

# International Conference on Migration Health 1-3 October 2018 Scientific Program Abstracts



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## Successfully Engaging Migrants in Health Care

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With recently increased international migration, including many who experience forced migration and sometimes perilous journeys to reach places of safety, ensuring appropriate healthcare access for migrants has become imperative. However, engaging migrants in healthcare of the host country is not always easy and can be impeded by host country legislation, cultural and linguistic barriers, or competing fears, anxieties and stigma.

To set the scene, two health programmes will be outlined, which included novel and tailored approaches to engaging migrants in health care. Dr Zenner will describe an approach to engaging migrants in latent TB screening and treatment in England. Dr Benson-Martin will describe a peer-led low-intensity mental health care intervention for refugees that has been implemented in two health districts in Germany.

The second part of the workshop will be a structured discussion to revisit lessons learnt in the two programmes and comparing this with the experience of participants. The workshop will encourage creative thinking and innovation in the fields of health promotion and healthcare access.

Participants will have an opportunity to discuss challenges and solutions, structured around four main themes:

- 1) Who is a 'migrant' and how do different migrants differ in their access and entitlement to health service provision
- 2) 'Make a Plan!' - what can be helpful to facilitate access, even with limited resources
- 3) 'Know your Community' - who are they and how does this knowledge affect what we do in migration health, and
- 4) 'Tweaking' - what to look for and how to use evaluation and monitoring to shape our programmes.

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### **The Art and Science of Screening Migrants**

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**Background:** Migrants may have medical conditions that are unique and do not reflect those encountered in the general population of their adopted home. These conditions can contribute to disparities in health and social situations, cause morbidity which may impact the ability of the migrant to integrate into a new community, present public health challenges to authorities, create diagnostic and treatment challenges to health providers, and may even lead to mortality. Many countries have developed guidelines to screen for conditions found in new migrant populations. However, development of such guidelines can be very challenging and sometimes controversial.

**Objective(s):** This symposium is meant to provide an understanding of what conditions need to exist to have a rationale screening recommendation, to introduce audience members to various guidelines including the newly issued European guidelines and to show an example of implementation of an innovative screening program. In addition, it is meant to stimulate the audience to “create” guidelines for specific infectious diseases.

**Method(s):** The First 45 minutes will be lecture based followed by 45 minutes of interactive exercises. The interactive exercise/s will be specific examples of populations coming from endemic areas (e.g. malaria endemic) to non-endemic countries and will challenge the audience, in an open discussion, to “be the expert” and decide how what the recommendations should be for their setting. The exercise/s are meant to show the process of guideline development and highlight the challenges encountered.

**Conclusions:** At the end of the workshop, participants are expected to be more familiar with the basic principles of screening programmes targeted toward migrant populations and be aware of the new European screening guidelines targeting newly arrived migrants. Participants will also learn from examples of how screening guidelines are implemented in multiple settings.

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**Screening and Treatment of Infectious Diseases in Migrants - Tuberculosis**

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Migrants circulating in Europe face a disproportionate burden of infectious diseases and better understanding how to engage them in screening and treatment programmes is important to improve health outcomes. In this talk I will:

- (i) Explore the burden of infection (TB, latent TB, MDR-TB) in migrants to Europe and implications for infection control
- (ii) Explore the effectiveness of screening approaches adopted across Europe
- (iii) Discuss and characterise the unique barriers to screening and treatment that migrants may face, and facilitators to improve uptake and outcomes

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### **HIV in Migrants**

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Migrants are heterogeneous and dynamic populations exposed to multiple risk-contexts for HIV infection. This heterogeneity hampers the concept of “migrant” as a single category for analyses. The contribution of migrants to national epidemics varies globally but is the highest in Europe. In the European Union and Economic Area, over half of HIV reports in persons born in a different country to that of residence originate from Sub-Saharan Africa (SSA), but HIV-positive persons from Latin-America & Caribbean and from Western, Central and Eastern Europe account for large numbers. These different geographical origins are associated with different epidemiological characteristics, and thus require distinct interventions. The epidemiological patterns largely resemble those of the countries of origin; with a fundamentally heterosexually acquired epidemic in migrants from SSA, a very high proportion of Men who have sex with Men (MSM) among cases from Latin-America and the highest proportion of persons who inject drugs among HIV-positive European migrants. Time trends are also different; for migrants from SSA sustained declines in new HIV reports have been observed from 2003 onwards whereas steady increases in HIV diagnoses in MSM from Latin America and the Caribbean have been reported. There is solid evidence that HIV acquisition among migrant MSM takes place largely after migration into European cities and accounts for a larger than previously thought proportion among heterosexual migrants from SSA. For most migrant groups, but particularly for undocumented migrants, difficulties to access HIV testing and health care are issues in many European countries and in some, undocumented migrants are not entitled to universal antiretroviral treatment.

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**Early Morning Sessions: Protection and Promotion of Health and Safety of Migrant Workers**

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**Background:** According to the ILO global estimates, in 2013, migrant workers accounted for 150 million. While a minority of migrant workers hold high-skilled jobs, many have jobs that are “dirty, dangerous and demanding (“three D-jobs”) and consequently face high risks of work-related injuries and diseases.

The objectives of this session are:

- To understand high safety and health risks of migrant workers and existing conditions;
- To share good practices to protect migrant workers; and
- To discuss measures for improving health and safety of migrant workers.

**Session outputs:**

- Data and information of health risks of migrant workers;
- International and national policies on the protection of migrant workers; and
- Good practices on the prevention and promotion of health for migrant workers at national and workplace levels.

**Expected outcomes:**

- Increased awareness and actions on "Health of Migrant Workers" within ISTM community including the establishment of a working group; and
- Bridging "Global Health Policy" to "Body of knowledge for Travel Health".

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### Migration-Specific Aspects of GeoSentinel

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**Background:** The GeoSentinel Surveillance Network has been collecting data on health issues of migrants, with a focus on infectious diseases, since 1995.

**Objective:** This session will provide a broad overview of GeoSentinel data collected over the last 20 years including findings from several analyses that have been done in the last decade including summaries of health problems of Syrian refugees and malaria in Eritrean migrants.

**Methods:** The GeoSentinel Network currently consists of 72 sites in 32 countries, which systematically collect data on individuals who have crossed international borders. Data 1995 to 2018 were extracted from the database. Basic demographics, region of migration, and frequencies of the top 5 diagnoses were determined for the most common regions of origin. Diagnoses of non-pathogenic protozoa were excluded.

**Results:** A total of 33,862 migrant records were identified; these represent 14% of the total GeoSentinel database. The mean age was 32 years (range < 1-103 years); 45% were female. The vast majority (87%) were seen as outpatients. The most common regions of origin were sub-Saharan Africa (32%), Southeast Asia (20%), South Asia (12%), South America (8%), and the Middle East (6%). Among migrants from sub-Saharan Africa, latent tuberculosis infection (LTBI) (16%), chronic hepatitis B (5.9%), dental problems (4.8%), anemia (3.5%), and schistosomiasis (3.0%) were the most common diagnoses. For migrants from SE Asia, the most common diagnoses were vitamin D deficiency (11.7%), LTBI (10.3%), eosinophilia (6.5%), chronic hepatitis B (5.8%), and dental problems (5.7%). By contrast, migrants from South Asia were diagnosed with LTBI (16.2%), vitamin D deficiency (9.0%); extrapulmonary TB (4.8%), pulmonary TB (4.52%), and various other micronutrient deficiencies (4.51%). South American migrants tended to be diagnosed with chronic Chagas disease (31%), strongyloidiasis (10.9%), LTBI (9.6%), neurocysticercosis (2.8%), and *Helicobacter pylori* infection (1.95%).

**Conclusions:** While certain diagnoses are common to most groups of migrants, such as LTBI and chronic hepatitis B, there are important regional differences in the infectious diseases encountered. In addition to highlighting the importance of considering screening for certain latent or chronic infectious diseases, there is a need to evaluate and treat underlying nutritional disorders and dental problems in recent migrants.

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**Educating the Next Generation of Health Care Providers for a Mobile World**

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Migration is everywhere, and moving fast. Never before have health care providers been challenged at such a global scale. Training in tropical medicine and imported diseases remains the essential core of travel medicine but it is no longer sufficient on its own. With migrants now taking any symptom and disease anywhere, fund of knowledge for providers now requires acute and chronic care across every clinical area and health profession. Like our mobile world itself, learners must also continually expand their skills in innovative and ever-changing information technology.

Among refugees and displaced populations, drivers of forced migration impact our thoughts, beliefs, attitudes and behavior, in both the patient and provider roles, inside and outside the clinical encounter. Emotion and bias remains difficult to avoid in health care. Health education must respond with training in cultural diversity, language, social determinants, ethical challenges, and interprofessional skills that is mainstreamed within core curricular programs, and no longer set aside in peripheral electives for a select few. Experience with social responsibility and humanitarian relief will increase providers ability to share health care services equitably across all populations. Skills in resilience, self-care and mindfulness have also become essential in health care.

After providing this overview of educational needs for the next generation of health care providers, this presentation provides examples of and reflections about curricular and extracurricular training in health care delivery and community engagement for refugees, specifically in the Mediterranean and in North America. Training tools aimed to improve knowledge of migrant health issues and digital tools that help health professionals in the decision-making process will be shared. Spanning medical students, public health students, and practicing health professionals, the speakers will present specific activities in Istanbul, Florence and Barcelona, as bridges of migration to Europe from the Middle East, Sub-Saharan Africa, and Latin America, respectively.

Finally, recognizing the unique collective experience in health care education and delivery among conference attendees, this workshop will engage the audience to share what they think belongs in the education for our next generation of health providers, and define actionable next steps for health educators and institutions.

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**Acute Health Problems, Public Health Measures and Administration Procedures during the Arrival/Transit Phase**

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<sup>1</sup>*MSF, Medical Operational Support Unit, Athens, Greece*

The medical humanitarian organization Médecins Sans Frontières (MSF) has worked to support people on the move in Greece since 1996.

The medical humanitarian organization, Médecins Sans Frontières (MSF) scaled up its operations in Europe throughout 2015 and focused on setting up mobile responses to attend to the needs of these unprecedented numbers of people on the move.

The main illnesses we treated were respiratory tract infections followed by trauma and skin infections. Most of these are directly linked to the living conditions of people on the journey: sleeping on the ground without protection or warmth in ever decreasing temperatures, no or limited access to hygiene facilities, irregular access to drinkable water and food, as well as a change in eating habits.

Anxiety symptoms formed the most common complaint related not only to the journey and past experiences but also to the reception conditions and the onward journey. Depression symptoms as well were related to previous experiences, often heightened by the migration journey, followed by adjustment symptoms.

Everything changes when you are dealing with a group of stranded people, rather than people in transit. We used to see people only briefly for quick health checks; they didn't want to stop for health services because Greece was just a transit point for them - a place from which they hoped to move on quickly. Now we need to start looking at existing medical conditions, such as depression, anxiety, post-traumatic stress disorder and other mental health-related symptoms, along with pregnancy and disability. MSF is also active in certain areas of treating chronic diseases.

In the past, anxiety was the number one health problem we treated in our mental health programmes, largely because people arriving in Greece were coming from areas of violent conflict or had experienced violence and trauma during their journey. Today, the number one health problem we see is no longer anxiety. It is depression, aggravated by the dismal living conditions and lack of information.

When it comes to people's health, we need to try to put politics aside. We should not punish people for having to flee for their lives.

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**Health Needs and Public Health Intervention during the Early Phase of Settlement at PoCs - the Experience of Migrants/ Refugees in Greece**

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<sup>1</sup>*Hellenic Center for Disease Control and Prevention, Athens, Greece*

**Background:** The number of migrants and refugees in Europe has increased dramatically in the past few years due to war, violence or prosecutions in their homeland, resulting in a global humanitarian crisis with the highest level of displacement ever recorded. Migration may affect physical, mental and social health. In this session this evolving issue will be discussed with peculiar focus on health needs of migrants/ refugees in Greece and public health intervention during the early phase of settlement at Points of Care (PoCs).

**Methods:** A search was conducted through PubMed, using keywords including refugees, migrants, Europe, health problems, for available data about health problems of migrants and refugees, health care access and public health intervention. Additional information was also collected from published data of the Hellenic Center for Disease Control and Prevention and the European Center for Disease Control and Prevention.

**Results:** The most common health problems recorded at PoCs during the early settlement include communicable diseases such as respiratory, gastrointestinal and dermatological infections, and non-communicable diseases such as chronic illness, maternal, newborn and child health issues, gynaecological/ obstetric, mental and social problems. Barriers to access to health care include legal, communication and cultural difficulties, structural and bureaucratic issues. Public health measures implemented at PoCs include provision of primary care services for the management of acute and chronic conditions, epidemiological and Syndromic surveillance, and screening for communicable diseases, preventive vaccinations, psychosocial support and dental services.

**Summary:** Many migrants and refugees are challenged with medical, mental and social problems. Their most usual health conditions are common primary care problems although there is a potential risk of communicable disease transmission. Provision of a systematic health-reception, based on a holistic approach by a multidisciplinary team, will not only benefit migrants and refugees but also will protect the public health of host countries.

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**Access to the Health Care System for Asylum Seekers and Refugees in Germany - Using the Example of the City State of Hamburg**

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Since the large influx of refugees and asylum-seekers into Europe and Germany in 2015 the health system was challenged with rapidly changing situations. First shelter and basic medical care was essential whereas now integration issues play a major role.

Refugees and asylum seekers as well as the various health professionals are still struggling with the various organisational, legal and language barriers.

Besides health service responses for refugees and asylum-seekers are still heterogeneous in Germany and vary within and between federal states. Yet no consistent guidelines or regulations exist regarding the operational aspects of health care apart from the process of the health entry examination of new arrivals as a public health measure according to existing law.

The city state of Hamburg received more than 60.000 refugees till the end of 2015. Within this critical situation the routine health care services collapsed and adequate provision of health care was difficult. Thus, the local health authority organised and coordinated the provision of basic medical care within the reception centres.

Hence the public health initiative of managing curative care filled a significant health service gap. This gap could partly be reduced during the following two years. A major factor enabling access to care is the provision of the electronic health insurance card within the initial registration process. Amongst others documentation is a key factor in order to provide continuous service provision to asylum seekers and refugees. But strong data protection regulations make it difficult to document electronically and secure dissemination to the established health care system. This often leads to treatment delays or doubles costly investigations.

It became evident that public health services play a key role in facilitating and steering governmental health efforts towards the migrant population. Even though this is not always openly apparent, public health services should be encouraged and empowered to play a stronger coordinative role in all aspects of health care of refugees and asylum seekers, curative and preventive alike. In addition, a stronger epidemiological knowledge base is very important in order to advise decision makers on policy design, cost effectiveness and ethical action.

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### **Digital Solutions to Enhance the Continuity of Care for Refugees and Migrants**

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The global expansion of information technology presents an opportunity to re-design the healthcare journey for refugees and migrants. There is good evidence that the use of telehealth (videoconferencing) is acceptable to patients and able to deliver quality care outcomes. However, the evidence base for best practice health implementation for mobile phone technology mHealth is an emerging field. In this workshop we focus on real life examples of digital health solutions for common problems in refugee and migrant health.

Workshop participants will gain insights into current uses of digital health solutions, human centered design principles and evaluation fundamentals.

Intended session outcomes;

- understand basic digital health terminology; ehealth, telehealth, mHealth, EMR, internet of things.
- Using real life case studies explore some of the design challenges associated with implementing digital health solutions.

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**Workshop - Vaccination Issues Along the Migration Pathway: Accomplishments and Challenges**

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<sup>1</sup>*Centers for Disease Control and Prevention, Immigrant, Refugee and Migrant Health Branch, Division of Global Migration and Quarantine, Atlanta, United States,* <sup>2</sup>*University of New South Wales, School of Public Health and Community Medicine, Sydney, Australia*

**Background:** Immunisation is a key component of national screening guidelines for newly-arrived migrants and refugees. While the USA has extensive immunisation requirements for arriving migrants, other OECD countries do not have mandatory vaccination requirements. Opportunistic catch-up immunisation of routine vaccines is an important consideration in the post-arrival setting. However, migrants and refugees are at risk of being under-immunised both on arrival due to factors associated with their pre-migration circumstances and the impact of the migration journey. Post-migration, migrants and refugees may experience barriers to accessing health services including immunisation. Under-immunisation leaves migrants and refugees vulnerable to preventable infections in their host country as well as during return visits to their countries of origin. In addition, under-immunisation of any population group impacts on the whole immunisation program, with outbreaks of vaccine-preventable diseases arising in low coverage communities.

**Objectives and workshop structure:** This interactive workshop will use case studies to highlight the specific challenges in the immunisation of migrants and refugees in both the pre-migration and post-migration settings and will draw from the presenters' experiences and research the field. The session will commence with an overview of the key issues and follow with a series of interactive problem-based scenarios using the US-bound refugees as an example of pre-migration immunisation and strategies for immunising newly arrived refugees in Australia as an example of post-migration immunisation.

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### **Mental Health Problems in Immigrants and Refugees: A General Approach in Primary Care**

G.E. Jarvis, Canada<sup>1</sup>

<sup>1</sup>McGill University, Montreal, Canada

**Background:** In 2017 there were 258 million international migrants worldwide. Approximately 10% of these were refugees and asylum seekers. Most international migrants settled in Asia (80 million) or Europe (78 million), but the country with the largest number was the United States (50 million). Turkey had the most refugees and asylum seekers (3.1 million). Migrants tended to be from India (17 million), male (52%), and 39 years old. Large-scale migration has strained the good will of receiving countries in addition to health and mental health services. While first generation immigrants were healthier than the general population, refugees were more distressed with higher rates of PTSD, depression, chronic pain and somatic disorders. Bringing linguistic, ethnic, religious and political diversity, migrants presented unique challenges to primary health care providers, who were often the first to evaluate their needs. Given the complexity of these issues, the mental health problems of migrants often went neglected or unnoticed.

**Objectives:** To compare and contrast approaches to the mental health problems of immigrants and refugees in primary care.

**Methods:** Relevant guidelines and papers were searched, retrieved, reviewed, and compared, with the goal of synthesizing general principles of primary care assessment and intervention in migrants with common mental disorders.

**Summary of Results:** Few published guidelines exist on this topic: The Canadian Collaboration for Immigrant and Refugee Health (CCIRH) in 2011, The Centers for Disease Control and Prevention in 2015, and two papers from the United States (2017) that are not principally about mental health care. The U.S. papers focus on refugees, not migrants in general. Only the CCIRH guidelines directly address the topic of primary care approaches to mental health problems in immigrants and refugees. It should be noted that the CCIRH authors found no published guidelines on this topic prior to 2011.

**Conclusions:** A general primary care approach to mental health problems in immigrants and refugees: (1) Evaluate pre-migration, migration and post-migration factors; (2) Use linguistic interpreters and culture brokers, and engage families, and community organizations; (3) Focus on special populations: children, women and elderly; and (4) Screen for depression and PTSD in refugees.

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**Undocumented Migrants and Mental Health in the Context of the S.P.R.A.R. (Protection Service for Refugees and Asylum Seekers) of Bologna (Italy).**

V. Spigonardo, Italy<sup>1</sup>

<sup>1</sup>*S.P.R.A.R. - Municipality of Bologna, Bologna, Italy*

From 2015 the number of refugees arriving in the Italian coasts became alarming and it compels the media users to face the cruelty of forced migration. In Italy, the public debate between policy makers tends to be focused on the impact of refugees migration on local safety and wellbeing. At the same time a new category of services as S.P.R.A.R. (Protection Service for Refugees and Asylum Seekers) are implemented in the context of social and health services as potential process of inclusion and legitimation.

Facing forced migrations means coping with potentially severe mental disorders due to war trauma and migratory distress. A Cultural Consultation Service (CCS) in Bologna (Italy) aims to address psychological distress in refugees and to promote best practices in the context of the S.P.R.A.R. and local mental health services.

**Method:** Government data regarding immigrant and refugee populations are reviewed, included the data from the (CCS) in Bologna.

**Results:** The rapid rise in total numbers of immigrants arriving on Europe's Mediterranean coasts has been alarming: 216.184 in 2014, 1.015.078 in 2015, 362.753 in 2016 and 172.301 in 2017 (UNHCR). From 2015 to 2017, the average of refugees arrivals on the Italian coasts has been 94.000 people every year. As consequence of a national program involving Italian municipalities, the City of Bologna opened several services for refugees as part of the SPRAR project. The CCS in Bologna provides them with psychopathological evaluation and support.

**Conclusions:** Refugees require psychological attention due to the logic of forced migration and its human consequences. The evaluation of psychological and psychiatric features in an intercultural setting (where patient and clinician are from different ethno-cultural background) requires the ability to manage several specific clinical tools (e.g.: the use of linguistic or cultural brokers, basic knowledge of medical anthropology, investigation of social determinants of health). In this perspective, The CCS in Bologna provides an helpful clinical model to services in other parts of the country dealing with refugees.

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**Surveillance Strategies in African Refugees in their Countries of Asylum**

M. Ope, Kenya<sup>1</sup>

<sup>1</sup>*Africa Field Program, Division of Global Migration and Quarantine, Centers for Disease Control and Prevention, Nairobi, Kenya*

The UN Refugee Agency estimates there were 16 million refugees globally in 2017, of whom approximately 5 million were in Africa. Refugees, escaping conflict and persecution, cross international borders and often arrive in poor rural communities or in sprawling cities affected by poverty. Overcrowding, poor nutritional status, and inadequate infrastructure contribute to communicable diseases, which quickly become major causes of morbidity and mortality. Eventually some refugees return to their country of origin; others remain in the country of asylum; while a few resettle in other countries. Surveillance strategies and priorities vary between the acute refugee crisis, the stable refugee situation in asylum, and the period immediately before resettlement to a third country. We will discuss cross-border collaboration in Africa before a refugee crisis, disease transmission factors, priority diseases, and surveillance strategies during each phase of a refugee's journey.

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**Health Surveillance for Newly Resettled Refugees in the USA**

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<sup>1</sup>*Centers for Disease Control and Prevention, Travelers' Health and Animal Importation, Atlanta, United States*

Health surveillance systems in the United States are often disease-focused. It can be difficult to find short-term and longer-term health outcomes for specific refugee groups after resettlement because health information is maintained in many different systems. This presentation will describe selected health surveillance systems present in the United States, the benefits and challenges of these systems with regard to refugee information, and efforts to synthesize this information for refugee populations. Specifically, this presentation will describe the CDC-supported Centers of Excellence in Refugee Health's development of expanded refugee health surveillance in one state and creation of a multistate surveillance network. This refugee health surveillance network will focus on conditions of public health importance (e.g., tuberculosis, hepatitis, and parasites), document care provided for those conditions (e.g., immunizations, presumptive treatments), and monitor the long-term health and wellness of refugees.

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**Publishing, Policy and the Press - Shaping the Public and Policy Discourse on Migration Health**

J. Weekers, Switzerland<sup>1</sup>

<sup>1</sup>*International Organisation for Migration, Migration Health, Geneva, Switzerland*

The intervention, from perspective of the UN migration agency, will raise and aim to correct several myths and misconceptions around migration and health of migrants. Such misconceptions, public discourse and media can fuel stigma and hamper efforts towards equitable health access for all and the spirit of the 2030 Agenda to leave no one behind. Mrs. Weekers' interventions will explore how IOM attempts to counter such misconceptions in collaboration with MS, WHO, other UN and partners across sectors using good practices and broadening the evidence base; and underline the opportunities offered in the domains of global health as well as global migration and development, including the SDGs , the Universal Health Coverage targets, Global health security/IHR as well as the Global Compact on safe , orderly and regular migration, and Global Compact for Refugees.