MIGRATION AND INFECTIOUS DISEASES
A SUMMARY OF THE ECDC REPORT
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Objectives

- To know the participants’ knowledge related with this topic at the baseline.
- To define the key concepts of communicable diseases
- To know what is GAR and which diseases are covered by it.
- To insights into some of the major communicable diseases of interest.
- To know the position of the European Commission related to communicable diseases
What do you know about...

Communicable diseases?
Their signs and symptoms?
Mechanisms of transmission of them?
Treatment of infectious diseases?
Migrant’s health situation and infectious diseases?
Migration and infectious diseases in the EU. European Centre for Disease Prevention and Control. Stockholm, 2009
Migration involves several stages, each of which presents opportunities for prevention and control of infectious diseases:

- **Pre-entry phase**: migrant’s health reflects the disease profile of his or her country of origin.
- **Transitional phase**: the process of moving, sometimes through intermediate countries, can influence a migrant’s health.
- **Post-entry phase**: the process of adapting to working and living conditions in the host country can also influence a migrant’s health.

Despite concerns that migrants are responsible for the spread of infectious diseases, most migrants to the EU are healthy.
Migration and health

• In population terms migrants bear a disproportionate burden of infectious disease.

• Socio-economic, cultural and legal factors, in particular, affect the physical and psychological health of migrant populations.

• Poor living and working conditions are critical factors.

• Migrants often live in poor quality, overcrowded housing, which increases the risk of diseases such as TB.

• High rates of domestic accidents, including lead poisoning, have been recorded among migrant children living in poor quality housing.
Migration and health

• Low skilled migrants tend to do jobs in higher risk occupational sectors. For example, the incidence of occupational accidents and diseases in construction and agriculture is higher than in other sectors.

• Migrants may be unfamiliar with safe use of equipment and often receive inadequate training, supervision and protection.
Migration and health

• Psychological health may be affected by the process of leaving family and coping with job insecurity, legal problems, unfamiliar language and culture. Stress and anxiety can result in more serious psychological problems.

• Refugees and asylum seekers often experience psychological trauma.

Migration and health

• **Limited access to healthcare for migrants is a critical factor.** Policies, laws and regulations governing service delivery, the characteristics of migrant communities and wider social attitudes can all influence access to and uptake of services.

• **Legal status** (lack of residence status and health insurance) is often a barrier to healthcare.
Migration and health

- Lack of culturally sensitive information in relevant languages, suitably trained professionals and services tailored to the specific needs of migrants are also barriers.

- Within migrant communities, culture, religion, beliefs about health, disease prevention and healthcare and limited knowledge of available services can prevent uptake of services.
Migration and infectious diseases in the EU

Tuberculosis (TB)

- The last 50 years have seen a decline in TB in most of what were the original EU countries.

- TB remains a challenge in some of the accession countries.

- The downward trend has also been interrupted by the re-emergence of TB among vulnerable populations including cases in migrants from countries where TB is less well controlled, which represent an increasing proportion of new cases.

Tuberculosis

• TB represents an emerging epidemic in many large European cities as it is strongly related to increasing migration from Asia, Africa and Latin America.

• Many of the migrants develop the infection in consequence of their socio-economic status in the host countries.

Tuberculosis

- **Material deprivation** appears to be far more of a determinant than country of origin.
- Many migrants develop TB as a consequence of their socio-economic status in the host country.
- Migrants who arrive with a history of TB may be at risk of reactivated TB infection because of overcrowded and poorly ventilated living conditions, homelessness and inadequate nutrition.
- Poor living conditions also expose previously uninfected migrants to the risk of new TB infection.

Tuberculosis

• Limited access to healthcare prevents migrant populations from accessing information that would enable them to avoid TB and to obtain early diagnosis and treatment of new or re-activated TB infection. This is compounded by limited efforts to raise awareness about TB in migrant populations who may be at the most risk.

• An increasing amount of evidence based on molecular epidemiological studies is indicating that the risk of TB transmission from migrant to host populations is low.

• This clearly demonstrates how the issue of TB control among migrants remains primarily a question of individual right to access diagnostic and treatment services for a curable infectious diseases.

HIV

- Migration is a factor influencing the epidemiology of HIV in Europe, which has largely been associated with transmission through unsafe sex among men who have sex with men and unsafe injecting drug use.

- In 2005, 46% of all cases of heterosexually acquired HIV infection in Western Europe involved migrants from high prevalence countries.

- In Spain, increased HIV among migrant women involved in sex work is changing the epidemiological profile of the disease.

• The increases in HIV/TB co-morbidity reported by many eastern European countries underline the need to strengthen TB and HIV control and treatment.

• In the West, access to both case management and disease control services must be ensured for migrants from Sub-Saharan Africa who are at an increased risk for HIV/TB co-morbidity.
HIV

- In the UK most HIV cases reported between 2004 and 2006 involved migrants from Sub-Saharan Africa who were infected prior to leaving their country of origin.

- In the UK, approximately 70% of HIV incidence is accounted for by migrants. Ninety percent of cases were in migrants from Sub-Saharan Africa and 85% involved infection acquired prior to arrival in the UK.

In Belgium, people categorised as foreign-born account for more than 50% of all reported HIV cases since the epidemic began.

In France, reported AIDS cases among migrants increased by 20% between 1999 and 2004.

Those who are foreign-born are disproportionately represented in HIV statistics in the Netherlands, Germany, Sweden, Ireland, Spain and Italy.

HIV

• Those who are foreign-born are disproportionately represented in HIV statistics in the Netherlands, Germany, Sweden, Ireland, Spain and Italy.

• Limited access to HIV prevention, counselling and testing, and treatment services, particularly for women migrants who may be more vulnerable because of their low social status or engagement in sex work, is a challenge.

• However, as is the case with TB, the risk of transmission of HIV from migrant to host communities appears to be low, although available evidence is limited.

Hepatitis A

- Hepatitis A is mainly transmitted through contaminated food and water, but infection can also occur through injecting drug use and sexual contact.

- There is little evidence to indicate that hepatitis A in Europe is associated with migration.

- Although infection in Hungary has been linked to migration from areas of high prevalence in former Yugoslavia and China. Children of migrants who return periodically to their family’s country of origin (circular migration) may be exposed to the virus.

Hepatitis A

- Children of migrants in the Netherlands who had visited hepatitis A endemic countries, such as Morocco and Turkey, were found to be among the most vulnerable to hepatitis A.

- Relatively high rates of infection have also been found among children of migrants in Spain who had returned to Morocco for their annual holidays.

- In countries with universal vaccination programmes and where high-risk groups have been targeted, incidence in children has decreased significantly.

Hepatitis B

- Hepatitis B (HBV) incidence in the EU and EEA/AFTA countries has declined over the past ten years from 6.7 cases per 100,000 population in 1995 to 1.5 cases per 100,000 population in 2005.

- In many European countries, immigrants from highly endemic regions are many times more frequently affected by HBV than the general population.

Areas for action: surveillance & monitoring

- Developing a common EU-wide definition of MIGRANT and standardised definitions for collection of communicable disease and epidemiological data.

- Improving the knowledge about the relationship between migration and infectious diseases and the burden of infectious diseases in migrants and allow data comparison between and within countries.

- Data collection models that avoid stigmatisation and discrimination need to be identified.

- Monitoring migrant access to and uptake of prevention, treatment and care services.

Areas for action: prevention & control programmes

- Consideration of the implications of changing patterns of migration and infectious diseases for prevention and control programmes, including developing consensus on the infectious diseases most relevant to migration.

- Conducting research to identify the nature of health inequalities, the different social and economic determinants of health in specific sub-groups of migrants and the extent of public health risk attributable to migration.

Areas for action: prevention & control programmes

- Developing evidence-based prevention and control policies and programmes that are tailored for migrants including the most vulnerable, with particular emphasis on the needs of women and children.

- Evaluating the cost effectiveness and public health benefits of approaches to screening, targeted vaccination programmes and active case finding and strengthening sharing of good practice.

Areas for action: healthcare services

• Exploring and developing good practice approaches to maximise access to healthcare, particularly for undocumented and uninsured migrants.

• Investigating the factors that limit access to and utilisation of health services and develop ‘migrant-friendly’ services and strategies to increase coverage and uptake, for example, outreach, information about services and involvement of migrant communities in service design and delivery.

• Developing training curricula and materials for public health and clinical care professionals to increase awareness of the specific needs of migrants and skills and competencies required to provide culturally sensitive services.

This unit

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