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EDITORIAL

Epidemiology of tuberculosis (TB) among migrants in the WHO European Region

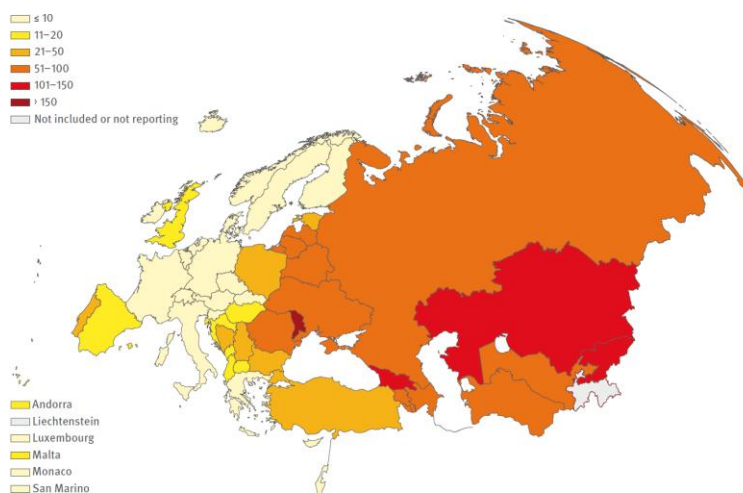
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TB does not respect any border. This is a concern as the incidence of multidrug-resistant TB (MDR-TB) continues to increase. Globally, TB remains a major public health problem. In 2012, an estimated 8.6 million people developed TB and 1.3 million died from the disease (including 320 000 deaths among HIV-positive people).

In the WHO European Region specifically, TB also continues to be a major public health issue. About 353 000 new TB cases and 35 000 deaths from TB were reported in 2012, mostly from eastern and central European countries (Fig. 1).

Fig. 1. Estimated TB incidence per 100 000 population, WHO European Region, 2012



Source: ECDC & WHO Regional Office for Europe (3)

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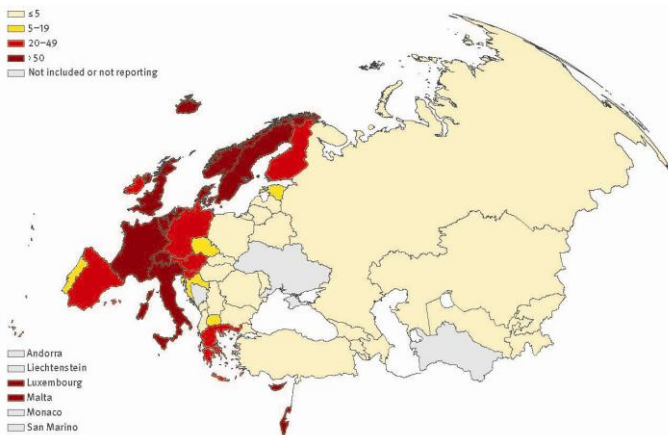
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Since the mid-2000s, TB incidence has fallen at an average rate of 5% per year. Nevertheless, notification rates in countries in which TB is a high priority have remained almost 8 times those in the rest of the region. TB is becoming increasingly difficult to treat in the WHO European Region. Since 2007 the rates of successful treatment for new and previously treated TB cases have continued to fall, from 72% and 50%, respectively, in 2005 to 66% and 47% in 2011. A recent study showed that the WHO European Region has the highest documented rate of MDR-TB in the world, both among new cases (35%) and previously treated cases (69%) (1). It is estimated that around 76 400 people in the region fall ill with MDR-TB every year. TB is a leading killer among people living with HIV, and this deadly combination is increasing in the WHO European Region.

In most settings, migrants are among the most vulnerable populations, placing them at greater risk for contracting and developing TB (2).

Fig 2. Percentages of notified TB cases of foreign origin among all TB cases, WHO European Region, 2012



Source: ECDC & WHO Regional Office for Europe (3)

TB cases of foreign origin represent 26.8% of all TB cases reported from European Union (EU)/European Economic Area (EEA) countries and only 2.3% from non-EU/EEA countries (Fig. 2). In many countries, TB cases of foreign origin represent a large majority, such as in Israel (90.0%), Norway (85.4%), Sweden (85.0%), Malta (83.7%), Iceland (81.8%), Cyprus (75.4%), Switzerland (74.5%), the Netherlands (73.2%), Luxembourg (71.1%) and the United Kingdom (70.0%). This can be seen as an indication of good access to TB diagnosis in these countries and a commitment on their part to the global effort to control TB. The smaller number of

TB cases reported by origin may also be related to the recording and reporting systems in these countries and/or access to diagnosis and treatment, or to similar rates of TB in the origin and recipient countries.

Strong evidence of association between MDR-TB and the origin of TB patients in the WHO European Region was identified in the 2014 European Centre for Disease Prevention and Control (ECDC) TB surveillance and monitoring report (3). In 14 countries out of 18 that reported MDR-TB by origin, foreign-born patients had a higher probability of having MDR-TB than natives, and in 10 of the countries this association was statistically significant (Belgium, the Czech Republic, Germany, Italy, Lithuania, Poland, Portugal, Spain, Turkey and the United Kingdom). The Republic of Moldova was the only country in which native patients had a higher risk of harbouring MDR-TB strains. It should be noted that all the MDR-TB cases notified in Denmark, Iceland, Ireland and Norway were found to be in patients of foreign origin, with no cases being observed among natives.

Despite the fact that TB among migrants is occasionally highlighted as problematic by political or populist movements, there is a lack of data to indicate significant TB transmission from migrants to the native population; in fact, most studies indicate that transmission of TB occurs within migrant communities themselves (4). This being the case, with targeted action the opportunity exists for TB programmes to initiate and scale-up screening for latent and active TB, to increase availability of rapid diagnostic tests for MDR-TB and to ensure access to effective treatment for all forms of TB.

Under the Wolfheze Transborder Migration Taskforce, in 2012 the WHO Regional Office for Europe facilitated discussions among national TB programme managers and finalized a minimum package for cross-border TB control and care (5). In addition, through various mechanisms, including International Health Regulations (IHR) and direct contact with the national programmes, the WHO Regional Office has been linking health authorities within and beyond Europe. A new initiative is currently being undertaken to use an electronic consilium tool (e-Consilium) to facilitate cross-border collaboration and consultation with clinicians.

In light of increasing rates of MDR-TB, both in the WHO European Region and globally, intensified action will continue to be necessary in order to prevent and control TB at all levels, and in order to reach the Post-2015 Global Strategy for Tuberculosis goal of TB elimination.

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OVERVIEW

Chagas disease, update on a migration related tropical disease in Europe

Dr Levente Emődy, Professor, Department of Medical Microbiology and Immunology, University of Pécs Medical School

On this year's World Health Day (7 April), WHO devoted special attention to vector-borne diseases. Chagas disease (historically called American trypanosomiasis) is a typical example of a vector-borne infection. With the increasing Latin American migration to non-endemic areas, Chagas disease has appeared as an emerging infectious disease in non-endemic continents, including Europe. In contrast to the endemic American areas, the means of transmission in Europe is characteristically non-vector-borne (direct). European-level, harmonized bodies designed to cope with this emerging public health problem have been created by WHO, the European Centre for Disease Prevention and Control (ECDC) and leading experts in the field of Chagas disease research and control.

Chagas disease – described by the Brazilian physician Dr Carlos Chagas in 1909 – is a protozoal infection caused by *Trypanosoma cruzi*, affecting the populations of Latin American countries. In endemic areas it is typically a vector-borne disease transmitted by Triatomine bugs from infected individuals or animals to a new host. Other means of transmission include: blood transfusion; transplantation of organs, tissues or their components; breastfeeding; and

congenital transmission, which occurs when the parasite crosses the placenta during pregnancy. The infection may also be foodborne. The acute disease phase presents itself most frequently with mild and non-typical symptoms (fever, malaise, swelling of one eye if the bite is nearby, a red and swollen area around the bite). Non-treated infections frequently develop into a chronic phase, eliciting heart failure and neurological or gastrointestinal manifestations. Blood tests to show the parasite or its genetic material, or detection of specific antibodies to the pathogen may confirm the diagnosis. It is also possible to reveal the parasite through xenodiagnosis. In this case, non-infected bugs take a blood meal from the patient, after which the parasite is sought in the bug's faeces. Treatment with nifurtimox or benznidazole is recommended for all acute infections, congenital infections, for immunocompromised individuals, and for children with chronic infections. In the case of adults presenting with chronic infection, consultation is advised regarding possible treatment with anti-parasitic agents; however, pregnancy is a clear contraindication to anti-parasitic intervention. In the chronic phase, with organ system manifestations, symptomatic therapy may also be helpful, following consultation with the relevant specialist.

In endemic areas Chagas disease accounts for significant morbidity (about 10 million patients) and mortality, and therefore also results in considerable economic loss (1). The emergence of the disease through increasing Latin American migration to non-endemic areas necessitates particular preparedness among health care personnel and also deserves the attention of the public. As the infection can remain symptom-free for decades, Latin American migrants may be not aware of the hazard they pose to the population of the receiving country. Furthermore, unregistered illegal migrants remain entirely outside the scope of the health care system. In Europe, spread of infection occurs by direct transmission of the parasite, rather than by means of vector-borne transmission.

As already mentioned, direct transmission can take place via blood transfusion, transplantation procedures, and transplacental transmission of the *Trypanosoma*. It is therefore highly important to diagnose and treat the infection in migrants, and exclude positively diagnosed individuals from blood, organ, tissue and cell donations.

Several publications have examined the problem of Chagas disease in Europe, including scientific papers in journals such as *Eurosurveillance*, Europe's journal on infectious disease epidemiology, prevention and control. In one such paper it was reported that by 2009, 4290 diagnosed cases of Chagas disease had been recorded among Latin-American immigrants in 9 European countries, with a prevalence of 1.3 per 1000 resident migrants from endemic countries (2). The prevalence in undocumented migrants may be even higher. The estimated number of congenital Chagas disease cases ranges between 20 and 183 in the countries involved in the 2011 study, in which the authors called for measures to tackle the problem at European level.

In 2010 WHO released a statement on Chagas disease in Europe, summarizing the recommendations set out by European governmental representatives and technical experts at an informal meeting (3). The recommendations included:

- setting up an integrated surveillance system to aggregate data and information about Chagas disease provided by European national health authorities;
- converting previous national technical recommendations into public health decisions;
- implementing strict guidelines on control measures for blood banks and organ transplant systems to eliminate the risk of Chagas disease transmission;

- testing target groups, such as women of child-bearing age and patients with heart conditions at risk of having been infected previously in endemic countries;
- implementing early detection practices and treating congenital transmission patients;
- improving access to diagnosis and medical care for anyone coming from areas in which Chagas disease is endemic;
- enhancing the capacity of national health systems to correctly diagnose, manage and treat Chagas disease; and
- harmonizing and validating diagnostic procedures through appropriate guidelines, with the support of relevant public health institutions.

At the 10th Workshop on Chagas Disease held in Barcelona on 6 March 2014 it was emphasized that Chagas disease needs to be considered as a worldwide public health issue that now includes countries of the WHO European Region (4). Leading experts from around the world overviewed the latest advances in the treatment of Chagas disease and discussed existing health policies. It is estimated that between 68 000 and 122 000 inhabitants could be infected in Europe. Despite this situation, no European-wide legislation exists to address the problem. Dr Joaquim Gascon, a leading expert in the field stated that "Apart from the lack of European legislation, we are faced with additional challenges that are slowing the progress being made in the fight against Chagas disease". He also emphasized the lack of experience on the part of health practitioners in the diagnosis and management of the disease.

To conclude, the following quote from a recent technical report of the ECDC is particularly relevant (5):

In Europe, Chagas disease is not systematically monitored, but available data suggest that prevalence rates are high enough in some countries to warrant concern. Spain, Italy, the Netherlands, the United Kingdom, Germany and France have the highest number of estimated cases in Europe. Key issues to be addressed are preventing transmission through blood, organ, tissue and cell donation by Latin American donors and congenital transmission in Latin American pregnant women who are infected with *T. cruzi*. However, only France, Italy, Spain and the United Kingdom are currently addressing transmission risks. There is a need to improve awareness and detection of Chagas disease in Europe and to improve access to health care for both legal and irregular Latin American migrants, to ensure that the disease is diagnosed and treated.

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NEWS

The EUPHA Granada Declaration calls upon all European governments to protect the health of migrants and ethnic minorities

(http://www.ephpa.org/IMG/pdf/Granada_Declaration.pdf)

In April 2014 in Granada the Andalusian School of Public Health hosted the 5th European Conference of the European Public Health Association (EUPHA) on Migrant and Ethnic Minority Health. Throughout the four-day event, 350 participants attended 12 workshops, 5 plenary sessions, 96 oral presentations and 120 poster presentations that covered different aspects of health migration.

The conference addressed the living standards of migrants in Europe and the impact of the current economic and financial crisis on migrants' lives and their access to health care.

The Granada declaration

As a result of the conference, the Granada declaration was adopted. This document reiterates the importance of

government cooperation to reduce inequities in Europe. In the context of the economic crisis, it highlights that migrants are one of the groups most negatively affected by the cuts on health and social services. Furthermore, in some European countries the crisis has led to a reduction of migrants' entitlements to public services.

The Granada declaration addresses also the determinants of health. Migrants and ethnic minorities are frequently exposed to poor living and employment conditions. Tackling the social determinants of health, as the access to good quality jobs, is essential to improve their health and wellbeing. Finally, this document calls for urgent action to avoid the raise of xenophobia, discrimination and violence against migrants and ethnic minorities in the European countries.

World Health Day 2014: Preventing vector-borne diseases

“Small bite, big threat”

(<http://who.int/mediacentre/news/releases/2014/small-bite-big-threat/en/>)

István Szilárd, Chief Scientific Adviser and coordinator of the ERASMUS Lifelong Learning Program co-financed CHANCE project, University of Pécs Medical School

Each year since 1950, the 7th day of April – marking the founding of WHO – is dedicated to global health as World Health Day. Its main aim is to draw worldwide attention to a subject of major importance to health and health threats globally. In 2012, the subject was ageing and health; in 2013 healthy blood pressure was the focus of the programme worldwide.

On 2 April 2014, WHO issued a declaration in Geneva.

“A global health agenda that gives higher priority to vector control could save many lives and avert much suffering. Simple, cost-effective interventions like insecticide-treated bed nets and indoor spraying have already saved millions of lives. No one in the 21st century should die from the bite of a mosquito, a sandfly, a blackfly or a tick” stated Dr Margaret Chan, WHO Director-General.

Discrimination – a European health hazard

Åsa Nihlén, Human rights focal point, WHO/Europe

Why human rights perspectives matter in communicable disease prevention and control among migrant populations in Europe today

In today’s Europe, a person’s health protection and access to health services are still very much a matter of national boundaries and legal status. This complicates a migrant’s right to health and sometimes leaves people on the move without access to health services in the receiving country. Even when access is granted, xenophobia and stereotypes may cause discriminatory practices within the health system, which in turn creates stigma and negatively affects a migrant’s health-seeking behaviour.

Public health measures need to be as inclusive as possible in order to be effective. Discrimination and exclusion are a public health hazard. This is particularly true in the case of communicable diseases, as these can spread rapidly within and across borders. Denying migrants their right to vaccinations, or not granting inclusive access to treatment and control programmes for some of the WHO European Region’s most common infectious diseases, infringes not only on the right to health of the migrant, but also that of populations.



Temporary immigration centre in Sicily, Italy, 2014.
WHO/Sara Barragán.

At one extreme of the discussion of public health inclusiveness is the ongoing debate over forced testing and treatment of certain diseases; should migrant reception facilities and related health services provide compulsory screening for certain communicable diseases? The public health community is split, with arguments concerning ethics, but also efficiency. The human rights framework is clear on this matter. Any screening for communicable diseases must always be carried out with informed consent, adequate pre-test information or counselling, post-test counselling, protection of confidentiality and referral to health care services.

Evidence – mainly from the HIV epidemic – has also shown that testing must be voluntary and that informed choice is central to creating a climate of confidence and trust between the person being tested and the service providers, which in turn is crucial for any follow-up action.

The Special Rapporteur on the right to health reported to the United Nations General Assembly in 2009 on the right to health and informed consent, stating that guaranteeing informed consent is a fundamental feature of respecting an individual's autonomy, self-determination and human dignity in an appropriate continuum of voluntary health-care services. The report also specified that public health measures should always strive for voluntary participation to be fully effective and minimize any compromise in terms of

individuals' rights to privacy and self-determination. According to the 1985 Siracusa Principles, any restrictions to this must be non-discriminatory; in accordance with the law, legitimate and necessary; and the least restrictive reasonably available alternative. Importantly, restrictions must be fully respectful of dignity, human rights and fundamental freedoms.

Certain groups deserve special consideration in terms of the protection of informed consent, as a result of vulnerabilities stemming from economic, social and cultural circumstances. One such group is migrants, regardless of their legal status.

For readers interested in human rights perspectives relating to migrants' health issues, I would recommend the reading the reports of the United Nations Special Rapporteur on the Right to Health, which encompass a wide selection of topics. These reports do not always exclusively cover migrant health issues, but the themes are always applicable and many perspectives and arguments can be taken from them to enrich the discussion on migrant health rights in Europe today.

It is possible to access these reports via the Office of the High Commissioner for Human Rights website.

(<http://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx>)

Saving lives of migrants in the Mediterranean: new European Union (EU) search and rescue rules

Matteo Dembech, Consultant, Public Health Aspects of Migration (PHAME) project, WHO/Europe

The policies of the Union – on border checks, asylum and immigration – and their implementation should be governed by the principle of solidarity and fair sharing of responsibility among Member States.

In October 2013, a working group entitled "Task Force Mediterranean" was set up by the EU in order to identify tools for preventing boats overloaded with migrants from sinking and thus the occupants from drowning while attempting to reach EU territory by crossing the Mediterranean Sea. The numerous tragedies at sea of recent years called for action and one of the goals of the Task Force was to reinforce border surveillance and to contribute to assuring the protection of migrants in the Mediterranean.

Article 80, Treaty on the functioning of the European Union

On 13 May 2014 the Council of the European Union adopted new rules for the surveillance of the EU's external sea borders by introducing a number of elements intended to reduce life-threatening risks related to so-called boat migration. The new binding rules apply to all Frontex operations and include more extensive provisions on the protection of human rights. Indeed, the rules mandate medical, legal and mediation staff presence on board rescuing vessels and minimize the possibility of push-backs and punishment of occasional rescuers.



Migrants being rescued in Sicily, Italy, 2013.
WHO/Matteo Dembech

The migration process often exposes migrants to an accumulation of disadvantages, including harmful situations

and vulnerability. The new rules pay specific attention to vulnerable groups, whereby “the participating units shall address the special needs of children, including unaccompanied minors, victims of trafficking, persons in need of urgent medical assistance, disabled persons, persons in need of international protection and other persons in a particularly vulnerable situation”.

Can we protect the health of migrants? Can we reduce health inequities? Can we improve inter-country governance? These are a few questions that countries and international organizations are asking themselves when confronted with the challenges posed by sudden migration. The new EU search and rescue rules are part of a long-needed set of reforms aiming to improve health for all, reduce health inequities and ultimately save the lives of migrants. This is further confirmation that recognition at the macro level and the involvement of the whole government and the whole society must be positioned at the base of the pyramid for successful reforms.

EVENTS

Who: International Migration, Integration and Social Cohesion in Europe (IMISCOE)
What: 11th annual conference, Immigration, Social Cohesion and Social Innovation
When: 27-29 August 2014
Where: Madrid, Spain
Link: <http://www.imiscoeconferences.org/>

Who: DEMIG – core funded by the European Research Council (ERC)
What: Determinants of International Migration
When: 23-25 September 2014
Where: Wolfson College, University of Oxford, United Kingdom
Link: <http://www.imi.ox.ac.uk/projects/demig/2014-conference>
DEMIG project: <http://www.imi.ox.ac.uk/projects/demig>

Who: Nordic Migration Research
What: 17th Nordic Migration Conference, Flows, places and boundaries – migratory challenges and new agendas
When: 13-15 August 2014
Where: Copenhagen University, Copenhagen, Denmark
Link: http://www.sfi.dk/17th_nordic_migration_conference-12235.aspx

Who: Institute for Social Science in the 21st Century
What: Crisis, Mobility and New Forms of Migration, International Conference
When: 2-4 September 2014
Where: University College Cork, Cork, Ireland
Link: <http://migration2014.wordpress.com/>

PUBLICATIONS

Guidelines for the screening, care and treatment of persons with hepatitis C infection

April 2014

http://apps.who.int/iris/bitstream/10665/111747/1/9789241548755_eng.pdf?ua=1

Worldwide, more than 185 million people are infected with the hepatitis C virus (HCV). It is predicted that one third of those who are chronically infected develop liver cirrhosis or hepatocellular carcinoma. Despite the high prevalence of the disease, most people infected with the virus are unaware of their infection. Treatment is successful in the majority of cases, but is costly, requires regular laboratory testing to monitor treatment response, and is associated with a high rate of side-effects caused by existing medications. Thus, very

few individuals receive treatment for HCV in most low- and middle-income countries. A number of new compounds are in various stages of development and are expected to cure more than 90% of individuals with HCV infection.

These are the first guidelines dealing with hepatitis C treatment produced by WHO and they complement existing guidance on the prevention of transmission of bloodborne viruses. They are intended for policy-makers and government officials who are developing programmes for the screening, care and treatment of individuals with HCV infection, especially in low- and middle-income countries.

The guidelines also serve as a framework and guidance for health care providers managing patients infected with HCV and for the establishment or expansion of related health care services.

From malaria control to malaria elimination: a manual for elimination scenario planning

April 2014

http://apps.who.int/iris/bitstream/10665/112485/1/9789241507028_eng.pdf

Since the mid-2000s, substantial progress has been made in controlling malaria worldwide through large-scale implementation of effective malaria interventions. Since 2000, there has been a 42% reduction in malaria mortality rates globally. However, existing WHO guidance for elimination of malaria comprises only limited discussion of the technical and operational feasibility of achieving this goal.

The Elimination Scenario Planning (ESP) manual is focused on what is needed to achieve very low levels of malaria transmission, and was designed to integrate with the overall programme planning cycle and complement other programme management and planning tools. It provides

malaria-endemic countries with a comprehensive framework to assess different scenarios for moving towards the elimination of malaria, depending on programme coverage and funding availability. It also helps countries to set realistic timelines and provides essential knowledge for strategic planning in the long term.

The ESP manual was produced with partners from the Clinton Health Access Initiative, Imperial College United Kingdom, Johns Hopkins University, the University of Southampton and the Global Health Group at the University of California. The manual addresses the technical, operational and financial factors affecting malaria control, and is applicable to programmes at any point on the path to malaria elimination.

The manual can be used in conjunction with malaria transmission model software, which allows users to explore the effect of a range of intervention packages on the malaria burden in their country and to understand better what levels of intervention might be needed to make elimination possible.

The European Centre for Disease Prevention and Control (ECDC) launched its technical report: "Assessing the burden of key infectious diseases among migrant populations in the EU/EEA"

May 2014

The comprehensive report presents the main findings and conclusions of an ECDC project. It provides information as well as could be used as essential source about the burden of infectious diseases among migrants in the European Union (EU)/European Economic Area (EEA) countries.

The project used data from the following data sources: the European Surveillance System, a literature review and a survey of disease focal points in EU/EEA countries. It covers HIV, tuberculosis (TB), hepatitis B and C, gonorrhoea, syphilis, measles, rubella, malaria and Chagas disease.

The most important conclusion of the report is that at a population level most migrants are healthy, and are only more affected by certain conditions such as HIV positivity and diseases such as TB.

The report highlights the need for better data collection and more research to improve understanding of the epidemiology of infectious diseases among migrants in Europe.

The full report is available on the website of the ECDC.

(<http://www.ecdc.europa.eu/en/publications/Publications/assessing-burden-disease-migrant-populations.pdf>)

An executive summary was also published.

(<http://www.ecdc.europa.eu/en/publications/Publications/assessing-burden-disease-migrant-populations-summary.pdf>)

RECOMMENDED READING

Nuttal 2005

International Health Regulations (2005): taking stock. Bull World Health Organ. 2014;92:310
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Reid et al. 2014

The immunization programme that saved millions of lives. Bull World Health Organ. 2014; 92:314–315
(<http://www.who.int/bulletin/volumes/92/5/14-020514.pdf?ua=1>)

Fleck 2014

Collaboration is key for new global tuberculosis strategy. Bull World Health Organ. 2014; 92:316–317
(<http://www.who.int/bulletin/volumes/92/5/14-030514.pdf?ua=1>)

Alvarez-del Arco and the Study Working Group, 2014

HIV testing policies for migrants and ethnic minorities in EU/EFTA Member States. Eur J Public Health (2014) 24 (1): 139-144.
(<http://eurpub.oxfordjournals.org/content/24/1/139.full.pdf+html>)

OPINION

The following articles represent the opinion of the author(s) and publications and do not necessarily represent the view of WHO, University of Pécs or the Editorial Board of this newsletter.

Dengue fever risk prediction for the World Cup in Brazil

It is estimated that about a million fans will travel to the 12 different cities hosting matches during the World Cup in Brazil. Scientists have published an analysis in *The Lancet Infectious Diseases* to call the attention of the authorities to possible outbreaks of the mosquito-borne dengue fever during this grand-scale, crowd-mobilizing event.

The threat is real, given that Brazil recorded more than 7 million cases of dengue fever between 2000 and 2013; a

higher record of reported cases than anywhere else in the world. This viral infection can cause a life-threatening illness and unfortunately there are no licensed vaccinations to prevent the problem.

High-risk alerts were triggered by the probabilistic forecast system developed for the north-eastern cities. The system can predict outbreaks and warn authorities to prompt them to implement the necessary migration and control actions.

(<http://www.bbc.com/news/health-27441789>)

([http://www.thelancet.com/journals/laninf/article/PIIS1473-3099\(14\)70781-9/fulltext](http://www.thelancet.com/journals/laninf/article/PIIS1473-3099(14)70781-9/fulltext))

Middle East respiratory syndrome (MERS): virus on the Plane

According to Public Health England (PHE) a passenger travelling on 24 April on BA flight 262 from Riyadh, passing through Heathrow and heading to Chicago, has been infected with MERS (Middle East respiratory syndrome).

PHE claims that chances of passengers contacting the virus is "extremely low".

Following the accident, hundreds of passengers flying with the same plane have been contacted and examined.

(<http://www.dailymail.co.uk/news/article-2619360/Heathrow-passengers-tracked-health-chiefs-American-passenger-flight-diagnosed-killer-Middle-Eastern-virus-derived-camels.html>)

What is MERS?

MERS, defined by the WHO as "Middle East respiratory syndrome" (MERS), is a viral respiratory disease caused by a novel coronavirus (MERS-CoV) that was first identified in Saudi Arabia in 2012. Coronaviruses are a large family of viruses that can cause diseases ranging from the common cold to Severe Acute Respiratory Syndrome (SARS)". MERS causes fever, coughing, shortness of breath,

pneumonia and kidney failure. It is found mostly in bats and camels.

Latest figures of WHO show 345 reported cases and 107 ending with mortality since 2012.

According to the PHE the period between exposure to MERS-CoV and when symptoms might develop is up to 14 days.

WHO recommendations

Infection prevention and control measures are critical to prevent the possible spread of MERS-CoV in health-care facilities. Health-care facilities that provide care for patients suspected or confirmed to be infected with MERS-CoV infection should take appropriate measures to reduce the risk of transmission of the virus from an infected patient to other patients, health-care workers, and visitors. Health-care workers should be educated, trained, and refreshed with skills on infection prevention and control.

(http://www.who.int/csr/bioriskreduction/infection_control/publication/en/)

(http://who.int/csr/disease/coronavirus_infections/MERS_home_care.pdf?ua=1)

WHO encourages all Member States to enhance their surveillance for severe acute respiratory infections (SARI) and to carefully review any unusual patterns of SARI or pneumonia cases. WHO urges Member States to notify or verify to WHO any probable or confirmed case of infection with MERS-CoV. WHO also encourages countries to raise awareness of MERS and to provide information to travellers as below. Information on the identification and investigation of cases:

(http://www.who.int/csr/disease/coronavirus_infections/MERS_CoV_investigation_guideline_Jul13.pdf)

Procedures for handling laboratory samples:
(http://www.who.int/csr/disease/coronavirus_infections/MERS_Lab_recos_16_Sept_2013.pdf?ua=1)

Guidelines for clinical management:
(http://who.int/csr/disease/coronavirus_infections/InterimGuidance_ClinicalManagement_NovelCoronavirus_11Feb13u.pdf?ua=1)

Pediatric Drug-resistant Tuberculosis in Madrid: Family Matters

Begoña Santiago and his co-authors are publishing their research in The Pediatric Infectious Disease Journal in April 2014. The retrospective study analyses

the case histories of children with TB diagnosis in 22 hospitals between 2005 – 2010. According to their results INH and MDR TB were showing higher rates among children born to foreign parents.

(http://journals.lww.com/pidj/Citation/2014/04000/Pediatric_Drug_resistant_Tuberculosis_in_Madrid_.3.aspx)

Reaching migrants is key to success in the global fight against TB: International Organization for Migration (IOM)

On the 2014 World TB Day (21 March) IOM launched a paper providing an overview of to what degree migrants are exposed to TB. Not only do they often suffer from marginalized social status; lack of access to health care is also a significant factor, especially for irregular migrants. They are

also afraid of being stigmatized because in many countries they risk deportation if they are found to have TB. "In an increasingly mobile world, it is vital that migrants are put at the centre of initiatives to combat the spread of TB and that low and high incidence countries work together to achieve a TB free world," says IOM Director General William Lacy Swing.

(<http://www.iom.int/cms/en/sites/iom/home/news-and-views/news-releases/news-listing/reaching-migrants-is-key-to-succ.html>)

INFORMATION SOURCES

International Association for Medical Assistance to Travellers (IAMAT) Travel Health Advice for Brazil's 2014 World Cup

(<http://www.iamat.org/blog/index.cfm/2014/3/31/Travel-Health-Advice-for-Brazils-2014-World-Cup>)

The IAMAT recently published an overview of the health

Centers for Disease Control and Prevention (CDC) Middle East respiratory syndrome (MERS) in the Arabian Peninsula

(<http://wwwnc.cdc.gov/travel/notices/alert/coronavirus-saudi-arabia-qatar>)

The CDC Travellers Health website provides an updated

WHO Global Alert and Response (GAR) Coronavirus infections

(http://www.who.int/csr/don/archive/disease/coronavirus_infections/en/)

The WHO Global Alert and Response website is also providing an overview globally on the spread of the

hazards that visitors to the 2014 Soccer World Cup in Brazil may encounter. It provides information about vaccinations and vector-borne diseases, along with not directly health-related advice on how to prevent problems or inconvenience during their trip. It also provides guidance on how to access medical services.

overview on the epidemic situation relating to Middle East respiratory syndrome (MERS), a coronavirus presenting a new health hazard for travellers to Middle Eastern countries. The article gives a real estimation of the risk and provides advice and hygiene protocols for prevention, along with suggestions on how to reach health services if showing early symptoms of the disease.

coronavirus infections. Travelers and health workers can easily gain the necessary information. It is especially important that when health service providers encounter MERS like symptoms in migrants, they check whether the migrant has arrived from a region where the disease is present.

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