Migrant Health – A cause for concern?

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The geopolitical drivers that influence human migration are complex and subject to change often influenced by conflict. Within this editorial, the term migrant is used as a generic for the heterogeneous population of asylum seekers, economic migrants and refugees. Population flows into Europe have reached unprecedented levels during the last few years. It is believed that some 355,361 new arrivals reached Europe by sea during 2016 (figure 1; data2.unhcr.org/en/situations/mediterranean), and predicted to reach 400 million by 2050. These are largely comprised of asylum seekers from Syria, Afghanistan Iraq and Nigeria. Beside political and economic impacts, health issues are a concern amongst newly arrived individuals. These countries have higher infection rates for diseases such as tuberculosis, with Afghanistan, Nigeria and Somalia having incidence rates of 125-332/100,000 of the population. Migrant and refugee populations are particularly vulnerable as often they have endured challenging journeys to Europe in less than desirable living conditions. Indeed, these stressful circumstances can result in activation of previously latent infection. Given these figures, it is not surprising that tuberculosis should be considered among newly arrived asylum seekers. Within the European economic area, some 25% of all cases of tuberculosis occur in foreign-born individuals [1]. Over 86% of European countries have implemented a tuberculosis screening programme for newly arrived asylum seekers.
Other health priority areas encompass communicable respiratory and gastrointestinal infections, psychological trauma, drug abuse and pregnancy. Despite the conditions that many migrants have endured during their journey to Europe, the majority are generally in good health. Specific screening generally includes infectious diseases such as tuberculosis, hepatitis B and C and HIV infection. More exotic infections have been described such as a cluster of cutaneous diphtheria amongst refugees arriving in Germany and Switzerland (Meinel, #23135), but occur relatively infrequently. Interestingly, several of these have been amongst those whose migratory routes took them through Libya. Indeed, cases of *Plasmodium falciparum* malaria have been reported amongst migrants who stayed in this presumed non-endemic county [2]. Similarly, patients presenting with louse-borne relapsing fever have been described in migrants transitioning through Libya, far beyond the lifespan of the disease vector, clothing lice [3]. Both scenarios raise interesting and as yet unresolved transmission possibilities, serving to remind those working with migrant healthcare of the need for continued vigilance. Often newly arrived migrants are detained in overcrowded conditions that can facilitate the transmission of infectious diseases as seen with a recent outbreak of measles [4]. Many have poorly documented vaccination histories, thus deployment of vaccines is a priority amongst such groups [5]. Within this issue, the review by Castelli and Sulis (this issue) and provides an overview of the phases of migration from first arrival to stable resettlement and evaluates the infection risks associated with the intervening transitional stages [5].
Given the huge influx of migrants from the south and east, migratory pathways from Latin America are often overshadowed. Within this group, presence of Chagas disease caused by *Trypanosoma cruzi*, is a particularly concerning. In many, this will be asymptomatic upon entry, but with potential to evolve to its chronic disease consequences of cardiomyopathy, gastrointestinal involvement with potentially fatal outcome. Monge-Maillo and Lopez-Velez (this issue), report that some 68,000 to 120,000 individuals with Chagas disease currently reside within Europe with the majority undiagnosed [6]. Cost benefit analysis clearly demonstrated the economic benefits associated with screening migrants from Latin America, particularly from regions such as Bolivia and Paraguay [6, 7]. The remaining dilemma is whether such a screening programme should apply to all migrants from Latin America, or be targeted to particular high risk groups? The trade off in cost would need to be offset against increased complexity for healthcare providers when deciding whether to implement screening.

In conclusion, vaccination to prevent spread of communicable disease and screening for sexually transmitted infections and diseases such as tuberculosis, viral hepatitis and HIV, coupled with targeted screening based on country of origin are justifiable and economically prudent. Beyond such measures, fear of introduction of exotic infectious diseases appears to be unsubstantiated amongst migrant populations beyond those risks shared by the whole population within our increasingly globalized world.

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References:


Figure 1: Migratory pathways and countries of origin (data correct as of 11.4.17 data2.unhcr.org/en/situations/mediterranean).