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Epidemiological risks and hazards associated with migration

„I know exactly (...) that everyone carries the plague because nobody, but nobody in the world is untouchable."

Albert Camus: The plague (1947.)

Annotation: Epidemiological risks and hazards associated with migration

The epidemiological segment of migration is one of the less-known risk elements of our days. The study points out the process of regular and irregular migration accelerated in the globalized world, and the risk of how big treat the diseases carried by the migrants pose to the members of the population affected by migration and between the migrants themselves. The summary includes a recommendation on correcting shortcomings in legislation and procedural protocols and also new elements.

Keys: condition system, epidemic risk, migration, psychological effect

1. Introduction

In connection with the researches related to the phenomenon of migration, risk analyzes, impact studies, prognostic consequences, and formulation of recommendations based on them should be mentioned. These risks analyze generalizable feature is, that they focus on phenomena which can be identified in social processes. At the same time, the risk factors related to regular and irregular processes in the context of migration and travel times is less found, as well as the predictive recommendations related to them. It is an essential requirement for regular and irregular migration risk analyzes to examine together the composition, the goals and related internal and external conflict sources of migrants and the elements of the known paths of movement. With many other risk elements also taken as components of the process, the research must focus on the most critical threats known, and the emphasis must be on the preventionon, substantive management of them.

In my opinion perhaps, the biggest risk factor is the epidemiological threat. Threat to public health or epidemiological danger may be one of the (if not the only) risk factors that are present in the primary, secondary and tertiary period of both regular and irregular migration and is a real threat to individuals, a smaller community, or a larger population.

2. Migration and risks

2.1 Migration as a health risk

Humanity has been infected and rarefied with series of such deadly deseases as various types of smallpox, scabies, tuberculosis, measles known since the time of historiography. In many of the world's low-immunized, low vaccination rated countries even nowdays it can cause acute illness, epidemics, and can be easily carried by patients when traveling to their destination country.[2] Health risk is an element related to migration (also), where at national and supranational level we must envolve preventive measures, and execute them where appropriate.[3]

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[2] Meglécz Katalin: A pandémiák története és kialakulásuk okai = History and causes of pandemics. Budapest, Hadmérnök, (2012.) 9. Pp. 92-98.

[3] Bengtsson Louise; Borg Stefan; Rhinard Mark: European security and early warning systems: from risks to threats in the European Union's health security sector. European Security. Bremen, (2017.) pp. 1-21.

Cholera-like illnesses firs appeared in the 4th-5th century b.C. in the territory of today's India and Greece. The epidemic of cholera was first described by Gaspar Correa who informed the world of the "Ganges delta desease" outbreak on the spring of 1543. This disease was located in the South Asian area of Bangladesh, and shortly it was discovered in India, due to the – even that time – critical hygienic conditions. The desease was spreaded first to Asia, then to the Middle-East countries, and in 1829 to Europe and America by the sailor merchants, travelers, and the large number of migrants traveling to and from India.

The first major plague epidemic outbreak in Europe was in a.C. 540, after a global climate change occurred around a.C. 535, caused by bacteria infected rodents migrated along with the migrants and traders, moving from Eastern Africa to northern areas.

In case of modern age deseases, one of the most serious epidemics was the Spanish flu, which after the first appearance in the 20th century in Spain, due to the European internal migration after World War I. later became one of the deadliest diseases in other countries as well. Severe acute respiratory syndrome is the atypical pneumonia caused by SARS coronavirus, which is a fast, aggressive, easily spreading disease caused the highest mortality rate in 2003. The modern version of the Spanish flu, influenza's mutated version: H1N1 first occurred in Mexico, then most probably young adult migrants first spread it to the USA, then it spreaded from there causing a worldwide epidemic. AIDS, which is typically related to underdeveloped health care systems and sexual culture of developing countries and the phenomenon of sex tourism, can also be linked to the sexual exploitation or livelihood of irregular migrants. WHO has also called attention[4] to the issue with the principle of "everyone is counting". Hepatitis A, -B, and C are also linked to migration flows from the countries of origin, which diseases are also one of the major epidemics of our modern world due to hygiene deficiencies, sexual relations, intravenous drug use, blood transfusions, and bleeding diseases.

Ebola which first appeared in Zaire, then in Sudan in 1976 as a consequence of the migratory push effects caused by the political, social and armed conflicts in the region, as well as the improperly managed health crisis, continued to move to Sierra Leone, and Liberia. In 2014 a vision of a world-wide deadly epidemic was pojected, because of infectious persons (one-one) occurred in other countries as well (Italy, Nigeria, Mali, Senegal, Spain, the United Kingdom and the USA).

The geopolitical situation of Hungary already reinstated its inevitable role even after the establishment of the state. The "wanderers", when they arrive in Hungary, or even go from east to west, from south to north, can only do so across our national borders[5]. At the international level, countries are addressing this state-of-the-art task in a number of ways today. The guarding of the state border, like efforts to limit territorial access, has long been a central state activity for sovereignty, secure control of the people in the deep, and for the integrity of the state[6]. This objective is supported by the physical and legal protection and guarding of the state border, and by the effective implementation of controls for the purpose of securing both migration and serious crime offenders. Each state and its obligated organization authorized to control foreigners[7] maintains the territorial sovereignty of the country and the security of its citizens on an ongoing basis within an organized framework.

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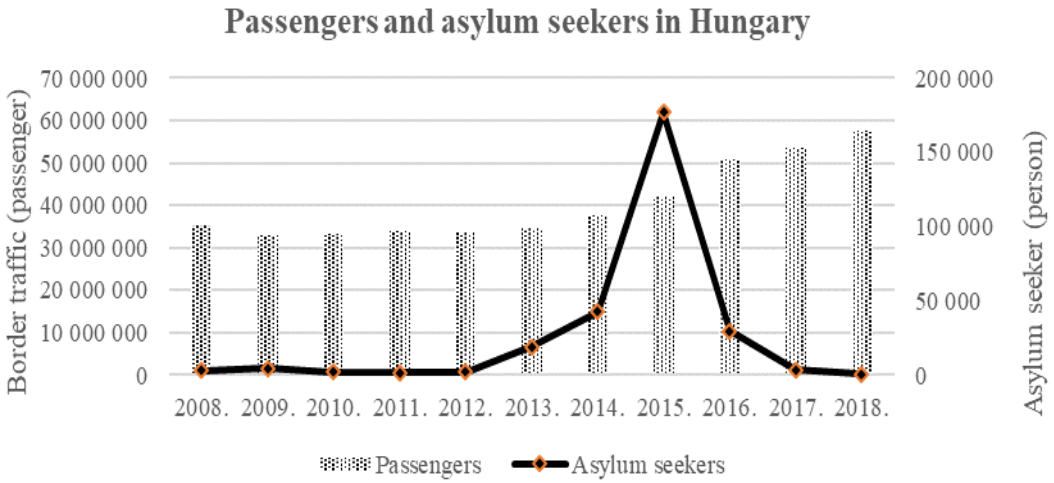
[4] Nduta Waweru: Good morning Africa on World Aids Day (2017.) https://thisisafrica.me/worlds-aids-day-2017/ (Download time: 22. 02. 2018.)

[5] Balogh Róbert: Migráció, mint anomália — a bevándorló-kérdéstől a bevándorló-veszélyig = Migration as an anomaly - from the immigrant issue to the immigrant threat - Jog- és politikatudományi folyóirat, Budapest (2008.) pp. 414-426.

[6] Malcolm, Anderson: Frontiers - Territory and State Formation in the Modern World - Cambridge Polity (1996.) pp. 5-12.

[7] Hautzinger, Zoltán: A magyar idegenjog rendszere és az idegenjogi (szak)igazgatás = The Hungarian foreign law system and the foreign law (specialized) administration - In Budapest: Pro Publico Bono Magyar Közigazgatás Nemzeti Közszolgálati Egyetem (2014.) pp. 69-78.

The number of migrants in regular border traffic at the borders of Hungary is growing steadily and dynamically. The number of persons appearing in irregular migration after the Schengen accession is also increasing due to the position of Hungary as a transit state and in 2014-2015. was an extremely high number in the 1990s.



2.2 Epidemiological risk of accelerated migration

A summary of the study of a research group worked in Hungarian Academy of Sciences in 2015 states that the developed countries of Europe are the favorite destinations for refugees and migrants starting from the Middle East, Western Balkans, North and Sub-Saharan African countries.[8] In addition revealing push and pull factors there is also a risk analysis significance of the study, since the migrants of these areas may occure as epidemiological risk factors for the population of European destination countries.

When examining the push and pull factors, it can be stated that the travel periods between the different starting and destination countries have changed substantially since 2000, their duration has been significantly reduced as a result of the increasingly brutal armed conflicts, the intensively communicated governmental, political views to enhance the economic and demographic situation of the aging European societies, and the impact of the European Union. The statements, the procedure documents and the found material evidences of the migrants who were taken under measures by law enforcement agencies, or who contacted the responsible authority themselves confirms, the fact that the "wanderers" reached their destination (typically without the use of means of transport) in several years, depending on the distance between the country of origin and destination.

The opportunity to reach faster the target country on old and newly formed migratory routes created a potential sorce of danger of epidemic emergencies and pandemics. It excludes that the infected human body can overcome the disease and become an inactive carrier, or to not to reach to the destiantion country through the transit countries because of the worsened health status.

2.3 Health threat during regular migration control

In the modern era, economically developed countries have developed an environment based on national normatives, and on regulations of contractual association of Member States,

[8] Szigetvári Tamás; Novák Tamás; Wagner Péter & Biedermann Zsuzsánna: Küldő országok és a kiáramlás felgyorsulásának egyes oka - Sending countries and some reasons for the acceleration of outflow – In.: Az európába irányuló és 2015-től felgyorsult migráció tényezői, irányai és kilátásai - Ed.: Csuka, Gyöngyi & Török, Ádám; Budapest, (2015.) pp. 36-46.

which also regulates under what circumstances and with wich authenticated certificate can a person who intent to enter, transit or stay on their territories turn to the authority responsible for checking the conditions.
The Schengen Member State Association9 requires the visa obligated travelers who wish to travel to it's territory to comply with the terms and conditions of issuing a prior authorization (visa), or grants exemption, or beneficiary procedure provided by law[10].
The EU rules on visa requirements and visa exemptions for non-EU citizens entering the territory of a Member State for short stays are governed by EC Regulation[11].
As a place for submitting a visa application, the Member States have primarily designated their visa issuing authorities and delegations outside their territory. The application process may be initiated by the Council of the European Union by asking for the harmonized Annex 9 of the Schengen Catalog COMIX 852 and by asking for supplementary files, in which the health status declaration and certification provisions do not appear.
During the border checks of the regular, legal environment respecting travelers the authorities also perform their tasks following the harmonized law and practices, the declared national law, and the actions of the leader authorized to issue them. The Codex[12], the Handbook[13] which sets out the uniform practice of the Codex, the norm of Border Traffic Control Regulation[14], makes the use of all these in the control of border traffic compulsory.
The 4th paragraph of the introduction of the Handbook already mentions the obligation to enforce health checks to the competent authority. The 22nd point describes the concept of "threat to public health" in the scope of the mandatory recommendation:
"Threat to public health refers to any disease with epidemic potential as defined by the International Health Regulations of the World Health Organisation and other infectious diseases or contagious parasitic diseases if they are subject of protection provisions applying to nationals of the Member States."
As set out in section 1.1 (e) of the "checks at border crossing points" refering to in Part II, Section I, point 1, the entry can only be initiated unless it does not pose threat to public health. 70 (k); 127 and 137 point of Regulation on Border Traffic Control[15] also provide the rules and obligations of public health control tasks, but there is no provision for the content, the preliminary theoretical and practical preparation of those responsible for the control, or for the epidemiological prevention rules applicable[16].
According to the Act on the Admission and Residence of Persons with the Right of Free Movement and Residence „*The provisions set out in Regulation (EC) No. 562/2006 of the*

[9] The Schengen Agreement was part of the first and third pillar of the European Union. Not all EU countries are members of the convention, and there are non-EU members as well. Not all signatory countries apply this convention.
[10] Hautzinger Zoltán: Szemelvények a migráció szabályozásáról = Outlines of migration control. Pécs, AndAnn kft. (2016.) pp. 19-20.
[11] Council Regulation (EC) No 539/2001 of 15 March 2001 listing the third countries whose nationals must be in possession of visas when crossing the external borders and those whose nationals are exempt from that requirement.
[12] REGULATION (EU) 2016/399 OF THE EUROPEAN PARLIAMENT AND OF THE COUNCIL of 9 March 2016 on a Union Code on the rules governing the movement of persons across borders (Schengen Borders Code)
[13] COMMISSION RECOMMENDATION establishing a common "Practical Handbook for Border Guards (Schengen Handbook)" to be used by Member States competent authorities when carrying out the border control of person. COM (2006) 5186 final
[14] Határforgalom-ellenőrzési Szabályzatról (Border Traffic Control Code for Hungarian Police) szóló 24/2015. (X. 15.) ORFK utasítás
[15] Határforgalom-ellenőrzési Szabályzatról szóló 24/2015. (X. 15.) ORFK utasítás
[16] Kondás Kornél: A Rendőrség helyi szerveinek feladatköre egészségügyi válsághelyzet esetén = Duties of local police departments in case of health crisis. Hadtudományi Szemle. Hadtudományi Szemle. Budapest (Nemzeti Közszolgálati és Könyvkiadó Zrt) (2017.) pp. 298-319.

European Parliament and of the Council of 15 March 2006 establishing a Community Code on the rules governing the movement of persons across borders (hereinafter referred to as "Schengen Borders Code") shall also apply to the admissions specified above." [17]
According to the Act on the Entry and Stay of Third-Country Nationals "*Third country nationals may enter the territory of the Republic of Hungary and stay for up to three months within a period of six months from the time of first entry (hereinafter referred to as "stay not exceeding three months") under the conditions set out in Regulation (EC) No. 562/2006 of the European Parliament and of the Council of 15 March 2006 establishing a Community Code on the rules governing the movement of persons across borders (hereinafter referred to as "Schengen Borders Code")"* [18] Illnesses – which can be a threat for the public health – as a limitation fund are listed in a ministerial decree, which is also basis of social disputes, while authorized by law classifying and identifying the diseases (tuberculosis, HIV, lysosus, thyroid and parathyroid bacterial status, hepatitis B), which pose a potential threat to the members of society in case of their entry.[19]
According to the Act on the Police "*The police will provide (...) the necessary care to prevent the loss of health due to detention. The inmate who is injured, sick, or otherwise in need for urgent medical treatment should be provided medical care*."[20] At the same time, the legistrator does not have any detailed order about the applicable protocol, or the order of support on those cases which are beyond the tasks of the emergency medical service and handeling ad hoc small-scale inmates, nor in the refered legistlation, neither in it's regulation on implementation[21], or in any other norm. (Large numbers of massive irregular migration health management tasks, taking into account the intent of preventing the overload of the local population's healthcare system.) The assurance of these tasks on national, social level (including staff, financial and logistical background) is missing. There are currently no statutory provisions in place to prevent or hinder transfection from people beyond emergency care, but requiring healthcare.[22]
The relevant national legislation refers to a binding EU recommendation, relevant EU norm, but the order of the implementation of public health control tasks is missing, or only partially set, which only shows the intention of the legislator in this respect.
Provision of normative and sustainability regulation at national level is justified, and it is proposed to be international, because migration is beyond state borders. This risk, caused by the lack of normative regulatory and material deficiencies, is significantly increased by the regular migration which occurres within a short-term period due to the economic potential of travelers. As a result, people can travel continental distances in up to 24, 48 hours as a carrier of a possible contagious disease, with border checks conducted in maximum a few minutes per person inspection period, if there is no specially ordered, additional checks.

2.4 Health threats caused by irregular migration

[17] A szabad mozgás és tartózkodás jogával rendelkező személyek beutazásáról és tartózkodásáról szóló (Act on the Entry and Stay of Persons with Free Movement and Residence Right) 2007. évi I. törvény 3.§ (5)
[18] A harmadik országbeli állampolgárok beutazásáról és tartózkodásáról szóló (Act on the entry and residence of third-country nationals) 2007. évi II. törvény 6. § (1)
[19] A szabad mozgás és tartózkodás jogával rendelkező személyek és a harmadik országbeli állampolgárok magyarországi tartózkodásával összefüggő közegészséget veszélyeztető betegségekről szóló (Decree of the Minister for Health on persons with the right to move and reside freely and on diseases affecting the public health of third-country nationals in Hungary) 32/2007. (VI. 27.) EüM rendelet, 1. sz. melléklet
[20] A rendőrségről szóló (Act on Police) 1994. évi XXXIV. törvény 18. § (2)
[21] A rendőrség szolgálati szabályzatáról szóló (Decree of the Minister of the Interior on the Police Regulations) 30/2011. (IX. 22.) BM rendelet
[22] A sürgős szükség körébe tartozó egyes egészségügyi szolgáltatásokról szóló (Health Ministerial Decree on Emergency Health Services) 52/2006. (XII. 28.) EüM rendelet

In emitting countries where irregular migrants come from to our country, the active immune protection, that would enable the immune system to defend itself by vaccination with dead or attenuated pathogen, is different from the Hungarian or European standadrs, or completely missing. By the Hungarian or European standards the ability to defend is long-lasting, the body recalls the pathogen. Active immunization results in the same processes as in the case of a real infection. The morbidity factors are different in a given population related to the frequency of illness, wounding and disability, which resulted in illnesses on our borders that we thought could no longer exist, such as diphtheria, leprosy, and cholera. According to Mikola, various infectious pathogens can cause different types of diseases in populations which originally lived far from eachother, so the therapeutic treatment is different as well.[23]
Nógrádi, in his study[24], draws attention to one of the previously neglected risk phenomena of the irregular migration, the epidemic threat. The threat of being infected are cumulatively manifested because of the hygiene (mental), health-care and social systems of the country of origin, the threats specific for the migration period and the massive movement and stay, as well as the psychological and physical exhaustion. The irregular state and the latency of the people who did not appeare before the authority will further deteriorate the indicators, since in the crowd some carriers may be sufficient to cause a larger epidemic, the source of which can be found by the authorities with considerable time and difficulty due to hiding and the latency of mortality.
The most frequent cases requiring healthcare: accidents, colds, burns, digestive problems, heart problems and pregnancy, in the case of vulnerable categories upper respiratory diseases and skin diseases. Typically, these diseases are not in the frame of emergency care, as they are not for the local population. Within the Hungarian police, for the first time - recognizing the possible public health and epidemic risk, for preventing and screening it - in 2014, at Szeged Border Policing Office (as a best practice) a temporary healthcare center had been established with health care personnels providing continuous examinations and care, disencumbering the elements of the national health care system which could ensure the original level of care for the own citizens. [25]
Regular and the irregular migration into the European Union has become a social and economic necessity, nevertheless the EU started to address the health and epidemiological issues, the risk factors of the process only during the Portuguese Presidency of the European Union in 2007. However, after revealing the set of problems and risk hazards, it has been put on the agenda of a number of key international forums. [26]
According to the summary of a study of the European Regional Office of the World Health Organization conducted in 2010, 11 out of 27 Member States have set up a policy toolkit in addition to the related legal regulatory environment, to pursue the task of providing a better

[23] Lóránth Ida idézetében: Járványt hoz a migráció. Betegségek, amelyekről azt hittük, már nem is léteznek = Migration is the cause of the epidemic. Diseases that we thought were no longer present. Budapest, Kórház 6./15 (2008.) pp. 11-12.
[24] Nógrádi György: Nemzetvédelem szögesdróttal – a migrációs válság és magyar vonatkozásai = National defense with barbed wire - the migration crisis and its Hungarian aspects – Felderítő szemle, XV/1, (2016.) Budapest, pp. 5-21.
[25] Sipos Edina: A Rendőrség szerepe a migránsok egészségügyi ellátásában; a személyi állomány védelmében tett intézkedések – előadás = The role of the police in the health care of migrants; measures to protect staff - lecture (2015.)
www.bm-tt.hu/assets/letolt/e5konf/nap11I/1_DrSiposEdina.ppt (Download time: 18. 02. 2016.)
[26] Szilárd István, Baráth Árpád: Migráció és egészségügyi biztonság: új foglalkozás-egészségügyi kihívások = Migration & Health Security: new occupational health challenges. Határrendészeti Tanulmányok, Pécs, (2011.) pp. 269-279.

and more accessible healthcare for third country nationals.[27] It can be stated that the political actions of each country are showing their own real migration involvement, and the fact if immigration is multi-generational, traditional phenomenon, or it is affecting as new, and in large waves. In the year 2016, the European Union Agency for Fundamental Rights, as an organization dealing with refugees their family members and their rights emphasized, that due to the increasing number of vulnerable (sick) migrants, this phenomenon should be paid more attention than before. Migration Vulnerability Studies focus on, and formulates recommendations for vulnerable persons both for the on-the-spot tasks, and for national, supranational levels of legislation. [28]

3. Primary, secondary and tertiary effects of health risks

Migration can be characterized as a set of processes along certain regularities. Migrants move in a given timeline, in a demarcated space, making shorter or longer-term, direct or indirect contact with each other and with other persons (control authorities, local population, members of service organizations).

These contacts may pose real threat to both parties, due to the potentially present diseases, as a member of the transit and host states can cause infection to the border crosser, and it is true backwards as well. During the migration, or the period of the official procedures, also during other waiting periods migrants can transfect each other, and others who are in contact with them. These primary, direct contacts can represent the primary impact of migration on public health and epidemiological situation.

As a secondary public health and epidemiological risk, the phenomenon, that emerges after the migratory time and the appearance of the disease symptoms, and which is beyond the disease carrier period can be mentioned. This risk, circumstance, which poses a concrete threat may occur due to the accelerated migration processes after the year 2000, when the travellers became in direct contact with the healthy human environment as a carrier - with a few days or a few weeks of incubation period - of the disease, so when potential conditions for the transmission of infection emerges, and the infection will occur. In these cases, (if the migrant gets and stays in contact with the relevant authorities of the state) the migrant can be defined as a source, through the personal contact lines the infection chain can be detected and handled. Connected to irregular migration - mainly the persons involved in its latent processes, without documents or personal identity[29] - and the introduction of illnesses in their new living area between the migrant diaspora and the host state's inhabitants without the knowledge, supply and treatment possibilities of the local authorities, can be assessed as an especially high-risk public health and epidemiological threat.

The yet just prognosticable, tertiary public health and epidemiological impact of massive and accelerated migration, which reached the developed European societies in the past few years can also be attributed to a radical decline in the migration process's temporal plane, when migration periods shortened to a few days, weeks, or months through continental and climatic zones and geological altitudes. These circumstances exclude the possibility for the migrant's body to respond to the rapid changes in environmental impacts by mortality or to be able to adapt on body and genetic level for the changed environmental conditions.

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[27] Gazard Billy, Frissa Souci, Nellums Laura, Hotopf Matthew, Hatch, Stephani L.: Challenges in researching migration status, health and health service use: an intersectional analysis of a South London community. Ethnicity & Health, London (2015.) pp. 564-593.

[28] Burns Nicola: The human right to health: exploring disability, migration and health. Disability & Society, 32(10) London (2017.) pp. 1463-1484.

[29] Elisabetta De Vito; Chiara de Waure; Maria Lucia Specchia; Paolo Parente; Elena Azzolini; Emanuela Maria Frisicale; Marcella Favale; Adele Anna Teleman & Walter Ricciardi: Are undocumented migrants' entitlements and barriers to healthcare a public health challenge for the European Union? - Public Health Rev.(2016.) 37: 13. pp. 2-6.

In case the migrant's body becomes unable to handle the environmental impacts of the previous 2-5 migration years after arriving to the host country, then known, or atypical diseases that are not, or less known by medicine may occur, which can be a serious risk factor if there is lack of treatment, or the use of preventive action in the field of population protection, while at the same time raising the possibility of genetic lesions for the descendant of those affected.

4. Psychological problems, the migration crisis

Associated with migration, different psychological impacts[30] occur, and typically both sides involved in the interaction - migrants and host country citizens - live encountering foreign cultures as a physical and psychological adaptation problem, a kind of culture shock.[31] In the case of migrants, external influences, internal tensions, unknown novelties can cause psychological symptoms, as in the same way for the members of the nations or organizations that are in contact with them.[32]

The migration crisis may also bring positive and negative results, where the migrants rebuild the consciousness of space identity, leave the old elements, and the new residential environment is integrated into their personality. If that does not happen, they can not break away emotionally from their past, become stuck in the mourning state, then they become unable to live in their new environment, won't build new relationships, won't create new sociophysical environment, and this process leads to psychological statelessness, to the state of learned helplessness, aggression. Migration is based on an voluntary decision, while in the case of exile or escape, it is a compulsive decision, where the individual has the only opportunity to leave the current place of residance to protect his or her own physical and psychological integrity. In these cases, not only an individual, but the entire community becomes a victim of persecution and destruction, resulting in a collective trauma. Migration, as leaving the place of residance itself can be considered a crisis but not a traumatic phenomenon. However, the persecution that triggers it, the events of the migratory period can result in traumatic experiences that can also cause psychological changes.

Most people deliberately decide to change their place of residence in order to overcome some of their deficiency, referring to an after deliberation of choice result, where the person compares the advantages and disadvantages of the current place to leave with the hoped-for advantages and disadvantages of the new place chosen. Because of its features, this is excluded from the victims, or other affected people of natural disasters, war, or other extensive social conflicts. The phenomenon of migration can be interpreted as a change in the living environment, that directly affects place identity which is lost in the new environment, in turn the integration of new one takes time, which is termed as mental homless state. This period clearly influences the mental stability of the migrant.

During the period of integration, age is of paramount importance in which an individual must be able to overcome the difficulties caused by acculturation. Children are relatively quick to master the language and culture of the host country. For adults this is a longer process, and for older people, the process of adaptation is very slow. Due to the different rhythm of the acculturation process, there are often intergenerational conflicts.

[30] Sipos Szandra: A migráció főbb pszichológiai megállapításai = Main psychological findings of migration- Budapest, Nemzetbiztonsági szemle (2016.) IV/1, pp. 18-33.

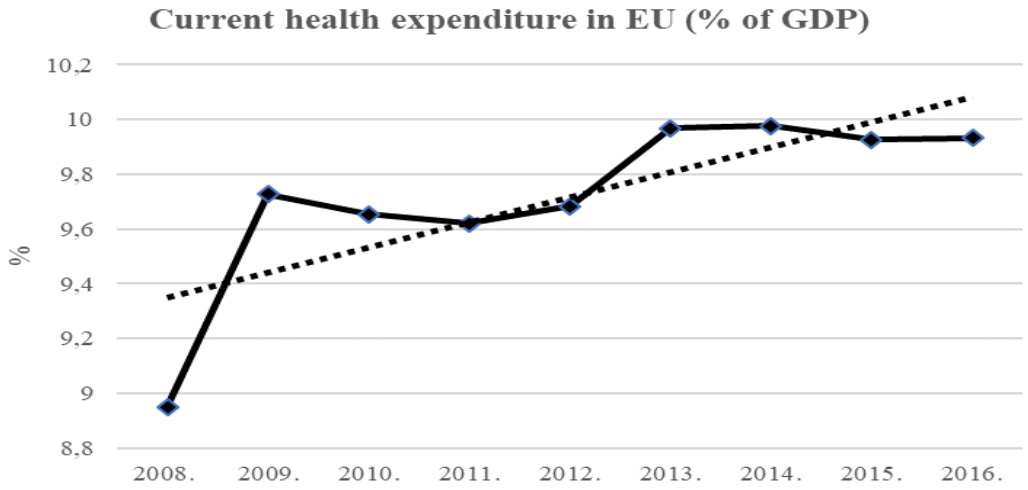
[31] Watters Charles: Migration and mental health care in Europe: Report of a preliminary mapping exercise. Journal of Ethnic and Migration Studies, 28 (1) Sussex (2002.) pp. 153-172.

[32] Borbély Zsuzsanna, Farkas Johanna, Tőzsér Erzsébet: A tömeges méretű illegális migráció pszichés következményei a rendészeti feladatellátás során = The psychological consequences of the massive illegal migration in the policing service provision. Hadtudományi szemle, Budapest 3/10 (2017.) pp. 288-304.

Migration research differentiates cultural shock, cultural adaptation process and acculturation in the context of culture. Cultural shock occurs when individuals encounter partially (totally) foreign cultures, causing serious adaptation problems. The process of cultural adaptation and acculturation refer to a complex phenomenon, resulting in a change in the individual's integration into the new culture.
Acculturation typically happens through multiple stations. First is acquiring the language of the host country, then comest the gradual correction of the behavior for the host culture. The inhibitory factor in acculturation is xenophobia and discrimination in the host society. The potential consequence of this negative effect is acculturation stress, which appears primarily in mental hygiene, showing the symptoms of confusion, anxiety, moodiness, depression, and exclusion.
Integration to the host society requires large number of problem-solving strategies from the migrants, and if one of them is not suitable they must switch between them to be able to cope with unknown difficulties.
More flexible personality structure, knowledge of the culture and language of the host country, a broader supportive network of contacts, secondary-, tertiary migration, pre-migration emotional preparation, and the use of previous acculturation experiences means advantages in integration.

5. Summary, vision

The process of migration, both of its regular and irregular appearance poses risk factors for migrants, members of the transit, or host societies, that can be traced back to human health, epidemiological or psychological reasons, and may create the basis for a real emergency. These risks are the epidemics affecting people living in societies with democratic order of law in high population areas with shortage of health consciousness, and the incidents, that can be traced back to psychological reasons. Handling these with state power is likely to be significantly hard.
The European response to the modern, massive irregular migration flows from 2014 to 2016 was primarily aimed at meeting the immediate needs of migrants. The long-term goal was creating migrants' security in their own country, and the intent to strengthen and maintain it. The recently developed policies in this field at the European context are in their envolving period. In the current state of the European economy and politics, efforts to tackle migration have made a balk, and due to the public opinion against irregular migration there were steps backwards, which are exaggeratedly apply to healthcare as well.



As a highly important complex task, measures should be taken considering the public health and epidemiological risk as a realistic threat – due to the health systems of the countries of origin involved in massive irregular and active regular migration, with significantly different levels of quality, content, supply system, and capacity – in order to protect the population of the own, transit and receptive nations. Due to the phenomenon of accelerated migration across countries and continents, developed societies and their governments need to think in supranational system and pursue a common migration and related health policy, effective application of which enables nations to prevent massive epidemics and to perform the necessary treatments. However, to apply these uniform policy thinking and measures, there is a need for a paradigm shift.

In order to respond quickly and efficiently to the upcoming tasks it is well-founded to develop and continuously apply a deeper, wider spectrum, more complex risk analysis protocol. Within this framework, it is necessary to emphasize the risk elements of public health and the danger of epidemics, to compare them at international level and to provide the necessary protocol based on well-grounded data, to apply it to the entire migration path and process leading from the countries of origin to the receptive societies.

Both international and national experiences have highlighted deficiencies in areas requiring further major development. Primarily in the fields of law enforcement and other authorities involved in migration management related tasks, denominational, charity, nongovernmental organizations, contact population, business organizations, media, the tasks must necessarily be handled. The efficiency analysis of the measures and improvements applied in this cases and the follow-up is a further top priority task.

Task system should be made to ensure – with the help of the established risk analysis, and assessment, prognosis data – the vaccination of personels involved in migration management, migrants, and local population with reasonable speed and availability of sufficient quantity. Also, the health-filtering and supply system should not encumber the host society's active healthcare system, the level of healthcare provided for the national society should not suffer any harm, and it should not become a news value. The logistical background of the mass and individual public health, epidemiological preventive measures should be ensured by establishing and filling the stocks enough for the duration and the size of the occurred tasks. Those performing the tasks should be provided with guides supporting the theorethical preparation, and with developed process control protocols deep enough for recognition and to take the necessary measures.

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