

Politics and Safety: Health Care for Immigrants

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ABSTRACT

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Europe is currently experiencing an unprecedented influx of refugees, asylum seekers and other migrants. More than 1.5 million people arrived in the European Union (EU) and European Economic Area (EEA) in 2015, fleeing countries affected by war, conflict or economic crisis. Member States are increasingly faced with the need to address the public health consequences of this massive arrival of migrants from various parts of the world, which puts national health systems under pressure. The migrant and refugee crisis in Europe has reached a critical point. The great majority of migrants and refugees are in a good physical condition; however, many are challenged with medical and mental problems, social isolation and economic devastation. There are different migrant groups with different rights to access of care. Many European countries are experiencing an increased wave of migrants and refugees and should consider therefore assessing their overall preparedness and response capacity for the management of the disease burden in this population which should be made on the actual migration flows, global disease patterns and consequent needs. Public health interventions in refugee camp settings will not only benefit migrants and refugees at individual level but also assist their integration in to the new home countries. In particular, it is important to consider the economic benefit of early interventions. Intersectoral and international collaboration is important to meet the heterogeneous needs of these populations which could foster integration. Providing newly arrived migrants and refugees a more 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. European Member States are facing a challenge to provide accessible and effective health care services for immigrants. It remains unclear how best to achieve this and what characterizes good practice in increasingly multicultural societies across Europe. Although local

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political debate, level of immigration and the nature of local health care systems influenced the selection and rating of

factors within each country, there was a broad European consensus on most factors. Yet, discordance remained both within countries, e.g. on the need for prioritizing cultural differences, and between countries, e.g. on the need for more consistent governance of health care services for immigrants. Experts across Europe asserted the right to culturally sensitive health care for all immigrants. There is a broad consensus among experts about the major principles of good practice that need to be implemented across Europe. However, there also is some disagreement both within and between countries on specific issues that require further research and debate.

INTRODUCTION

Europe is currently experiencing an unprecedented influx of refugees, asylum seekers and other migrants. More than 1.5 million people arrived in the European Union (EU) and European Economic Area (EEA) in 2015, fleeing countries affected by war, conflict or economic crisis. They come mostly from Syria, but also from Afghanistan, Eritrea, Iraq, Nigeria, Pakistan, Somalia, as well as the Western Balkans. Member States are increasingly faced with the need to address the public health consequences of this massive arrival of migrants from various parts of the world, which puts national health systems under pressure¹.

Throughout history, people have migrated from one place to another. People try to reach European shores for different reasons and through different channels. They look for legal ways, but they also risk their lives, to escape from political oppression, war and poverty, as well as to reunite with family and benefit from entrepreneurship and education.

DEFINITIONS: WHAT IS A REFUGEE? WHAT IS AN ASYLUM-SEEKER?

Asylum seekers are people who make a formal request for asylum in another country because they fear their life is at risk in their home country².

Refugees are people with a well-founded fear of persecution for reasons of race, religion, nationality, politics or membership of a particular social group who have been accepted and recognized as such in their host country. In the EU, the qualification directive sets guidelines for assigning international protection to those who need it.

Currently third-country nationals must apply for protection in the first EU country they enter. Filing a claim means that they become asylum applicants (or asylum seekers). They receive refugee status or a different form of international protection only once a positive decision has been made by national authorities.

ASYLUM DECISIONS IN THE EU

In 2017, there were 728,470 applications for international protection in the EU. There was a decrease of 44% compared to 2016, when there were almost 1.3 million applications.

In 2017, EU countries granted protection to more than 538,000 people, down by almost 25% on 2016. Almost one in three of these were from Syria while Afghanistan and Iraq rounded up the top three. Of the 175,800 Syrian citizens granted international protection in the EU, more than 70% received it in Germany (Eurostat data).

SITUATION IN THE MEDITERRANEAN

The European Border and Coast Guard Agency collects data on illegal crossings of the EU's external borders registered by national authorities. In 2015 and 2016, more than 2.3 million illegal crossings were detected. In 2017, the total number of illegal border-crossings into the EU dropped to 204,700, its lowest level in four years.

One person can go through a border more than once, so the number of people coming to Europe is lower, nevertheless, member states have been under an enormous amount of pressure.

In 2017, 439,505 people were denied entry at the EU's external borders. As of 26 June, more than 43,000 people have risked their lives reaching Europe by sea so far in 2018, with

over 1,000 feared to have drowned. 172,300 people reached Europe by sea in 2017, less than half those in 2016. The Mediterranean crossing remained deadly however, with 3,139 dead or missing in 2017, compared to 5,096 in 2016 (United Nations High Commissioner for Refugees - UNHCR data).

MIGRANTS ILLEGALLY PRESENT IN THE EU

In 2015, 2.2 million people were found to be illegally present in the EU. By 2017, the number had dropped to just over 600,000. "Being illegally present" can mean a person failed to register properly or left the member state responsible for processing their asylum claim - this is not, on its own, grounds for sending them away from the EU (UNHCR data).

WHAT EUROPEANS ARE THINKING

Migration has been an EU priority for years. Several measures have been taken to manage the crisis as well as to improve the asylum system. According to the results of a Eurobarometer poll released in May 2018, 72% of Europeans want the EU to do more when it comes to immigration.

The EU significantly increased its funding for migration, asylum and integration policies in the wake of the increased inflow of asylum seekers in 2015. In the forthcoming negotiations on the EU's post-2020 budget, Parlia-

ment will call for additional funding for migration.

According to the UN Refugee Agency, an average of 44,000 people was forced to flee their homes every day in 2017. The countries hosting the largest number of refugees are Turkey, Pakistan, Uganda, Lebanon, Iran and Germany. 85% of the world's refugees are hosted by developing regions.

EU - TURKEY AGREEMENT

The agreement is based on the proposal made by Turkey only for humanitarian purposes.

There are three main objectives in this proposal:

- (1) to prevent loss of lives in the Aegean,
- (2) to break the migrant smuggling networks
- (3) to replace illegal migration with legal migration.

According to the agreement, Turkey started to take back all irregular migrants as of 4 April 2016, while on the same date resettlement of Syrians in Turkey towards the EU countries was launched. In the first week of the deal, Turkey took back 325 irregular migrants from the Aegean islands. Within the scope of "1 for 1" formula, 78 Syrians were resettled in Germany, the Netherlands and Finland. For every Syrian to be taken back to Turkey from the Aegean islands, in return the EU will start to resettle another Syrian from Turkey.

RESULTS OF EU - TURKEY AGREEMENT

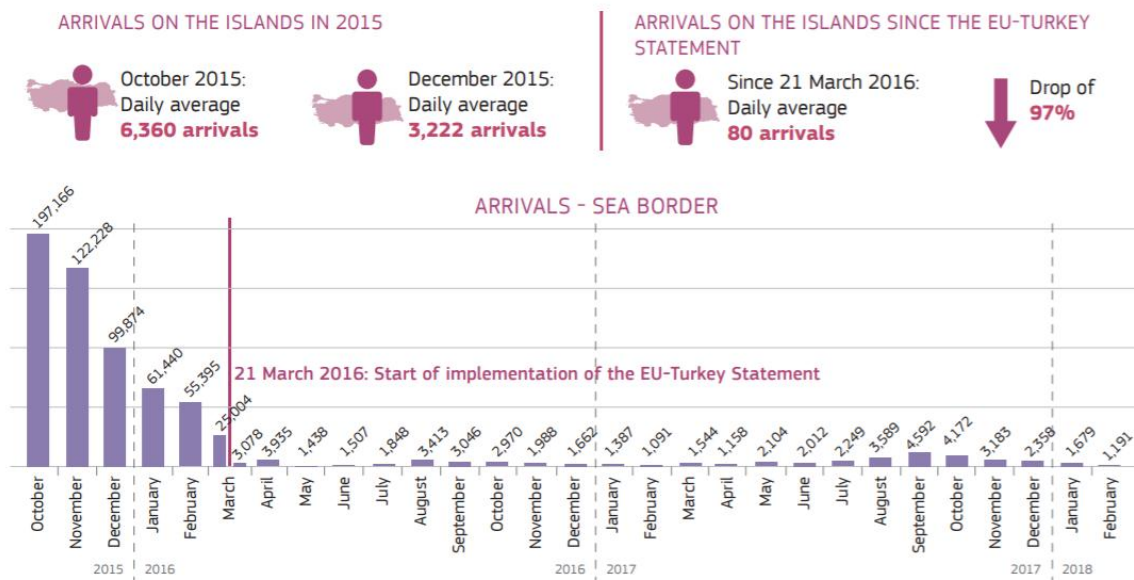
Two years later, irregular arrivals remain 97% lower than the period before the Statement became operational, while the number of lives lost at sea has decreased substantially. The EU has supported Turkey in its efforts to host refugees and had by the end of 2017 fully contracted the first tranche of the €3 billion from its Facility for Refugees in Turkey. Turkey has followed up on its commitment to step up measures against people smuggling and has been cooperating closely on resettlement and return. The EU-Turkey Statement has consistently delivered tangible results since it was agreed two years ago. While continuous efforts need to be made by all sides and all EU Member States, the EU-Turkey Statement has become an important element of the EU's comprehensive approach on migration.

The effects of the EU-Turkey Statement were immediate. Thanks notably to the cooperation with the Turkish authorities, arrivals decreased significantly – showing clearly that the business model of smugglers exploiting migrants and refugees can be broken. From 10,000 in a single day in October 2015, daily crossings have gone down to an average of around 80 today, while the number of deaths in the Aegean decreased from 1,175 in the 20 months before the Statement to 130. That is almost one

million people who have not taken dangerous routes to get to the European Union, and more

than 1,000 who have not lost their lives trying (Figure 1).

Figure 1. Immigrant's arrivals on the islands from October 2015 to March 2016.



HEALTH CARE FOR REFUGEES

The World Health Organization (WHO)³ mentioned in its Fact Sheet n° 31 “The Right to Health“, that means the right to health implies equal and timely access to health care services, the provision of health-related education and information, and the participation of the population in health-related decisions at national and community levels⁴. The right to health also implies equity in access to health care services for equal health needs.

Health care services should be physically and financially accessible for all sectors of the population, including vulnerable groups, and should be delivered on the basis of non-discrimination. Facilities, goods, and services

should respect medical ethics, as well as being gender- sensitive and culturally appropriate. In other words, they should be culturally and not only medically acceptable. Finally, they must be scientifically appropriate and of good quality. In short, access to health care is more than a legal right to health care. Many other aspects are involved. Meeting the health needs of migrants and ethnic minorities is a challenge for health care services. Inequitable variation in the use and accessibility of health care services for migrants, indigenous populations, and other minorities in EU countries is a matter of concern for both health care providers and policy-makers. A substantial body of scientific literature⁵⁻¹² and policy reports¹³⁻¹⁷ have doc-

umented differences between migrant groups and local populations in health care utilization in Europe. Migrants do not always have the right to the services they require (e.g. due to their legal status).

Even in countries where access to health care is guaranteed for all migrant populations, they often meet with obstacles to quality care for: individual, socio-cultural, economic, administrative and political reasons^{18,19}. There is therefore mounting pressure at the European level to ensure equal access for migrants to social and health care services, as reflected in the Portuguese Presidency of the EU in 2007 for example²⁰. Governments are increasingly encouraged to develop policies to reduce migrant health care inequalities²¹.

Migration itself is not a risk factor for health; migrants are often comparatively healthy³. However, vulnerability to physical, mental and social health problems may result from the process and the specific circumstances of migration. The specific health needs of migrants are not clearly understood and communication between health care practitioners and migrant people remains poor. In addition, there is often inadequate responsiveness of health care systems due to poor preparedness which is enhanced by legal issues that migrants have to face with in relation to health and other basic services²³. Approaches to manage migration health problems have not kept pace with in-

creasing challenges associated with the size, speed, diversity and disparity of current migration patterns and factors such as barriers to access health services have not sufficiently been addressed²⁴. Although a few publications on migrant and refugee health have appeared in recent years, comprehensive information on different aspects of health and migration, and how these can appropriately be addressed by the health systems of European countries, is still not easy to define.

HEALTH STATUS OF NEWLY ARRIVED REFUGEES

Health Problems During Travel and Arrival

Refugees are particularly vulnerable to contagious infectious diseases during their travel because of the destroyed health care systems, including vaccination services in their countries of origin, and public health infrastructures (e.g. potable water network and housing), overcrowded conditions with sub-optimal hygiene standards during travel, malnutrition and lack of access to health care services. On arrival, the most common health problems in migrants and refugees recorded at the Persons of Concern (PoCs) may be related to problems in their country of origin (e.g. political crisis, war) and the journey including accidental injuries, hypothermia, gynecological and obstetric complications, gastrointestinal and respiratory illnesses, dermatological, cardiovascular

events, mental illness and metabolic problems

(Table 1).^{22,23}

Table 1. Health status of newly arrived migrants

Diagnosis	Study reference ¹⁵		Study reference ¹⁰	
	Number	%	Number	%
Respiratory tract infection	744	23	22	6.7
Rheumatological	591	18	1	0.3
Headache/neurological	325	10	13	4.0
Epigastric pain	297	9		
Dermatological conditions	261	8	7	2.1
Allergic reactions or skin erythema	248	8		
Psychiatric conditions	177	5	7	2.1
Injuries	175	5	66	20.3
Dental problems	99	3		
Cardiac disease	92	3	10	3.1
Gastroenteritis	51	2	34	10.4
Gynaecological/obstetric	43	10	48	14.7
Fever	35	1		
Diabetes mellitus/metabolic	27	1	9	2.8
Genitourinary disease	13	0	4	1.2
Frostbite	5	0		21.9
Unknown			34	10.4
Total	3280	100	326	100

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In particular, unaccompanied minors, female and children migrants and refugees are vulnerable for specific problems in relation to maternal, newborn and child health, gynecological issues and violence²⁴. Although women and

young people among migrants and refugees are vulnerable to sexual and gender-based violence (SGBV) worldwide, little evidence exists concerning SGBV against refugees in Europe²⁵. In addition, drug and alcohol abuse,

nutrition problems and exposure to violence may increase refugees' vulnerability to non-communicable diseases (NCDs)²⁶. Furthermore, prior to migration, access to health care services may have been restricted or unavailable, which makes several health conditions less effectively managed in migrating people²⁷.

Mental and psychosocial illness is a significant health problem for migrants and refugees, in particular newly arrived people, including depression, anxiety disorder, alcoholism and drug abuse as a result of traumatic experiences prior to dislocation or during the migration process which may be related to war, hunger, physical and sexual abuse²⁷. Language difficulties, cultural and religious issues, racism and unemployment may further aggravate mental problems. Risk factors for mental illness in migrants and refugees include also age, gender, lower socioeconomic status and lack of social support²⁸⁻³⁰. Older people are more vulnerable. Women are also more vulnerable due to the increased risk of sexual abuse and pregnancy (poor access to oral contraception)²⁵. Vulnerable groups, such as children, are prone to respiratory and gastrointestinal infections and dermatologic conditions (e.g. scabies) due to sub-optimal hygienic and inadequate living conditions, and nutritional deprivation during migration. Gender specific problems, such as maternal, reproductive and access to contraception and family planning also

constitute important challenges for migrants. Therefore, access to reproductive health services, prenatal and obstetric care and preventive health care (e.g. screening) is crucial²⁵.

Health Problems During Early Settlement at PoCs

After the initial phase, migrants and refugees are usually hosted in reception centers before reaching their final destination. By definition, they originate from countries affected by war or economic crisis and undertake long, exhausting journeys to be accommodated in overcrowded reception centers or camps under poor hygienic conditions; these factors increase their risks for communicable diseases^{31,23,32-35}.

The country of origin and the local epidemiology is an important factor when considering infectious diseases in newly arrived migrants and refugees. The five most common countries of origin of migrants and refugees coming to Europe currently include Syria, Afghanistan, Iraq, Eritrea and Somalia. Hepatitis A is highly endemic in all five countries and also there is a risk for typhoid fever^{36,37}. There are recurrent cholera outbreaks in Afghanistan and Somalia and an ongoing outbreak in Iraq;³⁸ however, due to short incubation time, the risk for cholera transmission is low.

The incidence of tuberculosis (TB) in the above countries varies from as low as 17 new cases per 100 000 population in the Syrian Ar-

ab Republic to 189, 285 and 499 per 100 000 population in Afghanistan, Somalia and Eritrea, respectively³⁹.

The average TB rate in the European Region is 39 per 100 000 population.³⁶ The risk of migrants and refugees for acquiring TB or being infected, depends on factors such as the incidence of the disease in their country of origin, their living and working conditions in the country of immigration, access to health care services and welfare, history of close contact with an active case and the conditions of transport during their journey to Europe (e.g. poorly ventilated accommodation)³⁹.

HIV prevalence in the five most common countries of origin of migrants and refugees is low and therefore the risk of HIV importation to Europe by migrants is low;^{24,36} however, migrants still constitute 35% of new HIV cases in the EU/ EEA and there is increasing evidence that some migrants acquire HIV after their arrival²⁴. A Greek study which was carried out at Greek–Turkish borders, among migrants and refugees mainly originating from the Indian subcontinent, Somalia, Morocco and Iraq showed that 0.3% of them were tested positive for HIV²³.

Migrants and refugees from East Asia and sub-Saharan Africa have the highest seroprevalence of chronic hepatitis B virus (HBV) infection (10% HBsAg positive) and those from Eastern Europe and Central Asia and South

Asia have intermediate seroprevalence (4–6%)⁴⁰. Migrants from sub-Saharan Africa, Asia and Eastern Europe and older age groups have the highest risk for hepatitis C virus (HCV) prevalence ranging from 2.2 to 5.6%⁴¹. A Greek study, which was carried out among migrants and refugees originating from the Indian subcontinent, Somalia, Morocco and Iraq showed that 3.2 and 0.8% were tested positive for HBV and HCV, respectively;²³ these studies highlight the fact that migrants originating from intermediate or high hepatitis B and C prevalence countries who live in low HBV or HCV prevalence immigrant receiving countries are an important risk group for chronic HBV and HCV infection^{41,42}. Although infectious diseases among migrants are known to have a negligible impact on European epidemiology, screening programs need to be implemented and adapted to the different stages of the migratory process to better understand the trends and set priorities for action.

Far from being a biological threat as they are often perceived or accused of for political and social reasons, migrants and above all asylum seekers escaping from precarious situations cannot be systematically associated with the introduction of infectious pathogens in host countries. It should be highlighted that infectious diseases among migrant populations largely reflect poor living conditions and social marginalization and are, therefore, likely

to remain confined to their communities without spreading to the natives

Appropriate access to care regardless of the legal status to ensure early diagnosis and treatment is crucial for both the individual and the community in order to improve the health status and prevent the emergence of secondary cases. Last but not least, preventative interventions should be put in place at all levels to raise awareness on travel-related diseases among VFRs and their families.

The migrant and refugee crisis in Europe has reached a critical point. The great majority of migrants and refugees are in a good physical condition; however, many are challenged with medical and mental problems, social isolation and economic devastation. There are different migrant groups with different rights to access of care. Many European countries are experiencing an increased wave of migrants and refugees and should consider therefore assessing their overall preparedness and response capacity for the management of the disease burden in this population which should be made on the actual migration flows, global disease patterns and consequent needs.

Public health interventions in refugee camp settings will not only benefit migrants and refugees at individual level but also assist their integration in to the new home countries. In particular, it is important to consider the economic benefit of early interventions.

Intersectoral and international collaboration is important to meet the heterogeneous needs of these populations which could foster integration. Providing newly arrived migrants and refugees a more 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.

European Member States are facing a challenge to provide accessible and effective health care services for immigrants. It remains unclear how best to achieve this and what characterizes good practice in increasingly multicultural societies across Europe. Although local political debate, level of immigration and the nature of local health care systems influenced the selection and rating of factors within each country, there was a broad European consensus on most factors. Yet, discordance remained both within countries, e.g. on the need for prioritizing cultural differences, and between countries, e.g. on the need for more consistent governance of health care services for immigrants. Experts across Europe asserted the right to culturally sensitive health care for all immigrants. There is a broad consensus among experts about the major principles of good practice that need to be implemented across Europe. However, there also is some disagreement both within and between countries

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REFERENCES

1. International Migration Report 2015: Highlights: United Nations, Department of Economic and Social Affairs, Population Division; 2016.
2. IOM, Glossary on Migration, International Migration Law Series, No. 25, 2011.
3. WHO: Health of Migrants - The way forward. Report of a global consultation. Madrid, Spain, 3-5 March 2010.
4. UNCHR: The Right to Health. Factsheet 31 OHCHR-WHO; 2008 [<http://www2.ohchr.org/english/issues/health/right/>], accessed on 22/01/2011.
5. Reus-Pons M, Vandenheede H, Janssen F, et al. Differences in mortality between groups of older migrants and older non-migrants in Belgium, 2001-09. *European journal of public health*, 2016.
6. Zimmerman C, Kiss L, Hossain M. Migration and health: a framework for 21st century policy-making. *PLoS Med*. 2011;8(5):e1001034.
7. Kentikelenis A, Karanikolos M, Williams G, et al. How do economic crises affect migrants' risk of infectious disease? A systematic-narrative review. *European journal of public health*. 2015;25(6):937-44.
8. Arnold F, Katona C, Cohen J, et al. Responding to the needs of refugees. *Bmj*. 2015;351:h6731.
9. Pfortmueller CA, Schwetlick M, Mueller T, et al. Adult Asylum Seekers from the Middle East Including Syria in Central Europe: What Are Their Health Care Problems? *PLoS One*. 2016;11(2):e0148196.
10. Eonomopoulou A, Pavli A, Stasinopoulou P, et al. Migrant screening: Lessons learned from the migrant holding level at the Greek-Turkish borders. *J Infect Public Health*. 2016.
11. Benzeguir AK, Capraru T, Aust-Kettis A, et al. High frequency of gastrointestinal parasites in refugees and asylum seekers upon arrival in Sweden. *Scand J Infect Dis*. 1999;31(1):79-82.
12. Roggelin L, Tappe D, Noack B, et al. Sharp increase of imported *Plasmodium vivax* malaria seen in migrants from Eritrea in Hamburg, Germany. *Malar J*. 2016;15:325.
13. Sonden K, Castro E, Tornnberg L, et al. High incidence of *Plasmodium vivax* malaria in newly arrived Eritrean refugees in Sweden since May 2014. *Euro Surveill*. 2014;19:35.
14. Williams GA, Bacci S, Shadwick R, et al. Measles among migrants in the European Union and the European Economic Area. *Scand J Public Health*. 2016;44(1):6-13.
15. Crepet A, Repetto E, Al Rousan A, et al. Lessons learnt from TB screening in closed

- immigration centres in Italy. *Int Health*. 2016;8(5):324-9.
16. Klinkenberg E, Manisero D, Semenza JC, et al. Migrant tuberculosis screening in the EU/EEA: yield, coverage and limitations. *Eur Respir J*. 2009; 34(5):1180-9.
17. Gautret P, Botelho-Nevers E, Brouqui P, et al. The spread of vaccine-preventable diseases by international travellers: a public-health concern. *Clin Microbiol Infect*. 2012; 18 Suppl 5:77-84.
18. Jablonka A, Happle C, Grote U, et al. Measles, mumps, rubella, and varicella seroprevalence in refugees in Germany in 2015. *Infection* 2016.
19. Jones G, Haeghebaert S, Merlin B, et al. Measles outbreak in a refugee settlement in Calais, France: January to February 2016. *Euro Surveill*. 2016;21(11):30167.
20. Technical Report: Infectious diseases of specific relevance to newly-arrived migrants in the EU/EEA. ECDC: Stockholm: European Centre for Disease Prevention and Control (ECDC); 19 November 2015.
21. Global Health Sector Strategy on Viral Hepatitis 2016-2021. Towards ending viral hepatitis. Geneva: World Health Organization (WHO); 2016.
22. Firenze A, Restivo V, Bonanno V, et al. Health status of immigrants arrived to Italian coast. *Epidemiol Prev* 2014; 38: 78–82
23. Economopoulou A, Pavli A, Stasinopoulou P et al. Migrant screening: Lessons learned from the migrant holding level at the Greek–Turkish borders. *J Infect Public Health* 2016 May 5. pii: S1876-0341(16)30030-2.
24. World Health Organization. Migration and Health: Key Issues. <http://www.euro.who.int/en/health-topics/health-determinants/migration-and-health/migrant-health-in-the-european-region/migration-and-health-key-issues#292115>. [Accessed 18/10/2016].
25. Keygnaert I, Vettenburg N, Temmerman M. Hidden violence is silent rape: sexual and gender-based violence in refugees, asylum seekers and undocumented migrants in Belgium and the Netherlands. *Cult Health Sex* 2012; 14: 505–20.
26. De Vito E, de Waure C, Specchia ML, et al. Public Health Aspects of Migrant Health: A Review of the Evidence on Health Status for Undocumented Migrants in the European Region. Copenhagen: WHO Regional Office for Europe; 2015. WHO Health Evidence Network Synthesis Reports. <https://www.ncbi.nlm.nih.gov/pubmed/27536764>. [accessed 18/10/2016].
27. Migrant Health and the Right to Health in Europe. http://www.migrant-health-europe.org/files/Right%20to%20Health_Background%20Paper.pdf. [Accessed 18/10/2016].

28. Hermansson A-C, Timpka T, Thyberg M. The long-term impact of torture on the mental health of war-wounded refugees: findings and implications for nursing programmes. *Scand J Caring Sci* 2003; 4: 317–24.
29. Masmas TN, Møller E, Buhmannr C, et al. Asylum seekers in Denmark: a study of health status and grade of traumatization of newly arrived asylum seekers. *Torture* 2008; 2: 77–86.
30. Roth G, Ekblad S. A longitudinal perspective on depression and sense of coherence in a sample of mass-evacuated adults from Kosovo. *J Nerv Ment Dis* 2006; 5: 378–81
31. Redditt VJ, Janakiram P, Graziano D, et al. Health status of newly arrived refugees in Toronto, Ont: Part 1: infectious diseases. *Can Fam Physician* 2015; 7: e303–9.
32. Mertens E, Rockenschaub G, Economopoulou A, et al. Assessment of public health issues of migrants at the Greek-Turkish border, April 2011. *Euro Surveill* 2012; 2: pii: 20056.
33. Jablonka A, Solbach P, Happle C et al. Hepatitis A immunity in refugees in Germany during the current exodus. *Med Klin Intensivmed Notfmed* 2016.
34. Hellenic Center for Disease Control and Prevention. Epidemiological Surveillance at Points of Care in Refugees/Migrants. www.keelpno.gr. [Accessed 19/10/2016].
35. Jablonka A, Solbach P, Nothdorft S et al. Low seroprevalence of syphilis and HIV in refugees and asylum seekers in Germany in 2015. *Dtsch Med Wochenschr* 141; 14: e128–32.
36. European Center for Disease Control and Prevention. Infectious Diseases of Specific Relevance to Newly-Arrived Migrants in the EU/EEA. <http://ecdc.europa.eu/en/publications/Publications/Infectiousdiseases-of-specific-relevance-to-newly-arrived-migrants-in-EUEEA.pdf>. [Accessed 20/10/2016].
37. World Health Organization. The Global Prevalence of Hepatitis A Virus Infection and Susceptibility: A Systematic Review. 2010. http://apps.who.int/iris/bitstream/10665/70180/1/WHO_IVB_10.01_eng.pdf. [Accessed 20/10/2016].
38. World Health Organization. Global Health Atlas. <http://apps.who.int/globalatlas/>. [Accessed 20/10/2016].
39. World Health Organization Regional Office for the Eastern Mediterranean. WHO Eastern Mediterranean Region: Framework for Health Information Systems and Core Indicators for Monitoring Health Situation and Health System Performance. http://applications.emro.who.int/dsaf/EMROP_UB_2014_EN_1792.pdf?ua=1. [Accessed 20/10/2016].
40. Rossi C, Shrier I, Marshall L, et al. Sero-prevalence of chronic hepatitis B virus infection and prior immunity in immigrants and

refugees: a systematic review and meta-analysis. PLoS One 2012; 9: e44611.

41. Greenaway C, Thu Ma A, Kloda LA et al. The seroprevalence of hepatitis C antibodies in immigrants and refugees from intermediate and high endemic countries: a systematic re-

view and meta-analysis. PLoS One 2015; e0141715.

42. Gergely A, Bechet S, Goujon C et al. Hepatitis B screening in travelers: a retrospective analysis. Travel Med Infect Dis 2014; 12: 707–12.

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