Infectious Diseases among African irregular migrants in Italy. Just an individual problem?

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Abstract
Migration is one of the possible points of contact between the rich world and the poor world. This paper describes and analyzes the presence of infectious diseases in a large cohort of immigrants from Africa who have landed in Lampedusa and in Sicily from 2011 to 2015. In the experience of “Lampedusa 2011”, in over 75% of the cases observed, the population was healthy. At least 20% of cases, diseases were observed in relation to the migration route, especially the precarious conditions of the crossing of the Channel of Sicily. Infectious diseases or female genital pathologies and or reproductive problems were observed in less than 2% of the population. These experiences confirm the Healthy Migrant theory, a population predominantly represented by young people who are at risk of becoming ill during the difficult migration or in the host country due to poor living conditions. In the last years, our experience confirm the higher prevalence of HBV, HIV and TB infection in irregular migrant people compared to general population living in Italy. Taking care of such people is an act of civilization and ensures the health of those individuals and of community.
Introduction

In the last two decades, in view of international migration flows, there have been outstanding changes directly related to social, political and economic factors that have forced a huge amount of people to leave their land, their habits, their culture, often brutally.

The phenomenon of world globalization and some alterations of the political-economic order in the nearby counties of the near East and in eastern Europe, such as the fall of the Berlin Wall or the “fall of the wall of the Magheb” have determined an inevitable revival of the possibility to consider and plan their life beyond the natural and political boundaries of those people who are nowadays facing conditions of extreme poverty and are forced to suffer violence, torture, war and human misery in their own countries.

The Mediterranean area can be considered a good example to understand the complexity of migration. Africa and Europe are strictly interconnected by migration, both for geographical nearness and because of the huge socio-economic gap between the two continents: 15 out of 20 of the most developed Countries in the world are in Europe, while the 20 least developed Countries of that same world are in Africa (1).

This means that Europe appears as the new “promised land”, and migrants of African origin are willing to face long and difficult journeys to reach it, often travelling across the whole African Continent.

But who are these people? Where are they from? What are they looking for?

The word “migration” covers a wide range of movement, the reasons for it and the conditions under which it takes place (2-4). It is nevertheless important to keep in mind that not all migrants come from the same type of background, nor do all migrants move for the same reasons and under the same circumstances. The vulnerability of migrants from different backgrounds to communicable and non-communicable diseases is likely to be different and so is their capacity to respond to their health needs and participate in national public health programs (5,6).

Poverty and the desire for a better life continue to be among the most important factors motivating people to move. The fact that both real and relative poverty is becoming more evident, and that the gap between rich and poor countries is growing, this type of migration is likely to continue. The range of people moving for economic reasons is broad, and includes highly skilled migrants from social and economic backgrounds. However, the largest portion of migrants is, and will continue to be, made up of people fleeing disadvantaged socioeconomic and environmental backgrounds. These people are highly vulnerable and exposed to infection (particularly to HIV infection, to other sexually transmitted infections and to tuberculosis) due to frequent episodes of violence, torture, abuse and deplorable conditions of vulnerability they are submitted to along the migratory route (7-12). Immigrants with greater social marginalization (illegal immigrants, drug-addicted people, homosexuals, sex workers, victims of human beings trafficking, ethnic minorities, prisoners) are at additional risk of morbidity, exploitation and social exclusion due to high mobility, social status, linguistic and economic difficulties, cultural diversity, misinformation, low level of education, lack of work, difficult access to health care and prevention, social exclusion and gender issues (13-21).

Social and political attitudes to migration have become stricter in recent years, and countries have introduced measures designed to make in-migration (even for short periods) more difficult. In opposition to many expectations, the result has been a marked increase in the number of people
moving, rather than a marked decrease. Although it is difficult to exactly define how many people are involved in this irregular migration, the number is thought to be growing and possibly exceeding the number of people moving officially and in a recorded way (2-4, 22, 23). From the perspective of public health and infectious diseases prevention and control, irregular migrants present difficult challenges (10). Not only they remain unseen and benignly neglected by local authorities, but they also remain largely unreached by health initiatives. Their conditions of life, which are often characterized by overcrowded and promiscuous housing, poor hygiene, frequent mobility within and between cities, marginalization from health care systems and a reluctance/fear of being identified by judicial authorities, make the task of reaching them with screening, early diagnosis and treatment difficult. Conflicts remain a major cause of forced migration and the last twenty years have seen the number of refugees and Internally Displaced People (IDPs) come to constitute a significant proportion of all people around the world. Most refugees move from developing countries. The rights of IDPs, however, including their health, essentially remains the responsibility of their own governments and is often neglected, if not further abused once they flee. Many IDPs, as well as refugees, go on leaving their countries of origin and make their way to other countries, including EU countries. In the case of both refugees and IDPs, the social and environmental conditions in which most of them are forced to live, even temporarily, tend to be poor and lead to the spread of infectious diseases (2-4).

In this complex and difficult contest Sicily, and more recently Greece, have become a forced crossroads, a piece of land of arrival or transit where those people must have the right to be welcome, cared for and treated in the name of the basic human rights to ensure and guarantee collective health.

In the report for the first half of 2015, made known in Geneva by UN High Commission for Refugees (UNHCR), the total amount of migrants and refugees has reached 137,000 people (figure n°1), the vast majority of whom is fleeing war, conflicts and persecutions, seeking protection. The report shows that the route of the eastern Mediterranean Sea, from Turkey to

**Figure n°1: Migration from Africa to Italy and Greece in the first half of 2015**

<table>
<thead>
<tr>
<th>Month</th>
<th>Flussi Migratori Africa &gt; Italia/Grecia (2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>gennaio</td>
<td>1000</td>
</tr>
<tr>
<td>febbraio</td>
<td>1500</td>
</tr>
<tr>
<td>marzo</td>
<td>2000</td>
</tr>
<tr>
<td>aprile</td>
<td>4000</td>
</tr>
<tr>
<td>maggio</td>
<td>5000</td>
</tr>
<tr>
<td>giugno</td>
<td>8000</td>
</tr>
</tbody>
</table>

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Greece, has nowadays substituted the one situated in the central Mediterranean Sea (from North Africa to Italy) and it can be considered the most important one for those arriving by sea.

Data show an increase of 83% of refugees and migrants who have come through the Mediterranean Sea from January to June; as a matter of fact, in the same period 2014 the total number of migrants coming through the Mediterranean was 75.000 (figure n°2).

The resulting framework shows a fragmentation of the available data that requires a strong effort on the part of Public Health System to improve the quality of information and to implement specific programs of prevention and care. The data on the spread of some infectious diseases (such as HIV, TB, HBV) among the immigrant population and the indigenous are rather limited, although the clear disproportion of cases in the migrant population suggests that the immigrant status in the EU even nowadays rep-

![Figure n°2: Number of migrants in the years 2014 and 2015](image)

**Migrants and infectious diseases: the European scenario**


The report takes into account a group of infectious diseases considered relevant and is based on an analysis of data and information from a variety of sources: the European system of surveillance of infectious diseases (Tessy), a revision of literature and a survey conducted through a network of experts selected in all EU countries.

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HIV infection: between 2007 and 2011, 39% of new cases of HIV infection come from the immigrant population. This shows that there is a clear disproportion between the incidence of new cases of HIV among the indigenous population and the immigrant one. The increase in incidence has been observed especially among people from Latin America and Eastern Europe. Down instead the proportion of new infections in Sub-Saharan Africa. The route of transmission is found to be more frequently through unprotected heterosexual intercourse. It would seem obvious that many migrants are at high risk of acquiring the in-
Infection once they are in the EU: there is thus no “imported” cases, but problems related to increased susceptibility of these patients to infection once they get in EU, as well documented in the Italian study PRISMA (26) and in the European study aMASE (27) under publication.

**Tuberculosis:** also for tuberculosis, it was observed an increase of cases related to the migrant population: from 10% in 2000 to 25% in 2010 (25). In Western Europe, the majority of cases of TB is reported in the migrant population while, on the contrary the incidence of infection seems to be reduced in the European population. However, the increase of TB cases registered in the immigrant population has not caused an increase in the spread of TB in Europe. Therefore, this evidence suggests the need to implement specific strategies for prevention and care in those population groups of people who are at increased risk of infection.

**Hepatitis B virus (HBV):** it affects in a discriminatory way the immigrant populations who are not usually vaccinated as opposed to the people of Europe who, thanks to the spread of vaccine strategies against hepatitis B, have very limited prevalence rates of infection thanks to poor local circulation of the virus.

In many European countries immigrants from highly endemic regions are 5-90 times more frequently affected by HBV than the general population (28-32). Pregnant women involved in Médecins du mond (MdM) programs face multiple vulnerabilities. Only half of the pregnant women knew their HIV, hepatitis B or hepatitis C status when they arrived under the MdM program and, of these, 14.3% were HIV positive, 11.1% tested positive for hepatitis B and 2.8% for hepatitis C. In addition, 67.1% of the women wished to be screened for one or the other of these viruses, but 34.3% did not know where they could go for the test. (33)

**Experiences and activities aimed at the migrant population landed in Sicily**

The model of community health path adopted envisages an initial intervention of hospitality and triage at the pier and a subsequent activity of transcultural and social health care.

The phases of the intervention project have envisaged the following activities:

- Preparation of the host location and clinical diagnostic path: it has been necessary to draw routes linking the sites of hospitality and triage at the pier and the structures to host the assisted people: a clinic for a first diagnostic and/or therapeutic approach to offer to the people who presented symptoms and/or signs of disease; a first help centre, in the case of those landed people who have not showed any disease; transfer to Sicilian hospitals specifically identified in case of need for hospitalization.

- The presence and intervention of cultural mediators is fundamental to encourage and enable all the communication skills of interpretation through interventions of direct or indirect linguistic and cultural mediators. Mediators have used a triage form specially created and validated for the collection of personal data, medical history and symptoms and for the attribution of a code of evaluation of clinical conditions, necessary for the subsequent care pathway.

- Creation of a centralized DB for collecting and analyzing data on the physical and psychological condition of people just landed.

- Psychological and legal assistance through the activation of specific special windows to give psychological support, information on the right to health and access to care and to respond directly to the needs expressed by the migrants.

The program was launched in 2011 and made it possible to accommodate and assist
24,861 people who came through 106 landings (34).

The presence of infectious disease has been reported in 66 subjects (see Table n° 1).

In 184 cases out of the total of the population observed (0.3%), it has been necessary to use a transfer by helicopter rescue to the Sicilian hospital network previously identified. The clinical pictures that have requested the transfer to hospital are shown in Table 2 below in which it is possible to highlight that female genital pathologies and or reproductive problems have represented the largest part among women; in men, the diseases that have requested more urgent transportation have been infectious diseases and mental disorders.

After 2011 the activities of reception and service have undergone some changes related to the number of landings and migrants arrived in Sicily and at the specific request of screening for sexually transmitted infections manifested by the migrants themselves. Specific interventions for early diagnosis of tuberculosis have been started in some centers for identification and expulsion on the Italian territory.

Table n°1: Diagnosis of identified infectious diseases

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>n° of cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>TB infection</td>
<td>21</td>
</tr>
<tr>
<td>HBV infection</td>
<td>13</td>
</tr>
<tr>
<td>Scabies</td>
<td>8</td>
</tr>
<tr>
<td>Pneumonia/bacteria bronchopneumonia</td>
<td>5</td>
</tr>
<tr>
<td>Malaria</td>
<td>5</td>
</tr>
<tr>
<td>HCV infection</td>
<td>4</td>
</tr>
<tr>
<td>Acute gastroenteritis</td>
<td>4</td>
</tr>
<tr>
<td>HIV infection</td>
<td>2</td>
</tr>
<tr>
<td>Herpetic stomatitis</td>
<td>1</td>
</tr>
<tr>
<td>Purulent meningitis</td>
<td>1</td>
</tr>
<tr>
<td>Bacterial endocarditis</td>
<td>1</td>
</tr>
<tr>
<td>Visceral leishmaniasis</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>66</strong></td>
</tr>
</tbody>
</table>

A specific study evaluated the prevalence of HBV infection in a population of African migrants in Palermo (35).

Hepatitis B Virus (HBV) affects the liver and can result in chronic infection, which may lead to liver cirrhosis and hepatocellular carcinoma (HCC).

Worldwide, an estimated two billion people have been infected with hepatitis B virus (HBV) at some point in their lives and 360 million of them are estimated to have chronic infection (36). In the WHO European Region, 14 million people are estimated to have chronic hepatitis B and HBV is responsible for 36,000 deaths annually (37).

WHO classifies countries according to HBV endemicity, based on the prevalence of hepatitis B surface antigen (HBsAg) in the population. Endemicity is classified high in countries with a general population HBsAg prevalence above 8.0%, intermediate where this prevalence is between 2.0% and 8.0%, and low where HBsAg prevalence is below 2.0% (36). High-prevalence areas include sub-Saharan Africa, central and south-east Asia, the Pacific and South America. Southern parts of eastern and central Europe, the Middle East and India are classified as intermediate prevalence and western Europe and North America are classified as low prevalence areas (27) (see figure 3).

Between May 2014 and April 2015 a total of 265 males African migrants were tested for HbsAg, since it was requested. In HBsAg positive patients the biochemical and virological activity of infection and the possible presence of co-infections (HCV, HDV, HIV) were evaluated.

Among the 265 subjects tested, 19 (7.1%) resulted HBsAg positive. All had an average age of 28 years (range 18-42). The HBsAg positive patients came from Mali: 4 (21%); Ghana: 4 (21%); Gambia: 3 (15.7%); Nigeria and Guinea Bissau: 2 (10.5%); Senegal, Somalia and Costa d’Avorio: 1 (5.2%)

Hepatitis B Virus (HBV) affects the liver and can result in chronic liver disease, which may lead to liver cirrhosis and hepatocellular carcinoma (HCC).
Only 3 patients infected by HBV had elevated alanine-aminotransferase (ALT) serum levels (average level was 202 IU/L, range 61-323). The others 16 patients had normal ALT serum levels. In the normal ALT group, the serum HBV-DNA were detectable by PCR-Real Time in 11 patients (68.7%); (average level 1.688.284 copies/mL; range: 96-170.000.000). In the last 5 patients (31.3%) of this group, HBV-DNA were undetectable (<20 copies/mL). In the 3 patients with elevated alanine-aminotransferase serum levels, we observed serum HBV DNA detectable by PCR-Real Time (average level 16.277 copies/mL; range 128-47.740).

Our study points out an intermediate prevalence of HBV-infection in migrant African people. Two remarkable aspects emerged by the study: the elevated number (13 cases, 68.4%) of young healthy carrier of HBsAg (average age: 26.4 years, range: 18-37) and the relative frequency (21%, 4 cases) of coinfection with Human Immunodeficiency Virus (HIV).

Another important experience has been conducted to assess the prevalence of tuberculosis in young migrants confined in the Centres for Identification and Expulsion (CIE) (38). In Italy, notification of TB cases has decreased annually by an average of 2.5% going from a rate of 9.2 notified TB
Figure 3: Geographic distribution of chronic hepatitis B virus (HBV) infection – worldwide, 2006*

* For multiple countries, estimates of prevalence of hepatitis B surface antigen (HBsAg), a marker of chronic HBV infection, are based on limited data and might not reflect current prevalence in countries that have implemented childhood hepatitis B vaccination. In addition, HBsAg prevalence might vary within countries by subpopulation and locality.


...cases per 100 000 population in 1995 to a rate of 5.8 in 2011 (this is just below the European trend which consisted of an annual decrease of 2.9% starting from a rate of 22.7 in 1995 to a rate of 14.2 in 2011). (25)

The breakdown of TB cases by place of birth shows 39.8% native, 58.3% foreign, while 1.8% is of unknown origin. Average age at diagnosis for native TB cases is 56.1 years versus 35.5 years for foreign people. According to the European Union case definition, Italy has this classification of TB cases (2012) as it follows: confirmed 21.5%, probable 12.2%, possible 66.2%. This is far below the standard of the 30 European countries which is respectively 61.9%, 7.4% and 30.7%. (25)

In June 2012, Medecins sans Frontières (MSF), in collaboration with local health authorities, designed a “Pilot project for early diagnosis, treatment and monitoring of tuberculosis in migrants hosted in closed Centres of Identification and Expulsion and consequently prevent the spread of the disease” to improve and strengthen the prevention, diagnosis and care of tuberculosis in 4 out of 13 immigration centres in Italy.

The objectives of the project were: 1) to evaluate the TB screening tool and to identify factors leading to loss to follow-up 2) to determine the number of TB cases and suspected TB cases in the screened population 3) to identify significant risk factors for active TB in this specific population.

The investigators provided TB training for local staff, administered TB screening questionnaires to all inmates at admission in collaboration with local health staff and facilitated referrals to TB centers. TB questionnaires consisted of verbal screening on symptoms proving active TB, previous history of TB or previous contact with a TB case.

From August 2012 to December 2013, 1931 migrants were enrolled; the majority were young adult men with an average...
The screened migrants came from 93 different countries origin. The most represented countries were Tunisia, Morocco and Nigeria. Among the migrants screened, 54 (2.8%) had positive questionnaires: the majority were men, but HIV co-infected transsexuals had the highest risk of having a positive questionnaire due to previous TB. Most frequent answers were: previous history of TB (35%) and chronic cough (33%). Twenty-three (42.6%) were referred to TB centers. Reasons for not being referred were (in order): CIEs operational limitations, physician decision and host’s refusal. Active TB was diagnosed in four individuals (0.2% among screened) (see Tables 3 and 4).

The results confirm the higher incidence of active TB among irregular migrants in closed centres compared to general population living in Italy. The overall yield of this intervention is in the range reported for other migrant TB screening programs in open contexts. Referral outside the CIEs was not optimal, mainly because of CIEs operational limitations: since a high number of positive questionnaires were not referred, in order to ensure universal access to secondary health care, more effort must be done by CIEs staff towards the completion of the diagnostic workup.

In the last five years there have not been performed screening programs for HIV infection in immigrants who have landed in

Table 3: Preliminary results of the MSF TB screening protocol (1st August 2012 – 30th April 2013)

<table>
<thead>
<tr>
<th>Center</th>
<th>Total new inmates</th>
<th>Total TB questionnaires (% among new inmates)</th>
<th>Positive TB questionnaires (% among new inmates)</th>
<th>Second evaluation (% among positive questionnaires)</th>
<th>TB (% among new inmates)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milano</td>
<td>547</td>
<td>541 (98.9)</td>
<td>24 (4.4)</td>
<td>8 (33.3)</td>
<td>1 (0.2)</td>
</tr>
<tr>
<td>Roma</td>
<td>889</td>
<td>880 (99.0)</td>
<td>19 (2.1)</td>
<td>11 (57.9)</td>
<td>1 (0.1)</td>
</tr>
<tr>
<td>Trapani</td>
<td>416</td>
<td>385 (92.5)</td>
<td>11 (2.6)</td>
<td>4 (36.4)</td>
<td>2 (0.5)</td>
</tr>
<tr>
<td>Caltanissetta</td>
<td>7978</td>
<td>(98.7)</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Total</td>
<td>1931</td>
<td>1884 (97.6)</td>
<td>54 (2.8)</td>
<td>23 (42.6)</td>
<td>4 (0.2)</td>
</tr>
</tbody>
</table>

Table 4: Clinical characteristics of active TB cases (1st August 2012 – 30th April 2013)

<table>
<thead>
<tr>
<th></th>
<th>Sex</th>
<th>Age (years)</th>
<th>Nationality</th>
<th>Localization</th>
<th>Sputum Microscopy</th>
<th>Treatment compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Milano</td>
<td>M</td>
<td>38</td>
<td>Morocco</td>
<td>Pulmonary</td>
<td>Negative¹</td>
<td>Good</td>
</tr>
<tr>
<td>Roma</td>
<td>M</td>
<td>42</td>
<td>Algeria</td>
<td>Pulmonary</td>
<td>Negative</td>
<td>Bad²</td>
</tr>
<tr>
<td>Trapani</td>
<td>M</td>
<td>18³</td>
<td>Morocco</td>
<td>Pulmonary</td>
<td>Negative</td>
<td>Bad²</td>
</tr>
<tr>
<td>Caltanissetta</td>
<td>M</td>
<td>33</td>
<td>Ghana</td>
<td>Pulmonary</td>
<td>Not done</td>
<td>Not evaluable³</td>
</tr>
</tbody>
</table>

¹ Diagnosed in prison (2012): in continuation phase treatment (5th month), released from the CIE for medical reasons.
² Escaped from Infectious Diseases Unit after 2 days of hospitalization.
³ Diagnosed in Palermo Infectious Diseases Unit (2012) with voluntary treatment interruption: re-started initial phase treatment inside the CIE.
⁴ Just landed in Lampedusa island: reported 1 year of antibiotic treatment in Morocco for an unspecified lung disease.
Sicily. Therefore, no reliable data is available. However, the observation and the perception of an increased risk of sexually transmitted infections in the I-migrants from Libya has led us to make, in Lampedusa, in the month of July 2011, a special screening for the diagnosis of HBV infection and HIV in two specific cohorts who reported different migration patterns (see Figure No. 4). The methodological limitations and sampling of the study do not allow an accurate and meaningful analysis of the data, however, it has been highlighted a relevant difference of prevalence among the population from Tunisia and Morocco than from Libya, with a history of prolonged forced permanence in the concentration camps (39). In fact, the Tunisian population screened (171 people) filed a single case of HBV infection; no case of HIV infection was detected. The 194 people from the Horn of Africa region and sub-Saharan Africa, who reported about an extended period of stay in the concentration camps in Libya, have been found to be infected with HIV in one case; a co-infection of HIV/HBV in one case; HBV infection in 4 cases.

As could be expected, migration is changing the epidemiology of HIV infection; indeed in 2013, 24% of new diagnoses of HIV infection has been reported in not Italian patients (40). In the same year, the incidence was 4.9 new cases per 100,000 among Italian residents and 19.7 new cases per 100,000 among foreign residents. The highest incidences of foreigners were observed in Lazio, Campania, Sicily and Sardinia. Among the foreigners, the highest proportion of cases has shown that women are infected through heterosexual (38.3%), while among Italians by homosexual males (45.9%).

The data reported by the AIDS Operational Centre (AOC) Institute of Health reflects the cases observed in our unit that receives the largest number of migrants with infectious diseases in Sicily; in the period between 2009 and 2014 we observed 138 new diagnoses of HIV infection: 77 (55.9%) in not Italian patients and 61 in Italian patients living in Sicily. In our experience, men represent 59% of cases; the average age is 27 years in the foreign patients and 32 years in the Italian ones.

Figure n°4: Main migratory routes in Africa

Adapted From: H. De Haas, Trans-Saharan Migration to North Africa and the EU: Historical Roots and Current Trends, Migration Information Source, November 2006
Conclusions

In the light of the experiences described and the data reported, it cannot be denied the theory of the “Healthy Migrant” who, in most cases, leaves his/her land in good health.

To understand the main objective of all activities for the protection of the health of migrant populations, it is very important to always remember the Universal Declaration of Human Rights which, in Article 25, points out: “Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services”.

All activities for reception and assistance in the various landing points (Lampedusa, Pozzallo, Licata, Rosolini and, more recently, Palermo and Catania), have always considered the right to health as a milestone and a starting point for all activities aimed at these populations. But this is not enough; In fact, the observation of what is happening in the foreign population without a valid residence permit or for those asking for international protection, highlights a worrying limitation of the so-called “determinants of health” well indicated by the World Health Organization (41).

Among these people there is a further critical element represented by the difficulty of access to health facilities and the limited and difficult fruition of them. The natural consequence of this phenomenon is the observation of serious delays in the diagnosis and treatment of infectious diseases, with very serious consequences for the patient and with possible risk for the community health: Just an individual problem?

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