

# **International Tuberculosis (TB) Outbreak in Hmong Refugees —An Advocacy Opportunity Necessity**

## **Legislative and Policy Update California TB Controllers Association, 5/13/05**

(Note: item 7 c modified during 5/13 meeting)

### **1. Resettlement of Lao Hmong refugees from Wat Tham Krabok (WTK), Thailand**

- June 2004: US Department of State began resettlement of the 15,000 Hmong refugees in WTK
- January 2005: Centers for Disease Control and Prevention (CDC) advised halting resettlement, due to high levels of TB and multidrug-resistant (MDR) TB in WTK and California
- February 2005: TB screening in WTK enhanced, resettlement resumed
- As of March 31, nearly 10,000 refugees have resettled in 27 states in the US. Approximately one third (3,400) have come to 19 California counties

### **2. High rates TB in Hmong newcomers to California**

- Local health department TB and Refugee programs have detected 27 cases of active TB disease in the 3,400 Hmong refugees arriving in California since June, 2004
- The TB case rate in recently-arrived Hmong is almost 800 TB cases per 100,000 persons, nearly 100 times higher than the overall TB case rate in California
- 4 of the 27 California cases (15%) have the deadliest strain of TB, those resistant to multiple medicines used to treat TB
- This is 10 times greater than the proportion of all California cases that are MDR-TB
- MDR-TB requires prolonged, less effective, and more expensive therapy

### **3. Large TB outbreak in Wat Tham Krabok camp, Thailand**

- a. CDC investigation in Wat Tham Krabok (WTK) found a TB case rate of over 2,000 per 100,000 persons, one of the highest in the world (approximately 270 cases of active TB disease, including 17 MDR-TB cases)<sup>1</sup>

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<sup>1</sup> Personal communication on 5/6/05 from Dr. Susan Maloney, Division of Global Migration and Quarantine, CDC

- b. CDC's progress containing the outbreak in WTK
  - Enhanced screening; additional suspected cases detected
  - Half of the 270 cases have completed treatment, and will travel to US with their families once end of treatment cultures are negative
  - Expert MDR-TB consultation provided and second line drugs obtained
  - Recent expansion of TB staff, TB case managers at WTK
- c. Challenges include:
  - Development of MDR-TB
    - In infected contacts, since not treated (but they are screened within a month of departure to US)
    - If drug susceptible cases are inadequately treated
  - Spread of MDR-TB
    - Some MDR-TB cases refusing treatment (but can't resettle until treatment completed and cultures are negative)
    - No isolation of infectious cases (facility under construction)
  - Implementing US standards of care, since US is eventual destination for all Wat Tham Krabok residents
  - Data collection to assess outbreak containment, status of the MDR TB control program in the Wat.
- d. CDC's success in containing this outbreak directly determines
  - ⇒ our domestic TB program workload and effectiveness
  - ⇒ the level of the TB threat to the refugees and the US communities they are joining

#### 4. International cooperation is essential to stopping international spread

- Look at the TB situation in the Wat to see the challenges we'll face when we assume responsibility upon refugees' arrival in the US
- Sequential co-management of same cases and their families, across continents
- Communication
  - Real time notification of actual arrivals and new B classifications (under development)
  - CDC has provided assurance that health departments will receive information we need for the proper medical management of newly arriving refugees

## 5. Priorities for California health departments

First: cure the cases we already detected

Second: find any other cases

- Case rate of 800/100,000 is nearly 1%.
- For every 100 refugees not fully evaluated, there may be one infectious case in our state who, if untreated, can die of TB and before then, can spread TB to families and community

Third: prevent progression of latent infection to active TB disease

- When resettlement is complete, there may be 2100 Hmong newcomers with latent TB infection.
- If the 2,000 with presumed drug-susceptible infections are not treated, we could see 100 drug susceptible cases in the next 5 years
- As many as 100 are likely to be latently infected with MDR-TB strains. If their infections were not thought to be MDR-TB, or the alternative regimens don't work, we could see 5 additional MDR-TB cases in next 5 years from reactivation of latent MDR TB infections.

## 6. Huge workload for California health departments through 2008 (at least)

- a. 3,400 Hmong refugees who arrived since 6/04
  - 5 MDR-TB cases on treatment through 2005-6 with 2 years of periodic medical evaluations after treatment finished
  - 22 other TB cases to cure
  - Over 500 contacts (to CA and WTK cases) to evaluate, treat
  - Contacts infected with presumed MDR-TB require 1 year treatment and at least 1 year of periodic medical evaluations after treatment is finished
  - Re-screening certain arrivals
- b. 1,700 additional refugees to be resettled in California
  - Sicker refugees and their families come later in resettlement efforts
  - Ensure case was adequately treated overseas
  - Re-evaluate contacts, and treat latent TB infection to stop more TB from developing and spreading
- c. Continued TB and MDR-TB in Hmong refugees who arrived in prior resettlement efforts

## 7. California resources insufficient for sustained effort

- a. Direct medical costs for clinical services
  - Only 1/3 of 3,400 Hmong newcomers are receiving Medi-Cal
  - If they meet income limits, all refugees with known or suspected TB infection or disease should be eligible for Medi-Cal TB program
  - Gaps: no inpatient care in Medi-Cal TB, home IV infusions

- b. Public health costs: prioritize and evaluate efforts, coordination, health education, community liaison, provider outreach, data collection
- c. Resources mobilized to date
  - CDC: 3 weeks onsite Epi-Aids plus several weeks of direct assistance from public health advisor
  - CDHS redirected one time TB and Refugee funding to heavily impacted local health departments (LHDs); CDHS TB Branch staff still deployed in field
  - LHD: Current redirection “is not sustainable without seriously jeopardizing other TB and public health programs”<sup>2</sup>

8. Questions for the panel. Refugee resettlement is a federal responsibility, so key advocacy target is at the national level

What actions can California TB Controllers take to:

- obtain the federal funding needed for an effective, sustained domestic effort?
- help CDC rapidly contain the outbreak in the Wat, and establish an effective MDR TB control program in the Wat?

9. Questions for California TB Controllers

- What types of advocacy have you tried so far? What worked/didn't work?
- What barriers do you face?
- How can CTCA and other organizations help you overcome barriers?

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<sup>2</sup> Letter from Dr. Scott Morrow, President, California Conference of Local Health Officers to Senator Dianne Feinstein, 4/5/05