TB an “imported” disease in Europe: manipulated perception ?

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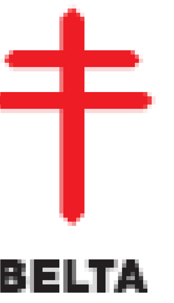


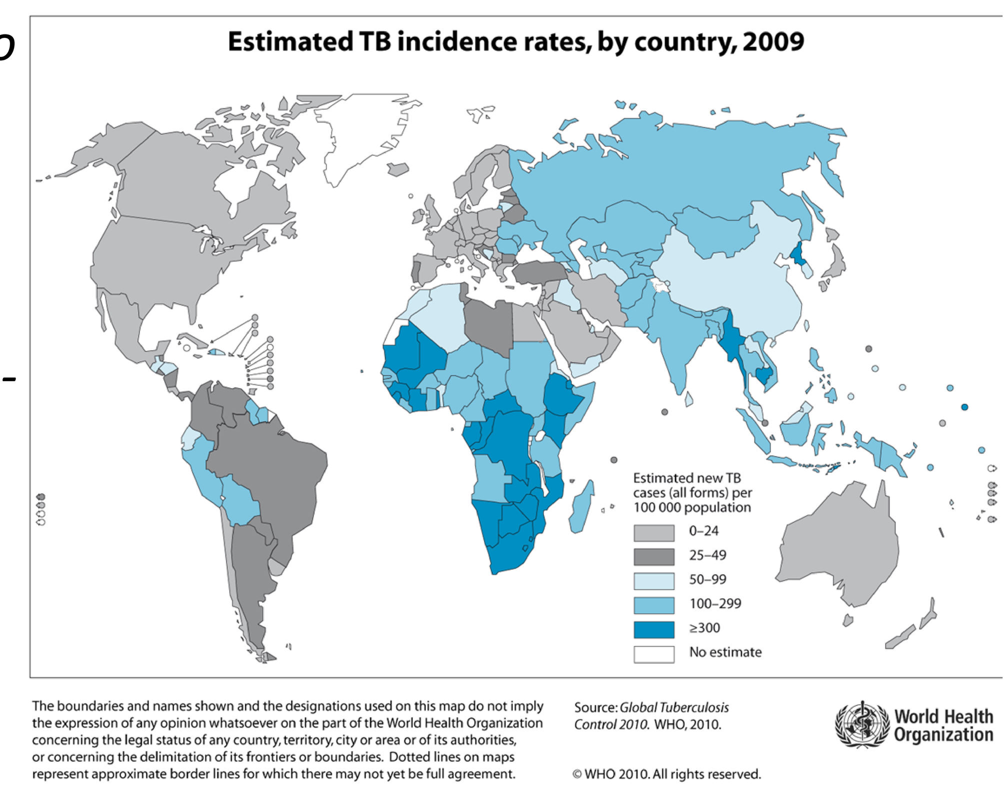
Introduction

These days, TB in low incidence countries in Europe is often represented as an imported disease, the vector of import alleged to be the incoming migrant populations, with big proportions of cases found in “foreign borns”. Migration is therefore often expressed as the strongest factor for the perseverance of TB in the EU.
But is this a true representation of reality or a manipulated one, influenced by increasing xenophobic tendencies in Europe ? Why this stubborn focus on migration when from the beginning we all knew that poverty and living conditions are the major contributing factor in the development of TB ?

History says

Robert Koch[1] stated as early as 1901 that *“Social misery does indeed go far to foster tuberculosis...the bad domestic conditions under which the poor have to live favours tuberculosis... It is to the abolition of these conditions that we must first and foremost direct our attention if we wish to attack the evil at its root, and to wage war against it with effective weapons”*

Janssens PG and colleagues[2] from the Tropical Institute of Antwerp stated in a more recent study that “*it is safe to say that Tuberculosis was not a very common problem in Africa, before the European invasion went looking for slaves and ivory*”. That the bacteria existed on the continent is beyond doubt, yet it was not causing the millions of deaths it does today. Africa is currently the hardest hit continent.



Gyselen A (former president of the IUATLD) et al[3] were of the opinion that “*colonizers, expedition armies, missionaries and development workers brought many indigenous people in contact for the first time with the “white plague” of white men”.*

In the same time period as “the scramble for Africa” took place, with mass migration towards the continent, Europe was hit by an enormous TB epidemic, with around 16.000 deaths a year in Belgium by the end of the 19th century.

So, a good question could be: **WHO imported WHAT to WHERE ?**

Worldwide DNA-strain typing databases will teach us more about the historical travelling of the *Mycobacterium tuberculosis* and its migration patterns. But even in the very unlikely scenario that research shows that Europeans did not import the bacteria into the African continent on a mass scale, they did import or create the social living conditions and poverty in which the bacteria could easily breed and linger.

Refocus on the real problem / Shift of attention

Evidence shows that among foreign-born persons in big cities (Manhattan[4], Brussels[5]) tuberculosis is largely caused by reactivation of latent infection, even years after arrival in their new home country.

An important research question is **“Why do migrants reactivate their latent infection ? ”**. We all know one is not supposed to reactivate one’s latent infection. Only a 10% of infections develop towards active TB, mostly due to a weakened immune system.

Attention must now be focused on the social determinants that cause reactivation. We have no evidence that these would be any different from those of the non-migrant population or for Europeans at the end of 19th century :

- poor living conditions, poor housing, crowding
- poverty and bad nutritional status
- limited possibilities to acquire an income and if income is acquired it’s low
- limited access to education especially higher education
- multiple stress factors influencing immunity: migration stress, document stress, xenophobia stress, dietary stress, climate stress,...

TB programmes focus mainly on screening for active disease and/or latent tuberculosis infection followed by effective treatment or preventive therapy. This solely medical, pharmaceutical approach has to be urgently complemented with improvement of living conditions and prevention of social misery amongst our migrant populations (and other risk groups).

Reimanova and Gustafson argue excellently in several papers[6,7] that the absence of policies that address poverty-related disadvantages among immigrants makes these populations more vulnerable to the reactivation of their tuberculosis long after they have been exposed in their countries of birth. Effective health prevention policy for tuberculosis within the immigrant population must attend to their poverty and other social determinants of health

Conclusion and suggestion

By de-racialising and de-medicalising the epidemic and looking at the common social determinants for transmission and reactivation EU countries could be more effective in preventing active cases and thus prevent transmission and treatment costs.

Suggested is that by improving majorly the reception of our guests, like a real host, we will prevent reactivation more effectively than all screening programmes together.

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