



TB in disasters.

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IN THIS ISSUE of the *Journal*, Drs Bieberly and Ali present a report of poor adherence to TB therapy following a hurricane, and suggest an increased risk of transmission due to in-migration and overcrowding.¹

In the developing world it is well known that disasters impact TB. Poor nutrition and overcrowding typical of refugee and displaced settings encourage the development and spread of TB, while access to TB control programmes may be reduced due to disrupted health care services and population displacement. Health care may be provided by international aid agencies that have a limited timeframe of intervention that does not allow TB treatment to be seen through to completion. Finally, refugees may come from or arrive in countries of high HIV prevalence, promoting the development of active TB and complicating diagnosis and management.

Given these challenges, many organisations working in humanitarian emergencies have avoided embarking on TB programmes. This is not surprising, given the warnings expressed by interagency guidelines that implementing TB programmes in unstable settings may fuel drug resistance and do more harm than good.² The latest recommendations from the WHO state that the emergency must be past before a TB programme can be considered.³ Nevertheless, each situation should be judged for its own difficulties.

While there may be more pressing needs during the acute phase of an emergency, acute emergencies can extend into chronic emergencies lasting years or even decades. Aid agencies confronted with the daily reality of patients in need of treatment have adapted interventions to be able to respond to TB in disaster settings, with successful outcomes reported in conflict-affected countries such as Angola, the Democratic Republic of Congo (DRC), south Sudan, northern Uganda, Somalia and East Timor.^{4,5} Similarly, satisfactory outcomes have been obtained in treating HIV, a condition requiring excellent adherence and drug access, in conflict settings.⁶

In these settings, the goal is not TB control but patient treatment, and the most important consideration is what will happen in case of medical team evacuation and/or population displacement. 'Runaway packs' have been successfully used during violence-related displacements in south Sudan for TB⁵ and in DRC for HIV.⁶ Patients are provided with a 30-day supply of medicines, a personal record card detailing their treat-

ment plan and other essential medical information. In such a context insistence on directly observed treatment is meaningless; instead, intensive efforts are placed on patient education to emphasise the importance of uninterrupted treatment and the possibilities for continuing treatment in other centres.

Such contingency planning has the potential for application beyond the war zones. It may be difficult to imagine that TB programmes in sub-Saharan Africa have anything to teach those in the United States, but perhaps in this instance that is precisely what is needed. Measures such as enhanced patient education for self-administered treatment, the provision of weekly and monthly supplies of medicines, community supporters and personal treatment records could help support adherence in any setting where disasters threaten to disrupt TB programmes, and this applies as much to New Orleans as it does to south Sudan.

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