

# Forced migrant health: priorities for health research

A report of a roundtable meeting held by the Academy of  
Medical Sciences on 15 June 2016

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# Executive summary

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- Recent changes in the scale and distribution of forced migrants across the globe are presenting new challenges to healthcare systems in host countries, including the UK and other European nations. On 15 June 2016, the Academy convened a roundtable to discuss priorities for health research in this area, and this report summarises the conclusions reached.
- The health challenges facing this diverse group span mental and physical health, and may be influenced by the factors which forced their migration, the conditions of their journey, and their ability to access healthcare upon arrival in their host nation.
- The current evidence base on the health of forced migrants is uneven and fragmented, and requires strengthening. A broad audit is needed to understand what data is being collected, who is collecting it, and where gaps in our knowledge exist.
- All stakeholders must be actively engaged in setting research priorities in order to embed a clear research agenda as widely as possible, including within health services used by forced migrants on arrival and those who have been settled long-term.
- Consistent terminology to identify forced migrants, improvements in data collection, and an improved ability to link data sets that already exist, will be crucial to support cross-disciplinary working.
- The status of research in this area varies across disciplines – fields such as tuberculosis research require evidence to direct interventions, while fields such as mental health need further evidence on both the effectiveness of existing therapies within migrant groups, and how to tailor treatments and services to the particular experiences and challenges faced by recent flows of forced migrants.
- Research methodologies must combine scientific rigour with culturally and socially tailored approaches to accommodate the diverse backgrounds of migrant groups. Traditional approaches often require repeated attendance in a single location, and may be less effective in these mobile populations. Technology, such as mobile phones, may play a key role in collecting data and delivering health solutions.
- To help provide a bridge to the wider migrant population, and utilise their extremely relevant experience, forced migrants with health expertise could be supported to deploy their skills within the research and health community.
- Clarity is needed on the sources and scale of research funding available in this area, particularly relating to the eligibility criteria for Official Development Assistance.
- Taking an international leadership role in funding and supporting migrant-focussed research could raise the profile of this field, and attract the early career researchers which the community needs to grow.
- Research in this area can deliver health benefits not only to forced migrant populations, but also to society more widely. The research community should seek to reiterate this message as widely as possible.
- Cooperation must occur at all levels, to ensure that researchers and stakeholders share experience and resources to deliver impact quickly and efficiently.

# Introduction

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**Forced migration reached an unprecedented level in 2015, with an estimated 19.6m individuals worldwide being displaced by a variety of factors including persecution, conflict, generalised violence or human rights violations.<sup>1</sup>**

The scale and speed of such forced migration has been felt across the globe, with over one million forced migrants entering the European Union in 2015.<sup>2</sup> For asylum applications from Syrian forced migrants alone, Germany and Sweden have received approximately 400,000 and 100,000, respectively, since 2011, and the UK has received 10,000 applications.<sup>3</sup> Combined with existing forced migrant populations which have arrived in the UK over the previous decades, this presents new challenges both to the UK healthcare system as it seeks to meet the health needs of these individuals during arrival and integration, and to the research community seeking to provide the evidence base needed for effective and equitable treatment of this diverse population.

Such populations are associated with a complex background of health determinants, derived both from external factors which forced their migration, and the often traumatic conditions of their journey. Upon arrival, these individuals frequently experience severe marginalisation and poverty, which can be further compounded for those without official documented status. This can continue to negatively impact their health status even after arrival. The heterogeneous nature of this group – fragmented by legal status, country of origin and other factors – requires an integrated approach to health issues which utilises all points of contact (both official and informal) to gather evidence and tailor health interventions according to individual circumstances.

Calls for evidence and cooperation on forced migrant health have been growing, for example from the European Centre for Disease Control, European Advisory Committee on Health Research, and the German National Academy of Sciences, the Leopoldina.<sup>4,5,6</sup> On 15 June 2016, the Academy of Medical Sciences convened a roundtable of relevant experts in forced migrant health research (see Annex I for details), which was held to:

- Explore our current understanding of the health challenges facing forced migrant populations.
- Discuss the role of research in improving the health of these individuals once in the UK.
- Consider the associated research priorities.

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<sup>1</sup> United Nations High Commissioner for Refugees (2015). *UNCHR global trends: forced displacement*.

<sup>2</sup> International Organization for Migration (2015). *Irregular migrant arrivals in Europe top one million in 2015*.

<sup>3</sup> Figures for April 2011 – July 2016, United Nations High Commissioner for Refugees.

<sup>4</sup> European Centre for Disease Prevention and Control (2015). *Expert Opinion on the public health needs of irregular migrants, refugees or asylum seekers across the EU's southern and south-eastern borders*.

[http://ecdc.europa.eu/en/publications/\\_layouts/forms/Publication\\_DispForm.aspx?List=4f55ad51-4aed-4d32-b960-af70113dbb90&ID=1377](http://ecdc.europa.eu/en/publications/_layouts/forms/Publication_DispForm.aspx?List=4f55ad51-4aed-4d32-b960-af70113dbb90&ID=1377)

<sup>5</sup> The European Advisory Committee on Health Research, 65th session of the Regional Committee for Europe

<sup>6</sup> The Leopoldina (2015). *Joint statement concerning healthcare for asylum seekers*.

<https://www.leopoldina.org/en/publications/detailview/publication/zur-gesundheitsversorgung-von-asylsuchenden-2015/>

# Research priorities

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The health challenges facing this diverse group span mental and physical health, and may further influenced by the factors which forced their migration, the conditions of their journey, and their ability to access healthcare in their host nation.

The situations which drive migrations from their country of origin can significantly shape their disease profiles, for example those fleeing war-torn regions are likely to present with heightened levels of trauma exposure and mental health issues. These factors can then also determine the pattern of health care use upon arrival, potentially magnifying and prolonging health problems.

## The evidence base

The current evidence base on the health of forced migrants is uneven and fragmented, with data on migrant status often not routinely collected, including by health services. The diversity of relevant determinants – from existing health problems, to experiences in transit, to employment status – means that the scale of the problem remains unclear. There is a pressing need for a clear understanding of the burden of ill-health across this highly heterogeneous population, to highlight gaps in the community's knowledge and provide direction for researchers and funding bodies. This would require **a broad audit of the evidence we currently have**, with a potential role for the Academy or others in providing an impartial presentation of the evidence, and a route through which the community can identify and highlight high-quality resources with which to judge the burden of ill-health.

Efforts to strengthen the evidence base should not hinder the **deployment of clinical services for which there is already sufficient evidence for expanded provision**, for example, mental health services for those with Post-Traumatic Stress Disorder (PTSD), or services for women affected by sexual abuse. While further evidence on the burden of disease in these areas would be beneficial to refine health interventions in the long term, the evidence base is already sufficient to warrant immediate action.

To best use existing evidence, identify gaps in our knowledge, and direct the collection of future evidence, participants suggested focussing on **which health service delivery approaches had best supported health and well being among forced migrants, and how this good practice could be translated to new contexts?** Participants then explored the current evidence base within several example research fields.

## Evidence spotlight: mental health

The high prevalence and tractability of psychological challenges among forced migrants is **not currently matched by appropriate resources**, a situation which some would argue is true across the UK population more widely. Forced migrants have often endured traumatic experiences and present with an array of associated mental disorders such as PTSD, depression and anxiety disorders, as well as psychosis or substance misuse. Traumatic experiences may include those associated with the factors driving their migration (e.g. conflict, torture and sexual abuse), those experienced during transit (e.g. near drowning), but also by adverse experiences upon arrival in the UK (e.g. poverty, racial discrimination and detention).

There is an existing evidence base on effective treatments for many of these conditions, but this is **not always being fully utilised to inform good practice**. The community should seek to understand the barriers preventing dissemination, seek feedback on how decision-makers perceive the existing evidence base, and identify factors which have supported the successful roll-out of good practice in other contexts.

Research is needed to understand how the health needs of forced migrants differ from other migrant populations, and from host populations. Some barriers to health may be common to many different groups of migrants (e.g. language barriers), and successful interventions could be rapidly transferred from other contexts. In contrast, some issues may be more specific to forced migrants (e.g. trauma-induced mental health problems), which demand tailored solutions. **Further research is needed to understand these similarities and differences**, so that service design and delivery can both capitalise on transferable lessons, and identify where innovative approaches to health delivery are needed.

There is **insufficient research data on the particular experiences of recent waves of migrants** to further tailor services. This includes insufficient evidence relating to unaccompanied minors, as recently highlighted by the House of Lords European Union Committee.<sup>7,8</sup> Participants noted that **further research to understand attitudes and access to domestic violence services among forced migrants in the UK is needed**. This would inform a more integrated approach to mental health, and could be strengthened by pan-European conversations with nations facing similar challenges.

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<sup>7</sup> House of Lords European Union Committee (2016). *Children in crisis: unaccompanied migrant children in the EU*. <http://www.publications.parliament.uk/pa/ld201617/ldselect/ldeucom/34/34.pdf>

<sup>8</sup> Save The Children (2012). *Untold atrocities: the stories of Syria's children*. [https://www.savethechildren.org.uk/sites/default/files/images/untold\\_atrocities.pdf](https://www.savethechildren.org.uk/sites/default/files/images/untold_atrocities.pdf)

## Evidence spotlight: anthropological perspectives

The relocation programmes adopted by the UK Government mean that the UK forced migrant population is likely to remain fairly modest over the coming years when compared to the rapid and substantial inflows seen in other European nations. Without **culturally and socially-tailored solutions**, health interventions are likely to be inefficient or ignored. This extends to all stages of health provision with challenges, such as linguistic differences in describing symptoms, creating barriers to even straightforward diagnosis. Success will be built on cooperation, and the UK research community should seek opportunities to **collaborate on data collection and the evaluation of interventions across the variety of settings where forced migrants are located**, including nations across Europe, the Middle East and North Africa. The mobility of such populations is a major hurdle to research and healthcare delivery, meaning that **traditional approaches to identification and follow up are less effective**. There is a need to understand the demographics of forced migrants, with the crises in Syria and North Africa displacing population with **disease profiles** distinct from those escaping conflict in areas such as sub-Saharan Africa.

## Evidence spotlight: tuberculosis

A historical focus on tuberculosis research in the UK means that the data is more developed than for some other fields, and the availability of research funding is marginally higher. We know that **the burden of disease in the UK is heavily skewed towards migrants** (spanning both economic and forced migrants), with 73% of the 7,892 cases reported in the UK in 2013 occurring in people born outside the UK.<sup>9</sup> However, the burden of disease varies significantly according to country of origin – a well-developed vaccination programme in Syria over recent decades has led to disease prevalence comparable to the UK, and an order of magnitude less than nations such as Afghanistan (19, 15 and 340 per 100,000, respectively).<sup>10</sup> Tackling this challenge is made more complex by many migrants carrying the disease in a latent state, and often presenting to the health system with a more progressed disease due to a reluctance or inability to access help. Pressing research questions include **how** best to screen for the disease, **where** within the health system to conduct this screening, **when** the windows of opportunity are to identify disease, and **how** to ensure successful uptake and completion of treatment.

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<sup>9</sup> Public Health England (2014). *Tuberculosis in the UK, 2014 report*.

[https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/360335/TB\\_Annual\\_report\\_4\\_0\\_300914.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/360335/TB_Annual_report_4_0_300914.pdf)

<sup>10</sup> World Health Organisation (2014). *Tuberculosis country profiles*. <http://www.who.int/tb/country/data/profiles/en/>



## Setting priorities

The recent changes in forced migration patterns have added renewed urgency and focus around health research questions. Priority setting must reflect these evolving demands for evidence, and participants discussed the best way to shape the trajectory of the sector. The model of the **James Lind Alliance Priority Setting Partnerships** was highlighted as a way of identifying and prioritising research topics with input from patients and clinicians.<sup>11</sup> The necessity of including wider stakeholders in this prioritisation process was repeatedly highlighted, with **Clinical Commissioning Groups** specifically noted.

As an overarching theme, **the community should reinforce the clear economic case for proactive treatment of forced migrants**, which is known to lead to lower per capita health expenditure compared to delayed access to health care.<sup>12</sup> This proactive approach could be incorporated at a fundamental level into Government relocation schemes, such as the **Syrian Vulnerable Person Resettlement Programme**.<sup>13</sup> This system, which transports migrants directly from refugee camps in the Middle East, will have significant implications for the trajectory of UK research as it creates a very distinct cohort for study. While this offers a tractable research population, the selection criteria for the programme may mean the group is not representative of forced migrant populations more widely. With this programme already underway, **swift action is needed to capture data on the burden of ill-health, and subsequent health outcomes, across the full timeline of the settlement process**.

**The research agenda must reflect lessons learned from historical groups of forced migration in the UK, Europe and globally.** It is important to understand the factors which dictated the trajectory of health and well-being in different populations, particularly those which have attained above average outcomes, such as ethnic Indian populations displaced from Uganda to the UK in the 1970s.<sup>14</sup> Organisations, such as 'The Faculty for Homeless and Inclusion Health', have longstanding standards of care for vulnerable groups.<sup>15</sup> **The community should explore whether, and how, these standards have been adopted in practice, in order to shape future guidelines.**

## Priority research needs

Participants explored the areas where evidence is most urgently needed:

- What are the post-migration determinants of health and well-being, are these UK-specific?
- What can we learn from previous cohorts of forced migrants, are we carrying across lessons from historical examples?
- Is evidence being used to inform policy and health practices? What evidence is required, and what evidence results in change?
- Do we understand the health context of the main countries of origin, including local cultural, epidemiological and health system factors?
- Do we understand the stages of the migration process and how these impact health (e.g. key transitions within UK asylum, settlement and detention systems)?
- How can we incorporate the influence of wider factors, such as education or employment, into the health agenda? Do we have enough evidence on the impact of forced migrant's right to work, or access to social housing?

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<sup>11</sup> [www.nets.nihr.ac.uk/identifying-research/james-lind-alliance](http://www.nets.nihr.ac.uk/identifying-research/james-lind-alliance)

<sup>12</sup> Bozorgmehr K & Razum O (2015). *Effect of restricting access to health care on health expenditures among asylum-seekers and refugees: a quasi-experimental study in Germany*. PLoS ONE **10**(7), e0131483.

<sup>13</sup> [www.gov.uk/government/publications/syrian-vulnerable-person-resettlement-programme-fact-sheet](http://www.gov.uk/government/publications/syrian-vulnerable-person-resettlement-programme-fact-sheet)

<sup>14</sup> Robinson V (1993). *Marching into the Middle Classes? The Long-term Resettlement of East African Asians in the UK*. Journal of Refugee Studies **6**(3), 230-247.

<sup>15</sup> [www.pathway.org.uk/faculty/the-faculty/](http://www.pathway.org.uk/faculty/the-faculty/)

- Can an integrated 'whole health' approach to treating migrants be achieved quickly enough to be effective, or are resources best focussed on smaller, tractable problems?
- How is the current political context of increasingly restricted access to health services influencing the health status and well-being of migrants?
- How is health literacy among forced migrants influencing access to the UK health system? What are the barriers and enablers?
- How does technology, such as mobile phones, currently feature in the migrant health care, and how can these new platforms be best utilised?

# Research methods

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## Research data

In many areas, the current data landscape is hindered by fragmented databases, unequal levels of data across different disciplines, and heterogeneous data capture techniques. **There is a strong demand for a broad data audit, to examine what data is being collected, who is collecting it, and how this sits within the wider landscape.** The number of factors relevant to forced migrant health make such an audit challenging, and a stepwise approach may be needed. Research topics, such as disease burden, health inequality, access to care, clinical and cost effectiveness, and others, would need to be identified and prioritised. This would allow an appraisal of the evidence base for policy making, highlighting any gaps or areas where practice is not keeping pace with updated evidence. Central to this process will be defining the group being studied. **The terminology used around forced migrants is widely divergent, and must be revisited in light of recent waves of migration.** At present, many health records do not adequately capture migrant status, or use proxies such as residency status or country of birth, which can be poor indicators for targeting health care. **The community must define a clear and simple question or approach** which can be rolled out across health care settings to identify forced migrants and address heterogeneity in current data capture practices.

## Cross-disciplinary working

Tackling the health challenges within this community requires **expertise from across disciplines and across countries**, particularly those European nations which have experienced high influxes of forced migrants. Collaborative working will maximise health impacts and efficiency, but is constrained by disease-specific data sets, held in fragmented locations, and frequently recorded in incompatible formats. **Individual studies should be designed to maximise compatibility with existing data sets** and lessen the need for time-consuming and resource-intensive cohort studies. Alongside data, expertise should also cross boundaries. To help provide a bridge to the wider migrant population, and utilise their extremely relevant experience, **forced migrants with health expertise could be supported to deploy their skills within the research and health community as quickly as possible.**

## Creative approaches

The inherently mobile nature of forced migrant populations presents a major barrier to research. Pragmatic consideration should be given to the value and limitations of official data, and **how best to connect these data sources, such as health records, for populations which are frequently dispersed.** Patient-held health records have been successful in some settings (such as refugee camps), but participants were keen to **explore novel approaches**, including those which make use of high levels of mobile phone ownership. Access to this technology opens up a variety of innovative possibilities, both for data capture and the delivery of health care and support. To effectively capture this potential, the community must **understand how migrants currently use mobile phones within their 'coping strategies'** – including to access health information, support networks and language services. Telemedicine could reduce barriers to healthcare by incorporating real-time language interpretation facilities, or allowing healthcare experts to be drawn on from across the UK and internationally. **A firm understanding is needed of the feasibility, benefits, and drawbacks of such approaches.** Participants highlighted confidentiality as a particular issue that should be explored further with this demographic.

## Growing the research community

The future of research in this expanding area relies on attracting the next generation of researchers from across many disciplines. **The skills pipeline must be strengthened, and funding bodies should encourage early career researchers to take the cross-disciplinary approaches needed.** The sector suffers from expertise being spread across the UK, as well as across the globe, and **ways to connect these pools of talent and experience are needed.** On the topic of PhD training programmes, participants were divided on the merits of focused schemes for migrant health research, versus protecting the breadth and flexibility for people to enter the field from different specialties. **Raising the status and visibility of the field may offer an indirect method to attract talented researchers to establish a career in the discipline.**

# Research funding

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## Funding sources and priorities

The community has an incomplete understanding of the funding landscape in this area. **Clarity is needed on the sources and scale of research funding available, to improve the allocation of resources.** Funding is fragmented across many stakeholders, with important contributions made by **EU research framework programmes, National Institute for Health Research, Medical Research Council**, and increasing deployment of **Official Development Assistance (ODA)**. Participants noted that EU research funding had demonstrated considerable agility over recent years – evolving and expanding to meet changing demand. This had provided substantial support to many researchers in this area, and may offer a model for responsive funding.

Several key funders in this area are linked to current Government policy priorities. There is great value in clarifying the nature of these limitations and **maintaining a funding landscape which includes funding bodies with agendas which are independent from Government.** The individual and specific eligibility criteria often attached to funding in this field may create barriers to access for researchers. Specifically, **participants highlighted widespread uncertainty about the eligibility of research focussed on UK-based migrants for ODA resources.** With the UK committing 0.7% of national income towards ODA, there is an **opportunity for the UK to take an international leadership role in this area** – backing our world-leading expertise with the resources needed to deliver global impact on forced migrant health concerns. This should work synergistically with other funding sources, including relevant EU programmes and investment by other host nations – particularly in light of the significantly greater number of migrants entering European nations other than the UK. **Success will require a strong and long-term vision from funding bodies including the UK Government**, to provide stability for the community and funding timelines which are proportionate to the scale of ethical approval in this area. These **priorities should be clearly communicated to the community**, with eligibility criteria that are aligned, wherever possible, to minimise fragmentation.

## Seizing opportunities

At present, the research agenda is closely coupled to the political agenda around forced migrants. However, research in this area can deliver health benefits to not only forced migrants, but also society as a whole, and **the research community should seek to reiterate this message wherever possible.** It is important to place forced migrant health into the wider context of UK public health, and to highlight the economic case for proactively addressing health issues in this group. Researchers should consider how best to work with the prevailing political agenda, and identify win-win opportunities which can satisfy both research and political interests. **Calls for support must be carefully tailored to address the mandate of different stakeholders**, recognising the strengths and remits of different funding bodies, to support the entire pipeline of research. The deployment of ODA resources into the research community via the Global Challenges Research Fund may present an important opportunity for this field. There is also a **role for local authorities and Clinical Commissioning Groups in financially supporting focussed studies**, and scope for far **greater coordination at a European and international level.** The academic community should also actively seek out partnerships with industry to ensure that collaborative opportunities are maximised.

# Global cooperation

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It is vital that UK research efforts contribute to, and benefit from, the global research community focussed on this issue. The UK has a wealth of expertise across the medical and social sciences, able to deliver impact both within and beyond the UK.

Stakeholders, and researchers themselves, should seek to work with counterparts across the globe to share experiences and resources, including European nations facing similar challenges. Such collaboration may be placed at risk by wider political changes, including the UK's departure from the European Union, and the research community should strive to maintain a high degree of cooperation now, and in the future. A great deal of the evidence needed in host nations has relevance in regions from which migrants move, and significant evidence gaps have been identified in front-line health delivery in these areas.<sup>16</sup> Barriers to health, such as low health literacy among forced migrants, are common across all settings and it is vital that good practice is communicated, refined, and deployed in partnership across nations.

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<sup>16</sup> Syria Public Health Network & Chatham House (2016). *Syria's health: the silent burden of chronic diseases*. <http://www.rcpsych.ac.uk/pdf/Syrias%20Health%20-%20The%20Silent%20burden%20of%20Chronic%20Diseases.pdf>

# Next steps

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The roundtable session identified a number of actions, to be addressed by the research community, funding bodies and other stakeholders.

These include the need to:

- Undertake a **broad audit of the current evidence base across physical and mental health**, to understand what data sources exist and which organisations are involved in recording data.
- Work across all stakeholders, particularly with Government, to **set out clear priorities for the evidence base** in order to deliver the best health and well-being outcomes for forced migrant populations.
- Take swift action to **integrate research within resettlement programmes**, to ensure that these cohorts are followed from the earliest possible moment.
- **Revisit historical lessons** from previous high levels of migration, and to understand whether lessons can be carried forward to the current day.
- **Increase coordination across disciplines and countries**, to maximise the sharing of expertise and good practice.
- **Revisit the principles of data collection**, to reduce fragmentation and increase compatibility across data sets, with a particular focus on improving health records.
- **Understand and use innovative methods for interacting with forced migrants**, including the potential use of mobile phones to capture data and deliver healthcare.
- **Strengthen the pipeline of skills entering the discipline**, by increasing the visibility and prestige of working in this area of research.
- **Clarify the sources and scale of funding available** for research, and identify any gaps, including a clear picture of the eligibility criteria around ODA resources.

# Annex I: Participant list

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## Participants

- **Professor Dame Anne Mills DCMG CBE FRS FMedSci** (Chair), Deputy Director and Provost, London School of Hygiene and Tropical Medicine
- **Professor Dawn Chatty FBA**, Emeritus Professor of Anthropology and Forced Migration, University of Oxford
- **Dr Osman Dar**, Director, One Health Project, Centre on Global Health Security, Chatham House
- **Professor Christopher Dye FRS FMedSci**, Director of Strategy, World Health Organization
- **Professor Jon Friedland FMedSci**, Head of Infectious Diseases and Immunity, Imperial College London
- **Dr Sally Hargreaves**, Senior Research Fellow, Imperial College London
- **Professor Emily Holmes**, Programme Leader, MRC Cognition and Brain Sciences Unit, Cambridge
- **Dr Neha Issar-Brown**, Programme Manager, Population and Systems Medicine Board, Medical Research Council
- **Dr Vittal Katikireddi**, Senior Clinical Research Fellow in Public Health, University of Glasgow
- **Professor Cornelius Katona**, Lead on Mental Health of Asylum Seekers and Refugees, Royal College of Psychiatrists; and Medical Director, Helen Bamber Foundation
- **Dr Philipa Mladovsky**, Assistant Professor in International Development, London School of Economics
- **Dr Jasmine Murphy**, Consultant in Public Health, Leicester City Council
- **Dr Bayard Roberts**, Senior Lecturer in Health Systems and Policy, London School of Hygiene and Tropical Medicine
- **Professor Charlotte Watts FMedSci**, Chief Scientific Adviser, Department for International Development; Professor in Social and Mathematical Epidemiology, London School of Hygiene and Tropical Medicine
- **Professor Christopher Whitty CB FMedSci**, Chief Scientific Adviser, Department of Health; Professor of Public and International Health, London School of Hygiene and Tropical Medicine
- **Dr Cathy Zimmerman**, Co-founder of Gender Violence & Health Centre, London School of Hygiene and Tropical Medicine

## Subsequent input

- **Dr Angela Burnett**, GP, Hackney; and Lead Doctor at Freedom From Torture

## In attendance

- **Dr Ben Bleasdale**, Policy Officer, Academy of Medical Sciences
- **Catherine Luckin**, Head of International, Academy of Medical Sciences
- **Dr Rachel Quinn**, Director of Medical Science Policy, Academy of Medical Sciences



# Annex II: Agenda

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|---------------|---|
| 12:00 – 12:05 | <b>Welcome from the Chair (Professor Dame Anne Mills DCMG CBE FRS FMedSci)</b>  |
| 12:05 – 13:15 | <p><b>Session 1: Wider determinants of health</b></p> <ul style="list-style-type: none"> <li>• What are the wider positive/negative determinants for health?</li> <li>• Where are the windows of opportunity to influence health?</li> </ul> <p>Brief introductory remarks from:</p> <ul style="list-style-type: none"> <li>• <b>Professor Jon Friedland FMedSci</b> – perspectives on infectious disease</li> <li>• <b>Professor Emily Holmes</b> – perspectives on psychological health</li> <li>• <b>Professor Dawn Chatty FBA</b> – an anthropological perspective</li> </ul> <p>Followed by open discussion.</p> |
| 13:15 – 14:00 | <p><b>Session 2: State of the evidence base</b></p> <ul style="list-style-type: none"> <li>• Where are the strengths/weaknesses of the current evidence base?</li> <li>• What are the disciplines and data sources needed to understand the problem?</li> <li>• What evidence do we have on interactions with local health services?</li> </ul>   |
| 14:00 – 14:15 | <i>Refreshments break</i>   |
| 14:15 – 15:00 | <p><b>Session 3: Role of research</b></p> <ul style="list-style-type: none"> <li>• What are the research priorities?</li> <li>• How does the funding landscape for research in this area look?</li> <li>• Which stakeholders need to be engaged to bring about change?</li> </ul>   |
| 15:00 – 15:45 | <p><b>Discussion of conclusions</b></p> <ul style="list-style-type: none"> <li>• What are the key conclusions from this meeting?</li> <li>• What are the next steps for the community?</li> </ul>   |
| 15:45         | <i>End</i>  |



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