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MIGRATION POLICY PRACTICE

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Chadian evacuees board a plane to Chad. IOM helped 314 Chadians leave the Central African Republic (CAR) and flew them back to Chad. This was the 19th evacuation flight conducted by IOM for third-country nationals exiting CAR. © IOM 2014 (Photo: Sandra Black).

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Tuberculosis and migration: A post-2015 call for action

Poonam Dhavan and Davide Mosca¹

Introduction

Tuberculosis (TB) is an infectious disease of global public health significance, with an estimated 8.6 million infections and 1.3 million deaths in 2012 alone. While several countries around the world will achieve the TB prevalence, incidence and mortality targets set out in the 2015 Millennium Development Goals (MDGs), a lot remains to be done. Regions such as Africa and Europe are not on track to achieve some of the MDG TB targets, and multidrug-resistant TB (MDR-TB) infections remain an alarming cause for concern.

TB is not merely an infectious disease, but also a social condition – it disproportionately affects the poorest populations globally. TB risk has been shown to follow a socioeconomic gradient, with poor nutrition status, poor living and working conditions, low education and awareness, and low health-care access acting as key social determinants of TB-related morbidity and mortality. Thus, it is unfortunate that in spite of the availability of effective diagnostic and treatment regimens, 3 million out of the estimated 9 million persons who have TB each year still remain undetected. In countries where TB incidence is not decreasing, this is often due to late diagnosis, treatment relapse and increased risk of infection in vulnerable population subgroups.

Migration is a growing and dynamic phenomenon around the world, with 232 million international migrants and an estimated 740 internal migrants worldwide. The population of international migrants is growing at 1.6 per cent annually, with increasing diversification in countries of origin. Needless to say, population movement of such scale and diversity has a major impact on population health worldwide.

People move across or within borders between areas with different health profiles, which affects disease burden, health-care access and

health-seeking behaviours. For example, it is interesting to note that the top countries of origin of international migrants also include several of the 22 high TB-burden countries (e.g. Afghanistan, Bangladesh, China, India, Indonesia, Pakistan, the Philippines and the Russian Federation). Therefore, the international migrant stock, including groups such as refugees, labour migrants, undocumented migrants, asylum-seekers and those in detention centres, merit special attention in global TB control. Similarly, given extensive health-care barriers that exist for internal migrants, especially in low- and middle-income countries, they are also a “key affected population”. Indeed, the absence of targeted TB prevention and control strategies for migrants can pose challenges to reaching or maintaining TB elimination targets in several countries of origin, transit and destination for migrants. Further, progress towards the MDG targets and future post-2015 TB targets will be impossible without expanding health systems coverage for TB services to migrants who remain a “key affected” and marginalized population in several countries.

Migration: Tuberculosis determinants and outcomes

International migration influences the epidemiology of TB and TB policy outcomes by serving as a bridge across countries or regions with varied disease prevalence and other socioeconomic factors. Modern migration processes may be considered a continuum with several phases, including origin, transit, and destination, and in some cases, return.

At origin: The individual’s health status, availability of and access to quality health systems, overall socioeconomic conditions, and occurrences of any disease epidemics and emergencies, including famines and political conflicts, make up the migrant’s health and TB risks at origin. Differences in migrant screening criteria in the pre-departure phase, such as detection and treatment protocols, links with post-arrival health care and management of latent TB infections also influence TB-related morbidity during transit and at destination. Discriminatory practices such as denial of work permits due to TB history is also a concern in case of mandatory pre-departure medical examinations and a factor potentially

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undermining proper compliance with TB treatment among migrants.

During transit: The migratory journey affects TB risk of migrants, especially when travel occurs under precarious conditions. Undocumented migrants may face violence and be held in detention centres with poor nutrition and ventilation, often in close proximity with others with pre-existing infections. Migrants and asylum-seekers who suffer physical and physiological abuse may become averse to seeking health care from public services or private health-care providers due to mistrust. Modern migration patterns characterized by frequent, repeated travels between a migrant's country of origin and country of destination also increase the likelihood of infection, transmission and interrupted treatment.

At destination: Migrants' integration into the host country's health system (access, availability, affordability and acceptability), their living and working conditions, and socioeconomic status all influence the risks of contracting and effectively treating TB. Difficulties accessing housing, jobs, health care and other social services expose migrants to TB risk factors. Migrants' wages, especially for unskilled labour migrants or those working in the informal sectors, can often be lower than what national counterparts receive, which makes health-care spending an unusually high burden at the household level. Migrants' own health-seeking behaviour and cultural practices may affect their expectations and use of TB services. Discriminatory practices such as deportation after positive TB diagnosis is another concern for migrants while in the country of destination. Migrants face higher exposure to TB infection due to overcrowded living and working conditions and increased vulnerability to human immunodeficiency virus (HIV), malnutrition and substance use induced by marginalization and social exclusion. Delays in TB diagnosis among migrants are commonly associated with difficulty accessing health care, lack of education and poor health-seeking behaviors. Migrants often do not have access to correct TB-related information on prevention, transmission and latent infections due to language barriers as well as cultural beliefs. Stigma-related fear, lack of awareness of entitlement to health services and low health-related spending capacity as proportion of household income, as well as migrant-unfriendly health services, all lead to reluctance in seeking care or adhering to treatment.

Upon return: Migrants who lived in poor housing, received low wages and had limited access to health care are likely to return home less healthy than when they left. When migrants return to their places of origin with untreated TB, MDR-TB or complications thereof, the availability of standardized treatment and access to reliable health-care services becomes an important factor in their health outcomes and has profound public health implications for their families and communities. This can place financial burden on households if they do not have adequate health and social protection upon return or strain health-care systems in countries of origin.

Migrants of specific legal and social status, such as workers, undocumented migrants, trafficked and detained persons, face particular health determinants. Among migrant workers with a legal status, their access to TB diagnosis and care is subject to their ability to access health-care services and health insurance coverage provided either by the State or the employer. Irregular migrants face particular challenges, such as fear of deportation, that delay or limit their access to diagnostic and treatment services. Deportation while on treatment or poor compliance with treatment may lead to drug-resistant infection and increased chances of spreading TB in countries of origin, transit and destination. Migrants in detention centres or trafficked persons in transit or host countries often live in unsanitary and unhealthy conditions for extended periods of time, creating pockets of vulnerability to TB infection.

Migrant health policies for tuberculosis

Public health principles

A population health approach to policy development is critical to align multisectoral strategies and interventions for migration health. Several public health principles are critical to any discourse on TB prevention and control for migrants. The first principle is to avoid disparities in health status and access to TB-related services between migrants and the host population. The second closely associated principle is to ensure migrants' health rights. This entails limiting discrimination or stigmatization, and removing impediments to migrants' access to preventive and curative interventions in line with basic health entitlements of the host population. The third principle is to reduce excess mortality and morbidity from TB among migrant populations, especially among those who are forcefully displaced or affected

by conflicts. The fourth and final principle is to minimize the negative impact of various phases of the migration process on migrants' TB-related outcomes. As TB is an infectious disease, attention has to be paid to balance the human rights of persons affected by TB with the needs to safeguard population health in host communities. In addition to public health principles, countries are required to uphold obligations to human rights instruments such as Article 12 of the International Covenant on Economic, Social and Cultural Rights, and General comment 14 that speaks of the right of migrant populations to access health services in a non-discriminatory manner. Finally, with growing attention to active systematic TB screening for at-risk groups such as migrants and refugees, sound screening principles should be followed. These principles include ensuring that any migrant screening programme is accompanied with appropriate treatment and care facilities, follows medical ethical principles, and ensures synergies between health and social services delivery.

Developments in global tuberculosis strategy

As the world counts down to the 2015 MDG targets, national governments, World Health Organization (WHO), the Stop TB Partnership, the Global Fund and other stakeholders in the fight against TB are designing new strategies and targets to reinforce efforts for TB elimination globally. There is widespread recognition that further progress will be subject to identifying risk groups (including migrants) and prioritizing interventions. The draft World Health Assembly resolution that will be considered by Member States in May 2014 explicitly recalls the 2008 World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants, and calls for greater collaboration between low- and high-TB-incidence countries to strengthen TB control and monitoring, including for labour migrants. The 2014 World TB Day campaign – with its call to find, treat and cure the 3 million people “missed” by TB programmes – notes how those missed include migrant groups. As the Global Fund issues guidance and implements its new funding model for the coming years, it again explicitly notes the need for countries to prioritize interventions and address “key affected populations”, including migrants, refugees and displaced populations (as well as miners and indigenous communities that are largely comprised of migrants in many countries).

These global health policy developments have not occurred in isolation, but are a response to growing evidence and understanding that social and economic inequalities sustain migrants' vulnerability to TB, as do discriminatory policies in non-health sectors such as immigration, labour and social protection. Migrants are particularly vulnerable to health inequities, inadequate social protection, discrimination, human rights violations and stigmatization. A high burden of TB-related (and other disease-related) morbidity and mortality among migrants can have negative economic effects at the household level for migrants and their families, at the societal level due to loss of productivity and revenue in the industries that hire them, and at the national government level through financial burden on health systems in both source and destination countries, and loss of remittances for countries of origin. Thus, policy action is needed to ensure that the needs of migrants are adequately addressed in global efforts for the “missing 3 million” people who are left out of TB-related health care around the world.

Four building blocks for action

In the Post-2015 Development Agenda, health is proposed to be addressed with the overarching goals of maximizing healthy life expectancy and universal health coverage; however, this should be accompanied with explicit focus on the underlying determinants of health and measure health coverage for marginalized populations like migrants. Likewise, national and international TB policies (and other related health and non-health policies) should explicitly recognize migrants as a marginalized and disadvantaged group in the post-2015 development era. This includes addressing migrants in adoption and implementation of the proposed *WHO resolution on the global strategy and target for TB prevention, care and control after 2015*. Design and implementation of multisectoral comprehensive TB policies should support the implementation of the four key pillars of the global migration health operational framework (2010), as proposed here.

Measurement and analysis of tuberculosis burden among migrants

Effective TB control policies and programmes need an epidemiologic evidence base. Whereas many countries have well-defined estimates for their general populations, national TB programmes, public health agencies and donors in high- and low-burden countries

are faced with a lack of evidence on TB burden and intervention effectiveness on migrants. TB prevalence surveys and other surveillance mechanisms should include migrant populations, and also migration-related variables (such as country of birth or last residence, length of stay and travel history) in routine health data monitoring and analysis. Appropriate data protection and confidentiality principles should be respected in case of undocumented migrants and trafficked or detained persons. Health-care systems that cater to migrants either before arrival or at destination, and even in settings such as refugee camps and detention centres, should report findings to national TB notification systems. Health authorities should make better use of administrative data such as census, labour surveys, immigration records and education data to identify migrant groups and ensure disaggregation of health information accordingly. There is a need for better documenting cost-effectiveness and relative merits of various tools and policies in place for migrant screening programmes to draw lessons from individual countries and inform coherent strategies in TB screening policies and practices. Evidence is needed also on the economic impact of not addressing TB among migrants, and review of TB funding practices for hard-to-reach migrants to inform future migration health policies.

Robust migrant-sensitive health systems for an effective tuberculosis response

National health policies should support a rights-based health systems approach, sensitizing medical and administrative personnel to health profiles of migrants and building cultural competency reflective of migrants' needs. TB diagnostics, treatment and care for migrants should be integrated within national TB programmes with dedicated resources, including MDR-TB and TB-HIV management and migrants' access to innovative TB technologies and services. Binational or regional policies are needed to establish cross-border referral systems with contact tracing and information sharing to ensure continuity of care for migrants and enhance harmonization of treatment protocols across borders. Close monitoring and communication is needed between health systems across countries, and investments should be made for capacity-building of TB clinics in both the receiving and sending countries. Other factors that influence TB outcomes, for example, overcrowded living and working conditions for miners, should be addressed. The health sector should work closely with non-health sectors like employers and border authorities whose

policies and systems impact TB-related outcomes among migrants. Migrant communities should be empowered through social mobilization and health communication policies for a participatory approach to TB prevention and control.

Intersectoral policy and legal frameworks: Health-in-all-policies approach

To achieve the global TB goals, it is critical to ensure policy coherence and shared solutions between health and non-health sectors, such as immigration and labour, and to implement the WHA 61.17 Resolution on the Health of Migrants. National TB policies need to clearly address migrants' issues, with political stewardship and accountability through monitoring and evaluation. Any policy or legal frameworks should be supported by timely and sufficient funding. TB policies should address health promotion for migrants – avoiding stigma, discrimination and restrictions to travel for people with no infectious TB and deportation for those affected by TB. National legislation should be adopted to improve migrants' access to TB services, regardless of legal migration status, and implement social protection measures as part of a multisectoral approach to TB control. National authorities should be equipped to regulate and monitor TB treatment offered by informal or private health-care providers, where vulnerable and poor populations including migrants often seek TB care. Low-incidence countries that implement overseas TB screening programmes should consider harmonization of screening protocols, along with measures such as contact tracing, detailed follow-up evaluation of migrants with latent TB infection, reducing migrant barriers to access health services and a cross-border or international registry to ensure tracing and continuity of care for individual TB patients. Health insurance schemes designed to cover migrants such as immigrants, workers and students, as well as their families, should consider portability of coverage for TB treatment and follow-up. In crises, especially prolonged conflict and disaster settings, pre-existing national TB programmes should be strengthened, and TB detection and treatment for displaced persons be included in the emergency health response. Non-health sector policies that can influence TB outcomes should be reviewed to ensure coherence with national TB policies for migrants. Finally, upstream-level interventions like poverty-reduction strategies, social protection and public campaigns against discrimination are needed as part of a multisectoral approach to reduce TB burden among migrants.

Networks and multi-country partnerships with common goals

Meaningful reductions in the risks of TB disease for migrants and surrounding communities need effective multisectoral partnerships between multiple public and private sector agencies, within and across countries. Policies should foster partnerships between various government sectors, private sectors (health-care providers, pharmaceutical companies, insurance agencies and employers), civil society

(including migrant groups), humanitarian and development agencies, and the international donor community. Political commitment is needed among migrant-receiving countries for sustained investments in targeted TB programmes in countries of origin and transit, especially in high-TB-incidence countries. Health policies for management of infectious diseases like TB should be considered in bilateral or regional agreements on migration (for example, labour migration and border management), with appropriate accountability mechanisms. ■

Emerging concerns in Tuberculosis and Migration

Multidrug-resistant tuberculosis (MDR-TB) is frequently caused by inadequate treatment or improper use of medications, leading to increased morbidity and mortality and high costs of treatment. Migrants are particularly vulnerable to MDR-TB due to overcrowded living conditions, delayed diagnosis from financial constraints, poor health literacy and health-seeking behaviours, poor treatment adherence and high default rates. Without timely TB diagnosis, treatment, contact tracing and cross-border continuity of care for migrants, hard-to-reach mobile populations and surrounding communities, MDR-TB control will remain a challenge.

Forced displacement of persons after conflict or a natural disaster is often associated with an increased risk of TB due to factors such as malnutrition, overcrowding in camps or other temporary shelters, and disruption of health services, resulting in the interruption of TB treatment that may result in drug resistance. There remains an ethical dilemma in postponing TB programmes until the social setting becomes more appropriate for implementation, and an analysis comparing the risks and benefits of delaying TB programmes in complex emergencies is needed.

Migrant workers in the mining industry are at a high risk for TB due to poorly ventilated, overcrowded living and working conditions and occupational hazards like silicosis. In Southern Africa, where a majority of mine workers are migrants from neighbouring countries, nearly one third of the TB infections are estimated to be linked to mining activities. The underlying social and structural determinants of this largely disproportionate TB burden in the mining industry lies outside the traditional health sector, and can only be addressed through sustained and multisectoral collaboration between ministries of labour, mining and health, as well as the private industry.

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