethnic minorities residing in the USA, with an emphasis on the impact of nativity, discrimination, and health lifestyle behaviors. The Healthy Migrant Effect and Health Lifestyle Theory were used to inform the design of this project. The use of these frameworks not only provides insightful results but also expands their application in mental health disparities research. Logistic regression models were implemented to examine risk factors associated with lifetime major depressive disorder, comparing immigrants to their American-born counterparts as well as to American-born Whites. Data were derived from the Collaborative Psychiatric Epidemiology Surveys (n = 17,249). Support was found for the hypothesis that certain immigrants, specifically Asian and Afro-Caribbean, have lower odds of depression as compared their non-immigrant counterparts. Although, Hispanic immigrants directionally had lower odds of depression, this finding was not statistically significant. Furthermore, engaging in excessive alcohol consumption was associated with higher rates of depression (odds ratio (OR) = 2.09, $p < 0.001$), and the effect of discrimination on depression was found to be significant, even when controlling for demographics. Of all racial and ethnic groups, foreign-born Afro-Caribbeans had the lowest rate of depression at 7 % followed by foreign-born Asians at 8 %.

Chadwick, K. A. et Collins, P. A. (2015). "Examining the relationship between social support availability, urban center size, and self-perceived mental health of recent immigrants to Canada: a mixed-methods analysis." Soc Sci Med **128**: 220-230.

The experiences of settlement in a new country (e.g., securing housing and employment, language barriers) pose numerous challenges for recent immigrants that can impede their health and well-

being. Lack of social support upon arrival and during settlement may help to explain why immigrant mental health status declines over time. While most urban centers in Canada offer some settlement services, little is known about how the availability of social supports, and the health statuses of recent immigrants, varies by city size. The objective of this mixed-methods study was to examine the relationship between self-perceived mental health (SPMH), social support availability, and urban center size, for recent immigrants to Canada. The quantitative component involved analysis of 2009-2010 Canadian Community Health Survey data, selecting for only recent immigrants and for those living in either large or small urban centers. The qualitative component involved in-depth interviews with managers of settlement service organizations located in three large and three small urban centers in Canada. The quantitative analysis revealed that social support availability is positively associated with higher SPMH status, and is higher in small urban centers. In support of these findings, our interviews revealed that settlement service organizations operating in small urban centers offer more intensive social supports; interviewees attributed this difference to personal relationships in small cities, and the ease with which they can connect to other agencies to provide clients with necessary supports. Logistic regression analysis revealed, however, that recent immigrants in small urban centers are twice as likely to report low SPMH compared to those living in large urban centers. Thus, while the scope and nature of settlements services appears to vary by city size in Canada, more research is needed to understand what effect settlement services have on the health status of recent immigrants to Canada, especially in smaller urban centers.

Chen, J. et Vargas-Bustamante, A. (2011). "Estimating the effects of immigration status on mental health care utilizations in the United States." J Immigr Minor Health **13**(4): 671-680.

Immigration status is a likely deterrent of mental health care utilization in the United States. Using the Medical Expenditure Panel Survey and National Health Interview survey from 2002 to 2006, multivariable logistic regressions were used to estimate the effects of immigration status on mental health care utilization among patients with depression or anxiety disorders. Multivariate regressions showed that immigrants were significantly less likely to take any prescription drugs, but not significantly less likely to have any physician visits compared to US-born citizens. Results also showed that improving immigrants' health care access and health insurance coverage could potentially reduce disparities between US-born citizens and immigrants by 14-29% and 9-28% respectively. Policy makers should focus on expanding the availability of regular sources of health care and immigrant health coverage to reduce disparities on mental health care utilization. Targeted interventions should also focus on addressing immigrants' language barriers, and providing culturally appropriate services.

Chen, Y., et al. (2013). "Association between mental health and fall injury in Canadian immigrants and non-immigrants." Accid Anal Prev **59**: 221-226.

The study was to determine the association between mental health and the incidence of injury among Canadian immigrants and non-immigrants. We used data from 15,405 individuals aged 12 years or more, who were living in British Columbia, Canada, and participated in the 2007-2008 Canadian Community Health Survey (CCHS). We calculated a 12-month cumulative incidence of fall injury based on self-reporting. Logistic regression model was used to examine the association of the 12-month cumulative incidence of fall injury with immigration status and mental health before and after adjustment for covariates. The results show that self-reported mood and anxiety disorders were significantly associated with an increased incidence of fall injury. The adjusted odds ratios were 1.81 (95% CI: 1.37, 2.38) for mood disorder and 1.55 (95% CI: 1.12, 2.13) for anxiety disorder. Immigrant status was a significant effect modifier for the association between mental health and fall injury, with stronger associations in immigrants than in non-immigrants especially in elderly people. People with poor self perceived health were more likely to have a fall injury. Both mental health and general health were related to fall injury. There was a stronger association between mental health and fall injury in immigrants compared with non-immigrants in the elderly. More attention should be paid to mental health in immigrants associated with fall injury.

Dang, H. A., Trinh, T. A. et Verme, P. (2021). Do Refugees with Better Mental Health Better Integrate? Evidence from the Building a New Life in Australia Longitudinal Survey. Iza Discussion Paper Series ; 14766. Bonn Iza**:** 58.

http://d.repec.org/n?u=RePEc:iza:izadps:dp14766&r=&r=lab

> Hardly any evidence currently exists on the causal effects of mental illness on refugee labor market outcomes. We offer the first study on this topic in the context of Australia, one of the host countries with the largest number of refugees per capita in the world. Analyzing the Building a New Life in Australia longitudinal survey, we exploit the variations in traumatic experiences of refugees interacted with time as an instrument for refugee mental health. We find that worse mental health, as measured by a one standard deviation increase in the Kessler mental health score, reduces the probability of employment by 14.1% and labor income by 26.8%. We also find some evidence of adverse impacts of refugees' mental illness on their children's mental health and education performance. These effects appear more pronounced for refugees that newly arrive or are without social networks, but they may be ameliorated with government support. Our findings suggest that policies that target refugees' mental health may offer a new channel to improve their labor market outcomes.

Das-Munshi, J., et al. (2014). "Born into adversity: psychological distress in two birth cohorts of second-generation Irish children growing up in Britain." J Public Health (Oxf) **36**(1): 92-103.

> BACKGROUND: Worldwide, the Irish diaspora experience health inequalities persisting across generations. The present study sought to establish the prevalence of psychological morbidity in the children of migrant parents from Ireland, and reasons for differences. METHODS: Data from two British birth cohorts were used for analysis. Each surveyed 17 000 babies born in one week in 1958 and 1970 and followed up through childhood. Validated scales assessed psychological health. RESULTS: Relative to the rest of the cohort, second-generation Irish children grew up in material hardship and showed greater psychological problems at ages 7, 11 (1958 cohort) and 16 (both cohorts). Adjusting for material adversity and maternal psychological distress markedly reduced differences. Relative to non-Irish parents, Irish-born parents were more likely to report chronic health problems (odds ratio [OR]: 1.29; 95% confidence interval [CI]: 1.08-1.54), and Irish-born mothers were more likely to be psychologically distressed (OR: 1.44; 95% CI: 1.13-1.84, when child was 10). Effect sizes diminished once material adversity was taken into account. CONCLUSIONS: Second-generation Irish children experienced high levels of psychological morbidity, but this was accounted for through adverse material circumstances in childhood and psychological distress in parents. Public health initiatives focusing on settlement experiences may reduce health inequalities in migrant children.

Durbin, A., et al. (2015). "Examining the relationship between neighbourhood deprivation and mental health service use of immigrants in Ontario, Canada: a cross-sectional study." BMJ Open **5**(3): e006690.

> OBJECTIVE: While newcomers are often disproportionately concentrated in disadvantaged areas, little attention is given to the effects of immigrants' postimmigration context on their mental health and care use. Intersectionality theory suggests that understanding the full impact of disadvantage requires considering the effects of interacting factors. This study assessed the inter-relationship between recent immigration status, living in deprived areas and service use for non-psychotic mental health disorders. STUDY DESIGN: Matched population-based cross-sectional study. SETTING: Ontario, Canada, where healthcare use data for 1999-2012 were linked to immigration data and area-based material deprivation scores. PARTICIPANTS: Immigrants in urban Ontario, and their age-matched and sex-matched long-term residents (a group of Canadian-born or long-term immigrants, n=501,417 pairs). PRIMARY AND SECONDARY OUTCOME MEASURES: For immigrants and matched long-term residents, contact with primary care, psychiatric care and hospital care (emergency department visits or inpatient admissions) for non-psychotic mental health disorders was followed for 5 years and examined using conditional logistic regression models. Intersectionality was investigated by including a material deprivation quintile by immigrant status (immigrant vs long-term resident) interaction. RESULTS: Recent immigrants in urban Ontario were more likely than long-term residents to live in most deprived quintiles (immigrants--males: 22.8%, females: 22.3%; long-term residents--both sexes: 13.1%, p<0.001). Living in more deprived circumstances was associated with greater use of mental health services, but increases were smaller for immigrants than for long-term residents. Immigrants used less mental health services than long-term residents. CONCLUSIONS: This study adds to existing research by suggesting that immigrant status and deprivation have a combined effect on recent

immigrants' care use for non-psychotic mental health disorders. In settings where immigrants are over-represented in deprived areas, policymakers focused on increasing immigrants' access of mental health services should broadly address the influence of structural and cultural factors beyond the disadvantage.

Durbin, A., et al. (2015). "Mental health service use by recent immigrants from different world regions and by non-immigrants in Ontario, Canada: a cross-sectional study." BMC Health Serv Res **15**: 336.

BACKGROUND: Given that immigration has been linked to a variety of mental health stressors, understanding use of mental health services by immigrant groups is particularly important. However, very little research on immigrants' use of mental health service in the host country considers source country. Newcomers from different source countries may have distinct experiences that influence service need and use after arrival. This population study examined rates of use of primary care and of specialty services for non-psychotic mental health disorders by immigrants to Ontario Canada during their first five years after arrival. Service use by recent immigrants in broad source region groups representing all world regions was compared to use by age-matched Canadian-born or long term immigrants (called long term residents). METHOD: This matched population-based cross-sectional study assessed likelihood of any use and counts of visits for each of primary care, psychiatric care and hospital care (emergency department visits or inpatient admissions) for non-psychotic mental health disorders from 1993-2012. Adult immigrants living in urban Ontario (n = 912,114) were categorized based on their nine world regions of origin. Sex-stratified conditional logistic regression models and negative binomial models were used to compare service use by immigrant region groups to their age-matched long term residents. RESULTS: Immigrant were more or less likely to access primary mental health care compared to age-matched long term residents, depending on their world region of origin. Regarding specialty mental health care (psychiatry and hospital care), immigrants from all regions used less than long term residents. Across the three mental health services, estimates of use by immigrant region groups compared to long term residents were among the lowest for newcomers from East Asian and Pacific (range: 0.16-0.82) and among the highest for persons from Middle East and North Africa (range: 0.56-1.23). CONCLUSION: This population-based study showed lower use of mental health services by recent immigrants than long-term immigrants or native born individuals, with variation in immigrants' use linked to world region of origin and type of mental health care. Variation across source region groups underscores the importance of identifying underlying individual characteristics that affect service use to make services more responsive to newcomers.

Fakhoury, J., Burton-Jeangros, C., Consoli, L., et al. (2021). "Mental health of undocumented migrants and migrants undergoing regularization in Switzerland: a cross-sectional study." BMC Psychiatry **21**(1): 175.

BACKGROUND: Undocumented migrants live and work in precarious conditions. Few studies have explored the mental health consequences of such environment. The objective of this study is to describe the mental health of migrants at different stages of a regularization program. METHODS: This cross-sectional study included migrants undocumented or in the process of regularization. We screened for symptoms of anxiety, depression and sleep disturbance using validated tools. We created a composite outcome of altered mental health including these components plus self-report of a recent diagnosis of mental health condition by a health professional. RESULTS: We enrolled 456 participants of whom 246 (53.9%) were undocumented. They were predominantly women (71.9%) with a median age of 43.3 (interquartile range: 15.5) years, from Latin America (63.6%) or Asia (20.2%) who had lived in Switzerland for 12 (IQR: 7) years. Overall, 57.2% presented symptoms of altered mental health. Prevalence of symptoms of anxiety, depression and sleep disturbance were 36% (95% confidence interval: 31.6-40.6%), 45.4% (95% CI: 40.8-50.1%) and 23% (95% CI: 19.2-27.2), respectively. Younger age (adjusted odd ratio: 0.7; 95% CI: 0.5-0.9 for each additional decade), social isolation (aOR: 2.4; 95% CI: 1.4-4.2), exposure to abuse (aOR: 1.9; 95% CI: 1.1-3.5), financial instability (aOR: 2.2; 95% CI: 1.4-3.7) and multi-morbidity (aOR: 3.2; 95% CI: 1.7-6.5) were associated with increased risk of having altered mental health while being in the early stages of the process of regularization had no effect (aOR: 1.3: 95% CI: 0.8-2.2). CONCLUSIONS: This study highlights the need for multi-pronged social and health interventions addressing the various domains of undocumented migrants living difficulties as complement to legal status regularization policies. Protection against unfair working conditions and

abuse, access to adequate housing, promoting social integration and preventive interventions to tackle the early occurrence of chronic diseases may all contribute to reduce the burden of altered mental health in this group. More research is needed to assess the long-term impact of legal status regularization on mental health.

Fassaert, T., et al. (2009). "Uptake of health services for common mental disorders by first-generation Turkish and Moroccan migrants in the Netherlands." BMC Public Health **9**: 307.

BACKGROUND: Migration and ethnic minority status have been associated with higher occurrence of common mental disorders (CMD), while mental health care utilisation by non-Western migrants has been reported to be low compared to the general population in Western host countries. Still, the evidence-base for this is poor. This study evaluates uptake of mental health services for CMD and psychological distress among first-generation non-Western migrants in Amsterdam, the Netherlands. METHODS: A population-based survey. First generation non-Western migrants and ethnic Dutch respondents (N = 580) participated in structured interviews in their own languages. The interview included the Composite International Diagnostic Interview (CIDI) and the Kessler psychological distress scale (K10). Uptake of services was measured by self-report. Data were analysed using weighting techniques and multivariate logistic regression. RESULTS: Of subjects with a CMD during six months preceding the interview, 50.9% reported care for mental problems in that period; 35.0% contacted specialised services. In relation to CMD, ethnic groups were equally likely to access specialised mental health services. In relation to psychological distress, however, Moroccan migrants reported less uptake of primary care services (OR = 0.37; 95% CI = 0.15 to 0.88). CONCLUSION: About half of the ethnic Dutch, Turkish and Moroccan population in Amsterdam with CMD contact mental health services. Since the primary purpose of specialised mental health services is to treat "cases", this study provides strong indications for equal access to specialised care for these ethnic groups. The purpose of primary care services is however to treat psychological distress, so that access appears to be lower among Moroccan migrants.

Ginieniewicz, J. et McKenzie, K. (2014). "Mental health of Latin Americans in Canada: a literature review." Int J Soc Psychiatry **60**(3): 263-273.

BACKGROUND: Latin Americans represent one of the fastest-growing immigrant populations in Canada. But very little is known about their mental health. AIMS: This paper reviews the literature on the mental health of Latin American immigrants to Canada. The paper also identifies potential areas to expand the research agenda. METHOD: Twenty-five papers were identified by a comprehensive electronic search undertaken in medical- and humanities-related databases. RESULTS RESULT: s are reported in three sections: (1) the rates of mental illness; (2) the risk factors that affect mental health; and (3) the access and barriers to care and services. Findings indicate that despite the diversity of immigration from Latin America to Canada, much of the information on mental health focuses on Central American refugees. The most frequently examined risk factor is displacement as a consequence of political persecution and torture in the home country. Access to mental health services in this population seems to be limited by cultural differences and language barriers. CONCLUSION: New research on this topic should reflect the growing diversity and heterogeneity of the Latin American population in Canada.

Guruge, S. et Butt, H. (2015). "A scoping review of mental health issues and concerns among immigrant and refugee youth in Canada: Looking back, moving forward." Can J Public Health **106**(2): e72-78.

BACKGROUND: Youth comprise a significant portion of the total immigrant population in Canada. Immigrant and refugee youth often have different migration trajectories and experiences, which can result in different mental health outcomes. Research is emerging in this area, but study findings have not yet been consolidated. RESEARCH QUESTION: What is known from the existing literature about mental health issues and concerns among immigrant and refugee youth in Canada? METHOD: We searched Embase, Health Star, Medline, CINAHL, PsycINFO, and Social Science Abstracts databases for the period 1990-2013 for Canadian studies related to the mental health of youth born outside Canada. Seventeen studies met inclusion criteria. RESULTS: Determinants of mental illness included pre-

migration experiences, number of years since immigration to Canada, post-migration family and school environment, in- and out-group problems, discrimination, and lack of equitable access to health care. Only a few common categories of mental illness were identified, and the burden of mental illness was shared differently across gender and immigration status, with female youth experiencing more mental health problems than male youth. Some studies identified fewer emotional and behavioural problems among refugee youth; others reported higher rates of psychopathology among refugee youth compared with their Canadian-born provincial counterparts. Pre-migration experiences and the kinds of trauma experienced were important for refugee youth's mental health. Findings also indicated the importance of family involvement, school settings as points of care and services, and in terms of timing, focusing on the first year of arrival in Canada. PRACTICE IMPLICATIONS: Professionals must work across health, social, and settlement sectors to address the various pre- and post-migration determinants of mental health and illness, and provide more timely and effective services based on how and when these determinants affect different groups of youth.

Hollander, A. C. (2013). "Social inequalities in mental health and mortality among refugees and other immigrants to Sweden--epidemiological studies of register data." Glob Health Action **6**: 21059.

The aim of this PhD project was to increase knowledge, using population-based registers, of how pre- and post-migration factors and social determinants of health are associated with inequalities in poor mental health and mortality among refugees and other immigrants to Sweden. Study I and II had cross-sectional designs and used logistic regression analysis to study differences in poor mental health (measured with prescribed psychotropic drugs purchased) between refugee and non-refugee immigrants. In Study I, there was a significant difference in poor mental health between female refugees and non-refugees (OR=1.27; CI=1.15-1.40) when adjusted for socio-economic factors. In Study II, refugees of most origins had a higher likelihood of poor mental health than non-refugees of the same origin. Study III and IV had cohort designs and used Cox regression analysis. Study III analysed mortality rates among non-labour immigrants. Male refugees had higher relative risks of mortality from cardiovascular disease (HR=1.53; CI=1.04-2.24) and external causes (HR=1.59; CI=1.01-2.50) than male non-refugees did, adjusted for socio-economic factors. Study IV included the population with a strong connection to the labour market in 1999 to analyse the relative risk of hospitalisation due to depressive disorder following unemployment. The lowest relative risk was found among employed Swedish-born men and the highest among foreign-born females who lost employment during follow-up (HR=3.47; CI=3.02-3.98). Immigrants, and particularly refugees, have poorer mental health than native Swedes. Refugee men have a higher relative mortality risk for cardiovascular disease and external causes of death than do non-refugees. The relative risk of hospitalisation due to depressive disorder following unemployment was highest among immigrant women. To promote mental health and reduce mortality among immigrants, it is important to consider pre- and post-migration factors and the general social determinants of health.

Hudson, D. L., et al. (2013). "Race, life course socioeconomic position, racial discrimination, depressive symptoms and self-rated health." Soc Sci Med **97**: 7-14.

Greater levels of socioeconomic position (SEP) are generally associated with better health. However results from previous studies vary across race/ethnicity and health outcomes. Further, the majority of previous studies do not account for the effects of life course SEP on health nor the effects of racial discrimination, which could moderate the effects of SEP on health. Using data from the Coronary Artery Risk Development in Young Adults (CARDIA) study, we examined the relationship between a life course SEP measure on depressive symptoms and self-rated health. A life course SEP was constructed for each participant, using a framework that included parental education and occupation along with respondents' highest level of education and occupation. Interaction terms were created between life course SEP and racial discrimination to determine whether the association between SEP and health was moderated by experiences of racial discrimination. Analyses revealed that higher levels of life course SEP were inversely related to depressive symptoms. Greater life course SEP was positively associated with favorable self-rated health. Racial discrimination was associated with more depressive symptoms and poorer self-rated health. Analyses indicated a significant interaction between life course SEP and racial discrimination on depressive symptoms in the full sample. This suggested that

for respondents with greater levels of SEP, racial discrimination was associated with reports of more depressive symptoms. Future research efforts should be made to examine whether individuals' perceptions and experiences of racial discrimination at the interpersonal and structural levels limits their ability to acquire human capital as well as their advancement in education and occupational status

Joly, M. P. et Wheaton, B. (2020). "Human rights in countries of origin and the mental health of migrants to Canada." SSM Popul Health **11**: 100571.

This study explores the effect of human rights violations in countries of origin on migrants' mental health, using archival data on human rights violations from 1970-2011, merged to a representative probability sample of 2412 adults living in a large Canadian metropolitan area. The context of exit is defined at the country level, as opposed to self-reported individual experiences of trauma. While most studies start from a question about direct exposure to human rights violations, they may miss the effect of the national-level social context - threat, instability, disruption of lives, and uncertainty - on mental health. Findings indicate that high levels of human rights violations in countries of origin have long-term effects on migrants' mental health. The impact of human rights violations is substantially explained by the combined effect of stressors both before and after migration, suggesting a cumulative process of stress proliferation following this context of exit.

Kerkenaar, M. M., et al. (2013). "Depression and anxiety among migrants in Austria: a population based study of prevalence and utilization of health care services." J Affect Disord **151**(1): 220-228.

BACKGROUND: Although migrants form a large part of the Austrian population, information about mental health of migrants in Austria is scarce. Therefore, we compared the prevalence of dysphoric disorders (depression and anxiety) and the corresponding utilization of health care services of Eastern European, western and other migrants with the non-migrant population in Austria. METHODS: We performed a telephone survey on a random sample of the general population of Austria aged 15 years and older (n=3509) between October 2010 and September 2011. Depression and anxiety were measured with the Patient Health Questionnaire-4 and utilization of health care services in the last 4 weeks was inquired. RESULTS: 15.0% of our sample had a migration background. Female migrants from Eastern Europe, first and second generation, had a higher prevalence of dysphoric disorders (29.7% and 33.4% respectively) than Austrian women (15.2%) ($p<0.001$). The prevalence in the other migrant groups did not differ significantly from the Austrian population. There was no gender difference in dysphoric disorders in the Austrian population. After adjustment for age and chronic diseases, having a dysphoric disorder was associated with a higher utilization of health care services among migrant and Austrian women, but not among men. LIMITATIONS: Because of the explorative nature of the study multiple testing correction was not performed. The reason for health care utilization was not assessed. CONCLUSIONS: Mental health of female migrants from Eastern Europe should be studied in more detail; men could be an underserved group, both in migrants and Austrians.

Kirmayer, L. J., et al. (2011). "Common mental health problems in immigrants and refugees: general approach in primary care." Cmaj **183**(12): E959-967.

BACKGROUND: Recognizing and appropriately treating mental health problems among new immigrants and refugees in primary care poses a challenge because of differences in language and culture and because of specific stressors associated with migration and resettlement. We aimed to identify risk factors and strategies in the approach to mental health assessment and to prevention and treatment of common mental health problems for immigrants in primary care. METHODS: We searched and compiled literature on prevalence and risk factors for common mental health problems related to migration, the effect of cultural influences on health and illness, and clinical strategies to improve mental health care for immigrants and refugees. Publications were selected on the basis of relevance, use of recent data and quality in consultation with experts in immigrant and refugee mental health. RESULTS: The migration trajectory can be divided into three components: premigration, migration and postmigration resettlement. Each phase is associated with specific risks and exposures. The prevalence of specific types of mental health problems is influenced by the nature of the

migration experience, in terms of adversity experienced before, during and after resettlement. Specific challenges in migrant mental health include communication difficulties because of language and cultural differences; the effect of cultural shaping of symptoms and illness behaviour on diagnosis, coping and treatment; differences in family structure and process affecting adaptation, acculturation and intergenerational conflict; and aspects of acceptance by the receiving society that affect employment, social status and integration. These issues can be addressed through specific inquiry, the use of trained interpreters and culture brokers, meetings with families, and consultation with community organizations. INTERPRETATION: Systematic inquiry into patients' migration trajectory and subsequent follow-up on culturally appropriate indicators of social, vocational and family functioning over time will allow clinicians to recognize problems in adaptation and undertake mental health promotion, disease prevention or treatment interventions in a timely way.

Kirmayer, L. J., et al. (2007). "Use of health care services for psychological distress by immigrants in an urban multicultural milieu." Can J Psychiatry **52**(5): 295-304.

OBJECTIVE: Research in the United States tends to attribute low rates of use of mental health services by immigrants to economic barriers. The purpose of our study was to examine this issue in the context of Canada's universal health care system. METHODS: A survey of the catchment area of a comprehensive clinic in Montreal interviewed random samples of 924 Canadian-born individuals and 776 immigrants born in the Caribbean (n = 264), Vietnam (n = 234), or the Philippines (n = 278) to assess their health care use for somatic symptoms, psychological distress, and recent life events. RESULTS: Overall rates of use of medical services in the past year were similar in immigrant (78.5%) and nonimmigrant (76.5%) groups. Rates of use of health care services for psychological distress were significantly lower among immigrants (5.5% compared with 14.7%, P < 0.001). This difference was attributable both to a lower rate of use of specialty mental health services by immigrants (2.5% compared with 11.7%, P < 0.001) and to differential use of medical services for psychological distress (3.5% compared with 5.8%, P = 0.02). When level of psychological distress was controlled, Vietnamese and Filipino immigrants were one-third as likely as Canadian-born residents to make use of mental health services. The lower rate of use by immigrants could not be explained by differences in sociodemographics, somatic or psychological symptoms, length of stay in Canada, or use of alternative sources of help. CONCLUSION: Immigrant status is associated with lower rates of use of mental health services, even with universal health insurance. This lower rate of use likely reflects cultural and linguistic barriers to care.

Koopmans, G. T., et al. (2013). "The use of outpatient mental health care services of migrants vis-a-vis Dutch natives: equal access?" Int J Soc Psychiatry **59**(4): 342-350.

BACKGROUND: Although the use of outpatient mental health care services by migrants in the Netherlands has increased in recent years, whether it aligns with the need for care is unclear. AIMS: To investigate ethnic-related differences in utilization in outpatient mental health care, taking need into account, and to examine whether socio-economic or cultural barriers explain such differences. METHODS: Data for the native population was taken from the second Dutch National Survey of General Practice (N = 7,772). An additional random sample was drawn (N = 1,305) from four migrant groups (Surinamese, Dutch Antilleans, Moroccans and Turks) living in the Netherlands. Participants were surveyed on mental health care utilization, indicators of need, educational level, proficiency in Dutch and acculturation. RESULTS: Use of outpatient mental health care was about 5% for the indigenous population. Among migrants, percentages of use ranged from 6.5% (Moroccans) to 9.0% (Turks). Corrected for need, however, all non-Dutch groups had a lower chance of service utilization than the native group. Acculturation predicted utilization but did not explain all ethnic-related differences; proficiency in Dutch and health beliefs were not explanatory factors. CONCLUSIONS: In non-Dutch-speaking migrant groups, utilization is about half the level of the native Dutch, suggesting that a substantial gap exists. Our study found that acculturation only partially explains the differences.

Lecerof, S. S., et al. (2015). "Does social capital protect mental health among migrants in Sweden?" Health Promot Int.

Poor mental health is common among migrants. This has been explained by migration-related and socio-economic factors. Weak social capital has also been related to poor mental health. Few studies have explored factors that protect mental health of migrants in the post-migration phase. Such knowledge could be useful for health promotion purposes. Therefore, this study aimed to analyse associations between financial difficulties, housing problems and experience of discrimination and poor mental health; and to detect possible effect modification by social capital, among recently settled Iraqi migrants in Sweden. A postal questionnaire in Arabic was sent to recently settled Iraqi citizens. The response rate was 51% (n = 617). Mental health was measured by the GHQ-12 instrument and social capital was defined as social participation and trust in others. Data were analysed by means of logistic regression. Poor mental health was associated with experience of discrimination (OR 2.88, 95% CI 1.73-4.79), housing problems (OR 2.79, 95% CI 1.84-4.22), and financial difficulties (OR 2.14, 95% CI 1.44-3.19), after adjustments. Trust in others seemed to have a protective effect for mental health when exposed to these factors. Social participation had a protective effect when exposed to experience of discrimination. Social determinants and social capital in the host country play important roles in the mental health of migrants. Social capital modifies the effect of risk factors and might be a fruitful way to promote resilience to factors harmful to mental health among migrants, but must be combined with policy efforts to reduce social inequities.

Liddell, B. J., et al. (2016). "The generational gap: Mental disorder prevalence and disability amongst first and second generation immigrants in Australia." J Psychiatr Res **83**: 103-111.

Despite unprecedented numbers of migrants internationally, little is known about the mental health needs of immigrant groups residing in common countries of resettlement. The majority of studies support the 'healthy migrant hypothesis', but few studies have examined: 1) shifts in prevalence patterns across generations; 2) how prevalence relates to disability in immigrant groups. Our study examined the prevalence of common mental disorders and disability in first and second generation migrants to Australia. Twelve-month and lifetime prevalence rates of affective, anxiety, and substance use disorders were obtained from the Australian National Survey of Mental Health and Wellbeing (N = 8841). First generation immigrants (born overseas) and second generation immigrants (both parents overseas) from non-English and English speaking backgrounds were compared to an Australian-born cohort. Disability was indexed by days out of role and the WHO Disability Assessment Schedule (WHODAS12). First generation immigrants with non-English speaking (1G-NE) backgrounds evidenced reduced prevalence of common mental disorders relative to the Australian-born population (adjusted odds ratio 0.5 [95% CI 0.38-0.66]). This lower prevalence was not observed in second generation immigrant cohorts. While overall levels of disability were equal between all groups ($p > 0.05$), mental health-related disability was elevated in the 1G-NE group relative to the Australian-born group ($p = 0.012$). The findings challenge the overarching notion of the "healthy migrant" and suggest a dissociation between reduced prevalence and elevated mental health-related disability amongst first generation immigrants with non-English speaking backgrounds. These findings highlight the heterogeneous psychiatric needs of first and second generation immigrants.

Lin, S. Y. (2013). "Beliefs about causes, symptoms, and stigma associated with severe mental illness among 'highly acculturated' Chinese-American patients." Int J Soc Psychiatry **59**(8): 745-751.

BACKGROUND: Literature about experiences of mental illness among ethnic minority has tended to focus on first-generation migrants. This study fills that gap by exploring experiences among highly acculturated Chinese-American patients with mental illness. MATERIAL S: Twenty-nine participants completed semi-structured interviews based on Kleinman's explanatory model, which were audio-taped, transcribed and coded for qualitative analysis. DISCUSSION: Beliefs about the causes of mental illness included biological factors, head trauma and personal losses. Issues relating to stigma and shame were also discussed. CONCLUSION: Highly acculturated ethnic minority patients may ascribe to a biomedical model at the same time as ascribing to culture-specific beliefs.

Lindert, J., et al. (2008). "[Mental health care for migrants]." Psychother Psychosom Med Psychol **58**(3-4): 123-129.

BACKGROUND: Global migration and the increasing number of migrants to Europe and Germany diversify the needs in the psychosocial and health care system. Migrants are a heterogeneous group as regards their country of emigration, reasons for migration and legal status. AIMS: We aim to give an overview on 1) mental health of migrants in Germany, 2) cultural associated explanatory of addictive behaviour, 3) utilisation and help-seeking behaviour migrants with particular regard to addicted migrants, and on 4) barriers within the psychosocial care system. RESULTS: Studies on migration, mental health and utilisation of psychosocial institutions especially of institutions for addicted persons show inconsistent results. The results may be conflicting because of the methods used (e. g. small sample size, variety of methods, studies on clinical populations, studies without control-groups, mono-ethnic studies) or because of differences between populations. Therefore, the comparability of results is limited. Migrants use health and psychosocial care institutions differently from non-migrants. Barriers within the psychosocial care system may be caused by uncertainty of learned behaviour of members of staff how to treat migrants or by institutional barriers. CONCLUSION: Our findings show that empirical studies on mental health of migrants are still rare. Further specific investigations are needed to get an in-depth understanding of migrants' mental health and their pattern of psychosocial and health care utilisation to modify responsiveness of services.

Lindert, J., et al. (2008). "Mental health, health care utilisation of migrants in Europe." Eur Psychiatry **23 Suppl 1**: 14-20.

BACKGROUND: Migration during the 1990s has been high and has been characterised by new migrations. Migration has been a key force in the demographic changes of the European population. Due to the different condition of migration in Europe, variables related to mental health of migrants are: motivation for migration, living conditions in the home and in the host country. AIMS: To give an overview on (i) prevalence of mental disorders; suicide; alcohol and drug abuse; (ii) access to mental health and psychosocial care facilities of migrants in the European region, and (iii) utilisation of health and psychosocial institution of these migrants. METHODS: Non-system review of the literature concerning mental health disorders of migrants and their access to and their consumption of health care and psychosocial services in Europe. RESULTS: It is impossible to consider "migrants" as a homogeneous group concerning the risk for mental illness. The literature showed (i) mental health differs between migrant groups, (ii) access to psychosocial care facilities is influenced by the legal frame of the host country; (iii) mental health and consumption of care facilities is shaped by migrants used patterns of help-seeking and by the legal frame of the host country. CONCLUSION: Data on migrant's mental health is scarce. Longitudinal studies are needed to describe mental health adjusting for life conditions in Europe to identify those factors which imply an increased risk of psychiatric disorders and influence help seeking for psychosocial care. In many European countries migrants fall outside the existing health and social services, particularly asylum seekers and undocumented immigrants.

Nakash, O., et al. (2013). "Common mental disorders in immigrant and second-generation respondents: results from the Israel-based World Mental Health Survey." Int J Soc Psychiatry **59**(5): 508-515.

BACKGROUND: The contrasting social status of ethnic groups differentially impacts the mental health of their members. This may be the case in Israel despite its egalitarian ideology. However, studies are a few and limited in scope. AIM: To study mental health disparities between immigrant and second-generation disadvantaged and advantaged Jewish groups. METHODS: Data were extracted from the Israel World Mental Health Survey. This included the Composite International Diagnostic Interview and the General Health Questionnaire. We compared 547 first-generation immigrants born in North Africa/Asia and 708 born in Europe/America; and 707 second-generation immigrants of North African/Asian origin and 449 of European/American origin. RESULTS: The prevalence rate of common mental disorders in the preceding year was approximately double for respondents of North African/Asian origin compared with their European/American counterparts following adjustment for socio-demographic confounders. Inmigrants: North African/Asian 12.4%, SE = 1.5; European/American 6.4%, SE = 1.0 (AOR = 2.1, 95% CI 1.4-3.4). Second generation: North African/Asian 10.1%, SE = 1.2; European/American 5.4%, SE = 1.1 (AOR = 1.7, 95% CI 1.1-3.2). Significant differences in emotional distress mean scores were observed only among second-generation respondents: North African/Asian

respondents reported higher emotional distress (M = 18.7, SE = 0.5) compared with European/American (M = 17.3, SE = 0.4) (Wald F = 13.31, p < .001). CONCLUSIONS: Results showed disparities in the mental health measures in both generations. It is likely that social causation factors, such as restricted opportunities in the context of higher aspirations, partially account for the findings.

Nguyen, H. T. et Connelly, L. B. (2017). "Out of sight but not out of mind: Home countries' macroeconomic volatilities and immigrants' mental health." Health Econ(Ahead of print).

We provide the first empirical evidence that better economic performances by immigrants' countries of origin, as measured by lower consumer price index (CPI) or higher gross domestic product, improve immigrants' mental health. We use an econometrically-robust approach that exploits exogenous changes in macroeconomic conditions across immigrants' home countries over time and controls for immigrants' observable and unobservable characteristics. The CPI effect is statistically significant and sizeable. Furthermore, the CPI effect diminishes as the time since emigrating increases. By contrast, home countries' unemployment rates and exchange rate fluctuations have no impact on immigrants' mental health.

Perez, G., et al. (2015). "A Community-Engaged Research Approach to Improve Mental Health Among Latina Immigrants: ALMA Photovoice." Health Promot Pract.

Recent Latina immigrants are at increased risk of poor mental health due to stressors associated with adapting to life in the United States. Existing social and health care policies often do not adequately address the mental health concerns of new Latino populations. Amigas Latinas Motivando el Alma, a community-partnered research project, seeks to improve immigrant Latinas' mental health outcomes. Using Photovoice methodology, promotoras (lay health advisors) reflected on community factors affecting mental health through photography and guided discussion. Discussions were audio-recorded, transcribed, and coded using content analysis to identify salient themes. Promotoras reviewed codes to develop themes that they presented in community forums to reach local policy makers and to increase community awareness. These forums included an exhibit of the promotoras' photographs and discussion of action steps to address community concerns. Themes included transitioning to life in the United States, parenting, education, and combating racism. Nearly 150 stakeholders attended the community forums and proposed responses to promotoras' photographic themes. Our findings suggest that Photovoice provides an opportunity for Latinas and the larger community to identify issues that they find most important and to explore avenues for action and change by creating sustainable partnerships between the community and forum attendees.

Robert, G., et al. (2014). "From the boom to the crisis: changes in employment conditions of immigrants in Spain and their effects on mental health." Eur J Public Health **24**(3): 404-409.

BACKGROUND: Migrant workers have been one of the groups most affected by the economic crisis. This study evaluates the influence of changes in employment conditions on the incidence of poor mental health of immigrant workers in Spain, after a period of 3 years, in context of economic crisis. METHODS: Follow-up survey was conducted at two time points, 2008 and 2011, with a reference population of 318 workers from Colombia, Ecuador, Morocco and Romania residing in Spain. Individuals from this population who reported good mental health in the 2008 survey (n = 214) were interviewed again in 2011 to evaluate their mental health status and the effects of their different employment situations since 2008 by calculating crude and adjusted odds ratios (aORs) for sociodemographic and employment characteristics. FINDINGS: There was an increased risk of poor mental health in workers who lost their jobs (aOR = 3.62, 95%CI: 1.64-7.96), whose number of working hours increased (aOR = 2.35, 95%CI: 1.02-5.44), whose monthly income decreased (aOR = 2.75, 95%CI: 1.08-7.00) or who remained within the low-income bracket. This was also the case for people whose legal status (permission for working and residing in Spain) was temporary or permanent compared with those with Spanish nationality (aOR = 3.32, 95%CI: 1.15-9.58) or illegal (aOR = 17.34, 95%CI: 1.96-153.23). In contrast, a decreased risk was observed among those who attained their registration under Spanish Social Security system (aOR = 0.10, 95%CI: 0.02-0.48). CONCLUSION: There was an increase in

poor mental health among immigrant workers who experienced deterioration in their employment conditions, probably influenced by the economic crisis

Rucci, P., et al. (2015). "Disparities in mental health care provision to immigrants with severe mental illness in Italy." Epidemiol Psychiatr Sci **24**(4): 342-352.

AIM: To determine whether disparities exist in mental health care provision to immigrants and Italian citizens with severe mental illness in Bologna, Italy. METHODS: Records of prevalent cases on 31/12/2010 with severe mental illness and >/=1 contact with Community Mental Health Centers in 2011 were extracted from the mental health information system. Logistic and Poisson regressions were carried out to estimate the probability of receiving rehabilitation, residential or inpatient care, the intensity of outpatient treatments and the duration of hospitalisations and residential care for immigrant patients compared to Italians, adjusting for demographic and clinical covariates. RESULTS: The study population included 8602 Italian and 388 immigrant patients. Immigrants were significantly younger, more likely to be married and living with people other than their original family and had a shorter duration of contact with mental health services. The percentages of patients receiving psychosocial rehabilitation, admitted to hospital wards or to residential facilities were similar between Italians and immigrants. The number of interventions was higher for Italians. Admissions to acute wards or residential facilities were significantly longer for Italians. Moreover, immigrants received significantly more group rehabilitation interventions, while more social support individual interventions were provided to Italians. CONCLUSIONS: The probability of receiving any mental health intervention is similar between immigrants and Italians, but the number of interventions and the duration of admissions are lower for immigrants. Data from mental health information system should be integrated with qualitative data on unmet needs from the immigrants' perspective to inform mental health care programmes and policies.

Salinero-Fort, M. A., et al. (2014). "Prevalence of common mental disorders in Latin American-born immigrants seen in Primary Health Care: differences over time." Aten Primaria **46**(5): 269-270.

Sandhu, S., et al. (2013). "Experiences with treating immigrants : a qualitative study in mental health services across 16 European countries." Soc Psychiatry Psychiatr Epidemiol **48**(1): 105-116.

Purpose While there has been systematic research on the experiences of immigrant patients in mental health services within certain European countries, little research has explored the experiences of mental health professionals in the delivery of services to immigrants across Europe. This study sought to explore professionals'experiences of delivering care to immigrants in districts densely populated with immigrants across Europe. Methods Forty-eight semi-structured interviews were conducted with mental health care professionals working in 16 European countries. Professionals in each country were recruited from three areas with the highest proportion of immigrants. For the purpose of this study, immigrants were defined as first-generation immigrants born outside the country of current residence, including regular immigrants, irregular immigrants, asylum seekers, refugees and victims of human trafficking. Interviews were transcribed and analysed using thematic analysis. Results The interviews highlighted specific challenges to treating immigrants in mental health services across all 16 countries including complications with diagnosis, difficulty in developing trust and increased risk of marginalisation. Conclusions Although mental health service delivery varies between and within European countries, consistent challenges exist in the experiences of mental health professionals delivering services in communities with high proportions of immigrants. Improvements to practice should include training in reaching appropriate diagnoses, a focus on building trusting relationships and measures to counter marginalisation.

Schouler-Ocak, M. (2015). "[Mental health care for immigrants in Germany]." Nervenarzt.

Immigrants represent a very heterogeneous population, with various stress factors for mental disorders. These individuals are confronted with numerous access barriers within the health care system, which are reflected in limited utilization of the mental health system and psychotherapy services. A particularly large gap in health service provision exists among refugees and asylum-seekers.

There is an urgent need for action in terms of opening up of the mental health system, improving and simplifying routes of access, and facilitating treatment options.

Siriwardhana, C., et al. (2014). "A systematic review of resilience and mental health outcomes of conflict-driven adult forced migrants." Confl Health **8**: 13.

BACKGROUND: The rising global burden of forced migration due to armed conflict is increasingly recognised as an important issue in global health. Forced migrants are at a greater risk of developing mental disorders. However, resilience, defined as the ability of a person to successfully adapt to or recover from stressful and traumatic experiences, has been highlighted as a key potential protective factor. This study aimed to review systematically the global literature on the impact of resilience on the mental health of adult conflict-driven forced migrants. METHODOLOGY: Both quantitative and qualitative studies that reported resilience and mental health outcomes among forcibly displaced persons (aged 18+) by way of exploring associations, links, pathways and causative mechanisms were included. Fourteen bibliographic databases and seven humanitarian study databases/websites were searched and a four stage screening process was followed. RESULTS: Twenty three studies were included in the final review. Ten qualitative studies identified highlighted family and community cohesion, family and community support, individual personal qualities, collective identity, supportive primary relationships and religion. Thirteen quantitative studies were identified, but only two attempted to link resilience with mental disorders, and three used a specific resilience measure. Over-reliance on cross-sectional designs was noted. Resilience was generally shown to be associated with better mental health in displaced populations, but the evidence on this and underlying mechanisms was limited. DISCUSSION: The review highlights the need for more epidemiological and qualitative evidence on resilience in forcibly displaced persons as a potential avenue for intervention development, particularly in resource-poor settings.

Spiritus-Beerden, E. et Verelst, A. (2021). "Mental Health of Refugees and Migrants during the COVID-19 Pandemic: The Role of Experienced Discrimination and Daily Stressors." Int J Environ Res Public Health **18**(12).

The COVID-19 pandemic is a defining global health crisis of our time. While the impact of COVID-19, including its mental health impact, is increasingly being documented, there remain important gaps regarding the specific consequences of the pandemic on particular population groups, including refugees and migrants. This study aims to uncover the impact of the COVID-19 pandemic on the mental health of refugees and migrants worldwide, disentangling the possible role of social and daily stressors, i.e., experiences of discrimination and daily living conditions. Descriptive analysis and structural equation modeling were used to analyze the responses of N = 20,742 refugees and migrants on the self-reporting global ApartTogether survey. Survey findings indicated that the mental health of refugees and migrants during the COVID-19 pandemic was significantly impacted, particularly for certain subgroups, (i.e., insecure housing situation and residence status, older respondents, and females) who reported experiencing higher levels of increased discrimination and increases in daily life stressors. There is a need to recognize the detrimental mental health impact of the COVID-19 pandemic on particular refugee and migrant groups and to develop interventions that target their unique needs.

Straiton, M., et al. (2014). "Mental health in immigrant men and women in Australia: the North West Adelaide Health Study." BMC Public Health **14**: 1111.

BACKGROUND: There is conflicting evidence of the healthy migrant effect with respect to mental health. This study aims to determine if there are differences in mental health and service use between Australian-born and foreign-born individuals living in South Australia and to consider the differing role of socio-demographic characteristics for Australian-born and foreign-born men and women. METHODS: Data from the North West Adelaide Health study was used to compare foreign-born men and women from English and non-English speaking backgrounds with Australian born men and women on four measures of mental health and service use. A series of logistic regression analyses were conducted. RESULTS: There were no differences between Australian-born and foreign-born individuals from English-speaking backgrounds on any measures. Men from non-English speaking backgrounds

had higher odds of depression. Employment and general health were important protectors of mental health for both Australian and foreign-born individuals, while being married was protective for foreign-born men only. Income was generally inversely related to mental health among Australians but the relationship was weaker and less consistent for those born abroad. CONCLUSIONS: Men from non-English speaking backgrounds men may be at increased risk of mental health problems but do not have higher levels of treatment. Help-seeking may need to be encouraged among this group, particularly among unmarried, unemployed men from non-English speaking backgrounds.

Straiton, M. L., et al. (2015). "Managing Mental Health Problems Among Immigrant Women Attending Primary Health Care Services." Health Care Women Int: 1-22.

Researchers in Norway explore treatment options in primary care for immigrant women with mental health problems compared with nonimmigrant women. Three national registers were linked together for 2008. Immigrant women from Sweden, Poland, the Philippines, Thailand, Pakistan, and Russia were selected for analysis and compared with Norwegian women. Using logistic regression, we investigated whether treatment type varied by country of origin. Rates of sickness leave and psychiatric referrals were similar across all groups. Conversational therapy and use of antidepressants and anxiolytics were lower among Filipina, Thai, Pakistani, and Russian women than among Norwegians. Using the broad term "immigrants" masks important differences in treatment and health service use. By closely examining mental health treatment differences by country of origin, gaps in service provision and treatment uptake may be identified and addressed with more success.

Strassmayr, C., et al. (2012). "Mental health care for irregular migrants in Europe: barriers and how they are overcome." BMC Public Health **12**: 367.

BACKGROUND: Irregular migrants (IMs) are exposed to a wide range of risk factors for developing mental health problems. However, little is known about whether and how they receive mental health care across European countries. The aims of this study were (1) to identify barriers to mental health care for IMs, and (2) to explore ways by which these barriers are overcome in practice. METHODS: Data from semi-structured interviews with 25 experts in the field of mental health care for IMs in the capital cities of 14 European countries were analysed using thematic analysis. RESULTS: Experts reported a range of barriers to mental health care for IMs. These include the absence of legal entitlements to health care in some countries or a lack of awareness of such entitlements, administrative obstacles, a shortage of culturally sensitive care, the complexity of the social needs of IMs, and their fear of being reported and deported. These barriers can be partly overcome by networks of committed professionals and supportive services. NGOs have become important initial points of contact for IMs, providing mental health care themselves or referring IMs to other suitable services. However, these services are often confronted with the ethical dilemma of either acting according to the legislation and institutional rules or providing care for humanitarian reasons, which involves the risk of acting illegally and providing care without authorisation. CONCLUSIONS: Even in countries where access to health care is legally possible for IMs, various other barriers remain. Some of these are common to all migrants, whilst others are specific for IMs. Attempts at improving mental health care for IMs should consider barriers beyond legal entitlement, including communicating information about entitlement to mental health care professionals and patients, providing culturally sensitive care and ensuring sufficient resources.

Ta, T. M., et al. (2015). "[Mental Health Care Utilization of First Generation Vietnamese Migrants in Germany]." Psychiatr Prax **42**(5): 267-273.

OBJECTIVE: Vietnamese migrants underutilize and are a "hard to reach group" within the existing mental health care system in Germany. METHODS: We analyzed migration related and clinical data for all first-time Vietnamese migrants seeking psychiatric help, within the first 30 months of a newly established outpatient clinic, offering culture-sensitive psychiatric treatment in native Vietnamese language. RESULTS: Most first time patients were female, first generation Vietnamese migrants with poor German language skills. Only 1 /3 of all patients had a psychiatric history, while this number was higher in patients with schizophrenia. Over time, more first time patients with depression were

seeking psychiatric care, accompanied with an increase of non-professional referrals within the Vietnamese communities. CONCLUSION: This first study on mental health care utilization in Vietnamese migrants in Germany points towards the fact that "migrants" cannot be considered as a homogeneous group. Mental health care utilization must be evaluated for specific migrant groups, and can be initially improved if offered in native language and when it is referred to by members of migrant communities.

Teunissen, E., et al. (2015). "Mental health problems of undocumented migrants in the Netherlands: A qualitative exploration of recognition, recording, and treatment by general practitioners." Scand J Prim Health Care **33**(2): 82-90.

OBJECTIVE: To explore the views and experiences of general practitioners (GPs) in relation to recognition, recording, and treatment of mental health problems of undocumented migrants (UMs), and to gain insight in the reasons for under-registration of mental health problems in the electronic medical records. DESIGN: Qualitative study design with semi-structured interviews using a topic guide. SUBJECTS AND SETTING: Sixteen GPs in the Netherlands with clinical expertise in the care of UMs. RESULTS: GPs recognized many mental health problems in UMs. Barriers that prevented them from recording these problems and from delivering appropriate care were their low consultation rates, physical presentation of mental health problems, high number of other problems, the UM's lack of trust towards health care professionals, and cultural differences in health beliefs and language barriers. Referrals to mental health care organizations were often seen as problematic by GPs. To overcome these barriers, GPs provided personalized care as far as possible, referred to other primary care professionals such as social workers or mental health care nurses in their practice, and were a little less restrictive in prescribing psychotropics than guidelines recommended. CONCLUSIONS: GPs experienced a variety of barriers in engaging with UMs when identifying or suspecting mental health problems. This explains why there is a gap between the high recognition of mental health problems and the low recording of these problems in general practice files. It is recommended that GPs address mental health problems more actively, strive for continuity of care in order to gain trust of the UMs, and look for opportunities to provide mental care that is accessible and acceptable for UMs.

Teunissen, E., et al. (2014). "Mental health problems in undocumented and documented migrants: a survey study." Fam Pract **31**(5): 571-577.

BACKGROUND: Undocumented migrants (UM) frequently report mental health problems. It is unknown to what extent these migrants seek help for these problems in general practice and how these issues are explored, discussed, registered and treated by GPs. OBJECTIVE: To gain insight in the registration and treatment of mental health problems in general practice of UM compared to documented migrants (DM). METHODS: A survey study of general practice patient records of UM and DM in nine general practices in the Netherlands. Consultation rates, registration of mental health problems, prescription of psychotropic medication and referrals to mental health care institutions of UM and DM patients were compared. RESULTS: A total of 541 migrants were included (325 UM and 216 DM). UM consulted a GP significantly less than DM (3.1 versus 4.9 times per year). Only 20.6% of the UM had at least one mental health problem diagnosis registered compared to 44.0% of the DM. In both groups, ~10% mentioned at least one main mental health complaint during the consultation that was not coded in the record. No significant differences were found in the prescription of psychotropic medication between the two groups. UM were referred less to mental health care institutions but more often to psychiatrists than to psychologists. CONCLUSION: UM had less consultations with their GP, and in these consultations, less mental health problems were registered. UM were referred less to psychologists but more often to psychiatrists. GPs are advised to explore and register mental health problems more actively in UM.

Tortelli, A., et al. (2014). "Different rates of first admissions for psychosis in migrant groups in Paris." Soc Psychiatry Psychiatr Epidemiol **49**(7): 1103-1109.

PURPOSE: The association between migration and psychosis has been reported in the past decades in many European countries. Despite large-scale migration into France, epidemiological data on the

incidence of psychosis in this population are lacking. In this study, we compare the incidence rates of first admission for psychosis among natives and first generation migrants. METHODS: Two-hundred and fifty-eight patients aged 15+ with first admission for psychosis were identified in the catchment area of the 20th district of Paris between 2005 and 2009. Standardised incidence rates and incidence rate ratios were calculated for migrant and native groups. RESULTS: We found higher rates of admissions for psychosis in the migrant group (IRR 2.9, 95 % CI 0.9-9.8) compared to individuals born in France. Among migrants, incidence was higher in individuals from Sub-Saharan Africa compared to natives (IRR 7.1, CI 95 % 2.3-21.8), whereas the incidence was similar for those from Europe (IRR 1.2, CI 95 % 0.3-5.1) and from North Africa (IRR 1.4, CI 95 % 0.4-5.6). CONCLUSIONS: Our findings suggest that Sub-Saharan migrants were identified as the most vulnerable migrant group for developing psychosis in France, but additional work is warranted to confirm these trends.

Virupaksha, H. G., et al. (2014). "Migration and mental health: An interface." J Nat Sci Biol Med **5**(2): 233-239.

Migration is a universal phenomenon, which existed with the subsistence of the human beings on earth. People migrate from one place to another for several reasons, but the goal or main reason behind changing the residence would be improving their living conditions or to escape from debts and poverty. Migration is also a social phenomenon which influences human life and the environment around. Hence, migration has a great impact on any geographical area and it is known as one of the three basic components of population growth of any particular region (the other two are, mortality and fertility). Migration involves certain phases to go through; hence, it is a process. Many times, lack of preparedness, difficulties in adjusting to the new environment, the complexity of the local system, language difficulties, cultural disparities and adverse experiences would cause distress to the migrants. Moreover subsequently it has a negative impact on mental well-being of such population. Due to globalization, modernization, improved technologies and developments in all the sectors, the migration and its impact on human well-being is a contemporary issue; hence, here is an attempt to understand the migration and its impact on the mental health of the migrants based on the studies conducted around.

Voss, A., Erim, Y., Straiton, M. L., et al. (2022). "Outpatient mental health service use following contact with primary health care among migrants in Norway: A national register study." BMJ Open **294**: 114725.

Majority of mental health problems are treated in primary care, while a minority require specialised treatment. This study aims to identify factors that predict contact with outpatient mental healthcare services (OPMH) among individuals who have been diagnosed with a mental health problem in primary healthcare services (PHC), with a special focus on migrants. Using linked national Norwegian registry data, we followed 1,002,456 individuals who had been diagnosed with a mental health problem in PHC for a period of two years. Using Cox regression, we applied Andersen's Model of Healthcare Utilisation to assess differences in risk of OPMH use between the majority population and eight migrant groups. We also conducted interaction analyses to see if the relationship between OPMH use and predisposing factors (gender, age, migrant status, civil status, education) differed across migrant groups. Migrants from Nordic countries, Western Europe and the Middle-East/North Africa had a higher risk of using OPMH services compared to the majority, while migrants from EU Eastern Europe, Sub-Saharan Africa and South Asia had a lower risk after controlling for all factors. Hazard ratios for non-EU Eastern Europeans and East/South East Asian's did not differ. Men had a higher risk than women. Additionally, the relationship between predisposing factors and OPMH use differed for some migrant groups. Education was not related to OPMH contact among five migrant groups. While lack of help-seeking at the primary care level may explain some of the lower rates of specialist service use observed for migrants compared to non-migrants in previous studies, there appear to be barriers for some migrant groups at the secondary level too. This warrants further investigation. Future research should look at differences between referrals and actual uptake of services among different migrant groups.

UN ACCES ET UN RECOURS AUX SOINS VARIABLES SELON LES PAYS D'ACCUEIL

Une comparaison des conditions d'accès aux soins des immigrés n'est pas un exercice aisé tant dans les pays de l'Union européenne que dans les autres grands pays migratoires comme les États-Unis, le Canada ou l'Australie.

Si l'on se réfère au rapport de l'Organisation mondiale de la santé [30] relatif à l'Union européenne, il y aurait 75 millions de migrants dans la région européenne de l'OMS, à hauteur de 8,4 % de la population totale et 39 % de tous les migrants dans le monde entier. Les chiffres pour les minorités ethniques ne sont pas disponibles, car il y a peu de consensus sur les définitions, mais le plus grand de ces groupes est probablement *la Roma* (population Roms), avec une population estimée à 12-15millions. L'étude montre qu'il existe des inégalités d'accès et de qualité des soins offerts à ces groupes de population. Ces inégalités varient selon le groupe spécifique étudié, les problèmes ou les services de santé concernés, et le pays concerné. Certains groupes peuvent à certains égards bénéficier d'avantages pour la santé, mais ce sont surtout des inconvénients qui sont documentés dans la littérature.

Aux États-Unis, de nombreuses études sur les minorités ethniques tendent à montrer leur difficulté d'accès aux services de santé, notamment pour les migrants non natifs. [31] La nouvelle loi pour des soins abordables en santé semble améliorer toutefois leur accès à une couverture maladie.[32] Une revue de la littérature canadienne portant sur l'accès des migrants aux soins de santé primaires classe les barrières d'accès aux soins en cinq groupes : la culture, la communication, le statut socio-économique, la structure du système de soins et la connaissance que les migrants ont de ce système de soins. [33] En Australie, malgré l'universalité du régime Medicare, les migrants recourent davantage aux urgences hospitalières qu'à la médecine ambulatoire. La barrrière lingusitique s'avère être un frein important à l'accès aux soins. [34]

Pour lutter contre ces inégalités en matière de santé, les systèmes de santé doivent donc non seulement améliorer les services offerts aux migrants et aux minorités ethniques, mais aussi aborder les déterminants sociaux de la santé dans de nombreux secteurs.

Des études comparées en Europe et dans les pays industrialisés

Agence des Droits Fondamentaux de l'Union européenne (2011). L'accès aux soins de santé des migrants en situation irrégulière dans dix États membres de l'Union européenne. Agence des droits fondamentaux de l'Union européenne.
http://fra.europa.eu/sites/default/files/fra-2011-fundamental-rights-for-irregular-migrants-healthcare_fr_0.pdf

Biswas, D., et al. (2012). "Access to health care for undocumented migrants from a human rights perspective: a comparative study of Denmark, Sweden, and The Netherlands." Health Hum Rights **14**(2): 49-60.

> BACKGROUND: Undocumented migrants' access to health care varies across Europe, and entitlements on national levels are often at odds with the rights stated in international human rights law. The aim of this study is to address undocumented migrants' access to health care in Denmark, Sweden, and the Netherlands from a human rights perspective. METHODS: Based on desk research in October 2011, we identified national laws, policies, peer-reviewed studies, and grey literature concerning undocumented migrants' access to health care in the three involved countries. Through treaties and related explanatory documents from the United Nations and the Council of Europe, we identified relevant international laws concerning the right to health and the rights of different groups of

[30] OMS, Bureau régional de l'Europe. (2010). How health systems can address inequities linked to migration and ethnicity.
[31] Derose (2009)
[32] Chen J (2016) et Clemans (2012)
[33] Ahmed (2015)
[34] Mahmoud, I. et Hou (2012)

undocumented migrants. A synopsis of these laws is included in the analysis of the three countries. RESULTS: Undocumented migrants in Denmark have the right to emergency care, while additional care is restricted and may be subject to payment. Undocumented migrants in Sweden have the right to emergency care only. There is an exception made for former asylum-seeking children, who have the same rights as Swedish citizens. In the Netherlands, undocumented migrants have greater entitlements and have access to primary, secondary and tertiary care, although shortcomings remain. All three countries have ratified international human rights treaties that include right of access to health care services. We identified international treaties from the United Nations and the Council of Europe that recognize a right to health for undocumented migrants and embrace governmental obligations to ensure the availability, accessibility, acceptability, and quality of health services, in particular for specific groups such as women and children. CONCLUSION: In the Netherlands, undocumented migrants' right to health care is largely acknowledged, while in Denmark and Sweden, there are more restrictions on access. This reveals major discrepancies in relation to international human rights law.

Bradby, H., et al. (2015). Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region, Copenhague : OMS Bureau régional de l'Europe

Refugees and asylum seekers are defined in many ways, but can be considered as those who did not make a voluntary choice to leave their country of origin and cannot return home in safety. Outcome data are limited and mostly focused on perinatal and mental health but do suggest significant levels of unmet need. This scoping review considered 72 studies in which refugees and asylum seekers formed part or all of the population studied. The results show that access to appropriate health care across the WHO European Region is very varied and is overwhelmingly shaped by legal frameworks and the regulation of the migration process. The need for improved communication with asylum seekers and coordinated action between agencies within and beyond the health care system is widely noted. Improved data are imperative to support intersectoral work to address the health care needs of asylum seekers and refugees.

Chauvin, P., et al. (2009). Access to healthcare for undocumented migrants in 11 eleven countries : 2008 survey report. Paris Médecins du Monde**:** 156 , tab., graph., fig.

The 14 organisations within the Médecins du Monde international network work with the most vulnerable populations throughout the world and in their own societies. Through the national programmes, they meet people in Europe who have fled extreme poverty, violent armies and police forces, conflict areas and disasters. A tiny minority of the children, women and men whom we try to support when they work in their countries end up coming here. After migration journeys which are very often long, dangerous and exhausting, many find themselves without permission to stay in the country, forced into the shadows of our towns and cities. At home, as abroad, Médecins du Monde aims to provide some support and tries to help this population protect what is often the only thing they have left—their health. This study shows how undocumented migrants' living conditions are harmful to their health and prevent them from building, or rebuilding, their lives. This is despite the fact that these children, women and men are in particular need of support, given what they have lived through and the migration journeys they have undertaken.

Clarke, J. M. (2016). "Stop denying migrants their fundamental right to healthcare." Bmj **353**.

Jonathan M Clarke, medical doctor, Kennedy scholar, and master of public health candidateHarvard TH Chan School of Public Health, Boston, MA, USAjclarke{at}mail.harvard.eduUndocumented migrants have particular healthcare needs, including those related to torture, but countries are restricting accessMany people think that all migrants to Europe have meaningful access to healthcare. As article 35 of the European Union's Charter of Fundamental Rights recognises, "Everyone has the right of access to preventive health care and the right to benefit from medical treatment".1But the reality is different: as the European Parliament acknowledged in 2013, "Access to the most basic healthcare services, such as emergency care, is severely limited, if not impossible, for undocumented migrants on account of the identification requirement, the high price of treatment and the fear of being detected

and reported to the authorities."2Two thirds of the 15 648 migrants attending clinics throughout Europe in 2014 run by the charity …

Communauté Européenne, (2018). Benchmarking Access to Healthcare in the EU. Report of the Expert Panel on effective ways of investing in Health (EXPH). Luxembourg Publications Office of the European Union**:** 78 , tabl., fig.
https://ec.europa.eu/health/sites/default/files/expert_panel/docs/opinion_benchmarking_healthcareaccess_en.pdf

Faced with growing evidence that some groups within European Union Member States have been unable to achieve access to necessary healthcare, the European Union has committed to action to reduce levels of unmet need, most recently as an element of the European Pillar of Social Rights. In response, the Expert Panel on Effective Ways of Investing in Health has been requested to propose a series of quantitative and qualitative benchmarks for assessing progress in reducing unmet need for healthcare and to discuss means by which EU funds or other mechanisms might be used to improve access to healthcare.

Constant, A. F., et al. (2016). Micro and Macro Determinants of Health: Older Immigrants in Europe. Iza Working Paper ; 8754. Bonn IZA**:** 38 , tab., graph., fig.
http://ftp.iza.org/dp8754.pdf

This working paper studies the health determinants of immigrant men and women over the age of fifty, in Europe, and compare them to natives. It utilizes the unique Survey of Health Aging and Retirement (SHARE) and augmented it with macroeconomic information on the 22 home countries and 16 host countries. Using Multilevel Analysis it can best capture the within and between countries variation and produce reliable results. It finds that during the first decade after arrival, immigrants report higher levels of subjective health compared to natives and to previous cohorts of immigrants. As time since migration passes by, reported subjective health decreases; immigrants' health becomes the same as that of comparable natives or it even decreases. The level of economic development of both the origin and the host country positively affect the individual's health, but the effect of the host country is much more pronounced. It appears that positive and negative deviations (of the host from the origin country) have different impacts on individual health: an increase in a positive deviation (the country of origin is more developed compared to the host country – a 'loss' for the immigrating individual) leads to a decrease in the immigrant's subjective health, while an increase in the absolute negative deviation (a 'gain' for the immigrating person) leads to an increase in the immigrant's subjective health. These differential effects can be explained as some variant of the Loss-Aversion Theory.

Cuadra, C. B. (2012). "Right of access to health care for undocumented migrants in EU: a comparative study of national policies." Eur J Public Health **22**(2): 267-271.

BACKGROUND: The aim of this article is to characterize policies regarding the right of access to health care for undocumented migrants in the 27 Member States of the European Union and to identify the extent to which these entitlements are congruent with human rights standards. METHODS: The study is based on a questionnaire sent to experts, non-governmental organizations and authorities in the Member States between April and December 2009, as well as on available reports and official websites. Primary sources were also consulted as regards legislation. RESULTS: Right of access to health care differs considerably between Member States. States can be grouped into 3 clusters: in 5 countries undocumented migrants have the right to access care that is more extensive than emergency care; in 12 countries they can only access emergency care and in 10 countries not even emergency care can be accessed. These variations are independent of the system of financing or the numbers of undocumented migrants present. Rather, they seem to relate to the intersection between practices of control of migration, the main types of undocumented migrants present and the basic norms of the welfare state-the 'moral economy' of the work society. CONCLUSION: International obligations articulated in human rights standards are not fully met in the majority of Member States. A more complete understanding of the differing policies might be obtained by considering the relationship between the formal and informal economy, as well as the role of human rights standards within the current 'moral economy'.

Dalla Zuanna, T., et al. (2017). "Avoidable hospitalization among migrants and ethnic minority groups: a systematic review." Eur J Public Health **27**(5): 861-868.

Background: The numbers of migrants living in Europe are growing rapidly, and has become essential to assess their access to primary health care (PHC). Avoidable Hospitalization (AH) rates can reflect differences across migrant and ethnic minority groups in the performance of PHC. We aimed to conduct a systematic review of all published studies on AH comparing separately migrants with natives or different racial/ethnic groups, in Europe and elsewhere. Methods: We ran a systematic search for original articles indexed in primary electronic databases on AH among migrants or ethnic minorities. Studies presenting AH rates and/or rate ratios between at least two different ethnic minority groups or between migrants and natives were included. Results: Of the 35 papers considered in the review, 28 (80%) were conducted in the United States, 4 in New Zealand, 2 in Australia, 1 in Singapore, and none in Europe. Most of the studies (91%) used a cross-sectional design. The exposure variable was defined in almost all articles by ethnicity, race, or a combination of the two; country of birth was only used in one Australian study. Most of the studies found significant differences in overall AH rates, with minorities (mainly Black and Hispanics) showing higher rates than non-Hispanic Whites. Conclusions: AH has been used, mostly in the US, to compare different racial/ethnic groups, while it has never been used in Europe to assess migrants' access to PHC. Studies comparing AH rates between migrants and natives in European settings can be helpful in filling this lack of evidence.

Dauvrin, M., et al. (2012). "Health care for irregular migrants: pragmatism across Europe: a qualitative study." BMC Res Notes **5**: 99.

BACKGROUND: Health services in Europe face the challenge of delivering care to a heterogeneous group of irregular migrants (IM). There is little empirical evidence on how health professionals cope with this challenge. This study explores the experiences of health professionals providing care to IM in three types of health care service across 16 European countries. RESULTS: Semi-structured interviews were conducted with health professionals in 144 primary care services, 48 mental health services, and 48 Accident & Emergency departments (total n = 240). Although legal health care entitlement for IM varies across countries, health professionals reported facing similar issues when caring for IM. These issues include access problems, limited communication, and associated legal complications. Differences in the experiences with IM across the three types of services were also explored. Respondents from Accident & Emergency departments reported less of a difference between the care for IM patients and patients in a regular situation than did respondents from primary care and mental health services. Primary care services and mental health services were more concerned with language barriers than Accident & Emergency departments. Notifying the authorities was an uncommon practice, even in countries where health professionals are required to do this. CONCLUSIONS: The needs of IM patients and the values of the staff appear to be as important as the national legal framework, with staff in different European countries adopting a similar pragmatic approach to delivering health care to IM. While legislation might help to improve health care for IM, more appropriate organisation and local flexibility are equally important, especially for improving access and care pathways.

de Freitas, C. et Martin, G. (2015). "Inclusive public participation in health: Policy, practice and theoretical contributions to promote the involvement of marginalised groups in healthcare." Soc Sci Med **135**: 31-39.

Migrants and ethnic minorities are under-represented in spaces created to give citizens voice in healthcare governance. Excluding minority groups from the health participatory sphere may weaken the transformative potential of public participation, (re)producing health inequities. Yet few studies have focused on what enables involvement of marginalised groups in participatory spaces. This paper addresses this issue, using the Participation Chain Model (PCM) as a conceptual framework, and drawing on a case study of user participation in a Dutch mental health advocacy project involving Cape Verdean migrants. Data collection entailed observation, documentary evidence and interviews with Cape Verdeans affected by psychosocial problems (n = 20) and institutional stakeholders (n = 30). We offer practice, policy and theoretical contributions. Practically, we highlight the importance of a

proactive approach providing minorities and other marginalised groups with opportunities and incentives that attract, retain and enable them to build and release capacity through involvement. In policy terms, we suggest that both health authorities and civil society organisations have a role in creating 'hybrid' spaces that promote the substantive inclusion of marginalised groups in healthcare decision-making. Theoretically, we highlight shortcomings of PCM and its conceptualisation of users' resources, suggesting adaptations to improve its conceptual and practical utility.

de Jong, L., et al. (2017). "A systematic literature review on the use and outcomes of maternal and child healthcare services by undocumented migrants in Europe." Eur J Public Health.

Background: Undocumented migrants, in particular pregnant women and their newborns, constitute a particularly vulnerable group of migrants. The aim of this study was to systematically review the academic literature on the use and outcomes of maternal and child healthcare by undocumented migrants in the European Union (EU) and European Free Trade Association (EFTA) countries. Methods: The databases, MEDLINE, Embase, CINAHL Plus, Global Health and Popline were searched for the period 2007 to 2017. Two independent reviewers judged the eligibility of studies. The final number of included studies was 33. Results: The results of quantitative, qualitative and mixed methods studies were analysed separately due to their differences in study design, sample size and quality. Overall, the quantitative studies found that undocumented women underutilised essential maternal and child healthcare services, and experienced worse health outcomes. Qualitative studies supported these results, indicating that undocumented migrants were hesitant to use services due to a lack of knowledge and fear of deportation. Studies included in the review covered 10 of 32 EU or EFTA countries, making a European comparison impossible. Conclusions: Despite major methodological differences between included studies, the results of this review indicate that the status of undocumented migrants exacerbates known health risks and hampers service use.

De Vito, E., et al. (2017). A review of evidence on equitable delivery, access and utilization of immunization services for migrants and refugees in the WHO European Region, Copenhague : OMS Bureau régional de l'Europe
http://www.euro.who.int/__data/assets/pdf_file/0005/351644/HEN53.pdf

This review focuses on existing immunization policies and practices for migrants and refugees and provides an overview of barriers and facilitators for access to and utilization of immunization services. Evidence was obtained by a scoping review of academic and grey literature in English and a further 11 languages and included official documents available from the websites of ministries of health and national health institutes of the WHO European Region Member States. The review highlights that vaccination policies tailored to migrants and refugees are very heterogeneous among WHO European Region Member States. By comparison, common barriers for the implementation and utilization of immunization services can be identified across countries. Outlined policy options are intended to strengthen information about immunization for migrants and refugees, support future evidence-informed policy-making, enable the achievement of national vaccination coverage goals and improve the eligibility of migrants and refugees to access culturally competent immunization services.

De, Vito E., et al. (2015). Public health aspects of migrant health: a review of the evidence on health status for undocumented migrants in the European Region, Copenhague : OMS Bureau régional de l'Europe

Undocumented migrants are people within a country without the necessary documents and permits. They are considered at higher risk for health problems because of their irregular status and the consequences of economic and social marginalization. A systematic review found 122 documents that suggested policies and interventions to improve health care access and delivery for undocumented migrants. Undocumented migrants mostly have only access to emergency care across Europe, and even in the countries where they are fully entitled to health care, formal and informal barriers hinder their access. This raises concerns for both public health and migrant care. On the basis of findings, policy options are suggested regarding data collection, research, entitlement to health care, information and communication, training and intersectoral approache.

Deville, W., et al. (2011). "Health care for immigrants in Europe: is there still consensus among country experts about principles of good practice? A Delphi study." BMC Public Health **11**: 699.

BACKGROUND: European Member States are facing a challenge to provide accessible and effective health care services for immigrants. It remains unclear how best to achieve this and what characterises good practice in increasingly multicultural societies across Europe. This study assessed the views and values of professionals working in different health care contexts and in different European countries as to what constitutes good practice in health care for immigrants. METHODS: A total of 134 experts in 16 EU Member States participated in a three-round Delphi process. The experts represented four different fields: academia, Non-Governmental Organisations, policy-making and health care practice. For each country, the process aimed to produce a national consensus list of the most important factors characterising good practice in health care for migrants. RESULTS: The scoring procedures resulted in 10 to 16 factors being identified as the most important for each participating country. All 186 factors were aggregated into 9 themes: (1) easy and equal access to health care, (2) empowerment of migrants, (3) culturally sensitive health care services, (4) quality of care, (5) patient/health care provider communication, (6) respect towards migrants, (7) networking in and outside health services, (8) targeted outreach activities, and (9) availability of data about specificities in migrant health care and prevention. Although local political debate, level of immigration and the nature of local health care systems influenced the selection and rating of factors within each country, there was a broad European consensus on most factors. Yet, discordance remained both within countries, e.g. on the need for prioritising cultural differences, and between countries, e.g. on the need for more consistent governance of health care services for immigrants. CONCLUSIONS: Experts across Europe asserted the right to culturally sensitive health care for all immigrants. There is a broad consensus among experts about the major principles of good practice that need to be implemented across Europe. However, there also is some disagreement both within and between countries on specific issues that require further research and debate.

Dorn, T., et al. (2011). "Health care seeking among detained undocumented migrants: a cross-sectional study." BMC Public Health **11**(1): 190.
https://doi.org/10.1186/1471-2458-11-190

As in many European countries, access to care is decreased for undocumented migrants in the Netherlands due to legislation. Studies on the health of undocumented migrants in Europe are scarce and focus on care-seeking migrants. Not much is known on those who do not seek care.

Epicum, Huma Neitwork (2009). Access to health care for undocumented mgrants and asylum seekers in 10 european countries : law and right. Epicum**:** 192 , tab.., graph., fig.
http://www.episouth.org/doc/r_documents/Rapport_huma-network.pdf

In 2007, the Platform for International Cooperation on Undocumented Migrants (PICUM)8 issued within the framework of a European project, a documented comparison of eleven countries regarding law and practice and raised the necessity to improve access to health care as an urgent priority in order to guarantee the minimum respect for Human Rights. Two years later, the present report seeks to provide an updated overview of the different systems regulating access to healthcare for undocumented migrants and asylum seekers in ten Members States.

Essink-Bot, M. L., et al. (2013). "Interpreting ethnic inequalities in healthcare consumption: a conceptual framework for research." The European Journal of Public Health **23**(6): 922-926.

Background: The increasing diversity of the Western-European population demands identification of potential ethnic healthcare inequities. We developed a framework that helps researchers in interpreting ethnic inequalities in healthcare consumption in equity terms. From this framework, we develop recommendations for the design of future studies. Methods: The framework was developed by analysing three typical studies on ethnic inequalities in healthcare consumption with respect to the potential of interpreting their results as healthcare inequities. Results: Analysing the effects of ethnic variations in healthcare consumption on health outcomes provides important clues about the

presence of potential ethnic healthcare inequities. Interpretation of ethnic variations in healthcare consumption as potentially inequitable requires appropriate adjustment for medical need for healthcare, patient preferences and treatment adherence. Because of the central position of medical need, studies need to be disease-specific and based on standardized assessment of risk factors and disease characteristics. A longitudinal study design is necessary to prevent reverse causation. Conclusion: The framework shows that ethnic inequalities in healthcare consumption can be justified if healthcare received meets the need for healthcare in all groups and is in accordance with informed patient preferences. It also shows that ethnic equality in healthcare consumption may hide healthcare inequities. We recommend further research on ethnic healthcare inequities using multi-ethnic cohort designs combined with linkage to healthcare registries. We also recommend research to identify clinically relevant ethnic differences in disease profiles and optimization of treatment regimens

European Union Agency for Fundamental Rights (2012). Migrants in an irregular situation: access to healthcare in 10 European Union Member States. Vienne FRA Bruxelles Office des publications de l'Union européenne**:** 76 , tab., graph., fig.
http://fra.europa.eu/en/publication/2012/migrants-irregular-situation-access-healthcare-10-european-union-member-states

This report explores the access to healthcare granted to irregular migrants in 10 EU Member States. It focuses on migrants who are present in an irregular situation, namely those who do not fulfil conditions for entry, stay or residence.

Evangelidou, S., Schouler-Ocak, M., Movsisyan, N., et al. (2022). "Health promotion strategies toward improved healthcare access for migrants and refugees in Europe: MyHealth recommendations." Health Promot Int.

MyHealth European project (2017-2020) was committed to elaborate on models to engage vulnerable migrants and refugees (VMR) in their health through community involvement. Low healthcare access and poor quality of healthcare services for VMR is a common reality in many European countries. The purpose of the present study, as part of MyHealth project, was the development of an agenda for actions and consequent recommendations to tackle the issue. A qualitative research design was applied at four study sites in Barcelona, Spain; Berlin, Germany; Brno, Czech Republic and Athens, Greece. The Metaplan® group discussions allowed the collection, organization and process of ideas and opinions elaborated in the collaborative groups. In total, 14 sessions took place: 4 with health and social professionals (n = 41) and 10 with VMR (n = 77). A participatory thematic analysis was performed at every session and overall for all sessions a thematic analysis synthesized the findings. The suggested actions were divided into two levels of recommendations: (i) local authorities at destination country-related, such as the investment in health professionals' cultural competences, and (ii) VMR-related, such as adaptation of help-seeking behavior patterns. Special attention was proposed to women survivors of violence and homeless minors. The study concluded to an agenda for action in Europe. We advocate for a public health paradigm shift where, while holding a bottom-up approach, VMR as well as professionals working with them are actively and meaningfully engaged in the decision-making process of access-enhancing and health promotion strategies in a given socio-cultural context.

Gil-Gonzalez, D., et al. (2015). "Is health a right for all? An umbrella review of the barriers to health care access faced by migrants." Ethn Health **20**(5): 523-541.

OBJECTIVE: To synthesise the scientific evidence concerning barriers to health care access faced by migrants. We sought to critically analyse this evidence with a view to guiding policies. DESIGN: A systematic review methodology was used to identify systematic and scoping reviews which quantitatively or qualitatively analysed data from primary studies. The main variables analysed were structural and contextual barriers (health system organisation) as well as individual (patients and providers). The quality of evidence from the systematic reviews was critically appraised. From 2674 reviews, 79 were retained for further scrutiny, and finally 9 met the inclusion criteria. RESULTS: The structural barriers identified were the lack of health insurance and the high cost of drugs (non-universal health system) and organisational aspects of health system (social insurance system and national health system). The individual barriers were linguistic and cultural. None of the reviews

provided a quality appraisal of the studies. CONCLUSIONS: Barriers to health care for migrants range from entitlement in non-universal health systems to accessibility in universal ones, and determinants of access to the respective health services should be analysed within the corresponding national context. Generate social and institutional changes that eliminate barriers to access to health services is essential to ensure health for all.

Gimeno-Feliu, L. A., et al. (2016). "Patterns of pharmaceutical use for immigrants to Spain and Norway: a comparative study of prescription databases in two European countries." Int J Equity Health **15**: 32.

BACKGROUND: Although equity in health care is theoretically a cornerstone in Western societies, several studies show that services do not always provide equitable care for immigrants. Differences in pharmaceutical consumption between immigrants and natives are explained by variances in predisposing factors, enabling factors and needs across populations, and can be used as a proxy of disparities in health care use. By comparing the relative differences in pharmacological use between natives and immigrants from the same four countries of origin living in Spain and Norway respectively, this article presents a new approach to the study of inequity in health care. METHODS: All purchased drug prescriptions classified according to the Anatomical Therapeutic Chemical (ATC) system in Aragon (Spain) and Norway for a total of 5 million natives and nearly 100,000 immigrants for one calendar year were included in this cross-sectional study. Age and gender adjusted relative purchase rates for immigrants from Poland, China, Colombia and Morocco compared to native populations in each of the host countries were calculated. Direct standardisation was performed based on the 2009 population structure of the OECD countries. RESULTS: Overall, a significantly lower proportion of immigrants in Aragon (Spain) and Norway purchased pharmacological drugs compared to natives. Patterns of use across the different immigrant groups were consistent in both host countries, despite potential disparities between the Spanish and Norwegian health care systems. Immigrants from Morocco showed the highest drug use rates in relation to natives, especially for antidepressants, "pain killers" and drugs for peptic ulcer. Immigrants from China and Poland showed the lowest use rates, while Colombians where more similar to host countries. CONCLUSIONS: The similarities found between the two European countries in relation to immigrants' pharmaceutical use disregarding their host country emphasises the need to consider specific immigrant-related features when planning and providing healthcare services to this part of the population. These results somehow remove the focus on inequity as the main reason to explain differences in purchase between immigrants and natives.

Gray, B. H. et Van, G. E. (2012). "Health Care for Undocumented Migrants: European Approaches." Issues in International Health Policy: 12p.

European countries have smaller shares of undocumented migrants than does the United States, but these individuals have substantial needs for medical care and present difficult policy challenges even in countries with universal health insurance systems. Recent European studies show that policies in most countries provide for no more than emergency services for undocumented migrants. Smaller numbers of countries provide more services or allow undocumented migrants who meet certain requirements access to the same range of services as nationals. These experiences show it is possible to improve access to care for undocumented migrants. Strategies vary along three dimensions: 1) focusing on segments of the population, like children or pregnant women; 2) focusing on types of services, like preventive services or treatment of infectious diseases; or 3) using specific funding policies, like allowing undocumented migrants to purchase insurance

Grelley, P. (2016). "L'accès aux soins des migrants : Contrepoint." Informations Sociales(194). https://www.cairn.info/revue-informations-sociales-2016-3-page-95.htm

La garantie d'accès aux soins de santé qui est édictée par la Charte des droits fondamentaux de l'Union européenne s'impose à tous les États membres de l'Union dans le ressort de leur juridiction et s'applique à toute personne, y compris aux migrants en situation irrégulière. L'Agence des droits fondamentaux de l'Union européenne (FRA) a voulu connaître le cadre juridique et les conditions réelles d'application de ces recommandations. Elle a organisé à cette fin une recherche portant sur dix pays de l'Union sélectionnés en fonction du mode de financement (assurance ou impôts ou mixte) de leur système de santé. Dans le premier groupe figurent l'Allemagne, la Belgique, la France, la Hongrie et la Pologne ; dans

le deuxième, l'Espagne, l'Irlande, l'Italie et la Suède ; la Grèce est le seul pays à avoir adopté un système mixte. Trois types de prestations ont été distinguées, qui concernent les soins médicaux d'urgence, les services médicaux primaires et, enfin, les services médicaux secondaires, une catégorie qui recouvre les consultations de spécialistes et les soins hospitaliers. Les conclusions de l'enquête montrent que, quel que soit le type de système de santé, il existe partout un écart assez sensible entre les principes et les réalités de terrain.

Guidi, C. F., et al. (2016). Inequalities by Immigrant Status in Unmet Needs for Healthcare in Europe: The Role of Origin, Nationality and Economic Resources. EUI Working Paper RSCAS 2016/55. San Domenico di Fiesole Robert Schuman Center for Advanced Studies.**:** 19 , tabl. graph.
https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2860634

The aim of the research is to assess whether there are inequalities in unmet needs for healthcare between natives and migrants within Europe. We used cross-sectional data from the European Statistics on Income and Living Conditions 2012. Our dependent variables were perceived unmet needs for medical and dental examination or treatment. Our main independent variable is immigrant status, defined using a combination of country of birth and citizenship (nationals born in the country of residence, reference; European Union-born nationals; non-EU born nationals; EU-born foreigners; non EU-born foreigners). The prevalence ratios of unmet needs according to immigrant status are obtained through sex-stratified robust Poisson regression models, sequentially adjusted by age, health status and socio-economic characteristics. The prevalence of medical unmet needs, adjusted by age and health status, is higher in foreign women, both EU-born and non-EU born, but it is no longer significant after the socioeconomic adjustment. For dental unmet needs, the risk is significantly higher for all foreigners, EU and non EU-born, men and women. Once adjusted for socioeconomic variables significant inequalities persist, although diminished, for both EU-born and non-EU-born foreign men and EU-born foreign women. This study contributes to the discussion of adequate access to healthcare systems and adaptation of services for migrants. While inequalities cannot be detected for naturalised immigrants, the higher risk of unmet need affecting foreigners, even within the EU, deserves further attention

Gulland, A. (2015). "The refugee crisis: what care is needed and how can doctors help?" British Medical Journal **351**.

Anne Gulland, freelance journalist, Londonannecgulland{at}yahoo.co.ukWhat can doctors do to help the refugee crisis?This was the first thought of many when the photographs of Aylan Kurdi, the Syrian boy who died trying to cross the Mediterranean, were published last week.Social media were awash with pleas from ordinary people for essential items such as soap and blankets to send to refugee centres in Europe. However, both Doctors of the World, which is the only charity providing medical aid in Calais, and Médecins sans Frontières (MSF) are urging doctors who wish to help to donate money.“We've had offers of help but for people wanting to work in our clinic in Calais, for example, we're asking that they speak perfect French and that they have experience of working with refugees,” said Nick Harvey, spokesperson for Doctors of the World.“If doctors want to help out they should donate to an organisation like ours and the money will go on things like bandages and medicines,” he said.A MSF spokesperson said, “What the last week has shown is that our government follows, not leads, and that the force of public opinion makes a crucial difference. If people want to continue to help, they should let their MPs, and other local and national leaders, know they …

Hanssens, L. G. M., et al. (2016). "Access, treatment and outcomes of care: a study of ethnic minorities in Europe." Int J Public Health **61**(4): 443-454.
http://dx.doi.org/10.1007/s00038-016-0810-3

Recent research has shown that ethnic minorities still have less access to medical care and are less satisfied with the treatment they receive and the outcomes of the health care process. This article assesses how migrants in Europe experience access, treatment and outcomes in the European health care systems.

Hiltunen, A. (2016). "Le contrôle de l'accès aux prestations sociales pour les citoyens européens démunis à la suite des arrêts Dano, Alimanovic et Garcia-Nieto." Informations Sociales **194**(3): 96-101.

https://www.cairn.info/revue-informations-sociales-2016-3-page-96.htm

> Depuis quelques années, des critiques de plus en plus vives ont été formulées contre une forme d'opportunisme social, qui serait le fait de citoyens de l'Union européenne (UE) économiquement inactifs faisant le choix délibéré de migrer vers le système de protection sociale de l'État leur étant le plus favorable sans intention de travailler. Cet article analyse la jurisprudence créée par les arrêts de la Cour de Justice européenne Dano, Alimanovic et Garcia-Nieto. Dans un contexte budgétaire difficile pour les finances sociales et un climat de suspicion accru à l'égard des bénéficiaires, ces arrêts déclarent incompatible avec le droit de l'UE la migration dans un autre État membre de citoyens de l'Union à des fins exclusives de prise en charge sociale. Ce revirement de jurisprudence remet en cause de l'égalité de traitement des citoyens de l'UE, notamment pour ce qui concerne l'accès aux prestations sociales.

Ingleby, D. (2010). How health systems can address health inequities linked to migration and ethnicity. Copenhagen WHO Regional Office for Europe**:** 44 , ill.

> [BDSP. Notice produite par SAPHIR R0xksAAB. Diffusion soumise à autorisation]. There are about 75 million migrants in the WHO European Region, amounting to 8.4% of the total population and 39% of all migrants worldwide. Figures for ethnic minorities are not available, because there is little consensus on definitions, but the largest of these groups is probably the Roma, with an estimated population of 12-15 million. There is substantial evidence of inequities in both the state of health of these groups and the accessibility and quality of health services available to them. Differences from the majority population vary, however, according to the specific group studied, the health problems or services involved, and the country concerned. Some groups may in certain respects enjoy health advantages, but it is mainly disadvantages that are documented. This briefing describes how, to tackle such health inequities, health systems must not only improve the services available to migrants and ethnic minorities, but also address the social determinants of health across many sectors. [Ed.].

Ingleby, D. (2019). "Moving upstream: Changing policy scripts on migrant and ethnic minority health." Health Policy **123**(9): 809-817.
http://www.ncbi.nlm.nih.gov/pubmed/31409514

> This article uses the concept of 'policy scripts' to explore the aims and assumptions underlying policies on migrant and ethnic minority health. Firstly, it analyses the shift in health policies from 'downstream' approaches (emphasising health care for the sick and injured) to 'upstream' ones (emphasising health protection for the whole population). The field of migrant health has been relatively slow to move upstream. Two factors appear to have impeded this shift: (a) the reluctance of the 'social determinants of health' movement to regard migrant status and ethnicity as important causes of health inequities; and (b) the one-sided emphasis on short-term emergency health provisions for migrants arising from the recent increase in forced migration worldwide, in particular the sudden peak in mixed migration to the EU in 2015. The article contends that (a) the usual arguments against treating migration and ethnicity as health determinants do not stand up to critical examination; and (b) the overwhelming emphasis on unauthorised entrants which characterises current discussions of migration policy, including health, is out of all proportion to their volume relative to that of other migrants. Fortunately, recent policy initiatives at UN level have the potential to restore the balance between 'upstream' and 'downstream' approaches, as well as between unauthorised entry and 'routine' migration.

Jiménez-Rubio, D. et Vall Castelló, J. (2020). "Limiting health-care access to undocumented immigrants: A wise option?" Health Economics **29**(8): 878-890.
https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.4115

> Abstract The number of undocumented migrants in high-income countries has increased in recent decades, imposing considerable political, fiscal, and social pressures on governments. This has fostered discussions on whether and to what extent undocumented migrants should get access to public programs and public benefits. Looking at the 2012 Spanish health reform, this is the first paper to document the impacts of a restriction on access to the health-care system for undocumented

migrants on health-care utilization, health-care system perceptions, and self-reported health in a high-income country. We show that such restrictions may significantly reduce planned care for undocumented migrants and result in sharp fall in positive opinions about the health-care services still left available to them. We also exploit the heterogeneity in implementing the policy across regions and report stronger effects in regions that enforced the national ban more fully. Furthermore, in the first 3 years since the implementation of the reform, we find suggestive evidence of a worsening in self-assessed health. This study is relevant for policymakers in the developed world, especially in countries that have recently implemented initiatives aimed at reducing the health-care coverage for targeted groups, such as the United Kingdom and the United States.

Kombila, H. (2016). "Focus - Les droits sociaux des migrants citoyens de l'Union européenne." Informations Sociales **194**(3): 102-105.
https://www.cairn.info/revue-informations-sociales-2016-3-page-102.htm

Les migrations constituent un enjeu essentiel pour la protection sociale, quelle que soit l'échelle spatiale concernée. Au sein de l'Union européenne (UE), un espace en partie fédéral, tout citoyen d'un État membre peut bénéficier de la protection sociale dans le pays où il travaille. Ces droits sociaux constituent l'un des piliers de l'intégration du continent. Ils ont facilité la libre circulation des personnes, au point que les pays de l'UE les plus touchés par la crise débutée en 2008 sont devenus ou redevenus des terres d'émigration. Au-delà de ses frontières, l'UE exerce un fort pouvoir d'attraction pour des populations souffrant de la pauvreté et de l'instabilité politique, voire contraintes à l'exil. Les travailleurs migrants sont souvent les plus touchés par la pauvreté. Et avec l'intensification de la crise, ils sont parmi les plus vulnérables à l'égard d'un chômage endémique. Ce numéro examine dans un premier temps la manière dont les travailleurs migrants ont été traités par la protection sociale, aux différentes étapes historiques de sa construction en France et en Europe, et analyse en particulier les liens entre statut des migrants, droit social et droits fondamentaux (première partie). Compte tenu des difficultés financières qui pèsent sur les États européens, les migrations sont souvent mises en avant comme une contrainte pour la protection sociale, bien que ce constat soit discuté par l'analyse économique (deuxième partie). L'analyse des règles et les conditions d'accès des migrants aux prestations et aux services sociaux se révèle donc essentielle pour comprendre les enjeux de leur intégration, en France comme au sein de l'UE (troisième partie).

Kombila, H. (2016). "Le respect des droits fondamentaux des migrants non ressortissants de l'Union européenne." Informations Sociales **194**(3): 28-36.
https://www.cairn.info/revue-informations-sociales-2016-3-page-28.htm

Le droit international et européen des droits de l'Homme incite les États comme la France à mettre en place des mécanismes de protection des droits fondamentaux. Avec l'aide de nombreuses associations, un filet de sécurité assure le respect des droits les plus essentiels tels que le droit d'asile, l'interdiction des peines et traitement inhumains et dégradants, le droit au respect de la vie privée et familiale ou encore le droit à un environnement adapté à l'âge des enfants. L'étroitesse de ce minimum vital de droits s'explique par la mise en œuvre de politiques migratoires restrictives. L'exercice, plein et effectif, des droits fondamentaux des migrants non ressortissants de l'Union européenne est en fait dépendant de la légalité de leur séjour. Dans un contexte d'afflux des migrants, il est indispensable de réfléchir à une politique d'accueil adaptée afin d'humaniser la politique migratoire européenne.

Keygnaert, I., et al. (2014). "Sexual and reproductive health of migrants: does the EU care?" Health Policy **114**(2-3): 215-225.

The European Union (EU) refers to health as a human right in many internal and external communications, policies and agreements, defending its universality. In parallel, specific health needs of migrants originating from outside the EU have been acknowledged. Yet, their right to health and in particular sexual and reproductive health (SRH) is currently not ensured throughout the EU. This paper reflects on the results of a comprehensive literature review on migrants' SRH in the EU applying the Critical Interpretive Synthesis review method. We highlight the discrepancy between a proclaimed rights-based approach to health and actual obstacles to migrants' attainment of good SRH. Uncertainties on entitlements of diverse migrant groups are fuelled by unclear legal provisions,

creating significant barriers to access health systems in general and SRH services in particular. Furthermore, the rare strategies addressing migrants' health fail to address sexual health and are generally limited to perinatal care and HIV screening. Thus, future European public health policy-making should not only strongly encourage its Member States to ensure equal access to health care for migrants as for EU citizens, but also promote migrants' SRH effectively through a holistic and inclusive approach in SRH policies, prevention and care.

Koller, T. (2010). Poverty and social exclusion in the WHO European Region: health systems respond. Copenhague OMS Bureau régional de l'Europe**:** 344 , tabl.

Inspirant de 22 études de cas réalisées dans la Région européenne de l'OMS, et de 3 documents de référence sur les Roms, les migrants et les enfants, cette publication examine la manière dont les systèmes de santé peuvent répondre aux besoins des populations en proie à la pauvreté et à l'exclusion sociale, et donc plus susceptibles d'être déchues de leur droit à la santé. Ces études révèlent les conditions sociales à l'origine de la forte vulnérabilité des populations, comment des interventions peuvent améliorer l'accessibilité, la disponibilité, l'acceptabilité et la qualité des services de santé, ainsi que la manière dont le système de santé agit sur les inégalités de santé déterminées par les facteurs sociaux en faisant intervenir ses quatre fonctions (stewardship, prestation de services, financement et création de ressources). Les études de cas sont utiles dans la mesure où elles rendent compte de la situation dans les pays. Ainsi ces derniers peuvent-ils tirer des enseignements de l'expérience des autres et, par conséquent, améliorer la santé des populations en proie à la pauvreté et à l'exclusion sociale, tel que demandé dans la résolution EUR/RC52/R7 du Comité régional de l'OMS relative à la pauvreté et à la santé.

Kontunen, K., et al. (2014). "Ensuring health equity of marginalized populations: experiences from mainstreaming the health of migrants." Health Promot Int **29 Suppl 1**: i121-129.

Migrants around the world significantly contribute to the economies of countries of origin and destination alike. Despite the growing number of migrants in today's globalized world, the conditions in which migrants travel, live and work can carry exceptional risks to their physical and mental well-being. These risks are often linked to restrictive immigration and employment policies, economic and social factors and dominant anti-migrant sentiments in societies, and are often referred to as the social determinants of migrants' health. These social determinants need to be addressed in order for migrants to attain their development potential and to concurrently contribute to sustainable development, while reducing the health costs of migration for both migrants and societies of origin and destination. A multi-sectoral approach is required to effectively address the social determinants of migrants' health, as many of the solutions to improving migrants' health lie not only in the health sector but in other sectors, such as labour and immigration. This requires collaboration across the different sectors and integrating migrants' health issues in different sectoral policies to avoid marginalization and exclusion of migrants and ensure positive health outcomes for migrants and their families. The paper will discuss a 'Health in All Policies' (HiAP) approach to migrants' health as, to date, there has not been much discussion on framing migrants' health within an HiAP approach. The paper will also present some examples from countries who have addressed different aspects of migrants' health in line with the recommendations of the 61st World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants (2008).

Marques, T. V. (2012). "Refugees and migrants struggle to obtain health care in Europe." Cmaj **184**(10): E531-532.

McGarry, K., Hannigan, A., De Almeidam, M., et al. (2018). What strategies to address communication barriers for refugees and migrants in health care settings have been implemented and evaluated across the WHO European Region? Health Evidence Network synthesis report 62. Copenhague OMS Bureau régional de l'Europe**:** x+37.
http://www.euro.who.int/en/data-and-evidence/evidence-informed-policy-making/publications/2018/what-strategies-to-address-communication-barriers-for-refugees-and-migrants-in-health-care-settings-have-been-implemented-and-evaluated-across-the-who-european-region-2018

The provision of effective health care to linguistically and culturally diverse migrant populations has been identified as a crucial public health issue. This scoping review examines strategies that have been implemented and evaluated to address communication barriers experienced by refugees and migrants in health care settings across the WHO European Region. Four main types of strategy were identified: cultural mediation, interpretation, translation of health information, and guidance and training for health care providers. These have been used to support access to health care, management of specific diseases and promotion of health across a wide variety of health care settings. Intersectoral collaboration was seen as important in the development and implementation of strategies. Policy considerations include the development of national policies and the promotion of intersectoral dialogue to augment the knowledge base and resolve the common issues identified, such as provision of training and confusion regarding the roles of mediators/interpreters, that affect strategy implementation and evaluation.

McKee, M., et al. (2013). "EU Crossborder health care collaboration. 64." Eurohealth **19**(4).

This issue of Eurohealth explores various topics related to the European Directive on the application of patients' rights in cross-border health care. Ten case studies look at specific aspects of EU cross-border health care collaboration, particularly at potential obstacles not fully covered by the Directive. Other articles look at dispensing prescriptions across EU Member States, European public health strategies, oral health in Europe, reporting health care waste in the Netherlands, the chronic care system in Spain, scaling-up e-health in Catalonia and dental health services for migrants in Cyprus.

Médecins du Monde (2017). Synthèse du rapport de l'Observatoire 2017. Les laissés pour compte : l'échec de la couverture santé universelle en Europe. Paris Médecins du Monde**:** 136 , annexes.
http://www.medecinsdumonde.org/fr/actualites/publications/2017/11/08/synthese-rapport-de-lobservatoire-2017

Le Rapport de l'Observatoire de Médecins du Monde décrit la situation actuelle de ceux et celles qui passent entre les mailles du filet des systèmes de santé européens et appelle les parties prenantes aux niveaux international, européen et national à faire de la couverture santé universelle une priorité. Le rapport 2017 pointe sur les oubliés de cette couverture maladie universelle.

Médecins du Monde (2016). Réseau international de Médecins du Monde : rapport de l'Observatoire 2016. L'accès aux soins des personnes confrontées à de multiples facteurs de vulnérabilité en santé dans 31 villes de 12 pays. Paris Médecins du Monde**:** 152 , annexes.
http://www.medecinsdumonde.org/fr/actualites/publications/2016/11/15/rapport-de-lobservatoire-2016

Le rapport du réseau international de Médecins du monde est fondé sur les données médicales et sociales collectées en 2015 dans 31 villes de 12 pays (Allemagne, Belgique, Espagne, France, Grèce, Luxembourg, Pays-Bas, Norvège, Royaume-Uni, Suède, Suisse et Turquie). Parmi les personnes interrogées, 94,2 % sont des ressortissants étrangers, dont 24,7 % de migrants ressortissants de l'UE et 69,5 % de migrants ressortissants de pays hors UE. La moitié des patients vus étaient autorisés à résider dans le pays dans lequel nous les avons rencontrés (50,6 % en Europe). De nombreux obstacles à l'accès aux soins ont été observés, notamment le manque de couverture médicale pour 67,5 %, le besoin d'interprétariat pour 40,8 % et les difficultés financières pour 24,3 %. Au cours des douze mois précédents, 21,5 % ont renoncé à des soins ou à des traitements, 9,2 % se sont vu refuser des soins dans une structure de santé, et 39,6 % des patients sans autorisation de séjour ont limité leurs déplacements

Mladovsky, P., et al. (2007). "Migration et santé dans les systèmes de santé de l'Union européenne." Euro Observer - Health Policy Bulletin of the European Observatory on Health Systems and Policies **9**(4): 8.

In this issue of Euro Observer, three countries? migrant health policies are described, revealing considerable differences. In Italy, policy regarding the health of migrants is relatively developed and at the central level, immigrant related health policy targets have been set since the 1990s. However, it is not clear how successful the government has been with implementation. The Netherlands stands out in Europe for its sustained and systematic attention to problems of migrant health, although a closer look at the current situation suggests there is a danger of these initiatives stagnating. In Spain, migrant

health and health care issues have only recently started to feature in national and regional plans for the integration of immigrants. In light of this variability, there appears to be a significant role for the EU to play in facilitating the development and transfer of evidence and information on immigrant health policy. Certainly, the Portuguese Presidency?s focus is designed to create the momentum needed to realize this objective. A good starting point would be addressing the methodological problems associated with migrant health research. Specifically, there is a need for: increased funding to develop research techniques; increased collaboration at the European level between national research centres; and increased attention paid to the methodological barriers to including data on migrants in national and European health surveys.

Nancy R, K. et P.W., G. (2015). "Race/Ethnicity and Overuse of Care: A Systematic Review." The Milbank Quarterly **93**(1): 112-138.

O'Donnell, C. A., et al. (2016). "Reducing the health care burden for marginalised migrants: The potential role for primary care in Europe." Health Policy **120**(5): 495-508.

Increasing diversity and numbers of marginalised migrants a feature across Europe. Entitlement to care, access and use of co-payments add to their care seeking burden. Strong primary care systems may mitigate that burden. External forces, such as austerity, must not be allowed to reduce migrant's access to primary care. Policies improving entitlement and reducing the impact of financial burdens could improve access to primary care for migrants.

O'Donnell, C., et al. (2013). "Health-care access for migrants in Europe." Lancet **382**(9890): 393.

Organisation Mondiale de la Santé (2010). Health of migrants - the way forward. Report of a global consultation. Genève OMS**:** 112 , tabl., fig., annexes.

In a globalized world defined by profound di
sparities, skill shortages, demographic imbalances, climate change as well as economic and political crises, natural as well as man-made disasters, migration is omnipresent. There are an estimated 214 million international migrants, 740 million internal migrants and an unknown number of migrants in an irregular situation all over the world. While these figures comprise a wide range of different migrating populations, such as workers, refugees, students, undocumented migrants and others, and their vulnerability levels vary greatly, the collective health needs and implications of a population cohort of this size are considerable. The health of migrants and health matters associated with migration are crucial public health challenges faced by governments and societies.

Organisation Mondiale de la Santé (2010). How health systems can address inequities linked to migration and ethnicity. Copenhague OMS Bureau régional de l'Europe**:** 44 , fig., annexes.

There are about 75 million migrants in the WHO European Region, amounting to 8.4% of the total population and 39% of all migrants worldwide. Figures for ethnic minorities are not available, because there is little consensus on definitions, but the largest of these groups is probably the Roma, with an estimated population of 12-15 million. There is substantial evidence of inequities in both the state of health of these groups and the accessibility and quality of health services available to them. Differences from the majority population vary, however, according to the specific group studied, the health problems or services involved, and the country concerned. Some groups may in certain respects enjoy health advantages, but it is mainly disadvantages that are documented. This briefing describes how, to tackle such health inequities, health systems must not only improve the services available to migrants and ethnic minorities, but also address the social determinants of health across many sectors.

Organisation Mondiale de la Santé (2019). Health diplomacy: spotlight on refugees and migrants, Copenhague : OMS Bureau régional de l'Europe
http://www.euro.who.int/en/publications/abstracts/health-diplomacy-spotlight-on-refugees-and-migrants-2019

La question des réfugiés et des migrants fait actuellement l'objet d'un débat politique intense dans le monde entier. Du point de vue de la santé publique, les mouvements de population, y compris les migrations forcées, constituent un phénomène complexe et figurent en bonne place à l'ordre du jour politique et stratégique de la plupart des États membres de l'OMS. La diplomatie de la santé et la santé des réfugiés et des migrants sont intrinsèquement liées. La mobilité humaine concerne tous les pays, et pose d'importants défis en termes de développement durable et de droits humains afin de garantir l'égalité et d'obtenir des résultats à la lumière des objectifs de développement durable. Cet ouvrage s'inscrit dans le cadre de l'engagement du Bureau régional de l'OMS pour l'Europe à œuvrer pour la santé des réfugiés et des migrants. Il présente les bonnes pratiques adoptées par les pouvoirs publics, les acteurs non étatiques et les organisations internationales et non gouvernementales pour tenter de faire face à la complexité de la migration, en renforçant la réactivité des systèmes de santé aux questions de santé des réfugiés et des migrants, et en coordonnant et en élaborant des solutions de politique étrangère en vue d'améliorer la santé aux niveaux mondial, régional, national et local. Nowadays, refugees and migrants are the focus of intense political debate worldwide. From the public health perspective, population movement, including forced migration, is a complex phenomenon and is a high priority on the political and policy agenda of most WHO Member States. Health diplomacy and the health of refugees and migrants are intrinsically linked. Human mobility is relevant to all countries and creates important challenges in terms of both sustainable development and human rights, to ensure equality and achieve results through the Sustainable Development Goals. This book is part of the WHO Regional Office for Europe's commitment to work for the health of refugees and migrants. It showcases good practices by which governments, non-state actors and international and nongovernmental organizations attempt to address the complexity of migration, by strengthening health system responsiveness to refugee and migrant health matters, and by coordinating and developing foreign policy solutions to improve health at the global, regional, country and local levels.

Organisation Mondiale de la Santé (2020). Collection and integration of data on refugee and migrant health in the WHO European Region. Copenhague OMS**:** viii + 98.
https://www.euro.who.int/en/publications/abstracts/collection-and-integration-of-data-on-refugee-and-migrant-health-in-the-who-european-region-2020

This technical guidance outlines current evidence, knowledge and best practice relating to the integration of migration health data into national health information systems. It highlights key principles, summarizes priority actions and challenges, maps existing international commitments and frameworks and provides practical policy considerations for promoting collection and integration of migration health data. Specific areas for intervention include establishing a multistakeholder working group for overseeing data collection and integration, creating a regulatory framework for preventing unauthorized access and use of health data for non-health purposes, integrating core variables into the data collection system and promoting data linkage. While the main intended audience of this technical guidance series is policy-makers across sectors at local, national and regional levels, the contents of this publication will also be of value for health- care practitioners, health planners and health information specialists and law enforcement officials.

Permanand, G., et al. (2016). "Europe's migration challenges: mounting an effective health system response." The European Journal of Public Health **26**(1): 3-4.
http://eurpub.oxfordjournals.org/content/eurpub/26/1/3.full.pdf

Govin Permanand1, Allan Krasnik2, Hans Kluge3 and Martin McKee41WHO Regional Office for Europe (and London School of Economics and Political Science), Copenhagen, Denmark2European Public Health Association, Migrant Health Section and University of Copenhagen Copenhagen, Denmark3WHO Regional Office for Europe, Copenhagen, Denmark4European Public Health Association and London School of Hygiene and Tropical Medicine, London, UKCorrespondence: Govin Permanand, WHO Regional Office for Europe, UN City, Marmorvej 51, 2100 Copenhagen, Denmark, Tel. +45 45 33 70 00; Fax. +45 45 33 70 01, e-mail: gop{at}euro.who.int Health systems are at the forefront of the response to the ongoing humanitarian crisis facing refugees and other migrants fleeing to Europe, both as a first point of contact for arrivals and later during their resettlement and beyond. (The term 'migrant' is used here with the

understanding that there are numerous groups that fall within this categorization, but which are distinct in terms of their status, e.g. asylum-seeker, refugee, undocumented migrant, economic migrant, family-reunited migrant, etc., where a specific group is mentioned by name, it is in a context where this specificity is required.) Yet even if the scale of migration is new, at least in the post-war period, some European countries have considerable experience of sudden large-scale immigration, whether from Algeria to France in the 1960s, East African Asians coming to the United Kingdom in the 1970s, refugees from former Yugoslavia in the 1990s and, more recently, across the Mediterranean to Italy, Malta and Spain. However, few lessons seem to have been learnt, and European health systems vary greatly in their ability to respond to this new challenge.1The situation is complicated further by differences in formal entitlement to health care,2 even though it is now clear that restricting access costs more money in the long run.3 The challenges facing undocumented migrants are particularly alarming, as many of those now moving either fall into this category already or will soon do so if their applications for asylum are rejected.Even where migrants are entitled to care they may face many barriers. These include language barriers and inadequate information about their rights and how to claim them.

Pottie, K., et al. (2015). "Access to healthcare for the most vulnerable migrants: a humanitarian crisis." Confl Health **9**: 16.

A series of Medecins Sans Frontieres projects for irregular migrants over the past decade have consistently documented high rates of 14 physical and sexual trauma, extortion and mental illness amidst severe healthcare, food, and housing limitations. Complex interventions were needed to begin to address illness and barriers to healthcare and to help restore dignity to the most vulnerable women, children and men. Promising interventions included mobile clinics, use of cultural mediators, coordination with migrant-friendly entities and NGOs and integrating advocacy programs and mental health care with medical services. Ongoing interventions, research and coordination are needed to address this neglected humanitarian crisis.

Priebe, S., et al. (2011). "Good practice in health care for migrants: views and experiences of care professionals in 16 European countries." BMC Public Health **11**: 187.

BACKGROUND: Health services across Europe provide health care for migrant patients every day. However, little systematic research has explored the views and experiences of health care professionals in different European countries. The aim of this study was to assess the difficulties professionals experience in their service when providing such care and what they consider constitutes good practice to overcome these problems or limit their negative impact on the quality of care. METHODS: Structured interviews with open questions and case vignettes were conducted with health care professionals working in areas with high proportion of migrant populations in 16 countries. In each country, professionals in nine primary care practices, three accident and emergency hospital departments, and three community mental health services (total sample = 240) were interviewed about their views and experiences in providing care for migrant patients, i.e. from first generation immigrant populations. Answers were analysed using thematic content analysis. RESULTS: Eight types of problems and seven components of good practice were identified representing all statements in the interviews. The eight problems were: language barriers, difficulties in arranging care for migrants without health care coverage, social deprivation and traumatic experiences, lack of familiarity with the health care system, cultural differences, different understandings of illness and treatment, negative attitudes among staff and patients, and lack of access to medical history. The components of good practice to overcome these problems or limit their impact were: organisational flexibility with sufficient time and resources, good interpreting services, working with families and social services, cultural awareness of staff, educational programmes and information material for migrants, positive and stable relationships with staff, and clear guidelines on the care entitlements of different migrant groups. Problems and good care components were similar across the three types of services. CONCLUSIONS: Health care professionals in different services experience similar difficulties when providing care to migrants. They also have relatively consistent views on what constitutes good practice. The degree to which these components already are part of routine practice varies. Implementing good practice requires sufficient resources and organisational flexibility, positive attitudes, training for staff and the provision of information.

Rechel, B., et al. (2013). "Migration and health in an increasingly diverse Europe." Lancet **381**.

Rechel, B., et al. (2012). "Monitoring migrant health in Europe: a narrative review of data collection practices." Health Policy **105**(1): 10-16.

BACKGROUND: Data on the health of migrants, including on health determinants and access to health services, are an essential pre-condition for providing appropriate and accessible health services to this population group. This article reviews how far current data collection systems in the European Union (EU) allow to monitor migrant health. METHODS: We searched the academic literature using PubMed and reviewed the results of recent EU-funded research projects on migrant health. RESULTS: Most EU member states lack information on the health of migrants, limiting the possibility for monitoring and improving migrant health. National death registers allow for disaggregation according to migrant status in 24 of 27 EU member states. Registry data on health care utilization by migrant status are available in only 11 of 27 member states, although in most cases this only covers secondary and not primary care. Only few countries collect large-scale survey data on migrant health and health care utilization. CONCLUSION: Many EU countries need to step up their organizational and regulatory efforts to monitor migrant health if the current lack of data on migrant health should be overcome. This could be done through the inclusion of improved questions on migration in existing data collection processes.

Rechel, B. et al. (2012). Migration and health in the European Union. European Observatory on Health Systems and Policies Series. Maidenhead Open University Press**:** XX+257.

Migrants make up a growing share of European populations. However, all too often their situation is compounded by problems with accessing health and other basic services. There is a need for tailored health policies, but robust data on the health needs of migrants and how best these needs can be met are scarce. This book thoroughly explores the different aspects of migration and health in the EU and how they can be addressed by health systems.

Royo-Bordonada, M. A., et al. (2013). "Health-care access for migrants in Europe: the case of Spain." Lancet **382**(9890): 393-394.

Sandhu, S., et al. (2013). "Experiences with treating immigrants: a qualitative study in mental health services across 16 European countries." Soc Psychiatry Psychiatr Epidemiol **48**(1): 105-116.

PURPOSE: While there has been systematic research on the experiences of immigrant patients in mental health services within certain European countries, little research has explored the experiences of mental health professionals in the delivery of services to immigrants across Europe. This study sought to explore professionals' experiences of delivering care to immigrants in districts densely populated with immigrants across Europe. METHODS: Forty-eight semi-structured interviews were conducted with mental health care professionals working in 16 European countries. Professionals in each country were recruited from three areas with the highest proportion of immigrants. For the purpose of this study, immigrants were defined as first-generation immigrants born outside the country of current residence, including regular immigrants, irregular immigrants, asylum seekers, refugees and victims of human trafficking. Interviews were transcribed and analysed using thematic analysis. RESULTS: The interviews highlighted specific challenges to treating immigrants in mental health services across all 16 countries including complications with diagnosis, difficulty in developing trust and increased risk of marginalisation. CONCLUSIONS: Although mental health service delivery varies between and within European countries, consistent challenges exist in the experiences of mental health professionals delivering services in communities with high proportions of immigrants. Improvements to practice should include training in reaching appropriate diagnoses, a focus on building trusting relationships and measures to counter marginalisation.

Schober, T. et Zocher, K. (2018). Health care utilization of refugees. Working Paper; 1819. Linz Johannes Kepler University of Linz**:** 37 , tabl., fig.

European countries experienced significant inflows of migrants in the past decade, including many refugees coming from regions engaged in armed conflicts. While previous research on migrant health largely focused on economic migration, empirical evidence on the health of refugees is sparse. We use administrative data from Austria to differentiate between economic migrants and refugees and analyze their health care expenditures in comparison to natives. The results distinctly show different expenditure patterns. Unlike economic migrants, we find substantially higher expenditures for refugees, most pronounced in the first year upon arrival. The difference is not explained by specific diseases or individual refugee groups, indicating a, generally, inferior health status. Further, by using the quasi-random placement of refugees as a natural experiment, we show that characteristics of the local health care sector do not have a significant effect on expenditure levels.

Stubbe Ostergaard, L. et Krasnik, A. (2018). Compendium of health system responses to large-scale migration in the WHO European Region, Copenhague : OMS - Bureau régional de l'Europe
https://euprimarycare.us14.list-manage.com/track/click?u=8dbddb206d6c9da3559d1d8d8&id=7e7e0d831e&e=607de764c3

The scale of international migration in the WHO European Region has increased substantially in the last decade. The dynamics of large-scale migration pose specific challenges and opportunities to health systems, and responses will differ from country to country. Strengthening health system responses is one of the priority areas in the 2016 Strategy and action plan for refugee and migrant health in the WHO European Region. Its agreed actions include the identification and mapping of practices for developing and delivering health services that respond to the needs of refugees, asylum seekers and migrants.

Semenza, J. C., et al. (2016). "Public health needs of migrants, refugees and asylum seekers in Europe, 2015: Infectious disease aspects." Eur J Public Health **26**(3): 372-373.

Shavers, V. L., et al. (2012). "The state of research on racial/ethnic discrimination in the receipt of health care." Am J Public Health **102**(5): 953-966.

OBJECTIVES: We conducted a review to examine current literature on the effects of interpersonal and institutional racism and discrimination occurring within health care settings on the health care received by racial/ethnic minority patients. METHODS: We searched the PsychNet, PubMed, and Scopus databases for articles on US populations published between January 1, 2008 and November 1, 2011. We used various combinations of the following search terms: discrimination, perceived discrimination, race, ethnicity, racism, institutional racism, stereotype, prejudice or bias, and health or health care. Fifty-eight articles were reviewed. RESULTS: Patient perception of discriminatory treatment and implicit provider biases were the most frequently examined topics in health care settings. Few studies examined the overall prevalence of racial/ethnic discrimination and none examined temporal trends. In general, measures used were insufficient for examining the impact of interpersonal discrimination or institutional racism within health care settings on racial/ethnic disparities in health care. CONCLUSIONS: Better instrumentation, innovative methodology, and strategies are needed for identifying and tracking racial/ethnic discrimination in health care settings

Simon, J., et al. (2015). Public health aspects of migrant health: a review of the evidence on health status for labour migrants in the European Region, Copenhague : OMS Bureau régional de l'Europe

Labour migrants form one important subgroup of international migrants. In 2010, labour migrants constituted 7.2–9.5% of the total working population in Belgium, Germany, Greece, Spain and the United Kingdom, and the number of labour migrants in the Russian Federation was estimated at 7–9 million in 2005. With labour migration at such a massive scale, provision of health care for this group has become an increasingly important issue within the WHO European Region. This report focuses on labour migrants specifically, irrespective of documentation status: those seeking work, those employed in the host country, and those who were previously employed or are seeking work but are

unable to continue working or find work and remain in the host country. The objective of this report is to address the following question by way of a systematic review of the English language literature: What policies and interventions work to improve health care access and delivery for labour migrants in the European Region?

Sole-Auro, A., et al. (2012). "Health care usage among immigrants and native-born elderly populations in eleven European countries: results from SHARE." Eur J Health Econ **13**(6): 741-754.

Differences in health care utilization of immigrants 50 years of age and older relative to the native-born populations in eleven European countries are investigated. Negative binomial and zero-inflated Poisson regression are used to examine differences between immigrants and native-borns in number of doctor visits, visits to general practitioners, and hospital stays using the 2004 Survey of Health, Ageing, and Retirement in Europe database. In the pooled European sample and in some individual countries, older immigrants use from 13 to 20% more health services than native-borns after demographic characteristics are controlled. After controlling for the need for health care, differences between immigrants and native-borns in the use of physicians, but not hospitals, are reduced by about half. These are not changed much with the incorporation of indicators of socioeconomic status and extra insurance coverage. Higher country-level relative expenditures on health, paying physicians a fee-for-service, and physician density are associated with higher usage of physician services among immigrants

Sole-Auro, A., et al. (2009). Health care utilization among immigrants and native-born populations in 11 European countries. Results from the Survey of Health, Ageing and Retirement in Europe. Barcelone, University of Barcelona. Department of Econometrics and Statistics**:** 29p.

This study examines health care utilization of immigrants relative to the native-born populations aged 50 years and older in eleven European countries. Methods. We analyzed data from the Survey of Health Aging and Retirement in Europe (SHARE) from 2004 for a sample of 27,444 individuals in 11 European countries. Negative Binomial regression was conducted to examine the difference in number of doctor visits, visits to General Practitioners (GPs), and hospital stays between immigrants and the native-born individuals. Results : We find evidence those immigrants above age 50 use health services on average more than the native-born populations with the same characteristics. Our models show immigrants have between 6% and 27% more expected visits to the doctor, GP or hospital stays when compared to native-born populations in a number of European countries. Discussion : Elderly immigrant populations might be using health services more intensively due to cultural reasons.

Straiton, M., et al. (2014). "Immigrants' use of primary health care services for mental health problems." BMC Health Serv Res **14**: 341.

BACKGROUND: Equity in health care across all social groups is a major goal in health care policy. Immigrants may experience more mental health problems than natives, but we do not know the extent to which they seek help from primary health care services. This study aimed to determine a) the rate immigrants use primary health care services for mental health problems compared with Norwegians and b) the association between length of stay, reason for immigration and service use among immigrants. METHODS: National register data covering all residents in Norway and all consultations with primary health care services were used. We conducted logistic regression analyses to compare Norwegians' with Polish, Swedish, German, Pakistani and Iraqi immigrants' odds of having had a consultation for a mental health problem (P-consultation). RESULTS: After accounting for background variables, all immigrants groups, except Iraqi men had lower odds of a P-consultation than their Norwegian counterparts. A shorter length of stay was associated with lower odds of a P-consultation. CONCLUSIONS: Service use varies by country of origin and patterns are different for men and women. There was some evidence of a possible 'healthy migrant worker' effect among the European groups. Together with previous research, our findings however, suggest that Iraqi women and Pakistanis in particular, may experience barriers in accessing care for mental health problems.

Suess, A., et al. (2014). "The right of access to health care for undocumented migrants: a revision of comparative analysis in the European context." Eur J Public Health **24**(5): 712-720.

> BACKGROUND: The recent introduction of adjustment measures in the Spanish context by means of the Royal Decree-law 16/2012 (RDL 16/2012), which limits access to health care for undocumented migrants, raises the question about the state of the matter in different European Union member states. METHODS: Narrative review of comparative studies published between 2009 and 2012 that analyzes the right to health care for undocumented migrants in the European context. RESULTS: The review shows a high degree of variability regarding health care entitlements of undocumented migrants in different European countries, a frequent legal restriction of access to health care, as well as barriers in the effective access to health care. The studies coincide in recommending access at all health care levels, regardless of the administrative status of the person seeking treatment. The analysis of the impact of the current economic crisis on access and quality of the health care directed to undocumented migrants, as well as the knowledge of the migrants' perspective are identified as future research areas. CONCLUSIONS: Compared with other European countries, the introduction of the measures established in the RDL 16/2012 modifies the place of the Spanish Public Health Care System from being situated in the group of countries that permit undocumented migrants access to all health care levels, towards the category of highest restriction.

Suphanchaimat, R., et al. (2015). "Challenges in the provision of healthcare services for migrants: a systematic review through providers' lens." BMC Health Serv Res **15**(1): 390.

> BACKGROUND: In recent years, cross-border migration has gained significant attention in high-level policy dialogues in numerous countries. While there exists some literature describing the health status of migrants, and exploring migrants' perceptions of service utilisation in receiving countries, there is still little evidence that examines the issue of health services for migrants through the lens of providers. This study therefore aims to systematically review the latest literature, which investigated perceptions and attitudes of healthcare providers in managing care for migrants, as well as examining the challenges and barriers faced in their practices. METHODS: A systematic review was performed by gathering evidence from three main online databases: Medline, Embase and Scopus, plus a purposive search from the World Health Organization's website and grey literature sources. The articles, published in English since 2000, were reviewed according to the following topics: (1) how healthcare providers interacted with individual migrant patients, (2) how workplace factors shaped services for migrants, and (3) how the external environment, specifically laws and professional norms influenced their practices. Key message of the articles were analysed by thematic analysis. RESULTS: Thirty seven articles were recruited for the final review. Key findings of the selected articles were synthesised and presented in the data extraction form. Quality of retrieved articles varied substantially. Almost all the selected articles had congruent findings regarding language andcultural challenges, and a lack of knowledge of a host country's health system amongst migrant patients. Most respondents expressed concerns over in-house constraints resulting from heavy workloads and the inadequacy of human resources. Professional norms strongly influenced the behaviours and attitudes of healthcare providers despite conflicting with laws that limited right to health services access for illegal migrants. DISCUSSION: The perceptions, attitudes and practices of practitioners in the provision of healthcare services for migrants were mainly influenced by: (1) diverse cultural beliefs and language differences, (2) limited institutional capacity, in terms of time and/or resource constraints, (3) the contradiction between professional ethics and laws that limited migrants' right to health care. Nevertheless, healthcare providers addressedsuch problems by partially ignoring the immigrants'precarious legal status, and using numerous tactics, including seeking help from civil society groups, to support their clinical practice. CONCLUSION: It was evident that healthcare providers faced several challenges in managing care for migrants, which included not only language and cultural barriers, but also resource constraints within their workplaces, and disharmony between the law and their professional norms. Further studies, which explore health care management for migrants in countries with different health insurance models, are recommended.

Suphanchaimat, R., et al. (2014). "HIV/AIDS health care challenges for cross-country migrants in low- and middle-income countries: a scoping review." HIV AIDS (Auckl) **6**: 19-38.

INTRODUCTION: HIV/AIDS has been one of the world's most important health challenges in recent history. The global solidarity in responding to HIV/AIDS through the provision of antiretroviral therapy (ART) and encouraging early screening has been proved successful in saving lives of infected populations in past decades. However, there remain several challenges, one of which is how HIV/AIDS policies keep pace with the growing speed and diversity of migration flows. This study therefore aimed to examine the nature and the extent of HIV/AIDS health services, barriers to care, and epidemic burdens among cross-country migrants in low-and middle-income countries. METHODS: A scoping review was undertaken by gathering evidence from electronic databases and gray literature from the websites of relevant international initiatives. The articles were reviewed according to the defined themes: epidemic burdens of HIV/AIDS, barriers to health services and HIV/AIDS risks, and the operational management of the current health systems for HIV/AIDS. RESULTS: Of the 437 articles selected for an initial screening, 35 were read in full and mapped with the defined research questions. A high HIV/AIDS infection rate was a major concern among cross-country migrants in many regions, in particular sub-Saharan Africa. Despite a large number of studies reported in Africa, fewer studies were found in Asia and Latin America. Barriers of access to HIV/AIDS services comprised inadequate management of guidelines and referral systems, discriminatory attitudes, language differences, unstable legal status, and financial hardship. Though health systems management varied across countries, international partners consistently played a critical role in providing support for HIV/AIDS services to uninsured migrants and refugees. CONCLUSION: It was evident that HIV/AIDS health care problems for migrants were a major concern in many developing nations. However, there was little evidence suggesting if the current health systems effectively addressed those problems or if such management would sustainably function if support from global partners was withdrawn. More in-depth studies were recommended to further explore those knowledge gaps.

Taha, N., et al. (2015). "How portable is social security for migrant workers? A review of the literature." International Social Security Review **68**(1): 95-118.

Cet article passe en revue les études récentes sur les mécanismes existants qui permettent la transférabilité des droits des travailleurs migrants en matière de sécurité sociale. Il montre que les migrants Nord-Nord sont ceux qui bénéficient du meilleur accès à la transférabilité de leurs droits. En ce qui concerne les migrants Sud-Nord, la coordination entre pays d'origine et pays d'accueil est limitée dans le domaine de la transférabilité de leurs droits sociaux. Ces migrants font face à des discours et des politiques qui les traitent comme des citoyens de second rang, alors même qu'ils fournissent aux pays d'accueil une main d'œuvre dont ils grand besoin. Quant aux migrants Sud-Sud, ils voient émerger de nouveaux mécanismes régionaux qui tiennent compte de la transférabilité de leurs droits, mais l'impact de ces mécanismes est encore largement méconnu. Le déficit de connaissances sur la transférabilité des droits des migrants en matière de sécurité sociale concerne également les migrations internes et les migrations Sud-Sud, le rôle du genre et des autres éléments constitutifs de l'identité sociale, la nature des emplois occupés par les migrants, ainsi que les spécificités de leur statut juridique au regard de l'immigration.

Woodward, A., et al. (2014). "Health and access to care for undocumented migrants living in the European Union: a scoping review." Health Policy Plan **29**(7): 818-830.

BACKGROUND: Literature on health and access to care of undocumented migrants in the European Union (EU) is limited and heterogeneous in focus and quality. Authors conducted a scoping review to identify the extent, nature and distribution of existing primary research (1990-2012), thus clarifying what is known, key gaps, and potential next steps. METHODS: Authors used Arksey and O'Malley's six-stage scoping framework, with Levac, Colquhoun and O'Brien's revisions, to review identified sources. Findings were summarized thematically: (i) physical, mental and social health issues, (ii) access and barriers to care, (iii) vulnerable groups and (iv) policy and rights. RESULTS: Fifty-four sources were included of 598 identified, with 93% (50/54) published during 2005-2012. EU member states from Eastern Europe were under-represented, particularly in single-country studies. Most study designs (52%) were qualitative. Sampling descriptions were generally poor, and sampling purposeful, with only four studies using any randomization. Demographic descriptions were far from uniform and only two

studies focused on undocumented children and youth. Most (80%) included findings on health-care access, with obstacles reported at primary, secondary and tertiary levels. Major access barriers included fear, lack of awareness of rights, socioeconomics. Mental disorders appeared widespread, while obstetric needs and injuries were key reasons for seeking care. Pregnant women, children and detainees appeared most vulnerable. While EU policy supports health-care access for undocumented migrants, practices remain haphazard, with studies reporting differing interpretation and implementation of rights at regional, institutional and individual levels. CONCLUSIONS: This scoping review is an initial attempt to describe available primary evidence on health and access to care for undocumented migrants in the European Union. It underlines the need for more and better-quality research, increased co-operation between gatekeepers, providers, researchers and policy makers, and reduced ambiguities in health-care rights and obligations for undocumented migrants

Un aperçu par pays

Allemagne

Bermejo, I., et al. (2012). "[Barriers in the attendance of health care interventions by immigrants]." Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz **55**(8): 944-953.

AIM: Analysis of barriers regarding attendance at the health care system under consideration of cultural and migration-related factors. METHOD: Cross-sectional survey with immigrants from Turkey (n = 77), Spain (n = 67), Italy (n = 95) and German resettlers from the former Soviet Union (n = 196), recruited on migration and addiction services of the German Caritasverband, the Arbeiterwohlfahrt and migrant organizations. RESULTS: Spanish and Italian immigrants mainly search for help within their families and social environment. Immigrants from the former Soviet Union use home remedies and experience more linguistic difficulties as barriers for the use of health services, just like Turkish immigrants. Turkish immigrants reported feeling misunderstood regarding their cultural peculiarities by the expert staff as another main barrier. Other major influencing factors were German language proficiency and the subjective wellbeing in Germany. CONCLUSION: The consideration of cultural-related as well as linguistic factors in health care services is an essential contribution for improving health care of immigrants.

Bozorgmehr, K. et Razum, O. (2015). "Effect of Restricting Access to Health Care on Health Expenditures among Asylum-Seekers and Refugees: A Quasi-Experimental Study in Germany, 1994-2013." PLoS One **10**(7): e0131483.

BACKGROUND: Access to health care for asylum-seekers and refugees (AS&R) in Germany is initially restricted before regular access is granted, allegedly leading to delayed care and increasing costs of care. We analyse the effects of (a) restricted access; and (b) two major policy reforms (1997, 2007) on incident health expenditures for AS&R in 1994-2013. METHODS AND FINDINGS: We used annual, nation-wide, aggregate data of the German Federal Statistics Office (1994-2013) to compare incident health expenditures among AS&R with restricted access (exposed) to AS&R with regular access (unexposed). We calculated incidence rate differences (IRt) and rate ratios (IRRt), as well as attributable fractions among the exposed (AFe) and the total population (AFp). The effects of between-group differences in need, and of policy reforms, on differences in per capita expenditures were assessed in (segmented) linear regression models. The exposed and unexposed groups comprised 4.16 and 1.53 million person-years. Per capita expenditures (1994-2013) were higher in the group with restricted access in absolute (IRt = 375.80 Euros [375.77; 375.89]) and relative terms (IRR = 1.39). The AFe was 28.07% and the AFp 22.21%. Between-group differences in mean age and in the type of accommodation were the main independent predictors of between-group expenditure differences. Need variables explained 50-75% of the variation in between-group differences over time. The 1997 policy reform significantly increased IRt adjusted for secular trends and between-group differences in age (by 600.0 Euros [212.6; 986.2]) and sex (by 867.0 Euros [390.9; 1342.5]). The 2007 policy reform had no such effect. CONCLUSION: The cost of excluding AS&R from health care appears ultimately higher than granting regular access to care. Excess expenditures attributable to the restriction were substantial and could not be completely explained by differences in need. An evidence-informed discourse on access to health care for AS&R in Germany is needed; it urgently requires high-quality, individual-level data.

Brzoska, P. et Razum, O. (2015). "[Accessibility and quality of rehabilitative services among migrants in Germany]." Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz **58**(6): 553-559.

BACKGROUND: Migrants comprise a large proportion of the population in Germany. As compared to non-migrants they are at a higher risk with respect tor occupational accidents, occupational diseases and early retirement due to disability. Tertiary preventive services such as rehabilitation, consequently, are of high relevance for this population group. OBJECTIVES: We provide an overview of the accessibility and quality of preventive services among migrants residing in Germany using medical rehabilitation (tertiary prevention) as an example. We also present strategies which aim to improve health care for this population group. MATERIALS AND METHODS: Summary of quantitative routine data analyses and of qualitative interviews with patients and health care professionals in rehabilitative

care. RESULTS: Migrants utilize rehabilitative health care services less often than non-migrants. Those who undergo medical rehabilitation report a lower satisfaction with health care and show less favorable health outcomes than non-migrants. This, for instance, becomes evident in the occupational performance and subjective treatment outcome after rehabilitation. Socioeconomic, sociodemographic and health factors only partially explain these associations. In addition, there is evidence that migrants face various barriers which affect the accessibility and quality of health care services. CONCLUSIONS: Health care institutions have to provide services which are more sensitive to the heterogeneity of the population in order to reduce barriers in health care. Diversity management can contribute to this goal.

Castaneda, H. (2009). "Illegality as risk factor: a survey of unauthorized migrant patients in a Berlin clinic." Soc Sci Med **68**(8): 1552-1560.

Unauthorized migrants face health disadvantages in many receiving nations. However, few studies have explored precisely how the condition of "illegality" influences illness experiences, medical treatment, and convalescence. This article presents a case study from Germany (2004-2006 and 2008), where unauthorized migrants face limited access to health care and the threat of deportation results in avoidance of services and treatment delays. This is confounded by unique laws which essentially criminalize health care workers for aiding migrants. This article provides a snapshot of 183 patients who attended a Berlin clinic that functions as the single largest source of medical assistance for unauthorized persons in Germany. The demographic information sketches a picture of labor migrants with a mean age of approximately 29 years. More women than men presented at this clinic, a result of its ability to successfully arrange prenatal care and delivery as well as a reflection of local labor markets. The diversity of countries of origin (n=55) is surprising, underscoring the utility of using illegal status as a unifying variable to highlight migrants' shared position in the global economy and the resulting barriers to basic medical services. Patients presented with a range of illnesses typical for their age group. However, the effects of illegal status resulted in four areas of disparities: 1) limits to the overall quality and quantity of care for mothers and infants; 2) delayed presentation and difficulties accessing a regular supply of medication for patients with chronic illnesses; 3) difficulties in accessing immediate medical attention for unpredictable injuries and other acute health concerns; and 4) a lack of mental health care options for generalized stress and anxiety affecting health. In Germany, an incoherent policy environment contributes to inadequate services and treatment delays. Solutions must address these legal ambiguities, which represent a primary barrier to equity in a nation with otherwise universal health coverage.

Ciftci, Y., Fuller, S. S., Goldsmith, L., et al. (2021). "Germany's new global health strategy: leaving migrants behind." BMJ Open **397**(10268): 20-21.

Gottlieb, N., Bozorgmehr, K., Trummer, U., et al. (2019). "Health policies and mixed migration - Lessons learnt from the 'Refugee Crisis'." Health Policy **123**(9): 805-808.
http://www.ncbi.nlm.nih.gov/pubmed/31451227

Gottlieb, N. et Schülle, M. (2020). "An overview of health policies for asylum-seekers in Germany." Health Policy **12**5(1) : 115-121.
https://doi.org/10.1016/j.healthpol.2020.09.009

Health policies for asylum-seekers are a subject of debate across European countries. However, information on current strategies to respond to these populations' health needs is scarce. To facilitate comparative research, this paper renders a detailed overview of Germany's asylum-seeker health policies. Following a description of the historic development and administrative structure of asylum-seeker health care in Germany, we provide a detailed account of asylum-seekers' scope of health entitlements, as it is defined by federal law. We explain the main mechanisms that are used to implement the law on local levels and regulate health care access; namely, the electronic health insurance card and the health care voucher. Financing and billing structures are described, and main points of critique of Germany's asylum-seeker health policies are summarized. Our description highlights fragmentation and internal variations as central features of Germany's asylum-seeker health policies. It explicates how these features are rooted in decentralization, and in the regulation of restricted health benefits through a parallel system, separate from statutory health insurance. As a

case-study, Germany's asylum-seeker health policies illustrate the administrative, economic and ethical burdens implied in granting health benefits through a parallel system, and in absence of central health governance. The (re)integration of asylum-seeker health care in statutory health insurance could reduce these burdens and contribute to equitable health care access.

Glaesmer, H., et al. (2011). "Health care utilization among first and second generation immigrants and native-born Germans: a population-based study in Germany." Int J Public Health **56**(5): 541-548.

OBJECTIVES: There are contradictory findings on health care utilization (HCU) of immigrants compared to native-born populations. Our study focuses on this topic using a population-based approach and differentiates generational cohorts of immigrants. METHODS: In a representative population survey in Germany (N = 2,510), immigrant background/generational cohort and HCU in the preceding 12 months were screened by means of self-rating instruments. RESULTS: 11.1% (7.0% first and 4.1% second generation) of the sample are immigrants. No differences have been detect with regard to subjective state of health, satisfaction with life and with health and functional disabilities. First generation immigrants contacted a medical specialist less likely, but they more frequently use general practitioners (GPs) than the native-born Germans and the second generation immigrants. CONCLUSIONS: First generation immigrants show remarkable differences in HCU compared to the native-born Germans and the second generation immigrants. Their HCU seems to be focused on primary care, and access to secondary care might be complicated. It seems relevant to especially pay attention to HCU of first generation immigrants and to support equal access to care for this subgroup.

Huschke, S. (2014). "Performing deservingness. Humanitarian health care provision for migrants in Germany." Soc Sci Med **120**: 352-359.

In this paper, I critically investigate humanitarian aid for migrant populations in Germany. I aim to enhance the existing literature on migrant deservingness and humanitarian aid by focusing on the performative aspects of concrete face-to-face interactions between physicians/volunteers and patients. I argue that despite efforts of volunteers to provide non-discriminatory care, the encounters between patients as aid-receivers and volunteers/physicians as aid-providers are inevitably shaped by power inequalities. These immanent power inequalities may lead patients to perform their deservingness, that is, to present themselves as helpless sufferers rather than empowered subjects. Simultaneously, patient-solicitants are prevented from feeling and enacting a sense of entitlement. Those patients who do not heed to the social mechanisms of humanitarian aid, such as being thankful and humble, cause disenchantment on the side of some medical professionals who provide care as part of humanitarian networks and subsequently, they may be turned away. The research project focused on the migration trajectories and illness experiences of undocumented Latin American migrants and their access to healthcare. The analysis draws on my long-term ethnographic fieldwork with 35 Latin American migrants in Berlin (2008-2011), 22 interviews with healthcare providers, and my experience as an activist/volunteer for a Berlin-based humanitarian NGO (2008-2012).

Jaschke, P. et Kosyakova, Y. (2019). Does facilitated access to the health system improve asylum-seekers' health outcomes? : Evidence from a quasi-experiment. IAB-Discussion Paper ; 7/2019. Nüremberg Institute for Employment Research**:** 30.
http://d.repec.org/n?u=RePEc:iab:iabdpa:201907&r=hea

As long as their asylum application is not approved or their duration of stay does not exceed 15 months, asylum-seekers who require doctor visit have to claim it either by the local authority for foreigners or the responsible social assistance office in Germany. Since 2016 several Federal states and municipalities in Germany have launched the procedure to hand out electronic health cards (eHC) which allow immediate direct access to the health system for asylum-seekers. In this paper, we examine whether being eligible to the eHC as a result of the policy change has had an effect on the health outcomes of asylum-seekers in Germany. For empirical identification, we take advantage of the variation of the policy change across regions and over time. Relying on data from the IAB-BAMF-SOEP Survey of Refugees, we find that the introduction of the reforms allowing asylum-seekers' faster and more direct access to the healthcare system indeed reduced the risk of emotional disorder. We

conclude by discussing the potential pros and contras of a comprehensive nationwide introduction of the eHC for asylum-seekers.

Kratzsch, L., Bozorgmehr, K., Szecsenyi, J., et al. (2022). "Health Status and Access to Healthcare for Uninsured Migrants in Germany: A Qualitative Study on the Involvement of Public Authorities in Nine Cities." Int J Environ Res Public Health **19**(11).

Non-governmental organisations (NGOs) regularly report data on their work with uninsured migrants (UM) within a (so-called) parallel health care system. The role and involvement of public authorities therein have yet been underrepresented in research. Our aim was to gain a better understanding of public authorities' role in the parallel health care system and their view of the health situation of UM. We conducted qualitative semi-structured interviews with 12 experts recruited by purposive sampling from local public health authorities (LPHAs), state-level public health authorities (SPHAs), and social services offices (SSO) in nine cities, recorded, transcribed, and subjected the data to qualitative content analysis. LPHAs are more often directly involved in providing medical services, while SSOs and SPHAs function as gatekeepers for access to social benefits, including health insurance, and in grant-funded projects. NGOs keep substituting for the lack of access to regular health care from public institutions, but even in settings with extended services, public authorities and NGOs have not been able to provide sufficient care through the parallel health care system: Experts report gaps in the provision of health care with respect to the depth and height of coverage, due to the fragmentation of services and (ostensible) resource scarcity. Our study highlights the necessity for universal access to regular health care to overcome the fragmentation of services and improve access to needed health care for UM in Germany.

Makowski, A. C. et Kofahl, C. (2014). "Benefit and adherence of the disease management program "diabetes 2": a comparison of Turkish immigrants and German natives with diabetes." Int J Environ Res Public Health **11**(9): 9723-9738.

There is an ongoing debate about equity and equality in health care, and whether immigrants benefit equally from services as the non-immigrant population. The study focuses on benefits from and adherence to the diabetes mellitus type 2 (DM 2) disease management program (DMP) among Turkish immigrants in Germany. So far, it has not been researched whether this group benefits from enrollment in the DMP as well as diabetics from the non-immigrant population. Data on the non-immigrant sample (N = 702) stem from a survey among members of a German health insurance, the Turkish immigrant sample (N = 102) was recruited in the area of Hamburg. Identical questions in both surveys enable comparing major components. Regarding process quality, Turkish diabetics do not differ from the non-immigrant sample; moreover, they have significantly more often received documentation and diabetes training. In terms of outcome quality however, results display a greater benefit on behalf of the non-immigrant sample (e.g., blood parameters and body mass index), and they also met more of the DMP criteria. This underlines the need of diabetics with Turkish background for further education and information in order to become the empowered patient as is intended by the DMP as well as to prevent comorbidities.

Mylius, M. et Frewer, A. (2014). "[Health care for undocumented migrants--a quantitative study on the role of local health authorities in Germany]." Gesundheitswesen **76**(7): 440-445.

Public welfare on a municipal level for groups with special health risks has been an important topic of public health service for more than a century. This notion has been taken up by the German "Protection against Infection Act" (IfSG) in section sign 19 IfSG. Local health service authorities may provide out-patient treatment in addition to counselling and diagnosis for patients with sexually transmitted infections and tuberculosis, which is covered by public resources in cases of apparent need. Due to altered legislation and increased global mobility, this may become important for migrants without access to regular health care.Aims of this study were recording, counselling, diagnosis and out-patient treatment of migrants without legal residence status under the German Protection against Infection Act in the public health care system.An electronic mail survey of all local health authorities (n=384) by means of a standardised questionnaire was undertaken. Data were

analysed using descriptive statistics. In the annex of the questionnaire the participants were asked to describe a case study.139 of 384 local health authorities completed the questionnaire (36.2%) of whom approximately a quarter (24.6%) described contacts to "illegal" migrants. Contacts to migrants without legal residence status are more frequent in cities with more than 100,000 inhabitants than in ismaller cities ($p<0.05$). 22.6% of all local health authorities make an effort to reach undocumented migrants for counseling and diagnosis. 25 of the local health authorities (18.4%) indicated the capability to provide treatment in accordance with section sign 19 IfSG. A majority of these local health authorities also have contacts to undocumented migrants (75%). 16 local health authorities (13.3%) provide out-patient treatment for diseases not listed in Protection against Infection Act. 56 authorities (46.7%) refer patients to aid organisations or to resident doctors.Only a small number of local health authorities have contacts to migrants without health insurance. The option-al out-patient treatment is provided by few local health authorities especially in cases of sexual transmitted diseases except for HIV/AIDS. In most cases undocumented migrants are only one group among others. The large number of cases in cities with more than 500,000 inhabitants shows the massive requirements.

Mylius, M. et Frewer, A. (2015). "Access to healthcare for undocumented migrants with communicable diseases in Germany: a quantitative study." Eur J Public Health **25**(4): 582-586.

BACKGROUND: Migrants without residence permits are de facto excluded from access to healthcare in Germany. There is one exception in relevant legislation: in the case of sexually transmitted infections and tuberculosis, the legislator has instructed the local Public Health Authorities to offer free and anonymous counseling, testing and, if necessary, treatment in case of apparent need. Furthermore, recommended vaccinations may be carried out free of charge. This study intends to comprehensively capture the services for undocumented migrants at Public Health Authorities in Germany. METHODS: An e-mail survey of all Local Public Health Authorities (n = 384) in Germany was carried out between January and March 2011 using a standardized questionnaire. RESULTS: One hundred thirty-nine of 384 targeted local Health Authorities completed the questionnaire (36.2%), of which approximately a quarter (n = 34) reported interaction with 'illegal' immigrants. Twenty-give authorities (18.4%) gave the indication to carry out treatment. This outpatient treatment option is mostly limited to patients afflicted with sexually transmitted infections with the distinct exception of human immunodeficiency virus/acquired immune deficiency syndrome. CONCLUSIONS: The study highlights the gap between legislation and the reality of restricted access to medical services for undocumented migrants in Germany. It underlines the need of increased financial and human resources in Public Health Authorities and, overall, the simplification of national legislation to assure the right to healthcare.

Rolke, K., Wenner, J. et Razum, O. (2018). "Organization of access to primary health care for newly arrived refugees in Germany." Public Health Panorama **4**(4): 586-591.

Access to health care for newly arrived refugees is organized differently among Germany's municipalities. In the federal state of North Rhine-Westphalia, municipalities choose between two different access models: the health care voucher (HCV) model and the electronic health card (EHC) model. The EHC model was developed to facilitate access to primary health care and reduce bureaucracy. Currently, only 22 out of 396 municipalities have implemented the EHC model. We conducted interviews with 23 local decision-makers in four municipalities to identify the challenges of introducing the EHC model and to illustrate this case study on organizing access to primary health care for refugees in Germany.

Rolke, K., Wenner, J. et Razum, O. (2019). "Shaping access to health care for refugees on the local level in Germany - Mixed-methods analysis of official statistics and perspectives of gatekeepers." Health Policy **123**(9): 845-850.
http://www.ncbi.nlm.nih.gov/pubmed/31326127

BACKGROUND: Analyses of refugee reception in European countries are increasingly focusing on the local level. We analyzed how gatekeepers can shape access to health care on a local level, taking as an example the federal state of North Rhine-Westphalia (NRW), Germany, where municipalities have implemented different local access models for newly arrived refugees. METHODS: We assessed the

details of and the rationale for the implementation of local access models (implementation analysis), and the potential access to health care for refugees in municipalities (local policy analysis). We covered three municipalities with a health care voucher model and three with an electronic health card model. We combined data from official reports and semi-structured interviews (N=21) with gatekeepers. RESULTS: Larger municipalities are more likely to implement the eHC. Gatekeepers report that costs, workload and control are the major aspects underlying the choice of a model in municipalities. Access plays only a minor role - even though some of the gatekeepers claim that the eHC can facilitate access. Regardless of the implemented model, gatekeepers on the local level can contribute to facilitating the access to health care for refugees. CONCLUSION: Potential access of newly arrived refugees is - among others - determined by the gatekeepers' support and the implementation of the access models. Within the legal framework, municipalities implement the models differently.

Schlopker, K., et al. (2009). "[Unresolved problems of undocumented migrants in Germany: an analysis of medical consultations in Berlin, Cologne and Bonn]." Gesundheitswesen **71**(12): 839-844.

INTRODUCTION: Little is known about health related problems of undocumented migrants in Germany. Patterns for medical consultations and socio-demographic characteristics are only available in isolated reports. This article identifies and compares empirical data from non-governmental organisations (NGOs) who provide medical care for unregistered migrants. METHODS: Annual reports of 2006 and 2007 of the Malteser Migranten Medizin (Berlin, Cologne) and the MediNetz Bonn were selected for this document analysis. RESULTS: We identified similarities and differences in the socio-demographic background and patterns of medical consultations between the explored regions. The number of documented migrants without medical insurance increased during the observed period. DISCUSSION: The patterns of health-care utilisation for undocumented immigrants changed in the observed period which might be caused by the EU enlargement to the East. The heterogeneous quality of the annual reports and the lack of information about the use of alternative health-care facilities limit the results of this analysis.

Volodina, A., et al. (2011). "Drug utilization patterns and reported health status in ethnic German migrants (Aussiedler) in Germany: a cross-sectional study." BMC Public Health **11**: 509.

BACKGROUND: Inadequate utilization of healthcare services by migrant populations is an important public health concern. Inadequate drug consumption and poor compliance to the therapeutic regimen are common manifestations of low health-care seeking behavior present in migrants even in the countries with well-established healthcare systems. There are few studies on the use of medicines among the different groups of migrants in Germany. The objective of this study is to investigate drug consumption patterns of ethnic German migrants (Aussiedler) and their current health status. METHODS: A cross-sectional study nested into a cohort of 18,621 individuals aged 20-70 years who migrated to Germany from the former Soviet Union between 1990 and 2005 was conducted. Data on consumption of drugs, drug handling, major health risk factors, and one-year disease prevalence were obtained for 114 individuals through a self-administered questionnaire and phone interviews. Results were compared to the data on the German population derived from the Disease Analyzer database and Robert Koch Institute (RKI) annual reports. Direct age standardization, test of differences, Chi-square test, and descriptive statistics were applied as appropriate. For drug classification the Anatomical Therapeutic Chemical (ATC) system was used. RESULTS: Of the respondents, 97% reported to have at least one disease within a 12-month period. The one-year prevalence of asthma (6.9%), hypertension (26.7%), chronic bronchitis (8.6%), and diabetes (4.9%) in migrants was similar to the general German population. 51% regularly took either over-the-counter (OTC) medication or prescription medicines. Six ATC groups were analyzed. The highest drug consumption was reported for the ATC cardiovascular (22%), nervous (9%), and muskulo-skeletal system (8%). 30% used OTC medicines obtained in the country of origin. Difficulties with drug handling were rare. Alcohol consumption did not differ from the German population ($p = 0.19$ males and 0.27 females), however smoking prevalence was lower ($p < 0.01$) in both sexes. CONCLUSION: Ethnic German migrants seem to differ only slightly from Germans in health status, drug utilization, and disease risk factors, and if so, not in an extreme way. Country of origin remains a source of medicines for a substantial part of

migrants. The study is limited by a small sample size and low response rate.

Waller, H. (2008). "[Health problems and health-care among unregistered migrants: a comparison between Germany and Italy]." Gesundheitswesen **70**(1): 4-8.

Public health aspects concerning health and health-care of unregistered migrants have been rarely investigated. This article aims at providing some empirical data which are derived from the documentation and annual reports of two health-care institutions specialised in health-care for unregistered migrants in Germany and Italy taking into account the different legal regulations between Germany and Italy for the health-care of irregular migrants. The data show that the patients in both institutions are rather young and immigrated often from East Europe and the former Soviet Union. Their main diseases did not differ much from the average spectrum except for showing a higher prevalence of "poverty-related illnesses" like infectious and skin diseases.

Autriche

Kohlenberger, J., Buber-Ennser, I., Rengs, B., et al. (2019). "Barriers to health care access and service utilization of refugees in Austria: Evidence from a cross-sectional survey." Health Policy **123**(9): 833-839. http://www.ncbi.nlm.nih.gov/pubmed/30878171

This paper provides evidence on (1) refugees' subjective well-being, (2) their access and barriers to health care utilization and (3) their perception of health care provision in Austria, one of the countries most heavily affected by the European 'refugee crisis.' It is based on primary data from the Refugee Health and Integration Survey (ReHIS), a cross-sectional survey of roughly five hundred Syrian, Iraqi and Afghan refugees. Results indicate that refugees' self-rated health falls below the resident population's, in particular for female and Afghan refugees. Whereas respondents state overall high satisfaction with the Austrian health system, two in ten male and four in ten female refugees report unmet health needs. Most frequently cited barriers include scheduling conflicts, long waiting lists, lack of knowledge about doctors, and language. Although treatment costs were not frequently considered as barriers, consultation of specialist medical services frequently associated with co-payment by patients, in particular dental care, are significantly less often consulted by refugees than by Austrians. Refugees reported comparably high utilization of hospital services, with daycare treatment more common than inpatient stays. We recommend to improve refugees' access to health care in Austria by a) improving the information flow about available treatment, in particular specialists, b) fostering dental health care for refugees, and c) addressing language barriers by providing (web-based) interpretation services.

Australie

Al Abed, N. A., et al. (2014). "Healthcare needs of older Arab migrants: a systematic review." J Clin Nurs **23**(13-14): 1770-1784.

AIMS AND OBJECTIVES: To explore the healthcare needs of older Arab migrants, focussing on Arab-Australians and their socio-cultural characteristics. BACKGROUND: Disparities in accessing healthcare services and addressing healthcare needs are evident among ethnic minorities including Arab migrants, particularly, older people. Racial stereotyping can also affect their ability to use these services. Arabs are a populous and diverse group with a long history of global migration. Australia is one of the most multicultural societies in the world, and Arab-Australians constitute an important ethnic minority group. DESIGN: Systematic review. METHODS: The electronic databases Academic Search Complete (EBSCO), MEDLINE (Ovid), Ageline, ProQuest, CINAHL, PubMed, PsychINFO and Google Scholar were searched from 1990-October 2012. Search terms included health care needs, aged care, ethnic, cultural, linguistics, social, ethnic groups, culturally and linguistically diverse, nonEnglish speaking, ageing, elderly, Arabs, Arabic-speaking and Australia. RESULTS: Eight articles reviewing the healthcare issues of Australians from Arabic-speaking background were identified using

the search strategy. An additional eight articles were identified through hand searching. CONCLUSIONS: Racial stereotyping can alter health-seeking behaviours and healthcare treatment. Increasing the understanding of specific cultural attributes of Arab-Australians will contribute to improving health outcomes. RELEVANCE TO CLINICAL PRACTICE: Healthcare providers and policymakers need to adopt more effective ways of communication with Arab-Australians to provide more culturally competent care and achieve better health outcomes.

Johnstone, M. J., et al. (2015). "Nursing Roles and Strategies in End-of-Life Decision Making Concerning Elderly Immigrants Admitted to Acute Care Hospitals: An Australian Study." J Transcult Nurs.

PURPOSE: There is a lack of clarity regarding nursing roles and strategies in providing culturally meaningful end-of-life care to elderly immigrants admitted to Australian hospitals. This article redresses this ambiguity. METHOD: A qualitative exploratory descriptive approach was used. Data were obtained by conducting in-depth interviews with a purposeful sample of 22 registered nurses, recruited from four health services. Interview transcripts were analyzed using content and thematic analysis strategies. RESULTS: Despite feeling underprepared for their role, participants fostered culturally meaningful care by "doing the ground work," "facilitating families," "fostering trust," and "allaying fear." DISCUSSION AND CONCLUSION: The Australian nursing profession has a significant role to play in leading policy, education, practice, and consumer engagement initiatives aimed at ensuring a culturally responsive approach to end-of-life care for Australia's aging immigrant population. IMPLICATIONS FOR PRACTICE: Enabling elderly immigrants to experience a "good death" at the end of their lives requires highly nuanced and culturally informed nursing care.

Mahmoud, I. et Hou, X. Y. (2012). "Immigrants and the utilization of hospital emergency departments." World J Emerg Med **3**(4): 245-250.

BACKGROUND: Immigrants with language barriers are at high risk of having poor access to health care services. However, several studies have indicated that immigrants tend to use emergency departments (EDs) as their primary source of care at the expense of primary care. This may place an additional burden on already overcrowded EDs and lead to a low level of patient satisfaction with ED care. The study was to review if immigrants utilize ED care differently from host populations and to assess immigrants' satisfaction with ED care. DATA SOURCES: Studies about immigrants' utilization of EDs in Australia and worldwide were reviewed. RESULTS: There are conflicting results in the literature about the pattern of ED care use among immigrants. Some studies have shown higher utilization by immigrants compared to host populations and others have shown lower utilization. Overall, immigrants use ED care heavily, make inappropriate visits to EDs, have a longer length of stay in EDs, and are less satisfied with ED care as compared to host populations. CONCLUSIONS: Immigrants might use ED care differently from host populations due to language and cultural barriers. There is sparse Australian literature regarding immigrants' access to health care including ED care. To ensure equity, further research is needed to inform policy when planning health care provision to immigrants.

Riggs, E., et al. (2014). "Hard to reach communities or hard to access services? Migrant mothers' experiences of dental services." Aust Dent J **59**(2): 201-207.

BACKGROUND: Good oral health is an important component of overall health which can help migrants settle in a new country. Infant oral health is intimately associated with maternal oral health knowledge and behaviours and therefore, encounters with dental services. This study aimed to explore the experiences of dental service use from the perspective of migrant mothers living in Melbourne, Australia. METHODS: A participatory research approach utilizing qualitative methods was adopted. Women from Iraq, Lebanon and Pakistan participated. Semi-structured focus groups and interviews were conducted and thematic analysis of the data was completed. RESULTS: Focus groups (n = 11) and interviews (n = 7) were conducted with 115 women. Despite an understanding that visiting the dentist was important for promoting oral health, the first dental contact for both the women and their children was typically for emergency care. Accessibility, cost and waiting lists were identified as significant barriers to attendance. Problematic interpreter encounters often led to negative experiences which were compounded by a perception that public services provided poorer

quality of care. CONCLUSIONS: Despite evidence of poorer oral health, migrant women face significant barriers in accessing mainstream dental services. Reorientation of such services, to address the accessibility and experience for migrant communities may help reduce oral health inequalities.

Tran, D. T., et al. (2015). "Variation in the use of primary care services for diabetes management according to country of birth and geography among older Australians." Prim Care Diabetes.

AIMS: To investigate variation according to country of birth and geography in the use of primary care services funded through Medicare Australia-Australian universal health insurance-for diabetes annual cycle of care among older overseas-born Australians with type-2 diabetes. METHODS: Records of Medicare claims for medical services were linked to self-administered questionnaire data for people with type-2 diabetes enrolled in the 45 and Up Study, including 840 participants born in Italy, Greece, Vietnam, Lebanon, China, India, or the Philippines and 12,444 participants born in Australia, living in 195 statistical local areas (SLAs) in New South Wales, Australia. Study outcomes included >/=6 claims for general practitioner (GP) visits, at least one claim for specialist, optometrist, Practice Incentive Payment for completion of diabetes annual cycle of care (PIP), GP Management Plan or Team Care Arrangement (GPMP/TCA), allied health, blood tests for glycosylated haemoglobin (HbA1c) and cholesterol, and urine test for micro-albumin. Multivariable multilevel logistic regression was performed, controlling for personal socio-demographic and health characteristics and geographical area remoteness and socio-economic status. RESULTS: Compared with Australia-born participants, people born in Vietnam and China had significantly lower rates of claims for allied health services (odds ratio [OR] 0.14, 95% confidence interval [CI] 0.05-0.43, and OR 0.40, 95%CI 0.18-0.87, respectively), those born in Italy had lower rates of PIP claims (OR 0.60, 95%CI 0.39-0.92) and micro-albuminuria testings (OR 0.65, 95%CI 0.47-0.89), and those born in the Philippines had lower claims for specialist services (OR 0.59, 95%CI 0.38-0.91). Participants born in Greece and China (GP visits), Vietnam (optometrist services), and India (micro-albuminuria tests) were more likely to claims for these services than Australia-born people. Significant geographic variation was observed for all study outcomes, with the greatest variations in claims for allied health services (variation 9.3%, median odds ratio [MOR] 1.74, 95% credible interval [CrI] 1.60-2.01), PIP (7.8%, MOR 1.65, 95%CrI 1.55-1.83), and GPMP/TCA items (6.6%, MOR 1.58, 95%CrI 1.49-1.73). CONCLUSIONS: Different approach among geographical areas and intervention programs for identified cultural groups and their providers are warranted to improve disparities in diabetes care.

Belgique

Ahaddour, C., et al. (2015). "Institutional Elderly Care Services and Moroccan and Turkish Migrants in Belgium: A Literature Review." J Immigr Minor Health.

In several European countries, including Belgium, the rapid ageing of the migrant population has emerged only recently on the political agenda. The aim of this literature review is threefold. Firstly, it provides a review of the available studies on the accessibility and use of institutional care services by Moroccan and Turkish migrants in the Flemish part of Belgium including Flanders and Brussels. Secondly, it identifies their specific needs regarding elderly care services. Finally, it provides an overview of the way in which Belgian policy has dealt with the issue of migration and elderly care. Literature published between 1965 and 2014 and relevant to the Belgian context has been included. This search yielded 21 references, of which 8 empirical studies, 5 policy literature, 3 theoretical studies, 3 news articles and 2 popularized reports. Mainstream elderly care remains relatively inaccessible for these migrants due to the language and a series of cultural and religious barriers, a low level of education, financial constraints, a lack of knowledge of health care systems, and the so-called return and care dilemmas. Their religious and cultural needs are currently not met by elderly care services. The inclusive and neutral Belgian policy seems to pay insufficient attention to these issues.

Dauvrin, M. et Lorant, V. (2014). "Adaptation of health care for migrants: whose responsibility?" BMC Health Serv Res **14**: 294.

BACKGROUND: In a context of increasing ethnic diversity, culturally competent strategies have been recommended to improve care quality and access to health care for ethnic minorities and migrants; their implementation by health professionals, however, has remained patchy. Most programs of cultural competence assume that health professionals accept that they have a responsibility to adapt to migrants, but this assumption has often remained at the level of theory. In this paper, we surveyed health professionals' views on their responsibility to adapt. METHODS: Five hundred-and-sixty-nine health professionals from twenty-four inpatient and outpatient health services were selected according to their geographic location. All health care professionals were requested to complete a questionnaire about who should adapt to ethnic diversity: health professionals or patients. After a factorial analysis to identify the underlying responsibility dimensions, we performed a multilevel regression model in order to investigate individual and service covariates of responsibility attribution. RESULTS: Three dimensions emerged from the factor analysis: responsibility for the adaptation of communication, responsibility for the adaptation to the negotiation of values, and responsibility for the adaptation to health beliefs. Our results showed that the sense of responsibility for the adaptation of health care depended on the nature of the adaptation required: when the adaptation directly concerned communication with the patient, health professionals declared that they should be the ones to adapt; in relation to cultural preferences, however, the responsibility felt on the patient's shoulders. Most respondents were unclear in relation to adaptation to health beliefs. Regression indicated that being Belgian, not being a physician, and working in a primary-care service were associated with placing the burden of responsibility on the patient. CONCLUSIONS: Health care professionals do not consider it to be their responsibility to adapt to ethnic diversity. If health professionals do not feel a responsibility to adapt, they are less likely to be involved in culturally competent health care.

Dauvrin, M., Detollenaere, J. et De, L., C. (2019). Asylum seekers in Belgium: options for a more equitable access to health care. a stakeholder consultation. KCE Report; 319B. Bruxelles KCE**:** 450 , fig., tabl., annexes.
https://kce.fgov.be/fr/node/4831

Tout migrant qui arrive sur le sol belge et y demande l'asile reçoit automatiquement un accès aux soins de santé pendant le temps que durent les procédures. Or plusieurs rapports belges et internationaux ont souligné que l'accès à ces soins n'est pas égal pour tous les demandeurs d'asile. Il a été demandé au Centre fédéral d'Expertise des Soins de Santé (KCE) de proposer des pistes pour remédier à cette situation, qui met la Belgique en porte-à-faux avec les traités internationaux qu'elle a signés. L'essentiel du problème réside dans le fait que le financement de ces soins de santé dépend d'instances différentes selon que le demandeur d'asile est hébergé dans un centre d'accueil collectif ou dans une Initiative locale d'accueil gérée par un CPAS. Le KCE propose de simplifier l'organisation de l'accès aux soins en intégrant tout dans une même enveloppe globale. Qui va gérer cette enveloppe ? Différentes options sont possibles ; le KCE les a analysées, mais la décision finale revient au pouvoir politique.

Bulgarie

(2015). Bulgaria : assessing health-system capacity to manage sudden large influxes of migrants. Copenhague OMS Bureau régional de l'Europe**:** vi+19.

Further to the arrival of large influxes of migrants at Greece's land and sea borders, the Greek Government invited the WHO Regional Office for Europe to organize a joint mission between 15 and 19 December 2014 to assess health system capacity to manage large influxes of migrants. The mission aims were threefold: to assess the ongoing preparedness and response activities of the local health system; to plan ad hoc technical assistance if required; and to pilot the draft WHO toolkit for assessing health system capacity to manage large influxes of migrants in the acute phase. The members of the assessment team undertook site visits at first reception centres and pre-departure facilities, and conducted interviews with all key stakeholders. From their findings, their main recommendations

include improvements in living conditions in migrant centres, the preparation of a national multisectoral contingency plan, a harmonized health data collection system and a strengthened migrant immunization policy.

Canada

Ahmed, S., et al. (2015). "Barriers to Access of Primary Healthcare by Immigrant Populations in Canada: A Literature Review." J Immigr Minor Health.

To summarize information obtained from original research about barriers to access of primary healthcare by Canadian immigrants' and to identify research gaps. Electronic databases of primary research articles and grey literature were searched without restricting the time period. The preferred reporting items for systematic reviews and meta-analyses statement was followed for literature selection. Articles were selected based on three criteria: (a) the study population was Canadian legal immigrant(s), (b) the research was about the barriers to accessing primary healthcare in Canada, and (c) the article was written in English. Relevant information from the articles was extracted into tabular format and classified for thematic analysis. Identified barriers were grouped into five themes: cultural, communication, socio-economic status, healthcare system structure and immigrant knowledge. The barriers to accessing primary healthcare in each of these categories can provide insight and subsequent direction for changes needed to improve immigrant care and mitigate their deterioration in health status. The demographic and ethno-cultural distributions of the study populations across the provinces highlight the need to expand research to encompass more varied immigrant groups across more regions of Canada, including more research on male immigrants and immigrant seniors, and to increase research related to health care providers' perspectives on the barriers.

Caulford, P. et D'Andrade, J. (2012). "Health care for Canada's medically uninsured immigrants and refugees: whose problem is it?" Can Fam Physician **58**(7): 725-727, e362-724.

Durbin, A., et al. (2015). "Examining the relationship between neighbourhood deprivation and mental health service use of immigrants in Ontario, Canada: a cross-sectional study." BMJ Open **5**(3): e006690.

OBJECTIVE: While newcomers are often disproportionately concentrated in disadvantaged areas, little attention is given to the effects of immigrants' postimmigration context on their mental health and care use. Intersectionality theory suggests that understanding the full impact of disadvantage requires considering the effects of interacting factors. This study assessed the inter-relationship between recent immigration status, living in deprived areas and service use for non-psychotic mental health disorders. STUDY DESIGN: Matched population-based cross-sectional study. SETTING: Ontario, Canada, where healthcare use data for 1999-2012 were linked to immigration data and area-based material deprivation scores. PARTICIPANTS: Immigrants in urban Ontario, and their age-matched and sex-matched long-term residents (a group of Canadian-born or long-term immigrants, n=501,417 pairs). PRIMARY AND SECONDARY OUTCOME MEASURES: For immigrants and matched long-term residents, contact with primary care, psychiatric care and hospital care (emergency department visits or inpatient admissions) for non-psychotic mental health disorders was followed for 5 years and examined using conditional logistic regression models. Intersectionality was investigated by including a material deprivation quintile by immigrant status (immigrant vs long-term resident) interaction. RESULTS: Recent immigrants in urban Ontario were more likely than long-term residents to live in most deprived quintiles (immigrants--males: 22.8%, females: 22.3%; long-term residents--both sexes: 13.1%, p<0.001). Living in more deprived circumstances was associated with greater use of mental health services, but increases were smaller for immigrants than for long-term residents. Immigrants used less mental health services than long-term residents. CONCLUSIONS: This study adds to existing research by suggesting that immigrant status and deprivation have a combined effect on recent immigrants' care use for non-psychotic mental health disorders. In settings where immigrants are over-represented in deprived areas, policymakers focused on increasing immigrants' access of mental health services should broadly address the influence of structural and cultural factors beyond the disadvantage.

Hyman, I., et al. (2014). "Self-management, health service use and information seeking for diabetes care among Black Caribbean immigrants in Toronto." Can J Diabetes **38**(1): 32-37.

OBJECTIVE: The objective of this research was to explore self-management practices and the use of diabetes information and care among Black-Caribbean immigrants with type 2 diabetes. METHOD: The study population included Black-Caribbean immigrants and Canadian-born participants between the ages of 35 to 64 years with type 2 diabetes. Study participants were recruited from community health centres (CHCs), diabetes education centres, hospital-based diabetes clinics, the Canadian Diabetes Association and immigrant-serving organizations. A structured questionnaire was used to collect demographics and information related to diabetes status, self-management practices and the use of diabetes information and care. RESULTS: Interviews were conducted with 48 Black-Caribbean immigrants and 54 Canadian-born participants with type 2 diabetes. Black-Caribbean immigrants were significantly more likely than the Canadian-born group to engage in recommended diabetes self-management practices (i.e. reduced fat diet, reduced carbohydrate diet, non-smoking and regular physical activity) and receive regular A1C and eye screening by a health professional. Black-Caribbean immigrant participants were significantly more likely to report receiving diabetes information and care through a community health centre (CHC) and nurses and dieticians than their Canadian-born counterparts. CONCLUSIONS: CHCs and allied health professionals play an important role in the management of diabetes in the Black-Caribbean immigrant community and may contribute to this group's favourable diabetes self-management profile and access to information and care. Additional research is necessary to confirm whether these findings are generalizable to the Black-Caribbean community in general (i.e. immigrant and non-immigrant) and to determine whether the use of CHCs and/or allied health professionals is associated with favourable outcomes in the Black-Caribbean immigrant community as well as others.

Kalich, A., et al. (2015). "A Scoping Review of Immigrant Experience of Health Care Access Barriers in Canada." J Immigr Minor Health.

Canadian population-based surveys report comparable access to health care services between immigrant and non-immigrant populations, yet other research reports immigrant-specific access barriers. A scoping review was conducted to explore research regarding Canadian immigrants' unique experiences in accessing health care, and was guided by the research question: "What is currently known about the barriers that adult immigrants face when accessing Canadian health care services?" The findings of this study suggest that there are unmet health care access needs specific to immigrants to Canada. In reviewing research of immigrants' health care experiences, the most common access barriers were found to be language barriers, barriers to information, and cultural differences. These findings, in addition to low cultural competency reported by interviewed health care workers in the reviewed articles, indicate inequities in access to Canadian health care services for immigrant populations. Suggestions for future research and programming are discussed.

Lofters, A. K., et al. (2015). "Primary care physician characteristics associated with cancer screening: a retrospective cohort study in Ontario, Canada." Cancer Med **4**(2): 212-223.

Primary care physicians can serve as both facilitators and barriers to cancer screening, particularly for under-screened groups such as immigrant patients. The objective of this study was to inform physician-targeted interventions by identifying primary care physician characteristics associated with cancer screening for their eligible patients, for their eligible immigrant patients, and for foreign-trained physicians, for their eligible immigrant patients from the same world region. A population-based retrospective cohort study was performed, looking back 3 years from 31 December 2010. The study was performed in urban primary care practices in Ontario, Canada's largest province. A total of 6303 physicians serving 1,156,627 women eligible for breast cancer screening, 2,730,380 women eligible for cervical screening, and 2,260,569 patients eligible for colorectal screening participated. Appropriate breast screening was defined as at least one mammogram in the previous 2 years, appropriate cervical screening was defined as at least one Pap test in the previous 3 years, and appropriate colorectal screening as at least one fecal occult blood test in the previous 2 years or at

least one colonoscopy or barium enema in the previous 10 years. Just fewer than 40% of physicians were female, and 26.1% were foreign trained. In multivariable analyses, physicians who attended medical schools in the Caribbean/Latin America, the Middle East/North Africa, South Asia, and Western Europe were less likely to screen their patients than Canadian graduates. South Asian-trained physicians were significantly less likely to screen South Asian women for cervical cancer than other foreign-trained physicians who were seeing region-congruent patients (adjusted odds ratio: 0.56 [95% confidence interval 0.32-0.98] versus physicians from the USA, Australia and New Zealand). South Asian patients were the most vulnerable to under-screening, and decreasing patient income quintile was consistently associated with lower likelihood of screening, although less so for immigrant patients. This study highlights certain physician characteristics that are associated with cancer screening for eligible patients, including immigrant patients, and that should be considered when designing physician-targeted interventions. We have also highlighted an ethnic community, South Asians, which requires particular attention, both among its patients and its primary care providers. Future research should further explore the reasons for these findings.

Muggah, E., et al. (2012). "Access to primary health care for immigrants: results of a patient survey conducted in 137 primary care practices in Ontario, Canada." BMC Fam Pract **13**: 128.

BACKGROUND: Immigrants make up one fifth of the Canadian population and this number continues to grow. Adequate access to primary health care is important for this population but it is not clear if this is being achieved. This study explored patient reported access to primary health care of a population of immigrants in Ontario, Canada who were users of the primary care system and compared this with Canadian-born individuals; and by model of primary care practice. METHODS: This study uses data from the Comparison of Models of Primary Care Study (COMP-PC), a mixed-methods, practice-based, cross-sectional study that collected information from patients and providers in 137 primary care practices across Ontario, Canada in 2005-2006. The practices were randomly sampled to ensure an equal number of practices in each of the four dominant primary care models at that time: Fee-For-Service, Community Health Centres, and the two main capitation models (Health Service Organization and Family Health Networks). Adult patients of participating practices were identified when they presented for an appointment and completed a survey in the waiting room. Three measures of access were used, all derived from the patient survey: First Contact Access, First Contact Utilization (both based on the Primary Care Assessment Tool) and number of self-reported visits to the practice in the past year. RESULTS: Of the 5,269 patients who reported country of birth 1,099 (20.8%) were born outside of Canada. In adjusted analysis, recent immigrants (arrival in Canada within the past five years) and immigrants in Canada for more than 20 years were less likely to report good health compared to Canadian-born (Odds ratio 0.58, 95% CI 0.36,0.92 and 0.81, 95% CI 0.67,0.99). Overall, immigrants reported equal access to primary care services compared with Canadian-born. Within immigrant groups recently arrived immigrants had similar access scores to Canadian-born but reported 5.3 more primary care visits after adjusting for health status. Looking across models, recent immigrants in Fee-For-Service practices reported poorer access and fewer primary care visits compared to Canadian-born. CONCLUSIONS: Overall, immigrants who were users of the primary care system reported a similar level of access as Canadian-born individuals. While recent immigrants are in poorer health compared with Canadian-born they report adequate access to primary care. The differences in access for recently arrived immigrants, across primary care models suggests that organizational features of primary care may lead to inequity in access.

Newbold, K. B. (2009). "Health care use and the Canadian immigrant population." Int J Health Serv **39**(3): 545-565.

Set within the "determinants of health" framework and drawing on Statistics Canada's longitudinal National Population Health Survey, this article explores health care utilization by Canada's immigrant population. Given the observed "healthy immigrant effect", whereby the health status of immigrants at the time of arrival is high but subsequently declines and converges toward that of the native-born population, does the incidence of use of health care facilities reflect greater need for care? Similarly, does the use of health care facilities by the native- and the foreign-born differ, and if so, are these differences explained primarily by socioeconomic, sociodemographic, or lifestyle factors, which may

point to problems in the Canadian health care system? This study identifies trends in the incidence of physician and hospital use, the factors that contribute to health care use, and differences in health care use between the native- and foreign-born.

Ngwakongnw, E., et al. (2014). "Use of acute care hospital services by immigrant seniors in Ontario: A linkage study." Health Rep **25**(10): 15-22.

BACKGROUND: Seniors constitute the largest group of hospital users. The increasing share of immigrants in Canada's senior population can affect the demand for hospital care. DATA AND METHODS: This study used the linked 2006 Census-Hospital Discharge Abstract Database to examine hospitalization during the 2004-to-2006 period, by immigrant status, of Ontario seniors living in the community. Hospitalization was assessed with logistic regressions; cumulative length of stay, with zero-truncated negative binomial regressions. All-cause hospitalization and hospitalizations specific to circulatory and digestive diseases were examined. RESULTS: Immigrant seniors had significantly low age-/sex-adjusted odds of hospitalization, compared with Canadian-born seniors (OR = 0.81). The odds varied from 0.4 among East Asians to 0.89 among Europeans, and rose with length of time since arrival from 0.54 for recent (1994 to 2003) to 0.86 for long-term (before 1984) immigrants. Adjustment for demographic and socio-economic characteristics did not change the overall patterns. Immigrants' cumulated length of hospital stay tended to be shorter than or similar to that of Canadian-born seniors. INTERPRETATION: Immigrant seniors, especially recent arrivals, had lower odds of hospitalization and similar time in hospital, compared with Canadian-born seniors. These patterns likely reflect differences in health status. Variations by world region and disease reflect the diverse health care needs of immigrant seniors.

Ngwakongnwi, E., et al. (2012). "Experiences of French speaking immigrants and non-immigrants accessing health care services in a large Canadian city." Int J Environ Res Public Health **9**(10): 3755-3768.

French speakers residing in predominantly English-speaking communities have been linked to difficulties accessing health care. This study examined health care access experiences of immigrants and non-immigrants who self-identify as Francophone or French speakers in a mainly English speaking province of Canada. We used semi-structured interviews to gather opinions of recent users of physician and hospital services (N = 26). Language barriers and difficulties finding family doctors were experienced by both French speaking immigrants and non-immigrants alike. This was exacerbated by a general preference for health services in French and less interest in using language interpreters during a medical consultation. Some participants experienced emotional distress, were discontent with care received, often delayed seeking care due to language barriers. Recent immigrants identified lack of insurance coverage for drugs, transportation difficulties and limited knowledge of the healthcare system as major detractors to achieving health. This study provided the groundwork for future research on health issues of official language minorities in Canada.

Ohle, R., et al. (2017). "The immigrant effect: factors impacting use of primary and emergency department care - a Canadian population cross-sectional study." Cjem: 1-6.

OBJECTIVE: In 2011, Canada had a foreign-born population of approximately 6,775,800. They represented 20.6% of the total population. Immigrants possess characteristics that reduce the use of primary care. This is thought to be, in part, due to a lower education level, employment, and better health status. Our objective was to assess whether, in an immigrant population without a primary care physician, similar socioeconomic factors would also reduce the likelihood of using the emergency department compared to a non-immigrant population without primary care. METHODS: Data regarding individuals >/= 12 years of age from the Canadian Community Health Survey from 2007 to 2008 were analysed (n=134,073; response rate 93%). Our study population comprised 15,554 individuals identified without a primary care physician who had a regular place for medical care. The primary outcome was emergency department as a regular care access point. Socioeconomic variables included employment, health status, and education. Covariates included chronic health conditions, mobility, gender, age, and mental health. Weighted logistic regression models were constructed to evaluate the importance of individual risk factors. RESULTS: The sample of 15,554 (immigrants n=1,767) consisted of 57.3% male and 42.7% female

respondents from across Canada. Immigrants were less likely than Canadian-born respondents to use the emergency department as a regular access point for health care (odds ratio=0.48 [95% CI 0.40 - 0.57]). Adjusting for health, education, or employment had no effect on this reduced tendency (odds ratio=0.47 [95% CI 0.38 - 0.58]). CONCLUSION: In a Canadian population without a primary care physician, immigrants are less likely to use the emergency department as a primary access point for care than Canadian-born respondents. However, this effect is independent of previously reported social and economic factors that impact use of primary care. Immigration status is an important but complex component of racial and ethnic disparity in the use of health care in Canada.

Pottie, K., et al. (2014). "Improving delivery of primary care for vulnerable migrants: Delphi consensus to prioritize innovative practice strategies." Can Fam Physician **60**(1): e32-40.

OBJECTIVE: To identify and prioritize innovative strategies to address the health concerns of vulnerable migrant populations. DESIGN: Modified Delphi consensus process. SETTING: Canada. PARTICIPANTS: Forty-one primary care practitioners, including family physicians and nurse practitioners, who provided care for migrant populations. METHODS: We used a modified Delphi consensus process to identify and prioritize innovative strategies that could potentially improve the delivery of primary health care for vulnerable migrants. Forty-one primary care practitioners from various centres across Canada who cared for migrant populations proposed strategies and participated in the consensus process. MAIN FINDINGS: The response rate was 93% for the first round. The 3 most highly ranked practice strategies to address delivery challenges for migrants were language interpretation, comprehensive interdisciplinary care, and evidence-based guidelines. Training and mentorship for practitioners, intersectoral collaboration, and immigrant community engagement ranked fourth, fifth, and sixth, respectively, as strategies to address delivery challenges. These strategies aligned with strategies coming out of the United States, Europe, and Australia, with the exception of the proposed evidence-based guidelines. CONCLUSION: Primary health care practices across Canada now need to evolve to address the challenges inherent in caring for vulnerable migrants. The selected strategies provide guidance for practices and health systems interested in improving health care delivery for migrant populations.

Richter, S. (2020). "Intersection of Migration and Access to Health Care: Experiences and Perceptions of Female Economic Migrants in Canada." J Public Health (Oxf) **17**(10).

More people are migrating than ever before. There are an estimated 1 billion migrants globally-of whom, 258 million are international migrants and 763 million are internal migrants. Almost half of these migrants are women, and most are of reproductive age. Female migration has increased. The socioeconomic contexts of women migrants need investigation to better understand how migration intersects with accessing health care. We employed a focused ethnography design. We recruited 29 women from three African countries: Ghana, Nigeria, and South Africa. We used purposive and convenient sampling techniques and collected data using face-to-face interviews. Interviews were audio-recorded and transcribed verbatim. Data were analyzed with the support of ATLAS.ti 8 Windows (ATLAS.ti Scientific Software Development GmbH), a computer-based qualitative software for data management. We interviewed 10 women from both South Africa and Ghana and nine women from Nigeria. Their ages ranged between 24 and 64 years. The four themes that developed included social connectedness to navigate access to care, the influence of place of origin on access to care, experiences of financial accessibility, and historical and cultural orientation to accessing health care. It was clear that theses factors affected economic migrant women's access to health care after migration. Canada has a universal health care system but multiple research studies have documented that migrants have significant barriers to accessing health care. Most migrants indeed arrive in Canada from a health care system that is very different than their country of origin. Access to health care is one of the most important social determinants of health.

Setia, M. S., et al. (2011). "Access to health-care in Canadian immigrants: a longitudinal study of the National Population Health Survey." Health Soc Care Community **19**(1): 70-79.

Immigrants often lose their health advantage as they start adapting to the ways of the new society.

Having access to care when it is needed is one way that individuals can maintain their health. We assessed the healthcare access in Canadian immigrants and the socioeconomic factors associated with access over a 12-year period. We compared two measures of healthcare access (having a regular doctor and reporting an unmet healthcare need in the past 12 months) among immigrants and Canadian-born men and women, aged more than 18 years. We applied a logistic random effects model to evaluate these outcomes separately, in 3081 males and 4187 females from the National Population Health Survey (1994-2006). Adjusting for all covariates, immigrant men and women (white and non-white) had similar odds of having a regular doctor than the Canadian-born individuals (white immigrants: males OR: 1.32, 95% C.I.: 0.89-1.94, females OR: 1.14, 95% C.I.: 0.78-1.66; non-white immigrants: males OR: 1.28, 95% C.I.: 0.73-2.23, females OR: 1.23, 95% C.I.: 0.64-2.36). Interestingly, non-white immigrant women had significantly fewer unmet health needs (OR: 0.32, 95% C.I.: 0.17-0.59). Among immigrants, time since immigration was associated with having access to a regular doctor (OR per year: 1.02, 95% C.I.: 1.00-1.04). Visible minority female immigrants were least likely to report an unmet healthcare need. In general, there is little evidence that immigrants have worse access to health-care than the Canadian-born population.

Siddiqi, A. A., et al. (2014). "Racial Disparities in Access to Care Under Conditions of Universal Coverage." Am J Prev Med **50**(2):220-225.

BACKGROUND: Racial disparities in access to regular health care have been reported in the U.S., but little is known about the extent of disparities in societies with universal coverage. PURPOSE: To investigate the extent of racial disparities in access to care under conditions of universal coverage by observing the association between race and regular access to a doctor in Canada. METHODS: Racial disparities in access to a regular doctor were calculated using the largest available source of nationally representative data in Canada-the Canadian Community Health Survey. Surveys from 2000-2010 were analyzed in 2014. Multinomial regression analyses predicted odds of having a regular doctor for each racial group compared to whites. Analyses were stratified by immigrant status-Canadian-born versus shorter-term immigrant versus longer-term immigrants-and controlled for sociodemographics and self-rated health. RESULTS: Racial disparities in Canada, a country with universal coverage, were far more muted than those previously reported in the U.S. Only among longer-term Latin American immigrants (OR=1.90, 95% CI=1.45, 2.08) and Canadian-born Aboriginals (OR=1.34, 95% CI=1.22, 1.47) were significant disparities noted. Among shorter-term immigrants, all Asians were more likely than whites, and among longer-term immigrants, South Asians were more like than whites, to have a regular doctor. CONCLUSIONS: Universal coverage may have a major impact on reducing racial disparities in access to health care, although among some subgroups, other factors may also play a role above and beyond health insurance.

Siddiqi, A., et al. (2009). "The role of health insurance in explaining immigrant versus non-immigrant disparities in access to health care: comparing the United States to Canada." Soc Sci Med **69**(10): 1452-1459.

Using a cross-national comparative approach, we examined the influence of health insurance on U.S. immigrant versus non-immigrant disparities in access to primary health care. With data from the 2002/2003 Joint Canada/United States Survey of Health, we gathered evidence using three approaches: 1) we compared health care access among insured and uninsured immigrants and non-immigrants within the U.S.; 2) we contrasted these results with health care access disparities between immigrants and non-immigrants in Canada, a country with universal health care; and 3) we conducted a novel direct comparison of health care access among insured and uninsured U.S. immigrants with Canadian immigrants (all of whom are insured). Outcomes investigated were self-reported unmet medical needs and lack of a regular doctor. Logistic regression models controlled for age, sex, nonwhite status, marital status, education, employment, and self-rated health. In the U.S., odds of unmet medical needs of insured immigrants were similar to those of insured non-immigrants but far greater for uninsured immigrants. The effect of health insurance was even more striking for lack of regular doctor. Within Canada, disparities between immigrants and non-immigrants were similar in magnitude to disparities seen among insured Americans. For both outcomes, direct comparisons of U.S. and Canada revealed significant differences between uninsured American immigrants and Canadian immigrants, but not between insured Americans and Canadians, stratified by nativity.

Findings suggest health care insurance is a critical cause of differences between immigrants and non-immigrants in access to primary care, lending robust support for the expansion of health insurance coverage in the U.S. This study also highlights the usefulness of cross-national comparisons for establishing alternative counterfactuals in studies of disparities in health and health care.

Subedi, R. P. et Rosenberg, M. W. (2014). "Determinants of the variations in self-reported health status among recent and more established immigrants in Canada." Soc Sci Med **115**: 103-110.

Studies have shown that immigrants are normally in better health on arrival compared to their Canadian-born counterparts. However, the health conditions of new immigrants deteriorate after a few years of their arrival in Canada. This phenomenon is popularly termed the "healthy immigrant effect" (HIE) in the immigrant health literature. Although different hypotheses have been proposed to understand HIE, the causes are subject to ongoing discussion. Unlike previous studies, this study explored the possible causes behind the variations in the health status of recent and more established immigrants comparing 2001 and 2010 Canadian Community Health Surveys (CCHS). Four different hypotheses - namely lifestyle change, barriers to health care services, poor social determinants of health, and work related stress - were tested to understand variations in health status. The study concludes that there is a statistically significant difference in the socioeconomic characteristics and health outcomes of immigrants having less than and more than 10 years of residency in Canada. Logistic regression models show that the health conditions of immigrants are associated with age, sex, ethnic origin, smoking habit, Body Mass Index (BMI), total household income, number of consultations made with a family doctor per year and work related stress

Wang, L. et Kwak, M. J. (2015). "Immigration, barriers to healthcare and transnational ties: A case study of South Korean immigrants in Toronto, Canada." Soc Sci Med **133**: 340-348.

The paper analyzes the healthcare-seeking behavior of South Korean immigrants in Toronto, Canada, and how transnationalism shapes post-migration health and health-management strategies. Built upon largely separate research areas in ethnicity and health, health geography, and transnationalism, the paper conceptualizes immigrant health as influenced by individual characteristics, the migration and resettlement experience, and place effects at both a local and a transnational scale. A mixed-method approach is used to capture insights into health status and experiences in accessing local and transnational healthcare among South Korean immigrants - a fast growing visible minority group in Canada. Statistical analysis of data from the Canadian Community Health Survey discloses patterns and trends in health and healthcare use among the Korean Canadian, overall foreign-born, and native-born populations. Focus groups reveal in-depth information on the decline of Korean immigrants' health status and the array of sociocultural, economic and geographic barriers in accessing healthcare in Canada, which gave rise to their transnational use of health resources in the home country. The transnational strategies included traveling to South Korea for medical examinations or treatment, importing medications from South Korea to Canada, and consulting health resources in South Korea by phone or email. The results provide timely knowledge on how a recent immigrant group adapts to Canada in the domain of health and adds a transnational perspective to the literature on ethnicity and health.

Wang, L., et al. (2008). "Ethnicity and utilization of family physicians: a case study of Mainland Chinese immigrants in Toronto, Canada." Soc Sci Med **67**(9): 1410-1422.

This paper seeks to examine how immigrants in a multicultural society access and utilize culturally- and linguistically-diverse family physicians. It focuses on Mainland Chinese (MLC) immigrants - the most important source of immigrants to Canada since 1996 - in the Toronto Census Metropolitan Area (CMA), Canada. Specifically, the paper aims to explore the choice between Chinese-speaking and non-Chinese-speaking family physicians by MLC immigrants and to determine the underlying reasons for MLC immigrants use of ethnically- and linguistically-matched family physicians. A wide range of data are analyzed including survey and focus group data, physician data from the College of Physicians and Surgeons of Ontario (CPSO) and geo-referenced 2001 Canadian Census data. A mixed-method approach is employed combining quantitative analysis of survey data and Census data, spatial analysis

of patient travel behaviour based on the survey and qualitative analysis based on focus groups. The paper reveals an overwhelming preference among MLC survey respondents for Chinese-speaking family physicians regardless of study areas and socioeconomic and demographic status. The focus groups suggest that language, culture and ethnicity are intertwined in a complex way to influence the choice of health care providers and health management strategies in the host society. The paper yields important policy implications for identifying health professional shortage areas for culturally-diverse populations, addressing issues related to foreign-trained physicians and enhancing primary care delivery relevant for immigrant populations.

Wanga, L. et Roisman, D. (2011). "Modeling spatial accessibility of immigrants to culturally diverse family physicians." Prof Geogr **63**(1): 73-91.

This article uses accessibility as an analytical tool to examine health care access among immigrants in a multicultural urban setting. It applies and improves on two widely used accessibility models-the gravity model and the two-step floating catchment area model-in measuring spatial accessibility by Mainland Chinese immigrants in the Toronto Census Metropolitan Area. Empirical data on physician-seeking behaviors are collected through two rounds of questionnaire surveys. Attention is focused on journey to physician location and utilization of linguistically matched family physicians. Based on the survey data, a two-zone accessibility model is developed by relaxing the travel threshold and distance impedance parameters that are traditionally treated as a constant in the accessibility models. General linear models are used to identify relationships among spatial accessibility, geography, and socioeconomic characteristics of Mainland Chinese immigrants. The results suggest a spatial mismatch in the supply of and demand for culturally sensitive care, and residential location is the primary factor that determines spatial accessibility to family physicians. The article yields important policy implications.

Danemark

Cantarero-Arevalo, L., et al. (2013). "Inequalities in asthma treatment among children by country of birth and ancestry: a nationwide study in Denmark." J Epidemiol Community Health **67**(11): 912-917.

BACKGROUND: Investigations in several Western countries have reported ethnic differences in asthma prevalence and treatment among children and in some countries these differences are increasing. The aim of this study was to analyse whether there are inequalities in asthma treatment by country of birth and ancestry among children residing in Denmark, and whether this potential association may vary between different household income groups. METHODS: Data were obtained by linking the Danish Civil Registration System, the Central Taxpayers' Register and the Danish National Prescription Register. POPULATION: the entire population of children in Denmark from 0 to 17 years of age in 2008 (n=1 209 091). Information on asthma treatment was obtained from the National Prescription Register. The analyses included multiple logistic regression models stratified by household income. RESULTS: Compared with ethnic Danes, immigrant children had the lowest OR for redeeming a prescription for asthma medication, both relief (OR 0.37; 95% CIs, 0.20 to 0.68) and preventive (OR 0.37; (0.22 to 0.59)). Similar associations were found among descendant children (OR for relief treatment 0.82 (0.79 to 0.89) and for preventive treatment 0.68 (0.61 to 0.75)). The pattern of the association remained after stratifying for household income. CONCLUSIONS: We found that, inequalities that cannot be explained by household income alone exist in treatments to prevent asthma as well as to relieve symptoms in children residing in Denmark, by country of birth and ancestry. The difference between immigrants and descendants may indicate that unfamiliarity with the Danish healthcare system is a contributory cause of the inadequate treatment of asthma.

Jensen, N. K., et al. (2011). "[Migrant status and access to health-care services in Denmark]." Ugeskr Laeger **173**(34): 2038-2041.

Access to health-care services in Denmark is dependent on migrant status. Emergency care is available to all migrant groups though people not officially residing in the country may be subjected to

payment. For regular immigrants and persons with refugee status access to health-care is regulated by The Health Act, whereas access to non-acute health-care for other migrant groups such as asylum seekers, undocumented migrants and persons subjected to human being trafficking is mainly regulated by The Alien Act. The most vulnerable migrant groups are the ones with the most restricted access to care.

Jensen, N. K., et al. (2011). "Providing medical care for undocumented migrants in Denmark: what are the challenges for health professionals?" BMC Health Serv Res **11**: 154-154. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3150245/

BACKGROUND: The rights of undocumented migrants are frequently overlooked. Denmark has ratified several international conventions recognizing the right to health care for all human beings, but has very scanty legislation and no existing policies for providing health care to undocumented migrants. This study focuses on how health professionals navigate and how they experience providing treatment for undocumented migrants in the Danish health care system. METHODS: The study was carried out as part of an EU-project on European Best Practices in Access, Quality and Appropriateness of Health Services for Immigrants in Europe (EUGATE). This presentation is based on 12 semi-structured interviews with general practitioners (9) and emergency room physicians (3) in Denmark. RESULTS: The emergency room physicians express that treatment of undocumented migrants is no different from the treatment of any other person. However, care may become more complicated due to lack of previous medical records and contact persons. Contrary to this, general practitioners explain that undocumented migrants will encounter formal barriers when trying to obtain treatment. Additional problems in the treatment of undocumented migrants include language issues, financial aspects for general practitioners, concerns about how to handle the situation including possibilities of further referrals, and an uncertainty as to whether to involve the police. CONCLUSIONS: The health professionals in our study describe that undocumented migrants experience an unequal access to primary care facilities and that great uncertainties exist amongst health professionals as how to respond in such situations. The lack of official policies concerning the right to health care for undocumented migrants continue to pass on the responsibility to health professionals and, thereby, leaves it up to the individual to decide whether treatment can be obtained

Espagne

Anton, J. I. et Munoz de Bustillo, R. (2010). "Health care utilisation and immigration in Spain." Eur J Health Econ **11**(5): 487-498.

The aim of this work was to analyse the use of health care services by immigrants in Spain. Using a nationally representative health survey from 2006-2007 and negative binomial and hurdle models, it was found that there is no statistically significant difference in the patterns of visits to general practitioners and hospital stays between migrants and natives in Spain. However, immigrants have a lower access to specialists and visit emergency rooms with a higher frequency than nationals.

Bas-Sarmiento, P., et al. (2015). "[Perceptions and experiences of access to health services and their utilization among the immigrant population]." Gac Sanit **29**(4): 244-251.

OBJECTIVE: To identify and describe the needs and problems of the immigrant population related to access and utilization of health services. METHOD: A descriptive, qualitative, phenomenological study was conducted using focus groups. The study area was the county of Campo de Gibraltar (Spain), which represents the gateway to Europe for immigration from Africa. The final sample size (51 immigrants from 11 countries) was determined by theoretical saturation. A narrative analysis was conducted with QSR NVivo9 software. RESULTS: Immigrants' discourse showed four categories of analysis: response to a health problem, system access, knowledge of social and health resources, and health literacy needs. Responses to health problems and the route of access to the health care system differed according to some sociodemographic characteristics (nationality/culture of origin, length of residence, and economic status). In general, immigrants primarily used emergency services, hampering health promotion and prevention. The health literacy needs identified concerned language

proficiency and the functioning of the health system. CONCLUSIONS: There is a need to promote interventions to enhance health literacy among immigrants. These interventions should take into account diversity and length of residence, and should be based on an action-participation methodology.

Carmona, R., et al. (2014). "[Use of health services for immigrants and native population: a systematic review]." Rev Esp Salud Publica **88**(1): 135-155.

BACKGROUND: Spain was among the top immigration destinations globally between 1990 and 2005, becoming in 2006 in the European country with the highest net migration. As a result of the migration process and the living conditions in the host countries, immigrants' health may be affected. Limited research has investigated access and use of health services for this population. The aim of this study was to describe the scientific evidence on the use of general and specialist medical services for the immigrant population compared to the native. METHODS: Systematic review. It has carried out a search of the national and international scientific literature of comparative studies on the use of general and specialist medical services among immigrant and native since 1994-2013. It was used the MEDLINE database as well as a manual search, no language limit or type of study. The methodological quality of the 29 studies included was evaluated. Subject, context, methodological and extrinsic characteristics were collected for comparison of the included studies. RESULTS: We selected 29 studies on the general practitioners' (9 from Spain) and 15 of specialist physician (7 from Spain), they mainly used health surveys as a source of information. Analyze both the attendance and contact with the general practitioner / specialist by nationality or country of birth (among others), mostly by adjusting variables of need and / or socioeconomic. CONCLUSION: Overall, the immigrant population in Spain have a similar use of general medical services than the native population, and less or similar use of the specialist physician services. These results are in line with studies in other countries.

Carrasco-Garrido, P., et al. (2007). "Health profiles, lifestyles and use of health resources by the immigrant population resident in Spain." Eur J Public Health **17**(5): 503-507.

BACKGROUND: Our study aimed at describing the health profiles, life styles and use of health resources by the immigrant population resident in Spain. METHODS: Cross-sectional, epidemiological study from the Spanish National Health Survey (NHS) in 2003. We analysed 1506 subjects of both sexes, aged > or =16 years, resident in Spain. RESULTS: The immigrant population present diseases that are similar to those of the autochthonous population. The autochthonous population had significantly higher values for alcohol consumption and smoking (60.8 and 39.6%) than immigrants (39.6 and 27.5%). The percentage of immigrants hospitalized in the preceding 12 months was observed to be higher than that of the Spanish population (11.4 vs. 8.2%, P < 0.05). The immigrant population consumed fewer medical drugs than the Spanish population (42.6 and 49.9%, respectively). CONCLUSIONS: Immigrants in Spain display better lifestyle-related parameters, in that they consume less alcohol and smoke less than the autochthonous population. As for the use of health-care resources, while immigrants register higher percentages of hospitalization compared with the Spanish population, there is no evidence of excessive and inappropriate use of other health-care resources.

Castano, J., et al. (2016). "Restricting Access to Health Care to Immigrants in Barcelona: A Mixed-Methods Study With Immigrants Who Have Experienced an Infectious Disease." International Journal of Health Services **46**(2): 241-261.
http://ejournals.ebsco.com/direct.asp?ArticleID=4344B0F18DFF77D58731

Austerity policies implemented in Spain in response to the ongoing economic crisis may have detrimental consequences for the health of immigrant populations and for public health in general. A mixed-methods study by the Public Health Agency of Barcelona and the University of Michigan indicates that the Real Decreto-ley 16/2012 (RDL) threatens the health of individuals and the population, especially in the case of infectious diseases. The study sought to determine the percentage of foreign-born persons with an infectious disease who had an Individual Health Card (IHC) prior to the RDL and to determine whether foreign-born persons with an infectious disease in Barcelona encountered problems accessing health care after the RDL. Results indicate that immigrants used the IHC to seek medical attention for

infectious diseases and chronic conditions. Results also show that 66% of respondents, including 54% of unemployed respondents, 3% of respondents working without contracts, and those in informal employment (9%), may be at risk of losing at least part of their health coverage. Universal health care access in Spain has been crucial for the control of communicable diseases among immigrant populations. Reducing access to a significant percentage of the total population may have deleterious effects on public health.

Cimas, M., et al. (2016). "Healthcare coverage for undocumented migrants in Spain: Regional differences after Royal Decree Law 16/2012." Health Policy **120**(4): 384-395.

?The implementation of the Spanish RDL 16/2012 which took away healthcare coverage for undocumented migrant arose huge differences among regions.?In decentralized health systems, within-country differences in access and/or entitlement can be as relevant as those reported among countries.?Central controversial regulations, such as policies of healthcare exclusion, may be useless if regional authorities have power to overcome them.

Cruz, I., et al. (2010). "Comparison of the consumption of antidepressants in the immigrant and native populations in a Spanish health region: an observational study." BMC Public Health **10**: 255.

BACKGROUND: Health professionals and organizations in developed countries adapt slowly to the increase of ethnically diverse populations attending health care centres. Several studies report that attention to immigrant mental health comes up with barriers in access, diagnosis and therapeutics, threatening equity. This study analyzes differences in exposure to antidepressant drugs between the immigrant and the native population of a Spanish health region. METHODS: Cross-sectional study of the dispensation of antidepressant drugs to the population aged 15 years or older attending the public primary health centres of a health region, 232,717 autochthonous and 33,361 immigrants, during 2008. Data were obtained from computerized medical records and pharmaceutical records of medications dispensed in pharmacies. Age, sex, country of origin, visits, date of entry in the regional health system, generic drugs and active ingredients were considered. Statistical analysis expressed the percentage of persons exposed to antidepressants stratified by age, gender, and country of origin and prevalence ratios of antidepressant exposition were calculated. RESULTS: Antidepressants were dispensed to 11% of native population and 2.6% of immigrants. Depending on age, native women were prescribed antidepressants between 1.9 and 2.7 times more than immigrant women, and native men 2.5 and 3.1 times more than their immigrant counterparts. Among immigrant females, the highest rate was found in the Latin Americans (6.6%) and the lowest in the sub-Saharans (1.4%). Among males, the highest use was also found in the Latin Americans (1.6%) and the lowest in the sub-Saharans (0.7%). The percentage of immigrants prescribed antidepressants increased significantly in relation to the number of years registered with the local health system. Significant differences were found for the new antidepressants, prescribed 8% more in the native population than in immigrants, both in men and in women. CONCLUSIONS: All the immigrants, regardless of the country of origin, had lower antidepressant consumption than the native population of the same age and sex. Latin American women presented the highest levels of consumption, and the sub-Saharan men the lowest. The prescription profiles also differed, since immigrants consumed more generics and fewer recently commercialized active ingredients.

Dalmau-Bueno, A., García-Altés, A., Vela, E., et al. (2021). "Frequency of health-care service use and severity of illness in undocumented migrants in Catalonia, Spain: a population-based, cross-sectional study." Lancet Planet Health **5**(5): e286-e296.

BACKGROUND: In Spain, legislation was passed in 2012 excluding undocumented migrants from the public health-care system. Catalonia was one of the Spanish regions that did not implement this legislation, and continued to guarantee access to health care to the whole population. We aimed to analyse health-care use and health status among undocumented migrants in Catalonia, and compare health-care use and health status with legal residents classified according to their socioeconomic position (SEP). METHODS: We did a population-based, cross-sectional study, with administrative individual data. The study included the resident population in Catalonia, Spain, in 2017, aged younger

than 65 years and with a maximum annual income of less than €18 000 per year, and classified into three socioeconomic (SEP) groups-low SEP, very low SEP, and undocumented migrants. Indicators regarding health-care service use (primary care, emergency care, mental health care, acute care), drug prescriptions, and selected chronic and infectious diseases were analysed. FINDINGS: Between Jan 1 and Dec 31, 2017, 4 071 988 residents of Catalonia were included in this study; undocumented migrants represented 2·8% (n=113 450) of this population. Of all undocumented migrants, 25 942 (61·0%) female participants aged 15-64 years and 19 819 (46·0%) male participants aged 15-64 years attended primary health-care centres: these rates were lower than in individuals with a very low SEP (84·8% in female participants and 72·1% in male participants). Hospital admission rates among male participants aged 15-64 years in the very low SEP group were more than three times as high as in undocumented migrants (111·6 vs 35·7). The highest tuberculosis rate was found in undocumented male migrants (incidence rate 4·35 [95% CI 3·55-5·16]). INTERPRETATION: Undocumented migrants made less use of health-care services than those in the low and very low SEP groups, but for some infectious diseases, incidence was higher in undocumented migrants. These results constitute an additional argument to support the maintenance of universal health coverage for all citizens. FUNDING: None.

Fuertes Goni, M. C., et al. (2010). "[Care for immigrant patients: facts and professionals' perception in 6 primary health care zones in Navarre]." An Sist Sanit Navar **33**(2): 179-190.

BACKGROUND: To describe utilisation of health care services and motives for consultation in Primary Care in the native and the immigrant population, and compare this with the perception of primary care professionals. METHODS: Data was collected on health care activity during the year 2006 for all people registered (N=86,966) in the 6 basic health care zones with the highest proportion of immigrants (14.4%) and on the following variables: country of origin, age, sex, year of inscription in the public health service. The health card and OMI-AP programme databases were used. A qualitative methodology of focus groups and in-depth interviews was employed. RESULTS: Seventy-two point four percent of immigrants requested care from the primary care professionals in 2006, of whom 50% proceeded from Ecuador and 70% were between 25 and 44 years old. Eighty-two percent of the natives made consultations and required more referrals to specialised care than the immigrants of the same age group. The most frequent consultation with natives and with immigrants was "acute respiratory infections" (7 to 23% according to age group). The second most frequent with immigrants was "administrative problems". The consultations with immigrants were not related to preventive aspects such as smoking and there were more consultations (p>0.001) for gynaeco-obstetric episodes (10.7%) and those related to work (19%) or psychosomatic problems (8.5%). The perception of the primary care professionals was that the immigrants carry out more consultations than the natives and generate a certain "disorder" in the clinic. CONCLUSION: Immigrants use healthcare services less than the native population. Nonetheless, this fact is not perceived in this way by the primary care professionals. Fewer preventive activities are carried out with immigrants, who suffer from more labour and psychosomatic problems.

Gimeno-Feliu, L. A., et al. (2015). "The healthy migrant effect in primary care." Gac Sanit **29**(1): 15-20.

OBJECTIVE: To compare the morbidity burden of immigrants and natives residing in Aragon, Spain, based on patient registries in primary care, which represents individuals' first contact with the health system. METHODS: A retrospective observational study was carried out, based on linking electronic primary care medical records to patients' health insurance cards. The study population consisted of the entire population assigned to general practices in Aragon, Spain (1,251,540 individuals, of whom 12% were immigrants). We studied the morbidity profiles of both the immigrant and native populations using the Adjusted Clinical Group System. Logistic regressions were conducted to compare the morbidity burden of immigrants and natives after adjustment for age and gender. RESULTS: Our study confirmed the "healthy immigrant effect", particularly for immigrant men. Relative to the native population, the prevalence rates of the most frequent diseases were lower among immigrants. The percentage of the population showing a moderate to very high morbidity burden was higher among natives (52%) than among Latin Americans (33%), Africans (29%), western Europeans (27%), eastern Europeans and North Americans (26%) and/or Asians (20%). Differences were smaller for immigrants

who had lived in the country for 5 years or longer. CONCLUSION: Length of stay in the host country had a decisive influence on the morbidity burden represented by immigrants, although the health status of both men and women worsened with longer stay in the host country.

Gimeno-Feliu, L. A., et al. (2013). "Differences in the use of primary care services between Spanish national and immigrant patients." J Immigr Minor Health **15**(3): 584-590.

Knowing what real use is made of health services by immigrant population is of great interest. The objectives are to analyze the use of primary care services by immigrants compared to Spanish nationals and to analyze these differences in relation to geographic origin. Retrospective observational study of all primary care visits made in 26 urban health centers. Main variable: total number of health centre visits/year. DEPENDENT VARIABLES: type of clinician requested; type of attention, and origin of immigrants. The independent variable was nationality. Statistics were obtained from the electronic medical records. The 4,933,521 appointments made in 2007 were analyzed for a reference population of 594,145 people (11.15% immigrants). The adjusted annual frequency for nationals was 8.3, versus whereas 4.6 for immigrants. The immigrant population makes less use of primary care services than national population. This is evident for all age groups and regardless of the immigrants' countries of origin. This result is important when planning health care resources for immigrant population.

Heras-Mosteiro, J., et al. (2016). "Health Care Austerity Measures in Times of Crisis: The Perspectives of Primary Health Care Physicians in Madrid, Spain." International Journal of Health Services **46**(2): 283-299. http://ejournals.ebsco.com/direct.asp?ArticleID=49278419B4EE515A7E00

The current financial crisis has seen severe austerity measures imposed on the Spanish health care system, including reduced public spending, copayments, salary reductions, and reduced services for undocumented migrants. However, the impacts have not been well-documented. We present findings from a qualitative study that explores the perceptions of primary health care physicians in Madrid, Spain. This article discusses the effects of austerity measures implemented in the public health care system and their potential impacts on access and utilization of primary health care services. This is the first study, to our knowledge, exploring the health care experiences during the financial crisis of general practitioners in Madrid, Spain. The majority of participating physicians disapproved of austerity measures implemented in Spain. The findings of this study suggest that undocumented migrants should regain access to health care services; copayments should be minimized and removed for patients with low incomes; and health care professionals should receive additional help to avoid burnout. Failure to implement these measures could result in the quality of health care further deteriorating and could potentially have long-term negative consequences on population health.

Hernandez-Quevedo, C. et Jimenez-Rubio, D. (2009). "A comparison of the health status and health care utilization patterns between foreigners and the national population in Spain: new evidence from the Spanish National Health Survey." Soc Sci Med **69**(3): 370-378.

The increasing proportion of immigrants in Spanish society is placing pressure on the National Health Care System to accommodate the needs of this population group while keeping costs under control. In the year 2000, a law was approved in Spain according to which all people, regardless of their nationality, are entitled to use health care services under the same conditions as Spanish citizens, provided that they are registered in the local population census. However, empirical evidence about differences in health status and health care utilization between the immigrant and the Spanish population is insufficient. This paper uses the 2003 and 2006 Spanish National Health Surveys to explore the existence of inequalities in health and in the access to health services for the immigrant population living in Spain, relative to that of Spaniards. Our results show that there are different patterns in the level of health and the medical care use between the national and the foreign population in Spain: while immigrants' self-reported health relative to that of the Spanish population depends upon individual nationality, all immigrants, regardless of their nationality, seem to face barriers of entry to specialized care. Further research is needed to understand the nature of these barriers in order to design more effective health policies.

Jenny, C., et al. (2016). "Restricting Access to Health Care to Immigrants in Barcelona: A Mixed-Methods Study

With Immigrants Who Have Experienced an Infectious Disease." International Journal of Health Services **46**(2): 241-261.

Austerity policies implemented in Spain in response to the ongoing economic crisis may have detrimental consequences for the health of immigrant populations and for public health in general. A mixed-methods study by the Public Health Agency of Barcelona and the University of Michigan indicates that the Real Decreto-ley 16/2012 (RDL) threatens the health of individuals and the population, especially in the case of infectious diseases. The study sought to determine the percentage of foreign-born persons with an infectious disease who had an Individual Health Card (IHC) prior to the RDL and to determine whether foreign-born persons with an infectious disease in Barcelona encountered problems accessing health care after the RDL. Results indicate that immigrants used the IHC to seek medical attention for infectious diseases and chronic conditions. Results also show that 66% of respondents, including 54% of unemployed respondents, 3% of respondents working without contracts, and those in informal employment (9%), may be at risk of losing at least part of their health coverage. Universal health care access in Spain has been crucial for the control of communicable diseases among immigrant populations. Reducing access to a significant percentage of the total population may have deleterious effects on public health.

Jimenez-Rubio, D. et Hernandez-Quevedo, C. (2011). "Inequalities in the use of health services between immigrants and the native population in Spain: what is driving the differences?" Eur J Health Econ **12**(1): 17-28.

In Spain, a growing body of literature has drawn attention to analysing the differences in health and health resource utilisation of immigrants relative to the autochthonous population. The results of these studies generally find substantial variations in health-related patterns between both population groups. In this study, we use the Oaxaca-Blinder decomposition technique to explore to what extent disparities in the probability of using medical care use can be attributed to differences in the determinants of use due to, e.g. a different demographic structure of the immigrant collective, rather than to a different effect of health care use determinants by nationality, holding all other factors equal. Our findings show that unexplained factors associated to immigrant status determine to a great extent disparities in the probability of using hospital, specialist and emergency services of immigrants relative to Spaniards, while individual characteristics, in particular self-reported health and chronic conditions, are much more important in explaining the differences in the probability of using general practitioner services between immigrants and Spaniards.

Llop-Girones, A., et al. (2014). "[Immigrants' access to health care in Spain: a review]." Rev Esp Salud Publica **88**(6): 715-734.

BACKGROUND: An important proportion of the population in Spain is immigrant and the international literature indicates their inadequate access to health services. The objective is to contribute to improving the knowledge on access to health care of the immigrant population in Spain. METHODS: Review of original papers published (1998-2012) on access to health services of the immigrant population in Spain published in Medline and MEDES. Out of 319 studies, 20 were selected, applying predefined criteria. The results were analyzed using the Aday and Andersen framework. RESULTS: Among the publications, 13 quantitative studies analysed differences in health care use between the immigrant and the native population, and 7 studied determinants of access of immigrants. Studies showed less use of specialized care by immigrants, higher use of emergency care and no differences in the use of primary care between groups. Five quantitative articles on determinants of access focused on factors related to the immigrant population (sex, age, educational level and holding private health insurance), but without observing clear patterns. The two qualitative studies analyzed factors related to health services, describing access to healthcare barriers such as the limited provision of information or the requirements for personal health card. CONCLUSION: Access to health care in immigrants has been scarcely studied, using different approaches and the barely analysed factors related to the services. No clear patterns were observed, as differences depend on the classification of migrants according to country of origin and the level of care. However, studies showed less use of specialized care by immigrants, higher use of emergency care and the existence of determinants of access

different to their needs.

Lopez Nicolas, A. et Ramos Parreno, J. M. (2009). "[Health services utilization by the immigrant and native-born populations in the autonomous region of Murcia (Spain)]." Gac Sanit **23 Suppl 1**: 12-18.

OBJECTIVE: To analyze the patterns of utilisation for three types of public health services (outpatient specialist visits, emergency visits and hospitalisations) in the Comunidad Autonoma de la Region de Murcia. We examine the differences between the average rates of utilization of these services among natives and non-Spanish immigrants, and whether these differences are due to differences in demographic structure, or to different behaviour between these groups. METHODS: We use econometric models for utilisation to exploit administrative records on health care utilisation and the well established Oaxaca decomposition method. This splits average rates of utilisation and/or average health expenditure into two components: the first one stands for the part of the difference that can be attributed to differential patterns of behaviour among the two groups; the second one represents the part of the difference in average expenditure that can be attributed to the fact that average demographic characteristics among both groups differ. RESULTS: The rates of use of outpatient specialist visits, emergencies and hospital nights by the native population are greater than the corresponding rates for the immigrant population. For individuals aged between 20 to 40 years old, the utilisation rates of African and Latin-American females are higher than those for native females. The average health expenditure of native males is greater than that of immigrants. The difference is mainly due to different demographic features among the native and immigrant populations, except for the <<rest of Europe>> group, whose individuals show a different behaviour. In fact, among the 20 to 40 age group, the average health expenditure of native females equals that of Latin-American women, which is in turn below that of African females. CONCLUSIONS: In this paper we show that the remarkable differences in the age-gender balance among different (in terms of nationality) groups of insured residents in Murcia has a considerable effect on consumption of health services and therefore on the average health care expenditure attributable to these groups.

Munoz, M. A., et al. (2012). "Primary health care utilization by immigrants as compared to the native population: a multilevel analysis of a large clinical database in Catalonia." Eur J Gen Pract **18**(2): 100-106.

BACKGROUND: Immigration is a relevant public health issue and there is a great deal of controversy surrounding its impact on health services utilization. OBJECTIVE: To determine differences between immigrants and non-immigrants in the utilization of primary health care services in Catalonia, Spain. METHODS: Population based, cross-sectional, multicentre study. We used the information from 16 primary health care centres in an area near Barcelona, Spain. We conducted a multilevel analysis for the year 2008 to compare primary health care services utilization between all immigrants aged 15 or more and a sample of non-immigrants, paired by age and sex. RESULTS: Overall, immigrants living in Spain used health services more than non-immigrants (Incidence Risk Ratio (IRR) 1.16 (95% Confidence Interval (CI): 1.15-1.16) and (IRR 1, 26, 95% CI: 1.25-1.28) for consultations with GPs and referrals to specialized care, respectively. People coming from the Maghreb and the rest of Africa requested the most consultations involving a GP and nurses (IRR 1.34, 95% CI: 1.33-1.36 and IRR 1.06, 95% CI: 1.03-1.44, respectively). They were more frequently referred to specialized care (IRR 1.44, 95% CI: 1.41-1.46) when compared to Spaniards. Immigrants from Asia had the lowest numbers of consultations with a GP and referrals (IRR 0.76, 95% CI: 0.66-0.88 and IRR 0.76, 95% CI: 0.61-0.95, respectively. CONCLUSION: On average, immigrants living in Catalonia used the health services more than non-immigrants. Immigrants from the Maghreb and other African countries showed the highest and those from Asia the lowest, number of consultations and referrals to specialized care.

Munoz-de Bustillo, R. et Anton Perez, J. I. (2010). "[Use of public health services by Latin American immigrants in Spain]." Salud Publica Mex **52**(4): 357-363.

OBJECTIVE: To identify patterns of public health care utilization by Latin American immigrants in Spain as compared to the local population. MATERIAL AND METHODS: This analysis is based on information provided by the 2006 National Health Survey on the frequency of visits to general practitioners,

specialists and emergency rooms, as well as hospital stays. The study uses a descriptive analysis involving tests of equality of distributions, medians and proportions, and a multivariate analysis with binomial negative and probit models. RESULTS: The distribution of Latin American immigrants show lower utilization rates of public health care services than the native-born population, with the exception of hospital stays. The pattern of health care use by Latin Americans and Spaniards is different, with the exception of hospital stays. The results of the multivariate analysis indicate statistically significant differences only in the case of hospital stays (the probability of staying in a hospital in the last year is 2.8% higher for Latin American immigrants than among locals) and utilization of emergency rooms (0.205 more visits than the Spanish-born population). CONCLUSIONS: There is no significant difference in utilization of public health care between Latin American immigrants and native-born populations in Spain, with the exception of a higher frequency of use of emergency rooms by the former.

Organisation Mondiale de la Santé (2018). Spain : assessing health-system capacity to manage sudden large influxes of migrants. Copenhague OMS Bureau régional de l'Europe**:** vi+19.
http://www.euro.who.int/__data/assets/pdf_file/0004/373216/spain-report-eng.pdf

The large numbers of migrants arriving from North Africa and the Middle East to Mediterranean countries pose new challenges to the recipient health systems, which must adapt and respond to the needs of both migrants and residents. This requires an efficient policy dialogue between the main stakeholders to share experiences and identify best practices. The WHO Regional Office for Europe provides advice and technical assistance through the Migration and Health Programme. This was established in 2012 as the Public Health Aspects of Migration in Europe project in response to the 2008 World Health Assembly resolution WHA61.17, the 2010 Global Consultation on Migrant Health and Health 2020. An assessment in Spain in 2014 involved all relevant stakeholders with the aim of strengthening the country's capacity to address public health implications of large immigration flows. The WHO toolkit was used during interviews and field visits. This report summarizes the results under the six functions of the WHO health system framework.

Otero-Garcia, L., et al. (2013). "Access to and use of sexual and reproductive health services provided by midwives among rural immigrant women in Spain: midwives' perspectives." Glob Health Action **6**: 22645.

BACKGROUND: There insufficient information regarding access and participation of immigrant women in Spain in sexual and reproductive health programs. Recent studies show their lower participation rate in gynecological cancer screening programs; however, little is known about the participation in other sexual and reproductive health programs by immigrant women living in rural areas with high population dispersion. OBJECTIVES: The objective of this study is to explore the perceptions of midwives who provide these services regarding immigrant women's access and participation in sexual and reproductive health programs offered in a rural area. DESIGN: A qualitative study was performed, within a larger ethnographic study about rural primary care, with data collection based on in-depth interviews and field notes. Participants were the midwives in primary care serving 13 rural basic health zones (BHZ) of Segovia, a region of Spain with high population dispersion. An interview script was designed to collect information about midwives' perceptions on immigrant women's access to and use of the healthcare services that they provide. Interviews were recorded and transcribed with participant informed consent. Data were analyzed based on the qualitative content analysis approach and triangulation of results with fieldwork notes. RESULTS: Midwives perceive that immigrants in general, and immigrant women in particular, underuse family planning services. This underutilization is associated with cultural differences and gender inequality. They also believe that the number of voluntary pregnancy interruptions among immigrant women is elevated and identify childbearing and childrearing-related tasks and the language barrier as obstacles to immigrant women accessing the available prenatal and postnatal healthcare services. CONCLUSIONS: Immigrant women's underutilization of midwifery services may be linked to the greater number of unintended pregnancies, pregnancy terminations, and the delay in the first prenatal visit, as discerned by midwives. Future research should involve samples of immigrant women themselves, to provide a deeper understanding of the current knowledge, attitudes, and practices of the immigrant population

regarding reproductive and sexual health to provide better health services.

Peralta-Gallego, L., Gené-Badia, J. et Gallo, P. (2018). "Effects of undocumented immigrants exclusion from health care coverage in Spain." Health Policy **122**(11): 1155-1160. http://www.sciencedirect.com/science/article/pii/S0168851018304160

Background In 2012 the Spanish government passed Royal Decree-Law 16/2012 (RDL) aimed at containing public expenditure in response to the economic crisis. This RDL redefined just who would be entitled to public health care. As a result, a large proportion of undocumented immigrants in Spain were excluded from basic publicly financed health care with access only being granted under particular circumstances (emergency care, maternal care, children under 18, asylum seekers and victims of human trafficking). Aim The aims of this paper are to identify the specific traits of this policy, review its impact on health and health care access, and to evaluate its economic impact. Results Most political parties and health professional groups opposed the RDL, and a large number of Spanish regions either declined to apply it or opted to apply it partially. To date, the RDL has had a considerable impact on the access of undocumented immigrants to public health care, with evidence suggesting that approximately 870,000 people have been excluded. A slight increase in infectious diseases has been reported, albeit not as high as originally predicted, and recent evidence points to an increase in mortality among this population subgroup. Conclusions Regional legislation favouring the coverage of undocumented immigrants might have acted as a counterweight and thus contained the negative health effects in this population subgroup. But the Constitutional Court invalidated all regional arrangements obliging regions to comply with the RDL.

Rue, M., et al. (2008). "Emergency hospital services utilization in Lleida (Spain): A cross-sectional study of immigrant and Spanish-born populations." BMC Health Serv Res **8**: 81.

BACKGROUND: The use of emergency hospital services (EHS) has increased steadily in Spain in the last decade while the number of immigrants has increased dramatically. Studies show that immigrants use EHS differently than native-born individuals, and this work investigates demographics, diagnoses and utilization rates of EHS in Lleida (Spain). METHODS: Cross-sectional study of all the 96,916 EHS visits by patients 15 to 64 years old, attended during the years 2004 and 2005 in a public teaching hospital. Demographic data, diagnoses of the EHS visits, frequency of hospital admissions, mortality and diagnoses at hospital discharge were obtained. Utilization rates were estimated by group of origin. Poisson regression was used to estimate the rate ratios of being visited in the EHS with respect to the Spanish-born population. RESULTS: Immigrants from low-income countries use EHS services more than the Spanish-born population. Differences in utilization patterns are particularly marked for Maghrebi men and women and sub-Saharan women. Immigrant males are at lower risk of being admitted to the hospital, as compared with Spanish-born males. On the other hand, immigrant women are at higher risk of being admitted. After excluding the visits with gynecologic and obstetric diagnoses, women from sub-Saharan Africa and the Maghreb are still at a higher risk of being admitted than their Spanish-born counterparts. CONCLUSION: In Lleida (Spain), immigrants use more EHS than the Spanish born population. Future research should indicate whether the same pattern is found in other areas of Spain and whether EHS use is attributable to health needs, barriers to access to the primary care services or similarities in the way immigrants access health care in their countries of origin.

Ruiz-Azarola, A., Escudero Carretero, M., López-Fernández, L. A., et al. (2020). "[The perspective of migrants on access to health care in the context of austerity policies in Andalusia (Spain)]." Gac Sanit **34**(3): 261-267.

OBJECTIVE: To conduct an assessment of migrant people regarding their access to the health system following entry into force of Royal Decree-Law 16/2012 along with the impact of economic cuts on such access. METHOD: Qualitative phenomenological study with semi-structured interviews, conducted in Andalusia (Spain), in two phases (2009-2010 and 2012-2013), with 36 participants. The sample was segmented by length of stay, nationality and area of residence. The nationalities of origin are Bolivia, Morocco and Romania. RESULTS: Elements facilitating access in both periods: regular administrative situation, possession of Individual Health Card, knowledge of the language, social networks and information. The results show differences in access to health care for migrants before

and after the enforcement of the RDL 16/2012, within austerity policies. In the second period, access barriers such as waiting times or incompatibility of schedules are aggravated and the socio-economic and administrative conditions of participants worsen. CONCLUSIONS: The design of policies, economic and regulatory health care, should take into account barriers and facilitators of access as fundamental main points of health protection for migrants and, therefore, for the general population.

Saurina, C. et Vall-Ilosera, L. (2012). "Factors determining access to and use of primary health care services in the Girona Health Region (Spain)." European Journal of Health Economics (The) **13**(4): 419-427.

Increased population flowing from abroad has generated an intense debate regarding the economic consequences of migration in public services such as health, where new and specific demands are being created. This new demand for health care gives rise to the need to identify those factors which influence the user's decision to contact the health services and those which determine the quantity of services consumed. The aim of this study is to identify which variables affect these two stages of the use of such services in the Girona Health Region (RSG), where immigrant population represents 21.96% of the total population. Specificati- on of a Hurdle model with a count response variable related to primary health care service visits in the RSG for 2006. The study data is based on a sample of users (immigrants and natives) taken from the population assigned to primary health care services in eight Basic Health Areas (ABS) of the RSG. Contacting primary health care services is associated with variables that ought to affect use of health care such as chronic illness and taking prescribed medication as well as being aged between 46 and 55. Using primary health care services once makes users more likely to make further visits. The number of visits is related not only with variables that ought affect use of health care but also with variables that ought not to affect use of health care such as working without a contract, living in rented accommodation, or being unemployed. Additionally, if we consider the birthplace of the user, we observe the same pattern, with different directions and intensities, depending on the origin of the patient. For example, a higher likelihood of first contact is shown in Eastern Europeans, South Americans, and North Africans that suffer from cholesterol. A higher attendance is observed in natives and Eastern Europeans that take prescribed medication as well as natives, Eastern Europeans, and North Africans living in rented accommodation. On the other hand, working without a contract supposes a higher attendance in natives but a lower attendance in Eastern Europeans and sub-Saharan Africans. We do not detect any socioeconomic barriers associated with making a first contact with primary health services for the users analyzed. However, we do note evidence of horizontal inequity in terms of attending health services, related to variables that ought to affect use of health care as well as socioeconomic factors (variables that ought not to affect use of health care). The user's origin is an important key in detecting different intensities of access and regular visits to primary health care services

Serre-Delcor, N., Oliveira, I., Moreno, R., et al. (2021). "A Cross-Sectional Survey on Professionals to Assess Health Needs of Newly Arrived Migrants in Spain." Front Public Health **9**: 667251.

Heightened conflicts and lack of safety due to reasons related to economic, social, ethnic, religious, sexual orientation, political, or nationality matters have increased migratory movements during the last, few decades. Unfortunately, when migrants arrive in new territories, they can face many barriers. For example, in Spain, some migrants have difficulties in accessing health services. The main objective of this study was to describe, from the perspective of social and healthcare professionals, health needs and barriers faced among migrants who recently arrived in Spain when accessing the health system. To accomplish this aim, we carried out a cross-sectional descriptive study using a newly created self-administered questionnaire. Statistical analysis was done using the SPSS 23.00(®) program. Survey collection was from April 2018 to October 2018, and the cohort comprised a total of 228 professionals. Most participants were females (76%), with an average age of 35 years [interquartile range (IQR) 29.8-43.0]. The most represented profession in the cohort was physician (48%), followed by social care professionals (32%), nursing (11%), and other (8%). Of these individuals, 61% stated having either little or limited knowledge of international migrant health rights, and 94% believed migrants must overcome barriers to receive health services. The four most reported barriers were as follows: language, cultural differences, administrative issues, and fear of being undocumented. Additionally, by order of importance, professionals viewed mental health disorders and infectious diseases as the most

common contributors to disease burden in this group. The four most popular strategies implemented by professionals to improve healthcare access further for migrants included intercultural competency training for professionals; access to community health agents; access to translators; and development of health system navigation skills among those newly arrived. Study results suggest that governments should make greater efforts to provide social and healthcare professionals with more effective tools that overcome communication barriers and cultural competence training modules.

Vazquez, M. L., et al. (2013). "Are migrants health policies aimed at improving access to quality healthcare? An analysis of Spanish policies." Health Policy **113**(3): 236-246.

Although until April 2012, all Spanish citizens regardless of their origin, residence status and work situation were entitled to health care, available evidence suggested inadequate access for immigrants. Following the Aday and Andersen model, we conducted an analysis of policy elements that affect immigrants' access to health care in Spain, based on documentary analysis of national policies and selected regional policies related to migrant health care. Selected documents were (a) laws and plans in force at the time containing migrant health policies and (b) evaluations. The analysis included policy principles, objectives, strategies and evaluations. Results show that the national and regional policies analyzed are based on the principle that health care is a right granted to immigrants by law. These policies include strategies to facilitate access to health care, reducing barriers for entry to the system, for example simplifying requirements and raising awareness, but mostly they address the necessary qualities for services to be able to attend to a more diverse population, such as the adaptation of resources and programs, or improved communication and training. However, limited planning was identified in terms of their implementation, necessary resources and evaluation. In conclusion, the policies address relevant barriers of access for migrants and signal improvements in the health system's responsiveness, but reinforcement is required in order for them to be effectively implemented

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Vazquez, M. L., et al. (2014). "[The impact of the economic crisis on the health and healthcare of the immigrant population. SESPAS report 2014]." Gac Sanit **28 Suppl 1**: 142-146.

Despite the economic crisis, the immigrant population of Spain continues to be high, with 5.7 million persons (11.4%). This population, whose health needs are similar to those of the general population, is more vulnerable due to their exposure to worse social determinants (living and working conditions together with a higher risk of exclusion from social services). In this article, we analyze how the economic crisis affects or can affect the health of the immigrant population in Spain by examining distinct population-specific or institutional factors that influence the effects of the crisis and the

available data. The available evidence is limited, but several effects can be identified: firstly, some social determinants, such as higher unemployment rates and worse working conditions, have deteriorated, which can be expected to lead to a worsening of health status. These consequences have already been described for mental health or have been estimated for infectious diseases. Secondly, political decisions have had a direct impact, excluding-with some exceptions-undocumented immigrants from the right to health care. Finally, the lower priority given to adapting health services to the specific characteristics of the immigrant population (most of whom are documented) together with the introduction of new barriers, has hampered or will hamper access to health care. As a result, the economic crisis can be expected to have a greater impact on the immigrant population.

Velasco, C., et al. (2015). "[Immigrant perceptions of the Spanish National Healthcare System and its services]." Aten Primaria.

OBJECTIVE: To analyse the perception, use and satisfaction of a group of immigrants living in Barcelona taking into account their gender, origin and social class. DESIGN: Cross sectional study. LOCATION: City of Barcelona, Spain. PARTICIPANTS: A group of 225 immigrant residents and users of social services in the city of Barcelona, from June to July 2012. MAIN MEASURES: the level of access and relationship with the public health system of immigrants living in Barcelona was analysed, based on a questionnaire. The responses were analysed in relation to: gender, age, social class, self-perceived health, national origin, time since arrival, and marital status. RESULTS: The large majority (89%) of the population surveyed declared that the most important aspect was <<to have been treated with respect>> in health services. However, 59.4% reported a perception of <<discrimination against immigrants>>, and 68.4% said that cultural differences affect <<totally or partially>> the quality of care received. For 66.7% of the participants, health care received in Barcelona is better than in their home country, mainly for its scientific, technical quality, and universal access. CONCLUSIONS: Despite the good assessment of universal public health care system this study showed deficiencies of the system in terms of the psychosocial component of health care to immigrants in Barcelona. It is necessary to deepen the study of knowledge and perceptions of minority groups in the current context.

Velasco, M., et al. (2012). "Differences in the use of health resources by Spanish and immigrant HIV-infected patients." Enferm Infecc Microbiol Clin **30**(8): 458-462.

BACKGROUND: HIV-immigrant use of health services and related cost has hardly been analysed. We compared resource utilisation patterns and direct health care costs between Spanish and immigrant HIV-infected patients. METHODS: All HIV-infected adult patients treated during the years 2003-2005 (372 patients) in this hospital were included. We evaluated the number of out-patient, Emergency Room (ER) and Day-care Unit visits, and number and length of admissions. Direct costs were analysed. We compared all variables between immigrant and Spanish patients. RESULTS: Immigrants represented 12% (n=43) of the cohort. There were no differences in the number of out-patient, ER, and day-care hospital visits per patient between both groups. The number of hospital admissions per patient for any cause was higher in immigrant than in Spanish patients, 1.3 (4.4) versus 0.9 (2.7), P=.034. A high proportion of visits, both for the immigrant (45.1%) and Spanish patients (43.0%), took place in services other than Infectious Diseases. Mean unitary cost per patient per admission, out-patient visits and ER visits were similar between groups. Pharmacy costs per year was higher in Spanish patients than in immigrants (7351.8 versus 7153.9 euros [year 2005], P=.012). There were no differences in the total cost per patient per year between both groups. The global distribution of cost was very similar between both groups; almost 75% of the total cost was attributed to pharmacy in both groups. CONCLUSIONS: There are no significant differences in health resource utilisation and associated costs between immigrant and Spanish HIV patients.

Villarroel, N. et Artazcoz, L. (2015). "Different Patterns in Health Care Use Among Immigrants in Spain." J Immigr Minor Health.

This study aims to analyze the differences in the use of primary care (PC), hospital, and emergency services between people born in Spain and immigrants. Data were obtained from the 2006 Spanish

National Health Survey. The sample was composed of individuals aged 16-64 years from Spain and the seven countries with most immigrants in Spain (n = 22,224). Hierarchical multiple logistic regression models were fitted. Romanian men were less likely to use health care at all levels compared to men from other countries. Women from Argentina, Bolivia and Ecuador reported a lower use of PC. Among women, there were no differences in emergency visits or hospitalizations between countries. Bolivian men reported more hospitalizations than Spanish men, whereas Argentinean men reported more emergency visits than their Spanish counterparts. In Spain, most immigrants made less than, or about the same use of health care services as the native Spanish population.

Etats-Unis

(2009). "Inadequate health care for migrants in the USA." Lancet **373**(9669): 1053.

Ahmed, N. U., et al. (2013). "Factors explaining racial/ethnic disparities in rates of physician recommendation for colorectal cancer screening." American Journal of Public Health **103**(7): e91-e99.

Objectives. Physician recommendation plays a crucial role in receiving endoscopic screening for colorectal cancer (CRC). This study explored factors associated with racial/ethnic differences in rates of screening recommendation. Methods. Data on 5900 adults eligible for endoscopic screening were obtained from the National Health Interview Survey. Odds ratios of receiving an endoscopy recommendation were calculated for selected variables. Planned, sequenced logistic regressions were conducted to examine the extent to which socioeconomic and health care variables account for racial/ethnic disparities in recommendation rates. Results. Differential rates were observed for CRC screening and screening recommendations among racial/ethnic groups. Compared with Whites, Hispanics were 34% less likely (P < .01) and Blacks were 26% less likely (P < .05) to receive this recommendation. The main predictors that emerged in sequenced analysis were education for Hispanics and Blacks and income for Blacks. After accounting for the effects of usual source of care, insurance coverage, and education, the disparity reduced and became statistically insignificant. Conclusions. Socioeconomic status and access to health care may explain major racial/ethnic disparities in CRC screening recommendation rates

Akbulut-Yuksel, M. et Kugler, A. D. (2016). Intergenerational Persistence of Health in the U.S.: Do Immigrants Get Healthier as they Assimilate? NBER Working Paper Series ; n° 21987. Cambridge NBER**:** 24 , tabl., fig. http://www.nber.org/papers/w21987

It is well known that a substantial part of income and education is passed on from parents to children, generating substantial persistence in socio-economic status across generations. In this paper, we examine whether another form of human capital, health, is also largely transmitted from generation to generation, contributing to limited socio-economic mobility. Using data from the NLSY, we first present new evidence on intergenerational transmission of health outcomes in the U.S., including weight, height, the body mass index (BMI), asthma and depression for both natives and immigrants. We show that both native and immigrant children inherit a prominent fraction of their health status from their parents, and that, on average, immigrants experience higher persistence than natives in weight and BMI. We also find that mothers' education decreases children's weight and BMI for natives, while single motherhood increases weight and BMI for both native and immigrant children. Finally, we find that the longer immigrants remain in the U.S., the less intergenerational persistence there is and the more immigrants look like native children. Unfortunately, the more generations immigrant families remain in the U.S., the more children of immigrants resemble natives' higher weights, higher BMI and increased propensity to suffer from asthma.

Armstrong, K., et al. (2013). "Prior Experiences of Racial Discrimination and Racial Differences in Health Care System Distrust." Medical Care **51**(2).

Purpose: Factors contributing to racial differences in health care system distrust (HCSD) are currently unknown. Proposed potential contributing factors are prior experiences of racial discrimination and racial residential segregation. Methods: Random digit dialing survey of 762 African American and 1267

white adults living in 40 US metropolitan statistical areas. Measures included the Revised Health Care System Distrust scale, the Experiences of Discrimination scale, metrics of access to care, sociodemographic characteristics, and the level of racial residential segregation in the city (using the isolation index). Results: In unadjusted analyses, African Americans had higher levels of HCSD, particularly values distrust, and greater experiences of discrimination. Experience of discrimination was also strongly associated with HCSD. Adjusting for sociodemographic characteristics, health care access, and residential segregation had little effect on the association between African American race and overall HCSD or values distrust. In contrast, adjusting for experiences of racial discrimination reversed the association so that distrust was lower among African Americans than whites (odds ratio 0.53; 95% confidence interval, 0.33ƒ_"0.85 for the overall measure). The Sobel test for mediation was strongly significant (P<0.001). Conclusions: Higher HCSD among African Americans is explained by a greater burden of experiences of racial discrimination than whites. Reasons for higher distrust among whites after adjusting for experiences of racial discrimination are not known. Efforts to eliminate racial discrimination and restore trust given prior discrimination are needed

Averett, S. L., Smith, J. K. et Wang, Y. (2019). Minimum Wages and the Health and Access to Care of Immigrants' Children. IZA Discussion Paper Series ; 12559. Bonn IZA**:** 35.
http://ftp.iza.org/dp12606.pdf

States are increasingly resorting to raising the minimum wage to boost the earnings of those at the bottom of the income distribution. In this paper, we examine the effects of minimum wage increases on the health of the children of immigrants. Their parents are disproportionately represented in minimum wage jobs, typically have less access to health care and are a growing part of the U.S. labor force. Using a difference-in-differences identification strategy and data drawn from the National Health Interview Survey from the years 2000 - 2015, we examine whether children of low-educated immigrants experience any changes in health or access to care when the minimum wage increases.

Baezconde-Garbanati, L., et al. (2013). "Reducing the Excess Burden of Cervical Cancer Among Latinas: Translating Science into Health Promotion Initiatives." Calif J Health Promot **11**(1): 45-57.

PURPOSE: Although deaths from cervical cancer are declining, Latinas are not benefiting equally in this decline. Incidence of invasive cervical cancer among Los Angeles', California Latinas is much higher than among non-Latina Whites (14.7 versus 8.02 per 100,000). This paper examines cervical cancer screening among Latinas. METHODS: Ninety-seven women of Mexican origin participated in 12 focus groups exploring barriers to screening. Saturation was reached. RESULTS: All participants knew what a Pap test was and most knew its purpose. More acculturated participants understood the link between HPV and cervical cancer. More recent immigrants did not. There was confusion whether women who were not sexually active need to be screened. Most frequently mentioned barriers were lack of time and concern over missing work. Lower income and less acculturated women were less likely to be aware of free/low-cost clinics. Older and less acculturated participants held more fatalistic beliefs, were more embarrassed about getting a Pap test, were more fearful of being perceived as sexually promiscuous, and were more fearful of receiving disapproval from their husbands. CONCLUSIONS: Latinas are informed regarding cervical cancer screening; rather they encounter barriers such as a lack of time, money and support. Health promotion interventions can be enhanced via peer-to-peer education, by addressing barriers to cervical cancer screening with in-language, culturally tailored interventions, and working with clinics on systemic changes, such as extended clinic hours.

Blewett, L. A., et al. (2010). "Immigrant children's access to health care: differences by global region of birth." J Health Care Poor Underserved **21**(2 Suppl): 13-31.

We use data from the National Health Interview Survey (2000-2006) to examine the social determinants of health insurance coverage and access to care for immigrant children by 10 global regions of birth. We find dramatic differences in the social and economic characteristics of immigrant children by region of birth. Children from Mexico and Latin America fare worse than immigrant children born in the U.S. with significantly lower incomes and little or no education. These social determinants, along with U.S. public health policies regarding new immigrants, create significant

barriers to access to health insurance coverage, and increase delayed or foregone care. Uninsured immigrant children had 6.5 times higher odds of delayed care compared with insured immigrant children.

Carreon, D. C. et Baumeister, S. E. (2015). "Health Care Access Among Asian American Subgroups: The Role of Residential Segregation." J Immigr Minor Health **17**(5): 1451-1457.

Few studies have examined differences in health care access across Asian American ethnicities and none have considered the effects of residential segregation. The segregation of Asians by neighborhood has been steadily increasing over the past few decades due in part to the settlement patterns of immigrants. Data from the 2009 National Longitudinal Study of Adolescent Health (n = 746) were used. We examined differences in yearly medical checkups between Asian subgroups as well as among foreign-born and US-born Asians. Results showed that immigrant Filipinos and Vietnamese were less likely to get a checkup compared with foreign-born Chinese. The effect of Asian subgroup was modified by the percentage of Asians in a census tract ($p < 0.01$). Koreans and other Asians had a higher probability of getting a checkup when living in a predominately Asian neighborhood. For Chinese and Vietnamese residential concentration of Asians had a stronger inverse association with having a yearly checkup.

Chaumba, J. (2011). "Health status, use of health care resources, and treatment strategies of Ethiopian and Nigerian immigrants in the United States." Soc Work Health Care **50**(6): 466-481.

Although different health risks and behaviors displayed by contemporary U.S. immigrants create challenges for health care providers, knowledge on the health of and variations among African immigrant groups in the United States lags behind. This study compared health status, use of health care resources, and treatment strategies of 362 Ethiopian and Nigerian immigrants. The results indicated that mental health and English-speaking ability varied by country of birth. Furthermore, the study sample reported a low use of health care resources. These results suggest the existence of potential health issues among subsections of the African immigrant population that may threaten the maintenance of good health.

Chen, J., et al. (2016). "Racial and Ethnic Disparities in Health Care Access and Utilization Under the Affordable Care Act." Medical Care **54**(2): 140-146.

Objective: To examine racial and ethnic disparities in health care access and utilization after the Affordable Care Act (ACA) health insurance mandate was fully implemented in 2014. Research Design: Using the 2011–2014 National Health Interview Survey, we examine changes in health care access and utilization for the nonelderly US adult population. Multivariate linear probability models are estimated to adjust for demographic and sociodemographic factors. Results: The implementation of the ACA (year indicator 2014) is associated with significant reductions in the probabilities of being uninsured (coef=−0.03, P<0.001), delaying any necessary care (coef=−0.03, P<0.001), forgoing any necessary care (coef=−0.02, P<0.001), and a significant increase in the probability of having any physician visits (coef=0.02, P<0.001), compared with the reference year 2011. Interaction terms between the 2014 year indicator and race/ethnicity demonstrate that uninsured rates decreased more substantially among non-Latino African Americans (African Americans) (coef=−0.04, P<0.001) and Latinos (coef=−0.03, P<0.001) compared with non-Latino whites (whites). Latinos were less likely than whites to delay (coef=−0.02, P<0.001) or forgo (coef=−0.02, P<0.001) any necessary care and were more likely to have physician visits (coef=0.03, P<0.005) in 2014. The association between year indicator of 2014 and the probability of having any emergency department visits is not significant. Conclusions: Health care access and insurance coverage are major factors that contributed to racial and ethnic disparities before the ACA implementation. Our results demonstrate that racial and ethnic disparities in access have been reduced significantly during the initial years of the ACA implementation that expanded access and mandated that individuals obtain health insurance.

Choi, S. (2011). "Longitudinal changes in access to health care by immigrant status among older adults: the importance of health insurance as a mediator." Gerontologist **51**(2): 156-169.

PURPOSE: This longitudinal study examined the role of health insurance in access to health care among older immigrants. DESIGN AND METHODS: Using data from the Second Longitudinal Study of Aging, the longitudinal trajectories of having a usual source of care were compared between 3 groups (all 70+ years): (a) late-life immigrants with less than 15 years of residence in the United States ("recent immigrants"; n = 133), (b) "earlier immigrants" (15 years or longer in the United States, n = 672), and (c) U.S. born (n = 8,642). A series of hierarchical generalized linear models were run to test the mediating relationship of health insurance between immigrant status and having a usual source of care. RESULTS: Although the probabilities of having a usual source of care increased over time across all three groups, recent immigrants were less likely to have Medicare and private insurance over time; this in turn was related to lower probabilities of having a usual source of care (indirect relationship). There was no direct relationship between immigrant status and having a usual source of care. IMPLICATIONS: To prevent the use of more expensive forms of care in the long run, policy efforts should expand late-life immigrants' health insurance coverage by increasing affordable health insurance options.

Choi, S. (2015). "How Does Satisfaction With Medical Care Differ by Citizenship and Nativity Status?: A County-Level Multilevel Analysis." Gerontologist **55**(5): 735-747.

PURPOSE OF THE STUDY: This study examined patient satisfaction among community-dwelling older adults by their citizenship and nativity statuses. Since the welfare reform of 1996, citizenship has been an important factor in determining health care access among foreign-born individuals. Little is known regarding how the perceived satisfaction of older noncitizens compares with that of U.S.-born and naturalized citizens and how it is affected by county-level contextual characteristics. DESIGN AND METHODS: The 2000-2007 Medical Expenditure Panel Survey and linked Area Resource File were analyzed for 27,383 individuals (65+). Two dimensions of satisfaction (perceived access and ease of access) were examined using the Consumer Assessment of Health Plans Survey. Multilevel models were conducted using STATA. RESULTS: After both individual- and county-level covariates were controlled for, noncitizens were less likely to agree that their providers had spent enough time with them ($p = .03$) or had sufficiently explained treatment ($p = .01$) compared with U.S.-born citizens. Noncitizens' overall ratings of their providers were also lower ($p < .001$). Among those reported needs, noncitizens reported greater difficulties in accessing acute care ($p < .001$), routine care ($p < .001$), and specialty care ($p = .009$). In these models, some county-level characteristics (e.g., % of foreign-born individuals) were negatively associated with individual-level satisfaction. Interestingly, noncitizens from counties with high densities of foreign-born populations had higher overall satisfaction levels than did their U.S.-born counterparts (i.e., interaction effect). IMPLICATIONS: Guided by the expanded Andersen model, this study demonstrates the importance of considering both individual- and county-level contextual characteristics to accurately understand older noncitizens' access to health care and patient satisfaction.

Clemans-Cope, L., et al. (2012). "The Affordable Care Act's coverage expansions will reduce differences in uninsurance rates by race and ethnicity." Health Aff.(Millwood.) **31**(5): 920-930.

There are large differences in US health insurance coverage by racial and ethnic groups, yet there have been no estimates to date on how implementation of the Affordable Care Act will affect the distribution of coverage by race and ethnicity. We used a microsimulation model to show that racial and ethnic differentials in coverage could be greatly reduced, potentially cutting the eight-percentage-point black-white differential in uninsurance rates by more than half and the nineteen-percentage-point Hispanic-white differential by just under one-quarter. However, blacks and Hispanics are still projected to remain more likely to be uninsured than whites. Achieving low uninsurance under the Affordable Care Act will depend on effective state policies to attain high enrollment in Medicaid and the Children's Health Insurance Program and the new insurance exchanges. Coverage gains among Hispanics will probably depend on adoption of strategies that address language and related barriers to enrollment and retention in California and Texas, where almost half of Hispanics live. If uninsurance is reduced to the extent projected in this analysis, sizable reductions in long-standing racial and ethnic differentials in access to health care and health status are likely to follow

Clough, J., et al. (2013). "Barriers to health care among Asian immigrants in the United States: a traditional review." J Health Care Poor Underserved **24**(1): 384-403.

Asian immigrants in the U.S. are far less likely to have health insurance or use health care services than both U.S.-born Asians and non-Hispanic Whites. Furthermore, Asian immigrants who access the U.S. health care system are less likely than non-Hispanic Whites to receive high-quality services. This paper reviews four barriers faced by Asian immigrants to participating in the U.S. health care system fully: (1) linguistic discordance between providers and patients; (2) health-related beliefs and cultural incompetency of health systems; (3) issues related to accessing health services; and (4) discrimination in the health care system. Interventions to improve the health of Asian immigrants must address barriers experienced at multiple levels, including those that occur interpersonally and institutionally, as well as broader societal factors that affect health care access and quality.

Cook, B. L., et al. (2012). "Measuring racial/ethnic disparities in health care: methods and practical issues." Health Serv.Res. **47**(3 Pt 2): 1232-1254.

OBJECTIVE: To review methods of measuring racial/ethnic health care disparities. STUDY DESIGN: Identification and tracking of racial/ethnic disparities in health care will be advanced by application of a consistent definition and reliable empirical methods. We have proposed a definition of racial/ethnic health care disparities based in the Institute of Medicine's (IOM) Unequal Treatment report, which defines disparities as all differences except those due to clinical need and preferences. After briefly summarizing the strengths and critiques of this definition, we review methods that have been used to implement it. We discuss practical issues that arise during implementation and expand these methods to identify sources of disparities. We also situate the focus on methods to measure racial/ethnic health care disparities (an endeavor predominant in the United States) within a larger international literature in health outcomes and health care inequality. EMPIRICAL APPLICATION: We compare different methods of implementing the IOM definition on measurement of disparities in any use of mental health care and mental health care expenditures using the 2004-2008 Medical Expenditure Panel Survey. CONCLUSION: Disparities analysts should be aware of multiple methods available to measure disparities and their differing assumptions. We prefer a method concordant with the IOM definition

De Gagne, J. C., et al. (2015). "A Mixed Methods Study of Health Care Experience Among Asian Indians in the Southeastern United States." J Transcult Nurs **26**(4): 354-364.

PURPOSE: The study explored health care experiences among Asian Indian immigrants living in the Southeastern United States. DESIGN AND METHOD: A concurrent triangulation mixed methods design was used with a purposive sample of 125 Asian Indian immigrants aged between 40 and 64 years in the survey and 10 participants in the focus group. RESULTS: The majority of the participants had health insurance and higher socioeconomic status. They had a moderate level of knowledge on the U.S. health care system and health insurance while presenting moderate satisfaction with the system. Barriers to health care services and needs in the health care system were identified from both quantitative and qualitative data. Some of the barriers were high costs, dissatisfaction with services, and inconvenience in accessing services. Participants called for self-management and community-based health programs as well as culturally tailored health care services. DISCUSSION AND CONCLUSION: Findings congruent with prior studies further support the importance of comprehending Asian Indians' unique cultural background and experiences in the health care system. This study can be the foundation for culturally competent care to advance the body of transcultural nursing knowledge. IMPLICATIONS FOR PRACTICE: Culturally congruent community-based health care programs are needed to provide better care for the ethnic minority to maintain and promote their health status.

De Gagne, J. C., et al. (2014). "The healthcare experiences of Koreans living in North Carolina: a mixed methods study." Health Soc Care Community **22**(4): 417-428.

This study examined the healthcare experiences of Korean immigrants aged 40-64 living in the North Carolina Triangle area of the Southeastern United States. Using a mixed methods design, we collected quantitative data via a questionnaire from 125 participants and conducted a focus group with 10 interviewees from December 2010 to February 2011. The quantitative data were analysed using t-tests and chi-square tests, and a thematic analysis was used for the focus group study. Questionnaire findings showed that only 27.2% had sufficient English skills to communicate adequately. Participants with insurance were significantly more likely to be employed (P < 0.001), had higher incomes (P = 0.011) and higher education (P < 0.001), and had greater English-speaking ability (P = 0.011) than those without insurance. Participants who did not use healthcare services showed significantly less knowledge (P < 0.001) of and less satisfaction (P = 0.034) with the healthcare system than those using healthcare services. Sixty-two participants (49.6%) reported having no health insurance for one or more of the following reasons: high costs (75.8%), medical tourism (22.6%) and lack of information or knowledge (6.5%). The following themes emerged from the data collected during the focus group: (i) barriers to utilisation of healthcare services; (ii) facilitators of utilisation of healthcare services; and (iii) social support seeking for health management. Our mixed methods study findings indicate that healthcare disparities exist among Korean immigrants and that a number of factors, including health literacy, may contribute to their poor health outcomes. Continued collaboration among community members, healthcare professionals and academicians is needed to discuss the community's health concerns and to develop sustainable programmes that will ensure meaningful access to care for those with limited English proficiency and medically underserved populations.

De Jesus, M. et Xiao, C. (2013). "Cross-border health care utilization among the Hispanic population in the United States: implications for closing the health care access gap." Ethn Health **18**(3): 297-314.

OBJECTIVES: To examine predictors of health care service utilization in Mexico or any other country in Latin America among the U.S. Hispanic population. METHODS: This study used data from the 2007 Pew Hispanic Healthcare Survey, a nationally representative survey of 4013 Hispanic adults. Using the Behavioral Model of Health Service Use (BMHSU) model, we examined three levels of predictive factors: (1) predisposing characteristics (e.g., language proficiency), (2) enabling resources (e.g., health insurance status), and (3) need (e.g., self-perceived health status). Multivariate logistic regression analyses were conducted to predict odds of seeking health care services in Mexico or any other country in Latin America. RESULTS: As hypothesized, lack of continuous health insurance coverage, perceived lack of quality health care, and low English proficiency increased the likelihood of seeking health care in Mexico or any other Latin American country among US Hispanic adults. Self-reported health status and usual source of care, however, were not significant predictors. CONCLUSIONS: Hispanic immigrants face critical access gaps to health care in the United States. Implications for closing the access gap for this population are discussed within the context of health care system reform and immigration reform in the United States.

Dedania, R. et Gonzales, G. (2019). "Disparities in Access to Health Care Among US-Born and Foreign-Born US Adults by Mental Health Status, 2013–2016." American Journal of Public Health **109**(S3): S221-S227. https://doi.org/10.2105/AJPH.2019.305149

Objectives. To compare access to care between US-born and foreign-born US adults by mental health status.Methods. We analyzed data on nonelderly adults (n?=?100?428) from the 2013?2016 National Health Interview Survey. We used prevalence estimates and multivariable logistic regression models to compare issues of affordability and accessibility between US-born and foreign-born individuals.Results. Approximately 22.2% of US-born adults and 18.1% of foreign-born adults had symptoms of moderate to severe psychological distress. Compared with US-born adults with no psychological distress, and after adjustment for sociodemographic characteristics, US-born and foreign-born adults with psychological distress were much more likely to report multiple emergency room visits and unmet medical care, mental health care, and prescription medications because of cost. Conclusions. Our study found that adults with moderate to severe psychological distress, regardless of their immigration status, were at greater risk for reporting issues of affordability when accessing health care compared with US-born adults with no psychological distress. Public Health Implications. Health care and mental health reforms should focus on reducing health care costs and establishing

innovative efforts to broaden access to care to diverse populations.

Derose, K. P., et al. (2009). "Review: immigrants and health care access, quality, and cost." Med Care Res Rev **66**(4): 355-408.

Inadequate access and poor quality care for immigrants could have serious consequences for their health and that of the overall U.S. population. The authors conducted a systematic search for post-1996, population-based studies of immigrants and health care. Of the 1,559 articles identified, 67 met study criteria of which 77% examined access, 27% quality, and 6% cost. Noncitizens and their children were less likely to have health insurance and a regular source of care and had lower use than the U.S. born. The foreign born or non-English speakers were less satisfied and reported lower ratings and more discrimination. Immigrants incurred lower costs than the U.S. born, except emergency department expenditures for immigrant children. Policy solutions are needed to improve health care for immigrants and their children. Research is needed to elucidate immigrants' nonfinancial barriers, receipt of specific processes of care, cost of care, and health care experiences in nontraditional U.S. destinations.

Dominguez-Villegas, R. et Bustamante, A. V. (2021). "Health Insurance Coverage In Mexico Among Return Migrants: Differences Between Voluntary Return Migrants And Deportees." Health Aff (Millwood) **40**(7): 1047-1055.

Between 2010 and 2019 the number of Mexican immigrants in the US declined by almost 780,000, or 7 percent. Repatriated migrants either return voluntarily to Mexico (returnees) or are forcibly removed from the US (deportees). As repatriated migrants navigate their return, access to health care in Mexico becomes a pressing need. Lack of a valid form of identification, limited awareness of services, and social stigma, among other factors, restrict health coverage in Mexico for return migrants. This study examined differences in health insurance coverage in Mexico between Mexican-born deportees and returnees from the US in a five-year period and a reference population of Mexican-born residents (nonmigrants and returnees who had been back in Mexico for five years or longer). Using data from Mexico's National Survey of Demographic Dynamics from 2014 and 2018, we found that 74.0 percent of voluntary returnees and 67.5 percent of deportees had health insurance, compared with 88.4 percent of the reference population, after adjustment for socioeconomic and demographic differences. Policy makers from federal, state, and local governments and community organizations need to improve the reintegration of repatriated migrants by reducing bureaucratic hurdles, preparing returnees and deportees for their return to Mexico, and strengthening health coverage options for return migrants.

Edward, J. (2014). "Undocumented Immigrants and Access to Health Care: Making a Case for Policy Reform." Policy Polit Nurs Pract **15**(1-2): 5-14.

The growth in undocumented immigration in the United States has garnered increasing interest in the arenas of immigration and health care policy reform. Undocumented immigrants are restricted from accessing public health and social service as a result of their immigration status. The Patient Protection and Affordability Care Act restricts undocumented immigrants from participating in state exchange insurance market places, further limiting them from accessing equitable health care services. This commentary calls for comprehensive policy reform that expands access to health care for undocumented immigrants based on an analysis of immigrant health policies and their impact on health care expenditures, public health, and the role of health care providers. The intersectional nature of immigration and health care policy emphasizes the need for nurse policymakers to advocate for comprehensive policy reform aimed at improving the health and well-being of immigrants and the nation as a whole.

Frank, A. L., et al. (2013). "Health care access and health care workforce for immigrant workers in the agriculture, forestry, and fisheries sector in the southeastern US." Am J Ind Med **56**(8): 960-974.

BACKGROUND: The Agriculture, Forestry, and Fishery (AgFF) Sector workforce in the US is comprised

primarily of Latino immigrants. Health care access for these workers is limited and increases health disparities. METHODS: This article addresses health care access for immigrant workers in the AgFF Sector, and the workforce providing care to these workers. CONTENTS: Immigrant workers bear a disproportionate burden of poverty and ill health and additionally face significant occupational hazards. AgFF laborers largely are uninsured, ineligible for benefits, and unable to afford health services. The new Affordable Care Act will likely not benefit such individuals. Community and Migrant Health Centers (C/MHCs) are the frontline of health care access for immigrant AgFF workers. C/MHCs offer discounted health services that are tailored to meet the special needs of their underserved clientele. C/MHCs struggle, however, with a shortage of primary care providers and staff prepared to treat occupational illness and injury among AgFF workers. A number of programs across the US aim to increase the number of primary care physicians and care givers trained in occupational health at C/MHCs. While such programs are beneficial, substantial action is needed at the national level to strengthen and expand the C/MHC system and to establish widely Medical Home models and Accountable Care Organizations. System-wide policy changes alone have the potential to reduce and eliminate the rampant health disparities experienced by the immigrant workers who sustain the vital Agricultural, Forestry, and Fishery sector in the US.

Gruber, J., Sabety, A., Sood, R., et al. (2022). Reducing Frictions in Healthcare Access: The ActionHealth NYC Experiment for Undocumented Immigrants. NBER Working Paper ; 29838. Cambridge NBER**:** 43.
https://www.nber.org/papers/w29838

In 2016, New York City designed and implemented an intervention reducing frictions in accessing safety-net care: randomly making initial primary care appointments for 2,428 undocumented immigrants. We leverage a novel survey-administrative data linkage to show that the program resulted in a more efficient allocation of care. The program increased self-reported access to primary care, leading to a 21% fall in emergency department (ED) use. This effect was driven by high-risk individuals whose ED visits fell by 42% on average. Among those visiting sponsored clinics, chronic condition diagnoses and preventive screens increased, positively affecting long-run health.

Halliday, T., Akee, R. Q. et Miyamura, J. (2019). The Impact of Public Health Insurance on Medical Utilization in a Vulnerable Population: Evidence from COFA Migrants. Working Paper No. 2019-1**:** 50 ,tabl., fig., annexes.
https://econpapers.repec.org/paper/haewpaper/2019-1.htm

In March of 2015, the State of Hawaii stopped covering the vast majority of migrants from countries belonging to the Compact of Free Association (COFA) in the state Medicaid program. As a result COFA migrants were required to obtain private insurance in health insurance exchanges established under the Affordable Care Act. Using statewide administrative hospital discharge data, we show that Medicaid-funded hospitalizations and emergency room visits declined in this population by 69% and 42% after the expiration of Medicaid eligibility. Utilization funded by private insurance did increase but not enough to offset the declines in publicly-funded utilization. This resulted in a net decrease in utilization. In addition, we show that uninsured ER visits increased as a consequence of the expiration of Medicaid benefits. Paradoxically, we also find a substantial increase in Medicaid-funded ER visits by infants after the expiration of benefits which is consistent with a substitution of ER visits for ambulatory care for the very young

Ingram, M. (2020). "Immigrants and Access to Care: Public Health Must Lead the Way in Changing the Nation's Narrative." American Journal of Public Health **110**(9): 1260-1261.
https://doi.org/10.2105/AJPH.2020.305790

Joseph, T. D. (2016). "What Health Care Reform Means for Immigrants: Comparing the Affordable Care Act and Massachusetts Health Reforms." J Health Polit Policy Law **41**(1): 101-116.

The 2010 Patient Protection and Affordable Care Act (ACA) was passed to provide more affordable health coverage to Americans beginning in 2014. Modeled after the 2006 Massachusetts health care reform, the ACA includes an individual mandate, Medicaid expansion, and health exchanges through which middle-

income individuals can purchase coverage from private insurance companies. However, while the ACA provisions exclude all undocumented and some documented immigrants, Massachusetts uses state and hospital funds to extend coverage to these groups. This article examines the ACA reform using the Massachusetts reform as a comparative case study to outline how citizenship status influences individuals' coverage options under both policies. The article then briefly discusses other states that provide coverage to ACA-ineligible immigrants and the implications of uneven ACA implementation for immigrants and citizens nationwide.

Hill, T. D., et al. (2012). "Immigrant status and cognitive functioning in late-life: an examination of gender variations in the healthy immigrant effect." Soc Sci Med **75**(12): 2076-2084.

Although some research suggests that the healthy immigrant effect extends to cognitive functioning, it is unclear whether this general pattern varies according to gender. We use six waves of data collected from the original cohort of the Hispanic Established Populations for the Epidemiologic Study of the Elderly to estimate a series of linear growth curve models to assess variations in cognitive functioning trajectories by nativity status and age at migration to the U.S.A. among women and men. Our results show, among women and men, no differences in baseline cognitive status (intercepts) between early- (before age 20) and late-life (50 and older) immigrants and U.S.-born individuals of Mexican-origin. We also find, among women and men, that middle-life (between the ages of 20 and 49) immigrants tend to exhibit higher levels of baseline cognitive functioning than the U.S.-born. Our growth curve analyses suggest that the cognitive functioning trajectories (slopes) of women do not vary according to nativity status and age at migration. The cognitive functioning trajectories of early- and late-life immigrant men are also similar to those of U.S.-born men; however, those men who migrated in middle-life tend to exhibit slower rates of cognitive decline. A statistically significant interaction term suggests that the pattern for middle-life migration is more pronounced for men (or attenuated for women). In other words, although women and men who migrated in middle-life exhibit higher levels of baseline cognitive functioning, immigrant men tend to maintain this advantage for a longer period of time. Taken together, these patterns confirm that gender is an important conditioning factor in the association between immigrant status and cognitive functioning.

John, D. A., et al. (2014). "Disparities in perceived unmet need for supportive services among patients with lung cancer in the Cancer Care Outcomes Research and Surveillance Consortium." Cancer **120**(20): 3178-3191.

BACKGROUND: The authors investigated the prevalence, determinants of, and disparities in any perceived unmet need for 8 supportive services (home nurse, support group, psychological services, social worker, physical/occupational rehabilitation, pain management, spiritual counseling, and smoking cessation) by race/ethnicity and nativity and how it is associated with perceived quality of care among US patients with lung cancer. METHODS: Data from a multiregional, multihealth system representative cohort of 4334 newly diagnosed patients were analyzed. Binomial logistic regression models adjusted for patient clustering. RESULTS: Patients with any perceived unmet need (9% overall) included 7% of white-US-born (USB), 9% of white-foreign-born (FB), 13% of black-USB, 8% of Latino-USB, 24% of Latino-FB, 4% of Asian/Pacific Islander (API)-USB, 14% of API-FB, and 11% of "other" patients ($P < .001$). Even after controlling for demographic and socioeconomic factors, health system and health care access, and need, black-USB, Latino-FB, and Asian-FB patients were more likely to perceive an unmet need than white-USB patients by 5.1, 10.9, and 5.6 percentage points, respectively (all $P < .05$). Being younger, female, never married, uninsured, a current smoker, or under surrogate care or having comorbidity, anxiety/depression, or a cost/insurance barrier to getting tests/treatments were associated with any unmet need. Patients with any unmet need were more likely to rate care as less-than-"excellent" by 13 percentage points than patients with no unmet need ($P < .001$). CONCLUSIONS: Significant disparities in unmet supportive service need by race/ethnicity and nativity highlight immigrants with lung cancer as being particularly underserved. Eliminating disparities in access to needed supportive services is essential for delivering patient-centered, equitable cancer care.

Kaplan-Lewis, E. et Percac-Lima, S. (2013). "No-show to primary care appointments: why patients do not come." J Prim Care Community Health **4**(4): 251-255.

BACKGROUND: Missed primary care appointments lead to poor disease control and later presentation to care. No-show rates are higher in clinics caring for underserved populations and may contribute to poorer health outcomes in this group. The objective of this study was to determine who were the patients not showing to primary care appointments and their reasons to no-show. METHODS: A retrospective study was conducted at a community health center serving a predominantly Latino, immigrant, low-income population. Adult patients >18 years old who did not show to primary care appointments during a 5-month period were called by a bilingual (English and Spanish) patient service coordinator. The patients' reported reason for missing the appointment was documented. Two-sided t test of proportions was used to compare demographic characteristics of the patients that showed to their appointments to patients that did not. RESULTS: Of 7508 scheduled appointments, 5604 were included in the analysis and 927 (16.5%) no-showed. There were 735 (79%) calls made to the patients who missed their appointments and 273 (37%) were reached. The 2 most common reasons for missing an appointment were forgetting (n = 97, 35.5%) and miscommunication (n = 86, 31.5%). When compared with patients who came to their appointments, patients who no-showed were younger (P < .0001), more likely to be black (P = .0423) or Hispanic (P = .0001), and to have Medicaid (P < .0001). CONCLUSIONS: No-show rates interfere with quality primary care. Interventions designed to target reasons for no-show are needed to help reduce the no-show rate, improve access and decrease health disparities in underserved patient populations.

Martinez-Donate, A. P., et al. (2014). "Healthcare access among circular and undocumented Mexican migrants: results from a pilot survey on the Mexico-US border." Int J Migr Bord Stud **1**(1): 57-108.

BACKGROUND: Temporary and unauthorized migrants may face unique obstacles to access health care services in the U.S. OBJECTIVE: This study estimated levels of health care access among Mexican migrants returning to Mexico from the U.S. and factors associated with access to health care, with emphasis on the role of modifiable, enabling factors. METHODS: We conducted a pilot probability health care survey of migrants in the border city of Tijuana, Mexico (N=186). RESULTS: Approximately 42% of migrants reported having used health care services in the U.S. during the past year. Only 38% had a usual source of care and approximately 11% went without needed medical care in the U.S. About 71% of migrants did not have health insurance in the U.S. Lack of health insurance and transportation limitations were significantly related to various access indicators. CONCLUSION: These results have implications for future policies and programs aimed to address modifiable health care access barriers faced by these vulnerable and underserved segments of the Mexican migrant population.

Miller, S. et Wherry, L. (2022). Covering Undocumented Immigrants: The Effects of a Large-Scale Prenatal Care Intervention. NBER Working Paper ; 30299. Cambridge NBER**:** 67.
https://www.nber.org/papers/w30299

Undocumented immigrants are ineligible for public insurance coverage for prenatal care in most states, despite their children representing a large fraction of births and having U.S. citizenship. In this paper, we examine a policy that expanded Medicaid pregnancy coverage to undocumented immigrants. Using a novel dataset that links California birth records to Census surveys, we identify siblings born to immigrant mothers before and after the policy. Implementing a mothers' fixed effects design, we find that the policy increased coverage for and use of prenatal care among pregnant immigrant women, and increased average gestation length and birth weight among their children.

Nandi, A., et al. (2008). "Access to and use of health services among undocumented Mexican immigrants in a US urban area." Am J Public Health **98**(11): 2011-2020.

OBJECTIVES: We assessed access to and use of health services among Mexican-born undocumented immigrants living in New York City in 2004. METHODS: We used venue-based sampling to recruit participants from locations where undocumented immigrants were likely to congregate. Participants were 18 years or older, born in Mexico, and current residents of New York City. The main outcome measures were health insurance coverage, access to a regular health care provider, and emergency department care. RESULTS: In multivariable models, living in a residence with fewer other adults,

linguistic acculturation, higher levels of formal income, higher levels of social support, and poor health were associated with health insurance coverage. Female gender, fewer children, arrival before 1997, higher levels of formal income, health insurance coverage, greater social support, and not reporting discrimination were associated with access to a regular health care provider. Higher levels of education, higher levels of formal income, and poor health were associated with emergency department care. CONCLUSIONS: Absent large-scale political solutions to the challenges of undocumented immigrants, policies that address factors shown to limit access to care may improve health among this growing population.

Portes, A., et al. (2009). "The U.S. Health System and Immigration: An Institutional Interpretation." Sociol Forum (Randolph N J) **24**(3): 487-514.

We examine the institutions that comprise the U.S. health system and their relationship to a surging immigrant population. The clash between the system and this human flow originates in the large number of immigrants who are unauthorized, poor, and uninsured and, hence, unable to access a system largely based on ability to pay. Basic concepts from sociological theory are brought to bear on the analysis of this clash and its consequences. Data from a recently completed study of health institutions in three areas of the United States are used as an empirical basis to illustrate various aspects of this complex relation. Implications of our results for theory and future health policy are discussed.

Pourat, N., et al. (2014). "Assessing health care services used by California's undocumented immigrant population in 2010." Health Aff (Millwood) **33**(5): 840-847.

Undocumented immigrants were excluded from the health benefit Marketplaces created by the Affordable Care Act partly because of claims that they contribute to problems such as high costs and emergency department (ED) crowding. This article examines the likely health care use and costs of undocumented immigrants in California in 2009-10. Using data from the 2009 California Health Interview Survey (CHIS), we developed a model that estimated the state's adult and child undocumented immigrant population, since the survey does not explicitly inquire about undocumented status. The survey also provided information on insurance status, doctor visits, and ED visits in the previous year. We found that undocumented immigrants in California, and the uninsured among them, had fewer or similar numbers of doctor visits, ED visits, and preventive services use compared to US citizens and other immigrant groups. Allowing undocumented immigrants to purchase insurance in the Marketplaces and ensuring receipt of low-cost preventive services can contribute to lower premiums and reduce resource strains on safety-net providers.

Prus, S. G., et al. (2010). "Comparing racial and immigrant health status and health care access in later life in Canada and the United States." Can J Aging **29**(3): 383-395.

Little comparative research exists on health experiences and conditions of minority groups in Canada and the United States, despite both countries having a racially diverse population with a significant proportion of immigrants. This article explores race and immigrant disparities in health and health care access across the two countries. The study focus was on middle and old age given the change and increasing diversity in health and health care policy, such as Medicare. Logistic regression analysis of data from the 2002-2003 Joint Canada/United States Survey of Health shows that the joint effect of race and nativity on health outcomes - health differences between native and foreign-born Whites and non-Whites - is largely insignificant in Canada but considerable in the U.S. Non-White native and foreign-born Americans within both 45-to-64 and 65-and-over age groups experience significant disadvantage in health status and access to care, irrespective of health insurance coverage, demographic, socio-economic, and lifestyle factors.

Rew, K. T., et al. (2014). "Immigrant and refugee health: cross-cultural communication." FP Essent **423**: 30-39.

Physicians in the United States increasingly care for culturally, linguistically, and educationally diverse immigrants with limited English proficiency. Language barriers contribute significantly to the health

disparities experienced by patients with limited English proficiency. Qualified professional interpreters should be used instead of ad hoc interpreters, such as a patient's friend or family member, an untrained bilingual staff member, or a bilingual stranger. Children should not be used as interpreters. Physicians and other health care professionals must be fluent to communicate with patients in another language. Use of electronic translation systems should be avoided. Cultural competence refers to the attitudes, knowledge, and skills needed to work well in cross-cultural situations and effectively provide care to diverse populations. Stereotypes are perpetuated when members of a group are assumed to share cultural values, beliefs, or attitudes. Attempting to memorize a list of what to do and what to avoid when working with any particular group is ineffective. Every patient's culture is multidimensional and dynamic and is not defined by race or language group.

Reyes, A. M. et Hardy, M. (2014). "Another health insurance gap: gaining and losing coverage among natives and immigrants at older ages." Soc Sci Res **43**: 145-156.

As the immigrant population grows older and larger, limitations on access to health insurance may create a new subgroup of people who remain outside or on the margin of coverage. Using the Survey of Income and Program Participation (SIPP) data from the 2004 and 2008 panels, we address the health insurance gap between foreign-born and native-born adults among those aged 50-64 and the 65 and older, two sub-populations that have received relatively little attention in past research. We argue that current practices leave a significant minority of older foreign-born residents inconsistently covered or without any insurance. We find that health insurance coverage for older immigrants is both less likely and more episodic even when compositional differences in SES and assimilation are controlled.

Reyes, A. M. et Hardy, M. (2015). "Health insurance instability among older immigrants: region of origin disparities in coverage." J Gerontol B Psychol Sci Soc Sci **70**(2): 303-313.

OBJECTIVES: We provide a detailed analysis of how the dynamics of health insurance coverage (HIC) at older ages differs among Latino, Asian, and European immigrants in the United States. METHOD: Using Survey of Income and Program Participation data from the 2004 and 2008 panels, we estimate discrete-time event history models to examine first and second transitions into and out of HIC, highlighting substantial differences in hazard rates among immigrants aged 50-64 from Asia, Latin America, and Europe. RESULTS: We find that the likelihood of having HIC at first observation and the rates of gaining and losing coverage within a relatively short time frame are least favorable for older Latino immigrants, although immigrants from all three regions are at a disadvantage relative to native-born non-Hispanic Whites. This disparity among immigrant groups persists even when lower rates of citizenship, greater difficulty with English, and low-skill job placements are taken into account. DISCUSSION: Factors that have contributed to the lower rates and shorter durations of HIC among older immigrants, particularly those from Latin America, may not be easily resolved by the Affordable Care Act. The importance of region of origin and assimilation characteristics for the risk of being uninsured in later life argues that immigration and health care policy should be jointly addressed.

Ro, A., Yang, H. W., Du, S., et al. (2021). "Severity of Inpatient Hospitalizations Among Undocumented Immigrants and Medi-Cal Patients in a Los Angeles, California, Hospital: 2019." American Journal of Public Health: e1-e8.
https://doi.org/10.2105/AJPH.2021.306485

Objectives. To compare the severity of inpatient hospitalizations between undocumented immigrants and Medi-Cal patients in a large safety-net hospital in Los Angeles, California. Methods. We conducted a retrospective analysis of all 2019 inpatient stays at a Los Angeles hospital (n?=?22?480), including patients of all races/ethnicities. We examined 3 measures by using insurance status to approximate immigration status: illness severity, length of hospital stay, and repeat hospitalizations. We calculated group differences between undocumented and Medi-Cal patients by using inverse probability weighted regression adjustment separately for patients aged 18 to 64 years and those aged 65 years and older. Results. Younger undocumented patients had less severe illness and shorter lengths of stay than their Medi-Cal counterparts. Older undocumented immigrants also had less severe illness, but

had similar lengths of stay and were more likely to have repeated hospitalizations. Conclusions. While existing work suggests that undocumented immigrants could have more severe health care needs on account of their poorer access to medical care, we did not see clear health disadvantages among hospitalized undocumented immigrants, especially younger patients. There were fewer differences between undocumented and Medi-Cal patients who were older. (Am J Public Health. Published online ahead of print October 14, 2021:e1?e8. https://doi.org/10.2105/AJPH.2021.306485)

Sieverts, S. H. (2013). "Demographic factors in immigrants' health care use." Health Aff (Millwood) **32**(10): 1858.

Sommers, B. D. et Parmet, W. E. (2015). "Health care for immigrants--implications of Obama's executive action." N Engl J Med **372**(13): 1187-1189.

Son, J. (2013). "Assimilation and health service utilization of Korean immigrant women." Qual Health Res **23**(11): 1528-1540.

In this case study, I present descriptive findings with regard to immigrant incorporation and health service utilization. Using focus groups and survey of Korean immigrant women in Wisconsin, I examine whether the ways in which they adapt to the U.S. society is relevant to their health services utilization and the alternatives they seek when available health services are less than satisfactory. The findings suggest that adherence to Korean identity appears to be associated with health service utilization. This is evident in the immigrants' evaluation of the U.S. health services as compared to those of Korea, and the consideration given by these immigrants to seeking health services in Korea instead of the United States. Such concerns on the part of these immigrants have important implications for health researchers, as they highlight the significance of immigrants' transnational experiences and their sense of personal agency in the use of health care.

Stimpson, J. P., et al. (2010). "Trends in health care spending for immigrants in the United States." Health Aff (Millwood) **29**(3): 544-550.

The suspected burden that undocumented immigrants may place on the U.S. health care system has been a flashpoint in health care and immigration reform debates. An examination of health care spending during 1999-2006 for adult naturalized citizens and immigrant noncitizens (which includes some undocumented immigrants) finds that the cost of providing health care to immigrants is lower than that of providing care to U.S. natives and that immigrants are not contributing disproportionately to high health care costs in public programs such as Medicaid. However, noncitizen immigrants were found to be more likely than U.S. natives to have a health care visit classified as uncompensated care.

Stimpson, J. P., et al. (2013). "Unauthorized immigrants spend less than other immigrants and US natives on health care." Health Aff (Millwood) **32**(7): 1313-1318.

Unauthorized immigrants and other immigrants who have been in the United States for less than five years have few options for accessing health care through public programs. In light of the ongoing national debate about immigration reform and the impact of the Affordable Care Act on immigrants, we examined differences in health care spending by nativity and legal status using Medical Expenditure Panel Survey data for the period 2000-09. We found that unauthorized, legal, and naturalized immigrants together accounted for $96.5 billion in average annual health care spending, compared to slightly more than $1 trillion for US natives. Unauthorized immigrants' share of health care spending was $15.4 billion-the smallest of the groups. Just 7.9 percent of unauthorized immigrants benefited from public-sector health care expenditures (receiving an average of $140 per person per year), compared to 30.1 percent of US natives (who received an average of $1,385). Policy solutions could include extending coverage to unauthorized immigrants for the prevention and treatment of infectious diseases or granting them access to the Affordable Care Act's insurance marketplaces, which start in 2014. The final version of federal immigration reform might also include strategies to expand immigrants' access to health care.

Stutz, M. et Baig, A. (2014). "International examples of undocumented immigration and the affordable care act." J Immigr Minor Health **16**(4): 765-768.

As it stands there is no viable health care option for undocumented immigrants of low socioeconomic status. Even more worrisome is that Affordable Care Act simply does not address this issue with any direct plan. The US is in a very influential time period in terms of undocumented immigration and its relationship with health care. The purpose of this paper is to examine international examples of undocumented immigrant health care and their implications for the United States' undocumented immigrant health care. This study found that physicians in the US must work to prevent the initiation of policies which exclude undocumented immigrants from accessing health care. Exclusionary policies implemented in European nations have had disastrous effects on physicians and patients. This paper examines the implications which similar policies would have if implemented in the US.

Toppelberg, C. O., et al. (2013). "Cross-Sectional Study of Unmet Mental Health Need in 5- to 7-Year Old Latino Children in the United States: Do Teachers and Parents Make a Difference in Service Utilization?" School Ment Health **5**(2): 59-69.

The aim of the study is to examine the rates of mental health service utilization in young Latino children of immigrants in relation to maternal and teacher reports of child mental health need. Specific knowledge is lacking about gaps in service utilization among young Latino children, the fastest growing and possibly the most underserved segment of the US child population. The associations of mental health service utilization (Service Assessment for Children and Adolescents) and mental health need (clinical levels of internalizing, externalizing, or total problems reported by mothers [Child Behavior Checklist] and teachers [Teacher's Report Form]) were examined in a community sample of young Latino children of immigrants (n = 228; mean age = 6) and compared across mothers' and teachers' responses. Mother-teacher agreement was also studied. Sixty-five children (28.5 %) had a mental health need; most (76.9 %) of these received no services. For all types of mental health need, service utilization was more likely when need was reported by mothers rather than teachers (p = .03). Teachers' reports were not associated with service utilization. Mother-teacher agreement was low for externalizing (r = .23; p </= 0.01) and total problems (r = .21; p </= 0.05), and nonsignificant for internalizing problems. This study is the first in the United States to document, in such a young Latino group, high rates of unmet need comparable to those among older Latino youth; low or no mother-teacher agreement on which children had a mental health need; low utilization of school-based services; and a lack of association between service utilization and teacher-reported mental health need-both for externalizing and internalizing problems. These findings suggest that schools are not effectively leveraging mental health services for young Latino children. Potential factors responsible for the findings are discussed.

Vargas Bustamante, A. et Chen, J. (2014). "The great recession and health spending among uninsured U.S. immigrants: implications for the Affordable Care Act implementation." Health Serv Res **49**(6): 1900-1924.

OBJECTIVE: We study the association between the timing of the Great Recession (GR) and health spending among uninsured adults distinguishing by citizenship/nativity status and time of U.S. residence. DATA SOURCE: Uninsured U.S. citizens and noncitizens from the 2005-2006 and 2008-2009 Medical Expenditure Panel Survey. STUDY DESIGN: The probability of reporting any health spending and the natural logarithm of health spending are our main dependent variables. We compare health spending across population categories before/during the GR. Subsequently, we implement two-part regression analyses of total and specific health-spending measures. We predict average health spending before/during the GR with a smearing estimation. PRINCIPAL FINDINGS: The probability of reporting any spending diminished for recent immigrants compared to citizens during the GR. For those with any spending, recent immigrants reported higher spending during the GR (27 percent). Average reductions in total spending were driven by the decline in the share of the population reporting any spending among citizens and noncitizens. CONCLUSIONS: Our study findings suggest that recent immigrants could be forgoing essential care, which later translates into higher spending. It portrays the vulnerability of a population that would remain exposed to income shocks, even after the

Affordable Care Act (ACA) implementation.

Vargas Bustamante, A., et al. (2014). "Identifying health insurance predictors and the main reported reasons for being uninsured among US immigrants by legal authorization status." Int J Health Plann Manage **29**(1): e83-96.

This study identifies differences in health insurance predictors and investigates the main reported reasons for lacking health insurance coverage between short-stayed (</= 10 years) and long-stayed (>10 years) US immigrant adults to parse the possible consequences of the Affordable Care Act among immigrants by length of stay and documentation status. Foreign-born adults (18-64 years of age) from the 2009 California Health Interview Survey are the study population. Health insurance coverage predictors and the main reasons for being uninsured are compared across cohorts and by documentation status. A logistic-regression two-part multivariate model is used to adjust for confounding factors. The analyses determine that legal status is a strong health insurance predictor, particularly among long-stayed undocumented immigrants. Immigration status is the main reported reason for lacking health insurance. Although long-stayed documented immigrants are likely to benefit from the Affordable Care Act implementation, undocumented immigrants and short-stayed documented immigrants may encounter difficulties getting health insurance coverage.

Viladrich, A. (2012). "Beyond welfare reform: reframing undocumented immigrants' entitlement to health care in the United States, a critical review." Soc Sci Med **74**(6): 822-829.

This article addresses the main scholarly frames that supported the deservingness of unauthorized immigrants to health benefits in the United States (U.S.) following the passage of the Personal Responsibility Work Opportunity Reconciliation Act (PRWORA), known as the Welfare Reform bill, in 1996. Based on a critical literature review, conducted between January 1997 and March 2011, this article begins with an analysis of the public health rhetorics that endorsed immigrants' inclusion into the U.S. health safety net. In this vein, the "cost-saving" and "the effortful immigrant" frames underscore immigrants' contributions to society vis-a-vis their low utilization of health services. These are complemented by a "surveillance" account that claims to protect the American public from communicable diseases. A "maternalistic" frame is also discussed as a tool to safeguard families, and particularly immigrant mothers, in their roles as bearers and caretakers of their American-born children. The analyses of the "chilling" and the "injustice" frames are then introduced to underscore major anthropological contributions to the formulation of counter-mainstream discourses on immigrants' selective inclusion into the U.S. health care system. First, the "chilling effect," defined as the voluntary withdrawal from health benefits, is examined in light of unauthorized immigrants' internalized feelings of undeservingness. Second, an "injustice" narrative highlights both the contributions and the limitations of a social justice paradigm, which advocated for the restoration of government benefits to elderly immigrants and refugees after the passage of PRWORA. By analyzing the contradictions among all these diverse frames, this paper finally reflects on the conceptual challenges faced by medical anthropology, and the social sciences at large, in advancing health equity and human rights paradigms.

Wafula, E. G. et Snipes, S. A. (2014). "Barriers to health care access faced by black immigrants in the US: theoretical considerations and recommendations." J Immigr Minor Health **16**(4): 689-698.

Although 54 % of the total black immigrant population is from the Caribbean and 34 % is from Africa, we know relatively little about barriers to healthcare access faced by black immigrants. This paper reviews literature on the barriers that black immigrants face as they traverse the healthcare system and develops a conceptual framework to address barriers to healthcare access experienced by this population. Our contribution is twofold: (1) we synthesize the literature on barriers that may lead to inequitable healthcare access for black immigrants, and (2) we offer a theoretical perspective on how to address these barriers. Overall, the literature indicates that structural barriers can be overcome by providing interpreters, cultural competency training for healthcare professionals, and community-based care. Our model reflects individual and structural factors that may promote these initiatives.

Wiewel, E. W., et al. (2013). "HIV diagnosis and utilisation of HIV-related medical care among foreign-born persons in New York City, 2001-2009." Sex Transm Infect **89**(5): 380-382.

OBJECTIVES: To measure trends in HIV diagnoses among foreign-born (FB) New Yorkers and compare the epidemic in FB with that in non-FB (NFB). METHODS: New York City (NYC) HIV/AIDS surveillance registry data were used to measure trends in HIV diagnoses in 2001-2009, calculate HIV diagnosis rates by area of birth, and compare demographic and care characteristics of FB and NFB diagnosed in 2006-2009. The registry contains data on all New Yorkers diagnosed with HIV infection, HIV disease and AIDS, and receives laboratory results on all New Yorkers living with HIV/AIDS. RESULTS: From 2001 to 2009, new HIV diagnoses among FB increased modestly in number but significantly as a percent of all cases (17% in 2001 to 28% in 2009; p<0.01). In 2006-2009, the annual rate of diagnosis was lower among FB than NFB (37 vs 56 per 100 000). Compared with NFB, FB persons were significantly more likely to be diagnosed concurrently with AIDS; FB had a lower median CD4 count at initiation of care. FB persons were less likely to have insurance, and 13% needed language interpretation services. CONCLUSIONS: The percentage of HIV diagnoses in NYC attributed to FB persons has increased. HIV infection may remain undiagnosed longer in FB than NFB. FB may benefit from targeted prevention outreach and other services.

Finlande

Tjukanov, N., Tiittala, P. et Salmi, H. (2021). "Health service use and costs among migrants in an irregular situation: Cross-sectional register-based study from a voluntary-based clinic." Int J Environ Res Public Health.

BACKGROUND: As few data based on actual demand for healthcare services in vulnerable migrant populations exist, we studied service use and healthcare costs in a cohort of migrants in an irregular situation. METHODS: In this single-centre retrospective register study, we examined the reasons for encounter, diagnoses, service use and costs of healthcare among patients at a voluntary clinic for migrants in an irregular situation in Helsinki, Finland. ICPC-2 classification and national unit costs for primary healthcare were used for the cost estimation. RESULTS: A total of 546 patient visits accounted for 620 ICPC-2 coded reasons for encounter, diagnoses and process codes. The most common health problems were teeth/gum disease (10%), acute upper respiratory infection (5%) and oesophageal disease (3%). Visits seldom led to complementary investigations (2%), follow-up visits (5%) or referrals (11%). The total cost of treatment, excluding dental health costs, was 71 euros per visit. CONCLUSIONS: Migrants in an irregular situation present with a variety of health concerns, the majority of which can be treated in a basic primary healthcare facility at a relatively low cost. This encourages research to evaluate the health and cost effects of extending public healthcare for migrants in an irregular situation beyond emergency care.

Tuomisto, K., Tiittala, P., Keskimaki, I., et al. (2019). "Refugee crisis in Finland: Challenges to safeguarding the right to health for asylum seekers." Health Policy **123**(9): 825-832.
http://www.ncbi.nlm.nih.gov/pubmed/31399260

In 2015 Finland received an unprecedented number of asylum seekers, ten times more than in any previous year. This surge took place at a time the Finnish Government was busily undergoing a wide-range health and social care reform amid growing nationalist and populist sentiments. Our aim is to explore the governance of a parallel health system for asylum seekers with a right-to-health approach. We concentrated on three right to health features most related to the governance of asylum seeker health care, namely Formal recognition of the right to health, Standards and Coordination mechanisms. Through our qualitative review, we identified three major hurdles in the governance of the system for asylum seekers: 1) Ineffectual and reactive national level coordination and stewardship; 2) Inadequate legislative and supervisory frameworks leading to ineffective governance; 3) Discrepancies between constitutional rights to health, legal entitlements to services and guidance available. This first-time large-scale implementation of the policies exposed weaknesses in the legal framework and the parallel health system. We recommend the removal of the parallel system and the integration of asylum seekers' health services to the national public health care system.

Grèce

Duijster, D., Grasveld, A., Sekundo, C., et al. (2020). "Inequalities Between Migrants and Non-Migrants in Accessing and Using Health Services in Greece During an Era of Economic Hardship." J Immigr Minor Health **50**(4): 444-457.

A cross-sectional study was conducted from April 2013 until March 2014 to explore the existence of inequalities in access to and utilization of health services by migrants compared to non-migrants in Greece and to test the influence of various factors on these disparities. Also, we investigated the influence of several socioeconomic and demographic characteristics. Study population included 1,152 migrants and 702 non-migrants. Migrants, participants suffering from a chronic disease, those without health insurance, and patients who assessed their health status as not at all good/a little good/moderate were statistically more likely to report unmet needs in getting their medication. Uninsured participants, females, those unemployed or without a permanent occupational status, and those who assessed their health status as not at all good/a little good/moderate were statistically more likely to report unmet needs in access to health services during the last year. Regarding the use of health services, those with health coverage, non-migrants, and females were statistically more likely to go for a blood test as a hospital outpatient. Greece, despite administrative delays and barriers, provided full coverage to the uninsured, asylum seekers, and migrants, even many groups of undocumented migrants.

Galanis, P., et al. (2013). "Public health services knowledge and utilization among immigrants in Greece: a cross-sectional study." BMC Health Serv Res **13**: 350.

BACKGROUND: During the 90s, Greece has been transformed to a host country for immigrants mostly from the Balkans and Eastern European Countries, who currently constitute approximately 9% of the total population. Despite the increasing number of the immigrants, little is known about their health status and their accessibility to healthcare services. This study aimed to explore the perceived barriers to access and utilization of healthcare services by immigrants in Greece. METHODS: A pilot cross-sectional study was conducted from January to April 2012 in Athens, Greece. The study population consisted of 191 immigrants who were living in Greece for less than 10 years. We developed a questionnaire that included information about sociodemographic characteristics, health status, public health services knowledge and utilization and difficulties in health services access. Statistical analysis included Pearson's x2 test, x2 test for trend, Student's t-test, analysis of variance and Pearson's correlation coefficient. RESULTS: Only 20.4% of the participants reported that they had a good/very good degree of knowledge about public health services in Greece. A considerable percentage (62.3%) of the participants needed at least once to use health services but they could not afford it, during the last year, while 49.7% used public health services in the last 12 months in Greece. Among the most important problems were long waiting times in hospitals, difficulties in communication with health professionals and high cost of health care. Increased ability to speak Greek was associated with increased health services knowledge ($p<0.001$). Increased family monthly income was also associated with less difficulties in accessing health services ($p<0.001$). CONCLUSIONS: The empowerment and facilitation of health care access for immigrants in Greece is necessary. Depending on the needs of the migrant population, simple measures such as comprehensive information regarding the available health services and the terms for accessibility is an important step towards enabling better access to needed services.

Gunst, M., Jarman, K., Yarwood, V., et al. (2019). "Healthcare access for refugees in Greece: Challenges and opportunities." Health Policy **123**(9): 818-824.
http://www.ncbi.nlm.nih.gov/pubmed/31229274

The arrival of more than one million refugees and migrants in Europe in 2015, most of whom transited through Greece, has placed significant strains on local health systems and demonstrated the need for preparedness to meet the immediate and longer-term health needs of arrivals in EU countries.

Population movements will continue to occur and the need for cost effective, appropriate provision of both primary and secondary health services to meet these needs is key. The Global Compact on Migration was ratified in 2018 and forms an overarching, international agreement to address safe, orderly and regular migration which benefits refugees and migrants as well as host communities; however, it did not give due emphasis to health. In this manuscript, we explore the evolution of the health response for refugees in Greece over the last three years, the challenges faced at different times of the response and the efforts to integrate refugees into Greece's health system.

Lahana, E., et al. (2011). "Do place of residence and ethnicity affect health services utilization? evidence from greece." Int J Equity Health **10**: 16.

BACKGROUND: Equal utilization of health services for equal need, is one of the main targets for public health systems. Given the public-private structure of the Greek NHS, the main aim of the study was to investigate the impact of underlying factors, such as health care needs, socio-demographic characteristics and ethnicity, on the utilization of primary and hospital health care in an urban and rural population of the Greek region, Thessaly. METHODS: A cross-sectional study was carried out in 2006 in Thessaly, a Greek region of Central Greece, in a representative sample of 1372 individuals (18+ years old, response rate 91.4%) via face-to-face interview. Health care needs were determined by self-perceived health status estimated by the SF-36 Health Survey, using the summary scores of physical and mental health. The utilization of primary care was measured by last month visits to 1) primary public services and 2) private practitioners visits and utilization of secondary care was measured by past year visits to 3) public hospital emergency departments and 4) admissions to public hospitals. Multivariable stepwise logistic regression analysis was applied in the whole sample and separately for the urban and rural population, in order to determine the predictors of health services utilization. Statistical significance was determined with a p value < 0.05. RESULTS: Health care needs were the most significant determinants of primary and secondary health services utilization in both the urban and rural areas. Poor physical and mental health was associated with higher likelihood of use. In the urban areas middle-aged, elderly and Greeks were more likely to use primary health services, whereas primary education was associated with more visits to the emergency departments. Wealthier individuals were two times more likely to be admitted to hospitals. Individuals from the rural areas with university education visited more the public primary services, while wealthier individuals visited more the private practitioners. Immigrants had a higher likelihood of visiting emergency departments. CONCLUSIONS: Although health care needs were the main determinant of health services utilization in both the urban and rural population, socio-economic and ethnic differences also seem to contribute to the inequities observed in some types of health services use, favouring the better-off. Such findings provide important information to policy makers, which attempt to reduce inequalities in health care according to place of residence and ethnicity.

Organisation Mondiale de la Santé. Bureau Régional de l'Europe (2015). Greece : assessing health-system capacity to manage sudden large influxes of migrants. Copenhague OMS Bureau régional de l'Europe**:** vi+19.

Further to the arrival of large influxes of migrants at Greece's land and sea borders, the Greek Government invited the WHO Regional Office for Europe to organize a joint mission between 15 and 19 December 2014 to assess health system capacity to manage large influxes of migrants. The mission aims were threefold: to assess the ongoing preparedness and response activities of the local health system; to plan ad hoc technical assistance if required; and to pilot the draft WHO toolkit for assessing health system capacity to manage large influxes of migrants in the acute phase. The members of the assessment team undertook site visits at first reception centres and pre-departure facilities, and conducted interviews with all key stakeholders. From their findings, their main recommendations include improvements in living conditions in migrant centres, the preparation of a national multisectoral contingency plan, a harmonized health data collection system and a strengthened migrant immunization policy.

Zavras, D., et al. (2013). "Impact of economic crisis and other demographic and socio-economic factors on self-rated health in Greece." Eur J Public Health **23**.

Italie

Caroppo, E., et al. (2014). "Health care for immigrant women in Italy: are we really ready? A survey on knowledge about female genital mutilation." Ann Ist Super Sanita **50**(1): 49-53.

BACKGROUND: Because of immigration, female genital mutilation (FGM) is an issue of increasing concern in western countries. Nevertheless operators without a specific training may ignore the health condition of women subjected to this practice and fail to provide them adequate assistance. The purpose of the study was to estimate the current knowledge about FGM among social and health care assistants working with asylum seeker. MATERIAL AND METHODS: From October to December 2012, a questionnaire was used to interview 41 operators working in CARA (Shelter for Refugees and Asylum Seekers) in central and southern Italy. RESULTS: Only 7.3% of respondents states to know well FGM, while 4.9% do not know it at all. 70.7% declare to have never met or assisted a woman with FGM, nevertheless all respondents work with asylum seeker from countries where FGM are performed. CONCLUSIONS: Migration fluxes to Italy over the past decade created a healthcare challenge: women with FGM have specific medical and psychological problems that doctors, nurses and social assistants without specific training are not usually able to manage.

De Luca, G., et al. (2013). "Health care utilization by immigrants in Italy." Int J Health Care Finance Econ **13**(1): 1-31.

Healthcare utilization studies show how well documented disparities between migrants and non-migrants. Reducing such disparities is a major goal in European countries. However, healthcare utilization among Italian immigrants is under-studied. The objective of this study is to explore differences in healthcare use between immigrant and native Italians. Cross-sectional study using the latest available (2004/2005) Italian Health Conditions Survey. We estimated separate hurdle binomial negative regression models for GP, specialist, and telephone consultations and a logit model for emergency room (ER) use. We used logistic regression and zero-truncated negative binomial regression to model the zero (contact decision) and count processes (frequency decisions) respectively. Adjusting for risk factors, immigrants are significantly less likely to use healthcare services with 2.4 and 2.7 % lower utilization probability for specialist and telephone consultations, respectively. First- and second-generation immigrants' probability for specialist and telephone contact is significantly lower than natives'. Immigrants, ceteris paribus, have a much higher probability of using ERs than natives (0.7 %). First-generation immigrants show a higher probability of visiting ERs (1 %). GP visits show no significant difference. In conclusion Italian immigrants are much less likely to use specialist healthcare and medical telephone consultations than natives but more likely to use ERs. Hence, we report an over-use of ERs and under-utilization of preventive care among immigrants. We recommend improved health policies for immigrants: promotion of better information dissemination among them, simplification of organizational procedures, better communications between providers and immigrants, and an increased supply of health services for the most disadvantaged populations.

de Waure, C., et al. (2015). "Health inequalities: an analysis of hospitalizations with respect to migrant status, gender and geographical area." BMC Int Health Hum Rights **15**: 2.

BACKGROUND: The quality of care includes several aspects which may be influenced by social-economic status. This study analyzes hospitalizations for several conditions, such as chronic diseases, cancer and appendectomy, in Italians and immigrant people living in Italy with the aim to evaluate possible inequalities in the quality of health care services due to migrant status, gender and geographical macro-areas (Northern, Central, Southern Italy). METHODS: The data source of hospital discharges for stroke, myocardial infarction, chronic liver disease, cervical cancer, mastectomy and appendectomy was the Ministry of Health. ICD 9 codes were used for data collection. Crude and standardized hospitalization rates per 100.000 were calculated. Italian resident population and an estimate of immigrants living in Italy were used as denominators while standardization was done with respect to the European population. The data we used covers the 2006-2008 period. RESULTS:

Immigrants showed significantly higher hospitalization rates for stroke, cervical cancer and appendectomy and significantly lower hospitalization rates for chronic liver diseases and mastectomy. Males showed significantly higher hospitalization rates than females for myocardial infarction, chronic liver diseases and appendectomy. Notwithstanding, differences related to migrant status and gender varied according to geographical macro-area. With respect to that, Southern Italy showed significantly higher hospitalization rates for stroke, myocardial infarction and chronic liver diseases and significantly lower hospitalization rates for mastectomy and appendectomy. CONCLUSIONS: The results of this study may reflect inequalities in the quality of health care, in particular in primary and secondary prevention, access to specialized care and inappropriateness, due to migrant status and gender. Also, differences between macro-areas suggest heterogeneities in the integration policies and the promotion of immigrants' health. Research should be endorsed in this field in order to further describe inequalities and their reasons and in the light of supporting policies development.

Devillanova, C. (2008). "Social networks, information and health care utilization: evidence from undocumented immigrants in Milan." J Health Econ **27**(2): 265-286.

This paper uses a novel dataset and research design to examine the effects of information networks on immigrants' access to health care. The dataset consists of an unusually large sample of undocumented immigrants and contains a direct indicator of information networks-whether an immigrant was referred to health care opportunities by a strong social tie (relative or friend). This measure allows to overcome some of the major identification issues that afflict most of the existing literature on network effects and to concentrate on one of the channels through which social contacts might operate. The analysis focuses on the time spent in Italy before an immigrant first receives medical assistance. Estimates indicate that networks significantly foster health care utilization: after controlling for all available individual characteristics and for ethnic heterogeneity, I find that relying on a strong social tie reduces the time to visit by 30%. The effect of information networks is stable across specifications and it is relatively large. Further investigation seems to confirm the quantitative importance of networks as an information device.

Franchi, C., et al. (2015). "Comparison of Health Care Resource Utilization by Immigrants Versus Native Elderly People." J Immigr Minor Health.

To compare the utilization of health care resources (drug prescriptions, hospital admissions and health care services) by immigrant versus native elderly people (65 years or more), by using administrative database of the Lombardy Region. For each immigrant (an older people born out of Italy), one person born in Lombardy (native) was randomly selected and matched by age, sex and general practitioner. The 25,508 immigrants selected were less prescribed with at least one drug (OR 0.72, 95 % CI 0.67-0.76) and had a lesser use of health care services (OR 0.79, 95 % CI 0.75-0.84) than natives. No statistically significant differences were found for hospital admission rates (OR 0.99, 95 % CI 0.99-1.04). A lower rate of health care resource utilization was observed in elderly immigrants who had been living in the host region for as many as 10 years.

Giuliana, L., et al. (2013). "Health care utilization by immigrants in Italy." International Journal of Health Care Finance and Economics **13**(1): 1-31.

Healthcare utilization studies show how well documented disparities between migrants and non-migrants. Reducing such disparities is a major goal in European countries. However, healthcare utilization among Italian immigrants is under-studied. The objective of this study is to explore differences in healthcare use between immigrant and native Italians. Cross-sectional study using the latest available (2004/2005) Italian Health Conditions Survey. We estimated separate hurdle binomial negative regression models for GP, specialist, and telephone consultations and a logit model for emergency room (ER) use. We used logistic regression and zero-truncated negative binomial regression to model the zero (contact decision) and count processes (frequency decisions) respectively. Adjusting for risk factors, immigrants are significantly less likely to use healthcare services with 2.4 and 2.7ÿ% lower utilization probability for specialist and telephone consultations, respectively. First- and second-generation immigrants' probability for specialist and telephone contact

is significantly lower than natives'. Immigrants, ceteris paribus, have a much higher probability of using ERs than natives (0.7ÿ%). First-generation immigrants show a higher probability of visiting ERs (1ÿ%). GP visits show no significant difference. In conclusion Italian immigrants are much less likely to use specialist healthcare and medical telephone consultations than natives but more likely to use ERs. Hence, we report an over-use of ERs and under-utilization of preventive care among immigrants. We recommend improved health policies for immigrants: promotion of better information dissemination among them, simplification of organizational procedures, better communications between providers and immigrants, and an increased supply of health services for the most disadvantaged populations. Healthcare utilization studies show how well documented disparities between migrants and non-migrants. Reducing such disparities is a major goal in European countries. However, healthcare utilization among Italian immigrants is under-studied. The objective of this study is to explore differences in healthcare use between immigrant and native Italians. Cross-sectional study using the latest available (2004/2005) Italian Health Conditions Survey. We estimated separate hurdle binomial negative regression models for GP, specialist, and telephone consultations and a logit model for emergency room (ER) use. We used logistic regression and zero-truncated negative binomial regression to model the zero (contact decision) and count processes (frequency decisions) respectively. Adjusting for risk factors, immigrants are significantly less likely to use healthcare services with 2.4 and 2.7ÿ% lower utilization probability for specialist and telephone consultations, respectively. First- and second-generation immigrants' probability for specialist and telephone contact is significantly lower than natives'. Immigrants, ceteris paribus, have a much higher probability of using ERs than natives (0.7ÿ%). First-generation immigrants show a higher probability of visiting ERs (1ÿ%). GP visits show no significant difference. In conclusion Italian immigrants are much less likely to use specialist healthcare and medical telephone consultations than natives but more likely to use ERs. Hence, we report an over-use of ERs and under-utilization of preventive care among immigrants. We recommend improved health policies for immigrants: promotion of better information dissemination among them, simplification of organizational procedures, better communications between providers and immigrants, and an increased supply of health services for the most disadvantaged populations

Marchesini, G., et al. (2014). "Under-treatment of migrants with diabetes in a universalistic health care system: the ARNO Observatory." Nutr Metab Cardiovasc Dis **24**(4): 393-399.

AIMS: To assess whereas prevalence, treatment and direct costs of drug-treated diabetes were similar in migrants and in people of Italian citizenship under the universalistic Italian health care system. METHODS AND RESULTS: Drug-treated diabetic individuals were identified in the population-based multiregional ARNO Observatory on the basis of 2010 prescriptions. Migrants were identified by the country-of-birth code on the fiscal identification code. Diabetes prevalence was calculated for Italians (n = 7,328,383) and migrants (n = 527,965). To assess the odds of migrants of having diabetes compared to Italians, we individually matched all migrants to Italians for major confounders (age, sex and place of residence). Finally, all migrants with diabetes were individually matched for confounders to Italians with diabetes to compare prescriptions, hospitalization rates, services use and direct costs for the National Health System. We identified 368,797 subjects with diabetes among Italians and 10,336 among migrants, giving prevalence of 5.03% and 1.96%, respectively. Migrants with diabetes were younger than Italians (52 +/- 13 years vs. 68 +/- 14 years, P < 0.001); after matching, their risk of disease was higher (odds ratio, 1.55, 95% confidence interval, 1.50-1.60). The total cost was 27% lower in migrants, due to lower cost of drugs (-29%), hospital admission (-27%) and health services (-22%). The number of packages/treated person-year of all glucose-lowering drugs was also lower in migrants (-15%) (P < 0.001). CONCLUSIONS: Compared to subjects of Italian ancestry, migrants to Italy show a higher risk of diabetes but less intense treatment. Inequalities in health care use are likely and are maintained also in a universalistic system.

Mipatrini, D., et al. (2017). "Access to healthcare for undocumented migrants: analysis of avoidable hospital admissions in Sicily from 2003 to 2013." Eur J Public Health **27**(3): 459-464.

Background: Access to healthcare services for undocumented migrants is one of the main public health issues currently being debated among European countries. Exclusion from primary healthcare services may lead to serious consequences for migrants' health. We analyzed the risk among undocumented

migrants, in comparison with regular migrants, of being hospitalized for preventable conditions in the Region of Sicily (Italy). We performed a hospital-based cross-sectional study of the foreign population hospitalized in the Sicily region between 1 January 2003 and 31 December 2013. The first outcome was the proportion of avoidable hospitalization (AHs) among regular and irregular migrants. Second outcomes were the subcategories of AHs for chronic, acute and vaccine preventable diseases. 85 309 hospital admissions were analyzed. In the hospitalized population, in comparison to regular migrants, undocumented migrants show a higher proportion of hospitalization for diseases preventable through primary and preventive care (AOR1.48, 95%CI 1.37-1.59). The proportion of avoidable hospitalizations associated with the lack of legal status is higher for vaccine preventable conditions (AOR 2.06, 95%CI 1.66-2.56) than for chronic conditions (AOR 1.47, 95%CI 1.42-1.63) and acute conditions (AOR 1.37; 95%CI 1.23-1.53). Between 2003 and 2013, the proportion of avoidable hospitalizations decreased both in regular and undocumented migrants but decreased faster for regular than for undocumented migrants. Undocumented migrants experience higher proportion of hospitalization for preventable conditions in comparison with regular migrants probably due to a lack of access to the national healthcare service. Policies and strategies to involve them in primary healthcare and preventive services should be developed to tackle this inequality.

Ravinetto, R., et al. (2009). "Access to health care for undocumented migrants in Italy." Lancet **373**(9681): 2111-2112.

Norvège

Bendixsen, S. K. N. (2020). "Existential Displacement: Health Care and Embodied Un/Belonging of Irregular Migrants in Norway." Cult Med Psychiatry **44**(4): 479-500.

Drawing on fieldwork and interviews in Oslo and Bergen, Norway, this article discusses irregular migrants' experiences of existential displacement and the tactics they use to try to re-establish a sense of emplacement and belonging. More specifically, it argues that irregular migrants' experiences of embodied unbelonging are a consequence of a violent form of governmentality that includes specific laws, healthcare structures, and migration management rationalities. The article makes this argument by tracing how these experiences translate into embodied effects that feature prominently in migrants' narratives of suffering while living in a country that purports to provide welfare services to all. The narratives of their state of being-in-the-world are ways through which migrants both experience and express the violence and deprivation they face. I argue that these narratives are instances of structures of feeling (Williams 1973), which are shaped by modes of governmentality. The article shows that irregular migrants' coping strategies centrally involve faith, religious communities and friends. Irregular migrants draw on these relationships to get by, access healthcare, and to resist the (health) effects of social deprivation and political violence. These relationships allow irregular migrants to find meaningful ways of being-in-the-world and rebuilding, to some extent, a sense of entitlement and belonging.

Diaz, E., et al. (2015). "How do immigrants use primary health care services? A register-based study in Norway." Eur J Public Health **25**(1): 72-78.

BACKGROUND: Immigrant's use of primary health care (PHC) services differs from that of native's, but studies are non-consistent, and the importance of individual explaining variables like socio-economic status, morbidity burden and length of stay in the host country is uncertain. METHODS: Registry-based study using merged data from the National Population Register and the Norwegian Health Economics Administration Database for all immigrants and natives >/=15 years registered in Norway in 2008 (3 739 244 persons), applying the Johns Hopkins ACG(R) Case-Mix System. Using multivariate binary logistic and negative binomial regression analyses, respectively, we compared overall use of PHC and number of visits to PHC between immigrants and natives, and investigated the significance of socio-economic, immigration and morbidity variables. RESULTS: A significantly lower percentage of immigrants used the general practitioner (GP) compared with natives. Among GP users, however, most immigrants used the GP at a 2-15% significantly higher rate compared with natives. Older

immigrants used their GP less and at lower rates than younger immigrants. A significantly lower percentage of immigrants from high-income countries, but a higher percentage of all other immigrants used emergency services compared with natives, with no differences in use rates. Morbidity burden and length of stay were essential explaining variables. CONCLUSION: Lower use of PHC among immigrants could be due to better health or to access barriers, and should be further studied, especially for the oldest immigrants. Adjusted high frequency of use may be appropriate, but it might also be a signal of non-effective contacts.

Diaz, E., et al. (2014). "Frequent attenders in general practice and immigrant status in Norway: a nationwide cross-sectional study." Scand J Prim Health Care **32**(4): 232-240.

OBJECTIVE: To compare the likelihood of being a frequent attender (FA) to general practice among native Norwegians and immigrants, and to study socioeconomic and morbidity factors associated with being a FA for natives and immigrants. DESIGN, SETTING AND SUBJECTS: Linked register data for all inhabitants in Norway with at least one visit to the general practitioner (GP) in 2008 (2 967 933 persons). Immigrants were grouped according to their country of origin into low- (LIC), middle- (MIC), and high-income countries (HIC). FAs were defined as patients whose attendance rate ranked in the top 10% (cut-off point > 7 visits). MAIN OUTCOME MEASURES: FAs were compared with other GP users by means of multivariate binary logistic analyses adjusting for socioeconomic and morbidity factors. RESULTS: Among GP users during the daytime, immigrants had a higher likelihood of being a FA compared with natives (OR (95% CI): 1.13 (1.09-1.17) and 1.15 (1.12-1.18) for HIC, 1.84 (1.78-1.89) and 1.66 (1.63-1.70) for MIC, and 1.77 (1.67-1.89) and 1.65 (1.57-1.74) for LIC for men and women respectively). Pregnancy, middle income earned in Norway, and having cardiologic and psychiatric problems were the main factors associated with being a FA. Among immigrants, labour immigrants and the elderly used GPs less often, while refugees were overrepresented among FAs. Psychiatric, gastroenterological, endocrine, and non-specific drug morbidity were relatively more prevalent among immigrant FA compared with natives. CONCLUSION: Although immigrants account for a small percentage of all FAs, GPs and policy-makers should be aware of differences in socioeconomic and morbidity profiles to provide equality of health care.

Diaz, E. et Kumar, B. N. (2014). "Differential utilization of primary health care services among older immigrants and Norwegians: a register-based comparative study in Norway." BMC Health Serv Res **14**: 623.

BACKGROUND: Aging in an unfamiliar landscape can pose health challenges for the growing numbers of immigrants and their health care providers. Therefore, better understanding of how different immigrant groups use Primary Health Care (PHC), and the underlying factors that explain utilization is needed to provide adequate and appropriate public health responses. Our aim is to describe and compare the use of PHC between elderly immigrants and Norwegians. METHODS: Registry-based study using merged data from the National Population Register and the Norwegian Health Economics Administration database. All 50 year old or older Norwegians with both parents from Norway (1,516,012) and immigrants with both parents from abroad (89,861) registered in Norway in 2008 were included. Descriptive analyses were carried out. Immigrants were categorised according to country of origin, reason for migration and length of stay in Norway. Binary logistic regression analyses were conducted to study the utilization of PHC comparing Norwegians and immigrants, and to assess associations between utilization and both length of stay and reason for immigration, adjusting for other socioeconomic variables. RESULTS: A higher proportion of Norwegians used PHC services compared to immigrants. While immigrants from high-income countries used PHC less than Norwegians disregarding age (OR from 0.65 to 0.92 depending on age group), they had similar number of diagnoses when in contact with PHC. Among immigrants from other countries, however, those 50 to 65 years old used PHC services more often (OR 1.22) than Norwegians and had higher comorbidity levels, but this pattern was reversed for older adults (OR 0.56 to 0.47 for 66-80 and 80+ years respectively). For all immigrants, utilization of PHC increased with longer stay in Norway and was higher for refugees (1.67 to 1.90) but lower for labour immigrants (0.33 to 0.45) compared to immigrants for family reunification. However, adjustment for education and income levels reduced most differences between groups. CONCLUSIONS: Immigrants' lower utilization of PHC services might reflect better health among immigrants, but it could also be due to barriers to access that pose public

health challenges. The heterogeneity of life courses and migration trajectories should be taken into account when developing public policies.

Lien, E., et al. (2008). "Non-western immigrants' satisfaction with the general practitioners' services in Oslo, Norway." Int J Equity Health **7**: 7.

BACKGROUND: Over the last few years the number of immigrants from the non-western parts of the world living in Oslo, has increased considerably. We need to know if these immigrants are satisfied with the health services they are offered. The aim of this study was to assess whether the immigrants' level of satisfaction with visits to general practitioners was comparable with that for ethnic Norwegians. METHODS: Two population-based surveys, the Oslo Health Study and the Oslo Immigrant Health Study, were performed on selected groups of Oslo citizens in 2000 and 2002. The response rates were 46% and 33%, respectively. In all, 11936 Norwegians and 1102 non-western immigrants from the Oslo Health Study, and 1774 people from the Oslo Immigrant Health Study, were included in this analysis. Non-western immigrants' and ethnic Norwegians' level of satisfaction with visits to general practitioners were analysed with respect to age, gender, health, working status, and use of translators. Bivariate (Chi square) and multivariate analyses (logistic regression) were performed. RESULTS: Most participants were either moderately or very satisfied with their last visit to a general practitioner. Non-western immigrants were less satisfied than Norwegians. Dissatisfaction among the immigrants was associated with young age, a feeling of not having good health, and coming from Turkey, Iran, Pakistan, or Vietnam as compared to Sri Lanka. The attendance rates in the surveys were rather low and lowest among the non-western immigrants. CONCLUSION: Although the degree of satisfaction with the primary health care was relatively high among the participants in these surveys, the non-western immigrants in this study were less satisfied than ethnic Norwegians with their last visit to a general practitioner. The rather low response rates opens for the possibility that the degree of satisfaction may not be representative for all immigrants.

Ruud, S. E., et al. (2015). "Use of emergency care services by immigrants-a survey of walk-in patients who attended the Oslo Accident and Emergency Outpatient Clinic." BMC Emerg Med **15**: 25.

BACKGROUND: The Oslo Accident and Emergency Outpatient Clinic (OAEOC) experienced a 5-6% annual increase in patient visits between 2005 and 2011, which was significantly higher than the 2-3% annual increase among registered Oslo residents. This study explored immigrant walk-in patients' use of both the general emergency and trauma clinics of the OAEOC and their concomitant use of regular general practitioners (RGPs) in Oslo. METHODS: A cross-sectional survey of walk-in patients attending the OAEOC during 2 weeks in September 2009. We analysed demographic data, patients' self-reported affiliation with the RGP scheme, self-reported number of OAEOC and RGP consultations during the preceding 12 months. The first approach used Poisson regression models to study visit frequency. The second approach compared the proportions of first- and second-generation immigrants and those from the four most frequently represented countries (Sweden, Pakistan, Somalia and Poland) among the patient population, with their respective proportions within the general Oslo population. RESULTS: The analysis included 3864 patients: 1821 attended the Department of Emergency General Practice ("general emergency clinic"); 2043 attended the Section for Orthopaedic Emergency ("trauma clinic"). Both first- and second-generation immigrants reported a significantly higher OAEOC visit frequency compared with Norwegians. Norwegians, representing 73% of the city population accounted for 65% of OAEOC visits. In contrast, first- and second-generation immigrants made up 27% of the city population but accounted for 35% of OAEOC visits. This proportional increase in use was primarily observed in the general emergency clinic (42% of visits). Their proportional use of the trauma clinic (29%) was similar to their proportion in the city. Among first-generation immigrants only 71% were affiliated with the RGP system, in contrast to 96% of Norwegians. Similar finding were obtained when immigrants were grouped by nationality. Compared to Norwegians, immigrants from Sweden, Pakistan and Somalia reported using the OAEOC significantly more often. Immigrants from Sweden, Poland and Somalia were over-represented at both clinics. The least frequent RGP affiliation was among immigrants from Sweden (32%) and Poland (65%). CONCLUSIONS: In Norway, immigrant subgroups use emergency health care services in different ways. Understanding these patterns of health-seeking behaviour may be important when designing emergency health services.

Sandvik, H., et al. (2012). "Immigrants' use of emergency primary health care in Norway: a registry-based observational study." BMC Health Serv Res **12**: 308.

BACKGROUND: Emigrants are often a selected sample and in good health, but migration can have deleterious effects on health. Many immigrant groups report poor health and increased use of health services, and it is often claimed that they tend to use emergency primary health care (EPHC) services for non-urgent purposes. The aim of the present study was to analyse immigrants' use of EPHC, and to analyse variations according to country of origin, reason for immigration, and length of stay in Norway. METHODS: We conducted a registry based study of all immigrants to Norway, and a subsample of immigrants from Poland, Germany, Iraq and Somalia, and compared them with native Norwegians. The material comprised all electronic compensation claims for EPHC in Norway during 2008. We calculated total contact rates, contact rates for selected diagnostic groups and for services given during consultations. Adjustments for a series of socio-demographic and socio-economic variables were done by multiple logistic regression analyses. RESULTS: Immigrants as a whole had a lower contact rate than native Norwegians (23.7% versus 27.4%). Total contact rates for Polish and German immigrants (mostly work immigrants) were 11.9% and 7.0%, but for Somalis and Iraqis (mostly asylum seekers) 31.8% and 33.6%. Half of all contacts for Somalis and Iraqis were for non-specific pain, and they had relatively more of their contacts during night than other groups. Immigrants' rates of psychiatric diagnoses were low, but increased with length of stay in Norway. Work immigrants suffered less from respiratory and gastrointestinal infections, but had more injuries and higher need for sickness certification. All immigrant groups, except Germans, were more often given a sickness certificate than native Norwegians. Use of interpreter was reduced with increasing length of stay. All immigrant groups had an increased need for long consultations, while laboratory tests were most often used for Somalis and Iraqis. CONCLUSIONS: Immigrants use EPHC services less than native Norwegians, but there are large variations among immigrant groups. Work immigrants from Germany and Poland use EPHC considerably less, while asylum seekers from Somalia and Iraq use these services more than native Norwegians.

Smaland Goth, U. G. et Berg, J. E. (2011). "Migrant participation in Norwegian health care. A qualitative study using key informants." Eur J Gen Pract **17**(1): 28-33.

BACKGROUND: Little is known about how migrants adapt to first-world public health systems. In Norway, patients are assigned a registered general practitioner (RGP) to provide basic care and serve as gatekeeper for other medical services. OBJECTIVES: To explore determinants of migrant compliance with the RGP scheme and obstacles that migrants may experience. METHODS: Individuals in leadership positions within migrant organizations for the 13 largest migrant populations in Norway in 2008 participated in this qualitative study. Semi-structured interviews, with migrants serving as key informants, were used to elucidate possible challenges migrant patients face in navigating the local primary health-care system. Conversations were structured using an interview guide covering the range of challenges that migrant patients meet in the health-care system. RESULTS: According to informants, integration into the RGP scheme and adequacy of patient-physician communication varies according to duration of stay in Norway, the patient's country of origin, the reason for migration, health literacy, intention to establish permanent residence in Norway, language proficiency, and comprehension of information received about the health system. Informants noted as obstacles: doctor-patient interaction patterns, conflicting ideas about the role of the doctor, and language and cultural differences. In addressing noted obstacles, one strategy would be to combine direct intervention by migrant associations with indirect intervention via the public-health system. CONCLUSION: Our results will augment the interpretation of forthcoming quantitative data on migrant integration into the public-health system and shed light on particular obstacles.

Straiton, M., et al. (2014). "Immigrants' use of primary health care services for mental health problems." BMC Health Serv Res **14**: 341.

BACKGROUND: Equity in health care across all social groups is a major goal in health care policy. Immigrants may experience more mental health problems than natives, but we do not know the

extent to which they seek help from primary health care services. This study aimed to determine a) the rate immigrants use primary health care services for mental health problems compared with Norwegians and b) the association between length of stay, reason for immigration and service use among immigrants. METHODS: National register data covering all residents in Norway and all consultations with primary health care services were used. We conducted logistic regression analyses to compare Norwegians' with Polish, Swedish, German, Pakistani and Iraqi immigrants' odds of having had a consultation for a mental health problem (P-consultation). RESULTS: After accounting for background variables, all immigrants groups, except Iraqi men had lower odds of a P-consultation than their Norwegian counterparts. A shorter length of stay was associated with lower odds of a P-consultation. CONCLUSIONS: Service use varies by country of origin and patterns are different for men and women. There was some evidence of a possible 'healthy migrant worker' effect among the European groups. Together with previous research, our findings however, suggest that Iraqi women and Pakistanis in particular, may experience barriers in accessing care for mental health problems.

Pays-Bas

de Back, T. R., et al. (2015). "Cardiovascular Health and Related Health Care Use of Moluccan-Dutch Immigrants." PLoS One **10**(9): e0138644.

OBJECTIVE: Studies regularly show a higher incidence, prevalence and mortality of cardiovascular disease among immigrant groups from low-income countries. Despite residing in the Netherlands for over 60 years, the Moluccan-Dutch cardiovascular disease profile and health care use are still unknown. We aimed to compare (a) the clinical prevalence of cardiovascular diseases and (b) the use of health care services by cardiovascular disease patients of 5,532 Moluccan-Dutch to an age-sex matched control group of 55,320 native Dutch. METHODS: We performed a cross-sectional analysis of data of the Achmea health insurance company for the period of 1 January 2009 to 31 December 2010. We collected information on health care use, including diagnostic information. Linear and logistic regression models were used for comparison. RESULTS: Moluccans had a higher clinical prevalence of ischemic heart diseases (odds ratio 1.26; 95% confidence interval 1.03-1.56), but tended to have a lower prevalence of cerebrovascular accidents (0.79; 0.56-1.11) and cardiac failure (0.67; 0.44-1.03). The clinical prevalence of cardiovascular diseases together tended to be lower among Moluccans (0.90; 0.80-1.00). Consultation of medical specialists did not differ. Angiotensin II inhibitors (1.42; 1.09-1.84), antiplatelet agents (1.27; 1.01-1.59) and statins (1.27; 1.00-1.60) were prescribed more frequently to Moluccans, as were cardiovascular agents in general (1.27; 0.94-1.71). CONCLUSION: The experience of Moluccans in the Netherlands suggests that, in the long run, cardiovascular risk and related health care use of ethnic minority groups may converge towards that of the majority population.

Denktas, S., et al. (2009). "Ethnic background and differences in health care use: a national cross-sectional study of native Dutch and immigrant elderly in the Netherlands." Int J Equity Health **8**: 35.

BACKGROUND: Immigrant elderly are a rapidly growing group in Dutch society; little is known about their health care use. This study assesses whether ethnic disparities in health care use exist and how they can be explained. Applying an established health care access model as explanatory factors, we tested health and socio-economic status, and in view of our research population we added an acculturation variable, elaborated into several sub-domains. METHODS: Cross-sectional study using data from the "Social Position, Health and Well-being of Elderly Immigrants" survey, conducted in 2003 in the Netherlands. The study population consisted of first generation immigrants aged 55 years and older from the four major immigrant populations in the Netherlands and a native Dutch reference group. The average response rate to the survey was 46% (1503/3284; country of origin: Turkey n = 307, Morocco n = 284, Surinam n = 308, the Netherlands Antilles n = 300, the Netherlands n = 304). RESULTS: High ethnic disparities exist in health and health care utilisation. Immigrant elderly show a higher use of GP services and lower use of physical therapy and home care. Both self-reported health status (need factor) and language competence (part of acculturation) have high explanatory power for all types of health services utilisation; the additional impact of socio-economic status and education is

low. CONCLUSION: For all health services, health disparities among all four major immigrant groups in the Netherlands translate into utilisation disparities, aggravated by lack of language competence. The resulting pattern of systematic lower health services utilisation of elderly immigrants is a challenge for health care providers and policy makers.

Liu, C. H., et al. (2011). "Barriers to health care for chinese in the Netherlands." Int J Family Med **2011**: 635853.

This study examines utilisation of the Dutch health care system by Chinese people in the Netherlands as well as their attitudes to the system, paying special attention to mental health. Information was gathered by semistructured interviews (n = 102). The main issues investigated are access, help-seeking behaviour, and quality of care. Results showed that most respondents used Dutch health care as their primary method of managing health problems. Inadequate knowledge about the system and lack of Dutch language proficiency impede access to care, in particular registration with a General Practitioner (GP). Users complained that the care given differed from what they expected. Results also showed that the major problems are to be found in the group coming from the Chinese-speaking region. Western concepts of mental health appear to be widely accepted by Chinese in the Netherlands. However, almost half of our respondents believed that traditional Chinese medicine or other methods can also help with mental health problems. The provision of relevant information in Chinese appears to be important for improving access. Better interpretation and translation services, especially for first-generation migrants from the Chinese-speaking region, are also required.

Schoevers, M. A., et al. (2010). "Health care utilisation and problems in accessing health care of female undocumented immigrants in the Netherlands." Int J Public Health **55**(5): 421-428.

OBJECTIVE: To obtain information about the actual use of health care facilities by undocumented women and to identify obstacles they experience in accessing health care facilities. METHODS: A mixed methods study, with structured questionnaires and semi-structured interviews, was chosen to obtain a complete understanding. One-hundred undocumented women were recruited. Diversity was sought according to age, origin and reason for being undocumented. RESULTS: Undocumented female immigrants have unmet health care needs (56%) and low health care utilisation. Sixty-nine per cent of the women reported obstacles in accessing health care facilities. These included many personal obstacles such as shame, fear and/or lack of information. Poor language proficiency (OR 0.28;. CI 0.09-0.90) reduces utilisation of primary health care services. CONCLUSION: Health care utilisation of undocumented women is low. Undocumented women refrain from seeking health care because of personal obstacles. These women need to be identified and informed about their rights, the health care system and the duty of professional confidentiality of doctors. Finally, institutional obstacles to access care should be removed since they strengthen reluctance to seek help.

Verest, W. J. G. M., Galenkamp, H., Spek, B., et al. (2019). "Do ethnic inequalities in multimorbidity reflect ethnic differences in socioeconomic status? The HELIUS study." Eur J Public Health **29**(4): 687-693. https://doi.org/10.1093/eurpub/ckz012

The burden of multimorbidity is likely higher in ethnic minority populations, as most individual diseases are more prevalent in minority groups. However, information is scarce. We examined ethnic inequalities in multimorbidity, and investigated to what extent they reflect differences in socioeconomic status (SES).We included Healthy Life in an Urban Setting study participants of Dutch (N = 4582), South-Asian Surinamese (N = 3258), African Surinamese (N = 4267), Ghanaian (N = 2282), Turkish (N = 3879) and Moroccan (N = 4094) origin (aged 18–70 years). Educational level, employment status, income situation and multimorbidity were defined based on questionnaires. We described the prevalence and examined age-adjusted ethnic inequalities in multimorbidity with logistic regression analyses. To assess the contribution of SES, we added SES indicators to the age-adjusted model.The prevalence of multimorbidity ranged from 27.1 to 53.4% in men and from 38.5 to 69.6% in women. The prevalence of multimorbidity in most ethnic minority groups was comparable to the prevalence among Dutch participants who were 1–3 decades older. After adjustment for SES, the odds of multimorbidity remained significantly higher in ethnic minority groups. For instance, age-adjusted OR for multimorbidity for the Turkish compared to the Dutch changed from 4.43 (3.84–5.13) to 2.34

(1.99–2.75) in men and from 5.35 (4.69–6.10) to 2.94 (2.54–3.41) in women after simultaneous adjustment for all SES indicators.We found a significantly higher prevalence of multimorbidity in ethnic minority men and women compared to Dutch, and results pointed to an earlier onset of multimorbidity in ethnic minority groups. These inequalities in multimorbidity were not fully accounted for by differences in SES.

Nouvelle Zélande

Kennedy, J., Kim, H., Moran, S., et al. (2021). "Qualitative experiences of primary health care and social care professionals with refugee-like migrants and former quota refugees in New Zealand." PLoS One **27**(5): 391-396.

Former quota refugees are known to have higher health and social care needs than the general population in resettlement countries. However, migrants with a refugee-like background (refugee-like migrants) in New Zealand are not currently offered systematic government-sponsored induction or health services. This study explored the experiences of New Zealand health and social care providers in general practice. Staff at two Wellington region general practices with known populations of refugee-like migrants and former quota refugees were approached to participate in an exploratory qualitative study. Semistructured audio-recorded interviews and focus groups were undertaken. Deductive and inductive analyses were used to identify key themes. Twelve interviews were undertaken with professionals with backgrounds in clinical pharmacy, cross-cultural work, general practice medicine, primary care nursing, reception and social work. Key themes from the interviews were communication challenges, organisational structure and teamwork, considerations to best meet core health and support needs, and the value of contextual knowledge. Healthcare workers perceived many similarities between working with refugee-like migrants and working with former quota refugees. Even though communication challenges were addressed, there were still barriers affecting the delivery of core health and support services. Primary care practices should focus on organisational structure to provide high-quality, contextually informed, interprofessional team-based health and social care.

Portugal

(2014). Portugal: assessing health-system capacity to manage sudden large influxes of migrants. Copenhague OMS Bureau régional de l'Europe**:** vii+10.

The area of migration and health is one of the topics to which the new WHO European health policy framework – Health 2020 – has drawn particular attention, along with other issues related to population vulnerability and human rights. Health 2020 provides a comprehensive framework for, as well as values and approaches to action that are much needed in public health work in the field of migration and health. A sudden influx of migrants has occurred on several occasions in the countries of the WHO European Region over recent years, posing significant challenges to the health systems of the recipient countries and requiring basic services to be scaled up to facilitate the appropriate response to the essential needs of the migrants and to fulfil their fundamental human rights. The unpredictable nature of the migration phenomenon calls Member States to strengthen the preparedness of their health systems to manage a potential large influx of displaced populations and to invest in emergency management capabilities and effective multisectoral coordination mechanisms. With this in mind, an assessment of Portugal’s health system capacity to manage large influxes of migrants was jointly conducted by the country’s Ministry of Health and WHO. Influxes in the southern European countries in particular underlined the need to identify best practices, share experiences and enter into an efficient policy dialogue between stakeholders. Portugal is implementing measures consistent with World Health Assembly resolution WHA 61.17 of 2008 and the Global Consultation on Migrant Health of 2010 in Madrid, Spain. In several aspects, Portugal could be seen as model for migrant integration practices, although in terms of preparedness there is scope to

Almeida, L. M., et al. (2014). "Obstetric care in a migrant population with free access to health care." Int J

Gynaecol Obstet **126**(3): 244-247.

OBJECTIVE: To evaluate differences in obstetric care between immigrant and native women in a country with free access to health care. METHODS: A cross-sectional study was carried out of immigrant mothers delivering in one of the four public hospitals in the Porto, Portugal, metropolitan area between February and December 2012. The comparison group included native Portuguese mothers who delivered in the same institutions. The participants (89 immigrant mothers and 188 Portuguese mothers) were recruited by telephone and completed a written questionnaire during a home visit. RESULTS: Immigrant women were more likely to have their first pregnancy appointment after 12 weeks of pregnancy (27.0% vs 14.4%, P = 0.011) and to have fewer than three prenatal visits (2.2% vs 0.0%, P < 0.001). They were also more likely to have had a cesarean delivery (48.3% vs 31.4%, P = 0.023), perineal laceration (48.8% vs 11.6%, P < 0.001), or postpartum hemorrhage (33.5% vs 12.3%, P < 0.001). CONCLUSION: Migrants were more prone to late prenatal care and to intrapartum complications. Unsatisfactory interactions with healthcare staff may play an important role in these findings.

Dias, S., et al. (2011). "Healthcare-seeking patterns among immigrants in Portugal." Health Soc Care Community **19**(5): 514-521.

Equity of access to health services is a major concern as it is an important precondition for positive health outcomes. However, inequities in use of health services among immigrant populations persist. Despite the increasing research in the field, patterns of healthcare seeking among immigrant populations and its associated factors are not fully understood. This study aimed to investigate healthcare-seeking patterns among immigrants in Portugal and identify factors associated with utilisation of health services. A cross-sectional study was conducted between October 2008 and May 2009 with a sample of 1,375 immigrants residing in the Lisbon region. Data were collected through a structured questionnaire applied by trained interviewers. Two stepwise logistic regressions were conducted to identify which factors were associated with utilisation of the National Health Service (NHS) and with healthcare seeking for the first time in Portugal at the Primary Health Care service, estimated by calculating odds ratios and 95% confidence intervals. Among participants, around 77% reported having used the NHS; 50% sought health-care for the first time at the Primary Health Care service and 33% at the emergency room. Lower odds of having used the NHS were associated with being male, Brazilian or eastern European compared with being African, and undocumented. Lower odds of having sought health-care for the first time at the Primary Health Care service were associated with being male and undocumented. These results suggest that further efforts are needed to tackle inequalities in access to care and promote the utilisation of health services, particularly among the more vulnerable immigrant groups. Increasing appropriate utilisation of health services, including the primary and preventive care services, may lead to better health outcomes. Immigrants' involvement and participation should be incorporated into the development of health strategies to improve access and utilisation of healthcare services.

Dias, S., et al. (2010). "Immigrant women's perceptions and experiences of health care services: Insights from a focus group study." Journal of Public Health **18**(5): 489-496.
https://doi.org/10.1007/s10389-010-0326-x

This study aimed to describe perceptions and experiences related to access and utilization of health care services of African and Brazilian immigrant women in Portugal.

Dias, S., et al. (2012). "Health workers' attitudes toward immigrant patients: a cross-sectional survey in primary health care services." Hum Resour Health **10**: 14.

BACKGROUND: Health workers' attitudes toward immigrant patients influence behaviour, medical decisions, quality of care and health outcomes. Despite the increasing number of immigrant patients in health services and the potential influence of health workers' attitudes, there is little research in this area. This study aimed to examine attitudes of different health workers' groups toward immigrant patients and to identify the associated factors. METHODS: This cross-sectional study was conducted with a random sample of 400 health workers from primary health care services in the Lisbon region, Portugal. Among those, 320 completed a structured questionnaire. Descriptive analysis and multiple linear regression analysis were used for the evaluation of data. RESULTS: Most participants did not

agree that immigrant patients tend to behave like victims, but about half considered that some are aggressive and dangerous. Doctors and nurses showed more positive attitudes than office workers. Among doctors, the older ones reported less positive attitudes compared to the younger ones. Health workers who have less daily contact with immigrants revealed more positive attitudes. Most participants evaluated their knowledge and competencies to work with immigrants as moderate or low. CONCLUSIONS: Although health workers reveal positive attitudes, this study reinforces the need to develop strategies that prevent negative attitudes and stereotyping in health services. Efforts should be made to improve workers' competencies to deal with culturally diverse populations, in order to promote quality of health care and obtain positive health outcomes among immigrant populations.

Dias, S., et al. (2011). "[Barriers in access and utilization of health services among immigrants: the perspective of health professionals]." Acta Med Port **24**(4): 511-516.

The growing international migration has reinforcing the importance of a greater adequacy of health services in order to respond effectively to immigrants' needs. Previous studies indicate that several difficulties in the access and utilization of health services persist for some immigrant groups. The objective of this study was to understand the perspective of different health professionals' groups about the barriers in access and utilization of services by immigrants. In a transversal study a questionnaire was applied to 320 primary health care professionals of Lisbon and Tagus Valley. Differences between professional groups were analysed using the Kruskal-Wallis test. To determine which groups diverged more in their perceptions, mean ranks of each group were compared. Of the total participants, 64.2% evaluated their knowledge and competencies to deal with immigrants as reasonable however, 15.2% evaluated it as bad. Around one third of professionals admitted to be unaware of the legislation which regulates migrants' access to services. The largest proportion considered that, at the individual level, the frequent change of residence, the lack of economic resources, the cultural and religious beliefs and traditions, the fear of denunciation when the immigrant is undocumented, the lack of knowledge about legislation and services, and the linguistic differences influence access and utilization of health services. Most considered as barriers at the professionals' and services' level the limited sociocultural skills, the complex bureaucratic procedures, the cost and the lack of interpreters. The divergences in the perception of these factors occurred mainly between office workers and the other professionals. The perceptions of health professionals about the barriers in access and utilization of services by immigrants highlight opportunities for intervention in the context of cultural diversity. Given the different perceptions among the professional groups, which may be reflection of the functions they perform, it is reinforced the importance of developing appropriate training to the different professional profiles. The capacity-building of health professionals to deal with cultural diversity may be an important component of human resources training, contributing to better adequate services to the needs of the immigrant.

Dias, S. F., et al. (2008). "Determinants of health care utilization by immigrants in Portugal." BMC Health Serv Res **8**: 207.

BACKGROUND: The increasing diversity of population in European Countries poses new challenges to national health systems. There is a lack of data on accessibility and use of health care services by migrants, appropriateness of the care provided, client satisfaction and problems experienced when confronting the health care system. This limits knowledge about the multiple determinants of the utilization of health services. The aim of this study was to describe the access of migrants to health care and its determinants in Portugal. METHODS: The study sample included 1513 immigrants (53% men), interviewed at the National Immigrant Support Centre, in Lisbon. Data were collected using questionnaires. The magnitude of associations between use of National Health Service and socio-demographic variables was estimated by means of odds ratios (OR) at 95% confidence intervals, calculated using logistic regression. RESULTS: Among participants, 3.6% stated not knowing where to go if facing a health problem. Approximately 20% of the respondents reported that they had never used the National Health Service, men more than women. Among National Health Service users, 35.6% attended Health Centres, 12% used Hospital services, and 54.4% used both. Among the participants that ever used the health services, 22.4% reported to be unsatisfied or very unsatisfied.

After adjusting for all variables, utilization of health services, among immigrant men, remained significantly associated with length of stay, legal status, and country of origin. Among immigrant women, the use of health services was significantly associated with length of stay and country of origin. CONCLUSION: There is a clear need to better understand how to ensure access to health care services and to deliver appropriate care to immigrants, and that special consideration must be given to recent and undocumented migrants. To increase health services use, and the uptake of prevention programs, barriers must be identified and approaches to remove them developed, through coherent and comprehensive strategies.

Royaume-Uni

Aung, N. C., et al. (2010). "Access to and utilisation of GP services among Burmese migrants in London: a cross-sectional descriptive study." BMC Health Serv Res **10**: 285.

BACKGROUND: An estimated 10,000 Burmese migrants are currently living in London. No studies have been conducted on their access to health services. Furthermore, most studies on migrants in the United Kingdom (UK) have been conducted at the point of service provision, carrying the risk of selection bias. Our cross-sectional study explored access to and utilisation of General Practice (GP) services by Burmese migrants residing in London. METHODS: We used a mixed-method approach: a quantitative survey using self-administered questionnaires was complemented by qualitative in-depth interviews for developing the questionnaire and triangulating the findings of the survey. Overall, 137 questionnaires were received (a response rate of 57%) and 11 in-depth interviews conducted. The main outcome variables of the study included GP registration, barriers towards registration, GP consultations, barriers towards consultations, and knowledge on entitlements to health care. Quantitative data were analysed using descriptive statistics, association tests, and a multivariate analysis using logistic regression. The qualitative information was analysed using content analysis. RESULTS: The respondents were young, of roughly equal gender (51.5% female), well educated, and had a fair level of knowledge on health services in the UK. Although the GP registration rate was relatively high (80%, 109 out of 136), GP service utilisation during the last episode of illness, at 56.8% (54 out of 95), was low. The statistical analysis showed that age being younger than 35 years, lacking prior overseas experience, having an unstable immigration status, having a shorter duration of stay, and resorting to self-medication were the main barriers hindering Burmese migrants from accessing primary health care services. These findings were corroborated by the in-depth interviews. CONCLUSIONS: Our study found that having formal access to primary health care was not sufficient to ensure GP registration and health care utilisation. Some respondents faced difficulties in registering with GP practices. Many of those who have registered prefer to forego GP services in favour of self-medication, partly due to long waiting times and language barriers. To ensure that migrants enjoy the health services they need and to which they are entitled, more proactive steps are required, including those that make health services culturally responsive.

Britz, J. B. et McKee, M. (2015). "Charging migrants for health care could compromise public health and increase costs for the NHS." J Public Health (Oxf).

BACKGROUND: This study explores the implications of the UK Department of Health's intention to introduce charging for undocumented migrants for primary health care. METHODS: Following a background review of relevant recent literature, 12 in-depth qualitative interviews were conducted with experts on vulnerable populations in England and/or the English health care system, in collaboration with Doctors of the World UK. Data were analysed qualitatively using thematic coding and framework analysis. RESULTS: Stakeholders were concerned that implementing charging for migrants in England could deter medically necessary treatment, leading to threats to public health and increased health care costs. Interviewees identified potential challenges and opportunities provided by the Health and Social Care Act 2012 to improve health care for migrants. CONCLUSIONS: There are considerable concerns about adverse consequences of implementing charges for undocumented migrants. It will be essential to evaluate the effects of this policy once it is implemented.

Gazard, B., et al. (2015). "Challenges in researching migration status, health and health service use: an intersectional analysis of a South London community." Ethn Health **20**(6): 564-593.

OBJECTIVES: This study aimed to investigate the associations between migration status and health-related outcomes and to examine whether and how the effect of migration status changes when it is disaggregated by length of residence, first language, reason for migration and combined with ethnicity. DESIGN: A total of 1698 adults were interviewed from 1076 randomly selected households in two South London boroughs. We described the socio-demographic and socio-economic differences between migrants and non-migrants and compared the prevalence of health-related outcomes by migration status, length of residence, first language, reason for migration and migration status within ethnic groups. Unadjusted models and models adjusted for socio-demographic and socio-economic indicators are presented. RESULTS: Migrants were disadvantaged in terms of socio-economic status but few differences were found between migrant and non-migrants regarding health or health service use indicators; migration status was associated with decreased hazardous alcohol use, functional limitations due to poor mental health and not being registered with a general practitioner. Important differences emerged when migration status was disaggregated by length of residence in the UK, first language, reason for migration and intersected with ethnicity. The association between migration status and functional limitations due to poor mental health was only seen in White migrants, migrants whose first language was not English and migrants who had moved to the UK for work or a better life or for asylum or political reasons. There was no association between migration status and self-rated health overall, but Black African migrants had decreased odds for reporting poor health compared to their non-migrant counterparts [odds ratio = 0.15 (0.05-0.48), $p < 0.01$]. CONCLUSIONS: Disaggregating migration status by length of residence, first language and reason for migration as well as intersecting it with ethnicity leads to better understanding of the effect migration status has on health and health service use.

Grit, K., et al. (2012). "Access to health care for undocumented migrants: a comparative policy analysis of England and the Netherlands." J Health Polit Policy Law **37**(1): 37-67.

The presence of undocumented migrants is increasing in many Western countries despite wide-ranging attempts by governments to increase border security. Measures taken to control the influx of immigrants include policies that restrict access to publicly funded health care for undocumented migrants. These restrictions to health care access are controversial, and evidence suggests they do not always have the intended effect. This study provides a comparative analysis of institutional, actor-related, and contextual factors that have influenced health care policy development on undocumented migrants in England and the Netherlands. For undocumented migrants, England restricts its access to care at the point of service, while the Netherlands restricts through the payment system for services. The study includes an analysis of policy papers and semistructured, in-depth interviews with various actors in both countries. Findings confirm the influence of such contextual factors as immigration considerations and cost concerns on health care policy making in this area. However, these factors cannot explain the differences between the two countries. Previously enacted policies, especially the organization of the health care system, affected the kind of restrictions for undocumented migrants. Concerns about the side effects of generous treatment of undocumented migrants on other groups played a substantial role in formulating restrictive policies in both countries. Evidently, policy development and implementation is critically affected by institutional rules, which govern the degree of influence that doctors and professional medical associations have on the policy process.

Hargreaves, S., et al. (2008). "Charging systems for migrants in primary care: the experiences of family doctors in a high-migrant area of London." J Travel Med **15**(1): 13-18.

BACKGROUND: There is speculation that a high number of migrants use free UK National Health Services to which they are not entitled. In response, the UK government has sought to develop and expand current overseas visitors (OVs) charging systems to target these noneligible migrants for payment. Current guidance to UK primary care providers is ambiguous, and little is known about existing procedures for dealing with new migrants. We aimed to explore the impact of OVs on primary

care services and to assess the views of health-care providers about current charging systems. METHODS: We undertook a 23-point semistructured questionnaire survey of family doctors working within a high-migrant area of London. Outcome measures were the following: the impact of OVs on their practices, current procedures for registering this patient group, and doctors' concerns around expanding existing charging systems. RESULTS: Ninety-two doctors from 53 practices completed the survey (practice response rate 82.8%). Fifty-one (55.4%) of the 92 doctors reported having systems in place to identify and charge OVs requesting registration, and follow-up procedures differed across practices. Significantly more doctors [65 (70.7%)] reported not having any OVs on their practice lists receiving free consultations ($p < 0.001$; 298 OVs reported in total). Of the 24 (26.1%) doctors who did, this equated to approximately pound3,000 monthly lost income in total for uncharged consultations across all the practices within the survey site. Seventy-eight (84.8%) doctors want a better system to identify and charge OVs in primary care but question the workability of proposals to streamline charging procedures across primary and secondary care. Concerns were raised about the implications for migrants unable to access appropriate health care and the impact on public health priorities. CONCLUSIONS: We identified variations in current procedures for identifying and registering OVs, which may result in the inappropriate exclusion of new migrants from free primary care services in the UK. Our findings suggest that the number of OVs receiving free primary care services is low. We need to explore models of appropriate health-care delivery to new migrants in the UK context, drawing on models of best practice from established health services in other migrant-receiving countries.

Hearn-Walker, J. (2009). "Migrants' access to health care needs to be improved, conference is told." Bmj **338**: b1244.

Maheswaran, R., et al. (2014). "Assessing the impact of selective migration and care homes on geographical inequalities in health--a total population cohort study in Sheffield." Spat Spatiotemporal Epidemiol **10**: 85-97.

Selective migration and moves to care homes may potentially contribute to observed socioeconomic gradients in mortality across cities and regions. Sheffield has striking socioeconomic gradients in area-level mortality across the city. We examined for evidence of selective migration and assessed the contribution of migration to observed mortality gradients. We used a total population cohort (539737 in 2001), linked mortality data (2001-2010) and linked data from a health survey carried out in 2000 (66% response rate yielding 10185 responses). We used lower super-output areas and electoral wards as the spatial units of analysis. We found clear evidence of selective migration. In the 25-44 age band, relative risks of mortality were 1.71 (95% CI 1.37-2.12) in migrants from low to high deprivation areas compared with people remaining in low deprivation areas, and 0.53 (0.42-0.65) in migrants from high to low deprivation areas compared with people remaining in high deprivation areas. Relative risks shrank towards unity with increasing age. Characteristics of migrants and non-migrants (illness prevalence, indicators of socioeconomic status, smoking prevalence) ascertained before migration were largely consistent with the relative risks for mortality and indicated that people carried their risks with them. There was also a clear care homes effect, with higher mortality in electoral wards with higher care home bed provision rates. Overall, however, adjustment for selective migration, which included moves to care homes, made little difference to gradients in inequality across the city. Our results suggest that selective migration, including moves to care homes, do not explain existing socioeconomic gradients in area level mortality across Sheffield.

Migge, B. et Gilmartin, M. (2011). "Migrants and healthcare: investigating patient mobility among migrants in Ireland." Health Place **17**(5): 1144-1149.

Drawing on detailed interviews with 60 recent migrants to Ireland, we discuss the extent and nature of patient mobility. The paper is framed by the typology of patient mobility outlined by Glinos et al. (2010), which highlights patient motivation and funding. We pay particular attention to four key areas: availability of health care for migrants living in Ireland; affordability of care as a push factor for patient mobility; how migrants' perceptions of care affect their decision about where to avail of care; and the impact of familiarity on patient mobility. We provide empirical support for this typology. However, our research also highlights the fact that two factors - availability and familiarity - require further

elaboration. Our research demonstrates the need for greater levels of awareness of culture specificity on the part of both migrants and healthcare providers. It also highlights the need to investigate the social and spatial activities of migrants seeking health care, both within and beyond national boundaries.

Poduval, S., et al. (2015). "Experiences among undocumented migrants accessing primary care in the United Kingdom: a qualitative study." Int J Health Serv **45**(2): 320-333.

Immigration is a key political issue in the United Kingdom. The 2014 Immigration Act includes a number of measures intended to reduce net immigration, including removing the right of non-European Economic Area migrants to access free health care. This change risks widening existing health and social inequalities. This study explored the experiences of undocumented migrants trying to access primary care in the United Kingdom, their perspectives on proposed access restrictions, and suggestions for policymakers. Semi-structured interviews were conducted with 16 undocumented migrants and four volunteer staff at a charity clinic in London. Inductive thematic analysis drew out major themes. Many undocumented migrants already faced challenges accessing primary care. None of the migrants interviewed said that they would be able to afford charges to access primary care and most said they would have to wait until they were much more unwell and access care through Accident & Emergency (A&E) services. The consequences of limiting access to primary care, including threats to individual and public health consequences and the additional burden on the National Health Service, need to be fully considered by policymakers. The authors argue that an evidence-based approach would avoid legislation that targets vulnerable groups and provides no obvious economic or societal benefit.

Salway, S., et al. (2016). "Obstacles to "race equality" in the English National Health Service: Insights from the healthcare commissioning arena." Soc Sci Med **152**: 102-110.

Inequitable healthcare access, experiences and outcomes across ethnic groups are of concern across many countries. Progress on this agenda appears limited in England given the apparently strong legal and policy framework. This disjuncture raises questions about how central government policy is translated into local services. Healthcare commissioning organisations are a potentially powerful influence on services, but have rarely been examined from an equity perspective. We undertook a mixed method exploration of English Primary Care Trust (PCT) commissioning in 2010-12, to identify barriers and enablers to commissioning that addresses ethnic healthcare inequities, employing:- in-depth interviews with 19 national Key Informants; documentation of 10 good practice examples; detailed case studies of three PCTs (70+ interviews; extensive observational work and documentary analysis); three national stakeholder workshops. We found limited and patchy attention to ethnic diversity and inequity within English healthcare commissioning. Marginalization of this agenda, along with ambivalence, a lack of clarity and limited confidence, perpetuated a reinforcing inter-play between individual managers, their organisational setting and the wider policy context. Despite the apparent contrary indications, ethnic equity was a peripheral concern within national healthcare policy; poorly aligned with other more dominant agendas. Locally, consideration of ethnicity was often treated as a matter of legal compliance rather than integral to understanding and meeting healthcare needs. Many managers and teams did not consider tackling ethnic healthcare inequities to be part-and-parcel of their job, lacked confidence and skills to do so, and questioned the legitimacy of such work. Our findings indicate the need to enhance the skills, confidence and competence of individual managers and commissioning teams and to improve organizational structures and processes that support attention to ethnic inequity. Greater political will and clearer national direction is also required to produce the system change needed to embed action on ethnic inequity within healthcare commissioning.

Saunders, C. L., Steventon, A., Janta, B., et al. (2020). "Healthcare utilization among migrants to the UK: cross-sectional analysis of two national surveys." J Health Serv Res Policy: 1355819620911392. http://www.ncbi.nlm.nih.gov/pubmed/32192359

Sime, D. (2014). "'I think that Polish doctors are better': newly arrived migrant children and their parents experiences and views of health services in Scotland." Health Place **30**: 86-93.

Understanding users perceptions and expectations of health care provision is key to informing practice, policy and health-related measures. In this paper, we present findings from a qualitative study conducted with recently migrated Eastern European children and their parents, reporting on their experiences of accessing health services post-migration. Unlike the case of adults, the experiences of newly migrated children have rarely been explored in relation to health services. We pay particular attention to three key areas: (1) migrant families views of health service provision; (2) barriers to health service use; and (3) transnational use of health services. By using a social capital approach, we show how concerns about the Scottish health care practices enacted by migrant parents are adopted by children and are likely to impact on families health beliefs and behaviours. The study highlights the important role of migrants active participation as users of health services. We conclude that appropriate health services need to consider more carefully migrants expectations and complex health care activities, in order to be fully inclusive and patient-centred.

Tomkow, L. J., Kang, C. P., Farrington, R. L., et al. (2019). "Healthcare access for asylum seekers and refugees in England: a mixed methods study exploring service users' and health care professionals' awareness." Eur J Public Health **30**(3): 556-561.
https://doi.org/10.1093/eurpub/ckz193

With the aim of decreasing immigration, the British government extended charging for healthcare in England for certain migrants in 2017. There is concern these policies amplify the barriers to healthcare already faced by asylum seekers and refugees (ASRs). Awareness has been shown to be fundamental to access. This article jointly explores (i) health care professionals' (HCPs) awareness of migrants' eligibility for healthcare, and (ii) ASRs' awareness of health services.Mixed methods were used. Quantitative survey data explored HCPs' awareness of migrants' eligibility to healthcare after the extension of charging regulations. Qualitative data from semi-structured interviews with ASRs were analyzed thematically using Saurman's domains of awareness as a framework.In total 514 HCPs responded to the survey. Significant gaps in HCPs' awareness of definitions, entitlements and charging regulations were identified. 80% of HCP respondents were not confident defining the immigration categories upon which eligibility for care rests. Only a small minority (6%) reported both awareness and understanding of the charging regulations. In parallel, the 18 ASRs interviewed had poor awareness of their eligibility for free National Health Service care and suitability for particular services. This was compounded by language difficulties, social isolation, frequent asylum dispersal accommodation moves, and poverty.This study identifies significant confusion amongst both HCP and ASR concerning eligibility and healthcare access. The consequent negative impact on health is concerning given the contemporary political climate, where eligibility for healthcare depends on immigration status.

Whyte, J., et al. (2015). "A study of HIV positive undocumented African migrants' access to health services in the UK." AIDS Care **27**(6): 703-705.

Newly immigrated persons, whatever their origin, tend to fall in the lower socioeconomic levels. In fact, failure of an asylum application renders one destitute in a large proportion of cases, often resulting in a profound lack of access to basic necessities. With over a third of HIV positive failed asylum seekers reporting no income, and the remainder reporting highly limited resources, poverty is a reality for the vast majority. The purpose of the study was to determine the basic social processes that guide HIV positive undocumented migrant's efforts to gain health services in the UK. The study used the Grounded Theory Approach. Theoretical saturation occurred after 16 participants were included in the study. The data included reflections of the prominent factors related to the establishment of a safe and productive life and the ability of individuals to remain within the UK. The data reflected heavily upon the ability of migrants to enter the medical care system during their asylum period, and on an emerging pattern of service denial after loss on immigration appeal. The findings of this study are notable in that they have demonstrated sequence of events along a timeline related to the interaction between the asylum process and access to health-related services. The results reflect that African migrants maintain a degree of formal access to health services during the period that they possess legal access to services and informal access after the failure of their asylum claim. The purpose of this paper is to examine the basic social processes that characterize efforts to

gain access to health services among HIV positive undocumented African migrants to the UK. The most recent estimates indicate that there are a total of 618,000 migrants who lack legal status within the UK. Other studies have placed the number of undocumented migrants within the UK in the range of 525,000-950,000. More than 442,000 are thought to dwell in the London metropolitan area. Even in cases where African migrants enter the UK legally, they often face considerable difficulty in their quest to gain legal employment due to barriers inherent to the system that grants work permits. With over a third of HIV positive failed asylum seekers reporting no income, and the remainder reporting highly limited resources, poverty is a reality for the vast majority.

Serbie

Pusztai, Z., Zivanov, I., Severoni, S., et al. (2018). "Refugee and migrant health – improving access to health care for people in between: a case study." Public Health Panorama **4**(2): 220-225.

Since 2015, Serbia has been a central waypoint along the western Balkans migration route. After the closure of the humanitarian corridor in March 2016, thousands remained trapped in Serbia reluctant to seek asylum, as this would undermine their chances of finding protection in one of the EU Member States. The WHO Country Office for Serbia needed to address the challenges involved in providing health services to persons with an often unregulated legal status and in the context of limited financial and human resources of the national health system. Further difficulties included unmet hygienic, sanitary and health needs of persons voluntarily staying outside state shelters, and the cultural and language barriers preventing provision of health care. Also have a look at the ORAMMA project. The project develops an integrated , mother centered, culturally oriented and evidence based approach for all phases of the migrant and refugee.

Suède

Beckman, A., et al. (2006). "The role country of birth plays in receiving disability pensions in relation to patterns of health care utilisation and socioeconomic differences: a multilevel analysis of Malmo, Sweden." BMC Public Health **6**: 71.

BACKGROUND: People of low socioeconomic status have worse health and a higher probability of being granted a disability pension than people of high socioeconomic status. It is also known that public and private general physicians and public and private specialists have varying practices for issuing sick leave certificates (which, if longstanding, may become the basis of disability pensions). However, few studies have investigated the influence of a patient's country of birth in this context. METHODS: We used multilevel logistic regression analysis with individuals (first level) nested within countries of birth (second level). We analysed the entire population between the ages of 40 and 64 years (n = 80,212) in the city of Malmo, Sweden, in 2003, and identified 73% of that population who had visited a physician at least once during that year. We studied the associations between individuals and country of birth socioeconomic characteristics, as well as individual utilisation of different kinds of physicians in relation to having been granted a disability pension. RESULTS: Living alone (ORwomen = 1.72, 95% CI: 1.62-1.82; ORmen = 2.64, 95% CI: 2.46-2.83) and having limited educational achievement (ORwomen = 2.14, 95% CI: 2.00-2.29; ORmen = 2.12, 95% CI: 1.98-2.28) were positively associated with having a disability pension. Utilisation of public specialists was associated with a higher probability (ORwomen = 2.11, 95% CI: 1.98-2.25; ORmen = 2.16, 95% CI: 2.01-2.32) and utilisation of private GPs with a lower probability (ORmen = 0.76, 95% CI: 0.69-0.83) of having a disability pension. However, these associations differed by countries of birth. Over and above individual socioeconomic status, men from middle income countries had a higher probability of having a disability pension (ORmen = 1.61, 95% CI: 1.06-2.44). CONCLUSION: The country of one's birth appears to play a significant role in understanding how individual socioeconomic differences bear on the likelihood of receiving a disability pension and on associated patterns of health care utilisation.

Green, J., Obuekwe, C. et Svanholm, S. (2021). "Politicians' views on societal responsibility and possibility to promote newly arrived migrants' health in Sweden." Int J Environ Res Public Health.

Newly arrived migrants in Sweden risk facing ill health. Politicians at the local and regional levels are involved in many decisions regarding the social determinants of health. The aim of this study was to explore politicians' views on different societal actors' responsibility and possibility to promote newly arrived migrants' health. Data were collected through online questionnaires completed by 667 politicians from municipality and regional councils in northern Sweden. Bivariate analysis was performed using the Wilcoxon signed-rank test. Multivariate analyses were performed using cluster analysis and binary logistic regression analysis. The results show that politicians generally rate societal actors' responsibility and possibility to promote the general population's health higher than newly arrived migrants' health. Moreover, they consider societal actors' responsibility to be greater than their possibility to promote health. Factors significantly contributing to politicians' high ratings of societal responsibility and possibility are attitude (odds ratio [OR] = 2.156, 95% confidence interval [CI]: 1.306-3.558), specific knowledge of newly arrived migrants' health status (OR = 1.528, 95% CI: 1.005-2.323), personal interest in public health (OR = 2.452, 95% CI: 1.460-4.119), being a municipality politician (OR = 1.659, 95% CI: 1.031-2.670) and being female (OR = 1.934, 95% CI: 1.333-2.806). This study shows that politicians generally rate societal responsibility and possibility to promote newly arrived migrants' health rather high. Personal characteristics are important for politicians' high or low ratings of responsibility and possibility, suggesting insufficient structural support for politicians in health promotion.

Hedemalm, A., et al. (2008). "Equality in the care and treatment of immigrants and native Swedes--a comparative study of patients hospitalised for heart failure." Eur J Cardiovasc Nurs **7**(3): 222-228.

The aim of this study was to compare immigrant and Swedish patients with heart failure (HF) regarding symptoms, diagnosis, medical treatment, discharge planning, readmission and mortality. The method was descriptive and retrospective using an audit protocol to review data from 214 medical records of 107 immigrants and 107 Swedish patients hospitalised for HF or chronic heart failure during 1994-2003. Descriptive statistics and significance testing were performed. Few differences between the patient groups were observed. Significantly larger number of immigrants were referred to the nurse-led HF clinic follow-up visits (P=0.026). Significantly more immigrants had ischemic heart disease on admission (P=0.025) and were prescribed short-acting nitrates at discharge (P=0.026). More Swedes were prescribed medications for insomnia (P=0.029). More immigrants than Swedes are referred to HF clinic after discharge, suggesting that physicians rely on specialised nurses to provide follow-ups, tailored to the needs of immigrant patients. The study indicates that the Swedish health care system has achieved its aim of equality in the care and treatment of this patient group. Further studies are needed to determine if this also applies to the quality of the provided care and treatment.

Kalengayi, F. K., et al. (2015). "'It is a dilemma': perspectives of nurse practitioners on health screening of newly arrived migrants." Glob Health Action **8**: 27903.

BACKGROUND: Screening newly arrived migrants from countries with high burden of communicable diseases of public health significance is part of the Swedish national strategy against the spread of these diseases. However, little is known about its implementation. OBJECTIVE: This study aimed at exploring caregivers' experiences in screening newly arrived migrants to generate knowledge that could inform policy and clinical practice. DESIGN: Using an interpretive description framework, we conducted semistructured interviews between November and December 2011 in four Swedish counties, with 15 purposively selected nurses with experience in screening migrants. Data were analyzed using thematic analysis. RESULTS: Participants described a range of challenges including discordant views between migrants and the nurses about medical screening, inconsistencies in rules and practices, and conflicting policies. Participants indicated that sociocultural differences resulted in divergent expectations with migrants viewing the participants as agents of migration authorities. They also expressed concern over being given a new assignment without training and being expected to share responsibilities with staff from other agencies without adequate coordination. Finally, they

indicated that existing policies can be confusing and raise ethical issues. All these were compounded by language barriers, making their work environment extremely complex and stressful. CONCLUSIONS: These findings illuminate complex challenges that could limit access to, uptake, and delivery of health screening and undermine public health goals, and highlight the need for a multilevel approach. This entails avoiding the conflation of migration with health issues, harmonizing existing policies to make health care services more accessible and acceptable to migrants, and facilitating health professionals' work in promoting public health, improving interagency collaboration and the skills of all staff involved in understanding and effectively responding to migrants' needs, and improving migrants' health literacy through community outreach interventions.

Mona, H., Andersson, L. M. C., Hjern, A., et al. (2021). "Barriers to accessing health care among undocumented migrants in Sweden - a principal component analysis." BMC Health Serv Res **21**(1): 830.

BACKGROUND: Undocumented migrants face many hardships in their everyday life such as poor living conditions, discrimination, and lack of access to healthcare. Previous studies have demonstrated considerable health care needs for psychiatric disorders as well as physical diseases. The aim of this paper was to find out the main barriers that undocumented migrants experience in accessing the Swedish healthcare system and to explore their relation with socioeconomic factors. METHODS: A cross-sectional study with adult undocumented migrants was performed in the three largest cities of Sweden in 2014-2016. Sampling was done via informal networks. A socioeconomic questionnaire was constructed including 22 barriers to health care. Trained field workers conducted the interviews. A principal component analysis was conducted of all barriers to reveal central components. Then, Pearson's chi-squared test was used to explore the characteristics of undocumented migrants experiencing barriers to care. RESULTS: Two main components/barriers were extracted: "Fear of being taken by police/authorities", which was related to fear of disclosure by or in relation to seeking health care, and "Structural and psychosocial factors" which was related to practical obstacles or shame of being ill. Lower age (74.1 % vs 56.0 %), lower level of education (75.0 % vs. 45.1 %), and having no children (70.3 % vs. 48.1 %) were significantly related to a higher likelihood of experiencing a barrier. CONCLUSION: Fear of deportation and practical and psychosocial factors constitute hinderance of access to healthcare for undocumented migrants in Sweden. This highlights the importance of clear instructions, both to undocumented migrants and health professionals about the right to health care according to the international law on human rights as well as the law of confidentiality.

Svanholm, S., Carlerby, H. et Viitasara, E. (2020). "Collaboration in health promotion for newly arrived migrants in Sweden." PLoS One **15**(5): e0233659.

As a group, newly arrived migrants in Sweden face inequities in health compared to the general population. Successful promotion of population health requires awareness of and focus on health from several sectors of society. In light of this, the aim was to study the views of local authority officials on collaboration in health promotion activities for newly arrived migrants. Data was collected through five focus group interviews with 23 local authority officials working with the integration of newly arrived migrants in the Establishment Program in a municipality or at the Employment Services in northern Sweden. An inductive qualitative latent content analysis was performed, and the analysis showed that the participating officials considered health promotion as desirable in the Establishment Program, but it also raised complex issues within the existing organisations. The officials described unclear roles, but also possible changes to the organisation that would improve the possibility of working to promote health. The present study adds to the relatively limited knowledge of health promotion in integration activities and offers clinical relevance for policymakers through the officials' suggestions for improvements in the Establishment Program. It also raises important questions for further research.

Wirehag, M., Andersson, L., Hjern, A., et al. (2021). "Living situations among undocumented migrants in Sweden: The effects of exclusion from fundamental housing rights." International Journal of Social Welfare **30**: 239-248.

Suisse

Maillefer, F., Bovet, É., Jaton, L., et al. (2019). "Facilitateurs et barrières pour l'accès aux soins chez les requérants d'asile du canton de Vaud en Suisse et recommandations." Recherche en soins infirmiers **137**(2): 26-40.
https://www.cairn.info/revue-recherche-en-soins-infirmiers-2019-2-page-26.htm

Introduction : face à un afflux exceptionnel de requérants d'asile en Suisse en 2015, les soignants ont dû faire face à de nouvelles problématiques. Contexte : il manque des travaux locaux ayant investigué parallèlement le vécu des requérants d'asile en lien avec le système de santé et les perceptions des professionnels de santé en contact avec les requérants d'asile. Objectifs : avoir une meilleure compréhension des besoins spécifiques des RA puis mettre en place des actions concrètes afin d'améliorer l'accès aux soins et augmenter l'efficience de la prise en charge.Méthode : étude qualitative comprenant des entretiens individuels et de groupe avec des requérants d'asile et trois focus group avec des soignants et des interprètes.Résultats : les résultats concernent l'accès aux soins dans le pays d'origine, les représentations sur les conditions de vie en Suisse, les effets du parcours migratoire sur la santé, les représentations vis-à-vis de la psychiatrie et de la bonne santé, la fréquentation des urgences, les motifs des rendez-vous manqués, l'aide par les pairs.Discussion : l'information, la confiance, suffisamment de temps, sont les éléments-clé identifiés pour créer un lien qui optimise l'accès aux soins.Conclusion : la recherche a permis une meilleure compréhension des besoins spécifiques. Des recommandations pour la pratique ont été émises.

Meynard, A., et al. (2012). "[Young and migrants: a multidisicplinary approach in a youth clinic in Geneva]." Rev Med Suisse **8**(345): 1286, 1288-1291.

Recent young migrants are a very heterogeneous population with mixed health needs. The global world mortality and morbidity of 12-25 year olds' is mostly related to accidents and other preventable causes or mental disorders. Most severe psychiatric disorders begin in this age group. Adolescence and the migrant status of young people and their families impact on their expression of needs. The adolescent and young adult program of Geneva University Hospitals is a specialized, multidisciplinary integrated team contributing to improve delivery of care through an easy access to care and preventative activities. In collaboration with Geneva's health network it offers a valuable continuity of care in this population.

Tzogiou, C., Boes, S. et Brunner, B. (2021). "What explains the inequalities in health care utilization between immigrants and non-migrants in Switzerland?" BMC Public Health **21**(1): 530.

BACKGROUND: Inequalities in health care use between immigrants and non-migrants are an important issue in many countries, with potentially negative effects on population health and welfare. The aim of this study is to understand the factors that explain these inequalities in Switzerland, a country with one of the highest percentages of foreign-born population. METHODS: Using health survey data, we compare non-migrants to four immigrant groups, differentiating between first- and second-generation immigrants, and culturally different and similar immigrants. To retrieve the relative contribution of each inequality-associated factor, we apply a non-linear decomposition method and categorize the factors into demographic, socio-economic, health insurance and health status factors. RESULTS: We find that non-migrants are more likely to visit a doctor compared to first-generation and culturally different immigrants and are less likely to visit the emergency department. Inequalities in doctor visits are mainly attributed to the explained component, namely to socio-economic factors (such as occupation and income), while inequalities in emergency visits are mainly attributed to the unexplained component. We also find that despite the universal health care coverage in Switzerland systemic barriers might exist. CONCLUSIONS: Our results indicate that immigrant-specific policies should be developed in order to improve access to care and efficiently manage patients in the health system.

Wolff, H., et al. (2008). "Undocumented migrants lack access to pregnancy care and prevention." BMC Public Health **8**: 93.

BACKGROUND: Illegal migration is an increasing problem worldwide and the so-called undocumented migrants encounter major problems in access to prevention and health care. The objective of the study was to compare the use of preventive measures and pregnancy care of undocumented pregnant migrants with those of women from the general population of Geneva, Switzerland. METHODS: Prospective cohort study including pregnant undocumented migrants presenting to the University hospital from February 2005 to October 2006. The control group consisted of a systematic sample of pregnant women with legal residency permit wishing to deliver at the same public hospital during the same time period. RESULTS: 161 undocumented and 233 control women were included in the study. Mean ages were 29.4 y (SD 5.8) and 31.1 y (SD 4.8) ($p < 0.02$), respectively. 61% of undocumented women (controls 9%) were unaware of emergency contraception (OR 15.7 (8.8;28.2) and 75% of their pregnancies were unintended (controls 21%; OR 8.0 (4.7;13.5)). Undocumented women consulted for an initial pregnancy visit more than 4 weeks later than controls and only 63% had their first visit during the first trimester (controls 96%, $p < 0.001$); 18% had never or more than 3 years ago a cervical smear test (controls 2%, OR 5.7 (2.0;16.5)). Lifetime exposure to violence was similar in both groups, but undocumented migrants were more exposed during their pregnancy (11% vs 1%, OR 8.6 (2.4;30.6)). Complications during pregnancy, delivery and post-partum were similar in both groups. CONCLUSION: Compared to women who are legal residents of Geneva, undocumented migrants have more unintended pregnancies and delayed prenatal care, use fewer preventive measures and are exposed to more violence during pregnancy. Not having a legal residency permit therefore suggests a particular vulnerability for pregnant women. This study underscores the need for better access to prenatal care and routine screening for violence exposure during pregnancy for undocumented migrants. Furthermore, health care systems should provide language- and culturally-appropriate education on contraception, family planning and cervical cancer screening.

PREVENTION ET COMPORTEMENT DE SANTE : UNE GRANDE DIVERSITE

Abarca Tomas, B., et al. (2013). "Tuberculosis in migrant populations. A systematic review of the qualitative literature." PLoS One **8**(12): e82440.

BACKGROUND: The re-emergence of tuberculosis (TB) in low-incidence countries and its disproportionate burden on immigrants is a public health concern posing specific social and ethical challenges. This review explores perceptions, knowledge, attitudes and treatment adherence behaviour relating to TB and their social implications as reported in the qualitative literature. METHODS: Systematic review in four electronic databases. Findings from thirty selected studies extracted, tabulated, compared and synthesized. FINDINGS: TB was attributed to many non-exclusive causes including air-born transmission of bacteria, genetics, malnutrition, excessive work, irresponsible lifestyles, casual contact with infected persons or objects; and exposure to low temperatures, dirt, stress and witchcraft. Perceived as curable but potentially lethal and highly contagious, there was confusion around a condition surrounded by fears. A range of economic, legislative, cultural, social and health system barriers could delay treatment seeking. Fears of deportation and having contacts traced could prevent individuals from seeking medical assistance. Once on treatment, family support and "the personal touch" of health providers emerged as key factors facilitating adherence. The concept of latent infection was difficult to comprehend and while TB screening was often seen as a socially responsible act, it could be perceived as discriminatory. Immigration and the infectiousness of TB mutually reinforced each another exacerbating stigma. This was further aggravated by indirect costs such as losing a job, being evicted by a landlord or not being able to attend school. CONCLUSIONS: Understanding immigrants' views of TB and the obstacles that they face when accessing the health system and adhering to a treatment programme-taking into consideration their previous experiences at countries of origin as well as the social, economic and legislative context in which they live at host countries- has an important role and should be considered in the design, evaluation and adaptation of programmes.

Agudelo-Suarez, A. A., et al. (2012). "A metasynthesis of qualitative studies regarding opinions and perceptions about barriers and determinants of health services' accessibility in economic migrants." BMC Health Serv Res **12**: 461.

> BACKGROUND: Access to health services is an important health determinant. New research in health equity is required, especially amongst economic migrants from developing countries. Studies conducted on the use of health services by migrant populations highlight existing gaps in understanding which factors affect access to these services from a qualitative perspective. We aim to describe the views of the migrants regarding barriers and determinants of access to health services in the international literature (1997-2011). METHODS: A systematic review was conducted for Qualitative research papers (English/Spanish) published in 13 electronic databases. A selection of articles that accomplished the inclusion criteria and a quality evaluation of the studies were carried out. The findings of the selected studies were synthesised by means of metasynthesis using different analysis categories according to Andersen's conceptual framework of access and use of health services and by incorporating other emergent categories. RESULTS: We located 3,025 titles, 36 studies achieved the inclusion criteria. After quality evaluation, 28 articles were definitively synthesised. 12 studies (46.2%) were carried out in the U.S and 11 studies (42.3%) dealt with primary care services. The participating population varied depending mainly on type of host country. Barriers were described, such as the lack of communication between health services providers and migrants, due to idiomatic difficulties and cultural differences. Other barriers were linked to the economic system, the health service characteristics and the legislation in each country. This situation has consequences for the lack of health control by migrants and their social vulnerability. CONCLUSIONS: Economic migrants faced individual and structural barriers to the health services in host countries, especially those with undocumented situation and those experimented idiomatic difficulties. Strategies to improve the structures of health systems and social policies are needed.

Albarran, C. R. et Nyamathi, A. (2011). "HIV and Mexican migrant workers in the United States: a review applying the vulnerable populations conceptual model." J Assoc Nurses AIDS Care **22**(3): 173-185.

> Mexican migrant workers residing in the United States are a vulnerable population at high risk for HIV infection. This article critically appraises the published data surrounding HIV prevalence in this vulnerable group, as seen through the lens of the Vulnerable Populations Conceptual Model. This model demonstrates how exposure to risk and resource availability affect health status. The health status of Mexican migrants in the United States is compromised by a number of factors that increase risk of HIV: limited access to health services, multiple sexual partners, low rates of condom use, men having sex with men, and lay injection practices. Migration from Mexico to the United States has increased the prevalence of HIV in rural Mexico, making this an issue of urgent binational concern. This review highlights the implications for further nursing research, practice, and policy.

Allen, J. D., et al. (2014). "Pathways between acculturation and health behaviors among residents of low-income housing: the mediating role of social and contextual factors." Soc Sci Med **123**: 26-36.

> Acculturation may influence health behaviors, yet mechanisms underlying its effect are not well understood. In this study, we describe relationships between acculturation and health behaviors among low-income housing residents, and examine whether these relationships are mediated by social and contextual factors. Residents of 20 low-income housing sites in the Boston metropolitan area completed surveys that assessed acculturative characteristics, social/contextual factors, and health behaviors. A composite acculturation scale was developed using latent class analysis, resulting in four distinct acculturative groups. Path analysis was used to examine interrelationships between acculturation, health behaviors, and social/contextual factors, specifically self-reported social ties, social support, stress, material hardship, and discrimination. Of the 828 respondents, 69% were born outside of the U.S. Less acculturated groups exhibited healthier dietary practices and were less likely to smoke than more acculturated groups. Acculturation had a direct effect on diet and smoking, but not physical activity. Acculturation also showed an indirect effect on diet through its relationship with material hardship. Our finding that material hardship mediated the relationship between acculturation and diet suggests the need to explicate the significant role of financial resources in interventions

seeking to promote healthy diets among low-income immigrant groups. Future research should examine these social and contextual mediators using larger, population-based samples, preferably with longitudinal data.

Almeida, L. M., et al. (2013). "Maternal healthcare in migrants: a systematic review." Matern Child Health J **17**(8): 1346-1354.

Pregnancy is a period of increased vulnerability for migrant women, and access to healthcare, use and quality of care provided during this period are important aspects to characterize the support provided to this population. A systematic review of the scientific literature contained in the MEDLINE and SCOPUS databases was carried out, searching for population based studies published between 1990 and 2012 and reporting on maternal healthcare in immigrant populations. A total of 854 articles were retrieved and 30 publications met the inclusion criteria, being included in the final evaluation. The majority of studies point to a higher health risk profile in immigrants, with an increased incidence of co-morbidity in some populations, reduced access to health facilities particularly in illegal immigrants, poor communication between women and caregivers, a lower rate of obstetrical interventions, a higher incidence of stillbirth and early neonatal death, an increased risk of maternal death, and a higher incidence of postpartum depression. Incidences vary widely among different population groups. Some migrant populations are at a higher risk of serious complications during pregnancy, for reasons that include reduced access and use of healthcare facilities, as well as less optimal care, resulting in a higher incidence of adverse outcomes. Tackling these problems and achieving equality of care for all is a challenging aim for public healthcare services.

Alvarez-del Arco, D., et al. (2013). "HIV testing and counselling for migrant populations living in high-income countries: a systematic review." Eur J Public Health **23**(6): 1039-1045.

BACKGROUND: The barriers to HIV testing and counselling that migrants encounter can jeopardize proactive HIV testing that relies on the fact that HIV testing must be linked to care. We analyse available evidence on HIV testing and counselling strategies targeting migrants and ethnic minorities in high-income countries. METHODS: Systematic literature review of the five main databases of articles in English from Europe, North America and Australia between 2005 and 2009. RESULTS: Of 1034 abstracts, 37 articles were selected. Migrants, mainly from HIV-endemic countries, are at risk of HIV infection and its consequences. The HIV prevalence among migrants is higher than the general population's, and migrants have higher frequency of delayed HIV diagnosis. For migrants from countries with low HIV prevalence and for ethnic minorities, socio-economic vulnerability puts them at risk of acquiring HIV. Migrants have specific legal and administrative impediments to accessing HIV testing-in some countries, undocumented migrants are not entitled to health care-as well as cultural and linguistic barriers, racism and xenophobia. Migrants and ethnic minorities fear stigma from their communities, yet community acceptance is key for well-being. CONCLUSIONS: Migrants and ethnic minorities should be offered HIV testing, but the barriers highlighted in this review may deter programs from achieving the final goal, which is linking migrants and ethnic minorities to HIV clinical care under the public health perspective.

Andreeva, V. A. et Pokhrel, P. (2013). "Breast cancer screening utilization among Eastern European immigrant women worldwide: a systematic literature review and a focus on psychosocial barriers." Psychooncology **22**(12): 2664-2675.

OBJECTIVE: Many countries host growing Eastern European immigrant communities whose breast cancer preventive behaviors are largely unknown. Thus, we aimed to synthesize current evidence regarding secondary prevention via breast cancer screening utilized by that population. METHODS: All observational, general population studies on breast cancer screening with Eastern European immigrant women and without any country, language, or age restrictions were identified. Screening modalities included breast self-examination, clinical breast examination, and mammography. RESULTS: The selected 30 studies were published between 1996 and 2013 and came from Australia, Canada, Denmark, Germany, Israel, the Netherlands, Spain, Switzerland, the UK, and the USA. The reported prevalence of monthly breast self-examination was 0-48%; for yearly clinical breast

examination 27-54%; and for biennial mammography 0-71%. The substantial methodologic heterogeneity prevented a meta-analysis. Nonetheless, irrespective of host country, healthcare access, or educational level, the findings consistently indicated that Eastern European immigrant women underutilize breast cancer screening largely because of insufficient knowledge about early detection and an external locus of control regarding decision making in health matters. CONCLUSIONS: This is a vulnerable population for whom the implementation of culturally tailored breast cancer screening programs is needed. As with other underscreened immigrant/minority groups, Eastern European women's inadequate engagement in prevention is troublesome as it points to susceptibility not only to cancer but also to other serious conditions for which personal action and responsibility are critical.

Awoh, A. B. et Plugge, E. (2015). "Immunisation coverage in rural-urban migrant children in low and middle-income countries (LMICs): a systematic review and meta-analysis." J Epidemiol Community Health.

BACKGROUND: The majority of children who die from vaccine-preventable diseases (VPDs) live in low-income and-middle-income countries (LMICs). With the rapid urbanisation and rural-urban migration ongoing in LMICs, available research suggests that migration status might be a determinant of immunisation coverage in LMICs, with rural-urban migrant (RUM) children being less likely to be immunised. OBJECTIVES: To examine and synthesise the data on immunisation coverage in RUM children in LMICs and to compare coverage in these children with non-migrant children. METHODS: A multiple database search of published and unpublished literature on immunisation coverage for the routine Expanded Programme on Immunisation (EPI) vaccines in RUM children aged 5 years and below was conducted. Following a staged exclusion process, studies that met the inclusion criteria were assessed for quality and data extracted for meta-analysis. RESULTS: Eleven studies from three countries (China, India and Nigeria) were included in the review. There was substantial statistical heterogeneity between the studies, thus no summary estimate was reported for the meta-analysis. Data synthesis from the studies showed that the proportion of fully immunised RUM children was lower than the WHO bench-mark of 90% at the national level. RUMs were also less likely to be fully immunised than the urban-non-migrants and general population. For the individual EPI vaccines, all but two studies showed lower immunisation coverage in RUMs compared with the general population using national coverage estimates. CONCLUSIONS: This review indicates that there is an association between rural-urban migration and immunisation coverage in LMICs with RUMs being less likely to be fully immunised than the urban non-migrants and the general population. Specific efforts to improve immunisation coverage in this subpopulation of urban residents will not only reduce morbidity and mortality from VPDs in migrants but will also reduce health inequity and the risk of infectious disease outbreaks in wider society.

Baezconde-Garbanati, L., et al. (2013). "Reducing the Excess Burden of Cervical Cancer Among Latinas: Translating Science into Health Promotion Initiatives." Calif J Health Promot **11**(1): 45-57.

PURPOSE: Although deaths from cervical cancer are declining, Latinas are not benefiting equally in this decline. Incidence of invasive cervical cancer among Los Angeles', California Latinas is much higher than among non-Latina Whites (14.7 versus 8.02 per 100,000). This paper examines cervical cancer screening among Latinas. METHODS: Ninety-seven women of Mexican origin participated in 12 focus groups exploring barriers to screening. Saturation was reached. RESULTS: All participants knew what a Pap test was and most knew its purpose. More acculturated participants understood the link between HPV and cervical cancer. More recent immigrants did not. There was confusion whether women who were not sexually active need to be screened. Most frequently mentioned barriers were lack of time and concern over missing work. Lower income and less acculturated women were less likely to be aware of free/low-cost clinics. Older and less acculturated participants held more fatalistic beliefs, were more embarrassed about getting a Pap test, were more fearful of being perceived as sexually promiscuous, and were more fearful of receiving disapproval from their husbands. CONCLUSIONS: Latinas are informed regarding cervical cancer screening; rather they encounter barriers such as a lack of time, money and support. Health promotion interventions can be enhanced via peer-to-peer education, by addressing barriers to cervical cancer screening with in-language, culturally tailored interventions, and working with clinics on systemic changes, such as extended clinic hours.

Berens, E. M., et al. (2015). "Informed Choice in the German Mammography Screening Program by Education and Migrant Status: Survey among First-Time Invitees." PLoS One **10**(11): e0142316.

> Breast cancer is the most prevalent cancer among women and mammography screening programs are seen as a key strategy to reduce breast cancer mortality. In Germany, women are invited to the population-based mammography screening program between ages 50 to 69. It is still discussed whether the benefits of mammography screening outweigh its harms. Therefore, the concept of informed choice comprising knowledge, attitude and intention has gained importance. The objective of this observational study was to assess the proportion of informed choices among women invited to the German mammography screening program for the first time. A representative sample of 17,349 women aged 50 years from a sub-region of North Rhine Westphalia was invited to participate in a postal survey. Turkish immigrant women were oversampled. The effects of education level and migration status on informed choice and its components were assessed. 5,847 (33.7%) women responded to the postal questionnaire of which 4,113 were used for analyses. 31.5% of the women had sufficient knowledge. The proportion of sufficient knowledge was lower among immigrants and among women with low education levels. The proportion of women making informed choices was low (27.1%), with similar associations with education level and migration status. Women of low (OR 2.75; 95% CI 2.18-3.46) and medium education level (OR 1.49; 95% CI 1.27-1.75) were more likely to make an uninformed choice than women of high education level. Turkish immigrant women had the greatest odds for making an uninformed choice (OR 5.30, 95% CI 1.92-14.66) compared to non-immigrant women. Other immigrant women only had slightly greater odds for making an uninformed choice than non-immigrant women. As immigrant populations and women with low education level have been shown to have poor knowledge, they need special attention in measures to increase knowledge and thus informed choices.

Berens, E. M., et al. (2014). "Participation in breast cancer screening among women of Turkish origin in Germany - a register-based study." BMC Womens Health **14**: 24.

> BACKGROUND: Population-based breast cancer screening programs were implemented to reduce breast cancer mortality and to improve recovery chances. Breast cancer screening participation among migrant women differs from that of autochthonous populations in several European countries. Here we investigate for the first time participation among women of Turkish origin in Germany. METHODS: Data of five screening units covering 2010 and 2011 as well as associated population registries were analysed. Women of Turkish origin were identified using a name-based algorithm. Participation ratios among women of Turkish origin and odds ratios compared to women of non-Turkish origin were calculated. Analyses were stratified and adjusted for age-groups and screening unit. RESULTS: A total of 208,500 participants in the five breast screening units were included, out of 423,649 eligible women in the catchment areas (participation 49.2%). Women of Turkish origin have a slightly higher chance to participate in breast cancer screening than women without Turkish origin (OR 1.17; 95% CI: 1.14-1.21). Only women of Turkish origin aged 65-69 years have a lower chance to participate than women without Turkish origin (OR: 0.71; 95% CI: 0.66-0.75). CONCLUSION: In spite of low participation in preventive measures among migrant populations, the overall breast cancer screening participation among women of Turkish origin in Germany seems to be higher compared to women of non-Turkish origin. Turkish women aged 65 years and above have a lower chance of participation than younger Turkish women. There is need for further research to study factors affecting participation in screening among migrant and non-migrant populations in Germany.

Brathwaite, A. C. et Lemonde, M. (2015). "Exploring Health Beliefs and Practices of Caribbean Immigrants in Ontario to Prevent Type 2 Diabetes." J Transcult Nurs.

> This qualitative study explored the beliefs held by adult Caribbean immigrants regarding type 2 diabetes (T2D) and their practices in preventing it. A purposive sample of 15 immigrants living in Ontario, Canada participated in the study. Semistructured interviews were used to collect data from participants. Four themes emerged from the data: beliefs that protect participants from developing T2D, cultural practices to stay healthy, preserving culture through preparation of meals, and cultural practices determine number of servings of fruit and vegetables per day. Findings indicate how beliefs and cultural practices influence prevention of T2D and the need to design culturally tailored

interventions for ethnic groups. Future research should explore health beliefs and cultural practices of other high-risk groups and use their findings to design and evaluate culturally tailored interventions to prevent T2D.

Brzoska, P. et Razum, O. (2014). "[Prevention among migrants--problems in health care provision and suggested solutions illustrated for the field of medical rehabilitation]." Dtsch Med Wochenschr **139**(38): 1895-1897.

In Germany, 16 million people have a migration background. As compared to the majority population, they have higher prevalences of some chronic diseases and are at a higher risk of occupational accidents, occupational diseases and retirement due to disability. Preventive health care services, therefore, are of high relevance in this population group. As a result of barriers to health care access and effectiveness, people with a migration background, however, benefit less from preventive services than the majority population. This is particularly the case for rehabilitation. In order to improve preventive health care for people with a migration background sustainably, current health care services must become sensitive to the needs of this population group. Diversity management can contribute to this process.

Carolan, M. (2010). "Pregnancy health status of sub-Saharan refugee women who have resettled in developed countries: a review of the literature." Midwifery **26**(4): 407-414.

OBJECTIVE: to present the literature relating to health status and pregnancy complications among sub-Saharan African women. BACKGROUND: sub-Saharan refugee women constitute a new and growing group of maternity service users in developed countries today. These women are perceived to be at high risk of pregnancy complication, based on concurrent disease and unusual medical conditions. As a result of these concerns, midwives may feel ill equipped to provide their pregnancy care. METHOD: searches were conducted of CINAHL, Maternity and Infant Care, MEDLINE and PsychINFO databases using the search terms 'migrants', 'Africa', 'sub-Saharan', 'pregnancy', 'refugees' and 'women'. Additional articles were located by pursuing references identified in key papers. FINDINGS: pregnant sub-Saharan women present as an at-risk population related to poor prior health, co-existing disease and cultural practices such as female genital mutilation. Nonetheless, principal pregnancy complications for this population include anaemia and high parity, rather than exotic disease. Higher rates of infant mortality and morbidity appear to persist following resettlement, and are not explained by maternal risk factors alone. Limited access to care is of concern. KEY CONCLUSIONS: further research is warranted into the impediments to care uptake among sub-Saharan African women. It is hoped that such research will inform the development of culturally appropriate and acceptable services for African refugees. IMPLICATIONS FOR PRACTICE: it is important that midwives are aware of common health problems among sub-Saharan women. Midwives also need to act to promote access to health services among this group. Social disadvantage and late access to care may impact on neonatal outcomes and thus warrant investigation.

Chakraborty, B. M. et Chakraborty, R. (2010). "Concept, measurement and use of acculturation in health and disease risk studies." Coll Antropol **34**(4): 1179-1191.

Acculturation, a concept with its root in social science and cultural anthropology, is a process intimately related to health behavior and health status of minority populations in a multicultural society. This paper provides a brief review of the subject of acculturation as it relates to health research, showing that this concept has a potential to identify risk factors that underlie increased prevalence of chronic diseases, particularly in immigrant populations. A proper understanding of this is helpful in designing intervention programs to reduce the burden of such diseases and to increase the quality of life in such populations. The concept is defined with an outline of its history showing its evolution over time. Criteria for measuring acculturation are described to illustrate the need of accommodating its multidimensional features. Drawing examples from health research in US Hispanics, the role of acculturation on health behavior is discussed to document that the discordant findings are at least partially due to either use of incomplete dimensions of the concept, or not accounting for the dynamic aspect of its process. Finally, with illustration of a finding from a study

among overweight Mexican American women of South Texas, a model of acculturation study is proposed that may be used in other immigrant populations undergoing the acculturation process.

Chen, Y., et al. (2013). "Association between mental health and fall injury in Canadian immigrants and non-immigrants." Accid Anal Prev **59**: 221-226.

The study was to determine the association between mental health and the incidence of injury among Canadian immigrants and non-immigrants. We used data from 15,405 individuals aged 12 years or more, who were living in British Columbia, Canada, and participated in the 2007-2008 Canadian Community Health Survey (CCHS). We calculated a 12-month cumulative incidence of fall injury based on self-reporting. Logistic regression model was used to examine the association of the 12-month cumulative incidence of fall injury with immigration status and mental health before and after adjustment for covariates. The results show that self-reported mood and anxiety disorders were significantly associated with an increased incidence of fall injury. The adjusted odds ratios were 1.81 (95% CI: 1.37, 2.38) for mood disorder and 1.55 (95% CI: 1.12, 2.13) for anxiety disorder. Immigrant status was a significant effect modifier for the association between mental health and fall injury, with stronger associations in immigrants than in non-immigrants especially in elderly people. People with poor self perceived health were more likely to have a fall injury. Both mental health and general health were related to fall injury. There was a stronger association between mental health and fall injury in immigrants compared with non-immigrants in the elderly. More attention should be paid to mental health in immigrants associated with fall injury.

Choi, S., et al. (2008). "Effects of acculturation on smoking behavior in Asian Americans: a meta-analysis." J Cardiovasc Nurs **23**(1): 67-73.

BACKGROUND: Cigarette smoking is the most preventable risk factor for many negative health consequences, such as cancer, heart disease, and lung disease. In the United States, the prevalence rate in Asian immigrants is high (26%-70%), with Southeast Asian men having the highest rate. Acculturation has been associated with smoking behavior in this ethnic group. OBJECTIVE: The purposes of this meta-analysis are to describe the extent to which acculturation affects smoking behavior in Asian immigrants and to compare the direction and magnitude of the effect between subgroups by gender and age. METHODS: Databases within PubMed, CINAHL, The Cochrane Library, and PsycINFO were searched. Twenty-one studies published in English or Korean from 1994 through 2005 met criteria, and 9 of these studies contained sufficient data. Among the 9 studies, 3 presented gender-specific data; thus, these studies were entered separately for men and women, making a total of 12 entries for final analysis. The odds ratio was used as an effect size statistic. The values of odds ratios were calculated from the data in the studies. RESULTS: The average effect size for men was 0.53 (95% confidence interval, 0.28-0.99), indicating that acculturated men are 53% less likely to smoke than nonacculturated or "traditional" men. The average effect size for women was 5.26 (2.75-10.05), suggesting that acculturated women are 5 times more likely to smoke than traditional women. In adolescents, the average effect size was 1.92 (1.22-3.01), indicating that acculturated adolescents are almost 2 times more likely to smoke than traditional adolescents. CONCLUSIONS: Acculturation may have a protective effect on smoking behavior in Asian men and a harmful effect in Asian women and adolescents. The magnitude of effect is larger in women and adolescents than in men. Smoking cessation programs should target acculturated women, adolescents, and traditional men.

Cooper Brathwaite, A. et Lemonde, M. (2015). "Health Beliefs and Practices of African Immigrants in Canada." Clin Nurs Res.

A purposive sample of 14 immigrants living in Ontario, Canada, participated in two focus groups. The researchers used semi-structured interviews to collect data and five themes emerged from the data: beliefs about diabetes were centered on diverse factors, preserving culture through food preferences and preparation, cultural practices to stay healthy, cultural practices determined number of servings of fruit and vegetables per day, and engaging in physical activity to stay healthy. Findings indicated how health beliefs and cultural practices influenced behavior in preventing type 2 diabetes (T2D). Future research should focus on other high-risk minority groups (South Asian, Caribbean, and Latin

American) to examine their health beliefs and cultural practices and use these finding to develop best practice guidelines, which should be incorporated into culturally tailored interventions.

Crawford, J., et al. (2015). "Cancer screening behaviours among South Asian immigrants in the UK, US and Canada: a scoping study." Health Soc Care Community.

South Asian (SA) immigrants settled in the United Kingdom (UK) and North America [United States (US) and Canada] have low screening rates for breast, cervical and colorectal cancers. Incidence rates of these cancers increase among SA immigrants after migration, becoming similar to rates in non-Asian native populations. However, there are disparities in cancer screening, with low cancer screening uptake in this population. We conducted a scoping study using Arksey & O'Malley's framework to examine cancer screening literature on SA immigrants residing in the UK, US and Canada. Eight electronic databases, key journals and reference lists were searched for English language studies and reports. Of 1465 identified references, 70 studies from 1994 to November 2014 were included: 63% on breast or cervical cancer screening or both; 10% examined colorectal cancer screening only; 16% explored health promotion/service provision; 8% studied breast, cervical and colorectal cancer screening; and 3% examined breast and colorectal cancer screening. A thematic analysis uncovered four dominant themes: (i) beliefs and attitudes towards cancer and screening included centrality of family, holistic healthcare, fatalism, screening as unnecessary and emotion-laden perceptions; (ii) lack of knowledge of cancer and screening related to not having heard about cancer and its causes, or lack of awareness of screening, its rationale and/or how to access services; (iii) barriers to access including individual and structural barriers; and (iv) gender differences in screening uptake and their associated factors. Findings offer insights that can be used to develop culturally sensitive interventions to minimise barriers and increase cancer screening uptake in these communities, while recognising the diversity within the SA culture. Further research is required to address the gap in colorectal cancer screening literature to more fully understand SA immigrants' perspectives, as well as research to better understand gender-specific factors that influence screening uptake.

Cristancho, S., et al. (2014). "Health information preferences among Hispanic/Latino immigrants in the U.S. rural Midwest." Glob Health Promot **21**(1): 40-49.

We investigated whether length of residence and other socio-demographic factors affect how rural Hispanic/Latino immigrants in the U.S. prefer to receive general health information. As part of a federally-funded participatory research project, we surveyed 894 adult Hispanics who were recruited through schools, community-based organizations (CBO) and faith-based organizations (FBO) in six rural communities of Illinois. Data suggest that workshops in Spanish at community settings are the most preferred health information strategy and home visits the least. Preference for these two strategies decreased significantly in the second generation, while preference for mailed printed materials increased. We further explored the role of length of residence in the U.S. on 'in-person' and 'impersonal' health information preferences controlling for other relevant socio-demographic factors finding that first generation and less educated Hispanic immigrants' prefer 'in-person' strategies. These findings suggest that rural health organizations and practitioners should implement not only culturally-appropriate but also acculturation-sensitive approaches to address Hispanic/Latino immigrants' specific health information needs.

de Freitas, C. et Martin, G. (2015). "Inclusive public participation in health: Policy, practice and theoretical contributions to promote the involvement of marginalised groups in healthcare." Soc Sci Med **135**: 31-39.

Migrants and ethnic minorities are under-represented in spaces created to give citizens voice in healthcare governance. Excluding minority groups from the health participatory sphere may weaken the transformative potential of public participation, (re)producing health inequities. Yet few studies have focused on what enables involvement of marginalised groups in participatory spaces. This paper addresses this issue, using the Participation Chain Model (PCM) as a conceptual framework, and drawing on a case study of user participation in a Dutch mental health advocacy project involving Cape Verdean migrants. Data collection entailed observation, documentary evidence and interviews with

Cape Verdeans affected by psychosocial problems (n = 20) and institutional stakeholders (n = 30). We offer practice, policy and theoretical contributions. Practically, we highlight the importance of a proactive approach providing minorities and other marginalised groups with opportunities and incentives that attract, retain and enable them to build and release capacity through involvement. In policy terms, we suggest that both health authorities and civil society organisations have a role in creating 'hybrid' spaces that promote the substantive inclusion of marginalised groups in healthcare decision-making. Theoretically, we highlight shortcomings of PCM and its conceptualisation of users' resources, suggesting adaptations to improve its conceptual and practical utility.

de Wet, C. et Yelland, M. (2015). "The challenges and opportunities in medical education for digital 'natives' and 'immigrants' in Scotland and abroad." Scott Med J.

Although the digital revolution only started towards the end of the twentieth century, it has already dramatically shifted our world away from traditional industries and ushered in a new age of information. Virtually every aspect of our modern lives has either been transformed or challenged, including medical education. This article describes three of the important factors that are causing seismic changes in medical education in Scotland and abroad. The first is the new generation of 'digital natives' that are arriving in medical schools. In response, faculty members have had to become 'digital immigrants' and adapt their pedagogies. Second, the rise of social media has allowed the creation of virtual learning environments and communities that augment but also compete with traditional brick-and-mortar institutions. Finally, an ever-increasing range of e-learning resources promise freely accessible and up-to-date evidence, but their sheer volume and lack of standardisation will require careful curation.

Dias, S., et al. (2013). "Health status and preventative behaviors of immigrants by gender and origin: a Portuguese cross-sectional study." Nurs Health Sci **15**(3): 309-317.

Migration has been associated with a greater vulnerability in health. Migrants, especially women, go through several experiences during the migration process and in the host countries that ultimately put their health at risk. This study examines self-reported health status and preventive behaviors among female and male immigrants in Portugal, and identifies sociodemographic and behavioral factors underlying gender differences. A sample of 1375 immigrants (51.1% women) was studied. Data were analyzed through logistic regression. Good health status was reported by 66.7% of men and by 56.6% of women (P < 0.001). Gender differences were also found across preventative behaviors. Among women and men, reported good health was associated with younger age, African and Brazilian origin (compared to Eastern European), secondary/higher education, no chronic disease, and concern about eating habits. Among women, good health was also associated with perceived sufficient income, no experience of mental illness, and regular physical exercise. When developing health programs to improve immigrants' health, special attention must be given to existing gender inequalities, and socioeconomic and cultural context, in accordance with their experience of living in the host country over time.

El-Hamad, I., et al. (2015). "Point-of-care screening, prevalence, and risk factors for hepatitis B infection among 3,728 mainly undocumented migrants from non-EU countries in northern Italy." J Travel Med **22**(2): 78-86.

BACKGROUND: Screening migrants from areas where hepatitis B virus (HBV) infection is endemic is important to implement preventive measures in Europe. The aim of our study was to assess (1) the feasibility of point-of-care screening in a primary care clinic and (2) hepatitis B surface antigen (HBsAg) prevalence, associated risk factors, and its clinical and epidemiological implications in undocumented migrants in Brescia, northern Italy. METHODS: A longitudinal prospective study was conducted from January 2006 to April 2010 to assess HBsAg reactivity and associated risk factors among consenting undocumented migrants who accessed the Service of International Medicine of Brescia's Local Health Authority. Genotyping assay was also performed in HBV DNA-positive patients. RESULTS: Screening was accepted by 3,728/4,078 (91.4%) subjects consecutively observed during the study period, 224 (6%) of whom were found to be HBsAg-positive. HBsAg reactivity was independently associated with the prevalence of HBsAg carriers in the geographical area of provenance (p < 0.001). On the contrary,

current or past sexual risk behaviors (despite being common in our sample) were not associated with HBV infection. Half of the HBsAg patients (111/224) had either hepatitis B e-antigen (HBeAg)-positive or -negative chronic HBV infection with a possible indication for treatment. HBV genotypes were identified in 45 of 167 HBV-infected patients as follows: genotype D, 27 subjects; genotype A, 8; genotype B, 5; and genotype C, 5. The geographical distribution of genotypes reflected the geographic provenance. CONCLUSIONS: Our results suggest that point-of-care screening is feasible in undocumented migrants and should be targeted according to provenance. Case detection of HBV infection among migrants could potentially reduce HBV incidence in migrants' contacts and in the general population by prompting vaccination of susceptible individuals and care of eligible infected patients.

Elewonibi, B. R. et BeLue, R. (2015). "Prevalence of Complementary and Alternative Medicine in Immigrants." J Immigr Minor Health.

Immigrants face barriers to accessing conventional health care systems. Hence, they are expected to have comparatively greater use of complementary and alternative medicine (CAM). This study examines the prevalence of and reason for CAM use in the U.S. population by citizenship status. Data on 34,483 U.S.-born, naturalized, and non-U.S. citizens from the 2012 National Health Interview Survey was used. CAM was categorized into four domains. Analyses controlling for socioeconomic variables were identified patterns of utilization and reasons for use. The prevalence of all CAM domains was lowest among non-U.S. citizens followed by naturalized citizens. The odds of using CAM were also higher for the immigrants who attained citizenship than for non-citizens. Individuals in all groups reported using more CAM for prevention. Factors related to cost, accessibility, or knowledge of CAM use may contribute to lower use of CAM by naturalized and non-U.S. citizens.

Fakoya, I., et al. (2008). "Barriers to HIV testing for migrant black Africans in Western Europe." HIV Med **9 Suppl 2**: 23-25.

Migrant black Africans are disproportionately affected by HIV in Western Europe; we discuss the barriers to HIV testing for sub-Saharan migrants, with particular emphasis on the UK and the Netherlands. Cultural, social and structural barriers to testing, such as access to testing and care, fear of death and disease and fear of stigma and discrimination in the community, can be identified. Lack of political will, restrictive immigration policies and the absence of African representation in decision-making processes are also major factors preventing black Africans from testing. HIV testing strategies need to be grounded in outreach and community mobilisation, addressing fear of diagnosis, highlighting the success of treatment and tackling HIV-related stigma among black African migrant communities.

Finnegan, D. A., et al. (2015). "Immigrant Caregivers of Young Children: Oral Health Beliefs, Attitudes, and Early Childhood Caries Knowledge." J Community Health.

The incidence of early childhood caries (ECC) is a global public health concern. The oral health knowledge of a caregiver can affect a child's risk for developing ECC. An exploratory study of the oral health knowledge and behaviors among caregivers of children 6 years of age and younger was conducted with a convenience sample of adults (n = 114) enrolled in English language or high school equivalency examination courses. The majority of study participants were born in Asia (47 %). Other birth regions included South America (16 %), Caribbean (16 %), Africa (10 %), and Central America (6 %). Study findings showed caregivers with low oral health knowledge were more likely to engage in behaviors that increase a child's risk for developing ECC. A statistically significant relationship was found between participants' rating of their child's dental health as poor and the belief that children should not be weaned from the nursing bottle by 12 months of age (P = 0.002), brushing should not begin upon tooth eruption (P = 0.01), and fluoride does not strengthen teeth and prevent dental caries (P = 0.005). Subjects who pre-chewed their child's food also exhibited behaviors including sharing eating utensils or a toothbrush with their child (P < 0.001). Additional caregiver behaviors included providing their child with a bottle containing cariogenic liquids in a crib (P < 0.001). As a result of this

research, it is pertinent that culturally sensitive oral health promotion programs are developed and implemented to raise awareness and reduce the risk of dental disease among immigrant populations.

Fisher, J. et Hinchliff, S. (2013). "Immigrant women's perceptions of their maternity care: a review of the literature part 1." Pract Midwife **16**(1): 20-22.

Every year since 2004, the Office for National Statistics (ONS) has recorded increasing levels of immigration with nearly 600,000 immigrants entering the UK in 2011 (ONS 2012). More than 50 per cent of these immigrants were women. With this increasing immigration to the UK, a review of the literature was conducted to understand the experiences that immigrant women have when encountering the maternity services in the UK. Twelve quantitative and qualitative studies were included in the review, each approach contributing uniquely to our understanding of the subject area. Five themes were identified when the articles in the review were analysed. They were: communication, impediments to accessing healthcare, relationships with healthcare providers, cultural standpoint and social circumstances. The first two of those themes will be considered in this article.

Fisher, J. et Hinchliff, S. (2013). "Immigrant women's perceptions of their maternity care: a review of the literature. Part 2." Pract Midwife **16**(2): 32-34.

In the first of this two part article, the methods of the literature review looking at immigrant women's perceptions of their maternity were outlined along with the first two themes identified, including communication and impediments to access of maternity care. In this concluding part, the remaining three themes of the literature review will be discussed and conclusions will be drawn, with recommendations for practice.

Han, H. R., et al. (2011). "Interventions that increase use of Pap tests among ethnic minority women: a meta-analysis." Psychooncology **20**(4): 341-351.

OBJECTIVE: Although a variety of intervention methods have been used to promote Pap test screening among ethnic minority women in the US, the effectiveness of such interventions is unclear. We performed a meta-analysis to examine the overall effectiveness of these interventions in increasing Pap test use by ethnic minority women in the US. METHODS: A search of databases (MEDLINE, Cumulative Index to Nursing and Allied Health Literature, PsycINFO, and Science Citation Index-Expanded) and review articles for articles published between 1984 and April 2009 identified 18 randomized and non-randomized controlled trials. The primary study outcome was the difference in the proportion of Pap tests between the treatment and comparison groups. RESULTS: The pooled mean weighted effect size (d) for the 18 studies was 0.158 (95% confidence interval [CI]=0.100, 0.215), indicating that the interventions were effective in improving Pap test use among ethnic minority women. Among the intervention types, access enhancement yielded the largest effect size (0.253 [95% CI=0.110, 0.397]), followed by community education (0.167 [95% CI=0.057, 0.278]) and individual counseling or letters (0.132 [95% CI=0.069, 0.195]). Combined intervention effects were significant for studies targeting Asian (0.177 [95% CI=0.098, 0.256]) and African American women (0.146 [95% CI=0.028, 0.265]), but not Hispanic women (0.116 [95% CI=-0.008, 0.240]). CONCLUSIONS: Pap test use among ethnic minority women is most likely to increase when access-enhancing strategies are combined. Further research is needed to determine whether more tightly controlled trials of such interventions might reveal an improved rate of cervical cancer screening in Hispanic women as well.

Galanis, P., et al. (2013). "Public health services knowledge and utilization among immigrants in Greece: a cross-sectional study." BMC Health Serv Res **13**: 350.

BACKGROUND: During the 90s, Greece has been transformed to a host country for immigrants mostly from the Balkans and Eastern European Countries, who currently constitute approximately 9% of the total population. Despite the increasing number of the immigrants, little is known about their health status and their accessibility to healthcare services. This study aimed to explore the perceived barriers to access and utilization of healthcare services by immigrants in Greece. METHODS: A pilot cross-sectional study was conducted from January to April 2012 in Athens, Greece. The study population

consisted of 191 immigrants who were living in Greece for less than 10 years. We developed a questionnaire that included information about sociodemographic characteristics, health status, public health services knowledge and utilization and difficulties in health services access. Statistical analysis included Pearson's x2 test, x2 test for trend, Student's t-test, analysis of variance and Pearson's correlation coefficient. RESULTS: Only 20.4% of the participants reported that they had a good/very good degree of knowledge about public health services in Greece. A considerable percentage (62.3%) of the participants needed at least once to use health services but they could not afford it, during the last year, while 49.7% used public health services in the last 12 months in Greece. Among the most important problems were long waiting times in hospitals, difficulties in communication with health professionals and high cost of health care. Increased ability to speak Greek was associated with increased health services knowledge (p<0.001). Increased family monthly income was also associated with less difficulties in accessing health services (p<0.001). CONCLUSIONS: The empowerment and facilitation of health care access for immigrants in Greece is necessary. Depending on the needs of the migrant population, simple measures such as comprehensive information regarding the available health services and the terms for accessibility is an important step towards enabling better access to needed services.

Gallo, F., et al. (2017). "Inequalities in cervical cancer screening utilisation and results: A comparison between Italian natives and immigrants from disadvantaged countries." Health Policy(Ahead of print). http://dx.doi.org/10.1016/j.healthpol.2017.08.005

Cervical screening underutilisation is well documented among immigrants from poor countries. Participation rate to cervical screening was lower for immigrants than for Italians.?Increasing age, illiteracy, being single, negatively influenced immigrants? participation.?Severe lesions nearly double among immigrants in first screens compared to Italians. Policy makers should support screening providers in establishing coalitions with immigrants' organisations.

Goldstein, L. B., et al. (2009). "Stroke-related knowledge among uninsured Latino immigrants in Durham County, North Carolina." J Stroke Cerebrovasc Dis **18**(3): 229-231.

BACKGROUND: Knowledge of stroke risk factors and symptoms is a necessary prerequisite for improving prevention and reducing treatment delays. Little is known about stroke-related knowledge among the US immigrant Latino population. METHODS: A previously published stroke knowledge survey was translated into Spanish and administered orally to a convenience sample of 76 Latino Spanish-speaking clients of a community-based health care management program for uninsured residents of Durham County, North Carolina, between January and March 2007. RESULTS: Of respondents, 81% could not correctly name a single stroke risk factor, 57% could not correctly identify a stroke symptom, and only 45% said they would telephone emergency services (dial 9-1-1), call an ambulance, or go to a hospital if they or a family member were having a stroke. However, 80% of respondents knew that a stroke could be prevented, and 86% knew that a stroke could be treated. CONCLUSION: Stroke-related knowledge may be particularly poor in the uninsured Latino immigrant population. Novel approaches will be needed to improve awareness and prevention in this high-risk group.

Grandahl, M., et al. (2015). "Immigrant women's experiences and views on the prevention of cervical cancer: a qualitative study." Health Expect **18**(3): 344-354.

BACKGROUND: Many Western countries have cervical cancer screening programmes and have implemented nation-wide human papillomavirus (HPV) vaccination programmes for preventing cervical cancer. OBJECTIVE: To explore immigrant women's experiences and views on the prevention of cervical cancer, screening, HPV vaccination and condom use. DESIGN: An exploratory qualitative study. The Health Belief Model (HBM) was used as a theoretical framework. SETTING AND PARTICIPANTS: Eight focus group interviews, 5-8 women in each group (average number 6,5), were conducted with 50 women aged 18-54, who studied Swedish for immigrants. Data were analysed by latent content analysis. RESULTS: Four themes emerged: (i) deprioritization of women's health in home countries, (ii) positive attitude towards the availability of women's health care in Sweden, (iii)

positive and negative attitudes towards HPV vaccination, and (iv) communication barriers limit health care access. Even though the women were positive to the prevention of cervical cancer, several barriers were identified: difficulties in contacting health care due to language problems, limited knowledge regarding the relation between sexual transmission of HPV and cervical cancer, culturally determined gender roles and the fact that many of the women were not used to regular health check-ups. CONCLUSION: The women wanted to participate in cervical cancer prevention programmes and would accept HPV vaccination for their daughters, but expressed difficulties in understanding information from health-care providers. Therefore, information needs to be in different languages and provided through different sources. Health-care professionals should also consider immigrant women's difficulties concerning cultural norms and pay attention to their experiences.

Haderxhanaj, L. T., et al. (2014). "Acculturation, sexual behaviors, and health care access among Hispanic and non-Hispanic white adolescents and young adults in the United States, 2006-2010." J Adolesc Health **55**(5): 716-719.

PURPOSE: To examine national estimates of sexual behaviors and health care access by acculturation among adolescents. METHODS: Using the 2006-2010 National Survey of Family Growth, four acculturation groups of Hispanic and non-Hispanic whites aged 15-24 years were analyzed by sexual behaviors and health care access. RESULTS: In analyses adjusted for demographics, English-speaking immigrants, Hispanic natives, and non-Hispanic white youth were less likely to have a partner age difference of >/=6 years (adjusted odds ratio [AOR], .28; 95% confidence interval [CI], .13-.60; AOR, .13; 95% CI, .07-.26; AOR, .16; 95% CI, .08-.32, respectively) and more likely to use a condom at the first vaginal sex (AOR, 1.99; 95% CI, 1.10-3.61; AOR, 2.10; 95% CI, 1.33-3.31; AOR, 2.39; 95% CI, 1.53-3.74, respectively) than Spanish-speaking immigrants. Non-Hispanic white youth and Hispanic natives were more likely to have a regular place for medical care (AOR, 2.07; 95% CI, 1.36-3.16; AOR, 3.66; 95% CI, 2.36-5.68, respectively) and a chlamydia test in the past 12 months (AOR, 3.62; 95% CI, 1.52-8.60; AOR, 2.94; 95% CI, 1.32-6.54) than Spanish-speaking immigrants. CONCLUSIONS: Interventions to reduce risk and increase health care access are needed for immigrant Hispanic youth, particularly Spanish-speaking immigrants.

Harcourt, N., et al. (2014). "Factors associated with breast and cervical cancer screening behavior among African immigrant women in Minnesota." J Immigr Minor Health **16**(3): 450-456.

Immigrant populations in the United States (US) have lower cancer screening rates compared to none immigrant populations. The purpose of this study was to assess the rates of cancer screening and examine factors associated with cancer screening behavior among African immigrant women in Minnesota. A cross sectional survey of a community based sample was conducted among African immigrants in the Twin Cities. Cancer screening outcome measures were mammography and Papanicolau smear test. The revised theoretical model of health care access and utilization and the behavioral model for vulnerable populations were utilized to assess factors associated with cancer screening. Only 61 and 52% of the age eligible women in the sample had ever been screened for breast and cervical cancer respectively. Among these women, duration of residence in the US and ethnicity were significant determinants associated with non-screening. Programs to enhance screening rates among this population must begin to address barriers identified by the community.

Harris, M. F. (2012). "Access to preventive care by immigrant populations." BMC Med **10**: 55.

Many immigrant populations lack access to primary health care. A recently published study on cholesterol screening among immigrant populations in the US found disparities in cholesterol screening in those originating from Mexico, largely due to limited access to healthcare. This inverse care affects immigrants in many destination countries despite their greater health need.Please see related article: http://www.equityhealthj.com/content/11/1/22.

Hjelm, K. et Bard, K. (2013). "Beliefs about health and illness in latin-american migrants with diabetes living in sweden." Open Nurs J **7**: 57-65.

The study explored beliefs about health and illness in Latin American migrants diagnosed with diabetes mellitus (DM) living in Sweden, and investigated the influence on health-related behavior including self-care and care-seeking behavior. Migrants are particularly affected in the diabetes pandemia. Beliefs about health and illness determine health-related behaviour and health but no studies have been found on Latin American migrants with DM. An explorative study design with focus-group interviews of nine persons aged 36-77 years from a diabetes clinic was used. Health was described from a pathogenetic or a salutogenetic perspective: 'freedom from disease or feeling of well-being', and being autonomous and able to work. Economic hardship due to expenses for medications and food for DM affected health. Individual factors such as diet, exercise and compliance with advice, and social factors with good social relations and avoidance of stress, often caused by having experienced severe events related to migrational experiences, were considered important for maintaining health and could cause DM. Disturbed relations to others (social factors), punishment by God or Fate (supernatural factors), intake of diuretics and imbalance between warmth and cold (natural factors) were also perceived as causes. A mix of biomedical and traditional explanations and active self-care behaviour with frequent use of herbs was found. It is important to assess the individual's beliefs, and health professionals, particularly nurses, should incorporate discussions of alternative treatments and other components of explanatory models and co-operate with social workers to consider influence of finances and migrational experiences on health.

Hwang, W. C., et al. (2008). "A conceptual paradigm for understanding culture's impact on mental health: the cultural influences on mental health (CIMH) model." Clin Psychol Rev **28**(2): 211-227.

Understanding culture's impact on mental health and its treatment is extremely important, especially in light of recent reports highlighting the realities of health disparities and unequal treatment. This article provides a conceptual paradigm for understanding how culture influences six mental health domains, including (a) the prevalence of mental illness, (b) etiology of disease, (c) phenomenology of distress, (d) diagnostic and assessment issues, (e) coping styles and help-seeking pathways, and (f) treatment and intervention issues. Systematic interrelationships between each of these domains are highlighted and relevant literature is reviewed. Although no one model can adequately capture the complex facets of culture's influence on mental health, the Cultural Influences on Mental Health (CIMH) model serves as an important framework for understanding the complexities of these interrelationships. Implications for clinical research and practice are discussed.

Ioasa-Martin, I. et Moore, L. J. (2012). "Problems with non-adherence to antipsychotic medication in Samoan New Zealanders: a literature review." Int J Ment Health Nurs **21**(4): 386-392.

This paper explores what is known about adherence to antipsychotic medications in general and the possible reasons for non-adherence in Samoan New Zealanders. Samoan New Zealanders are either Samoan-born immigrants or their descendents born in New Zealand. Clinicians recognize a high prevalence of non-adherence among Samoan New Zealanders. The authors hypothesize that traditional Samoan beliefs play a prominent role in problems with adherence. To investigate this hypothesis, a review of the literature on adherence in Samoan New Zealanders was undertaken. Documents from the Ministry of Health support the hypothesis. To investigate this issue, the Ministry of Health initiated a qualitative research project to examine the nature of Samoan traditional beliefs. The results of this study are summarized. No research had previously been undertaken on adherence in Samoan New Zealanders. In general, there is a lack of research on all aspects of the mental health of Pacific peoples in New Zealand. Literature reviews of adherence research consistently show that interventions that improve adherence address the beliefs, behaviours, and relationships surrounding adherence. This finding supports the author's hypothesis that traditional beliefs play an important role in the problem of adherence. Further definitive study with Samoan New Zealanders is required.

Jadalla, A. A., et al. (2015). "Acculturation as a predictor of health promoting and lifestyle practices of Americans: a descriptive study. " J Cult Divers **22**(1): 15-22.

A cross-sectional descriptive study was done using the Acculturation Rating scale of Arab Americans-II, and the Health Promotion and Lifestyle Profile II to assess the relationship between acculturation and

health promotion practices among Arab Americans. Findings showed that attraction to American culture was the most important predictor of physical activity; whereas attraction to Arabic culture was the most important predictor of stress management and nutritional practices. Results suggest that, when demographics are controlled, acculturation predicts various health promotion practices in different patterns among members of this group. These findings contribute to a better understanding of acculturation's influence on immigrants' health promotion practices.

Johnson, C. E., et al. (2008). "Cervical cancer screening among immigrants and ethnic minorities: a systematic review using the Health Belief Model." J Low Genit Tract Dis **12**(3): 232-241.

OBJECTIVE: To systematically review all studies examining sociocultural factors influencing cervical cancer screening among immigrant and ethnic minorities in the United States along the theoretical framework of the Health Belief Model. MATERIALS AND METHODS: MEDLINE/PubMed, Cumulative Index to Nursing and Allied Health Literature, EMBASE, and Cochrane database searches were conducted searching for English language, US-based studies to examine minority and immigrant populations within the theoretical framework of the Health Belief Model. Fifty-five of more than 3,381 potentially relevant articles were included in the final analysis. RESULTS: Commonly held beliefs across several cultural groups emerged including the following: fatalistic attitudes, a lack of knowledge about cervical cancer, fear of Pap smears threatening one's virginity, as well as beliefs that a Pap smear is unnecessary unless one is ill. Beliefs unique to specific cultural groups included: body-focused notions among Hispanics, as childbirth, menses, sex, and stress were considered to play a role in one's susceptibility to cancer. African Americans identified administrative processes in establishing health care as barriers to screening, whereas Asian immigrants held a variety of misconceptions concerning one's susceptibility to cancer as well as stigmatization imposed by their own community and providers. CONCLUSION: Health care providers and policy makers must be cognizant of the various sociocultural factors influencing health-related beliefs and health care utilization among immigrant and ethnic minorities in the United States. Culturally relevant screening strategies and programs that address these sociocultural factors must be developed to address the growing disparity in cervical cancer burden among underserved, resource-poor populations in the United States.

Joo, J. Y. (2014). "Effectiveness of culturally tailored diabetes interventions for Asian immigrants to the United States: a systematic review." Diabetes Educ **40**(5): 605-615.

PURPOSE: The purpose of this systematic review is to evaluate the effectiveness of tailoring community-based diabetes intervention to Asian immigrant cultures. METHODS: The Cochrane processes and Preferred Reporting Items for Systematic Reviews and Meta-Analyses recommendations guided this systematic review. PubMed, the Cumulative Index to Nursing and Allied Health Literature, Ovid, and PsycINFO were searched for analyses and syntheses of primary research published since 2000 that described interventions tailored for the cultures of Asian immigrants with diabetes. This search yielded a total of 9 articles published from 2005 to 2013. The Amsterdam-Maastricht Consensus List for Quality Assessment was used to assess the quality of the studies. RESULTS: Retrieved studies' populations were foreign-born adults >50 years of age with type 2 diabetes. The review revealed that culturally tailored diabetes programs are effective at improving patients' objectively measured clinical outcomes, in particular A1C levels, and psychobehavioral outcomes. Patients were also highly satisfied with bilingual health care providers and bilingual educational programs. CONCLUSIONS: There is strong evidence of the effectiveness of tailoring diabetes interventions to Asian immigrant populations' cultures. Further studies, including longitudinal studies and studies with rigorous research designs that subclassify Asian immigrants, are needed to encourage the implementation of culturally tailored diabetes intervention for this ethnic minority.

Joshi, S., et al. (2014). "Differences in health behaviours between immigrant and non-immigrant groups: a protocol for a systematic review." Syst Rev **3**: 61.

BACKGROUND: Health behaviours are important determinants of health and adoption of unhealthy behaviour is considered as one of the mechanisms through which immigrants' health changes over time in the host country. The change in health behaviours over time can contribute either to

improving or worsening the overall health status of immigrants. Despite being the important mediators for the change in overall health status and chronic health conditions, no previous review (either general or systematic) has examined differences in key health behaviours simultaneously between immigrants and non-immigrants. This study aims to provide a systematic overview of the current global literature on differences in key health behaviours (that is, tobacco smoking, physical activity and alcohol drinking) between immigrant and non-immigrant groups. METHODS/DESIGN: Empirical studies in English language reporting quantitative data simultaneously on both immigrant and non-immigrant groups will be considered for this systematic review. Electronic scientific searches will be conducted on seven databases to identify relevant studies of interests: MEDLINE, CINAHL, PsycINFO, EMBASE, Global Health, SocINDEX and ProQuest. In addition, Google/Google Scholar will be used to find the relevant studies and personal contact with experts will also be undertaken. Titles, abstracts and keywords of studies identified in the search strategies will be screened for inclusion criteria. The authors will select the studies following the PRISMA guidelines. The quality of included studies will be appraised using the Critical Appraisal Skills Programme (CASP) checklists. A descriptive summary statistics of included studies will describe the study designs, socio-demographic characteristics, and the exposure (immigrant and non-immigrant groups) and outcome (key health behaviours) measures. P-values and confidence intervals (CIs) for the associations between exposure and key health behaviours will also be reported. DISCUSSION: This systematic review will facilitate a better understanding of differences in key health behaviours between immigrant and non-immigrant counterparts. It will provide a rigorous and reliable research base for future research and advance information on key health behaviours for a range of immigrant groups compared to non-immigrants in the high-migrant-receiving countries. SYSTEMATIC REVIEW REGISTRATION: This systematic review protocol has been registered with PROSPERO (registration number: CRD42014008688).

Kalengayi, F. K., et al. (2015). "'It is a dilemma': perspectives of nurse practitioners on health screening of newly arrived migrants." Glob Health Action **8**: 27903.

BACKGROUND: Screening newly arrived migrants from countries with high burden of communicable diseases of public health significance is part of the Swedish national strategy against the spread of these diseases. However, little is known about its implementation. OBJECTIVE: This study aimed at exploring caregivers' experiences in screening newly arrived migrants to generate knowledge that could inform policy and clinical practice. DESIGN: Using an interpretive description framework, we conducted semistructured interviews between November and December 2011 in four Swedish counties, with 15 purposively selected nurses with experience in screening migrants. Data were analyzed using thematic analysis. RESULTS: Participants described a range of challenges including discordant views between migrants and the nurses about medical screening, inconsistencies in rules and practices, and conflicting policies. Participants indicated that sociocultural differences resulted in divergent expectations with migrants viewing the participants as agents of migration authorities. They also expressed concern over being given a new assignment without training and being expected to share responsibilities with staff from other agencies without adequate coordination. Finally, they indicated that existing policies can be confusing and raise ethical issues. All these were compounded by language barriers, making their work environment extremely complex and stressful. CONCLUSIONS: These findings illuminate complex challenges that could limit access to, uptake, and delivery of health screening and undermine public health goals, and highlight the need for a multilevel approach. This entails avoiding the conflation of migration with health issues, harmonizing existing policies to make health care services more accessible and acceptable to migrants, and facilitating health professionals' work in promoting public health, improving interagency collaboration and the skills of all staff involved in understanding and effectively responding to migrants' needs, and improving migrants' health literacy through community outreach interventions.

Kowal, S. P., et al. (2015). ""If they tell me to get it, I'll get it. If they don't....": Immunization decision-making processes of immigrant mothers." Can J Public Health **106**(4): e230-235.

OBJECTIVE: To understand information-gathering and decision-making processes of immigrant mothers for scheduled childhood vaccines, vaccination during pregnancy, seasonal flu and pandemic vaccination. METHODS: We conducted 23 qualitative semi-structured interviews with immigrated

mothers from Bhutanese refugee, South Asian and Chinese communities. Participants lived in Edmonton, Alberta and had at least one child under eight years old. Using NVivo qualitative software, we generated an inductive coding scheme through content analysis of interview transcripts. RESULTS: Our three main findings on information gathering and use in vaccination decisions were: 1) participants in all three communities passively received immunization information. Most mothers learned about vaccine practices exclusively from health care practitioners during scheduled visits. Social networks were primary sources of information in origin countries but were lost during immigration to Canada; 2) participants demonstrated universal trust in vaccines (i.e., no anti-vaccination sentiment). They were comfortable in receiving vaccines for themselves and their children, regardless of past adverse reactions; 3) participants' recollection of the H1N1 vaccination campaign was almost nil, demonstrating the lack of reach of public health vaccination campaigns to designated priority groups (pregnant women and children) in Alberta. CONCLUSION: Our results highlight the limitations of Alberta's current vaccination communication strategies in reaching immigrant women. When immigrant mothers receive vaccination information, our results indicate they will likely follow recommendations. However, our study shows that current communication strategies are not making this information accessible to immigrant women, which limits their ability to make informed vaccination decisions for themselves and their children.

Landale, N. S., et al. (2015). "Behavioral functioning among Mexican-origin children: does parental legal status matter?" J Health Soc Behav **56**(1): 2-18.

Using data on 2,535 children included in the Los Angeles Family and Neighborhood Survey, we investigate how the legal status of immigrant parents shapes their children's behavioral functioning. Variation in internalizing and externalizing problems among Mexican youth with undocumented mothers, documented or naturalized citizen mothers, and U.S.-born mothers is analyzed using a comparative framework that contrasts their experience with that of other ethnoracial groups. Our findings reinforce the importance of differentiating children of immigrants by parental legal status in studying health and well-being. Children of undocumented Mexican migrants have significantly higher risks of internalizing and externalizing behavior problems than their counterparts with documented or naturalized citizen mothers. Regression results are inconsistent with simple explanations that emphasize group differences in socioeconomic status, maternal mental health, or family routines.

Lebrun, L. A. et Dubay, L. C. (2010). "Access to primary and preventive care among foreign-born adults in Canada and the United States." Health Serv Res **45**(6 Pt 1): 1693-1719.

OBJECTIVE: To conduct cross-country comparisons and assess the effect of foreign birth on access to primary and preventive care in Canada and the United States. DATA SOURCES: Secondary data from the 2002 to 2003 Joint Canada-United States Survey of Health. STUDY DESIGN: Descriptive and comparative analyses were conducted, and logistic regression models were used to assess the effect of immigrant status and country of residence on access to care. Outcomes included measures of health care systems and processes, utilization, and patient perceptions. PRINCIPAL FINDINGS: In adjusted analyses, immigrants in Canada fared worse than nonimmigrants regarding having timely Pap tests; in the United States, immigrants fared worse for having a regular doctor and an annual consultation with a health professional. Immigrants in Canada had better access to care than immigrants in the United States; most of these differences were explained by differences in socioeconomic status and insurance coverage across the two countries. However, U.S. immigrants were more likely to have timely Pap tests than Canadian immigrants, even after adjusting for potential confounders. CONCLUSIONS: In both countries, foreign-born populations had worse access to care than their native-born counterparts for some indicators but not others. However, few differences in access to care were found when direct cross-country comparisons were made between immigrants in Canada versus the United States, after accounting for sociodemographic differences.

Lee-Lin, F., et al. (2015). "A breast health educational program for Chinese-American women: 3- to 12-month postintervention effect." Am J Health Promot **29**(3): 173-181.

PURPOSE: To test the efficacy of a culturally targeted breast cancer screening educational program in increasing mammogram completion in Chinese-American immigrant women. DESIGN: Randomized controlled study. SETTING: Chinese communities, Portland, Oregon. SUBJECTS: From April 2010 to September 2011, 300 women were randomized to receive a theory-based, culturally targeted breast cancer screening educational intervention (n = 147) or a mammography screening brochure published by the National Cancer Institute (n = 153). INTERVENTION: The two-part intervention consisted of group teaching with targeted, theory-based messages followed by individual counseling sessions. MEASURES: Mammography completion, perceived susceptibility, perceived benefits, perceived barriers, perceived cultural barriers, and demographic variables. ANALYSIS: A 2 x 3 mixed logistic model was applied to determine odds ratio of mammogram completion. RESULTS: Behavior changed in both groups, with a total of 170 participants (56.7%) reporting a mammogram at 12 months. The logistic model indicated increased odds of mammogram completion in the intervention compared to the control group at 3, 6, and 12 months. When controlling for marital status, age, and age moved to the United States, the intervention group was nine times more likely to complete mammograms than the control group. CONCLUSION: The culturally targeted educational program significantly increased mammogram use among Chinese immigrant women. Further testing of effectiveness in larger community settings is needed. The intervention may also serve as a foundation from which to develop education to increase cancer screening among other minority subgroups.

Legido-Quigley, H. et McKee, M. (2012). "Health and social fields in the context of lifestyle migration." Health Place **18**(6): 1209-1216.

Migrants occupy different social fields encompassing both their origin and their destination. Much previous work on interactions within these fields has focused on economic migrants. In this paper we seek to understand the social fields occupied by British pensioners who have moved to Spain and how these interact with their health and their experience of the healthcare system. We explore the links between health, social fields, healthcare, place and social relationships. We use in-depth interviews conducted among those living in a variety of settings. We draw upon Bourdieu's concept of habitus and social fields and differentiate, between ways of being and ways of belonging in the fields. We identified three social fields. The first embraced interviewees' social networks back in the UK where implicit comparisons of healthcare were made. The second embraced their expatriate social networks in Spain which includes their conceptualization of a "healthy life", while the third included the interaction with Spanish institutions, including the healthcare system. This conceptual framework provides new insights for those considering retirement abroad, and those that want to understand how lifestyles and navigating distinct social fields influence health and the healthcare experience

Leung, L. A. (2014). "Healthy and unhealthy assimilation: country of origin and smoking behavior among immigrants." Health Econ **23**(12): 1411-1429.

Smoking rates in the country of origin were used to empirically examine whether immigrants converge toward natives' level of smoking prevalence with assimilation. Results show that assimilation is associated with a lower likelihood of ever quitting smoking for immigrants from countries with lower smoking rates relative to the USA and a higher likelihood for immigrants from countries with higher smoking rates, but for current or ever smoking, the estimated effects of assimilation are statistically insignificant. Although these findings demonstrate that health assimilation depends on the country of origin, the extent to which this pattern of assimilation is due to peer influence, differences in responsiveness to anti-smoking interventions such as taxes or smoke-free air restrictions, and/or other factors remains unclear because of the limitations of this study.

Ljunge, M. (2014). "Social capital and health: evidence that ancestral trust promotes health among children of immigrants." Econ Hum Biol **15**: 165-186.

This paper presents evidence that generalized trust promotes health. Children of immigrants in a broad set of European countries with ancestry from across the world are studied. Individuals are examined within country of residence using variation in trust across countries of ancestry. The approach addresses reverse causality and concerns that the trust measure picks up institutional

factors in the individual's contextual setting. There is a significant positive estimate of ancestral trust in explaining self-assessed health. The finding is robust to accounting for individual, parental, and extensive ancestral country characteristics. Individuals with higher ancestral trust are also less likely to be hampered by health problems in their daily life, providing evidence of trust influencing real life outcomes. Individuals with high trust feel and act healthier, enabling a more productive life.

Lood, Q., et al. (2015). "Bridging barriers to health promotion: a feasibility pilot study of the 'Promoting Aging Migrants' Capabilities study'." J Eval Clin Pract **21**(4): 604-613.

RATIONALE, AIMS AND OBJECTIVES: Improving the possibilities for ageing persons to take control over their health is an increasingly important public health issue. Health promotion has previously been visualized to succeed with this goal, but research has primarily focused on ageing persons who are native-born, leaving the generalizability to persons who are foreign-born unexplored. Therefore, as part of the development of a larger health promotion initiative for ageing persons who have experienced migration, this study aimed to assess the feasibility of an adapted protocol. The specific feasibility objectives were to assess recruitment procedure, retention rates, study questionnaire administration and variability of collected data. METHOD: Forty persons who were >/=70 years, and who had migrated from Finland, Bosnia and Herzegovina, Croatia, Montenegro or Serbia to Sweden were randomly allocated to a health promotion programme or a control group. The programme was linguistically adapted with regard to translated information material, bilingual health professionals and evaluators, and a person-centred approach was applied to both programme development and provision. The data analysis was explorative and descriptive. RESULTS: The results visualized structural and linguistic barriers to recruitment and study questionnaire administration, and describe strategies for how to bridge them. Retention rates and data variability were satisfying. CONCLUSIONS: Calling for iterative and pragmatic programme design, the findings describe how to move towards a more inclusive health care environment. Person-centred and bilingual approaches with attention to the possibilities for building authentic relationships between participants and providers are emphasized, and a structured methodology for developing study questionnaires is suggested.

Makowski, A. C. et Kofahl, C. (2014). "Benefit and adherence of the disease management program "diabetes 2": a comparison of Turkish immigrants and German natives with diabetes." Int J Environ Res Public Health **11**(9): 9723-9738.

There is an ongoing debate about equity and equality in health care, and whether immigrants benefit equally from services as the non-immigrant population. The study focuses on benefits from and adherence to the diabetes mellitus type 2 (DM 2) disease management program (DMP) among Turkish immigrants in Germany. So far, it has not been researched whether this group benefits from enrollment in the DMP as well as diabetics from the non-immigrant population. Data on the non-immigrant sample (N = 702) stem from a survey among members of a German health insurance, the Turkish immigrant sample (N = 102) was recruited in the area of Hamburg. Identical questions in both surveys enable comparing major components. Regarding process quality, Turkish diabetics do not differ from the non-immigrant sample; moreover, they have significantly more often received documentation and diabetes training. In terms of outcome quality however, results display a greater benefit on behalf of the non-immigrant sample (e.g., blood parameters and body mass index), and they also met more of the DMP criteria. This underlines the need of diabetics with Turkish background for further education and information in order to become the empowered patient as is intended by the DMP as well as to prevent comorbidities.

Malmusi, D. (2015). "Immigrants' health and health inequality by type of integration policies in European countries." Eur J Public Health **25**(2): 293-299.

BACKGROUND: Recent efforts to characterize integration policy towards immigrants and to compare immigrants' health across countries have rarely been combined so far. This study explores the relationship of country-level integration policy with immigrants' health status in Europe. METHODS: Cross-sectional study with data from the 2011 European Union Survey on Income and Living Conditions. Fourteen countries were grouped according to a typology of integration policies based on

the Migrant Integration Policy Index: 'multicultural' (highest scores: UK, Italy, Spain, Netherlands, Sweden, Belgium, Portugal, Norway, Finland), 'exclusionist' (lowest scores: Austria, Denmark) and 'assimilationist' (high or low depending on the dimension: France, Switzerland, Luxembourg). People born in the country (natives, n = 177 300) or outside the European Union with >10 years of residence (immigrants, n = 7088) were included. Prevalence ratios (PR) of fair/poor self-rated health between immigrants in each country cluster, and for immigrants versus natives within each, were computed adjusting by age, education, occupation and socio-economic conditions. RESULTS: Compared with multicultural countries, immigrants report worse health in exclusionist countries (age-adjusted PR, 95% CI: men 1.78, 1.49-2.12; women 1.58, 1.37-1.82; fully adjusted, men 1.78, 1.50-2.11; women 1.47, 1.26-1.70) and assimilationist countries (age-adjusted, men 1.21, 1.03-1.41; women 1.21, 1.06-1.39; fully adjusted, men 1.19, 1.02-1.40; women 1.22, 1.07-1.40). Health inequalities between immigrants and natives were also highest in exclusionist countries, where they persisted even after adjusting for differences in socio-economic situation. CONCLUSION: Immigrants in 'exclusionist' countries experience poorer socio-economic and health outcomes. Future studies should confirm whether and how integration policy models could make a difference on migrants' health.

Marino, R. J., et al. (2014). "Cost-minimization analysis of a tailored oral health intervention designed for immigrant older adults." Geriatr Gerontol Int **14**(2): 336-340.

AIM: This paper presents an economic evaluation, from a societal viewpoint, comparing a community-based oral health promotion program aimed at improving the gingival health of immigrant older adults, with one-on-one chairside oral hygiene instructions at a public dental clinic in Melbourne, Australia. METHODS: The costs associated with implementing and operating the oral health promotion program were identified and measured using 2008 prices. The intervention was based on the Oral Health Information Seminars/Sheets model, and consisted of 10 20-min oral hygiene group seminars and four 10-min supervised individual brushing sessions carried out by a non-oral health professional educator. Health outcomes were measured as a reduction in gingival bleeding. Clinical data showed a 75% reduction in mean gingival bleeding scores among those who took part in the intervention. A population of 100 active, independent-living older adults living in Melbourne, and members of Italian social clubs, was used for modeling in this analysis. RESULTS: This analysis estimated that if an oral hygiene program using the Oral Health Information Seminars/Sheets model was available to 100 older adults, the net cost from a societal perspective would be AUD$6965.20. In comparison, a standard individual oral hygiene instruction program, at public dental clinics, given equivalent levels of case complexity and assuming the same level of effectiveness, would cost AUD$40 185.00. Per participant cost of a community-based oral health promotion program was $69.65 versus $401.85 for chairside instruction. CONCLUSIONS: Findings confirm that community-based oral health interventions are highly cost-effective and an efficient use of society's financial resources.

Martin, Y., et al. (2014). "The lower quality of preventive care among forced migrants in a country with universal healthcare coverage." Prev Med **59**: 19-24.

OBJECTIVE: To assess the association between socio-demographic factors and the quality of preventive care and chronic care of cardiovascular (CV) risk factors in a country with universal health care coverage. METHODS: Our retrospective cohort assessed a random sample of 966 patients aged 50-80years followed over 2years (2005-2006) in 4 Swiss university primary care settings (Basel/Geneva/Lausanne/Zurich). We used RAND's Quality Assessment Tools indicators and examined recommended preventive care among different socio-demographic subgroups. RESULTS: Overall patients received 69.6% of recommended preventive care. Preventive care indicators were more likely to be met among men (72.8% vs. 65.4%; p<0.001), younger patients (from 71.0% at 50-59years to 66.7% at 70-80years, p for trend=0.03) and Swiss patients (71.1% vs. 62.7% in forced migrants; p=0.001). This latter difference remained in multivariate analysis adjusted for gender, age, civil status and occupation (OR 0.68; 95% CI 0.54-0.86). Forced migrants had lower scores for physical examination and breast and colon cancer screening (all p</=0.02). No major differences were seen for chronic care of CV risk factors. CONCLUSION: Despite universal healthcare coverage, forced migrants receive less preventive care than Swiss patients in university primary care settings. Greater attention should be paid to forced migrants for preventive care.

Martinez, J. L., et al. (2013). "Healthy eating for life: rationale and development of an English as a second language (ESL) curriculum for promoting healthy nutrition." Transl Behav Med **3**(4): 426-433.

> Low health literacy contributes significantly to cancer health disparities disadvantaging minorities and the medically underserved. Immigrants to the United States constitute a particularly vulnerable subgroup of the medically underserved, and because many are non-native English speakers, they are pre-disposed to encounter language and literacy barriers across the cancer continuum. Healthy Eating for Life (HE4L) is an English as a second language (ESL) curriculum designed to teach English language and health literacy while promoting fruit and vegetable consumption for cancer prevention. This article describes the rationale, design, and content of HE4L. HE4L is a content-based adult ESL curriculum grounded in the health action process approach to behavior change. The curriculum package includes a soap opera-like storyline, an interactive student workbook, a teacher's manual, and audio files. HE4L is the first teacher-administered, multimedia nutrition-education curriculum designed to reduce cancer risk among beginning-level ESL students. HE4L is unique because it combines adult ESL principles, health education content, and behavioral theory. HE4L provides a case study of how evidence-based, health promotion practices can be implemented into real-life settings and serves as a timely, useful, and accessible nutrition-education resource for health educators.

Mathews, R. et Zachariah, R. (2008). "Coronary heart disease in South Asian immigrants: synthesis of research and implications for health promotion and prevention in nursing practice." J Transcult Nurs **19**(3): 292-299.

> Although the literature reflects that Asian Indians in the United States and globally have the highest rates of morbidity and mortality because of coronary heart disease (CHD) and diabetes, few studies have described the clinical implications in the United States. Traditional risk factors dictate practice, yet these risk factors do not fully explain the rates. Central obesity, lipoprotein (a), and insulin resistance may have a strong role. The literature suggests that proactive nursing using culturally specific clinical measures are necessary to reduce risk factors for CHD and diabetes in South Asians. Additional research and prevention strategies focused on immigrant South Asians in the United States are recommended.

Matteelli, A., et al. (2000). "Supervised preventive therapy for latent tuberculosis infection in illegal immigrants in Italy." Am J Respir Crit Care Med **162**(5): 1653-1655.

> In a multicenter, prospective, randomized, open-label study of isoniazid-preventive therapy (IPT) for latent tuberculosis infection, illegal immigrants from countries where tuberculosis is highly endemic were enrolled at two clinical sites in Northern Italy. Of 208 eligible subjects, 82 received supervised IPT at a dose of 900 mg twice weekly for 6 mo (Regimen A), 73 received unsupervised IPT 900 mg twice weekly for 6 mo (Regimen B), and 53 received unsupervised IPT 300 mg daily for 6 mo (Regimen C). Supervised IPT was delivered at either one tuberculosis clinic or one migrant clinic. The probability of completing a 26-wk regimen was 7, 26, and 41% in Regimens A, B, and C, respectively ($p < 0.005$, Log- rank test calculated using Kaplan-Meier plots). The mean time to dropout was 3. 8, 6, and 6.2 wk in Regimens A, B, and C, respectively ($p = 0.003$ for regimen A versus either Regimens B or C). Treatment was stopped in five subjects (2.4%) because of adverse events. The rate of completion of preventive therapy for latent tuberculosis infection among illegal immigrants was low. Supervised, clinic-based administration of IPT significantly reduced adherence. Alternative strategies to implement preventive therapy in illegal immigrants are clearly required.

McMahon, T. et Ward, P. R. (2012). "HIV among immigrants living in high-income countries: a realist review of evidence to guide targeted approaches to behavioural HIV prevention." Syst Rev **1**: 56.

> BACKGROUND: Immigrants from developing and middle-income countries are an emerging priority in HIV prevention in high-income countries. This may be explained in part by accelerating international migration and population mobility. However, it may also be due to the vulnerabilities of immigrants including social exclusion along with socioeconomic, cultural and language barriers to HIV prevention. Contemporary thinking on effective HIV prevention stresses the need for targeted approaches that

adapt HIV prevention interventions according to the cultural context and population being addressed. This review of evidence sought to generate insights into targeted approaches in this emerging area of HIV prevention. METHODS: We undertook a realist review to answer the research question: 'How are HIV prevention interventions in high-income countries adapted to suit immigrants' needs?' A key goal was to uncover underlying theories or mechanisms operating in behavioural HIV prevention interventions with immigrants, to uncover explanations as how and why they work (or not) for particular groups in particular contexts, and thus to refine the underlying theories. The realist review mapped seven initial mechanisms underlying culturally appropriate HIV prevention with immigrants. Evidence from intervention studies and qualitative studies found in systematic searches was then used to test and refine these seven mechanisms. RESULTS: Thirty-four intervention studies and 40 qualitative studies contributed to the analysis and synthesis of evidence. The strongest evidence supported the role of 'consonance' mechanisms, indicating the pivotal need to incorporate cultural values into the intervention content. Moderate evidence was found to support the role of three other mechanisms - 'understanding', 'specificity' and 'embeddedness' - which indicated that using the language of immigrants, usually the 'mother tongue', targeting (in terms of ethnicity) and the use of settings were also critical elements in culturally appropriate HIV prevention. There was mixed evidence for the roles of 'authenticity' and 'framing' mechanisms and only partial evidence to support role of 'endorsement' mechanisms. CONCLUSIONS: This realist review contributes to the explanatory framework of behavioural HIV prevention among immigrants living in high-income countries and, in particular, builds a greater understanding of the suite of mechanisms that underpin adaptations of interventions by the cultural context and population being targeted.

Mejean, C., et al. (2007). "Influence of socio-economic and lifestyle factors on overweight and nutrition-related diseases among Tunisian migrants versus non-migrant Tunisians and French." BMC Public Health **7**: 265.

BACKGROUND: Migrant studies in France revealed that Mediterranean migrant men have lower mortality and morbidity than local-born populations for non-communicable diseases (NCDs). We studied overweight and NCDs among Tunisian migrants compared to the population of the host country and to the population of their country of origin. We also studied the potential influence of socio-economic and lifestyle factors on differential health status. METHODS: A retrospective cohort study was conducted to compare Tunisian migrant men with two non-migrant male groups: local-born French and Tunisians living in Tunisia, using frequency matching. We performed quota sampling (n = 147) based on age and place of residence. We used embedded logistic regression models to test socio-economic and lifestyle factors as potential mediators for the effect of migration on overweight, hypertension and reported morbidity (hypercholesterolemia, type-2 diabetes, cardiovascular diseases (CVD)). RESULTS: Migrants were less overweight than French (OR = 0.53 [0.33-0.84]) and had less diabetes and CVD than Tunisians (0.18 [0.06-0.54] and 0.25 [0.07-0.88]). Prevalence of hypertension (grade-1 and -2) and prevalence of hypercholesterolemia were significantly lower among migrants than among French (respectively 0.06 [0.03-0.14]; 0.04 [0.01-0.15]; 0.11 [0.04-0.34]) and Tunisians (respectively OR = 0.07 [0.03-0.18]; OR = 0.06 [0.02-0.20]; OR = 0.23 [0.08-0.63]). The effect of migration on overweight was mediated by alcohol consumption. Healthcare utilisation, smoking and physical activity were mediators for the effect of migration on diabetes. The effect of migration on CVD was mediated by healthcare utilisation and energy intake. No obvious mediating effect was found for hypertension and hypercholesterolemia. CONCLUSION: Our study clearly shows that lifestyle (smoking) and cultural background (alcohol) are involved in the observed protective effect of migration.

Mendoza, F. S. (2009). "Health disparities and children in immigrant families: a research agenda." Pediatrics **124 Suppl 3**: S187-195.

Children in immigrant families now comprise 1 in 5 children in the United States. Eighty percent of them are US citizens, and 53% live in mixed-citizenship families. Their families are among the poorest, least educated, least insured, and least able to access health care. Nonetheless, these children demonstrate better-than-expected health status, a finding termed "the immigrant paradox" and one suggesting that cultural health behaviors among immigrant families might be protective in some areas of health. In this article the strength of the immigrant paradox, the effect of acculturation on health,

and the relationships of acculturation, enculturation, language, and literacy skills to health disparities are reviewed. The current public policy issues that affect the health disparities of children of immigrant families are presented, and a research agenda for improving our knowledge about children in immigrant families to develop effective interventions and public policies that will reduce their health disparities is set forth.

Meynard, A., et al. (2012). "[Immunization and preventive care for young people in Switzerland]." Rev Med Suisse **8**(345): 1261-1265.

Children of foreign origin have better immunization coverage than children of swiss origin. This difference fades as children reach the teenage years and disappears in adulthood. On the other hand migrants have less access to preventive services. In teenagers, school immunization programs are the strongest determinant of good coverage. Immunization is only one aspect of adolescent preventive care but it provides the opportunity for a wider range of preventive activities. Multi-sectoral approaches including national and cantonal policies, school health services, primary care are needed to improve vaccine coverage and preventive opportunities at the same time. This article highlights the benefits of preventive services for young people whatever their origin and offers practical recommendations for immunization catch up in 11-25 year olds'.

Mir, G., et al. (2013). "Principles for research on ethnicity and health: the Leeds Consensus Statement." The European Journal of Public Health **23**(3): 504-510.

Background: There is substantial evidence that health and health-care experiences vary along ethnic lines and the need to understand and tackle ethnic health inequalities has repeatedly been highlighted. Research into ethnicity and health raises ethical, theoretical and methodological issues and, as the volume of research in this area grows, so too do concerns regarding its scientific rigour and reporting, and its contribution to reducing inequalities. Guidance may be helpful in encouraging researchers to adopt standard practices in the design, conduct and reporting of research. However, past efforts at introducing such guidance have had limited impact on research practice, and the diversity of disciplinary perspectives on the key challenges and solutions may undermine attempts to derive and promote guiding principles. Methods: A consensus building Delphi exercisef_"the first of its kind in this area of research practicef_"was undertaken with leading academics, practitioners and policymakers from a broad range of disciplinary backgrounds to assess whether consensus on key principles could be achieved. Results: Ten key principles for conducting research on ethnicity and health emerged, covering: the aims of research in this field; how such research should be framed and focused; key design-related considerations; and the direction of future research. Despite some areas of dispute, participants were united by a common concern that the generation and application of research evidence should contribute to better health-care experiences and health outcomes for minority ethnic people. Conclusion: The principles provide a strong foundation to guide future ethnicity-related research and build a broader international consensus

Molin, K. R., et al. (2013). "Perceptions of disease aetiology and the effect of own behaviour on health among poly-pharmacy patients with non-Western backgrounds in Denmark." Int J Pharm Pract **21**(6): 386-392.

OBJECTIVES: To examine the perceptions of disease aetiology and the effect of own behaviour on health among poly-pharmacy patients with non-Western backgrounds in Denmark. METHODS: The study was based on 26 extended medication reviews with patients of non-Western backgrounds aged 50+ who use at least four prescription drugs regularly. The reviews were conducted by 12 pharmacists with the same mother-tongue background as the participants. The reviews included patient interviews on which the data in this article are based. In total, four open-ended questions from the patient interviews were analysed by the means of Giorgi's phenomenological method. KEY FINDINGS: The analysis shows that stress was most commonly perceived as the cause of the participants' diseases for reasons that included (1) having left their country of origin and family, (2) worry over the political situation in their country of origin and (3) the problems involved in living as an immigrant in Denmark. Most of the participants perceived their own efforts as having little impact on their own health status, although some participants considered them as having considerable influence. CONCLUSIONS: To a

great extent, the explanations of the participants about possible disease aetiology are focused on stress, immigration and psychological well-being. Although many participants perceived that their own efforts did not have much impact on their health status, our study revealed a large diversity in the responses of non-Western immigrants, particularly regarding the importance of their own efforts on their health status.

Morawa, E. et Erim, Y. (2015). "Health-related quality of life and sense of coherence among Polish immigrants in Germany and indigenous Poles." Transcult Psychiatry **52**(3): 376-395.

Immigrants are faced with several impediments in the host country that may affect their quality of life (QoL), but little is known about the impact of these stressors as well as about the protective role of sense of coherence (SoC) in the context of Polish immigration to Germany. Health Related QoL (Short Form Health Survey SF-36) and SoC (Sense of Coherence Scale SOC-29) were assessed in a total sample consisting of 511 participants aged between 18 and 84 years (260 Polish immigrants in Germany and 251 indigenous Poles). Polish immigrants reported a significantly lower mental and physical health-related QoL than the German norm population, but they were comparable to native Poles. This result remained the same when the model was adjusted for age but physical health status was better for immigrants compared with indigenous Poles. Both groups scored significantly lower for SoC than Germans, but did not differ from each other. The main differences concerning the examined variables were with respect to the German norm population and are putatively shaped by culture.

Norredam, M., et al. (2010). "Migrants' utilization of somatic healthcare services in Europe--a systematic review." Eur J Public Health **20**(5): 555-563.

BACKGROUND: Utilization of services is an important aspect of migrants' access to healthcare. The aim was to review the European literature on utilization of somatic healthcare services related to screening, general practitioner, specialist, emergency room and hospital by adult first-generation migrants. Our study question was: 'Are there differences in migrants' utilization of somatic healthcare services compared to non-migrants?' METHODS: Publications were identified by a systematic search of PUBMED and EMBASE. Appropriateness of the studies was judged independently by two researchers based on the abstracts. Additional searches were conducted via the references of the selected articles. The final number of studies included was 21. RESULTS: The results suggested a diverging picture regarding utilization of somatic healthcare services by migrants compared to non-migrants in Europe. Overall, migrants tended to have lower attendance and referral rates to mammography and cervical cancer screening, more contacts per patient to general practitioner but less use of consultation by telephone, and same or higher level of use of specialist care as compared to non-migrants. Emergency room utilization showed both higher, equal and lower levels of utilization for migrants compared to non-migrants, whereas hospitalization rates were higher than or equal to non-migrants. CONCLUSION: Our review illustrates lack of appropriate epidemiological data and diversity in the categorization of migrants between studies, which makes valid cross-country comparisons most challenging. After adjusting for socio-economic factors and health status, the existing studies still show systematic variations in somatic healthcare utilization between migrants and non-migrants.

Oh, K. M., et al. (2014). "The influences of immigration on health information seeking behaviors among Korean Americans and Native Koreans." Health Educ Behav **41**(2): 173-185.

Korean Americans (KAs) have low screening rates for cancer and are often not well informed about their chronic diseases. Reduced access to health-related information is one reason for gaps in knowledge and the widening health disparities among minority populations. However, little research exists about KAs' health information seeking behaviors. Guided by the Structural Influence Model, this study examines the influence of immigration status on KAs' trust in health information sources and health information seeking behaviors. Cross-sectional surveys were conducted in the Washington, D.C., metropolitan area as well as in the Gwangju metropolitan city in South Korea during 2006-2007. Two hundred and fifty-four KAs and 208 native Koreans who were 40 years of age or older completed the surveys. When comparing native Koreans to KAs, we found KAs were 3 times more likely to trust health information from newspapers or magazines (odds ratio [OR] = 3.13; 95% confidence interval

[CI] = 1.49-6.54) and 11 times more likely to read the health sections of newspapers or magazines (OR = 11.35; 95% CI = 3.92-32.91) in multivariate adjusted models. However, they were less likely to look for health information from TV (OR = 0.29; 95% CI = 0.12-0.72) than native Koreans. Our results indicate that immigration status has profound influences on KAs' health information seeking behaviors. Increasing the availability of reliable and valid health information from printed Korean language magazines or newspapers could have a positive influence on increasing awareness and promoting screening behaviors among KAs.

O'Mahony, J. et Donnelly, T. (2010). "Immigrant and refugee women's post-partum depression help-seeking experiences and access to care: a review and analysis of the literature." J Psychiatr Ment Health Nurs **17**(10): 917-928.

ACCESSIBLE SUMMARY: * This literature review on post-partum depression (PPD) presents an analysis of the literature about PPD and the positive and negative factors, which may influence immigrant and refugee women's health seeking behaviour and decision making about post-partum care. * A critical review of English language peer-reviewed publications from 1988 to 2008 was done by the researchers as part of a qualitative research study conducted in a western province of Canada. The overall goal of the study is to raise awareness and understanding of what would be helpful in meeting the mental health needs of the immigrant and refugee women during the post-partum period. * Several online databases were searched: Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, MEDLINE (Ovid), EBM Reviews - Cochrane Database of Systematic Reviews. * Review of the literature suggests: 1 Needs, issues and specific risk factors for PPD among immigrant and refugee women have been limited. 2 Descriptive accounts regarding culture and PPD are found in the literature but impact of cultural factors upon PPD has not been well studied. 3 Few studies look at how social support, gender, and larger institutions or organizational structures may affect immigrant and refugee women's help-seeking and access to mental health care services. 4 More research is needed to hear the immigrant and refugee women's ideas about their social support needs, the difficulties they experience and their preferred ways of getting help with PPD. ABSTRACT: This review and analysis of the literature is about the phenomenon of post-partum depression (PPD) and the barriers and facilitators, which may influence immigrant and refugee women's health seeking behaviour and decision making about post-partum care. As part of a qualitative research study conducted in a western province of Canada a critical review of English language peer-reviewed publications from 1988 to 2008 was undertaken by the researchers. The overall goal of the study is to raise awareness and understanding of what would be helpful in meeting the mental health needs of the immigrant and refugee women during the post-partum period. Several online databases were searched: Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsycINFO, MEDLINE (Ovid), EBM Reviews - Cochrane Database of Systematic Reviews. Findings suggest: (1) needs, issues and specific risk factors for PPD among immigrant and refugee women have been limited; (2) descriptive accounts regarding culture and PPD are found in the literature but impact of cultural factors upon PPD has not been well investigated; (3) few studies examine how social support, gender, institutional and organizational structures present barriers to the women's health seeking behaviour; and (4) additional research is required to evaluate immigrant and refugee women's perspectives about their social support needs, the barriers they experience and their preferred support interventions.

Pauti, M. D., et al. (2009). "[Development of actions for the prevention of HIV, hepatitis and sexually transmitted infections among immigrants consulting in the doctors of the world "Missions France"]." Med Mal Infect **39**(3): 191-195.

The mission France of Doctors of the World has for objective to facilitate the access to care and to rights in the common law system for vulnerable populations and to bring testimonies out. The objective of the project is to ensure daily actions of prevention: to bring people to screen for HIV and hepatitis as well as obtaining full access to treatment for populations consulting in the Reception centers for Care and Orientation (RCCO). The screening is proposed systematically to all new patients (90% of them are immigrants) after a medical consultation or a special prevention consultation. The prevalence of HIV, hepatitis B and C was respectively 15, 10.5, and 7 times higher than the national

average among patients screened in 2007, The centers of Doctors of the World are privileged places to inform, prevent, offer screening, and bring healthcare to this population particularly exposed to risks.

Pfarrwaller, E. et Meynard, A. (2012). "[Being a migrant and an adolescent: which strategies for health promotion?]." Rev Med Suisse **8**(345): 1272-1278.

Young recently arrived migrants represent a vulnerable population. The influence of socioeconomic and environmental factors on health is now well known. The accumulation of protective factors can counterbalance the negative effect of risk factors, based on the concept of health assets. The migration process may threaten this balance. Some studies have observed better health in migrants than in the host population, but this is not a permanent effect as health deteriorates with time. Pre-migration experiences as well as post-migration conditions in the host country largely influence migrants' health outcomes. Family and social support and integration into the host society are primordial factors that need to be strengthened.

Platt, L., et al. (2013). "Systematic review examining differences in HIV, sexually transmitted infections and health-related harms between migrant and non-migrant female sex workers." Sex Transm Infect **89**(4): 311-319.

OBJECTIVES: To assess the evidence of differences in the risk of HIV, sexually transmitted infections (STI) and health-related behaviours between migrant and non-migrant female sex workers (FSWs). METHODS: Systematic review of published peer-reviewed articles that reported data on HIV, STIs or health-related harms among migrant compared with non-migrant FSWs. Studies were mapped to describe their methods and focus, with a narrative synthesis undertaken to describe the differences in outcomes by migration status overall and stratified by country of origin. Unadjusted ORs are presented graphically to describe differences in HIV and acute STIs among FSWs by migration and income of destination country. RESULTS: In general, migrant FSWs working in lower-income countries are more at risk of HIV than non-migrants, but migrants working in higher-income countries are at less risk. HIV prevalence was higher among migrant FSWs from Africa in high-income countries. Migrant FSWs in all countries are at an increased risk of acute STIs. Study designs, definitions of FSWs and recruitment methods are diverse. Behavioural data focussed on sexual risks. DISCUSSION: The lack of consistent differences in risk between migrants and non-migrants highlights the importance of the local context in mediating risk among migrant FSWs. The higher prevalence of HIV among some FSWs originating from African countries is likely to be due to infection at home where HIV prevalence is high. There is a need for ongoing monitoring and research to understand the nature of risk among migrants, how it differs from that of local FSWs and changes over time to inform the delivery of services.

Povlsen, L. et Ringsberg, K. C. (2008). "Learning to live with type 1 diabetes from the perspective of young non-western immigrants in Denmark." J Clin Nurs **17**(11c): 300-309.

AIMS AND OBJECTIVES: To explore how young adults with a non-western immigrant background and type 1 diabetes since childhood/adolescence have perceived learning to live with the disease, with special focus on health education and support. BACKGROUND: A national Danish study found significantly poorer metabolic control in non-western immigrant children and adolescents as compared with ethnic Danes. Subsequent studies have primarily focused on immigrant parents, whereas little is known about how immigrant children/adolescents have perceived the diagnosis and the diabetes care and support provided. DESIGN: A mixed quantitative and qualitative design was applied. This included data on metabolic control for 2002-2006 and semi-structured interviews in 2006 with eleven strategically selected young immigrants. Data were analysed using qualitative content analysis. FINDINGS: The findings are described in three thematic categories: Perceptions and reactions at the time of diagnosis; Learning to manage the disease; Present and future life with diabetes. Some findings were similar to those in studies describing children and adolescents of western origin, but the participants also shared perceptions which appeared to be related to their immigrant background. Above all, they described their parents as having difficulty coping with the disease and providing them with sufficient support. CONCLUSIONS: The diagnosis of diabetes in immigrant children and

adolescents requires special pedagogic and psychosocial approaches to bridge the gaps related to culture and traditions and introduce the concept of diabetes management, not least to the parents, in a more optimum way. RELEVANCE TO CLINICAL PRACTICE: Diabetes care should be a continuous and holistic process, constantly aiming to explore existing knowledge and the need for additional education and support for both the patient and his/her family. Special attention should be paid to the fact that immigrants may have limited pre-knowledge of chronic diseases in childhood, including the concept of selfcare.

Priebe, S., et al. (2011). "Good practice in health care for migrants: views and experiences of care professionals in 16 European countries." BMC Public Health **11**: 187.

BACKGROUND: Health services across Europe provide health care for migrant patients every day. However, little systematic research has explored the views and experiences of health care professionals in different European countries. The aim of this study was to assess the difficulties professionals experience in their service when providing such care and what they consider constitutes good practice to overcome these problems or limit their negative impact on the quality of care. METHODS: Structured interviews with open questions and case vignettes were conducted with health care professionals working in areas with high proportion of migrant populations in 16 countries. In each country, professionals in nine primary care practices, three accident and emergency hospital departments, and three community mental health services (total sample = 240) were interviewed about their views and experiences in providing care for migrant patients, i.e. from first generation immigrant populations. Answers were analysed using thematic content analysis. RESULTS: Eight types of problems and seven components of good practice were identified representing all statements in the interviews. The eight problems were: language barriers, difficulties in arranging care for migrants without health care coverage, social deprivation and traumatic experiences, lack of familiarity with the health care system, cultural differences, different understandings of illness and treatment, negative attitudes among staff and patients, and lack of access to medical history. The components of good practice to overcome these problems or limit their impact were: organisational flexibility with sufficient time and resources, good interpreting services, working with families and social services, cultural awareness of staff, educational programmes and information material for migrants, positive and stable relationships with staff, and clear guidelines on the care entitlements of different migrant groups. Problems and good care components were similar across the three types of services. CONCLUSIONS: Health care professionals in different services experience similar difficulties when providing care to migrants. They also have relatively consistent views on what constitutes good practice. The degree to which these components already are part of routine practice varies. Implementing good practice requires sufficient resources and organisational flexibility, positive attitudes, training for staff and the provision of information.

Rodriguez-Sales, V., et al. (2013). "Coverage of Cervical Cancer Screening in Catalonia for the Period 2008-2011 among Immigrants and Spanish-Born Women." Front Oncol **3**: 297.

BACKGROUND: Female immigration in Catalonia, Spain, increased dramatically in the last 10 years. The Public Health system in the Region, provides a free of charge opportunistic cervical cancer screening. AIM: This study examines cervical cancer screening coverage and prevalence of cytology abnormalities in Catalonia by immigration status. METHODS: The study analyzes the cytologies registered among women aged 25-65 that have been attended at the Primary Health Centers (PHC) for any reason (n = 1,242,230) during 2008-2011. Coverage was estimated from Governmental data base Information System Primary Care (SISAP) that includes 77% of PHC. The database is anonymous, and includes information on age, country of birth, diagnostic center, and cytology results. RESULTS: During the period 2008-2011, 642,643 smears were performed in a total of 506,189 women over 14 years, of whom 18.3% were immigrants. Cytology coverage was higher among immigrant women compared to Spanish born (51.2 and 39% respectively). Immigrant women also had a higher prevalence of abnormal Paps compared to the Spanish population, 4.5 and 2.9% respectively ($p < 0.001$). CONCLUSION: Immigrant women in Catalonia had a high access to the Public Health Services and to cervical cancer screening facilities. The higher prevalence of abnormal cytologies in immigrant women compared to

native women indicates the relevance to prioritize cervical cancer screening activities on a regular base in new comers.

Rondet, C., et al. (2014). "Are immigrants and nationals born to immigrants at higher risk for delayed or no lifetime breast and cervical cancer screening? The results from a population-based survey in Paris metropolitan area in 2010." PLoS One **9**(1): e87046.

OBJECTIVES: This study aims to compare breast cancer screening (BCS) and cervical cancer screening (CCS) practices of French women born to French parents with those of immigrants and nationals born to immigrants, taking their socioeconomic status into account. METHODS: The study is based on data collected in 2010 in the Paris metropolitan area among a representative sample of 3000 French-speaking adults. For women with no history of breast or cervical cancer, multivariate logistic regressions and structural equation models were used to investigate the factors associated with never having undergone BCS or CCS. RESULTS: We confirmed the existence of a strong gradient, with respect to migration origin, for delaying or never having undergone BCS or CCS. Thus, being a foreign immigrant or being French of immigrant parentage were risk factors for delayed and no lifetime screening. Interestingly, we found that this gradient persisted (at least partially) after adjusting for the women's socioeconomic characteristics. Only the level of income seemed to play a mediating role, but only partially. We observed differences between BCS and CCS which suggest that organized CCS could be effective in reducing socioeconomic and/or ethnic inequities. CONCLUSION: Socioeconomic status partially explained the screening nonparticipation on the part of French women of immigrant origin and foreign immigrants. This was more so the case with CCS than with BCS, which suggests that organized prevention programs might reduce social inequalities.

Saywell, R. M., Jr., et al. (2004). "A cost-effectiveness comparison of three tailored interventions to increase mammography screening." J Womens Health (Larchmt) **13**(8): 909-918.

BACKGROUND: Mammography is the primary method used for breast cancer screening. However, adherence to recommended screening practices is still below acceptable levels. This study examined the cost-effectiveness of three combinations of tailored telephone and mailed intervention strategies for increasing adherence to mammography. METHODS: There were 1044 participants who were randomly assigned to one of four groups. A logistic regression model with adherence as the dependent variable and group as the independent variable was used to test for significant differences, and a ratio of cost/improvement in mammogram adherence evaluated the cost-effectiveness. RESULTS: All three of the interventions (tailored telephone, tailored mail, and tailored telephone and mail) had significantly better adherence rates compared with the control group (usual care). However, when also considering costs, one emerged as the superior strategy. The cost-effectiveness ratios for the three interventions show that the tailored mail (letter) was the most cost-effective strategy, achieving 43.3% mammography adherence at a marginal cost of dollar 0.39 per 1% increase in women screened. The tailored mail plus telephone achieved greater adherence (49.4%), but at a higher cost (dollar 0.56 per 1% increase in women screened). CONCLUSIONS: A tailored mail reminder is an effective and economical intervention to increase mammography adherence. Future research should confirm this finding and address its applicability to practice in other settings.

Saurina, C., et al. (2010). "A qualitative analysis of immigrant population health practices in the Girona Healthcare Region." BMC Public Health **10**: 379.

BACKGROUND: The research we present here forms part of a two-phase project - one quantitative and the other qualitative - assessing the use of primary health care services. This paper presents the qualitative phase of said research, which is aimed at ascertaining the needs, beliefs, barriers to access and health practices of the immigrant population in comparison with the native population, as well as the perceptions of healthcare professionals. Moroccan and sub-Saharan were the immigrants to who the qualitative phase was specifically addressed. The aims of this paper are as follows: to analyse any possible implications of family organisation in the health practices of the immigrant population; to ascertain social practices relating to illness; to understand the significances of sexual and reproductive health practices; and to ascertain the ideas and perceptions of immigrants, local people and professionals regarding health and the health system. METHODS: Qualitative research based on

discursive analysis. Data gathering techniques consisted of discussion groups with health system users and semi-structured individual interviews with healthcare professionals. The sample was taken from the Basic Healthcare Areas of Salt and Banyoles (belonging to the Girona Healthcare Region), the discussion groups being comprised of (a) 6 immigrant Moroccan women, (b) 7 immigrant sub-Saharan African women and (c) 6 immigrant and native population men (2 native men, 2 Moroccan men and 2 sub-Saharan men); and the semi-structured interviews being conducted with the following healthcare professionals: (a) 3 gynaecologists, (b) 3 nurses and 1 administrative staff. RESULTS: Use of the healthcare system is linked to the perception of not being well, knowledge of the healthcare system, length of time resident in Spain and interiorization of traditional Western medicine as a cure mechanism. The divergences found among the groups of immigrants, local people and healthcare professionals with regard to healthcare education, use of the healthcare service, sexual and reproductive healthcare and reticence with regard to being attended by healthcare personnel of the opposite sex demonstrate a need to work with the immigrant population as a heterogeneous group. CONCLUSIONS: The results we have obtained support the idea that feeling unwell is a psycho-social process, as it takes place within a specific socio-cultural situation and spans a range of beliefs, perceptions and ideas regarding symptomology and how to treat it.

Saw, A., et al. (2013). "Smoking cessation counseling for Asian immigrants with serious mental illness: using RE-AIM to understand challenges and lessons learned in primary care-behavioral health integration." Health Promot Pract **14**(5 Suppl): 70s-79s.

Engagement in modifiable risk behaviors, such as tobacco use, substantially contributes to early mortality rates in individuals with serious mental illness (SMI). There is an alarmingly high prevalence of tobacco use among subgroups of Asian Americans, such as immigrants and individuals with SMI, yet there are no empirically supported effective smoking cessation interventions that have been tailored to meet the unique cultural, cognitive, and psychological needs of Asian immigrants with SMI. In this article, we share the experiences of clinicians in the delivery of smoking cessation counseling to Asian American immigrants with SMI, in the context of an Asian-focused integrated primary care and behavioral health setting. Through a qualitative analysis of clinician perspectives organized with the RE-AIM framework, we outline challenges, lessons learned, and promising directions for delivering smoking cessation counseling to Asian American immigrant clients with SMI.

Seedat, F., et al. (2014). "Engaging new migrants in infectious disease screening: a qualitative semi-structured interview study of UK migrant community health-care leads." PLoS One **9**(10): e108261.

Migration to Europe - and in particular the UK - has risen dramatically in the past decades, with implications for public health services. Migrants have increased vulnerability to infectious diseases (70% of TB cases and 60% HIV cases are in migrants) and face multiple barriers to healthcare. There is currently considerable debate as to the optimum approach to infectious disease screening in this often hard-to-reach group, and an urgent need for innovative approaches. Little research has focused on the specific experience of new migrants, nor sought their views on ways forward. We undertook a qualitative semi-structured interview study of migrant community health-care leads representing dominant new migrant groups in London, UK, to explore their views around barriers to screening, acceptability of screening, and innovative approaches to screening for four key diseases (HIV, TB, hepatitis B, and hepatitis C). Participants unanimously agreed that current screening models are not perceived to be widely accessible to new migrant communities. Dominant barriers that discourage uptake of screening include disease-related stigma present in their own communities and services being perceived as non-migrant friendly. New migrants are likely to be disproportionately affected by these barriers, with implications for health status. Screening is certainly acceptable to new migrants, however, services need to be developed to become more community-based, proactive, and to work more closely with community organisations; findings that mirror the views of migrants and health-care providers in Europe and internationally. Awareness raising about the benefits of screening within new migrant communities is critical. One innovative approach proposed by participants is a community-based package of health screening combining all key diseases into one general health check-up, to lessen the associated stigma. Further research is needed to develop evidence-based community-focused screening models - drawing on models of best practice from other countries receiving high numbers of migrants.

Selkirk, M., et al. (2014). "A systematic review of factors affecting migrant attitudes towards seeking psychological help." J Health Care Poor Underserved **25**(1): 94-127.

Research indicates that service utilization rates in migrant groups are low, although levels of distress appear high when compared with host populations. This paper systematically reviews quantitative and qualitative literature on factors associated with attitudes toward seeking psychological help among working age migrants. Data were extracted from MEDLINE, EMBASE, PsycINFO, Science Direct and SAGE databases. Eight quantitative studies and 16 qualitative studies met the inclusion and exclusion criteria. The majority of studies were conducted in North America (67%). Although results of quantitative studies were heterogeneous, stronger identification with host than heritage culture, fluency in host country language, psychological attributions of distress, higher educational levels, higher socioeconomic status, female gender, and older age were associated with more favourable attitudes toward help-seeking in some migrant groups. Three major themes emerged from the qualitative literature: logistical barriers, cultural mismatch between service providers and participants, and preferences for other sources of assistance.

Shirazi, M., et al. (2013). "Afghan immigrant women's knowledge and behaviors around breast cancer screening." Psychooncology **22**(8): 1705-1717.

BACKGROUND: This community-based participatory research was conducted to provide a preliminary understanding of how Afghan women in Northern California view their breast health. METHODS: Results were based on demographics and in-depth semi-structured interviews conducted with 53 non-English-speaking first-generation immigrant Muslim Afghan women 40 years and older. RESULTS: Findings showed low levels of knowledge and awareness about breast cancer and low utilization of early-detection examinations for breast cancer among participants. CONCLUSIONS: The findings also suggest a significant need for a community-based breast health education program that recognizes the unique social, cultural, and religious dynamics of the Muslim Afghan community.

Shokar, N. K., et al. (2015). "Against Colorectal Cancer in Our Neighborhoods, a Community-Based Colorectal Cancer Screening Program Targeting Low-Income Hispanics: Program Development and Costs." Health Promot Pract **16**(5): 656-666.

BACKGROUND: Colorectal cancer is the second leading cause of cancer-related death in the United States. Despite universal screening recommendations, screening rates in the United States remain suboptimal, especially among the poor, the uninsured, recent immigrants, and Hispanics. This article describes the development of a large community-based colorectal cancer screening program designed to address these disparities. METHOD: The Against Colorectal Cancer in our Neighborhoods program is a bilingual, evidence-based, theory-guided, multicomponent community screening intervention, targeting the uninsured and developed using a systematic planning process. It combines community health worker-led outreach, bilingual and culturally tailored community education, and no-cost screening with provision of the fecal immunochemical test or colonoscopy and navigation services. A detailed process and outcome evaluation is planned. Program development cost calculated prospectively (in 2011 dollars) using a societal perspective and micro-costing methods was $243,278, of which $180,344 was direct cost. DISCUSSION: The detailed description of the development processes and costs of this health promotion program targeting low-income Hispanics will inform health program decision makers about the resource requirements for planning and developing new programs to reduce disease burden in communities.

Small, R., et al. (2014). "Immigrant and non-immigrant women's experiences of maternity care: a systematic and comparative review of studies in five countries." BMC Pregnancy Childbirth **14**: 152.

BACKGROUND: Understanding immigrant women's experiences of maternity care is critical if receiving country care systems are to respond appropriately to increasing global migration. This systematic review aimed to compare what we know about immigrant and non-immigrant women's experiences of maternity care. METHODS: Medline, CINAHL, Health Star, Embase and PsychInfo were searched for the period 1989-2012. First, we retrieved population-based studies of women's experiences of

maternity care (n = 12). For countries with identified population studies, studies focused specifically on immigrant women's experiences of care were also retrieved (n = 22). For all included studies, we extracted available data on experiences of care and undertook a descriptive comparison. RESULTS: What immigrant and non-immigrant women want from maternity care proved similar: safe, high quality, attentive and individualised care, with adequate information and support. Immigrant women were less positive about their care than non-immigrant women. Communication problems and lack of familiarity with care systems impacted negatively on immigrant women's experiences, as did perceptions of discrimination and care which was not kind or respectful. CONCLUSION: Few differences were found in what immigrant and non-immigrant women want from maternity care. The challenge for health systems is to address the barriers immigrant women face by improving communication, increasing women's understanding of care provision and reducing discrimination.

Smith, A., et al. (2013). "The influence of culture on the oral health-related beliefs and behaviours of elderly chinese immigrants: a meta-synthesis of the literature." J Cross Cult Gerontol **28**(1): 27-47.

Neglect of the mouth can lead to impairment, disability, and discomfort; as a result, it can have a negative impact on quality of life in old age. Some minority groups in North America shoulder a disproportionate burden of dental impairment compared to people of European origins, possibly because of different cultural beliefs and a distrust of Western oral healthcare. This paper explores these factors in elderly Chinese immigrants through a meta-synthesis of selected literature that reveals a dynamic interplay of traditional Chinese beliefs about oral health, immigration, and structural factors mediating access to Western dentistry. It also identifies several conceptual issues and gaps in knowledge, offers avenues of research including the cross-cultural application of two recent models of oral health, and discusses various strategies for improving access to dental services for minority populations.

Spallek, J., et al. (2010). "Prevention among immigrants: the example of Germany." BMC Public Health **10**: 92.

BACKGROUND: A large and increasing part of the European population has a history of migration. Germany, for example, is home to about 15 million people with migrant background, which amounts to 19% of its population. Migrants may have differences in their lifestyle, health beliefs and risk factors compared to the autochthonous populations. DISCUSSION: As for example studies on children's participation in routine prevention activities have shown, these differences can have a relevant impact on the access of migrants to the health care system and are likely to lower their participation in prevention programs compared to the autochthonous population. To increase the uptake of prevention programs, barriers to access must be identified and approaches to reduce them must be developed. SUMMARY: Taking the example of Germany, a need exists for prevention programs that include (migrant sensitive) and specifically address (migrant specific) migrants. These should be of sufficient scale, evidence-based, sustainable and evaluated at regular intervals.

Tugwell, P., et al. (2011). "Evaluation of evidence-based literature and formulation of recommendations for the clinical preventive guidelines for immigrants and refugees in Canada." Cmaj **183**(12): E933-938.

BACKGROUND: This article describes the evidence review and guideline development method developed for the Clinical Preventive Guidelines for Immigrants and Refugees in Canada by the Canadian Collaboration for Immigrant and Refugee Health Guideline Committee. METHODS: The Appraisal of Guidelines for Research and Evaluation (AGREE) best-practice framework was combined with the recently developed Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to produce evidence-based clinical guidelines for immigrants and refugees in Canada. RESULTS: A systematic approach was designed to produce the evidence reviews and apply the GRADE approach, including building on evidence from previous systematic reviews, searching for and comparing evidence between general and specific immigrant populations, and applying the GRADE criteria for making recommendations. This method was used for priority health conditions that had been selected by practitioners caring for immigrants and refugees in Canada. INTERPRETATION: This article outlines the 14-step method that was defined to standardize the guideline development process for each priority health condition.

Swinkels, H., et al. (2011). "Development of guidelines for recently arrived immigrants and refugees to Canada: Delphi consensus on selecting preventable and treatable conditions." Cmaj **183**(12): E928-932.

BACKGROUND: Setting priorities is critical to ensure guidelines are relevant and acceptable to users, and that time, resources and expertise are used cost-effectively in their development. Stakeholder engagement and the use of an explicit procedure for developing recommendations are critical components in this process. METHODS: We used a modified Delphi consensus process to select 20 high-priority conditions for guideline development. Canadian primary care practitioners who care for immigrants and refugees used criteria that emphasize inequities in health to identify clinical care gaps. RESULTS: Nine infectious diseases were selected, as well as four mental health conditions, three maternal and child health issues, caries and periodontal disease, iron-deficiency anemia, diabetes and vision screening. INTERPRETATION: Immigrant and refugee medicine covers the full spectrum of primary care, and although infectious disease continues to be an important area of concern, we are now seeing mental health and chronic diseases as key considerations for recently arriving immigrants and refugees.

Tiittala, P. J., et al. (2015). "Achieving high acceptability of HIV testing in a population-based survey among immigrants in Finland." Scand J Public Health **43**(4): 393-398.

AIMS: The aim of this study was to assess the acceptability of human immunodeficiency virus (HIV) testing among migrants in Finland and the factors contributing to non-acceptance. METHODS: The Finnish Migrant Health and Wellbeing Study 'Maamu' was the first national population-based Health Interview and Examination Survey (HIS/HES) among migrants in Finland. A total of 386 Kurdish, Russian and Somali immigrants in Helsinki participated in the study. RESULTS: Despite the participants' different sociodemographic backgrounds, a high rate of test acceptability (92%, 95% CI 90-95) was achieved. HIV test acceptance was associated with pretest counselling, ability to understand spoken Finnish or Swedish and employment status. No participants tested positive for HIV. CONCLUSIONS: The results imply that a universal HIV testing strategy is well accepted in a low-HIV prevalence immigrant population and can be included in a general health examination in immigrant population-based surveys.

Vahabi, M., et al. (2015). "Breast cancer screening disparities among urban immigrants: a population-based study in Ontario, Canada." BMC Public Health **15**: 679.

BACKGROUND: Breast cancer is one of the leading cause of mortality and morbidity in Canada. Screening is the most promising approach in identification and treatment of the disease at early stage of its development. Research shows higher rate of breast cancer mortality among ethno-racial immigrant women despite their lower incidence which suggests disparities in mammography screening. This study aimed to compare the prevalence of appropriate mammography screening among immigrant and native borne women and determine predicators of low mammography screening. METHODS: We conducted secondary data analyses on Ontario linked social and health databases to determine the proportion of women who were screened during the two-year period of 2010-2012 among 1.4 million screening-eligible women living in urban centres in Ontario. We used multivariate Poisson regression to adjust for various socio-demographic, health care-related and migration related variables. RESULTS: 64% of eligible women were appropriately screened. Screening rates were lowest among new and recent immigrants compared to referent group (Canadian-born women and immigrant who arrived before 1985) (Adjusted Rate Ratio (ARR) (0.87, 95% CI 0.85-0.88 for new immigrants and 0.90, 95% CI 0.89-0.91 for recent immigrants. Factors that were associated with lower rates of screening included living in low-income neighborhoods, having a male physician, having internationally-trained physician and not being enrolled in primary care patient enrolment models. Those not enrolled were 22% less likely to be screened compared to those who were (ARR 0.78, 95% CI 0.77-0.79). CONCLUSION: To enhance immigrant women screening rates efforts should made to increase their access to primary care patient enrolment models and preferably female health professionals. Support should be provided to interventions that address screening barriers like language, acculturation limitations and knowledge deficit. Health professionals need to be educated and take an active role in offering screening guidelines during health encounters.

Wyatt, L. C., et al. (2014). "Health-related quality of life and health behaviors in a population-based sample of older, foreign-born, Chinese American adults living in New York City." Health Educ Behav **41**(1 Suppl): 98s-107s.

> Although the New York City Chinese population aged >/= 65 years increased by 50% between 2000 and 2010, the health needs of this population are poorly understood. Approximately 3,001 Chinese individuals from high-density Asian American New York City areas were included in the REACH U.S. Risk Factor Survey; 805 (26.8%) were aged >/= 65 years and foreign-born. Four health-related quality of life and three behavioral risk factor outcome variables were examined. Descriptive statistics were conducted by gender, and logistic regression models assessed sociodemographic and health factors associated with each outcome. Few women were current smokers (1.3% vs. 14.8% of men), 19% of respondents ate fruits and vegetables more than or equal to five times daily, and one-third of individuals received sufficient weekly physical activity. Days of poor health were similar to the national population aged >/= 65 years, while self-reported fair or poor health was much greater among our Chinese sample; over 60% of respondents rated their health as fair or poor. Lower education and lower obesity were significantly associated with cigarette smoking among men, and older age was significantly associated with insufficient physical activity overall. Female gender was significantly associated with all poor health days; older age was significantly associated with poor days of physical health, and lower income was significantly associated with poor days of physical health and fair or poor self-reported health. This study provides important health-related information on a rapidly growing older population and highlights future research areas to inform culturally appropriate health promotion and disease prevention strategies and policies within community-based settings.

Yu, J. (2010). "Young people of Chinese origin in western countries: a systematic review of their sexual attitudes and behaviour." Health Soc Care Community **18**(2): 117-128.

> People of Chinese origin are a growing population group in western countries. The community is seen to be marginalised, under-researched and neglected, in fact the least understood ethnic minority. This paper reports on a systematic review of sexual attitudes and behaviour among ethnic Chinese young people (mainly aged 13-25 years) living in western countries. An extensive literature search was conducted to cover the period of 1989 and 2009 using Medline, CINAHL, PsycINFO and ScienceDirect databases. There has been a dearth of literature in this area. However, results from existing literature show that ethnic Chinese youth reported poorer sexual health knowledge than white young people in their host countries, while they were found to be more likely to disapprove of uncommitted sex, be virgins, lose their virginity at a later age and have fewer sexual partners. Factors associated with their sexual attitudes and behaviour have also been identified. Countries like the United Kingdom, United States and Canada have become multicultural societies with many diverse ethnic groups. Without doubt educators and sexual health professionals need to provide sex education and services which should be culturally appropriate to people from diverse ethnic backgrounds. An understanding of their sexual values, sexual behaviour and associated factors is the first step towards achieving this goal.

L'impact de la pandémie de Covid-19 sur la population migrante

Enquête Premiers Pas de l'Irdes[35]

Réalisée à partir des données de l'enquête Premiers pas, menée en 2019 auprès de personnes étrangères sans titre de séjour et de structures leur proposant de l'assistance, une étude de l'Irdes[36] éclaire les risques encourus par cette population du fait de l'épidémie et des confinements successifs. La vulnérabilité des personnes sans titre de séjour aux facteurs de risque médicaux, leur situation économique ainsi que leurs problèmes de santé mentale les rendent plus fragiles aux conséquences de la mise en quarantaine. Ce Questions d'économie de la santé s'inscrit dans la suite des travaux menés à partir de l'enquête Premiers pas sur la santé et l'accès aux soins des personnes étrangères sans titre de séjour en France. Il vient compléter trois autres Questions d'économie de la santé. Le premier revenait sur l'histoire des droits des personnes étrangères sans titre de séjour en France et dressait un état des lieux des connaissances concernant l'Aide médicale de l'État (AME). Le second présentait la méthodologie de l'enquête et le troisième était consacré à l'analyse de l'accès à l'AME.

ÉTUDES FRANÇAISES

Agier, M., Atlani-Duault, L., Desgree Dulou, A., et al. (2020). "Les migrants dans l'épidémie : un temps d'épreuves cumulées." De Facto **18**.

Ce numéro spécial de De facto, la revue de l'Institut des migrations, se penche sur l'impact du confinement et des bouleversements liés à l'épidémie de Covid-19 sur les immigrés.

Blanpain, N. et Papon, S. (2021). Décès en 2020 et début 2021 : pas tous égaux face à la pandémie de Covid-19. France, portrait social. Edition 2021., Paris : Insee**:** 11-26, tabl., fig.
https://www.insee.fr/fr/statistiques/5435421

En raison de l'épidémie de Covid-19, le nombre de décès en France s'est fortement accru en 2020 et au premier semestre 2021 : + 9,1 % toutes causes confondues en 2020 et + 7,3 % au premier semestre 2021 par rapport aux périodes équivalentes de 2019. Les risques de décéder ont augmenté dès 35 ans pour les hommes et 55 ans pour les femmes, tandis que la mortalité des plus jeunes, surtout celle des hommes, a baissé compte tenu de l'effet « protecteur » des confinements. L'espérance de vie à la naissance a reculé de 0,5 an pour les femmes et 0,6 an pour les hommes en 2020, essentiellement du fait de la hausse de la mortalité des personnes de 70 ans ou plus. La perte d'espérance de vie en 2020 affecte en particulier les régions les plus touchées par les deux premières vagues de l'épidémie : Île-de-France, Grand Est, Auvergne-Rhône-Alpes, Bourgogne-Franche-Comté et Hauts-de-France, mais aussi Mayotte, qui a cumulé épidémies de Covid-19 et de dengue. La pandémie a été plus meurtrière pour les personnes nées à l'étranger, en particulier celles nées en Afrique ou en Asie. Celles-ci résident en effet plus souvent dans les régions les plus touchées par l'épidémie et dans des communes à l'habitat dense, facteur associé à des risques de décès plus forts en 2020.

Brun, S. et Simon, P. (2020). "L'invisibilité des minorités dans les chiffres du Coronavirus : le détour par la Seine-Saint-Denis." De Facto **19**: 68-78.
http://icmigrations.fr/2020/05/15/defacto-019-05/

Comment expliquer la surmortalité due à la Covid-19 en Seine-Saint-Denis ? Si la pauvreté est un facteur évident, les discriminations ethno-raciales ont, en toute vraisemblance, un impact sur l'exposition au virus. Encore faudrait-il avoir des données solides pour le mesurer.

[35] Enquête Premiers pas. Site de l'Irdes.
[36] Marsaudon, A., Dourgnon, P., Jusot, F., et al. (2020). "Anticiper les conséquences de l'épidémie de la Covid-19 et des politiques de confinement pour les personnes sans titre de séjour." Questions D'economie De La Sante (Irdes)(253): 6.

Carillon, S., Gosselin, A., Coulibaly, K., et al. (2020). "Immigrants facing Covid 19 containment in France : An ordinary hardship of disaffiliation." J Migr Health **1-2**: 100032.

> In order to limit the spread of the SARS-CoV-2 virus, the majority of governments have introduced population containment. Certain population groups, including immigrants in precarious situations, are experiencing the impact of this measure in a brutal manner. This article is based on accounts of containment experiences collected by telephone within the framework of a pre-existing intervention research carried out among immigrants to France from Sub-Saharan Africa who are in a precarious situation. It highlights certain social effects of containment and the logics at work in the precarious situations. This research shows how this a priori unprecedented situation affects individual capacities to act and generates a 'disaffiliation process' causing individuals to shift towards 'social non-existence', repeating lived experiences and exacerbating pre-existing logics. The ordeal of containment proves to be an ordinary experience for these individuals.

Crouzet, L., Scarlett, H., Colleville, A. C., et al. (2022). "Impact of the COVID-19 pandemic on vulnerable groups, including homeless persons and migrants, in France: A qualitative study." Prev Med Rep **26**: 101727.

> Social inequalities tended to increase in the context of the pandemic, particularly in relation to the measures taken to manage and reduce the risk of COVID-19. When lockdown measures required the general population "to stay home", what were homeless people expected to do? The ECHO study is a cross-sectional, descriptive study with a convergent mixed-method design. Data were collected across shelters in France both during and immediately following the lockdown (April - June 2020). This article presents the study's qualitative findings, with a focus on understanding both the experiences and perceptions among these populations of the measures taken to limit the COVID-19 infection. A total of 26 semi-directed individual interviews were conducted across seven shelters in both Lyon (42%) and Paris (58%). Data were analysed using thematic content analysis with partial blinded coding. Four key themes were identified: 1- Reactions to the introduction of lockdown: a sudden implementation reminiscent of prior violent or traumatic circumstances amongst participants, 2- Accommodation during lockdown: participants' conflicting visions of the shelter, 3- Influence of the media and public communication: an abundant flow of information impacting participant's wellbeing and representations on the pandemic, and 4- The individual impact of lockdown: perceived health and limitations to daily life activities. The most vulnerable populations have borne the heaviest burden during the pandemic. It is therefore crucial that we improve both the availability of information, and the health literacy of, all groups within the national population.

Gosselin, A., Melchior, M., Desprat, D., et al. (2021). "Were immigrants on the frontline during the lockdown? Evidence from France." Eur J Public Health.
https://doi.org/10.1093/eurpub/ckab094

> In France, immigrants' excess of mortality was higher than natives' during the Spring 2020 lockdown. Were immigrants in frontline jobs and more exposed to Covid-19? Based on a nationally representative survey, we model the probability to work in a frontline job according to migratory status, taking sociodemographic and occupational characteristics into account. Compared to natives (Metropolitan France), being an African immigrant was associated to higher probability to work in a frontline job [adjusted odds ratio (aOR) = 1.82 (1.23–2.71)], as well as being born in French Overseas Departments [aOR = 1.64 (1.23–2.18)], reflecting racial division of work and higher Sars-Cov-2 exposure of immigrant and minority populations.

Gosselin, A., Warszawski, J. et Bajos, N. (2022). "Higher risk, higher protection. COVID-19 risk among immigrants in France: results from the population-based EpiCov survey." Eur J Public Health.

> BACKGROUND: Immigrants and ethnic/racialized minorities have been identified as being at higher risk of COVID-19 infection, but few studies report on their exposures and prevention behaviours. This study aims to examine the social distribution of COVID-19 exposure (overcrowding, working outside the home, use of public transport to go to work) and prevention behaviours (use of face masks, washing hands, respect for physical distance) in France during the first wave of the epidemic.

METHODS: We used the EpiCov population-based survey from a random sample of individuals aged 15 years or more. We determined the distribution of the self-reported outcomes according to migratory status and sex, using chi2 tests. We modelled the probability of outcomes with logistic regression. Finally, we focused the analysis on the Greater Paris area and accounted for neighbourhood characteristics. RESULTS: A total of 111,824 participants were included in the study. Overall, immigrant groups from non-European countries were more exposed to COVID-19-related factors and more respectful of prevention measures. The probability of overcrowding and the use of public transport was higher for immigrants from sub-Saharan Africa (aOR=3.71 [3.19;4.32], aOR=6.36 [4.86; 8.32]) than for the majority population. Immigrant groups were less likely to have a non-systematic use of face masks and to breach physical distancing than the majority population (for immigrants from sub-Saharan Africa, aOR=0.32 [0.28; 0.37] and aOR=0.71 [0.61; 0.81], respectively). Living in a neighbourhood with a higher share of immigrants was associated with higher exposure and better prevention behaviours. CONCLUSIONS: In France, immigrants had a higher exposure to COVID-19-related factors and more systematic prevention behaviours.

Iresp (2021). Inégalités Sociales de Santé en temps de crise sanitaire, Lyon : Iresp Auvergne Rhône-Alpes
http://ireps-ara.org/portail/portail.asp?idz=1340

Réalisé à partir de la veille documentaire de l'Ireps Auvergne Rhône-Alpes, ce dossier interroge la question des inégalités sociales de santé dans le contexte de l'épidémie à Covid-19. Ces ressources font écho à l'article "Inégalités sociales de santé au temps du coronavirus : constats et pistes d'actions en promotion de la santé". Article qui aborde la crise sanitaire liée à la pandémie de Covid-19 au prisme des inégalités sociales qu'elles révèlent et engage une réflexion sur des pistes d'actions collectives en promotion de la santé.

Khlat, M., Ghosn, W., Guillot, M., et al. (2022). "Impact of the COVID-19 crisis on the mortality profiles of the foreign-born In France during the first pandemic wave." Social Science & Medicine: 115160.
https://www.sciencedirect.com/science/article/pii/S027795362200466X

Background Immigrants in Western countries have been particularly affected by the COVID-19 crisis. Objective: We analysed excess mortality rates among the foreign-born population and changes in their distinctive mortality profiles (“migrant mortality advantage”) during the first pandemic wave in France. Data and methods Deaths from all causes in metropolitan France from 16 March to May 17, 2020 were used, with information on sex, age, region of residence and country of birth. Similar data from 2016 through 2019 were used for comparisons. Results During the pre-pandemic period (2016–2019), immigrant populations (except those from Central and Eastern Europe) had lower standardized mortality rates than the native-born population, with a particularly large advantage for immigrants from sub-Saharan Africa. In the regions most affected by COVID-19 (Grand-Est and Île-de-France), the differences in excess mortality by country of birth were large, especially in the working-age groups (40–69 years), with rates 8 to 9 times higher for immigrants from sub-Saharan Africa, 3 to 4 times higher for immigrants from the Americas and 3 times higher for immigrants from Asia relative to the native-born population. The relative overall mortality risk for men born in sub-Saharan Africa compared to native-born men, which was 0.8 before the pandemic, shifted to 1.8 during the first wave (0.9 and 1.5 for women). It also shifted from 0.8 to 1.1 for men from North Africa (0.9–1.1 for women), 0.7 to 1.0 for men from the Americas (0.9–1.3 for women), and 0.7 to 1.2 for men from Asia and Oceania (0.9–1.3 for women). Conclusion Our findings shed light on the disproportionate impact of the first wave of the pandemic on the mortality of populations born outside Europe, with a considerable burden of excess mortality within the working-age range, and a complete reversal of their mortality advantage.

Ledésert, B., Leclerc, C. et Trottet, L. (2021). "Inégalités face à la Covid-19 – Profils de territoire." Sante Publique **33**(6): 847-852.
https://www.cairn.info/revue-sante-publique-2021-6-page-847.htm

Introduction : En pleine crise sanitaire de la COVID-19, les Observatoires régionaux de santé (ORS) et la Fédération nationale des ORS ont choisi de mettre à disposition leur expertise dans le développement

et la production d'indicateurs de santé ; et ce afin venir en appui aux politiques publiques locales et nationales, en prévision de la gestion du déconfinement de la population.But de l'étude : L'objectif de ce travail était de caractériser, le plus finement possible, les territoires, y compris ultramarins, à partir d'indicateurs pouvant décrire à la fois la population susceptible de présenter des formes graves de la COVID-19 et les situations démographiques et sociales pouvant favoriser la circulation du Sars-Cov-2 à l'origine de cette maladie. Résultats : 1 250 fiches profils, une pour chaque établissement public de coopération intercommunale (EPCI) dans les départements français (hors Mayotte) présentant 34 indicateurs ont été produites. Une synthèse nationale incluant une typologie de ces territoires en sept classes a également été élaborée. Conclusion : Ce travail montre la possibilité de décliner, de manière systématique et à des échelons géographiques fins, des séries d'indicateurs en lien avec une thématique spécifique. Assorti d'une typologie des territoires, cet outil peut contribuer, avec d'autres, à la gestion d'une crise sanitaire.

Marsaudon, A., Dourgnon, P., Jusot, F., et al. (2020). "Anticiper les conséquences de l'épidémie de la Covid-19 et des politiques de confinement pour les personnes sans titre de séjour." Questions D'economie De La Sante (Irdes)(253): 6.
https://www.irdes.fr/recherche/questions-d-economie-de-la-sante/253-anticiper-les-consequences-de-l-epidemie-covid-19-et-des-politiques-de-confinement-pour-les-personnes-sans-titre-de-sejour.pdf

À partir des données de l'enquête Premiers pas, réalisée en 2019 auprès de personnes étrangères sans titre de séjour et de structures leur proposant de l'assistance, cette étude éclaire les risques encourus par cette population du fait de l'épidémie et des confinements successifs. La vulnérabilité des personnes sans titre de séjour aux facteurs de risque médicaux, leur situation économique ainsi que leurs problèmes de santé mentale les rendent plus fragiles aux conséquences de la mise en quarantaine. Alors qu'un second confinement est en place, il est important d'en anticiper les conséquences sur une population mal connue. Ce Questions d'économie de la santé s'inscrit dans la suite des travaux menés à partir de l'enquête Premiers pas sur la santé et l'accès aux soins des personnes étrangères sans titre de séjour en France. Il vient compléter trois autres Questions d'économie de la santé. Le premier revenait sur l'histoire des droits des personnes étrangères sans titre de séjour en France et dressait un état des lieux des connaissances concernant l'Aide médicale de l'État (AME). Le second présentait la méthodologie de l'enquête et le troisième était consacré à l'analyse de l'accès à l'AME.

Melchior, M., Desgrées du Loû, A., Gosselin, A., et al. (2021). "Migrant status, ethnicity and COVID-19: more accurate European data are greatly needed." Clin Microbiol Infect **27**(2): 160-162.

Rambliere, L., Pisarik, J. et Prioux, M. (2022). "Caractéristiques et parcours vaccinal des personnes en situation de précarité vaccinées contre la Covid-19 sur un lieu de distribution alimentaire à Paris." BULLETIN EPIDEMIOLOGIQUE HEBDOMADAIRE (BEH) - Covid-19(15): 9.
http://beh.santepubliquefrance.fr/beh/2022/Cov_15/pdf/2022_Cov_15_1.pdf

Afin de faciliter l'accès à la vaccination contre la Covid-19 des populations précaires, le Samusocial de Paris a mis en place des actions de vaccination sur un site de distribution alimentaire dans le nord parisien. Dans le contexte de l'ouverture à tous de la dose de rappel, l'objectif de ce travail était de décrire le profil des personnes ayant recours à ce dispositif plutôt qu'à un dispositif de droit commun, de comprendre leur parcours vaccinal et d'identifier les facteurs associés. L'étude VEDA est une étude transversale rétrospective menée entre le 1er décembre 2021 et le 17 mars 2022 à porte de la Villette à Paris. À l'issue de leur vaccination, les personnes étaient interrogées en face-à-face dans une des différentes langues de l'enquête. La majorité des 447 personnes interrogées étaient en situation de grande précarité, tant administrativement qu'au niveau des ressources et de l'hébergement. Environ 40% des personnes primo-vaccinées avaient été exposées au virus, majoritairement de manière asymptomatique. Plus d'un tiers des personnes interrogées avaient eu recours tardivement à la vaccination (après novembre 2021). Les facteurs favorisant ce recours tardif étaient d'avoir moins de 40 ans, d'être en situation de logement précaire, de ne pas avoir de couverture maladie et de ne pas fréquenter ce lieu de distribution alimentaire. Ce travail met en évidence l'intérêt d'actions de vaccination implantées sur des sites de distribution alimentaire pour toucher des populations

particulièrement éloignées des soins. Ce travail souligne l'importance de cibler les plus jeunes et les plus précaires pour leur future dose de rappel dans un contexte de fermeture progressive des centres de vaccination.

Sehili, D. et Dufournet, T. (2020). "Épidémie de Covid-19 : des vulnérables et des invincibles." Medecine : De La Medecine Factuelle a Nos Pratiques **16**(7): 296-300.

La démonstration générale soutenue dans cet article vise à comprendre les comportements transgressifs, voire « déviants » en lien avec la non-observance des consignes pour faire face à la crise sanitaire. Cette première partie d'article propose de faire une analyse comparative entre l'épidémie de COVID-19 et celle du VIH/SIDA afin de montrer la prégnance de rhétoriques similaires, reposant sur le ciblage stigmatisant de certaines populations, au sein des discours politiques, médicaux et médiatiques. Cette focalisation sur des pratiques individuelles, plutôt que sur la prise en compte de conditions de prévention socialement inégalitaires, induit une reconnaissance in fine différentielle du risque et de la transgression. Pour le dire autrement, le ciblage de populations pensées comme « vulnérables » ou « invincibles » doit se lire comme des discriminations, négatives ou positives, en termes de génération et de genre (ce que est développé plus particulièrement ici) et de classe et de race (ce qui sera présenté dans une seconde partie d'article).

Veran, J. F., Viot, M., Mollo, B., et al. (2020). Etude PréCARES, Précarités et Covid-19 : Evolution de l'Accès et du Recours à la Santé. Paris Médecins sans frontières**:** 106.
https://www.msf.fr/sites/default/files/2020-12/2020_12_17_PreCARES-MSF_Covid-Precarit%C3%A9_HD.pdf

Ce document propose des analyses relatives à l'expérience des personnes en situation de précarité rencontrées par les équipes de MSF pendant la première vague de l'épidémie de Covid-19, comprenant la vie pendant le confinement et l'évolution de l'accès aux soins, la perception des symptômes associés à la Covid-19 et des éléments concernant leur santé mentale. Le rapport présente des axes d'approfondissement à travailler collégialement au regard des types de situation de précarité (vivre dans un FTM, à la rue) et des types de services d'urgence : CHU, distributions alimentaires. Ce travail propose aussi des pistes d'action et de plaidoyer à instruire sans attendre, dans le contexte de seconde vague épidémique en France.

Warszawski, J., Meyer, L., Franck, J. E., et al. (2022). "Trends in social exposure to SARS-Cov-2 in France. Evidence from the national socio-epidemiological cohort-EPICOV." **17**(5): e0267725.

BACKGROUND: We aimed to study whether social patterns of exposure to SARS-CoV-2 infection changed in France throughout the year 2020, in light to the easing of social contact restrictions. METHODS: A population-based cohort of individuals aged 15 years or over was randomly selected from the national tax register to collect socio-economic data, migration history, and living conditions in May and November 2020. Home self-sampling on dried blood was proposed to a 10% random subsample in May and to all in November. A positive anti-SARS-CoV-2 ELISA IgG result against the virus spike protein (ELISA-S) was the primary outcome. The design, including sampling and post-stratification weights, was taken into account in univariate and multivariate analyses. RESULTS: Of the 134,391 participants in May, 107,759 completed the second questionnaire in November, and respectively 12,114 and 63,524 were tested. The national ELISA-S seroprevalence was 4.5% [95%CI: 4.0%-5.1%] in May and 6.2% [5.9%-6.6%] in November. It increased markedly in 18-24-year-old population from 4.8% to 10.0%, and among second-generation immigrants from outside Europe from 5.9% to 14.4%. This group remained strongly associated with seropositivity in November, after controlling for any contextual or individual variables, with an adjusted OR of 2.1 [1.7-2.7], compared to the majority population. In both periods, seroprevalence remained higher in healthcare professions than in other occupations. CONCLUSION: The risk of Covid-19 infection increased among young people and second-generation migrants between the first and second epidemic waves, in a context of less strict social restrictions, which seems to have reinforced territorialized socialization among peers.

ÉTUDES ETRANGERES

Arya, N., Redditt, V. J., Talavlikar, R., et al. (2021). "Soigner les réfugiés et les nouveaux arrivants à l'ère post-COVID-19: Revue des données probantes et conseils pour les MF et les professionnels de la santé." Can Fam Physician **67**(8): e209-e216.

> OBJECTIF: Guider les cliniciens qui travaillent dans divers milieux cliniques de soins primaires quant aux façons de prodiguer des soins et du soutien efficaces aux réfugiés et aux nouveaux arrivants, durant et après la pandémie de la maladie à coronavirus 2019 (COVID-19). SOURCES D'INFORMATION: L'approche décrite intègre les recommandations tirées de guides de pratique clinique fondés sur des données probantes portant sur la santé des réfugiés et la COVID-19, de leçons concrètes apprises de cliniciens du Réseau canadien sur la santé des réfugiés (Canadian Refugee Health Network) qui travaillent dans divers milieux de soins primaires, ainsi que de contributions de personnes ayant vécu l'expérience d'une migration forcée. MESSAGE PRINCIPAL: La pandémie de la COVID-19 a amplifié les iniquités sociales et de santé pour les réfugiés, les demandeurs d'asile, les migrants sans papiers, les travailleurs transitoires de l'étranger et d'autres nouveaux arrivants. Les réfugiés et les nouveaux arrivants sont confrontés à des risques d'exposition en première ligne, à des problèmes d'accès aux tests de dépistage de la COVID-19, à l'exacerbation des préoccupations liées à la santé mentale, et aux difficultés d'accéder aux soins de santé et aux services sociaux et d'établissement. Les lignes directrices existantes sur les soins cliniques aux réfugiés sont utiles, mais des stratégies créatives au cas par cas doivent être utilisées pour surmonter les obstacles additionnels dans le contexte de la COVID-19 et des nouveaux environnements de soins, comme la nécessité d'une traduction simultanée virtuelle et d'habiletés en littératie numérique. Les cliniciens peuvent lutter contre les iniquités et plaider en faveur de meilleurs services en collaboration avec des partenaires communautaires. CONCLUSION: La pandémie de la COVID-19 amplifie les iniquités structurelles. Les réfugiés et les nouveaux arrivants nécessitent et méritent des soins de santé et du soutien efficaces durant ces moments éprouvants. Cet article présente des approches pratiques et les priorités en matière de défense des droits pour offrir des soins dans le contexte de la COVID-19.

Badanta, B., González-Cano-Caballero, M., Fernández-García, E., et al. "The consequences of the COVID-19 pandemic on the refugee population: a rapid review." Perspectives in Public Health **0**(0): 17579139221093159. https://journals.sagepub.com/doi/abs/10.1177/17579139221093159

> Aims:This is a rapid review examining the available evidence about the repercussions of the COVID-19 pandemic on the refugee population.Methods:A search in the databases such as PubMed, Scopus, CINAHL, PsycINFO, and Web of Science was conducted and all relevant original articles, letters, and editorial and policy papers were included.Results:From 208 publications matching the search criteria, 36 were included. These publications were categorized into three distinct domains: Public Health, Policies and Financing, and Technology. Our findings revealed that the situation of the refugee population has worsened during the pandemic. Difficulty accessing healthcare, violation of human rights, lack of access to technology devices, unfavorable government policies, and economic crisis were the most important aspects impacted by COVID-19.Conclusion:Governments, health managers, health professionals, and policy makers should be aware of refugees' problems during the pandemic to provide immediate solutions.

Balakrishnan, V. S. (2021). "Impact of COVID-19 on migrants and refugees." Lancet Infect Dis **21**(8): 1076-1077.

Burton-Jeangros, C., Duvoisin, A., Lachat, S., et al. (2020). "The Impact of the Covid-19 Pandemic and the Lockdown on the Health and Living Conditions of Undocumented Migrants and Migrants Undergoing Legal Status Regularization." Front Public Health **8**: 596887.

> Introduction: Undocumented migrants are at high risk of adverse consequences during crises because of a lack of access to essential securities and sources of support. This study aims to describe the impact of the COVID-19 crisis on the health and living circumstances of precarious migrants in Switzerland and to assess whether those undergoing legal status regularization fared better than undocumented migrants. Materials and methods: This cross-sectional mixed methods study was

conducted during the COVID-19 lockdown in April-May 2020. Undocumented and recently regularized migrants taking part in an ongoing cohort study were asked to respond to an online questionnaire. A subsample was selected to undergo semi-directed phone interviews. Results: Overall, 117 of the 379 (30.9%) cohort study participants responded to the questionnaire. Seventeen interviews were conducted. Migrants faced cumulative and rapidly progressive difficulties in essential life domains. As a consequence, they showed high prevalence of exposure to COVID-19, poor mental health along with frequent avoidance of health care. Moreover, the loss of working hours and the related income overlapped with frequent food and housing insecurity. Around one participant in four had experienced hunger. Despite these unmet needs, half of the participants had not sought external assistance for reasons that differ by legal status. Both groups felt that seeking assistance might represent a threat for the renewal or a future application for a residency permit. While documented migrants were less severely affected in some domains by having accumulated more reserves previously, they also frequently renounced to sources of support. Conclusions: The cumulated difficulties faced by migrants in this period of crisis and their limited search for assistance highlight the need to implement trust-building strategies to bridge the access gap to sources of support along with policies protecting them against the rapid loss of income, the risk of losing their residency permit and the exposure to multi-fold insecurities.

Devillanova, C., Colombo, C., Garofolo, P., et al. (2020). "Health care for undocumented immigrants during the early phase of the Covid-19 pandemic in Lombardy, Italy." Eur J Public Health **30**(6): 1186-1188.

Despite concern on the impact of coronavirus disease 2019 (COVID-19) pandemic on undocumented immigrants, quantitative evidence on the issue is scant. We analyze socioeconomic and health conditions of 1590 undocumented immigrants in Milan, Lombardy, one of the regions with the highest COVID-19 clinical burden in the world that does not guarantee access to primary care for these individuals. We document a sharp reduction in visit number after lockdown, with 16% frequency of acute respiratory infections, compatible with COVID-19. Moreover, housing conditions make it difficult to implement public health measures. Results suggest the need to foster primary care by undocumented immigrants to face COVID-19 emergency.

Etowa, J., Sano, Y., Hyman, I., et al. (2021). "Difficulties accessing health care services during the COVID-19 pandemic in Canada: examining the intersectionality between immigrant status and visible minority status." Int J Equity Health **20**(1): 255.

BACKGROUND: Difficulties accessing health care services can result in delaying in seeking and obtaining treatment. Although these difficulties are disproportionately experienced among vulnerable groups, we know very little about how the intersectionality of realities experienced by immigrants and visible minorities can impact their access to health care services since the pandemic. METHODS: Using Statistics Canada's Crowdsourcing Data: Impacts of COVID-19 on Canadians-Experiences of Discrimination, we combine two variables (i.e., immigrant status and visible minority status) to create a new variable called visible minority immigrant status. This multiplicative approach is commonly used in intersectionality research, which allows us to explore disadvantages experienced by minorities with multiplicative identities. RESULTS: Main results show that, compared to white native-born, visible minority immigrants are less likely to report difficulties accessing non-emergency surgical care (OR = 0.55, p < 0.001), non-emergency diagnostic test (OR = 0.74, p < 0.01), dental care (OR = 0.71, p < 0.001), mental health care (OR = 0.77, p < 0.05), and making an appointment for rehabilitative care (OR = 0.56, p < 0.001) but more likely to report difficulties accessing emergency services/urgent care (OR = 1.46, p < 0.05). CONCLUSION: We conclude that there is a dynamic interplay of factors operating at multiple levels to shape the impact of COVID-19 related needs to be addressed through changes in social policies, which can tackle unique struggles faced by visible minority immigrants.

Fasani, F. et Mazza, J. (2020). Being on the Frontline? Immigrant Workers in Europe and the COVID-19 Pandemic. Iza Discussion Paper Series ; 13963. Bonn Iza**:** 38 , fig., annexes.
http://ftp.iza.org/dp13963.pdf

We provide a first timely assessment of the pandemic crisis impact on the labour market prospects of immigrant workers in Europe by proposing a novel measure of their exposure to employment risk. We characterize migrants' occupations along four dimensions related to the role of workers' occupations in the response to the pandemic, the contractual protection they enjoy, the possibility of performing their job from home and the resilience of the industry in which they are employed. We show that our measure of employment risk closely predicts actual employment losses observed in European countries after the first wave of the COVID-19 pandemic. We estimate that, within industries and occupations, Extra-EU migrants and women are exposed to higher risk of unemployment than native men and that women are losing jobs at higher rates than equally exposed men. According to our estimates, more than 9 million immigrants in the EU14+UK area are exposed to a high risk of becoming unemployed due to the pandemic crisis, 1.3 million of which are facing a very high risk.

Fielding-Miller, R. K., Sundaram, M. E. et Brouwer, K. (2020). "Social determinants of COVID-19 mortality at the county level." PLoS One **15**(10): e0240151.

As of August 2020, the United States is the global epicenter of the COVID-19 pandemic. Emerging data suggests that "essential" workers, who are disproportionately more likely to be racial/ethnic minorities and immigrants, bear a disproportionate degree of risk. We used publicly available data to build a series of spatial autoregressive models assessing county level associations between COVID-19 mortality and (1) percentage of individuals engaged in farm work, (2) percentage of households without a fluent, adult English-speaker, (3) percentage of uninsured individuals under the age of 65, and (4) percentage of individuals living at or below the federal poverty line. We further adjusted these models for total population, population density, and number of days since the first reported case in a given county. We found that across all counties that had reported a case of COVID-19 as of July 12, 2020 (n = 3024), a higher percentage of farmworkers, a higher percentage of residents living in poverty, higher density, higher population, and a higher percentage of residents over the age of 65 were all independently and significantly associated with a higher number of deaths in a county. In urban counties (n = 115), a higher percentage of farmworkers, higher density, and larger population were all associated with a higher number of deaths, while lower rates of insurance coverage in a county was independently associated with fewer deaths. In non-urban counties (n = 2909), these same patterns held true, with higher percentages of residents living in poverty and senior residents also significantly associated with more deaths. Taken together, our findings suggest that farm workers may face unique risks of contracting and dying from COVID-19, and that these risks are independent of poverty, insurance, or linguistic accessibility of COVID-19 health campaigns.

Fiorini, G., Rigamonti, A. E., Galanopoulos, C., et al. (2020). "Undocumented migrants during the COVID-19 pandemic: socio-economic determinants, clinical features and pharmacological treatment." J Public Health Res **9**(4): 1852.

Population groups such as undocumented migrants have been almost completely forgotten during the COVID-19 pandemic, though they have been living in all European countries for decades and new arrivals have continued throughout the pandemic. The aim of this study was to investigate their health conditions during the current pandemic. We analysed the records of 272 patients with respiratory issues attending the outpatient clinic of a large charity in Milan, Italy: amongst them, 18 had COVID-19 confirmed by rhino-pharyngeal swab and 1 of them deceased. All the patients attending the clinic appeared to have several risk factors for COVID-19 and chronic conditions suspected to predispose to the disease and/or to worsen severity and outcomes: hypertension, immunosuppression and previous close contact with COVID-19 patients were the most important ones. Presenting symptoms were worse in patients with COVID-19 than in those with other respiratory issues. These results are discussed in light of the necessity to provide better healthcare to undocumented migrants.

Hargreaves, S., Kumar, B. N., McKee, M., et al. (2020). "Europe's migrant containment policies threaten the response to covid-19." Bmj **368**: m1213.

Kluge, H. H. P., Jakab, Z., Bartovic, J., et al. (2020). "Refugee and migrant health in the COVID-19 response." Lancet **395**(10232): 1237-1239.

Knights, F., Carter, J., Deal, A., et al. (2021). "Impact of COVID-19 on migrants' access to primary care and implications for vaccine roll-out: a national qualitative study." Br J Gen Pract **71**(709): e583-e595.

BACKGROUND: COVID-19 has led to big changes in UK primary care, including rapid digitalisation, with unknown impact on migrant groups. AIM: To understand the pandemic's impact on recently-arrived migrants and their access to primary health care, and implications for vaccine roll-out. DESIGN AND SETTING: Qualitative study involving semi-structured interviews with primary care professionals (PCPs) and migrants in urban, suburban, and rural settings across England. METHOD: Sixty-four PCPs and administrative staff, and 17 recently-arrived migrants were recruited using purposive, convenience, and snowball sampling. In-depth, semi-structured interviews were conducted by telephone. Data were analysed iteratively, informed by thematic analysis. RESULTS: PCPs and migrants concurred that digitalisation and virtual consultations have amplified existing inequalities in access to health care for many migrants, due to a lack of digital literacy and access to technology, compounded by language barriers. PCPs were concerned that virtual consultations resulted in difficulties building trust and risked missing safeguarding cues. Both PCPs and migrants highlighted challenges around registering and accessing health care due to physical closure of surgeries, as well as indirect discrimination, language and communication barriers, and a lack of access to targeted and tailored COVID-19 information or interventions. Migrants reported a range of specific beliefs, from acceptance to mistrust, around COVID-19 and potential COVID-19 vaccines, often influenced by misinformation. Innovative opportunities were suggested, including translated digital health advice using text templates and YouTube; these merit further exploration. CONCLUSION: Pandemic-related changes to primary care delivery may become permanent; some migrant groups are at risk of digital exclusion and may need targeted additional support to access services. Solutions are needed to address vaccine hesitancy in marginalised groups to ensure equitable COVID-19 vaccine uptake.

Kondilis, E., Puchner, K., Veizis, A., et al. (2020). "Covid-19 and refugees, asylum seekers, and migrants in Greece." Bmj **369**: m2168.
https://www.bmj.com/content/bmj/369/bmj.m2168.full.pdf

Lebras, H. (2020). L'épidémie et son terrain social. Paris Fondation Jean Jaurès**:** 19.
https://jean-jaures.org/nos-productions/l-epidemie-et-son-terrain-social

Pauvreté, présence de minorités, proportion de personnes âgées, densité... : ces facteurs ont-ils favorisé le développement de l'épidémie due au coronavirus dans certains territoires ? Pour l'historien et démographe Hervé Le Bras, l'importance de la contagion tient davantage à l'importance des clusters initiaux qu'aux facteurs économiques et sociaux « classiques ».

Marchi, M., Magarini, F. M., Chiarenza, A., et al. (2022). "Experience of discrimination during COVID-19 pandemic: the impact of public health measures and psychological distress among refugees and other migrants in Europe." BMC Public Health **22**(1): 942.

BACKGROUND: The COVID-19 pandemic has had a disproportionately hard impact on refugees and other migrants who are often exposed to the virus with limited means to protect themselves. We tested the hypothesis that during the COVID-19 pandemic, refugees and other migrants have suffered a negative impact on mental health and have been unjustly discriminated for spreading the disease in Europe (data collection from April to November 2020). METHODS: Participants in the ApartTogether Survey (N = 8297, after listwise deletion of missing items final N = 3940) provided data regarding to their difficulties to adhere to preventive recommendations against COVID-19 infection (CARE), self-perceived stigmatization (SS), and psychological distress (PD). Structural Equation Modeling was used to investigate PD as a mediator in the pathway linking CARE to SS, while adjusting for the housing and residence status. To improve confidence in the findings, single hold-out sample cross-validation was performed using a train/test split ratio of 0.8/0.2. RESULTS: In the exploratory set (N = 3159) SS was associated with both CARE (B = 0.200, p < 0.001) and PD (B = 0.455, p < 0.001). Moreover, PD was also associated with CARE (B = 0.094, p = 0.001) and mediated the effect of CARE on SS (proportion mediated = 17.7%, p = 0.001). The results were successfully replicated in the confirmation set (N = 781;

total effect = 0.417, p < 0.001; proportion mediated = 29.7%, p < 0.001). Follow-up analyses also found evidence for an opposite effect (i.e., from SS to CARE, B = 0.132; p < 0.001), suggesting that there might be a vicious circle between the self-perceived stigmatization and the access to health care and the use of preventive measures against COVID-19 infection. CONCLUSIONS: Refugees and other migrants who had more difficulties in accessing health care and preventive measures against COVID-19 infection experienced worse mental health and increased discrimination. These negative effects appeared to be stronger for those with more insecure housing and residence status, highlighting from one side the specific risk of insecure housing in the impact of COVID-19 upon mental health and infection protection, and for another side the need to proper housing as a strategy to prevent both COVID-19 and mental distress.

Milli, C., Petrelli, A., Silvestri, C., et al. (2022). "Socioeconomic and demographic risk factors in COVID-19 hospitalization among immigrants and ethnic minorities." BMJ Open **32**(2): 302-310.

BACKGROUND: Immigrants and ethnic minorities have been shown to be at increased risk of hospitalization from COVID-19. Our aim was to analyse the contribution of socioeconomic and demographic risk factors on hospital admissions for COVID-19 among immigrants and ethnic minorities compared to the majority population. METHODS: We used nationwide register data on all hospitalized COVID-19 cases between February and June 2020 (N = 2232) and random controls from the general population (N = 498 117). We performed logistic regression analyses and adjusted for age, sex, comorbidity, and socioeconomic and demographic factors. The main outcome measure was hospitalization with COVID-19 and was estimated using odds ratios (OR) and 95% confidence intervals (95% CI). RESULTS: Among 2232 COVID-19 cases, the OR of hospitalization with COVID-19 among immigrants and descendants of non-Western origin was 2.5 times higher (95% CI: 2.23-2.89) compared with individuals of Danish origin with most pronounced results among individuals from Iraq, Morocco, Pakistan and Somalia. The OR was largely attributed to comorbidity and socioeconomic factors, especially household size, occupation, and population density. CONCLUSION: There is a significantly higher OR of hospitalization with COVID-19 among non-Western immigrants and ethnic minorities compared with ethnic Danes. This knowledge is crucial for health policymakers and practitioners in both the current and future pandemics to identify more vulnerable groups and target prevention initiatives.

Mondello, S., Visalli, C., Kobeissy, F., et al. (2021). "Exploring the evidence for the effectiveness of health interventions for COVID-19 targeting migrants: a systematic review protocol." **11**(12): e057985.

INTRODUCTION: Owing to their inherent vulnerabilities, the burden of COVID-19 and particularly of its control measures on migrants has been magnified. A thorough assessment of the value of the interventions for COVID-19 tailored to migrants is essential for improving their health outcomes as well as promoting an effective control of the pandemic. In this study, based on evidence from primary biomedical research, we aimed to systematically identify health interventions for COVID-19 targeting migrants and to assess and compare their effectiveness. The review will be conducted within a programme aimed at defining and implementing interventions to control the COVID-19 pandemic in Italy, funded by the Italian Ministry of Health and conducted by a consortium of Italian regional health authorities. METHODS AND ANALYSES: Data sources will include the bibliographic databases MEDLINE, Embase, LOVE Platform COVID-19 Evidence, and Cochrane Central Register of Controlled Trials. Eligible studies must evaluate health interventions for COVID-19 in migrants. Two independent reviewers will screen articles for inclusion using predefined eligibility criteria, extract data of retained articles and assess methodological quality by applying the Cochrane Risk of Bias tool. Disagreements will be resolved through consensus or arbitrated by a third reviewer if necessary. In synthesising the evidence, we will structure results by interventions, outcomes and quality. Where studies are sufficiently homogenous, trial data will be pooled and meta-analyses will be performed. Data will be reported according to methodological guidelines for systematic review provided by the Cochrane Collaboration and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses statement. ETHICS AND DISSEMINATION: This is a review of existing literature, and ethics approval is not required. We will submit results for peer-review publication and present at relevant conferences. The review findings will be included in future efforts to develop evidence-informed recommendations,

policies or programmatic actions at the national and regional levels and address future high-quality research in public health.

Norredam, M., Hayward, S., Deal, A., et al. (2022). "Understanding and addressing long-COVID among migrants and ethnic minorities in Europe." Lancet Reg Health Eur **19**: 100427.

OCDE (2022). The unequal impact of Covid-19: A spotlight on frontline workers, migrants and racial/ethnic minorities. Paris OCDE**:** 16.
https://www.oecd.org/coronavirus/policy-responses/the-unequal-impact-of-covid-19-a-spotlight-on-frontline-workers-migrants-and-racial-ethnic-minorities-f36e931e/

The young, the low educated, migrants, racial/ethnic minorities and low-wage workers were over-represented in jobs that cannot be done remotely and were therefore exposed to a higher risk of infection or job loss when the pandemic began. Many of those employed in these at-risk jobs were the frontline workers who continued to work in their physical workplace and in contact with other people throughout the pandemic to deliver essential goods and services. Indeed, the crisis has highlighted the extent to which society depends upon frontline workers who are often employed in low-paid jobs whose quality matches neither the importance of the work, nor the hazards involved. Other workers in at-risk jobs suffered particularly large losses in employment and income. In particular, both migrants and workers from racial/ethnic minorities were hit harder initially and are recovering more slowly.

OCDE (2022). What has been the impact of the Covid-19 pandemic on immigrants?An update on recent evidence?, Paris : OCDE
https://www.oecd.org/coronavirus/policy-responses/what-has-been-the-impact-of-the-covid-19-pandemic-on-immigrants-an-update-on-recent-evidence-65cfc31c?utm_source=Adestra&utm_medium=email&utm_content=Impact-of-COVID-19-on-Immigrants&utm_campaign=ELS%20Newsletter%20September%202022&utm_term=els

While the Covid-19 crisis had a disproportionate impact on immigrants during the first months of the pandemic, the longer run effects are more mixed. Employment rates of foreign-born people are up, back to or near pre-crisis levels for most countries. However, long-standing weaknesses in access to training remain, and immigrants are still more likely than the native-born to catch the disease, to develop severe symptoms, and to face higher mortality risks. Following a first OECD policy brief published after the first wave (OECD, 2020[this policy brief provides new evidence on the impact of the pandemic on immigrant integration in terms of health, labour market outcomes and training, as OECD countries start to recover from the crisis.

Oliva-Arocas, A., Benavente, P., Ronda, E., et al. (2022). "Health of International Migrant Workers During the COVID-19 Pandemic: A Scoping Review." Front Public Health **10**: 816597.

BACKGROUND: The coronavirus (COVID-19) pandemic and control measures adopted have had a disproportionate impact on workers, with migrants being a group specifically affected but poorly studied. This scoping review aims to describe the evidence published on the impact of the COVID-19 pandemic on the physical and mental health of migrant workers. METHODS: Papers written in English covering physical and mental health among international migrant workers during the COVID-19 pandemic, retrieved from six electronic databases searched on July 31, 2021, were included. A total of 1,096 references were extracted, of which 26 studies were finally included. RESULTS: Most of the migrant populations studied were born in Asia (16 of 26) and Latin America (8 of 26) and were essential workers (15 of 26). Few studies described the length of stay in the host country (9 of 26), the legal status of the migrant population (6 of 26), or established comparison groups (7 of 26). Ten studies described COVID-19 outbreaks with high infection rates. Fourteen studies evaluated mental health (anxiety, depression, worries, fears, stress, and post-traumatic stress disorder). Three of the 26 studies presented collateral positive effects of the COVID-19 pandemic because of improved hygiene. CONCLUSION: There is a limited number of original publications related to the impact of the COVID-19 pandemic on the physical and mental health of migrant workers around the world. These publications

mainly focus on migrants born in Asia and Latin America. The physical, long-term impact of the COVID-19 pandemic has, so far, not been evaluated. The positive collateral effects of improving healthcare conditions for migrant workers should also be further investigated.

OMS (2021). WHO Global Evidence Review on Health and Migration Series (GEHM) Reports. Refugees and migrants in times of COVID-19: mapping trends of public health and migration policies and practices. Geneva, World Health Organization

Refugees and migrants have been disproportionately affected by both the direct effects of the COVID-19 pandemic and the restrictive migration measures put in place, which, in turn, have hampered coordinated and consistent public health responses. This report maps how the needs of refugee and migrant have been addressed in COVID-19 responses across countries and how these have varied considerably from inclusive policies to discriminatory practices. Many countries ensured access to health care for refugees and migrants regardless of migration status, and several countries also suspended forced returns and prioritized alternatives to immigration detention. An integrated approach to migration and public health policies covering protection-sensitive access to territories, a flexible approach to migration status and non-discriminatory access to health care is suggested as a policy consideration to uphold international conventions protecting the right to health without discrimination for refugees and migrants.

Page, K. R., Venkataramani, M., Beyrer, C., et al. (2020). "Undocumented U.S. Immigrants and Covid-19." New England Journal of Medicine.
https://www.nejm.org/doi/full/10.1056/NEJMp2005953

Paul, R. (2020). "Europe's essential workers: Migration and pandemic politics in Central and Eastern Europe during COVID-19." Eur Policy Anal **6**(2): 238-263.

How do countries navigate the tradeoffs between public health and economic reopening? What explains variation in state responses to COVID-19? Historically, governments have tackled pandemics as external, nonconventional security threats, restricting immigration to protect citizens from contagious outsiders. Central and Eastern European (CEE) countries could not frame COVID-19 this way because European integration and free-movement migration blur the line between insiders and outsiders. This article examines the conditions and coalitions that shaped policy outcomes, and argues that migration systems played a double role in policy change: as structures for policy diffusion and as venues for migrants' agency. Governments learned from one another's experiences, but diffusion occurred unevenly according to countries' position within migratory systems.

Raju, E. et Ayeb-Karlsson, S. (2020). "COVID-19: How do you self-isolate in a refugee camp?" Int J Public Health **65**(5): 515-517.
https://doi.org/10.1007/s00038-020-01381-8

Razieh, C., Zaccardi, F., Islam, N., et al. (2021). "Ethnic minorities and COVID-19: Examining whether excess risk is mediated through deprivation." Eur J Public Health.
https://doi.org/10.1093/eurpub/ckab041

People from South Asian and black minority ethnic groups are disproportionately affected by the COVID-19 pandemic. It is unknown whether deprivation mediates this excess ethnic risk.We used UK Biobank with linked COVID-19 outcomes occurring between 16th March 2020 and 24th August 2020. A four-way decomposition mediation analysis was used to model the extent to which the excess risk of testing positive, severe disease and mortality for COVID-19 in South Asian and black individuals, relative to white individuals, would be eliminated if levels of high material deprivation were reduced within the population.15,044 (53.0% women) South Asian and black and 392,786 (55.2% women) white individuals were included. There were 151 (1.0%) positive tests, 91 (0.6%) severe cases and 31 (0.2%) deaths due to COVID-19 in South Asian and black individuals compared to 1,471 (0.4%), 895 (0.2%) and 313 (0.1%), respectively, in white individuals. Compared to white individuals, the relative risk of testing positive for COVID-19, developing severe disease and COVID-19 mortality in South Asian

and black individuals were 2.73 (95% CI: 2.26, 3.19), 2.96 (2.31, 3.61) and 4.04 (2.54, 5.55), respectively. A hypothetical intervention moving the 25% most deprived in the population out of deprivation was modelled to eliminate between 40-50% of the excess risk of all COVID-19 outcomes in South Asian and black populations, whereas moving the 50% most deprived out of deprivation would eliminate over 80% of the excess risk of COVID-19 outcomes.The excess risk of COVID-19 outcomes in South Asian and black communities could be substantially reduced with population level policies targeting material deprivation.

Rothman, S., Gunturu, S. et Korenis, P. (2020). "The mental health impact of the COVID-19 epidemic on immigrants and racial and ethnic minorities." Qjm **113**(11): 779-782.

Serafini, R. A., Powell, S. K., Frere, J. J., et al. (2021). "Psychological distress in the face of a pandemic: An observational study characterizing the impact of COVID-19 on immigrant outpatient mental health." Psychiatry Res **295**: 113595.

Undocumented immigrants have disproportionately suffered during the novel coronavirus disease 2019 (COVID-19) pandemic due to factors including limited medical access and financial insecurity, which can exacerbate pandemic-associated distress. Psychological outcomes for immigrant outpatients were assessed after transition to telepsychiatry in March 2020. Mental health was assessed with Patient Health Questionnaire (PHQ-2) and Generalized Anxiety Disorder (GAD-2) inventories, a novel coronavirus-specific survey, and the Kessler Psychological Distress Scale (K10+). Feedback on telepsychiatry sessions and access to non-clinical resources were also gathered, after which multivariable linear regression modeling identified psychosocial factors underlying changes in distress levels. 48.57% and 45.71% of participants reported worsened anxiety and depression levels due to the pandemic, respectively. From March to April, PHQ-2 and GAD-2 scores significantly increased by 0.81 and 0.63 points, respectively. The average total psychological distress score was 23.8, with 60% of scores reflecting serious mental illness. Factors that most influenced K10+ scores included a pre-existing depressive disorder, food insecurity, and comfort during telepsychiatry visits. 93.75% of participants believed access to remote psychiatry helped their mental health during COVID-19. The negative impact of COVID-19 on mental health in vulnerable populations stems from medical and psychosocial factors such as pre-existing psychiatric conditions and unmet essential needs.

Wise, J. (2021). "Covid-19: Migrants face barriers accessing healthcare during the pandemic, report shows." Bmj **374**: n2296.

Zhang, C. X., Boukari, Y., Pathak, N., et al. (2022). "Migrants' primary care utilisation before and during the COVID-19 pandemic in England: An interrupted time series analysis." Lancet Reg Health Eur **20**: 100455.

BACKGROUND: How international migrants access and use primary care in England is poorly understood. We aimed to compare primary care consultation rates between international migrants and non-migrants in England before and during the COVID-19 pandemic (2015-2020). METHODS: Using data from the Clinical Practice Research Datalink (CPRD) GOLD, we identified migrants using country-of-birth, visa-status or other codes indicating international migration. We linked CPRD to Office for National Statistics deprivation data and ran a controlled interrupted time series (ITS) using negative binomial regression to compare rates before and during the pandemic. FINDINGS: In 262,644 individuals, pre-pandemic consultation rates per person-year were 4.35 (4.34-4.36) for migrants and 4.60 (4.59-4.60) for non-migrants (RR:0.94 [0.92-0.96]). Between 29 March and 26 December 2020, rates reduced to 3.54 (3.52-3.57) for migrants and 4.2 (4.17-4.23) for non-migrants (RR:0.84 [0.8-0.88]). The first year of the pandemic was associated with a widening of the gap in consultation rates between migrants and non-migrants to 0.89 (95% CI 0.84-0.94) times the ratio before the pandemic. This widening in ratios was greater for children, individuals whose first language was not English, and individuals of White British, White non-British and Black/African/Caribbean/Black British ethnicities. It was also greater in the case of telephone consultations, particularly in London. INTERPRETATION: Migrants were less likely to use primary care than non-migrants before the pandemic and the first year of the pandemic exacerbated this difference. As GP practices retain remote and hybrid models of service delivery, they must improve services and ensure primary care is accessible and responsive to

migrants' healthcare needs. FUNDING: This study was funded by the Medical Research Council (MC_PC 19070 and MR/V028375/1) and a Wellcome Clinical Research Career Development Fellowship (206602).

Pour poursuivre la recherche

EN FRANCE

Assfam (Association Service Social Familial Migrants)

Comede
Site gouvernemental sur l'immigration (France)

GISTI (Groupe d'information et de soutien des immigrés)

Institut Convergences Migrations (IC Migrations)
Atlas des migrants en Europe

La Cimade

Médecins du Monde – Observatoire de l'accès aux soins

Maison des réfugiés (Migrations santé)https://www.maisondesrefugies.paris/Migrations-Sante-France_a39.html

ODSE - Observatoire du droit à la santé des étrangers

A L'ETRANGER

Agence des droits fondamentaux de l'Union européenne

Conseil de l'Europe
Plan d'action du Conseil de l'Europe sur la protection des personnes vulnérables dans le contexte des migrations et de l'asile en Europe (2021-2025)

MIPEX – Outil de mesure de la politique d'intégration des migrants

OMI - Office des migrations internationales
- Pour la France : https://www.iom.int/fr

OMS Migration et santé
World report on the health of refugees and migrants: Health for all, including refugees and migrants: Time to act (2022)

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