



## **EASL position statement on liver disease and migrant health**

### **Executive summary**

**Aim:** The aim of this statement is to inform policy makers about the importance of liver disease, infection with hepatitis viruses and alcohol abuse in migrant, asylum seeker and refugee communities and to identify effective policies that prevent liver disease from occurring or that help to screen, treat and follow-up migrants who have or who go on to develop liver disease after migration.

### **Main messages**

The current system of providing healthcare to asylum seekers and migrants is failing vulnerable populations. European governments should adopt a public health- and human rights-based approach to migrant health. Asylum seekers and irregular migrants must have knowledge of their rights in health related-matters and be granted access to affordable and timely healthcare treatment in patient-friendly, non-discriminatory settings. Linkage and retention in care should be warranted in a comparable setting for the migrants who need prolonged or lifetime treatments and for all other forms of medical care or support. Neither the migrants nor the health care personnel caring for them should be criminalised or put at risk of being criminalised for seeking treatment or providing it. The adoption of these measures will not only benefit the migrants, but also the hosting populations. In fact, policy measures that protect vulnerable groups in general tend to result in an improvement in the population health as an all.

### **Findings**

- Frequency and aetiology of liver disease in migrants are not necessarily any higher than in the host population
- Some liver diseases, particularly Hepatitis A, are often acquired en route during migration or after migration in host countries due to poor reception facilities, while sexual transmission of Hepatitis B and C (and of HIV) may result from abuse in the same settings.
- Screening programmes for Hepatitis B and C in migrants are not adequate. Point-of-care testing should be made available and lead to prompt institution of appropriate antiviral treatment.
- Levels of exposure to alcohol may change radically after migration into Western countries, from regions where there are religious, social or financial constraints on the use of alcohol.
- Migrants, particularly those undocumented or asylum seekers, often fall out of safety nets and are not appropriately informed about their rights to receive appropriate health care in the host country. As a consequence, they may not receive the treatment they need
- Healthcare professionals are not always aware of their obligations to provide treatment to irregular migrants and asylum seekers

- EU Member States have reduced access to free treatment and specialist care for migrants over the past decade. This may have resulted in a rise in mortality in migrants in some countries
- The ethical obligations of healthcare workers towards their patients are being compromised in some EU Member States as a result of changes to national immigration legislation

### Recommendations

- European countries must improve reception facilities for migrants to remove preventable sources of Hepatitis A infection such as overcrowding, lack of access to decent sanitation and washing facilities and unsafe food and water. All facilities must be upgraded to meet the minimum levels mandated in the EU asylum seekers directive
- Migrant screening programmes, for newly arrived migrants, preferably at the port of arrival, should be expanded to include HBV and HCV, and be finalized to provide early access to curative treatment for all infected (HCV) or adequate long-term suppressive therapy when needed (HBV)
- Appropriate timing of screening for communicable diseases is essential in order to map potential risks and to offer adequate care at the port of entry
- All migrants, undocumented or not, should be offered affordable and understandable healthcare, treatment and referrals to specialist services where needed
- The use of cultural mediators able to communicate in the migrant's own language must be implemented to facilitate access and use of healthcare facilities in the host country
- Information about the risk of abusive alcohol use should be provided early and effectively
- Long term or lifelong treatments, as all other types of health support, must be maintained through the cessation or national and super-national networks able to provide continuity of care for migrants who continue to move across countries
- Healthcare professionals should be trained on their obligations to treat migrants and asylum seekers. All such patients must be involved in discussions on their treatment decisions and treated with respect and in a culturally sensitive manner. European and national level specialist medical societies should support and engage in raising awareness around this issue
- Governments must not require healthcare workers to report undocumented migrants to the police or immigration authorities
- European and national level specialist medical societies should engage with EU and member state authorities to promote the creation and funding of specialist training and integration programmes for migrant healthcare workers.

### Background

Definitions: It is important to define who we mean when discussing the health status of "migrants" as, over recent years, the term has come to encompass a wide range of people who leave their country of origin for any number of reasons. "Migrant" can encompass all foreign-born people within a population; or all non-citizens, whether documented (i.e., with recognised status, whether permanent or temporary) or undocumented. The International Organisation for Migration (IOM) defines a

migrant as *any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is*<sup>i</sup>.

### Recent asylum seeker flows into the European Union

In 2017, six hundred and fifty thousand first-time asylum seekers applied for international protection in the Member States of the EU.<sup>ii</sup> Syria was the main country of citizenship for asylum seekers, followed by Iraq, Afghanistan, Nigeria and Pakistan.<sup>iii</sup> Germany, Italy, France, Greece, UK and Spain were the six most popular countries for first-time asylum seeker applications.<sup>iv</sup>

Asylum seekers are young and male: Over 80% of the first-time asylum seekers in the EU-28 in 2017 were less than 35 years old. Nearly one third were under 18 years old. Less than 1% of first-time asylum applicants were aged 65 or over. Three quarters of applicants aged between 14 and 35 were male.<sup>v</sup>

### Migration flows

A total of 4.3 million people immigrated to one of the EU-28 Member States during 2016.<sup>vi</sup> Germany reported the largest total number of immigrants (1,029,900) in 2016, followed by the United Kingdom (589,000), Spain (414,700), France (378,100), and Italy (300,800). A total of 21 of the EU Member States reported more immigration than emigration in 2016. In most EU Member States, the majority of non-nationals were citizens of non-member countries.<sup>vii</sup> The main countries of origin for non-EU migrants in the EU28 in 2017 included Morocco, Turkey, Kosovo, and China.<sup>viii</sup>

### Liver health conditions of migrants, refugees and asylum seekers

It is sometimes assumed that migrants bring disease with them. However, studies show that this is not necessarily the case.<sup>ix</sup> Whilst migrants suffering from HBV were often infected at birth or in early childhood in their countries of origin,<sup>x</sup> other infectious liver diseases are often acquired after the migrant or asylum seeker arrives in the European Union. This is particularly true of Hepatitis A, which has become a problem in Greek hosting centres because of extremely poor living conditions and little access to health treatment. In 2016, a total of 177 laboratory confirmed cases were reported. Eighty four percent occurred in camps in Greece and the majority of cases occurred in Syrian children below the age of 15.<sup>xi</sup> Amnesty International has described the conditions in the camps on the Greek islands in 2017 as “appalling” and falling below minimum EU standards. An ECDC technical report in 2016 found that of the 14 HBsAg prevalence estimates available for the general population of migrants, 57% were lower than the in-country estimate in the general population, 36% were comparable and only 7% (one study) was higher. For hepatitis C, 70% of the ten general migrant population estimates are comparable to the in-country prevalence, and 30% are lower.<sup>xii</sup>

Other studies have found that migrants can often be comparatively healthy compared to the communities into which they are migrating (the so-called ‘healthy migrant effect’).<sup>xiii</sup> Depending on their age and social status, new arrivals in Europe may be suffering from non-communicable diseases such as Non Alcoholic Fatty Liver Disease (NAFLD) or liver cirrhosis, or infectious liver diseases such as Hepatitis A, B or C. Liver cancer mortality has also been reported to be higher in migrants from North Africa, Sub-Saharan Africa and East Asia.<sup>xiv</sup>

However, given their countries of origin, the relatively young age of most recent arrivals and the nature of their journey to Europe, they are more likely to be suffering from or at risk of contracting infectious liver diseases. Children and young adults may have missed out on vaccination programmes for Hepatitis B.<sup>xv</sup> Migrants and asylum seekers of all ages are likely to have been exposed to violence, unsanitary housing conditions, unsafe food and water and, potentially, coercion into sex work<sup>xvi</sup> if arriving via so-called irregular migration routes through Libya<sup>xvii</sup>, Turkey, and Egypt.

Knowledge about addiction in migrant populations in Europe is limited. The highest quality prevalence estimates of hazardous and harmful alcohol use ranged from 17-36% in camp settings and 4-7% in community settings.<sup>xviii</sup> However, where it occurs, addiction to alcohol or drugs may give rise to an increased risk of liver disease (alcohol related liver disease and cirrhosis and/or Hepatitis C from injecting drug use).

### **Migrant health in the host state: screening, linkage and access to care, obstacles to care and treatment**

Migrant health on arrival in the host state is influenced by a number of factors. These include migrant-centred health and other policies in the host state, the migrant or asylum seeker's immigration status and access to services, host state policies on inclusion and discrimination, language and cultural values, separation from families or friends, the duration of their stay in one country and their journey from their countries of origin to their host state and the housing offered to them. Migrants generally experience a number of economic, administrative, legal and other barriers to accessing healthcare.<sup>xix</sup> They may also be reluctant to seek treatment because of fears of being detained deported and/or separated from their children.

#### **Screening**

A recent meta-analysis study on the effectiveness and cost-effectiveness of migrant screening practices in 10 EU countries found that most countries focus on single diseases only, usually active or latent tuberculosis infection. Less than half of the studies included in the meta-review reported on other infections such as Hepatitis B or C. Uptake of screening by migrants was high, particularly in primary care settings, but in almost 25% of cases screening was not completed and a diagnosis was not made. Data on cost-effectiveness appear to be scarce but suggest that screening is moderately to highly cost-effective depending on the disease and migrant sub-groups screened.<sup>xx</sup> It is clear that screening policies need to be improved and better targeted towards the migrant groups that need them. There is a particular need to increase screening for HBV and HCV.

Barriers to screening included lack of staff training and support, lack of professionalism, poor management, screening in different settings, funding and communication difficulties. Facilitators of screening include well-trained screening staff, culturally appropriate services, patient involvement in delivery and testing in user-friendly outreach settings.<sup>xxi</sup>

#### **Access to treatment**

Healthcare is a human right and migrants and asylum seekers should not be excluded from health systems and access to treatment.<sup>xxii</sup> Unfortunately, they are and there is evidence that such practices have resulted in increased mortality rates for undocumented migrants.<sup>xxiii</sup> Public health organisations

and representatives have also expressed concern that public health could be compromised as sick undocumented migrants are deterred from seeking treatment, even for serious conditions.<sup>xxiv</sup>

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Access to healthcare for migrants and asylum seekers in Europe (and elsewhere) has been described as a humanitarian crisis.<sup>xxvi</sup> European countries most affected were not prepared for the increased number of arrivals in 2015 and scrambled to provide an adequate healthcare response, be it for political, financial or other reasons.

In addition, access is limited by additional structural barriers. In several countries, legislation restricts the ability of non-nationals and undocumented migrants to access non-emergency care. As of 2016, 21 EU Member States plus Turkey provided free emergency healthcare to undocumented migrants.<sup>xxvii</sup> Only 4 plus Switzerland provided free primary and secondary care.<sup>xxviii</sup>

Research suggests that migrants do not have adequate information about their rights to seek healthcare and medical professionals may also not be well-informed about their right to care, particularly given the complexity of rules determining eligibility based on residence status and other factors.<sup>xxix</sup> This can lead to improper refusals to register and treat vulnerable migrant patients. Where healthcare is provided it is sometimes of inferior quality to that provided to the native-born population.<sup>xxx</sup> And even where patients are treated in primary care or mobile clinic settings it is often impossible to refer them on to specialist care in secondary settings because of legislation prohibiting that or on payment conditions that the migrant cannot meet. Reference?

Where liver conditions suffered by migrants are treatable, such as HCV, migrants should be offered treatment with direct acting antivirals. People who are newly arrived who suspect they have not been vaccinated for HBV should be vaccinated. Advice on the health risks of alcohol consumption and injecting drug use should be provided where possible to at-risk populations.

### **Role of physicians – ethics and other considerations**

There is a growing trend for healthcare workers to be drawn into immigration enforcement systems. In 2016, five EU Member States plus Bosnia Herzegovina, required healthcare professionals to report undocumented migrants who seek treatment to the immigration authorities, or at least make available non-clinical patient records upon request to immigration authorities for tracing purposes.<sup>xxxi</sup> These developments have been strongly criticised by Doctors of the World and other health professionals and NGOs, as well as statutory bodies tasked with representing doctors and upholding medical ethics and standards. In January 2018 the Chair of the House of Commons Select Committee on Health in the UK wrote to the head of NHS Digital expressing serious concerns about this practice and requesting them to immediately cease all transfers of patient information to the Home Office.<sup>xxxii</sup> In June 2017 the American Medical Association adopted a policy supporting protections that prohibit immigration enforcement officials from using medical records as a potential source of actionable information on a patient's immigration status.<sup>xxxiii</sup>

EASL takes the view that these developments present healthcare workers and health facilities with a conflict between their duty to treat patients in need and their legal obligations under such legislation. The first priority of healthcare workers is to treat patients in need. They should not be forced into

breaking the law in order to comply with their ethical obligations towards patients. Healthcare systems should be a place of sanctuary, not criminalisation, and legislation that obstructs this should be revoked. In July 2018 the European Parliament adopted a resolution calling on Member States to ensure that organisations and individuals offering humanitarian assistance to undocumented migrants should not be criminalised. EASL welcomes this expression of support from MEPs.<sup>xxxiv</sup>

### **Inclusion and support for migrant and refugee healthcare workers**

Data on the number of healthcare workers who have moved to the European region as migrants or asylum seekers is patchy. However, we know that healthcare workers have moved from countries such as Syria, Iraq and Afghanistan. In a time of increasing shortages of specialist doctors in countries such as Germany and the UK, EASL recommends that efforts should be made by all European countries to quickly recognise migrants' medical qualifications and develop training and inclusion programmes for migrant doctors allowing them to integrate quickly into employment in their host state healthcare systems and, as a consequence, into the life of their host state.

### **Recommendations**

- European countries must improve reception facilities for migrants to remove preventable sources of Hepatitis A infection such as overcrowding, lack of access to decent sanitation and washing facilities and unsafe food and water. All facilities must be upgraded to meet the minimum levels mandated in the EU asylum seekers directive
- All migrants, including undocumented, should be offered affordable and understandable healthcare, treatment and referrals to specialist services where needed
- Migrant screening programmes should be expanded to include HBV and HCV
- Healthcare professionals should be trained on their obligations to treat migrants and asylum seekers. All such patients must be involved in discussions on their treatment decisions and treated with respect and in a culturally sensitive manner. European and national level specialist medical societies should support and engage in raising awareness around this issue
- Governments must not require healthcare workers to report undocumented migrants to the police or immigration authorities, and should put in place rules that safeguard people from such violations of their privacy and confidentiality
- European and national level specialist medical societies should engage with EU and member state authorities to promote the creation and funding of specialist training and integration programmes for migrant doctors

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