

diseases (syphilis, malaria, tuberculosis and bacterial pneumonia) in developing countries could prevent more than 1.2 million deaths annually. In resource-limited settings, laboratory medicine is still one of the most neglected pillars of the health care. In such settings, primary health care services largely depend on diagnostic point of care testing; therefore the benefits need to outweigh the costs. To optimise the diagnostic point-of-care, there is a need for strict evaluation focused on relevant clinical outcomes and operational costs and these evaluations differ from the conventional tests. However, there is no consistent, standardized approach to assess the point-of-care testing technologies in resource-limited settings. Diagnostic point-of-care testing possesses significant importance in infections like TB or HIV, because it eliminates the long turnaround times and delays and the resulting loss of patients from the testing and therapy pathway. An ideal rapid diagnostic point-of-care test used in resource-limited settings should fulfil the following criteria: allowing a quick clinical decision, can be used by a health care worker (possibly by a nonprofessional), affordable, rapid, acceptable test efficacy, and cost effectiveness.

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Session: *Infectious Diseases in Refugees, Migrants and Internally Displaced Persons*

Date: Saturday, March 5, 2016

Time: 10:15-12:15

Room: G.01-03

Infectious diseases in refugees and migrants during the European Migrant Crisis 2015



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Abstract: Migrant Crisis in Europe 2015 had two major routes, Balkan route via Greece, Hungary, Austria to Germany and African route with mainly economic refugees and migrants via Mediterranean Malta Lampedusa, Sicily to continental Italy, France, Spain and UK. Here we present first data on migrant health of the Balkan route from September to October 2015.

About 316 000 political and humanitarian refugees, 95% from Syria, Iraq and Afghanistan passed through checkpoint Hegyeshalom, Nickelsdorf 50 km east from Vienna and 10 km from Bratislava, between September 6th and October 20th. Most of them were healthy young people with children, about 10 percent sick per transport, in 97 trains from Zakanyi Croatian Boundary or Röszke, HU- Serbian Boundary to Hegyeshalom, Nickelsdorf HU, AT checkpoint. Sick patient's reported themselves to the symptomatic field health center with 8-12 HC Tropicteam staff serving in 5 languages. In RTI patients, nasal/tonsil swabs was taken to Mueller Hinton agar and transported to National reference Laboratory for ATB resistance, Nitra, SK.

No major tropical diseases were noted, no case of malaria or leishmaniasis was detected. Even less cases of emerging ID including HIV and tuberculosis were detected as well. Majority of ID included pneumonia upper respiratory tract infections, skin and soft tissue infections, scabies, few cases (<3%) of diarrhoea but no case of cholera have been observed in described period. Among acute cases, diabetic coma, myocardial infarction, hypertension crisis and has been noted. From 155 positive results from bacteriology from migrants, only 2 MRSA strains and 3 penicillin resistant

pneumococci were obtained, the rest was commensal bacterial flora and *Candida albicans*.

Balkan route in refugee crisis in 2016 in Europe from Syria, Iraq does not represent major health threat to continental EU, only few cases of transmissible diseases were noted and an absence of tropical diseases, multiresistant pathogens and no outbreaks were observed within first 2 months of exodus. Only few MRSA and penicillin resistant strains from patients from upper and lower respiratory tract infections were isolated. Spectrum of diagnoses was similar to surrounding Slovak, Hungarian and Austrian population of that EU region.

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From evidence to impact: Improving treatment for Kala Azar patients in India



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Background: Visceral leishmaniasis (VL), or Kala-Azar is a life-threatening systemic infection caused by protozoan *Leishmania*, with sand flies as its vectors affecting the poorest of the poor people. India bears 50% of global VL burden and was committed to eliminate VL elimination by 2015. New treatment modalities were proposed by WHO since 2010, yet first line treatment in India has remained unchanged since 2006. The 2014 release of India National Road Map of Kala azar Elimination marked a milestone in the progress towards the elimination goal: Single Dose liposomal amphotericin B (Ambisome®) or SDA was adopted in the national programme. Role of evidence in the policy change is explored.

Methods & Materials: Médecins Sans Frontières (MSF) started a VL treatment programme in Bihar, India since 2007, using 20 mg/kg intravenous Ambisome and treated over 11,000 patients with excellent results. With lack of high quality evidence, a phase 4 trial of new treatment modalities including SDA was commenced in August 2012 by MSF, Drug for Neglected disease initiative (DNDi) and Rajendra Memorial research Institute (RMRI). Effectiveness and safety data presented in December 2013. Additionally, a qualitative study to determine patient perspectives of these new treatments was conducted. At the same time, advocacy wise, a successful negotiation with Gilead as Ambisome producer has led to free donation of the drug to the Indian Government, further facilitating the process towards policy change.

Results: By supporting MoH facilities in implementing alternative regimen such as Ambisome, MSF demonstrated its feasibility at different level of health care, including primary health centres. Evidence from formal trial is indispensable; however, debunking the perception that such a 'complex' treatment could not be implemented as first line treatment was as important. Various factors