Refugees, asylum seekers, migrants and infectious diseases

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Outlines

• 1. European migrant crisis
• 2. Medical evaluation, specific diagnoses and preventive measures
• 3. Fundamental rights and economical aspects
• 4. Conclusions
1. European migrant crisis

Idomeni, Greece

Syria
Largest influx of refugees since the Second World War:

- More than 1 million refugees arrived in Europe in 2015.
- Already more than 150,000 in 2016.
OBSTACLE COURSE TO EUROPE
A POLICY-MADE HUMANITARIAN CRISIS AT EU BORDERS

www.msf.org
January 2016
Des alternatives à la route des Balkans existent déjà

Depuis le 1er janvier, 143.886 réfugiés et migrants sont arrivés en Europe par la mer Égée. Mais beaucoup d'entre eux n'ont pas pu poursuivre leur route vers le Nord. Ils sont bloqués en Grèce depuis la fermeture de la route des Balkans. En conséquence, d'autres routes migratoires apparaissent : par l'Albanie, par la Bulgarie... Il y a aussi de fortes chances que l'accord conclu entre l'Union européenne et la Turquie provoquera également l'apparition de nouvelles routes migratoires.

Les principales routes migratoires

**Routes migratoires terrestres**
- Routes migratoires fermées
- Routes migratoires en train vers la Grèce
- Routes migratoires par la Mer Égée
- Routes migratoires par la mer Méditerranée
- Routes migratoires vers la Turquie

**Routes migratoires maritimes**
- Routes migratoires par les côtes du Maroc
- Routes migratoires vers le Royaume-Uni
- Routes migratoires vers l'Égypte

**Les migrants en chiffres en 2015**

1.046.599 personnes ont été introduites dans les 28 pays de l'UE, selon l'UNHCR.

1.322.190 demandes d'asile ont été introduites dans les 28 pays de l'UE, selon Eurostat.

Si le nombre de demandes d'asile est plus élevé que le nombre de personnes entrées dans l'UE, c'est notamment parce que certains migrants ont introduit plusieurs demandes d'asile dans différents pays.

**Introduction de demandes d'asile**

- Allemagne: 336,620
- Hongrie: 147,176
- Sud-Afrique: 130,986
- Autriche: 129,015
- Italie: 84,085
- France: 72,929
- Pays-Bas: 56,970
- Belgique: 44,760
- Portugal: 42,172
- Suède: 39,515
- Allemagne: 39,000
- Royaume-Uni: 38,625

Source: Eurostat

**292,540 personnes**

ont obtenu la protection d'un pays de l'UE

La durée des procédures d'asile explique que ce nombre soit relativement peu élevé comparé au nombre de demandes d'asile introduites en 2015.

**Origines des migrants à partir de janvier 2016**

- Algériens: 45%
- Syriens: 20%
- Érythréens: 13,2%
- Irakiens: 7,3%
- Somalis: 5,5%
- Autres: 5,5%
Belgium

Statistiques d’asile
Rapport mensuel
Décembre 2015


Top 10 des demandes d’asile en 2015

<table>
<thead>
<tr>
<th>Pays d’origine</th>
<th>Nombre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irak</td>
<td>7.722</td>
</tr>
<tr>
<td>Syrie</td>
<td>7.554</td>
</tr>
<tr>
<td>Afghanistan</td>
<td>7.099</td>
</tr>
<tr>
<td>Somalie</td>
<td>1.932</td>
</tr>
<tr>
<td>Indéterminé</td>
<td>846</td>
</tr>
<tr>
<td>Russie</td>
<td>777</td>
</tr>
<tr>
<td>Guinée</td>
<td>752</td>
</tr>
<tr>
<td>RD Congo</td>
<td>650</td>
</tr>
<tr>
<td>Albanie</td>
<td>538</td>
</tr>
<tr>
<td>Iran</td>
<td>537</td>
</tr>
<tr>
<td>Autres pays</td>
<td>7.069</td>
</tr>
<tr>
<td><strong>Total 2015</strong></td>
<td><strong>35.476</strong></td>
</tr>
</tbody>
</table>
Localisation of asylum centres

25/04/2016

www.fedasil.be

<table>
<thead>
<tr>
<th>OPVANGCENTRA/METAFOUDRADEN</th>
<th>AANTAL NOMBRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fedasil</td>
<td>24</td>
</tr>
<tr>
<td>Croix-Rouge</td>
<td>26</td>
</tr>
<tr>
<td>Rode Kruis</td>
<td>23</td>
</tr>
<tr>
<td>Caritas</td>
<td>2</td>
</tr>
<tr>
<td>Mutualités socialistes</td>
<td>1</td>
</tr>
<tr>
<td>Samu Social</td>
<td>2</td>
</tr>
<tr>
<td>Privépartners/Partners privés</td>
<td>14</td>
</tr>
<tr>
<td>TOTAAL</td>
<td>92</td>
</tr>
</tbody>
</table>
2. Medical evaluation

https://epidemio.wiv-isp.be

http://ecdc.europa.eu

Epidemiology of infectious diseases in the country of origin

Table 1. Infectious diseases to consider according to country of origin

<table>
<thead>
<tr>
<th>Disease</th>
<th>Indicator</th>
<th>Syria</th>
<th>Afghanistan</th>
<th>Iraq</th>
<th>Eritrea</th>
<th>Somalia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria [3]</td>
<td>Cases reported to WHO in 2012, 2013, 2014</td>
<td>0, 0, and NA</td>
<td>0, 0, 0</td>
<td>3, 4, and 5</td>
<td>8, 0 and NA</td>
<td>65, 7 and NA</td>
</tr>
<tr>
<td>Typhoid fever</td>
<td>Risk of typhoid</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Cholera¹</td>
<td>Risk</td>
<td>No recent outbreak</td>
<td>Recurrent outbreaks</td>
<td>On-going outbreak in Baghdad, Babylon, Najaf, Qadisiyyah, and Muthanna.</td>
<td>NA</td>
<td>Recurrent outbreaks</td>
</tr>
<tr>
<td>Hepatitis A²</td>
<td>Risk</td>
<td>High endemicity</td>
<td>NA</td>
<td>High endemicity</td>
<td>High endemicity</td>
<td>High endemicity</td>
</tr>
<tr>
<td>Hepatitis B²</td>
<td>Risk of soil transmitted helminthiasis (ascaris, whipworm, hookworm)</td>
<td>+</td>
<td>++</td>
<td>+</td>
<td>++</td>
<td>++</td>
</tr>
<tr>
<td>Leishmaniasis³</td>
<td>Risk of urinary schistosomiasis</td>
<td>✓</td>
<td>Non-endemic country</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Leishmaniasis²</td>
<td>Risk of cutaneous leishmaniasis</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Leishmaniasis³</td>
<td>Risk of visceral leishmaniasis</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Hepatitis B²</td>
<td>Prevalence of chronic hepatitis B</td>
<td>Intermediate prevalence: 5.6%</td>
<td>High prevalence: 15.5%</td>
<td>High prevalence: 15.5%</td>
<td>High prevalence: 15.5%</td>
<td>High prevalence: 12.4%</td>
</tr>
<tr>
<td>Hepatitis C²</td>
<td>Prevalence</td>
<td>High prevalence: 3.1%</td>
<td>High prevalence: 1.1%</td>
<td>High prevalence: 3.2%</td>
<td>High prevalence: 1%</td>
<td>NA</td>
</tr>
<tr>
<td>HIV</td>
<td>Prevalence</td>
<td>Low</td>
<td>NA</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Malaria⁶</td>
<td>Risk of malaria</td>
<td>Malaria-free</td>
<td>Risk of P. vivax &gt;&gt; P. falciparum</td>
<td>Malaria-free</td>
<td>Risk of P. falciparum &gt;&gt; P. vivax</td>
<td>Risk of P. falciparum</td>
</tr>
<tr>
<td>Measles</td>
<td>Incidence per 100 000 in 2013 and 2014</td>
<td>1.64 and 2.68</td>
<td>1.41 and 1.75</td>
<td>2.09 and 3.02</td>
<td>0.77 and 0.02</td>
<td>2.17 and 9.12</td>
</tr>
<tr>
<td>Polio⁷</td>
<td>Cases reported to WHO in 2012, 2013 and 2014</td>
<td>0, 35 and NA</td>
<td>-46, 17, and 28</td>
<td>0, 0, and 2</td>
<td>0, 0, and 0</td>
<td>1, 195 and 5</td>
</tr>
<tr>
<td>Tuberculosis⁸</td>
<td>Incidence/100 000</td>
<td>Low: 17</td>
<td>High: 189</td>
<td>Low: 25</td>
<td>High: 40 to 499</td>
<td>High: 285</td>
</tr>
<tr>
<td>Antimicrobial resistance</td>
<td>Risk of carriage of multidrug-resistance</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Rabies</td>
<td>Risk level for humans contracting rabies</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
</tbody>
</table>

Healthy migrant effect: Process of self-selection where only the healthiest in a society migrate¹.


Specific risks in relation to the countries visited during their journey and conditions experienced during migration.

Chios

Idomeni
Conditions of living in the host country

Centre of Oignies (Red cross)

Grande Synthe (Dunkerke)
Unhealthy living conditions facilitates epidemics (poor access to water and sanitation,...).
« Infectious diseases in migrants are not a significant burden for the host country but well a potential threat to the refugees themselves ». 

www.ecdc.europa.eu: Infectious diseases of specific relevance to newly arrived migrants in the EU.
Primary diagnoses observed in asylum-seekers by MdM in the Maximilien garden in September 2015 (n=3907)

With the courtesy of MdM and Dr Gerlant van Berlaer
Infectious diseases of specific relevance to newly arrived migrants

- Acute respiratory tract infections
- Influenza
- Tuberculosis
- Measles
- Scabies
- Louse-borne relapsing fever
- Cutaneous diphteria
- Shigellosis
- Typhoid fever
- hepatitis A
- Meningoccocal meningitis
- Malaria
- ...

https://epidemio.wiv-isp.be
Tuberculosis

Target 3.3. for 2030:
- 90% reduction in TB deaths.
- 80% reduction in TB incidence.

Afghanistan: 189/100 000

Irak: 43/100 000

Syria: 17/100 000

Somalia: 274/100 000

Eritrea: 78/100 000
Tuberculosis

• Screening for tuberculosis (Xray) in Immigration office (if contra-indicated (pregnancy, under five): Mantoux)

• Screening document to be checked in the asylum centre. Testing to be completed in the asylum centre within 2 weeks.

• Number of tuberculosis diagnosed in asylum seekers in 2015: 97 (47 in Immigration office) (represent 10% of the diagnosis of TB in Belgium in 2015)

Informations transmitted by Dr Maryse Wanlin (FARES)
Measles

• > 10 cases of measles in « la jungle » in Calais in February 2016.

• Vaccination campaign against measles by MSF in Calais (>2000 vaccines) and Grande Synthe (>500)

• 3 cases in May in the Fedasil centre of Elsenborn.
Scabies

- **Sarcoptes scabiei**
- Associated with *crowding, homelessness*
- Intense generalized *pruritus* worse at night
- Inflammatory pruritic papules (fingers webs,...)

**Diagnosis:**
- epidemiological and clinical
- Microscopic examination

**Treatment:**
- 5% permethrin cream
- 10-25% benzoyl benzoate
- Ivermectin

**Prevention and control:**
- *Isolation*, washing and drying clothes at 60°
- Access to personnal hygiene and health care
- *Aggressive control of outbreaks*
Body lice

- *Pediculus humanus humanus*
- **Risk factors:** poor living conditions, poor personal hygiene, crowded shelters, refugee camps
- **Vector of:**
  - Louse-borne relapsing fever (*Borrelia recurrentis*)
  - Trench fever (*Bartonella quintana*)
  - Epidemic typhus (*Rickettsia prowazekii*)
Louse-borne relapsing fever

• **27 confirmed cases** in Europe between July and October 2015 among **refugees from countries of the Horn of Africa** (Eritrea and Somalia)

• Exposed to body lice during their journey to Europe (Lybia or upon arrival in Italy,...)

Figure 1. Distribution of the 27 cases of louse-borne relapsing fever in Europe by reporting country in 2015, and main migration routes.*

**Louse-borne relapsing fever**
- **●**: one case
- **●**: 3 cases
- **●**: 15 cases

**Main migration routes**
- **→**: East Africa
- **→**: Central Mediterranean
- **→**: Western Mediterranean and West Africa
- **→**: Eastern Mediterranean and Western Balkan
- **→**: Other
Louse-borne relapsing fever

- **Incubation period:** 4-8 days
- **Symptoms:**
  - sudden onset, high fever, chills, headache, meningism, myalgia/arthralgia, nausea, vomiting, during ± 5 days.
  - Relapses over several days to weeks.
  - Letality: 10-40% without treatment, 1-5% with treatment.
- **Diagnosis:** Giemsa stained blood films, PCR
- **Treatment:** doxycycline, penicilline
  - Complication: Jarisch-Herxheimer reaction.
- **Prevention and control:**
  - Prevent overcrowding
  - Checking for lice infestation
  - Raising awareness among patients and clinicians
Cutaneous diphtheria

- *Corynebacterium diphtheriae*, *corynebacterium ulcerans* and *corynebacterium pseudotuberculosis*: nonsporulating, unencapsulated, pleomorphic Gram positive bacillus.
- In the tropics, cutaneous diphtheria infections prevail over respiratory infections.
- 7 patients with toxigenic cutaneous diphtheria reported to eCDC in the summer 2015:
  - Denmark: 1 patient from Eritrea
  - Sweden: 2 patients from Eritrea
  - Germany: 1 patient from Eritrea, 1 from Ethiopia, 1 from Libya, 1 from Syria


Cutaneous diphtheria

- Entry via a wound.
- Ulcer with a grey-yellow or grey-brown membrane.
- Frequent coinfection with *staphylococcus aureus* and *streptococci group A*.
- Majority of corynebacterium isolated from the skin are not toxinogenic.
- Toxigenic complications: myocarditis, nephritis, polyneuropathy and paralysis.

Cutaneous diphtheria

• **Diagnosis:**
  – Culture (Small Gram positive bacillus at direct examination)
  – **Exotoxin** has to be researched by the laboratory of reference: Universitair Ziekenhuis Brussel (Dr Pierard): PCR and Elek’s test.

• **Treatment:**
  – Penicilline, Amoxicilline, Erythromycine, Azithromycine
  – Systemic Toxin induced symptoms: Purified equine diphtheria antitoxin (DAT)

• **Prevention and control:**
  – Isolation of patient
  – Close contacts: prophylactic antibiotic
  – Vaccination

Shigellosis

• More than 6000 cases are reported in general population in Europe each year.

• A few cases were reported to eCDC in refugees between July and November 2015:
  – Austria: 23 cases (Afghanistan (13), Syria (6), Iraq (2))
  – Greece: 15 children in the Eleonás camp in Athens (Afghanistan (12), Iraq (1),...)
  – Germany: 30 cases (Ethiopia (6), Syria (5), Afghanistan (4),...)

Eleonás camp
Figure 1. Distribution of shigellosis cases among refugees in 2015 and migration routes to and in Europe, as of 26 November 2015

Main migration routes:
- East Africa
- Central Mediterranean
- Western Mediterranean and West Africa
- Eastern Mediterranean and Western Balkan
- Other

Legend:
- : one case
- : 3 cases
- : 15 cases
Access to treatment and possibility to stay for medical reason (9ter) are necessary to allow testing and treatment in accordance with the sustainable development goals: 90-90-90 in 2020.
Vaccination

• Since 4th of February 2016: Asylum seekers are vaccinated at their arrival in Belgium at the Immigration office or in the asylum centre, together with Xray:
  - **MMR** if born after 1970. (Measles, Mumps, Rubella).
  - **Tetanos, diphteria, pertussis** (if not vaccinated within 10 years or pregnant woman (24-32 weeks of pregnancy)).
  - **Poliomyelitis** (if from Afghanistan, Pakistan, Nigeria, Somalia).
  - Influenza if indicated.
  - + usual vaccination in children

[Links]
www.zorg-en-gezondheid.be/vaccinatie-vluchtelingen-vanaf-nu-bij-aankomst-in-belgi%C3%AB
New screening file to facilitate the transfer of medical information to the centre
3. Fundamental rights and economical aspects
Article 35

Health care

Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union’s policies and activities.
The right to health is a basic social right protected in international and European human rights law. Core obligations deriving from this right apply to everyone, regardless of their status as migrants in a regular or irregular situation.

FRA’s analysis show that providing timely access to health screening and treatment not only contributes to fulfilling the right of everyone to health but is also cost-saving compared to providing medical treatment only in emergency cases.

Conclusion

The cost of excluding AS&R from health care appears ultimately higher than granting regular access to care. Excess expenditures attributable to the restriction were substantial and could not be completely explained by differences in need. An evidence-informed discourse...
Goal 3: Ensure healthy lives and promote well-being for all at all ages:
Achieve universal health coverage, (...)

WMA Resolution on Global Refugee Crisis

Adopted by the 66th General Assembly, Moscow, Russia, October 2015

The WMA:

- Calls on other countries to improve their willingness to receive refugees and asylum seekers;
- Calls on national governments to ensure that refugees and asylum seekers are enabled to live in dignity by providing access to essential services;
- Calls on all governments to work together to seek to end local, regional, and international conflicts, and to protect the health, safety and welfare of populations;
World Medical Association Issues Health Warning over Refugee Deal

(28.03.2016) Concern that refugees fleeing to Europe are receiving inadequate health care has been expressed by the World Medical Association.

WMA President Sir Michael Marmot said the recent EU agreement signed with Turkey failed to address the humanitarian concerns facing the thousands of refugees making the perilous journey from Turkey to Greece.

"We appeal to the national leaders to put the needs of the individuals at the heart of this mass migration. Their needs for housing, food, regular medical care and simple dignity have been largely overlooked so far. As physicians we have a duty to speak out about the risks to the health of these desperate people."
Conclusions

• **War** and **deterioriation of the conditions of living** increase the **risk of infectious diseases and epidemics**.

• **Access to** adequate conditions of living and to healthcare is necessary to reduce the occurrence of infectious diseases and to allow **correct management** in this vulnerable population.

• **To guarantee access to healthcare** not only permits to respect **the fundamental rights** of the migrants, but also **reduces costs**.
Conclusions

• The risk for local population is pretty low: population has to be adequately informed to avoid contra-productive reactions.

• Shouldn’t we develop a **national surveillance and support team** for the **prevention and management of infectious diseases** in migrants and asylum seekers settings in Belgium?

• **It is an investment in our common future** to welcome and host the refugees with dignity.
I thank you for your attention

STI prevention symposium in the asylum centre of Oignies (Red cross) in March 2016.