

Special Article - Migrant Healthcare

Hepatitis C and Migration: A Public Health Challenge

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Magnitude of the Challenge

Hepatitis C (HCV) is a major cause of liver cirrhosis and hepatocellular carcinoma [1]. Globally between 130 and 150 million people are estimated to be infected with the virus [2,3], and around 500,000 people die each year from HCV-related liver diseases. Despite the burden HCV imposes on national healthcare systems and budgets, HCV has failed to attract the type and level of attention it calls for from health policy makers, healthcare workers, and indeed the public at large. HCV's relatively slow evolution and the fact that the symptoms associated with it are typically late in presenting have possibly detracted from it being seen as an urgent problem [4]. In Europe, where in 2013 over 30,000 new cases of infection were reported, there is agreement that HCV has been systematically under-reported, in part because of the lack of screening and under-reporting [5]. Major advances in treatment options, however, have helped to highlight the problem of HCV and a number of Calls for Action by the Hepatitis B and C Public Policy Association in 2010 [6], 2012 [7] and 2016 [8], WHO resolutions [9] and guidelines [10], as well as a meeting by the Viral Hepatitis Prevention Board [11] have all called for more attention to the problem. All these calls for action have mentioned the growing role of migration as a possible driver of the epidemic.

Migration and HCV in Europe

In 2015 alone, over one million migrants, refugees and asylum seekers arrived in Europe [12], adding to an existing migrant population of around 72 million people [13]. Many of them are from countries where both HBV and HCV are significantly more prevalent than in Europe. The contribution of migrants to the changing epidemiology of HCV in Europe has been referred to in a number of studies [14-16]. Proportionately high rates of HCV in migrant populations have been reported in Italy, the Netherlands, Sweden and the UK [17-20] and in 2014 the ECDC reported that in Spain the prevalence of HCV ranged between 0.4% and 0.9% among migrants from Latin America, 1.9% among migrants from North Africa and between 9% and 15% among migrants from sub-Saharan Africa and Eastern Europe [21]. Similarly in Germany, where between 23 and 37% of all reported HCV is in people of foreign nationality, migration from Turkey and Eastern Europe is thought to be an important factor in changing patterns of HCV [22].

Although rates of HCV among migrant populations typically reflect the prevalence of the disease in countries of origin, there are also reports that HCV rates among migrants in Europe are higher than in home countries [23]. This suggests that the migration process itself may prompt behaviors that expose migrants to a higher risk of HCV [14,24]. An earlier study of drug use in six European cities highlighted the extent to which drug dealers targeted the children of migrants who they saw as caught between two cultures, socially marginalized and vulnerable [25]. Migrants are also represented in other known HCV risk groups, such as prisoners [26], and men who have sex with men [27].

Barriers to Seeking Treatment for HCV

Many of the same social and behavioral factors that contribute to a heightened risk of HCV in migrants and ethnic minorities can equally affect migrants' health care seeking behavior and their interaction with the healthcare system. Migrants often feel marginalized from host country health systems and are reluctant to use them because of negative experiences they have had with healthcare personnel who they feel are not interested in their welfare or who do not want to understand them [28]. Stigma has also been highlighted as a barrier to HCV screening among migrants [29], and the fear of loss of anonymity associated with medical recording can be an obstacle to their active participation in healthcare initiatives. The fact that migrants are not always aware of what services are available to them does not help, especially where irregular migration is concerned [28].

A common feature among migrants and refugees is also self-perceived loss of power and difficulty in making key decisions on health and healthcare seeking. How common HCV is in countries of origin, how it is seen, and what are understood by migrants and refugees to be the sources of infection and its treatment are all factors in how migrants respond to HCV. Culturally defined attitudes to disease prevention and treatment vary widely and this can easily complicate public health initiatives; in the case of hepatitis some cultures do not have an equivalent name for the disease [30], and instead rely on terms for symptoms that can be typical of other diseases as well as HCV. Language is thus an important factor in the successful outreach to people from different cultures and providing effective care, even when and where translators are available. Related to this, research has shown that the lack of information materials in the languages of migrants can be a major barrier to generating the level of awareness needed in diseases prevention [29]. Migrants from countries with limited healthcare systems and low health literacy rates, moreover, tend to develop fatalistic attitudes to diseases for which there was little treatment in countries of origin, and some have difficulty conceptualizing diseases whose natural history is long and asymptomatic [31].

Conclusion

Mass migration into Europe is changing the epidemiology of HCV. To what extent countries are prepared to respond to the

challenge is not clear. The public health sectors' response to migration has been slow, and in the case of HCV there is little evidence of concerted action. Although studies [32] have shown the cost-effectiveness of screening migrants for HCV, only four countries in the EU have adopted migrant screening policies [33,34] and while there have been some advances in the form of migrant friendly hospitals, migrants on the whole continue to be ignored as a group that has special psychosocial as well as medical needs. If the goal of HCV eradication is to be achieved much more inclusive policies and practices will be required.

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