Migrants and communicable diseases: experiences in Belgium

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UNIVERSITAIR ZIEKENHUIS ANTWERPEN

Overview

- Migrants: different definitions
- Trajectory of the newly arrived asylum seeker
- Screening upon arrival
- TB
- HIV
- HBV/HCV
- Access to care

Migrantion: what do you mean…?

- Migrants (UN)
    - a long-term migrant as a ‘person who moves to a country other than that of his or her usual residence for a period of at least a year
    - the term migrant is used as a generic for the heterogeneous population of asylum seekers, economic migrants and refugees
- Newly arrived migrants (ecdc):
    - individuals who have migrated to a host country within the EU/EEA in the past five years.
- Irregular migrant (ecdc):
    - a person who, owing to unauthorised entry, breach of a condition of entry, or the expiry of his or her visa, lacks regular status in a transit or host country. The definition also covers those persons who have entered a transit or host country lawfully but have stayed for a longer period than authorised or subsequently taken up unauthorised employment.
- ‘transmigrants’

Migration: what do you mean…?

- Refugee (ecdc):
  - A person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his or her nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country (3).

- Asylum seeker (ecdc):
  - A person who awaits a decision on the application for refugee status under relevant international and national instruments.

TRANSIT

- Violence (physical, sexual)
- Crowded unhygienic living conditions
- Poor access to preventive health care and vaccination

A. ON ARRIVAL

- Pre-arrival risk factors
- Transit risk factors
- Pre-arrival health assessment

PRE-ARRIVAL

- infectious diseases epidemiology in countries of origin
- Inadequate housing and sanitation
- Poor access to preventive health care and vaccination
- Cultural practices
  - * Ritual scarification
  - * Female Genital Mutilation etc.
- Environmental
  - * Contact with contaminated fresh water
  - * Walking barefoot, etc

B. EARLY SETTLEMENT

Reception centers and refugee camps

- Crowded unhygienic living conditions
- Health care access barriers:
  - * Entitlement to care
  - * Language and cultural barriers
  - * Stigma
  - * Fear of deportation

C. LATE RESETTLEMENT

- Pre-arrival health screening and assessment
- Post-arrival health screening and vaccination update
- Risk behaviors (alcohol, drug use, sexual)
- Health care access barriers
  - * Entitlement to care
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D. RETURN VFR TRAVEL

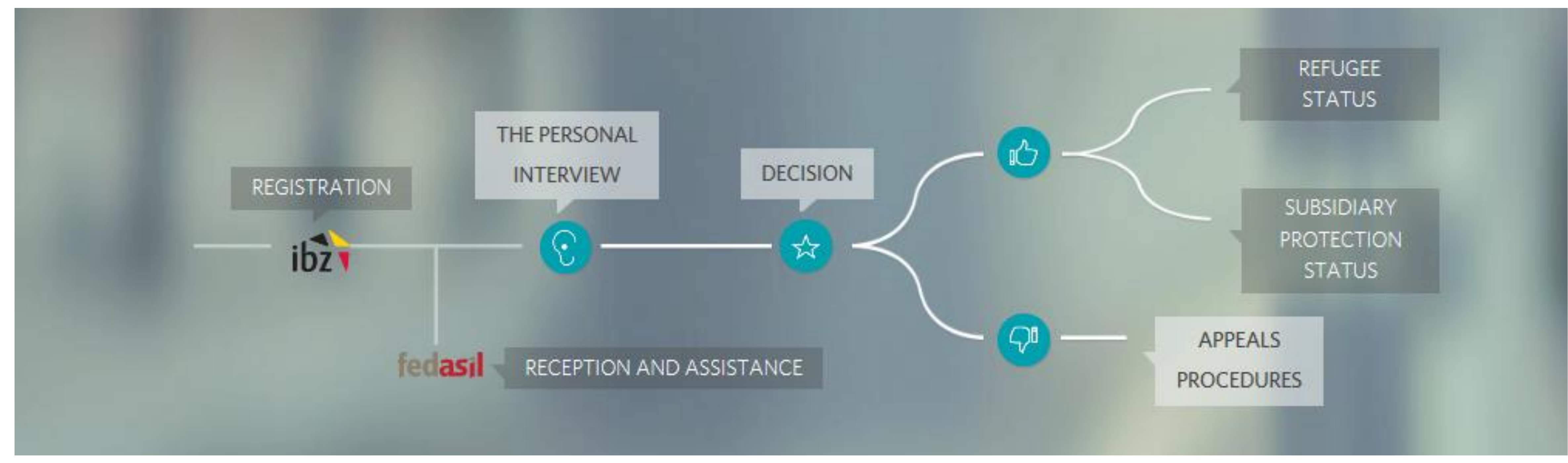
- Health risk misperception
- Lack of pre-travel health advice
- Increased risk of exposure due to proximity with the local population and health care use
- Increased risk of infection for susceptible children born in host country

VFR: Traveler visiting friends and relatives.

Greenaway, J Trav med 2019

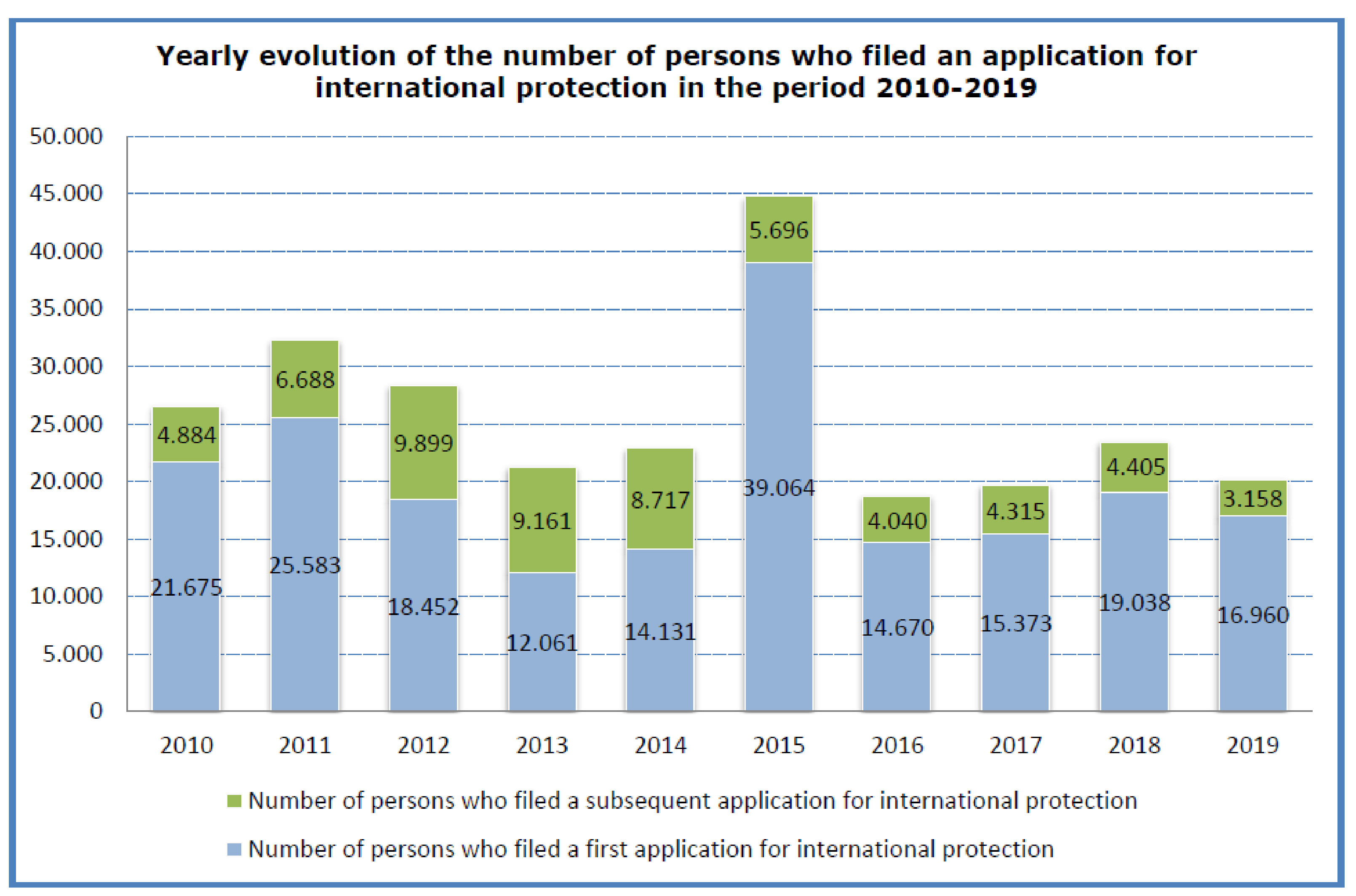
Figure 1. Risk factors for infectious disease exposure or burden at different stages of migration pathway.

Trajectory of an asylum seeker in Belgium



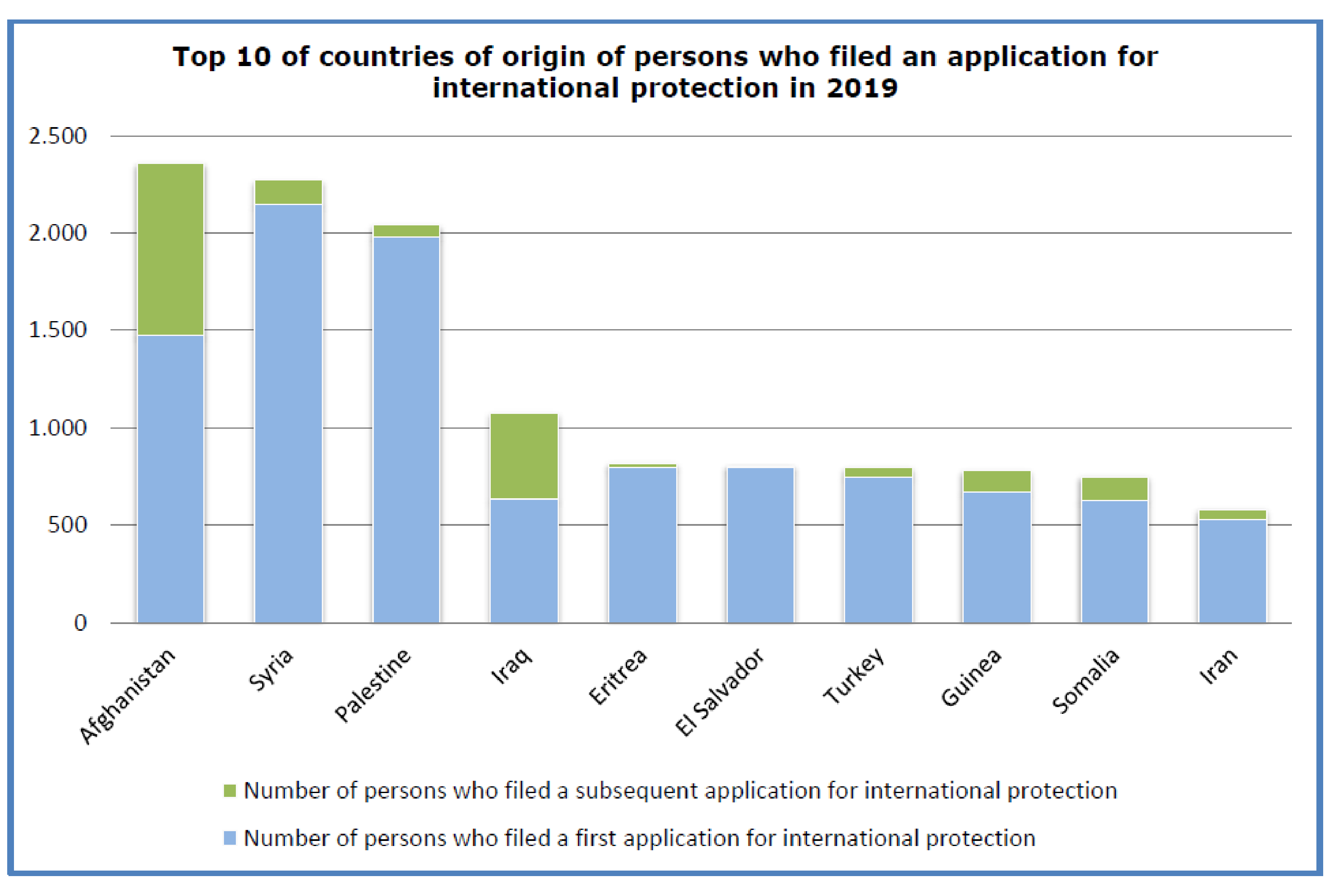
https://www.cgrs.be/en

How many?



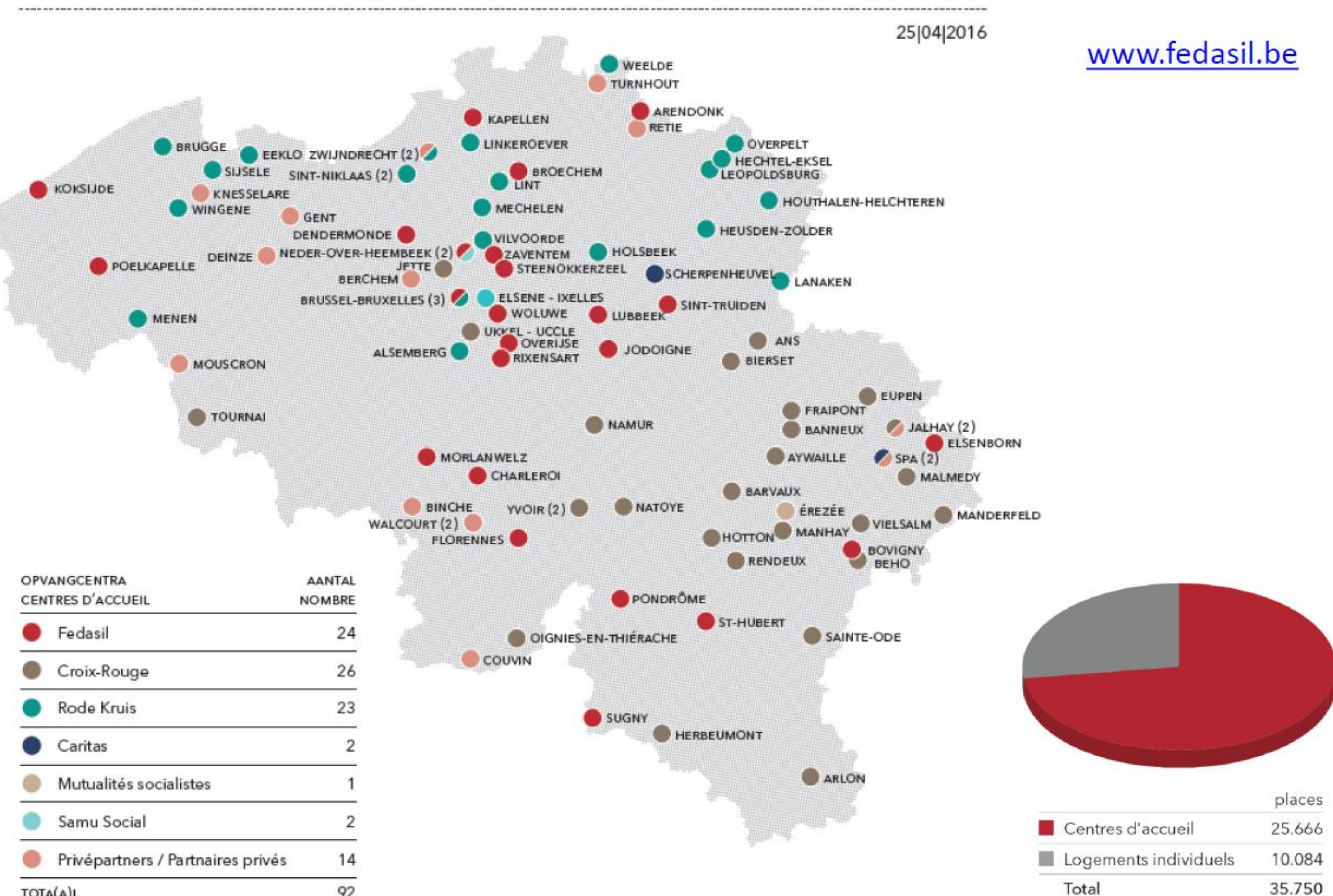
https://www.cgrs.be/en

Where do asylum seekers come from in 2019?



https://www.cgrs.be/en

Localisation of asylum centres



OPVANGCENTRA CENTRES D'ACCUEIL	AANTAL NOMBRE
Fedasil	24
Croix-Rouge	26
Rode Kruis	23
Caritas	2
Mutualités socialistes	1
Samu Social	2
Privépartners / Partnaires privés	14
TOTA(A)L	92

www.fedasil.be

	places
Centres d'accueil	25.666
Logements individuels	10.084
Total	35.750

Screening and vaccination of asylum seekers

New screening file to facilitate the transfer of medical information to the centre

fedasil
AGENCE FEDERALE POUR L'ACCUEIL DES DEMANDEURS D'ASILE

FICHE de SCREENING MÉDICAL à l'ENTRÉE

NOM : **Prénom :** **Date:**
Sexe : ☐Masculin ☐ Féminin Nom du chef de la famille :
Pays d'origine : Date de Naissance:
Numéro S.P. provisoire: . . Numéro S.P. définitive : . . ou N.N. : - -

DÉPISTAGE des MALADIES INFECTIEUSES

- Dépistage Ebola[1]? ☐Non ☐Oui (→ contrôle température pendant 21 jours)
- **Dépistage Tuberculose** :
  - Rx thorax? ☐Oui
    ☐Non → raison: ☐panne Rx ☐refus Rx ☐manque temps ☐
    ☐Indication test I.D. au centre: ☐< 5 ans ☐ femme enceinte? ☐

  Si dépistage TBC à la structure d'accueil : ☐***test I.D.*** ☐***Rx thorax effectuée à la date effective de***
- Remarque(s) / suspicion autres maladies infectieuses ?:

VACCINATION des demandeurs d'asile *(uniquement si date vacc. diffère date entrée)*

☐ **enfant < 6 ans → vaccination par O.N.E./ Kind & Gezin (à organiser par structure d'accueil)**
☐ **mineur 6 ans jusqu'à < 18 ans** **Date vacc**
- Originaire d'un pays à risque polio (Afghanistan, Pakistan, Somalie ou Nigéria) ? ☐Non
  ☐Oui → Vaccination contre polio par Imovax® ? ☐Non ☐Oui : N° du lot vaccin

☐ **adulte (18 et plus)**
- Originaire d'un pays à risque polio (Afghanistan, Pakistan, Somalie ou Nigéria) ? ☐Non
  ☐Oui → Vaccination contre polio par Imovax® ? ☐Non ☐Oui : N° du lot vaccin
- Né après 1970 ? ☐Non
  ☐Oui → Vaccination contre R.O.R. par M-M-R VaxPro® ? ☐Non ☐Oui : N° du lot vaccin
- Remarque(s):

ANAMNÈSE MÉDICALE :
- Impression santé générale? ☐ très bonne ☐bonne ☐moyenne ☐mauvaise ☐très mauvaise ☐??
- Mentionne problème de santé sur fiche inscription? ☐Non ☐Oui :
- Remarque(s):

Uniquement si femme (> 14 ans):
- Enceinte? ☐Non ☐?? ☐Oui : Date prévue d'accouchement
  ou grossesse de semaines ou de mois
- Grossesse à risque ? ☐Non ☐Oui: **date vacc**
- Grossesse entre 24 à 32 semaines ? ☐Non
  ☐Oui → Vaccination contre Di-Te-Per par Boostrix® ? ☐Non ☐Oui : N° du lot vaccin

CONCLUSION:
☐A première vue, rien de particulier à signaler au niveau santé
☐Référence vers poste médical au dispatching → Evaluation par poste médical réalisée ? ☐Non ☐Oui
- ☐Pathologie médicale: ☐aiguë et/ou ☐chronique; ☐stabilisée / sous contrôle ☐non stabilisée / évolutive ☐ ??
- Prise de médicaments ? ☐Non ☐Oui : →encore assez pour jours ou semaines
- Remarque(s) :

☐Action(s) méd. suivante(s) à faire :
- Référence urgente vers les urgences? ☐Non ☐Oui →hôpital de
- Suivi (para)médical immédiat nécessaire? ☐Non ☐Oui
  - Auprès service médical de la structure d'accueil : endéans les heures ou jours max.
  - Chez médecin généraliste: endéans les heures ou jours max.
  - Chez...
- **Il y a des besoins d'accueil spécifiques pour raisons médicales et/ou psy:** ☐**Non** ☐**Oui**
  Si Oui, merci de remplir aussi le côté verso et d'envoyer la checklist à INSTROOM / la structure d'accueil!

[1] A la date de 1/11/2015 : que Guinée Conakry et Sierra Léone (et attente d'être déclaré « ebola free » à partir de 7 novembre 2015 !)

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Greenaway, J Trav med 2019

Figure 1. Risk factors for infectious disease exposure or burden at different stages of migration pathway.

Reported infectious diseases in Fedasil Centres in 2016

Tuberculosis	**72**
Scabies	**345**
Hepatitis A	1
Rubella, diphteria, tetanos	0
Measles	[illegible]
Mumps	[illegible]
[illegible]	**134**
[illegible]	8
LBRF	0
Pertussis	0

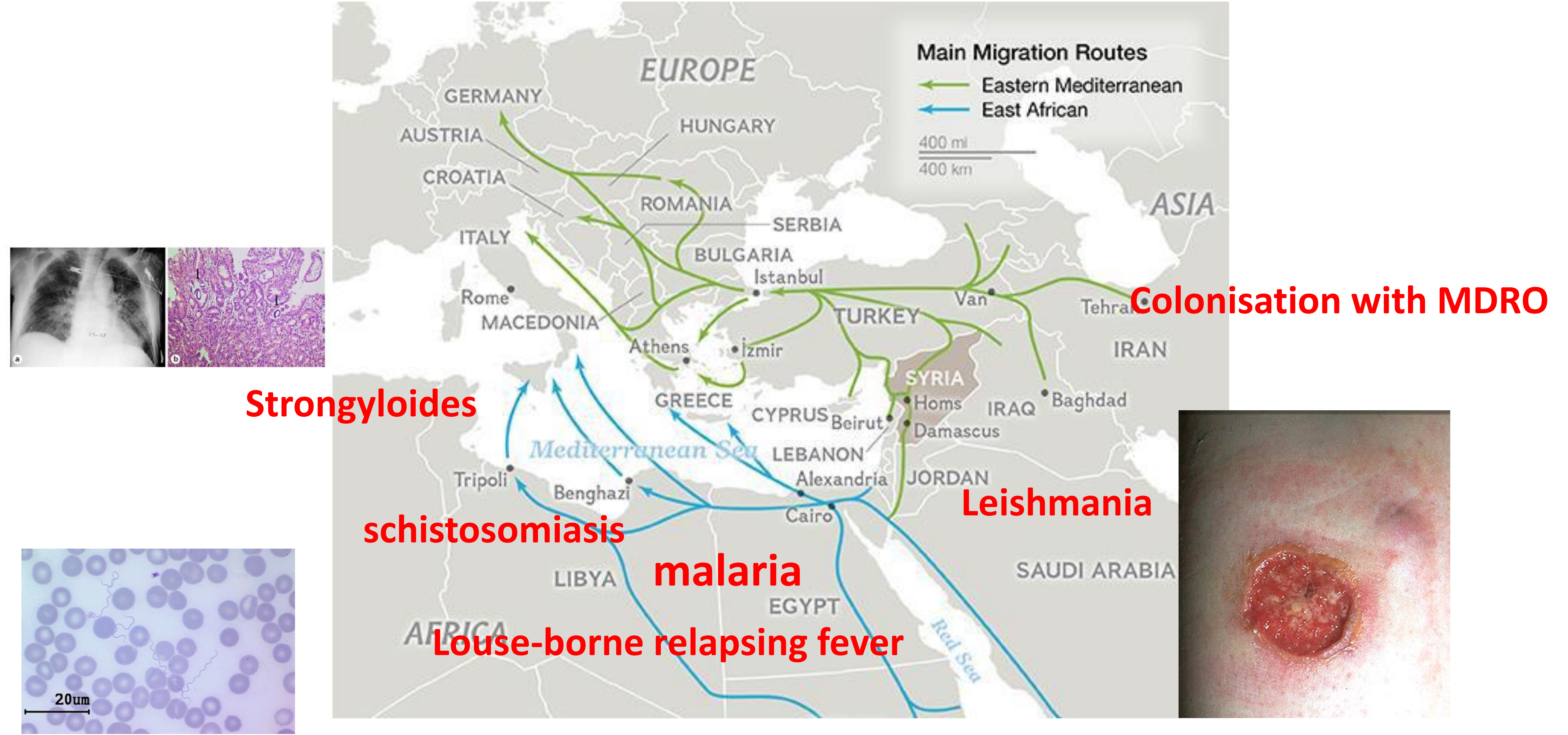
Refugees are a generally healthy population!

Overcrowding, infections during travel…

fedasil
FEDERAAL AGENTSCHAP VOOR DE OPVANG VAN ASIELZOEKERS

Courtesy of AM Hoogewys)

Tropical and exotic infections: cases, not a tsunami

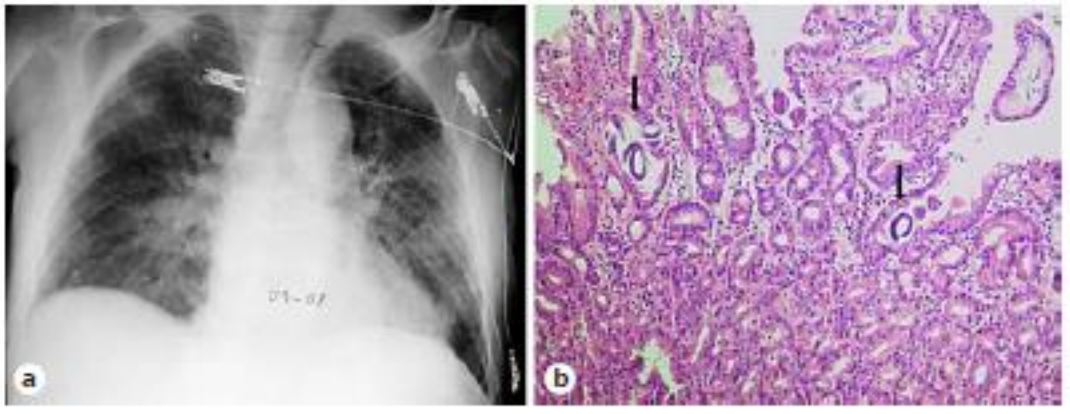


International Journal of *Environmental Research and Public Health*

Review

Effectiveness of Screening and Treatment Approaches for Schistosomiasis and Strongyloidiasis in Newly-Arrived Migrants from Endemic Countries in the EU/EEA: A Systematic Review

Eric N. Agbata [1,2,*], Rachael L. Morton [3], Zeno Bisoffi [4,5], Emmanuel Bottieau [6], Christina Greenaway [7], Beverley-A. Biggs [8,9], Nadia Montero [10], Anh Tran [3], Nick Rowbotham [3], Ingrid Arevalo-Rodriguez [10,11], Daniel T. Myran [12], Teymur Noori [13], Pablo Alonso-Coello [14], Kevin Pottie [15] and Ana Requena-Méndez [16]



Strongyloides hyperinfestation
in 77-year old male from Paraguay
(*Olaru, Respiration 2017*)

Int. J. Environ. Res. Public Health **2019**, *16*, 11; doi:10.3390/ijerph16010011

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Greenaway, J Trav med 2019

Figure 1. Risk factors for infectious disease exposure or burden at different stages of migration pathway.

Vaccination policy 2017

at dispatching	In the RC
POLIO (Imovax®) ≥ 6 y, people from Afghanistan Pakistan, Nigeria, RDCongo, Syria **Measles –Mumps-Rubella** (M.M.R. VaxPro®) ≥ 18 y born after 1970 Exept pregnant women **Diphteria-tetanus-Pertussis(Boostrix®)** All from 12 y	**Children 0-18 y:** **All vaccinations** • < 6 y: via Kind & Gezin • 6 to18 y via C.L.B **Adults** **All vaccins to be administered yet** Plus 2nd dose MMR (M.M.R. VaxPro®)

Max 2 shots!

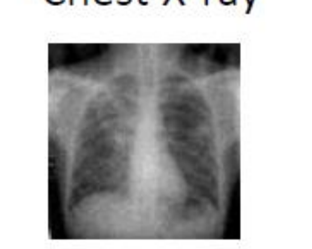
Screening tbc at arrival: 95% coverage

At dispatching (DVZ)

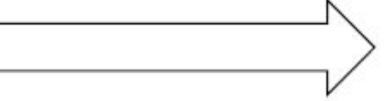
In the RC or individual

Children > 5, adolescents, adult men and non-pregnant women

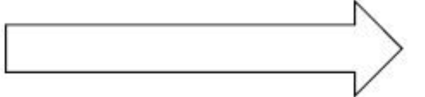
Chest X-ray



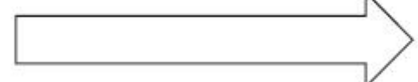
Pregnant women



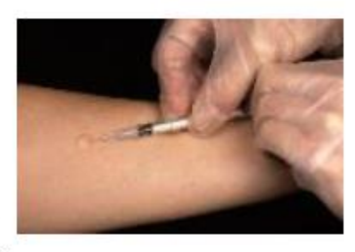
Children until 5



Female non accompanied minors



Intra dermal test VRGT



Chest X ray if not pregnant

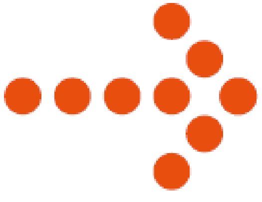
INVITATION

You are new in Belgium ?

You can have your lungs tested for free

What if tuberculosis is detected ?

- With proper treatment, tuberculosis can be cured fully
- Will you be expelled when you got TBC ?
  No, the screening has no consequences on your residence
  When you got tuberculosis, you will be treated with medicine in Belgium



www.vrgt.be

Greenaway, J Trav med 2019

Figure 1. Risk factors for infectious disease exposure or burden at different stages of migration pathway.

Belgium = low TB-incidence country, but….

Incidentie /100.000
30
25
20
15
10
5
0
Limiet lage incidentielanden
8,6 /100.000
1980
1985
1990
1995
2000
2005
2010
2015
2017
Observatie
Voorspelling

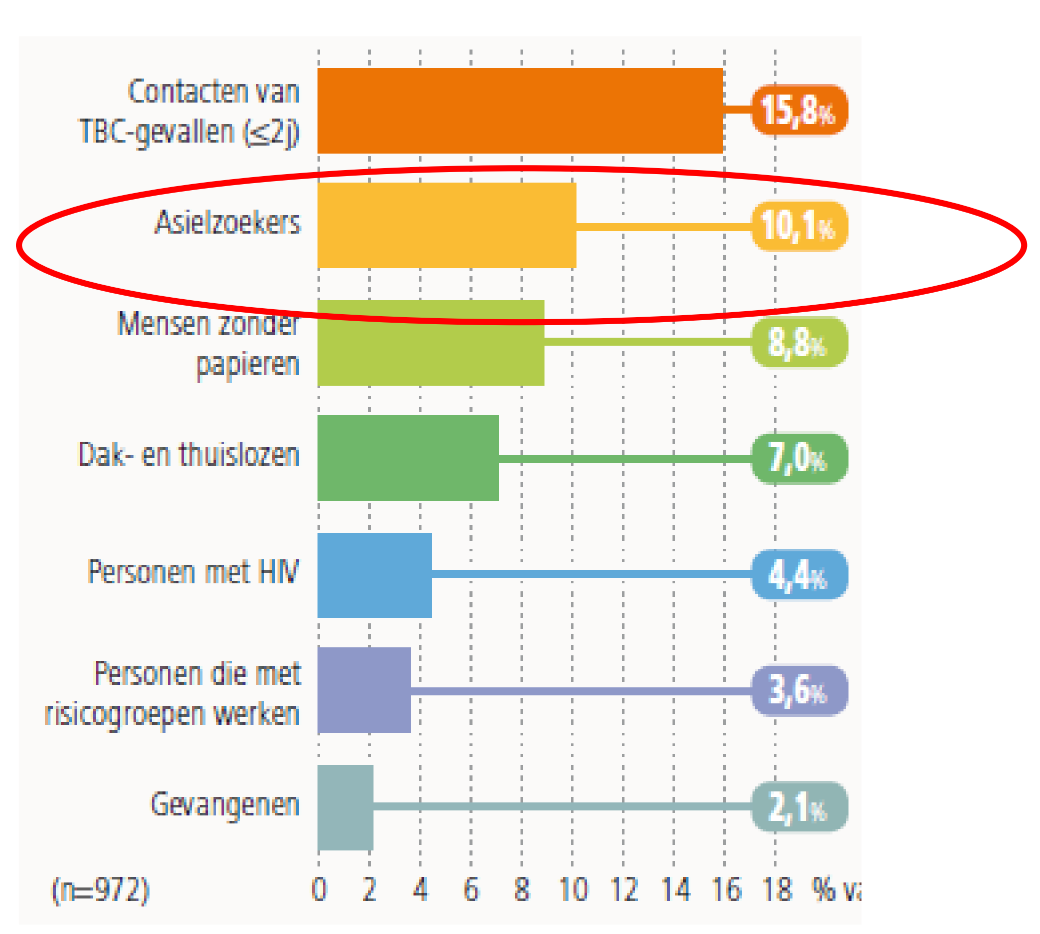
n = 972

2018
981 cases (Pulm + Extrapulm)

Incidence: 8,6 / 100.000

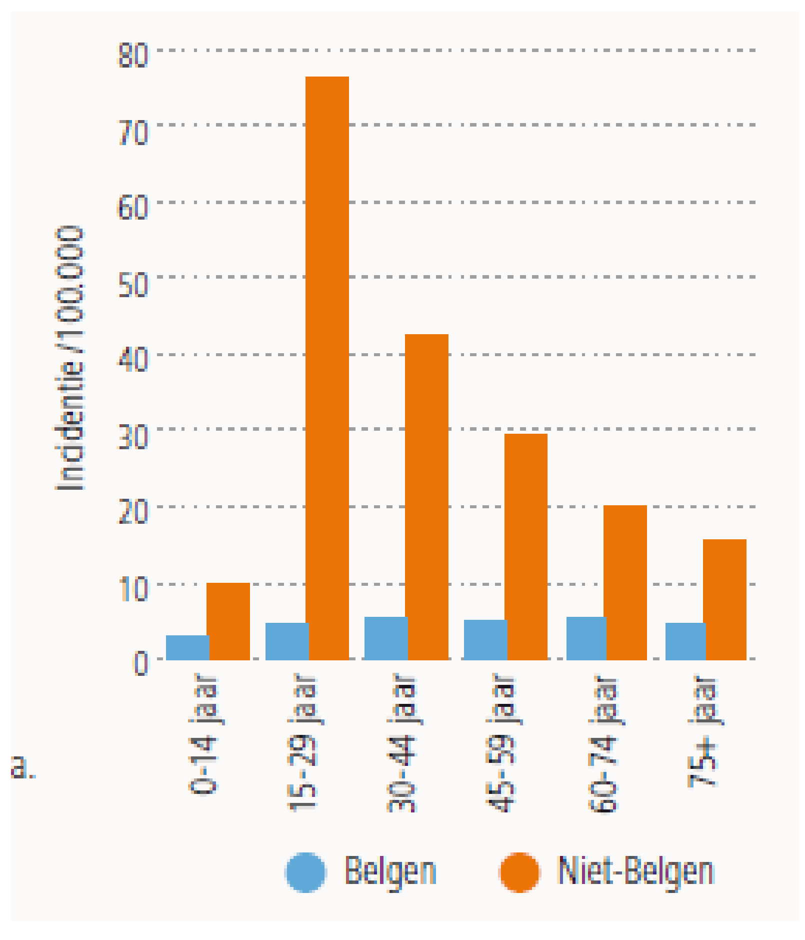
https://tuberculose.vrgt.be/sites/default/files/Tuberculose%20in%20Belgi%C3%AB%20infografiek%20register%202017_1.pdf

Risk groups for TB in Belgium 2017

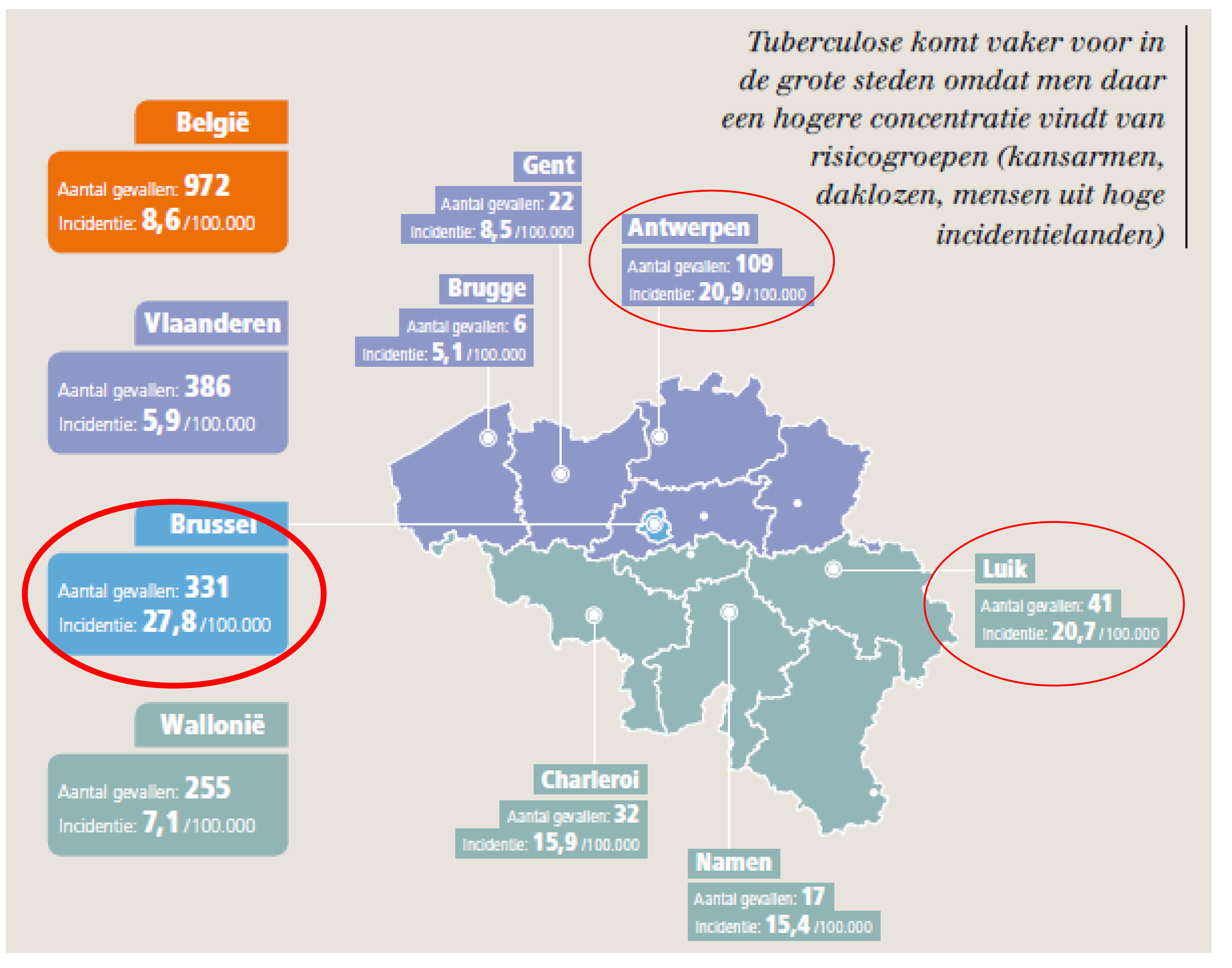


www.vrgt.be

Incidence in non-Belgians up to 8 x higher



www.vrgt.be



2017 data

Big city problem

www.vrgt.be

Absoluut aantal MDR TB-patiënten

% MDR TB onder alle TB-patiënten

Jaar	05	06	07	08	09	10	11	12	13	14	15	16	17	18
MDR TB aantal	10	19	18	18	15	18	17	20	15	12	16	12	4	9

Linker as: 0, 5, 10, 15, 20, 25

Rechter as: 0%, 1%, 2%, 3%, 4%, 5%

Legende: MDR TB aantal; % MDR TB

Characteristics programme

Specialised and trained TB-nurses and social workers

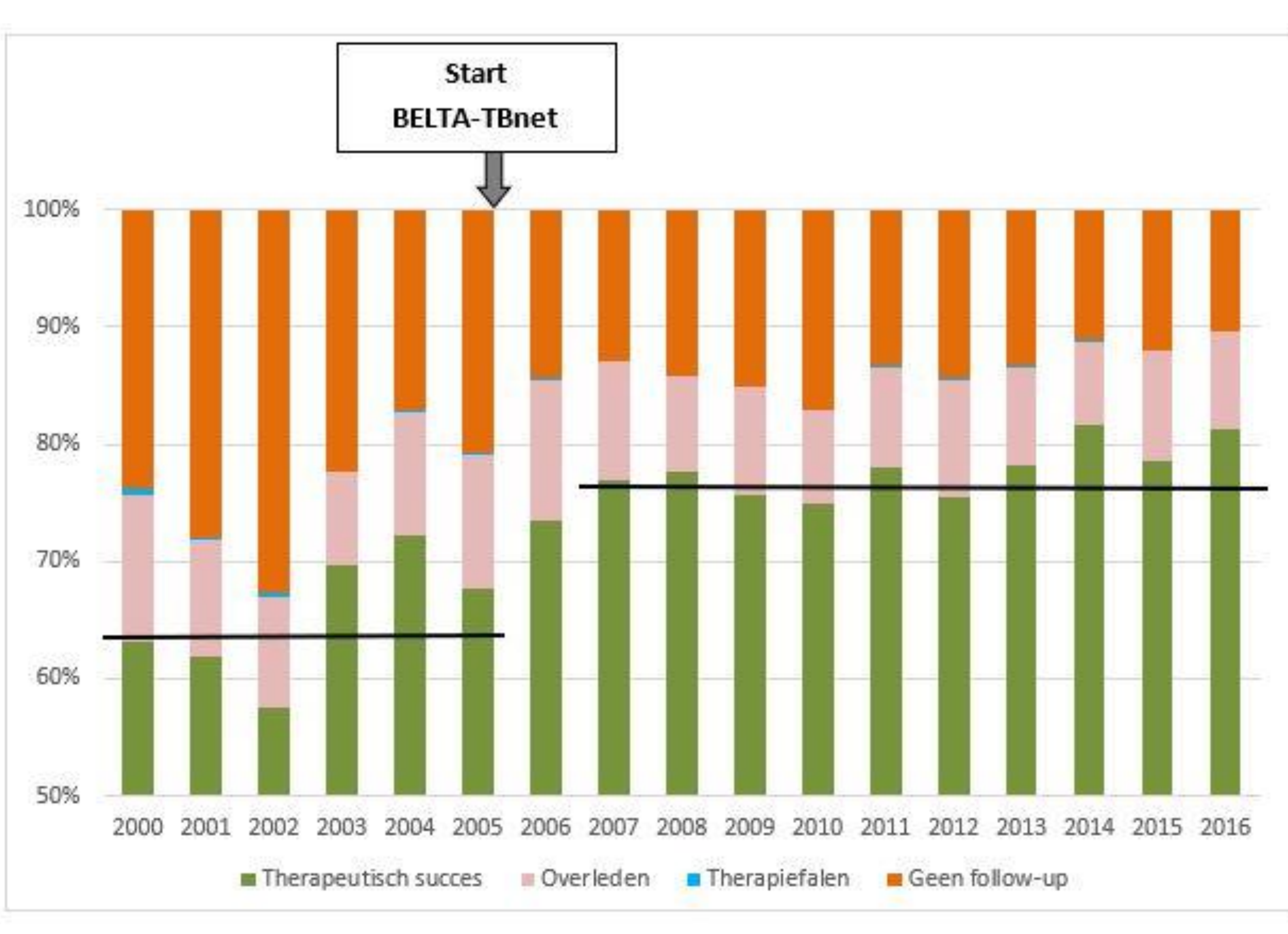
Active screening asylum seekers, detainees

Notification + Contact investigation

Training: first line health care

Free for the patient: **BELTA-TBnet programme** (Guido Groenen)

- All diagnosis and treatment
- All human beings
- MDR


Start
BELTA-TBnet
100%
90%
80%
70%
60%
50%
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
Therapeutisch succes
Overleden
Therapiefalen
Geen follow-up

Position paper 9206: call for coordination with a view to eliminating tuberculosis in Belgium: threats and solutions (March 2016) (SHC 9206) (only available in Dutch or French)

In this position paper on public health policy, the Superior Health Council of Belgium provides an expert opinion on the tuberculosis eradication plan for the Belgian population and puts a particular focus on vulnerable people (homeless people, prison inmates and migrants). This position paper aims at providing the authorities in charge of Public Health, Social Security, Anti-poverty Policy and Justice, as well as the Immigration Office and various administrations and Belgian institutions concerned with tuberculosis with specific recommendations on the best scientific practice for tuberculosis eradication in Belgium (WHO 2050).

Fragmented competencies

Need for more coordinated approach accross communities and departments

TB: prevention or treatment??

Federal level

State structure

- **Fragmented competences**
- **Slow decision making process**
- **Particularly difficult for cross-cutting topics**

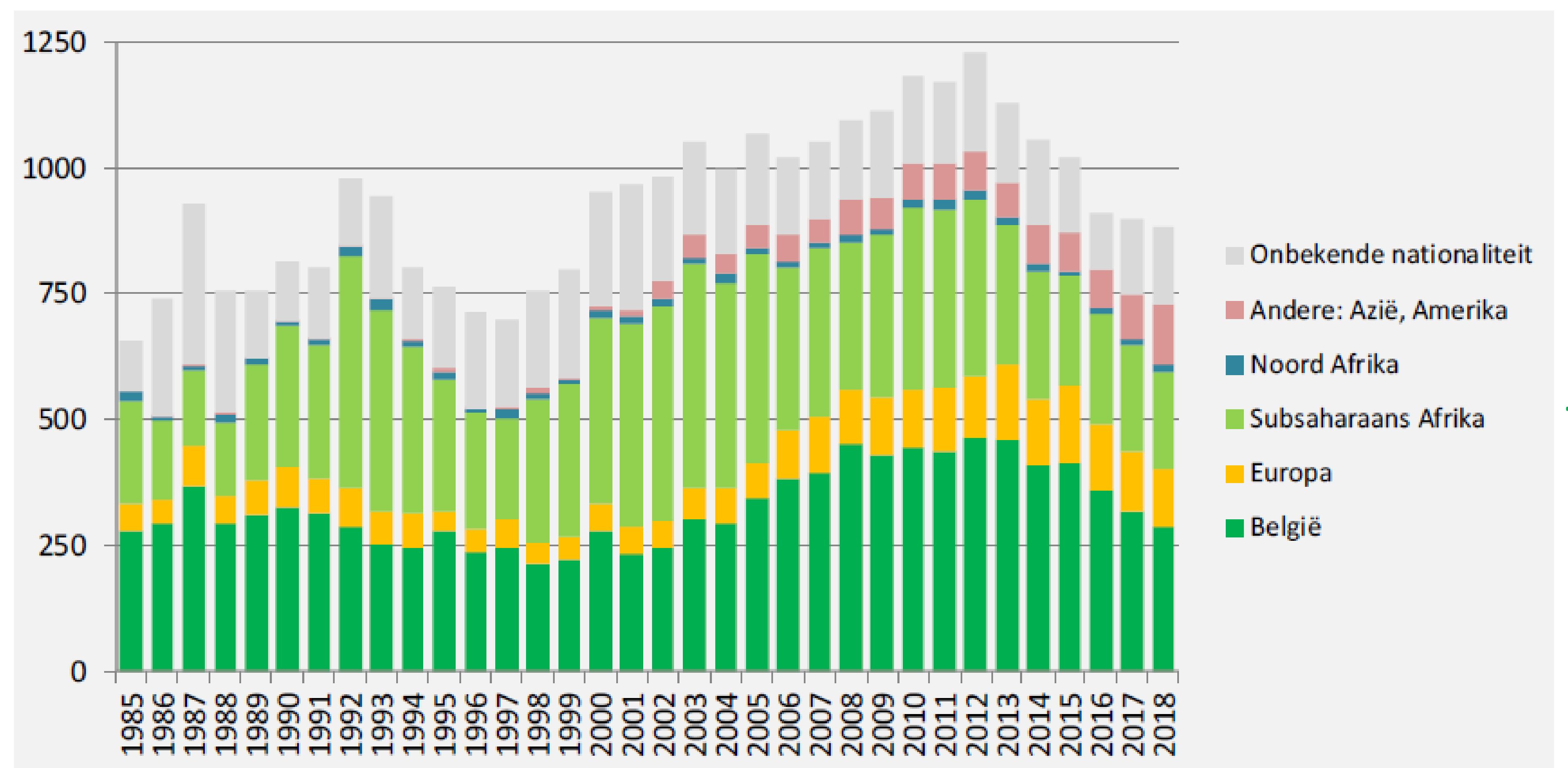
Three regions

1 federal MoH
3 regional MoH's (Flanders, Wallonie, Brussels)

3 official languages (+ English)

HIV in Belgium (2018)

Figuur 4. Evolutie van het jaarlijks aantal nieuwe hiv-diagnoses, per nationaliteit (gegroepeerd), België, 1985-2018



Cumulative PLHA: 16,673

New HIV in 2018: 882

Overall -38% since 2012!!

+50% LAM, SEA

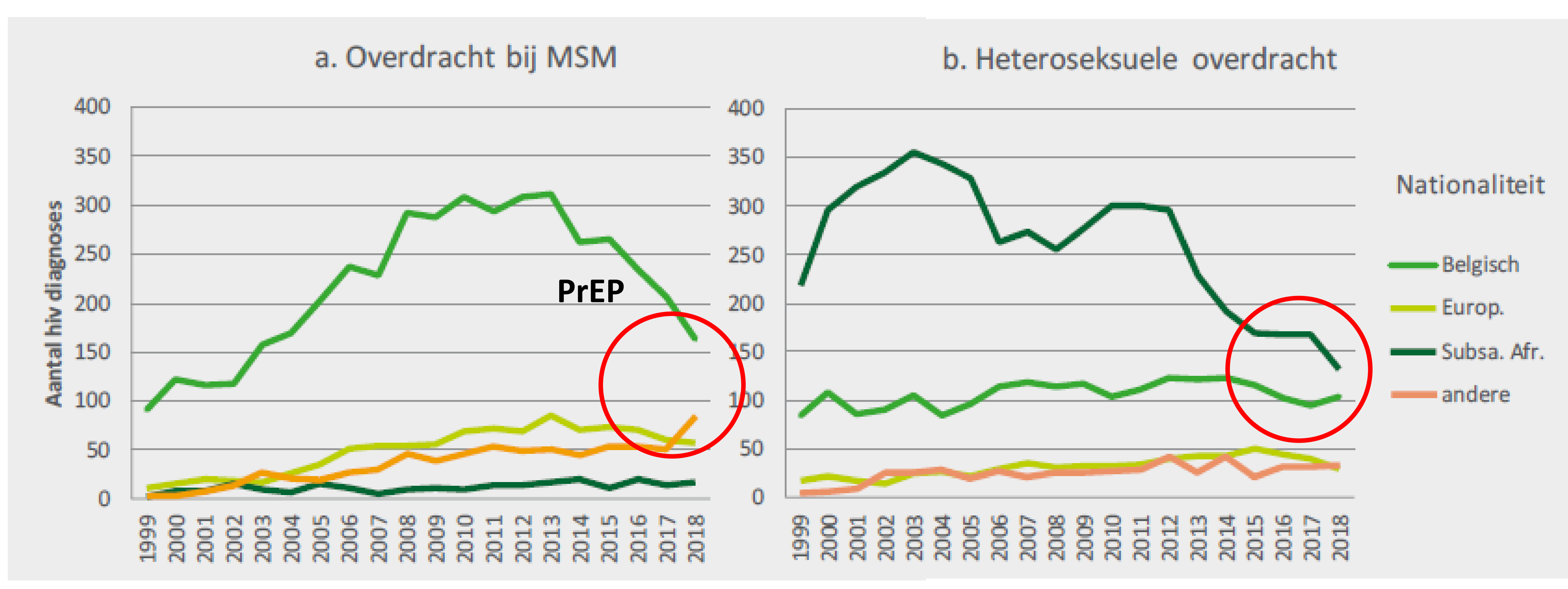
-43% in persons from sSA

49% MSM

47% hetero

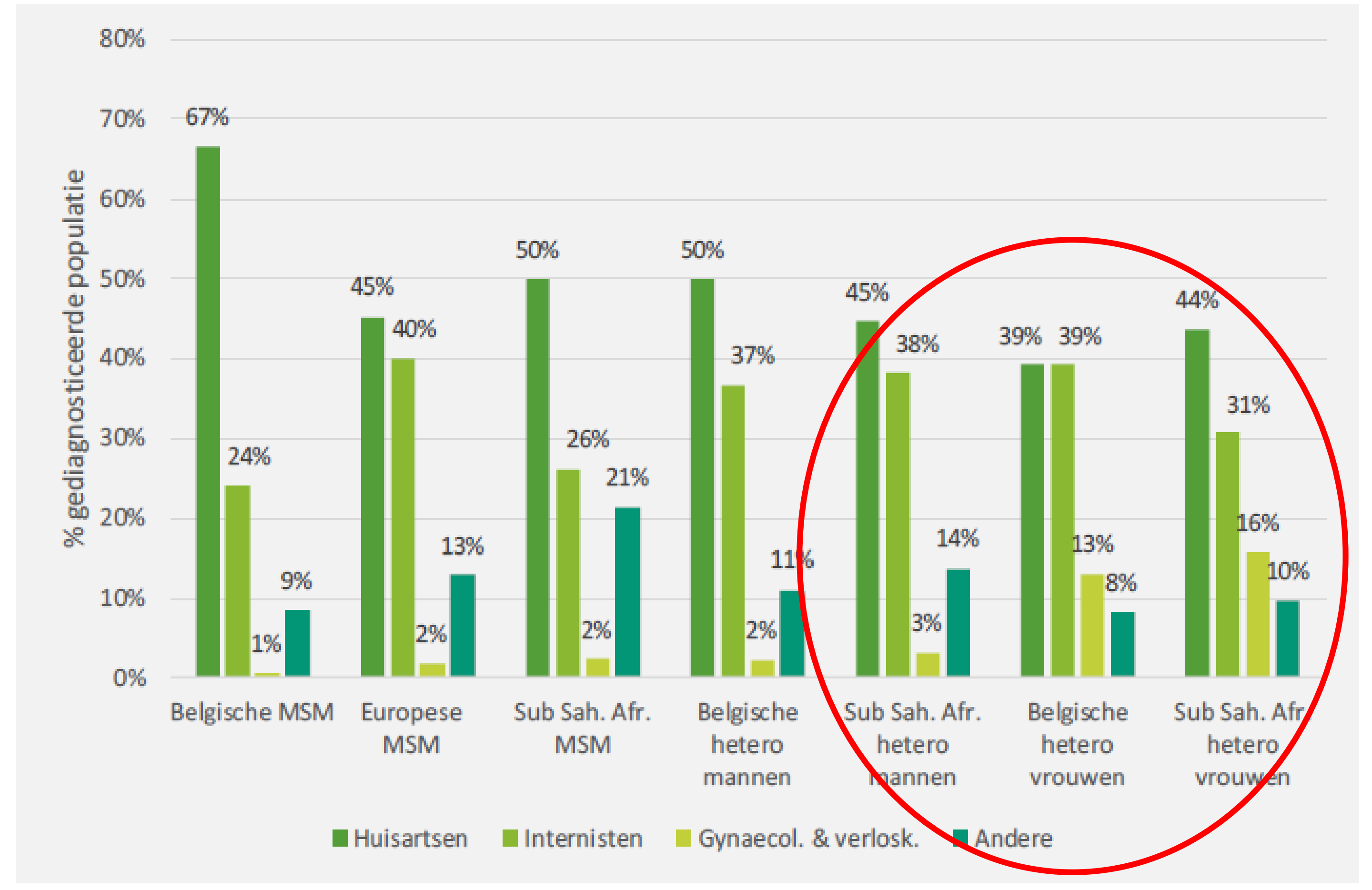
43% sSA (2/3 women)
34% Belgian

Figuur 6. Evolutie van het jaarlijks aantal nieuwe diagnoses per overdrachts-wijze en nationaliteit, België, 1999-2018



Who makes HIV-diagnosis?

Figuur 24. Type arts die de diagnose vaststelde per type populatie, 2016-2018.



Late diagnosis in 30-40%

Low treshold testing

First line
But also specialists

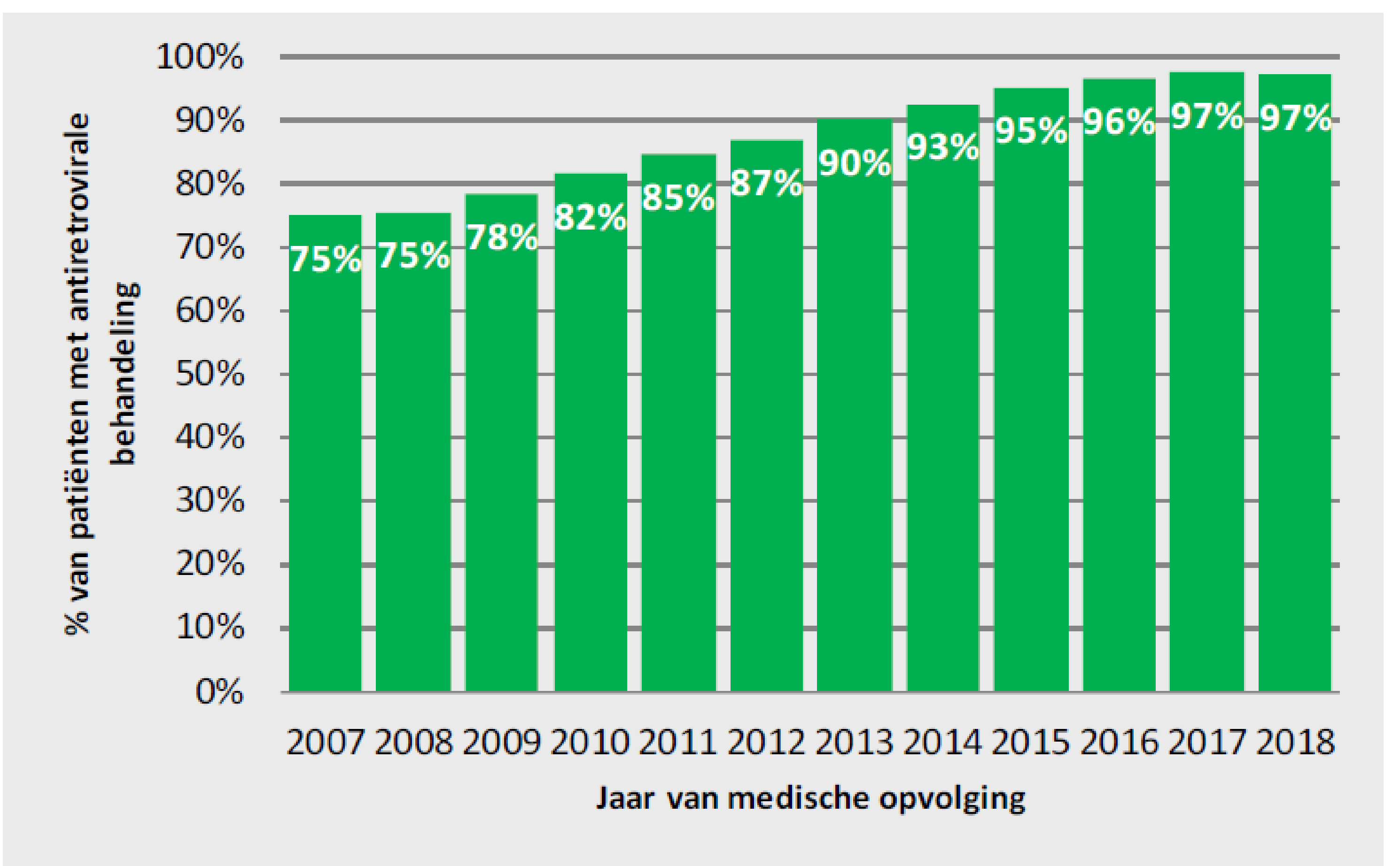
➔ Training needs:

- **Indicator diseases**
- **Use every opportunity…**

Barriers to testing:
-non-awareness (pt + doctor!)
-access to care
-(self)-stigma
-so many other things to do…

Excellent linkage to care

Figuur 37. Aandeel patiënten dat antiretrovirale behandelingen kreeg per jaar van opvolging in de Hiv-Referentiecentra, 2007-2018



91% with HIV have Dx

97% with Dx are on ARV

97% on ARV are undetectable

Provided access to care and treatment

Received: 4 December 2018 | Revised: 2 February 2019 | Accepted: 10 March 2019
DOI: 10.1002/jmv.25457

RESEARCH ARTICLE

WILEY

Prevalence and risk factors of hepatitis B virus infection in Middle-Limburg Belgium, year 2017: Importance of migration

Özgür M. Koc[1,2,3] | Cécile Kremer[4] | Rob Bielen[1,2] | Dana Busschots[1,2] | Niel Hens[4,5] | Frederik Nevens[6] | Geert Robaeys[1,2,6]

1131 people screened
Overall prevalence of HbsAg+ 0,97%

- **0,67 Belgians**
- **2,55% first generation migrants**

Litzroth et al. BMC Public Health (2019) 19:39
https://doi.org/10.1186/s12889-018-6347-z

BMC Public Health

RESEARCH ARTICLE Open Access

Low hepatitis C prevalence in Belgium: implications for treatment reimbursement and scale up

Amber Litzroth[1*], Vanessa Suin[2], Chloé Wyndham-Thomas[1], Sophie Quoilin[1], Gaëtan Muyldermans[1], Thomas Vanwolleghem[3,4], Benoît Kabamba-Mukadi[5], Vera Verburgh[2], Marjorie Jacques[2], Steven Van Gucht[2] and Veronik Hutse[2]

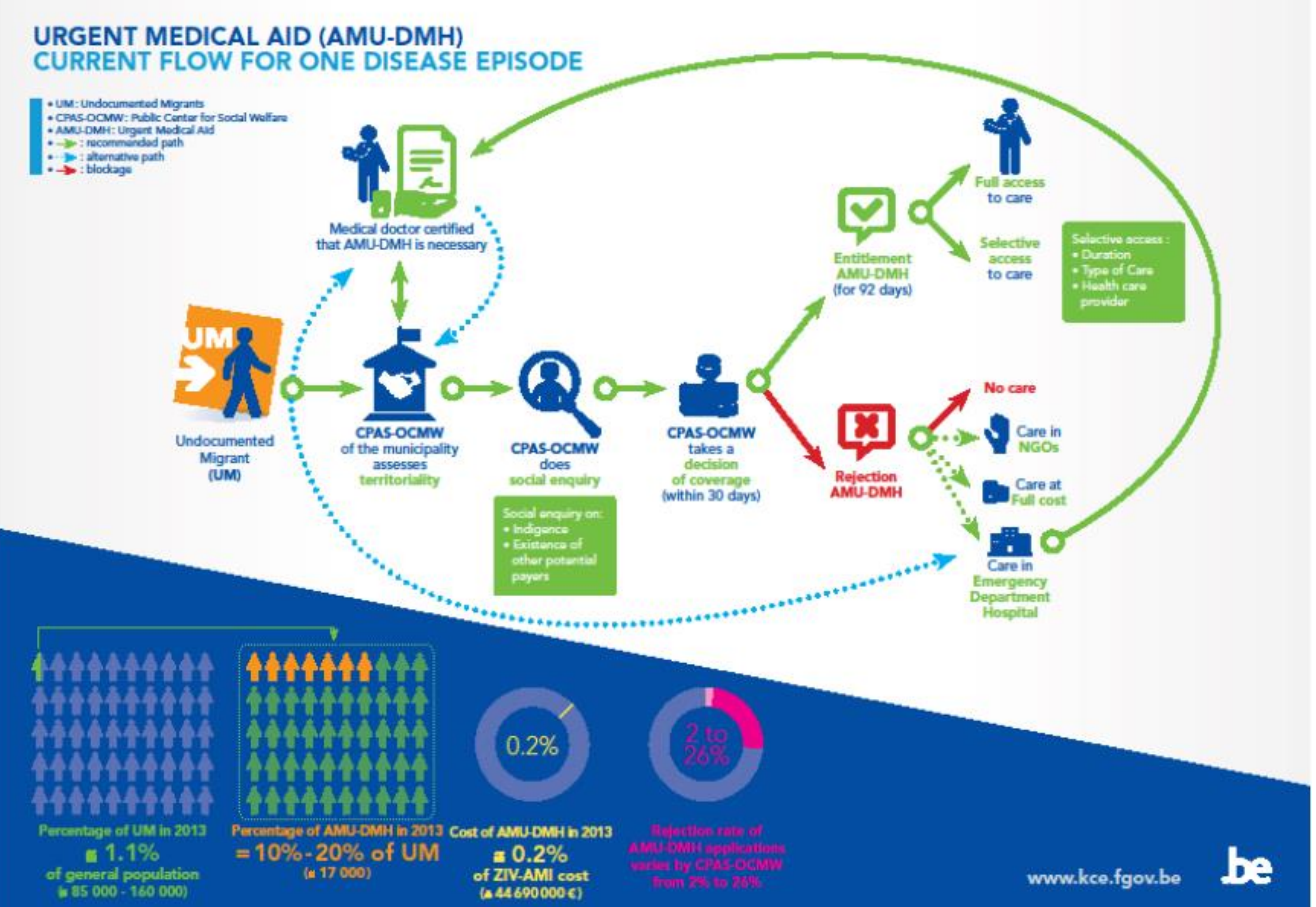
DAA reimbursed since 1/2019 (conditionally)

Calcumated prevalence HCV+ in general population 0,22%

Estimated prevalence of HCV in risk groups ~8%
- **HIV**
- **IVDU**
- **Prisoners**
- **migrants**

One of the main limitations of this study is that we may have underrepresented some specific risk groups, such as people with HIV/HCV coinfection, people with evidence of multiple transfusions, prisoners, migrants and injecting drug users (IDU). Due to exclusion of known immunocompromised individuals, we may have missed those people with HIV/HCV coinfection, which mainly occurs in men who have sex with men (MSM) and IDU. In 2013 there

Figure 1 – Overview of Urgent Medical Aid



Medical lifeline for patients without papers

Slow and bureaucratic process

Under threat by budget cuttings…

In de buurt > Brussel

“Schurft, malaria en tuberculose in Noordstation”: chauffeurs De Lijn vrezen voor eigen gezondheid

SZM | 03 mei 2019 | 19u35

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Brussel-Noord

Dokters van de Wereld: ‘Geen uitbraak van tbc, schurft of malaria in Brussel-Noord’

Een transitmigrant urineert nabij de stopplaats van De Lijn in Brussel-Noord.
Beeld Wouter Van Vooren

Federal and regional elections: 26/5/2019

Conclusions

- Newly arriving migrants
  - generally healthy population
  - minimal impact on local epidemiology/’medical footprint’
- Later stages of migration
  - Social determinants influence health
  - Burden of disease for individual health
  - Access to care = essential
- Coordination across sectors
- Neutral and objective approach is essential

Thanks to…

- Wouter Arrazola de Oñate/VRGT
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- Commissariaat Generaal voor de Statenlozen
- Collega’s ITG & UA
- Patients who happen to be migrants/refugees