What *is* quality People-Centred Care?

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Life after TB diagnosis

Primary Health Care

Stigma
Discrimination
Limited services
Queues

Social service ???
Community ???

Other health care facilities of 2nd-3rd level

Suffering from comorbities
Stigma and discrimination towards TB/HIV
Large queues
Out-of-pocket payments
Far from home

TB hospital

Far from home
Long stay
Braking up of family connections
Braking up of social connections

HIV service

Far from home
Shock of diagnosis

DOT in TB service

Far from home
Limited opening hours
Travel costs need

Family

Stigma / Self stigmatization
Catastrophic expanses
Loss of earnings

Job

Working hours match the ones in the clinic
Not allowed
Stigma

Ambulatory model is a part of PCC

- No epidemiological criteria for hospital admission and discharge
- Quality DOT at outpatient facilities
- DOT services provided as close as possible (PHC, home, workplace, community, etc.)
- Incentives for adherence improvement (food/hygienic kits, transport reimbursement, cash…)

Why out-patient care?

Early papers:

- **Andrews RH. Bull WHO. 1960 (Madras, India)**
- **Brooks S. Am Rev Resp Dis. 1973 (Ohio)**
- **Riley R. Am Rev Resp Dis. 1974 (Baltimore)**
- **Gunnels J. Am Rev Resp Dis. 1974 (Arkansas)**
- **Rouillon A. Tubercle. 1976 (Review):**

Conclusions:

Smear and culture correlate with infectivity only in untreated cases

Evidence that smear and culture positive TB patients on therapy do not infect skin test negative close patients

- **The Madras Experience**

(Bull WHO 1966; 34:517-32)

The first clinical trials of ambulatory TB treatment demonstrated no more household conversions after the start of treatment

Most household contacts had been exposed for months before diagnosis and treatment

Susceptible contacts already infected

Patients no longer infectious

- **Gunnels JJ, Batles JH & col**

(Am Rev Resp Dis, 1974 Mar;109(3):323-30):

A series of 6 TST results showed no transmission among 25 TST negative contacts after the start of treatment

What about MDR-TB?

Rapid impact of effective treatment on transmission of multidrug-resistant tuberculosis

A. S. Dharmadhikari,*† M. Mphahlele,‡ K. Venter,‡ (INT J TUBERC LUNG DIS 18(9): 1019–1025 Q **2014** The Union http://dx.doi.org/10.5588/ijtld.13.0834

A series of five human-to-guinea pig TB transmission studies was conducted to test various interventions for infection control.

CONCLUSIONS:

- ***In this model, effective treatment appears to render MDR-TB patients rapidly noninfectious***
- ***Further prospective studies on this subject are needed.***

Why ambulatory model?

- **Reducing DR-TB transmission**

Tomsk, Siberia. Glemanova, et al., Bull WHO, 2007; 85:703-711.

MDR-TB occurred among adherent patients who had been hospitalized. Odds Ratio: 6.34 for hospitalized vs. patients treated as outpatients.

- **Good treatment results**

The American journal of tropical medicine and hygiene https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3741248/

A meta-analysis of treatment outcomes of patients treated in hospitals versus ambulatory-based models was performed in accordance with PRISMA guidelines. None of the differences between the two models were statistically significant for any of the outcomes considered. This work improves the quality of the evidence available supporting the World Health Organizations (WHO) recommendation that patients be treated using mainly ambulatory care…

- **Economic effectiveness.** USAID project “Strengthening TB Control in Ukraine” studied the effectiveness of different models of care. The ratio of the cost of model "outpatient“ and the model "inpatient + outpatient“ was **1:5**

- **Friendly to patient:** keeps family and social connections, allows working/studying, continuing usual lifestyle

Середня вартість моделі лікування одного ТБ пацієнта з вибірки дослідження

Модель	Кількість пацієнтів	Вартість (грн) на 1 пацієнта	«Вартість» (ММО) на 1 пацієнта
Стціонарно-амбулаторна	28	14898	1412
Амбулаторна	37	2788	279

1:5

People-centred care

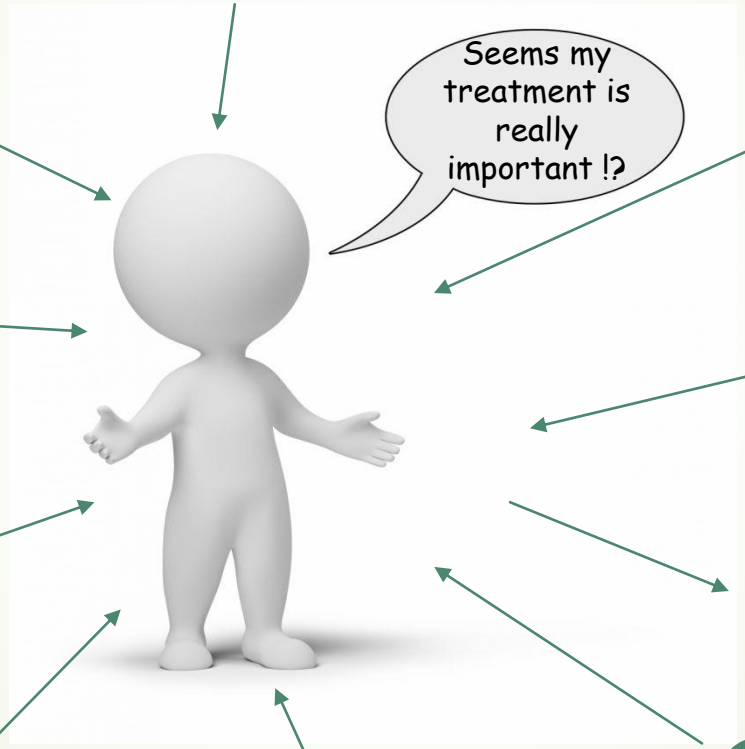
- ✓ Ambulatory model of care
- ✓ Social determinants are taken into consideration (needs assessment)
- ✓ Diagnostic services organized to minimize diagnosis and treatment start delay
- ✓ Integrated health services (on the basis of PHC and/or referral system in place)
- ✓ Social support
  - housing for homeless
  - work or social payments for unemployed
  - registration, passport issuing, legal consultations
  - home help for disable
  - incentives for treatment adherence (food/hygienic kits, transport reimbursement, cash, hot dinners etc.)
- ✓ Psychological support (professional psychologist)
- ✓ Community and peer support
- ✓ Possibility to work/study, keep the usual lifestyle when health status allows
- ✓ Patients and their families are protected from catastrophic financial expenses
- ✓ Feedback from patients and family members on regular basis

Life after TB diagnosis within the patient-centered model

Social service / CSOs
Social support

Primary Health Care
integrated services

Other Health Care facilities of 2nd-3rd level
Free
In convenient time



TB hospital
Only when needed

HIV service
integrated with other

Psychologist
Psychological support

Job
As usual

DOT
in convenient place
transport costs reimbursement

Family support

Community support / peer to peer support

THANK YOU !

References:

1. Theory of airborne infections transmission control interventions. Impact of treatment. Presentation. Prof. Edward A. Nardell, Harvard Medical School

http://slideplayer.com/slide/6573952/

2. COST EFFICIENCY. Retrospective study of organizational model of health care to TB patients in Kryvyi Rih, UKRAINE. USAID project “Strengthening Tuberculosis Control in Ukraine”

http://tb.ucdc.gov.ua/retrospektyvne-doslidzhennya-ekonomichnoyi-efektyvnosti-organizatsiynykh-modeley-nadannya-medychnoyi-dopomogy-patsientam-z-tb-u-m-kryvyy-rig