

**A GENDER-FOCUSED QUALITATIVE STUDY
ON HEALTH CARE-SEEKING BEHAVIOUR
AND ACCESS TO TUBERCULOSIS TREATMENT
AMONG MOBILE POPULATIONS
FROM THE REPUBLIC OF MOLDOVA**



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LIST OF ACRONYMS

DOT	Directly Observed Treatment
FGD	Focus group discussion
HIV	Human Immunodeficiency Virus
IDI	In-Depth Interview
IOM	International Organization for Migration
LPA	Local Public Authorities
MDR TB	Multidrug-Resistant Tuberculosis
NBS	National Bureau of Statistics
NTRP	National Tuberculosis Response Program
PPI	Phthisiopneumology Institute “Chiril Draganiuc”
SIMETB	Information Monitoring and Evaluation system of TB patients in the Republic of Moldova
TB	Tuberculosis
VST	Video-supported treatment
WHO	World Health Organization
XDR TB	Extensively drug-resistant tuberculosis

DEFINITIONS AND CONCEPTS

Circular migration – the fluid movement of people between countries, including temporary or long-term movement which may be beneficial to all involved, if occurring voluntarily and linked to the labour needs of countries of origin and destination.

Country of destination – in the migration context, a country that is the destination for a person or a group of persons, irrespective of whether they migrate regularly or irregularly.

Country of origin – in the migration context, a country of nationality or of former habitual residence of a person or group of persons who have migrated abroad, irrespective of whether they migrate regularly or irregularly.

Extensively drug-resistant tuberculosis (XDR-TB) is a form of tuberculosis caused by bacteria that are resistant to some of the most effective TB drugs. XDR-TB strains have arisen after the mismanagement of individuals with multidrug-resistant TB (MDR-TB).

Foreigner – a person in a State of which he is not a citizen or national.

Gender – the socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for individuals based on the sex they were assigned at birth.¹

Informal work – according to the International Labour Organization, informal work refers to all the activities carried out by workers, which, from a legislative or practical point of view, are not covered by formal systems or are insufficiently covered by them.

International migrant – a person who moves to a country other than that of his or her usual residence for a period of at least a year (12 months), so that the country of destination effectively becomes his or her new country of usual residence.

Long-term migration – internal or external migration for a period longer than 1 year.

Migrant – according to the Glossary on Migration of the International Organization for Migration² this is an umbrella term, not defined by international law, which reflects the common understanding of a person leaving his or her place of usual residence, either within a country or crossing international borders, either temporarily or permanently and for various reasons. The definition does not refer to the (1) legal status of person, (2) nature of move (voluntary or involuntary), (3) reason for the move, or (4) length of stay.

Multidrug-resistant TB (MDR TB) is caused by an organism that is resistant to at least isoniazid and rifampin, the two most potent TB drugs. These drugs are used to treat all persons with TB disease.

¹ IOM Full Glossary of Terms (2020): <https://www.iom.int/sites/g/files/tmzbd1486/files/documents/IOM-SOGIESC-Glossary-of-Terms.pdf>.

² IOM Glossary on Migration (2019): https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf.

Mobile population – any person who moves from one area to another (whether internally or externally) usually for a short period of time (less than 1 month).

Returning migrants – persons returning to their country of citizenship after having been international migrants (whether short term or long term) in another country and who are intending to stay in their own country for at least a year.

Sex – the classification of a person as having female, male and/or intersex sex characteristics. While infants are usually assigned the sex of male or female at birth based on the appearance of their external anatomy alone, a person’s sex is a combination of a range of bodily sex characteristics.³

Short-term migration – internal or external migration for less than 1 year.

Specialists – by this term are defined all the interviewed medical workers: phthisio-pneumologists, family doctors, and nurses.

Tuberculosis – an infectious disease caused by the M. tuberculosis complex, transmitted by air, rarely through digestive way, and in extremely rare cases transmitted congenitally, which can affect all organs of the body, but primarily the lungs.

The **Xpert MTB/RIF** is a **cartridge-based** nucleic acid amplification test (**NAAT**) for **simultaneous rapid** tuberculosis diagnosis **and rapid** antibiotic sensitivity test. It is an automated diagnostic test **that can identify** Mycobacterium tuberculosis (**MTB**) **DNA and resistance to rifampicin (RIF)**.

³ IOM Full Glossary of Terms (2020): <https://www.iom.int/sites/g/files/tmzbd1486/files/documents/IOM-SOGIESC-Glossary-of-Terms.pdf>.

EXECUTIVE SUMMARY

The Republic of Moldova belongs to the 18 High Priority Countries for tuberculosis (TB)⁴ control in Europe and Central Asia.⁵ In recent years, progress has been made on TB diagnosis and treatment through the joint efforts of state institutions, civil society, and with the support of international organizations. As a result, the number of new cases of tuberculosis has been steadily declining. Nevertheless, the Republic of Moldova still faces a high number of TB patients who delayed visiting the doctor, leading to advanced tuberculosis processes and a high rate of multidrug-resistant tuberculosis (MDR TB), which rank the country among the 30 high MDR-TB burden countries globally.⁶ Thus, tuberculosis remains one of the priority public health issues, and its prevention and control represent strategic objectives of the National Tuberculosis Control Programme for 2021–2025.

In the context of migration, the detection, treatment, and prevention of tuberculosis continue to be a concern for both countries of origin, such as the Republic of Moldova, and those of destination. Unfortunately, the risks of tuberculosis associated with migration, and especially various vulnerabilities for migrants of different genders, have been insufficiently addressed by those involved in the migration process. The International Organization for Migration (IOM), through its programmes, contributes to the prevention, detection, and cross-border control of tuberculosis, by offering a wide range of services on diagnosis and treatment of tuberculosis, as well as various measures aimed at promoting public health, including health and well-being of the mobile population.⁷ The collection of additional data on TB, migrants, and gender dynamics is a crucial step in formulating more effective, evidence-based migrant health policies. Consequently, it is essential to develop tailored TB control policies to reduce the burden of TB in these groups and in the community at large, especially as migrants are at increased risk of developing and transmitting MDR TB.

Research to date suggests that a targeted approach is needed, specifying different risk groups for tuberculosis. Awareness rising actions that include screening and early referral to the doctor are extremely important for disease prevention. For TB patients undergoing treatment psychosocial and socioeconomic support is essential for adherence, given the complex and lengthy treatment process.

The current study explores the differences between men and women in the knowledge, attitudes, and practices on the diagnosis, surveillance, treatment, and prevention of tuberculosis among the mobile population in the Republic of Moldova. The study is based on the analysis of qualitative data from ten focus group discussions (FGDs) out of which seven with TB patients with external migration experience three with medical specialists, two with phthisio-pneumologists and one with family doctors. There have been also, 66 interviews conducted, among them 16 with phthisio-pneumologists and 50 interviews with the TB patients (with external migration experience). Fieldwork was conducted between September and November 2021.

The results of the study could serve as a basis for formulation of pertinent recommendations to the relevant state and civil society actors to develop and implement effective, migrant oriented and gender sensitive and appropriate responsive TB policies to effectively identify, intervene, and provide adequate health services to TB patients.

⁴ The 18 high-priority countries are: Armenia, Azerbaijan, Belarus, Bulgaria, Estonia, Georgia, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, the Republic of Moldova, Romania, the Russian Federation, Tajikistan, Turkey, Turkmenistan, Ukraine and Uzbekistan.

⁵ ECDC/WHO Europe: Tuberculosis Surveillance and Monitoring in Europe 2021 (2019 data). <https://www.ecdc.europa.eu/sites/default/files/documents/tuberculosis-surveillance-monitoring-Europe-2021.pdf>.

⁶ WHO Global Tuberculosis Report 2021, p.35; <https://www.who.int/publications/i/item/9789240037021>.

⁷ Human Mobility & Tuberculosis: <https://www.iom.int/human-mobility-tuberculosis>.

Key Findings

The study found that most interviewed migrants with TB, both men and women, declared that they had limited knowledge of TB before diagnosis. However, many of them knew the symptoms of TB as a persistent cough for more than two to three weeks associated with fever, while some also mentioned sweating and excessive weight loss. However, when these symptoms occur, many of those who have had cases of tuberculosis in the family did not associate them with this disease, attributing other causes to them, such as smoking, colds/bronchitis, or the working environment (dust, toxic substances, etc.). Several women over the age of 50 attributed excessive sweating to menopause. Only people who have been treated previously for tuberculosis, whether they have given up treatment or relapsed, have been among those who have acknowledged that they had tuberculosis.

In the Republic of Moldova, the TB patients with migration experience are mostly men of working age. Women account for around 20 to 30 per cent of TB patients in the Republic of Moldova. According to the estimates of the specialists interviewed, among mobile TB patients the percentage of women is lower, given that the percentage of women with migration experience is smaller compared to that of men. While 10 years ago most Moldovan migrants diagnosed with TB had returned from the Russian Federation, now there is a wide range of destination countries, including from the European Union (EU). In the recent years there has been an increased number among migrants who work in countries like Poland and the Czechia, considering many circular migrants leaving to these countries for seasonal work.

Many of the interviewees, regardless of gender, were diagnosed with tuberculosis in the Republic of Moldova. The patients who returned with an established TB diagnosis from abroad, have been to the Russian Federation and Romania. It should be noted that in these countries Moldovans do not face a language barrier regarding access to the (health) services. Some of them went to private clinics for examinations, assuming that they were not covered by medical insurance in these countries or in case they faced difficulties in addressing to the public health institutions due to the COVID-19 pandemic.

Overall, the study confirmed that the COVID-19 pandemic has affected the addressability to health services. On the one hand, some of the interviewed persons avoided seeing a doctor for fear of being diagnosed with COVID-19 or of becoming infected. On the other hand, others underwent a radiological examination out of concern for COVID-19 complications, thus being diagnosed with early-stage tuberculosis. Some of the phthisio-pneumologists believe that the examinations of risk groups, including migrants, have decreased since the beginning of the pandemic, and this is reflected by the increased number of late detections of TB with severe, advanced forms, and extensively drug-resistant-tuberculosis (XDR TB). Also, travel restrictions from the host countries to the Republic of Moldova have contributed to the postponement of some migrants' return to the country of origin and visiting the doctor.

Focusing on work for the need to earn money, is the main cause of not seeing a doctor abroad when the first symptoms of tuberculosis appear. Other barriers in accessing health services in destination countries include fear of losing a job, ignorance of the host country's language, lack of health insurance and related concerns about high service costs, lack of information (where, how, who to address), irregular stay, and shortness of the period of stay abroad. In this context, the most vulnerable are circular migrants of all genders, especially those who work informally.

According to the interviewed experts labour migration is a widespread phenomenon, which on the one hand can be a source of infection for the mobile population given the favourable environment of transmission of the Koch bacilli,⁸ through factors such as overcrowded living conditions, interaction with many people, physical exhaustion through work, poor nutrition, stress, etc. On the other hand, the environment, in which migrants work and live – particularly cold weather, dust, mildew, moisture, overcrowded rooms and lack of ventilation – can lead to the activation of latent tuberculosis. Some specialists even pointed out that latent tuberculosis could develop into disease and that not all cases of tuberculosis are imported from abroad. Indeed, the study identified people who either completed tuberculosis treatment and after the resumption of the migration process had relapsed or after a short period of stay abroad had the first symptoms of tuberculosis.

The active detection of tuberculosis among the mobile population of the Republic of Moldova is relatively low. The number of people with migration experience, who are part of the high-risk group for TB, is underestimated at the level of primary medical care. At the same time, migrants who return to the Republic of Moldova usually do not undergo TB screening if they do not have any symptoms associated with disease, even if the screening is for free.

One of the key findings from this study is that women, compared to men, often see a doctor from the onset of symptoms. Specialists also perceive women as showing greater adherence to treatment. However, women react much more emotionally to the diagnosis of tuberculosis, they seem to be much more psycho-emotionally affected and are more cautious in interacting with family members. Parents, grandparents, both men and women, are concerned not to infect their children and this fear persists in households with babies or preschool children. Concern for health and recovery is equally important for both migrant women and men. However, the study identified other major concerns about the diagnosis of tuberculosis, between women and men. Women are extremely affected by the possible reaction of the community, by the *“word of mouth”*, stigmatization, while men are more worried about how they would provide financial support for their family. To avoid gossip, some patients hid their diagnosis from friends and sometimes family. Single mothers, especially if they do not receive support from the extended family, are vulnerable both psycho-emotionally and financially.

Compliance with treatment is determined primarily by the degree of awareness of the risks of treatment abandonment. Patients with children are more responsible for following the treatment, but on the other hand, if the family does not have financial savings, other income, are burdened by debts/ credits, then the risk of TB for patients leaving the treatment increases, as soon as they think they can work abroad. Besides the risk of treatment abandonment is also high in case of unmarried young people with migration experience due to their previous lifestyle which triggers their desire to return abroad as soon as possible. At the same time, people who once have abandoned treatment, tend to repeat this when their health improves.

⁸ TB is transmitted through the *Mycobacterium tuberculosis* / tubercle bacillus, which was detected by Robert Koch.

Conclusions and Recommendations

Gender dynamics in TB enrolment, treatment and cure rates are not uniform, even though no significant differences among women and men in delays in diagnosis and treatment of TB were identified. The study results showed that men are more likely to seek medical care later compared to women and are more vulnerable to discontinue TB treatment while women are more sensitive in terms of psycho-emotional reactions. Health workers and patients highlighted negative perceptions and lack of basic knowledge about the disease, and stigma was widely reported and worse in women patients.

Although the National authorities included migrants as a key population in the National Tuberculosis Response Programme, important next steps are still necessary to promote further free tuberculosis screening for migrants and motivate them to access primary health care. Especially, the long-term outpatient treatment is a challenge for the patients requiring a greater resource support to meaningfully address national TB screening and treatment goals. Both patients and doctors consider the lack of financial resources for daily needs as a key factor in treatment abandonment for people who decide to go abroad. Most of the experts believe that the patients undergoing TB treatment should be restricted from leaving the country until treatment is completed. However, the TB patients rather want/need incentives to complete treatment.

In terms of migration, there is need for cross-border cooperation between states to exchange information on the TB patients of all gender and age groups. Also, it is necessary to establish possible joint tuberculosis treatment mechanisms with the host countries, at least with countries at least with those with a large number of migrants from the Republic of Moldova and/or with a high number of TB patients.

A positive step towards early diagnosis of tuberculosis could be the mandatory radiological examination of the employees both at the employment stage and periodically during the work to be requested by the recruitment agency and/ or the employer in the host country.

The eradication of the TB epidemic by 2030 is one of the health objectives of the Sustainable Development Goals⁹ that the Republic of Moldova has assumed. The National Tuberculosis Response Programme for 2021-2025 is aligned with the 2030 Tuberculosis Elimination Strategy. This document focuses on the implementation of innovative strategies to reduce the burden of TB in the Republic of Moldova.¹⁰

⁹ TB eradication pertains to SDG 3 - "Good Health and Well-being".

¹⁰ National Tuberculosis Response Programme for 2021–2025.



CHAPTER 1. INTRODUCTION AND BACKGROUND

The contemporary era can certainly be called an era of migration. In recent years, international migration has grown unprecedentedly. Worldwide, it reaches over 272 million people or 3.5 per cent of the world's population. The phenomenon of population migration is characteristic virtually to any state.¹¹

The Republic of Moldova is among the countries most affected by labour migration. Almost a quarter of the population of the Republic of Moldova currently lives abroad either temporarily or for a long time abroad. According to IOM data, about 350,000 Moldovan citizens are employed in short-term labour migration¹². According to the labour force survey, men predominate in the share of the population abroad working or looking for work, with 67.5 per cent men¹³ and 32.5 per cent women.¹⁴ However, labour migration, apart from the economic and development opportunities offered, also implies many social and health risks.

The country faces a high tuberculosis burden and is one of the 30 countries in the world with a high number of MDR TB cases.¹⁵ Migrants are specifically vulnerable TB, especially to the drug-resistant strains of tuberculosis. This is due to the high level of migration to countries with a high incidence of tuberculosis, such as the Russian Federation, but also because of interrupted treatment cycles during migration. In 2019, the MDR TB rate was 26.9 per cent among new cases and 56.1 per cent among retreatment cases.¹⁶ According to National Tuberculosis Control Programme data,¹⁷ the rate of the patients lost from treatment surveillance varies between 7 per cent for sensitive tuberculosis and 20 per cent for drug-resistant tuberculosis. Migrants face different barriers in accessing health-care and tuberculosis treatment, such as mobility, language barriers, informal employment, limited social support systems, possible stigma, and discrimination in the society, etc.

A large global drop in the number of people newly diagnosed with TB was reported in 2020. This fell from 7.1 million in 2019 to 5.8 million in 2020, an 18 per cent decline back to the level of 2012 and far short of the approximately 10 million people who developed TB in 2020.¹⁸ Around 10 million people worldwide became infected with TB in 2019, a number that has been declining very slowly in recent years. Men (≥ 15 years old) accounted for 56 per cent of those who developed TB in 2019; women (aged ≥ 15 years) accounted for 32 per cent and children (aged <15 years) for 12 per cent.¹⁹

¹¹ *World Migration Report 2020* (2019): https://publications.iom.int/system/files/pdf/final-wmr_2020-ru.pdf.

¹² Impact of the COVID-19 pandemic on migration: mobility, number, and profile of returned migrants, specific vulnerabilities of groups affected by declining remittances, IOM, 2020.

¹³ According to national statistics, the share of women in the adult population of the Republic of Moldova is 53.3 per cent compared to 46.7 per cent of men. Source: NBS. 2019.

¹⁴ Statistical Compendium of Extended Migration Profile of the Republic of Moldova for the years 2017–2019 (2020): http://www.bma.gov.md/sites/default/files/sites/default/files/atasamente/comunicate/cs_al_pme_2017-2019_ed_2020.pdf.

¹⁵ WHO Global Tuberculosis Report 2021, p.35.

¹⁶ National TB Response Programme for 2021–2025.

¹⁷ National Tuberculosis Control Programme for 2016–2020, <http://lex.justice.md/md/367268/>.

¹⁸ WHO World TB Report 2021 <https://www.who.int/publications/i/item/9789240037021>.

¹⁹ WHO Global Tuberculosis Report 2020.

In the Republic of Moldova, during 2019, there were 2,879 new and relapse cases of tuberculosis, which is a rate of 71.7 per 100,000 population, with a reduction of 4.5 per cent compared to 2018 (3,016 new cases and relapses, 75.1 per 100,000 population)²⁰ and by 20.2 per cent compared to 2015 (3,607 new cases and relapses, 89.4 per 100,000 population). Tuberculosis affects more men than women, with a ratio of 74 per cent men and 26 per cent women in new and relapsed cases recorded in 2019. The highest rates of tuberculosis were reported among adults aged 35 to 44 years old. The rate of children up to 18 years of age in all new cases and relapses was 136 cases, 4.7 per cent in 2019.²¹ In 2020, almost one in 10 patients diagnosed with TB had a history of migration, which is a decrease of 4.4 per cent compared to 2015 (Annex 3).

Since the 2000s, the Republic of Moldova has been successfully implementing several policies and measures aimed at the prevention and care of tuberculosis and the constant involvement of primary care in early detection and directly observed treatment (DOT). Universal access to quality diagnosis and treatment of tuberculosis is ensured for all persons, with full geographical coverage of the country. The Republic of Moldova is the first country in the region to extend the availability of the GeneXpert rapid method to the entire network of 59 laboratories performing smear microscopy. As a result, access to drug-resistant tuberculosis screening is universal.

Since 2001 directly observed treatment (DOT) has been implemented and the frame of reference by adopting all clinical and diagnostic approaches recommended by the World Health Organization (WHO); laboratory networks have been strengthened; recommended international treatment strategies for drug-resistant tuberculosis cases have been adopted, emphasis has been made on the community and civil society involvement at all stages of tuberculosis response, including information, social mobilization, active screening in key groups, strengthening support to the patients to ensure compliance with treatment, but also the adoption of the person-centred model.²²

Since August 2018, screening by lung radiography is provided to actively detect pulmonary tuberculosis and lung cancer through the employment of mobile radiological facilities for reaching people at high risk of tuberculosis and lung cancer in rural areas of the administrative territories of the Republic of Moldova.

The person-centred care model has been introduced and, as a result, the range of services available to people with TB has significantly improved and has been decentralized at the community level. The sustained political commitment has led to increased funding for outpatient services and creation of incentives for patients from the sources of the National Medical Insurance Company, in parallel with a gradual reduction in the excessive number of beds to improve clinical outcomes. The “Roadmap for the modernization of the phthisio-pneumology service” was approved, which outlined all the activities regarding the control of tuberculosis to streamline the treatment of the tuberculosis patients by early detection and extension of outpatient treatment. As a result of the adopted measures, the number of beds in the civil sector has been reduced from 1,420 in 2014 to 865 beds in 2020. A Regulation has been drawn upon some interventions to increase adherence to the TB treatment in outpatient conditions.²³

²⁰ National TB Response Programme for 2021–2025.

²¹ Ibid.

²² Assessment of the need for specialist inpatient care for tuberculosis under the conditions of the epidemiological transition and the WHO recommendations 2021 on the treatment of multidrug-resistant tuberculosis, PAS, 2021 - www.pas.md/ro/PAS/Studies/Details/317.

²³ National TB Response Programme for 2021–2025.

Thus, in recent years, there is a tendency towards stabilization of the TB epidemiological situation. Statistical data from the recent years show an improvement of epidemiological indicators, because of the provision of person-centred tuberculosis care services (prevention, detection treatment). However, tuberculosis remains a burden on public health system, disproportionately affecting the socially vulnerable and marginalized population, as well as other risk categories. Migrants were included in the increased TB risk categories due to their mobility,²⁴ working and living conditions, limited access to medical services in the host countries, etc.

Some studies, carried out in other countries have shown that fear and stigma associated with TB have different impacts on men and women, often due to women living in more precarious social and economic conditions than men. A deficient health system coupled with the lack of access to treatment and irregular migration make patients, particularly migrant women, default on their treatment and drive them into developing multi-drug resistant TB (MDR-TB). However, the intersecting factors of gender and migration have been generally neglected in TB research and policy interventions.²⁵

Very few sociological studies have been conducted on the intersection of TB, gender, and migration and none in the Republic of Moldova and the European region. Therefore, the existing gender gaps in diagnosis remain unexplained. Possible explanations include immunological differences between the sexes and epidemiological factors, such as increased social exposure in men.²⁶ Some authors consider that the differences between the detection rates of the cases are false and that in reality a much larger number of women are affected, their diagnosis being affected by social factors.²⁷ Several studies have also shown that women are more concerned about social stigma than men.²⁸ Thus, a clearer understanding of the barriers to accessing TB services for both women and men is necessary.

In this context, IOM in close collaboration with the National Tuberculosis Response Programme, the Phthisiopneumology Institute “Chiril Draganiuc” and the Ministry of Health conducted a qualitative sociological study among the Moldovan nationals with migration experience outside of the Republic of Moldova. The study has been carried out within the framework of the IOM project “Enhancing Gender-Sensitive TB Detection, Surveillance, Treatment and Prevention Among Mobile Populations from the Republic of Moldova” (TB-MIG) funded by the IOM Development Fund.

The study is part of the NTRP actions for the years 2021–2025,²⁹ that aims to contribute to a comprehensive and holistic understanding of migrants’ barriers, considering gender perspectives, in accessing health-care for the prevention, detection, and treatment of TB. The results of the study can be used to facilitate the implementation of the objectives set out in the National TB Response Programme, alongside the elaboration and development of evidence-based policies, programmes, and projects to support TB actions, to ensure that healthy migrants can make a positive contribution to healthy communities and sustainable development of the Republic of Moldova.

²⁴ Tuberculosis prevention and care for migrants (2014): https://www.who.int/tb/publications/WHOIOM_TBmigration.pdf.

²⁵ Report on the health of refugees and migrants in the WHO European Region: no public health without refugee and migrant health (2018): <https://www.euro.who.int/en/publications/abstracts/report-on-the-health-of-refugees-and-migrants-in-the-who-european-region-no-public-health-without-refugee-and-migrant-health-2018>.

²⁶ Kurasawa T. Tuberculin skin tests of patients with active pulmonary tuberculosis and non-tuberculous pulmonary disease. *Kekkaku* 1990; 65: pp. 47–52.

²⁷ Johansson E, Long N H, Diwan V K, Winkhurst A. Gender and tuberculosis control: perspectives in health seeking behaviour in men and women in Vietnam. *Health Policy* 2000; 52: pp. 33–51.

²⁸ Rajeswari R, Balasubramanian R, Muniyandi M, Geetharamani S, Thresa X, Venkalesani P. Socio-economic impact of tuberculosis on tuberculosis patients and their families in India. *Int J Tuberc Lung Dis* 1999; 3: pp. 869–877.

²⁹ National Tuberculosis Response Programme 2021-2025: <https://cancelaria.gov.md/sites/default/files/document/attachments/956-msmps.pdf>.

CHAPTER 2. METHODOLOGY

Research Objectives

Aim of the study: To determine the differences between men and women in the knowledge, attitudes, and practices on the diagnosis, surveillance, treatment, and prevention of tuberculosis among the mobile population in the Republic of Moldova.

Research objectives:

- To assess the knowledge, attitudes, and practices regarding the access to health-care among the mobile population affected by tuberculosis, from a gender perspective.
- To describe the perception of the specialists on the migration phenomena and its influence on the access of the mobile population to TB health services.
- To identify the barriers to access and continuity of medical care for the mobile population affected by tuberculosis.

Study Populations

The study aimed to understand mobile population's attitudes, practices, and health-seeking behaviour in the Republic of Moldova. The data were gathered by interviewing the following:



95 TB patients with confirmed diagnosis living in the Republic of Moldova,³⁰ 18+ years old, with international migration experience (at least six months of living abroad accumulated in the last three years).



36 Health specialists - phthisiopneumologists, family doctors, nurses.

The sampling of the TB patients was based on selection criteria among people diagnosed with TB with external migration experience. In selecting the respondents, the gender aspect was considered in the first place, alongside other criteria as the place of living: rural/urban; region (Centre, North, South); ambulatory versus hospital treatment; type of TB (including MDR TB), etc. The TB patients included in the study were identified with the support of the National TB Response Programme and Phtisiopulmonology Institute. The sample covered 95 TB patients with migration experience, the semi-structured interviews was 50 TB patients (27 men and 23 women), while in the focus groups 45 TB patients were interviewed (7 focus groups).

³⁰ All the respondents were Moldovan citizens, except from three non-citizens interviewed patients.

In order to ensure the heterogeneity of the respondents, several sampling points were selected, depending on the number of TB patients with migration experience: Public Medical-Sanitary Institution “Institute of Phthisiopneumology “Chiril Draganiuc”; Public Medical-Sanitary Institution “Balti Clinical Hospital”; RH Anenii-Noi; RH Cahul; RH Criuleni; RH Ialoveni; RH Făleşti; RH Floresti; RH Hânceşti; RH Orhei; RH Soroca; RH Ştefan Vodă; RH Străşeni.

Also, 36 health professionals were interviewed during the study. The sample for the semi-structured interviews was 16 health-care specialists, while in the focus group discussions 20 health-care specialists (3 focus groups including 2 focus groups with phthisio-pneumologists and 1 focus group with family doctors) were interviewed.

For more detailed information regarding the research design, please see Annex 1.

Respondents were interviewed in relation to a number of topics regarding their experience as migrants and the diagnosis, treatment and challenges as tuberculosis patients. The following main subjects were covered by the research:

- Knowledge, attitudes, practices related to TB, including gender differences.
- Access to health services among mobile population affected by TB.
- Psychological and Social aspects related to TB.
- Relations between health workers and patients.
- Proposals to improve the TB treatment results.

For more information about the topics of the study please see the research tools in the Annex 2.

Data was collected via semi-structured interviews and focus group discussions with the voluntary participation of respondents and observing ethical standards in qualitative research. All data was collected and analysed by the consultants that developed the research tools and were familiar with the research topic.

The focus groups and interviews with TB patients were conducted face-to-face, in Public Health Institutions, except two interviews with female TB patients that were carried out by phone due to distance and health situation. All interviews with health-care providers were conducted face-to-face, the focus group discussions with specialists were conducted online, via the Zoom platform.

The interviews with patients and TB health-care providers were carried out in two languages – Romanian and Russian depending on respondents’ choice. All interviews were recorded with the consent of the patients and TB health-care providers, and afterwards the interviews were transcribed and analysed.

Data Analysis

The data was analysed using the method of thematic frame and by comparing the collected data based on gender, country of destination, type of TB and where the treatment was started. The analysis was based on the transcription of interviews and FGDs.

The analysis envisaged to discover certain trends and recurrent patterns, but also to highlight divergent views from what the interviewed people said, and opinions and perceptions were analysed according to gender. The corresponding quotes were selected for every theme and every sub-theme. The main analysis themes were based on the structure of the research tools, but others derived from the collected data.

Ethical considerations

The Ethical Committee of the Phthisiopneumology Institute “Chiril Draganiuc” granted ethical approval to conduct the research activities. IOM made sure that the research was carried out in line with the IOM Ethics and Conducts regulations, IOM data protection principles,³¹ as well as in line with the WHO Code of Conduct for responsible Research³² and the Standards for Reporting Qualitative Research (SRQR) of the Enhancing the Quality and Transparency of Health Research (EQUATOR) network.³³

The study followed the principles of the Helsinki Declaration³⁴ for guaranteeing confidentiality of the study participants – both the TB patients and health-care professionals. The collected data were stored anonymously so that the data collection tools did not include the patient’s name or other information through which the person could be identified. The patients eligible for the study were provided with information about the study conveyed in a language understood by the patient while also an informed consent was sought from them.

Respondents, TB patients, were offered a package of food and personal hygiene items as an incentive for their time spent for participation in the study.

Limitations of the study

The study has several limitations, which is mainly linked to its qualitative design and the selection and sampling of participants.

1. The study design is qualitative and hence even though the sample was rather large it does not aim for representativeness. Although the authors aimed for saturation, when conducting the interviews and FGDs, the design only allowed to describe phenomena and related trends in the society without allowing for generalization of expression in percentages.
2. A certain selection bias and the setting in which interviews were conducted, might have influenced the findings. The study only included TB patients and is limited to those who were diagnosed and undergoing treatment. Patients were recruited through medical workers. Although participation in the study was voluntary, and a safe and friendly environment was ensured during the discussions and anonymity and confidentiality were granted, reluctance of some of the participants was noted to express their opinion on this topic. The specialists were also recruited through representatives of the medical institutions, which also might have impeded them in expressing some opinions openly.
3. Migrants who are treated for TB abroad and were not in the country during the study, were not included in the study sample, due to which the subject was addressed only in interviews with the specialists. Also, the patients who dropped out of the treatment and were not in the country during the study were not interviewed.
4. The data presented in this study uses the binary sex categories of male and female. The migration of people with diverse gender identities and/or expressions, and that of those who are intersex, has not to date been explicitly captured in migration data. IOM looks forward to sharing more comprehensive and inclusive migration data in the future.

³¹ IOM Data Protection Principles: <https://publications.iom.int/books/iom-data-protection-manual>.

³² Code of Conduct for responsible Research (2017): <https://www.who.int/about/ethics/code-of-conduct-responsible-research.pdf>.

³³ Standards for reporting qualitative research: a synthesis of recommendations: <https://www.equator-network.org/reporting-guidelines/srqr/>.

³⁴ WMA Declaration of Helsinki (2018): <https://www.wma.net/policies-post/wma-declaration-of-helsinki-ethical-principles-for-medical-research-involving-human-subjects/>.

CHAPTER 3.

MIGRATION EXPERIENCE OF THE TUBERCULOSIS PATIENTS

3.1. Interviewed tuberculosis patients' profile

Women account for around 20 to 30 per cent of TB patients in the Republic of Moldova (Annex 3).³⁵ According to the estimates of the specialists interviewed, among mobile TB patients the percentage of women is lower, given that the percentage of women with migration experience is smaller compared to that of men. Nevertheless, in this study, for the in-depth interviews an approximately equal number of female and male respondents was sought for, and female respondents accounted for about a quarter of all interviewees in the FGDs.³⁶ This was decided given the specificity of the study and the focus on gender issues, allowing to shed equal light on the perspectives of both genders.

Most respondents are people of working age, mostly young people up to 40 years old, but a group of respondents over 50 years old with significant migration experience was also outlined. Statistics show that about a quarter of the TB patients detected in 2020 in the Republic of Moldova were from the age group 35 to 44 years (Annex 5).

Some specialists pointed out that some of the young, unmarried migrants diagnosed with TB are also diagnosed with HIV infection.³⁷ Apparently, most of them acquired the HIV infection via unprotected sex and later became vulnerable to other infections, given their compromised immunity. It should be noted that in the Republic of Moldova the rate of co-infection with TB and HIV among new cases and relapse cases of TB has increased in recent years from 5 per cent in 2011, to 10.2 per cent in 2019.³⁸

Compared to previous studies conducted in the field of migration and tuberculosis, but also from the health staff's statements, the countries of destination of Moldovan migrants identified with TB have largely diversified. Thus, if 10 years ago most of the TB patients with migration experience returned from the Russian Federation, now they come from a wide range of countries, including the EU (Italy, Germany, France, Romania, Greece, the United Kingdom, Netherlands, etc.). In particular, the share of those returning to the Republic of Moldova from Poland and the Czechia with TB symptoms has increased, but also from the United Kingdom, Ukraine (especially those who go on seasonal work) and Israel. However, it is characteristic for most of the interviewees that they previously had migration experience in the Russian Federation, even if their last destination was another country. Two thirds of the interviewed respondents stated that before the last destination country they also worked in the Russian Federation.

³⁵ In 2020 out of 202 patients with a migration history, 166 were men (82.2%) and 36 women (17.8%).

³⁶ We interviewed practically all women who: have been/are undergoing tuberculosis treatment in the last three years and have experienced external migration; were in the Republic of Moldova at the time of data collection; agreed to participate in the study.

³⁷ People living with HIV have a significantly higher risk (15–22 times higher) of developing tuberculosis than people without HIV. Tuberculosis is the most common disease among people living with HIV, including those taking antiretroviral therapy, and is the leading cause of death for people living with HIV.

³⁸ National TB Response Programme for 2021–2025.



(phthisio-pulmonologist,
FG specialists)

If three to five years ago most of the patients were coming to us from Russia, now I think almost 100 per cent, the situation has changed radically. I already forgot now when a TB patient returned from Russia, instead, they are coming from Poland, Greece, Germany.

The study participants, based on their migration experience and period of stay in the host country, can be classified into several groups:



a. circular migrants – mainly from the Russian Federation, Czechia, Poland, Germany, the vast majority with previous work experience in the Russian Federation.



b. medium or long-term labour migrants – they are either single or have a family in the Republic of Moldova but have been out of the country for a longer period (more than six months).



c. migrants settled (temporarily or for a long-term) in the host country – are Moldovan nationals living abroad (Russian Federation, Italy, Spain, etc.), who have their families with them in the host country. They mostly return to the Republic of Moldova only on holidays.

The study also interviewed several foreign nationals, who were on TB treatment. These patients come from mixed families (mainly of women from Moldova and men from other countries) who came to live in Moldova, being previously migrants in the Russian Federation, Ukraine, or Turkey.

Another category of mobile TB patients are people who have abandoned treatment in the Republic of Moldova while going abroad, only exceptionally aiming to continue it in the host country. These experiences were researched and analysed largely from the perspective of the interviewed specialists, while also paying due consideration to the discussions with the TB patients.

Most of the TB patients can be classified as labour migrants, but also a few students studying abroad and young housewives with small children who were abroad with their families were identified.

Construction and agriculture are the main sectors in which the interviewed TB patients worked abroad. Other areas of activity of the respondents abroad are in the following sectors: personal care, housekeeping, food industry, hospitality, transport, etc. People who have worked in construction, agriculture, but also in other fields that involved exposure to cold, moisture, dust, use of various chemicals, etc., tend to attribute to these conditions an important role in getting tuberculosis.

3.2. Working and living conditions in the host country

Most of the male respondents rated working conditions as difficult and at high risk of damage of the respiratory tract. The women, especially those who worked in the hospitality sector, housekeeping, and/or personal care (see Annex 6, Case Study 2), rated their working conditions abroad as satisfactory or good. What characterizes both sexes are the exhausting work and the overtime hours worked. Most people mentioned that they worked 10–12 hours a day or more. Some respondents worked for several months without days off. It should be noted that in the vast majority of these cases it was the choice of respondents to work overtime out of a desire to earn more money.

Difficult working conditions in the host country



M, 65 years old,
returned from the
Russian Federation

I thought it was bronchitis. I was working in a car wash, and I thought I had a cold there because of the humidity.



M, 29 years old,
returned from
United Kingdom

Living conditions were good while working conditions were worse. For five years I was a chef in a French restaurant, where the ventilation system did not work very well. All five years that I worked there I was breathing the smoke from food. In addition, the humidity in England is very high and harmful to the lungs.



M, 37, returned from
the Netherlands

I was painting ships for two years. We usually worked 10 to 12 hours. I could work 16 to 17 hours and even 24 hours. It depends on when and what needs to be done. It's one thing when you work officially and another one is unofficially. We were working to deliver the item – the ship which had to be delivered.



M, 45 years old,
returned from the
Russian Federation

From 8.00 to 20.00, Saturday was a short day from 8.00 to 17.00. Some days were quieter, others more stressful. It happened that I stayed overnight, when necessary, for the urgent orders. I used to work at night. I worked in the tailoring factory, I was at the press, I worked with the iron, I stayed three to four times a month at night. I used to work sometime day and night for almost 24 hours.



F, 30 years old,
returned from Poland

In Poland, I had good living conditions, but I was employed on a farm where I worked with wet straw brought from the field. As I was laying the straw on the ground, clouds of mould were coming up. I didn't eat very well because I wanted to lose weight.

Many of the interviewed specialists confirmed that most of the TB patients are those who had migration experiences with poor working and/ or living conditions, representing an increased TB risk.



phthisio-pneumologist,
FG specialists

- *Working conditions are still difficult, they live in crowded homes,*
- *with emotional stress, many of the patients are going abroad with*
- *latent tuberculosis, while in difficult conditions the disease appears*
- *again... Because we have a few cases where there was tuberculosis*
- *in the family. The person went abroad and when he returned, we*
- *examined him as a migrant and also as a contact with a family*
- *member who one to two years ago had TB and we found that the*
- *returned person also had tuberculosis. This leads us to believe that*
- *latent tuberculosis develops into disease and that not all tuberculosis*
- *is from abroad”.*

Most respondents were able to save financial resources to cover the needs of the family (current expenses, children’s education, debts, buy a house, etc.). In the attempt to keep spending to a minimum, but in several situations for the lack of alternatives, many respondents admit that they have lived in inadequate conditions.

Living conditions in the host country differ from case to case, depending on the work sector, the country of destination, and the sex of migrants. The women, for the most part, described the living conditions as satisfactory, living with the family (own or ones cared for) or sharing the room/apartment with two to three other women. The men, in turn, have different experiences regarding living conditions, the most precarious one being among the migrants involved in construction, who lived on the construction site (in trailers) or in the unfinished buildings where they worked on. Some respondents noted that at the beginning of their migration, with reference to the Russian Federation, they had periods in which they lived in extremely difficult conditions without access to basic hygiene facilities. For instance, they lived in unadopted trailers, in the houses they were building or repairing, or in makeshift dwellings in the field or even on the streets. Although compared to previous studies,³⁹ the living conditions of some of the migrants in the Russian Federation have improved, they still remain the worst, along with those in other Eastern European countries such as the Czechia, Poland and Romania. Those migrants with TB interviewed in this study, who had work experience in Western European countries, said that they had good and very good living conditions.



M, 27 years old,
returned from the
Russian Federation

- *I slept in the car, in the basement and outside.*

³⁹ Labor migration and remittances in Moldova: Is the boom over? Trends and Preliminary Findings from the 2006-2008 Household Panel Survey, IOM-CBS-AXA; Moldovans in the Russian Federation: Socio-Economic Profile and Policy Challenges, IOM, 2013.



M, 24 years old,
returned from Romania

- *The conditions were good. I lived in a hotel, two to three people in a room, even one person at a time. I was installing double-glazed windows, plastered facades and sometimes we used to work in the cold and rain.*



F, 31 years old,
returned from Poland

- *I had good conditions, only it was a bit mouldy, but from time to time we were keeping the window opened. I was the only one living with my husband. There were several rooms, in a two-storey house, there were four rooms located on both the first and the second floor. The bathroom was shared on each floor.*



M, 19 years old,
returned from Poland

- *The conditions were good, I lived in a three-storey hostel, it had both heat and kitchen. There were three people in the room, myself, my brother, and the brother-in-law.*

Living conditions in the host country

Several respondents stated that they had decent working and living conditions in the host country, making it even more difficult for them to accept the diagnosis of TB.



M, 41 years old,
returned from the
Russian Federation

- *In Moscow, we did not work in humid conditions, on the contrary, we worked in the sun. In September I was tanned as if I were at the seaside.*



F, 52 years old,
returned from Italy

- *In general, only those from socially vulnerable families are considered to have tuberculosis. They have to get these concepts out because that's not really the case. But that's what everyone says, even doctors ask you, what conditions do you live in, what do you eat. They come to your home and check.*

In the perception of some interviewees, the frequently asked questions of medical workers about living and working conditions were frustrating. These questionnaires make them uncomfortable, as they feel like specialists are trying to label them or place them in a vulnerable category as if only those who live or work in inappropriate conditions can get TB.

CHAPTER 4.

KNOWLEDGE AND PERCEPTIONS ABOUT TB

Tuberculosis is perceived as a contagious disease, which most often is associated by the population with the disadvantage social categories - “alcoholics”, “ex-prisoners”, “homeless people,” who have “nothing to eat”.



F, 47 years old,
returned from the
Russian Federation

- *I don't seem to be from alcoholics, I didn't drink, I didn't smoke, nothing, and I got here, I've got totally stressed... I heard that most of those who are in prison have tuberculosis because their whole room is closed there.*
- *I didn't think everyone could get sick.*

In this context, the concept of community isolation of these people and, in some cases, of condemning their lifestyle persists. Consequently, TB is considered a “shameful disease” with a strong emotional impact on the people diagnosed (see Chapter Psychosocial Implications of TB Diagnosis). The specialists believe that these perceptions are fuelled by the frequent spread of TB among vulnerable people, but also by the attitude and the way of treatment of TB patients during the Soviet period (isolation, forced treatment, home disinfection, etc.). At the same time, the relatively high share of people dying of TB is still present in the collective memory. This perception was confirmed in the study by the main associations of respondents with TB such as “fear”, “disease”, “bacteria”, “shame”, “village talk”, “stress”, “death”, but also “smoking”.

Very few TB patients with a history of migration knew that those who work abroad could get a free chest X-ray upon return to Moldova. Some of the people, when they return to the Republic of Moldova for a while, have some medical examinations, but even fewer perform chest X-ray.



M, 27 years old,
returned from the
Russian Federation

- *I knew something. In our village there was a man who had been ill with tuberculosis, he had been in prison for many years. We used to avoid him when we went to the pond, not to use his towel, not to drink water from the same pot with him... I never thought that I would contact this disease, I felt strong, I was a sturdy boy.*

Many of the TB patients in the study said they had limited knowledge of TB before infection, especially the most common symptom of it – cough, which is associated with many other conditions and often neglected. Even if some information was disseminated through the media and/or discussed in the community, the interviewees neglected this topic, as they did not think they would ever face this diagnosis. – “I did not think it could happen to me”, “even now I do not believe that it happened to me.”

The interviewed patients attributed becoming ill with TB to the following reasons and conditions:



lifestyle: smoking, working overtime, poor nutrition, etc.



the environment in which they worked and/or lived (cold, humidity, mould, exposure to toxic substances, etc.)



stressful situations (illness of a family member, quarrels, divorce, debts, loans, etc.)



sick people in the entourage – few respondents mentioned that TB is an airborne disease.

Since most of the respondents were in treatment during the interview or had recently completed tuberculosis treatment, they managed to acquire some knowledge.

The main sources of information on TB for the patients are:

- a. **health workers** - both doctors and nurses have an important role in informing the patients about TB, treatment, and protection of people around them. Several respondents stated that doctors calmed them down with the information they provided, encouraging patients to follow rigorous treatment for recovery. The message conveyed by practically all specialists is that TB is treatable, but a firm and constant attitude is required in adhering to the treatment. In fact, the biggest dilemma of the interviewed TB patients is whether TB is curable or is just “inhibited” and “becomes latent”. Most of them mentioned that their colleagues at the hospital told them that *“this microbe stays in your body forever”*, some were convinced of this through the cases of relapse that they knew. Some of the patients mentioned that they had talked to their doctors who either confirmed their hypothesis or told them firmly that the disease is curable and that they should follow the medication with confidence. This dual approach creates confusion, so that some of the patients wonder, *“Is TB really curable or not”*?!
- b. **online sources** - both doctors and patients mentioned that the number of patients who turn to online sources for various information about TB is increasing. Compared to men, women, especially young ones, but also people with a higher level of education, surf the internet more often in search of possible scenarios, advice, or natural remedies. Several interviewees admitted that they regretted about the information obtained from unverified online sources which provoked panic and got them scared in vain.
- c. **other TB patients** - they are an important source of information and especially of experiences. Inpatient interaction with other TB patients is both a source of information and misinformation.
- d. **relatives/ friends/ acquaintances who previously had the same diagnosis** - also convey different information to patients about the treatment, experiences, etc.

e. **other sources** - several interviewees remembered that they had received leaflets and brochures both in the hospital and in the offices of phthisio-pneumologists, even if some of them admit that they did not study them. Also, during the study, only a few respondents reported that they saw videos on TV about TB, which urged people who cough for more than two weeks to go to the doctor.



(ID1, specialist)

The patients are very curious, if you go into the ward and it suits them, you can sit in the hospital ward for an hour and explain to them and they still ask questions. They are curious patients. It's a pity that we don't always have time to explain them much.

Several doctors stated that they are constantly communicating with the TB patients, and given that the treatment is long-lasting, they come to know details from the personal lives of the patients. At the same time, some of the specialists admit that they do not have time to answer all the patients' questions and that alternative sources of information are other patients, as well as information from the Internet.

Thus, some of the TB patients end up believing more in the treatment with natural products than with medicines. Most frequently "badger fat" was invoked, some of the patients mentioning that they had discussed this with their doctor and the doctor told them that a balanced diet rich in protein is enough, while others recommended that they also could use badger fat, however, being warned that it could not replace drug treatment. Another practice that is talked about half-heartedly among respondents is the consumption of dog meat, usually referring to the experience of other people and not to their own. Other methods of natural treatments mentioned are products and tinctures for enhancing immunity such as propolis, and honey with various plants fermented in alcohol.

CHAPTER 5. TUBERCULOSIS SYMPTOMS

The symptomatic picture of the disease differs from respondent to respondent while most often the following were mentioned:

- Increased fatigue.
- Lack of appetite/ weight loss/ significant decrease in body weight.
- Fever/ febrile condition.
- Heavy sweating, especially at night.
- Morning or night episodes of cough; persistent cough.
- Difficult breathing/ “I started to choke”.
- Mucus, sputum/vomiting, including with blood (usually after coughing, but also may be spontaneous).

Other symptoms of the disease reported are chest, back, head, or even abdominal pain (often perceived as gastrointestinal problems), or, in case of several women, ovarian pain and suspicion of gynaecological problems. The extrapulmonary localization of TB in the study was noticed only in a few cases, manifested with specific symptoms such as pain in the joints, bones, loss of mobility.

Severe fatigue is one of the first symptoms of TB, but it is often ignored due to the exhausting work of the migrants and only when it becomes more severe, mostly accompanied by breathlessness, by the evolution of the disease, people working abroad decide to return to the country and/ or to consult a doctor on a case-by-case basis.

The interviewed specialists confirm that TB patients often ignore the prolonged cough, they believe that “it’s because of smoking” or “it’s just a cold that doesn’t go away, bronchitis as they say” and thus postpone the visit to the doctor. In such cases they resort to the doctor only once symptoms worsen (bloody sputum, shortness of breath, severe fatigue, etc.), in advanced stages of the disease.



M, 70 years old,
returned from Spain

- *When I returned from Spain, I started coughing. I came back before Easter. I coughed all summer and about two weeks ago I went to the family doctor... I was taking some pills from the pharmacy, and it seemed like it was leaving me alone, then I started coughing again and I felt like I was suffocating. I went to the doctor.*

In the case of patients whose disease's onset was characterized by cough and/or fever, they admit that have sensed a cold, most often trying to treat themselves without consulting a specialist. Some of the migrants have lived and worked with TB symptoms for months and could not imagine what would have motivated/ caused them to go to the doctor earlier.

Some of the interviewed specialists mentioned that there are frequent cases when the migrants come with advanced forms of TB from abroad and decide to return home only when they cannot work anymore, a fact confirmed by some of the patients participating in the study - *"the money is dirty, they will not leave you alone easily"*. Doctors say that they try to understand and justify the behaviour of people with *"limited health literacy skills"*, their desire to earn more money, but cannot understand the behaviour of employers who tolerate obvious symptoms of the TB patients, especially if they work in households.



IDI, specialist

• *A lady working as a housekeeper in Russia came with tuberculosis in its prime and very contagious. Tuberculosis that was at least about eight months old, that's how terribly the lungs were affected, with three pluses in the sputum. She was cleaning in a family where there were also small children... She lost about 20 kg. Didn't the mistress see that she was melting when she saw it with her own eyes?!*

The indifference of the employers was also mentioned by some of the interviewed respondents. They turned to their superiors for help at the onset of symptoms as they trusted them, and the latter, in turn, became worried that subordinates could be infected with COVID-19, and that a potential outbreak at work could destabilize the company's work schedule. Due to this, they were insisting that migrants ignore symptoms and treat themselves without resorting to medical services.



F, 23 years old,
returned from Poland

• *The first time I went to the boss, he didn't want to do anything. He told me to take pills, syrups, that they would help me. They were afraid of corona virus and wouldn't let me go to the doctor. I stayed like that for a month and when I saw that my health state was getting worse, the temperature had risen to 38, I said whatever happens and shall go to the doctor.*

People who have had TB before were more alert to the symptoms and when they noticed any changes, they sensed that it could be a relapse and they mostly went back to the phthisio-pneumologists who treated them in the past.



M, 31 years old,
returned from Poland

• *I have felt like I was losing weight, I wasn't eating, I was falling asleep so that I came to the hospital. I knew that I was sick once again... I suddenly realized that the disease had returned, I didn't take care of myself.*

CHAPTER 6.

ACCESS TO MEDICAL SERVICES

6.1 In the host country

The profile of the mobile population from the Republic of Moldova is very diverse from the perspective of their status of residence, the sector of work in the host country, the period spent abroad, and the intention of returning home. No gender-specific differences were noted regarding the impediments to accessing medical services, they mostly reflect the status of residence and working conditions in the host country. Thus, while some of the patients, mostly those with a short period of stay in the destination country, are not familiar with the process of consulting a doctor, those who have settled abroad for a long time know the intricacies of the local health system. Subsequently, the most vulnerable in accessing health services are circular migrants, especially those who work without a contract. At the same time, during the study it was established that in a series of cases people have benefitted of medical services in the host country, at least establishing a diagnosis, despite their irregular status. While some of the migrants thought that they could not access health-care because they did not have the necessary documents, for others this was not an obstacle, especially when their health deteriorated drastically.



M, 31 years old,
returned from
Romania

- *We worked for people, but not legally, with a Moldovan passport (in UE).*
- *Even though you can only legally stay for three months, I stayed longer.*
- *When I got to not being able to walk and had a fever, I called the family doctor, and he called the ambulance because I was very ill. They took me to Timisoara, and I stayed in the hospital for three weeks.*

Access to medical services abroad is also conditioned by the country of destination. Thus, in some countries, such as the United Kingdom, the registration with the family doctor is mandatory or offers some advantages, while in other countries, such as the Russian Federation, an optimal solution to benefit from health care, according to the respondents' experience, is to turn to medical services against payment. Several interviewees stated that their employers, friends, colleagues in the host countries encouraged and/or advised them to go to the doctor and, in some cases, even accompanied them.



M, 28 years old,
returned from the
United Kingdom

- *We had a family doctor there as well, but there was a problem with the host, and we changed it and then we didn't manage to register with the new family doctor yet. When we go back, we will certainly go to the family doctor.*



M, 42 years old,
returned from the
Russian Federation

- *I had a fever, and one morning I started to get a little pain in one side.*
- *The boss suggested we go to the hospital. There I did the X-ray, then they*
- *sent me for a CT scan, and the next day I went to the doctor. I asked him*
- *if I could be treated there but he told me to go home. That's the rule,*
- *everyone is being treated at home.*

Most of those who accessed medical services in Europe were asked if they would prefer to be treated abroad or return home for treatment. A large part of the interviewees chose to return to the Republic of Moldova, most often citing the cost of living (food, rent of housing, etc.) which had to be borne.

Besides, a significant part of respondents did not go to the doctor abroad, even if they had symptoms, for various reasons, the desire to continue working, to earn more money, driven by the financial problems of the family, debts/credits, and dependence on the foreign income of the household. Also, some respondents were worried that they might lose their job (especially those with hourly or daily wages did not want to be absent from work). Among other barriers were ignorance of the host country's language, lack of health insurance and concerns about high service costs, lack of information, irregular stay and concern about deportation, short stay abroad, and/or proximity of the established term of return to the Republic of Moldova - *"I had to go home soon anyway"*, etc.



F, 21 years old,
returned from Spain

- *When I was abroad, I just coughed, I had no other symptoms, no*
- *weakness, no fever, no weight loss. I went to the doctor there and I was*
- *tested for COVID-19, then they said it was the flu, but I didn't go to the*
- *doctor anyway, because we were preparing to go home on vacation. I*
- *went already to the family doctor here...*



M, 45 years old,
returned from France

- *In Paris, I first went through the "rays" (X-rays), and suddenly they told*
- *me something was wrong. I also went through the scanner and there*
- *they told me: "urgently to the doctor!". I was diagnosed with*
- *tuberculosis and then I immediately got my ticket and arrived in*
- *Chisinau. We didn't have an insurance policy there. I didn't know that*
- *one could get cured for free in France. You don't really know the*
- *language. I thought it was possible to use the online translator on*
- *Google, but since I was contagious, I was afraid the doctor won't be*
- *able to hold the phone so close.*

6.2 In the Republic of Moldova

In the Republic of Moldova, access to emergency medical services, primary health-care consultation, and diagnosis and treatment of communicable diseases such as TB and HIV, is provided to all Moldovan citizens regardless of their medical or insurance status. However, in practice, **a widespread perception is that any consultation at a doctor involves certain costs**, given that there are certain procedures that can be facilitated, or offered much faster if the patient pays for medical services, in addition to some rather widespread informal payments, procurement of drugs, etc. Thus, some people prefer to try natural treatments or self-medication, going directly to pharmacies for recommendations, thus delaying the consultation of a specialist which for TB cases is crucial. Another category of people with TB symptoms chose to go to private institutions for examinations.

Lack/insufficient number of phthisio-pneumologists in some regions of the country is a barrier in accessing quality medical services. The specialists, being overwhelmed, find it difficult to adequately talk and communicate with the patients. Also, the waiting time for the patients is rather long – “*you lose all day*”.

Inadequate physical conditions of some offices of the Phthisiopneumology service within the Advisory Sections of the District Hospitals (SR) (lack of repairs, obsolete furniture, limited space, lack of adequate ventilation, etc.) also represent, in the opinion of specialists, certain barriers for the TB patients in accessing medical services.

Migrants’ short stays in Moldova and not seeing preventive health examinations as a priority due to other obligations – such as applying for different documents and certificates, visiting relatives, solving other health problems, etc. – make it difficult for family doctors to examine migrants, even though they are considered as a risk group for TB. If migrants go to the doctor for obtaining certain certificates for them or family members, family doctors ask them or even condition the release of those documents by performing a chest X-ray - “*they need a certificate, information, then put first the condition: perform X-ray. It is a sort of blackmail, but with that condition we succeed*”. However, the family doctors pointed out that they did not have much leverage to determine the mobile population to undergo the medical examinations.

Barriers in accessing doctors, especially specialist doctors were pointed out by some of the TB patients. It is not possible to queue at the family doctor (not everyone agrees to receive patients who are not scheduled) or to make an appointment in a few days or weeks. Moreover, consulting the family doctor is not always equivalent to a final diagnosis, it could require consultation with other specialists and/or analyses/examinations that take time again.



F, 35 years old,
returned from Poland

- *I had to wait a month to get to the family doctor. When I got to the*
- *doctor, he gave me directions for tests at a certain date. In short, I*
- *arrived at the family doctor on September 25 and until October 16 I*
- *kept giving tests. On October 16, I was hospitalized in Chisinau. All in*
- *all, it took two and a half months for me to be consulted by the phthisio-*
- *pulmonologist.*

Although there is an alternative of going to a private health centre, and according to respondents an X-ray is around 200 lei (12 USD), some respondents, mostly those with low income prefer to use their financial resources for other purposes, since they do not perceive their health as the main priority.



M, 49 years old,
returned from Poland

•
•
• *Until you get the X-ray, you have to wait your turn for a whole month,
and this is a waste of time. If you want faster, you have to pay, although
with this money you can buy something to eat.*
•
•

Another challenge for some of the patients, albeit rather exceptionally, in consulting a family doctor for tuberculosis treatment is due to health providers' misperceptions about the place of residence and related confidentiality. A TB patient who returned from the United Kingdom in 2020 mentioned that she had difficulty in registering with her family doctor in the area where she lived in Chisinau, as this was not where she had her place of residence. The respondent was detected with TB during a prophylactic examination performed in a private diagnostic centre where she was referred to the phthisio-pneumologist in the sector, who consulted her and then referred her to the family doctor. The latter insisted that the patient went to follow the treatment in the locality where the patient was registered with the family doctor. She was denied registration at the polyclinic in the sector, although she had previously been confirmed that she could be registered because she had the de facto home, being the owner of the apartment, but her place of residence was in another locality where she left from before labour migration. But for keeping confidentiality the patient was reluctant to go to the place where her residence was registered, the more so since her daughter and her five-year-old grandson lived there, and she was prone to avoid by all means their eventual infection. This whole process lasted about two weeks, until the patient finally was registered at the district centre, where she was offered a treatment plan.

CHAPTER 7. TUBERCULOSIS DIAGNOSIS

7.1 Establishing the tuberculosis diagnosis

It can take from a few days up to a few months from the onset of TB symptoms until consultation of a specialist. Most often contact with a doctor is being postponed by smokers, people with chronic bronchitis or those who have worked in a harmful environment and thus can explain the persistent cough, which is one of the most common symptoms.

However, referral to a doctor is imperative for establishing the TB diagnosis. The qualitative study elucidated different contexts in which patients with migration experience were diagnosed with TB:

- 1) **Routine medical examination** - a common practice for some people who are involved in medium or long-term labour migration, characteristic of both women and more responsible men.



M, 31 years old,
returned from the
United Kingdom

- *I came home on holiday for two months from England. Before returning*
- *abroad, I decided to go to the doctor to make sure I wasn't sick. Usually,*
- *when I return home from abroad, I consult more widely. I had an X-ray*
- *at the hospital and tuberculosis was diagnosed.*

- 2) **Medical examination required for employment** - it is valid in the case of those who work in the Russian Federation, Israel or in some factories from Czechia, Poland, but also those who were to engage in some spheres of interaction with the public in the Republic of Moldova.



F, 35 years old,
returned from Ukraine

- *I wanted to get hired this summer, but I needed medical training. After*
- *performing all the tests, they told me to go to the village doctor to*
- *have my stamp. When I went to the doctor, after the chest X-ray, he*
- *asked me if I had a fever or other symptoms. I hadn't had any symptoms.*
- *I had been working in the field all summer, I hadn't felt anything.*

- 3) **Consulting a doctor because of persistent TB symptoms** - the most common way by which the patients have been diagnosed, many of them have first tried self-treatment and since it did not work, they went to the doctor or were guided by family members to contact it for examination. In some isolated cases, the respondents' friends or relatives, mostly people with a higher level of education or those who had gone through TB, sensed and warned the respondents that they could have TB, and then the patients went to the doctor to confirm the diagnosis.



IDI, specialist

- *A young boy came to the consultative department on his own. I asked him: How did you get here? - Some guys sent me, I was telling them: I'm sorry, I don't know what's wrong with me. – But what really? - I'm coughing. – Do you have temperature in the evening, in the morning, don't you? Do you lose weight? Do you sweat at night? They knew it and they said: we think you have tuberculosis. Go and check.*

4) Consulting a doctor with another health problem (intervention, injury, fracture, etc.), without having any specific TB symptoms, while TB is detected in the process of examinations.



F, 32 years old, returned from Czechia

- *I had no symptoms, but I was going to be hospitalized for surgery and I did all the tests. X-rays showed that my lungs were affected. I returned home in May, and I did the examinations in September. I didn't even think I had anything, and I didn't even feel bad.*



M, 59 years old, returned from the Russian Federation

- *When I went, I had a bone displaced on my shoulder and I had X-rays. There (in the Russian Federation) they examined my lungs and told me that I had a lung disease and needed to go to the doctor, to be diagnosed so that I could be treated. Nothing was hurting me and I had no idea about it.*

5) Detected during TB screening campaigns - Several respondents, mostly men from rural areas, were diagnosed during TB screening campaigns performed by the mobile radiologic teams. In most cases, those patients had no TB symptoms.



M, 53 years old, returned from the Russian Federation

- *I had no symptoms. I just went through a routine health check. Some acquaintances told me that an equipped car with doctors was coming to the train station, and one could have there a free medical check-up, but I had no symptoms.*

While some of the patients have been diagnosed straight with TB, there were cases when the diagnosis has been more difficult to be establish, so that the specialists have first indicated treatments for other lung conditions such as bronchitis or pneumonia. Such cases were encountered in practice both in the Republic of Moldova and other countries.

a) correct diagnosis, established in the Republic of Moldova



F, 55 years old,
returned from the
Russian Federation

- *I have bronchitis and diabetes. At one point I lost my appetite, I often vomited. I lost 15 kg in two months. The family doctor told me that I needed an X-ray of my lungs. There they told me that I had spots, tuberculosis.*
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-

b) misdiagnosis, established in the Russian Federation



M, 41 years old,
returned from the
Russian Federation

- *I had a CT scan and was told I had bronchitis. I was treated for bronchitis for two months, the temperature was maintaining at 39, I took all kinds of medicines. I went back to the doctor, he listened to me and told me that there was a suspicion of pneumonia, but nothing clear and precise.*
-
-
-

c) misdiagnosis, established in Czechia



M, 23 years old,
returned from
Czechia

- *I did not feel that something was hurting me or that I had a fever, I did not feel anything. I just started coughing and spitting, spilling blood and then I went straight to the hospital. There (Czechia) they checked my stomach and said that everything was fine. I was coughing for about two weeks, I thought I had a cold, I didn't take any pills. I was thinking mostly that it was out of smoking... There at the hospital I had an endoscopic exam and they told me it was still normal... Then I didn't stay there anymore and went to Moldova. Here I was tested and found that I had TB. When I arrived, I had already a hole in my lungs.*
-
-
-

d) misdiagnosis, established in the Republic of Moldova



M, 27 years old,
returned from the
Russian Federation

- *I have been coughing steadily for about three years. It was a dry cough. I thought it was because I quit smoking, it cleansed my lungs. In these three years a stain has formed on my lungs. I went to the doctor, of course. He listened to me without analysis. He told me that everything was fine, that I was coughing, that my lungs were clearing, that I had a cold. He gave me something for the cough.*
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Analysing the differences among women and men, revealed that women migrants go to the doctor usually at the onset of TB symptoms, while men largely ignore the first signs of the disease. In some cases, men are brought to medical examinations by their life partners, mothers, or daughters, who are worried about their coughing, their sudden weight loss, but also about other specific TB symptoms.

All the specialists interviewed agreed that women, except for those who abuse alcohol, compared to men, go to the doctor faster after the onset of symptoms for various reasons.



Perception of the body. Some of the experts believe that women are more attentive to changes in their bodies, they are more sensitive to fatigue and pain - *“Usually women have complaints, they feel the disease. Men are stronger, they may have very advanced TB without feeling actually the disease”*. Other experts believe that in terms of endurance, including pain, women are stronger, while their earlier consultation of a doctor resides in fact in the vices that are more specific to men - *“the man simply smokes, drinks and if the cough appears, he usually doesn’t pay attention to it”*.



Concern for children and other family members. Another explanation regarding the women consulting the doctor in the early stages of the disease, is their closer relationship with children and the concern that they could be infected, but also the responsibility for the well-being of children and family in general.



Need to provide income. Another reason for the late referral to a doctor, especially characteristic of the men, is the desire to work for a while to accumulate financial resources. Besides, in some cases, the specifics of remuneration in the field of construction at the completion of the project. Thus, the migrants work until they are no longer physically fit to do any activity.



IDI, specialist

- *Women are more responsible, maybe they are closer to children.*
- *And she realizes that if she is not healthy, nobody could know what*
- *they will do then. And often the women work while their husbands*
- *don’t work so that she could be the only source of income in the*
- *family. And she thinks that if she doesn’t go and see what’s wrong*
- *with her, then someday she won’t be able to handle the family’s*
- *problems. Men are more cowardly, and there is a well-known*
- *stereotype, that the wife is permanently pushing her husband: come*
- *on, go and examine yourself.*
-
-
-



IDI, specialist

- *When he came from Czechia, he also had diarrhoea, he was extraordinarily overwhelmed. When I asked him why he did not go to the doctor, he told me that during the COVID a lot of people were out of work, but he had to work to finish the project. “I’m dying, but I’m staying to the end”.*

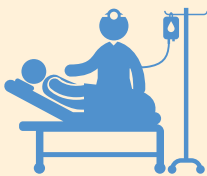
However, there are exceptions among the migrant women, who are late to see a doctor, especially women who come from socioeconomically disadvantaged backgrounds and choose to go abroad for a better life, having no support in the Republic of Moldova. This category also includes people who have had previously TB experiences in their family.



IDI, specialist

- *At home she still had nothing to return to – abandoned house, her parents passed away, she was alone... She didn’t understand that she had TB and this was serious... She weighed 37 kg, being in a very severe health state and extremely exhausted. Her state of health was extremely bad... she called for the ambulance from the bus station (on her return from Poland).*

The TB patients who are migrants in treatment can be classified by their TB history into three groups:



- with primary diagnose** – most of them.
- with relapse** – they had tuberculosis a few years ago (from two to ten years or more), finalized the treatment in the Republic of Moldova and after new work experiences abroad, the disease recurred.
- after treatment abandonment (mostly repeated)** – these patients represent the problematic group. They mostly go to the doctor usually at the worsening of their health state, follow the treatment until the symptoms improve and then leave abroad again - *“they undergo a treatment course, then leave, then come back again to take another treatment course and then are leaving again and so on and so forth”.*

The vast majority of the interviewed TB patients were diagnosed with TB in the Republic of Moldova, apart from a significant number of respondents whose last destination was either the Russian Federation or Romania. It should be noted that the migrants employed in the Russian Federation on basis of a work permit basis, alongside those who work in factories in this country, are examined annually, including a chest X-ray, through which asymptomatic cases are detected. At the same time, there is no language barrier for Moldovans both in the Russian Federation and Romania, and some of the migrants with health problems turn to private offices for examinations. Moldovans diagnosed

with TB in the Russian Federation are instructed by medical staff in this country to return to Moldova to undergo treatment, warning the patients that the costs of their TB treatment are rather high in the Russian Federation, while in Moldova they can receive free treatment. In the case of those in Romania, usually the treatment is offered for stabilization of the patients and later they are being asked to return to the Republic of Moldova and continue the treatment. In other EU countries (Germany, Italy, etc.), if people go to the doctor and are diagnosed with TB, they could undergo full free treatment in the respective countries.



M, 41 years old,
returned from the
Russian Federation

- *I could not be treated there since I was not a Russian citizen. They gave*
- *me the CT scan and all the test results and suggested that I go back to*
- *Moldova for treatment.*
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Several doctors in the hospital mentioned that in fact “Russia and Ukraine offer treatment options for tuberculosis for free”, an information that was not confirmed by the study data. In the opinion of these specialists the citizens of the Republic of Moldova choose to return to the country for financial reasons, but also out of the desire to be close to home, to their loved ones.

Circular migration to the Russian Federation has declined significantly in recent years (due to the economic crisis, the devaluation of the Russian currency, it is no longer financially profitable), but also because of higher risks and worsening working conditions. Thus, labour migration from the Republic of Moldova has been oriented to a greater extent towards other countries, such as Poland, Czechia, Romania, Germany, France, etc. At the same time, some of the Moldovan citizens who were originally circular migrants, after decades of living in the Russian Federation, now are permanent residents there, having workplaces, housing and even families there, however still not being citizens of the Russian Federation. Since they are practically disconnected from the Republic of Moldova, they return only sometimes on vacation. Even this category of people, if detected with TB, is being sent for treatment to the Republic of Moldova. Some of them do not live in the Republic of Moldova, sometimes they do not have relatives or friends who could host them considering the long period of time that they must stay away from their family for TB treatment.



phthisio-pulmonologist,
FG specialists

- *A patient from Moldova, who has a family in Russia and had been*
- *living there for many years, was diagnosed there and was sent here*
- *for treatment. The poor man lived here, all alone, being ill with a*
- *multidrug-resistant form, he lived here in Moldova for 24 months*
- *until he finished his treatment.*
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The study found that some of the interviewed migrants who previously had TB, finalized the treatment, but the disease came back over time. In many of these situations, the period of recurrence coincided with the process of resumption of labour migration, regardless of whether this happened immediately after the end of treatment or after 10 years, with women being especially sensitive in this regard.⁴⁰



F, 37 years old,
returned from the
Russian Federation

- *I finished all treatment the first time and I was cured... It was in 2010*
- *and now it's 2020 [refers to the year of diagnosis]. I didn't have anything*
- *for 10 years, and now when I went back to work, I got here again.*
-
-
-

In the opinion of several specialists interviewed, the return of the disease can be caused by an environment favourable to its development, including in the conditions of the migration process, or by a new infection that is perceived by completely cured patients as a “return of the disease”.



IDI, specialist

- *They save money to send home and sometimes they still eat what*
- *God has given to them – malnutrition. Living in a crowd, with people,*
- *coming from all sides. And this also favours the decrease of immunity,*
- *stress, thoughts about home, what children do and whether they*
- *didn't get sick eventually... and all this from the morning until 9 in*
- *the evening. That is a physical and psychological overload...*
- *Tuberculosis can relapse under certain conditions. As long as the*
- *disease leaves sequelae, there are consequences left, and sometimes*
- *they could turn the disease back.*
-
-
-

7.2 COVID-19 and the tuberculosis diagnosis

The vast majority of the phthisio-pneumologists stated that the number of people diagnosed with TB has decreased since the onset of the COVID-19 pandemic. These data are also confirmed by the records (Annex 3). Thus, in 2020 there were 1,123 new cases of TB which is a significant decrease compared to 2019 (1,902 cases). The assumptions about this decrease are different. Some of the interviewed specialists attribute it primarily to the reduction in the intensity of human interactions, of the crowds of people and of their mobility due to the restrictions imposed by the pandemic. Others, however, believe that the efforts of the medical staff have been directed mainly towards COVID-19 while other diseases have been partially neglected - “since family medicine focused more on the pandemic, now we somewhat forgot about tuberculosis, unfortunately”, arguing that the number of late visits to the doctor has increased. Several phthisio-pneumologists have warned of an increase in the number of children diagnosed with TB in the sector under their management, which, in their opinion, is a clear signal that COVID-19 poses new challenges to TB prevention and treatment.

⁴⁰ Given the small number of respondents in such a situation, more in-depth studies are necessary to confirm or refute this hypothesis.



IDI, specialist



An old man, a grandpa, returned from Russia, from seasonal work. Until he was diagnosed, the grandpa managed to infect three children, including a child of one year and two months. You can imagine, at an early age the child has already severe tuberculosis.

However, there are also voices admitting that the fear of COVID-19, of its adverse effects prompted some people to have a radiological examination and thus allowing early forms of TB be detected in a series of cases. Other health professionals, especially family physicians, have noted that, on the contrary, the COVID-19 pandemic has led to a poorer referral of patients to the physician, as they avoid medical institutions under the fear of becoming infected, or some believe that they will be diagnosed with COVID-19 regardless of the disease they will address with, based on misinformation spread in online media.

Indeed, some of the TB patients participating in the study reported that although they had some symptoms (cough, fever) they thought they might be infected with COVID-19. The worsening of the health determined them to take a COVID-19 test and only after it was negative, they went to the doctor.



M, 45 years old,
returned from France

I was sweating profusely at night, I had lost my appetite, I was tired. I was going up to the second, the third floor with difficulty, I was suffocating. All this lasted about two months, but I thought it was the coronavirus, I thought I was infected somewhere on the train, in the bus... I took the COVID-19 test there and it came back negative. I called a Romanian family doctor, who gave me the direction to pass the (X-ray) and there they told me that it was not good.

Many of the interviewed patients noted that because of COVID-19 they preferred to go to private medical institutions, since the access to state medical institutions was more difficult. This situation is valid both for the Republic of Moldova and for other countries.



M, 41 years old,
returned from the
Russian Federation

I went to a private medical institution, because there was the pandemic, and it was difficult to reach the doctors from the state polyclinic.

7.3 Psychosocial implications of the tuberculosis diagnosis

The perception that TB is a “shameful disease”, which is characteristic of socially vulnerable categories and/or people perceived as “socially degraded” (alcoholics, drug users, ex-prisoners, homeless people, etc.) makes this diagnosis cause enormous stress on people involved in the migration process, who do not identify themselves with these layers of population. Thus, people diagnosed with TB go through a “shock” and women seem to be more affected or at least prone to expose their emotions - “*I cried a lot*”, “*I withdrew to myself, I didn’t tell anyone at first, I was just crying*”.



F, 52 years old,
returned from Italy

- *Shame. It looks as if you killed someone, but in fact you’re not to blame.*
- *I feel like everyone is pointing fingers at me. I still can’t believe it’s true.*

Apart from being concerned about the evolution of the disease and the consequences on their health and on the health of their family members (avoiding the risks of infecting them), the respondents are strongly affected by the possible dissemination of information in the community (predominantly rural ones) and the reaction of the latter to their diagnosis. Particularly concerned about this are parents who have children in educational institutions and who fear that they could be isolated, stigmatized, or even verbally abused.



F, 23 years old,
returned from Poland

- *I was thinking about what people would say, those with whom I sat at a table, in a room. Then I thought that the most important thing is to think about myself and my health. I have to treat myself so that my children don’t have a sick mother.*

Another extremely affected category are people who enjoy a certain status in the community, former teachers, Local Public Authorities (LPA) employees, or people who come from families with a higher socioeconomic status. Often, they are the ones who deny the diagnosis, turn to other specialists for another opinion, and then look for levers so that they can benefit from the treatment as discreetly as possible (e.g., avoiding family doctors and collaborating directly with the phthisio-pneumologist in the district centre; sending other family members to procure their pills; showing up only for examinations). Denial of diagnosis is also specific to young people who have been diagnosed during prophylactic checks or have had mild symptoms. Some of the patients, even after receiving TB treatment, state that - “*I don’t think I had this (TB)*”.

Some of the interviewed patients reported that they are overwhelmed by worries and fears, even if they follow the treatment indicated by the specialists and feel good. Some of them have taken excessive precautions, despite doctors’ instructions to have a normal lifestyle. Respondents who have young children in the family are even more cautious in this regard.



M, 27 years old,
returned from the
Russian Federation

- *When I found out that I had tuberculosis, my wife was pregnant. My first*
- *concern was not to infect the family, mother, and child. I stayed isolated*
- *in another house for five months... To be honest, even now, when I was*
- *released home, I'm afraid to be around my child, my wife. I strive to*
- *respect a certain distance. Even when I go to friends, I avoid them and*
- *prefer to protect them.*
-
-
-



M, 69 years old,
returned from the
Russian Federation

- *My wife knows everything, but I told the children that I had a light shape*
- *and that doctors prescribed me some pills. I did not go into details,*
- *fearing that they would not want to bring to me my grandchildren.*
-
-
-

Family members are the ones who mostly provide support and emotional backing to migrants with TB, most often in this regard being mentioned life partners, but also siblings. A large part of the respondents is supported by their parents, while others by their children, even from an early age. The study identified isolated cases in which the interviewees were rejected by family members, most often due to other conflicts, while the TB diagnosis became a trigger for the rejection. The medical staff also has a supporting role for the TB patients, but unlike family members, they encourage the patients with medical prognoses and examples from their own professional experience.



F, 35 years old,
returned from Ukraine

- *My husband supported me and convinced me that I should follow the*
- *treatment. Half a year, he said, it's not that long, but I'll be sure I'm fine*
- *instead. Even my 13-year-old son made sure to remind me to take the*
- *pills. When my husband went abroad, he asked him to take care of me,*
- *and he did.*
-
-

The study found that the more pronounced the fear of discrimination and labelling, the greater the self-isolation of the patients. From socially active people, with a lot of interactions with neighbours, friends, godfathers, they turn to isolate themselves in the family, even when they are aware that they are not contagious, however they still were afraid of not infecting those around them. - *"you start avoiding people yourself"*. Also, some of the specialists have noticed that some of the TB patients isolate themselves, avoid communication with those around them, either out of concern that they would be marginalized or out of a sense of social responsibility.

A few TB patients, people who are used to working a lot abroad, being permanently active, noticed that the most difficult period for them was the one in the hospital.



M, 45 years old,
returned from France

- *The first months were harder for me. I was used to being free, agitated,*
- *I couldn't sit in one place, without work, I was permanently on the phone*
- *and then it was hard for me...*
-
-

CHAPTER 8. TUBERCULOSIS TREATMENT

Both TB specialists and patients perceive TB treatment as complicated and challenging, in terms of treatment regimen (a large number of pills, usually 9–16 per day) duration (from minimum 6 months to 9–12 months, and up to 2 years for MDR TB) as well as side effects (i.e. exacerbation of gastrointestinal problems, or of other previous health problems, headaches, etc.).

Regarding the differences among women and men, women seem to have a more responsible attitude towards tuberculosis treatment. The interviewed specialists confirm this, stating that *“women take the diagnosis of TB and their treatment more seriously”*. Several phthisio-pneumologists pointed out that the women in patients’ families are an important resource for dealing with treatment adherence issues.



phthisio-pneumologist,
FG specialists

- *Women are more responsible, really. When we lose a man from treatment, when he goes somewhere, we look for the woman next to him, because she supports him a lot. This refers not so much to alcohol and smoking, but mainly to food... No matter who is this woman, she could be his sister-in-law, sister, mother-in-law, etc., but there must be a woman who could support him.”*

Some of the men who are on TB treatment have acknowledged that their life partner’s support is significant in adhering to the treatment and ensuring their nutrition. They often bring their wives even for picking up the food based on the tickets offered, - *“many of the men come with their wives, because the wife knows better what to buy in the family”*.

This was best felt by the TB patients who did not have their wives with them for a while, as they were abroad. It should be noted that if in the case of the men over 45 of age, the partners returned to the Republic of Moldova to be with them during treatment, then in the case of younger men, who also have children, some of the women were forced to go abroad to earn money for being able to support their family and give their partners a chance to follow the treatment to the end.

All phthisio-pneumologists stressed that there are no differences in treatment protocols related to gender, except for the adaptation of the scheme for pregnant women. There are other priority factors in the treatment schemes such as body mass, comorbidities, lung destruction, form of TB (sensitive to TB drugs or drug resistant), etc.

Interviewed foreigners with TB declared that they paid for the medical services in the process of establishing the diagnosis, while the tuberculosis treatment was offered to them free of charge on an outpatient basis. In the case of hospitalization, foreign nationals must bear the costs. The specialists also pointed out that in some situations the control and monitoring of these TB patients is difficult, given the fact that these people are part of the mobile population category.

It should be mentioned that in the Republic of Moldova there is no legislation that stipulates the right to tuberculosis treatment for foreigners located on the Moldovan territory. Based on the Project Performance Review of the TB-MIG project, conducted by the IOM Development Fund expert, found that migrants who are not citizens of the Republic of Moldova cannot benefit from the same medical services as Moldovan citizens and recommended the development of a referral mechanism to the health services including TB treatment for foreigners.

8.1 Inpatient treatment

Most of the interviewed specialists believe that regardless of the form of TB, the initiation of treatment should be performed in a hospital setting. This gives to specialists the opportunity to monitor the evolution of the patient’s condition, to perform several examinations in case of comorbidities and to react promptly to possible side effects of the treatment. Besides, the hospital observes a certain diet and rest schemes, which can contribute to improving the patient’s health. Also, some patients also mentioned that they prefer hospital treatment for the conditions they offer (food, sleep regime, medical care).



M, 31 years old, returned from Germany

- *I wanted to go to the hospital, even if I didn’t feel very bad, to make sure*
- *I get well. There you are calmer, the food is on time, you sleep on time.*
- *At home you may not even have time for this.*
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-

Some of the experts believe that when making the decision to hospitalize or not the patient, each case should be considered separately while in the case of patients with the bacillary form of TB or those with lung destruction, hospitalization should be mandatory. For the TB patients with mild, “closed” forms, the patient’s opinion should be considered whether they feel more comfortable following outpatient or hospital treatment. Indeed, the study confirmed that some people insist on being hospitalized after a TB diagnosis, being afraid not to infect family members, especially if there are children in the household. Several migrants who were diagnosed abroad chose to go directly to the hospital on their return to the Republic of Moldova, avoiding contact with family members.



M, 41 years old, returned from the Russian Federation

- *I am the only breadwinner of the family, my wife and three children were*
- *in Moldova, I was in Russia. When I saw that I was feeling worse, I*
- *immediately took my plane ticket. I called the ambulance right at the*
- *airport and I was hospitalized, with the suitcase from the plane I came*
- *directly here, to the hospital... I didn’t want to go home to my wife and*
- *children.*
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Some phthisio-pneumologists have insisted on forced treatment for TB patients with the bacillary form since they pose a risk of infection to other members of the community. In their opinion, the approach of keeping the treatment voluntary, at the decision of the TB patient, is wrong.



phthisio-pneumologist,
FG specialists

- *NGOs are trying to accuse us, phthisio-pneumologists, that we are submitting the proposal for forced treatment. They are blaming us for unlawful isolation of the patients from the society and for violating the citizen's right to move. We should put the issue differently: We do not restrict the person, we strive to fight the source of infection, because the person is a source that poses a danger to society, including the family...*

Although doctors are aware that restrictions on movement abroad would restrict the right of people with TB to free movement, they believe that priority should be given to public health, and now the measures to prevent the spread of COVID-19 have strengthened this belief.

Another issue mentioned in discussions with the patients was related to DOT and treatment monitoring practices. Thus, several hospitalized people, from different hospital institutions, stated that they witnessed how some of the patients avoided ingesting the pills. The medical staff did not supervise all the patient all the time, and the patients took advantage without realizing the consequences. In the perception of the interviewees, the specialists become negligent on this aspect for various reasons, such as indifference, fatigue, lack of time, but also excessive trust in some of the patients. Several men interviewed reported that doctors and nurses divide hospitalized patients into two categories – those you can trust and those you cannot. Subsequently, the patients in the first category are allowed to administer the pills in instalments throughout the day, while the others are directly supervised. However, many of those hospitalized stated that discarded TB drugs were found in common bathrooms and/or on the territory of hospitals. In the opinion of most respondents, the waste of pills is primarily to the detriment of patients who do not administer the treatment correctly, and those who choose this path are to bear the consequences.



M, 40 years old,
returned from
Czechia

- *In Chisinau, at the hospital, I saw people throwing away their pills. They probably didn't want to be treated, there were a lot of old drug addicts there. I didn't ask them because I didn't really talk to anyone. The doctors notice the facts but couldn't manage the issue.*



M, 19 years old,
returned from
Poland

- *There was one bathroom for three to four rooms there and there was a trash can where you could find pills and whatever you want. You could have seen them every time in the can, they were also outside, behind the hospital.*

Meanwhile, another category of interviewees noticed that they interacted with demanding medical staff, who observed the rigors of DOT, so that they preferred to discuss only their own experience of drug administration, without knowing what was happening in other wards to other patients.

The biggest dissatisfaction among the patients were the challenges they faced during hospitalization – an issue which is difficult to manage. There are different types of patients with an inadequate behaviour, such as use of alcohol, physical and psychological abuse, which is of concern to the patients, especially women. Although several actions were taken to protect the hospitalized, such as contracting security services, separating the patients on different floors, according to sex, but also sorting them according to age and interests, some interviewees pointed out that they still would not want to return to hospital, despite the decent conditions provided there.

The interviewed phthisio-pneumologists confirmed this challenge, with particular reference to the “Vorniceni hospital”, so that many of the patients refuse to be admitted to this institution or after a short stay return to the district and ask the doctor to send them to another hospital or to be treated on the outpatient basis.



M, 45, returned from the United Kingdom

- *There is an old man in my ward, God forbid what he is doing there. I*
- *decided to ask the doctor to let me go home, because I couldn't stand*
- *that mess anymore. And it's not about the hygienic conditions, they are*
- *good, but they should somewhat group the patients.*



IDI, specialist

- *Men took their wives home from the hospital, because more than 30*
- *to 40 per cent of the patients were returned from detention... There*
- *where women who came with the husband and asking respectfully*
- *“I want to be treated, but don't send me there, because there is no*
- *good treatment there”. We had elderly people, men and women,*
- *who kindly asked us not to send them to Vorniceni.*

At the same time, some respondents stated that they were more indifferent to the inmates, being concerned only with their health.



F, 41 years old, returned from the Russian Federation

- *The atmosphere in the hospital was strange. There were patients who*
- *drank, smoked, had a messy lifestyle... But I can't say that they bothered*
- *me, I went there to treat myself, not to look for godfathers.*

8.2 Outpatient treatment

After being discharged from hospital, the TB patients are referred to the phthisio-pneumologist at the district level, who in turn communicates with the family doctor regarding the directly observed treatment. In the case of patients with MDR TB, some doctors contact their colleagues in the districts by phone to make sure that they have second-line preparations in stock. Also, if the doctors in the hospital consider that there is a risk of abandoning the treatment, the phthisio-pneumologists from the

district level are being informed. Most of the patients go to a phthisio-pneumologist after discharge, those who live in the district centres receive treatment at the phthisio-pneumology service within the district Consultative Section, and those from rural localities receive it at the local Health Centre. Some of the TB patients from rural areas with higher socioeconomic status choose to receive treatment in the district centre, out of the desire to maintain confidentiality and to prevent the information to be spread in their community.

However, several respondents stated that they were not hospitalized, not even at the beginning of the disease. Usually, this category of patients includes those early diagnosed, non-contagious and/or those who either live alone or the lodging allows them to isolate themselves from other family members. In the same time, some interviewees are of the opinion that they followed the outpatient treatment from the beginning due to their decent living conditions.



F, 47 years old,
returned from Italy



I can ensure any condition at home, obviously it is better to stay home, at home even the walls cure you, as they say.



M, 69 years old,
returned from the
Russian Federation



I was told that I was not in danger because I was at the beginning of the illness. I was not hospitalized and come every day to take pills. That's right, you spend money on the transport. If I come by minibus, it cost 6 lei (0.5 USD), by trolleybus it is cheaper. For the days off they give me pills in advance, for holidays as well, otherwise I have to take them daily from the polyclinic.

Several doctors have argued that the responsibility for treatment, regardless of the disease, must be primarily with the patient, who must show interest in being treated. According to the interviewed specialists, the approach in the health system of the Republic of Moldova is that first the doctor is responsible for the treatment and then the patient. If in the municipalities and district centres there are phthisio-pneumologists, health specialists and nurses, then in rural localities, this task falls on the family doctor/nurse. Family medicine and the medical system in the Republic of Moldova in general are facing an acute shortage of health staff.⁴¹ In this context, long-term outpatient treatment, even if it is DOT, is a challenge.

⁴¹ According to NBS data, in the last five years the number of doctors has decreased by 618 specialists from 13,012 in 2015 to 12,394 in 2020. An analysis conducted by UNDP specifies that there is a general shortage of medical staff, especially in rural areas. The COVID-19 preparedness and response plan highlight the specific shortage of doctors and nurses specializing in epidemiology and infection prevention and control. A total of 71.6 per cent of hospitals do not have epidemiologists and there are only 0.8 infection control specialists (including 0.3 infection control doctors) for 250 beds. (Source: UNDP, Covid-19, Action Plan for Economic Response and Recovery).



IDI, specialist

- *If he doesn't want to be treated, he doesn't take the pills even being in the hospital... For the directly observed treatment on the outpatient basis there is no sufficient medical staff, the existent one is aged and, besides all the existing problems, COVID was added so that now they have many cases, they work in the outbreaks, self-isolation.*

In the current study different practices of receiving medicines in outpatient treatment have been found and outlined. Thus, most of patients go daily to the local family doctor's office and/or the district phthisio-pulmonologist to receive the appropriate medications, except only for days off and/or holidays, for which the patients receive medication in advance. Although several patients, who seemed dissatisfied with having to go to the doctor's office daily, were proposed to have their medications brought home at a pre-set time, just few of them accepted the scenario, the argument of those who refused being the desire to avoid questions from neighbours.

Some of the respondents, mostly young people, stated that they take the pills using the video supported treatment (VST) system, in which case some of them are assisted by relatives or neighbours, and go to the doctor once every one or two weeks. For the most part, both patients and specialists have pointed out that VST is suitable for responsible people, who do not abuse alcohol or drugs, and have shown good treatment adherence for at least a month.

There are respondents who managed to agree with the doctor who provided the treatment to receive the pills from the doctor once a week. This category includes people practicing daily or seasonal work or people receiving the medicines from another locality for various reasons (change of place of residence during treatment, being registered in a locality other than that of actual residence, etc.).

Practices in outpatient treatment



M, 49 years old, returned from Czechia

- *For example, I've been asked to indicate a time when they can come and bring my medicine home, but I didn't want extra publicity.*



M, 65 years old, returned from the Russian Federation

- *I didn't want to go every day after the pills since my legs hurt, but I didn't want to "come to light" either. I stayed at home, and they brought my medicines home.*




M, 27 years old, returned from the Russian Federation

- *The doctor gives me the medicines once for seven days and I take them on video. I work every day. I can't even take a break during the day to go after the pills. However, I know that I am taking my medication at seven in the morning, I'm doing it to treat faster.*

The study also identified isolated cases when patients obtained the drugs for a longer period (one to three months) from phthisio-pneumologists, thus having the opportunity to continue working abroad. They continue their treatment abroad, being provided with medicines by medical institutions in the Republic of Moldova through their relatives. There are a few such cases per year per district. Some respondents from districts stated that even if they did not have any experience, they admit that in some of the cases, depending on the responsibility of the patients, such cases could be allowed. They mainly refer to men who being close to completing the treatment, declare that they are financially incapacitated and have to go abroad to work. In these situations, the patients keep in touch with doctors by phone or online, and if they have to come for examinations and tests, they return to the Republic of Moldova. The experts' opinions are divided on these experiences. On the one hand, some of them believe that it is good to offer such a possibility to the patients perceived as responsible, and the phthisio-pneumologist must be the one who decides on this. Positive experiences of administration of medication such as VST could be helpful in this regard. On the other hand, it is considered that the TB treatment must be directly observable, and the patient's condition monitored, while such a setup is difficult to achieve remotely.


8.3 Tuberculosis Treatment abroad

Moldovan migrants who choose to follow TB treatment in other countries are rather exceptions. The most common causes of return to the Republic of Moldova for TB treatment pertain to costs, both those related to treatment and those related to daily needs (rent, food, etc.), given that in case of TB they could be either unable to work or having reduced work capacity.



F, 52 years old, returned from Italy

- *I was thinking of treating myself there, but I changed my mind. I had to give all the tests from the beginning, and you can't stay in the host family to be treated, you have to have your own private home. I also would have had much higher expenses there. I will treat myself in Moldova and then will return to Italy.*
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M, 29 years old, returned from United Kingdom

- *I want to be treated here, in Moldova because I have to pay a lot more money there as the treatment is paid, it's not free. At the polyclinic I was asking a few people who work there, and they told me that half of the treatment is paid for by the patient and half by the state...*
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Another reason frequently cited in favour of the treatment in Moldova is **the fear of being deported, of being subsequently banned the entry to the host country or the concern that employers will no longer offer them the opportunity to work**, should the diagnosis become known to them. Other barriers to treatment in the host country include distance from the family (in the case of circular migrants), limited knowledge or ignorance of the language of communication in the host country, poor and congested living conditions in the host country.

The study found that Moldovan citizens who are diagnosed and/or initiated the treatment in the Republic of Moldova and completed it in another country are mainly young people, who have either family members or relatives who provide support for them in the host countries. Therapeutic failure in the Republic of Moldova and worsening of the patients' health are key factors in the decision to follow the treatment abroad. The most common treatment experiences abroad are linked to Italy (with the support of the Red Cross) and Germany; TB treatment of Moldovans abroad was also reported in the Russian Federation, the United States, and Belgium.

The conditions of treatment in the host countries were mentioned by phthisio-pneumologists based on the patients' reports. The first aspect refers to accommodation and sanitary conditions in which the TB patients are treated in these countries, namely, well-equipped spaces, good nutrition, etc. The second aspect that has been referred was the closed system in which the TB patients are being treated for a longer period, three to six months or even longer.



IDI, specialist

- *A very serious patient, who was diagnosed for the first time, was hospitalized. He was so serious that he weighed about 38 kg. He stayed for about a month and a half, recovered a bit and then disappeared... Now he is in Germany, he went to medical services there. He had someone there, brothers and sisters, and he went there. I don't know the history anymore and neither if he was treated or not.*

According to some of the doctors, in some countries, such as Germany, patients with TB, regardless of country of origin and nationality, are treated, and in case of treatment abandonment the authorities inform the country of origin and request information about the patient so that they know the evolution of the case.



IDI, specialist

- *We received the information as follows, even an official letter came from the consulate: "This patient has been in Germany with MDR tuberculosis", then there was information about the treatment, with what remedies, alongside stamped extracts. So, they gave us time to look for him and to provide them with a report. We looked for the patient, we went to the family, together with the family doctor, we found him.*

The interviewed specialists also stated that in bilateral meetings and/or scientific conferences they discussed with their colleagues in the Russian Federation the issues of initiating tuberculosis treatment for the migrants from the former Soviet Union, including the Republic of Moldova, at least for their elimination of bacilli. Phthisio-pneumologists in the Russian Federation have stated that they cannot cover the costs of treatment for these categories of people in their public health system.

8.4 Conditions and risk factors for treatment discontinuation

The main risk factors for abandoning TB treatment are:

- lack of responsibility, limited health literacy skills/poor health culture;
- alcohol abuse;
- improving health / perception that if one is discharged from the hospital, it means that one is healthy, although patients are being explained the need to continue the treatment on an outpatient basis;
- migration for work, in the context of lack of financial resources, need to support the family, payment of loans, debts, but also insistence, encouragement from (former) employers;
- social pressure, as an effect of stigmatization and discrimination;
- lack or insufficient support (material and/ or emotional) from the family;
- refusal of hospitalization mainly due to the category of patients (alcohol abuse, aggression, etc.) and hospital conditions;
- side effects of the treatment and long duration treatment duration (fatigue, saturation);
- free treatment without measures to hold abandoning patients accountable.

As seen above, there are plenty of factors that could contribute concomitantly to the abandonment of tuberculosis treatment. The patients decide for themselves at the time of abandonment that there is no other solution or that this is the best option for them.



M, 41 years old,
returned from the
Russian Federation

- *I was prescribed a 22-months course of treatment, and, after discharge,*
- *I would have to continue the outpatient treatment. Last time I didn't*
- *finish the treatment because I was feeling sick from the medication.*
- *Cirrhosis had appeared.*



M, 31 years old,
returned
from Germany

- *As far as I understand, after discharge, we will have to go to the doctor*
- *every day to receive the pills. I think I'll go, but I don't know for how long.*
- *I don't rule out that, at some point, I will stop the treatment, I think it*
- *would be good the medicine to be given at least for a month ahead. I tell*
- *you - I have to do 10-20 km (by public transport) to the hospital every*
- *day for six months, that's impossible.*

For the mobile TB patients, the biggest risk factor in treatment abandonment is **going to work abroad due to lack of financial resources**. According to the data provided by NTRP for the year 2020 out of the total number of patients lost to surveillance, 18.5 per cent invoked the departure abroad as a

reason for abandoning treatment. On the one hand the presence of children is a strong factor in adherence to treatment, but on the other hand, if the family cannot provide for the minimum necessary living conditions for children (food, clothing and/or expenses on health and education), the risk of abandoning treatment is higher as soon as the TB patients feel better and think that they will cope with the work abroad.

In this context, considering the sense of responsibility for the children, the mothers are perceived as more motivated than fathers to follow the treatment, given that they fear as being primarily responsible for children's health, not to infect them, and secondly, they worry about the children's future in case something bad happens to them.

According to other specialists, single people involved in the migration process, especially young ones, have a more pronounced tendency to give up TB treatment after a certain period of stay in the Republic of Moldova. The main arguments in this regard refer to the lifestyle they have become accustomed when being abroad like "they can't take it anymore; they get bored", but also to the fact that some of them feel that the context of TB detection constrains their usual way of interaction with friends in their home country. Thus, from the psycho-emotional point of view it becomes rather complicated for them to continue the treatment without having the attachment and motivation provided by the family and children.



IDI, specialist

- *After all, you know what it depends on, I noticed, a young age man, when he still has no family, is alone. He grabs his bag faster and leaves, no one stops him. When there is a family, when there are children, when also the wife is talking to him... The abandonment happens less among those who are married while those who are alone are like "migratory birds", they make the decision and move faster, no one stops them.*

For the women who raise their children on their own, without the support of the extended family, it is difficult to follow the TB treatment for a long time, they simply cannot cope with the daily expenses, including the provision of food, and choose to temporarily give up treatment, go to work abroad in the hope that they will accumulate some savings that will allow them to follow the treatment later.



phthisio-pneumologist,
FG specialists

- *Only two months ago, a patient of mine abandoned MDR TB treatment and left. I still don't know where to. She was treated for two months and left, she left because she lives alone, without a husband, has a small child, simply has nothing to support herself with.*



phthisio-pneumologist,
FG specialists

We have in our records 14 patients with (treatment) abandonment and 10 of them have left abroad (since 2009). There's nothing we can do about it.

Some experts mentioned that in discussions with relatives of the migrants, some of those who abandoned the TB treatment have pursued treatment abroad, but this can only be confirmed if they present some documents or if the necessary examinations that are conducted in the Republic of Moldova confirm that they are healthy. Otherwise, the TB patients are still listed in the records as cases of treatment abandonment.



phthisio-pneumologists,
FG specialists

They are listed as (treatment) abandonment cases with us, they have gone abroad, and we cannot catch them. There are patients who say: "I went to Italy and received treatment for tuberculosis..." But we have no evidence for removal of the case from our records. There are others who were in Portugal, where they received treatment, but we still don't have any evidence for getting them out of our records.

However, most of the patients who abandon TB treatment in the Republic of Moldova because of going abroad, return to the doctor only, when their health deteriorates. Phthisio-pneumologists say they talk to the family members, try to contact them through social networks (Facebook, Odnoklassniki, Viber, WhatsApp) and other applications to convince them to undergo medical checks when they return to the country or to make these checks abroad and to send their results to Moldova. This process is difficult and time consuming, with many of TB patients not cooperating in this regard or not completing the process so that they can be considered as "treated cases".



IDI, specialist

We have a missing patient, abandoned treatment, at the last meeting of the committee last year, we have been told that if no TB treatment results, there is need for three months in a row test results to confirm the TB status. For example, March 1, April 1, and May 1. And if they're all negative, we'll take the patient out of records, the X-ray is good.

Some of the TB patients who are feeling well have been hired to work, others have raised families in the host country and are afraid to go to the doctors there so that they do not identify any health issues which could create problems at the workplace or even for their legal status in the host country.

It should be noted that the risk of abandonment is higher among patients who previously had already abandoned treatment. The fear of the consequences from dropping out of the treatment persists among the new people diagnosed with TB, while those who have given up treatment but have returned to a serious condition and then got back to the treatment again, tend to remain in this vicious circle.



phthisio-pneumologist,
FG specialists

• *I have a patient with multidrug-resistant TB since 2015. He was treated in hospital for six months and then left. A year and a half later, his father brought him in his arms, I hospitalized him, he underwent treatment for six months and left again. He's leaving here and there, either to Romania, either to Russia, the last time he's gone to Portugal.*

Most of the experts say that it is very good that tuberculosis treatment is free, but there is a perception in society that *“everything that is free is of poor quality”* and in this context some of the patients do not appreciate the opportunity of free treatment. The doctors warn the patients on the extremely high cost of the drugs, but without certain conditions, including financial ones, the patients do not acknowledge all the implications of the treatment. It has been suggested that an agreement is concluded at the start of treatment. It should include the costs of the treatment scheme, which while being free of charge for the patient, the latter should reimburse a share of 10 to 25 per cent of the costs in case of abandonment of the treatment. Another recommendation referred to the option of inflicting penalties on persons that have resumed the treatment after the abandonment - *“let the person know that for the resumption of the TB treatment after the abandonment, a certain amount for the treatment would have to be paid”*.

8.5 Prevention of abandonment

Most of the health-care professionals talk to people who tell them about their intention to leave for working abroad before the end of treatment and try to convince them that their priority is to get better and then they will work/will be able to work. They also warn them of the risks they face if they do not follow the treatment to the end.



IDI, specialist

• *How much do we still talk to them and show them that they do not have to leave if they have not finished the treatment... that their conditions will worsen there, including emotional stress, malnutrition, physical work, many hours of work, insufficient sleep, all these lead to aggravation of the disease. But some of them still say - “Give me the pills, I’ll drink them.*

Many of the interviewed patients confirmed that the specialists were the ones who first warned them about the risks of discontinuing the treatment. In some cases, respondents did not mention the intention to re-emigrate for work, but doctors anticipated this interest, giving them both the information needed to prevent abandonment and concrete examples from their practice.



F, 55 years old,
returned from the
Russian Federation

- *The doctor says from the beginning not to abandon the treatment,*
- *because things are getting worse, a form of drug-resistant tuberculosis*
- *is developing. That's why if you want to live, you have to treat yourself.*
- *It's harder at first, then you get used to it and take the pills lightly.*
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During the interviews and group discussions with the patients, they often mentioned that during the hospitalization period, regardless of institution, they witnessed the death of other TB patients. While some of them were terrified that this could happen to them, others, most of them, admit that these scenes really showed them the risks of abandonment.



M, 37 years old,
returned from the
Russian Federation

- *I saw the consequences. When I was hospitalized, I saw people who died*
- *just because they didn't follow the treatment. Four people died in a*
- *week, while I was in hospital in Chisinau.*
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It is more difficult to manage the situations in which the TB patient does not show up to take the treatment and when attempting to bring him/her back to the treatment, it is found out that he/she has gone abroad. In these situations, discussions with family members, the attempts to communicate through social networks (if the person is open) are the levers through which doctors communicate about the need to continue treatment. However, if people leave, they usually stay for at least three months (Poland, Czechia) or even years (Germany, Portugal, France, etc.).

The specialists pointed out that migration from the Republic of Moldova continues to have as its main purpose the work abroad, due to the difficulties of the people to earn a decent living at home. In their opinion, if people cannot earn resources to cover their daily living, they will continue to leave in order to identify opportunities. This phenomenon is more acute among those who have previous migration experiences, as is the case of the TB patients included in the study.



IDI, specialist

- *No one goes to Russia or any other country because they really like*
- *Russia, to see the beautiful places in the villages there, etc., but*
- *people go for black labour to earn a piece of bread for supporting*
- *their family. Once the patients return and the families have a budget,*
- *we must support them during the treatment, so that they do not*
- *give up. Then, let them go back to society, to find a job, to have a*
- *somewhat normal status.*
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CHAPTER 9.

APPRECIATION OF SERVICES

9.1 Medical services

In general, most of the interviewed TB participants were satisfied with the medical services they received in the Republic of Moldova. At the same time, the lack of doctors or their overburdening has a negative effect on the level of patient satisfaction. There is also a direct correlation between the relationships established with the doctor and the level of satisfaction with medical services. All patients appreciate that the TB treatment is free and for some of them this was a surprise, given that they have been used to paying usually for medical services. Insufficient communication with the patients can sometimes lead to unclear situations for the TB patients and diminish confidence in the services provided.



M, 31 years old,
returned from the
United Kingdom

- *I asked the nurse to bring me a pill and she brought it to me. I know what that pill looks like, it's square, but she brought me a round one. I don't know what she gave to me. In general, as for the pills, I think they should come with the blister and cut the pill in front of you.*
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The TB patients who have been hospitalized in a serious condition are very satisfied with the fact that with the help of doctors they have managed to overcome the critical condition they were in. The hospitalized patients also appreciate that they are being examined and counselled on other comorbidities they have.



M, 31 years old,
returned from
Germany

- *I was in the hospital because I was in a serious condition, I couldn't walk, I couldn't eat. They told me it was better to go to hospital and now I'm a different person.*
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The dissatisfaction in the hospital, as we mentioned, refers more to those hospitalized, and some of the patients, especially men, declared that they were not satisfied with the food in hospitals, either with its quality or insufficient quantity.

At the level of phthisio-pneumology services within the district's consultative sections, the caring attitude of the doctors and nurses is appreciated⁴² even if some of the patients mentioned that they may not always have access to a phthisio-pneumologist for questions and consultations.

⁴² It could also be the effect of the location of the interviews, given that most of them were conducted in the offices of the phthisiopneumology services within the SRFthisiopneumology consultative sections.

The interaction with the family doctor is more intense in the diagnosis stage of TB, and in this sense the experiences are different. The patients who were misdiagnosed (respiratory infections, pneumonia, etc.) and were treated incorrectly for a long time by family doctors without being referred to a phthisio-pneumologist were dissatisfied. In the stage of continuing treatment on outpatient scheme, the biggest dissatisfaction does not refer to the medical act itself, but to the aspects of interaction and finally to maintaining the confidentiality.

9.2 Psychological services and social benefits

The phthisio-pneumologists appreciate the support of fellow psychologists or of the social workers employed in the consultative sections. They consider that the initial psychological support, immediately after establishing the diagnosis is very important for both patients of all genders and their families. This support also maintains its importance during the treatment of TB, should any crisis situations occur.



IDI, specialist

- *According to the new order from 2020, we have a psychologist, who advises the patient and the family. The psychologist has a very big role in our efforts of disciplining the patient, the inclusion of the psychologist in the service is welcome because we work side by side. When a patient who came to us was diagnosed with TB, he/she is consulted in one of the first place by the psychologist who gives not only primary advises but also supports the patient during the treatment while also advising the family accordingly.*

Psychological care is sometimes appreciated as much as medical care by the TB patients. The study established several situations in which the interviewees were counselled by the psychologist, both inpatient and outpatient. The men are more reluctant to share their experiences related to TB, probably because of social stigma - *“I heard there was a psychologist, but I didn’t need it”*, while the women recounted in detail the benefits of their discussions with the psychologists.



F, 39 years old,
Returned from the
Russian Federation

- *I talked to the one on the spot and I felt good, honestly, I don’t remember what he told me, but I remember that I felt relaxed, like I lost 10 kg. I talked to my family, and I felt good. The more you talk, the easier it becomes to you. I didn’t especially address him; he just was in the office when I came in and started asking me questions. It was a spontaneous meeting. Honestly, I didn’t expect for a psychologist in the hospital.*

Both the interviewed specialists and patients pointed out that psychological services are disguised, and psychologists often resort to different techniques: avoid presenting themselves professionally, start the discussion by completing a routine questionnaire about treatment, thus reducing the possible reluctance from the patient's side. Few patients who have undergone treatment in the host country have reported that consulting a psychologist is a common practice abroad as part of the treatment process (see Annex 6, Case Study No. 1).

Although many of the interviewees, both women and men, mentioned in the discussions that they had witnessed several deaths during their stay in the hospital, which marked some of them deeply, few managed to discuss these feelings with a specialist.



F, 41 years old,
returned from the
Russian Federation

- *There was a girl in the hospital with me. One day I went out to talk to*
- *my sister who had come to visit me, and when I entered our ward, I*
- *saw the girl lying dead on the floor. I went out into the hallway and*
- *started crying, but I wanted to scream out. I was depressed, my doctor*
- *was with me, but he suggested that I talk to a psychologist. I was*
- *panicking and the psychologist helped me. Sometimes I would talk to*
- *her on the phone, other times she would come to me. I found a friend*
- *in her person.*

9.3 Support for treatment adherence

a) Incentives for better treatment compliance

TB patients that follow outpatient DOT receive a daily incentive of 35 lei (2 USD) in the form of a food voucher and compensation for transportation costs. Almost all patients are satisfied with this support. However, some of the patients consider this is a very small amount in relation to their food needs, particular for financially vulnerable families with numerous family members. Some of the TB patients reported that they are not satisfied with the quality of the products.

Some of the interviewed migrants perceive this support as a way to accentuate their vulnerability and initially refuse to benefit by mentioning that *“there are people who are poorer than me”, “I could afford myself to buy food”*.

The interviewed specialists mentioned that these incentives on the one hand represent a motivating factor for the TB patients, and on the other hand provide a better diet for them. Some of the phthisio-pneumologists have pointed out that it is difficult to work with food stores, given the fact that on the one hand many entrepreneurs do not want to offer these services out of fear of infection, and on the other hand the way of reporting and evidence for certain categories of products included in the protocol creates additional difficulties in their activity. In some districts, partnerships have been established for years with the commercial entities, while in others only centralized purchase of food was succeeded through the hospital, which is then distributing it to the patients. The latter practice is viewed with reluctance by some of the specialists.



IDI, specialist



This is my case and there are other districts, where the patients receive the food items at the hospital warehouse. Such a practice is strictly forbidden; it should not be this way... I insist for a long time that the patient has a food card in hand and according to it must receive the food from the store.

The “food card” option could be a solution that would solve several challenges related to the cost and quality of food at the outlets currently selected to provide these services. It would exclude any suspicions regarding the non-compliant use of food cards, etc. It also would protect the TB patients from worrying about spreading information about their disease and preventing their stigma and discrimination. Other phthisio-pneumologists have doubts that the implementation of the card is possible, given the fluctuation of people and the days they attend each month. This barrier can be remedied by monthly requests to the financial institution on the amount required to be transferred for the next month.

b) Allowance for temporary incapacity for work

In the Republic of Moldova, the allowance for temporary incapacity for work caused by tuberculosis, AIDS or oncological disease is established regardless of the duration of the social contribution period,⁴³ therefore even those involved in the migration process can benefit from it. The study found that this legislation is applied differently in different districts, which probably refers to the degree of information of the TB patients and the cooperation between state institutions to facilitate these allowances. In some districts, the psychologist or social worker working in the counselling department provides information and logistical support so that all TB patients can benefit from the allowance. However, in the opinion of some of the patients, the process is a bureaucratic one, it requires addressing several institutions to obtain documents and certificates, while the amount offered is a modest one,⁴⁴ not covering even the existence minimum.⁴⁵ So, some of the patients give up on this request, but there are also people who do not even know that they have this right. Among them are mainly young people and those with a higher standard of living.

The interviewed specialists, but also some of the patients, women and men, mentioned that any support provided during the treatment period is important, however, the functional mechanisms of patient responsibility must be identified, considering that some of them tend to abuse the system of facilities.

⁴³ DECISION No. 108, of 03.02.2005, on the approval of the Regulation on the conditions for establishing, calculating, and paying compensation for temporary incapacity for work.

⁴⁴ The basis for calculating the allowance for temporary incapacity for work caused by tuberculosis, AIDS or oncological disease, for those who do not have the required contribution period of 3 years in total or 9 months in the last 24 months prior to the date of illness, is 35 per cent of the average monthly salary forecasted, established by the Government, for the year in which the insured risk occurred. The amount of the average monthly salary per economy, forecasted for 2021 is 8716 lei, was approved by Government Decision no. 923/2020.

⁴⁵ The subsistence minimum per month was 2088.4 lei in 2020 - <https://statbank.statistica.md/>.



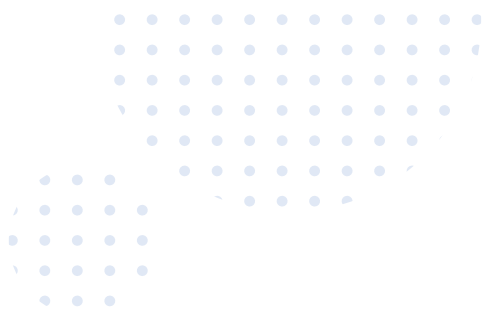
phthisio-pneumologist,
FG specialists

- *He came back from abroad (Germany) after abandoning... He came,*
- *was attributed the disability group, and then left for Ukraine. He*
- *stayed in Ukraine for nine months, and since the established*
- *disability expired, he came to us to for establishing it again. Last*
- *time I said I won't attribute him the disability since he hasn't followed*
- *the treatment. Only if he gets treatment, he could be established*
- *the disability group.*

In different contexts, the phthisio-pneumologists highlighted the contribution of civil society organizations – most often the Center for Health Policies and Studies, called PAS Centre,⁴⁶ the leading NGO in Moldova in TB and HIV, the Health and Community Development Centre (AFI) Act for Involvement⁴⁷ and “Speranta Terrei” – that implement projects in support of public information, diagnosis, tuberculosis treatment and psychosocial support for the patients. Some of the doctors also appreciated the trainings and logistic support provided to the specialists.

⁴⁶ Center for Health Policies and Studies: <https://pas.md/en/PAS>.

⁴⁷ Health and Community Development Centre (AFI) Act for Involvement: <http://afi.md/>.



CHAPTER 10.

COSTS OF THE TUBERCULOSIS DIAGNOSIS AND TREATMENT

10.1 Diagnostic expenses

The costs incurred by the TB patients until the diagnosis is made, differ from case to case, depending on how and where the diagnosis is made. Some of the respondents did not have any expenses in establishing the diagnosis, this category includes the migrants examined in TB screening, those who went directly to the phthisio-pneumologist (abandonment, recurrence), but also some of those who were referred by the family doctor. Others, especially those who did not admit having TB, mentioned that they had incurred several expenses until the TB diagnosis was established. However, it was difficult for many respondents to estimate what expenses they incurred in this process. Even so, the invoked expenses can be divided into three categories, which include:

- a) medical tests and examinations** – expenses for this purpose were borne by both patients who chose to go to private medical institutions, in the Republic of Moldova or abroad, at the onset of symptoms, and those who went to the polyclinic or hospital on their own initiative, not being medically insured. Some of the respondents endured several rounds of analysis and examinations until the final diagnosis, each time assuming the related expenses. The study data show that although the migrants are at risk and should be screened for free for TB, regardless of their health insurance status, this is not always the case, even in cases where the returned migrants evidenced some of the TB symptoms.



F, 52 years old,
returned from Italy

- *I went to a private clinic (in the Republic of Moldova), because I didn't*
- *have an insurance policy... I spent money. I paid for the tests and the*
- *X-ray to a private clinic."*



M, 33 years old,
returned from Portugal

- *I only paid for the first X-ray I did at the district hospital and since I didn't*
- *have an insurance policy, they told me to pay at the cashier there.*



M, 45 years old,
returned from France

- *I went to a private clinic in France because there was no queue. I think*
- *there it was also possible to pass for free, but there you had to wait, they*
- *would have scheduled you. It costed me approximately 400-450 euros:*
- *300 euros for the scanner and 50 euros for the X-rays. And for the doctor*
- *5 euros or 25 euros, I don't remember.*



b) self-administered treatments or misdiagnosis – respondents who initially assumed that they had contracted a virus or COVID-19 or who were misdiagnosed with bronchitis or pneumonia reported such costs.



F, 40 years old,
returned from the
United Arab Emirates

- *I went to the village doctor, he listened to me and told me that I had*
- *bronchitis, nothing serious, he recommended me some teas and pills*
- *then. About a month later I went to the doctor again, he already said*
- *that I had pneumonia. I still paid for the pneumonia treatment and only*
- *the treatment for tuberculosis was for free.*

c) transport or travel costs – difficult to estimate for respondents. More affected by these costs are people from rural areas located at a larger distance from the district centres where the offices of phthisio-pneumology services are located within the district consultative phthisio-pneumology sections, but also people with mobility difficulties who cannot use public transport and are forced to call to relatives or taxi services.



10.2 Treatment costs

Almost of the patients reported that they did not have any direct costs for the TB treatment during hospitalization. Most commonly, the costs associated with treatment are perceived as those for a better diet, recommended to the TB patients. Expenditure on medicines refers to hepatoprotectors and, where appropriate, gastroprotectors, recommended by the phthisio-pneumologists, noting that they are not indicated in national clinical protocols. In the case of TB patients' certain health problems may be exacerbated, side effects may occur, such as allergies, muscle aches, and not all medications for these conditions are provided free of charge by medical institutions. Some of the patients also ask their doctors what they might recommend for rehabilitation, faster recovery, and they are being prescribed certain vitamins.

Some of the interviewed patients stated that they spend between tens and hundreds of Moldovan lei per month on medicines, vitamins and supplements recommended by specialists. These amounts are mostly acceptable to the patients, many of them do not question the need for their administration since they have the priority of speedy recovery.




M, 33, returned
from Poland

- *If the doctor told me to take it, do you think I will think on how much it*
- *costs?! I don't even know how much I spend on Silimarin (hepatoprotector)*
- *and others.*

However, for some of the patients, the cost of hepatoprotectors constitutes a rather big effort, and some respondents, especially in rural areas, said it would have been more useful for them to receive money instead of food vouchers, for covering the costs for hepatoprotectors. At the same time, there


are several respondents to whom the specialists did not indicate anything else than anti-tuberculosis treatment, in compliance with WHO recommendations and national clinical protocols.

Treatment costs




M, 46 years old, returned from the Russian Federation

-
-
- *We buy hepatoprotectors out of our own money. They cost about 200 lei (12 USD) per month.*
-
-
-



M, 27 years old, returned from the Russian Federation

-
-
- *84 lei (5 USD) I'm buying Silimarin for the liver and vitamin C, that's what the doctor said it should be.*
-
-
-




F, 38 years old, returned from the Russian Federation

-
-
- *I always buy vitamins because you need to take care of your body. I eat more milk and fruit. From medicines, protectors for the liver. I don't even know how much I spend; I didn't do a calculation. The doctor at the hospital told me what supplements I could take.*
-
-
-



M, 41 years old, returned from Poland

-
-
- *I do not take drugs to protect the liver, the doctor did not prescribe them to me. Now I'm hearing about Silimarin for the first time.*
-
-
-



M, 49 years old, returned from Czechia

-
-
- *When I was hospitalized in Chisinau, they gave me these pills, then I went home and here the doctor prescribed me Holiver, Silimarin, vitamin C. I also had small haemoglobin. I was buying medicines for 450 lei per month. Now my haemoglobin is normal, and I spend less.*
-
-
-

In some districts have been identified some good practices and solutions in providing hepatoprotectors to TB patients. This support has been covered through the costs borne by the medical institution, civil society or covered by the District Council in coordination with the National Tuberculosis Control Programme (2016–2020). Although the Program was already finalized, some of the positive practices still have continuity in several districts. More than a few specialists pointed out that they could not explain: “Why are the hepatoprotectors compensated for the tuberculosis patients?” based on compulsory health insurance. In their opinion, at least the patients covered by health insurance should benefit from hepatoprotectors in the treatment of TB. Phthisio-pneumologists said that although they had discussed this issue several times with the decision makers, including the National Medical Insurance Company, no solutions had been found yet to date.

The study identified as an exception a case of a patient who incurred costs of several thousand lei during inpatient treatment, due to lack of necessary medicines (other than the TB drugs) in the hospital but were necessary for the patient who was in serious condition. Her family members bought them from their own resources.



F, 30 years old,
returned from Poland

• *Namely, I received an antibiotic that cost a hundred and a few lei an ampoule for the infusion when I was in resuscitation, already diagnosed with tuberculosis. The doctors noticed that the treatment didn't help me much and decided to switch to another treatment while the medicines should have arrived the next day. Waiting for another day was a lot for me and then my mother bought the medicines from the pharmacy for more than five thousand lei for three days of treatment, then for another three thousand lei, because the order had not yet arrived. I was vomiting all the medicine I was taking - it didn't help me at all.*

10.3 Coping/ overcoming strategies

By the end of TB treatment, a large proportion of patients are provided with temporary work incapacity allowance. However, the allowance is very small compared to their needs. Thus, most of the migrants resort to savings, the sale of household goods (means of transport, appliances, jewellery, etc.), if they have them, and/ or benefit from the support of extended family, friends or in the form of help or loan.

Resources and income during TB treatment



M, 49 years old,
returned from
Czechia

• *We have a disability pension - 600 lei 21 bani (32 USD).*



M, 69 years old,
returned from the
Russian Federation

• *I accumulated debts. My sister-in-law lent me a thousand and a half, she said I would return it when I have it.*



M, 31 years old,
returned from the
United Kingdom

• *I have people who could help me, but I have not yet reached this situation. So far, I've been able to make ends meet.*



M, 45 years old,
returned from France



I'm on the sick leave now... There is about 300 euros a month I am getting on the card from France.

Young families with children are extremely vulnerable if the person involved in labour migration, usually the main breadwinner, is no longer able to provide for them. These families are mainly those who also have loans, including real estate or consumer ones, which have been invested in the repair, endowment of housing. Under these conditions, many TB patients start working as soon as their health allows. Most of the men and some of the women still work in construction, which involves physical exertion and an unsuitable environment for people with respiratory problems. Although doctors warn them about the health risks of doing this work, the patients say they have no other choice. Another area that provides them with extra income is day labour, mainly in agriculture. The work in the field of construction and agriculture is informal.



M, 27, returned
from the
Russian Federation



I work here, on the spot, unofficially, in construction.

Formal employment and/or return to work in Moldova of people under TB treatment is rather an exception. Some of the experts believe that debacillated TB patients should be allowed to return to work with the consent of the phthisio-pneumologist. There must be a clear regulation that stipulates the conditions under which a TB patient in treatment can return to work, so that Public Health Centres do not implement different approaches. The respondents who are treated for TB and are employed said that they feel more comfortable psychologically, more self-confident and believe that professional activity is beneficial and should not be restricted to those who are able to work and who do not present any contamination danger for other people.



F, 30 years old,
returned from Poland



I was and I am still employed. I continue to work and follow the treatment with video sending. I've been feeling much better since I went to work. The activity was positive for the body. I have a non-transmissible form, not dangerous to other people. I also have an acquaintance with whom I was hospitalized with in Chisinau and she is also allowed to work, because she also has a closed form of tuberculosis.

CHAPTER 11. STIGMA AND DISCRIMINATION

The situation regarding discrimination against TB patients is generally less pronounced compared to previous studies,⁴⁸ both in the opinion of specialists and patients - “before the TB was a verdict, now the world is brighter”. Many of the respondents, mostly the most informed about the causes of TB, said that they were not embarrassed by the diagnosis, as in the most frequent cases they became ill abroad, working to support their families or to improve their standard of living.



M, 31 years old,
returned from
Germany



I am not ashamed. I went and worked for the family, I got sick. Shame on someone who drinks and sleeps under bridges.

However, some of the interviewed migrants, men and women, reported situations where they felt stigmatized or, more often, worried that they might be stigmatized. Thus, some of them avoid communicating the diagnosis, including to the extended family, friends, neighbours so as not to be marginalized or excluded from the community. Many of the respondents said they were trying to keep their diagnosis secret, even though people who found out about the diagnosis did not reject them and did not change their attitude towards them. Another concern of the patients refers to the possible duality of their acquaintances - “maybe he does not show on his face that he is afraid of me, but who knows what he says about me from behind”. (M, 39 years old, returned from Germany).



M, 40 years old,
returned from
Czechia



It becomes known because the doctors have a long tongue. The doctor told someone and in the village the post office works fast. As for me, if anyone asks me, I say that I have a cold, that I am being treated for pneumonia. The more they know, the worse they sleep. At school, maybe not everyone knows, everything is fine.

One aspect addressed by the patients participating in the study refers to ensuring confidentiality by the local specialists during outpatient treatment. Although many people are concerned that doctors may leak confidential information. There were not so many cases reported in the study, nevertheless the TB

⁴⁸ Access to diagnosis and treatment of patients with tuberculosis, barriers to adequate care and financial difficulties of patients and their families, PAS Center, 2018.

patients feel ashamed and uncomfortable, and resign since the situation cannot be changed. A small proportion of patients had conflicts with doctors due to non-confidentiality. In the case of one respondent, he had to change his place of residence, both because of his disagreement with the local doctor and because of the concern of being questioned by the villagers.



M, 29 years old,
returned from the
United Kingdom

- *I ran away from the village because of the family doctor, she is too*
- *open to everyone. She was walking out in the hallway and, for everyone*
- *to hear, screamed at me to come in and take my pills. The corridor was*
- *always full of people. It was enough to tell me to come closer. From the*
- *village I moved to the city, and now I stay in rent. In the village every*
- *day and every time you meet someone who asks questions.*
-
-
-

The phthisio-pneumologists in district centres pointed out that stigmatization and discrimination of TB patients persists even among medical staff. Some of the doctors are concerned about their own health and the health of their patients, given that it is a contagious disease, while others have certain stereotypes about the TB patients and prefer to avoid them by referring them to the phthisio-pneumologists.



phthisio-pneumologist,
FG specialists

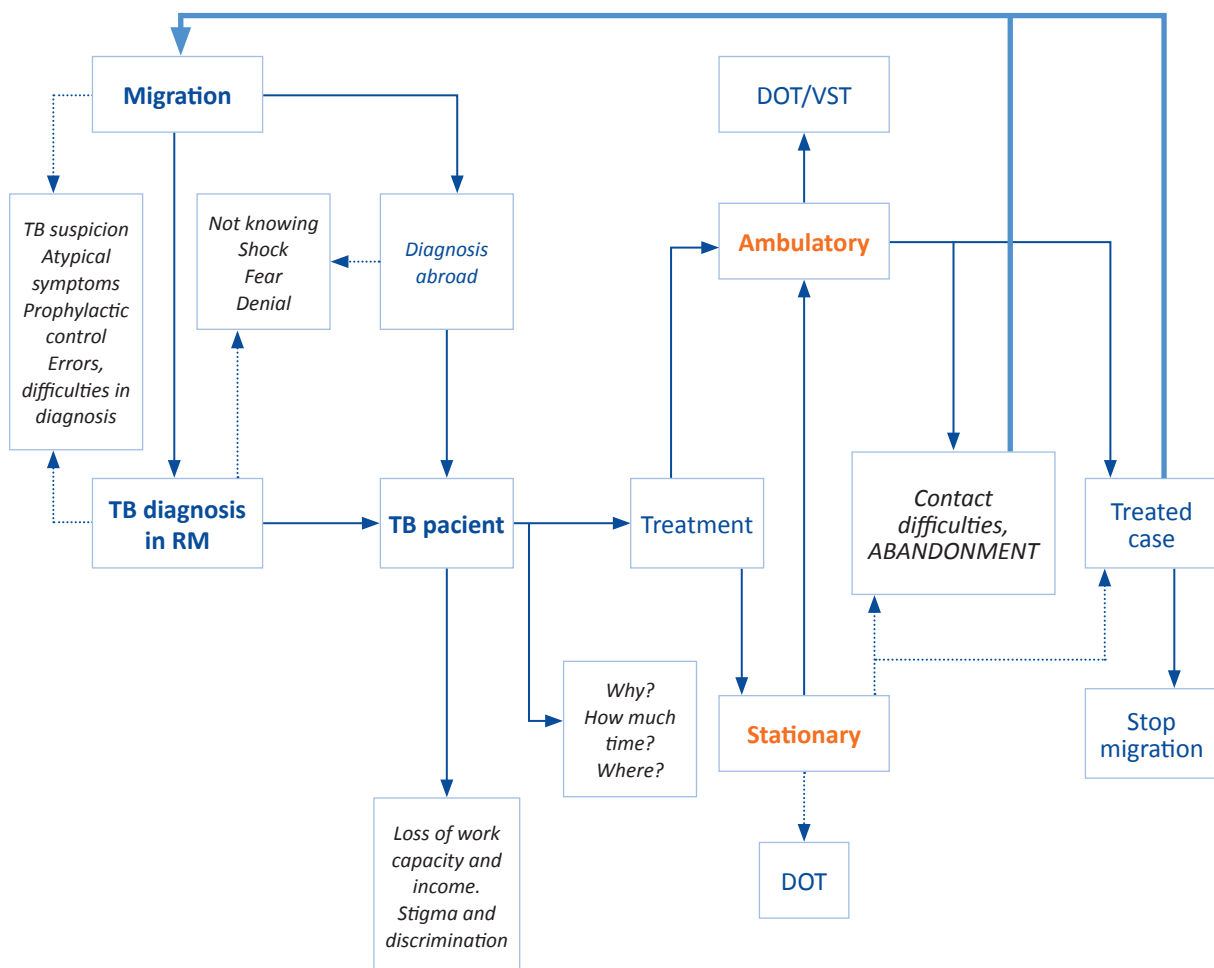
- *Medical colleagues are not so afraid of tuberculosis, they just want*
- *the patient to have nothing to do with them, and they do not care*
- *that he has tuberculosis or any consequences from tuberculosis,*
- *let the pneumologist handle this. Even if the TB patient has a heart*
- *attack or something else, it doesn't matter – if he has tuberculosis,*
- *that's it, let the phthisio-pneumologist take care of him.*
-
-
-

CHAPTER 12. RESPONDENTS' RECOMMENDATIONS

It is evident that the health seeking and treatment behaviour of men and women living with TB co-infection or suffering from TB, requires a systematic assessment from a gender perspective to improve the TB responses. Future studies could further define those groups vulnerable to access problems and explore social stigma in greater depth.

The situations of TB patients and how are they being managed are very different. Figure 1 illustrates the complexity of the phenomenon from the onset of the first symptoms until the completion of treatment. There are several challenges in this process, addressed in the above chapters, which also require appropriate interventions. Both the interviewed TB patients and the specialists proposed some suggestions and recommendations that are presented in this chapter.

Scheme 1. The process that the TB patients with migration experience go through



In different contexts, the phthisio-pneumologists mentioned that a complex approach is needed in the diagnosis and treatment of TB, **universally** valid for all the TB patients, regardless of their status:

- involvement of all actors in the community (family doctor, social worker, LPA, police, etc.);
- identification of psychological and/or socioeconomic support mechanisms for families with TB members, especially those with children.

Regarding the specific category of migrants, the following recommendations were proposed:

A) DIAGNOSIS

- **Mandatory pulmonary X-ray examination for people who go to work abroad.** There is a good practice among the men going to work in Israel under the Bilateral Intergovernmental Agreement on the Temporary Employment of Workers from the Republic of Moldova in the State of Israel.⁴⁹ Every year, through the prophylactic screening of the potential workers in this country, several TB cases are being detected in the early stages. Doctors are aware that these examinations can be performed among the migrants who are going to work legally and recommend that they also apply to countries like Poland, Czechia, etc.

Another suggestion was to introduce a mandatory X-ray examination once a year, analogous to the COVID-19 test or the green passport, when crossing the border for exiting. It was suggested that upon entering the Republic of Moldova, signing a declaration on one's own responsibility regarding the referral to the family doctor and performing the chest X-ray.

- **Inclusion of migrants in the list of people with the TB risk by family doctors.** Although migrants must be included in the risk group according to regulations, de facto only few family doctors perform comprehensive TB screening for this category of population, given the difficulties listed in Chapter VII.
- **Public information on the TB risks and the importance of preventive examinations** through various media and communication channels (TV, radio, online), but also targeting the mobile population by offering leaflets at the border crossing checkpoints, including leaflets in the package of documents offered to those going to work abroad, displaying information through embassies, consulates, etc. Talking to the relatives of the migrants to encourage the latter to undergo TB screening.
- **Incentives for the migrants who undergo radiological examination of the lungs**, e.g., skip-the-line access to the processing of identity documents, offering packages of discounted medical examinations, etc. Some experts believe that incentives do not discipline the patients and punitive measures should be imposed to make progress in this regard (e.g., fines for the migrants returning to the Republic of Moldova who did not perform the X-ray exam during a period of two weeks to one month; prohibiting the processing of certain personal documents without the prior presentation of the test results, etc.).

⁴⁹ The Agreement entered into force on 6 January 2013; was extended until 5.01.2024.

B) TREATMENT

- **Prohibition of crossing the border by the persons in treatment.** In this regard, the interviewed specialists have been aware of the limitation of the right to free movement, but state that this is a reliable solution for keeping people in long-term tuberculosis treatment. This measure will ensure the right to health for the TB patient and a healthy environment for the community.
- **Applying penalties, requesting commitments for people who abandon treatment.** This is perceived as a necessary measure for the accountability of the TB patients with a history of treatment abandonment.
- **Socioeconomic and psychosocial support for TB patients.** So that patients benefit of a minimum standard of living and are not forced by circumstances to abandon the treatment.
- **Bilateral agreements with destination countries on the continuation of TB treatment in the host country.** According to some of the doctors, in many EU countries TB incidence is low and they do not have a health system adapted to this disease, so it is easier for them to tell the patients to return to their country of origin to receive treatment.



IDI, specialist



In your country you have problems with the TB while we here have other problems, so they say, go to your country for treatment, it's free.

- **Ensuring universal access to TB control measures and treatment for all migrants of all genders,** including international migrants.
- **Provision of the necessary medication for TB treatment for a period of several months to labour and circular migrants “considered to be responsible” in advance** to enable them continuing their work abroad, under clear conditionalities (written down in a Regulation).



IDI, specialist



There was one case, a young man, was diagnosed with early tuberculosis. After two months of treatment, he felt well, but he felt the same even until he was diagnosed. And after two months of treatment, he said, you want to give me the medication for four months and I leave, because I have a chance to go. And wherever I go, the work is waiting for me. I have to reimburse credit, I have children and I can't stay, nothing bothers me, I will drink the pills and work there. And what should we do in such cases?!

Some experts believe that in the current context, where migration in the Republic of Moldova is a widespread phenomenon and technologies offer a wide range of communication options, more flexible DOT mechanisms should be identified, especially for young people diagnosed with TB, the recommendation also mentioned by most of the interviewed patients.



IDI, specialist

- *With this VST, especially because it is about young, moving people who want to leave. And they want to be treated, but you don't have the right to give them the pills, but they want to go, but you don't want to miss them... And it's as if you want to give them, but how do you monitor them?! Let say he/ she would agree (through an approved protocol), to enter this programme, to be given the pills, for him/ her to take them every morning. Why not?!*



F, 52 years old,
returned from Italy

- *"It would be good if they give us the pills for at least three months, so that we could work abroad. Let's come for a check-up and then pick up our drugs again."*

■ Reward measures for the patients who manage to follow the full treatment cycle

Both the patients who completed the treatment and those who are still being treated mentioned that offering rewards at the end of therapy would motivate a significant portion of the patients to have better adherence. On the other hand, there are voices that worry that such a practice can create "treatment addicts", so people will try to contaminate themselves repeatedly to get the benefits.



F, 30 years old,
returned from
Poland

- *I think it would be good for the state to offer some reward to the people who completed the treatment. I think a lot of people would be interested in receiving that money.*



M, 29 years old,
returned from the
United Kingdom

- *I do not think it is right to give money to people who were treated for free. You need to follow the treatment for your health and if you care about yourself, you will follow the treatment to the end. It could happen that after the treatment the person gets sick again to receive more money.*

C) MONITORING

- **Update the Information Monitoring and Evaluation system of TB patients in the Republic of Moldova (SIME TB).** Some experts stated that there is no adequate evidence at the central level regarding the country where the TB patients return from. For now, the SIME TB system allows access only to the data of the patients returning from the Russian Federation and Ukraine and it is necessary that more countries are included. NTRP representatives mentioned that by the end of 2022 year this option will be available.⁵⁰
- **Identifying mechanisms for cooperation and monitoring in the field of TB with specialists from other countries** – in order to ensure the transfer of information on diagnosis and treatment of citizens of the Republic of Moldova, both those who were diagnosed in the Republic of Moldova and those diagnosed outside the country. Some of the experts believe that there should be a Council or other form of organization that can request information about the TB patients who are citizens of the Republic of Moldova residing in other countries and that, in turn, could provide relevant information to the specialists from other countries. Several phthisio-pneumologists mentioned the option of granting access to the SIMETB system to colleagues from other countries who could enter or verify the situation of people with TB, however, this is difficult to implement as it involves the use of personal data.

Some phthisio-pneumologists mentioned that there are patients, especially those in the Russian Federation, who choose to work there for a while, including after the diagnosis of TB. Even if they return to their country of origin, it may take several days or even up to a few months until they consult a doctor. During this period, the TB patient, including those with bacilli, interact and expose other people to risk, both in the destination country and in the Republic of Moldova. In order to reduce such practices, it is important for the medical system in the destination country to inform the responsible authorities in the country of origin that the given citizen has been diagnosed with TB, so that later on, if the patient does not go to the doctor, he/she could be identified more quickly.

⁵⁰ In collaboration with the PPI, the NTP and the MoH, IOM provides the necessary support to develop a designated migration module for processing comprehensive migration data within the SIME TB system. The designated migration module will comprise medical data entries disaggregated by gender and migration profile: migrant category, country of origin, host country, duration of migration, time since arrival, access to health-care after arrival, behavioural risk factors, laboratory tests, imaging results, treatment type and interventions. These activities are organized within the 24-month project “Enhancing Gender-Sensitive TB Detection, Surveillance, Treatment and Prevention among Mobile Populations from the Republic of Moldova (TB-MIG) funded by the IOM International Development Fund.



CONCLUSIONS

Profile. The TB patients with migration experience are mostly young, middle-aged men. Women account for about a quarter (20–30%) and this share reflects the gender statistics on TB patients in the Republic of Moldova. HIV infection is also evident among young people diagnosed with TB, given that HIV contributes to a much higher risk of developing TB.

The TB patients with migration experience, participants in the study, returned to the Republic of Moldova from a wide range of host countries. However, many of them previously worked in the Russian Federation, and later moved to other destination countries, especially in the EU. No gender-specific issues were identified regarding the last country of destination of the TB patients.

Most of the TB patients have worked abroad in construction or agriculture. Other areas of activity of the respondents abroad are personal care, housekeeping, food industry, hospitality sector, transportation, etc. Some respondents believe that smoking and occupational hazards have played a significant role in their TB illness.

Exhausting work, more than eight hours a day, and often without days off, is characteristic for people working abroad, especially for circular migrants. The interviewed men, compared to women, apparently experienced more difficult working conditions abroad as more difficult. As for living conditions on their last trip abroad, they were largely rated as good, although some respondents acknowledged that they had previously lived in poor conditions. Poor living conditions are specific mostly to migration to Eastern Europe and very rarely reported from EU countries. The experts believe that living conditions, poor nutrition, but also the stress associated with going abroad, the latter attributed especially to the women, determine the activation of latent forms of TB. Also, there are a few cases of relapses among migrants going to work abroad.

Knowledge and perceptions. Despite the TB awareness and information campaigns carried out in the Republic of Moldova, most respondents initially had little knowledge about this disease. TB patients' main sources of information about TB were health workers, other patients, as well as relatives or acquaintances who have faced the same diagnosis. Some of the interviewees, especially young women, and more educated people, tend to look for relevant online information.

TB continues to be considered a shameful disease, a perception that triggers some of the patients to hide the diagnosis in the community or even in the extended family. The association of TB with socially disadvantaged people, unhealthy living conditions, alcohol consumption, causes stress and panic among patients, especially women.

Symptoms. Coughing, fatigue, weight loss, and excessive sweating were most reported in the study. Smokers, both men and women, associated coughing with smoking. Symptoms were often attributed to transient viruses or respondents tried to justify them by reactions to climate, humidity, volume and working environment. In the case of those detected in the early stages of the disease, mostly asymptomatic, acceptance of the diagnosis was a challenge. Most of the migrants, especially men, address to the doctor late, with advanced forms of TB, complaining of pain.

Access to health care. Several respondents both men and women, thought that they cannot access health care abroad due to their irregular stay or informal work status, while others have chosen to consult doctors, especially when their health has deteriorated. The practices of providing medical services for migrants differ from country to country, so that some respondents incurred costs for medical tests while others were examined free of charge.

A range of barriers to accessing health services in the host country were identified such as prioritizing work over health, the need to earn money, fear of losing the job, ignorance/poor knowledge of the language in the host country, lack of/poor information on access to health care, pandemic conditions, etc. No gender-specific differences were noted regarding the impediments to accessing medical services, they mostly reflect the status of residence and working conditions in the host country. Circular migrants have the most serious difficulties in accessing medical services abroad, thus preferring to return to the Republic of Moldova for examinations.

Diagnosis. Health-seeking behaviour is gender-specific, as women migrants go to the doctor at the onset of the TB symptoms more often than the men, while the latter largely ignore the first signs of the disease. In some cases, they are brought by life partners or mothers, daughters to medical examinations, as they are worried about coughing, their sudden weight loss, but also other specific TB symptoms.

Although the migrants are a high-risk group that needs to be examined prophylactically, most of the patients only got screened once clinical symptoms occurred. Most of them were diagnosed with TB in the Republic of Moldova. About one in ten patients interviewed, both women or men, were initially misdiagnosed, either in the Republic of Moldova or abroad.

The COVID-19 pandemic has affected the process of diagnosing TB in several ways. On the one hand, in the last two years, the number of diagnosed patients decreased and the specialists attribute it mainly to the decrease of consulting a medical doctor. On the other hand, due to the increased caution regarding similar symptoms of COVID-19, several incipient cases were detected.

The study found that some of the interviewed migrants who previously had TB were treated, but the disease recurred over time. This phenomenon is being met among both women and men. In many of these situations, the relapse coincided with the process of resumption of labour migration, regardless of whether this happened immediately after the end of treatment or after ten years.

Treatment. TB treatment is considered difficult and challenging, in terms of schedule, duration, and side effects, and no differences between women and men were found. The vast majority of the interviewees initiated treatment in inpatient conditions, which was appreciated by the specialists. Although the administration of medicines must be supervised directly by the health staff, the study found that some of the specialists have too much trust in the patients' responsible behaviour, which contribute to practices of avoiding ingestion of medicines (all or some) by the patients. Most of the migrants consider the conditions in the hospital to be satisfactory, and the reluctance of some to enter or return to the hospital is specific to a certain category of patients.

The experiences in following outpatient treatment are different, depending on the wishes, needs and responsibilities of the patients. Thus, while some of the patients receive the pills at the local health centre, others, for reasons of confidentiality or convenience, go to the medical institution in the district centre. The patients with digital skills, usually younger ones both women and men, perceived by the specialists as more responsible and/or those engaged in some activities, can follow treatment by the VST method.

TB patients sometimes appreciate psychological care as much as medical care. However, men are more reluctant to share their experiences related to TB with a psychologist, probably because of social stigma, while women recounted in detail the benefits of their discussions with the psychologists.

Following TB treatment abroad is rather an exception. Usually, these patients are young and/or have family or relatives abroad and are guided by the perception that in other countries they will be provided with better conditions. There are isolated cases of patients that re-emigrated during the treatment, being provided with drugs for a period of one to three months by the phthσιο-pneumologist from the Republic of Moldova, however, the specialists' opinions on these practices are divided.

Costs. Until the diagnosis of TB is established, some of the interviewees incur expenses for medical tests and examinations, for self-administered treatments or misdiagnosis, for transportation costs, etc. During outpatient treatment, the costs incurred by some of the patients were directed to a better diet, but also to purchase vitamins and drugs to alleviate the side effects of the treatment. In isolated cases, the respondents paid for some additional medicines (other than TB drugs) needed for the inpatient treatment.

Most of the interviewees claim that they did not incur excessive costs related to establishing the diagnosis and/or treatment of TB, although are not able to estimate them, while few of them displayed different experiences on this subject. During the treatment, psycho-emotional support, but also the economic support of the family of origin and extended family is extremely important. Finding themselves in a situation where they can no longer emigrate for work, and cannot officially get employed in the Republic of Moldova, migrants with TB, mostly men, resort to various coping measures: savings, loans, sale of goods, involvement in informal work (construction, day workers). Some of them are provided small allowances for temporary incapacity of work.

Abandonment. In the opinion of specialists, but also of some of the patients, women seem to be more responsible for compliance with treatment, respectively less vulnerable for abandoning TB treatment. For the most part, people who stop taking medication consider this to be the only or most viable solution for them in this situation. The invoked and potential reasons that may trigger abandonment include alcohol abuse, poor health culture, improving of health status, social stigma, etc. In this sense, single men are perceived as more prone to abandoning the treatment.

However, among the mobile population, the highest risk of abandonment resides on the decrease of income during the treatment and the patients' desire to emigrate for its regaining. The doctors' efforts to prevent abandonment are constant. For some of the interviewed patients an important argument against abandonment was the deaths among hospitalized patients, often with recurrent TB, which respondents have been witnesses to.

Stigma and discrimination. The study shows a decrease in the phenomenon of stigma and social discrimination in relation to the TB patients, compared to previous studies, or the mobile population seems to be less affected by the phenomenon. A few interviewees said they were not embarrassed by the diagnosis, as they most likely got TB while working abroad. The most common form of segregation is self-isolation, with many respondents expressed concern that they may be rejected by their peers, community, and even family. Nevertheless, stigma was widely acknowledged and experienced more by women. Women are overprotective in relation to family members, which can affect their quality of life. Some of the health workers say that they have colleagues of other specializations who treat the TB patients differently, mostly out of a desire to protect themselves from infection.

The way forward. The specialists participating in the study voiced several recommendations regarding both the diagnosis and the treatment of TB patients with migration experience. The ones regarding the diagnosis refer to: requesting a radiological examination when crossing the border to another destination country for work purposes; treating migrants as a category of patients with high-risk of contracting and spreading TB; continuous information to the population, including mobile one, on TB symptoms and the need to see a doctor as soon as possible. The specialists did not have any gender-specific recommendations.

According to the interviewees, in order to increase treatment compliance of TB patients involved in migration, it is necessary to increase their socioeconomic support. Some of the phthisio-pneumologists also opted for the forced treatment of people with bacillary form that pose a risk of infection to other members of the community. Among other proposals of the interviewed specialists were the prohibition of crossing the border for the patients undergoing treatment without the consent of the phthisio-pneumologist; identifying tougher levers, including financial ones, in case of abandonment; establishment of bilateral agreements with destination countries on the continuation of TB treatment in the host country or the extension of the period of supply of medicines, through the VST system, for those wishing to emigrate, etc.

The results of this study will be used to facilitate the implementation of the objectives set out in the NTRP for 2021–2025 years, but also to elaborate and develop programmes and projects to support TB specialists and patients from the perspective of tuberculosis prevention and diagnosis, treatment compliance, and prevention, but also the management of post-treatment situations.

The findings of the study will inform health policy makers, care providers, especially the phthisio-pneumologists and primary care physicians. Finally, this report is addressed to migrants, women and men, and also their families for information and awareness to motivate them to go to the doctor for preventive examination and also when they have relevant symptoms.

In conclusion, it is evident that external migration is a risk factor for infection and illness of people with TB and TB recurrence is both determined by the living and working environment, but also by other aspects such as poor nutrition, stress, over-exhaustion, etc. Besides, the involvement in the migration process can lead to late referral to a doctor and it is one of the main reasons for abandoning treatment. In this context, efforts to actively detect TB should be stepped up and functional mechanisms should be identified to keep people in treatment. It should be noted that a higher psycho-emotional vulnerability is characteristic to migrant women diagnosed with TB, which is mainly determined by their concern for the safety of family members, while among migrant men with TB the socioeconomic factors contribute to an increased risk of abandoning treatment.

Annex 1. Research participants

Focus group discussions

No	Category, location	Quantity	No of participants	Date
TB patients, (18+ years old) with experience of international migration				
1	TB patients, Balti	1 FGD	9 participants (2 females, 7 males)	14 September 2021
2	TB patients, Chisinau	1 FGD	7 participants (2 females, 5 males)	15 September 2021
3	TB patients, Vorniceni	1 FGD	5 participants (2 females, 3 males)	21 September 2021
4	TB patients, Orhei	1 FGD	8 participants (2 females, 6 males)	21 September 2021
5	TB patients, Stefan Voda	1 FGD	6 participants (2 females, 4 males)	22 September 2021
6	TB patients, Ialoveni	1 FGD	5 participants (2 females, 3 males)	23 September 2021
7	TB patients, Hincesti	1 FGD	5 participants (5 males)	12 October 2021
Health specialists				
1	Phthσιο-pneumologists, hospital	1FGD	7 participants (6 females, 1 male)	19 October 2021
2	Pisio-pneumologists, district	1FGD	6 participants (4 females, 6 males)	20 October 2021
3	Family doctors	1FGD	7 participants (7 females)	2 October 2021
	Total	10 FGDs	65 participants	

Semi-structured interviews

No	Category	Quantity	Distribution by sex
1	TB patients, (18+ years old) with experience of international migration	50	23 females, 27 males
2	Phthσιο-pneumologists, hospital	2	2 females
3	Phthσιο-pneumologists, district	12	8 females, 4 males
4	Nurses from Advisory Sections of the District Hospitals	2	2 females
	Total	66 IDIs	

Annex 2. Guidelines

Guideline 1. Semi-structured interview/ TB patients with migration history

Under the first objective: Assessing knowledge, attitudes, practices, and access to health services among mobile population affected by tuberculosis, including gender differences.

Introductions

Presenting and voicing discussion rules:

- Discussion rules: sincere answers are expected – there are no correct or wrong opinions, just different points of view; confidentiality and anonymity are ensured; audio recording need.

Data about respondent:

- Sex, age, occupation, type of TB, place of residence in the Republic of Moldova.

Migration history (*questions will be asked depending on the context*)

1. Please describe your experience as labor migrant abroad, where you have worked, how the living and working conditions were.
 - In what country/ies have you worked over the last 3 years? For how long?
 - What/where (what sector) have you worked while abroad?
 - How many hours per day have you worked? How many days per week?
 - How would you assess the working conditions in the host country?
 - How many persons were living in the same room?
2. In how far has the diagnosis of TB influenced you in working abroad or not?
 - After having been diagnosed with TB, have you worked abroad again? If yes, please describe the context.
 - If you have not left abroad after having been diagnosed TB, have you thought to leave? What or who determined you to stay in the Republic of Moldova?

Knowledge, attitudes, practices related to TB, including gender differences

3. Please tell what you knew about TB before you were diagnosed?
 - What do you think is the cause of TB?
 - What kind information materials about TB did you receive? Which was the most useful for you?
 - What would be the most efficient means, in your opinion, to communicate about TB prevention?
4. In your opinion, how can a person protect himself/herself from TB?
 - What can family members or others do?
5. Please describe how and when you realized that you might have TB?
 - Since when do you have TB?

What were the first TB symptoms you got? How long did the symptoms last until you went to the doctor? Were you at home or abroad?

Access to health services among mobile population affected by tuberculosis

6. What did you do when you realized that you might have TB?
 - To whom did you turn to first, when you got the symptoms (family, friends, doctor)?
 - What treatment did you take before going to the doctor? (If you went to somebody else than a doctor) Why didn't you go to the doctor at once?
7. Please describe where have you been diagnosed (abroad or in Moldova) and how you started TB treatment
 - If abroad, have you initiated the treatment?
 - To what extent have you thought to follow the treatment abroad, in the country where you have worked?
8. How was it for you on TB treatment?
 - Did you have intentions to drop out the treatment? Why? What has motivated you to continue?
 - What doctors and other specialists can do to prevent cases of treatment drop out?
9. After detection, have you been admitted to a hospital?
 - If yes, how do you assess hospital services?
 - If you were not in a hospital, have you been suggested to be admitted to a hospital?
 - Why did you refuse?
10. In your opinion, what aspects can be improved in the provision of TB treatment in the Republic of Moldova? But in the country where you worked, how can treatment for people like you be improved?

Psychological and Social aspects

11. How have you reacted to the diagnosis?
 - Who has encouraged you/supported you at that moment? Who supports or has supported you the most during the TB treatment process? How specifically?
 - What would have been helpful for you to overcome that moment?
12. How was the reaction of your environment (family, friend, neighbours, co-workers) when you were diagnosed with TB?
 - Have you felt stigmatized while you've been diagnosed with TB?
13. Besides the treatment, what other assistance has been provided to you?
 - What specifically?
 - Have you benefited from food packages? How do you find this support?
 - What would be helpful/useful to you during the treatment?
14. How have you managed from financial point of view during this period, taking into account that you not working abroad anymore?
15. What do you think would have helped you the most during the diagnosis and / or treatment of TB? What other suggestions would you have?

Guideline 2. Interview Guide for Focus Group Discussions for TB health providers

Under the third objective: Identifying barriers in access to and continuity of TB health-care for mobile population affected by TB (from doctor's viewpoint)

Introducing the participants and presenting the discussion rules

- Introducing the discussion topic
 - Discussion rules: sincere answers are expected – there are no correct or wrong opinions, just different points of view; confidentiality and anonymity are ensured; audio recording need
 - Data about the respondent: sex, age, length in service (experience)?
1. Please briefly describe the TB situation in the locality / sector you work in.
 2. What is the profile of persons affected by TB in terms of migration experience and gender?
 - How many patients out of 10 have migration history? From what countries?
 - What about the share of men and women among those with migration history?
 3. At what stage do TB patients reach out to you most frequently? (early, late, with advance processes, bilateral processes, with caverns, etc.)
 - What specific aspects are there for men and women when they consult a doctor?
 - What about those with migration experience?
 4. What prevents people from getting diagnosed with TB early?
 - Are there any differences between men and women in this respect?
 - What can be done for early detection of TB among migrants?
 - As a doctor, what would you need in this respect?
 5. What are the prophylactic measures performed by you over the last year among the population involved in migration?
 - Which ones do you consider to be more efficient?
 6. What can you tell us about patients who drop out of treatment?
 - How many per cent of your patients drop out of treatment?
 - What is their profile in terms of gender, age, occupation??
 - Have you noticed any specific category of patients prone to drop out the treatment?
 7. According to your experience, how can patients with migration experience be motivated to take the treatment course until the very end?
 - Do you notice any gendered differences and/or specifics for migrants here?
 8. What other suggestions do you have in order to improve TB treatment and prevention?

Guideline 3. Semi-structured interviews for TB health providers

Under the second objective: Studying the perception of TB health providers regarding the migration phenomenon and the gender aspects and their influence on access to TB health care for mobile population

Introducing the participants and presenting the discussion rules

- Introducing the discussion topic
- Interview rules: sincere answers are expected – there are no correct or wrong opinions, just different points of view; confidentiality and anonymity are ensured; audio recording need
- Data about the respondent: gender, age, length in service (experience)?

TB patients' profile

1. Please briefly describe the TB situation in the district/ sector you work in.
2. What population categories are your patients from? What is the rate of patients with migration history / How many out of 10 patients have been working abroad? In what countries?
3. What is the profile of your patients by gender? What is the profile of patients with migration history? Is there anything specific by gender criterion?

TB diagnosis

4. What activities are you carrying out for early detection of TB among migrants? / What measures are undertaken to monitor this risk group? In your opinion, how efficient are the undertaken efforts?
5. From your experience, are TB patients with migration experience mainly detected in the host country or in the Republic of Moldova? What is the basis for your opinion?
6. What are gender specific aspects related to TB diagnosis?

TB treatment

7. How do you establish the action /TB treatment plan for patients? To what extent does it differ from gender perspective?
8. What specific approaches do you use for patients involved in migration?
9. How frequent the cases of treatment drop-out or refusal are? In your opinion, what are the main causes for these decisions?
10. Which tendencies do you see on treatment drop-out or refusal related to patients with migration experience or related to gender?
11. What measures are there undertaken to combat treatment drop-out? How useful are these measures?
12. What else might be undertaken to motivate the patients involved in migration to continue their treatment until the very end?
13. In your opinion, what measures to prevent treatment drop-out work better for women? What about men?

Hospital admission

14. In your opinion, for which patient the treatment effect is better – for those treated in inpatient facilities or for those treated in outpatient conditions? What are the reasons?

15. What specific attitudes, behaviours regarding hospitalization among the patients with migration history have you noticed?
16. What is specific to women and men in relation to hospital treatment?

Relations between health workers and patients

17. How do you explain to the patient about treatment importance and adherence?
18. From your experience, what is the specific support provided by family in case of patients involved in migration? To what extent does it differ among patients women and men?
19. What is the level of your cooperation with doctors from other countries in relation to TB treatment continuity, in case of migrant patients?
20. To what extent do you encounter difficulties in adjusting the treatment schemes from one country to other?
21. How do you solve these problems?

Formulation of proposals to improve the TB treatment results

22. In your opinion, what should be done to get a higher efficiency of TB treatment among the persons involved in migration?
23. What measure may be undertaken by authorities to increase the TB detection rate at the incipient stage?
24. What communication means would be more efficient to inform migrants about TB risks? In your opinion, how should these messages be adjusted based on gender?
25. What other suggestions do you have in relation to TB diagnosis and treatment among patients involved in migration?

Guideline 4. Interview Guide for Focus Group Discussions for TB patients with migration experience

Under the third objective: Identifying barriers in access to and continuity of TB health care for mobile population affected by TB

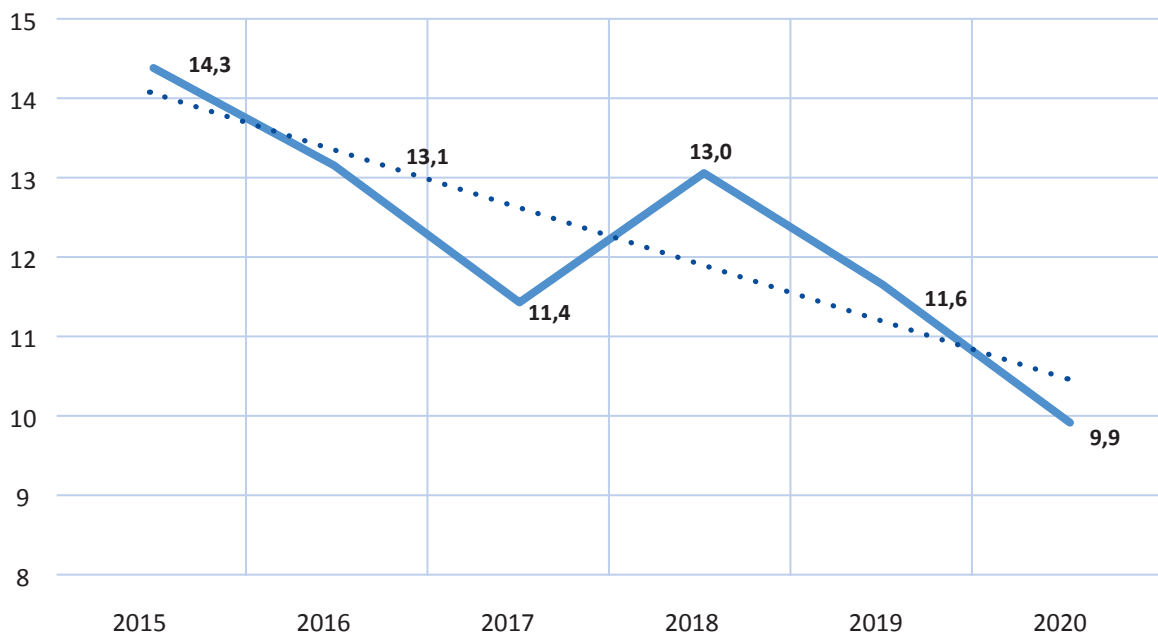
Introductions

Presenting and voicing discussion rules:

- Discussion rules: sincere answers are expected – there are no correct or wrong opinions, just different points of view; confidentiality and anonymity are ensured; audio recording need.
 - Data about respondent: sex, age, occupation, type of TB, place of residence in the Republic of Moldova, country(ies) of destination(s).
1. What word/ phrase/ image do you think of when I say "TB"? Please explain why.
 2. Did you have any impediments/barriers in consulting a doctor when feeling the first symptoms?
 - What specific barriers/impediments?
 3. What are the barriers, in your experience, in accessing TB services for persons suspected to be infected and working abroad?
 - To what extent do you think that these barriers differ for women and men?

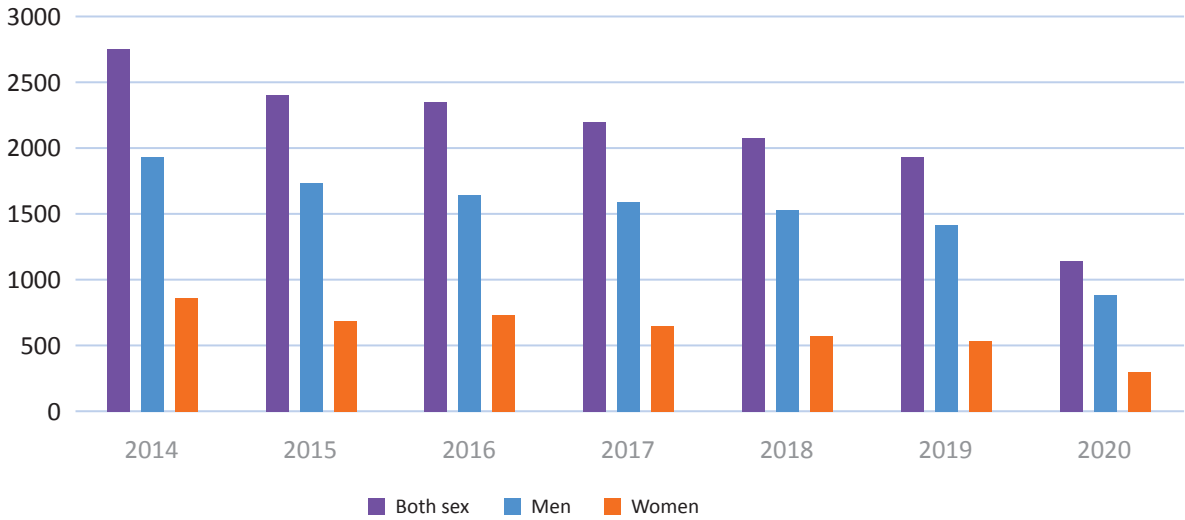
4. In your opinion, why do people drop out of TB treatment and what can be done to improve treatment adherence?
 - Is there anything specific to persons with migration history?
5. What were the costs you have incurred while diagnosing TB (transport, medical tests/investigations/ devices, consultations, treatment)?
6. If have not left abroad after detecting TB, have you thought to leave? What or who determined you to stay in the Republic of Moldova?
7. From psychological-emotional point of view, which are or were the most difficult moments in the treatment?
 - With whom have you discussed about these moments with? What about somebody from the health providers?
8. What steps are needed to detect TB at an as early as possible among migrants?
9. What is needed to ensure that migrants adhere to TB treatment?
10. What other suggestions do you have?

Annex 3. Percentage of TB patients with history of migration, Republic of Moldova, 2015–2020



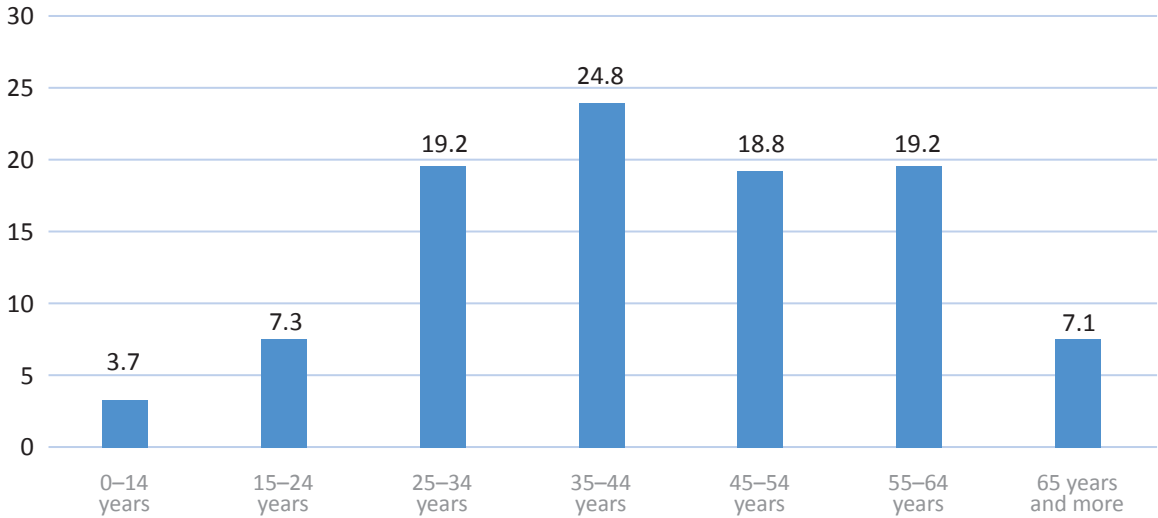
Source: Developed by the authors based on data provided by NTRP.

Annex 4. Number of new active TB cases by sex, Republic of Moldova, 2014–2020



Source: NBS, https://statbank.statistica.md/PxWeb/pxweb/en/30%20Statistica%20sociala/30%20Statistica%20sociala__08%20SAN__SAN020/SAN020600rcl.px/?rxid=b2ff27d7-0b96-43c9-934b-42e1a2a9a774.

Annex 5. Percentage of new TB cases by age group, Republic of Moldova, 2020



Source: authors’ calculations based on NBS data.

Annex 6. Case studies

Case study 1. Tuberculosis patient, returning from Germany

“This year [2021], in January, after the holidays, I was in Berlin, Germany, with the whole family [husband, wife, 2 minors], but only I am sick. I didn’t work there; we were poor people... I don’t know who I got infected from. There is a different climate than here, both in summer and autumn, also in winter it rains constantly, probably because of this I got sick ... I didn’t live in the house, but in a house called „Heim” [home]. My family lived in one room: my husband, two daughters, and me.

At first, I had a fever, my husband lent money from someone and purchased some pills for me from the pharmacy; I took them and on the same day my fever went away. Then I lost weight, I reached 47 kg, I didn’t eat for practically 2 months, I kept on the water. At first, I was scared, then I got used to it, I didn’t even ask for food. We didn’t call the ambulance because it is different there compared to Moldova, the ambulance doesn’t come in 15 minutes. One day my husband had a broken leg and I waited five hours for the doctor to see him. We have been told that the ambulance comes only when the person is dying, in addition, you have to pay if the person does not feel very bad [false call].

I did the X-ray, but nothing suspicious could be seen on the film. They said I smoked and that’s why. They tested me on COVID-19 twice in Germany to make sure. Then one day I was talking on the phone with my mother, I suddenly got sick. The 14-year-old daughter called the guard and they called an ambulance.

I was hospitalized, I was communicating through “Google Translate”, the doctors were translating me into Russian. I was in shock, it seemed to me that I would not leave that hospital and I would not see my children, I would not see anyone anymore. I was having nervous breakdowns, I was shouting that they had made a lab rat out of me, I was breaking things. The first ten days it was hard for me to drink the pills, there were too many ... the nurse was sitting next to me until I was taking them all. This irritated me, so I shouted. They offered me a consultation with a psychologist in Russian. He told me that everything would be fine, that I would not die of this disease, but that I should be treated. If I don’t, I’ll die sooner. I was in the hospital for three months, during which time I did not see my children at all. I asked them to come, but the hospital was very far from our home. They set off once, but they got lost. When they got home, I told them on the phone not to try again.

After three months I was discharged, I stayed home for another two weeks, and I had a fever again. Then I told them that I had a fever out of medication, that they are not treating me properly, that the pills were too strong, and that my hair was falling out. I called the ambulance again and they hospitalized me again, this time for 20 days. They changed then the treatment schedule and the fever did not return. They also called the children for a check-up to see if they didn’t get sick.

They deported my husband first. I had a lot of stress then. The children were left alone. I was in the hospital. Thank God there were good people there who took care of the children. The German authorities wanted to take the children and send them elsewhere. The husband, being in Moldova, changed his name and came again to protect his children. Then we were deported, and my husband stayed there. He stayed there and cried for two weeks, got on the bus, and came home. He said he didn’t need any money, but to be with his family. My family, husband, and children supported me a lot.

I did not leave voluntarily, they deported me, even though I had documents that I had to be treated there for two years. They sent me home. I said I was being treated, but they didn’t even want to hear. They just forcibly sent me home.

I am at home already for three months and I came to the office myself to continue the treatment. I want to be treated both for myself and for my family ... It's hard ... All I need is health, what else can I ask for?! Though, I asked for some help and today they said they would give me some food tickets. I need money, it's good that the drugs are for free. In our country, only TB pills are for free, while in Germany everything was free, for allergies, for the stomach, and for hair, for everything."

Case study 2. Tuberculosis patient, 62 years old, returned from Italy

"I worked as a teacher for over 20 years in the Republic of Moldova, after that, due to economic problems, the serious situation, I had to go abroad with my husband. Gradually my children also came, after which the children returned home. When the pandemic started, my husband and I decided to return to Moldova (after 16 years of working abroad).

I'm back home, all right. I was on records with the thyroid gland. I also had treatment there in Italy (working legally), and here. At one point, being at home, vomiting occurred. The children advised me to go for a rigorous check-up. We went to the German Diagnostic Centre, did the whole test package for the thyroid gland, and then they asked me when the last time was, I had the X-ray. Every time (once a year) when I was coming home, I did all the tests, but I hadn't done X-rays for about two or three years.

I went to the therapist for a consultation and there I was told what disease I had in a brutal way, which completely discouraged me. In such situations, doctors should be more cautious, talking differently with each other. If the person is more emotional, they shouldn't throw the diagnosis in its face. The sky fell on my head. I am always keeping ideal cleanliness in everything and never thought that this disease could come upon me. I didn't understand where it came from. It was a shock to me. I didn't want to live anymore. I had been a teacher for so many years, dear, I couldn't even imagine what it would be like for the village to find out that I had tuberculosis.

I practically haven't coughed in the last few years, maybe just sometimes, I didn't have a fever. I had some sweating, but it has been around for about 12 years since menopause began. When I had the sputum test, my neck ached for two days, as I struggled to gather it, because I had no sputum at all.

I didn't want to be told I had tuberculosis. Until the diagnosis, I knew that tuberculosis is a disease that can be taken by people who live in prisons, who consume alcohol. Tuberculosis was equivalent to degradation for me. It's a little different now. For me, it was a light form, because I was treated for only six months.

I was worried about the situation I was creating for others around me. I was afraid I would infect my children. Even now, I don't allow anyone to use my cup, even if I wasn't contagious from the outset. My family supported me a lot, and then a few doctors I met. My brothers were notified when I had practically finished treatment. Even so, I haven't told to one of them to this day. I closed myself in. I didn't want to go to anyone, even though many invited me to visit on birthdays so that I was inventing all sorts of reasons all the time.

I decided I didn't want to go to the village for treatment. I asked the district doctor to receive me there and everything was very discreet. I notified the family doctor in the village, but I asked her to keep this a secret. The lady knows me, since I taught her children, she respects me a lot and she respected my wish. She supported me a lot, she told me that with such a diagnosis I can live 100 years. I was not very worried about my health, because I did not see any symptoms, but what the world would say. All this destroys you psychologically.

The first two months of treatment were difficult because I also had stomach problems, and the medications turned out to be very strong for me. At first, I was visiting the doctor once a week (other family members went instead of me), then I was included in the VST programmes.

All treatment was for free. Besides, I was offered a little financial support, 35 lei a day. At first, I didn't even want to accept it, because I was completely desperate, I felt like the last person, so as if this help offended me too.

There were moments when I was thinking of going to Italy, but not to work or receive treatment, but to go so that no one would know about me, to leave without return."

Case study 3. Tuberculosis patient, 31 years old, returned from Czechia, with migration experience in Poland and the Russian Federation

"Last time I was in the Czech Republic, I was also in Poland, in Russia. In Russia, how to say, for two years like that: - two months there and a month at home, in Poland 3 months, in the Czech Republic for half a year. In Russia I worked in construction, in Poland at a sausage factory, in the Czech Republic at a plastics plant.

First, I went to Russia, but it just didn't work out (it wasn't financially profitable), it wasn't the same rouble rate as before, so to speak. That's why I tried in other countries, Poland and then in the Czech Republic ... We were with my wife, both with the Moldovan passport, we were going for three months, but were staying there for half a year. Simply when you return, you pay there at the customs, put another 100 euros and you're done.

About three months after I got home, I just had a simple cough (two weeks) and it was this COVID-19 pandemic and I was afraid it would be serious and after the X-ray they told me that they suspected tuberculosis. They put me at once under the treatment and prescribed me treatment for eight months, that's why I haven't even gone anywhere (abroad) ... I'm already thinking of Germany, about a better paid job and better conditions, I have friends there.

I just don't think I had tuberculosis. There are people who feel weak, they have symptoms that really can think that it is a disease related to breathing, but if a person feels good enough, how can he think in his mind that he is infected or sick.

I was just shocked then, by this disease, I didn't know where you could get such a disease from, especially when you are young, still having your whole life ahead of you ... In my case, there is no one in the family to be sick of something like that, among the close people likewise. This came to me unexpectedly. So, I just don't know - a shock, it's not that simple, you come to think about what's worse - you can die.

I didn't even hide the thing (TB diagnosis). Why hide as others do? Every people close to me knows what it's like. The doctor told me it was a closed form; I knew I wasn't infecting others. I didn't notice any changes towards me from the people around me.

Suddenly, when they told me I had tuberculosis, several people from my entourage came with advice like a dog or badger lard, back and forth, I didn't try anything like that. I remained with only the pills they prescribed to me.

The village doctor used to give me the pills and so that I wouldn't go every day, he would give me them for a week. The doctor told me the number of pills needed and I was taking them the same time each day. I was interested in everything to be fine. I didn't think like others who were given the pills and they did not take them, they hid them.

I was receiving treatment, but I was dealing with what could be done in the country (animals, agriculture), with one, with another and I did not sit still. We didn't have any problems with money, finances, but we live with our parents, my wife works, as they say, we find a way out.

In such a situation, with such an illness, I have in mind that you can't work just anywhere, for example to work as a day labourer where you have to work in the sun, you don't have to, it's not good. Also, it's hard to work with this in construction, dust..."

Case study 4. Tuberculosis patient, 42 years old, returned from the Russian Federation

"I haven't been home at all for six years, all the time I was in Russia. In general, I've been to several countries, but I've been in Russia for the last ten years. We worked in construction ... outside and inside, depending on the season. The living conditions were good, I lived in the apartment, I had hot water, heat.

I had no major symptoms, I worked until the last day. I did not feel bad, I did not lose weight, the fever was around 37.1, then it decreased. I was coughing a little, but I thought it was from cigarettes. It was like that about three months. Sometimes I felt better, then worse, I drank some flu pills, I went to the pharmacy myself and took them.

One morning I couldn't get up, my side ached. The boss suggested we go to the hospital, and I was even myself intending to go to the doctor, but that's how it turned out. I stayed in the hospital and did all the tests, X-rays. When they said to me "Tuberculosis", it was like they hit me in the head. I didn't have a very good reaction, but I know it's treatable, the doctor told me, and that's all. I didn't need a psychologist. For what?! What can it do to me?! I was not sick with my head, only my lungs were sick. No one else was diagnosed, I don't know anyone from my colleagues or family who would have had TB. Tuberculosis is not so easily transmitted. I, for example, worked with two other boys, they're doing the X-ray already for a second time and everything is fine, they didn't get infected.

Doctors in Russia, to tell you the truth, do not compare with ours. A female doctor there did not behave very nicely. He shouted a lot, but I got ahead of her. He said that we, with our bacilli, come there and that "Gastarbeiters" only create problems there. I asked if I could be treated there and I was told no, that's the law, everyone is treated at home. I asked her more details, why I can't be treated there, she told me that I didn't have that much money to pay for the treatment. I took a plane ticket and came home. I asked to be prescribed some pills, because I was going to fly, among other people, they refused. And then they say that doctors take I don't know what oath and protect people from disease. I went to the pharmacy alone and bought ten pills and drank one every day, I don't remember what pills and how much I spent.

I passed the tests there on 16 August and on the 19th I was already at home. I was living with a woman in Russia, "civil marriage", she was Russian, but I left her there, I don't think she cried too much. They were already waiting for me at home, the parents agreed with the village doctor, and everything was organized. Well ... parents like parents ... I didn't have time to talk to them much, the word is short at my home.

When I arrived in the country, I called the doctor in Russia to have the result of the tomography via Viber, so as not to repeat the examination. He said to pass the phone to my doctor, and she would read it to him, she did not want to make an effort and send the documents. She didn't behave very well, even though I paid for everything there, only for the CT scan I paid 5,000 rubbles.

I was in the hospital for a month and a half, now I'm at home. Everything was fine, with the food and the pills. I was taking the pills once a day, either the nurse looked at me or she didn't. At the hospital there, everyone seems to be responsible for their own health, and I think that's right. Those girls aren't gendarmes, if you don't want to live, then just wait to die. I want to be treated since I want to live. I'm still young I don't want to die. Those who don't drink the pills think they have nothing to live for. They have no purpose.

The hospital closed two weeks ago as they opened a COVID-19 ward. Some of the patients were transferred to Vorniceni, others, who could, follow the treatment at home. I didn't spend a penny on the hospital, I didn't spend anything on medicines or doctors. My brother was coming to my hospital every day and was bringing me every time some goodies. He is from the city and had the opportunity to visit me. It's very important when you see that there are people who care about you, it's more motivating. There were people in the hospital who stayed for two to three months, and no one came to them. When they bring you food from home and you see that someone doesn't have it, but you have, you are braver, you share more with the one who doesn't have it.

I still haven't received food vouchers, because I've been back in the village only for two weeks. As long as you can't work, any help is welcome. No loan, I still have savings. It would be strange to spend so many years among foreigners and come home without money. The doctor says it is not possible to work for one who is on the sick leave. I have four months left. For now, I'm not in a hurry, I'm receiving medication and I'm resting.

What border can you talk about until you're treated? You go there and then you have to start treatment again. I'm not going anywhere. I don't know yet, I haven't made any plans. At the moment I want to be treated."

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