

## **Frequently asked questions on migration and health**

### **What are the common health problems of refugees and migrants arriving in the European Region?**

The health problems of refugees and migrants are similar to those of the rest of the population, although some groups may have a higher prevalence. The most frequent health problems of newly arrived migrants include accidental injuries, hypothermia, burns, cardiovascular events, pregnancy- and delivery-related complications, diabetes and hypertension. Female migrants frequently face specific challenges, particularly in maternal, newborn and child health, sexual and reproductive health, and violence. The exposure of migrants to the risks associated with population movements – psychosocial disorders, reproductive health problems, higher newborn mortality, drug abuse, nutrition disorders, alcoholism and exposure to violence – increase their vulnerability to noncommunicable diseases (NCDs). The key issue with regard to NCDs is the interruption of care, due either to lack of access or to the decimation of health care systems and providers; displacement results in interruption of the continuous treatment that is crucial for chronic conditions.

Vulnerable children are prone to acute infections such as respiratory infections and diarrhoea because of poor living conditions and deprivation during migration, and they require access to acute care. Lack of hygiene can lead to skin infections. Furthermore, the number of casualties and deaths among refugees and migrants crossing the Mediterranean Sea has increased rapidly, with a reported 1867 people drowned or missing at sea in the first 6 months of 2015, according to the United Nations High Commissioner for Refugees (UNHCR).

### **Do migrants contribute to the spread of communicable diseases?**

In spite of the common perception of an association between migration and the importation of infectious diseases, there is no systematic association. Communicable diseases are associated primarily with poverty. Migrants often come from communities affected by war, conflict or economic crisis and undertake long, exhausting journeys that increase their risks for diseases that include communicable diseases, particularly measles, and food- and waterborne diseases. The European Region has a long experience of communicable diseases such as tuberculosis (TB), HIV/AIDS, hepatitis, measles and rubella and has significantly reduced their burden during economic development, through better housing, good water and sanitation, efficient health systems, vaccines and antibiotics. These diseases have not, however, been eliminated and still exist in the European Region, independently of migration. This is also true of vector-borne diseases in the Mediterranean area, such as leishmaniasis, with outbreaks recently reported in the Syrian Arab Republic. Leishmaniasis is not transmitted from person to person and can be effectively treated. The risk for importation of exotic and rare infectious agents into Europe, such as Ebola, Marburg and Lassa viruses or Middle East respiratory syndrome

(MERS), is extremely low. Experience has shown that, when importation occurs, it involves regular travellers, tourists or health care workers rather than refugees or migrants.

## **Tuberculosis**

Migrants' risk for being infected or developing TB depends on: the TB incidence in their country of origin; the living and working conditions in the country of immigration, including access to health services and social protection; whether they have been in contact with an infectious case (including the level of infectiousness and how long they breathed the same air); and the way they travelled to Europe (the risk for infection is higher in poorly ventilated spaces). People with severe forms of infectious TB are often not fit to travel. The incidence of TB in the countries of origin varies from as low as 17 new cases per 100 000 population in the Syrian Arab Republic to 338 in Nigeria. The average TB rate in the European Region is 39 per 100 000 population. TB is not easily transmissible, and active disease occurs in only a proportion of those infected (from 10% lifetime risk to 10% per year in HIV-positive people) and within a few months or a few years after infection. TB is not often transmitted from migrants to the resident population because of limited contact.

## **HIV infection and viral hepatitis**

Conflict and emergencies can disrupt HIV services; however, the prevalence of HIV infection is generally low among people from the Middle East and North Africa. Hence, there is a low risk that HIV will be brought to Europe by migrants from these countries. The proportion of migrants among people living with HIV varies widely in European countries, from below 10% in eastern and central Europe to 40% in most northern European countries; in western Europe, the proportion is 20–40%. Despite a decline during the past decade, migrants still constitute 35% of new HIV cases in the European Union and the European Economic Area; however, there is increasing evidence that some migrants acquire HIV after their arrival.

As many developing countries have a high burden of viral hepatitis, the increasing influx of refugees from highly endemic countries is changing the disease burden in Europe.

## **Respiratory diseases and MERS-CoV**

Refugees do not pose an increased threat of respiratory infections – from, for example, influenza, respiratory syncytial virus, adenovirus, parainfluenza virus – to the populations of the countries they migrate to because these are common infections that circulate widely in the host countries. However, physical and mental stress and deprivation related to lack of housing, food and clean water increase refugees' risk for respiratory infections, which can cause severe disease in vulnerable groups (pregnant women, neonates, children below the age of 5 years, people with chronic underlying conditions, the elderly).

Since September 2012, 15 laboratory-confirmed cases of MERS coronavirus (CoV) infection, including seven related deaths, have been reported by eight countries in the WHO European Region. Most of the cases were imported and did not result in further spread of the virus. The risk that another traveller infected with MERS-CoV will enter the European Region remains, but it is low. Most travellers to Europe do not transit through the countries currently reporting MERS-CoV cases; if they do, they will probably not use local hospitals. The only unknown factor is their likelihood of contact with camels and camel products. While the risk of a larger outbreak in European Union countries is considered small, the outbreak in the Republic of Korea earlier this summer demonstrates that this possibility cannot be excluded.

## Vector-borne diseases

The risk for reintroduction and localized outbreaks of vector-borne diseases such as malaria and leishmaniasis can be increased by a mass influx of refugees, as seen by the recent resurgence of malaria in Greece that was directly linked to an influx of migrants from Pakistan. This experience highlights the continual threat of reintroduction and the need for continued vigilance to ensure that any resurgence can be rapidly contained. At the moment, two countries in the WHO European Region, Tajikistan and Turkey, are at high risk for reintroduction of malaria due to importation from Afghanistan and the Syrian Arab Republic, respectively.

## Antimicrobial resistance

Antimicrobial resistance is not a disease in itself but a complication of the treatment of disease. In certain situations, such as crowded settings with poor hygienic conditions in refugee camps, infections can easily occur and spread. Whether an infection is caused by resistant pathogens depends on its origin, which can be the environment, animals, food or humans.

## Food- and waterborne diseases

The risk for food- and waterborne illness can increase in the poor living conditions associated with migration. Some people might have been affected before their departure, but most typically get ill during their journey and especially in overcrowded settlements. Living conditions can disrupt the supplies of safe food and water and can lead to unsanitary conditions for obtaining, storing or preparing food and water. When the supply of safe food and water is uncertain, people may use contaminated food ingredients or eat spoiled food. Overcrowding is a critical determinant of outbreaks of food- and waterborne diseases. Diarrhoea is the commonest symptom but can be accompanied by nausea, vomiting or fever. Examples of such diseases are salmonellosis, shigellosis, campylobacteriosis and hepatitis A. Infants and young children, pregnant women and elderly and immunocompromised individuals, including those with HIV/AIDS, are particularly susceptible to these diseases.

The Sphere Handbook<sup>1</sup> sets the water intake requirement for survival at 2.5–3 L of drinking-water per person per day; in camps, the total basic water need is 15 L per person. Those standards are not met during the journeys of most migrants, and drinking-water is often of unknown origin and untreated. Hand-washing with soap and personal hygiene, including laundry, often cannot be observed.

At border points, there is usually no drinking-water, toilets or shower facilities. Waste bins and regular removal of waste in reception centres are insufficient, posing additional health threats for migrants, as flies, mosquitoes and rodents find easy breeding places.

## Heat

Very hot weather can cause illness and death. When the outdoor temperature is higher than the skin temperature, the only heat loss mechanism available is evaporation (sweating). Therefore, any factors that hamper evaporation, such as high ambient humidity or tight-fitting clothes, can result in a rise in body temperature that may culminate in life-threatening heatstroke. It can trigger exhaustion, heart attacks or confusion and can worsen existing

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<sup>1</sup> SPHERE. Humanitarian charter and minimum standards in humanitarian response, 2011. SPHERE project handbook (<http://www.spherehandbook.org/en/essential-health-services-non-communicable-diseases-standard-1-non-communicable-diseases/>).

conditions such as cardiovascular and respiratory diseases.

An individual's risk for heat stress is increased by a wide range of factors, including chronic medical conditions, social isolation, overcrowding, being confined to bed and certain medical treatments.

## **What interventions should be used to prevent the spread of communicable diseases?**

### **Tuberculosis**

European countries should ensure universal health coverage of refugees and migrants (both documented and undocumented), including early diagnosis of TB and effective care for the duration of the treatment course. This is essential not only to respect human rights but also to succeed in TB control and elimination in the WHO European Region. The Region is the only one of the WHO regions with a consensus document on the minimum package of cross-border TB control and care interventions. This includes ensuring access to medical services irrespective of a migrant's registration status and a non-deportation policy until intensive TB treatment has been concluded. TB cases are notifiable under the *International Health Regulations* (2005).

### **HIV infection and viral hepatitis**

Health systems must enhance viral hepatitis prevention and care programmes. Several countries in the WHO European Region vaccinate only high-risk groups against hepatitis B, contrary to the WHO recommendation to introduce universal vaccination of newborns, which is the most effective way to prevent mother-to-child transmission. Social, economic and political factors in the origin and destination countries of migrants influence their risks for infection with HIV and hepatitis viruses. These include poverty, separation from a spouse, social and cultural norms, language barriers, substandard living conditions and exploitative working conditions, including sexual violence. Isolation and stress may lead migrants to engage in risk behaviour, which increases the risk for infection. This risk is exacerbated by inadequate access to HIV services and fear of being stigmatized. Female migrants may be particularly vulnerable. Some countries in Europe do not provide HIV services for people of uncertain legal status, who can include migrants. WHO supports policies to provide HIV testing, prevention and treatment services irrespective of migrants' legal status. Mandatory HIV testing is applied to migrants in some countries; WHO and the European Centre for Disease Prevention and Control strongly advise against mandatory HIV testing for migrants but support routine offering of HIV rapid testing and linkage to HIV treatment and care. Similarly, voluntary screening of migrants for viral hepatitis has been shown to be cost-effective. Some countries fear that allowing HIV-positive asylum seekers to enter their countries would result in an overwhelming number of requests for treatment or that an influx of asylum seekers or refugees living with HIV would pose a substantial public health threat. Both of these concerns are contrary to the evidence and have no moral, legal or public health basis.

### **Respiratory diseases and MERS-CoV**

Transit and host countries should have the capacity to recognize and treat severe respiratory disease. These countries or WHO should consider offering seasonal influenza vaccine to at-risk refugees, starting in October–November 2015, that is, before influenza becomes widespread in the Region. Laboratory capacity to detect MERS-CoV, treatment facilities

equipped with isolation wards, arrangements for contact tracing, consistent application of adequate measures to prevent infection and provision of public health advice are all crucial to obviate or mitigate transmission.

### **Vector-borne diseases**

Experience in Turkey shows that a well-prepared health system can prevent reintroduction of vector-borne diseases. Since 2012, Turkey's health system has demonstrated strong capacity and flexibility in adapting to changing needs, and, so far, reintroduction of malaria and outbreaks of leishmaniasis have been prevented.

### **Antimicrobial resistance**

Knowledge about the patterns of antimicrobial resistance that are prevalent in a migrant's country or region of origin and in the recipient country is important for treatment. Preferably, patients should be tested, so that doctors can make informed decisions about individual treatment. This requires access to the host country's health system. Depriving migrants from access to the health system may result in lack of access to the appropriate antimicrobials. This will not benefit the patient and can induce resistance in the microorganisms that come in contact with them.

### **Food- and waterborne diseases**

It is important to prevent the development of foodborne and waterborne diseases among migrants, especially during their stay in camps, where they can easily attain epidemic proportions, especially in spontaneous migrant settlements. Information about safe food handling practices, such as WHO's five keys to safer foods, should be disseminated. Access to safe drinking-water is critical for the prevention of food- and waterborne diseases, and thorough assessments of water and sanitation should be conducted at borders and reception centres. These should include the establishment of an emergency water supply (packaged or tanker water) and water treatment, disinfection, storage and distribution. Local authorities must monitor water quality and make hand-washing facilities and sufficient soap available near toilets. Although the Sphere Handbook recommends one toilet for no more than 20 people in emergencies, this cannot be respected in most circumstances: 10 toilets are available for the thousands of migrants arriving daily at the reception centre in Gevgelija, in the southern part of the former Yugoslav Republic of Macedonia, and the situation in the Serbian reception centre is no better.

### **Heat**

The most important actions to take during a heat-wave are: to avoid or reduce exposure, to communicate risks effectively, to take particular care of vulnerable population groups and to manage mild and severe heat illness. The WHO Regional Office for Europe has prepared information sheets with public health advice for different audiences on preventing the health effects of heat.

## **Why are noncommunicable diseases important for large arrivals of refugees and migrants?**

NCDs are common causes of preventable morbidity and mortality:

- the major NCDs are cardiovascular diseases, diabetes, cancer and chronic lung diseases;

- the prevalence of NCDs such as diabetes and hypertension in adults in certain low- and middle-income countries is as high as 25–35%.<sup>2</sup>

### **People with NCDs may be more vulnerable due to the conditions prevalent during migration**

NCDs have common characteristics that can make affected people more vulnerable when they are refugees or migrants.

NCDs:

- require the provision of continuous care over an extended time (often lifelong);
- often require regular treatment with a drug, a medical technology or an appliance;
- can have acute complications that require medical care, incur health costs and may limit function, affect daily activities and reduce life expectancy;
- necessitate coordination of care provision and follow-up between different providers and settings; and
- may be associated with the need for palliative care.

### **Challenges specific to sexual and reproductive health and action taken by WHO to address them**

During the past 20 years, diverse issues related to sexual and reproductive health have been seen in the WHO European Region due to increased migration. For example, female genital mutilation has become a topical issue in the Region in countries such as Belgium, Norway, Sweden and the United Kingdom, and countries have asked for guidance from WHO in tackling this issue. Furthermore, a proportion of the migrant and refugee population has undiagnosed NCDs, such as cardiovascular disease and diabetes; these health problems cause problems during pregnancy and can result in severe maternal morbidity and sometimes death.

Unregistered migrants, who do not have access to and are not informed about the availability of reproductive health services, including antenatal care, are of concern, as this can result in late diagnosis and sometimes life-threatening conditions for women, mothers and their babies.

An analysis led by the WHO Health Evidence Network of the status of maternal health of refugees and migrants is under way and will be ready in 2016. This target group will be covered in the WHO European Sexual and Reproductive Health Action Plan, which will be presented to the 65th session of the Regional Committee for Europe in 2016.

### **How does sudden migration affect the health of people with NCDs?**

The conditions in which refugees and migrants travel can acutely exacerbate or cause a life-threatening deterioration in the health of people with NCDs. Elderly people and children are particularly vulnerable. Complications can result from:

- *physical injuries*: direct traumatic injuries (such as secondary infection, poor glycaemic control) that compromise management of acute injury;

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<sup>2</sup> WHO Global Health Observatory, 2014 survey data. <http://apps.who.int/gho/data/node.main.A875?lang=en>

- *forced displacement*: loss of access to medication or devices, loss of prescriptions, lack of access to health care services, leading to prolongation of disruption of treatment;
- *degradation of living conditions*: loss of shelter, shortages of water and regular food supplies and lack of income add to physical and psychological strain;
- *interruption of care*: due to destruction of health infrastructure, disruption of medical supplies and inability to access health care providers, who may have been killed, injured or are unable to return to work; also, interruption of power supplies or safe water can have life-threatening consequences, especially for people with end-stage renal failure who require dialysis.

### **Minimum standards for responding to the needs of NCD patients among refugees and migrants**

- Identify individuals with NCDs to ensure continuing access to the treatment they were receiving before their migration.
- Ensure treatment of people with acute, life-threatening exacerbation and complications of NCDs.
- When treatments for NCDs are not available, establish clear standard operating procedures for referral.
- Ensure that essential diagnostic equipment, core laboratory tests and medication for routine management of NCDs are available in the primary health care system. Medications that are on the local or WHO essential medicines list are appropriate.

### **Key indicators**

- All primary health care facilities have clear standard operating procedures for referral of patients with NCDs to secondary and tertiary care facilities.
- All primary health care facilities have the necessary medication to continue pre-emergency treatment of patients with NCDs, including for pain relief.

### **What are the WHO recommendations for triage and screening of migrants upon arrival?**

WHO does not recommend obligatory screening of refugee and migrant populations for diseases, because there is no clear evidence of benefits (or cost-effectiveness); furthermore, it can trigger anxiety in individual refugees and the wider community.

WHO strongly recommends, however, offering and providing health checks to ensure access to health care for all refugees and migrants in need of health protection. Health checks should be done for both communicable and noncommunicable diseases, with respect for migrants' human rights and dignity.

The results of screening must never be used as a reason or justification for ejecting a refugee or a migrant from a country:

- Obligatory screening deters migrants from asking for a medical check-up and jeopardizes identification of high-risk patients.
- In spite of the common perception that there is a link between migration and the importation of infectious diseases, there is no systematic association. Refugees and migrants are exposed mainly to the infectious diseases that are common in Europe, independently of migration. The risk that exotic infectious agents, such as Ebola virus, will be imported into Europe is extremely low, and when it occurs, experience shows that it affects regular travellers, tourists or health care workers rather than refugees or migrants.

Triage is recommended at points of entry to identify health problems in refugees and migrants soon after their arrival. Proper diagnosis and treatment must follow, and the necessary health care must be ensured for specific population groups (children, pregnant women, elderly).

Each and every person on the move must have full access to a hospitable environment, to prevention (such as vaccination) and, when needed, to high-quality health care, without discrimination on the basis of gender, age, religion, nationality or race. This is the safest way to ensure that the resident population is not unnecessarily exposed to imported infectious agents. WHO supports policies to provide health care services to migrants and refugees irrespective of their legal status as part of universal health coverage.

## **Does WHO advocate breastfeeding in the context of large-scale migration?**

The life-saving role of breastfeeding during emergencies, notably large-scale migration, is firmly supported by evidence and guidance. The *Global strategy for infant and young child feeding* outlines means for improving infant and young child feeding in emergencies. In all situations, the best way for preventing malnutrition, some diseases and mortality among infants and young children is to ensure that they start breastfeeding within 1 hour of birth, breastfeed exclusively (with no food or liquid other than breast milk, not even water) until 6 months of age and continue breastfeeding with appropriate complementary foods up to 2 years or beyond. Even in emergency situations, the aim should be to create and sustain an environment that encourages frequent breastfeeding of children up to at least 2 years of age. Unfortunately, there is a widespread misconception that stress or inadequate nutrition, which are common during large migration movements, can decrease a mother's ability to breastfeed successfully. Under these exceptional circumstances, unsolicited or uncontrolled donations of breast-milk substitutes may undermine breastfeeding and should be refused. Instead, breastfeeding should be actively protected and supported. As part of health assistance in this context, hospitals and other health care services should have trained health workers who can help mothers to establish breastfeeding and overcome any difficulties.

## **What does WHO recommend with regard to vaccination for newly arrived migrants?**

Transmission of vaccine-preventable diseases to host country populations is just as likely to happen after the return of a resident of that country from a holiday in an endemic country as after the arrival of a migrant from the country. There are still large gaps in the immunity of



populations across the Region, either because countries decide not to avail themselves of the benefits of vaccination or because of limited access to vaccination services.

The WHO Regional Office for Europe does not routinely collect information on transmission of vaccine-preventable diseases among migrants or on their immunization coverage. However, well-documented outbreaks of measles have originated by transmission from migrants, mobile populations, international travellers and tourists alike. Equitable access to vaccination is of prime importance and is one of the objectives of the European Vaccine Action Plan 2015–2020. The plan proposes that all countries in the Region pay special attention to ensuring the eligibility and access of migrants, international travellers and marginalized communities to (culturally) appropriate vaccination services and information. We applaud the many countries, such as those receiving large influxes of migrants, that are including migrants into their routine vaccination programmes. Immunization coverage of all countries can be accessed at:

[http://www.who.int/immunization/monitoring\\_surveillance/routine/coverage/en/](http://www.who.int/immunization/monitoring_surveillance/routine/coverage/en/).

## **What health care access does WHO recommend for refugees and migrants?**

Legal status is one of the most important determinants of the access of migrants to health services in a country. Each and every refugee and migrant must have full, uninterrupted access to a hospitable environment and, when needed, to high-quality health care, without discrimination on the basis of gender, age, religion, nationality or race. WHO supports policies to provide health care services irrespective of migrants' legal status. As rapid access to health care can result in cure, it can avoid the spread of diseases; it is therefore in the interest of both migrants and the receiving country to ensure that the resident population is not unnecessarily exposed to the importation of infectious agents. Likewise, diagnosis and treatment of NCDs such as diabetes and hypertension can prevent these conditions from worsening and becoming life-threatening.

## **Are countries in the European Region adequately prepared to respond to the public health challenges of large migration?**

Health systems in the countries receiving migrants are well equipped and experienced to diagnose and treat common infectious and NCDs; they should also be prepared to provide such health care to migrants. Under the *International Health Regulations (2005)*, all countries should have effective disease surveillance and reporting systems, outbreak investigation ability and case management and response capacity. Should a rare exotic infectious agent be imported, Europe is well prepared to respond, as shown over the past 10 years with imported cases of lassa fever, Ebola virus disease, Marburg virus disease and MERS, due to good laboratory capacity, treatment facilities equipped with isolation wards, a trained health workforce and a system for contact tracing. While we should remain vigilant, this should not be our main focus.

Responding quickly and efficiently to the arrival of large groups of people from abroad requires effective coordination and collaboration between and within countries as well as between sectors. A good response to the challenges faced by migrant groups requires good preparedness: preparedness is the basis for building adequate capacity in the medium and long term, requiring robust epidemiological data and migration intelligence, careful planning,

training and, above all, adherence to the principles of human rights. Defining contingency scenarios to adequately address current or potential large influxes of migrants into a country will improve coordination among the numerous stakeholders involved, improve resilience and avoid the distress of the health system.

Access of vulnerable groups such as young children to acute care for common and severe conditions must be assured, as children can deteriorate quickly if they do not have adequate care. Where necessary, health care professionals should learn to detect and treat communicable diseases that they don't often see. In addition, they should strengthen their preparedness to communicate with foreigners who speak different languages and are from different cultural backgrounds (through interpreter services or other means). High-quality care for migrant groups cannot be ensured by health systems alone. The social determinants of health, such as education, employment, social security and housing, all have a considerable impact on the health of migrants.

## **What is WHO doing to address the public health implications of the large influxes of refugees and migrants into the European Region?**

WHO works to: develop migrant-sensitive health policies; strengthen health systems to provide equitable access to services; establish information systems to assess migrant health; share information on best practices; increase the cultural and gender sensitivity and specific training of health service providers and professionals; and promote multilateral cooperation among countries in accordance with resolution WHA61.17 on the health of migrants endorsed by the Sixty-first World Health Assembly in 2008.

Health issues related to people's movements have been on the agenda of the WHO European Region for many years. The WHO European health policy framework Health 2020 has drawn particular attention to migration and health, with population vulnerability and human rights. Following the political, economic and humanitarian crises in the north of Africa and the Middle East, the WHO Regional Office for Europe, in collaboration with the Italian Ministry of Health, established the Public Health Aspects of Migration in Europe project in April 2012. The aims are to strengthen health systems capacity to meet the health needs of mixed inflows of migrants and host populations; promote immediate essential health interventions; ensure migrant-sensitive health policies; improve the quality of the health services delivered; and optimize use of health structures and resources in countries receiving migrant populations. Up to August 2015, the Regional Office had conducted joint assessment missions with ministries of health in Bulgaria, Cyprus, Greece, Italy, Malta, Portugal, Serbia and Spain, with the new "Toolkit for assessing health system capacity to manage large influxes of migrants in the acute phase", to respond to and address the complex, resource-intensive, multisectoral, politically sensitive issues in health and migration.

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