Key infectious diseases affecting migrant populations in the EU/EEA: Data from ECDC risk assessments and technical reports

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Workshop on health and movement across borders
Instituto de Salud Carlos III, Madrid
25 February, 2016
Outline

- Background

- Key infectious diseases affecting migrants in the EU/EEA
  - HIV
  - TB

- ECDC risk assessments on newly arrived migrants and refugees

- Ongoing projects on migrant health and infectious diseases
  - Preparedness for communicable disease control at migrant reception/detention centres
  - Evidence-based guidance for prevention of infectious diseases among newly arrived migrants in the EU/EEA

- Conclusions
How it all started...

- **THE PORTUGUESE PRESIDENCY TO THE EU COUNCIL 2007**
  - Successful in putting ‘Health and Migration’ on the EU agenda
  - Recognizing infectious diseases as a priority in relation to the health of migrants

- **EU COUNCIL CONCLUSIONS DECEMBER 2007**
  - ‘WELCOMES the activities of the ECDC in the field of migrant health and looks forward to a report on migration and infectious diseases’

- **ECDC RESPONDED TO THIS CALL**
  - Hosted expert meeting to identify priority areas
  - Developed a series of technical documents on specific diseases of particular burden to migrants and foreign-born populations
Migrant Health Report Series – HIV
ECDC work on TB among migrants

- **Wealth inequality and tuberculosis elimination in Europe**
  Suk JE, Manissero D, Büscher G, Semenza JC.

- **Migrant tuberculosis screening in the EU/EEA: yield, coverage and limitations**
  Klinkenberg E, Manissero D, Semenza JC, Verver S.

- **Effectiveness of tuberculosis contact tracing among migrants and the foreign-born population**
  Mulder C, Klinkenberg E, Manissero D.

- **Assessing the impact of different BCG vaccination strategies on severe childhood TB in low-intermediate prevalence settings**
  Manissero D, Lopalco PL, Levy-Bruhl D, Ciofi Degli Atti ML, Giesecke J.

- **Tuberculosis transmission between foreign- and native-born populations in the EU/EEA: a systematic review**
  Sandgren, Schepisi, Sotgiu, Huitric, Migliori, Manissero, van der Werf, Girardi
  Eur Respir J 2014; 43: 1159–1171
Burden of infectious diseases among migrants 2014

**Objective**: To produce a comprehensive overview of the key infectious diseases affecting migrant populations in the EU/EEA

<table>
<thead>
<tr>
<th>Disease</th>
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<tbody>
<tr>
<td>TB</td>
<td>RUBELLA</td>
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<td>HIV</td>
<td>GONORRHOEA</td>
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<td>HEPATITIS B</td>
<td>SYPHILIS</td>
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<td>HEPATITIS C</td>
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<td>MEASLES</td>
<td>CHAGAS DISEASE</td>
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</table>
### Completeness (%) of variables collected through TESSy (2011-2013)

<table>
<thead>
<tr>
<th>Variable</th>
<th>HIV</th>
<th>TB</th>
<th>HBV</th>
<th>HCV</th>
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*Not under EU surveillance*
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<th>Malaria</th>
<th>Chagas disease*</th>
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<tbody>
<tr>
<td>Country of birth</td>
<td>62</td>
<td>95.6</td>
<td>19.1</td>
<td>14.4</td>
<td>17</td>
<td>26</td>
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<tr>
<td>Country of nationality</td>
<td>28</td>
<td>96.3</td>
<td>6.8</td>
<td>6.6</td>
<td>4</td>
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<tr>
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<td>17</td>
<td>20.2</td>
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<td>9</td>
<td>10</td>
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<td>5</td>
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<td>Region of origin</td>
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</tbody>
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*Not under EU surveillance
HIV
HIV infections diagnosed, EU/EEA 2004-2013, transmission mode and origin

Source: ECDC/WHO (2014). HIV/AIDS Surveillance in Europe, 2013. Data from Estonia and Poland excluded due to incomplete reporting on transmission mode during the period; cases from Italy and Spain excluded due to increasing national coverage over the period.
HIV infections diagnosed, EU/EEA, 2004-2013
Heterosexual cases from countries with generalized epidemics

Source: ECDC/WHO (2014). HIV/AIDS Surveillance in Europe, 2013. Data from Estonia and Poland excluded due to incomplete reporting on transmission mode during the period; cases from Italy and Spain excluded due to increasing national coverage over the period.
SSA West: Benin (BJ), Burkina Faso (BF), Cabo Verde (CV), Cote d’Ivoire (CI), Gambia (GM), Ghana (GH), Guinea (GN), Guinea-Bissau (GW), Liberia (LR), Mali (ML), Mauritania (MR), Niger (NE), Nigeria (NG), Senegal (SN), Sierra Leone (SL), Togo TG (15 countries)

SSA Central: Central African Republic (CF), Chad (TD), Democratic Republic of Congo (CD), Congo (CG), Angola (AO), Cameroon (CM), Equatorial Guinea (GQ), Gabon (GA), Zambia (ZM) (9 countries)

SSA East: Kenya (KE), Tanzania (TZ), Uganda (UG), Djibouti (DJ), Eritrea (ER), Ethiopia (ET), Mozambique (MZ), Madagascar (MG), Malawi (MW), Zimbabwe (ZW), Burundi (BI), Rwanda (RW), Comors (KM), Mauritius (MV), Seychelles (SC), Reunion (RE), Mayotte (YT), Somalia (So) (18 countries)

SSA Austral: Botswana (BW), Lesotho (LS), Namibia (NA), South Africa (ZA), Swaziland (SZ) (5 countries)

SSA Unknown: If region of origin is Sub Saharan Africa, and there are no information about country of birth or country of nationality
Proportion of HIV diagnoses among natives and migrants, EU/EEA, 2014

Migrants 37%
Natives 63%

Proportion HIV diagnoses among migrants* by country of report, EU/EEA, 2014 (n= 25 525)

* Migrants are all persons born outside of the country in which the diagnosis was made. Data presented here are among cases with known region of origin; There were no cases reported among migrants in Hungary, Liechtenstein, Poland or Romania

Availability of ART for undocumented migrants living in Europe, 2014

Source: ECDC. From Dublin to Rome: ten years of responding to HIV in Europe and Central Asia: Stockholm, ECDC; 2014
Where do migrants get infected with HIV (prior to or after arrival to the EU)?

Tuberculosis
TB cases of foreign origin

- In 2013, the proportion of TB cases of foreign origin in the EU/EEA was 28.0% (range 0.3–94.7%).

**Figure 6:** Percentage of TB cases of foreign origin by country, EU/EEA, 2013

- < 1%
- 1 to 24.9%
- 25 to 49.9%
- 50 to 74.9%
- ≥ 75%
- Not included or not reporting
Trend in origin of TB cases in the EU/EEA, 2007-2013

Ködmön et al. Eurosurveillance March 2016
Trends of TB cases with non-EU/EEA origin, 2007-2013

Ködmön et al. Eurosurveillance March 2016
ECDC risk assessments on migrant health
2011-2015
Increased influx of migrants at the Greek–Turkish border

April 2011

www.ecdc.europa.eu

EXECUTIVE SUMMARY

Currently there are no major outbreaks related to infectious diseases reported in Libya, the cities in the region or the reception and detention camps in EU countries (Italy, Malta and Greece). The risk of importation of infectious diseases from North Africa to the EU is therefore considered to be low.

From a public health perspective, the most urgent concerns related to the living conditions of the migrants in the reception and detention centres are overcrowding and poor sanitation, as these are important risk factors for infectious disease outbreaks.

Outbreak-prone infectious diseases in crowded conditions as may exist in the reception and detention centres are mainly measles, diarrhoea, influenza, pertussis and acute respiratory infections. The risk for vaccine-preventable diseases largely depends on the susceptible population. In addition, poor sanitary conditions may increase the risk for diarrhoeal diseases.

Public health measures that may be taken in order to mitigate the risk of infectious disease outbreaks are:

- An appropriately adapted surveillance system for early warning purposes, including entry health assessment and proper referral systems.
- Dedicated mother-and-child services as well as mental healthcare facilities at the reception and detention centres. Specific vaccination strategies in order to 1) protect both children and adults against those diseases which they are more vulnerable to, due to the emergency conditions they are experiencing, and to 2) ensure children continue with their immunisation history. In addition, specific attention should be paid to healthcare workers’ immunisation status in the specific situations.
- The majority of the current migrants are healthy adult males, for whom the infectious disease risk is considered to be limited. The International Organization for Migration (IOM) has a view that the situation may get more complex as the second wave of migrants is anticipated to include more vulnerable persons, e.g. women and children, or persons with pre-existing medical conditions.
- ECDC, in collaboration with the Member States, the European Commission and international organisations, is committed to closely monitor the situation in order to rapidly identify and assess potential communicable disease threats.

For the purpose of this risk assessment, ‘migrants’ is defined as including refugees, asylum seekers, displaced populations, irregular migrants and in some cases labour migrants, as defined by IOM in the Glossary on Migrants, 2004 available at http://www.iom.int/sites/default/files/publib/docs/Publications/Glossary%20migrants%20.pdf

Stockholm, April 2011
© European Centre for Disease Prevention and Control, 2011. Reproduction is authorized, provided the source is acknowledged.
Risk assessments and technical reports
2013

Suspected outbreak of poliomyelitis in Syria:
Risk of importation and spread of poliovirus in the EU
23 October 2013

Main conclusions and recommendations
This cluster of cases of acute flaccid paralysis among Syrian citizens increases the risk for the importation of wild poliovirus to the EU/EAA and further re-establishment and transmission in the Member States.

Recommendations:
- Countries hosting Syrian citizens in designated areas ( camps) should assess the level of transmission of wild poliovirus among them. Such assessments can be carried out through enhanced clinical surveillance, environmental surveillance, and systematic collection of stool samples from symptomatic and asymptomatic persons.
- EU Member States receiving refugees and asylum seekers from Syria should assess their vaccination status on arrival and provide polio vaccination and other vaccinations as needed.
- Regional and international efforts to assess the risk and provide vaccination and other public health services to Syria and to Syrian refugees hosted by neighbouring countries should be supported.
- The situation observed the need for Member States to consider implementing the recommendations made in the ECDC risk assessment of wild-type poliovirus transmission in Israel [2] ( see Annex).
- Countries should review their national preparedness plans, and ensure that items such as a framework and responsibilities for outbreak response, enhanced activity and reporting timelines, and vaccine of choice for outbreak response are in place.

Source and date of request
European Commission, 19 October 2013.

Public health issue
The potential risk to the EU related to the cluster of cases of acute flaccid paralysis (AFP) with onset in early October 2013 reported from Deir Al-Zor province in Eastern Syria.

Consulted experts
ECDC, ECDC
Aziz Kassab, Elizabeth Bancroft, Denis Coulotvance, Camilla Cronell, Niklas Danielsson, Ramit Jais, Srigita de Jong, Peter Krems, Lucia Martin-Celisandrno, est Saugy and Estina Huber.
Risk assessments and technical reports
2015

Rapid Risk Assessment
Louse-borne relapsing fever in the EU
17 November 2015

ECDC threat assessment for the EU
Twenty-seven confirmed cases of louse-borne relapsing fever (LBRF) were diagnosed in EU countries and Switzerland between July and October 2015. These cases, diagnosed among refugees from countries of the Horn of Africa, were not unexpected as the disease is present in north-eastern Africa.

The information available indicates that most of the 27 cases are likely to have been exposed to body lice infestations and louse-borne relapsing fever during their journey to Europe. Symptoms of the three cases reported in Italy occurred shortly after entry, suggesting an infection with Borrelia recrudescens prior to the time they arrived in Italy. The transmission of Borrelia recrudescens to the eight cases recorded in Germany is likely to have taken place towards the end of their journey to Libya or upon arrival in Italy. The Netherlands reported cases of LBRF with onset in late summer 2015. These cases used the same migration route through Libya as the German cases. The hypothesis of transmission of LBRF in the countries involved before arrival in Europe.

In Tunisia, however, the two affected individuals were living in Italy since 2011 and they denied recent travel to endemic regions. Therefore, they are likely to have become infected while being housed in the same overcrowded facility as the newly arrived infected cases. This points to the possibility of locally acquired transmission of LBRF among migrants within the EU.

An increase of refugees from LBF-endoemic areas has been observed in the EU since 2014, indicating that similar importation of cases and subsequent transmission could occur in EU/EEA countries. These events highlight the importance of early detection and notification, timely implementation of public health measures in order to reduce the risk of outbreaks. Furthermore, LBF should be considered in differential diagnosis of fevers, especially in refugees from LBF-endoemic areas. LBF should be considered in differential diagnosis of fevers, especially in refugees from LBF-endoemic areas.

Body lice infestation is linked to low socioeconomic status, overcrowded housing, and poor personal hygiene. Refugees are vulnerable to body lice infestation due to challenging living conditions during migration, and after entry into the EU due to crowded conditions in temporary shelters. People in close contact with migrants hosting body lice infected with Borrelia recrudescens at risk of being exposed to the disease. Once in the EU, there is a risk of spread from infected individuals infected with body lice to the homeless or other vulnerable populations.

Fever and rash are the most common symptoms of LBRF during the acute phase of the disease. The disease is accompanied by fever, headache, and dizziness, and can lead to encephalitis and meningitis. Mortality is rare but can occur in individuals with underlying conditions.


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Rapid Risk Assessment
Risk of importation and spread and other vector-borne diseases in the arrival of migrants to the EU
21 October 2015

Threat assessment for the EU
In 2015, the European Union received a record number of 1.2 million asylum seekers, the majority of whom originated from the Middle East and the Horn of Africa. The majority of asylum seekers arrive in the EU by sea, mainly through Greece and Italy.

Asylum seekers generally originate from countries with medium to high burden of vector-borne diseases, such as malaria, dengue, chikungunya, and zika virus. The risk of importation of vector-borne diseases is therefore likely to be high and it is expected that most cases of these diseases will be imported to the EU from countries of origin or countries of transit.

Many of these diseases are associated with high morbidity and mortality, and can cause severe economic and social impact in the EU. The importation of these diseases can also set off a chain reaction, leading to secondary spread within the EU.

ECDC encourages all healthcare providers and public health authorities to remain vigilant for cases of imported vector-borne diseases. Surveillance and control measures should be adapted to the local epidemiological situation and can include targeted screening, case finding, and contact tracing.

Suggested citation: European Centre for Disease Prevention and Control. Risk of importation and spread of vector-borne diseases in the arrival of migrants to the EU – 21 October 2015.

© European Centre for Disease Prevention and Control, Stockholm, 2015
Communicable disease risks associated with the movement of refugees in Europe during the winter season

ECDC threat assessment:

- Newly arrived migrants and refugees do not represent a threat to Europe with respect to communicable diseases

- The risk to refugees has increased due to overcrowding at reception facilities, resulting in poor hygiene and sanitation arrangements

- It is therefore expected that the incidence of respiratory and gastrointestinal conditions will increase in the coming months

- Also, low coverage for some vaccines may result in refugees developing diseases such as measles and chickenpox
Infectious diseases of specific relevance to newly-arrived migrants to the EU/EEA

- This document provides a checklist of infectious diseases to be considered among newly arrived migrant populations (for frontline healthcare workers).

- Although the risk of these infectious diseases are low, they should still be considered so as to ensure early diagnosis and treatment, or prevented by immunisation when indicated.
Infectious diseases to consider according to country of origin

- Table lists which infectious diseases to be aware of when screening symptomatic and asymptomatic newly arrived migrants.

- The top five countries of origin for newly arrived migrants entering the EU in 2015.

- Those who migrate are often younger and healthier and may therefore not be representative of the population of origin.

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Table 1. Infectious diseases to consider according to country of origin

<table>
<thead>
<tr>
<th>Disease</th>
<th>Indicator</th>
<th>Syria</th>
<th>Afghanistan</th>
<th>Iraq</th>
<th>Eritrea</th>
<th>Somalia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria [3]</td>
<td>Cases reported to WHO in 2012, 2013, 2014</td>
<td>0, 0, and NA</td>
<td>0, 0, 0</td>
<td>3, 4, and 5</td>
<td>8, 0 and NA</td>
<td>65, 7 and NA</td>
</tr>
<tr>
<td>Typhoid fever</td>
<td>Risk of typhoid</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cholera*</td>
<td>Risk</td>
<td>No recent outbreak</td>
<td>Recurrent outbreaks</td>
<td>On-going outbreak in Baghdad Babylon, Najaf, Qadisiyyah, and Muthanna.</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hepatitis A¹</td>
<td>Risk of soil transmitted helminthiasis (ascaris, whipworm, hookworm)</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Hepatitis E¹</td>
<td>Risk of urinary schistosomiasis</td>
<td>✓</td>
<td>Non-endemic country</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Leishmaniasis²</td>
<td>Risk of cutaneous leishmaniasis</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Leishmaniasis³</td>
<td>Risk of visceral leishmaniasis</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hepatitis B¹</td>
<td>Prevalence of chronic hepatitis B</td>
<td>Intermediate prevalence: 5.6%</td>
<td>High prevalence: 10.5%</td>
<td>Low prevalence: 1.3%</td>
<td>High prevalence: 15.5%</td>
<td>High prevalence: 12.4%</td>
</tr>
<tr>
<td>Hepatitis C¹</td>
<td>Prevalence</td>
<td>High prevalence: 3.1%</td>
<td>High prevalence: 1.1%</td>
<td>High prevalence: 3.2%</td>
<td>High prevalence: 1%</td>
<td>NA</td>
</tr>
<tr>
<td>HIV</td>
<td>Prevalence</td>
<td>Low</td>
<td>NA</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
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<tr>
<td>Malaria⁴</td>
<td>Risk of malaria</td>
<td>Malaria-free</td>
<td>Risk of P. vivax &gt;&gt; P. falciparum</td>
<td>Malaria-free</td>
<td>Risk of P. falciparum &gt;&gt; P. vivax</td>
<td>Risk of P. falciparum</td>
</tr>
<tr>
<td>Measles⁵</td>
<td>Incidence per 100 000 in 2013 and 2014</td>
<td>1.04 and 2.68</td>
<td>1.41 and 1.75</td>
<td>2.09 and 3.02</td>
<td>0.77 and 0.02</td>
<td>2.17 and 9.12</td>
</tr>
<tr>
<td>Polio⁶</td>
<td>Cases reported to WHO in 2012, 2013 and 2014</td>
<td>0, 0, and NA</td>
<td>46, 17, and 28</td>
<td>0, 0, and 0</td>
<td>0, 0, and 0</td>
<td>1, 195 and 5</td>
</tr>
<tr>
<td>Tuberculosis⁷</td>
<td>Incidence/100 000</td>
<td>Low: 17</td>
<td>High: 189</td>
<td>Low: 25</td>
<td>High: 40 to 499</td>
<td>High: 285</td>
</tr>
<tr>
<td>Antimicrobial resistance</td>
<td>Risk of carriage of multidrug-resistance Gram-negative bacteria</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Rabies</td>
<td>Risk level for humans contracting rabies</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>
Vaccinations to be offered in the absence of documented evidence of prior vaccination

- Vaccination should be offered as needed according to the national immunisation guidelines
- Priority should be given to easily transmitted and/or serious infectious diseases
- Additional vaccinations should be considered for the following diseases depending on:
  - living conditions
  - season
  - epidemiological situation

<table>
<thead>
<tr>
<th>Disease/age group</th>
<th>Children and adolescents (&lt;18 years)</th>
<th>Adults (&gt; 18 years)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Priority vaccinations</strong></td>
<td></td>
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</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td>Administer to individuals ≥ 9 months of age. Two doses of MMR* should be administered at least one month apart but preferably longer according to national guidelines. Measles vaccine provided before 12 months of age does not induce protection in all and should be repeated after 12 months of age.</td>
<td>Administer one or two doses of MMR to all individuals, according to national guidelines*</td>
</tr>
<tr>
<td>Diphtheria, tetanus, pertussis, polio, Hib</td>
<td>Administer to individuals ≥ 2 months, three doses of DTaP-IPV-Hib (Hib-component only for children &lt;6 years unless other country-specific recommendations) containing vaccines at least one month apart, followed by a booster dose according to national guidelines. Pentavalent- and hexavalent combination vaccines are authorised up to six years of age.</td>
<td>Administer to all adults, three doses of TdAP-IPV- ** containing vaccines according to national guidelines</td>
</tr>
<tr>
<td><strong>To be considered</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Administer to individuals ≥ 2 months, three doses according to national guidelines** Administer to new-born infants of HBsAg-positive mothers within 24 hours of birth, according to national guidelines</td>
<td>Administer to all adults, with or without previous screening, according to national guidelines</td>
</tr>
<tr>
<td>Meningococcal disease</td>
<td>National guidelines for meningococcal vaccines against serogroups A, B, C, W135 and Y should be followed, unless the epidemiological situation suggests otherwise.</td>
<td></td>
</tr>
<tr>
<td>Pneumococcal disease</td>
<td>Administer to individuals ≥ 2 months with 1–3 doses of conjugate vaccine at least one month apart, according to national guidelines</td>
<td>Administer to individuals ≥ 65 years, according to national guidelines</td>
</tr>
<tr>
<td>Varicella</td>
<td>National guidelines should be followed unless the epidemiological situation suggests otherwise. If used, administer to individuals ≥ 11 months of age, two doses of varicella at least one month apart, but preferably longer.</td>
<td>National guidelines should be followed unless the epidemiological situation suggests otherwise. Consider vaccinating non-immune non-pregnant women of childbearing age.</td>
</tr>
<tr>
<td>Influenza</td>
<td>National guidelines should be followed unless the epidemiological situation suggests otherwise. Consider vaccinating risk groups over six months of age ahead of and during influenza season.</td>
<td>National guidelines should be followed unless the epidemiological situation suggests otherwise. Consider vaccinating risk groups, including pregnant women, ahead of and during influenza season.</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Administer BCG according to national guidelines. Re-vaccination with BCG is not recommended.</td>
<td>BCG is generally not recommended for adults, unless specific reasons suggest otherwise.</td>
</tr>
</tbody>
</table>
Objectives

 To produce scientific advice on the main health needs of certain migrant populations in relation to the prevention and control of communicable diseases

 Provide options for addressing these needs

Methods

 ECDC conducted interviews with experts from Member States

 Non-systematic review of available evidence including a selection of relevant ECDC Risk Assessments and publications
Expert Consultation: Questions

- What type of infectious diseases have you encountered among asylum seekers/refugees/migrants?

- What type of measures have you taken to address these concerns? What public health actions have you taken and what steps have you considered?

- Do you have guidelines how to address these public health concerns?

- Who is involved in the response? Is it the national/local government/NGOs/Foundations/WHO/international org?

- What other type of health problems have you encountered? Mental health problems/violence/malnutrition/etc
Identified needs include:

- **Reception centres/systems** for newly arrived migrants in order to assure health assessments immediately upon arrival

- **Adequate shelter** to avoid crowding and ensuring good sanitation / hygienic conditions

- **Health education and health promotion** emphasizing the benefits of screening, immunization and other measures

- **Screening** for communicable diseases according to their country of origin and ensuring rapid linkage to care

- **Vaccination services** should be reinforced

- **Syndromic surveillance** should be considered to generate alerts to initiate timely public health responses
Ongoing ECDC projects related to migrant health
Preparedness for sudden influxes of migrants

Objective
To bolster preparedness for communicable disease control at migrant reception / detention centres through the development of two separate tools:

- **Tool A**: a check-list assessing reception / detention centre needs during sudden influxes of migrants. The tool should consider human resources, medicines and vaccines, sanitation and disinfection, and physical infrastructure.

- **Tool B**: a protocol for monitoring potential disease outbreaks at migrant reception / detention centres. The tool should be based on best practices and evidence surrounding syndromic surveillance.
Evidence-based guidance for prevention of infectious diseases among newly arrived migrants in the EU/EEA
Project objectives

1. Collect and synthesise the scientific evidence on screening and prevention for infectious diseases among migrants, taking into account the:
   a. Individual and public health benefits of screening
   b. Limitations and ethical considerations regarding screening
   c. Screening options
   d. Treatment options
   e. Costs-effectiveness of screening and treatment

2. Review national and international policies, practices and guidelines on screening for ID among migrants

3. Consult key experts in countries working with prevention of infectious diseases among migrants

4. Draft evidence-based guidance on screening and prevention of infectious diseases among migrants
Target audience of the guidance

- National and sub-national policy makers in EU/EEA Member States
- Health practitioners
- NGOs and patient organisations working with migrant communities
Priority conditions of ECDC guidance (currently being considered)

- TB active/latent
- HIV
- Hep B
- Hep C

- Intestinal parasites
  - Schistosomiasis, strongyloidiasis

- Childhood vaccinations
  - MMR, diphtheria, polio, Hib
First advisory group meeting – country feedback

- **24/24 countries** – Europe-wide guidelines for screening would be useful

- **12/22 countries** – newly arrived migrants are having an impact on infectious diseases epidemiology in their country

- **10/22 countries** – have national guidelines for screening of infectious diseases among newly arrived migrants

- **6/22 countries** – routinely screen newly arrived migrants for infectious diseases at national level

- The infectious diseases for which routine screening is occurring are TB, hep B and C, and HIV
Conclusions

- Migrants/refugees do not represent a threat to Europe with respect to communicable diseases

- Nevertheless, migrants/refugees are overrepresented with respect to certain communicable diseases (i.e. HIV, TB) and may have lower vaccination coverage depending on country of origin

- The risk to refugees arriving in Europe of contracting communicable diseases has increased due to the current overcrowding at reception facilities, resulting in poor hygiene and sanitation arrangements

- Ensuring right to health is critically important
Conclusions

- Reception centres/systems for newly arrived migrants should be strengthened in order to assure health assessments immediately upon arrival (differ depending on country of first arrival, transit or final destination)

- Important to improve general hygiene measures and preventing or minimising overcrowding in reception centres

- Access to public healthcare for early diagnosis and treatment of communicable diseases, including primary and emergency healthcare, should be ensured

- Vaccination should be offered as needed according to the national immunisation guidelines
Since January 2016, 103,519 migrants, including asylum seekers are reported to have arrived to Europe by land and sea routes. Tragically 411 migrants are known to have drowned or are missing.

In comparison, in 2015, 1,046,599 migrants, including asylum seekers are reported to have arrived to Europe by land and sea routes.

Recent trends
(update as of the 21st February 2016)

<table>
<thead>
<tr>
<th>Country</th>
<th>Arrivals Previous week 7th – 14th Feb</th>
<th>Current week 14th – 21st Feb</th>
<th>Percentage change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Italy</td>
<td>89</td>
<td>589</td>
<td>552%</td>
</tr>
<tr>
<td>Greece</td>
<td>7,968</td>
<td>17,254</td>
<td>117%</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>82</td>
<td>79</td>
<td>-4%</td>
</tr>
<tr>
<td>Weekly arrivals</td>
<td>8,138</td>
<td>17,918</td>
<td>129%</td>
</tr>
</tbody>
</table>
Main migrant route (changing?)
Acknowledgments

 Maarit Kokki
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Thank You

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