Consultation on Tuberculosis and Migration in the Western Pacific Region

26–27 March 2013
Manila, Philippines
REPORT

CONSULTATION ON TB AND MIGRATION IN THE WESTERN PACIFIC REGION

Convened by:

WORLD HEALTH ORGANIZATION
REGIONAL OFFICE FOR THE WESTERN PACIFIC

Manila, Philippines
26-27 March 2013

Not for sale

Printed and distributed by:

World Health Organization
Regional Office for the Western Pacific
Manila, Philippines

April 2013
## CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>SUMMARY</td>
<td>i</td>
</tr>
<tr>
<td>1. INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Objectives</td>
<td>2</td>
</tr>
<tr>
<td>1.2 Temporary advisers, resource persons, observers and secretariat</td>
<td>2</td>
</tr>
<tr>
<td>1.3 Participants</td>
<td>2</td>
</tr>
<tr>
<td>1.4 Methodology of the consultation</td>
<td>2</td>
</tr>
<tr>
<td>2. PROCEEDINGS</td>
<td>3</td>
</tr>
<tr>
<td>2.1 Openings</td>
<td>3</td>
</tr>
<tr>
<td>2.2 Plenary presentations</td>
<td>3</td>
</tr>
<tr>
<td>2.3 Break-out groups: discussing guiding principles</td>
<td>7</td>
</tr>
<tr>
<td>2.4 Country presentations</td>
<td>11</td>
</tr>
<tr>
<td>2.5 Break-out groups: addressing concerns</td>
<td>14</td>
</tr>
<tr>
<td>3. CONCLUSIONS AND RECOMMENDATIONS</td>
<td>18</td>
</tr>
</tbody>
</table>

### ANNEXES:

- Annex 1 - Programme of Activities
- Annex 2 - List of Participants
- Annex 3 - Tuberculosis Control in Migrant Populations: Guiding Principles and Proposed Actions

Key words: Tuberculosis, Migration, Universal Access, High-Risk Populations, MDR-TB
SUMMARY

Many countries and areas in the Western Pacific Region face considerable challenges in TB control among migrants. In response to the request from Member States, the World Health Organization (WHO) Regional Office for the Western Pacific drafted a Regional Framework on TB and Migration in the Western Pacific that translates the global guidance into overarching principles for TB control among migrants and adds special considerations and key actions for different subgroups of migrants.

The Consultation on TB and Migration in the Western Pacific Region was held in Manila, Philippines, from 26 to 27 March 2013. The objectives of the consultation were:

(1) to recognize migration as an important challenge in further advancing TB control in the Western Pacific Region;

(2) to consult health and immigration authorities from Member States on the content and applicability of the draft framework in the context of the Western Pacific Region;

(3) to share experiences and good practices in TB control among migrants; and

(4) to collect country input to finalize the framework.

Member States highly appreciated the development of the draft framework and accepted it as a document that provides a direction for “migrant TB interventions”. The key conclusions and recommendations of the meeting were as follows:

(1) The document should have a less “binding” title. A title to be considered is “TB control in migrant populations: guiding principles and proposed actions”.

(2) The introduction of the document should explicitly state (a) the purpose of the document, which is providing a “direction”, and (b) the hierarchical relationship between the guiding principles and national policies is one in which the principles do not override country laws and regulations.

(3) The guiding principles describing “free treatment” and “legal status” were found to be the most sensitive issues and should be rephrased based on the suggestions from Member States.

(4) The WHO Regional Office for the Western Pacific will revise the document based on the country input, and the revised document will be circulated to Member States and partners for a second round of review before the document is finalized.
1. INTRODUCTION

As globalization has progressed, migration has dramatically increased over the past few decades. Migrants are often socially marginalized and carry significant risk factors for ill health including tuberculosis (TB). Migrants are among the most difficult to treat due to their diverse and highly mobile nature. As such, migrants are at an increased risk of developing drug-resistant TB. Irregular treatment is another factor that contributes to the development of drug-resistant TB. In addition, due to the increased vulnerability to certain infectious diseases and numerous access barriers to social services, migration has significant public health implications including TB control.

Many countries and areas in the Western Pacific Region rank high in terms of foreign-born TB cases. Dynamic population movements are also occurring within countries, mainly from rural to urban settings. There are also a number of border areas where population movements are intense and casual, which poses challenges for health-care delivery and referral.

Recognizing these challenges, Member States expressed the need for guidance on TB control among migrant populations. During a consultation on TB control held in Manila, Philippines, in November 2011, countries requested that WHO develop a regional framework on tuberculosis and migration in the Western Pacific. The Stop TB (STB) and Leprosy Elimination Unit of the WHO Regional Office for the Western Pacific developed a draft framework in 2012 and presented it during the Eighth Technical Advisory Group (TAG) Meeting for TB Control in the Western Pacific Region in October 2012. Meeting participants expressed great appreciation for the draft framework and STB TAG recommended organizing a meeting in early 2013 to finalize the framework in consultation with low-, intermediate- and high-TB burden countries.

In parallel with these bottom-up demands from the Member States, the Sixty-first World Health Assembly (WHA) in 2008 passed a resolution on the health of migrants (WHA61.17), calling on Member States to promote migrant-sensitive health policies. In response, WHO and the International Organization for Migration (IOM) organized a Global Consultation on Migrant Health in 2010, which produced global guidance on this important matter.

The draft Regional Framework on TB and Migration in the Western Pacific translates the global guidance into overarching principles for TB control among migrants and adds special considerations and key actions for different subgroups of migrants.

The framework presents a multisectoral approach, which requires involvement of different ministries, including immigration authorities, across national and regional borders. The STB TAG explicitly recommended the inclusion of the WHO Regional Office for South-East Asia, and authorities from Myanmar, Thailand and Indonesia in future consultations.

Following the recommendations of the TAG meeting, a consultation was organized in Manila, Philippines, to finalize the Regional Framework on Tuberculosis and Migration in the Western Pacific.
1.1 Objectives

The objectives of the meeting are:

(1) to recognize migration as an important challenge in further advancing TB control in the Western Pacific Region;

(2) to consult health and immigration authorities from Member States on the content and applicability of the draft framework in the context of the Western Pacific Region;

(3) to share experiences and good practices in TB control among migrants; and

(4) to collect country input to finalize the framework.

1.2 Temporary advisers, resource persons, observers and secretariat

The temporary advisers were Dr Takanori Hirayama, Research Institute of Tuberculosis (Japan), Dr Victoria Lynn Krause, Centre for Disease Control Northern Territory Government (Australia), and Dr Jaime Lagahid, Department of Health (Philippines).

The resource persons were Dr Jaime F. Calderon, Jr., IOM Regional for Asia and the Pacific (Thailand), Dr Paul Douglas, Department of Immigration and Citizenship (Australia), Dr Einar Heldal, Independent TB consultant (Norway), and Mr Rayden Llano, Consultant (United Kingdom of Great Britain and Northern Ireland).


The secretariat was composed of representatives from WHO headquarters, WHO Regional Office of the Western Pacific, and WHO country offices (China, Cambodia, Thailand, and Myanmar).

1.3 Participants

The target audience for this consultation was national TB programme managers and high-level representatives from immigration authorities from Member States, i.e. Australia, Brunei Darussalam, Cambodia, China, Hong Kong (China), Japan, Lao People’s Democratic Republic, Macau (China), Malaysia, Mongolia, New Zealand, Papua New Guinea, Philippines, Republic of Korea, Singapore, and Viet Nam. The full list of participants is in Annex 2.

1.4 Methodology of the consultation

During the two-day meeting, half of the meeting schedule was allocated to plenary presentations on (i) global policies and developments in “migrant health”, (ii) regional situation and country experiences, and (iii) the draft regional framework on TB and migration. The other half of the schedule was used for “break-out groups” where participants were given the opportunity to (i) review the framework focusing on guiding principles and key actions, (ii) discuss potential for harmonization of country realities/contexts with framework guidance, and (iii) explore proposed actions, next steps and priorities. The meeting focused on
obtaining vital input from the Member States. When time permitted, the observers provided additional comments.

2. PROCEEDINGS

2.1. Opening

Dr Shin Young-soo, WHO Regional Director for the Western Pacific, opened the consultation and welcomed the participants and partners. He noted the participation of representatives from immigration authorities and emphasized the role of border control in disease control activities.

Over the past two decades, encouraging progress has been made in reducing TB burden in the Western Pacific Region. Despite this progress, the TB burden remains unacceptably high in the Region with many cases undetected.

Dr Shin highlighted that migrants live and travel in marginalized areas with little or no access to health services. Such vulnerability and the highly mobile nature of migrants with TB often result in incomplete treatment, increasing the risk of developing multi-drug resistant TB (MDR-TB). Hence, treating the migrant community is key to stopping the spread of MDR-TB.

Dr Shin noted that finalization of the draft Regional Framework on TB and Migration in the Western Pacific would mean a wider scope of activities and require the involvement of the WHO Regional Office for South-East Asia. He concluded his speech by saying that a cross-sectoral approach is needed in the fight against TB, involving many different ministries and authorities.

2.2 Plenary presentations

2.2.1 Regional TB situation with a focus on migrant health

Dr Tauhid Islam, Medical Officer, WHO Regional Office for the Western Pacific, presented the regional TB situation focusing on migrant health. He introduced the overall topic of the consultation meeting, stressing that "TB and Migration" is a relatively new arena of focus in TB control.

Despite significant progress made in the past, the global TB burden remains enormous. It was estimated that there were 8.7 million TB cases and 1.4 million TB deaths in 2011. The Western Pacific Region bears 19% of total TB burden with an estimated incidence of 1.7 million cases, accompanied by the alarmingly increasing burden of MDR-TB. Emergence of extensively drug-resistant TB (XDR-TB) further poses major challenges in the Region.

Migration has contributed to economic and social development. For some societies, migration is essential to compensate for demographic trends and skill shortages, and to assist home communities with remittances. Migration itself is not a risk factor for health, yet migrants represent a diverse population that carry different types of issues with different levels of risks. As such, the health system often faces the challenges of integrating the health needs of migrants.
Historically, human migration has had a major impact on the spread of TB. The incidence of TB among foreign-born population is higher than the incidence in native populations in most low- and intermediate-burden countries. Multiple risk factors associated with migration influence the disease transmission and development of drug resistance in migrants, which includes, for instance, lack of access to health care, poor living conditions, risk of poor adherence to treatment and lack of continuity of care.

Although there are limitations in data availability at regional and global levels, Malaysia, Republic of Korea and Australia reported more than 1000 foreign-born TB cases in 2011. The proportion of foreign-born to total TB notifications is considerably high in Australia, Brunei Darussalam, New Zealand and Singapore, indicating that migration poses significant challenges in intermediate- and low-burden countries. Initiatives to address country-specific issues on TB among migrants are in place in the Region. Participants were encouraged to share such country experiences, views and practices during the consultation.

2.2.2 Update on development in migrant health

Dr Jaime F. Calderon, Regional Migration Health Adviser of the IOM, presented an overview of the migration health situation and updates on the development in migrant health in Asia and the Pacific. He first emphasized that there would be several upcoming international conferences on migrant health in 2013, and recommended that the countries bring this issue forward to their own governments.

“Migrant health” addresses the physical, mental and social needs of migrants, and the public health needs of host countries. The goals for migrant health are (1) to ensure the right of migrants to health, (2) to avoid disparities in health status and access, (3) to reduce excess mortality and morbidity among migrants, and (4) to minimize negative impact of the migration process. These goals provided the operational framework for the 2008 WHA Resolution 61.17 on the health of migrants.

Dr Calderon highlighted the issues of three major infectious diseases in relation to population mobility: First, 68% of people living with HIV in Asia and the Pacific acquire the virus during migration. Artemisinin drug-resistant malaria has been increasingly reported in several border areas in the Greater Mekong Subregion (GMS). Data from the project supported by TB REACH, a funding mechanism of Stop TB Partnership and the IOM Health Assessment Programme have shown a significant number of TB cases among migrants.

Alongside the key international instruments and existing regional policy and legal frameworks on migrant health, a series of regional policy dialogue has taken place to promote the health and social protection of migrants.

Dr Calderon also emphasized that there is a need to look at “Triple A-Q” factors (Availability, Accessibility, Acceptability and Quality) to create more migrant-sensitive health systems. These include, for example, the provision of language services, culturally tailored health promotion and disease control, and migrant-friendly support staff.

Finally, Dr Calderon highlighted that efforts have been made to promote bilateral and regional partnerships on migrant health but tend to focus on HIV/AIDS. Hence it is hoped that the framework on TB and migration provides useful guidance on how to address the TB-specific issues in the Region.

2.2.3 WHO’s perspective on ethics and human rights in migrant TB

Dr Ernesto Jaramillo, Medical Officer, WHO headquarters, presented WHO’s perspective on ethics and human rights in migrant TB. He first noted that "ethics" is not
explicitly mentioned in the documents on migration. Likewise, neither is "migration" explicitly mentioned in the documents on TB ethics, indicating that "ethics and human rights in migrant TB" is a new topic to be explored.

With the exaggerated media reports on MDR- and XDR-TB crossing borders, people may perceive that migrants are sources of trouble. In contrast, some studies show that TB transmission from migrants to local people is very limited, which may help people realize that the picture is not as threatening as is often presented by the media.

Looking at history and the present time, migration has been a major force behind development, contributing to creating the majority of wealth in many countries. In light of "reciprocity", one of the fundamental ethical principles is that host countries ought to protect human rights of migrants including access to health services. However, a number of challenges are present in several stages of TB control for migrants. The WHO guidance on ethics of TB prevention, care and control outlines several key points that need to be considered to ensure an ethics- and human rights-sensitive TB programme, such as, obligation to provide access to TB services and not to abandon care of patients. Considering these key points in the context of migrants and TB, the main ethical issues are confidentiality, consent, diagnosis in the absence of treatment, respect of privacy, stigmatisation, implications of research, third party notification, and repatriation. “Migration and Health” faces numerous ethical issues that no one has yet addressed. However, the discussion is able to inform policy decisions and practices of national TB programmes.

The importance of “subsidiarity”, another fundamental ethical value, was also highlighted—what is considered ethical in one country may be unethical in another. Such issues require considerable debate and discussion to balance individual perspectives with public health implications. While developing systematic guidelines for every situation is not feasible, it will be possible to provide guiding principles and norms for particular situations. In this regard, the Western Pacific Region is a pioneer in starting the regional discussion on TB and migration.

2.2.4 TB and migration from an immigration policy perspective

Dr Paul Douglas, Chief Medical Officer of the Department of Immigration and Citizenship, Australia, presented TB and migration from an immigration policy perspective using Australia as an example. There are several drivers to screening TB among migrants, which include (1) legislated requirements for an Australian visa, (2) decreasing morbidity and mortality from an individual client perspective, (3) public health implications to protect the citizens, (4) emergence of drug-resistant TB from a clinical perspective.

Dr Douglas emphasized that, from a policy perspective, migration is more about sovereignty of a country and border protection where politics often come in. In Australia, TB is very much interlinked with the media and is often used a political topic. The “dangerous disease” portrayed by the media present an opportunity for political messages, and citizens are being told by the government that “this is something that must be addressed”.

Regarding the legislative framework, visa types and rules are stipulated in the Migration Act and Regulations. Visa eligibility depends on meeting a health requirement. The rationale behind the health requirement includes (1) to protect the Australian community from public health risk mainly, TB, (2) to contain public expenditure on health care and community services, and (3) to safeguard Australians' access to health services in short supply.

Around 2200 panel doctors and radiologists in 164 countries conduct medical and X-ray examinations, using a risk framework for local clearance offshore, and a risk matrix for temporary entry requirements onshore. Applicants with inactive TB are to be enrolled in the
surveillance programme when they arrive onshore. Having a process to provide free care and follow-up for clients with increased risk of reactivation is becoming a very critical policy perspective.

Australia is a member of the intergovernmental immigration and refugee health working group, collaborating with Canada, New Zealand, the United Kingdom of Great Britain and Northern Ireland, and the United States. The cooperation has been progressively strengthened and extended by the involvement of international organizations and institutions. Monitoring mechanisms of the immigration TB screening programme are in place, and it was found that one in five TB patients are detected through post-surveillance screening, demonstrating the effectiveness of the activity.

Finally, Dr Douglas presented the impact of the pre-migration screening of the domestic TB control programme with a cost-saving analysis in the United States, which also has significant implications for policy-makers.

2.2.5 Inventory of migrant screening policies in the Western Pacific Region

Mr Fukushi Morishita, WHO consultant, presented the findings of the regional policy review on immigration TB screening in the Western Pacific Region.

Previous studies show that the immigration TB screening policies and procedures are greatly diversified across nations. To provide an overview of different policy set-ups and to identify challenges to provide TB diagnosis, treatment and care services for migrants, the regional policy review was conducted as part of the preparation for the consultation meeting on TB control in intermediate- and low-TB burden countries and areas in the Western Pacific Region that was held in November 2011.

The results confirmed that there is great diversity in the immigration TB screening policy among the selected eight countries and areas in the Region. Variations were found in the objectives of the programme, responsible authorities, screening points, types of migrants screened, screening methods, actions for active and latent TB infection (LTBI), and so on. Given such diversity, a direct comparison of the programmes would be a challenging task. Even so, it was revealed that some manage a complex screening system (i.e. Australia and New Zealand) while others do not have screening systems (i.e. Japan and Hong Kong (China)), implying clear strategic differences between countries.

There are several challenges and concerns common to the countries, which include (1) continuity of care, (2) MDR-TB management, (3) the increasing number of foreign-born TB cases, and (4) dealing with undocumented migrants. The way forward to address each challenge was discussed during the previous consultation meeting. It was determined that there were needs to (1) to strengthen the international referral system, (2) to increase response capacity to MDR-TB among migrants, (3) to enhance surveillance and monitoring systems, and (4) to clarify ethical and legal issues in cross-border TB management. Based on these discussions, the countries requested the WHO Regional Office for the Western Pacific to develop guiding principles for countries to move forward.

2.2.6 The Regional Framework on TB and Migration in the Western Pacific Region

Dr Catharina van Weezenbeek, Team Leader of the Stop TB and Leprosy Elimination Unit, WHO Regional Office for Western Pacific, presented the draft Regional Framework on TB and Migration in the Western Pacific, focusing on definitions of migrant categories, the development process, and contents of the framework.
Different categories of migrants face different challenges. The proposed migrant categories for the framework were internal migrants, labour migrants, irregular migrants, casual cross-border migrants, and refugees. Other possible migrant categories, such as students, are not included in the draft but can be added if different approaches are found to be required. There is also a need to recognize that migrants can move between different categories depending on individual-specific contexts.

The draft framework was formulated through an extensive literature and policy review and brainstorming by the Stop TB and Leprosy Elimination Unit, WHO Regional Office for the Western Pacific. The framework was developed based on two key background documents: (1) Resolution WHA61.17 on the Health of Migrants, which requested Member States to take action on migrant-sensitive health policies and practices, and (2) the operational framework on migrant health, which was a result of the Global Consultation on Migrant Health in 2010. The draft framework on TB and Migration attempts to translate its general principles and key components into the context of TB control in the Region, moving from a consensus-based global policy to concrete actions for TB control in the Western Pacific.

The four components include: (1) monitoring migrant health, (2) policy and legal frameworks, (3) migrant-sensitive health systems, and (4) partnerships, networks and multicountry frameworks. Each of the guiding principles, the proposed key actions and rationale were presented with some examples of good country practices.

2.3 Break-out groups: discussing guiding principles

The participants were split into three groups and given two and a half hours to discuss the guiding principles of the draft framework and their feasibility, potential bottlenecks and relevant issues. Dr Victoria Lynn Krause, Director, Centre for Disease Control, Northern Territory Government of Australia, chaired the plenary debriefing session.

As an introduction to the plenary session, Dr van Weezenbeek clarified the rationale of the framework and objectives of the consultation. The draft framework is not something that overrides the country legislation or regulations. It aims to put together the best evidence about what works and what does not work in order to provide a direction to move forward. The consultation aims to obtain country input and exchange opinions and experiences to improve the document.
2.3.1 **Group 1 (Australia, Brunei Darussalam, Japan, New Zealand, Singapore)**

Group 1 consisted of mainly migrant-receiving countries, and was chaired by Dr Einar Heldal, WHO consultant. The rapporteur, Dr Jaramillo, reported the following for further consideration.

<table>
<thead>
<tr>
<th>Discussion point</th>
<th>Comments/suggestions</th>
</tr>
</thead>
</table>
| Overall contents/structure/tone of the framework | • The notion of equity needs to be considered throughout the document.  
• Definition of TB needs to be clear, and further discussion is needed on whether the document exclusively focuses on active TB or includes LTBI.  
• The document should consider including “students” and “longer-term visitors”. |
| Monitoring migrant health | Guiding principles | • No major concerns were raised.  
Key actions | • Key action 1 – Examples of migration variables “country of birth” and “nationality” should be used in place of “(country of) origin”  
• Key action 2: Notification data in pre-migration screening should also be reported to destination country.  
• Key action 3: Examples of possible “innovative approaches” can be included (i.e. engaging private sector and NGOs). |
| Policy and legal frameworks | Guiding principles | • Principle 1: It is important to refer to the relevant documents that have binding power. This will increase the value of the framework.  
• Principle 3: “Free access” should be replaced by “universal and equitable access”. Accordingly the term “free of charge” needs to be rephrased.  
• Principle 4: Further discussion is needed on whether LTBI is included.  
• Principle 5: Concerns were expressed by the countries on the issue of “deportation policies” which requires the engagement of other sectors. |
| Key actions | • Key action 1: “Free TB care” needs to be rephrased. |
| Migrant-sensitive health systems | Guiding principles | • Principle 1: “Free TB services” needs to be rephrased.  
• Principle 3: “International law” should be cited. |
| Key actions | • Key action 2: “Free TB care” needs to be rephrased. |
| Partnerships, networks, and multicountry frameworks | Guiding principles | • Principle 3: “Informed consent” and “feedback to referring country” should be discussed more in detail and included in the document.  
Key actions | • Key action 1: The dialogues can be not only “encouraged” but also “strengthened”. |

Dr Douglas added that a little more work is needed on the issue of legal status. Therefore, an extra session can be added to discuss this, involving both health and immigration people.
2.3.2 Group 2 (China, Hong Kong (China), Malaysia, Mongolia, Republic of Korea)

Group 2 consisted of a mixture of countries that are mainly migrant-receiving and -sending countries. The group was chaired by Mr Rayden Llano, WHO consultant. The rapporteur, Dr Fabio Scano, Medical Officer, WHO Country Office in China, reported the following for further consideration.

<table>
<thead>
<tr>
<th>Discussion point</th>
<th>Comments/suggestions</th>
</tr>
</thead>
</table>
| Overall contents/structure/tone of the framework | • The language used in the document is prescriptive: the word “should” can be removed.  
• Key actions do not necessarily mention each of the guiding principles.  
• The language used in the document might clash with current legislation in certain countries.  
• The document does not fully take into consideration cost implications of the implementation. |
| Monitoring migrant health |  |
| Guiding principles | • Principle 1: There is no need to explain that data should be used confidentially because that should be the standard.  
• Principle 2: Countries should be advised on how to do this. Not all countries will carry out a prevalence survey in the upcoming years.  
• Principle 3: Ability to access care is difficult to assess. There may be a challenge on how to link TB diagnosis with universal access to treatment within the context of a national legal framework.  |
| Key actions | • No major concerns were raised. |
| Policy and legal frameworks |  |
| Guiding principles | • Principle 1: This can be rephrased to reflect countries policies on TB control (i.e. bilateral agreements). “Access to TB care” is difficult to assess.  
• Principle 3: This should be rephrased based on the existing WHO documents. “Free” should be replaced with “equitable”. National legal frameworks might treat undocumented migrants differently from documented migrants.  
• Principle 4: Consideration should be given to the issue of infection control for patients traveling after diagnosis.  
• Principle 5: National labour laws and/or immigration policy might impede implementation of this principle.  |
| Key actions | • No major concerns were raised. The language can be modified. |
| Migrant-sensitive health systems |  |
| Guiding principles | • Principle 2: implementation of this principle is very resource dependent. Examples of the service provision can be rephrased by focusing on “meet the needs of migrants”  
• Principle 3: the principle can focus on individual benefit of early TB diagnosis.  |
| Key actions | • The word “standard” is a bit prescriptive and can be rephrased. |
| Partnerships, networks, and multicountry frameworks |  |
| Guiding principles | • No comments  |
| Key actions | • No comments |
2.3.3 Group 3 (Cambodia, Lao People’s Democratic Republic, Myanmar, Papua New Guinea, Philippines, Viet Nam)

Group 3 consisted of the mainly migrant-sending countries, and was chaired by Dr Islam. The rapporteur, Dr Rajendra Yadav, Medical Officer of the WHO Country Office in Cambodia, reported the following for further consideration.

<table>
<thead>
<tr>
<th>Discussion point</th>
<th>Comments/suggestions</th>
</tr>
</thead>
</table>
| Overall contents/structure/tone of the framework      | • The terminology should be consistent throughout the document (i.e. TB, TB disease, active TB)  
• Some suggested including “students” as an additional category. |
| Monitoring migrant health Guiding principles          | • Principle 1: “Outcome data” should be included in addition to case notification.  
• Principle 1-2: The proposed variables and methodologies should be reflected in the WHO global guideline for prevalence survey so that it would be helpful for countries to change their protocols.  
• Principle 3: Programme data (i.e. number of health facilities, and number of labs) also should be analysed together with epidemiological data. |
| Key actions                                           | • Key action 1: “Outcome data” should be added, but there may be an issue of country specific feasibility (a case-based electronic system is recommended).  
• Key action 2: “Non-traditional health care delivery” should be defined or clarified.  
• Key action 3: “Innovative approaches” and “traditional instruments” need to be more specific. |
| Policy and legal frameworks Guiding principles        | • No major concerns were raised.                                                      |
| Key actions                                           | • Key action 3: “Linkage” should be more specific.                                    |
| Migrant-sensitive health systems Guiding principles    | • Principle 1: The word “eliminated” should be replaced with “addressed”.  
• Principle 3: This should include not only “screening” but also “treatment”. |
| Key actions                                           | • Key action 1: There is also a need to establish focal points in other departments/ministries (i.e. immigration department).  
• Key action 2: The word “legislated” should be deleted.  
• Key action 3: “NTP” should be used instead of “health clinics”. |
| Partnerships, networks, and multicountry frameworks Guiding principles | • Principle 3: “Regional or subregional” should be replaced with “between countries”. |
| Key actions                                           | • No comments.                                                                        |

2.3.4 Plenary discussion

Dr van Weezenbeek followed up on the issue of “prescriptive tone”, saying that this can be addressed by using less prescriptive wording, such as “consider” and “setting priority”. Yet the frequent use of such words may undermine the value of the document. She also suggested that the afternoon session of day 2 could be used in a different way from the initial plan. It was then proposed that the session would focus on most important issues identified on day 1 instead of discussing application to migrant categories.

Dr Ooi Peng Lim, Deputy Director, the Ministry of Health, Singapore, raised concerns on finalizing the draft framework in the absence of representation from other sectors (i.e. immigration, foreign affairs, and labour). In the national understanding of Singapore, a
framework is rather binding, and there is a much uncertainty about the attitude of other sectors toward the draft framework.

Dr van Weezenbeek responded that involving all sectors is not feasible. The intended outcome of the meeting was not to sign off on the document but to agree on the guiding principles that provide a direction and that are acceptable to the countries. An introduction section of the framework should explicitly mention how to use the framework. She further proposed that the draft framework will be revised based on the input obtained during the consultation and will be shared with the countries for further review and feedback from other sectors.

Dr Lim welcomed the proposed way forward that the draft would be again circulated to the respective countries in case other sectors have strong objections.

2.3.5 **Way forward**

Dr van Weezenbeek proposed the agenda for the break-out groups and the way forward after the consultation. It was proposed that the break-out groups discuss the following three points: (1) what needs to be clarified and included in the introduction section of the framework including a proposed title, (2) possible solutions to the key issues including “free treatment” and “repatriation”, and (3) suggestions on structure and technical issues. It was suggested that the draft framework would be revised based on the input, and the revised document would be shared with countries and partners in May 2013.

All participants agreed on the proposed way forward and proceeded with the country presentations.

2.4 **Country presentations**

2.4.1 **TB among migrants in Japan**

Dr Dai Yoshizawa, Deputy Director of TB and Infectious Disease Division, Ministry of Health, Labour and Welfare, Japan, presented the overview of the situation on TB and migration in Japan, current practices to provide TB services for migrant populations, and challenges and steps forward.

In Japan, while the proportion of foreign patients among total TB patients is still very small, there has been a slight increase recently. The proportion of those aged 20–29 years increased greatly from 9.1% in 1998 to 29.6% in 2011, representing a major issue in TB control for foreigners in Japan. People from three countries: China (30%), Philippines (24%) and the Republic of Korea (9%) occupy the majority of TB cases among foreigners.

Japan does not have TB interventions that target migrant population primarily because most of the relevant laws are applicable regardless of nationalities. However, in practice, post-entry screening services based on existing relevant legislations have been conducted at schools, at workplaces and by local government for its residents.

The costs of all TB services are covered under the Infectious Disease Law regardless of nationalities or health insurance status, yet a small portion of co-payment might cause financial hardship. Language services are provided through telephone translation and local government schemes, but language barriers and lack of information on the disease and services may still pose significant challenges for foreign TB patients. International referral can be coordinated for selected countries on a case-by-case basis.
The key challenges include (1) streamlining existing legislation to provide effective TB services for migrant populations; (2) improving communication with foreign patients; and (3) the need for better/coordinated mechanisms for international referral.

2.4.2 Casual-cross border migrants in the Torres Strait

Dr Rendi Moke, TB physician, Western Province, Papua New Guinea, presented the situation on casual-cross border migrants in the Torres Strait focusing on efforts to address issues and its achievements.

Papua New Guinea shares international borders with Solomon Islands on the east, Indonesia on the west, and Australia on the south. The Western Province shares the sea-border with Torres Strait in Australia. Inhabitants on either side of the border are permitted to cross the border anytime under treaty agreement. Many people on the Papua New Guinea side cross the border to seek medical care in the Torres Strait Clinic, and 78% of them are TB-related conditions. A total of 92 TB patients were diagnosed in Australia and handed over to Papua New Guinea by the end of 2012 of which 33 were MDR-TB cases and one was a XDR-TB case (a result of poor treatment supervision).

AusAID and other partners have provided considerable support to the province and country to build their capacity in TB services and primary health care including human resources, infrastructure and diagnostics. Gene Xpert was procured and has contributed to the increased case finding of MDR-TB cases. Overall, capacity-building has resulted in fewer patients seeking health services across the border, improved cross-border communication, and improved patient retrieval.

2.4.3 Irregular migrants between Cambodia and Thailand

Dr Koeut Pichenda, Deputy Director of the National Centre for Tuberculosis and Leprosy Control, Cambodia, presented the overview of the situation on irregular migrants between Cambodia and Thailand with focus on the progress of an active case-finding project.

The Cambodian- Thailand border in Banteay Meanchey Province is a major return channel for Cambodian irregular migrants who travel to Thailand for work as undocumented migrants and who, subsequently, are detained and deported by Thai immigration authorities. The reasons for this irregular migration are often related to underlying socioeconomic issues in Cambodia, as well as demand for migrant labour and improved income in Thailand. Of the Cambodian migrants in Thailand, 38% have been in the Thai Immigration Detection Centres for over a month in crowded conditions and 150 to 200 are deported each day.

With funding from TB-REACH, the TB screening project for this population has been implemented at a deportation point, Poipet, in collaboration with the Immigration Department, IOM and a public hospital. Screening tools involve symptom screening, chest X-ray, sputum smear and Gene Xpert MTB/RIF. Different screening algorithms were used for different migrant groups based on treatment history and TB symptoms. Between February and December 2012, there were 10 879 verbally screened, of which 5955 were referred to hospitals for symptom and X-ray screening, resulting in 126 bacteriologically positive TB cases with two confirmed MDR-TB cases.

Dr Pichenda concluded that actively screening migrants upon their return via the deportation channel would facilitate the earliest possible TB detection and treatment that would potentially avert secondary infections and delays in diagnosis and treatment.

2.4.4 TB among migrants in Malaysia
Dr Suzana Mohd Hashim, Senior Principal Assistant Director, TB and Leprosy Sector, Disease Control Division of the Ministry of Health, Malaysia, presented an overview of the situation on TB among migrants in Malaysia. She first noted that Malaysia has faced a number of challenges in terms of health of migrants due to a significant number of migrants coming from neighbouring countries for many purposes.

The routine surveillance system of the TB programme is designed to capture the country of origin for non-Malaysians in addition to basic demographic and clinical information. All foreigners intending to enter the country for work are subject to entry TB screening where they are categorized as “fit” or “unfit” for a work permit. An authorized private agency is responsible for screening using chest X-ray as a main screening tool.

By law, a non-Malaysian who has at least one of 26 infectious diseases, including TB, is not permitted to work in the country. A total of 740,000 work permit applicants were screened by X-ray in 2011, of which 1.3% were categorized as “unfit” and not given work permits. The proportion of foreign-born TB cases among total notification was 14% in 2011 with an increasing trend in recent years. Given a large number of migrants (two million documented and estimated two million undocumented), the importation of TB is a major public health threat in Malaysia. The majority of foreign-born TB cases in 2011 were those from Indonesia (35.9%) and Philippines (33.3%). The key challenges include an increasing trend of foreign-born TB, cost of management, and poor treatment outcome in this cohort.

Finally, Dr Hashim mentioned that the draft framework is timely and needed. However, there are several concerns:

- The scope of the framework is beyond the Ministry of Health and requires input from other ministries (i.e., foreign affairs, human resource, internal affairs, labour).
- Some guiding principles in the framework contradict existing acts, rules and regulations.
- Terms used in the framework can be interpreted in different ways by different agencies.
- The framework is favourable for migrant-sending countries. More resources are needed for migrant-receiving countries.

2.4.5 TB among migrants in Australia

Dr Krause presented the situation on TB among migrants in Australia. Immigration currently contributes to 60% of Australia’s population growth. TB is one of 60 national notifiable diseases. The TB notification rate decreased dramatically in the 1960s and 1970s, and has remained stagnant since 1985. In contrast to other groups, notification rates of TB among overseas-born people are rising and make up 87%–90% of all notified cases yearly.

Overseas-born patients tend to be younger in age than Australian-born patients. Among overseas-born cases, 45% are diagnosed within three years after arrival. Overseas students represent a growing number of TB cases. Among health-care workers with TB, the percentage of those born overseas has risen to 94% in recent years. In 2010, 37 MDR-TB cases were diagnosed, of which 34 were born overseas.

Strategies to reduce the overseas-born TB burden include (1) optimizing the pre-migration screening approach by improving diagnostic and screening methods, (2) providing systematic post-migration follow-up, (3) working with educational institutions and immigration authorities to better address overseas-born student TB, and (4) providing standardized national protocols to screen and protect all health-care workers and patients.
2.4.6  TB among internal migrants in China

Dr Xiaoqiu Liu, Vice Director, Department of Programme and Policy, the National Centre for TB Control and Prevention, China, presented the TB situation among internal migrants in China.

In China, the migrant population has increased sharply from 147 million in 2005 to 213 million in 2011. Among migrants, less that 30% are enrolled in the social insurance scheme. TB notification rates among internal migrants are slightly higher than those for the local population. TB control for migrants was piloted in select cities during 2005–2010 through the provision of DOTS, applying the same policies as for the local population. The Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) project has also been implemented since 2006. Lessons learnt from the projects helped formulate a series of national polices on key issues such as the provision of routine TB screening at the workplace, provision of transportation and food subsidy and recruitment of staff designated only for a particular migrant group. In some cities, local policies are in place to provide special services and arrangements for migrants.

The national TB surveillance data show that 8.1% out of all TB cases are migrants, of which 93% received on-site management while 7% opted for transfer to their place of origin. Treatment success in migrant populations is as high as that in the local population, however the default rate is extremely high for the cohort of transferred patients among migrants (90.8%).

The key challenges include unaffordable medical costs for migrants, funding gaps within the programme, barriers to detect and manage migrant TB, diagnostic delay, discrimination, need for additional funding for on-site management, and poor implementation of the referral system. Amid these challenges, several opportunities have been identified to offer free TB diagnosis and treatment, subsidize treatment, provide living expenses during treatment and expand MDR-TB services for migrants.

2.5  Break-out groups: Addressing concerns

2.5.1  Group 1 (Australia, Brunei Darussalam, Japan, New Zealand, Singapore)

<table>
<thead>
<tr>
<th>Agenda 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction of the framework / title / multisector “buy in”</td>
</tr>
<tr>
<td>▪ The name of the document “framework” is a right word, but “pathway” may be a gentler word. The suggested tile is “Pathway toward migrant-sensitive services for TB control in the Western Pacific Region”.</td>
</tr>
<tr>
<td>▪ Association of Southeast Asian Nations (ASEAN), International Union against Tuberculosis and Lung Disease (UNION) and IOM would provide possible venues to promote the framework.</td>
</tr>
<tr>
<td>▪ The introduction should refer to the WHA resolution on the health of migrants.</td>
</tr>
<tr>
<td>▪ The framework should not be presented as a new set of rules. Instead, it is a supporting document for approaches to implementation of the WHA resolution</td>
</tr>
<tr>
<td>▪ Migrant groups and migrant flows should be defined in the introduction.</td>
</tr>
<tr>
<td>▪ A notion of “shared responsibility” between host country and country of origin should be included in the document.</td>
</tr>
<tr>
<td>▪ The rationale of migrant TB control should be strengthened in the introduction by describing different perspectives (public health, economic development, humanitarian/human rights).</td>
</tr>
<tr>
<td>▪ The introduction should clearly state that the framework document only “addresses TB” but implementation should be integral part of the broader migrant health policy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Agenda 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key concerns and solutions</td>
</tr>
<tr>
<td>▪ Instead of “free treatment”, the framework should promote “equitable access and removal of financial barriers” at country and individual level. Options include government funding, insurance, and special funding. Treatment for MDR-TB is costly and will be a challenging task</td>
</tr>
</tbody>
</table>
that requires innovative approaches.

- The term “repatriation” should be defined. Different scenarios can be considered for voluntary repatriation and forced repatriation. The framework should place more focus on a notion of “shared responsibility” and the importance of “continuity of care” and “non-infectiousness before leaving the country” to address the issue of repatriation. The guiding principle can be rephrased, and one of the options could be “reviewing legislation if TB is a sole reason for repatriation”.
- Students should be a separate group as there are clear entry points for screening and specific options to control TB in this group.
- Health staff and teachers may be included as a subgroup of labour migrants.

### Agenda 3
Structure and technical issues

- It is encouraged that (1) the currently available referral forms are shared among countries and partner agencies, (2) a focal point for international referral in each country is identified, and (3) the referral form contains core information on foreign-born TB and the rationale.

### Agenda 1
Introduction of the framework / title / multisector “buy in”

- All countries agreed on the title “Framework”. But “Pathway (tools) towards Migrant-Sensitive TB Services” and “Principles on TB and Migration” could be other options.
- The introduction should explicitly state that (1) the framework provides a “direction”, (2) countries are not expected to implement right away, (3) it is subject to existing laws and regulations, (4) it is not about protecting certain countries or blaming others, (5) it is about recognizing that migrant affects all countries and, as such, we have to work together within country-specific realities, (6) it is a multisector effort that requires buy-in from all stakeholders, (7) it does not prescribe a single solution, and (8) alternative options should be included in the event that an ideal solution is not feasible.
- The introduction should be extended and provide more background on who can use the document and what we want to achieve with the framework. The rationale for addressing TB in migrants can be merged with the introduction. A one-page summary of migrant categories is needed, and a glossary of migrant definitions should be included (this can be developed with IOM).

### Agenda 2
Key concerns and solutions

- Tone and contents in the current version are perceived as being prescriptive therefore it should be toned down using softer language (i.e. consider, promote, etc.).
- The framework should present ideal strategies but should also provide alternative options.
- The framework should focus on patients, not on legal status.
- A policy of “free treatment” should be rephrased according to WHA resolutions that all countries endorsed and that suggests “universal access without financial hardship and promotes equitable access to health promotion, disease prevention and care for migrants subject to national laws and practice”.
- If current legislation dictates that TB status affects legal status, all feasible steps should be taken to ensure the continuity of care through proper cross-country referral. This should be in line with the International Health Regulations. Patient responsibility to fully comply with treatment should also be mentioned in the framework. The framework may provide examples of how countries in the Region deal with these sensitive issues.
### Agenda 3

**Structure and technical issues**

- It would be useful to keep the migrant chapters, but these may be shortened to avoid repetition. The chapters may immediately provide concrete options for that group. Boxes of successful initiatives and lessons learnt may be included, and success stories should come from this Region.
- If feasible, suggestions for operational steps may be included before the migrant chapters.
- Among those in group 2, there was no strong sentiment to include students as a separate category because students with TB have access to care and are part of group of documented migrants that do not lose their status.
- As part of the way forward, it was proposed to (1) develop an inventory of how cross-border referral mechanisms currently work in the Region in order to develop a “model” example of how it should work, and (2) to develop standardized international referral form.

### 2.5.3 Group 3 (Cambodia, Lao People’s Democratic Republic, Myanmar, Papua New Guinea, Philippines, Viet Nam)

#### Agenda 1

**Introduction of the framework / title / multisector “buy in”**

- The introduction should clarify the purpose of the document, how it can be used, what can/needs to be done, and that it provides a “direction” which does not override country laws and regulations.
- The introduction should explicitly mention that the document (1) provides a “direction” and “way forward”, (2) does not override country laws and regulations, and (3) requires multisector “buy-in”. The key words should be “multi-stakeholder”, “multisectoral”, “set of recommendations”, and “partnership”.
- The introduction should include the rationale describing the magnitude of the problem as well as the risk and benefits for the other sectors. General and specific objective for TB control among migrants should be included in the introduction.

#### Agenda 2

**Key concerns and solutions**

- Treatment should remain “free for the patients”. The framework could mention a need for advocacy, benefits for the public, cost-benefit issue, financial resource and sustainability issue.
- An attitude toward legal status and repatriation may be different depending on the status of migrant (legal or illegal), which needs consideration. The framework could emphasize that TB is curable and there is a risk of sending back patients.

#### Agenda 3

**Structure and technical issues**

- Students can be a separate group or can be combined with labour migrants as a group of “regular migrant”.
- The classification of migrant group could be reviewed by looking at how other agencies classify migrant population.
- Boxes or annexes can be added to illustrate examples of good practices and success stories.

### 2.5.4 Plenary discussion

The chairperson, Dr Douglas, summarized the group presentations. All were pleased with the major contents of the document but all agreed that some minor revisions were required. While two groups suggested the need to acknowledge students as a separate migrant group, one group did not. While one group proposed that “free treatment” should stay in the document, two groups suggested that it should be replaced with “universal and equitable access without financial hardship”.

- 16 -
Dr Krause supported an opinion that “multisector approach” could be included in the title. In response to this, Dr van Weezenbeek said that this document was developed for the national TB programme; if it were to be a broad document, it would take years to set up national discussions with other sectors. The aim of the document is to set a direction “from the TB people” by consulting immigration authorities to better understand what is feasible and what is not.

The participants then exchanged opinions on what should be the appropriate title of the document. One of the suggested titles, “pathway”, might be unprecedented for this kind of documents. For Singapore, the term “framework” is not suitable due to the perceived “binding” power. In the discussion, “general principles and (proposed) actions” and “a model” were proposed.

There was an opinion that the issue of migration involves many countries outside of the Region, therefore, the term “Region” should come at the end of the title just to show that this document is developed for the Western Pacific. Alternatively, it can be removed from the title by clarifying the working process of the document in the introduction.

Most countries agreed to include “students” as a separate migrant group in the document. The participant from the Republic of Korea, however, disagreed with this, explaining that foreign students have higher criteria for health examination and good access to health services with no fear of deportation. Hence, they are not considered as a vulnerable group in need of specific approaches. Throughout the discussion, it was suggested that the document editorial team follow up on the current situation by collecting information from student-receiving countries to decide whether students as separate migrant group should be added.

Dr van Weezenbeek summarized a set of key recommendations on the changes in the title, tone, introduction, contents, structure, and some sensitive issues (see next section). In response to the country requests, it was also suggested that the WHO Regional Office for the Western Pacific start working on two products: (1) the standardized international referral forms with a basic package of patient information, and (2) an inventory and/or standards of existing cross-border communication and referral systems in the Region. She added that finalization of the document is the very first step, and more initiatives would take place to make progress in this area.

All country representatives were given an opportunity to express their stance on these initiatives including this document. All countries proclaimed their full support for these initiatives and the document.

Dr Jaramillo delivered the final remarks and expressed his deepest appreciation to all participants for their attendance and hard work throughout the consultation. He also thanked the WHO Regional Office for the Western Pacific Regional Office for organizing this meeting, highlighting their leadership and pioneering spirit to promote TB control among migrants.

Dr van Weezenbeek expressed sincere appreciation to all participants and officially closed the consultation meeting.
3. CONCLUSIONS AND RECOMMENDATIONS

In conclusion, Member States highly appreciated the development of the draft framework and accepted it as a document that provides a direction for “migrant TB interventions”, while recognizing country-specific realities including compatibility with national legal frameworks and applicability to country-specific migrant subgroups and health service delivery models.

Based on this consensus, the following recommendations were made:

1. The document should have a less “binding” title: “TB control in migrant population: guiding principles and proposed actions”

2. The introduction of the document should explicitly state:
   a. the purpose of the document, which is to provide a “direction”; and
   b. the hierarchical relationship between the guiding principles and national policies, wherein the principles do not override country laws and regulations.

3. The document editorial team will follow up on the current situation of student-receiving countries to determine whether an additional migrant group is necessary.

4. Several sensitive issues in the document should be addressed as follows:
   a. The guiding principles and key actions that promote “free treatment for migrants” should refer to “equitable access without financial hardship” as agreed upon in the WHA resolutions 64.9 and 61.17.
   b. The guiding principles describing legal or contractual status of patients as well as national deportation policies should be rephrased in a way that the principles focus on ensuring access to treatment either in the destination country or the country of origin.
   c. Careful consideration should be given to the guiding principles/actions in circumstances where the Ministry of Health and immigration authorities are unable to make decisions without consulting other sectors.
   d. The guiding principles and proposed actions of the document should be rephrased using a less prescriptive tone.

5. The process to finalize the framework document will be as follows:
   a. The document will be revised within three weeks after the consultation meeting.
b. The revised document will be shared with Member States and partners for a second round of review. It is encouraged that the ministry of health and immigration authorities share this version with other sectors for their comments.

c. The Stop TB and Leprosy Elimination Unit, WHO Regional Office for the Western Pacific, will finalize the document, incorporating feedback from Member States.
PROGRAMME OF ACTIVITIES

Tuesday, 26 March 2013

08:30 – 09:00 Registration

09:00 – 09:30 (1) Opening ceremony

  o Welcome remarks
    by Dr Shin Young-soo, Regional Director
    WHO/WPRO

  o Objectives of the meeting

  o Self-introduction of participants and observers
    of the meeting

Presenter: Dr C. van Weezenbeek

Background

09:30 – 10:00 (2) Regional TB situation in Migrant Health

Presenter: Dr T. Islam

10:00 – 10:30 Group photo/Coffee/tea break (30 minutes)

10:30 – 10:50 (3) Update on developments in migrant health

Presenter: Dr J. Calderon

10:50 – 11:10 (4) WHO perspective on ethics and human rights in migrant TB

Presenter: Dr E. Jaramillo

11:10 – 11:40 (5) TB and migration from an immigration policy perspective

Presenter: Dr P. Douglas

11:40 – 12:00 (6) Inventory of migrant screening policies in WPR

Presenter: Mr F. Morishita

12:00 – 12:30 (7) The Regional Framework on Tuberculosis and Migration in the Western Pacific Region

Presenter: Dr C. van Weezenbeek

12:30 – 13:30 Lunch
Consultation on four principal components of the Framework and related guiding principles

13:30 – 16:00 (8) Break-out Groups to discuss the four components
(a) Monitoring migrant health
(b) Policy and legal frameworks
(c) Migrant sensitive health systems
(d) Partnerships, networks and multi-country frameworks

16:00 - 17:00 (9) Plenary debriefing

17:00 Reception

Wednesday, 27 March 2013

08:30 – 09:00 (10) Summary of Day 1 discussions and conclusions Dr T. Islam

Examples from the field

0900 – 09:20 (11) TB among migrants in Japan TBD
09:20 – 09:40 (12) Casual cross-border migrants in the Torres Strait Dr R. Moke
09:40 – 10:00 (13) Irregular migrants between Cambodia and Thailand Dr P. Koeut
10:00 – 10:30 Coffee/Tea break (30 minutes)
10:30 – 11:00 (14) TB among migrants in Malaysia Dr S. Mohd Hashim
11:00 – 11:30 (15) TB among migrants in Australia Dr V. Krause
11:30 – 12:15 (16) TB among internal migrants in China Dr L. Xiaoqiu
12:15 – 12:30 (17) Introduction to afternoon "Playground exercise" Dr C. van Weezenbeek
12:30 - 13:30 Lunch

Application of the Framework for specific populations

13:30 – 16:30 (18) Interactive consultation on application of the Framework using the ‘playground’ methodology

16:30 – 17:00 (19) Plenary debriefing and discussion on way forward

17:00 Closing
INFORMATION BULLETIN NO. 2

PROVISIONAL LIST OF PARTICIPANTS

1. COUNTRY PARTICIPANTS

AUSTRALIA

Dr Christina Bareja
Assistant Director
Vaccine Preventable Diseases Surveillance Section
Health Emergency Management Branch
Office of Health Protection
Department of Health and Ageing
G.P.O. Box 9848
Canberra, A.C.T. 2601
Australia
Tel.: (612) 6289 2729
Email: christina.bareja@health.gov.au

BRUNEI DARUSSALAM

Dr Hajah Shodeena Haji Mohamad
Senior Medical Officer of Health
Department of Health Services
Ministry of Health
Commonwealth Drive
Bendat Seri Begawan BB3910
Tel.: (673) 238 2041/422 1235
Fax.: (673) 238 1851
Mobile: (673) 883 3501
Email: shodeena.mohammad@moh.gov.bn
Ms Hajah Rafizah Haji Abdul Hamid
Head
National Tuberculosis Coordinating Centre, Kiarong
Ministry of Health
JLN Menteri Besar
Telefax:  (673) 245 5055
Mobile:  (673) 889 6978
Email:  Rafizah.hamid@moh.gov.bn
         Hamidrafizah@ymail.com

CAMBODIA

Dr Koeut Pichenda
Deputy Director
National Center for Tuberculosis and Leprosy Control
No. 1, Str. 278-95
Boeung Keng Kang 2
Khan Chamkar Morn
Phnom Penh
Tel.:  (855)  12 839 647
Fax:  (855)  23 224 671
Email:  pichenda73@yahoo.com

Mr Sok Saret
Deputy Director
Department of Immigration
Russian Boulevard, Opposit
International Airport
Phnom Penh
Tel.:  (855) 1287 0999
Email:  soksaret99@yahoo.com

CHINA, PEOPLE'S
REPUBLIC OF

Dr Liu Xiaoqiu
Vice Director
Department of Programme and Policy
National Center for TB Control and Prevention
No. 155 Chang Bai Road
Chang Ping District
Beijing
Tel.:  (8610) 5890 0515
Fax:  (8610) 5890 0535
Email:  Leon@chinatb.org

Dr Wang Jun
Service Bureau of Disease Control
Ministry of Health
No. 1 Xizhimenwai
South Road
Beijing 100044
Tel.:  (8610) 6879 2739
Fax:  (8610) 6879 2554
Email:  wangjun@moh.gov.cn
HONG KONG, SPECIAL ADMINISTRATIVE REGION

Dr Tam Cheuk-ming
Consultant Chest Physician
Department of Health
15/F, Wu Chung House
Queen's Road East
Hong Kong
Tel.: (852) 2572 6023
Fax: (852) 2834 6627
Email: cm_tam@dh.gov.hk

JAPAN

Dr Dai Yoshizawa
Deputy Director
TB and Infectious Disease Division
Health Service Bureau
Ministry of Health, Labour and Welfare
1-2-2 Kasumigaseki
Chiyoda-ku, Tokyo 100-8916
Tel.: (813) 3595 3426
Fax: (813) 3506 7325
Email: yoshizawa-dai@mhlw.go.jp

Dr Shizuka Nagai
Information Specialist
Quarantine Division
Narita Airport Quarantine Station
Passenger Terminal 2
Narita International Airport
1-1 aza-Furugome-Furugome
Narita-shi Chiba 282-0004
Tel.: (81 4) 7634 2309
Fax: (81 4) 7634 2319
Email: nagai-shizuka@keneki.go.jp

LAO PEOPLE'S DEMOCRATIC REPUBLIC

Dr Somphone Soulaphy
Head
Communicable Disease Control Division
Department of Communicable Disease Control
Ministry of Health
Simeuang Road, Vientiane
Tel.: (856) 2126 4324/20556 05918
Fax: (856) 2126 4326
Email: sphone59@yahoo.com

Dr Soth Bounmala
Chief
Budget and Planning Division
Coordinator, Global Fund for National Tuberculosis Center
National Tuberculosis Center
Ban dongpalane thong
Sisattanak District, Vientiane
Tel.: (856) 021 2179 55
Fax: (865) 452 855
Email: sothbounmala@gmail.com
MALAYSIA

Mdm Saleha Bee binti Adam
Director
Cooperate and Communication Division
Immigration Department of Malaysia Headquarters
Level 1 (PODIUM)
No. 15, Persiarian Perdana
Precint 2, 62550 Putrajaya
Tel.: (603) 8880 1493 / (601) 2278 3497
Fax: (603) 8880 1506
Email: saleha@imi.gov.my

Dr Suzana Mohd Hashim
Senior Principal Assistant Director
TB/Leprosy Sector
Disease Control Division
Ministry of Health Malaysia
Level 4, Block E10, Complex E
Federal Government Administrative Centre
62590 Putrajaya
Tel.: (603) 8883 4507/ (601) 7986 9993
Fax: (603) 8883 4304
Email: suzanamhashim@moh.gov.my

MONGOLIA

Mr Munkhbat Myatadvorj
3rd Deputy Director
Mongolian Immigration Agency
Khan-Uul district
10th khoroo
Ulaanbaatar 17120
Tel.: (976) 9902 0630
Fax.: (976) 1170 133472
Email: munkhbat.m@immigration.gov.mn

Dr Batjargal Nyamdulam
Epidemiologist
Tuberculosis Surveillance and Research Department
National Centre for Communicable Diseases
Nam-Yan-Ju Street
Bayanzurkh District
Ulaanbaatar 210648
Tel.: (976) 9609 7775
Fax: (976) 1145 1166
Email: dumana999@yahoo.com

NEW ZEALAND

Mr Cecil Grant Storey
Principal Technical Specialist
Ministry of Health
P.O. Box 5013, Wellington
Tel.: (644) 816 4375
Fax: (644) 496 2191
Email: grant_storey@moh.govt.nz
PAPUA NEW GUINEA

Dr Rendi Moke
TB Physician, Western Province
World Vision International (Daru Hospital)
P.O. Box 4254, Boroko
Port Moresby
Tel.: (675) 7190 8356
Email: rendimoke@yahoo.com

PHILIPPINES

Dr Maria Theresa O. Montenegro
Chief, Medical Section
Bureau of Immigration
Magallanes Drive
Intramuros, Manila
Telefax.: (632) 527 3303
Email: drtheremont@yahoo.com

Dr Andrea G. Sales
Medical Officer III
Bureau of Quarantine
Department of Health
Corner 25th and Delgado Street
South Pier, Manila
Tel.: (634) 6416 3526
Fax: (632) 3209 104
Email: annie6251950@yahoo.com

REPUBLIC OF KOREA

Mr Jaewon Kim
Immigration Officer
Division of Residence Control
Ministry of Justice
8th Floor, 11 Byeyangsangga 3-ro
Gwacheon-si, Gyanggi-do
Tel.: (812) 500 9068
Fax: (812) 500 9077
Email: kimjw70@korea.kr

Dr Lee Yeon-Kyeng
Research Scientist
Division of HIV and TB Control
Korea Centers for Disease Control and Prevention
187 Osongsanmyeong 2(i)-ro
Yeongje-ri, Osong-eup, Cheongwon-gun
Chungcheonbuk-do 363-951
Tel.: (824) 3719 7325
Fax: (824) 3719 7339
Email: daviefranch@gmail.com

SINGAPORE

Dr Ooi Peng Lim
Deputy Director (Policy and Control)
Ministry of Health
16 College Road, Singapore 169854
Tel.: (65) 6325 8341
Fax: (65) 6325 1168
Email: ooi_peng_lim@moh.gov.sg
2. TEMPORARY ADVISERS

Dr Takanori Hirayama
Chief
Planning and Medical Doctors Training Division
Department of Programme Support
Research Institute of Tuberculosis
Japan Anti-Tuberculosis Association
Tokyo, Japan
Tel.: (814) 2493 5711
Email: hirayama@jata.or.jp
t.hirayama1128@gmail.com

Dr Victoria Lynn Krause
Director
Centre for Disease Control
Northern Territory Government
G/F, Building 4, Royal Darwin Hospital
TIWI, NT 0810
P.O. Box 40596
Casuarina N.T. 0811
Australia
Tel.: (618) 8922 8510
Fax.: (618) 8922 8310
Mobile: (618) 4178 68848
E-mail: vicki.krause@nt.gov.au

Dr Jaime Lagahid
Director III (NCDPC-IDO)
Head Executive Assistant
Office of the Secretary
Department of Health
San Lazaro Compound
Sta. Cruz, Manila
Philippines
Telefax: (632) 651 7801
E-mail: jylagahid@co.doh.gov.ph
3. RESOURCE PERSONS

Dr Jaime F. Calderon, Jr.
Regional Migration Health Adviser
International Organization for Migration
Regional Office for Asia and the Pacific
18th Floor, Rajanakarn Building
183 South Sathorn Road, Sathorn
Bangkok 10120
Thailand
Tel.: (662) 343 9448
Fax: (662) 343 9499
Mobile: (668) 1 832 6900
E-mail: jcalderon@iom.int

Dr Paul Douglas
Chief Medical Officer
Global Manager Health
Department of Immigration and Citizenship
GPO Box 9984
Sydney, NSW
Australia 2001
Tel.: (612) 8666 5760
Email: paul.douglas@immi.gov.au

Dr Einar Heldal
Independent TB Consultant
Arvollveien 60D
0590 Oslo
Norway
Mobile: (47) 9751 7465
Email: einar.heldal@c2i.net

Mr Rayden Llano
Consultant
London House
Meclenburgh Square
London
United Kingdom WC1N2AB
Tel.: (44) 745 065 2821
Email: rayden.llano@gmail.com
4. REPRESENTATIVES OF PARTNER AGENCIES AND OBSERVERS

**ASIAN DEVELOPMENT BANK**

Ms Emiko Masaki  
Social Sector Economist  
Human and Social Development Division  
Southeast Asia Department  
Asian Development Bank,  
6 ADB Avenue, Mandaluyong City  
Tel.: (632) 632 4448  
Fax: (632) 636 2409  
Email: emasaki@adb.org

**INTERNATIONAL ORGANIZATION FOR MIGRATION**

Dr Poonam Dhavan  
Coordinator, Public Health Research Epidemiology  
Migration Health Division  
Manila (Global) Administrative Centre  
International Organization for Migration  
28th Floor, Citibank Tower  
8741 Paseo de Roxas  
Makati City  
Philippines  
Tel.: (632) 230 1631  
Fax: (632) 848 1257  
Email: pdhavan@iom.int

**KOREAN INSTITUTE OF TUBERCULOSIS**

Dr Kyung Hyun Oh  
Head, Educational & Technical Cooperation  
Korean Institute of Tuberculosis  
482 Mansuri, Gango-e-myeon, Cheongwon-gun, Chungcheongbuk-do  
Republic of Korea  
Tel: (8243) 249 4920  
Fax: (8243) 249 4989  
E-mail: kyunghyun.oh@gmail.com

**MEDECINS SANS FRONTIERES**

Dr Maria Guevara  
Regional Humanitarian Representative (ASEAN)  
Medecins Sans Frontieres (MSF)/Doctors Without Borders  
Tel.: (852) 2959 4229  
Mobile: (852) 9221 6212  
Fax: (852) 2337 5442  
Email: maria_guevara@msf.org.hk

**MINISTRY OF HEALTH, WELFARE AND LABOUR, JAPAN**

Dr Nobuyuki Nishikiori  
Deputy Director  
International Affairs Division  
Minister's Secretariat  
Ministry of Health, Labour and Welfare  
1-2-2 Kasumigaseki  
Chiyoda-ku  
Tokyo 100-8916, Japan  
Tel: (813) 3595 2404  
Fax: (813) 3502 6678  
Email: nishikiori-nobuyuki@mhlw.go.jp
THE ASEAN SECRETARIAT

Dr Ferdinal M. Fernando
Assistant Director/
Head, Health and Communicable Diseases Division
Cross-Sectoral Cooperation Directorate
Socio-Cultural Community Department
The ASEAN Secretariat
Bangkok, Thailand
Tel: (6221) 726 2991 ext. 423
Fax: (6221) 739 8234 ext 3504
Email: ferdinal.fernando@asean.org

THE INTERNATIONAL UNION
AGAINST TUBERCULOSIS AND
LUNG DISEASE

Dr Ral Antic
Chair, Scientific Committee (The UNION)
Director
Department of Thoracic Medicine
Royal Adelaide Hospital
Adelaide, South Australia 5000
Tel.: (618) 8222 5372
Fax: (618) 8222 59572
Email: ral.antic@health.sa.gov.au

5. SECRETARIAT

WHO WESTERN PACIFIC
REGIONAL OFFICE
(WHO/WPRO)

Dr Catharina van Weezenbeek
(Responsible Officer)
Team Leader
Stop TB and Leprosy Elimination
WHO/WPRO
U.N. Avenue
1000 Manila
Philippines
Tel.: (632) 528 9706
Fax: (632) 521 1036
E-mail: vanwezenbeekc@wpro.who.int

Dr Tauhidul Islam
(Co-Responsible Officer)
Medical Officer
Stop TB & Leprosy Elimination
WHO/WPRO
U.N. Avenue
1000 Manila
Philippines
Tel.: (632) 528 9720
Fax: (632) 521 1036
E-mail: islamt@wpro.who.int

Mr Tom Hiatt
Technical Officer
Stop TB & Leprosy Elimination
WHO/WPRO
U.N. Avenue
1000 Manila
Philippines
Tel.: (632) 528 9708
Fax: (632) 521 1036
WHO/WPRO COUNTRY OFFICES

Dr Fabio Scano
Medical Officer, Stop TB & Leprosy Elimination
Office of the WHO Representative in China
401, Dongwai Diplomatic Office Building
23, Dongzhimenwai Dajie
Chaoyang District
Beijing 100600
China
Tel.: (8610) 6532 1288
Fax: (8610) 6532 2359
Email: scanof@chn.wpro.who.int

Dr Rajendra-Prasad Hubraj Yadav
Medical Officer
Office of the WHO Representative in Cambodia
No. 177-179 corner Streets Pasteur (51) and 254 Sankat Chak Tomouk
Khan Daun Penh,
Phnom Penh, Cambodia
Tel.: (855) 2321 6610
Fax: (855) 2321 6211
Email: yadavr@wpro.who.int

Dr Miwako Kobayashi
Junior Professional Officer
Stop TB Unit
Office of the WHO Representative in Cambodia
No. 177-179 corner Streets Pasteur (51) and 254 Sankat Chak Tomouk
Khan Daun Penh
Phnom Penh
Cambodia
Tel.: (855) 2321 6610
Fax: (855) 2321 6211
Email: kobayashim@wpro.who.int

WHO/SEARO COUNTRY OFFICE

Dr Brent Burkholder
Programme Coordinator and
Team Leader for Communicable Diseases
Office of the WHO Representative in Thailand
4th Floor
Ministry of Public Health
Tiwanon Road
Nonthaburi 11000
Thailand
Tel.: (662) 591 8198/590 1524
Fax: (662) 591 8199/590 1525
Email: burkholderb@searo.who.int
Dr Erwin Cooreman
Medical Officer (TB)
World Health Organization
Country Office for Myanmar
Room 1028, Traders Hotel
223 Sule Pagoda Road
Kyauktada Township
Yangon, Myanmar
Tel.: (951) 241 9323/ 250 5834 ext. 4234
Fax: (951) 241836/(951) 250 273
Mobile: (95) 9430 64741
E-mail: cooremane@searo.who.int

WHO HEADQUARTERS

Dr Ernesto Jaramillo
Medical Officer
Stop TB Department
HIV/AIDS, TB and Malaria
and neglected diseases cluster (HTM)
Avenue Appia 20
CH – 1211 Geneva 27
Switzerland
Tel.: (41 22) 791 3034
Fax: (4122) 791 4199
Email: jaramilloe@who.int
Annex 3

Tuberculosis Control in Migrant Populations: Guiding Principles and Proposed Actions

(Draft)
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbreviations</td>
<td>3</td>
</tr>
<tr>
<td>Glossary of migration-related terms</td>
<td>4</td>
</tr>
<tr>
<td>Chapter 1. Introduction</td>
<td>9</td>
</tr>
<tr>
<td>1.1 Migration: trends, health impacts and importance</td>
<td>9</td>
</tr>
<tr>
<td>1.2 Global consensus development on migrant health</td>
<td>10</td>
</tr>
<tr>
<td>1.3 Purpose and scope of document</td>
<td>10</td>
</tr>
<tr>
<td>1.4 Classification of migrant populations</td>
<td>12</td>
</tr>
<tr>
<td>Chapter 2. Guiding principles and proposed actions</td>
<td>14</td>
</tr>
<tr>
<td>2.1 Monitoring migrant health</td>
<td>15</td>
</tr>
<tr>
<td>2.2 Policy and legal frameworks</td>
<td>17</td>
</tr>
<tr>
<td>2.3 Migrant sensitive health systems</td>
<td>20</td>
</tr>
<tr>
<td>2.4 Partnerships, networks and multi-country frameworks</td>
<td>24</td>
</tr>
<tr>
<td>References</td>
<td>27</td>
</tr>
</tbody>
</table>

**Abbreviations**
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>APEC</td>
<td>Asia-Pacific Economic Forum</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
</tr>
<tr>
<td>GFMD</td>
<td>Global Forum on Migration and Development</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>IDP</td>
<td>internally displaced person</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
</tr>
<tr>
<td>MDR-TB</td>
<td>multidrug-resistant tuberculosis</td>
</tr>
<tr>
<td>NTP</td>
<td>National TB Programme</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
**Glossary of migration-related terms**

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asylum seeker</td>
<td>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.</td>
</tr>
<tr>
<td>Border control</td>
<td>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.</td>
</tr>
<tr>
<td>Border crossing</td>
<td>The physical act of crossing a border either at an established checkpoint or elsewhere along the border.</td>
</tr>
<tr>
<td>Casual cross-border migrant</td>
<td>A person who moves informally across porous borders into neighbouring countries, usually over the span of days or weeks.</td>
</tr>
<tr>
<td>Circular migration</td>
<td>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.</td>
</tr>
<tr>
<td>Contractual labour</td>
<td>Labour supplied for a specific purpose over a fixed period of time by a contractor.</td>
</tr>
<tr>
<td>Country of destination</td>
<td>The country that is a destination for migratory flows (regular or irregular). See also host country, receiving country.</td>
</tr>
<tr>
<td>Country of origin</td>
<td>The country that is a source of migratory flows (regular or irregular). See also sending country.</td>
</tr>
<tr>
<td>Deportation</td>
<td>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.</td>
</tr>
<tr>
<td>Documented migrant</td>
<td>A migrant who entered a country lawfully and remains in the country in accordance with his or her admission criteria.</td>
</tr>
<tr>
<td>Foreigner</td>
<td>A person belonging to, or owing an allegiance to, another state.</td>
</tr>
<tr>
<td>Host country</td>
<td>See country of destination, receiving country.</td>
</tr>
<tr>
<td>Illegal migrant</td>
<td>See irregular migrant, undocumented migrant.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Immigration</td>
<td>A process by which non-nationals move into a country for the purpose of settlement.</td>
</tr>
<tr>
<td>Immigration status</td>
<td>Status of a migrant under the immigration law of the host country.</td>
</tr>
<tr>
<td>Internal migrant</td>
<td>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.</td>
</tr>
<tr>
<td>Internal migration</td>
<td>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).</td>
</tr>
<tr>
<td>Internally displaced persons (IDPs)</td>
<td>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.</td>
</tr>
<tr>
<td>International migration</td>
<td>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.</td>
</tr>
<tr>
<td>International student</td>
<td>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.</td>
</tr>
<tr>
<td>Involuntary repatriation</td>
<td>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.</td>
</tr>
<tr>
<td>Irregular migrant</td>
<td>A person who enters a country, often in search of employment,</td>
</tr>
</tbody>
</table>
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 country of destination.

**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 (RCPs) 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 – Geneva Conventions (1949) and Additional Protocols to the Geneva Conventions (1977), Regulations Respecting the Laws and Customs of War on Land Annexed to the Fourth Hague
The Convention (1907), 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 *country of origin*.

**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 *irregular migrant, irregular migration*. 
Chapter 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 not only positively impact 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. (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. 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 TB 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 multidrug-resistant TB (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 healthcare 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. 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

<table>
<thead>
<tr>
<th>Category</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal migrants</td>
<td>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. (2)</td>
</tr>
<tr>
<td>Labour migrants</td>
<td>Individuals engaged in a remunerated activity in a state of which he or she is not a national and is legally admitted. (16)</td>
</tr>
<tr>
<td>Casual cross-border migrants</td>
<td>Individuals who move informally across porous borders into neighbouring countries, usually over the span of days or weeks</td>
</tr>
<tr>
<td>Irregular migrants</td>
<td>Individuals who enter a country, often in search of employment, without the required documents or permits, or who overstay their authorized length of stay. (17, 18)</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Refugees and other displaced populations</td>
<td>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.</td>
</tr>
<tr>
<td>International students</td>
<td>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)</td>
</tr>
</tbody>
</table>
Chapter 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. 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)

Fig. 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 this 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.

**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)

![Cumulative risk of tuberculosis chart](chart.png)
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.” (9, 26–28) While some countries may not be able to fulfil this obligation due to resource constraints, the International Covenant on Economic, Social and Cultural Rights 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.

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.

<table>
<thead>
<tr>
<th>Guiding principles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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.</strong> 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. 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)</td>
</tr>
<tr>
<td><strong>TB services should be delivered to migrants in a culturally and linguistically appropriate way subject to resource constraints.</strong> 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. Beyond this, Member States may consider the development of national standards for culturally and linguistically appropriate health services and the</td>
</tr>
</tbody>
</table>
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.

**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. 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.

**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, 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 5. 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.

Box 6. 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)

Box 7. 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.

Box 8. 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.
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 on an 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. 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)

**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. 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.

<table>
<thead>
<tr>
<th>Key actions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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.</strong> 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.</td>
</tr>
<tr>
<td><strong>Establish links between relevant authorities and health providers in origin, transit and destination countries to improve cross-border coordination and referral of TB patients.</strong> 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.</td>
</tr>
</tbody>
</table>

**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 (CCG) 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 that 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.

**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.
References


21 Gushulak, B. D. & MacPherson, D. W. Health Aspects of the Pre-Departure


32 Government of Japan. Law Concerning the Prevention of Infections and Medical Care for Patients of Infections. Law No. 114, 143rd extraordinary Diet session, 2008.


46 Siddiqui, I., Rashid, R. & Zeitlyn, B. Information campaigns on safe migration
