IOM Briefing Note 3: Population Mobility and Tuberculosis in Southern Africa

This briefing note provides an overview of **the relationship between population mobility and Tuberculosis (TB) in the Southern African Development Community (SADC)**. Population mobility within the SADC region is growing, both inter and intra-regionally. The region is affected by a high prevalence of communicable diseases, in particular the human immunodeficiency virus (HIV), tuberculosis (TB) and malaria. **Population mobility is increasingly recognised as a central determinant of health,** affecting health outcomes in various ways.[1-6]

Population mobility impacts on the health vulnerability not just of the individual that moves but also on the communities that are left behind, lived in, passed through and returned to. An individual's health profile stems not just from his or her behaviour but also from a range of social, economic and structural factors specific to the unique conditions of a location, hence a "**spaces of vulnerability**" approach is promoted when addressing migration and health.

While underscoring the benefits of migration, it has also been linked to changes in health seeking behaviour of the migrant. Migration as a process tends to delay or prevent health seeking behaviour, and – as a result - can be associated with the transmission of undiagnosed and untreated communicable diseases. Therefore, effective disease control programmes must actively engage with the reality of diverse population movements and its impact on programming.

The Southern Africa region is urged to adopt a multi-sectoral and multi-level approach whereby stakeholders become active participants in design, implementation, and monitoring **communicable disease control programmes that address the health needs of migrants and communities affected by the migration process.**

Box 1: Spaces of Vulnerability

The spaces of vulnerability approach is based on the understanding that health vulnerability stems not only from individual but also a range of societal and economic factors specific to the unique conditions of a location, including the relationship dynamics among migrants and sedentary populations. These factors must be taken into consideration when addressing migration health concerns and interventions must consider and target both migrants and the communities with which they interact, including families in communities of origin. Spaces of vulnerability are those areas where migrants live, work, pass-through or from which they originate or return to. They may include: land and water border posts, and ports, truck stops or hot spots along transport corridors, construction sites, commercial farms, fishing communities, mines, informal settlements, migrant communities of origin, detention centres, and emergency settlements. [7]

Tuberculosis in Southern Africa

Southern Africa has the highest TB incidence rates in the world, averaging at 591/100,000 compared to the global average of 126/100,000. Incidence rates range from 156 (Malawi) to 1382 (Swaziland).

TB incidence in the southern African countries including regional and global

Country	Incidence (per 100,000)	Estimated number of cases per year
Swaziland	1,382	17,000

South Africa	860	450,000
Namibia	651	15,000
Lesotho	916	19,000
Zimbabwe	552	78,000
Mozambique	552	140,000
Zambia	410	60,000
Botswana	414	8,400
Tanzania	164	81,000
Malawi	156	26,000
AFRICA	255	2,300,000
GLOBAL	122	8,600,000

Data source: World TB Report, WHO, 2014

Population Mobility and TB

Some mobility related vulnerabilities might heighten the risk of acquisition and transmission of TB in mobile populations.[9, 10]

- People who are on the move (migrants) tend to delay, lack access to or may face barriers in accessing TB screening, testing and treatment initiation.
- Continuity of care whilst on the move from place to place or across regional and international borders, can also be a challenge resulting in some abandoning treatment altogether. This will have an impact on the growing challenge of drug-resistant TB in the region. There is no system in place to track and ensure migrants on TB treatment continue with care and treatment as they move between countries and regions
- Lack of money to access health services where such is requirement,
- Different screening, diagnosis and treatment regimens from country to country are just a few of the challenges migrants may face in accessing TB services and adhering to TB treatment.

Migrants in spaces of vulnerability might face increased vulnerability to TB, including MDR and XDR-TB, due to their conditions of stay. These include, overcrowded living conditions, poor sanitation, shortage of proper medical care for people with symptoms of TB i.e. where access to prevention, diagnosis and treatment may be limited, delayed diagnosis due to financial constraints, poor health literacy and healthcare seeking behaviours, poor treatment adherence, high default rates and co-infection with HIV. These spaces may include: mines, prisons, detention facilities, rented accommodation in urban centres and informal settlements.

- **Forced displacement** of persons after conflict or a natural disaster is also 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.
- **Mineworkers in the SADC region** are at particular risk of acquiring TB.[11] Mineworkers, particularly migrant mineworkers, are vulnerable to acquiring TB due to the conditions in which they work (underground with inadequate ventilation, no direct sunlight and sporadic use of protective gear), and challenges they face in the continuity of treatment and care when they visit and/or return home. Additionally, due to the likelihood of acquiring silicosis, ex-mineworkers are more vulnerable than non-mineworkers, to TB infection long after they

have stopped working on the mines. Families of current and ex-mineworkers are further exposed to TB infection due to challenges in non-disclosure of TB status by mineworkers. This creates a key barrier to effective case finding. Contract workers, who sometimes constitute the majority of those working on mines, may have challenges in accessing primary healthcare facilities including testing and treatment because of the nature of the work that they do that forces them to be on the move most of the time, looking for better work/mining opportunities based on contracts they get into.[11]

Key Messages

- **Inadequate TB screening and active case finding and treatment programmes in the SADC region.** SADC countries have the highest rates of TB and TB/HIV co-infection in the world, and have a disproportionately high concentration of deaths due to TB and HIV related illnesses. Harmonization of screening, active case finding and treatment protocols becomes an essential element.
- **Increasing levels of Multi Drug Resistant (MDR) and Extreme Drug Resistant (XDR)-TB are being recorded in the SADC region**. MDR TB is frequently caused by inadequate treatment or improper use of medications, leading to increased morbidity and mortality and high costs of treatment. There is also a growing evidence of people who, for the first time, present with MDR or XDR TB. This is due to exposure to persons who have been on TB treatment before and defaulted on their treatment.
- **Migrant and mobile populations are often excluded from TB prevention and treatment programmes**, and struggle to access health services. As a result, migration and mobility may interfere with TB screening, diagnosis, and treatment.[11] Responses to TB must acknowledge and respond to national and regional population movements
- **There is no comprehensive cross border TB patients' referral system in place**. Referrals, prevention and treatment programmes between and across borders need to respond to the health needs of migrant and mobile communities. This will require health systems in the SADC region that are structured so as to ensure continuity of care for migrant and mobile populations.[12]
- **Undiagnosed and/or untreated cases** can result in migrants transmitting TB infection both in communities of origin and/or host communities at the countries of destination. Their families and communities around mines such as in informal settlements are in turn at increased risk of contracting TB.[13]
- Information, Education and Communication (IEC) interventions are not evidence informed and are uncoordinated and fragmented. Information provided does not adequately address socio-cultural and gender barriers, stigma and attitudes that influence the prevention and treatment seeking behaviour of the migrant populations.

IOM's Approach to Addressing Population Mobility and TB

The 61st World Health Assembly Resolution on the Health of Migrants (WHA 61.17), adopted in May 2008, calls upon governments to "promote migrant-sensitive health policies" and "to promote equitable access to health promotion and care for migrants". Guided by this resolution, IOM, WHO and the Government of Spain organised a Global Consultation on the Health of Migrants – The Way Forward in March 2010. The consultation developed a four pronged operational framework through

which health issues could be viewed with migrants - including displaced and conflict populations - in mind.

<table>
<tr><th colspan="2">Addressing Population Mobility and TB</th></tr>
<tr><td><u>Monitoring migrant health</u>

In order to ensure evidence based programming and policy development, IOM strengthens existing knowledge on the health of migrants via research and information dissemination.</td><td><u>Policy and legal framework</u>

In order to create an enabling policy and legislative environment that facilitates the realisation of migrants' right to health, IOM works closely with government counterparts and UN partners to ensure that regional and national level policies and legal instruments, or national strategic plans, are developed, amended and finalised with migration health concerns incorporated.</td></tr>
<tr><td>Within the context of TB:

• Analyse TB epidemiological data to monitor the burden of TB and treatment outcomes amongst migrant populations.
• Ensure that appropriate cross-border and regional surveillance and monitoring systems are in place to collect and analyse data on TB prevalence.
• Ensure that monitoring systems are adapted to the specific realities of migration and mobility between and across borders.
• Build evidence on TB and HIV prevalence through Integrated Biological Behavioural Studies.</td><td>Within the context of TB:

• Advocate and build capacity of stakeholders for the implementation of the SADC Declaration on TB in the Mining Sector
• Ensure inclusion of mobility in the national HIV and TB Strategies.
• Advocate for universal and equitable access to TB prevention, diagnostics and treatment for all TB patients, regardless of residential status, nationality or legal status in National TB control policies.
• Ensure coordinated and coherent regional and national policies (e.g. national strategic plans or bilateral agreements) which expounds for shared solutions between health and non-health sectors such as immigration/border management and labour.
• Promote harmonisation of treatment protocols, transfers/referrals for TB patients across borders.</td></tr>
<tr><td><u>Migration sensitive health systems</u>

Recognising that services, even if available, may not be sensitive to the needs and rights of migrants or to the vulnerabilities associated to the migration process, IOM takes a public health approach that supports strengthening community and other health systems to facilitate social and behaviour change and support improved utilization of health services</td><td><u>Partnerships, networks & multi-country frameworks</u>

IOM focuses on establishing and strengthening multi-sectorial partnerships, information sharing/ communication, coordination and collaboration, with the ultimate aim of increasing sustainability of interventions that promote and support realisation of migrants' right to health.</td></tr>
<tr><td>Within the context of TB:

• Promote proper TB infection control and access to TB testing and treatment for all migrants, including irregular migrants and migrants held in prisons and/or detention centres.
• - Ensure access to rapid screening, treatment and continuity of care for people on the move.
• - Ensure that people living with TB who plan to travel receive sufficient medication for the duration of their trip and even beyond the borders based on the harmonised treatment protocol.</td><td>Within the context of TB:

• Foster partnerships between various governmental sectors, private sectors (private healthcare providers, pharmaceutical companies, insurance sector, and employers), civil society (including migrant groups such as the ex-mine workers associations), humanitarian and development agencies and the international donor community.
• Facilitate the establishment of cross-border and intra-country referral systems between and within countries to facilitate smooth exchange of</td></tr>
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• Promote provision of referrals to treatment services in other areas of the country/region, and disseminate information on such services. • - Promote the provision of patient-held records (health passports) that indicate medication regimens, clinical findings and drug sensitivities. • Ensure quality of services provided to migrants through such methods as short questionnaires with returning mobile and temporary migrants on their treatment behaviour whilst they were away • Ensure that testing and treatment is delivered in a culturally and linguistically appropriate/ sensitive manner. • Improve living and working conditions associated with TB transmission in spaces of vulnerability. For example, silica dust levels should be controlled to ensure that exposure to silicosis and TB are minimised. Explore ways in which DOTs (including language, medication supplies, patient follow-up across borders) may be adapted to mobility and migration.	information and to ensure the continuity of treatment and care for individuals living with TB. • Ensure bilateral or regional agreements on migration (for example, labour migration and border management) include health issues especially, the management of TB. • Facilitate and promote regional information sharing and exchange visits to promote best practises on TB and HIV programming. • Partner with civil society organisations to promote cross-border portability of social benefits, especially in the mining sector.

Box 2: The SADC Framework on Population Mobility and Communicable Diseases.[16]

The framework aims to improve harmonisation and coordination of responses; improve access to healthcare services – including prevention programmes; to improve disease surveillance and epidemic preparedness; improve information, education and participation of mobile people; increase operations research and sharing of information; and, address legal and administrative barriers.[21][1] The Framework provides guidance on:

- the protection of the health of cross-border mobile people in the face of communicable diseases, including source, transit and destination communities; and
- the control of communicable diseases in the face of movement of people across borders in the region.

Box 3: The SADC Declaration on TB in the Mining Sector, 2012[14]

Due to the nature of circular labour migration system in the mining sector of southern Africa, most notably between South Africa, Lesotho, Swaziland and Mozambique, it was recognised that addressing TB in particular in the mining sector, required a concerted regional approach.

At the Southern Africa Development Community (SADC) Ministerial meeting held in South Africa in November 2011, the Ministers of Health, led by the Minister from Lesotho, discussed issues relating to HIV and TB in the mining sector. Concerns were raised relating to the high incidence of TB in mines and lack of sustainable support for retired mineworkers infected with HIV and TB. This was agreed to be contributing to poverty among affected families and communities in the region. In order to address this concern and show commitment, the Ministers held an Extraordinary High Level Meeting of the Ministers of Health and Labour/Employment sectors in April 2012, wherein a

[1] The 2009 Framework has not yet been adopted by SADC Member States. A costing exercise is underway to provide possibilities for a regional funding and implementation system.

Declaration on TB in the Mining Sector was tabled and endorsed for submission to the SADC Heads of State Summit. In August 2012, the Declaration was signed by the Heads of States.

The Declaration on TB in the Mining Sector outlines the justification, and the priority areas for urgent action for TB, HIV, Silicosis and other occupational respiratory diseases in the mining sector:

1. Strengthen accountability, coordination and collaboration at national and regional levels;
2. Promote a supportive policy and legislative environment;
3. Strengthen programmatic interventions;
4. Strengthen disease surveillance systems;
5. Strengthen M&E; and
6. Strengthen financing.

Today, the Declaration serves as a key advocacy and operational tool on which governments and other stakeholders base their interventions. Moreover, the process by which this Declaration came into fruition – the regional and multi-sectorial coordination approach – set the tone for the subsequent implementation phase. Today, there are various multi-country and multi-sectorial coordination mechanisms to continue the spirit of the Declaration and ensure effective implementation.

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