United Nations
Educational, Scientific and
Cultural Organization

UNESCO Chair on Training and Empowering
Human Resources for Health Development
in Resource-Limited Countries
University of Brescia

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DI BRESCIA

Società Italiana di Medicina delle Migrazioni
S.I.M.M.

I determinanti delle migrazioni ….
… le migrazioni come determinante di salute

Prof. Francesco CASTELLI, MD, FRCP (London), FFTM RCPS (Glasg), FESCMID

Professore di Malattie Infettive

Direttore, Clinica di Malattie Infettive e Tropicali

UNESCO Chair *Training and empowering human resources for health development in resources limited countries*

Università di Brescia

MigFacts: International Migration

244 million international migrants globally in 2015[1]

An international migrant is a person who is living in a country other than his or her country of birth[2]

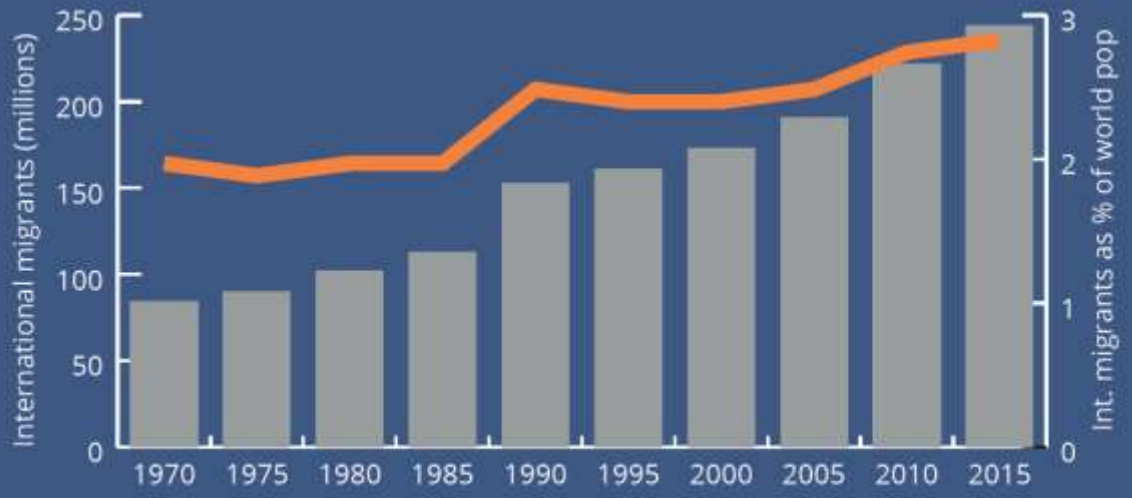
As the world population grows so does the number of internationl migrants: there are **three times more international migrants in 2015 than in 1970**

The international migrant population has remained relatively stable over the last few decades:

2.2 to 3.3 per cent

of the world's population

2017: 257.7 million



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IOM • OIM INTERNATIONAL ORGANIZATION FOR MIGRATION

THE UN MIGRATION AGENCY

By the end of 2016, 65.6 million individuals were forcibly displaced worldwide as a result of persecution, conflict, violence, or human rights violations. That was an increase of 300,000 people over the previous year, and the world's forcibly displaced population remained at a record high.

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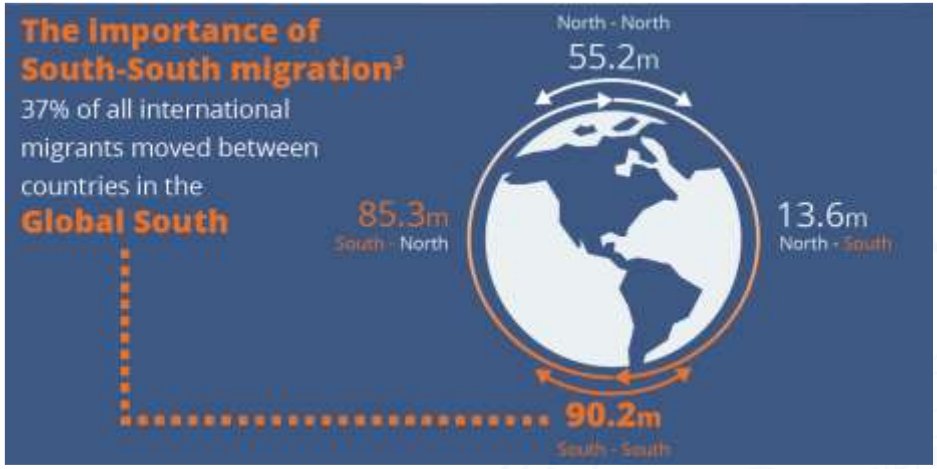
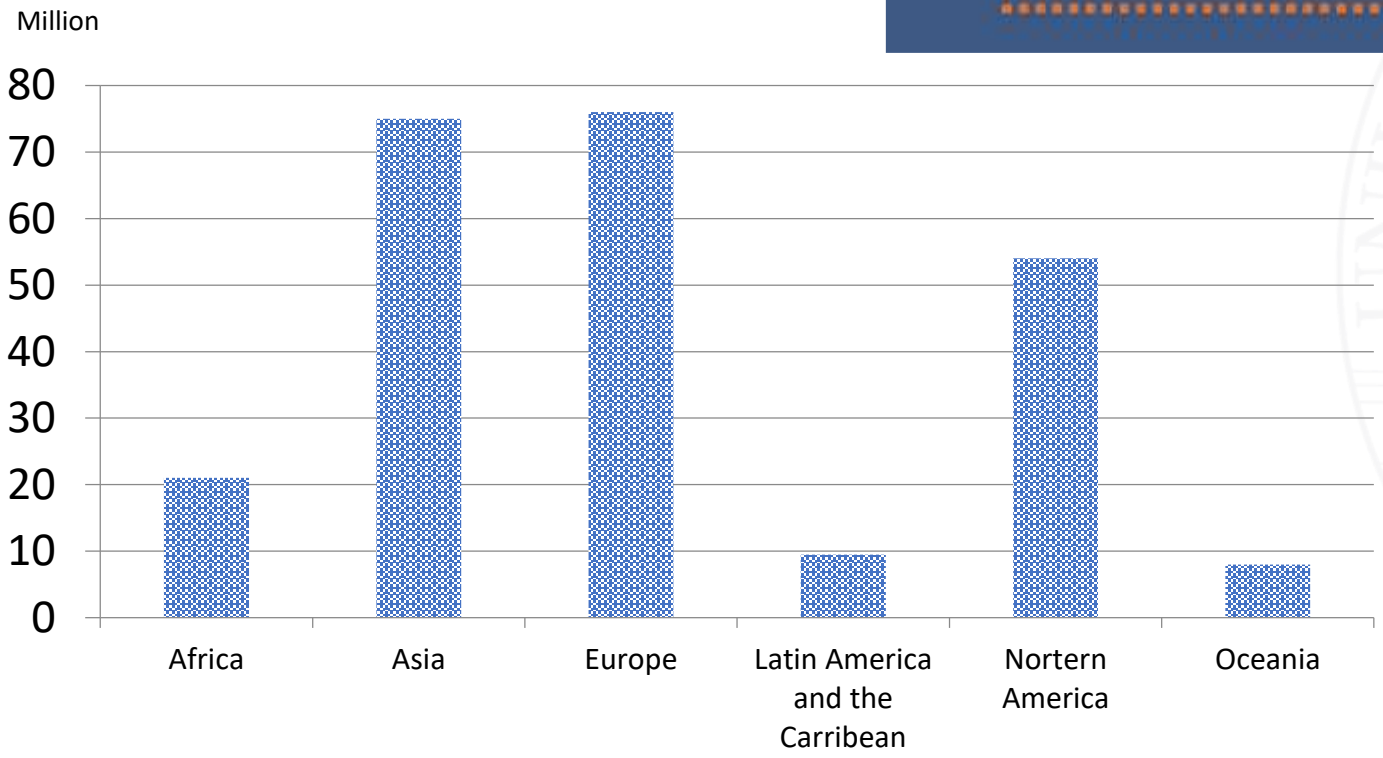
Fonte: http://www.unhcr.org/figures-at-a-glance.html

UNHCR The UN Refugee Agency

International migrants by region of residence, 2015





Source: UN DESA, 2015. www.un.org/en/development/desa/population/migration/data/estimates2/estimates15.shtml, modified

Determinants of migration
or
«*why do people migrate?*»

- **«Push» factors**
- **«Pull» factors**
- **«Choice» factors**

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Determinants of migration
or
«*why do people migrate?*»

- **«Macro» factors**
- **«Meso» factors**
- **«Micro» factors**

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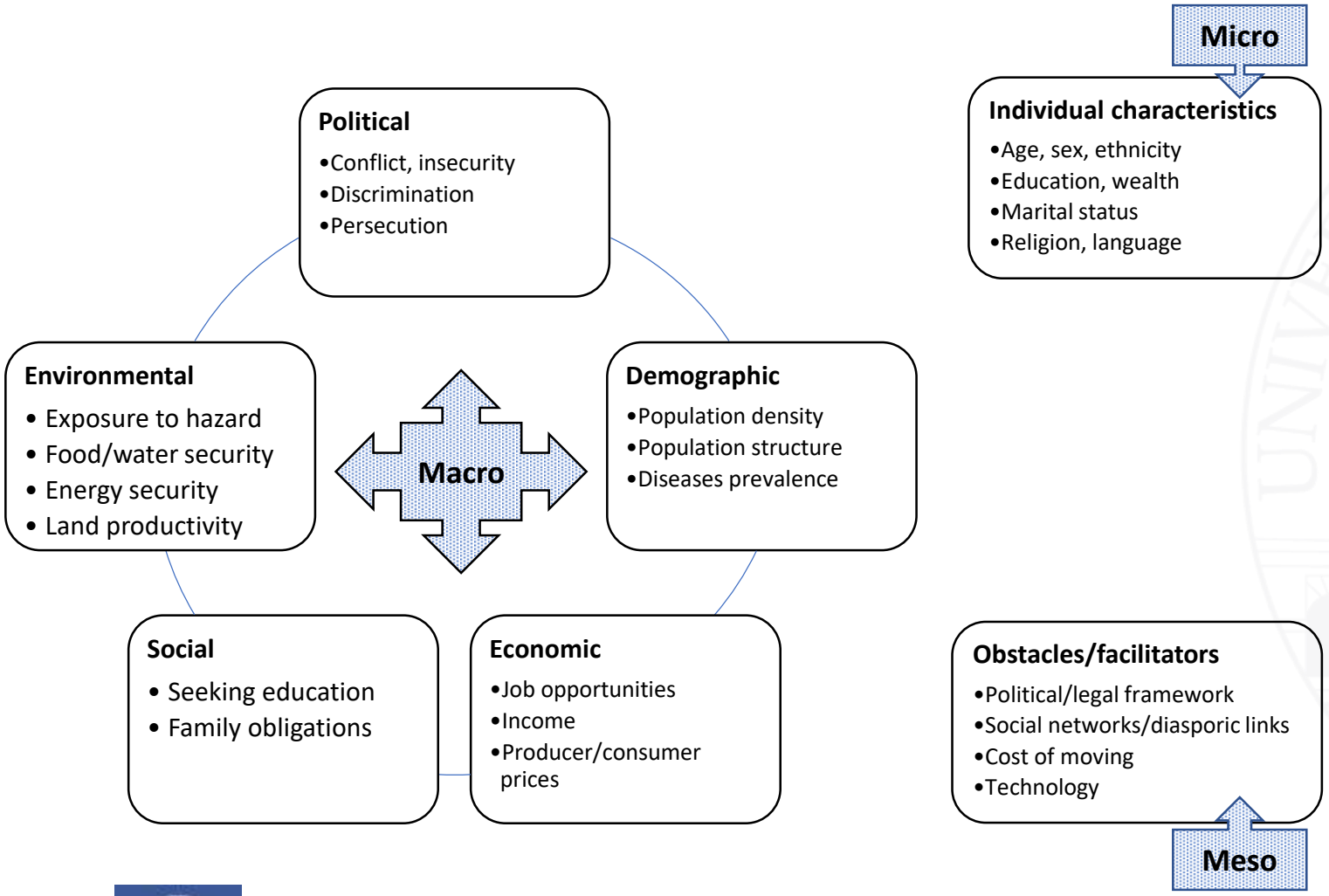
Complex drivers of migration: macro-, meso- and micro-factors



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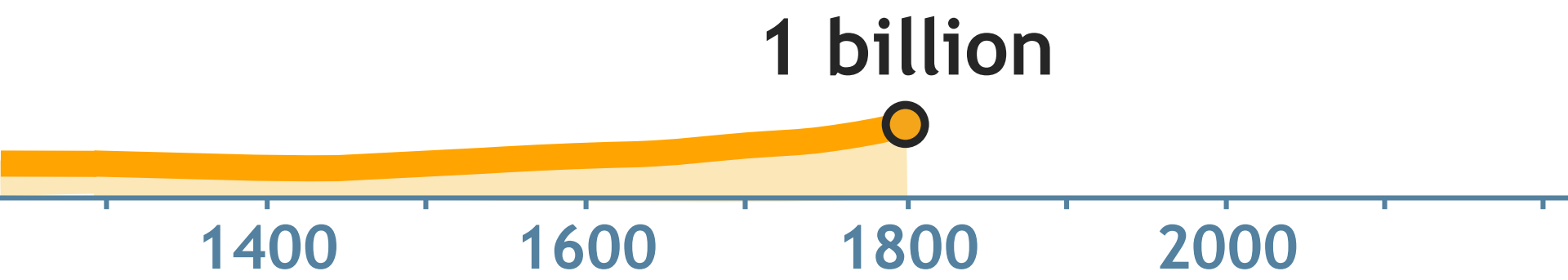
Foresight: Migration and Global Environmental Change (2011) Final Project Report The Government Office for Science, London, modified

World population in year

1800

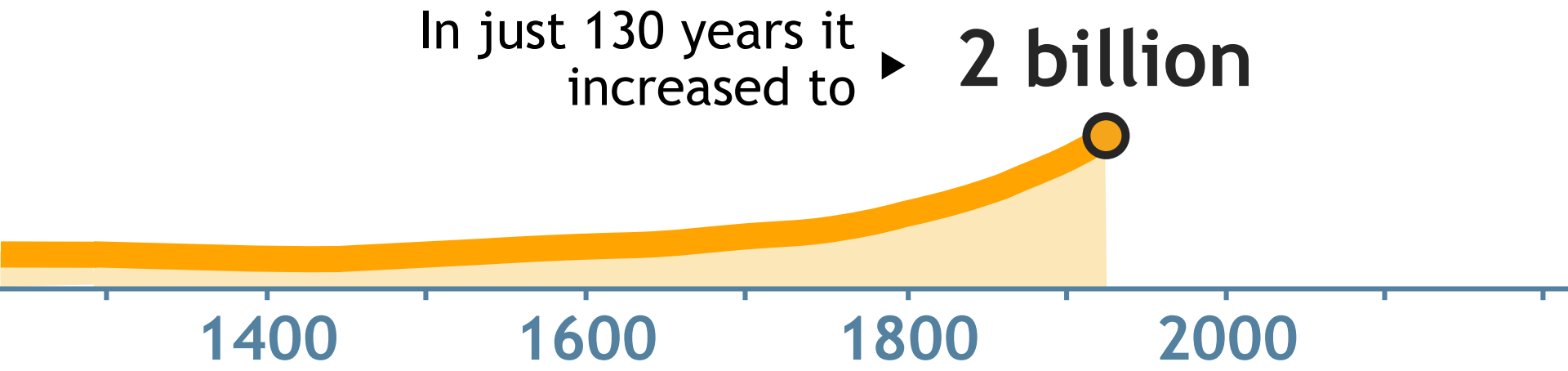
It took about 7 million years for the human population to reach 1 billion. Then something happened.



Sources: Biraben 1980; McEvedy & Jones 1978; UN World Pop. Prosp. 2012; combined by Gapminder.

World population in year

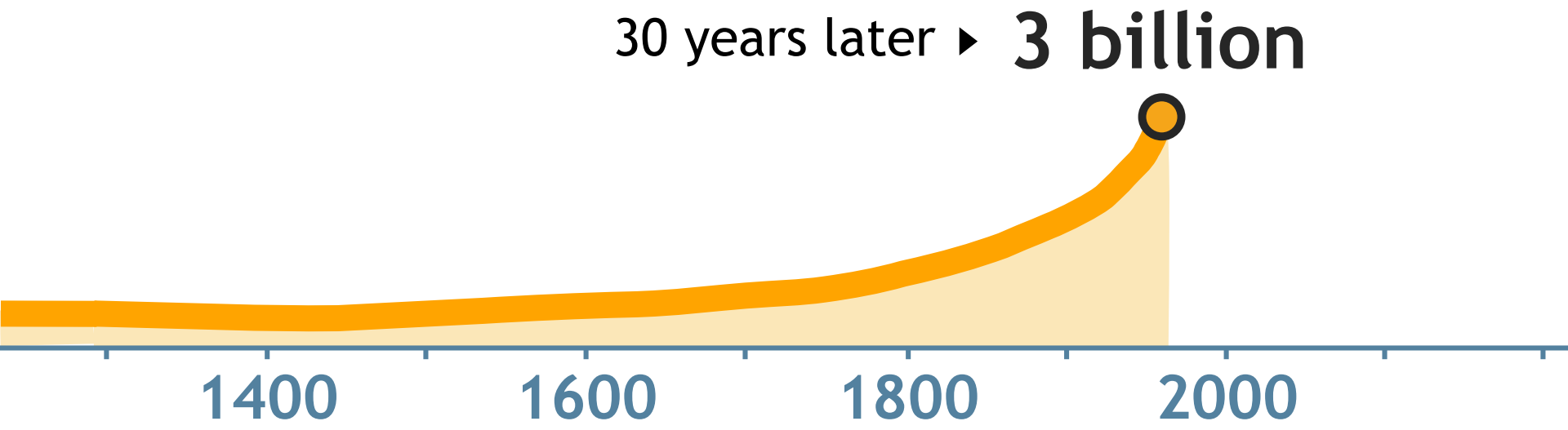
1930



Sources: Biraben 1980; McEvedy & Jones 1978; UN World Pop. Prosp. 2012; combined by Gapminder.

World population in year

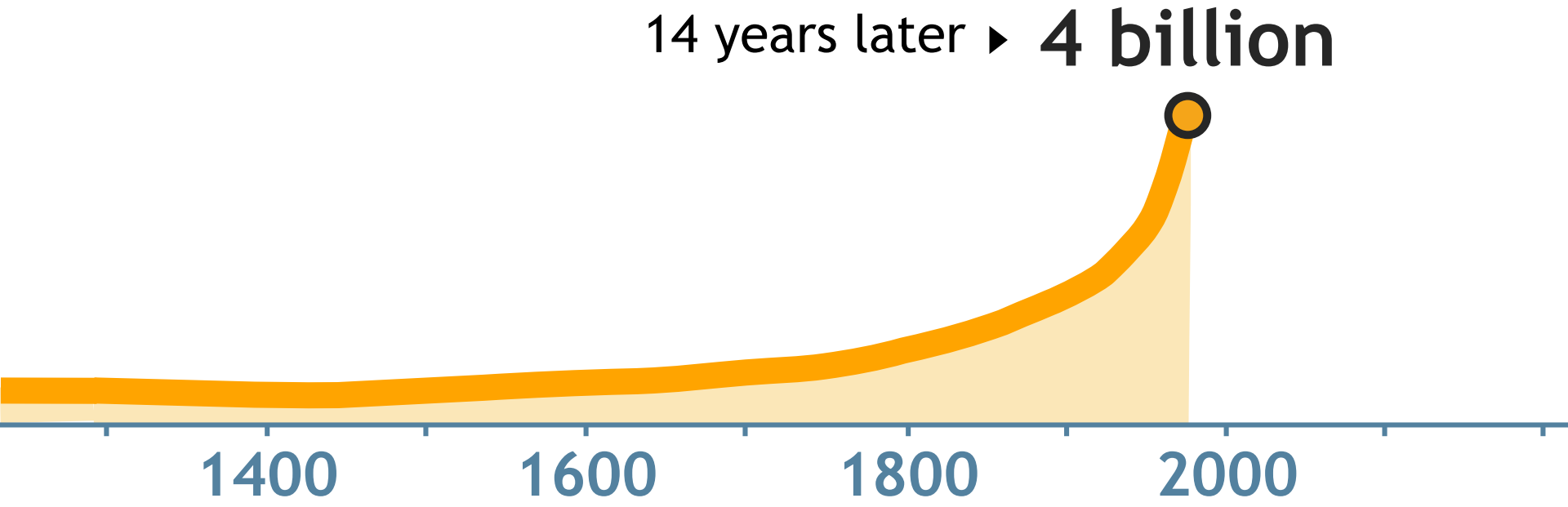
1960



Sources: Biraben 1980; McEvedy & Jones 1978; UN World Pop. Prosp. 2012; combined by Gapminder.

World population in year

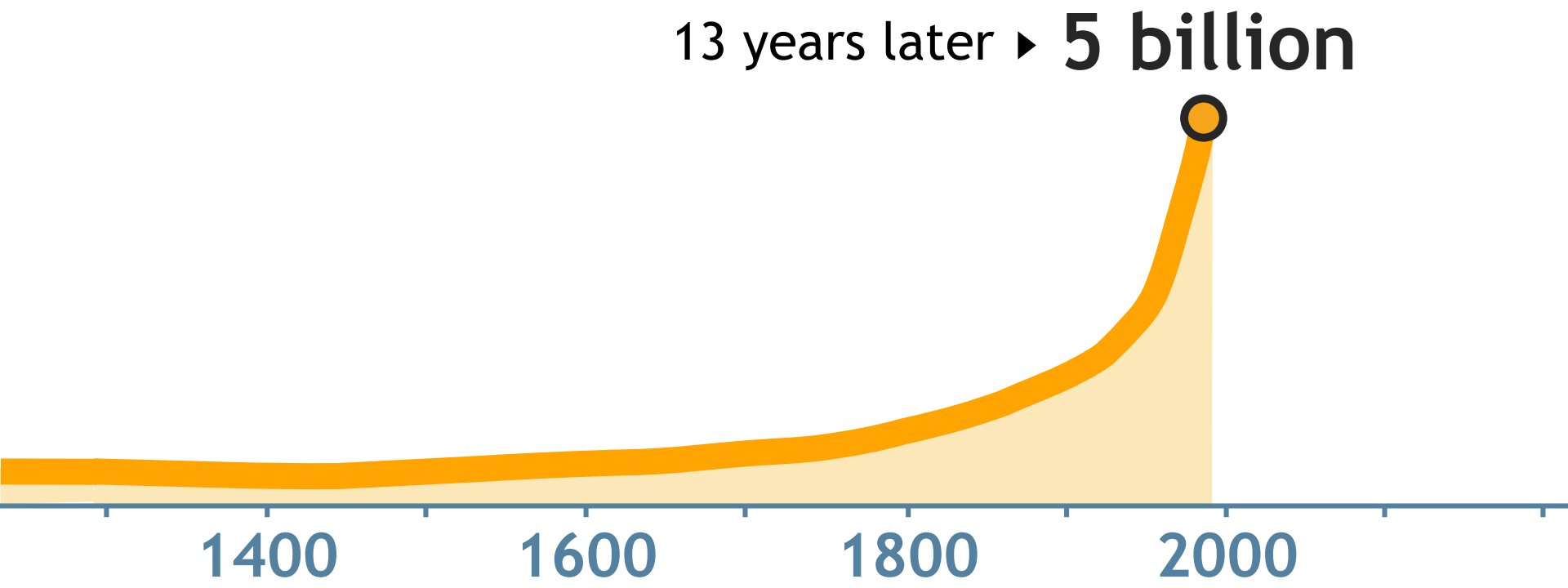
1974



Sources: Biraben 1980; McEvedy & Jones 1978; UN World Pop. Prosp. 2012; combined by Gapminder.

World population in year

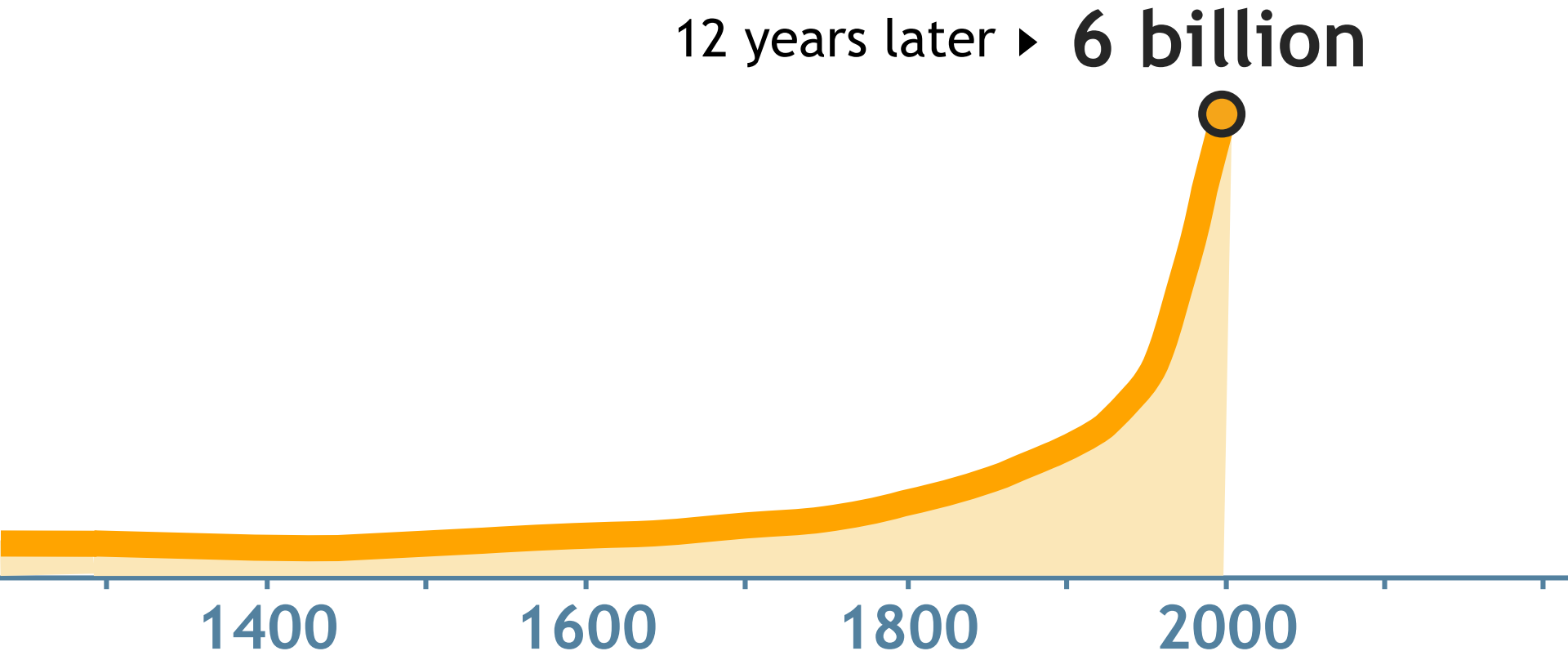
1987



Sources: Biraben 1980; McEvedy & Jones 1978; UN World Pop. Prosp. 2012; combined by Gapminder.

World population in year

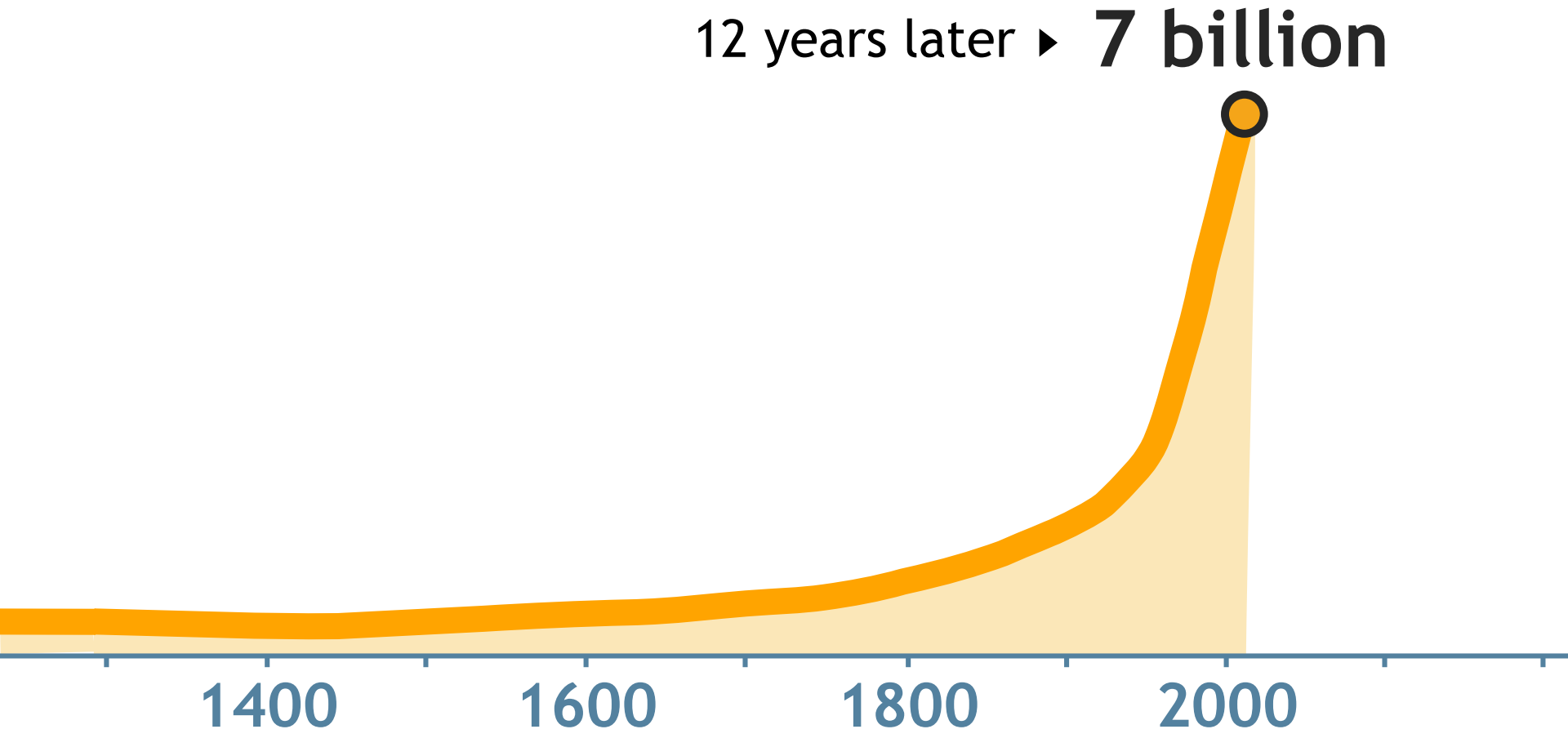
1999



Sources: Biraben 1980; McEvedy & Jones 1978; UN World Pop. Prosp. 2012; combined by Gapminder.

World population in year

2011

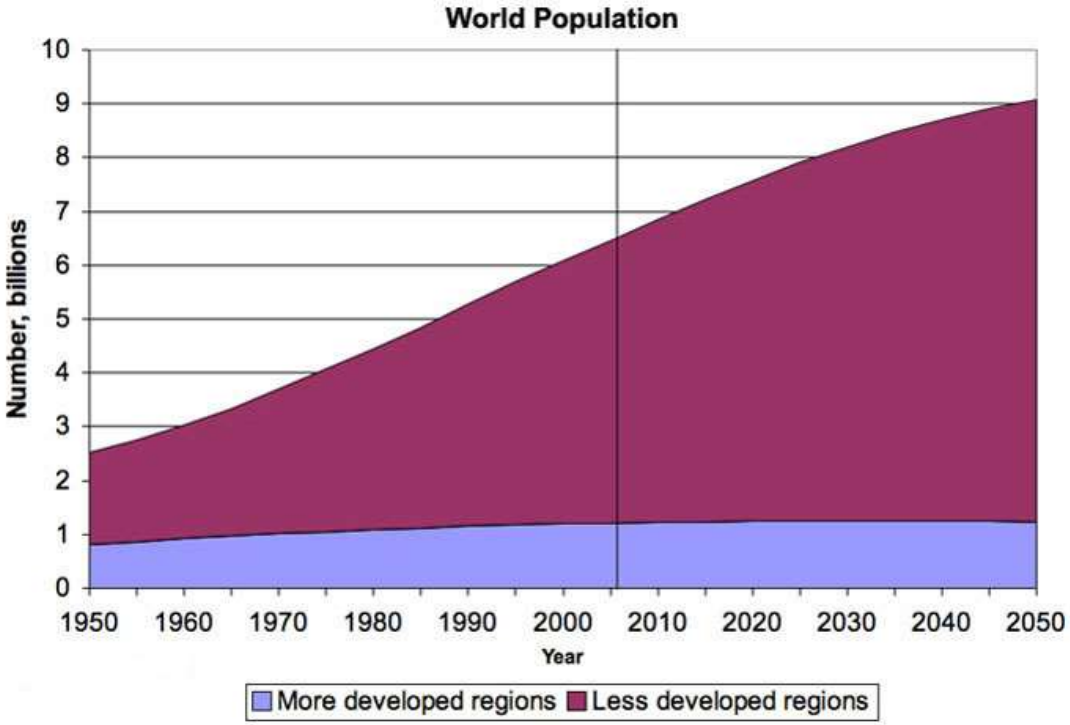


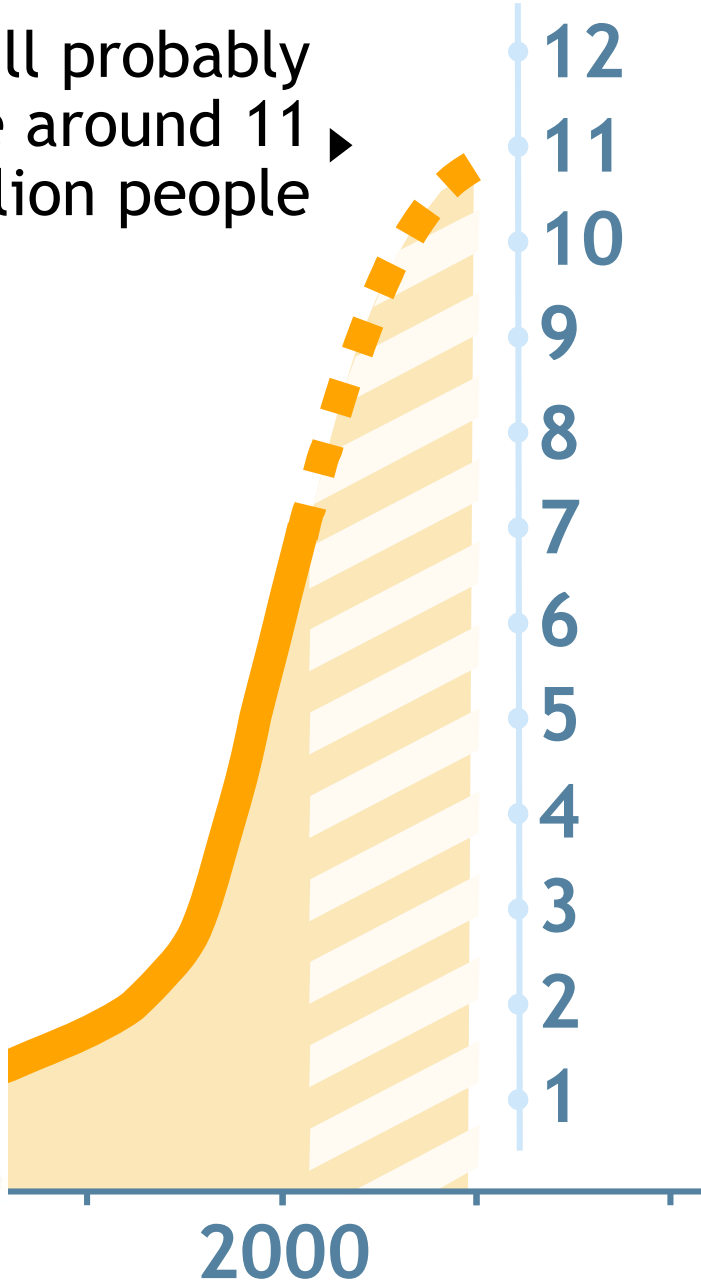
Sources: Biraben 1980; McEvedy & Jones 1978; UN World Pop. Prosp. 2012; combined by Gapminder.

UN World Population Forecast

Billion people

In 2100 there will probably be somewhere around 11 billion people





Sources: Biraben 1980; McEvedy & Jones 1978; UN World Pop. Prosp. 2012; combined by Gapminder.

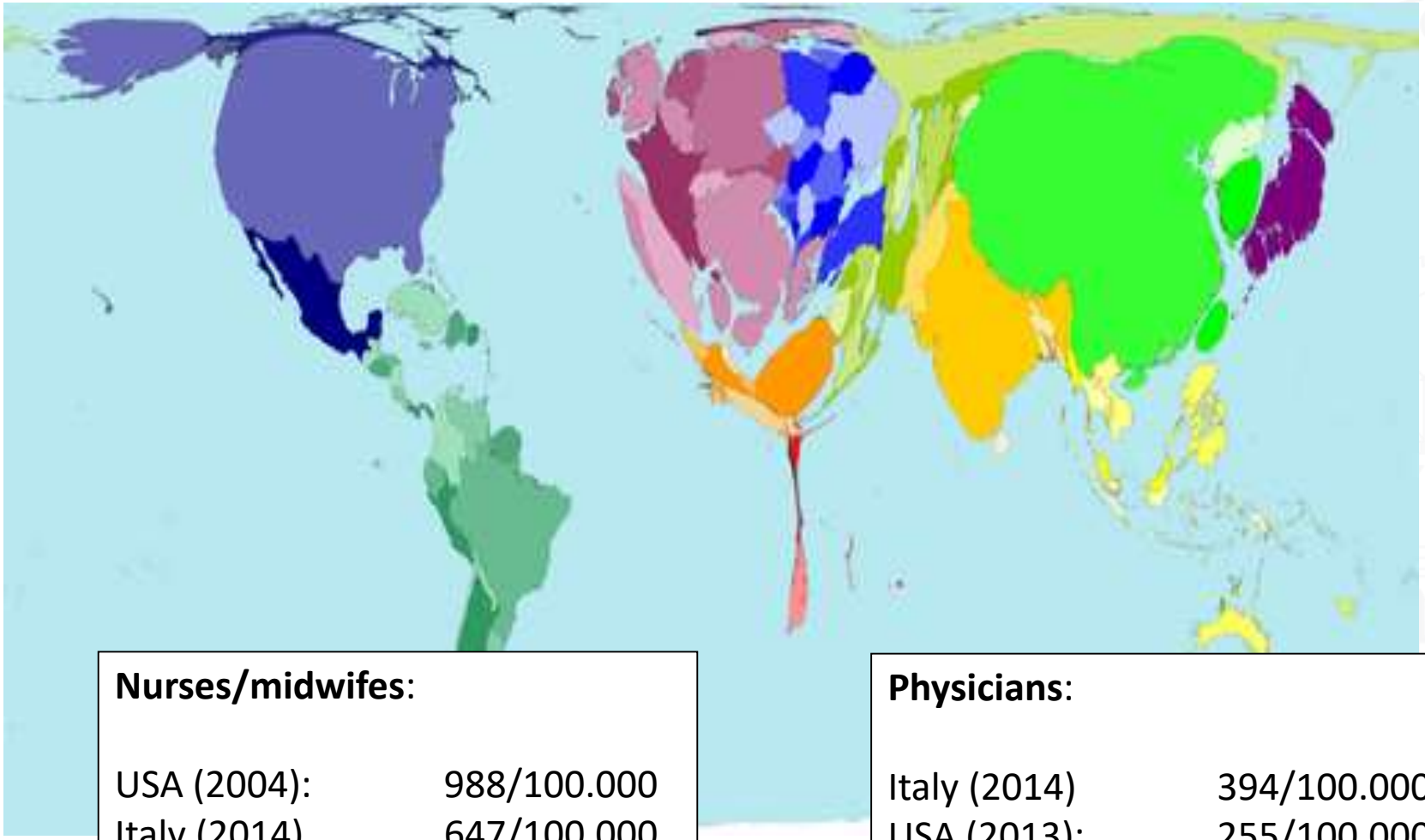
Will Saving Poor Children Lead to Overpopulation?

Short answer — No. The opposite.

Gapminder® Answers

https://www.gapminder.org/videos/will-saving-poor-children-lead-to-overpopulation/

Health force working in the world



Nurses/midwifes:

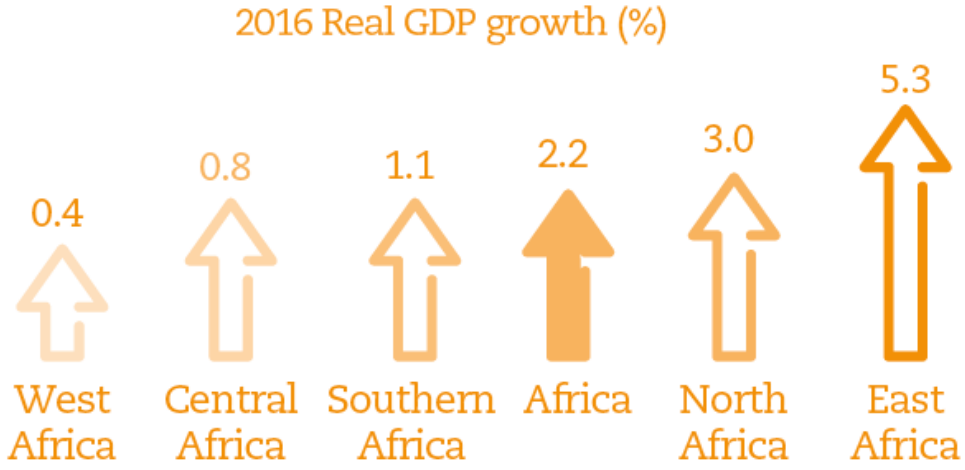
USA (2004):	988/100.000
Italy (2014)	647/100.000
Tanzania (2012:	43/100.000

Physicians:

Italy (2014)	394/100.000
USA (2013):	255/100.000
Tanzania (2012:	3/100.000

http://www.worldmapper.org/display.php?selected=219

East Africa maintains its lead in regional growth



African Economic Outlook 2017

SPECIAL THEME:
Entrepreneurship and Industrialisation

Figure 1.1. **Africa's economic growth, 2013-18**

Source: Adapted from AfDB Statistics Department data.
StatLink http://dx.doi.org/10.1787/888933474872

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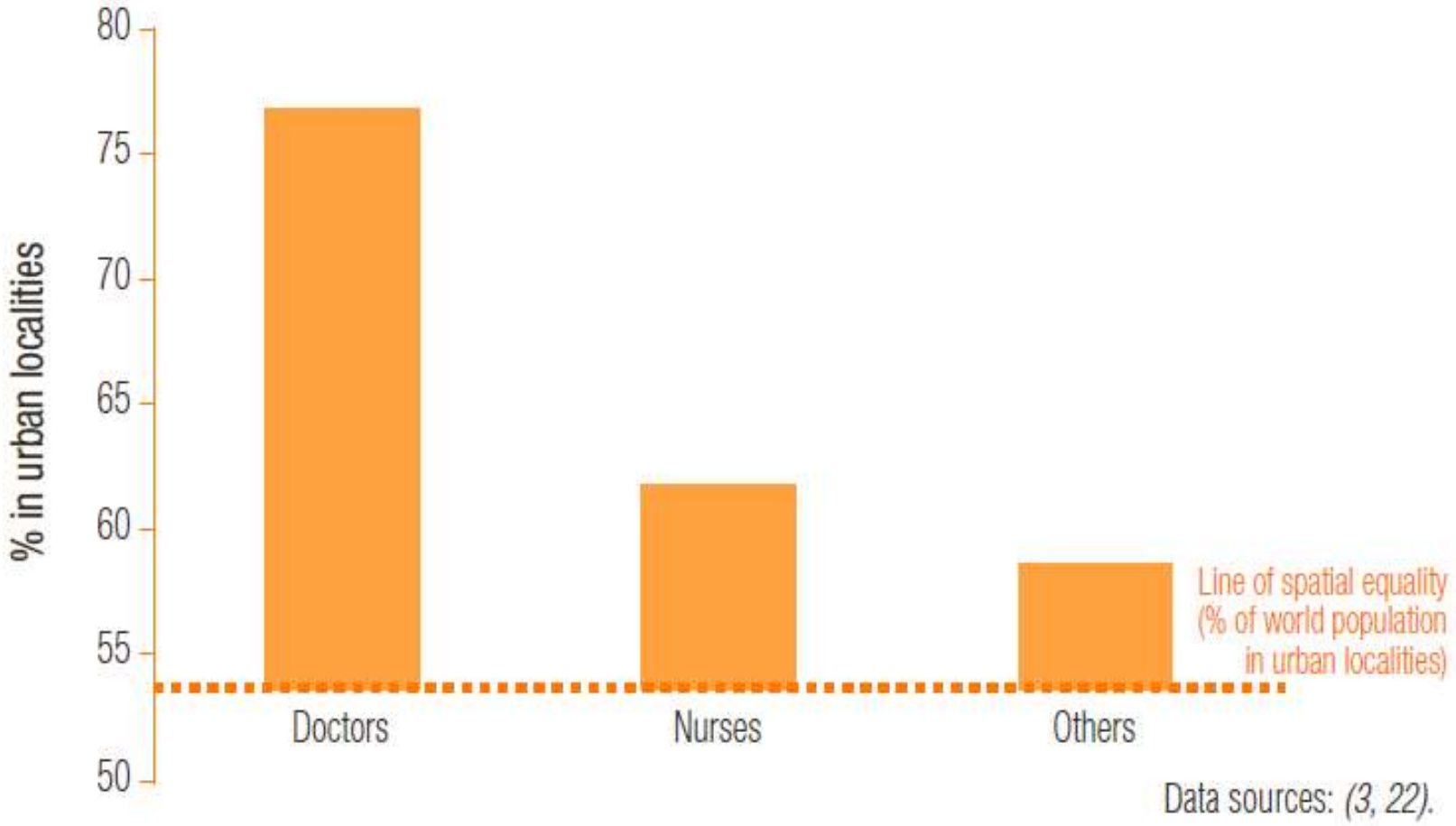
Rural-urban distribution of healthcare providers



Source: WHO, 2006
http://www.who.int/whr/2006/whr06_en.pdf

MDG region (in bold)	MMR[a]	Range of MMR uncertainty (80% UI)		Number of maternal deaths[b]	Lifetime risk of maternal death:[c] 1 in
		Lower estimate	Upper estimate		
World	216	207	249	303 000	180
Developed regions[d]	12	11	14	1 700	4 900
Developing regions	239	229	275	302 000	150
Northern Africa[e]	70	56	92	3 100	450
Sub-Saharan Africa[f]	546	511	652	201 000	36
Eastern Asia[g]	27	23	33	4 800	2 300
Eastern Asia excluding China	43	24	86	378	1 500
Southern Asia[h]	176	153	216	66 000	210
Southern Asia excluding India	180	147	249	21 000	190
South-eastern Asia[i]	110	95	142	13 000	380
Western Asia[j]	91	73	125	4 700	360
Caucasus and Central Asia[k]	33	27	45	610	1 100
Latin America and the Caribbean	67	64	77	7 300	670
Latin America[l]	60	57	66	6 600	760
Caribbean[m]	175	130	265	1 300	250
Oceania[n]	187	95	381	500	150

Trends in
Maternal Mortality
1990 to 2015
Estimates by WHO, UNICEF, UNFPA, World
and the United Nations Population Division

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Global health equity and climate stabilisation: a common agenda

Sharon Friel, Michael Marmot, Anthony J McMichael, Tord Kjellstrom, Denny Vågerö

Although health has improved for many people, the extent of health inequities between and within countries is growing. Meanwhile, humankind is disrupting the global climate and other life-supporting environmental systems, thereby creating serious risks for health and wellbeing, especially in vulnerable populations but ultimately for everybody. Underlying determinants of health inequity and environmental change overlap substantially; they are signs of an economic system predicated on asymmetric growth and competition, shaped by market forces that mostly disregard health and environmental consequences rather than by values of fairness and support. A shift is needed in priorities in economic development towards healthy forms of urbanisation, more efficient and renewable energy sources, and a sustainable and fairer food system. Global interconnectedness and interdependence enable the social and environmental determinants of health to be addressed in ways that will increase health equity, reduce poverty, and build societies that live within environmental limits.

Lancet 2008; 372: 1677–83

See Perspectives page 1625

Commission on Social Determinants of Health, International Institute for Society and Health, Department of Epidemiology and Public Health, University College London, London, UK (S Friel PhD, M Marmot PhD); **Commission on Social Determinants of Health and**

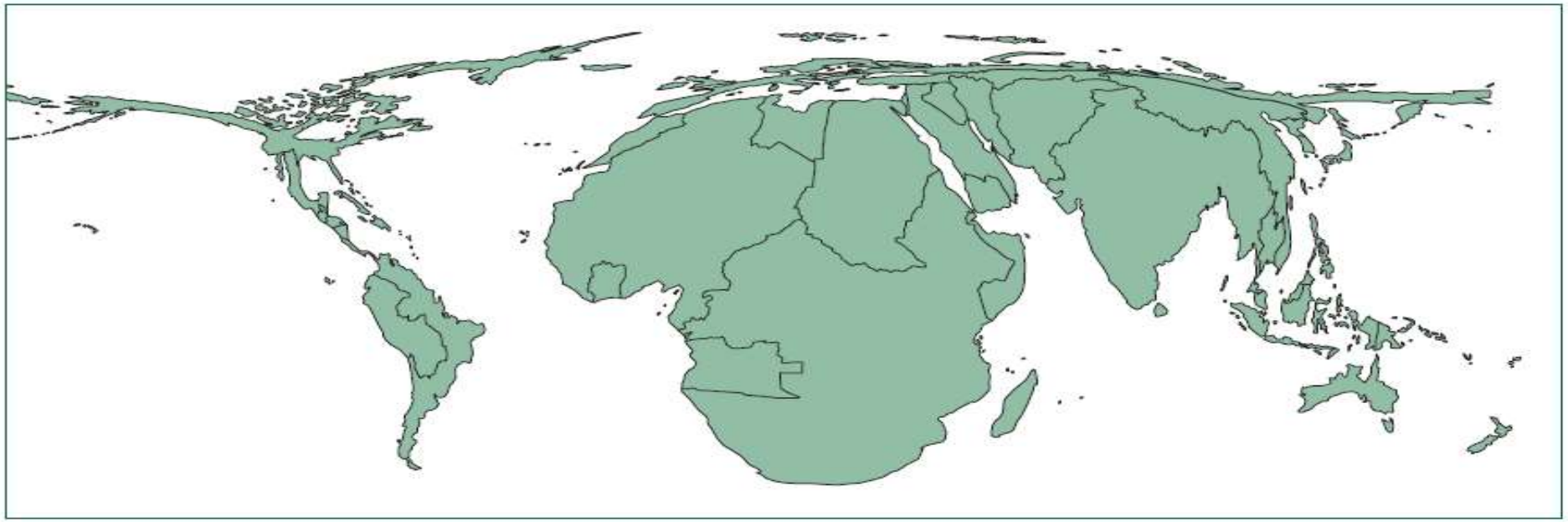

Figure 1: **Deaths attributable to anthropogenic climate change between 1970 and 2000, density-equalling cartogram[6]**

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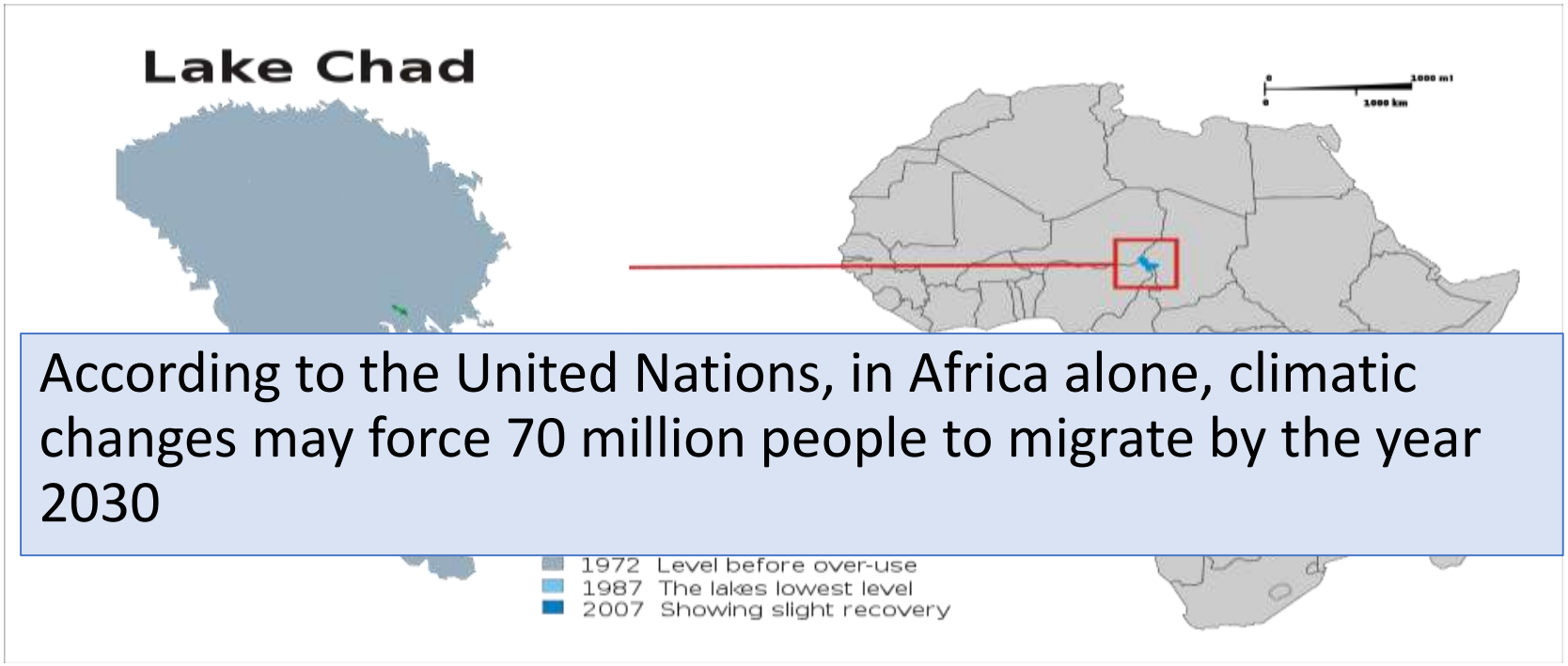
In the year 2000, climate changes have caused more than 150.000 deaths, all occurring in the poorest part of the world population, producing only 3% of greenhouse emissions



According to the United Nations, in Africa alone, climatic changes may force 70 million people to migrate by the year 2030

Lake Chad was about 25,000 square kilometers in surface area back in 1963. Now the lake is about one-twentieth the size it was in the mid 1960s

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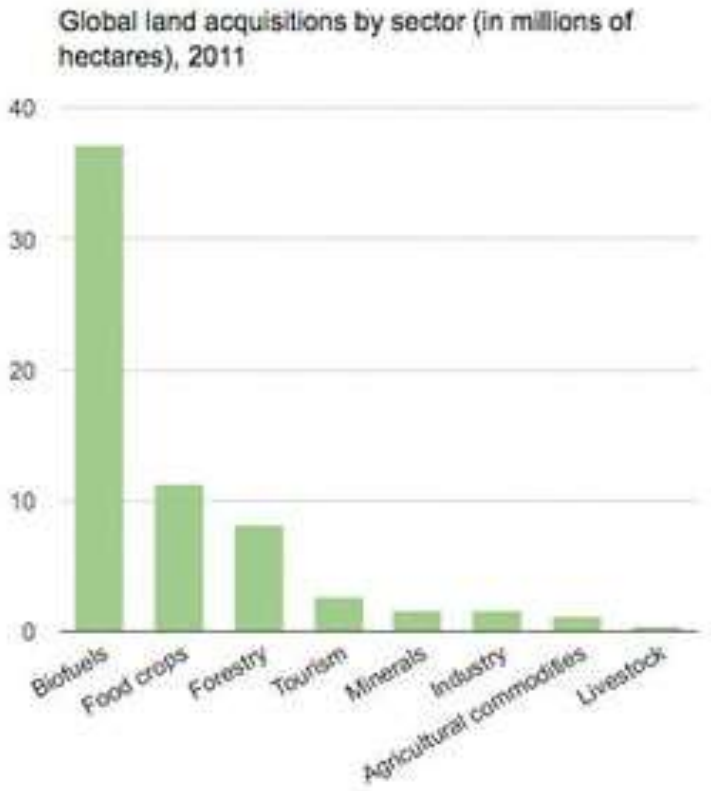

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Two hours walk to the Health Center …

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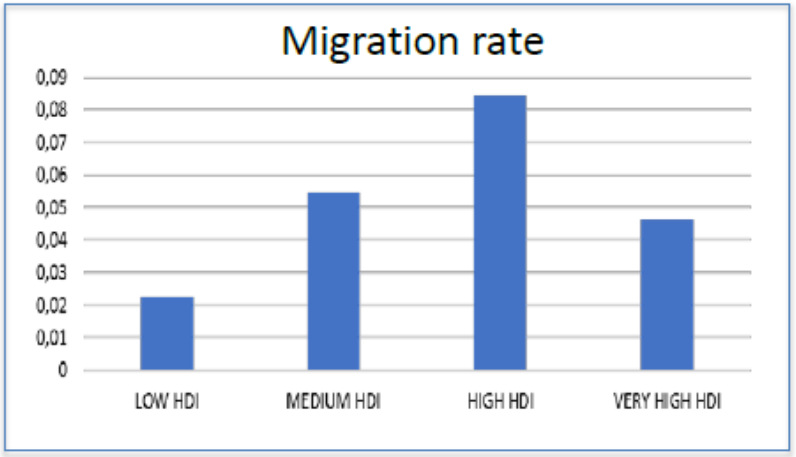
Economic migrants, refugees, asylum seekers… whom are we speaking about?

Migration patterns over time

Outline spectrum of health needs and variation by migrant group

Conclusions: relevant variables

- The same variables remain in all the regressions → robustness
- Distance and border: geographical structures (negative and positive coefficients)
- Expected GDP destination at destination: economic pull (positive coefficient)
- **Expected degree of education in the area of origin** (migrant selectivity) (highly positive)

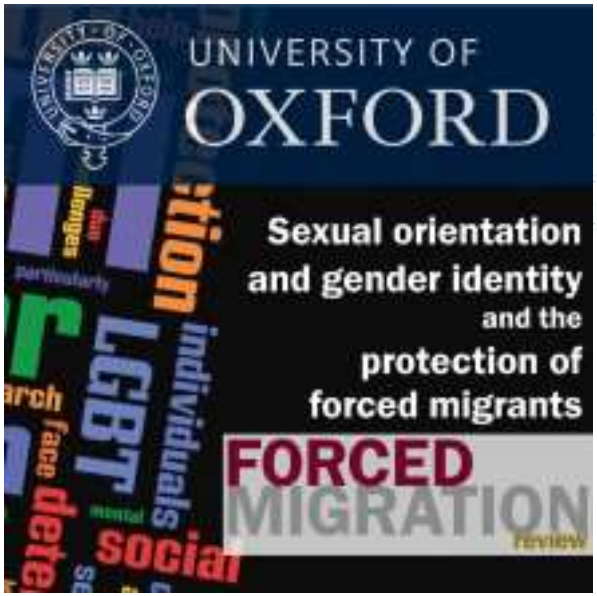


There is a known NONLINEAR relation between some of the considered variables (e.g. education, GDP origin) and migration rates that calls for different modelling approaches.

Revista do Direito
https://online.unisc.br/seer/index.php/direito/index
ISSN on-line: 1982 - 9957
DOI: 10.17058/rdunisc.v1i51.9442

MIGRATION DUE TO SEXUAL ORIENTATION AND GENDER IDENTITY

MIGRAÇÃO EM RAZÃO DE PERSEGUIÇÃO POR ORIENTAÇÃO SEXUAL OU IDENTIDADE DE GÊNERO



Daniel Braga Nascimento[1]
Emilie de Haas[2]
Roberta Camineiro Baggio[1]

Abstract: The concept of the term refugee is set out in Art. 1, item I of the Law 9.474 / 97 of the Foreign Statute of Brazil, which defines a refugee as any individual with a well-founded fear of persecution due to race, religion, nationality, political opinion or social group. The Convention of 1951 does not establish a specific category for persecution related to sexual orientation or gender identity. In many countries homosexuality is punished by imprisonment, or the death penalty (Saudi Arabia, Iran, Yemen, Mauritania and Sudan, as well as in regions of Nigeria and Somalia), among other penalties that deny full citizenship, segregate, discriminate and deny rights to this group. Due to the persecution these individuals suffer in their home countries, it is possible to ask: were gay, lesbian, bisexual, transgender and intersex individuals included in the social group category due to its flexible criteria? The United States, Canada and several European countries have been accepting refugee applications for individuals with well-founded fear of persecution because of their sexual orientation or gender identity. By employing this criterion, the CONARE (National Committee for Refugees of Brazil) has granted refuge to gay, lesbian, bisexual, transgender and intersex individuals who are persecuted in their home countries due to their sexual orientation or gender identity. This article explores the concept of the term refugee and its expansion over the past years, focusing especially on the basis of the refugee criterion related to social group. The aim is therefore to analyze the category of social group in the concept of refugee. It also aims to examine the possibility of framing said populations in the category of social group in order to facilitate their obtainment of a Refugee status.

Keywords: Asylum. LGBT. Migration. Persecution. Refugees.

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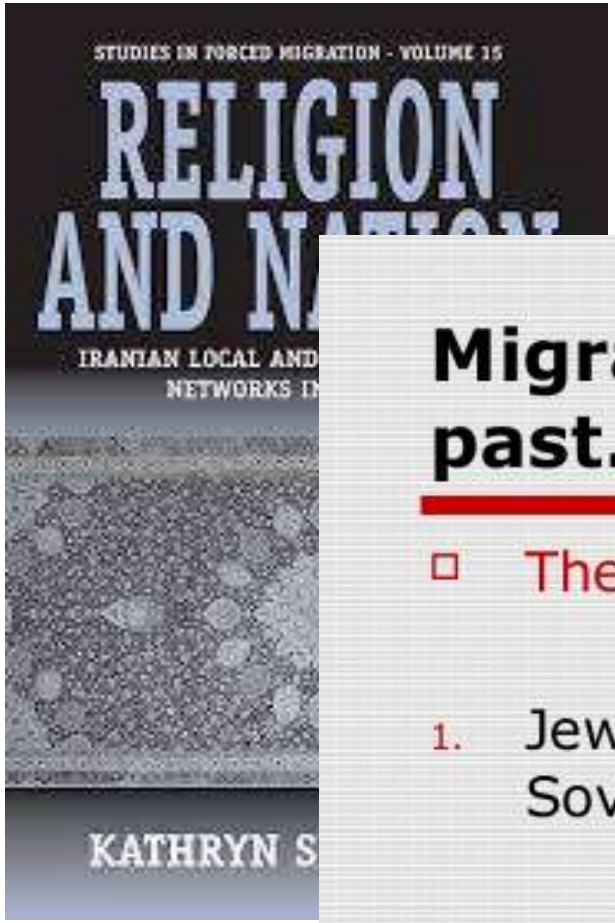

Migration: Peeping through the past...

- The near past

1. Jewish migrations from Germany or Post Soviet Jewish migrations to Israel.
2. Muslim migrations from India
3. Hindus and Sikhs being forced to migrate

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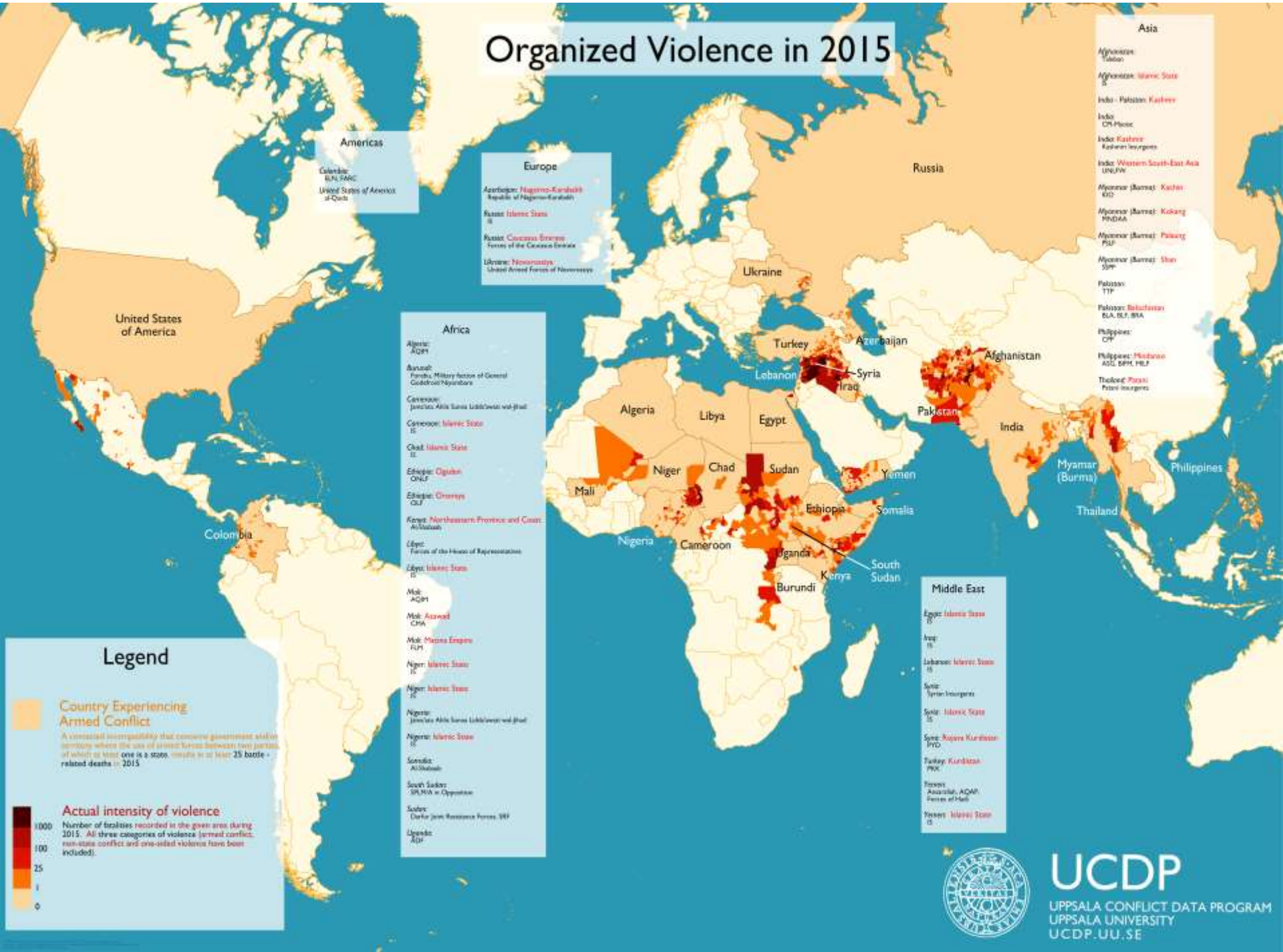
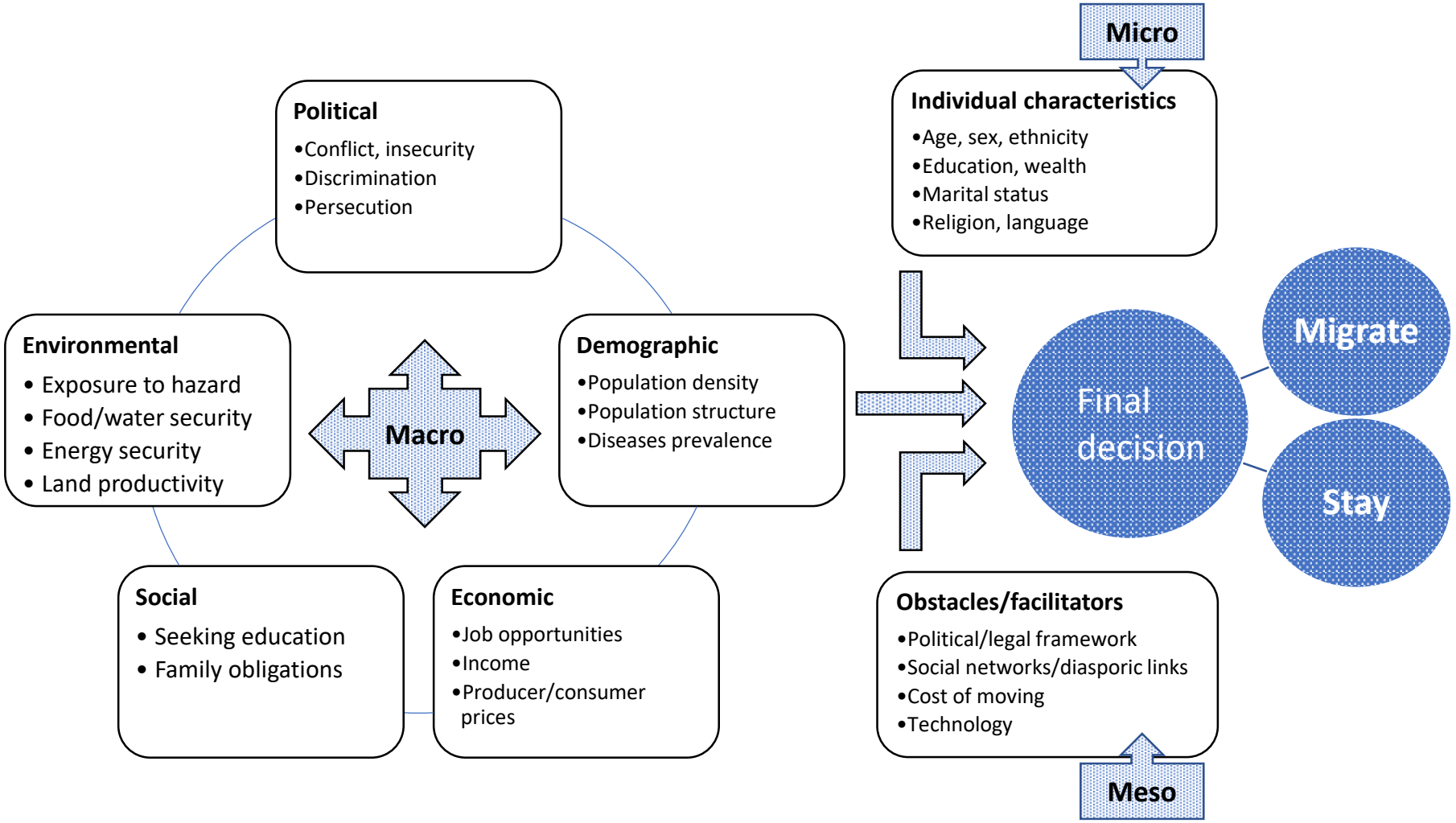
Organized Violence in 2015



UCDP

UPPSALA CONFLICT DATA PROGRAM
UPPSALA UNIVERSITY
UCDP.UU.SE

Complex drivers of migration: macro-, meso- and micro-factors



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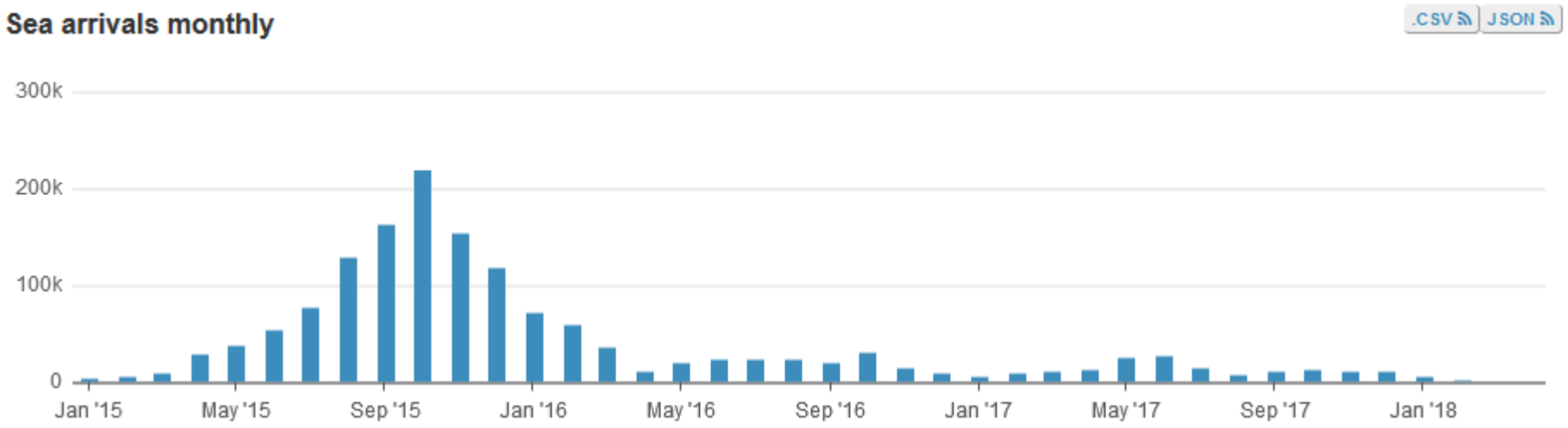
Foresight: Migration and Global Environmental Change (2011) Final Project Report The Government Office for Science, London, modified

https://www.google.it/search?q=enea&espv=2&biw=1440&bih=849&site=webhp&source=lnms&tbm=isch&sa=X&ved=0ahUKEwjAwo_amo3KAhXHXhoKHb8IBLIQ_AUIBygC&dpr=1.5#imgrc=i1EFXq0ervCM4M%3A

Arrivi via mare in Italia



Marzo 2016,
Accordo UE-Turchia

Febbraio 2017,
Accordo di Malta

Fonte: UNHCR (visitato il 13.3.2018)
http://data2.unhcr.org/en/situations/mediterranean

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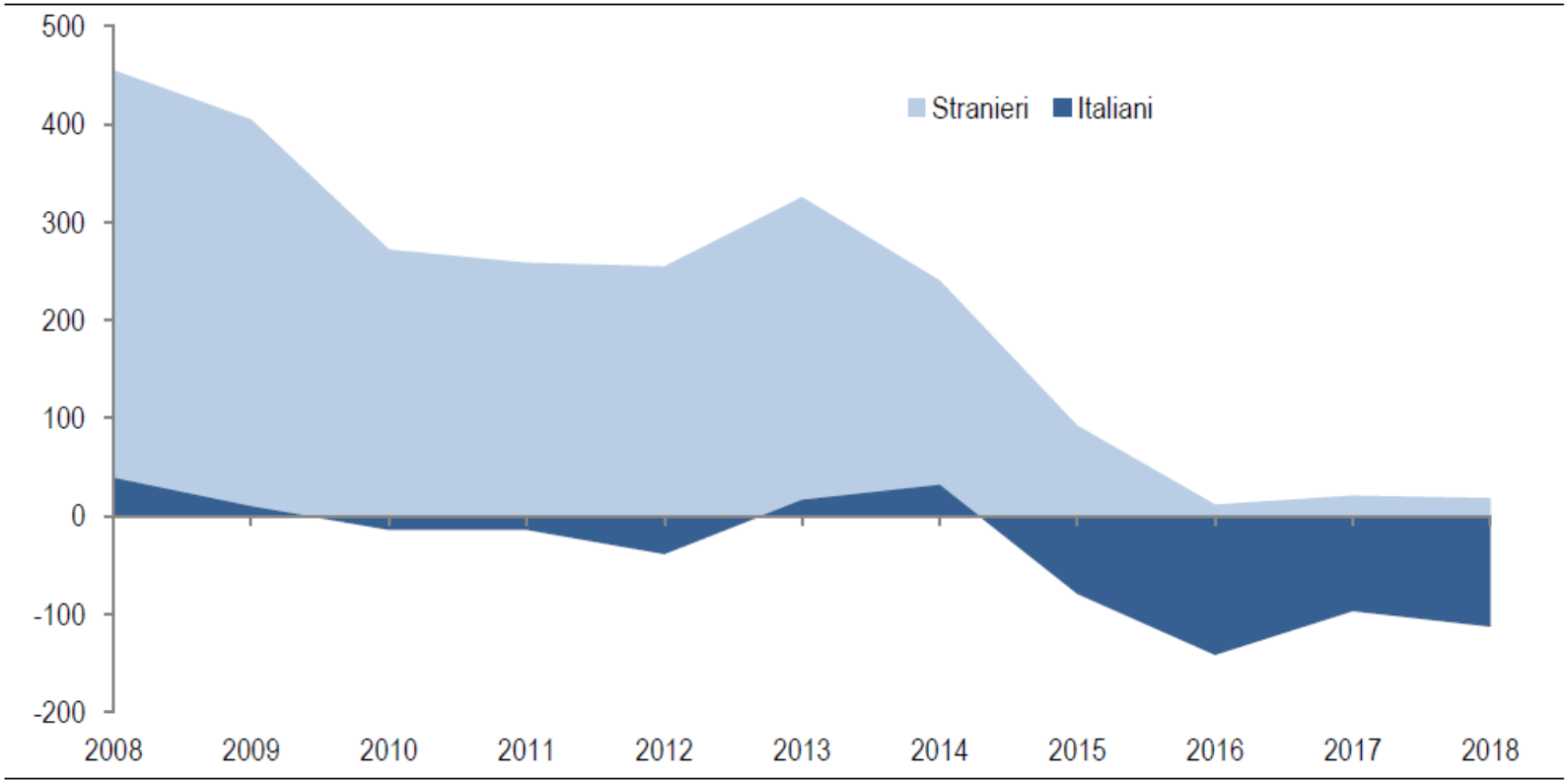
Variazione annuale della popolazione residente di cittadinanza italiana e straniera – Italia

Dati ISTAT 1 gennaio 2008-2018, valori in migliaia



(*) 2018 stima.

Fonte: ISTAT, Indicatori demografici, 2017, 8 febbraio 2018, pagina 10, http://www.istat.it/it/archivio/208951 (accesso il 13.3.2018)

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Stranieri residenti in Italia

- N = 5.065.000 (8,4% della popolazione residente)
- Genere femminile = 52,4%
- Provenienza europea = 51,7%
- Primi 5 paesi:
  - Romania, Albania, Marocco, Cina, Ucraina
- Religione = cristiana 53,3%, musulmana 32,6%

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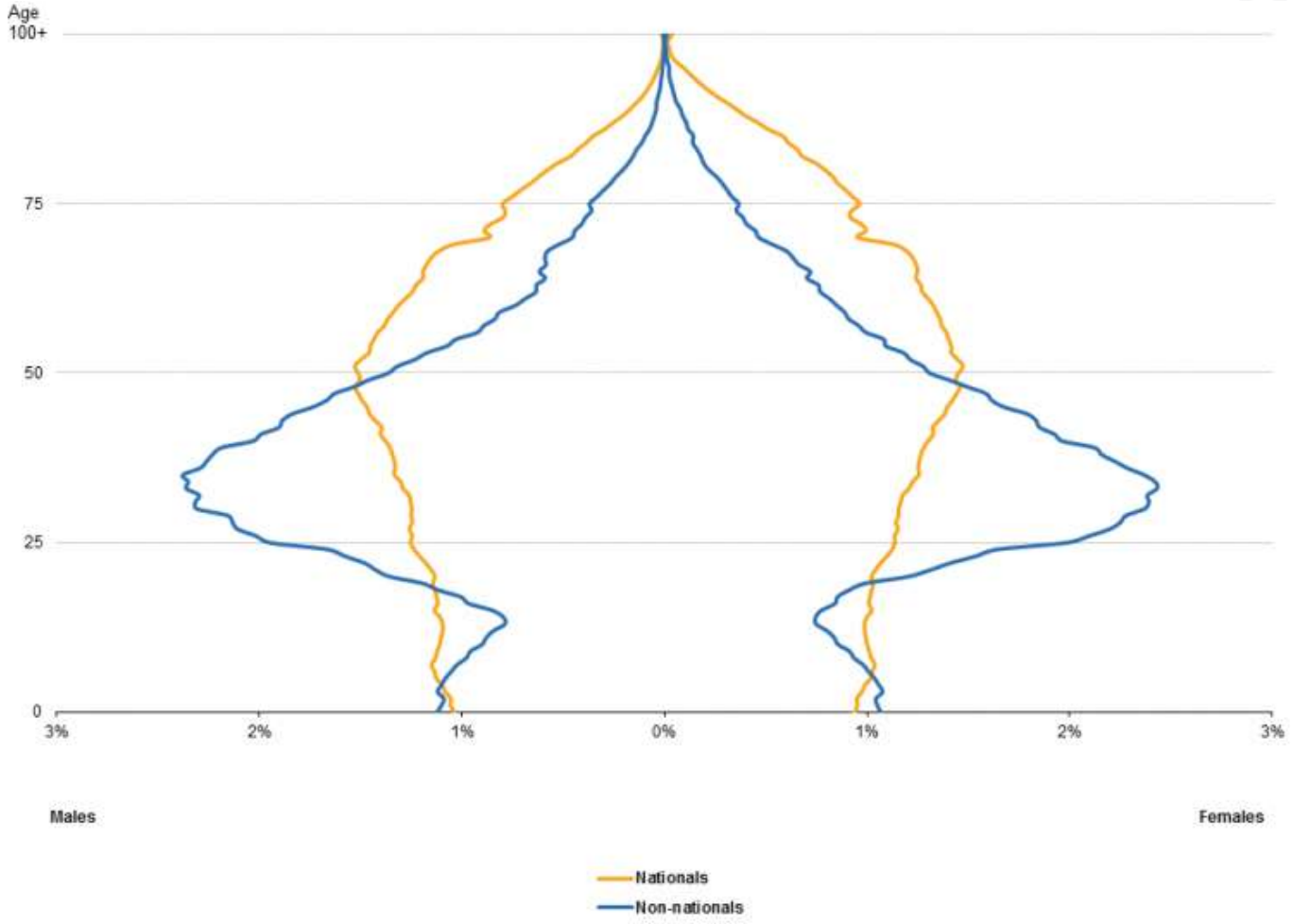
Fonte: Centro Studi e Ricerche IDOS, Dossier statistico immigrazione, 2017, pagina 13

Age structure of the national and non-national populations, EU-28, 1 January 2016 (%)



Source: Eurostat (online data code: migr_pop2ctz)

http://ec.europa.eu/eurostat/statistics-explained/index.php/Migration_and_migrant_population_statistics

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Non communicable diseases in migrants

- *Prevalence of risk factors and disease in the country of origin*
- *Genetic factors*
- *Lifestyle and behavior*
- *Cultural factors*
- *Access to prevention and care*

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Determinanti di salute

Determinanti sociali

Determinanti prossimali

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Determinanti di salute

Determinanti sociali

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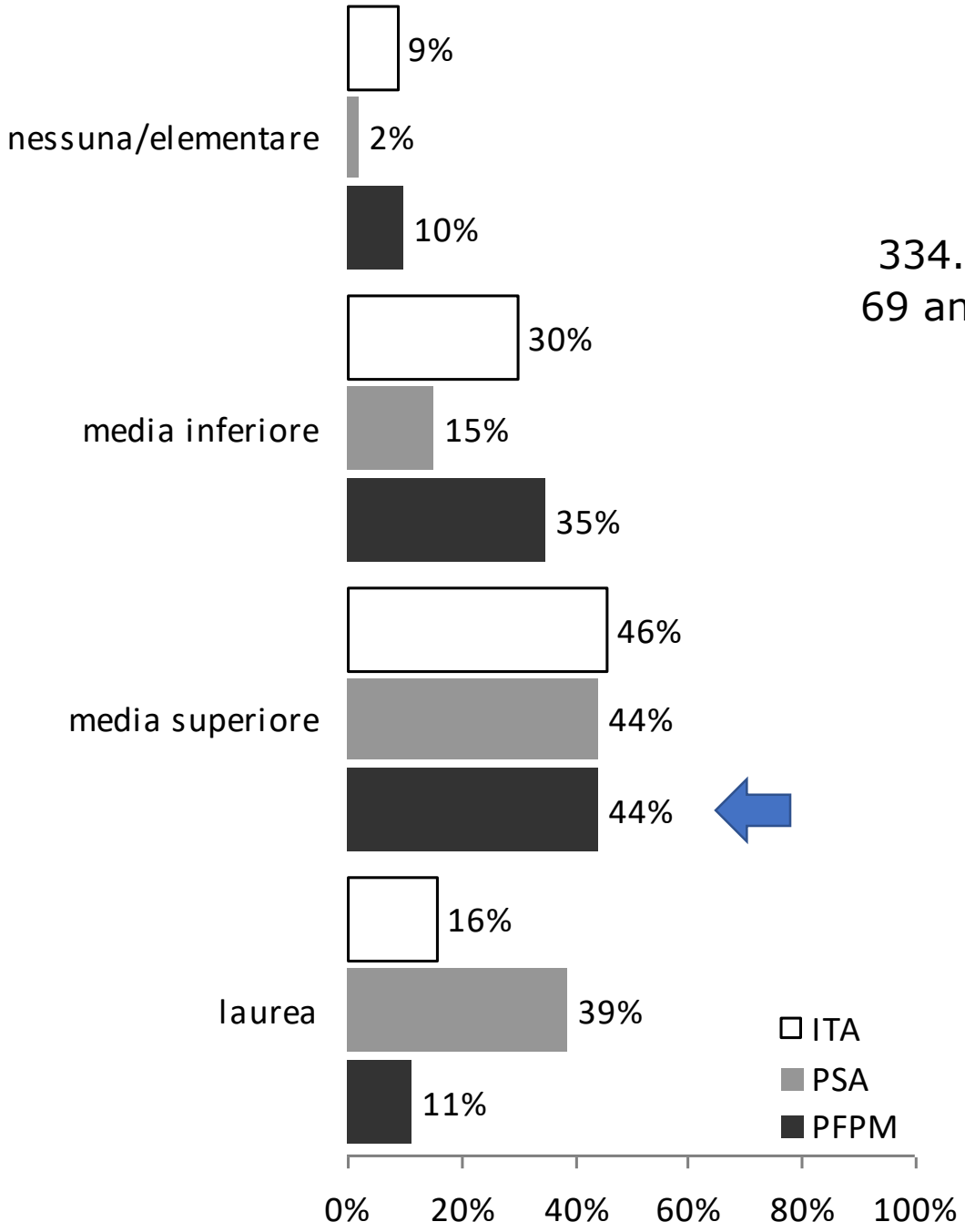
Istruzione

Sistema PASSI 2008-2016

334.567 interviste a persone tra 18 e 69 anni di età di cui 15.277 a stranieri



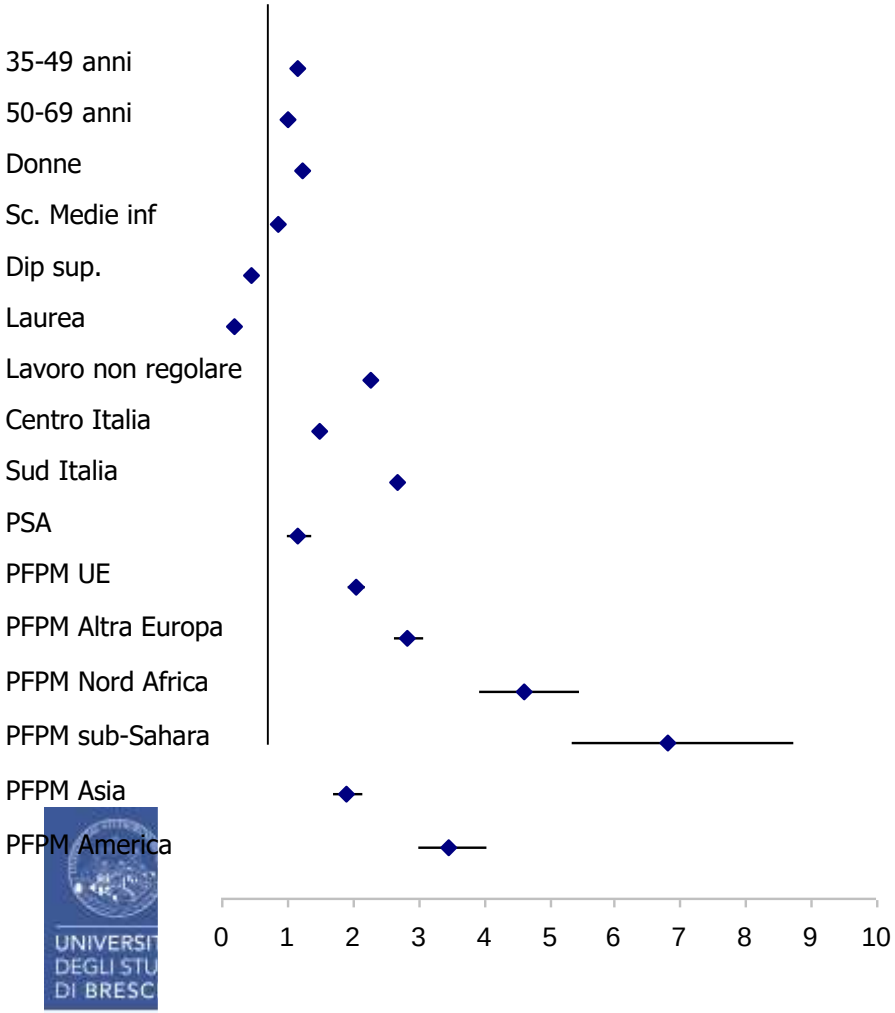
PSA = paese di sviluppo avanzato

PFPM = paese a forte pressione migratoria

Lavoro

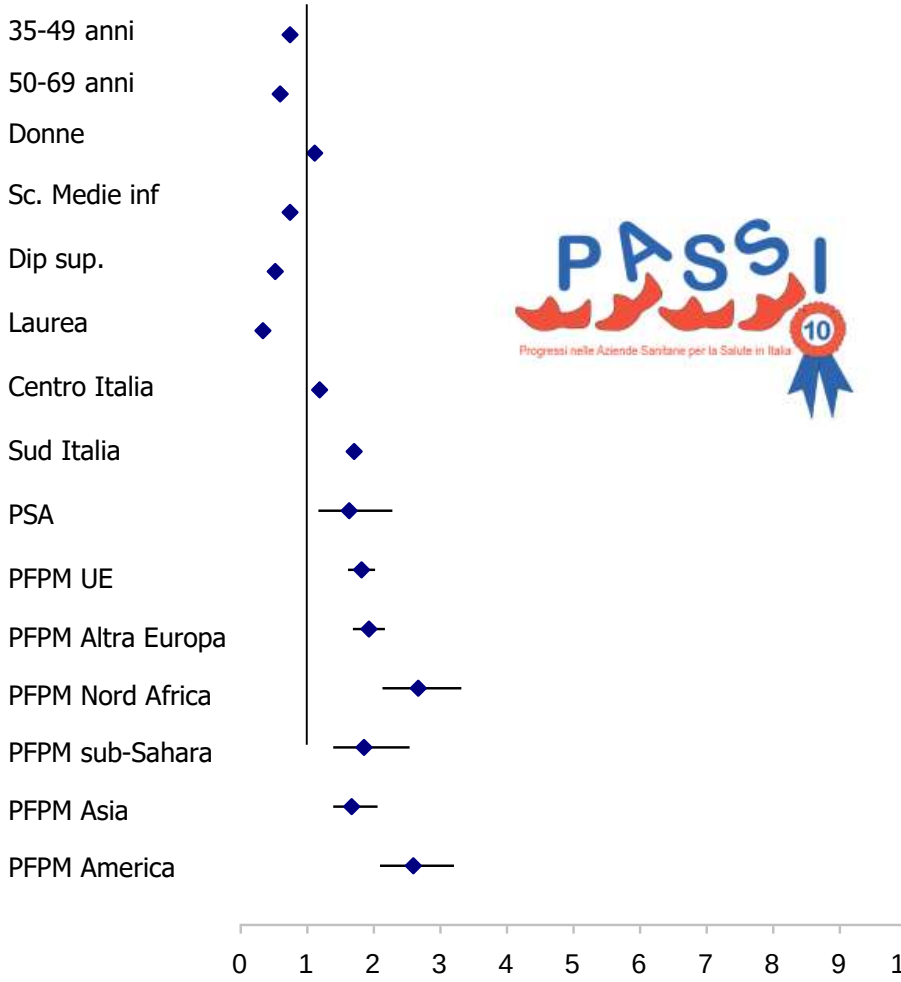
Difficoltà economiche

(su tutti i lavoratori italiani e stranieri)



Paura di perdere il lavoro

(su tutti i lavoratori *regolari* italiani e stranieri)

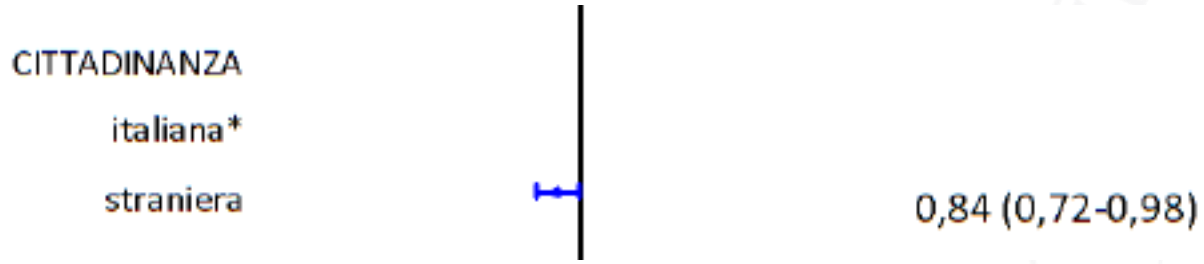


PASSI 10
Progressi nelle Aziende Sanitarie per la Salute in Italia

Lavoro

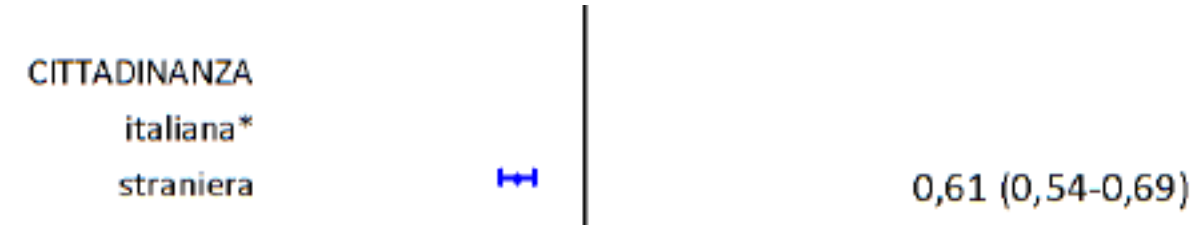
Regressione logistica per l'uso dei dispositivi di protezione individuale (%)

PASSI 2010-12



Regressione logistica per l'aver ricevuto informazioni su come prevenire gli infortuni sul lavoro e/o le malattie professionali (%)

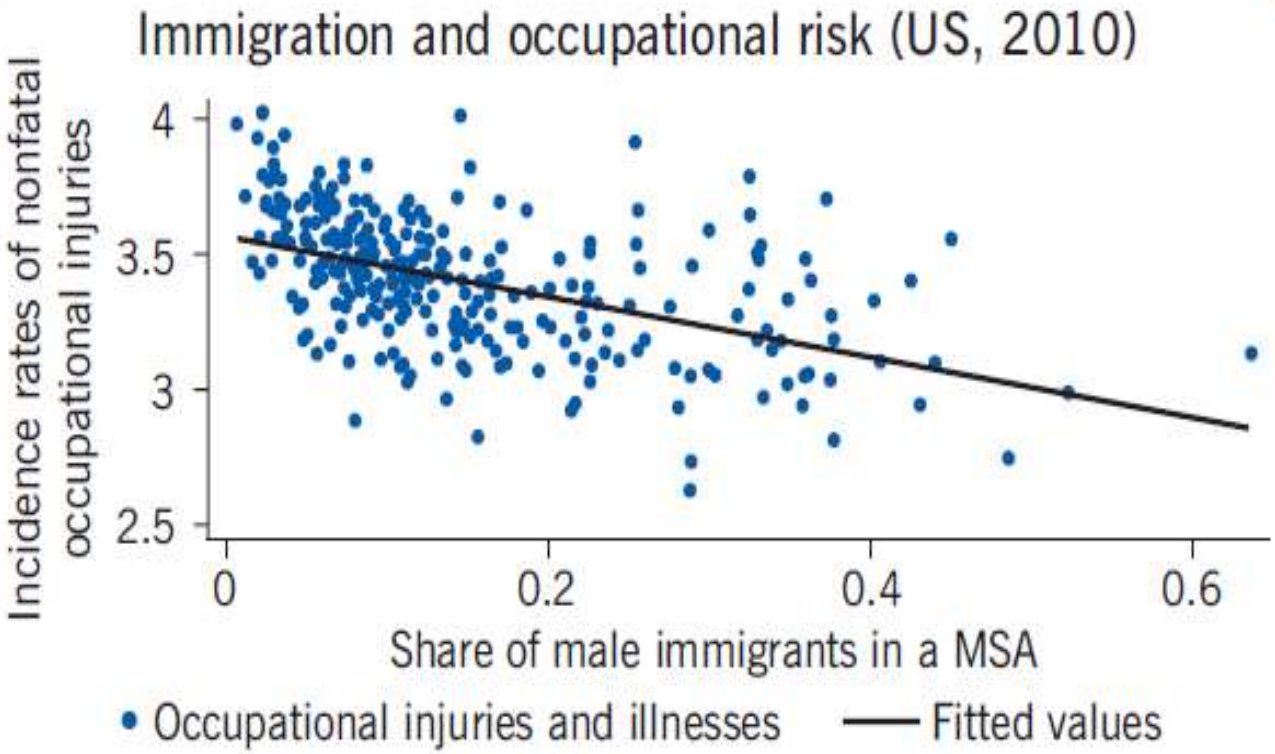
PASSI 2010-12



Do immigrants improve the health of native workers?

Immigration crowds native workers out of risky jobs and into less strenuous work, with consequent benefits to their health

Keywords: immigration, occupational choice, job quality, health

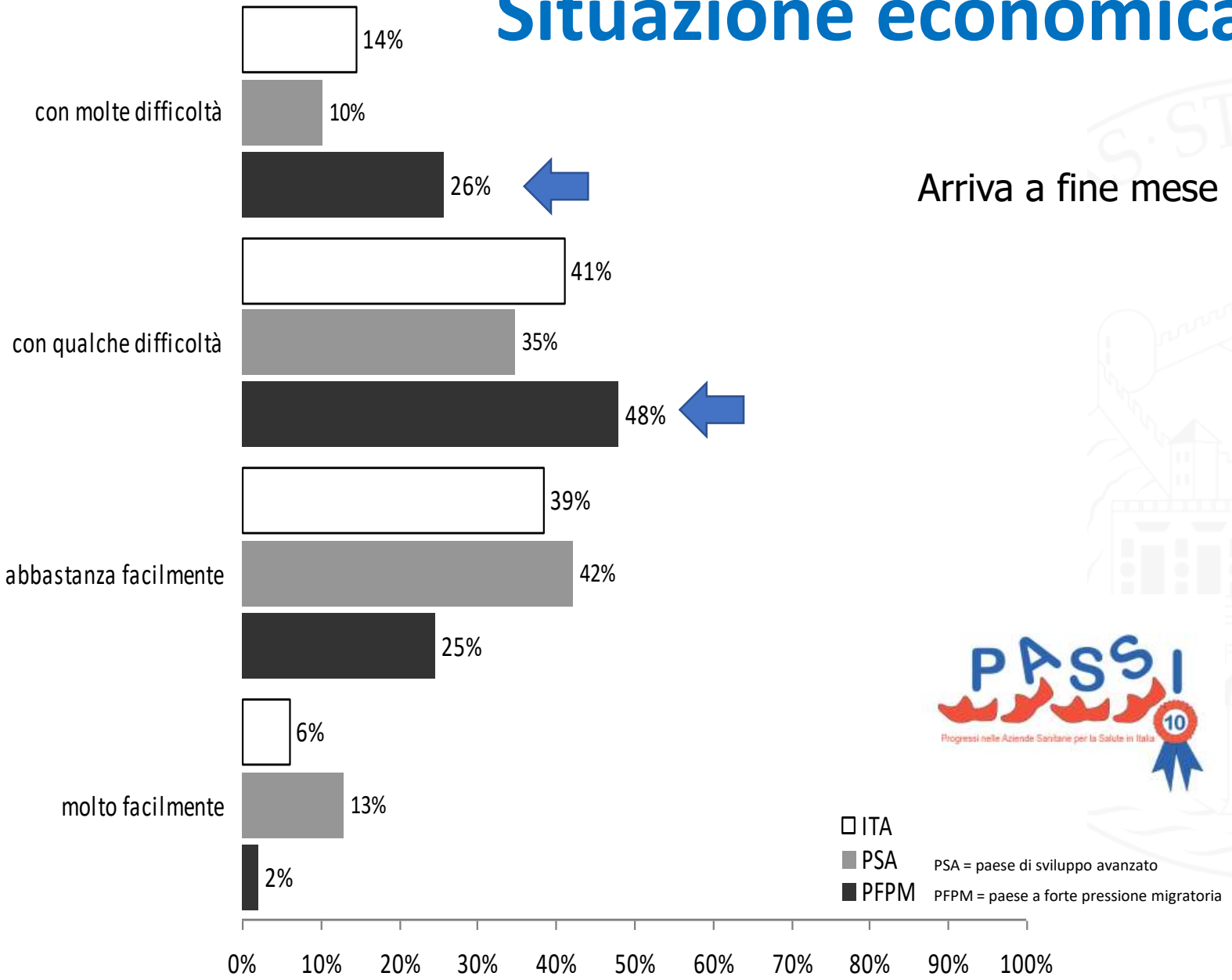


Source: Author's calculations based upon Industry Injury and Illness Data (Bureau of Labor Statistics, 2010), and the American Community Survey (2010).

OSEA GIUNTELLA
University of Oxford, UK, and IZA, Germany

Situazione economica

Arriva a fine mese



PASSI 10
Progressi nelle Aziende Sanitarie per la Salute in Italia

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Determinanti di salute

Determinanti prossimali

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Cosa mangiano gli immigrati?

Alimentazione	
Piatti tipici del tuo stato di origine o di un altro stato estero	13,4
Piatti tipici italiani	32,9
In egual misura piatti italiani e di stato di origine o altro stato estero	53,7

, Fonte: Alessio Petrelli Anteo Di Napoli, Alessandra Rossi, Daniele Spizzichino, Gianfranco Costanzo, Monica Perez, Sovrappeso e obesità nella popolazione immigrata adulta residente in Italia, Epidemiol Prev 2017; 41 (3-4) Suppl 1: 26-32.

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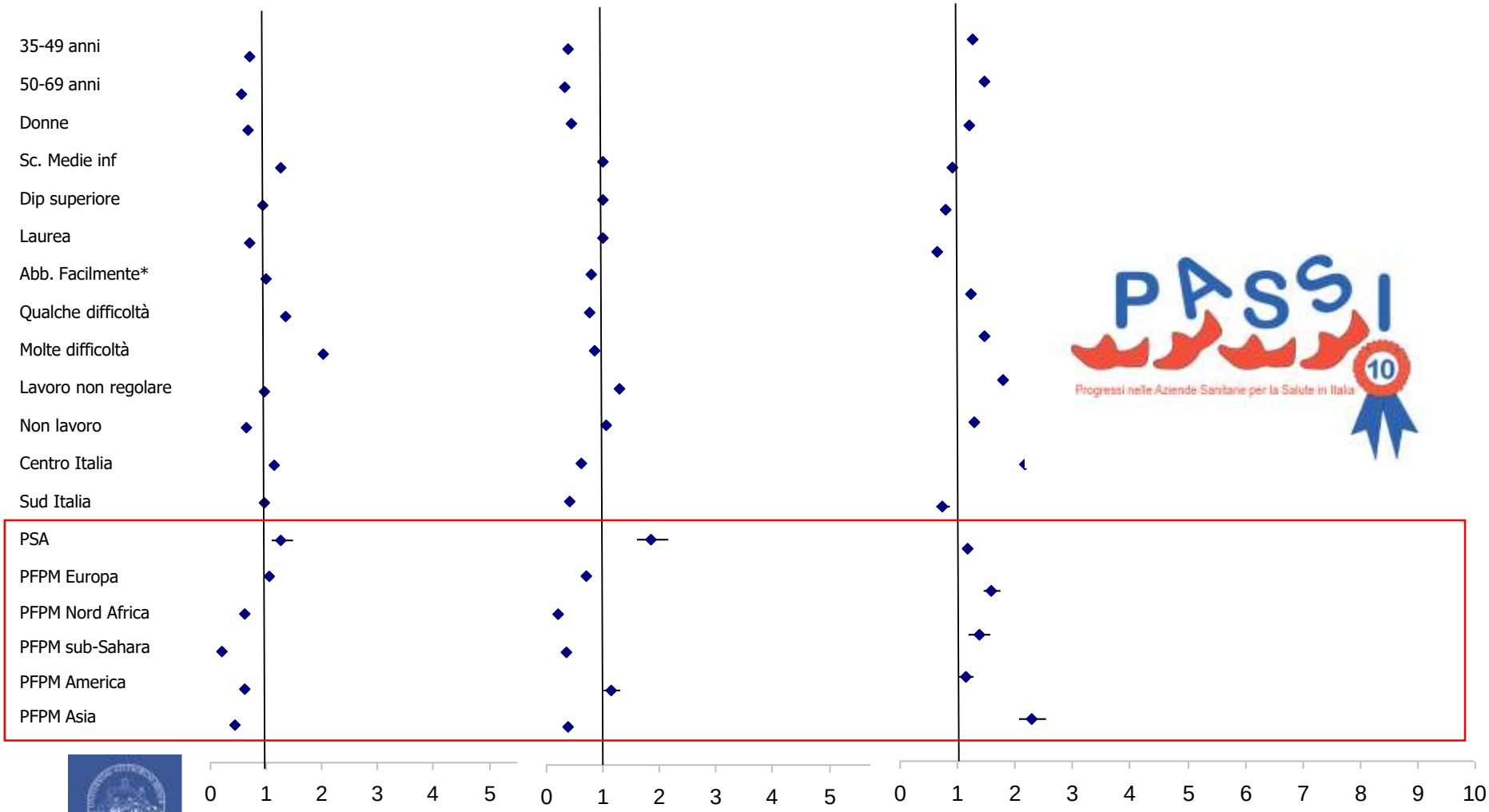
Fumo Alcool Sedentarietà



PASSI 10
Progressi nelle Aziende Sanitarie per la Salute in Italia

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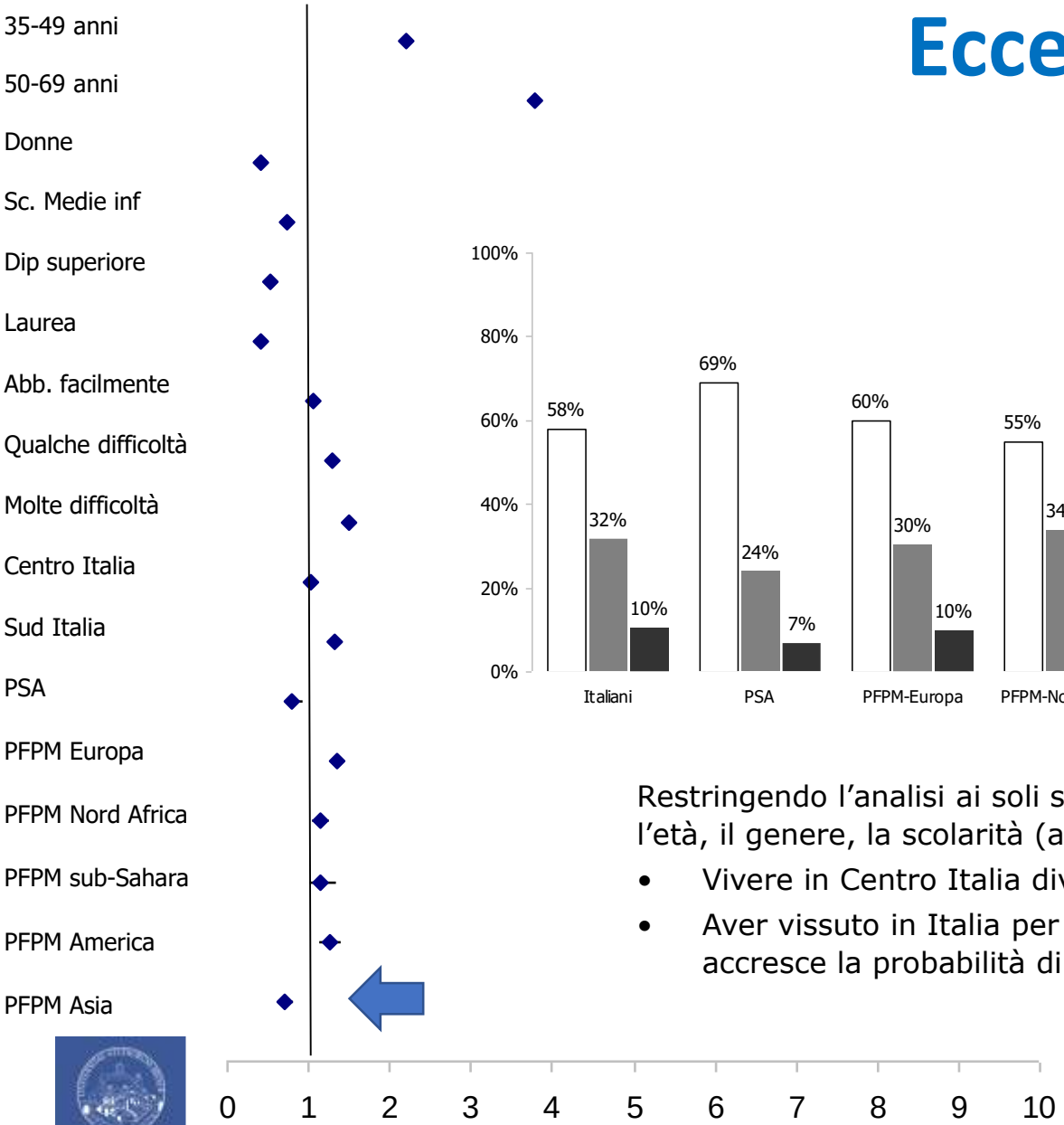
* non significativo

Eccesso ponderale



Restringendo l'analisi ai soli stranieri PFPM restano significative: l'età, il genere, la scolarità (alta)

- Vivere in Centro Italia diventa un fattore protettivo
- Aver vissuto in Italia per almeno 10 anni è un aspetto che accresce la probabilità di essere sovrappeso/obesi

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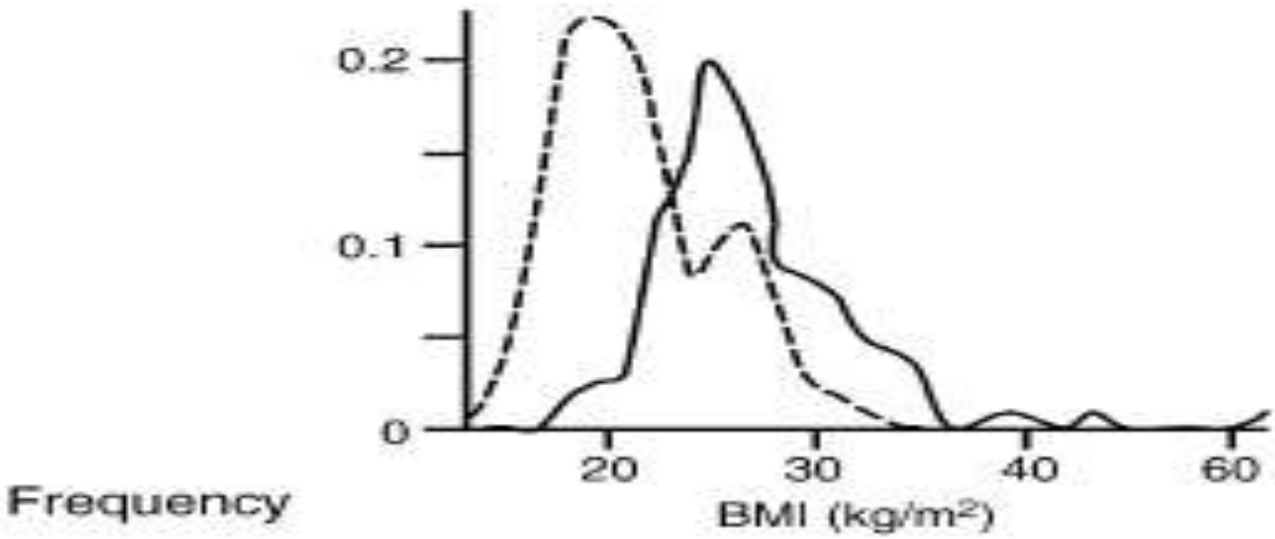
PASSI 10
Progressi nelle Aziende Sanitarie per la Salute in Italia

Impact of migration on coronary heart disease risk factors: comparison of Gujaratis in Britain and their contemporaries in villages of origin in India

Randomly sampled Gujaratis aged 25–79 yrs living in Sandwell (*n* = 242) ——
age-, gender- and caste-matched remaining in their villages of origin in Navsari, India (*n* = 295). – – –



Patel et al Atherosclerosis 185 (2006) 297–306

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Economic migrants, refugees, asylum seekers… whom are we speaking about?

Migration patterns over time

Outline spectrum of health needs and variation by migrant group

Ethnic origin and cardiovascular risk

Variable	β coefficient	Standard error	OR (95% CI)	p
Framingham risk score				
Moderate vs low	0·93	0·67	2·49 (0·67–9·20)	0·18
High vs low	1·72	0·66	5·28 (1·45–19·16)	0·007
Atherosclerosis, mean maximum IMT	2·14	0·60	8·49 (2·89–27·80)	0·0002
PAI-1	0·04	0·015	1·04 (1·01–1·08)	0·006
Lipoprotein (a)	0·26	0·13	1·29 (1·01–1·08)	0·03
Homocysteine	–0·006	0·03	0·99 (0·94–1·06)	0·69
Fibrinogen	0·31	0·25	1·36 (0·84–2·21)	0·95
Ethnicity:				
South Asians vs Europeans	1·51	0·57	4·51 (1·46–13·89)	0·02
Chinese vs Europeans	0·05	0·63	1·05 (0·30–3·63)	0·91
Years in Canada (per year in Canada)	0·04	0·01	1·04 (1·01–1·06)	0·03
Centre	0·17	0·17	1·18 (0·84–1·67)	0·36

Table 4: **Predictors of cardiovascular disease by multivariate logistic regression**

Anand SS et al. *Differences in risk factors, atherosclerosis, and cardiovascular disease between ethnic groups in Canada: the Study of Health Assessment and Risk in Ethnic groups (SHARE)*

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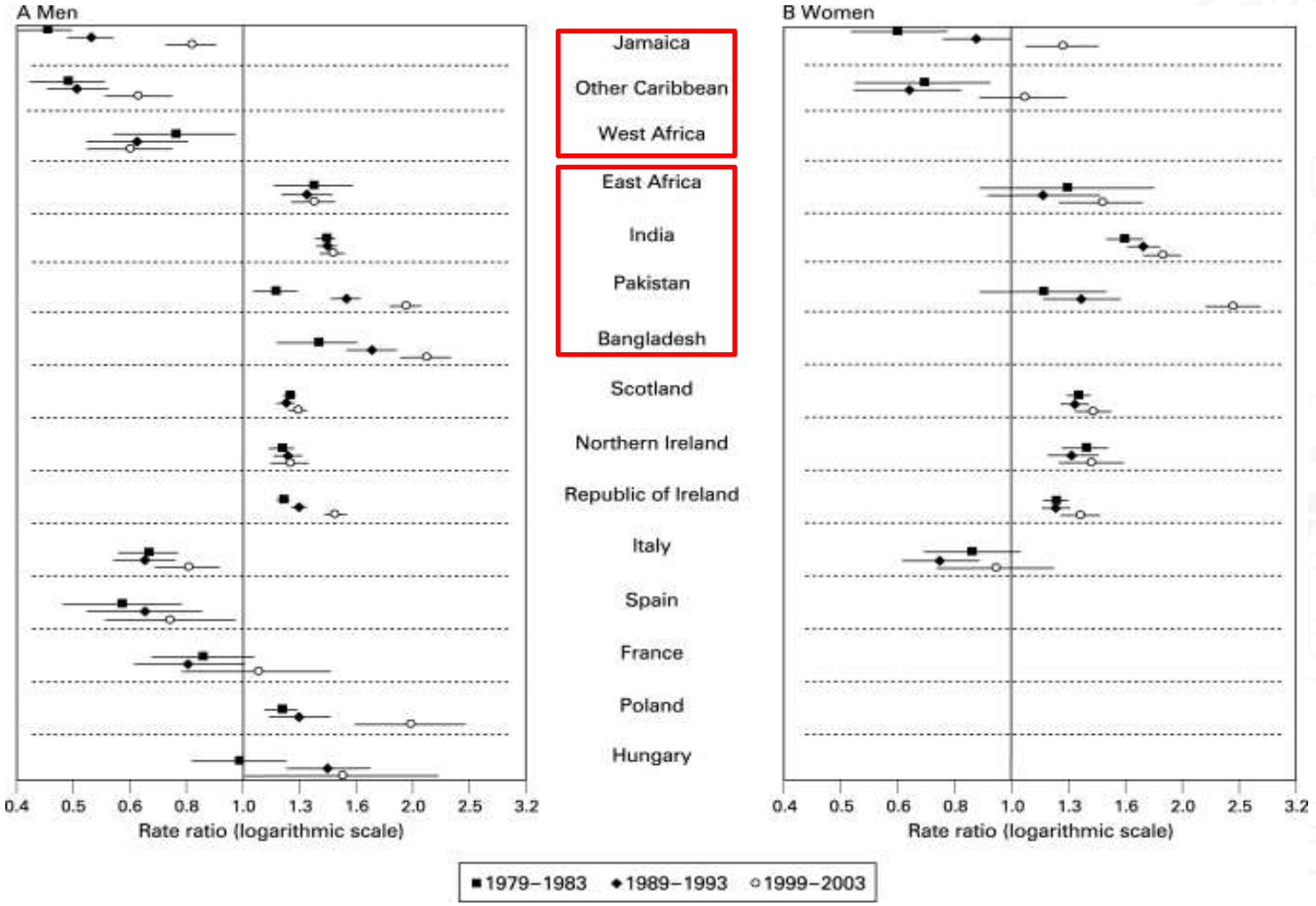
Coronary artery disease

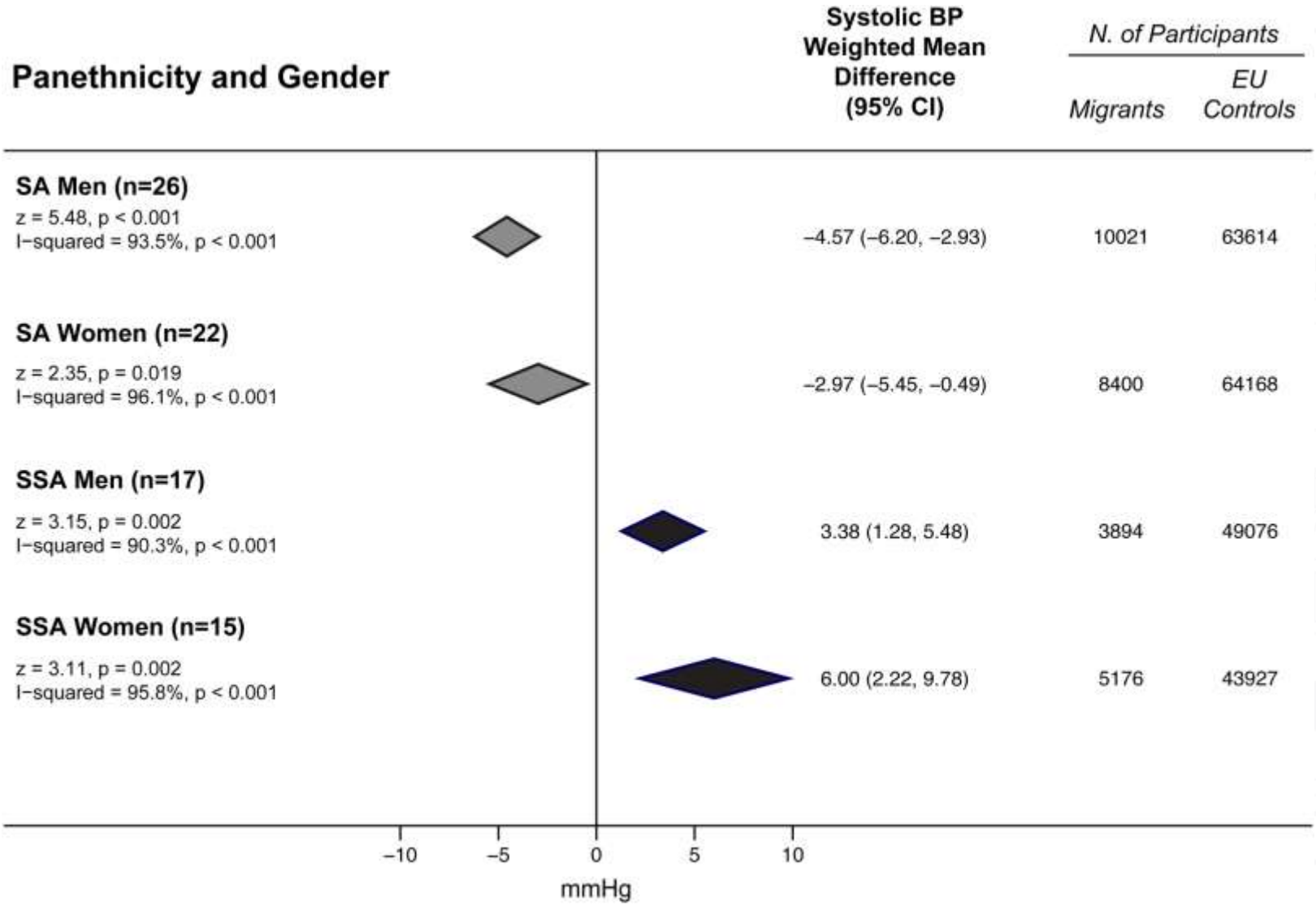


*Harding S, Rosato M. *Heart* 2008;**94**:463–470.

Ethnicity and Blood Pressure in Europe

South Asian

Subsaharan Africa



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Modesti PA et al. (2016) PLoS ONE 11(1): e0147601.

Low adherence to anti-hypertensive treatment Database Regione Lombardia

- Younger age
- Women
- Depression
- Co-morbidities (cancer, dementia, respiratory and rheumatologic diseases)
- Immigrants
- No relationship with income

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Mancia G et al J Hypertens 2014, 32:1708–1716

European Heart Journal (2016) **37**, 2315–2381
doi:10.1093/eurheartj/ehw106

2016 European Guidelines on cardiovascular disease prevention in clinical practice

The Sixth Joint Task Force of the European Society of Cardiology and Other Societies on Cardiovascular Disease Prevention in Clinical Practice (constituted by representatives of 10 societies and by invited experts)

Recommendation for ethnic minorities

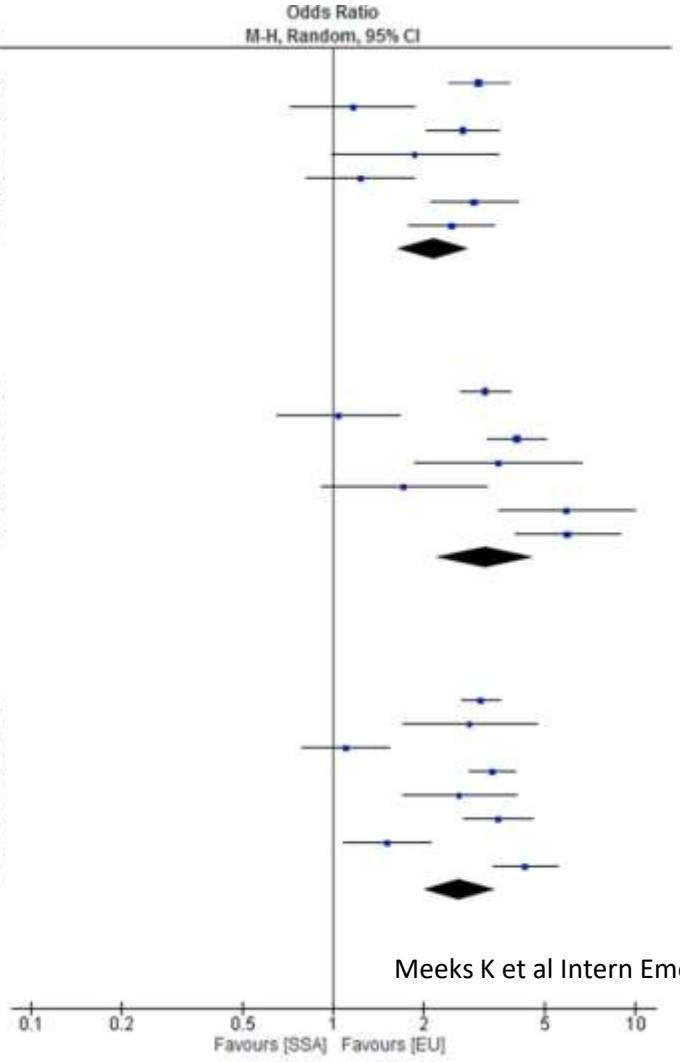
Recommendation	Class[a]	Level[b]	Ref[c]
Ethnicity should be considered in CVD risk assessment.	IIa	A	207, 208

Disparities in type 2 diabetes prevalence among ethnic minority groups resident in Europe: a systematic review and meta-analysis

SubSaharian Africa

Study or Subgroup	SSA Events	SSA Total	EU Events	EU Total	Weight	Odds Ratio M-H, Random, 95% CI	Year
Male							
Cappuccio 1997	157	877	181	2701	17.3%	3.04 [2.41, 3.82]	1997
Riste 2001	42	180	46	222	12.4%	1.16 [0.72, 1.87]	2001
Zaninotto 2007	62	961	345	13795	16.4%	2.69 [2.03, 3.55]	2007
Agyemang 2011	25	193	18	244	9.6%	1.87 [0.99, 3.54]	2011
Carlsson 2013	24	502	6193	158787	13.7%	1.24 [0.82, 1.87]	2013
Tillin 2013	64	347	112	1564	15.3%	2.93 [2.10, 4.09]	2013
Meeks 2014	179	1562	49	987	15.4%	2.48 [1.79, 3.43]	2014
Subtotal (95% CI)		4622		178300	100.0%	2.15 [1.63, 2.83]	
Total events	553		6944				
Heterogeneity: $Tau^2 = 0.10$; $Chi^2 = 25.71$, df = 6 (P = 0.0003); $I^2 = 77\%$							
Test for overall effect: Z = 5.45 (P < 0.00001)							
Female							
Cappuccio 1997	245	1644	210	4038	17.1%	3.19 [2.63, 3.88]	1997
Riste 2001	39	188	52	259	14.1%	1.04 [0.65, 1.66]	2001
Zaninotto 2007	102	1401	322	16949	16.8%	4.05 [3.22, 5.10]	2007
Agyemang 2011	62	400	12	242	11.8%	3.52 [1.85, 6.67]	2011
Carlsson 2013	10	237	3156	126248	11.9%	1.72 [0.91, 3.24]	2013
Tillin 2013	60	283	21	485	13.4%	5.94 [3.53, 10.02]	2013
Meeks 2014	310	2500	27	1164	14.9%	5.96 [4.00, 8.89]	2014
Subtotal (95% CI)		6653		149385	100.0%	3.18 [2.18, 4.65]	
Total events	828		3800				
Heterogeneity: $Tau^2 = 0.21$; $Chi^2 = 44.03$, df = 6 (P < 0.00001); $I^2 = 86\%$							
Test for overall effect: Z = 5.98 (P < 0.00001)							
Total							
Cappuccio 1997	402	2521	391	6739	14.3%	3.08 [2.66, 3.57]	1997
Whitty 1999	17	360	154	8973	9.9%	2.84 [1.70, 4.74]	1999
Riste 2001	81	368	98	481	12.3%	1.10 [0.79, 1.54]	2001
Zaninotto 2007	164	2362	667	30744	14.0%	3.36 [2.82, 4.01]	2007
Agyemang 2011	87	593	30	486	10.9%	2.61 [1.69, 4.03]	2011
Tillin 2013	124	630	133	2049	13.1%	3.53 [2.71, 4.59]	2013
Carlsson 2013	36	739	9349	285035	12.2%	1.51 [1.08, 2.11]	2013
Meeks 2014	556	4062	76	2151	13.3%	4.33 [3.39, 5.54]	2014
Subtotal (95% CI)		11635		336658	100.0%	2.62 [1.98, 3.45]	
Total events	1467		10898				
Heterogeneity: $Tau^2 = 0.14$; $Chi^2 = 63.05$, df = 7 (P < 0.00001); $I^2 = 89\%$							
Test for overall effect: Z = 6.78 (P < 0.00001)							

Test for subgroup differences: $Chi^2 = 2.79$, df = 2 (P = 0.25), $I^2 = 28.2\%$



Meeks K et al Intern Emerg Med (2016) 11:327–340

Mortality rate ratios (MRRs) combined for men and women in 6 European countries, by region of origin and cause of death

Cause of death	Region of origin (local-born = 1, ref.)							
	MRR (95 % CI)							
	North Africa	Sub-Saharan Africa	Caribbean	Other Latin America	South Asia	East Asia	Eastern Europe	Turkey
Infectious diseases	2.55 (2.39–2.71)	4.60 (4.34–4.67)	2.48 (2.20–2.79)	1.42 (1.24–1.63)	2.06 (1.85–2.29)	1.04 (0.77–1.41)	0.84 (0.69–1.02)	0.92 (0.75–1.13)
TB	2.73 (2.09–3.57)	9.41 (7.52–11.76)	1.25 (0.69–2.27)	23.05 (19.10–27.81)	19.05 (15.81–22.97)	0.56 (0.08–3.98)	2.28 (1.37–3.79)	3.22 (1.72–6.01)
HIV/AIDS	0.45 (0.37–0.55)	5.52 (5.12–5.94)	9.28 (8.19–10.52)	1.00 (0.72–1.40)	0.71 (0.53–0.94)	0.28 (0.13–0.42)	0.35 (0.22–0.57)	0.24 (0.14–0.42)
Cancer	0.80 (0.78–0.82)	0.95 (0.92–0.99)	0.77 (0.74–0.80)	0.47 (0.44–0.49)	0.53 (0.51–0.56)	0.80 (0.73–0.88)	1.05 (1.01–1.09)	0.67 (0.63–0.71)
Oesophagus and oral cavity	0.33 (0.29–0.38)	0.61 (0.53–0.70)	0.32 (0.27–0.38)	0.04 (0.02–0.08)	0.42 (0.35–0.51)	0.96 (0.69–1.34)	0.70 (0.60–0.82)	0.34 (0.25–0.45)
Stomach	1.44 (1.31–1.59)	1.01 (0.84–1.21)	2.15 (1.95–2.36)	0.28 (0.20–0.40)	0.95 (0.78–1.15)	0.80 (0.50–1.29)	1.97 (1.71–2.27)	1.88 (1.51–2.33)
Colon/rectum	0.64 (0.58–0.70)	0.75 (0.66–0.85)	0.82 (0.74–0.90)	0.74 (0.64–0.85)	0.44 (0.37–0.52)	0.67 (0.48–0.92)	0.76 (0.66–0.86)	0.60 (0.49–0.74)
Liver	2.17 (1.92–2.45)	2.96 (2.68–3.27)	0.96 (0.78–1.19)	0.61 (0.47–0.80)	1.04 (0.84–1.29)	5.09 (3.94–6.57)	0.76 (0.58–0.99)	0.89 (0.69–1.15)
Breast	0.90 (0.84–0.97)	1.45 (1.33–1.58)	0.67 (0.61–0.74)	0.52 (0.45–0.60)	0.61 (0.53–0.71)	0.27 (0.17–0.44)	0.86 (0.78–0.96)	0.41 (0.32–0.52)
Hodgkin's disease and leukaemia	1.55 (1.41–1.70)	0.86 (0.72–1.03)	1.72 (1.53–1.94)	0.75 (0.59–0.94)	0.43 (0.32–0.58)	1.16 (0.78–1.72)	1.61 (1.39–1.87)	1.47 (1.20–1.80)
Lung and bronchus	0.71 (0.67–0.74)	0.70 (0.65–0.76)	0.73 (0.69–0.78)	0.36 (0.32–0.40)	0.43 (0.39–0.47)	0.69 (0.57–0.84)	1.08 (1.01–1.16)	0.67 (0.60–0.75)
Cardiovascular diseases	1.25 (1.22–1.28)	1.15 (1.10–1.20)	0.78 (0.75–0.81)	0.39 (0.36–0.42)	1.25 (1.21–1.30)	0.63 (0.55–0.71)	1.27 (1.22–1.32)	1.29 (1.21–1.37)
Diabetes	2.12 (1.96–2.29)	1.25 (1.07–1.46)	1.44 (1.27–1.63)	0.27 (0.19–0.38)	1.89 (1.66–2.15)	0.33 (0.17–0.66)	1.25 (1.06–1.47)	1.96 (1.65–2.33)
Injury-related	1.06 (1.02–1.09)	0.79 (0.75–0.82)	1.05 (1.00–1.10)	0.68 (0.63–0.72)	0.61 (0.57–0.65)	0.74 (0.65–0.84)	1.90 (1.82–1.98)	0.52 (0.48–0.57)
Unintentional injuries	1.22 (1.17–1.27)	0.86 (0.81–0.91)	1.43 (1.35–1.52)	0.94 (0.87–1.01)	0.60 (0.55–0.66)	0.77 (0.66–0.91)	2.25 (2.13–2.37)	0.52 (0.47–0.58)
Suicide	0.60 (0.56–0.64)	0.57 (0.52–0.62)	0.52 (0.46–0.58)	0.36 (0.32–0.42)	0.55 (0.49–0.62)	0.51 (0.39–0.67)	1.42 (1.31–1.54)	0.43 (0.37–0.50)
Homicide	2.83 (2.56–3.14)	1.78 (1.51–2.10)	0.84 (0.62–1.13)	0.39 (0.26–0.59)	1.35 (1.08–1.68)	1.89 (1.44–2.48)	1.52 (1.18–1.96)	1.89 (1.44–2.47)

MRRs were adjusted for sex, age, and country of destination

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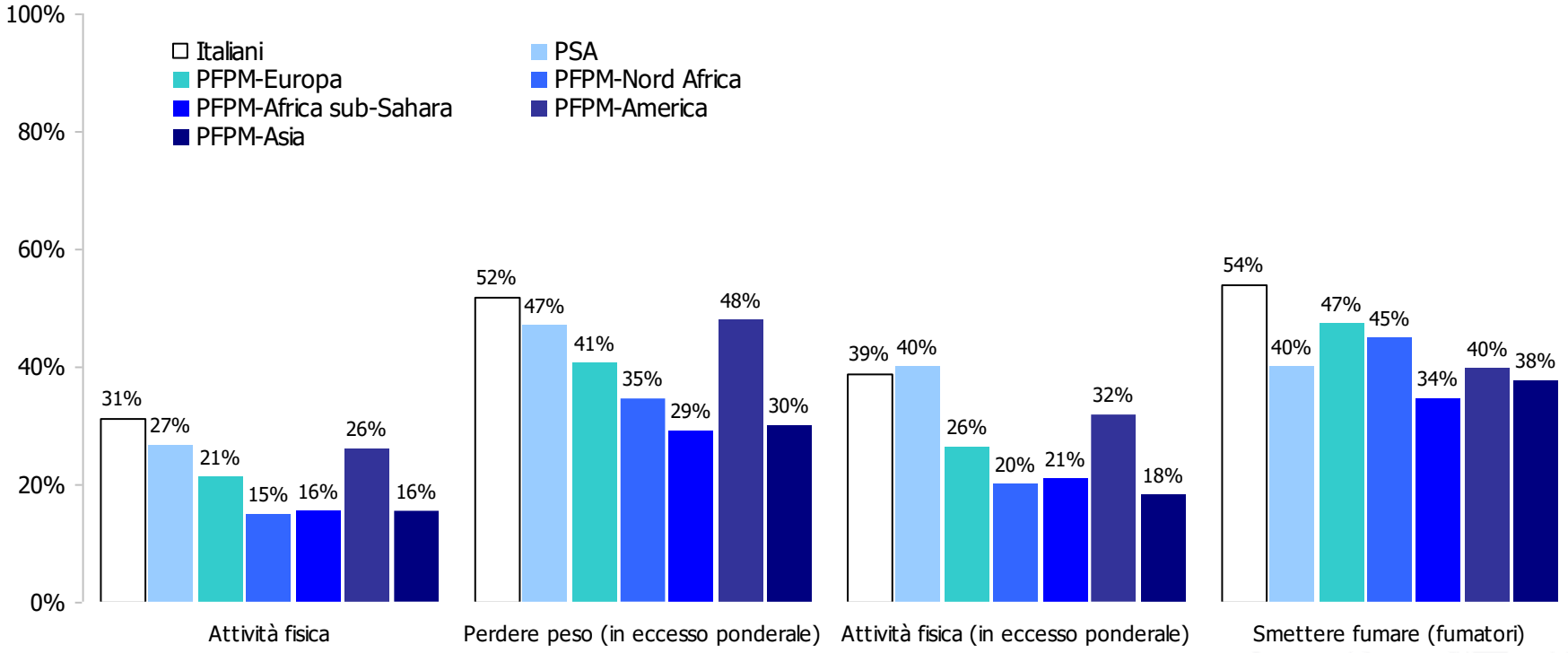
Eur J Epidemiol (2016) 31:655–665

Consigli degli operatori sanitari per cittadinanza



- Al netto di età, genere, istruzione, situazione economica e luogo di residenza la cittadinanza ha un effetto rispetto ai consigli che gli operatori sanitari danno alle persone.

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PASSI 10
Progressi nelle Aziende Sanitarie per la Salute in Italia

Editorial

FIC Federazione Italiana di Cardiologia
Italian Federation of Cardiology

Migration and chronic noncommunicable diseases: is the paradigm shifting?

Francesco Castelli[a,b], Lina R. Tomasoni[c] and Issa El Hamad[d]

J Cardiovasc Med 2014, 15:693–695

exception and virtually all nationalities are represented

Clinical Microbiology and Infection xxx (2017) 1–7

Contents lists available at ScienceDirect

Clinical Microbiology and Infection

journal homepage: www.clinicalmicrobiologyandinfection.com

Review

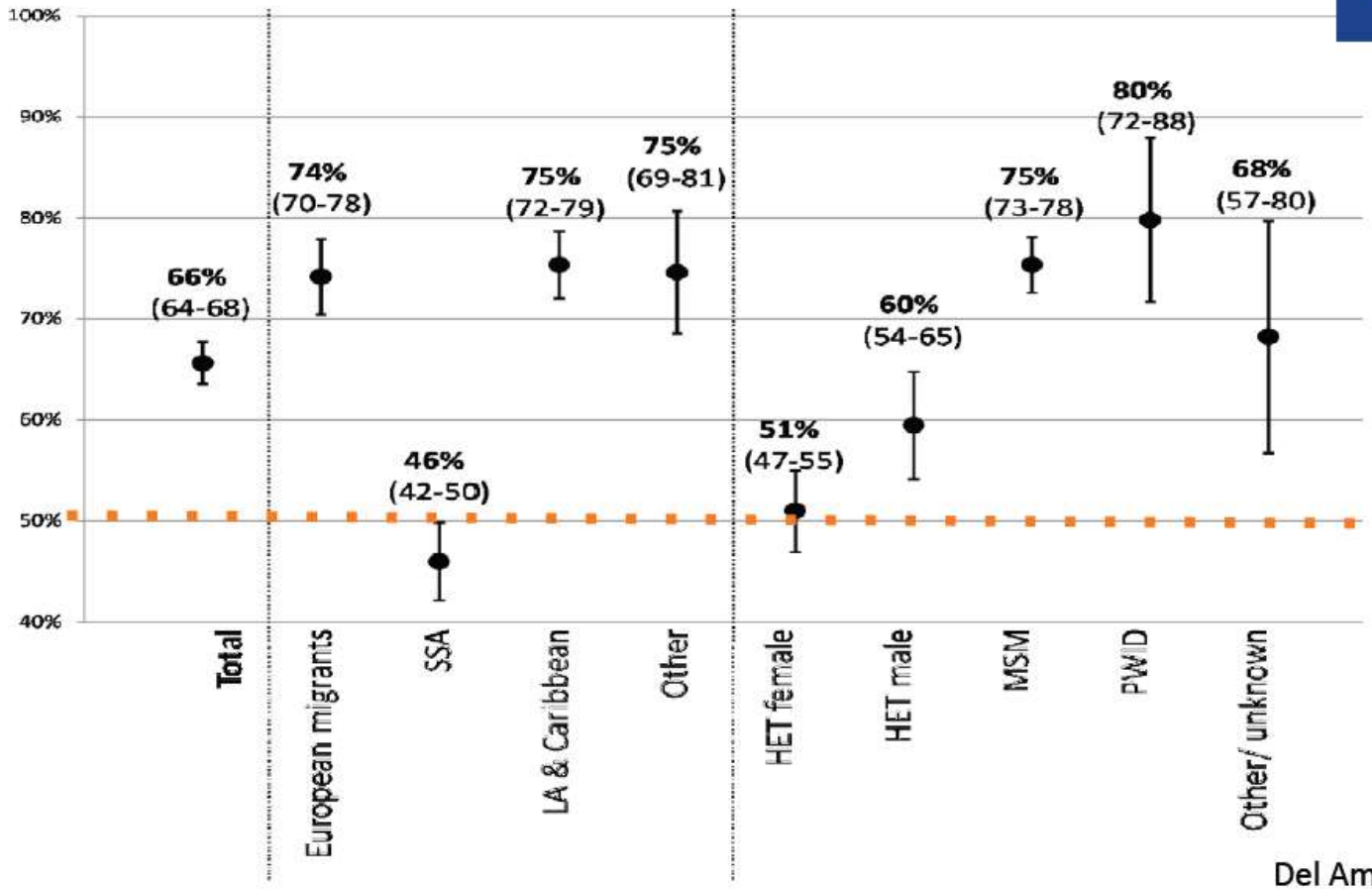
Migration and infectious diseases

F. Castelli [1, 2, *], G. Sulis [1]

[1] University Department of Infectious and Tropical Diseases, University of Brescia and Spedali Civili General Hospital, Brescia, Italy
[2] UNESCO Chair 'Training and empowering human resources for health development in resource-limited countries', University of Brescia, Brescia, Italy

A significant share of HIV-positive migrants living in Europe acquired HIV infection after migration

Percentage of Migrants who acquired HIV infection after migration by Area of Origin and Risk Factor



Del Amo J, 2017

Increased risk of virological failure to the first antiretroviral regimen in HIV-infected migrants

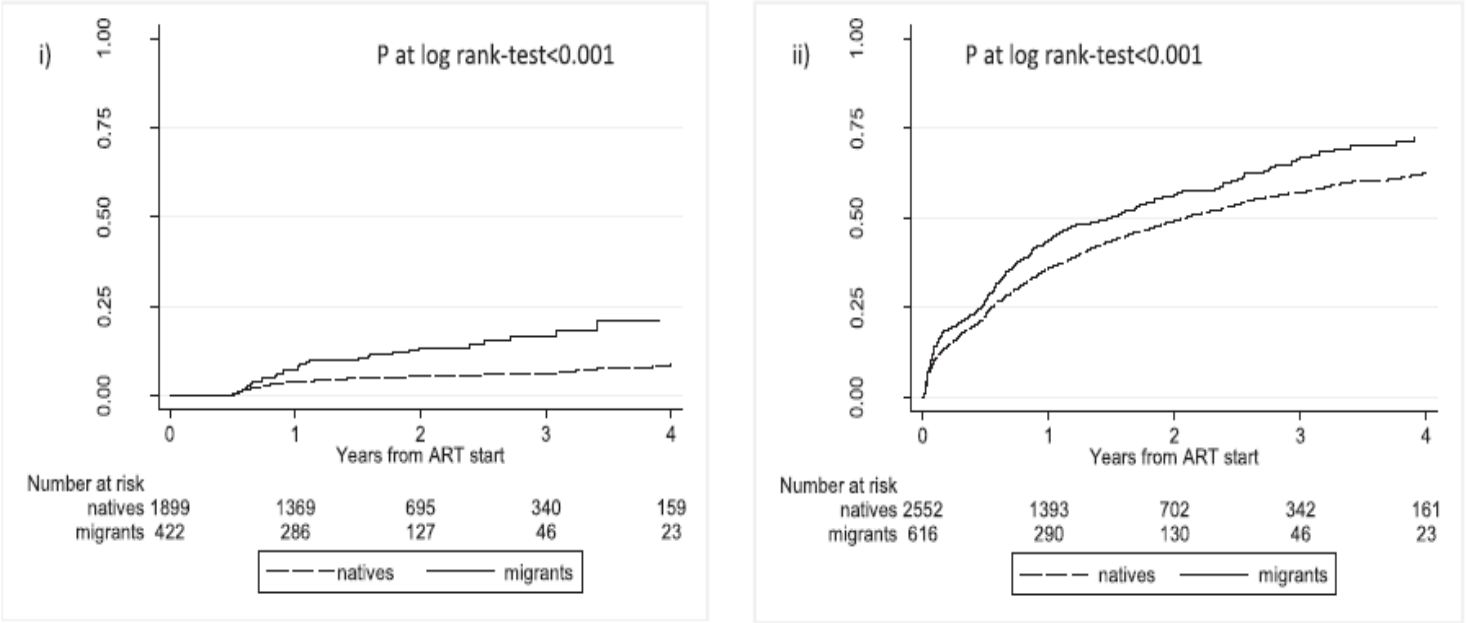


FIG. 1. Kaplan-Meier curves representing cumulative probability of (i) virologic failure (HIV RNA >200 copies/mL) and (ii) treatment failure of first antiretroviral regimen.

Saracino A et al, CMI, 2016

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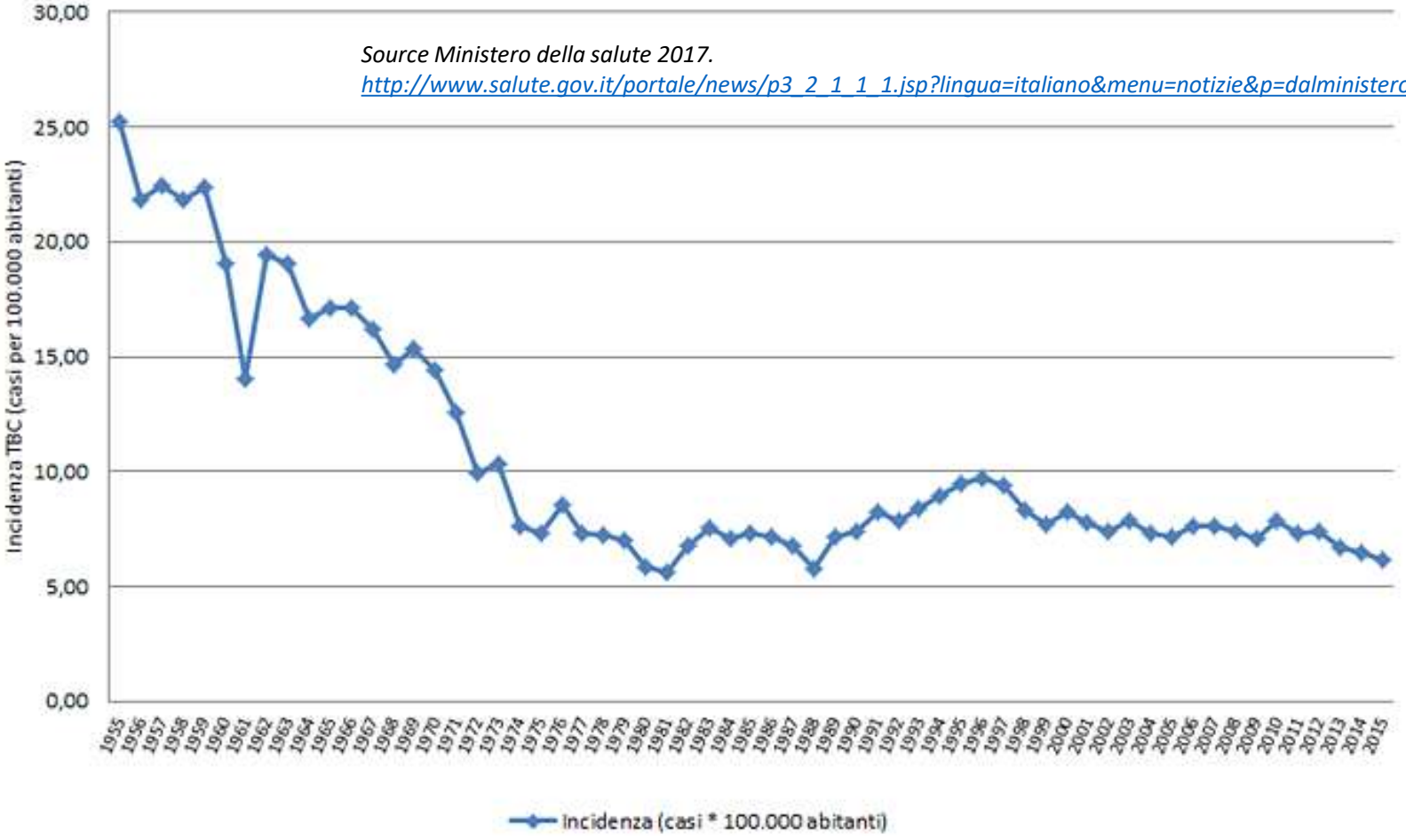
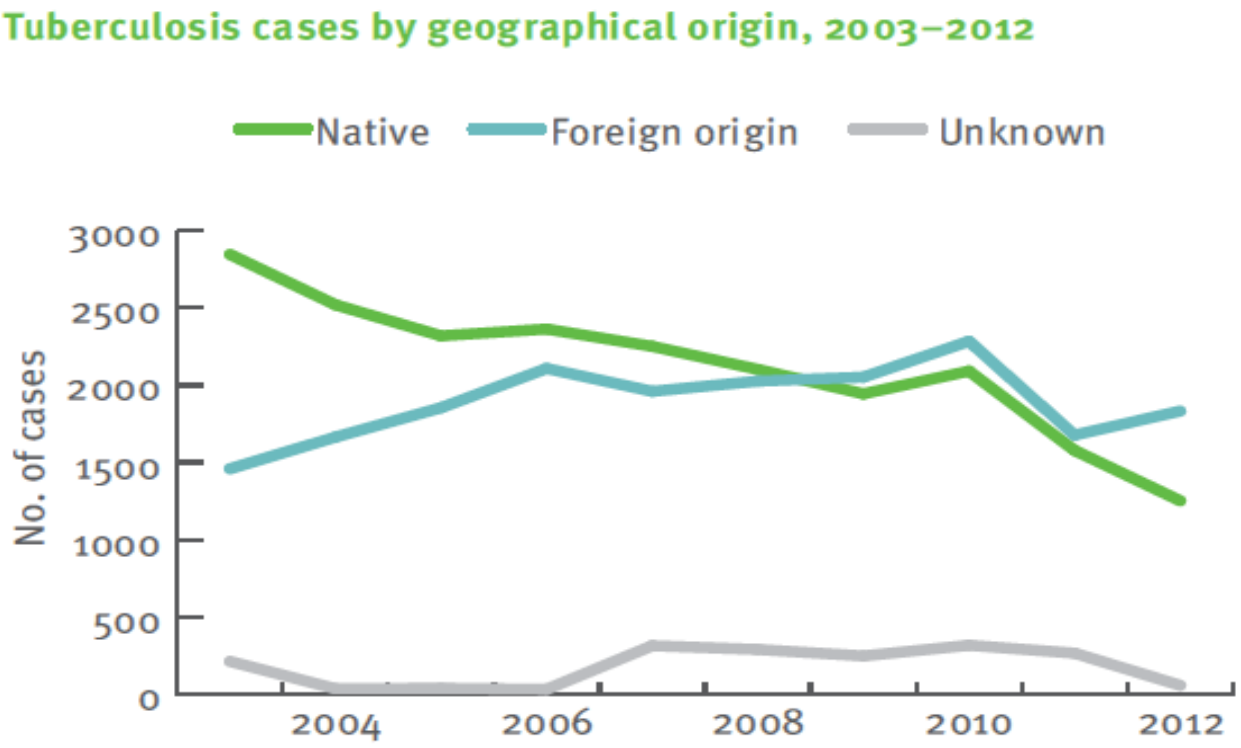
Casi di tubercolosi in Italia - anni 1955-2015



Source Ministero della salute 2017.
http://www.salute.gov.it/portale/news/p3_2_1_1_1.jsp?lingua=italiano&menu=notizie&p=dalministero&id=2873

Numero di casi di TB in Italia 2007 - 2012



Source ECDC/EURO TB report 2014

KAP survey on malaria preventive measures of migrants

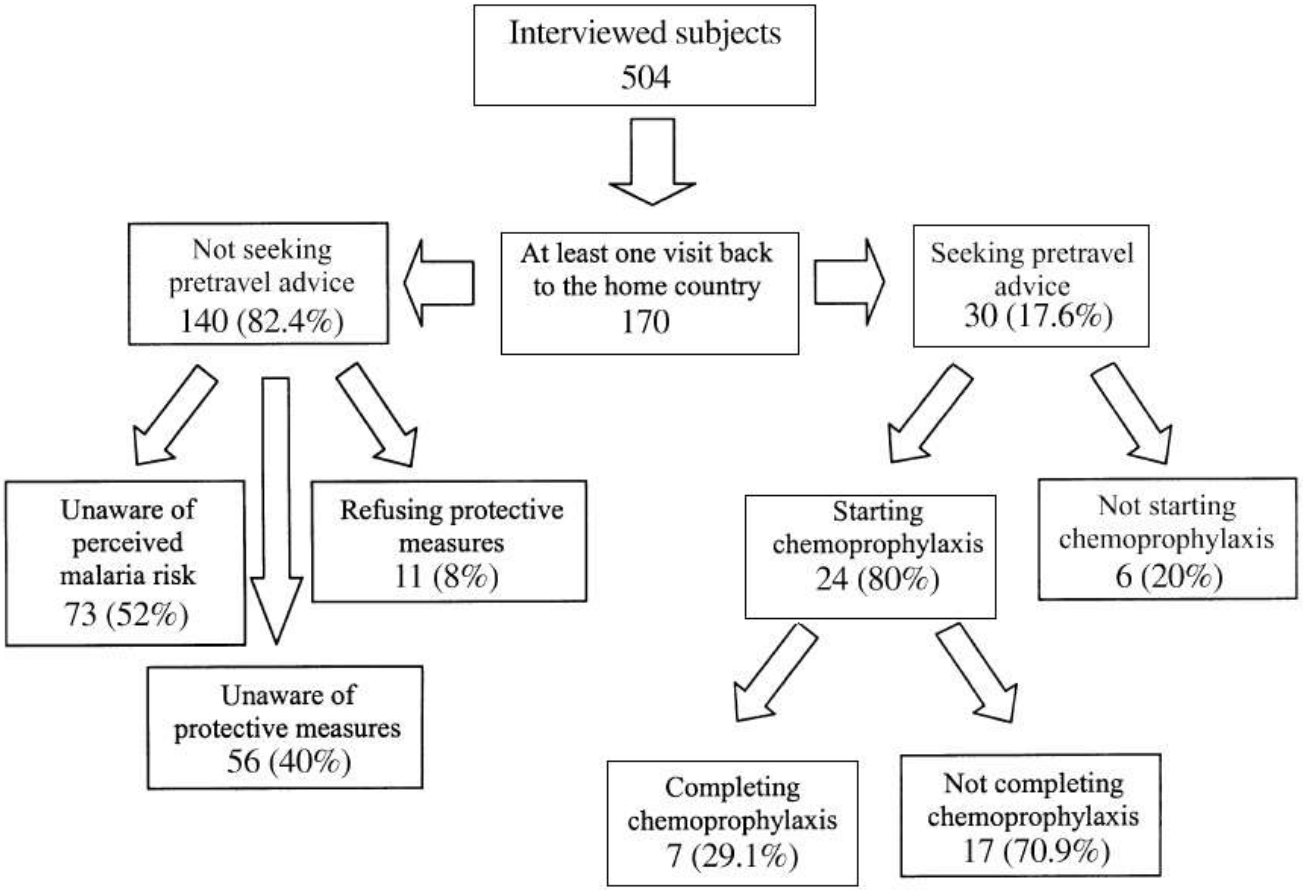


Figure Attitudes and practices regarding malaria infection among the study population.

Scolari et al., JTM, 2002

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In sintesi…

- Stranieri PFPM svantaggiati dal punto di vista socio-economico
- Stili di vita:
  - Maggiore sedentarietà
  - Stranieri Est-Europa: maggiore fumo
  - No differenza o minore consumo di alcol
  - Modesto aumento del rischio per eccesso ponderale
- Complessivamente, determinanti di salute meno favorevoli
- Meno consigli su stili di vita da parte degli operatori sanitari

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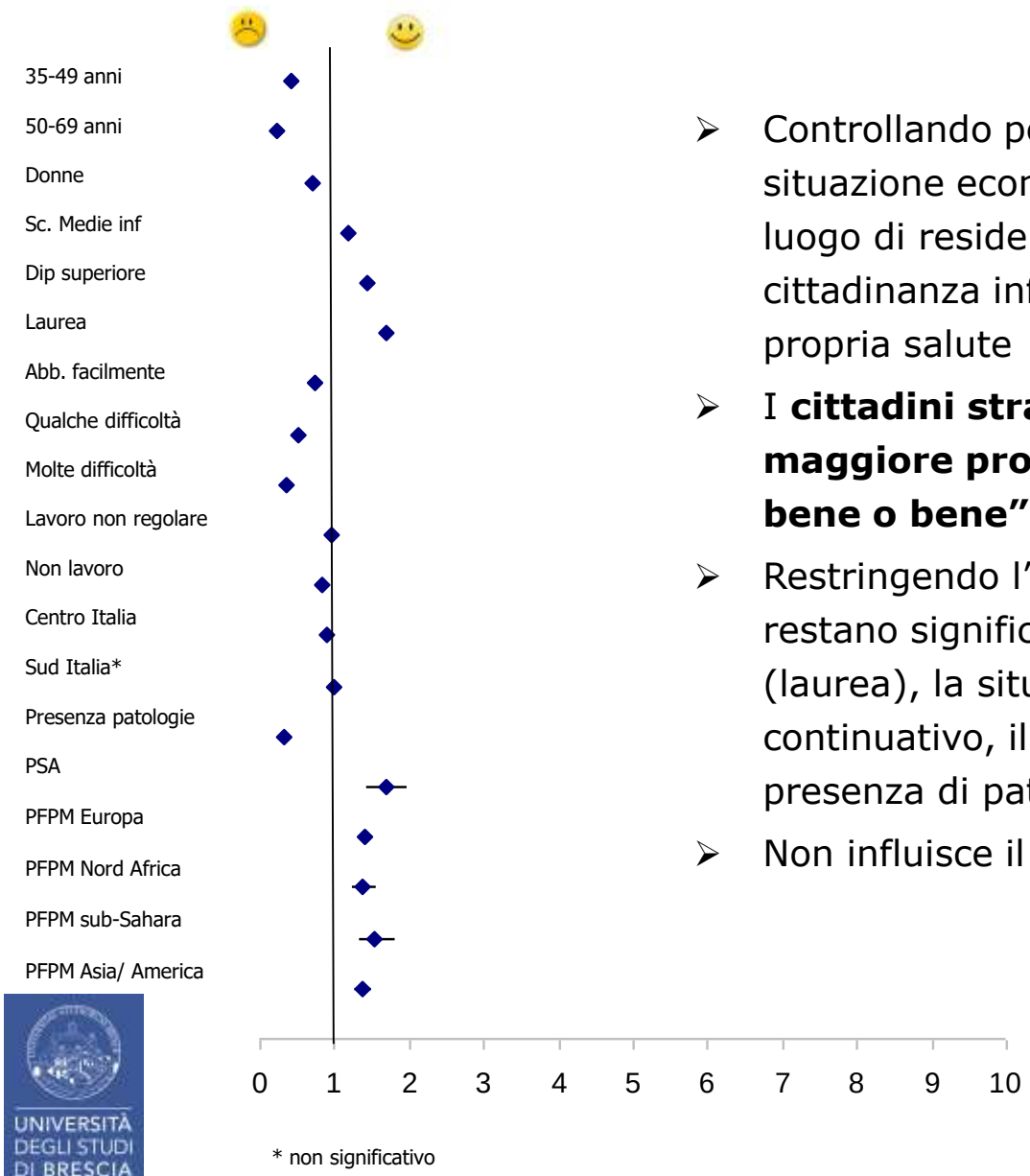
Tuttavia, salute percepita positivamente …



* non significativo

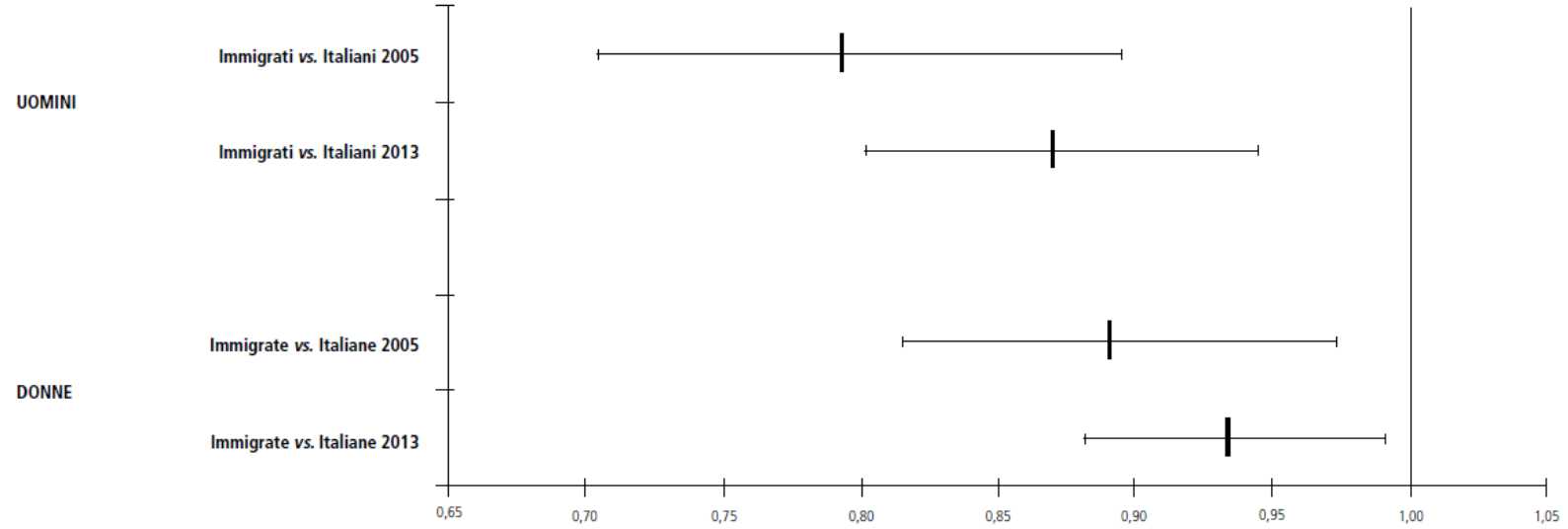
- Controllando per età, genere, istruzione, situazione economica, situazione lavorativa, luogo di residenza e presenza di patologie, la cittadinanza influenza la percezione della propria salute
- I **cittadini stranieri (PSA e PFPM) hanno maggiore probabilità di "sentirsi molto bene o bene" rispetto ai cittadini italiani**
- Restringendo l'analisi ai solo stranieri PFPM restano significative: l'età, il genere, la scolarità (laurea), la situazione economica, il lavoro non continuativo, il vivere in Centro Italia e la presenza di patologie
- Non influisce il numero di anni vissuti in Italia

UNIVERSITÀ DEGLI STUDI DI BRESCIA

PASSI 10
Progressi nelle Aziende Sanitarie per la Salute in Italia

Probabilità di avere una peggiore salute fisica

Figura 2. Probabilità di avere una peggiore salute fisica percepita (1° quartile PCS) 2005-2013. PRR (IC95%) da modello log-binomiale.
Figure 2. Probability of worse self-perceived physical health (1st quartile PCS); years 2005-2013. PRR (95%CI) by log-binomial model.



Nota: modello aggiustato per età, livello di istruzione, condizione professionale, risorse economiche, IMC. / ***Note:*** *model adjusted by age, educational level, occupational status, self-perceived economic resources, BMI.*

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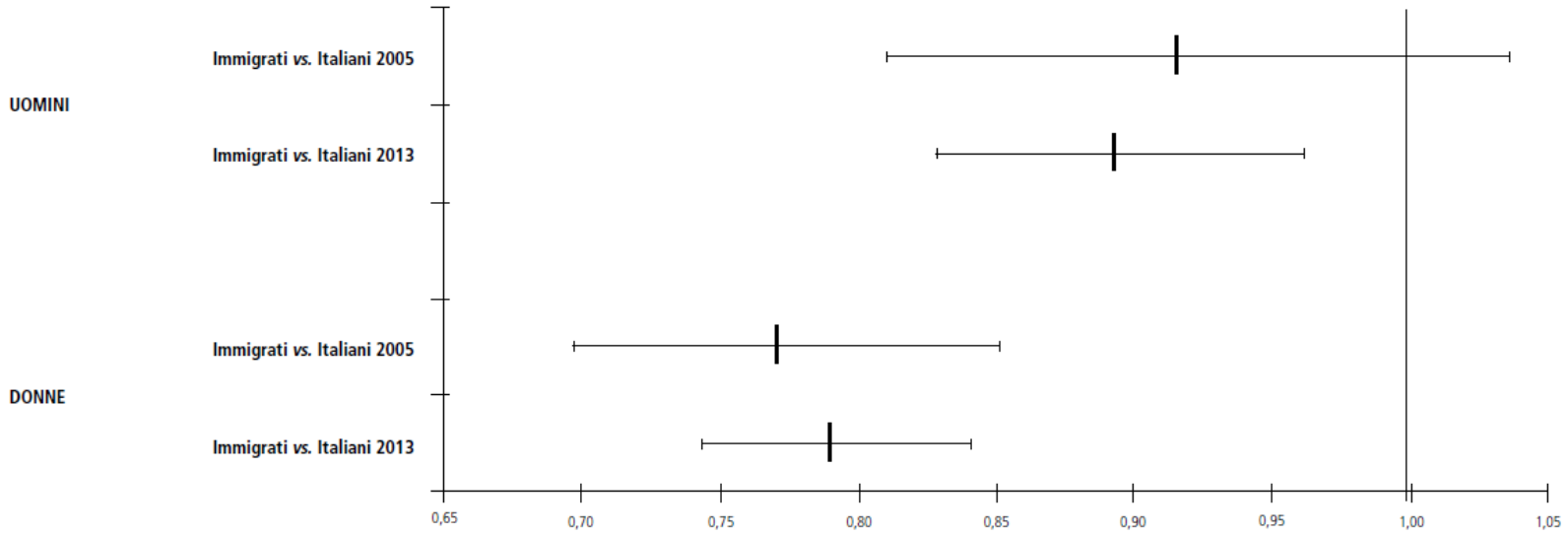
Probabilità di avere una peggiore salute mentale

Figura 3. Probabilità di avere una peggiore salute mentale percepita (1° quartile MCS) 2005-2013. PRR (IC95%) da modello log-binomiale.
Figure 3. Probability of worse self-perceived mental health (1st quartile MCS); years 2005-2013. PRR (95%CI) by log-binomial model.



Nota: modello aggiustato per età, livello di istruzione, condizione professionale, risorse economiche, IMC. / ***Note:*** *model adjusted by age, educational level, occupational status, self-perceived economic resources, BMI.*

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I determinanti delle migrazioni

- Fenomeno complesso e multifattoriale
- Fattori controllabili e non controllabili
- Migrante economico o forzato

Le migrazioni come determinante di salute

- Effetto migrante sano → effetto migrante esausto
- Determinanti di salute sfavorevoli per stranieri
- Transizione epidemiologica – malattie croniche