Modern practice of TB care considering chronic cases and migrants

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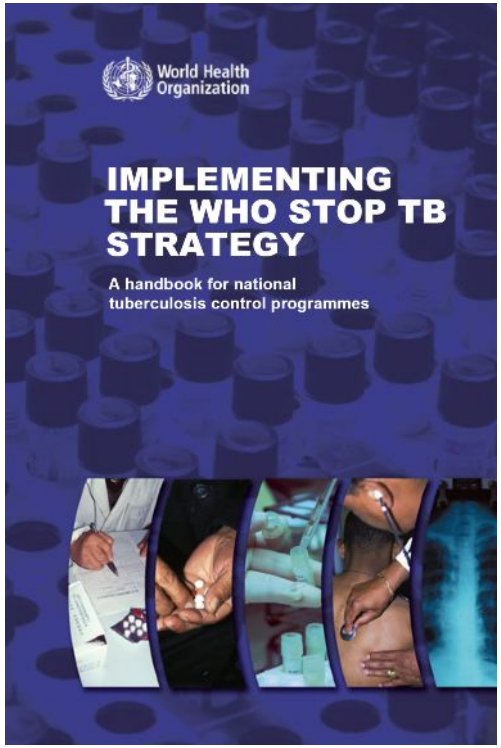
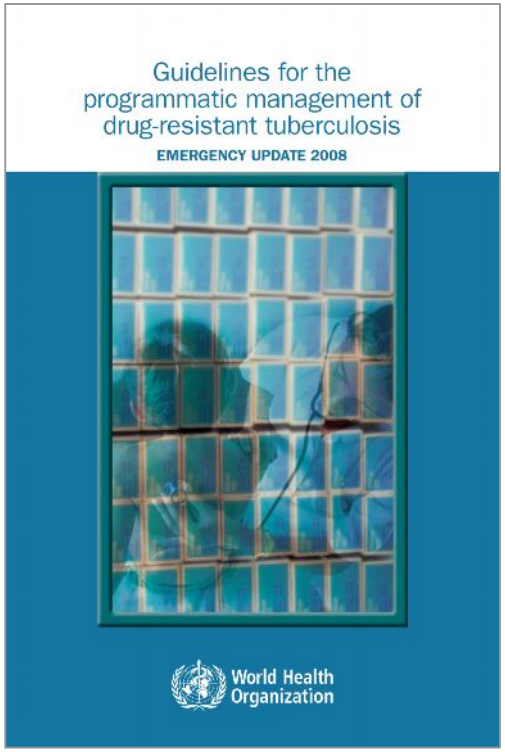
Recommended re-treatment regimens



Patient diagnostic category	TB patient diagnostic category	TB treatment regimens	
		Initial phase	Continuation phase
II	Relapses Treatment after default	**Preferred** 2 HRZES/1 HRZE **Optional** 2 $(HRZES)_3$/1 $(HRZE)_3$	**Preferred** 5 HRE **Optional** 5 $(HRE)_3$
II	**Treatment failure of Category I** *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.	**Preferred** 2 HRZES/1 HRZE **Optional** 2 $(HRZES)_3$/1 $(HRZE)_3$	**Preferred** 5 HRE **Optional** 5 $(HRE)_3$
IV	**Treatment failure of Category I** *In settings with:* • Adequate programme performance; • Representative DRS data showing high rates of MDR-TB and/or capacity for DST of cases; • Availability of 2nd-line drugs.	Specially designed standardized[b] or individualised regimens with the use of 2nd-line drugs	
IV	Still smear- or culture-positive after supervised re-treatment regimen); proven or suspected MDR-TB cases[c]	Specially designed standardized or individualised regimens with the use of 2nd-line drugs	

End-of-life supportive measures



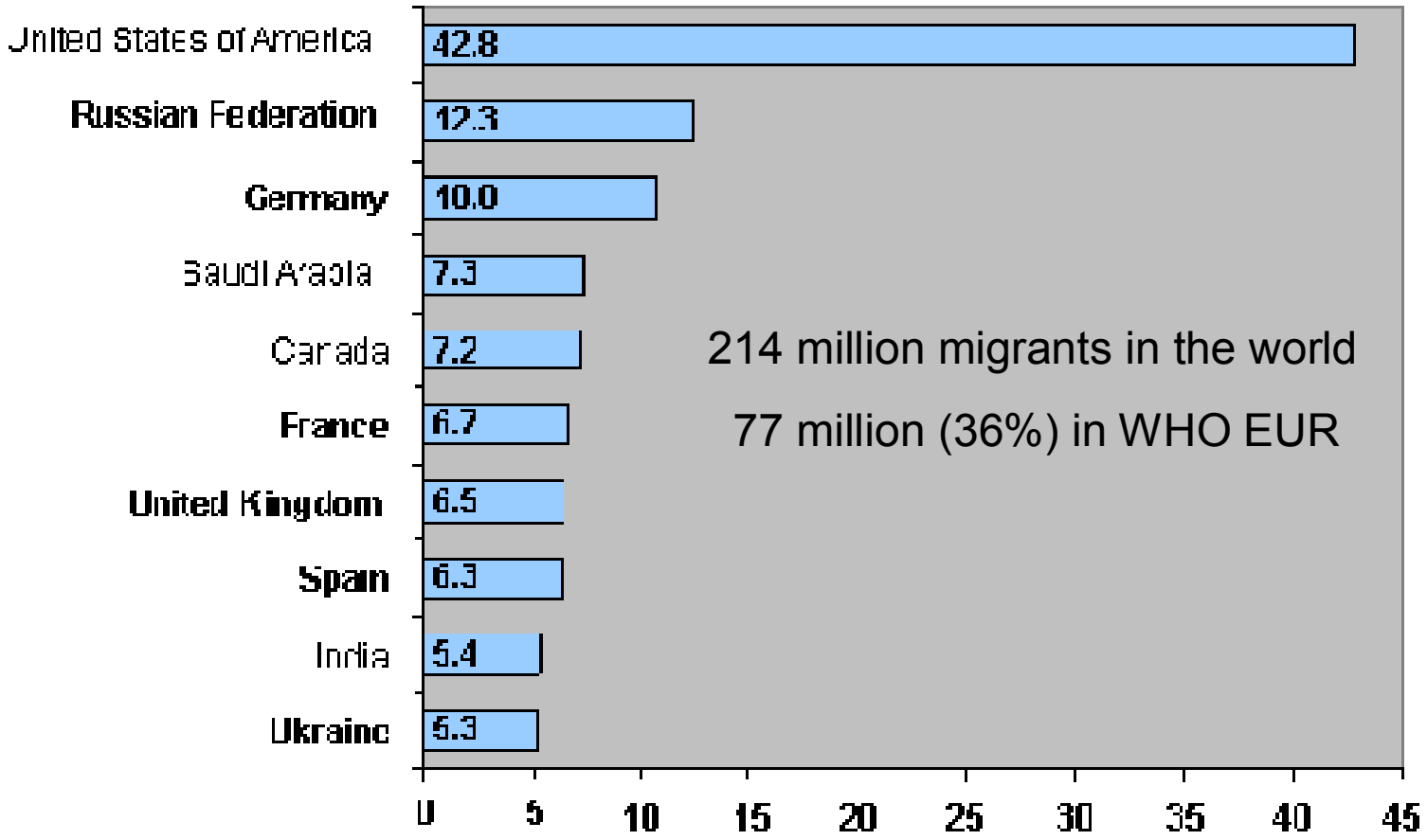
BOX 13.1 END-OF-LIFE SUPPORTIVE MEASURES

- **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).

Migration is a fact of life

Source: IOM

Top ten countries with migrants; world, 2009



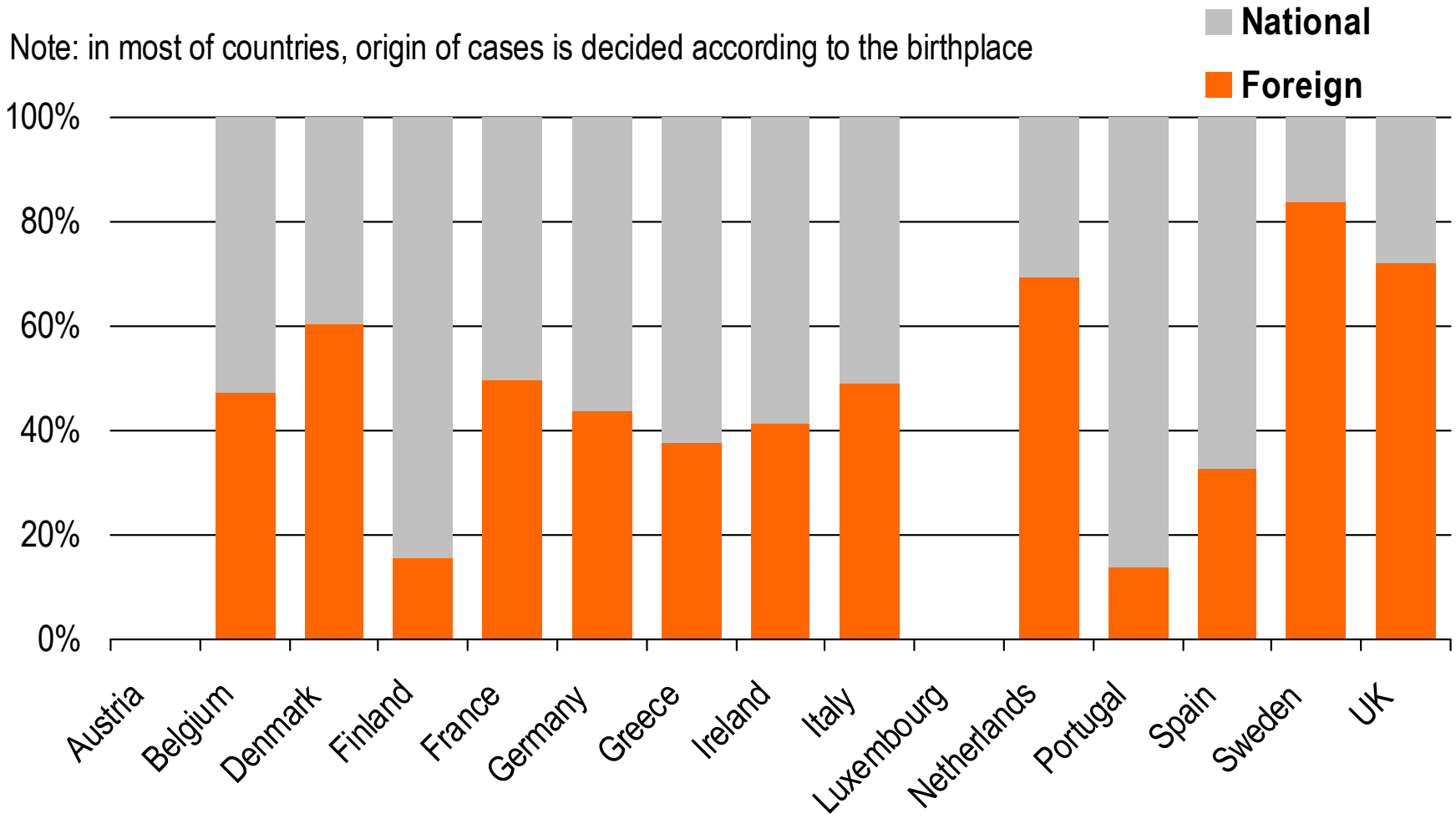
UN Population Division. *International Migration 2009*

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:

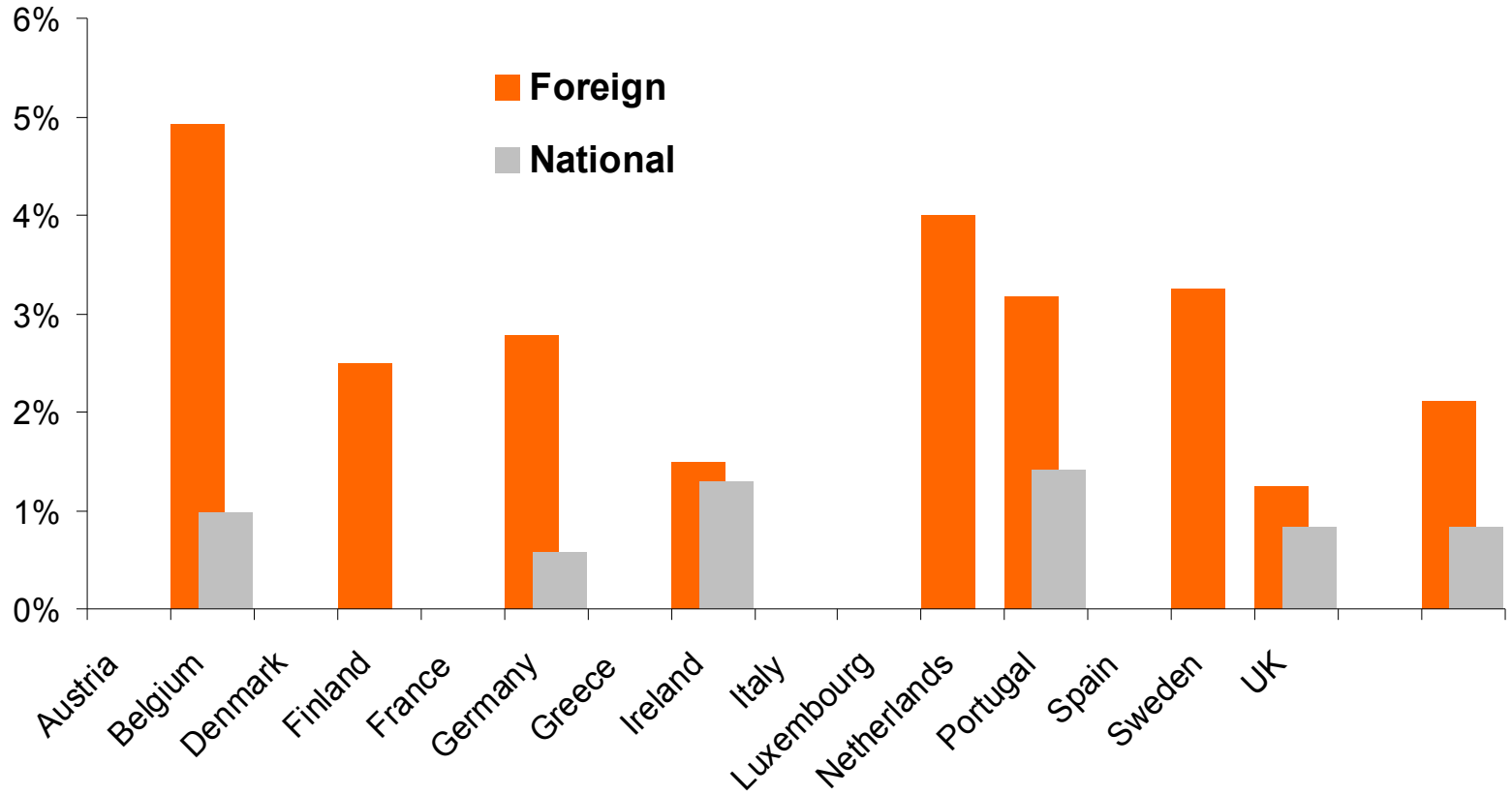
- Increased vulnerability to determinants of ill-health
- Inequitable access to health services
- Sub-standard quality of health care
- Higher negative impact when sick

TB notified cases by origin; EU-15, 2008



ECDC/WHO-EURO: *Tuberculosis surveillance in Europe 2008*. Stockholm, ECDC, 2010

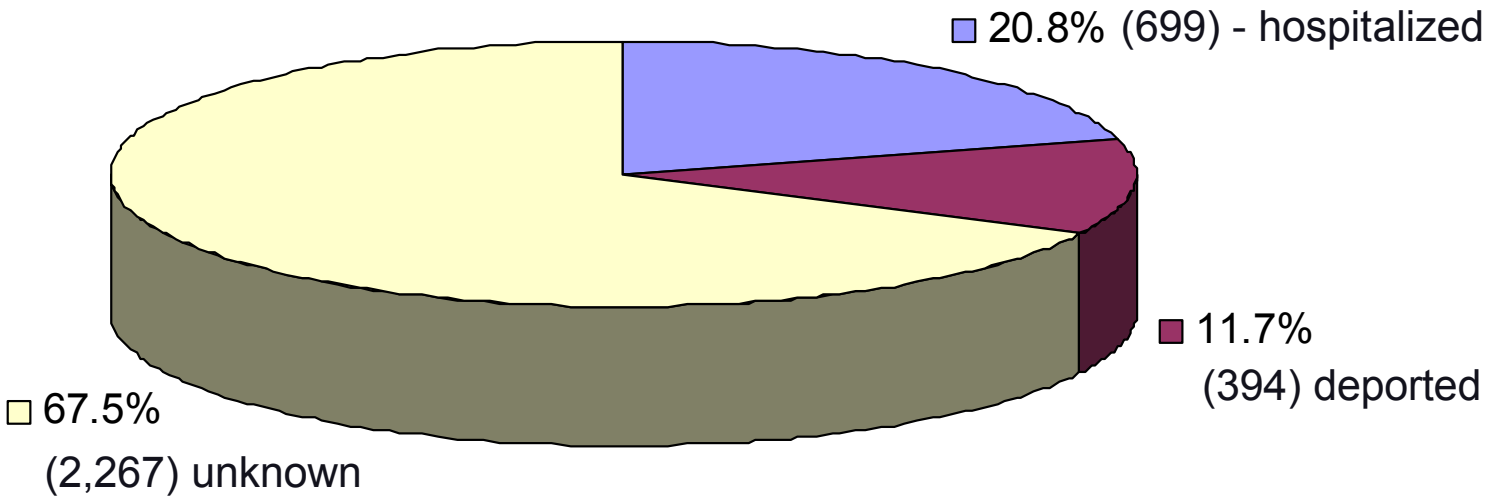
MDR-TB among TB cases with DST by national and foreign origin; EU-15, 2008



ECDC/WHO-EURO: *Tuberculosis surveillance in Europe 2008*. Stockholm, ECDC, 2010

TB detection in migrants; Russia, Mar-Dec 07

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

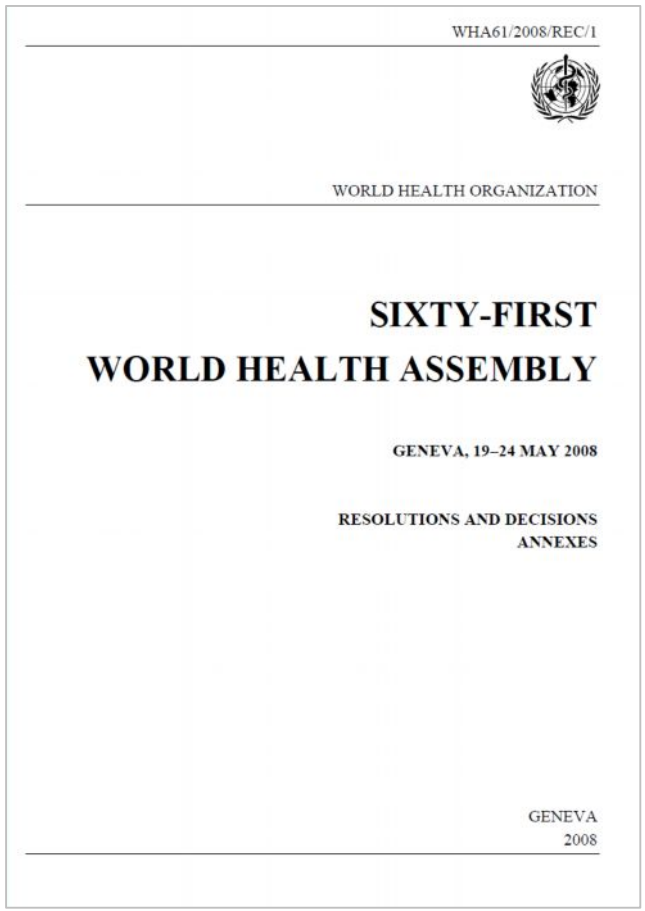


Source: N. Frolova, Unit for Surveillance of Inf. and Parasitic Diseases, Moscow. Presentation in Wolfheze 2008

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



WHA61/2008/REC/1

WORLD HEALTH ORGANIZATION

SIXTY-FIRST
WORLD HEALTH ASSEMBLY

GENEVA, 19–24 MAY 2008

RESOLUTIONS AND DECISIONS
ANNEXES

GENEVA
2008

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

Monitoring Migrant Health

- To ensure the standardization and comparability of data on migrant health
- To support the appropriate aggregation and assembling of migrant health information
- To map good practices in monitoring migrant health, policy models, health system models.

Policy- legal frameworks

- To adopt relevant international standards on the protection of migrants and respect for rights to health in national law and practice
- To implement national health policies that promote equal access to health services for all migrants
- To extend social protections in health and improve social security for all migrants.

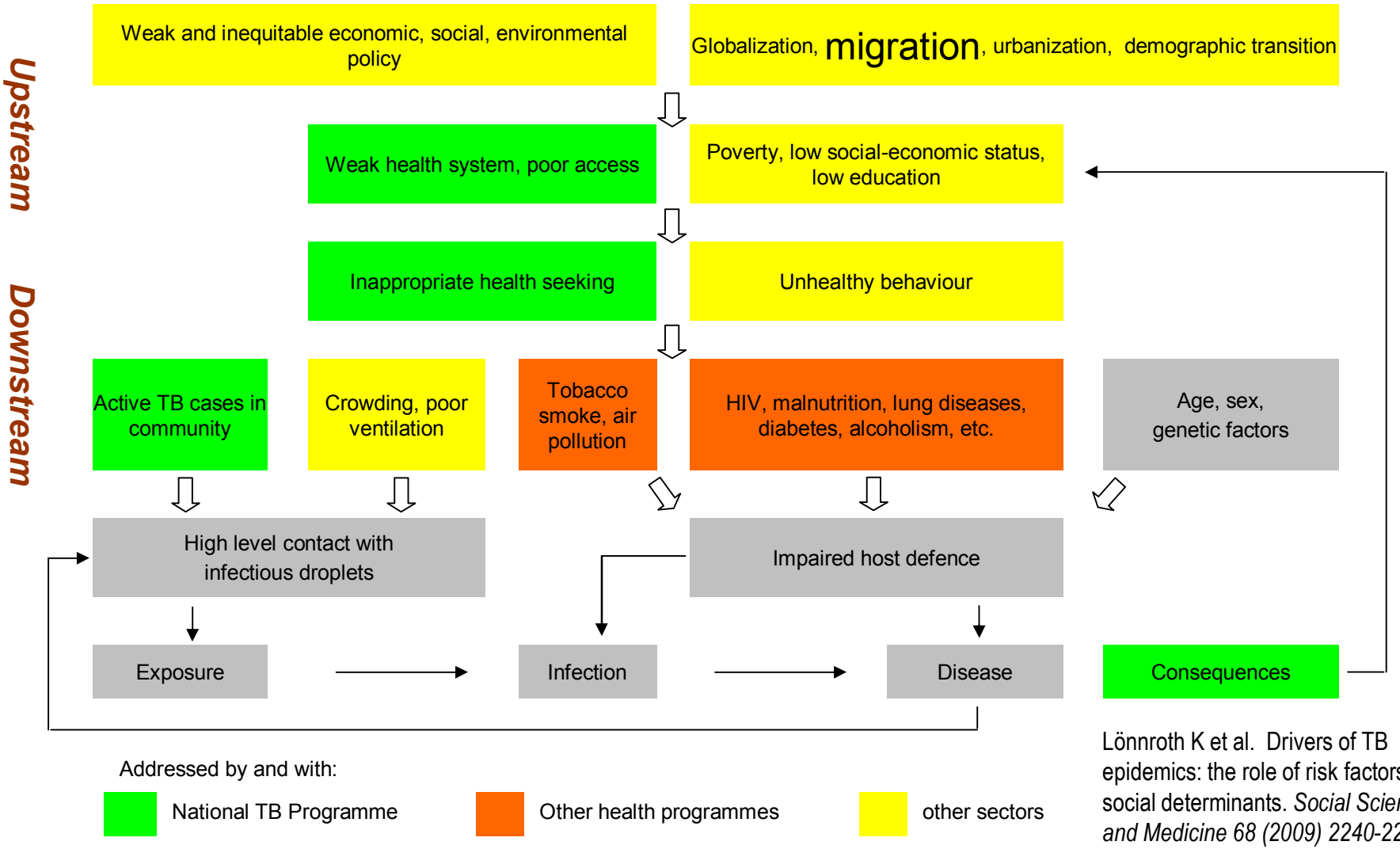
Migrant sensitive health systems

- To ensure that health services are delivered to migrants in a culturally and linguistically appropriate way
- To enhance the capacity of the health and relevant non-health workforce to address the health issues associated with migration
- To deliver migrant inclusive services in a comprehensive, coordinated, and financially sustainable fashion.

Partnerships, networks, multi country frameworks

- To establish and support migration health dialogues and cooperation across sectors and among large cities and countries of origin, transit and destination
- To address migrant health matters in global and regional consultative migration, economic and development processes (e.g. Global Forum on Migration and Development).

Socioeconomic determinants of TB



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

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

Wolfheze 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.