Key issues on HIV, TB and international population mobility

Migration and Health Department

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1 Disclaimer: The content of this report is based on the synthesis of the seven country situation assessment reports and may not necessarily reflect that of the position of the International Organization for Migration.
Executive summary

Within the overall contexts of the Commission’s communication on Combating HIV/AIDS within the European Union and in the neighbouring countries, 2006-2009 and the European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011), the Portuguese Presidency has focussed, *inter alia*, on “health and migration”. This led to the “EU Partnership to reduce HIV and public health vulnerabilities associated with population mobility”. Migration and HIV were put on the agenda of the 12-13 October 2007 EU and neighbouring countries National AIDS Coordinators meeting. With financial support from Portugal, IOM coordinated the preparation of a seven country rapid assessments and the present paper based on them. The paper was presented and discussed at a meeting of the seven countries organised by IOM in Geneva on 10-11 September 2007 and finalized following it.

In a first part, after reviewing and synthesizing the policy and legal frameworks for both migration and for HIV, AIDS and TB, the paper presented the country migration and epidemiological profiles. This review and synthesis were carried out from the perspective of highlighting characteristics and findings for migration, HIV, AIDS and TB which were most relevant for discussion and action at the EU level.

The review and synthesis resulted in two outcomes:

i) identifying and selecting from the country reports a number of examples of activities which presented a EU level interesting order to stimulate further consideration. These examples are just listed in a second part of this paper because they are presented in more detail in a companion paper “Migration and HIV, AIDS and TB: moving forward at country level in the European Union”.

ii) Identifying eleven key issues for EU level action.

These eleven key issues are presented and briefly discussed in a third part of the paper. The ten key issues are:

1. The importance of a human rights approach
2. Including migrants in national AIDS plans
3. Co-operation with sending and transit countries
4. Diversity of country situations
5. Diversity of the status of migrants
6. Organization of health services for HIV and AIDS
7. Impact of ARVs
8. Co-infections
9. Prisons and detention centres
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Introduction

1. Background

The European Union (EU) is active in dealing with migration and with HIV, AIDS and TB. The health of migrants is receiving increasing attention as shown by the following quotes. The first quote approached migrants’ health from the perspective of migration and the second one from that of HIV and AIDS:

“In order to successfully integrate and participate in all aspects of life, migrants must be provided with basic rights in terms of access to education, housing, healthcare and social services. At present, the level of rights varies greatly among Member States.”

“HIV and AIDS strategies are closely linked to strengthening the general European values on human security and the protection of human rights, including sexual and reproductive rights, the rights of minorities and the fundamental rights of migrants, refugees and displaced persons.”

Furthermore, strategies need to be developed and implemented at several levels: At the country, the EU regional and the global levels as stressed in the “European Programme for Action to Confront HIV/AIDS, Malaria and Tuberculosis through External Action (2007-2011)” where it is recognized that “strategies should address other specific vulnerable groups, e.g. … migrants … who are often placed in vulnerable situations.” Finally, the European Centre for Disease Prevention and Control (ECDC) pointed out, following a recent workshop that “The HIV situation in the EU is increasingly influenced by international travel and migration, which underlines the need for a global and European-wide approach to HIV prevention and control”.

2. The process leading up to the Lisbon meeting

It is in this context that one of the principal goals of the Portuguese EU Presidency is to foster a debate on various issues concerning migration, including “health and migration”. A meeting of the AIDS Coordinators of the EU, of the World Health Organisation, its EURO Region and Neighbouring Country offices entitled “Translating principles into action” is to take place in Lisbon, Portugal, on the 12th and 13th of October, 2007 to discuss and agree on European priority policy and programme recommendations.

The International Organization for Migration (IOM) has commissioned a six-country-study on EU partnership on HIV, TB and mobility to prepare for this meeting with financial support from the Government of Portugal. Bulgaria, Germany, Hungary, Italy, Malta and Portugal prepared country reports. The Netherlands also contributed a report. The countries were selected according to their adhesion to the European Union (founding Member States, early and recent adhesion) as well as countries having diverse migration profiles.

In June and July 2007, consultations were held between IOM and the countries to set the methodology to be used for the country studies. The country reports used the following methodology:

i) A desk review of available data and literature in the country to present the legal and policy framework on migration as well as on HIV, AIDS and TB;

ii) A rapid assessment of the medical services for HIV, AIDS and TB on their views of migrants and HIV, AIDS and TB as well as the views of migrants on the services they knew and their experiences in accessing these services.

The reason for bringing TB into the picture was to begin to explore co-infection with HIV and AIDS among migrants and the issues such co-infections raised.

The rapid review, mapping and assessments were conducted by the countries in July-August. Once the country reports became available during the second half of August, IOM prepared on their basis two outputs in early September: i) the present report on key issues, and, ii) a companion report on examples of country activities of regional interest.

In view of the time and resource constraints (3-months or less) and the period in which these studies had to be conducted, coinciding with summer holidays, the countries made a considerable effort in a complex field where some of them had little previous experience in. Under these constraints, the aim of this synthesis report is to assist in launching a process which will lead to protecting the health rights of migrants in the areas of HIV, AIDS and TB in line with those of nationals of the countries while improving the health of all.

The present report is based on the seven country reports available and reflects the information included in them. The report was presented at the Consultation held by IOM in Geneva on 10-11 September 2007 where, with the country reports presented, it served as a basis for the Consultation to formulate a recommendation for the Lisbon meeting to be held on 12-13 October 2007. This recommendation also recommended that the issue of migration and health be included in the process of preparation of the EU public health strategy. The Portuguese Presidency is introducing this recommendation and the results of the Geneva consultation into the EU mechanisms.

The Geneva meeting was important because it shed light on a little known and complex area of migrant health with many implications for sending, transit and receiving countries. HIV, AIDS and TB showed that health in general is crucial to the success of the migration process and that the linkages between HIV and migration are an area where the EU can achieve concrete results.

This report is presented in three parts:

I. The main findings from the seven country reports listed in the references at the end of the paper.

II. Identification of examples of activities of potential interest at the regional level.

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7 To complement the national reports, EU data on HIV new infections is provided in Annex A.

8 Health In Europe: a Strategic Approach.

III. Discussions of these findings in order to highlight some of their implications at a regional level to facilitate the identification of areas of cooperation.

I. Policy and Legal Context of migration, HIV, AIDS, TB

The country reports followed an outline prepared by IOM in consultation with the Portugal National AIDS Coordination Office, Ministry of Health. This part follows the format to present major findings. The reports demonstrated the impact of migration policies and laws on the health sector relating to HIV, AIDS and TB as well as on the behaviour of the migrants themselves.

It should be kept in mind that the country reports were not designed to provide exhaustive information on a country situation. The country reports presented a rapid review based on what each country’s experts believed to be of particular significance for HIV, AIDS and TB in a country’s context. Thus, when countries provided different information which was not comparable regionally, it does not necessarily mean the data was only available for that particular country. Rather, it might mean this particular information was judged to be significant in a particular national context amongst the priority challenges.

1. Migration policy and legal context

Migration issues fall under one of the key attributes of States. Among the country studied, States were more concerned about immigration than emigration. This is one reason the country reports contained little information about emigration. In some countries, emigration is not tracked whereas there is generally well-established immigration regulations and record keeping. Another reason was that emigration was not perceived as affecting directly crucial sectors or public health of the sending country. Among these seven countries, two have been receiving immigrants for quite a while (Netherlands and Germany), with some emigration. Two countries were until a few decades ago countries of emigration (Italy and Portugal) and have now become countries of immigration. This shift in direction of migration flow required major policy and legal adaptations. Two other countries had few international movements until recently (Bulgaria and Hungary), but have now become emigration, transit and immigration countries. Bulgaria has a policy actively discouraging emigration of young people of reproductive age. Malta used to be an emigration country, but is now both a transit and an immigration country. Malta, being a small country, has highlighted that even a small number of undocumented migrants in absolute terms represents a considerable burden relative to its own total populations, e.g. 1% of its national issue is to cope with the immigrants and 10% of its army and police forces are being engaged in this connection.

In practice, wealthy, professional immigrants with health insurance are not of public health concern. Policy and legislative efforts among these countries focus mainly on determining the conditions for accepting a migrant with documentation while controlling undocumented ones. For example, the Act 40 of 1998 in Italy aimed specifically at “fighting irregular migration”. Country reports clearly demonstrated that information is much more available and complete for documented than undocumented migrants. Italy has a yearly publication that compiled data on migration. Estimates for undocumented migrants can vary widely, e.g. in Germany where there is no statutory definition of illegal residency, the reported estimated
range of undocumented migrants in the country varied between 100,000 to 1 million. Naturally the range of estimations of migrants has significant impact on the quality of data for policy and programme decisions as highlighted by Italy.

States have various instruments to control and manage flows of migrants. In particular States set the conditions for migrants to be documented and they legislate on nationality. The implementation of these legal instruments can be extremely complex. For example, Germany has many different and overlapping categories for migrants as shown in Figure 1 below. Hungary also reported many categories of migrants.

Figure 1
Definition of “migrants”, Germany (Schmitt 2006: modified from Razum 2003)

1. Germans according to citizenship, with German parents *
2. Immigrants with foreign citizenship, holding a residence title
3. Foreigners according to citizenship, born in Germany (not immigrated), holding a residence title
4. Foreigners according to citizenship, immigrated for a short period of time, holding a residence title
5. Foreigners according to citizenship with central focus of life in Germany, holding a residence title
6. Immigrants who acquired German nationality *
7. Ethnic German repatriates (immigrant with German nationality) *
8. Immigrants with dual citizenship*
9. Foreigners, dual citizenship, born in Germany (not immigrated) *
10. Refugees (so-called asylum seekers)
11. Immigrants without legal status (without residence title), irregular resident of third-country nationals
* registered as “German nationality” in official statistics

States have opted for *jus soli* or *jus sanguinis* as the two major approaches for nationality. At times, a State might, for demographic, socio-economic, or political reasons change the rules of definition for nationality. Hungary and Germany present particular cases in which many foreigners (three quarters in the Hungarian case) or immigrants (e.g., in Germany, the majority of the immigrants from Russia who represent 9% of the total, are German on the basis of *jus sanguinis*) are in fact their own nationals immigrating back following the vagaries of history. Consequently, great care must be exercised in analysing and comparing data while taking into account these historic circumstances if one attempts to compare immigration data across countries.

The country reports highlighted several important trends in policy. First, there is a shift in perspective from one which considered migrants as a temporary phenomenon (as is denoted by the German terminology “Gastarbeiter – guest-worker) to a permanent one as denoted by the Italian Consolidation Act. Such an evolution is very clearly presented in the report from Portugal. Until the 1980’s, there was no immigration policy and a weak legislation on this issue. Towards the end of the 90’s, the first initiatives emerged to integrate immigrants. In the last few years one witnessed the adoption of a systematic immigration policy through a battery of measures, ranging from promoting tolerance, integrating school children to
establishing local immigrant support centres (CLAI). These trends have led to a complex and difficult act of formulation and implementation. For example, the Bulgarian report showed that the migration policy is set within the framework of human rights, international and European standards, while keeping the balance between control of “illegal migration and free movement of people”. These trends and the considerable attention now received on migration opened the possibility for a dialogue between the migration authorities and health and AIDS authorities to promote changes in the interest of health within the territory of a country.

The report from Portugal also pointed out an emerging trend which could have significant implications for health. It has observed that legislative controls were not always effective when implemented alone, particularly if they focus only on the undocumented migrants. When migration laws did not control immigration as desired, the result was the need for several waves of regularization of undocumented migrants. The most recent one have taken place in 2004. A new approach has been introduced in Portugal to match more precisely flows of migrants to the needs of the economy. Because labour is a key factor in migration, a law adopted in 2003 not only fines companies employing undocumented migrants, but also makes them bear the costs for the stay and repatriation of these illegally employed people. Migrant workers’ rights are also promoted through fines of employers who under pay or do not pay the welfare contributions for the workers. The impacts of such measures deserve to be carefully evaluated, including in health.

2. HIV, AIDS and TB policy and legal frameworks

a. HIV and AIDS policy and legal frameworks

i) International frameworks

Both the UN system (e.g. Millenium Development Goals and UNGASS, 2001) and the EU (e.g. from the Dublin to the Bremen Declarations) have been active the last few years in setting frameworks for policy and programme development. The country reports of Bulgaria, Germany, Italy and Portugal specifically refer to these texts and have consequently placed HIV and AIDS high on their agenda as well as identifying migrants as a target group for HIV responses.

ii) National Plan or legal frameworks

Each of the country reports presented the national plan or the legal framework for HIV. In some cases, migrants are specifically identified as one of the target groups, particularly for prevention. Italy does not have a specific plan against AIDS, but has a legal framework and has identified migrants as a main target group. The Netherlands operates under a similar set up, but stresses that the ultimate responsibility for a healthy lifestyle belongs to citizens. Bulgaria has a programme composed of two tracks: (1) a National Action Plan and (2) a programme for the Prevention and Control of HIV/AIDS. The latter is implemented with a grant from the GFTAM. In the case of Portugal, AIDS is integrated into the National Health Plan. Germany, as a federal state, has a national AIDS strategy limited to federal commitments. The states and local authorities are responsible for the implementation of the national AIDS strategy.

On the European stage, Germany has taken, along with Portugal and Slovenia, an active role in policy and legislative development and hosted the meeting adopting the Bremen
Declaration (completing the Dublin and Vilnius ones). This is reinforced for migrants by a recent National Integration Plan (2007) addressing challenges for the integration of migrants, including in health. In the case of Malta, the National Sexual Health Policy which is being formulated does not include a section on migrant.

iii) Public sector and NGO collaboration

There is close collaboration between the public health sector and NGOs working on HIV and sometimes the collaborative arrangements are well-developed. For example, in the Netherlands, the Centre for Infectious Disease Control of the Ministry of Health is responsible for an integrated policy on prevention and control of HIV and STI. Where indicated, the Centre for Infectious Disease Control, delegated to NGOs coordination of the HIV prevention targeted at specific risk groups. The NGO - STI Aids Netherlands coordinates HIV prevention programmes of the migrant as an at-risk group and conducts information, education and communication campaigns. In Germany, the Government collaborate with NGOs and with migrant communities. In Malta, most NGOs are involved in prevention activities whereas in Bulgaria, People living with HIV have organized themselves into NGOs.

iv) HIV prevention and testing

In the Netherlands, after shifting from a restrictive testing policy to an active one in 1999, primary prevention is specifically aimed at migrants from endemic countries. However, there is no specific screening carried out for these migrants. As shown in the following graph, the median number of CD4 cell counts at diagnosis is lower in heterosexual men and women from HIV endemic regions compared to Dutch heterosexuals. This indicates late HIV diagnosis with a poor prognosis as a result.

Figure 2: Netherlands median CD4 counts at diagnosis indicating late diagnosis (data 1996-2005)

![Figure 2: Netherlands median CD4 counts at diagnosis indicating late diagnosis (data 1996-2005)](chart)

Data used from Report 2006 HIV Monitoring Foundation (HMF), Amsterdam
Migrants are identified as an important target group for prevention and treatment in Germany and, like citizens, they have access to counselling and testing from every physician and local health services. Entry to Germany of PLHIVs is not restricted unless they represent a clear threat.

Italy follows the principles of universality (all citizens have similar rights) and of access and, consequently, migrants have access to services. Of particular note are institutional developments on emerging health threats, e.g. the national CDC created in 2004 and the 2007 establishment of a National Centre for the Promotion of Health of Migrant Populations and the Fight against the Diseases of Poverty. Besides general prevention activities, studies have been conducted to establish a migrant profile based on their perceptions and behaviour, following WHO and UNAIDS recommendations. Prevention strategies are being tailored to reach migrants. Because of the complexity of migrant issues, a network of experts has been established under the National Institute of Health as part of the European “AIDS and Mobility” project. The report stated that the activities are still at an experimental stage.

In Bulgaria, there is universal free of charge HIV testing and the focus is on ensuring geographical coverage through a decentralized HIV provider-initiated testing as shown by the two following maps. The first map represents the public health sector infrastructure and the second one, the GFTAM funded support for vulnerable groups (migrants do not appear to be included).

Prevention for HIV, AIDS or TB in Malta is not covered by any specific provisions, but is available free of charge. Like in Germany, there is no law restricting entry for migrants with HIV, AIDS or TB.

Map 1. Bulgaria (a)
Bulgaria (b) Program “Prevention and Control of HIV/AIDS” funded by the Global Fund

v) On treatment

Due to the complexity of treatment of AIDS, the problems created by side effects of treatments and those related to viral resistance, the Netherlands has opted for gearing resources in 24 hospitals (four of which are specialized in paediatric HIV), which are the only hospitals where HIV may be treated. These 24 hospitals are distributed evenly across the country and each geographical region has one or more HIV treatment centres. This concentration aims to ensure that each hospital has a sufficient case load of HIV patients to further build its expertise.

In Germany, the concern is to provide competent close-to-home support for all citizens and documented migrants. For the latter, the goal is to assist them in overcoming access barriers: Every physician can provide needs-based treatment for HIV, AIDS and TB. However there exist also specialized centres for HIV and AIDS in large cities. Health insurance is compulsory, but for those who cannot pay, including migrants, different schemes cover the costs. However, the rapid assessment in Hamburg showed that it is a complex issue which impacts on health behaviours and creates serious difficulties for the physicians and the health sector. An important characteristic is that the Residence Act forbids deportation if the deportation could result in a substantial danger to life, which can apply to AIDS. In the case of asylum, the possibilities of treatment have to be verified in the country of deportation, even if relevant, in rural areas.

In the case of Portugal, health being a fundamental right, all people have the right to assistance in the case of emergency. Undocumented migrants can access anonymously health services so their status is not a direct issue. However, if they do not contribute to welfare, they have to cover their own health care expenses. Exceptions can be made, for example, undocumented children or maternity issues are covered. Measures have been taken in 2007 to significantly facilitate the access of undocumented migrants to the National Health Service. These general measures apply also to HIV, AIDS and TB.

Bulgaria stresses that its treatment and care for HIV and AIDS follows the principles of universal access. Since 2004, HAART is being made available beyond Sofia to other major
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cities (the locations correspond to the concentrations of HIV cases). PLHIVs participate in the various stages of the HIV programmes and are represented in the government bodies. Because HIV, AIDS and TB costs are not covered by the health insurance, the costs are covered directly by the Ministry of Health. For migrants not covered special measures have been taken jointly by the Ministers of Health, Ministry of Foreign Affairs and the Ministry of Justice to cover these costs.

In Malta, nationals and EU citizens are entitled to equivalent access to care, treatment and free medicines. Medicines are free for persons who have a low income and those suffering from chronic diseases. Otherwise, costs of medicines have to be born in a number of cases by the patients. In practice, migrants can receive free confidential diagnosis from all the sites where this service is available and treatment free of charge through a specialised unit in the main hospital as for Maltese nationals.

b. TB Policy and Legal Frameworks

On TB, country reports highlighted several points. In Italy the same principles for HIV and the institutional developments previously presented are also relevant for TB. Therefore, both documented and undocumented migrants share equal rights as with the citizens. TB is still considered a major public health issue and receives considerable attention. Specifics for TB are covered by a 1998 regulation. In the area of co-infection, guidelines have been adopted in Italy for preventive treatment of HIV-positive people.

In Bulgaria, the TB programme is fully based on the European Expansion Plan to Stop TB and aims to provide access to the entire population. The new fifth National Programme for Prevention and Control of Tuberculosis (2007-2011) follows European and WHO recommendations and takes the MDGs into consideration. Due to shortages in resources, a complementary programme is funded by the GFTAM. TB incurred costs are covered just as those for HIV and AIDS.

Germany is focussing on scaling up efforts in TB control with a particular concern for MDR-TB and to breaking chains of infection. From this perspective, migrants are an important group, but the country report did not provide information on TB screening.

3. Migration profiles

a. Some points on data

Although the country reports provide a wealth of data in their migration profiles, data remains a complex issue. Migration profiles are dependant on availability and quality of data scattered throughout many sources. Data are also affected by the legal status of the migrants. Data for undocumented migrants are particularly problematic: their numbers, characteristics, living and health conditions are poorly known. For example, in Hungary, since 2001, migrants with invalid resident permits are no more classified as “foreign citizens residing in the country”. This change resulted in a considerable drop in the total number as shown in the Figure below. Compilation, processing and publication of data are thus costly and burdensome operations.
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Matching migration data with health data requires considerable development in order to be of greater assistance to decision-makers. Because the data situation is already complicated within countries, one can see that harmonization between countries represents a real challenge.

Nonetheless, much useful data for the health sector exists as shown in the reports. Some examples are highlighted.

**Figure 3. Hungary. Impact of an administrative decision on numbers of migrants**

![Graph showing the impact of an administrative decision on numbers of migrants in Hungary.](source)

**b. Migrants’ countries of origin**

History and geography still play an important role when migrants select their country of destination. They can also facilitate the access to specific destination countries, especially if bilateral agreements have been concluded such as between Portugal and Lusophone countries. Examples of the role of historical ties or of location on the migratory route include the British migrants or boat people to Malta; boat people to Italy; or Romanian and former Yugoslavian migrants to Hungary. As the role of the historical source of migrants diminishes, Hungary observed an increase in undocumented migrants originating from outside of Europe. However, as shown in the above Hungarian graph, migrants do not come only from developing countries, but also from countries within the EU as well as from America.

**c. Spatial distribution of migrants**

Migrants tend to be concentrated in major cities and economic centres. For example, in Germany migrants are not attracted by the former GDR. Of 96% live in the former West Germany and in Berlin. In Italy, the major of migrants concentrate in the North and the smallest are in the South as shown in the following map.
In Bulgaria, 35% of foreigners with a permanent residency are located in the capital city, Sofia. A similar percentage is found in Budapest (33%). In Portugal, roughly 75% of immigrants are concentrated in four areas with Lisbon having the lion’s share.

d. Sex ratios

An important area in the profile of migration for public health is the sex ratio and family composition. The sex ratio varies considerably, from a majority of females in Malta, to a balanced one as in the case of Italy whereas in Portugal around 40% of migrants are women. Among boat people, a large majority of migrants are male. For example, 98% of the arrivals in Malta are men. In a given country, male and female migrants do not necessarily originally come from the same country. For example, in Germany, female migrants come nowadays more from Thailand, Peru, Philippines, Latvia, Belarus, Cuba and Ukraine whereas male migrants are mostly from Algeria, Slovenia, Tunisia, Hungary, Lebanon, India and Croatia. Bi-national couples or marriages can represent significant numbers. For instance, close to 7% in Germany where among one quarter of marriages one of the partner has experienced migration. In relation to sex work, Germany highlighted the fact that migrant sex workers work in the more dangerous locations such as home or hotels and are ready to accept greater risks due to economic pressure. From a health perspective, it is important to note from the reports that migrants live less frequently alone and have a higher fertility than nationals. However, these questions received little attention in some of the country reports9.

e. Economic activity

Foreign labours represent an important part of the foreign market. In Italy 1/6 of new hires are foreign labourer and this percentage is expected to increase. Most migrants can be found in construction, services or agriculture sectors. In Germany, migrants of working age are more frequently unemployed than nationals. This situation is more so for women migrants which are often found in industry, trade, hotel and restaurant sectors. Because of legal or de facto restrictions, migrants are rarely found in civil service or as an employer. For example, in Portugal, migrants cannot be self-employed.

9 Hungary, Netherlands, Bulgaria.
f. Length of transit or of stay

The report from Malta provided unique information on the time it took migrants to reach the country. Although over a third of migrants had come directly to Malta, over 50% spent more than two years before reaching the country. The length of stay of migrants varies considerably. In Malta, more than half of the migrants have been there less than two years, but Malta is a transit country. In other countries, migrants can stay for decades, e.g. in Germany.

4. HIV, AIDS and TB epidemiological profiles

In the Netherlands, HIV is concentrated in MSM and in IDUs in contrast to the general populations where the estimated HIV prevalence is 0.2% (in adults 15-49 years of age). The surveillance system provides detailed data for registered cases whether they be nationals or migrants. Only some highlights are provided here. The median age for HIV diagnosis with heterosexual origin was quite high at 40.4 years for Dutch men, 32.3 for Dutch women, and ranging between 28.7 and 42.1 for migrants. Among registered PLHIVs, 43% were born abroad, of which 41% from sub-Saharan Africa, 25% Latin America/Caribbean and 15% from Western Europe. For TB, which is a notifiable disease, the incidence is declining but is highest among foreign born persons. There is active TB case finding one by Municipal Health Services with tracing of contacts and screening of high risk groups defined as a TB incidence of over 50/100 000. Asylum seekers are mandatorily screened at entry and prisoners are screened within the first week of incarceration. Data is available for TB cases co-infected with HIV: it should be noted that the co-infection rate remained stable over the last 20 years oscillating around 4%.

Figure 4: Number and % of HIV co-infections in TB patients in the Netherlands

In Bulgaria, the number of HIV cases is still small. They are concentrated in the two major cities and along the Black Sea. HIV cases are mostly male and of heterosexual origin.
Information is not provided on migrants. In the case of TB, the number of registered cases increased considerably until 1998 and have since declined. The geographical distribution of TB is quite different from that of HIV. A major problem for TB is the late diagnosis due to several factors. An important factor is belonging to a vulnerable group with no health insurance or being in a member of a high risk group such as prisoners, IDUs, Roma, refugees or migrants.

In Hungary, HIV is concentrated in Budapest and its region, whereas TB is distributed at the borders and towards the East, particularly the border with Ukraine. Annex III provides the maps for HIV and TB geographic distributions which are quite different.

HIV, AIDS, TB are all notifiable diseases in Germany and the HIV epidemic is on the rise. The highest incidence rates are reported in the large cities (Hamburg, Berlin and Munich). MSM represent 60% of infections, heterosexual and IDUs, 13% each. Of new infections diagnosed, 40% were found among migrants, half of whom came from sub-Saharan Africa (but only 6% of them acquired HIV in Germany), 9% from Western Europe (half of whom acquired their infection in Germany). An important gender issue is that nearly half of new infections are diagnosed in women. There are three times as many cases of TB diagnosed than of HIV with migrants represented in some cities over 50% (Hamburg, Berlin, Frankfurt). See the map of percentage of foreign-born in TB cases below. There are no data on HIV and TB co-infection.

Map 3. Germany: Proportion of TB-cases with a foreign country of birth according to administrative district

In Italy, AIDS is notifiable and many data of both medical and socio-economic nature as well as on national and geographic origins are recorded. Data published is on AIDS cases and not on HIV infections. A decentralized surveillance system is presently being developed. The HIV epidemic has evolved from mainly drug related to becoming mainly sexual transmission among both MSM and heterosexuals. Behavioural risk-taking coupled with availability of ARVs have resulted in a second wave of the epidemics. Data on the incidence of HIV infection among migrants are lacking in part due to insufficient information on the estimates of total number of migrants as the denominator. Still, despite the increasing numbers of migrating men and women, the number of AIDS cases diagnosed in them has been declining.
for men and remains stable for women as shown in the graph below. This should be seen against the fact that similar changes have not occurred in the countries of origin of the migrants. As for TB, incidence is on the decline, most cases are concentrated in some high risk groups, e.g. elderly, and an area of concern is the emergence of MDR strains. Among new TB cases, migrants represent an increasing share of the total numbers in the country. Africa and Europe were the major regions of origin of these TB infected migrants. The rate of HIV and TB co-infection is estimated at 10%.

**Figure 5. Italy: Number of AIDS cases among foreign citizens in Italy (age ≥ 18 years), 1992–2003**

![Graph showing AIDS cases among foreign citizens in Italy](image)

In Malta, the numbers of HIV, AIDS and TB cases are small, but significant compared to the total population of the island. Screening for TB is carried out for irregular migrants, including pregnant women and Latent TB. Co-infections with hepatitis B and C and for TB are monitored.
II. Examples of activities of special interest

There are a number of activities mentioned in the seven country reports which are of considerable interest. These activities aim at identifying and solving problems related to migrants infected with HIV or TB. Every country, whatever its point of departure on HIV and TB, has special achievements which can inspire and give ideas to others. An attempt has been made by IOM to select activities that will have policy and programme implications pertaining to migrants on HIV, AIDS and TB. The goal is to place migrants on the same footing with nationals and ensure they are not discriminated against and can access all services, care and treatment. A common thread among these examples is that of vulnerability and the complexity of its expressions and implications. In a certain way, these selected examples reflect different attempts by countries to even the playing field so that migrants effectively, and not just in theory, enjoy rights recognised in international standards and conventions.

Collectively, these examples illustrate a range of issues and a variety of actions, highlighting the complexity of the health issues of migrants. Five areas have been identified:

i) Setting a framework under international standards;
ii) Strategic organization issues;
iii) Local organization issues;
iv) Data issues;
v) Staff training.

In addition, the examples show that the goal of improving the health of migrants relating to HIV, AIDS and TB can be reached through different strategies, depending on the point of departure or the human and financial resources available. This is why we do not use the fashionable term of “best practice”. These examples are current and may need careful evaluation. One can learn from them, they can stimulate and enrich debates, but they are not prescribed solutions. The diversity of the history and situations of the seven EU countries and of the epidemics, as described in the reports, is such that it calls for prudence and pragmatism. The political, socio-economic, migratory and epidemic trajectories of EU countries have to be taken into account as much as possible.

The table below provides a synoptic view of the examples which have been written up by the authors of the country reports and are presented in a companion paper “Migration and HIV, AIDS and TB: moving forward at country level in the European Union”.

MHD, IOM 18
### Table 1. Examples of activities of special interest

<table>
<thead>
<tr>
<th>Issue</th>
<th>Country</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting a framework under international standards</td>
<td>Bulgaria</td>
<td>The road to Fight AIDS</td>
</tr>
<tr>
<td></td>
<td>Italy</td>
<td>Guiding principles for HIV and TB programmes for migrants</td>
</tr>
<tr>
<td></td>
<td>Portugal</td>
<td>A holistic approach for the integration of immigrants and their improved health</td>
</tr>
<tr>
<td>Strategic organization issues</td>
<td>Bulgaria</td>
<td>Scaling-up HIV prevention, diagnosis, treatment, care and support services</td>
</tr>
<tr>
<td></td>
<td>Germany</td>
<td>Refund of travel to access services</td>
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<tr>
<td></td>
<td>Hungary</td>
<td>Recommendations based merely on the findings of the Hungarian rapid HIV/AIDS assessment</td>
</tr>
<tr>
<td></td>
<td>Malta</td>
<td>Integration of Migrants in Open Centres: the impact of physical location of open centres and the integrative preparatory programmes within open centres</td>
</tr>
<tr>
<td></td>
<td>Netherlands</td>
<td>Division of labour between Government organizations and NGOs</td>
</tr>
<tr>
<td>Local organization issues</td>
<td>Germany</td>
<td>Entrepreneurs Without Borders</td>
</tr>
<tr>
<td></td>
<td>Italy</td>
<td>National Institute for the Promotion of Health of Migrant Populations and the Prevention of Diseases of Poverty’ (NIMPD), San Gallicano</td>
</tr>
<tr>
<td></td>
<td>Portugal</td>
<td>Local Immigrant Support Services (CLAI)</td>
</tr>
<tr>
<td>Data</td>
<td>Italy</td>
<td>Instruments of particular relevance for HIV and TB data collection</td>
</tr>
<tr>
<td></td>
<td>Netherlands</td>
<td>HIV surveillance in the Netherlands</td>
</tr>
<tr>
<td>Staff training</td>
<td>Italy</td>
<td>The Centre of Migration and Social Medicine training course on migration health</td>
</tr>
</tbody>
</table>
III. Discussion of key issues identified

Many issues can be identified in the country reports. The objective here is not to discuss them all, but to highlight a number of issues which are of particular relevance for regional activities or cooperation. An example relating to communication is developed further to illustrate the benefits of regional cooperation.

1. The importance of a human rights approach

Although both migration and HIV are governed by a human rights approach, in practice migration policies and laws tend to seek to control and to manage migration, introducing distinctions between migrants and their treatment and modifying rules depending on economic needs. In contrast, health policies and laws, guided by humanitarian and public health concerns, have as objective universal access to health services. The dialectics between the migration and the health sectors result in uncertainties and situations detrimental to migrants’ health as well as to public health. The health sector is the weaker partner in the dialogue with migration authorities and consequently has to cope with the situations created by changing or restrictive migration policies. This need not be so because measures to control migration and which result in discriminating against migrants’ access to health services raise public health issues and can ultimately affect the HIV and TB epidemics as well as the costs to the health system. Such issues tend to be overlooked by the migration sector decision-makers. Dialoguing with migration authorities through the common denominator of human rights at a regional level could lead to improving the health outcomes for migrants and the health systems. The inclusion of health, and specifically HIV, AIDS and TB objectives and considerations in the revisions of migration policies should be advocated in the overall interest of the populations.

2. Including migrants in national AIDS plans strategies

All countries have a national AIDS plan or a legal framework, but the issue of migrants is often not specifically addressed. However, the revision of texts, plans, guidelines, practices being worked upon, provides the opportunity to specifically include migrants. At the same time, because issues concerning migrants in general and their health in particular, are dealt with by numerous organizations leading to administrative complexity, inefficiencies and also suffering of migrants, there would be an opportunity to improve administrative organization with resulting benefits to data collection, etc.

It would be opportune to harmonize such inclusions at a European level. By also spelling out the advantages and costs in so-doing, countries would provide the health sector with a solid base to negotiate partnerships with other sectors and participate in the revision of their instruments. For example, detention centres and prisons often pose serious public health problems in the areas of HIV and TB, and migrants are often disproportionately affected. Incorporating the issue in the HIV plan could facilitate a dialogue with the Ministries responsible for the health of migrants in prisons and detention centres.

3. Cooperation with sending and transit countries

At present, health systems have to cope with the health issues resulting from migratory movements. However, they would gain by cooperating with sending and transit countries.
whether they are located inside the EU or outside of it. The EU has launched initiatives in this area which can contribute to controlling the HIV and TB epidemics\textsuperscript{10}.

4. **Diversity of the country situations**

Not only are the seven countries different from one another, but their HIV and AIDS epidemics and migration patterns and histories are also diverse. Such diversity can be a source of richness for cooperation through exchange of experiences and division of labour for example in pioneering activities and research. More fundamentally, by placing migration and HIV and AIDS under international standards, the countries, whatever their differences, have common goals and approaches. Over time, harmonization and convergence are possible while respecting differences. For example, it might be difficult to agree on the definition of a “migrant” and definitions of “undocumented migrant”. However, since all countries agree on protecting the rights of migrants and ensuring universal access, the lack of common definition should not stop countries from discussing the problems of and the solutions to universal access. Whatever the criteria used to classify a migrant as “undocumented”, many of the problems encountered by such migrants and by the health systems in reaching out to them on HIV and AIDS are similar.

5. **Diversity of the situation of migrants**

If the countries are very diverse, migrants also form a heterogeneous group ranging from wealthy European retirees or businessmen to poor unskilled workers from developing countries. Focus of activities has been aimed at the lower socio-economic groups as well as at women and children. However, in the area of HIV and AIDS, although wealthier migrants may have health insurance, they can still be an element of the public health concerns in HIV, AIDS and TB. Full use of the possibilities opened by the European Health Insurance Card should also be made. HIV and TB strategies tend to focus on prevention and testing of migrants from countries with high prevalence. However, it should be kept in mind that the effectiveness of such a strategy depends very much on the relative importance of migrants from these high prevalence countries among the total number of migrants: the smaller it is, the less effective such an approach would be.

The major difference between migrants is found in the distinction between documented and undocumented ones. Documented migrants enjoy rights to health services, but can face de facto barriers due to various factors such as language, culture or insufficient knowledge of the health system. Undocumented migrants face these barriers in an exacerbated way as well as difficulties specifically attached to their status, such as health behaviour determined by fear of being caught, perceived or real inaccessibility of services, late use of services or finding themselves in detention centres. The problems faced by migrants, and especially undocumented ones, can be further compounded by conditions of poverty which increases their vulnerabilities and exposures to risks. From the HIV and AIDS perspective, the fewer the undocumented migrants are among the migrants, the better. Undocumented migrants represent the most difficult and costly migrants to handle for the health system, so improving the situation can be done both through dialogue inside countries, but also at the regional level.

\textsuperscript{10} On migration, the three Presidencies will work to ensure a regular dialogue and pursue practical cooperation between countries of origin, transit and destination. They will continue with the implementation of the “Global Approach to Migration” and the 2006 Action Plan “Priority Actions focussing on Africa and the Mediterranean”.

\url{http://www.eu2007.pt/UE/vEN/Politicas/Emprego_Consumidores/min.htm}
6. **Organization of health services for HIV and AIDS**

HIV and AIDS are complex issues in general and have become more so with the progress made in treatments, but also due to related issues of drug resistance. This complexity is increased when relating to migrants.

Two basic strategies can be found in the country reports with respective advantages and limitations:

i) Centres of excellence where all the facets of the required expertise are concentrated in order to ensure the availability of the highest quality of health services. These require significant resources which are not available for wide geographical dispersion. On one hand they can meet many of migrants’ needs in accessibility such as the help provided by linguistic and cultural mediators, but they might generate other obstacles for the migrants such as time and financial costs to access them including transport costs incurred.

ii) Offering services where the needs may be located and close to home support is another strategy. The proximity of services can make them accessible to migrants, such a proximity could help meet a number of their health needs.

The issue which emerges from these two strategies is how to ensure that an optimal balance can be reached.

7. **Impact of ARVs**

With the arrival and availability of ARVs, programmes have a tendency to shift their focus to active testing which has implications for costs, effective availability and access of testing services for migrants, their counselling, but also their care and treatment. Ensuring universal access for migrants complicates further already complex and taxing issues for health systems. Doctors and supporting staff noted that they spend more time with migrants, face added difficulties due to unavailability of records and in ensuring compliance in treatments. Since the introduction of HAART, health services increasingly focus on compliance, drug resistance, co-morbidities which become even more complex when dealing with migrants.

8. **Co-infections**

The degree of co-infection between HIV, AIDS and TB varies considerably depending on the risk groups and the prevalence of the country of origin. TB is often an early indicator of HIV, in part due to more systematic screening. When one includes hepatitis then, co-infection can represent a significant proportion of total cases of HIV, AIDS or TB. The issue is expected to gain increasing importance, in particular in relation to MDRs. In view of the possible role migrants play in co-infection and that little is known about the actual situation, a coordinated European approach could be helpful.

The geographical distribution of HIV and of TB prevalence illustrates the fact that until now they only partly overlap as shown, for example in the maps of Annex B. To the extent they overlap, it is possible that co-infected migrants play a certain role because they tend to be
concentrated in certain areas of higher prevalence. However, this is an issue which deserves closer scrutiny before reaching any firm conclusions.

9. Prisons and detention centres

The percentage of migrants imprisoned can vary considerably as well as information available on their health situation and screening and testing practices. TB screening is normally carried out whereas HIV testing is voluntary. Treatment interruptions appear common and access to specialized treatment is not systematically ensured (high cost of prison transport encourage alternative visit to prisons by specialists). Disaggregated data for migrants is not available and access to health data is difficult from either prison or detention centres. A complicating factor is that health issues of detainees are under the prison authorities and not the health authority. One avenue to explore would be under the “Lisbon Agenda for Prisons” which contains specific references on HIV, AIDS and TB, but integrated into a more general approach11.

10. Data collection and research

Existing data on HIV, AIDS, TB and migrants is scattered throughout a variety of sources and locations making it difficult to piece together as a basis for decision-making, research or international comparisons. Furthermore, because migrant health issues and infectious diseases are closely inter-related to their legal status and to poverty, health, legal and socio-economic data have to be pieced together. Guidelines at the European level could be of great assistance in such a task.

The situation for undocumented migrants is especially complex because, if hospitals, detention centres or physicians can provide information on diagnosis and cases treated, the denominator to be used is not known with precision.

It is thus not surprising that confronted with such data issues, research has neglected a field which was not high on the political agenda until recently. Of course, this resulted in the under financing of research. It should be pointed out that some of the country reports have shown the contribution that qualitative research and rapid assessments can make to developing knowledge on a vast and complex area. The situation is evolving in a positive direction, but the challenges ahead remain considerable. Data and research coordination are certainly areas where cooperation within the EU framework can lead to concrete results.

Country reports often stressed the costs incurred by the health systems, including private physicians, due to difficulties in providing services to migrants. This is particularly so for undocumented migrants who often incur extra costs due to their status. Such research would benefit from being conducted within two different frameworks: the traditional one used in health economics but also within a much larger framework. Such a larger framework needs to be defined, but would require identifying the larger economic system in which undocumented migrants live and work: on the one hand, the economic contributions of the undocumented migrants, e.g. to employers or renters and on the other hand, the costs, not only to health, but also to public finance, insurance, etc. This would shed light on the real cost-benefits of undocumented migration and facilitate a dialogue of all the concerned sectors, including migrant associations.

11. Communication

Reaching out to migrants, whatever their status, is important and has to be tailored to the needs and problems of migrants in order to promote and ensure equal access to hospital as with the nationals. Hospital use by migrants, especially undocumented ones, requires a minimum knowledge of the health system, overcoming language barriers and the fear of dealing with official institutions or of incurring costs. Training of staff, production of IEC materials in migrants’ languages, appropriate cultural and gender sensitive relations with patients could be greatly facilitated at the EU level as well as being cost-effective.

Host communities of migrants can also be fearful of migrants in general and harbour negative stereotypes on their health and on HIV, AIDS and TB. Combating racism and xenophobia through the integration of corresponding EU directives can be facilitated at the EU level. A number of myths held by host communities need to be dispelled. For example, myths that migrants only bring in HIV and TB when in fact they generally arrive healthy; that they overuse health services when the opposite is true. Here also, coordinated research on such myths and collaborative efforts at dispelling myths could be cost effective.

Migrant communities often react in a hostile manner to their compatriots once they hear the particular migrants are infected with HIV or TB. This factor plays an important role in the behaviour of migrants and deters use of facilities even when they are entitled to them in order to avoid stigma and discrimination from migrant communities. It would be useful to design campaigns specifically to reduce stigma and discrimination shown by migrant communities to their own members who are HIV infected. Communicating with migrants on issues of gender and children related to HIV, AIDS and TB has received insufficient attention, but is necessary.
Annex A.

Background information excerpted from: HIV/AIDS in Europe: trends and EU-wide priorities

Table: HIV infections newly diagnosed in 2005 and rates per million population by country, European Union, reported by 31 December 2005

<table>
<thead>
<tr>
<th>Country</th>
<th>Year reporting started</th>
<th>2005 n</th>
<th>Rate (per million population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>EU</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austria</td>
<td>1998</td>
<td>453</td>
<td>55.3</td>
</tr>
<tr>
<td>EU</td>
<td>Belgium</td>
<td>1986</td>
<td>1066</td>
</tr>
<tr>
<td>EU</td>
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<td>1986</td>
<td>43</td>
</tr>
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</tr>
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</tr>
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</tr>
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<td>1986</td>
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<tr>
<td>EU</td>
<td>France †</td>
<td>2003</td>
<td>3165</td>
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<td>Germany</td>
<td>1993</td>
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<td>EU</td>
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<td>8868</td>
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<tr>
<td>Total European Union (EU)</td>
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<td></td>
<td>23 620</td>
</tr>
</tbody>
</table>

NB Country report Bulgaria : HIV infections not included in the table because the country had not yet become a member of EU

- 40% cases were non residents
- † 2005 data from January-June
- ‡ No national data available but HIV reporting exists in some regions
Providing specific services for migrant communities

In western European countries, many HIV infections have been diagnosed in immigrants from countries with generalised HIV epidemics. These people represent an important group, with unique challenges for HIV prevention and care services. There is a need of specific services for immigrant communities with prevention activities tailored to their needs, and communication about immigrant health issues which does not add to existing stigma.

The HIV situation in the EU is increasingly influenced by international travel and migration, which underlines the need for a global and European-wide approach to HIV prevention and control.

Annex B. Geographical distribution of HIV and TB in Hungary and Bulgaria

**Prevalence of registered HIV cases in Hungary in 2006**

- Hospital where HIV infected patients are treated (Saint Laslo Hospital)

**Incidence of TB in Hungary in 2006**

- Hospitals with pulmonology department

Source: Epinfo 14.7.
EU Partnerships to reduce HIV & public health vulnerabilities associated with population mobility

Registered HIV cases by Region (1986-06.2007)

No data about distribution by region for 26 cases

Source: National Center of Health Informatics - Bulgaria

REPUBLIC OF BULGARIA
TB INCIDENCE 2005
40.1 / 100,000

Source: National Center of Health Informatics - Bulgaria
EU Partnerships to reduce HIV & public health vulnerabilities associated with population mobility

References and acknowledgements:

Lee-Nah Hsu, MHD, IOM, Project Manager May 2007-October 2007

Jacques du Guerny, Consultant, synthesis report.


Immunology Department of the Szt. Laszlo Hospital, Ministry of Health, Publíec Health Institute of the Universiøty of Sciences, Pecs, HIV/AIDS and Tropical Medicine Division of the Szt. Laszlo Hospital, Hungary Country Report: EU Partnerships to Reduce HIV& Public Health Vulnerabilities Associated with Population Mobility, September 2007.