8th Regional TB Symposium - Tashkent, Uzbekistan

New Frontiers: Innovation and Access

TB and Labour Migration

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Introduction

Migration permanent change of residence of individuals or of social groups in the process, which is reflected in the other region (internal) of the same country or in another country (external) transfer form.

According to UN DESA 2017 international migration report

- 258 million people living in the country other than their country of birth
- 3,4% of world population make up international migrants

International migration has the tendency to increase towards high income countries turning from 9,6 to 14 percent from 2000 to 2017.
Armenia: economic situation

- small landlocked country, population: 2.9 million
- economic situation remains difficult since independence due to geographical, political problems
  - low GDP (gross domestic product): despite 3% increase in 2015, now decreasing
  - unemployment rising: 18.5% in 2015 (highest rate within the past 5 years)
- emigration is a consequence of the socio-economic situation:
  - 25% of population live abroad
- money transfers by individuals play a great role in economy:
  - 20% of annual GDP make up transfers
Migration in Armenia

- Migration processes in Armenia have their peculiarities:
  - Economically driven, traditional family structure, historically formed diaspora

- “short term” labour migration is typical among 39-49 age group men
  - Preferable countries for labour migration: Russian Federation; Ukraine; Belarus; Kazakhstan
  - The average duration of short term migration: 74.3% is absent up to 1 year, among them 31% is absent until 3 months

- “long term” migration- with the intent for permanent residence: USA and Europe

- Migration for professional education and best quality job: is typical among 20-30 age group population

(Data from National Statistics Service (Migration Processes 2011-2014))
TB and Labour Migration

High level of interruptions in TB treatment regardless of the type of treatment

- Late diagnosis and treatment of TB:
  - 5 times longer in the host country than for diagnosed cases in Armenia

- High percentage of treatment interruptions:
  - 3.9 times higher among labour migrants

- Low effectiveness of the treatment:
  - 3.1 times higher risk of developing DRTB

- High rate of TB-HIV/AIDS co-morbidity:
  - 4.7 times higher than among all TB patients in Armenia


Reasons for defaulting from drug-resistant tuberculosis treatment in Armenia: a quantitative and qualitative study

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Why focus on this problem?

MSF MDRTB project with new TB drugs 2015-2018: 155 patients

High Rate LTFU: > 30%

<table>
<thead>
<tr>
<th>Patients with</th>
<th>LTFU outcome: 42 (total enrollment 155 patients)</th>
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<tr>
<td>Age, year (median, max-min)</td>
<td>43.1 [24-71]</td>
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<tr>
<td>Men</td>
<td>35 (83%)</td>
</tr>
<tr>
<td>Previously treated -after failure - after LTFU -other</td>
<td>36 (85%) 17 (48%) 7 (19%) 12 (33%)</td>
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<tr>
<td>MDR sensitive to second-line (Confirmed MDR)</td>
<td>8 (19%)</td>
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<tr>
<td>Pre-XDR resist to FQ</td>
<td>13 (30%)</td>
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<td>Pre-XDR resist to Inj</td>
<td>12 (29%)</td>
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<td>XDR</td>
<td>9 (22%)</td>
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Reasons for LTFU
Patients cohort with new drugs April 2015 to March 31 2018

Patients with LTFU n=42

- Left for RF: 42%
- Left for Europe: 19%
- Stigma and not believed Rx: 15%
- Social problems: 12%
- Other: 12%

Current activities addressing treatment completion:
- Social support
- Counselling of difficult patients
- Patients education

Factors related to LTFU:
- Migration for economic reasons (>40%)
- Left for better Rx
- Other social issues
Patients’ Opinion
Based on interviews and field observation

The patient should be given an opportunity to become a key responsible for his / her treatment.

- Patients are aware of possible complications and difficulties in case of treatment interruption

- The main cause of treatment interruption is social status of the family

- On health vs social status of the family: preference is given to the second

- Patients prefer working income from temporary financial support

- Minimum income for most of interviewed and observed patients about 400USD / which is similar with the monthly amount that are transferred to families

(https://www.armstat.am/file/article/mig_rep_07_6.pdf)
MSF Support / Model of Care

- Model of distant treatment has been applied: prescribed preconditions to provide medicines for treatment
  - lack of drug supply for more than 2 months
  - lack of treatment follow-up and monitoring

- Efforts were made to organize patients treatment in the host country
  - successful treatment transfer was held to USA, India, European countries in case of legitimate migration of the patient

- Problems encountered in countries nearby from within the regional TB programs
  - state regulatory barriers
  - different approaches to the treatment
  - limited access to new drugs
Social Support

➢ Social support:

✓ within the state program: financial support for treatment adherence and transportation money for DOT

✓ Additional support by MSF: extra-transportation money, food support for extremely needy patients, social administrative support, heating support

➢ Some impact but without long term improvement
Areas for Advocacy

- Key solutions is on state level
  - Interstate agreements to ensure treatment access
  - Reduction of country regulatory barriers to improve access for regional programs
  - Development of state social support policy to be directed to patients social integration
  - Implementation of WHO patient-centered care for specific group of patients via innovations.
Conclusion

- Migration is a challenge

- Cooperation between regional NTPs could improve impact and reduce transmission

- Patient-centered approach in different areas of TB care may lead to successful treatment outcomes
Acknowledgment

Our partners from National TB control centre
Our colleagues from American University of Armenia
Our patients
MSF team

Thanks for your attention