

Minimal Occurrence of Suspected Tuberculosis among Immigrants of War from Ukraine Shelters and Orphanage in Comparison to HIV Positive Cambodian Children from Orphanage

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Original Article

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Abstract:

Armed conflicts are connected with huge migration and refugees of war transfer at borders often without appropriate checks for vaccination, or immunization calendars. Within the last 10 years due to war, sporadic cases of measles and polio have been exported from Syria to Israel or from Afghanistan to Pakistan and vice versa (12). The aim of this study was to compare occurrence of Tuberculosis in 2 shelters, 1 with refugees of war and 1 with orphans, 1 from Ukraine and the second in Cambodia and a shelter of homeless people in Jarna Slovakia (3 countries of different incidence of TB).

Introduction

Several outbreaks have followed: industrial; seismologic; armed conflict; related catastrophes or natural disasters. Floods are mostly related with ID outbreaks such as Hepatitis A, *Leptospira* spp and cholera; armed conflicts with measles (Syria) cholera (Yemen, Rwanda).

Due to large number of refugees, no time for accurate vaccination control and checks at the border is possible. In 2015, our teams when facing 20-28,000 refugees of war from Iraq and Syria at Health Post Nickelsdorf AT, were unable to check any data on vaccination.

Due to such events with large migration and travel emergencies (Kabul Dec. & Jan. 2021-22) subsequent checks for ID with rapid tests are performed, when exodus is regulated, e.g. in Italy and Greece after ship events when routine checks with rapid tests for HIV, HBV, HCV and malaria performed after emergency landings in Malta, Lampedusa, Sicily, Canaria, Lesbos, Chios and other EU border hotspots in the Mediterranean.(1-3). No real rapid test for TB is available, and closest to the ideal test is probably Gene X pert rapid test, when after 30 minutes results can be obtained and suspected cases are radiographed or tested with PPD. In such cases when no time or sources for Gene X pert test are available, a simple WHO recommended questionnaires is available.

Patients and Methods

Three settings with the simple WHO questionnaire or interview are:

1. Phnom Penh 101 children of Cambodian origin, 30 of them underwent also Gene X pert testing
2. Vyšne Nemecke Border, Pruske Guest House and Shelter, and the Bratislava Shelter (refugees of war from Ukraine in March 2022)

3. Jarna Homeless Shelter, Trnava District-and, Mea Culpa Homeless Shelter Bratislava (homeless population)

Results and discussion

1 Phnom Penh HIV orphanage setting

From 102 children 50 (about 50%) were treated for TB; from the rest all were negative for Gene X pert testing. However, the Kingdom of Cambodia is among SEA countries with overall incidence for more than 800 per 100.000 population.

2 Ukraine Border, and Shelter setting, migrants of war

Between Feb. 28 & March 28, 102 refugees of war were questioned, none of them reported positive answers to any of 5 questions (unexplained cough last 3 months; weight loss 10% and more; fever of unknown origin, previous diagnosis of TB or chronic lung disease; (contact or family presence with /of TB known positive persons). The reason for zero positive answers may be also the fear of a travel ban, or of a quarantine, or of deportation. However, Covid testing was negative. Also, the incidence of TB in UA is 10 times less than in Cambodia, and primary healthy population is escaping, with a small proportion of at risk individuals such as COPD, low SE status; homelessness; chronic lung disease; higher age; etc.

HIV is 10 times less frequent in Ukraine in comparison to Kingdom of Cambodia. In addition when checking 10 individuals in the Pruske Shelter and the Bratislava Main University temporary shelter for transit, none of 39 people transiting reported even one positive answer on any question of the WHO adapted test / questionnaire.

3 Slovak Shelter for Homeless Setting

In Jarna where 10 homeless and 21 low socio-economic status based families from the Roma marginalized community are located, only 1 case was noted without any coincidence with homeless, paradoxically in the only regularly employed and working person. In another homeless, elderly, non-migrant person, anamnestic receipt of anti TB drugs was noted.

Conclusion

Paradoxically, positivity of the questionnaire based screening for clinical check, or Gene X pert PCR based diagnostic sampling was highest in the community of orphans with HIV, where up to 50% were on anti TB triple therapy; however, none of them had confirmed active TB with the Gene X pert test.

The 2nd community with 1 confirmed and 1 suspected case was the homeless sheltered Slovak / Roma population from Jarna.

At the 3rd community, Ukrainian refugees of war, none responded positively to the WHO structured rapid questionnaire. The reason is, that a primary healthy population was escaping the conflicts, mainly children and young mothers; the proportion of males was 2%, and no at risk population was present among the Ukrainian cohort (HIV, smokers, homeless, low SE status, contacts etc.).

Another explanation of zero occurrence of TB among refugees of war from Ukraine is, that in UA still anti TB vaccine is administered routinely and is compulsory in children over last 70 years, in contrast to Slovakia, where the elderly population and children in last 10 years received no vaccine, since the incidence in SK dropped below 6 per 100.000, as it is in most EU countries.

Renewal of TB vaccination therefore is advisable, since sporadic cases have been observed in our study only in the Slovak population of homeless.

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