" *The Network for the control of cross-border health threats in the Mediterranean Basin and Black Sea*"

Report

of the Survey on "Screening practices for infectious diseases among newly arrived migrants in the Countries of the Mediterranean Basin and Black Sea" (including comments and recommendations from the "Workshop on Screening practices for infectious diseases among newly arrived migrants", ISS-Rome, 28-29 May 2015)

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and
the Network for the control of cross-border health threats in the Mediterranean Basin and Black Sea

MedPreMIER Project

With the support of the Italian Ministry of Health

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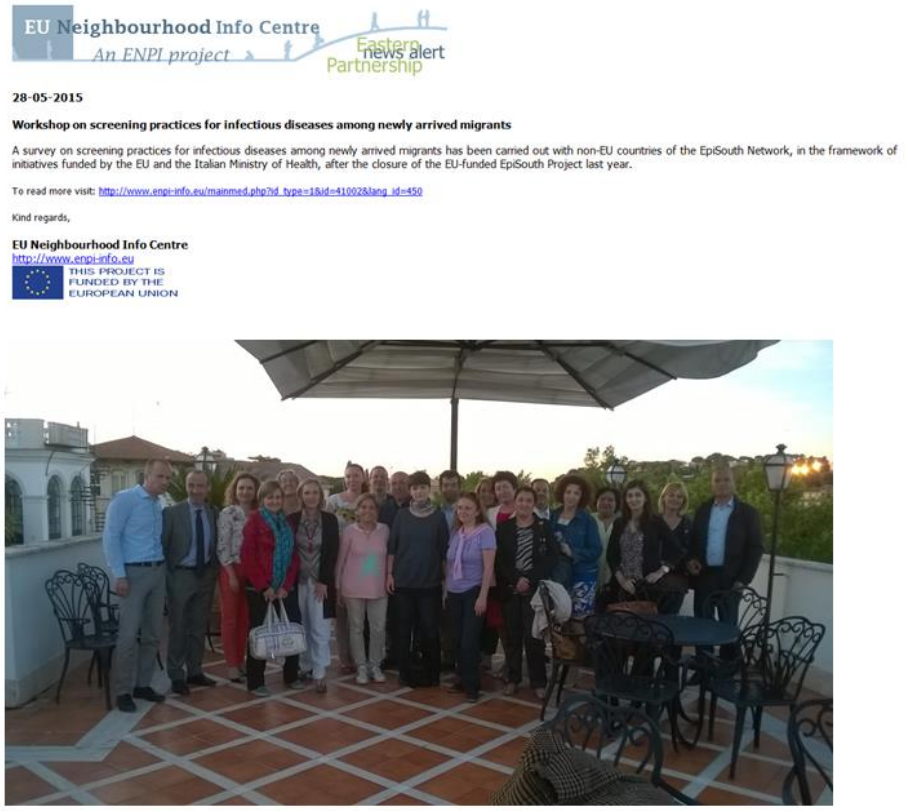

EU Neighbourhood Info Centre
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28-05-2015

Workshop on screening practices for infectious diseases among newly arrived migrants

A survey on screening practices for infectious diseases among newly arrived migrants has been carried out with non-EU countries of the EpiSouth Network, in the framework of initiatives funded by the EU and the Italian Ministry of Health, after the closure of the EU-funded EpiSouth Project last year.

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"….Migration management is a shared responsibility, not only among EU Member States, but also vis-à-vis non-EU countries of transit and origin of migrants. By combining both internal and external policies, the Agenda provides a new, comprehensive approach grounded in mutual trust and solidarity among EU Member States and institutions". (European Agenda on Migration, May 2015)

Abbreviations

ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EU	European Union
FP	Focal Points
HIV	Human immunodeficiency virus
ID	Infectious Diseases
ISS	Italian National Institute of Health
MMR vaccine	Measles, Mumps, Rubella vaccine
NRC	Number of Responding Countries
STD	Sexually Transmitted Diseases
TB	Tuberculosis
VPD	vaccine preventable diseases
UN	United Nations

1. Introduction

The recent changes in migration dynamics have raised concern on the potential effect of migration on the transmission of ID both in the Mediterranean countries as well as in the European Union, and hence on public health in both regions. Health care systems in most countries in the Mediterranean region and in European Union are generally not designed to collect migrant specific health information and they often cannot reach people who are not seeking healthcare, because of langue barriers or different societal and cultural factors, and the information on ID among migrants remains patchy, lacking comprehensive and continuous data [1;2].

Screening newly arrived migrants for ID could be a useful tool to further monitor their health, and for identifying new or asymptomatic cases of an ID and it can also offer opportunities for prevention and early detection of a disease [3; 4; 5] . However, the information on current screening programmes and practices is limited, and the factors influencing the differences in chosen practices are not clear. In 2014, ISS was tasked by ECDC of a survey on screening practices among newly arrived migrants in the EU/EEA countries and Switzerland in order to establish the extent to which countries have implemented screening programmes and how it was carried out [6]. Results showed that the implementation of screening programmes varied, and the practices were different among countries, but establishing EU-level guidance for screening would be useful, although this guidance would have to take into account differences between individual countries. As several non-EU Mediterranean countries are currently involved in the management of migrant influx, it is important to study which screening practices for ID among newly arrived migrants are adopting these countries, especially those that are experiencing large migration flows, and to promote opportunities for sharing information and practices among all the countries facing this challenge.

2. The study

A survey on screening among newly arrived migrants in non-EU countries of Mediterranean and Black Sea regions was developed. Items investigated in the survey were based on results of a literature review investigating the scientific evidence for screening practices and their implementation carried out during a previous study conducted with the same methodology among EU/EEA countries and Switzerland [6].

Further, a Workshop was organised at ISS in Rome, 28-29 May 2015, to share and discuss the preliminary results of the survey.

2.1 Objectives

The objectives of this study were to review current screening practices and policies for migrants in non-EU countries of Mediterranean and Black Sea regions and to differentiate the screening practices, policies and recommendations between different communicable diseases and between different migrant sub-groups.

3. The Survey

3.1 Materials and methods

A 15-point questionnaire on screening among newly arrived migrants in non-EU countries of Mediterranean and Black Sea regions was developed and piloted with the country's referents of Tunisia and Jordan. The finalized questionnaire (Annex 1) was sent electronically by using a web-based survey tool in November 2014 to the 20 country* Focal Points (FP) of the Network for the control of cross-border health threats in the Mediterranean Basin and Black Sea (consolidated on the basis of the EpiSouth Network established with the EpiSouth and the EpiSouth Plus Projects) [7]. Each country FP has coordinated the data collection for the survey, also by asking other country experts if the case. Those who did not reply to the questionnaire after the initial contact, were reminded by e-mail or by phone.

For the questionnaire, screening was defined as a systematic practice of medical examination, involving laboratory and/or other diagnostic testing, for searching and identifying cases of a specific ID in a target population. Newly arrived migrants, adapting the UN definition of migrants, were defined as persons, other than

* Albania, Algeria, Bosnia and Herzegovina, Egypt, Republic of Macedonia/FYROM, Israel, Jordan, Kosovo, Lebanon, Libya, Morocco, Montenegro, Palestine, Serbia, Tunisia, Turkey, Georgia, Armenia, Moldova, Ukraine

travelers or tourists, who had arrived in the last year (less than 12 months) to a country other than their usual residence [8].

The questionnaire investigated the current screening practices and the presence of guidelines in each country, both at national and sub-national level. For each implemented screening programme, respondents were asked to specify the diseases screened for, at what level in the migration process screening took place, what was the target population, and whether the screening was compulsory for these target populations. More than one level and target population could be indicated. The different levels for screening were defined as: (I) pre-entry level, screening before entering or travelling to the receiving country; (II) entry level, screening at the point of entry (e.g., harbors or airports); (III) holding level, screening in the migrant centres defined as reception/holding/transit facilities commonly used to house asylum-seekers; (IV) community level, screening after arrival and after partial integration to the community in the receiving country (e.g., in the primary care). Potential target populations for screening were defined as: (I) all newly arrived migrants; (II) asylum-seekers; (III) arrivals from endemic areas; (IV) other target groups, with a possibility to further specify.

We also asked the respondents to describe whether the screening data collected from their implemented screening programmes was generally available for public health purposes, and what actions, such as vaccination campaigns, treatment or control measures, were taken based on the screening results. Finally, we asked the expert's opinions on the general usefulness of screening programmes and what is their opinion on the screening programmes implemented in their countries.

3.2 Analysis

A frequency analysis was performed for all the categorical variables, and the proportions of responses were calculated on the bases of the number or respondents for each question. The Chi-squared test or Fisher's exact test was used for testing differences in frequency of categorical variables, where appropriate.

We acquired data on refugees and resident populations from UN-DESA for the year 2013 and performed a further analysis on the chosen screening practices [8]. We chose the data on refugees as a proxy for newly arrived migrants, as in the available information from UN-DESA on migrant flows the migrants were not defined as having arrived during the last year, and therefore did not meet our definition for newly arrived migrants. Based on this data we ranked and categorized the countries equally into three groups on the basis of the proportion of refugees in the population: low (<25/100,000), medium (25-400/100,000) and high (>400/100,000). We studied the association between this parameter and the implementation of screening programs and national guidelines by

using a Fisher's exact test, a p-value <0.05 was regarded as significant. Data were analyzed by using STATA version 11.0 .

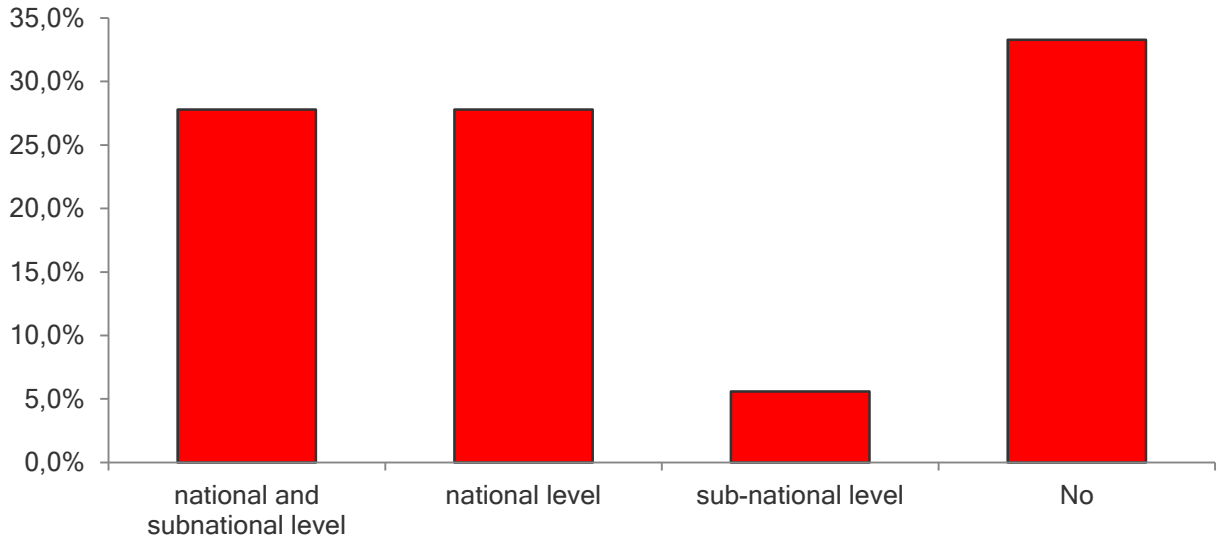
3.3 Results

Of the 20 country experts enrolled, 18 (90%) submitted a valid completed questionnaire. All the respondents were experts from National Institutes of Public Health or from National Ministries of Health, but one from Ministry Civil Affairs, of 18 non-EU Mediterranean and Black sea countries.

Fifty-six percent (9/16), of the countries responding to the specific question, routinely uses migration centres for administrative detention of asylum seekers and irregular migrants; and about the same percentage (50%, 8/16) consider that newly arrived migrants are having an impact on ID epidemiology in their country.

Screening among newly arrived migrants was implemented in 61,1% (11/18) of the responding countries. Screening is performed at national level in the majority of the countries (10 countries, of which 5 at both national and subnational level); one country reported having only regional/subnational screening at place (Figure 1). National guidelines for screening among newly arrived migrants, at least for one disease, were available in 37,5% (6/16) of the countries. Therefore, although 11 countries implement screening practices, only 6 had national reference documents or guidelines. The countries who had guidelines had also implemented screening, but 5 countries had implemented screening without any national guidelines or reference documents.

Figure 1. The implementation of screening among newly arrived migrants in non EU Mediterranean and Black sea countries on national and/or subnational level (NRC, number of responding countries =18)



When comparing the proportion of refugees in the population and the implementation of screening programs, countries with high proportions had implemented screening programs more often (Table 1). Similarly, those with high or medium proportion of refugees had more often guidelines for screening among newly arrived migrants. Having a high proportion of refugees in 2013 was associated with the existence of relevant guidelines (p=0.05), but not with the implementation of screening programmes (p=0.53).

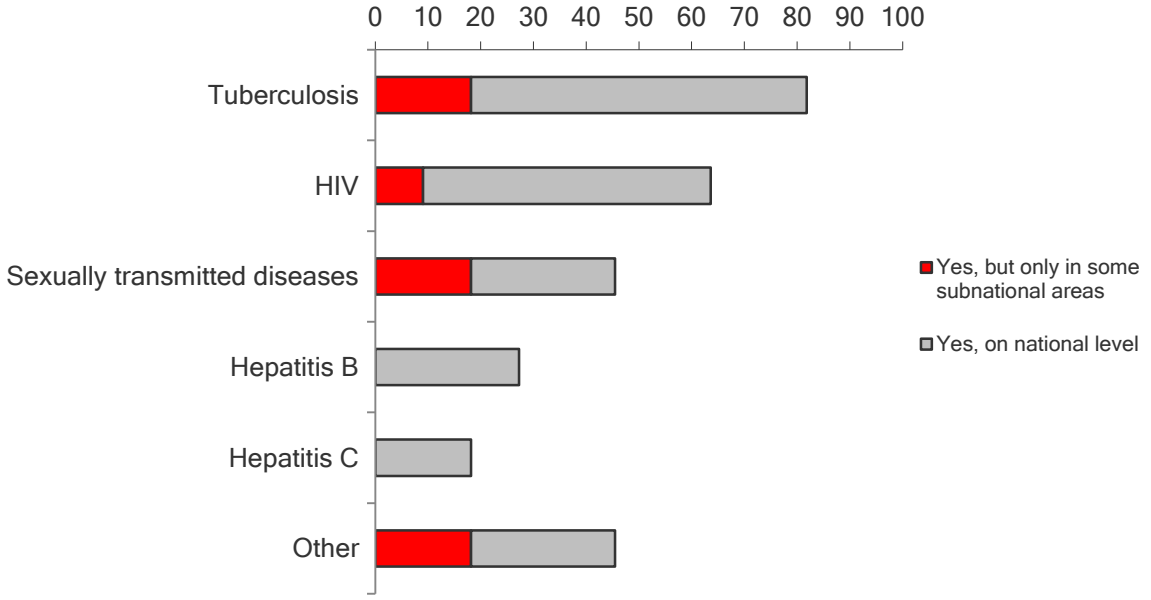
Table 1. Association between the proportion of refugees in the population and the implementation of screening programs and guidelines for screening.

	Low proportion	Medium proportion	High proportion	p-value
Countries with guidelines for screening	25 % (1/4)	0% (0/4)	83 % (5/6)	0.052
Countries with implemented screening programs	50% (2/4)	50 % (3/6)	83 % (5/6)	0.532

TB is the most frequently screened ID, mainly at national level (Figure 2): all experts, but two, who reported having implemented routine screening programs and responded to the question on specific diseases screened for, reported screening for TB (9/11, 81,8%).

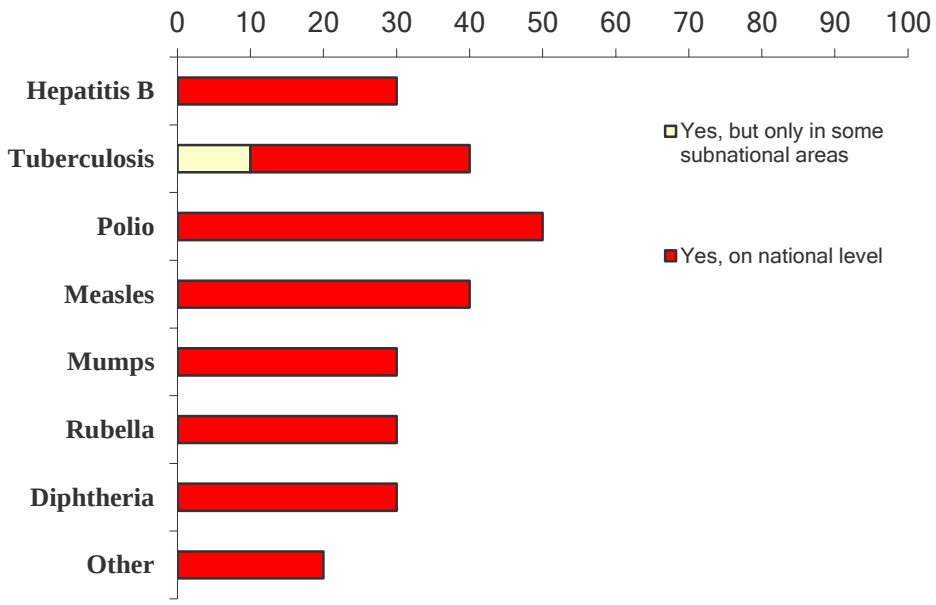
Other diseases screened for included HIV (7/11; 63,6%), Hepatitis B (3/11; 27,3%), STD (3/11; 27,3%) and Hepatitis C (2/11; 18,2%); 45,5 % of the experts reported screening activities in their country for other diseases/etiological agents (e.g. *Salmonella typhi*, other species of *Salmonella* spp., malaria, leprosy).

Figure 2. Infectious diseases screened for (NRC=11)



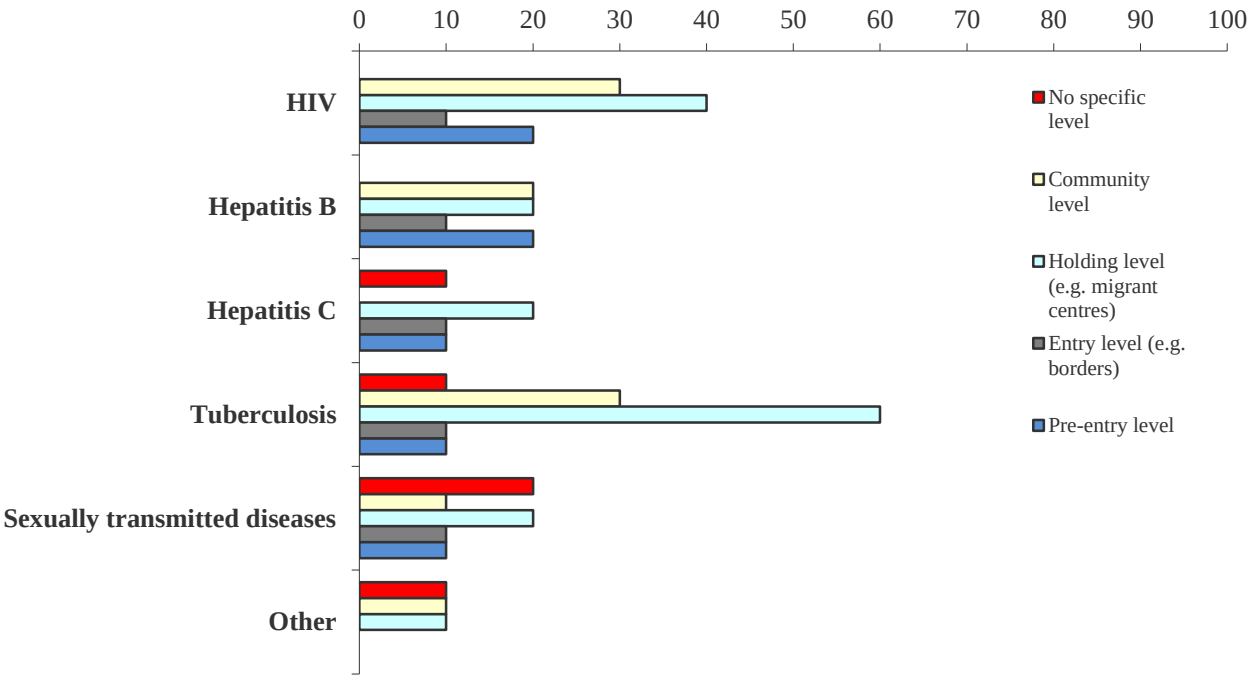
Checking for vaccination status can be considered part of the screening practice. Vaccination status is checked in 90,1% (10/11) of the countries that implement screening among newly arrived migrants, always at national level, but one case for TB where screening is provided only at sub-national level. At national level, the screening is performed mainly for polio (5/10; 50%) followed by measles (4/10; 40%), TB (3/10; 30%), Hepatitis B (3/10; 30%), Mumps (3/10; 30%), Rubella (3/10; 30%), Diphteria (3/10; 30%) and other ID (2/10; 20%) (Hib, Tetanus, Pertussis) (Figure 3). It should be noted that, with the exception of Poliomyelitis, the vaccination status for the other VPD is checked by less than 50% of the respondents.

Figure 3. Infectious diseases for which vaccination status is checked for (NRC =10)



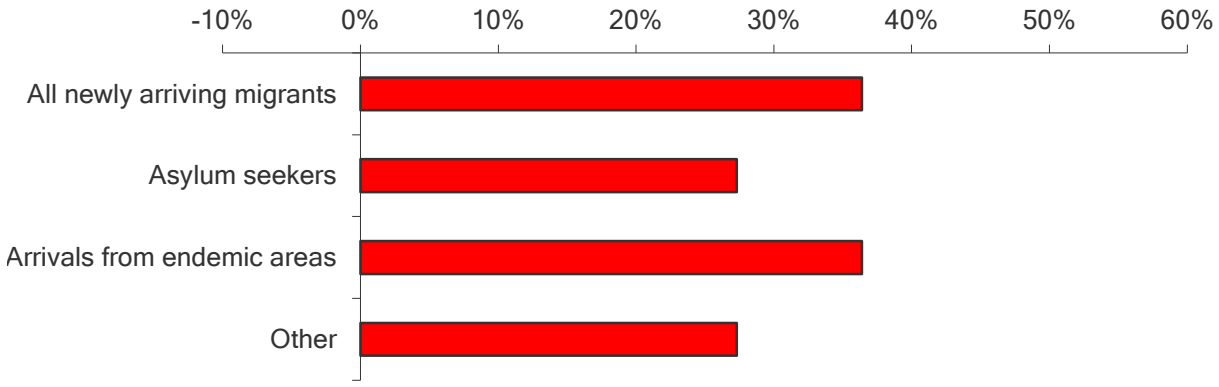
For the majority of screened ID, holding level is the most common level where screening is performed, particularly for TB, HIV, Hepatitis C; nevertheless, community level is represented too and it should be noted that in some cases a pre-entry screening (mainly for HBV, HIV, HCV) is also required (Figure 4). For TB, screening at the holding level was most common: 60% of respondents reported screening at the holding level and 30% at the community level; pre-entry screening was reported to be implemented only by one countries (10%) and entry level screening by one country (10%). For HIV, 40% reported screening at the holding level and 30% at the community level; two countries reported a pre-entry screening for HIV and one country at entry level. For Hepatitis B, the pre-entry, holding and community level were reported by 2 countries each and entry level by one country.

Figure 4. The level of screening among newly arrived migrants for each disease screened for (NRC =10)



The target groups are the people coming from endemic areas (36.4%) or, if the origin of migrants is uncertain, all newly arrived migrants (36.4%); 27.3% screens only asylum-seekers and the same percentage screens other target categories (mainly migrant workers). The screening is always compulsory.

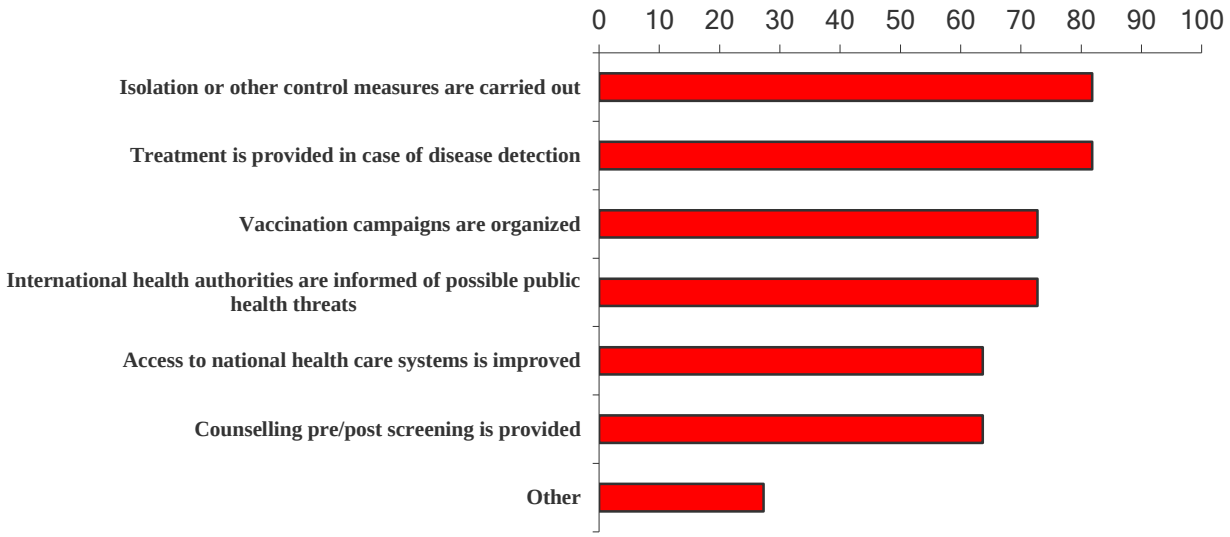
Figure 5. Target population for screening (categories not mutually exclusive) (NRC =11)



The data on screening were collected and available for public health purposes in 72,8% of the countries. The screening is performed in order to act: actions that are mainly carried out following the screening data is the implementation of control measures, treatment, vaccination campaigns, international reporting, improvement of access to health care system .

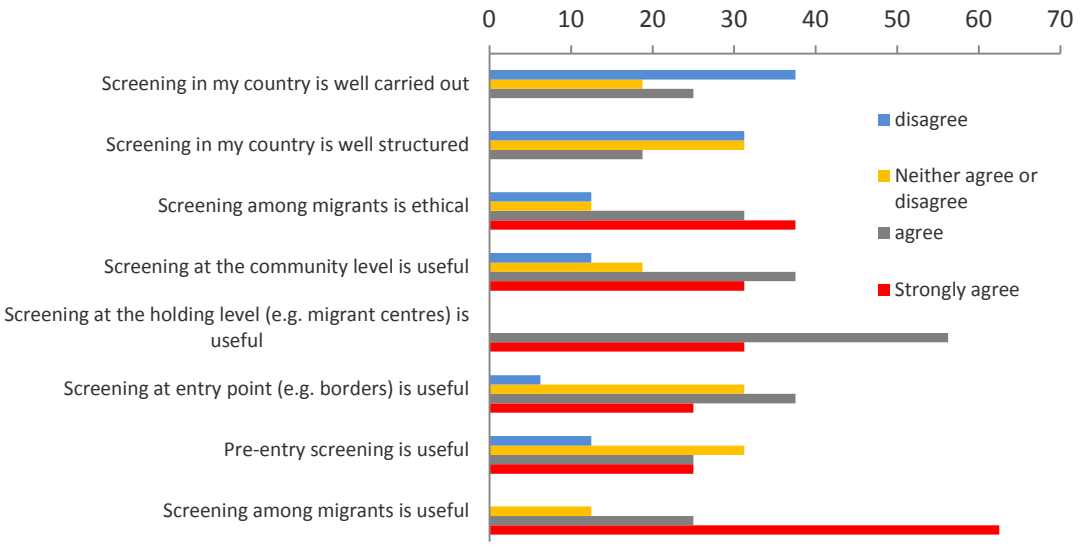
The actions directed by these data included isolation or other control measures (81,8%), treatment in the case of disease detection (81,8%), providing international health authorities information of possible public health threats (72,7%), vaccination campaigns (72,7%), improvement of the access to the national health care systems (63,6%), pre/post-screening counselling (63,6%), and other 27.3% (Figure 6).

Figure 6. Actions based on the screening data (NRC =11).



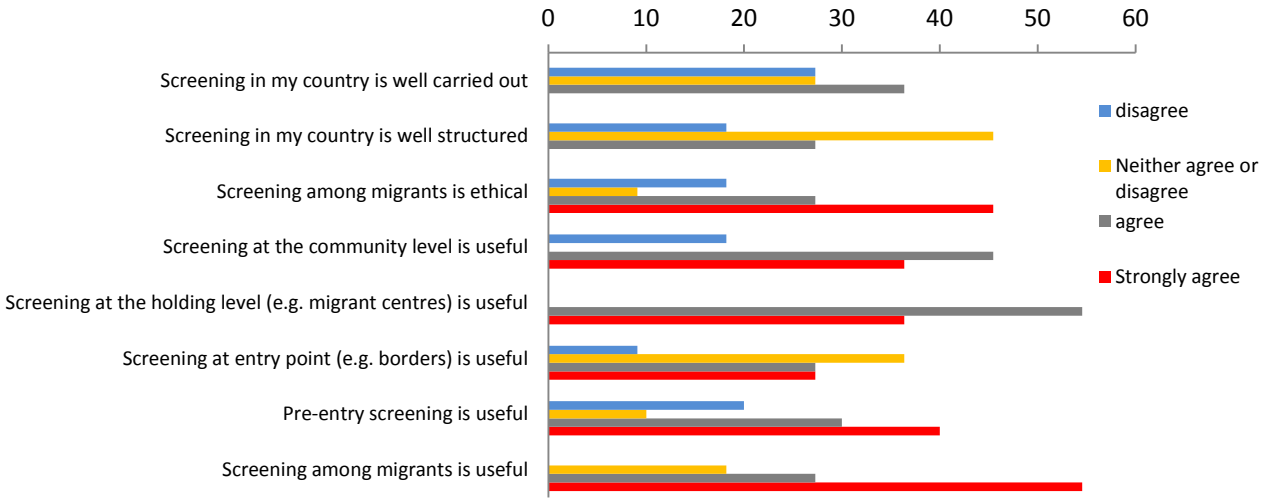
With regard to experts opinions (including countries both performing and not performing screening): screening among migrants was considered useful (agree + strongly agree) by 87,5% (14/16) of the country experts participating to the survey and responding the question; especially if the screening was conducted at the holding level (14/16, 87,5%) and at the community level (11/16; 68,8%) (Figure 7). Entry level screening was considered useful by 62,5% (10/16) of the respondents, and similarly, 50% (8/16) considered pre-entry-level screening useful. In total, only three and four countries considered that the screening was well structured and well carried out in their country, respectively.

Figure 7. General opinions on screening among migrants (NRC=16 countries both performing and not performing screening)



When considering only those countries that perform screening, the percentage of experts believing that screening is useful is still high but decrease under 80%; nevertheless, the screening performed in their own countries is not always considered well carried out and well structured (Figure 8).

Figure 8. General opinions on screening among migrants (NRC=11 countries performing screening)



4. The Workshop

The Workshop on *"Screening practices for infectious diseases among newly arrived migrants"* was held at ISS, in Rome, on 28 and 29 May 2015 with the aim of sharing the preliminary results of the Survey described and of enriching these results with further information and details provided by country cases presentations and discussion with the participants to the Workshop (see further details in the Workshop Programme in Annex 2.).

Out of the 20 non-EU countries of Mediterranean and Black Sea Regions, which were invited to take part in the survey on screening practices, 12 were represented in the Workshop (Albania, Bosnia and Herzegovina, Israel, Jordan, Kosovo, Lebanon, Moldova, Morocco, Rep of Macedonia, Serbia, Tunisia and Ukraine). Moreover, also Greece, Italy, Malta and Spain, were invited to the Workshop to report their screening practices and related experience.

Two lectures were delivered by two experts coming from Italy and United Kingdom to contextualize the workshop's thematic.

The results of the two surveys on Screening practices for ID among newly arrived migrants, conducted with EU/EEA countries and non-EU countries of Mediterranean and Black Sea Regions, were reported and the main results compared and discussed.

Among those countries participating, nine were implementing screening procedures (4 EU and 5 non-EU) relying on national guidance and were therefore asked to present their experience on the basis of a guiding template (Annex 3).

During the discussion further relevant issues were raised and they are taken in consideration in the conclusions of this report.

5. Discussion on the survey's results

The literature review helped to understand the additional information needs and potential gaps in knowledge, on which the survey was based. Therefore, the survey allowed a clearer view of the screening practices in most of the non-EU countries of the Mediterranean and Black Sea Regions.

At the time of the survey, 61% of the countries had implemented national or sub-national screening programs targeted to newly arrived migrants. The implementation of screening, often in place in migrant centres, was associated with the proportion of refugees in the population.

In those countries where screening programs were implemented, the practices varied, and around half of the countries had established national guidelines for screening. Experts participating in the survey widely agreed on the usefulness of screening programs among newly arrived migrants.

Results from the survey showed that countries with screening programs targeting newly arrived migrants, did so first and foremost to detect TB, confirming previous findings of international studies on screening programs [4,5], but screening for other ID was implemented too, and in this case diseases screened for varied by country. Screening programs were specifically targeted for subgroups of newly arrived migrants, most often asylum-seekers at the holding level. Also, other subgroups were targeted in some countries, but this depended on the disease in question and on the availability of resources.

Comparing the results of the survey among non-EU countries, to those of the EU countries [6], the main differences regard the percentage of countries having guidelines for screening (56% EU vs 37% Non-EU), and the diseases screened for: in EU the attention is focused on TB (100% of the countries performing screening) and less

on other ID (all under 35%); in non- EU countries the main attention is addressed to TB (81%), but also to HIV (70%) and other STD (50%). Moreover, in non-EU countries the screening performed is always compulsory, while in EU countries in the great majority of the cases (61%).

At the same time, both surveys show almost the same percentage of countries performing screening (59% EU vs 61% Non-EU) and considering screening useful (96% EU vs 87% Non-EU).

Certain studies on screening have proved that it can be reasonably cost-effective and possibly useful in helping to reduce the burden of the disease for infections such as TB or Hepatitis B, although there remains further discussion on how, where and for who screening should be implemented and where it is most effective [9-12]. For example, in the case of TB, especially certain vulnerable populations are thought to benefit from screening, as difficult travel and housing conditions increase the risk of the disease, thus making screening at the holding level useful [13]. However, in practice all newly arrived migrants cannot be automatically reached in migrants centres, and in some cases diseases can develop years after the migration, and sometimes they can only be detected in later phases. Therefore, depending on the disease, it can be also reasonable and appropriate to perform screening at the first contact with the healthcare, i.e. often at the community level after the arrival.

As noted above, many of the countries that had implemented screening programs, had chosen to perform screening in migrant centres that are used to house asylum-seekers, while the most common target groups for screening are “all newly arrived migrants” and “arrivals from endemic areas”. These choices may reflect certain practical aspects of implementing screening programmes, as the population in the migrant centres is easy to reach for screening. But this practice may also be based on the assumptions of usefulness of screening in migrant centres and similar facilities because of increased risk of ID in these settings.

While taking into account that screening programs for newly arrived migrants were different, and implemented at different levels, the overall perception of the experts on the usefulness of screening targeting newly arrived migrants was clear, especially at the holding level.

Additionally, a variety of actions were taken on the basis of screening results, which supports the idea that screening programs and their results can provide useful information to guide public health actions and are thus valuable tool for monitoring ID among migrants. With regard to experts opinions (including countries both performing and not performing screening): screening among migrants was considered useful by almost 90% of the country experts participating to the survey and responding the question; especially when the screening is conducted at the holding level. When considering only countries performing screening, the proportion of experts

believing that screening is useful was still high but decreased under 80%; nevertheless, the screening performed in their own countries is not always considered well carried out or well structured, which indicates that there is a further need for guidance and room for improvement in the currently implemented programs.

A potential limitation is that we did not ask the differences in practices between individual prioritized diseases, and our definition of screening was very broad. Whilst including all ID, and various screening methods into our survey we reached a scope of assessing screening practices on a very broad scale, we also lost the specificity of information on methods and other details of each screening program, targeted for commonly screened diseases, such as TB or Hepatitis B. Furthermore, our analysis on the proportion of refugees in the population took into consideration only one important subgroup of newly arrived migrants, but did not take into account other important migrant groups and changes in the total migration. Therefore, our analysis only gave a partial view on the situation in non-EU countries of Mediterranean and Black Sea Regions.

However, a first picture of the current screening practices for different ID in non- EU countries is provided, based on the expert opinions on screening from 18 different countries. The analysis also took into account the proportion of refugees in the population, which showed an association between a high proportion of refugees in the population and the existence of national guidelines for screening but not with the implementation of screening programmes.

Whether screening among migrants for ID is effective or cost-effective from a public health perspective, remains an open question in our study and needs further research. Literature does suggest that in the cases of TB and Hepatitis B screening can be maintained on a relatively effective basis, and further consideration on the effectiveness of screening programs is clearly important for the development of guidelines. It is also clear, that screening is not to be seen only as a tool for cost-effectiveness of health care, but also as a tool for improving the situation of vulnerable populations, and it could be simply considered as a part of routine healthcare in most of the immigrant subgroups.

When discussing the benefits of screening, the importance of providing treatment in the case of disease detection or using the screening-data for public health purposes (e.g. by organizing vaccination campaigns) is clear, and such activities already take place in the majority of countries performing screening, underlining the usefulness of screening programs.

The discussion carried out during the Workshop has underlined further aspects related to migration and screening in the Countries of Mediterranean and Black Sea Regions.

Firstly, the countries migration patterns are heterogenic: i.e. urges in some countries; transit migration countries and/or final destination countries; recent migration (1st generation); evolving migration history (2nd -3rd generation). Also, speed of movement is growing and the routes are changing.

The above generates differential levels of risk for I D, and this should be considered in the screening procedures.

Appropriate consideration and management of health aspects (including screening) of migration can greatly contribute to stability and social security.

The discussion confirmed that screening is performed by most countries in different ways (protocols/target diseases/ target groups); reasons for screening vary (security/prevalence estimation/therapy and follow-up/ facilitated access to health care); evidence of cost-effectiveness of screening should be further investigated and methodological options for screening should be refined also on the basis of screening success variables highlighted in the workshop's presentations.

6. Conclusions and the way forward

All the participants to the Workshop agreed on the fact that the issue of screening of ID in newly arrived migrants is very relevant for all the participant countries and several aspects should be further studied and shared (for example the preparation of country booklets on national screening procedures in accordance with a template to ensure comparability was proposed), consensus on harmonized guidelines should be promoted with recommendations on public health connected aspects (treatment and PH measure, better early treatment) to sensitize policy makers on the importance of screening.

Attention also on new tools for monitoring ID among migrants (web-based surveillance tools and epidemic intelligence methods) has been called upon during the Workshop to facilitate risk assessment and timely outbreak detection. At the same time, actions for prevention (health education, supply of protective measures such as condoms, simple hygienic rules, access to rapid testing) should be also considered for this target group.

Finally, it was underlined that, to ensure a national as well as a regional impact of programmes dealing with ID in newly arrived migrants, a better collaboration between the different stakeholders involved (Ministries of Health, Ministries of Interior, Ministries of Foreign Affairs etc), and Networks present in the Region should be promoted and implemented.

The participants will jointly collaborate towards a common effort which can ensure a concerted initiative that can address the critical gaps and needs identified and mentioned above.

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Survey on screening of infectious diseases among newly arriving migrants

Welcome to the survey on screening of infectious diseases among migrants in Mediterranean countries.

This survey is in the framework of the Italian Project MedPremier, aimed at enhancing the monitoring of Migrant Health and Infectious Diseases, coordinated by the Istituto Superiore di Sanità (ISS, Rome-Italy) and financed by the Italian Ministry of Health.

The objective of this survey is to better understand some of the key issues in relation to the screening of infectious diseases among migrants in the Mediterranean region and southeast Europe.

The results of this survey will produce a draft report which will be shared and discussed with the participants.
Than the report will be finalised with the participants' comments and integrations.

In this survey, screening is considered to be a systematic practice of medical examination, involving laboratory and/or other diagnostic testing, for searching and identifying cases of a specific infectious disease in a target population.

Newly arrived migrants is used to refer to a person, other than traveller or tourist, who has arrived to a country other than that of his or her usual residence in the last year (less than 12 months), regardless of immigration status. This includes asylum-seekers, refugees and economic migrants etc.

The questionnaire takes approximately 10 minutes to be filled. You don't need to complete the survey just in one session: you can answer to some questions, stop and continue later using the same link. However, it is needed to complete the page and go to the next page in order to save the answers.

We kindly ask you to fill the survey before December 1st.

Thank you in advance for your contribution.

Maria Grazia Dente

In the case of questions or in the need of clarifications, please contact: mariagrazia.dente@iss.it or christian.napoli@iss.it

Survey on screening of infectious diseases among newly arriving migrants

1. Respondent (Please fill in the contact details only if the respondent is someone else than the person invited to the survey):

Name:	
Institution	
Email Address:	

2. Would you say that newly arriving migrants are having an impact on infectious disease epidemiology in your country?

- ◯ Yes
- ◯ No
- ◯ I don't know

3. Does your country routinely use migration centres for administrative detention of asylum seekers and irregular migrants?

- ◯ Yes
- ◯ No
- ◯ I don't know

4. Does your country have national guidelines for screening of infectious diseases among newly arriving migrants?

- ◯ Yes
- ◯ No
- ◯ I don't know

5. Does your country routinely screen newly arriving migrants for infectious diseases on national or subnational level?

- ◯ Yes, on national and subnational level
- ◯ Yes, on a national level
- ◯ Yes, on sub-national level
- ◯ No
- ◯ I don't know

6. If your country routinely screens newly arriving migrants on national or subnational level, which infectious diseases are screened for:

	Yes, on national level	Yes, but only in some subnational areas	No	I don't know
HIV	◯	◯	◯	◯
Hepatitis B	◯	◯	◯	◯
Hepatitis C	◯	◯	◯	◯
Tuberculosis	◯	◯	◯	◯
Polio	◯	◯	◯	◯
Measles	◯	◯	◯	◯
Rubella	◯	◯	◯	◯
Sexually transmitted diseases	◯	◯	◯	◯
Other, please specify	◯	◯	◯	◯

Please specify what other disease is screened for:

7. If your country screens newly arriving migrants on national or subnational level, for which infectious diseases is vaccination status checked:

	Yes, on national level	Yes, but only in some subnational areas	No	I don't know
Hepatitis B	◯	◯	◯	◯
Tuberculosis	◯	◯	◯	◯
Polio	◯	◯	◯	◯
Measles	◯	◯	◯	◯
Mumps	◯	◯	◯	◯
Rubella	◯	◯	◯	◯
Diphtheria	◯	◯	◯	◯
Other, please specify	◯	◯	◯	◯

Please specify for what other disease vaccination status is checked:

8. At what level is screening among newly arriving migrants practiced in your country (choose one or more levels)?

	Pre-entry level	Entry level (e.g. borders)	Holding level (e.g. migrant centres)	Community level	No specific level	I don't know
HIV	☐	☐	☐	☐	☐	☐
Hepatitis B	☐	☐	☐	☐	☐	☐
Hepatitis C	☐	☐	☐	☐	☐	☐
Tuberculosis	☐	☐	☐	☐	☐	☐
Polio	☐	☐	☐	☐	☐	☐
Measles	☐	☐	☐	☐	☐	☐
Rubella	☐	☐	☐	☐	☐	☐
Sexually transmitted diseases	☐	☐	☐	☐	☐	☐
Other, please specify	☐	☐	☐	☐	☐	☐

Please specify for what other disease is screened for:

9. What is the target population of screening among newly arriving migrants in your country (choose one/many)?

- ☐ All newly arriving migrants
- ☐ Asylum seekers
- ☐ Arrivals from endemic areas
- ☐ I don't know
- ☐ Other, please specify

10. Is the screening compulsory for immigrants included in the above selected target groups?

- ◯ Yes
- ◯ No
- ◯ I don't know

Comments, if any:

11. Is the data on screening results collected and available for public health purposes?

- ◯ Yes
- ◯ No
- ◯ I don't know

Comments, if any:

12. Which actions are directed by the screening data ?

	Yes	No	I don't know
International health authorities are informed of possible public health threats	◯	◯	◯
Vaccination campaigns are organized	◯	◯	◯
Access to national health care systems is improved	◯	◯	◯
Isolation or other control measures are carried out	◯	◯	◯
Treatment is provided in case of disease detection	◯	◯	◯
Counselling pre/post screening is provided	◯	◯	◯
Other, please specify	◯	◯	◯

Please specify what other actions:

13. To what extent do you agree or disagree with the following statements about screening of infectious diseases among migrants?

	Strongly agree	agree	Neither agree or disagree	disagree	strongly disagree	I don't know
Screening among migrants is useful	◯	◯	◯	◯	◯	◯
Pre-entry screening is useful	◯	◯	◯	◯	◯	◯
Screening at entry point (e.g. borders) is useful	◯	◯	◯	◯	◯	◯
Screening at the holding level (e.g. migrant centres) is useful	◯	◯	◯	◯	◯	◯
Screening at the community level is useful	◯	◯	◯	◯	◯	◯
Screening among migrants is ethical	◯	◯	◯	◯	◯	◯
Screening in my country is well structured	◯	◯	◯	◯	◯	◯
Screening in my country is well carried out	◯	◯	◯	◯	◯	◯

Comments, if any:

14. Do you have any additional comments on screening of infectious diseases among migrants?

15. If possible, please send references and/or links to any national guidelines or Standard Operating Procedures your country uses for guiding screening practices among migrants:

16. If the questionnaire was filled in collaboration with other national experts, please list their names and institutions:

1.
2.
3.
4.
5.

Survey on screening of infectious diseases among newly arriving migrants

The questionnaire is now finished.

If you answered to all the questions and are finished with the survey, please click "Done". After this, answers cannot be further modified by using the same link.

Thank you for your participation!

In the case of questions or in the need of clarifications, please contact: mariagrazia.dente@iss.it or christian.napoli@iss.it

The Network for the control of cross-border health threats in the Mediterranean Basin and Black Sea:

Workshop on "Screening practices for infectious diseases among newly arrived migrants" and "Vaccine Preventable Disease (VPD): strategies and coverage"

28-29 May 2015

Marotta Room
Via del Castro Laurenziano 10
ISS, Rome (Italy)

(Ver. 25 May)

28 May – 1st day

9:00am – 4:00pm

"Screening practices for infectious diseases among newly arrived migrants"

8:30-9:00 am – Participants' registration

9:00-9:30 Openings and Workshop's aims

- Stefania Salmaso (Head of National Center for Epidemiology, Surveillance and Health Promotion-CNESPS, ISS)
- Daniela Rodorigo/Pasqualino Rossi (DG Communication and International relations - Italian Ministry of Health)
- Silvia Declich (Head of Communicable Disease Epidemiology Unit – CNESPS, ISS)

9:30 -10:15 Is screening for infectious diseases in newly arrived migrants effective?

- Paolo Giorgi Rossi (AUSL and Arcispedale S. Maria Nuova, IRCCS, Reggio Emilia, Italy)
- Manish Pareek (NIHR Academic Clinical Lecturer/Specialist Registrar, Department of Infection and Tropical Medicine University of Leicester, UK)

10:15 – 10:30 Results of the EU/EEA Countries' Survey - Tommi Kärki (EPIET- CNESPS/ISS)

10:30 – 10:45 Results of the Mediterranean Basin and Black Sea Countries' Survey (Christian Napoli and Maria Grazia Dente - CNESPS/ISS)

10:45 -11:15 Discussion

11:15-11:30 Coffee Break

11:30:1:00 pm Round Table: Screening Procedures at National Level - 1st part

Countries' presentations

1:00-2:00 pm Lunch

2:00- 4:00 pm Round Table: Screening Procedures at National Level - 2nd part

Countries' presentations

Discussion

4:30-10:30 pm Network consolidation activities and Social Dinner (see related programme)

29 May – 2nd day

9:30 am – 1:30pm

"Vaccine Preventable Disease (VPD): Strategies and Coverage"

(9:00-10:00 – Project Advisory Board Meeting - internal)

9:30-10:00 – Coffee and registration of participants

10:00-10:30 – VPD in Mediterranean Basin and Black Sea: the Polio case – Donato Greco (Member of the European Regional Certification Commission for Poliomyelitis Eradication)

10:30-11:15 Presentation of the Vaccine Preventable Disease (VPD): Strategies and Coverage Project

- Project's aims and activities (Silvia Declich)

- Project's survey on VPD strategies and coverage and questionnaire (Cristina Giambi - CNESPS/ISS)

11:15-12:15 Working in groups: testing the questionnaire for the survey and discussing possible integrations and amendments (countries and facilitators)

12:15-12:45 Information and updating on the Medilabsecure Project (Maria Grazia Dente e Flavia Riccardo - CNESPS/ISS)

12:45-1:15 pm Conclusions of the Workshop and the way forward (Silvia Declich)

1:15 pm -2:00 pm Lunch

OUTLINE

- Overview of patterns of immigration to your country (estimations of numbers, nationalities, migration routes, type of migrants status, relevant national laws etc.)
- Availably and type of Immigration centers
- Diseases screened and target groups addressed
- Availably of National guidance: main features and inspiring documents
- Evidence of screening's effectiveness in your country
- Lessons learned and recommendations
- Results and examples of screening practices targeting newly arrived migrants
- Challenges and Possible solutions