Imported Infections

V K E Lim, FRCPath, Department of Medical Microbiology, Faculty of Medicine, Universiti Kebangsaan Malaysia, P O Box 12418, Kuala Lumpur, Malaysia

One of the consequences of globalisation and international travel is the threat of imported infections. The article in this issue[1] on imported malaria is a timely reminder of the dangers posed by such infections to Malaysia. There are over a million migrant workers in the country both legal and illegal. In addition Malaysia receives several million tourists annually. Movements of large numbers of people is a potent force in the emergence and spread of infections[2]. Migrants and travellers may not only carry with them the microbial pathogens but also the arthropod vectors that transmit them. Migrants also bring with them their cultural traditions and behaviour patterns which can influence their capacity to spread the disease to the indigenious populations. Their social standing and economic position often result in living conditions for migrants that are less than ideal. Overcrowded slums without potable water supply or sewage facilties contribute to the spread of many respiratory and gastrointestinal infections. The migrants also change the environment by clearing land for agricultural or building purposes and this change to the ecology of the environment can have profound effects on vector populations.

The Special Task Force for Foreign Workers, Ministry of Home Affairs reported that as of 1 May 1996 there were over half a million foreign workers in Malaysia. The majority were from South East Asia and South Asia. The greatest numbers came from Indonesia followed by Bangladesh and the Phillipines. There were also foreign workers from Thailand, Pakistan, India, Sri Lanka, Myanmar. Nepal and Nigeria. These are the legal migrant workers. In addition there is a sizeable population of illegal migrant workers which is estimated to be in the region of one million persons. These workers come from countries where certain important infections are very prevalent.

In 1992, The World Health Organisation reported over 2 million cases of malaria in India, nearly 400,000 in Sri Lanka, over 200,000 in Vietnam and over a hundred thousand cases each in Thailand, Phillipines, Myanmar, Bangladesh and Pakistan. Resistance to antimalarials has developed in South-East Asia. In Thailand there are indications that 50% of cases in certain border areas no longer respond to mefloquin and that sensitivity to quinine is diminishing in areas of Thailand and Vietnam[3]. Although leprosy is becoming uncommon in may countries including Malaysia, it is still a major problem in some countries of this region. In 1995 it was estimated that India had some 680,000 cases of leprosy, Indonesia 60,000 cases, Bangladesh and Myanmar 30,000 cases each[4]. The World Health Organisation also reported that in 1995 the prevalence of curable sexually transmitted diseases among adults aged 15 - 49 years in South and South-East Asia was 128 per 1000 population, the second highest among the regions of the world. It is estimated that the largest numbers of new cases of syphilis, gonorrhoea and chlamydial infection occurred in South and South-East in 1995. The most rapid increase in the number of HIV infections is also taking place in South and South-East Asia. There were 5.2 million cases of HIV/AIDS in this region as of December 1996 and Asia is expected to overtake Africa in terms of new infections annually by the late 1990s[5]. Other commonly encountered infections in the South-East and South Asian region include tuberculosis, Hepatitis B, gastrointestinal infections like cholera and typhoid and dengue fever. In addition, certain parasitic infections like leishmaniasis and schistosomiasis which are either not endemic or very uncommon in Malaysia are encountered in the migrants' countries of origin.

Many of our migrant workers are accommodated in temporary, makeshift and crowded quarters in urban areas. These shanty towns have no safe water nor

Table I
Selected infectious diseases among migrant workers in Malaysia, 1993-1995

Infection	No of reported cases (% of total cases reported)		
	1993	1994	1995
Tuberculosis	1368 (11.3%)	1230 (10.5%)	1361 (11.6%)
Leprosy	115 (32.4%)	118 (35.5%)	94 (30.2%)
Malaria	6113 (15.3%)	7421 (12.6%)	8592 (14.5%)
Dengue	74 (1.3%)	74 (2.6%)	192 (2.9%)
Filariasis	22 (2.9%)	10 (1.6%)	55 (7.6%)

Source: International Health Unit, Division of Public Health, Ministry of Health of Malaysia

proper sewage of refuse disposal. Such conditions predispose to the spread of respiratory, food-borne and water borne infections. To supplement their income migrants are also involved in the street-food industry thus increasing the potential for outbreaks of food and water infections. Vectors that transmit malaria, dengue fever, Japanese encephalitis and yellow fever are native to Malaysia, thus such infections if imported can easily spread within the country. Among the common infections reported among migrant workers are tuberculosis, leprosy, malaria, dengue fever and filariasis. (Table I) In addition there has been some 548 cases of HIV infection (3.18% of total cases) up to June 1996. Thus far 3 cases of leishmaniasis have also been documented.

Several steps has been taken by the Ministry of Health to reduce the impact on health as a result of the presence of these migrant workers. These include (a) the appointment of a panel of clinics in the countries of origin of workers for the examination of workers prior to departure (b) an annual medical examination in Malaysia upon renewal of their work permits (c) implementing a monitoring mechanism which involves the private sector to further improve the efficiency of disease notification and to assist in tracing of the worker for treatment or deportation (d) introducing a health insurance scheme for foreign workers (e) continuing to provide preventive and curative care to workers in detention camps.

The issue of migrant workers is an emotional one and the migrant often becomes a convenient scapegoat for the ills of the nation. Decisions and action to control the potential spread of infectious diseases by migrants should be made and taken rationally based on properly collected data. There is a need for better and earlier detection and notification of these infections as well as epidemiological investigations to ascertain the source. While the initial and subsequent health screening procedures are useful, the effectiveness is limited as quality control is difficult. Also such examinations may not detect incubating or latent infections and carrier states. What is more important is to establish an environment which ensures and encourages the migrant worker to seek early medical attention when the need arises. Early detection and treatment of cases together with the implementation of appropriate public health measures are crucial in preventing epidemics. Improving the living conditions of these migrants will also contribute significantly to the prevention of outbreaks of infectious diseases. Perhaps it is time for the employers to take greater responsibility in the provision of adequate housing and access to health care for their migrant workers.

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