

Tuberculosis Control in Migrant Populations

Guiding Principles and Proposed Actions



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CONTENTS

Abbreviations.....	iv
Glossary of migration-related terms.....	v
1. Introduction.....	1
1.1 Migration: trends, health impacts and importance.....	1
1.2 Global consensus development on migrant health.....	2
1.3 Purpose and scope of document.....	3
1.4 Classification of migrant populations.....	5
2. Guiding principles and proposed actions.....	7
2.1 Monitoring migrant health.....	8
2.2 Policy and legal frameworks.....	10
2.3 Migrant sensitive health systems.....	13
2.4 Partnerships, networks and multi-country frameworks.....	17
References.....	20

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
APEC	Asia-Pacific Economic Cooperation
ASEAN	Association of Southeast Asian Nations
GFMD	Global Forum on Migration and Development
HIV	human immunodeficiency virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IOM	International Organization for Migration
MDR-TB	multidrug-resistant tuberculosis
NTP	national TB control programme
TB	tuberculosis
WHO	World Health Organization

GLOSSARY OF MIGRATION-RELATED TERMS

International Organization for Migration (1)

Asylum seeker	A person who seeks safety from persecution or serious harm in a country other than his or her own and awaits a decision on the application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any non-national in an irregular or unlawful situation, unless permission to stay is provided on humanitarian or other related grounds.
Border control	A state's regulation of the entry and departure of people to and from its territory, in exercise of its sovereignty, whether this is conducted at the physical border or outside of the territory in an embassy or consulate.
Border crossing	The physical act of crossing a border either at an established checkpoint or elsewhere along the border.
Casual cross-border migrant	A person who moves informally across porous borders into neighbouring countries, usually over the span of days or weeks.
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.
Contractual labour	Labour supplied for a specific purpose over a fixed period of time by a contractor.
Country of destination	The country that is a destination for migratory flows (regular or irregular). See also <i>host country</i> , <i>receiving country</i> .
Country of origin	The country that is a source of migratory flows (regular or irregular). See also <i>sending country</i> .
Deportation	The act of a state in the exercise of its sovereignty in removing a non-national from its territory to his or her country of origin or third state after refusal of admission or termination of permission to remain.

Documented migrant	A migrant who entered a country lawfully and remains in the country in accordance with his or her admission criteria.
Foreigner	A person belonging to, or owing an allegiance to, another state.
Host country	See <i>country of destination, receiving country</i> .
Illegal migrant	See <i>irregular migrant, undocumented migrant</i> .
Immigration	A process by which non-nationals move into a country for the purpose of settlement.
Immigration status	Status of a migrant under the immigration law of the host country.
Internal migrant	A person who moves within the borders of a country, usually measured across regional, district or municipal boundaries, resulting in a change of usual place of residence.
Internal migration	A movement of people from one area of a country to another area of the same country for the purpose or with the effect of establishing a new residence. This migration may be temporary or permanent. Internal migrants move but remain within their country of origin (for example, rural to urban migration).
Internally displaced persons	People or groups of people who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border.
International migration	Movement of people who leave their country of origin, or the country of habitual residence, to establish themselves either permanently or temporarily in another country. An international frontier is therefore crossed.
International student	A person admitted by a country other than his or her own, usually under special permits or visas, for the specific purpose of following a particular course of study in an accredited institution of the receiving country.

Involuntary repatriation	The return of refugees, prisoners of war and civil detainees to the territory of their state of origin induced by the creation of circumstances that do not leave any other alternative. Repatriation is a personal right (unlike expulsion and deportation which are primarily within the domain of state sovereignty), as such, neither the state of nationality nor the state of temporary residence or detaining power is justified in enforcing repatriation against the will of an eligible person, whether refugee or prisoner of war or civil detainee. According to contemporary international law, prisoners of war, civil detainees or refugees refusing repatriation, particularly if motivated by fears of political persecution in their own country, should be protected from refoulement (return of a refugee or refugee claimant to his or her country of origin) and given, if possible, temporary or permanent asylum.
Irregular migrant	A person who enters a country, often in search of employment, without the required documents or permits, or who overstays his or her authorized length of stay. The term “irregular” is preferable to “illegal” because the latter carries a criminal connotation and is seen as denying migrants’ humanity.
Irregular migration	Movement that takes place outside the regulatory norms of the sending, transit and receiving countries. There is no clear or universally accepted definition of irregular migration. From the perspective of destination countries it is entry, stay or work in a country without the necessary authorization or documents required under immigration regulations. From the perspective of the sending country, the irregularity is for example seen in cases in which a person crosses an international boundary without a valid passport or travel document or does not fulfil the administrative requirements for leaving the country. There is, however, a tendency to restrict the use of the term “illegal migration” to cases of smuggling of migrants and human trafficking.
Labour migrant	A person engaged in a remunerated activity in a state of which he or she is not a national and is legally admitted.
Labour migration	Movement of people from one state to another, or within their own country of residence, for the purpose of employment. Labour migration is addressed by most states in their migration laws. In addition, some states take an active role in regulating outward labour migration and seeking opportunities for their nationals abroad.

Less- or low-skilled and semi-skilled migrant worker	There is no internationally agreed definition of a less- or low- skilled and semi-skilled migrant worker. In broad terms, a semi-skilled worker is considered to be a person who requires a degree of training or familiarization with the job before being able to operate at maximum/optimal efficiency, although this training is not of the length or intensity required for designation as a skilled (or craft) worker, being measured in weeks or days rather than years, nor is it normally at the tertiary level. Many so-called “manual workers” (for example, production and construction workers) should therefore be classified as semi-skilled. A less- or low-skilled worker, on the other hand, is considered to be a person who has received less training than a semi-skilled worker or has not received any training but has still acquired his or her competence on the job.
Migrant	At the international level, no universally accepted definition for “migrant” exists. The term migrant was usually understood to cover all cases where the decision to migrate was taken freely by the individual concerned for reasons of “personal convenience” and without intervention of an external compelling factor; it therefore applied to people, and family members, moving to another country or region to better their material or social conditions and improve the prospects for themselves or their family.
Migration	The movement of a person or a group of people, either across an international border, or within a state. It is a population movement, encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced people, economic migrants and people moving for other purposes, including family reunification.
Non-discrimination	The refusal to apply distinctions of an adverse nature to human beings simply because they belong to a specific category. Discrimination is prohibited by international law, for example in Article 26, International Covenant on Civil and Political Rights, 1966, which states: “All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”

Receiving country	Country of destination or a third country. In the case of return or repatriation, also the country of origin. Country that has accepted to receive a certain number of refugees and migrants on a yearly basis by presidential, ministerial or parliamentary decision. See also <i>country of destination</i> .
Refugee	A person who, owing to a well-founded fear of being persecuted, is outside the country of his or her nationality and is unable or unwilling to return and has obtained official recognition of his or her refugee status.
Regional consultative processes	Non-binding consultative forums, bringing representatives of states, civil society (nongovernmental organizations) and international organizations together at the regional level to discuss migration issues in a cooperative manner. Some regional consultative processes also allow participation of other stakeholders, for example, nongovernmental organizations or other civil society representatives.
Regular migration	Migration that occurs through recognized, authorized channels.
Repatriation	The personal right of a refugee, prisoner of war or a civil detainee to return to his or her country of nationality under specific conditions laid down in various international instruments – <i>Geneva Conventions (1949) and Additional Protocols to the Geneva Conventions (1977)</i> , <i>Regulations Respecting the Laws and Customs of War on Land Annexed to the Fourth Hague Convention (1907)</i> , human rights instruments and customary international law. The option of repatriation is bestowed upon the individual personally and not upon the detaining power. In the law of international armed conflict, repatriation also entails the obligation of the detaining power to release eligible people (soldiers and civilians) and the duty of the country of origin to receive its own nationals at the end of hostilities. Even if treaty law does not contain a general rule on this point, it is today readily accepted that the repatriation of prisoners of war and civil detainees has been consented to implicitly by the interested parties.
Rural–urban migrants	Internal migrants who move from rural to urban areas, often in response to poverty, low agricultural incomes, low productivity, population growth, shortages, fragmentation and inequitable distribution of land, environmental degradation, and the relative lack of economic opportunities in rural areas.

Seasonal migrant worker	A migrant worker whose work, or migration for employment, is by its character dependent on seasonal conditions and is performed only during part of the year.
Sending country	A country from which people leave to settle abroad permanently or temporarily. See also <i>country of origin</i> .
Skilled migrant	A migrant worker who, because of his or her skills or acquired professional experience, is usually granted preferential treatment regarding admission to a host country, and is therefore subject to fewer restrictions regarding length of stay, change of employment and family reunification.
Undocumented migrant	A non-national who enters or stays in a country without the appropriate documentation. This includes, among others, a person who: (a) has no legal documentation to enter a country but manages to enter clandestinely; (b) enters or stays using fraudulent documentation; and (c) after entering using legal documentation, has stayed beyond the time authorized or otherwise violated the terms of entry and remained without authorization. See also <i>irregular migrant</i> , <i>irregular migration</i> .

1. Introduction

1.1 Migration: trends, health impacts and importance

Human migration, defined as the “movement of a person or a group of persons, either across an international border, or within a State”, has been increasing over the last several decades (1). According to current United Nations estimates, there are approximately 232 million international migrants worldwide, with over 71 million living in Asia, and an additional 740 million internal migrants moving within their own countries (2,3). The total number of migrants worldwide is greater than the population of all but the world’s two most-populous nations.

While few countries collect sufficiently disaggregated data on the health of migrants, population movements “generally render migrants more vulnerable to health risks and expose them to potential hazards and greater stress” (4). Key risk factors in the migration process include poverty, poor and dangerous working conditions, limited access to health-care services, and social exclusion, among other factors.

In the face of continued globalization, climate change and ongoing political instability, it is anticipated that the size and scale of migration will continue to increase (5). Against this backdrop, there is little doubt that the health needs of migrant populations are considerable and merit greater attention for several reasons:

- **Healthy migrants contribute to positive development outcomes (6,7).** In destination countries, migrants help meet unmet needs in the labour market by working in many crucial low- and high-skill jobs that cannot be filled by national workers alone. They also make significant contributions to economies of host countries through domestic consumption and tax payments, as well as expand opportunities for trade with their knowledge of markets in origin countries. At the same time, migrants also drive development in origin countries by way of remittances, which totalled US\$ 338 billion in 2008 and increased to US\$ 406 billion in 2012 (8). The 2008 figure represents over three times the total amount of official development aid received by developing countries in the same year.

- **Health promotion and disease prevention among migrants contributes to overall public health.** Vulnerable populations, such as migrants, are often at increased risk of ill health as a result of the poor conditions through which they travel and then work and live. Efforts to promote their access to health services positively impact not only the health of migrants but overall public health as well, particularly by reducing the risk of communicable disease spread to surrounding communities and communities of origin.
- **Migrants have a right to health.** Beyond public health considerations, Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognizes the right of everyone, including migrants, to “the enjoyment of the highest attainable standard of physical and mental health” (9). This is delineated even more explicitly in General Comment No. 14, which stipulates that signatory countries to the ICESCR must “ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups”, including migrant populations (10).

1.2 Global consensus development on migrant health

Noting that “the health of migrants is an important public health matter”, the Sixty-first World Health Assembly in May 2008 passed a resolution on the Health of Migrants (WHA61.17), calling on Member States to:

1. promote migrant-sensitive health policies;
2. promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race;
3. establish health information systems in order to assess and analyse trends in migrants’ health, disaggregating health information by relevant categories;
4. devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;

5. raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues; and
6. promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process (11).

In response, in March 2010 the World Health Organization (WHO), the International Organization for Migration (IOM) and the Ministry of Health, Social Services and Equality of Spain organized a Global Consultation on Migrant Health in Madrid, Spain, which based on the consensus of a wide range of stakeholders produced an outline for an operational framework on migrant health (12). Founded on the public health principles of the 2008 WHO resolution (WHA61.17), the migrant health framework aims to: ensure migrants' health rights; avoid disparities in health status and access; reduce excess mortality and morbidity; and minimize the negative impact of the migration process.

1.3 Purpose and scope of the guiding principles and proposed actions on TB control in migrant populations

Noting that reducing the burden of tuberculosis (TB) in vulnerable populations is essential to achieve a "TB-Free World", the WHO *Stop TB Strategy* calls for more concerted efforts by Member States, national TB control programmes (NTPs) and development partners to protect poor and vulnerable subgroups from TB, TB/HIV, and multidrug-resistant TB (MDR-TB) (13).

Often shouldering a much higher TB burden than the general population, migrants are especially vulnerable, but they are also among the most difficult to reach and treat due to their diverse and highly mobile nature. Recognizing these inherent difficulties and the limited success of current national policies on migrant TB control, there has been a demand among Member States in the Western Pacific Region for additional guidance on curbing the TB epidemic in migrant populations (Box 1). To this end, the WHO Regional Office for the Western Pacific, in consultation with key stakeholders, has adapted the aforementioned, consensus-based global framework on migrant health for migrant TB control.

Entitled *Tuberculosis Control in Migrant Populations: Guiding Principles and Proposed Actions*, this consensus-based document offers a *direction* for countries to gradually move towards, subject to their existing national laws and regulations. It is the product of a regional consultation of health and immigration officials from 13

Western Pacific Member States conducted 26–27 March 2013 in Manila, 12 of which endorsed the document. One Member State, while recognizing the importance of addressing TB control in migrants, withheld its support until a broader regional consensus on migrant health is reached.

Cognizant that Member States face country-specific realities, this document, where possible, presents multiple ways forward, drawing on many excellent initiatives already under way in the Region. It is hoped that this guidance will help both origin and destination countries partner together more effectively to protect migrants from TB in line with the *International Standards for Tuberculosis Care (14)*. Given that this will require cross-sectoral collaboration, it is strongly encouraged that this document be shared with and used by other relevant sectors in the formulation and implementation of migrant-sensitive TB control policies.

BOX 1: Why are special guiding principles and actions for TB control in migrant populations needed?

TB is an infectious bacterial disease caused by *Mycobacterium tuberculosis*, which most commonly affects the lungs. At present, one third of the world's population is infected with TB. In most healthy people, however, infection with *Mycobacterium tuberculosis* does not cause TB disease and infectiousness. In fact, only 5–10% of infections develop into active disease that can be transmitted to others; of these, 80% will develop into active TB within two years, with the remaining 20% developing at some point in the individual's lifetime. Hence, active TB may develop years after a migrant has crossed a border, even in those migrants who have been screened.

While it is not possible to predict who will "break down" from infection to active disease, there is overwhelming evidence that vulnerable populations are at increased risk. Consequently, it is crucial 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.

MDR-TB is essentially a human-made problem that develops because of low-quality drugs and/or inadequate treatment regimens, and it is difficult and expensive to treat. The development of migrant-sensitive TB control policies is especially critical given the high mobility of migrants—which increases the likelihood of transmission and treatment default, their lack of access to health-care services, their often dire living conditions and their propensity to inadequately self-treat in the private sector. In formulating such policies, however, policy-makers should note that TB is primarily transmitted within migrant communities, with very limited evidence of transmission from migrant groups into host country populations (15).

1.4 Classification of migrant populations

There are many different ways to categorize and group migrant populations. Recognizing that the following list is not exhaustive, this document focuses on six migrant categories: 1) internal migrants; 2) labour migrants; 3) casual cross-border migrants; 4) irregular migrants; 5) refugees and other displaced populations; and 6) international students (Table 1). These subgroups were selected in consultation with Member States based on the migrant demographics of the Region and may overlap in certain instances.

TABLE 1. Definition of migrant categories

Category	Definition
Internal migrants	Individuals who move within the borders of a country, usually measured across regional, district or municipal boundaries, resulting in a change of usual place of residence <i>(2)</i> .
Labour migrants	Individuals engaged in a remunerated activity in a state of which he or she is not a national and is legally admitted <i>(16)</i> .
Casual cross-border migrants	Individuals who move informally across porous borders into neighbouring countries, usually over the span of days or weeks.
Irregular migrants	Individuals who enter a country, often in search of employment, without the required documents or permits, or who overstay their authorized length of stay <i>(17, 18)</i> .

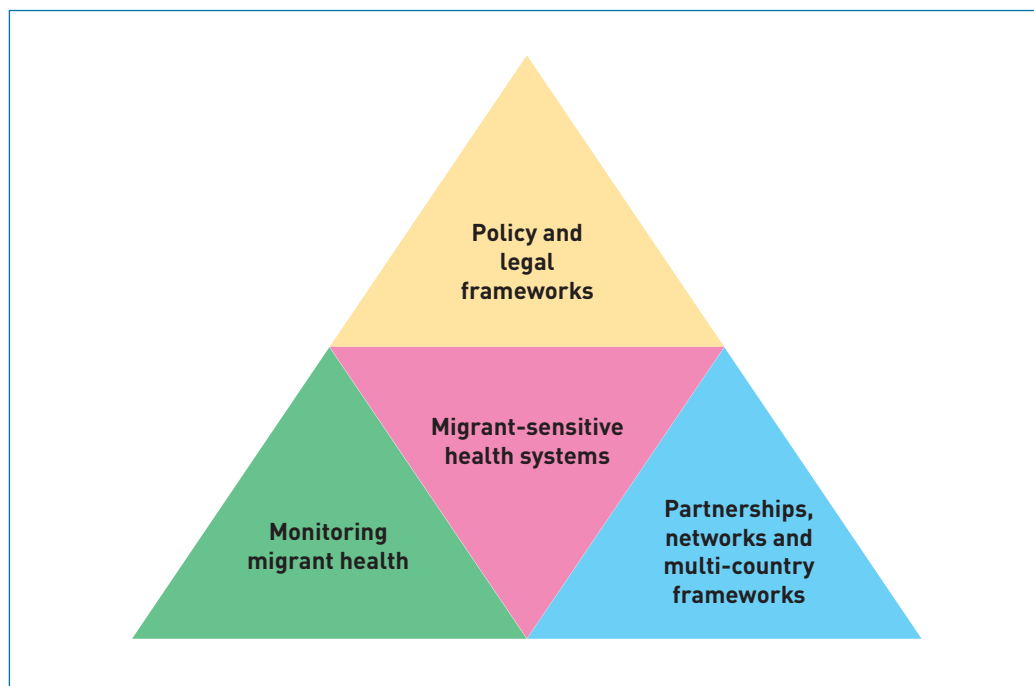
TABLE 1. Definition of migrant categories (continuing)

Refugees and other displaced populations	Refugees are individuals who, owing to a well-founded fear of being persecuted, are outside the country of their nationality and are unable or unwilling to return and have obtained official recognition of their refugee status (19). Internally displaced persons are defined as persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized state border.
International students	Individuals admitted by a country other than their own, usually under special permits or visas, for the specific purpose of following a particular course of study in an accredited institution of the receiving country (20).

2. Guiding principles and proposed actions for migrant TB control

Recognizing that reducing the burden of TB in migrant populations will require improvements in TB surveillance, policy, health service delivery, and cross-country collaboration and coordination, the guiding principles and proposed actions presented here are based on the four pillars of the global migrant health framework recommended in Madrid in 2010 (Figure 1). The four pillars are: 1) monitoring migrant health; 2) policy and legal frameworks; 3) migrant-sensitive health systems; and 4) partnerships, networks and multi-country frameworks (12).

FIGURE 1. Four pillars of the migrant health framework



2.1 Monitoring migrant health

The collection of additional data on migrants and their access to health care is a crucial first step in formulating more effective, evidence-based migrant health policies as noted in the 2008 WHO resolution on migrant health (WHA61.17) that calls on Member States to:

- establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories (11).

This is especially critical within the context of TB care and control. Current TB monitoring and surveillance mechanisms often do not adequately or sufficiently capture migrant health information crucial for the formulation and implementation of effective migrant TB policies. The following guiding principles and key actions aim to promote better monitoring and analysis of essential migrant TB data.

GUIDING PRINCIPLES

TB surveillance systems, including TB prevalence surveys, should be designed, to the extent possible, to be inclusive of migrant populations. This implies the collection and inclusion of migrant-relevant information, such as migrant category, country of origin and duration of residence. These variables will help ensure that especially vulnerable subgroups within a particular migrant category are not masked and overlooked (21, 22). As this information is very sensitive, it is important to explain to migrants why the data are being collected and there should be safeguards in place to prevent the use of these data in a discriminatory or harmful manner. Importantly, migrant TB case-notification data should also be reported jointly with national data to NTPs.

TB epidemiological and cohort data should be analysed, where possible, to monitor the burden of TB and outcomes of treatment in migrant populations. These analyses will support improved TB control in migrant populations through the formulation and implementation of tailored, evidence-based policies and interventions designed to fill gaps in service delivery.

KEY ACTIONS

Promote the inclusion of migration variables into TB prevalence surveys and TB case notification and treatment outcome data. Migrant category, country of birth/nationality and duration of residence are key variables that may be considered for inclusion (Box 2).

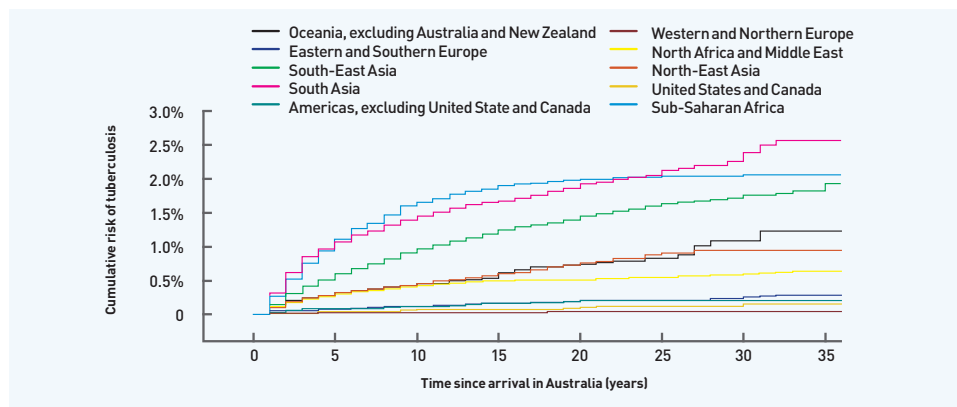
Promote the reporting of TB case notification and treatment outcome data from nontraditional settings to NTPs. TB screening data collected by immigration authorities, for instance, can significantly help to improve TB surveillance in migrant populations and provide valuable information for TB control in both origin and destination countries.

BOX 2: Australia: collection of migration-related variables

While the TB case-notification rate among native-born Australians has decreased since the 1960s, rates among foreign-born people have continually risen and accounted for 90% of all TB cases in 2010. Against this backdrop and an upward trend in the number of MDR-TB cases, Australia has recognized the importance of collecting detailed migrant TB data to support the development of tailored, evidence-based policies for migrant populations.

Key variables that are routinely collected include migrant type, country of birth and year of first arrival. Analysing notifications of foreign-born TB cases by their time since arrival, for instance, has led to the observation that most foreign-born TB cases present within the first two to three years after arrival – a finding that has informed Australia’s immigration policy of follow-up TB screening for two years after arrival among migrants who have previously had active TB or who have been diagnosed with inactive TB.

Building on this, data disaggregation by both region of origin and “time since arrival” has allowed for even more detailed analyses. As shown in the chart below, incidence of TB is highest just after arrival but varies substantially by region of origin, an insight that has been used to further inform Australia’s TB screening policies (23).



2.2 Policy and legal frameworks

At the policy level, most countries have attempted to reduce the TB burden of their migrant populations through rigorous screening policies designed to prevent the entry of migrants with active TB at least until treated (5). Evidence has shown, however, that a significant proportion of TB among migrants is actually reactivated or newly acquired as a result of the poor conditions through which migrants travel and then work and live (24, 25). Viewed from this perspective, traditional policy approaches to migrant TB control are not sufficient to prevent TB among migrants after arrival in their country of destination. Emphasizing the crucial importance of expanding migrants' access to TB care, the following guiding principles and key actions are intended to guide future policy responses as called for by the WHO migrant health resolution (WHA61.17) calling on Member States to:

- promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race (11).

GUIDING PRINCIPLES

National TB control policies should promote universal and equitable access to TB diagnosis and treatment for all TB patients regardless of residential status, nationality or legal status, subject to national laws and resource constraints.

As outlined in the relevant human rights instruments regarding the right to health care and WHO resolutions WHA58.33, WHA61.17 and WHA64.9, governments should provide universal access to TB care “while preventing and providing protection against disastrous financial risks” (Box 3) (9, 26–28). While some countries may not be able to fulfil this obligation due to resource constraints, the ICESCR notes that signatory countries should “move as expeditiously and effectively as possible” towards providing universal and equitable TB care to migrant populations (10). Where existing national laws do not allow for this, countries should work to make alternative arrangements with countries of origin so as to ensure continuity of care and successful completion of TB treatment in case of forcible removal.

National TB guidelines and manuals should endeavour to take into account the specific needs of migrant populations. To this end, where relevant and feasible, tailored TB interventions should be proactively developed and included in line with international standards, such as WHO guidelines and the International Standards for Tuberculosis Care.

TB status should not affect the legal or contractual status of patients to the extent allowed by national laws and regulations. If migrants fear deportation or loss of employment due to their TB status, they are likely to attempt to conceal their need for medical care and delay seeking TB treatment or procure inadequate drug regimens in the private health-care sector (29, 30). This not only negatively impacts their health, but also significantly increases the likelihood of further TB disease spread, including the development and transmission of MDR-TB. Consequently, countries are urged to recognize the importance of providing migrants with TB care not only to protect migrants themselves but society at large. Prompted by this understanding, in some countries irregular migrants found with active TB are granted temporary legal status during the full course of treatment to ensure treatment adherence. However, where existing national laws dictate that the legal and/or contractual status of migrants is dependent on TB status, all feasible steps should be undertaken to ensure continuity of care and TB treatment. In the case of deportation of migrants with active TB, this includes proper cross-country referral and compliance with the International Health Regulations (2005) (31). The ultimate goal is for all TB patients to receive TB treatment, be it in the destination or origin country.

KEY ACTIONS

Conduct advocacy and public education efforts to build support among the government and other stakeholders, including private medical providers and employers, on the importance of ensuring access to TB care for migrant populations. These efforts should emphasize the substantial public health benefits to be gained, such as the prevention of MDR-TB, as well as the health rights of migrants and the cost-effectiveness of prevention, early diagnosis and treatment (Box 4).

Promote the availability of adequate resources for migrant TB policy development, formulation of strategies and programme implementation subject to national laws and regulations.

Encourage policy coherence between NTPs and other relevant sectors (for example, immigration, labour). In particular, Member States might consider policy alternatives to the deportation of migrants found to have active TB as well as mechanisms to ensure migrants' job security and workplace-supported treatment delivery.

BOX 3: Japan: universal access to TB care for migrant populations

Recognizing the importance of ensuring that all individuals with active TB are diagnosed and treated, Japan has provided publicly funded TB services under a TB control law since the 1950s – later superseded by a more comprehensive infectious disease law. The law stipulates that the prefectural government shall bear the expenses of the following medical care to be provided to the patient:

1. medical examination
2. provision of drugs and medical equipment
3. medical treatment, surgery and other kinds of medical care
4. hospitalization, nursing during medical treatment and other care (32).

Under the current era of an increasing migrant population in Japan, this historical principle of free TB care supported by law works positively for TB control among migrants because all individuals can access standardized quality TB care regardless of nationality or health insurance status.

To achieve the same objective, some countries have extended health insurance coverage more broadly to all migrant populations regardless of immigration status, which has resulted in significant public health successes, most notably with respect to the control of communicable diseases (29, 33).

BOX 4: Viet Nam: removal of institutional barriers to care

In some countries, residency registration policies limit people's access to health services to their official place of residency, which is not easily transferred. Initially designed to discourage rural-to-urban migration, these registration policies have now effectively become a barrier for internal migrants in accessing necessary health services as migrants have remained largely undeterred from moving to urban centres. In the 2004 Viet Nam Migration Survey, for instance, 42% of those surveyed reported experiencing difficulties because of their non-permanent residential status, and of those who did not re-register, 48% believed re-registration was not possible, while 22% did not think it was necessary and 9% did not know how (34).

Recognizing the importance of removing these institutional barriers, however, Viet Nam's 2007 Law on Residence has lessened requirements for permanent registration in centrally administered cities and removed geographical restrictions for registrations of birth (34). Where possible, countries might also consider informing migrants in departure and destination areas of registration rules and procedures and of the availability of health and other social services.

2.3 Migrant-sensitive health systems

Even when national TB policies are aligned with international standards on migrant health, migrant populations often remain unable to access care due to a lack of understanding of enrolment processes, financial barriers to care, and discriminatory behaviour by health providers and administrative staff (35). These are often exacerbated further by health providers' lack of training on migrant health issues, as well as language and cultural barriers, which can apply not only to international migrants but also to internal migrants who may travel long distances to other parts of their own country with a different cultural environment. In order to truly make inroads in migrant TB care, these barriers to adequate health service delivery also need to be addressed. The following guiding principles and key actions aim to help Member States move towards more migrant-sensitive health systems in line with the WHO resolution on migrant health (WHA61.17) (11). The resolution calls on Member States to:

- promote migrant-sensitive health policies;
- devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery; and
- raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues.

GUIDING PRINCIPLES

Physical, financial, administrative and cultural barriers in accessing TB diagnosis and treatment for migrants should be addressed to the extent allowed by national laws and resource constraints. Many migrants initially delay seeking care because of a lack of knowledge of TB, which is often compounded by the fact that many migrants are simply unaware of the availability of TB care. To this end, countries might consider mechanisms by which to inform migrants of the availability of TB services, perhaps through their place of employment, as well as where and how they can access them (Box 5). In addition, Member States should endeavour to sensitize and train health providers on migrant health issues as well as a migrant's right to health services subject to national laws. Sensitizing administrative staff is particularly important as they are often the first point of contact and can create barriers to care if they discriminate or discourage migrants from seeking necessary treatment (35).

BOX 5: Thailand: implementation of a TB community education initiative

In an effort to educate refugees on TB, a former Khmer refugee camp in Thailand implemented a community education initiative as part of its TB programme with great success (44). Consisting of two phases, all TB patients were first required to attend a four-day course on TB (one hour per day), after which they were instructed to relay the information they had learnt to their housemates. As a follow-up, TB programme staff subsequently conducted home visits in order to evaluate how much the housemates had learnt from the patient, as well as assess them for TB symptoms. Given that stigmatization decreases as more TB patients are cured, community education efforts such as this represent a powerful approach to reduce stigma and facilitate early detection and treatment.

TB services should be delivered to migrants in a culturally and linguistically appropriate way subject to resource constraints. This ideally includes the provision of interpreting services so that patients and health providers can communicate effectively and the creation of multilingual patient education materials (Box 6). Beyond this, Member States may consider the development of national standards for culturally and linguistically appropriate health services and the requalification of migrant health providers in destination countries (35).

BOX 6: Japan: provision of interpretation services

In addition to providing migrant populations with free universal access to TB care, Japan has also undertaken various initiatives to further ensure migrants' access to needed TB care. In Tokyo, for instance, a translator telephone dispatch service has been established to assist public health nurses in explaining treatment and administrative processes to foreign patients, with a wide variety of languages spoken, for example, Burmese, English, French, Indonesian, Korean, Mandarin Chinese, Nepali, Portuguese, Spanish, Tagalog, Thai and Vietnamese. Meanwhile, in Shiga prefecture, poster and education materials have been developed as well as protocols to manage TB in the workplace.

The goal of TB screening, regardless of the location of screening (that is to say, pre-arrival, on-arrival or post-arrival), should be to benefit the individual with early TB diagnosis and treatment and to protect the society. To that end, TB screening programmes should ideally make arrangements whether in the origin or destination country so that appropriate treatment can be expeditiously provided for all patients found to have active TB. It is crucial to align diagnosis and treatment capacity (28).

KEY ACTIONS

Consider the creation of focal points within NTPs and other relevant sectors (for example, immigration, labour, education) for migrant TB issues.

Conduct public education efforts to educate migrants on TB and inform them of available health-care resources. In the Philippines, for instance, audio-visual training and health awareness materials for labour migrants have been developed by IOM for use in pre-departure orientations (36). Upon arrival in the destination country, these educational efforts can also be carried out in places of employment with large groups of migrants. Given the difficulty of reaching out to certain migrant groups, countries should consider the placement of posters in public locations with information on where TB services can be accessed.

Raise awareness among employers, health providers and administrative staff on the importance of promoting migrants' access to TB care. Advocacy efforts aimed at employers should emphasize how promoting migrant health not only benefits migrants but also promotes a healthy, productive workforce (Box 7).

BOX 7: South Africa: development of TB control initiatives in the workplace

Many migrant workers develop active TB after arriving in the destination country because of the poor conditions in which they live and work, such as overcrowded and poorly ventilated living and working quarters (41, 42). By the same token, however, the workplace also represents a valuable opportunity to promote migrant health and provide TB care, which benefits both migrants and their employers with a healthy, productive workforce. Recognizing this opportunity, the TB Care Association in Cape Town, South Africa, has developed a system for referring TB patients from government TB clinics to participating workplaces, which host health education workshops and provide TB treatment for their employees (43).

Encourage the development of standards for health service delivery that address the health needs of migrants. Some examples might include:

- provision of interpreting services;
- provision of institutional and community-based cultural support (Box 8), ideally drawn directly from the migrant communities themselves;
- education of health providers and administrative staff on migrant health issues; and
- provision of information and educational materials in multiple languages.

Establish links between TB screening programmes and NTPs in both destination and origin countries to ensure continuity of care for patients found to have active TB. This is especially relevant in countries where migrants with active TB may lose their legal status.

Promote access to TB care for migrants held in detention facilities. In particular, arrangements should be made to ensure proper infection control as well as the availability of adequate TB treatment.

BOX 8: China: implementation of migrant-sensitive TB control policies

The internal migrant population in China has been increasing sharply in recent years, rising from 147 million in 2005 to 213 million in 2011. With limited access to health services and over 70% lacking social insurance coverage, internal migrants shoulder a higher burden of TB than their urban resident counterparts (37–39). Recognizing the importance of reducing migrants' barriers to TB care (40), various migrant-sensitive policies have been piloted since 2006 with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. Some of these include: 1) workplace TB screenings during routine employee physical examinations; 2) monthly food and transportation subsidies for TB patients; 3) health education workshops in the workplace; 4) designated health staff that focus exclusively on risk groups such as migrants; and 5) financial incentives for health providers who diagnose and treat migrant TB cases.

In some cities, even more far-reaching policies have been put in place, such as the provision of free medical services beyond TB care, local medical insurance coverage, psychological support and additional care from patients' employers. Collectively, these policies have contributed to decreased notification of migrant TB cases, with infectious cases declining by 8% from 32 298 in 2010 to 29 592 in 2011.

2.4 Partnerships, networks and multi-country frameworks

While traditionally viewed as a unidirectional phenomenon, human migration has become increasingly circular and complex, underscoring the need to move beyond narrow unilateral approaches to migration (5). To this end, the Sixty-first World Health Assembly in 2008 called on countries to address migrant health issues in a more integrated and harmonized manner (WHA61.17), calling on Member States to:

- promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process (11).

Building on this resolution, the following guiding principles and key actions are intended to promote the cross-country collaboration and coordination needed to effectively reduce the burden of TB in migrant populations.

GUIDING PRINCIPLES

Migration health dialogues and cooperation should be established and supported across sectors and among key cities, regions and countries of origin, transit and destination, where feasible and appropriate. Some potential venues include regional economic communities, for example, the Asia-Pacific Economic Cooperation (APEC) forum, regional associations such as Association of Southeast Asian Nations (ASEAN), and regional consultative processes such as the Colombo Process dedicated specifically to discussing issues surrounding migration. The Global Forum on Migration and Development (GFMD) also represents another important forum to raise migrant health issues as governments of countries sending and receiving migrants convene at this forum annually (45).

Cross-border coordination mechanisms for migration and health might be considered in strategic border areas where the volume of population movement is high or where associated health concern is mounting. This will enable local authorities, health administrations and health staff to provide migrant-sensitive

health services effectively (Box 9). Some examples include the development of programmes to inform pre-departure migrants about health risks and service rights as well as the development of bilateral or regional agreements to support the portability of health-care benefits and the harmonization of TB treatment protocols (46, 47).

BOX 9: Papua New Guinea and Australia: cross-border coordination and referral in the Torres Strait

Papua New Guinea's Western Province, with a total population of 219 103 as of 2011, is a coastal, south-western province that shares an international sea border with Australia's Torres Strait Islands. Given the historical sea and land use of the Torres Strait area by its indigenous residents, a treaty between Australia and Papua New Guinea was signed in 1978 that, to date, allows for residents from both countries to freely cross the border.

While there is no provision for medical care in the agreement, casual cross-border migrants from Papua New Guinea have been seeking health services in Australia's Torres Strait Islands for many years. In 2011 it was decided that all TB patients from Papua New Guinea receiving treatment in the Torres Strait clinics, as well as those with other medical conditions, were to be transferred back home and that major efforts would be undertaken to build the capacity of the Western Province's health-care system and its TB services.

Importantly, to facilitate proper cross-border referral of patients, a Clinical Collaboration Group was established between Australian and Papua New Guinean doctors, which held its first official meeting in Daru, Western Province, in February 2013. All Papua New Guinean patients who seek care in the Torres Strait clinics are now referred back home through email and mobile communication between designated cross-border communications officers, with positive programme results thus far.

Referral mechanisms should be established where necessary between and within countries to facilitate smooth exchange of information and ensure the continuity of TB treatment and care. At present, referral mechanisms are often lacking when migrant TB patients are deported (or return to their home province in the case of internal migrants), and treatment protocols are rarely harmonized across countries to ensure appropriate TB care (48). Where possible, however, contact with the new TB treatment centre should be made prior to transfer and a reliable mechanism to transfer records should also be adopted (44). In the event of a discrepancy between the treatment protocols used by the transferring and

receiving programmes, a plan should be jointly developed to address this, and efforts should be made to notify the transferring programme of the treatment outcomes of transferred patients (Box 10).

KEY ACTIONS

Encourage and strengthen local, regional and international migration dialogues and processes to assist governments in coordinating and harmonizing health policies, including those related to TB. In 2008, a capacity-building workshop was organized by the APEC Health Working Group on Social Management Policies for Migrants to Prevent the Transmission of HIV/AIDS (45). Similar efforts should be undertaken for TB care and control.

Establish links between relevant authorities and health providers in origin, transit and destination countries to improve cross-border coordination and referral of TB patients. At a minimum, mobile TB patients should ideally be given referral cards in multiple languages that include information on diagnosis, treatment status and required follow-up, as well as the contact information of health facilities in their destination country. In an effort to ensure follow-up care, countries might also consider the establishment of a regional “clearing house” to facilitate notification of patients’ arrival to the relevant authorities in the destination country. Where possible, mobile TB patients should also ideally receive sufficient medication to be able to complete the intensive treatment phase.

BOX 10: Cambodia: establishment of joint active case finding initiative at key strategic border sites

In 2010, close to 100 000 Cambodian casual cross-border migrants were deported from Malaysia and Thailand. Setting up active case finding initiatives at the border locations where many of these migrants are repatriated represents a valuable and as yet untapped opportunity to make significant inroads in reducing the burden of TB in this vulnerable group.

To this end, the IOM TB REACH project, in partnership with the Cambodian NTP and WHO, has begun to pilot innovative TB screening strategies targeting the daily flows of Cambodian migrants being deported from Malaysia and Thailand to the border district of Poi Pet in Banteay Meanchey Province. The use of innovative diagnostic tools, such as Xpert MTB/RIF, is allowing for quick TB diagnosis in this highly mobile group, and all detected TB cases are being referred to existing local government TB services.

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