Modern practice of TB care considering chronic cases and migrants

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Recommended re-treatment regimens

<table>
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<tr>
<th>Patient diagnostic category</th>
<th>TB patient diagnostic category</th>
<th>TB treatment regimens</th>
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</table>
| II                          | Relapses                      | **Preferred** 2 HRZES/1 HRZE  
                            | Treatment after default     | **Preferred** 5 HRE          |
|                             |                               | **Optional** 2 (HRZES)$_3$/1 (HRZE)$_3$  
                            |                               | **Optional** 5 (HRE)$_3$      |
| II                          | Treatment failure of Category I | **Preferred** 2 HRZES/1 HRZE  
                            |                               | **Preferred** 5 HRE           |
|                             | *In settings where:*  
                            | Representative DRS data show low rates of MDR-TB or individualized DST shows drug-susceptible disease  
                            | or  
                            | *In settings of:*  
                            | • Poor programme performance;  
                            | • Absence of representative DRS data and/or capacity for DST of cases;  
                            | • Insufficient resources to implement Category IV treatment. |
| IV                          | Treatment failure of Category I | **Preferred** 2 HRZES/1 HRZE  
                            |                               | Specially designed standardized or individualized regimens with the use of 2nd-line drugs  
                            |                               | **Preferred** 5 HRE           |
| IV                          | Still smear- or culture-positive after supervised re-treatment regimen; proven or suspected MDR-TB cases* | Specially designed standardized or individualized regimens with the use of 2nd-line drugs |
End-of-life supportive measures

BOX 13.1 END-OF-LIFE SUPPORTIVE MEASURES

- **Pain control and symptom relief.** Paracetamol, or codeine with paracetamol, gives relief from moderate pain. Codeine also helps control cough. Other cough suppressants can be added. If possible, stronger analgesics, including morphine, should be used when appropriate to keep the patient adequately comfortable.

- **Relief of respiratory insufficiency.** Oxygen can be used to alleviate shortness of breath. Morphine also provides significant relief from respiratory insufficiency and should be offered if available.

- **Nutritional support.** Small and frequent meals are often best for a person at the end of life. It should be accepted that the intake will reduce as the patient’s condition deteriorates and during end-of-life care. Nausea and vomiting or any other conditions that interfere with nutritional support should be treated.

- **Regular medical visits.** When therapy stops, regular visits by the treating physician and support team should not be discontinued.

- **Continuation of ancillary medicines.** All necessary ancillary medications should be continued as needed. Depression and anxiety, if present, should be addressed.

- **Hospitalization, hospice care or nursing home care.** Having a patient die at home can be difficult for the family. Hospice-like care should be offered to families who want to keep the patient at home. Inpatient end-of-life care should be available to those for whom home care is not available.

- **Preventive measures.** Oral care, prevention of bedsores, bathing and prevention of muscle contractures are indicated in all patients. Regular scheduled movement of the bedridden patient is very important.

- **Infection control measures.** The patient who is taken off antituberculosis treatment because of failure often remains infectious for long periods of time. Infection control measures should be continued (see Chapter 15).
Top ten countries with migrants; world, 2009

- United States of America: 42.8
- Russian Federation: 12.3
- Germany: 10.0
- Saudi Arabia: 7.3
- Canada: 7.2
- France: 6.7
- United Kingdom: 6.5
- Spain: 6.3
- India: 5.4
- Ukraine: 6.3

214 million migrants in the world
77 million (36%) in WHO EUR

UN Population Division. *International Migration 2009*
Migration and health

Most migrants are healthy but conditions surrounding the migration process and the new life in the host community can pose health risks:

- Increased vulnerability to determinants of ill-health
- Inequitable access to health services
- Sub-standard quality of health care
- Higher negative impact when sick
TB notified cases by origin; EU-15, 2008

Note: in most of countries, origin of cases is decided according to the birthplace

MDR-TB among TB cases with DST by national and foreign origin; EU-15, 2008

TB detection in migrants; Russia, Mar-Dec 07

600,000 persons examined –
3,058 TB cases detected (>500 per 100,000)

- 20.8% (699) - hospitalized
- 11.7% (394) deported
- 67.5% (2,267) unknown

Source: N. Frolova, Unit for Surveillance of Inf. and Parasitic Diseases, Moscow. Presentation in Wolfheze 2008
Survey on migrant workers; Tajikistan, Apr-Jun 09

- Joint IOM-WHO/EURO survey in Apr-Jun 2009: interview of 509 migrant workers and 10 TB patients
- Construction industry (74%), services (10%); 8% trade (6%)
- Housing abroad: sharing room with 4 people (24%), with 5-8 people (20%), sleeping in workplace (24%)
- 53% without any sick benefit from the employer
- 47% fell sick while abroad, 31% sought medical treatment, 58% paid for medical treatment
- 10 workers with TB (in-depth interview):
  - All of them developed TB symptoms and were diagnosed in Russia
  - Returned to Tajikistan because of high cost of treatment and fear of deportation
  - Six migrants incurred catastrophic expenditure
- Roundtable in Moscow, 21 Jul 09: IOM, WHO, countries authorities (Health & Migration).
  Recommendations for joint assessment, amendments in countries’ legislation, unified system of medical control, obligatory medical insurance, bilateral agreement, pilot in Tajikistan
Resolution WHA 61.17

Calls for:
- Migrant-sensitive health policies
- Equitable access to services
- Information systems to assess migrant health
- Sharing information on best practices
- Raising cultural and gender sensitivity and specific training of health service providers and professionals
- Bi/multilateral cooperation among countries
- Reducing the global deficit of health professionals
## WHO/IOM consultation on Migrant Health (Madrid, 3-5 Mar 10): main recommendations

<table>
<thead>
<tr>
<th>Monitoring Migrant Health</th>
<th>Policy- legal frameworks</th>
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<tbody>
<tr>
<td>• To ensure the <strong>standardization</strong> and comparability of data on migrant health</td>
<td>• To adopt relevant international standards on the protection of migrants and respect for <strong>rights</strong> to health in national law and practice</td>
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<td>• To support the appropriate <strong>aggregation</strong> and assembling of migrant health information</td>
<td>• To implement national health policies that promote <strong>equal access</strong> to health services for all migrants</td>
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<td>• To map <strong>good practices</strong> in monitoring migrant health, policy models, health system models.</td>
<td>• To extend <strong>social protections</strong> in health and improve social security for all migrants.</td>
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<th>Migrant sensitive health systems</th>
<th>Partnerships, networks, multi country frameworks</th>
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<td>• To ensure that health services are delivered to migrants in a culturally and linguistically appropriate way</td>
<td>• To establish and support migration health dialogues and <strong>cooperation</strong> across sectors and among large cities and countries of origin, transit and destination</td>
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<td>• To enhance the capacity of the health and relevant non-health workforce to address the health issues associated with migration</td>
<td>• To address migrant health matters in <strong>global and regional consultative migration</strong> economic and development processes (e.g. Global Forum on Migration and Development).</td>
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<td>• To deliver migrant inclusive services in a comprehensive, coordinated, and financially sustainable fashion.</td>
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Socioeconomic determinants of TB

Weak and inequitable economic, social, environmental policy

Globalization, migration, urbanization, demographic transition

Poverty, low social-economic status, low education

Weak health system, poor access

Age, sex, genetic factors

Inappropriate health seeking

Unhealthy behaviour

HIV, malnutrition, lung diseases, diabetes, alcoholism, etc.

Tobacco smoke, air pollution

Active TB cases in community

Crowding, poor ventilation

Crowding, poor ventilation

Tobacco smoke, air pollution

Impaired host defence

High level contact with infectious droplets

Consequences

Exposed

Infection

Disease

Addressed by and with:

National TB Programme

Other health programmes

Other sectors

Lönnroth K et al. Drivers of TB epidemics: the role of risk factors and social determinants. Social Science and Medicine 68 (2009) 2240-2246

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Tashkent, 15 April 2011
Three levels of action for NTP

Within NTP and with other public health programmes

- Improve management of co-morbidities (HIV, diabetes, etc.)
- Undertake interventions for risk populations (PLWH, homeless, prisoners, etc.)

Involving the health system

- Strengthen all health system functions to improve capacity in addressing TB determinants

Beyond health system (upstream TB determinants)

- Improve social, economical and environment conditions of TB patients/families
- Coordinate with other sectors
- Advocate for social changes
Examples for action on TB and migration

The status of migrant increases the risk of TB infection, TB disease, poor access to health services, treatment defaulting and drug resistance, death

**Level 1 actions (NTP and public health programmes)**
- Screen for TB early detection
- Use of peer educators/mediators for treatment observation and patient support
- Education of migrants, training of TB providers on co-morbidities and cultural sensitivities

**Level 2 actions (health system)**
- Provide services (TB and co-morbidities) free-of-charge; confidential access also to illegal migrants; information about patients’ rights; legal assistance
- Decentralize TB services at primary care level to increase access

**Level 3 actions (beyond health system)**
- Collaboration between ministries (health, migration) for access to services
- Collaboration between countries (donor and recipient) for access to services
- Awareness campaigns against anti-discrimination measures
Wolfheze 2010: 31 May – 3 Jun 2010

…..a working group was established at this 20-year jubilee edition of Wolfheze Workshops. ….the working group will define the minimum standards of TB care across the borders to ensure patients’ rights and public health interests.