Prevalence of intestinal parasitic infections among asylum seekers

We read the article "Parasitic stool testing in newly arrived refugees in Calgary, Alta"[1] in the December issue of *Canadian Family Physician* with great interest. DeVetten and colleagues concluded that, given the high prevalence of positive test results for intestinal parasites observed in some refugee groups, targeted screening should be considered in newly arrived refugees at greater risk of infection.

In the Asylum Seekers Centre of Castelnuovo di Porto (one of the largest centres in Italy), 300 migrant newcomers from sub-Saharan Africa, upon their arrival, were screened for protozoa and helminth eggs from March to May 2017. Asylum seekers were divided by geographic area of origin into those from West Africa (n = 159) and those from East Africa (n = 141). The results of stool analysis showed a prevalence of intestinal parasitic infections of 20.12% in migrants from West Africa and 23.40% in those from East Africa, with no statistically significant differences; the overall prevalence in the studied population was 21.66%. In total, 10% of the participants reported recently receiving an antiparasitic treatment for the presence of abdominal symptoms.

This result was somewhat unexpected, as prevalence rates of intestinal parasitosis were different from those reported for the migrants' geographic regions of birth.[2-4] It is likely that the prevalence of intestinal parasitic infections among asylum seekers can be influenced not only by geographic area of origin but also by migration route. In particular, in some cases migrations from different geographic regions partially take place on common routes, such as along the coasts of North Africa and the Mediterranean.[5] Moreover, migrations are often interrupted by economic problems and detention in prison. In these cases, the mixture of different ethnic groups in common areas for long periods might affect the overlap in prevalence of intestinal parasitosis among different migrant populations.

Therefore, we agree with the suggestions of DeVetten et al about the importance of screening for intestinal parasites in newly arrived refugees. However, we believe that the identification of groups at risk might present some substantial difficulties if it is based only on geographic origin.

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Acknowledgment

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Competing interests

None declared

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Pour reconnaître la stigmatisation

Nous savons gré à Dre Dubin et à ses collègues[1] d'avoir attiré l'attention sur l'obstacle aux soins aux patients que constitue la stigmatisation et d'avoir expliqué certains de ses moteurs dans le système de soins de santé canadien. La complexité du processus de stigmatisation est largement reconnue, et des efforts considérables ont été déployés pour en comprendre les différentes formes et les facteurs qui y contribuent[2]. Comme Dubin et collègues l'indiquent dans leur commentaire, la stigmatisation est souvent abordée en termes de stéréotypes ou d'actes de discrimination manifestes (la stigmatisation effective); il est important de noter toutefois que la stigmatisation peut être vécue de plusieurs façons, souvent interdépendantes. Par exemple, la simple conscience des attitudes sociétales négatives ou l'anticipation de subir une