Challenges and options to address vaccination needs of irregular migrants, refugees or asylum seekers in the EU

Karam ADEL ALI, ECDC on behalf of ECDC Vaccine-Preventable Diseases Programme
ProVacMed Network Meeting, 17 June 2016 – Rome, Italy

Star-marked (*) slides featured are courtesy of Teymur Noori, ECDC
High profile on EU political agenda

- “Migrants health” gaining new political momentum, following influx of refugees & asylum seekers
  
  - EU Commission President Juncker’s European Agenda for Migrants
    - EU Civil Protection Mechanism in support of countries at higher exposure
    - Increasingly targeted financial aid mechanisms, e.g. Asylum Migration Integration Fund; EU Emergency Assistance Instrument
      → 700 M EUR 2016-2018 (implemented through partner organisations)
      → +60 M EUR announced at end 2015 to support ‘health needs’

- ECDC work on migrants started in 2007 → EU Council Conclusions “Health and Migration in the EU” calling inter alia for

  ECDC to produce a series of reports on migration and infectious diseases in the EU, including HIV, tuberculosis and vaccine preventable diseases

#For more information, please visit: http://ecdc.europa.eu/en/healthtopics/migrant-health/Pages/migrant-health-series.aspx
Long-standing migrant health challenges from a healthcare system perspective (1/2)

Challenge of definitions

- Broad definition of who constitutes a migrant

Challenge of data scarcity

- How many migrants are there in any given country
- High-quality data on
  - Health determinants
  - Health status
  - Challenge of carried vs. acquired health problems
  - Healthcare service utilisation not available in most EU
Long-standing migrant health challenges from a healthcare system perspective (2/2)

Challenge of horizontal & vertical health equity

- Legal restrictions on entitlements to health services
- User fees and impeded access to health insurance
- Language and underdeveloped health literacy
- Unfamiliarity with own rights
- Social exclusion and discrimination (direct & indirect)
- Discrepancies between policy and practice

- **Non-homogeneous group**
- **Diverse health needs**
Need for reinforced capability in countries?

Key role of pro-active public health and healthcare systems with capability to identify, assess, address needs

Significantly increased flow of ‘irregular’ migrants, refugees, and asylum seekers

SHARP INCREASE IN INFLUX

Despite ‘healthy migrant effect’, there is potentially higher vulnerability to communicable diseases, poor mental health, maternal-child health problems*


Factors spanning across:
- Social
- Economic
- Cultural
- Legal
UAMS = 2.4% (lowest since start); Afghanistan = 45% of UAMs followed by Somalia, The G...
Applications for asylum received by Sweden
(In thousands)

In the four-month period from August to November, Sweden received 112,000 asylum applications. The amount is larger than Sweden’s previous annual record.

Note: 2015 data is up to November.

Source: Swedish Migration Agency

LAZARO GAMIO/THE WASH
Executive Summary

Currently there are no major outbreaks related to infectious diseases reported in Libya, Jordan, and other countries along the main route from North Africa to the EU. However, some cases have been reported from Tunisia and Algeria.

From a public health perspective, the risk assessment concerns related to the living conditions of the migrants, reception and detention centers, and overcrowding and poor sanitation, as these are important risk factors for infectious diseases.

The risk assessment for infectious diseases is complicated and may vary in the reception and detention centers, depending on the infectivity of the population. In addition, poor sanitary conditions may increase the risk of spread of diseases.

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

1. As appropriate, adopt surveillance systems for early warning purposes, including early health assessments for pregnant women and children
2. Establish dedicated health facilities at the reception and detention centers
3. Develop specific vaccination strategies in order to protect both children and adults against diseases. All vulnerable groups should be vaccinated
4. In addition, specific attention should be paid to institutions housing vulnerable populations

The majority of the current refugees are healthy adults; however, the infectious disease risk is moderate. The International Organization for Migration (IOM) has observed that some of the conditions in which they are likely to be exposed are knowingly poor, e.g., shelters and children in need of immediate assistance

ECDC, in collaboration with the World Health Organization (WHO) and other partners, is working to improve the situation in order to reduce the risk of outbreaks and provide care for the vulnerable populations.
Suspected outbreak of poliomyelitis in Syria: Risk of importation and spread of poliovirus in the EU
23 October 2013

Main conclusions and recommendations
The number of cases of acute flaccid paralysis among Syrian children is increasing. This risk for the importation of wild polio virus into the EU and further re-establishment and transmission in the Member States.

Recommendations:
• The European Centre for Disease Prevention and Control (ECDC) should assess the risk of transmission of wild poliovirus among the EU. Such assessments should be carried out through risk assessment, forecasting, and scenario analysis. The results should be shared with the Member States.
• ECDC should work with its partners to establish a surveillance system to monitor the situation in the EU and in the region of origin.

Source and date of request
European Commission, 23 October 2013

Public health issue
The number of cases of acute flaccid paralysis among Syrian children is increasing.

Consulted experts
ECDC

© European Centre for Disease Prevention and Control, Stockholm, 2013

1. Infectious disease risks among newly-arrived migrants in the EU/EEA

Migrant populations entering the EU/EEA, and particularly children, are at risk of developing diseases at the same rate as other EU populations, and in some cases may be more vulnerable. As they also benefit from the same level of protection as indigenous populations, including those which can be prevented by routine vaccination. In addition, there are specific risks of infectious diseases in relation to the country of origin, the situation of returnees and the conditions they experienced during migration. This document aims to highlight the risks of infectious diseases for newly-arrived migrants. It also highlights the symptoms and medical problems that may affect these populations.

The risk of EU/EEA countries of infectious disease outbreaks is a consequence of the extremely low. Although the likelihood that the specific infectious disease risks highly vary among migrants is low, in some cases very low, they should still be considered and treated in a timely manner, or prevented by vaccination which risks significant health benefits for EU/EEA populations.

2. Infectious diseases to consider according to origin

Table 1 provides examples of which infectious diseases to be aware of when screening and vaccinating newly-arrived migrants. The table is presented in alphabetical order by migrant region where the disease is present. It is important to note that some diseases are highly prevalent in specific countries or regions and may be high among migrants. In addition, a longer period in transit allows the development of different infectious diseases. It is recommended to check the conditions of returning migrants and the countries they experienced during migration. This document aims to highlight the risks of infectious diseases for newly-arrived migrants. It also highlights the symptoms and medical problems that may affect these populations.
ECDC Expert opinion on the public health needs of irregular migrants, refugees or asylum seekers

Objectives

- To produce scientific advice on the main health needs of migrant populations in relation to communicable diseases
- Provide options for addressing these needs

Methods

- ECDC conducted interviews with 14 senior experts
- Non-systematic review of available evidence

Public health needs identified:

- **Reception centres/systems** to assure health assessments immediately upon arrival
- **Adequate shelter** to avoid crowding and ensuring good sanitary hygiene conditions
- **Health education and health promotion** emphasizing the benefits of screening, immunisation, and other measures (i.e. language specific information and cultural mediators)
- **Guidance on screening** for communicable diseases
- **Vaccination services** should be reinforced (what and when to vaccinate, stock-outs)
- **Syndromic surveillance guidance** to generate alerts to initiate timely public health responses

Examples of infectious diseases to be aware of based on country of origin

<table>
<thead>
<tr>
<th>Disease</th>
<th>Indicator</th>
<th>Syria</th>
<th>Afghanistan</th>
<th>Iraq</th>
<th>Eritrea</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria</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>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Prevalence of chronic Hep B</td>
<td>Intermediate: 5.6%</td>
<td>High: 10.5%</td>
<td>Low: 1.3%</td>
<td>High: 15.5%</td>
</tr>
<tr>
<td>Measles</td>
<td>Incidence per 100,000 in 2013, 2014</td>
<td>1.84 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>
</tr>
<tr>
<td>Polio</td>
<td>Cases reported to WHO in 2012, 2013, 2014</td>
<td>0, 35 and NA</td>
<td>46, 17, and 28</td>
<td>0, 0, and 2</td>
<td>0, 0, and 0</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Incidence/100,000</td>
<td>Low: 17</td>
<td>High: 189</td>
<td>Low: 25</td>
<td>High: 40 to 499</td>
</tr>
<tr>
<td>Rabies</td>
<td>Risk level for humans to contract</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

ECDC threat assessment:

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

- Risk of outbreaks as a consequence of current influx of migrants is low, however it should still be considered to ensure these are recognised or prevented timely.

- The risk to refugees has increased due to overcrowding of reception facilities, resulting in poor hygiene and sanitation arrangements, ... and potential risk of contracting the disease in arrival or hosting country.
Some key challenges to protect migrants against VPDs

- Vaccinating immigrants “in transit” or at final destination?
- What to do in absence of vaccination record?
- How to record vaccinations being performed?
- How to address the issue of unaccompanied minors?
- Which vaccines to prioritise?
- Which schedule to follow? E.g. NIP?
- How to handle cases of shortages of vaccines in EU?

At both national and sub-national levels:

- Capacity to vaccinate?
- Capacity for effective surveillance?
- Capacity for response to potential outbreaks?
Ensuring newly arrived migrants’ adequate protection, particularly vulnerable children

Measles outbreak in Calais (2016)

Options for reviewing and acting upon vaccination status (1/3)

- Vaccination to be offered based on national guidelines of hosting country.
- Vaccination status to be assessed using available documentation.
- If no or uncertain documentation exists, consider individual as unvaccinated, administering first doses asap following entry or registration.
- When possible combination vaccines to be used to facilitate vaccination.
- In case of shortage, prioritise children but aim for at least one dose dT-containing vaccine in adults.
- The timing needed for completing primary series to be taken into account in relation to logistics of potential transfers to other camps or settings.

Vaccinations to be offered in the absence of documented evidence of prior vaccination (2/3)

Table 3. Vaccinations to be offered in the absence of documented evidence of prior vaccination

<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>Priority vaccinations</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 vaccines, according to national guidelines.</td>
</tr>
<tr>
<td>Measles, mumps, rubella</td>
<td></td>
<td></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 IPV- ** containing vaccines according to guidelines.</td>
</tr>
</tbody>
</table>

Vaccinations to be offered in the absence of documented evidence of prior vaccination (3/3)

<table>
<thead>
<tr>
<th>To be considered</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis B</strong></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>
</tr>
<tr>
<td><strong>Meningococcal disease</strong></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>
</tr>
<tr>
<td><strong>Pneumococcal disease</strong></td>
<td>Administer to individuals ≥ 2 months with 1–3 doses of conjugate vaccine at least one month apart, according to national guidelines.</td>
</tr>
<tr>
<td><strong>Varicella</strong></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>
</tr>
<tr>
<td><strong>Influenza</strong></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>
</tr>
<tr>
<td><strong>Tuberculosis</strong></td>
<td>Administer BCG according to national guidelines. Re-vaccination with BCG is not recommended.</td>
</tr>
</tbody>
</table>

In context of aP-containing vaccine shortages...

- ECDC survey targeting NFPs for VPD including the following questions:

  - Does your government/national vaccination programme currently offer vaccinations for irregular migrants and asylum seekers?

  - Has the provision of vaccinations to irregular migrants and asylum seekers exacerbated the shortage of vaccines in your country?

  - Do you expect that the provision of vaccinations to irregular migrants and asylum seekers will exacerbate the shortage of vaccines in the coming 12 months?

In context of aP-containing vaccine shortages...

### Table 3. Provision of vaccinations to irregular migrants and asylum seekers

<table>
<thead>
<tr>
<th>Country</th>
<th>Vaccinations offered to irregular migrants/asylum seekers?</th>
<th>Adults</th>
<th>Volume</th>
<th>Present</th>
<th>Future</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Belgium     | For all <18 years: according to the national vaccination programme | For asylum seekers:  
- from Afghanistan, Pakistan, Somalia and Nigeria: IPV  
- born after 1970: MMR  
- Tdap booster | Around 6 850  
(January-August 2015) | Yes, for IPV | Yes, for IPV |
| Bulgaria    | For asylum seekers <15 years:  
DTPa-IPV-Hib (pentavalent), MMR shortly after entry; then the schedule continues according to the national immunisation programme | For registered asylum seekers:  
Td, IPV, MMR | Around 2 000, since November 2013 | No | Yes, for DTPa-IPV-Hib (Pentavalent) |
| Croatia     | For registered asylum seekers:  
According to the national vaccination program | For registered asylum seekers:  
Td, IPV, MMR | A few dozen | No | Maybe, depends on asylum seeker |
| Czech Republic | For those < 15 years: measles and polio | | N/A | N/A | N/A |
| Estonia     | No | | N/A | No | No |
| Finland     | For asylum seekers <18 years, according to the national vaccination program | For asylum seekers:  
- IPV for those coming from polio-risk countries or those who share accommodations with them.  
- MMR, Td | No data | No | Maybe, depends on asylum seeker |
| Germany     | According to official recommendations† | No data | Unknown | Yes | |
| Hungary     | For registered individuals, age- | No data | | No | Maybe |

---

Evidence-based guidance on prevention and assessment of communicable diseases among migrants in the EU/EEA

Objectives

- Collect and **synthesise the scientific evidence** on screening and prevention for infectious diseases among migrants;

- **Review national and international policies**, practices and guidelines on screening for ID among migrants;

- **Consult key experts** in countries working with prevention of infectious diseases among migrants;

- **Draft evidence-based guidance** on screening and prevention of infectious diseases among migrants;

Target audience

- National and sub-national policy makers in EU/EEA Member States
- Health practitioners
- NGOs and patient organisations working with migrant communities
Objective

- Provide MS and Commission with data and policy analysis concerning VPDs migrants population in order to support policy makers in EU;

Outputs

- Survey among MS on current practices on immunisation of migrants & asylum seekers entering the countries;
- Technical report mapping policies and laws on childhood and adult immunisation of migrants requiring health assistance in MS;
- Evidence-based guidance on prevention and assessment of communicable diseases among migrants in the EU/EEA (VPD section);
Thank You!

karam.adelali@ecdc.europa.eu
lucia.pastore.celentano@ecdc.europa.eu