

# MIGRATION, TUBERCULOSIS AND THE LAW: AN URGENT NEED FOR A RIGHTS-BASED APPROACH

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## EXECUTIVE SUMMARY

Tuberculosis (TB) is among the top 10 causes of death worldwide and the leading cause of death among infectious diseases. Migration—from one country to another or within a country—increases vulnerability to TB acquisition, disease and death. Migrants' vulnerability to TB extends across the breadth of their journey, beginning in the country of origin and spanning each and every stage to their destination and can persist for many years after their journey itself. The TB vulnerability of some migrants and refugees stems from numerous factors, including poverty, poor nutrition, overcrowded living conditions (including in closed facilities in many cases), poor working conditions (such as mining operations), and limited access to appropriate, affordable health services, including voluntary TB screening and treatment.

The public health approach to TB control recommended by the World Health Organization (WHO) and other health authorities is straightforward. As TB is a disease that is wholly preventable, treatable and curable, standard public health approaches focus on the need to identify and treat every person with active TB, wherever they are located and whatever their immigration or socioeconomic status. The application of these basic approaches to TB has saved more than 50 million lives globally since 2000 and contributed to an inadequate but steady decline in TB-related deaths over the last two decades.

To bring people into the care system to diagnose and treat TB cases and to avert further TB transmission, it is broadly agreed that TB control efforts must be grounded in human rights principles and a respect for the dignity and autonomy of every individual with the disease. Indeed, this approach is a cornerstone of global efforts to combat communicable diseases, as reflected in nearly four decades' experience in the HIV and AIDS response and in the International Health Regulations, which call for any measure to prevent the spread of an infectious disease to use the least restrictive means possible.

In the case of TB, scores of countries, from all regions and income classifications, are failing to apply these basic tenets of sound, human rights-based disease control in the context of migration. Our analysis shows that the most common single legal means deployed by countries in response to TB among migrants is to bar the entry, stay or residence of any person with active TB. In some cases, this extends even to refugees and asylum seekers. In addition to ignoring the reality that TB can be treated and cured and that intervening at just one point in migration is ineffective, these laws violate the international "right of everyone to the enjoyment of the highest attainable standard of physical and mental health," as well as the fundamental right to protection against discrimination. Once they arrive at their destination, legal barriers to accessing basic health services on an equitable basis confront migrants in a diverse set of countries—which similarly undercuts the response and violates the international rights norms. In some countries, 'prohibited' migrants who have entered the country, including those who were 'prohibited' from entry on the basis of TB, are subject to deportation on the basis of their health status. Linking completion of TB treatment to attainment and maintenance of legal status, meanwhile, occurs in a sub-set of major countries, yet contravenes not only public health recommendations that treatment must in all cases be voluntary but also "the right to control one's health and body, including... the right to be free from...non-consensual medical treatment." Meanwhile, every year hundreds of thousands of migrants are placed in detention under conditions of overcrowding and poor access to health services that drive TB transmission and do not fit international legal norms. In short, we find that existing laws and policies regarding TB and migration too often flagrantly violate the most basic human rights and undermine sound TB control.

We find some evidence for optimism, however. Countries are starting to recognize the need for comprehensive approaches to TB in migration in their TB national strategic plans. Several of the OECD countries that receive

the most migrants do provide for affordable access to TB and other basic medical care for migrants regardless of immigration status. And South Africa provides an example in the global South of both national legislative framework and a set of regional agreements that, while insufficiently implemented, provide a basis for rights-based realization of access to TB health services for migrant and mobile populations.

We live in a world that is increasingly globalized, with diverse cultures linked through travel options that are cheaper than ever, expanding industry and trade, communications and family ties. More people are on the move than ever before, and population mobility will only increase as a result of urbanization, multi-country commodity and industrial supply chains, and the economic benefits associated with migration. Tragically, the global community's notable failures to prevent human rights atrocities and conflict, unless reversed, will also contribute to waves of refugees and internally displaced people. In such an interconnected world, pretending that countries can build walls to shut the rest of the world out is an illusion.

For migration and TB as for a host of other international challenges, the touchstones for effective action are clear – policies and programs must be based on the best available scientific evidence, and all actions must strictly adhere to international human rights agreements. All countries should take immediate steps, through the review and revision of national laws where indicated, to align national law and policy frameworks with human rights and public health principles. Regional bodies should lead the way toward development of harmonization and coordination protocols to ensure the continuity of good-quality care to migrants with TB, in accordance with human rights. At the international level, the pressing TB burden among migrants and the alarming tendency of countries to respond to this problem with coercion and exclusion rather than with sound public health approaches must be elevated on the global political agenda.

# 1. INTRODUCTION

**M**ore people are on the move than ever before.<sup>1</sup> Across the world, many millions are migrating from the countryside to the city in the most pronounced period of urbanization in history.<sup>2</sup> More people than ever are visiting other countries for leisure or educational opportunities. There are more refugees and internally displaced persons than ever before, fleeing military conflict, the breakdown of civil order and other humanitarian disasters.<sup>1,3</sup> And tens of millions of people have moved to a country other than the one in which they were born, in search of economic opportunities or to reunify their families.

Migration is associated with clear benefits for the individuals and households who move — and for their new countries and communities, which are economically and culturally enriched.<sup>1</sup> Yet, notwithstanding the many benefits of the free movement of people, the current, unprecedented wave of migration has been met with a profound backlash that has included scapegoating, xenophobia, and violence in a climate marked by economic inequality, political instability, and closing civil society space.<sup>4</sup> At a moment when the human rights environment continues to deteriorate in many countries, one of the central challenges of our times is to resist these trends and to reinforce international human rights principles.

In the quest to remain true to our highest human rights aspirations in the face of growing authoritarianism and xenophobia, health is a major point of contention. Migrants may experience poverty, isolation, lack of social support, violence, harassment and limited access to health services. This can increase migrants' health-related risks and vulnerabilities. Yet it is common for migrants, especially undocumented migrants, to be

excluded from access to even the most basic health and social services.

The worldwide response to HIV and AIDS, properly regarded as one of the greatest achievements in the history of global health, has definitively demonstrated that a respect for human rights and dignity is not only wholly consistent with, but also essential to, an effective fight against infectious diseases.<sup>5</sup> The importance of human rights to effective disease control is reflected in the International Health Regulations adopted by member states of the World Health Organization (WHO), which mandate the least coercive and invasive approaches for management of international health emergencies.<sup>6</sup> Yet many countries fail to heed the lessons of HIV/AIDS when it comes to the tuberculosis (TB) response.

As TB is a disease that can be effectively prevented and treated through the timely delivery of affordable diagnostic and treatment tools, a cornerstone of the TB response is the imperative to deliver these strategies to people with, or vulnerable to, TB regardless of where they are located. Yet TB remains a major health risk confronted in migration — with heightened vulnerability for many migrants throughout the process, from before they leave their countries of origin, through their journey, and often long after they have arrived at their destination. Legal and policy responses, however, rarely deal with TB in migration comprehensively.

In a tragic denial of the extent to which our world is inextricably bound together, many countries are, in effect, attempting to build a wall against infectious disease by denying entry, stay or residence for people who are infected with tuberculosis. As we show, this is the most common legal tool used by countries when they encounter migrants with

TB but one that is both unjust and extraordinarily counterproductive to the effort to end TB. Rather than adopt the most effective approach — i.e., providing treatment to all people with TB, regardless of their immigration status — many countries are using counterproductive and discriminatory policies to burden refugees and migrants with tuberculosis, such as denial of essential health services, detention and other punitive practices, and coercive TB treatment.

These national practices violate two key pillars of the international human rights architecture — the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” as recognized in the International Covenant on Economic, Social and Cultural Rights,<sup>7</sup> and the right to be free of discrimination, as embodied in a broad range of international human rights instruments and specifically applied to migrants and people with disabilities, among others.<sup>8</sup> Many other rights — such as the right to privacy and the right to benefit from the advances of science — are further undermined by approaches to TB and migration in many countries.

This report explores why a human rights approach is so vital for migrants and refugees with, and vulnerable to, tuberculosis. After summarizing the relationship between TB and migration, it briefly describes the international human rights instruments that are implicated by discriminatory policies and practices against migrants with tuberculosis. The report then delves into five categories of national approaches that violate human rights standards: denial of entry, stay or residence on the basis of TB and health status; legal restrictions on access to medical services for migrants; deportation and continuity of care; migration detention

and TB, and requirements that migrants and refugees with tuberculosis undergo coercive TB treatment, including as a condition for entry or legal status. For each of these categories, the report describes the extent of the discriminatory policy approach, how the discriminatory policy undermines sound TB control efforts, why the approach violates fundamental principles of human rights, and

how a human rights–based approach is not only a fairer but also a more effective way to manage TB at a time of unprecedented human mobility.

One of the central findings of this report is the degree to which a rights-based approach to TB overlaps with and markedly strengthens the most effective public health strategies

for fighting TB. If the global community is serious about minimizing the illness and mortality associated with the leading cause of infectious disease worldwide, it will ensure that all TB control efforts, including those that affect people on the move, are fully consistent with recognized human rights principles.

## 2. MIGRATION AND TUBERCULOSIS

Our world is more interconnected than it has ever been. Travel between and within countries has never been easier, more available or more affordable, and the Internet and other forms of communications technology are linking diverse cultures and societies as never before. In 2016, global trade in goods and services approached US\$ 21 trillion,<sup>9</sup> and complex commodity and industrial supply chains are stitching the global community together in unprecedented ways.

### AN UNPRECEDENTED ERA OF MIGRATION

The interconnectedness of the global community is reflected in the unprecedented movement of people. In 2015, the number of people residing in a country other than the one of their birth (244 million) exceeded the national population of all but four countries.<sup>1</sup> The number of international migrants is vastly exceeded by the number of people who have migrated within their own country (740 million in 2009).<sup>1</sup>

While current international discourse often focuses on South-to-North migration, a high proportion of international migration is taking place between countries of the global South. The rate of South-to-South migration

increased by 70% between 1990 and 2017. In particular, Africa and Asia have experienced the fastest increases in numbers of international migrants. Between 2000 and 2017,<sup>10</sup> the number of international migrants in Africa increased from 15 to 25 million, or 67%, while it increased 62% in Asia.<sup>11</sup> More than 70% of international migrants are 20 to 64 years old, 52% are male, and 48% are female.<sup>1</sup> Nearly half of international migrants in 2015 were born in Asia.<sup>1</sup> Remittances — totaling US\$ 575 billion in 2016, a 4.5-fold increase over amounts in 2000 — directly link international migrants to their families and communities in their country of origin.<sup>1</sup>

The pace of growth in international migration has surpassed earlier projections.<sup>1</sup> International migration has increased by 69% since 1990; there were 152.5 million international migrants in 1990 and 172.6 million in 2000.<sup>12</sup>

Workers account for more than 70% of international migrants,<sup>1</sup> but a major contributor to global population movement is the forced displacement of people due to civil conflict. At the end of 2017, there were 25.4 million refugees worldwide, the largest number on record, as well as 40.3 million internally displaced persons.<sup>13</sup> Syria on its own is

responsible for 5.5 million of the world's refugees.<sup>1</sup> More than 700,000 Rohingya people have fled Myanmar following what investigators for the United Nations have depicted as “amount[ing] to the gravest crime under international law” — genocide.<sup>14</sup> Developing regions host 84% of all refugees,<sup>15</sup> highlighting the extent to which poorer countries shoulder the burden of the global refugee crisis.

Human migration has occurred for thousands of years and takes place for many reasons, including push-and-pull factors such as economic opportunity, conflict, displacement and environmental change. Migration is motivated by numerous and interconnected social, economic and political factors and forces, which vary regionally and affect certain individuals and populations disproportionately. Currently, the management of international migration and national borders is increasingly securitized, including in the context of the Global Compact on Safe, Orderly, and Regular Migration and the Global Compact on Refugees.<sup>16</sup>

### ENDING TUBERCULOSIS — A MAJOR GLOBAL HEALTH PRIORITY

Preventing, diagnosing and treating tuberculosis poses one of the most pressing global

health challenges. One of the 10 leading causes of death worldwide, tuberculosis caused 10 million people to become ill in 2017 and resulted in 1.6 million deaths. TB-related deaths in 2017 included 300,000 among people living with HIV.<sup>17</sup> Although TB is responsible for more deaths than any other infectious disease, important progress has been made in combatting the disease; the incidence of TB is falling at a rate of 2% each year,<sup>18</sup> and the TB mortality rate by 3% each year.<sup>19</sup> These declines can be traced to effective diagnosis and treatment tools and strategies, which saved an estimated 54 million lives from 2000 to 2017.<sup>20</sup> Provision of antiretroviral therapy to people who are co-infected with HIV and TB markedly reduces the risk that an individual will progress to active TB disease.

Across the world, TB disproportionately affects the poorest and most vulnerable segments of society. Globally, low- and middle-income countries account for 95% of TB deaths.<sup>2</sup> In both resource-rich and resource-poor settings, tuberculosis risk is inversely associated with socioeconomic status, with the strongest risk factors including homelessness or housing instability, overcrowding, malnutrition, prior incarceration and unemployment.<sup>21, 22</sup>

The rise of resistance to recommended anti-TB medicines, combined with the slow generation of new medications to treat TB, has created considerable global concern. In 2017, 558,000 new TB cases were resistant to rifampicin — the most effective anti-TB drug — 82% of which were resistant to multiple drugs.<sup>23</sup>

As part of the Sustainable Development Goals, United Nations member states have pledged to end the TB epidemic by 2030. The WHO has put in place a strategy to end TB, with ambitious milestones set for 2020, toward the ultimate aim of reducing TB deaths by 95% and new cases by 90% by 2035. Plans to end TB build on recent momentum from new investments in TB control measures over the past decade.<sup>14</sup> Currently, however, the pace of decline in TB deaths falls short of the pace required to meet the WHO's 2020 milestones.<sup>14</sup> TB treatment is highly effective, with a global treatment success rate of 82% in 2016, but gaps in detection of TB persist, as nearly 40% of TB cases were not reported in 2016.<sup>24</sup>

### DURING TRANSIT

Migration can occur under precarious conditions that can include violence, travel in confined quarters with inadequate ventilation, poor sanitation and nutrition, and limited access to healthcare. Repeated travel can increase the chances of infection, transmission, and interruption of treatment.

#### Law and policy issues:

- Immigration entry restrictions for TB.
- Legal context and process for immigration and asylum-seeking.

### AT DESTINATION

Increased vulnerability to TB for some migrants persists long after arrival due to living and working conditions; limited access to healthcare, work, education and nutrition; and health-seeking behavior linked to fear of immigration consequences.

#### Law and policy issues:

- Visa and work permit conditions linked to TB/health status.
- Criminalization of irregular immigration.
- Affordable access to healthcare services.
- Deportation rules and regulations.

## MIGRATION AND TB

### PLACE OF ORIGIN

Vulnerability to TB is based on availability of and access to health services as well as the socio-economic determinants of health. Some countries also have higher TB and HIV burdens, increasing vulnerability.

#### Law and policy issues:

- Domestic legal and policy environments affecting health services & social determinants.
- International assistance commitments from wealthy states.
- Pre-departure medical examination requirements.

### UPON RETURN

Migrants who lived in poor housing or worked under poor conditions, may well return less healthy than when they left—particularly from certain types of work like mining or from a deportation and detention process. They may return with untreated TB and may not have access to suitable treatment upon return.

#### Law and policy issues:

- Deportation process and link to continuity of care.
- Health and wellbeing standards in detention.
- Regional agreements on cross-border coordination of TB care.

People moving within and between national borders are among those at especially high risk of TB infection and disease, due to barriers they face accessing services, or due to environmental, biological or behavioral factors.<sup>25</sup> Migration is increasingly recognized as an important determinant of health,<sup>26</sup> as conditions associated with the process of migration may expose migrants to a variety of factors that affect health, including discrimination, exclusion, poverty, social and cultural differences, and language barriers.<sup>27</sup> Documentation status — or lack thereof — is itself a key determinant of health, as is making irregular immigration status a crime. Those subject to forced migration, including refugees, asylum seekers and internally displaced persons, may be at particularly high risk of TB and other poor health outcomes.

Studies comparing TB prevalence among the locally born and international migrants have highlighted the disproportionate TB burden and comparatively poor health outcomes among migrants. For example, migrant and refugee populations have been found to have a TB prevalence 7 to 90 times greater than the general population in Norway;<sup>28</sup> 14 times the local-born population in the United States of America<sup>29</sup> and 19 times the general population in Germany.<sup>30</sup> International migrants account for 65% of all active TB cases in Canada<sup>31</sup> and 69.1% of all TB cases in Germany.<sup>32</sup> Cambodian migrant workers being deported from Thailand have TB rates almost four times the general Cambodian population at 1,000 per 100,000 population, a significant disparity in a country with a high TB burden.<sup>33</sup>

While higher rates of prevalence among migrants and refugees immediately upon arrival may be unsurprising in cases where individuals migrate from high-incidence to medium- or low-incidence countries, high TB incidence persists over many years among migrant and refugee populations, indicating that their vulnerabilities extend well beyond those associated with being born in a high-burden country. For example, among Somali migrants and refugees living in Denmark, high initial incidence declined

only gradually in the first seven years after arrival.<sup>34</sup> In Brazil, the proportion of national TB cases among Bolivian migrants rose from 15% in 1998 to 53% in 2008.<sup>35</sup> In some countries that belong to the Organization for Economic Co-operation and Development (OECD), an intergovernmental economic organization of mostly wealthy countries, migrant TB cases have increased between 2000 and 2013, even as local-born cases have remained flat or decreased during this period.<sup>36</sup> In OECD countries, migrant and refugee populations had TB incidence rates 8.7 to 18.4 times the rate of the locally born population, altogether accounting for more than half of all TB cases in these countries.<sup>37</sup>

People subject to forced migration, including refugees, asylum seekers, and internally displaced persons, are especially vulnerable to TB. This vulnerability often begins in their home country, due to their poor access to quality health services, lack of bargaining power and insecure access to sanitation and nutrition. Economic, social and legal status during migration and once in the destination country can have a significant bearing on their health and well-being. For example, although Syria had a relatively low TB burden of 23 per 100,000 in 2012, the subsequent breakdown of the health system during the conflict, poor living conditions for forced migrants, and other factors have combined to greatly increase TB vulnerability among the refugees who have fled to neighboring countries.<sup>38</sup> The influx of refugees from Syria has been associated with a 27% increase of TB cases in Lebanon between 2011 and 2012<sup>39</sup> and an increase in TB cases among migrants in Turkey between 2011 and 2015, despite a decrease in overall TB incidence in Turkey.<sup>40</sup>

As the remainder of this report reveals, laws and policies can have a profound effect on TB risks, incidence and outcomes. First, the failure of TB and HIV responses to take into account the relationship between migration and TB — at the global, regional and national levels — may account in large part for the insufficient and uneven progress that has been made in fighting TB.<sup>41</sup> Closing this gap in policy and programmatic responses will

require investments in focused research on the dynamics of migration and health and on effective interventions to mitigate the TB burden among migrant and refugee populations. Migrant-aware and mobility-sensitive health systems, and laws and regulations that implement health care and migration, should also address the vulnerabilities and needs of different types of migrants and refugees, including forced migrants and those lacking legal status.<sup>42</sup>

Second, contemporary global policy processes, practices and frameworks may risk the health and well-being of those who move. This is especially the case at a moment when migration policy is increasingly being driven by xenophobia, often masked as security concerns. The counterproductive nature of many policy and legal responses to migration and TB is the primary focus of this report.

There are encouraging signs that the global community is increasingly recognizing the urgent need for action both to address TB and to ensure that approaches to improve TB and other health outcomes are grounded in scientific evidence and human rights principles, taking into account the role of migration and the needs of migrant populations. The convening of the first United Nations High Level Meeting on Tuberculosis underscores international recognition that there have been inadequate measures to address TB, which — despite being preventable, treatable and curable — kills more people than any other infectious disease globally. In addition, United Nations member states, through Resolutions 61.17 (2008) and 70.15 (2017) of the World Health Assembly and other international declarations and instruments, have formally endorsed migrant-sensitive health policies and equitable access to health promotion, disease prevention and care for migrants, without discrimination based on gender, age, religion, nationality or race. The challenge now is to translate these signs of new commitment into concrete steps to align national laws, policies and practices with international human rights norms and with sound public health principles.

### 3. MIGRATION AND TB: THE LEGAL AND HUMAN RIGHTS CONTEXT

International law outlines the human rights implicated in the context of migration and TB. These include key rights outlined in the Universal Declaration of Human Rights and other international covenants, including among others the right to benefit from scientific progress, the right to life, the right to liberty and security of person, the right to freedom from inhumane and degrading treatment, and the right to nutrition.

Among the fundamental human rights most clearly implicated by migration and TB is the “right to enjoyment of the highest attainable standard of physical and mental health,” articulated in the WHO Constitution, the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights (ICESCR), and other international human rights treaties.<sup>43</sup> The right to the highest attainable standard of health applies to all people, including migrants, regardless of their migratory status.<sup>44</sup> Indeed, as many migrant and refugee populations are marginalized, states are obliged to place particular emphasis on ensuring their right to health.<sup>45</sup>

The primary treaty containing the right to health is the ICESCR. Article 12 of the ICESCR guarantees “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”<sup>46</sup> The ICESCR has been ratified by 169 countries to date<sup>47</sup> — and every country has ratified at least one treaty that contains the right to health.<sup>48</sup> For example, the African Charter on Human and Peoples’ Rights expressly guarantees the right to health (Article 16),<sup>49</sup> and in 2018, the Inter-American Court on Human Rights held that the American Convention on Human

Rights’ Article 26, linked to economic, social, educational, scientific and cultural standards in the Charter of the Organization of American States,<sup>50</sup> encompasses an autonomous right to health.<sup>51</sup>

The Committee on Economic, Social and Cultural Rights, charged with monitoring ICESCR implementation,<sup>52</sup> provides the authoritative interpretation of the right to health in its General Comment 14.<sup>53</sup> States are required to respect, protect, and fulfill the right to health, including by refraining from denying or limiting equal access to health care and by implementing legislation and taking other measures to ensure equal access to health care.<sup>54</sup> General Comment 14 explains that the right to health extends beyond health care to also include the underlying determinants of health, “such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.” According to General Comment 14, the right to health requires that all health-related facilities, goods and services, including those pertaining to the underlying determinants of health, must be available in sufficient quantity, accessible without discrimination, acceptable, ethical, culturally appropriate and of good quality.

The right to health includes core obligations, “minimum essential levels of each of the rights... [without which it] would be largely deprived of its *raison d’être*,” including the right to “essential primary health care.”<sup>55</sup> While in general, states must act within

available resources to progressively achieve the full realization of the right to health and other economic, social, and cultural rights, “mov[ing] as expeditiously and effectively as possible towards” doing so,<sup>56</sup> core obligations are non-derogable. States “cannot, under any circumstances whatsoever, justify...non-compliance” with these core obligations (para. 47), which include non-discrimination. Core obligations “of comparable priority” especially relevant to TB include sufficient nutritious food; basic shelter, housing, sanitation, and safe water; essential drugs; immunization against major diseases; measures to prevent, treat, and control epidemic and endemic diseases; and information on major health problems in the community.<sup>57</sup>

Two treaties speak directly to migrants’ right to health, in particular refugees and migrant workers. The Refugee Convention and its 1967 Protocol mandate that refugees shall receive the same social security, including with respect to sickness, as nationals (Refugee Convention, article 24).<sup>58</sup> The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families provides that migrant workers shall receive equal treatment to nationals with respect to access to health and social services, and that both migrant workers and their family members shall receive equal treatment to nationals with respect to “any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health.”<sup>59</sup> These provisions effectively guarantee non-discrimination with respect to TB care, as lack of effective treatment for TB could prove fatal.

The non-discrimination element of the right to health, and human rights more generally, applies to all migrants, including those without legal status. The Committee on Economic, Social and Cultural Rights explains, “The Covenant rights apply to everyone including non-nationals, such as refugees, asylum-seekers, stateless persons, migrant workers and victims of international trafficking, regardless of legal status and documentation.”<sup>60</sup> The Committee provides as an example of non-discrimination based on nationality that all children — including undocumented migrants — have the “right to receive education and access to adequate food and affordable health care.” In a 1997 decision, the African Court on Human and Peoples’ Rights also affirmed that the rights enumerated in the African Charter apply to nationals and non-nationals alike, as part of the Charter’s prohibition against discrimination based on national origin.<sup>61</sup>

Collectively, these elements of the right to health afford robust protection for migrants at all phases of their journey, from when they are still in their country of origin preparing to depart, through their travels, throughout their stay in the country to which they migrate and — for migrants who depart that

country — the journey back to and upon arrival in their country of origin (or a third country). The clear prohibition against discrimination in international human rights instruments provides all migrants the same guarantees under the right to health as citizens. States must ensure that, like the rest of the population, migrants’ right to participate in health-related decisions is fulfilled, the confidentiality of their personal health information respected, and TB treatment never compulsory.

Other human rights recognized by the international community support and surround the right to health. Article 6 of the International Covenant on Civil and Political Rights (ICCPR) guarantees the right to life. The Human Rights Committee has clarified that the right to life is “the supreme right from which no derogation is permitted even in time of public emergency.”<sup>62</sup>

Closely connected with the rights to health and dignity, the right to the benefits of scientific progress is protected by Article 15 of the ICESCR and obligates governments to make the results of science, including scientific applications and technologies and information, accessible without discrimination.<sup>63</sup> The

right is also closely linked with the right to seek, receive and impart information and ideas, the right to development, and the rights to participation and to make informed decisions on the use of scientific advances.<sup>64</sup>

Of particular relevance to migration, Article 9(1) of the ICCPR provides that “[n]o one shall be subjected to arbitrary arrest or detention” and “no one shall be deprived of his liberty except on such grounds and in accordance with such procedures as are established by law.”<sup>65</sup> The prohibition of arbitrary detention is not limited to criminal cases. Instead, Article 9 applies in all cases in which there is a deprivation of liberty.<sup>66</sup> Liberty of person is defined by the United Nations Human Rights Committee as “freedom from confinement of the body” and is a right which is “precious both for its own sake, and because deprivation of liberty has historically been a principal means by which other human rights are suppressed.”<sup>67</sup> All persons deprived of liberty “shall be treated with humanity and with respect for the inherent dignity of the human person.”<sup>68</sup>

### Is the country a state party to the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and the International Covenant on Economic, Social and Cultural Rights (ICESCR)?

2 — ratified

1 — signed

0 — not signed or ratified

30 HBCs	State Party to Migrant Workers’ Convention <sup>69</sup>	State Party to ICESCR <sup>70</sup>
Angola	0	2
Bangladesh	2	2
Brazil	0	2
Cambodia	1	2
China	0	2
Congo (Republic of)	2	2
Central African Republic	0	2
Democratic Peoples’ Republic of Korea	0	2
Democratic Republic of Congo	0	2
Ethiopia	0	2
India	0	2

30 HBCs	State Party to Migrant Workers’ Convention <sup>69</sup>	State Party to ICESCR <sup>70</sup>
Indonesia	2	2
Kenya	0	2
Lesotho	2	2
Liberia	1	2
Mozambique	2	0
Myanmar/Burma	0	2
Namibia	0	2
Nigeria	2	2
Pakistan	0	2
Papua New Guinea	0	2
Philippines	2	2
Russian Federation	0	2

30 HBCs	State Party to Migrant Workers' Convention <sup>69</sup>	State Party to ICESCR <sup>70</sup>
Sierra Leone	1	2
South Africa	0	2
Thailand	0	2
Tanzania, United Republic of	0	2

OECD Countries Receiving Largest Numbers of Migrants		
USA	0	1
Canada	0	2
Germany	0	2
UK	0	2
Australia	0	2

30 HBCs	State Party to Migrant Workers' Convention <sup>69</sup>	State Party to ICESCR <sup>70</sup>
Viet Nam	0	2
Zambia	0	2
Zimbabwe	0	2

OECD Countries Receiving Largest Numbers of Migrants		
Spain	0	2
Italy	0	2
Turkey	2	2
Switzerland	0	2
France	0	2

Table 1

## 4. HUMAN RIGHTS, MIGRATION AND TB: HOW DO CURRENT APPROACHES MEASURE UP?

Given that TB is preventable, treatable and curable, the sound approach to TB control, consistent with public health principles and human rights requirements, focuses on the delivery of non-discriminatory, good-quality prevention, diagnostic and treatment services for all people with TB and at risk of TB, regardless of their citizenship status and wherever they are located. Unfortunately, many countries have enacted laws and policies that bar or restrict the entry, residence and stay of people with latent and/or active TB.

Some countries withhold essential medical services from some migrants with TB as a matter of national policy, others have legal requirements for people with TB to undergo treatment as a condition to acquire legal status, and many detain and deport migrants, including those who develop TB — often without providing access to the health services warranted by a TB diagnosis. These laws are counterproductive from a TB control standpoint and violate fundamental human rights.

*“As we come to understand that the migration process itself can be a determinant of ill health for migrants and migrant-hosting communities, the paradigm has progressively shifted from one of migrants as possible culprits of disease-spreading to one that recognizes migrants, particularly the most marginalized, as being vulnerable to negative health outcomes of mobility.”<sup>71</sup>*

— Health of Migrants — The Way Forward: Report of a global consultation (2010)

## A. TB AND HEALTH-RELATED RESTRICTIONS ON ENTRY, STAY AND RESIDENCE

Many countries have a long history of health-related travel exclusions, which have been influenced to some degree by the perception that migrants have higher disease risk, as a result of associations (real or perceived) of disease with certain racial and social classes.<sup>72</sup> For example, in the United States, the Immigration Act of 1891 provided that “persons suffering from a loathsome or a dangerous contagious disease” could be excluded from entry.<sup>73</sup>

In exercising sovereignty, states may impose immigration and visa restrictions. In exercising their sovereign prerogative to determine who enters their country, states can undertake only those measures that are consistent with human rights and other international obligations, including non-discrimination based on “other status,”<sup>74</sup> which includes health status.<sup>75</sup> If states limit rights, they must show that limitations are necessary to achieve a legitimate aim, that the means actually achieve the stated aim, and that they are the least restrictive means.<sup>76</sup>

HIV/AIDS has called into doubt the public health and human rights grounding of such health-related restrictions, leading to massive changes in national immigration approaches as they related to HIV.<sup>77</sup> From 2011 to 2015, the number of countries maintaining restrictions on entry, stay or residence of people living with HIV fell from 50 to 35.<sup>78, 79</sup> Travel restrictions based on HIV status have become disfavored due to the stigmatizing and discriminatory effect of such laws and the lack of evidence of any public health benefit.<sup>80</sup>

Travel restrictions based on TB, as in the case of HIV, undoubtedly increase TB-related stigma and discrimination, reinforcing the often misplaced stereotype of migrants as “disease vectors” and specifying in law that the health condition is “undesirable.” Likewise, there is no compelling evidence

that TB-related restrictions contribute to public health efforts to control TB — either globally or in the countries in which restrictions are imposed.

Yet, the hard-earned lessons regarding travel restrictions in the context of HIV/AIDS are often not applied with respect to TB. Indeed, TB-related restrictions on entry, stay and residence are common in many parts of the world and among countries from diverse income classifications.

Several OECD countries have entry restrictions on the basis of TB and/or health status, including those with pre-entry TB screening prior to departure.<sup>81</sup> In the United States, active TB remains one of the seven specifically listed communicable diseases of public health significance that triggers inadmissibility under the Immigration and Nationality Act and accompanying regulations.<sup>82</sup> This restriction applies to all migrants, including refugees, though refugees and others may be able to receive a waiver in some cases.<sup>83</sup> Similarly, Canada defines active TB as a condition “dangerous to public health,” rendering foreign nationals inadmissible on grounds of being a “danger to public safety,” unless the foreign national is treated according to Canadian standards.<sup>84</sup> Australian law also conditions entry for migrants, including refugees and those applying for humanitarian visas, on a negative TB diagnosis.<sup>85</sup> For persons coming to the United Kingdom from a specified list of countries, the UK immigration office requires the visa applicant to be screened for active TB and have a negative result in order to receive a medical clearance certificate, which is a condition to obtain a visa.<sup>86</sup>

Many countries in the global South also have entry restrictions on the basis of TB and/or health status. China specifically precludes visas for foreigners with infectious tuberculosis as well as for “other infectious diseases that may severely jeopardize the public health.”<sup>87</sup> In Liberia, non-citizens can be excluded from immigration for “all forms of TB,” which may include latent TB.<sup>88</sup>

In some countries, legal provisions broadly allow for discretion in excluding

“undesirable” or “prohibited” migrants. For example, in Botswana, the Immigration Act prohibits entry and presence of persons “infected with or suffering from a prescribed disease, unless the person has the written authority with or without conditions, of an immigration officer to enter and remain in Botswana.”<sup>89</sup> The Act does not set forth which illnesses are “prescribed.” The Minister can issue a deportation order against “undesirable immigrants,” and if they do not comply with the deportation order, they are subject to involuntary removal.<sup>90</sup> In Ethiopia, the state can deny or cancel entry visas of persons “suspected of suffering from a dangerous contagious disease.”<sup>91</sup> The act does not specify whether this applies to TB.

A threshold flaw in these national restrictions on entry, stay and residence based on TB status is that such approaches, justified by proponents on the basis of public health, do not actually promote public health. The WHO, the global community’s designated health authority, has emphasized that screening of migrants for active or latent TB “should always be done with the intention to provide appropriate medical care, and never to exclude or preclude entry.”<sup>92</sup> However, the blanket exclusions of people living with TB demonstrate on their face that their purpose is not to ensure proper medical care for those living with TB disease or infection, but rather to exclude such individuals from national territory. Experience has shown that laws such as those in Australia, Canada, the United States and UK that exclude people with active TB are especially suspect from a public health standpoint. Screening for active TB in the “foreign-born” populations in Canada and the United States has detected few such cases.<sup>93</sup> Rather, most cases of active TB occur due to the reactivation of latent TB infection,<sup>94</sup> suggesting that universal access to voluntary latent TB testing and preventive treatment would be far more effective than discriminatory exclusions in preventing the spread of TB.

In addition to lacking a public health basis, exclusionary TB-related travel policies violate fundamental human rights norms.

Blanket policies excluding all people with TB disease and/or infection constitute prohibited discrimination with respect to the right to equal protection of the law. In cases where deportation or entry restrictions on the basis of health or TB status exist, the principle of non-refoulement applies for refugees and asylum seekers, as well as for migrants under the Convention Against Torture. Non-refoulement prohibits the return of refugees to a country where their “life or freedom would be threatened” based on their “race, religion, nationality, membership of a particular social group or political opinion,”<sup>95</sup> or where there is a threat of torture or cruel, inhuman or degrading treatment<sup>96</sup> or other of the most serious human rights violations.<sup>97</sup> Deportations based on TB or other health status also raise the question of non-refoulement. Refugees and other migrants may never be returned to a country where they face persecution, where they face a real risk of torture or cruel, degrading or inhuman treatment or punishment, or other of the most serious human rights violations.<sup>98</sup>

The Siracusa Principles on the Limitation and Derogation Provisions in the International Covenant on Civil and Political Rights guide states when they limit rights provided for in the ICCPR. These principles require that any restrictions be provided for by law, not applied arbitrarily, and use no more restrictive means than are required for the achievement of the purpose of the limitation.<sup>99</sup>

Blanket restrictions, on their face, violate these human rights principles. To qualify as the least restrictive means to achieve

the stated purpose, travel restrictions must involve an individualized determination. Merely having TB cannot justify such restrictions, as individuals with TB are not necessarily contagious. Those who are contagious who receive treatment and undertake appropriate voluntary measures may be cured and unable to transmit infection to others. Indeed, health-related restrictions have been found under international legal principles to be justified only in cases of “an outbreak of a highly contagious disease, such as cholera, plague, or yellow fever.”<sup>100</sup>

Similarly, blanket TB-related travel restrictions cannot be justified on economic grounds. As UNAIDS and the International Organization of Migration have advised, restrictions for the purpose of avoiding TB-related costs must include a case-by-case determination of the relevant facts as to whether exclusion was needed to avert “a real and substantial demand on public resources,” and that this demand was neither “offset by contributions made to the society and economy” nor “outweighed by human rights obligations or humanitarian concerns.”<sup>101</sup> By their very nature, blanket exclusions sidestep the case-by-case determination required by international law.

Entry restrictions based on TB or other health status raise other serious human rights issues. These include risks of violating the right to privacy (for example, if TB status is revealed to the government or to the migrant’s employer), the right to informed consent as part of the right to health, and protection of the family unit (if the family

is broken apart).<sup>102</sup> Screening or any other measures taken as part of a policy of restricting entry based on TB status (and in cases of deportation based on TB status) must include safeguards to protect these rights.

Health screening of any kind raises important human rights considerations, as recognized by both WHO and the International Organization of Migration in their proposed health frameworks for the Global Compact on Safe, Orderly and Regular Migration.<sup>103, 104</sup> WHO advises that states should avoid restrictive health practices for migrants, including arbitrary restrictions on freedom of movement, stigmatization, deportation and other discriminatory practices. The framework further calls on states to take affirmative, protective measures, including safeguards in the context of health screening “to ensure non-stigmatization, privacy and dignity, and to ensure that screening procedures are carried out based on informed consent and to the benefit of both the individual and the public.” Screening should be linked to accessing risk assessment, treatment, care and support.<sup>105</sup>

In summary, it is clear that migrants are protected under international law from blanket restrictions on entry, stay and residence based solely on their TB status. Such laws and policies violate a broad array of international human rights, fail the requirement of being the least restrictive means available, and promote neither public health nor economic savings.

## B. LAWS RESTRICTING ACCESS TO MEDICAL CARE FOR MIGRANTS

In the context of migration and TB, one of the most flagrant violation of migrants’ right to health is the denial of essential health services. Although the global community has embraced the goal of ensuring universal health coverage by 2030 — and many countries at all income levels have made

important progress towards expanding health coverage<sup>106</sup> — many national health insurance schemes exclude or limit coverage for migrants whose status is undocumented.<sup>3</sup> Where national laws provide some measure of access or entitlement to health services for migrants, coverage can vary substantially for different types of migrants (e.g., refugees, asylum seekers, permanent residents, migrant workers, documented or undocumented migrants). Often, migrants

are excluded from health systems or health coverage altogether or must pay unaffordable sums to access TB and other health services.

Legal status is one of the most significant determinants of access to affordable and adequate health services for migrants and refugees.<sup>107</sup> Documented migrants, including documented migrant workers, often have access to different levels of health coverage from undocumented migrants. Undocumented or “irregular” migrants who

lack state identification may be excluded from admission into health facilities altogether, from subsidized or lower cost services, or may avoid seeking health services on the basis of immigration status. Asylum seekers who lack legal status and documentation may also face significant barriers to health service access.

Closely linked with legal status, the United Nations Working Group on Arbitrary Detention has emphasized that making irregular migration a criminal offence rather than an administrative one exceeds the legitimate interests of states in protecting their territories and regulating migration flows.<sup>108</sup> Fear of immigration consequences has a direct impact on health seeking and, in the context of TB, a patient's willingness to provide accurate and complete data to facilitate contact tracing. For example, in Sweden, fear of deportation, and that migrants' data would be shared with immigration authorities, has led patients to avoid sharing relevant health and other information in the context of TB, impeding effective contact tracing.<sup>109</sup>

Fear of deportation is a significant issue in the United States, where anti-immigration rhetoric creates a culture of fear among undocumented migrants, with the effect of deterring migrants from accessing health services. A February 2018 poll of 91 health

care providers and staff in 26 U.S. states found that 65% had seen a change in migrant patients' attitudes or feelings towards health center access in the past year; most respondents cited increased immigration-related fear among patients as the driver of health avoidance.<sup>110</sup> Other examples of criminalizing immigration status, France, Germany and the United Kingdom penalize irregular entry, which can subject migrants to prison and/or a fine.<sup>111</sup> In the context of tuberculosis, health avoidance due to fear of immigration consequences could result in serious deterioration of the health of patients, as well as increased risk of transmission in households and communities.

During a March 2018 Human Rights Commission hearing in South Africa, legal status, lack of identity documents, institutionalized xenophobia and improperly imposed fees upon admission, among other challenges, were identified as barriers for migrants accessing public health services.<sup>112</sup> In the United States, undocumented migrants are excluded from access to federally funded and subsidized insurance,<sup>113</sup> although hospital emergency departments are required to provide a medical screening examination to anyone seeking treatment, regardless of immigration status.<sup>114</sup> Germany, Denmark and some other European countries restrict access for undocumented

migrants to emergency care, which is reportedly provided free of charge.<sup>115</sup>

In addition to health avoidance, cost barriers based on immigration status, and exclusion from health admission on the basis of not having a state identity document, immigration status can manifest in additional ways. For example, one study in Kazakhstan found substantial delays in treatment seeking among undocumented migrants, as well as hesitance by doctors to provide TB treatment to undocumented persons, in part because the supply of available TB drugs is determined based on the needs of the registered population.<sup>116</sup>

Internal migrants with TB also may face substantial impediments to health care access in some countries. In China, for example, the Hukou household registration system, which limits health care and other social services to the location of permanent residency, can make it very difficult for those migrating inside the country to access health care services.<sup>117</sup> Although China ostensibly provides free TB services, high out-of-pocket costs can be catastrophic for people with TB and their families, increasing the likelihood of delays and premature termination of treatment.<sup>118</sup>

### LEGAL ENVIRONMENT ASSESSMENTS ON TB HIGHLIGHT HEALTH BARRIERS FOR INTERNAL MIGRANTS

In Ukraine, the Legal Environment Assessment found that internally displaced persons have limited access to medical and social services due to loss of identity documents and financial barriers. Loss of such documents effectively places an individual in a legal limbo, as it is difficult to obtain a certificate of registration as an internally displaced person.<sup>119</sup> Likewise, the Legal

Environment Assessment in India found that internal migrants who lack identity documents face significant barriers accessing all social services, including TB and other health services, as well as accessing ration cards for subsidized food and education, among other entitlements. As the Legal Environment Assessment in India further determined, "[T]he lack of documentation exacerbates already precarious circumstances that are ripe for TB to exploit, such as impoverishment due to job insecurity, and claustrophobic living conditions in urban slums."<sup>120</sup>

Some countries have taken steps to provide health care access for migrant populations, although the nature and extent of these provisions vary substantially among countries and regions. South Africa is one good example, a leader in providing a legal framework for access to health services for all.<sup>121</sup> While there is no specific language on access for migrants, refugees or asylum seekers in South Africa's National Health Act, the legislation provides for free primary health care services for all persons,<sup>122</sup> and certain categories of migrants are subject to the same rights as South African citizens, including migrants who entered illegally

from states belonging to the Southern African Development Community (SADC).<sup>123</sup>

In Zimbabwe, while not targeting migrants specifically, mobile clinics provide free screening, diagnosis and referrals to health clinics where those who test positive for TB can access free TB treatment.<sup>124</sup> On the Namibian side of the Angola border, free TB and HIV services are provided to Namibians and Angolans alike, some of whom cross the border regularly to access health care services.<sup>125</sup> In Brazil, under Article 4 of the 2017 immigration legislation, Migration Law (N° 13.445), non-citizens are placed on equal

footing with citizens in access to public health, social welfare and social security,<sup>126</sup> and migrants have access to universal health coverage regardless of their legal status;<sup>127</sup> access is available without payment of a premium, and most health services do not require co-payment.<sup>128</sup> Thailand mandates equal access to social security benefits, including health services, for people who have paid taxes, regardless of immigration status;<sup>129</sup> however, migrants may encounter enrollment barriers<sup>130</sup> as well as potentially unaffordable premiums for voluntary health coverage.<sup>131</sup>

### ACCESS TO TB AND HEALTH SERVICES FOR MIGRANTS IN SOUTH AFRICA

The South African National Health Act and regulatory framework are notable for the provision of access to health care services for all persons in South Africa, including migrants.<sup>132</sup> This enabling framework is especially critical given the country's role as a regional economic hub and magnet for migration in the SADC region,<sup>133, 134</sup> and because TB is the leading cause of mortality.<sup>135</sup> Moreover, access to health services for migrants is critical given the country's industrial infrastructure, notably its mining industry, which contributes to the spread of TB in the SADC region — as miners in South Africa, many of whom are migrants from elsewhere in the region, continue to face extremely high risk of tuberculosis as an occupational hazard.<sup>136</sup>

Migrants permanently resident in the country who have not attained citizenship, migrants with temporary residence or work permits, and migrants who entered illegally from SADC states have access to reduced fees under the Uniform Patient Fee Schedule.<sup>137</sup> In Gauteng province, where many migrants reside, undocumented migrants of SADC, asylum seekers, permanent residents and non-South Africans with temporary resident or work permits are entitled to a means test for higher levels of care (i.e., at hospital) and, as such, receive the same health benefits as South African citizens.<sup>138</sup>

Under this progressive framework, however, there is an urgent need for full implementation and enforcement. Administrative

barriers remain a challenge in practice in some settings.<sup>139</sup> Administrative officers at health facilities act as “gatekeepers” in ways that undermine migrants’ access.<sup>140</sup> There have been documented cases of improper demands for upfront fees from migrants seeking emergency treatment, as well as misclassification of refugees and asylum seekers, who were classified as full fee-paying patients.<sup>141</sup> In urban centres — such as Johannesburg, a hub for many internal and international migrants — state authorities have at times scapegoated migrants for the poor functioning of the health care system.<sup>142</sup>

*“Treatment continuity is of course key but basic access to healthcare is difficult for non-nationals in South Africa. This is due to a range of reasons, notably linked to a reluctance by healthcare facility managers and frontline staff to implement existing protective legislation at a local level. The South African public healthcare system is struggling and all who are reliant on it - including South African citizens - face access challenges. But non-nationals face specific challenges associated with language barriers, unnecessary demands for documentation, and anti-foreigner sentiments. Many international migrants are fearful of accessing healthcare for fear of being reported, detained and deported should they not have the documentation required to be in the country legally.”*

—Jo Veary, African Centre for Migration & Society, South Africa

### THE RIGHT TO HEALTH FOR UNDOCUMENTED MIGRANT WORKERS IN THAILAND

In May 2018, there were 2,189,868 registered migrants in Thailand, yet there were many more who were undocumented, including many from Myanmar, Cambodia and Laos.<sup>143</sup> Approximately 10% of the workforce and 3 million migrant workers travel from Myanmar to Thailand for work in the fishing, tourism and other industries.<sup>144</sup> Cambodia is a migrant-sending country, with most employment-seekers migrating to Thailand.<sup>145</sup> TB is a significant issue for migrant workers — Cambodian migrant workers being deported from Thailand have TB rates almost four times higher than the general Cambodian population, at 1,000 per 100,000.<sup>146</sup>

While migrants often attempt to migrate to Thailand regularly, due to cost and other barriers, many have no choice but to do so irregularly,<sup>147</sup> in some cases relying on unlicensed brokers or other means.<sup>148</sup> Lack of documentation increases the risk of human trafficking, exploitation and health vulnerabilities,<sup>149</sup> and migrants often face poor living and working conditions, poor nutrition and low pay,<sup>150</sup> putting them at high risk for tuberculosis.<sup>151</sup>

While Thailand has one of the more progressive policies on undocumented migrant health coverage among high-burden tuberculosis countries — with a separate insurance scheme for migrant workers not covered, including undocumented migrants<sup>152</sup> — at 22,000 baht, the voluntary insurance coverage may be prohibitively expensive, with the effect of limiting access to TB and other health services. This, in turn, has created challenges for Cambodia ensuring that upon deportation or voluntary return, there is adequate access to TB testing and screening.<sup>153</sup>

The recent strict criminal measures imposed in Thailand, which penalize irregular migrants with up to five years of prison time and hefty fines<sup>154</sup> and have been accompanied by mass deportations of irregular migrants, are likely an additional deterrent to health seeking, along with cost. At the Northwest Cambodian border,<sup>155</sup> there were reportedly 3,750 deportations in April<sup>156</sup> and 6,932 in June 2018.<sup>157</sup> Internationally run programs have been set up to target the population of deported Cambodian migrant workers through systematic screening and case referrals,<sup>158</sup> highlighting the scope of the TB and health vulnerabilities and barriers for migrant workers in the region who are subject to deportation at this border.

In OECD countries, approaches vary widely with respect to health coverage for undocumented migrants. Among OECD countries receiving high numbers of migrants, four provide no legal entitlement to health services or limit such services solely to emergency procedures (Table 2). With

certain limitations (such as the period of time spent in the country), irregular migrants in France receive health services free of charge.<sup>159</sup> Likewise, emergency and primary care in the United Kingdom is free regardless of immigration status.<sup>160</sup> However, even in high-income countries that provide health

care access to migrant populations, migrants still encounter impediments or deterrents to health service utilization, including fear of deportation, language barriers, or lack of awareness of their legal rights to health coverage.<sup>161, 162</sup>

### DO A COUNTRY'S LAWS PROVIDE FOR ACCESS TO PRIMARY HEALTH CARE FOR UNDOCUMENTED MIGRANTS?

OECD Receiving Countries Receiving High Numbers of Migrants and Refugees	No legal entitlement or emergency only (No) Legal entitlement to at least free or affordable primary health services (Yes)
USA	No <sup>163</sup>
Canada	No <sup>164</sup>
Germany	No <sup>165</sup>
UK	Yes <sup>166</sup>
Spain	Yes <sup>167</sup>
Italy	Yes <sup>168</sup>
Turkey	No <sup>169</sup>
Switzerland	Yes <sup>170</sup>
France	Yes <sup>171</sup>

Table 2

Restrictions on access to health services for undocumented migrants are quite common in Europe. A 2012 study found that of the 27 European countries surveyed, in 10 states even emergency care was inaccessible for undocumented migrants since it is not affordable, twelve states provide only emergency or urgent care to undocumented migrants, while in only five states are undocumented migrants entitled to health services beyond emergency care for no or a moderate fee.<sup>172</sup>

Withholding essential health services for people with TB undermines global TB control efforts. As TB is preventable, treatable and often curable through the timely provision of affordable diagnostic and treatment strategies — and as discontinuity of treatment can lead to potentially deadly drug resistance — the entire global community has an important stake in providing timely diagnostic and treatment services and in ensuring continuity of care for all people receiving TB treatment or TB prophylaxis.

Withholding health services on the basis of immigration status also represents a clear violation of international human rights covenants. States are obligated to respect the right to health by refraining from “denying or limiting equal access for all persons, including ... asylum seekers and illegal immigrants, to preventive, curative and palliative health services.”<sup>173</sup> States must also abstain from imposing discriminatory practices.<sup>174</sup> As such, the right to health care clearly

encompasses the right to affordable prevention, primary and secondary health services. WHO’s recommendations for the Global Compact on migration and the Resolution on Promoting the Health of Refugees and Migrants includes the promotion of continuity and quality of care as a priority “in particular for ... people living with HIV/AIDS, tuberculosis... and other chronic health conditions...”<sup>175</sup>

In many countries, there is also a compelling case to be made that prohibitions or limitations of health services for undocumented migrants violate national constitutions. Countries with a right to health have been shown to provide more and better health services and achieve better health outcomes.<sup>176</sup> Provisions guaranteeing the constitutional right to health have been critical to holding state actors accountable in tuberculosis-related human rights litigation, including in Colombia<sup>177</sup> and Kenya,<sup>178</sup> as have the constitutional rights to freedom from degrading and inhuman treatment and the right to life,<sup>179</sup> among others. The right to health has also been a key legal protection in other health-related human rights litigation, such as in the context of detention and abuse of post-partum women in health facilities,<sup>180</sup> and in cases concerning access to antiretroviral medicines.<sup>181</sup> More than half of countries globally provide some measure of constitutional protection of the right to health, with a 2013 study finding that 105 out of 191 countries surveyed provide some measure of constitutional protection of the

right to health, though the scope of the right varies significantly.<sup>182</sup>

Some countries provide for a constitutional right to health for “all,” “everyone” or similar, which can provide a legal basis for equal access for migrants and refugees. This is the case in South Africa, where the constitution provides that “everyone” has the right to access healthcare services and that “no one” can be refused emergency medical services.<sup>183</sup> Other constitutions, however, specify only that “citizens” have a right to health, rather than explicitly extending that right to all. One example is China, where Article 45 of the Constitution obligates the state to develop social insurance and social relief and provide medical and health services for citizens.<sup>184</sup> Undocumented migrants can typically access TB and other health services if they pay out of pocket but may be required to provide identification documents and a valid visa.<sup>185</sup> Similar examples are found throughout the world, such as Article 29 of Mozambique’s constitution, which provides citizens the right to medical and health care within the terms of the law;<sup>186</sup> Myanmar’s constitution, which provides the right to health care for every citizen;<sup>187</sup> and Vietnam’s constitution which provides entitlement to health care for its citizens.<sup>188</sup> Such limitations may or may not be dispositive, but they align poorly with the need to ensure that migrants have equitable access to TB services and other health care, as expected in international standards.

### DOES THE CONSTITUTIONAL TEXT PROVIDE FOR A RIGHT TO HEALTH FOR ALL (VS. ONLY TO CITIZENS)?

Angola	Yes <sup>225</sup>
Bangladesh	No <sup>226</sup>
Brazil	Yes <sup>227</sup>
Cambodia	Yes <sup>228</sup>
China	No <sup>229</sup>
Congo (Republic of)	n/a
Central African Republic	n/a
Democratic Peoples’ Republic of Korea	No <sup>230</sup>
Democratic Republic of Congo	Yes <sup>231</sup>
Ethiopia	n/a
India	n/a

Indonesia	Yes <sup>232</sup>
Kenya	Yes <sup>233</sup>
Lesotho	n/a <sup>234</sup>
Liberia	n/a
Mozambique	No <sup>235</sup>
Myanmar/Burma	No <sup>236</sup>
Namibia	n/a
Nigeria	n/a <sup>237</sup>
Pakistan	n/a
Papua New Guinea	n/a
Philippines	Yes <sup>238</sup>

Russian Federation	No <sup>239</sup>	Canada	n/a
Sierra Leone	n/a <sup>240</sup>	Germany	n/a <sup>246</sup>
South Africa	Yes <sup>241</sup>	UK	n/a
Thailand	No <sup>242</sup>	Australia	n/a
Tanzania, United Republic of	n/a	Spain	Yes <sup>247</sup>
Vietnam	No <sup>243</sup>	Italy	Yes <sup>248</sup>
Zambia	n/a <sup>244</sup>	Turkey	n/a
Zimbabwe	No <sup>245</sup>	Switzerland	n/a
USA	n/a	France	n/a <sup>249</sup>

Table 3 Continued

Right to health is in in the constitution and is seems to apply to “all people” or other inclusive language (yes)

Only mentions citizen or expressly excludes non-citizens (no)

N/A — No express right to health in the constitution

An important step toward both realizing migrants' right to health and strengthening TB control efforts is to enhance regional harmonization and collaboration, in line with the right to health. A case in point is SADC, a region with high TB prevalence and incidence and substantial migration but where cross-border referral systems for TB care are rare.<sup>189, 190</sup> Aiming to improve referral systems and continuity of care in the region, the SADC region has implemented a number of relevant regional protocols, frameworks and measures, including the Protocol on Health in the SADC Region and the Harmonised Minimum Standards for the Prevention, Treatment and Management of Tuberculosis in the SADC Region, which call for increased coordination and harmonization of treatment protocols. In addition, the Strategic Framework for Cross-Border and Regional Programming in Tuberculosis (TB) Prevention and Control for East, Central and Southern Africa Health Community (ECSA-HC) Region sets forth specific targets in cross-border management of tuberculosis, including that member states should provide free treatment to all, including mobile populations (with a target of 70% for 2018 and 100% for 2020), and member states should establish and have in place functional cross-border committees, with a target of 100% by 2020.<sup>191</sup> The strategic

framework also provides that migration laws, regulations and treaties “among and between member states that facilitate unhindered access to TB care services for mobile populations” are required. The SADC Declaration and Protocol for the Harmonized Management of TB in the Mining Sector also sets forth a framework for countries to follow to ensure continuity of care for miners, including cross-border linkages, referral and feedback mechanisms, and mapping of current and ex-mineworkers, among others. The SADC Policy Framework for Population Mobility and Communicable Diseases recognizes the need to improve cross-border referral systems, because “patients do get lost to health systems once they cross borders and may be re-started on treatment as new patients thus increasing the chance of drug resistance and sub-optimal outcomes.”<sup>192</sup> The TB and Population Mobility Guidelines specifically provide for establishment of SADC regulated cross-border notification and referral systems for DR-TB.<sup>193</sup> However, while drafted in 2009, this framework remains in draft form because of a reluctance by certain member states to ratify it, due to unwarranted fears that such a regional framework would lead to patient mobility into better resourced countries such as South Africa, Botswana and Namibia.<sup>194</sup>

While these frameworks provide a basis for increasing access to affordable, uninterrupted TB treatment, their promise has yet to be realized due to the general absence of domestic frameworks. Health passports, while touted as a potentially transformative intervention to improve health access and continuity for migrants, have yet to be implemented.

### NATIONAL STRATEGIC PLANS FOR TB

While not legislative measures, national strategic plans (NSP) on tuberculosis are critical planning documents for the tuberculosis response in many countries, including to ensure evidence-based and targeted approaches to address the needs of vulnerable populations. As such, where such strategies include migrants, there is potential to increase accountability and clarify and expand the scope of migrants' access to TB prevention, testing and treatment. Strategic plans are an opportunity to form a cohesive national-level plan to implement an effective approach to TB, and to include specific interventions for those most at risk.

Some countries specify migrants as vulnerable, key or marginalized populations in their NSPs. India, for example, recognizes migrant workers, refugees, internally displaced people

and undocumented migrants as key affected populations due to their limited access to quality TB services.<sup>195</sup> The Indian NSP further specifies migrant-specific activities, including undertaking detailed review of accessibility issues, including in the context of “authorities dealing with migrants...”<sup>196</sup> and enhancing or implementing TB surveillance for migrants and other vulnerable populations.<sup>197</sup> Similarly,

the Namibian National Strategic Plan recognizes the vulnerability of mobile populations, providing that cross-border populations, migrants and nomadic groups are key populations at higher risk of TB and/or facing barriers accessing care.<sup>198</sup> Provision of activities or programmes to address the needs of migrants and refugees may assist in ensuring

that adequate financial and human resources are targeted to the identified activities.

However, where countries do not have NSPs in place, or where migrants and mobile populations are not specifically identified as vulnerable populations, this is a missed opportunity to set forth targeted plans and interventions to address their needs.

### DOES THE COUNTRY’S NATIONAL STRATEGIC PLAN FOR TUBERCULOSIS SPECIFICALLY INCLUDE MIGRANTS OR REFUGEES (INCLUDING SUB-POPULATIONS OF MIGRANTS) AS A KEY, VULNERABLE OR HIGH-RISK POPULATION FOR TB?

Bangladesh <sup>250</sup>	Yes	Kenya <sup>257</sup>	Yes	Russian Federation <sup>265</sup>	No
Brazil <sup>251</sup>	No	Liberia <sup>258</sup>	Yes	South Africa <sup>266</sup>	No
Cambodia <sup>252</sup>	Yes	Mozambique <sup>259</sup>	Yes	Sierra Leone <sup>267</sup>	Yes
China <sup>253</sup>	Yes	Myanmar <sup>260</sup>	Yes	Thailand <sup>268</sup>	Yes
Democratic Republic of the Congo <sup>254</sup>	Yes	Namibia <sup>261</sup>	Yes	Tanzania <sup>269</sup>	No
Ethiopia <sup>255</sup>	No	Nigeria <sup>262</sup>	Yes	Vietnam <sup>270</sup>	Yes
India <sup>256</sup>	Yes	Pakistan <sup>263</sup>	Yes	Zimbabwe <sup>271</sup>	Yes
		Philippines <sup>264</sup>	No		

Table 4

## C. DEPORTATION AND CONTINUITY OF CARE

While limited information is available concerning the extent to which deportation on the basis of TB status occurs globally, deportation of migrant workers on the basis of TB status has been documented in several Gulf countries, including the United Arab Emirates (UAE),<sup>199</sup> Oman,<sup>200</sup> and Qatar.<sup>201</sup> UAE law requires migrant workers to undergo TB

testing, and a latent, active, or suspected prior TB diagnosis generally results in deportation and refusal of a work permit.<sup>202</sup> In Russia, the law allows for revocation of an entry permit on the basis of health status or where a permit holder does not have a certificate on “the absence of illness”,<sup>203</sup> such persons can be subject to deportation if they do not leave the country within 15 days.<sup>204</sup> In some countries, “prohibited” migrants who have entered the country, including those

who were “prohibited” from entry on the basis of TB or health status, may be subject to deportation, including, for example, in Liberia,<sup>205</sup> South Africa<sup>206</sup> and Tanzania.<sup>207</sup> A 2008 survey of 26 low- and intermediate-incidence countries found that in most, the law allowed for deportation while individuals were on TB treatment and/or this occurred in practice.<sup>208</sup>

### TB, DEPORTATION AND THE RIGHT TO HEALTH FOR MIGRANT WORKERS IN THE UAE

The challenges of migrants with TB are vividly illustrated in the United Arab Emirates (UAE), where migrants account for 88.4% of the total population.<sup>209</sup> Through the country’s kafala system, migrants are legally bound to specific employers and subjected to extremely low wages and highly exploitative work environments<sup>210</sup> that increase their vulnerability to forced labor, human trafficking and egregious human rights abuses.<sup>211</sup> Low wages can lead to housing in close quarters, which can increase the risk of TB transmission. While recent reforms have established

minimum labor standards for migrant workers in the UAE,<sup>212</sup> migrant workers still have much weaker legal protections than Emirati workers.<sup>213</sup>

A January 2018 Universal Periodic Review submission by the Treatment Action Group documented violations of the rights to health and science of migrant workers in the context of tuberculosis, including the use of unsound TB screening procedures and deportation decision-making whereby individuals with latent TB or without any history of TB were deported on the basis of having lung scars.<sup>214</sup> Lung scars can result from tuberculosis, a past case of tuberculosis, or other conditions, and

it is not possible to differentiate the cause with the diagnostic tool used.<sup>215</sup> Individuals who never had TB or TB symptoms, but did have lung scars from previous respiratory conditions, were deported. These policies have the potential to impact many individuals. In Abu Dhabi alone (one of nine emirates) in 2016, there were 400 new visa applicants (an unknown number of whom are already in the country) and 199 renewal applications where TB was detected.<sup>216</sup>

Under the law, the new visa applicants in the country at the time would be subject to deportation in the case of TB, while migrant workers renewing their visas would be required to undergo mandatory hospitalization and treatment.<sup>217</sup> Aiming to encourage people with TB to come forward for health care,<sup>218</sup> a new rule introduced in 2016 (Decree No. 5/2016) imposed testing requirements for visa renewals, previously only required

for first-time visa applicants, as well as treatment and involuntary hospitalization requirements<sup>219</sup> for renewal migrant workers with TB, under threat of deportation. Those unable to complete the treatment are rendered medically unfit and deported to their home country; visa renewals are conditional on treatment success.<sup>220</sup> The law has been the subject of media attention, including underscoring that there was a lack of clarity concerning its implications.<sup>221</sup>

These laws and practices concerning TB and deportation should be aligned with international standards and the Gulf Cooperation Council Human Rights Declaration, which provides that all people are to be treated equally regardless of their origin and provides that every person has the right to health care and to the benefits of scientific progress.<sup>222</sup>

Deportation on the basis of TB status also undermines sound TB control by deterring health-seeking behavior among migrants with known or suspected TB infection. To address these issues, WHO Europe recently emphasized that states must ensure universal health coverage for documented

and undocumented refugees and asylum seekers in line with the European Region consensus document on the minimum package of cross-border TB control and care interventions,<sup>223</sup> which specifically includes a non-deportation policy until intensive TB treatment has been completed.

Recognizing that deportation can interfere with TB treatment, some countries have taken measures such as issuing temporary legal status for irregular migrants until the completion of treatment.<sup>224</sup>

## D. COERCIVE TREATMENT FOR MIGRANTS WITH TB

Some countries require that migrants who are identified upon screening as having

active TB undergo treatment as a condition of gaining legal status. This approach is especially common for refugees and asylum seekers, with prevalence rates documented as high as 9% to 45% for latent TB and 11% for active TB.<sup>272</sup> Among heavy migrant-receiving

countries in Europe, for example, countries that have treatment requirements for refugees with active TB include France, Italy, Spain and Turkey.<sup>273</sup>

### COUNTRIES REQUIRING REFUGEES TO UNDERGO TB TREATMENT BASED ON A 2016 SURVEY<sup>274</sup>

Country	Active TB screening for refugees	Latent screening for refugees	Requirement to undergo treatment for refugees
Germany	Routine	Not routine	No
UK	Routine	Routine	No
Spain	Routine	Routine	Yes
Italy	Not routine	Not routine	Yes
Turkey	Routine	Routine	Yes
Switzerland	Routine	None	No
France	Routine	Routine	Yes

Source: ERS and WHO Europe: Tuberculosis Care Among Refugees Arriving in Europe: a ERS/WHO Europe Region Survey of Current Practices

Table 5

Countries that have stepped forward to host large numbers of refugees and asylum seekers merit praise and appreciation. However, conditioning legal status or visas upon submitting to testing and treatment violates international rights standards. According to General Comment 14, a key element of the right to health is “the right to control one’s health and body, including ... the right to be free from ... non-consensual medical treatment.”<sup>275</sup> As such, compulsory treatment is an impermissible violation of the right to bodily integrity and contrary to international human rights standards.<sup>276</sup> The United Nations Special Rapporteur on the Right to Health has specifically emphasized that mandatory hospitalisation and forced treatment for TB patients fails to respect

human rights, creates fear and stigma with respect to TB and people with TB, and may drive people with TB symptoms away from health systems.<sup>277</sup> Involuntary approaches to treatment impede the rights to health, informed consent, freedom from inhuman and degrading treatment, and freedom of movement, among others.<sup>278</sup>

The human rights implications of coercive treatment are especially serious when such practices are imposed on a highly vulnerable population, such as refugees, many of whom have already undergone extreme hardship and trauma and may have suffered other rights violations during the forced migration process. Refugees may have few immigration alternatives, which may

disempower them from enforcing their rights during the immigration process. They may be concerned that treatment refusals could result in adverse immigration consequences (e.g., such as refusal of asylum), making the imposition of coercive treatment especially egregious.<sup>279</sup>

Nor is coercive treatment consistent with the tenets of recommended TB control, which recognize that testing<sup>280</sup> and treatment should in all cases be voluntary.<sup>281</sup> In very rare cases in which a refusal of treatment may threaten the further spread of TB, isolation is available to protect the public health, subject in all cases to due process of law.<sup>282</sup>

## E. MIGRATION DETENTION AND TB

Every year, hundreds of thousands of migrants are held in migration or administrative detention solely on the basis of their immigration status. The United States holds, by far, the largest number of persons in migration detention (323,591 in 2017), followed by Malaysia (86,795 migrants), France (45,937), the Russian Federation (37,526), and the United Kingdom (32,526).<sup>283</sup> The length of detention, procedural safeguards, and conditions in detention settings vary significantly by region and country. Seventy percent of those held in detention in the United States are held for less than a month,<sup>284</sup> while migrants in Malaysia are typically detained for periods between two months and two years.<sup>285</sup> Contrary to international standards,<sup>286</sup> laws in some countries directly or implicitly allow for indefinite migrant detention.<sup>287</sup>

Migration detention conditions often fail to meet minimum international standards, with substantial overcrowding, poor access to health services, inadequate procedural and due process safeguards, and prevalent abuse, including degrading treatment such as shackling of detainees.<sup>288</sup> These conditions also occur in countries with high

TB burdens. For example, in Indonesia, some centers are overcrowded and have been described by Human Rights Watch as “appalling” and rife with physical abuse.<sup>289</sup>

Although definitive evidence is not available on TB transmission in the context of migrant detention, there are reasons to believe that the conditions in which migrants are often detained may contribute to transmission of the disease. Migrants as a population are highly vulnerable to TB, and other settings that deprive people of their liberty, such as prisons and jails, are centers for TB transmission. Many migratory populations, including refugees and asylum seekers, are held in correctional facilities, in violation of international standards that expressly prohibit the detention of asylum seekers and irregular migrants in police stations, prisons and remand institutions designed for people in the criminal justice system.<sup>290</sup> TB and HIV prevalence among prisoners and persons deprived of liberty are up to 1,000 times the rates of the general population, and in some high-burden countries, prison populations account for 25% of the TB burden.<sup>291</sup>

Detention and/or deportation undermines TB control by contributing to interruption or discontinuation of TB treatment or prophylaxis. Continuity of TB care demands integrated referral mechanisms, but referral

mechanisms are generally lacking when migrants with TB are deported or when internal migrants with TB return to their home.<sup>292</sup> The typical failure of detention and deportation systems to ensure continuity of TB care not only undermines the health and well-being of migrants living with TB but also increases risks of TB transmission (including drug-resistant TB) to the communities to which migrants return.

Apart from their counterproductive public health impact, many national policies, such as automatic or mandatory detention, clearly violate international law. The right to liberty and security of person as guaranteed by Article 3 of the Universal Declaration of Human Rights and Article 9 of the ICCPR extends to “everyone” and, more specifically, “to all persons at all times and circumstances, including migrants and asylum seekers, irrespective of their citizenship, nationality or migratory status.”<sup>293</sup> Further, pursuant to accepted norms related to the restriction of rights and official United Nations criteria established specifically to guide deprivation of liberty of migrants, immigration detention is only permissible as an exceptional measure of last resort, for the shortest period, and only when utilized for a legitimate purpose.<sup>294</sup> The draft Global Compact provides that states may utilize immigration detention solely as a

measure of last resort and work toward alternative approaches.<sup>295</sup> Because detention in the context of migration, just as any restriction of rights, must be proportionate, and detention decisions must be made on an individual basis, automatic or mandatory detention is arbitrary and impermissible.<sup>296</sup>

UNHCR, The United Nations Refugee Agency, has developed the Beyond Detention strategy to end the detention of asylum seekers and refugees by 2019. The strategy aims to (1) end the detention of children; (2) ensure that alternatives to detention are available in law and implemented in practice; and (3) ensure that conditions of detention, where detention is necessary and unavoidable, meet international standards.<sup>297</sup> While there has been modest progress in implementation of this strategy, a pressing need remains to ensure that domestic legal frameworks comply with international standards and ensure rights and procedural safeguards in detention.<sup>298</sup>

In the rare circumstances where detention of migrants may be required, international instruments outline clear rights and protections related to the conditions of such detention. These international provisions make plain that the denial of medical care or the provision of substandard health services to migrants is legally impermissible. All detained migrants have the right to access free appropriate medical care, including mental health care.<sup>299</sup> The Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) require states to provide free health care for persons deprived of liberty without discrimination on grounds of their legal status in a way

that ensures continuity of treatment of care for tuberculosis, HIV and other infectious diseases.<sup>300</sup> The Mandela Rules specifically provide that a physician or qualified health professionals should see, speak with and examine persons deprived of liberty, paying particular attention to identifying health care needs and taking all necessary measures for treatment,<sup>301</sup> which would include voluntary tuberculosis screening and treatment.

#### **LEGAL FRAMEWORKS DO NOT ADEQUATELY PROTECT THE RIGHT TO HEALTH IN MIGRATION DETENTION**

United Nations guidance mandates that irregular immigration should never be considered a criminal offense, because this is disproportionate and always exceeds legitimate state interests.<sup>302</sup> Still, unauthorized entry or stay is a criminal offense, rather than an administrative matter, in many countries. Other countries lack legal frameworks that regulate migration detention and provide standard procedures for the provision of health services for migrants in detention.<sup>303</sup> The application of criminal offences or the lack of appropriate legal frameworks often means that immigration issues are handled through the criminal justice system, where migrants and refugees are often detained in correctional centers. International standards expressly prohibit the detention of asylum seekers and irregular migrants in police stations, prisons and remand institutions designed for those within the criminal justice system.<sup>304</sup> Still, in a number of high-burden tuberculosis countries, migrants, including some refugees and asylum seekers, are detained in prison facilities. This is the case in South Africa, where irregular migrants

are held in police holding cells prior to admission to migration detention centers, and in Botswana, where refugees and asylum seekers have been held in the same facilities as general prison populations.<sup>305</sup>

In some cases, such detention is expressly authorized in domestic law. In Kenya, Article 43 of the 2011 Kenya Citizenship and Immigration Act provides that a person “unlawfully present” in Kenya can “be kept and remain in police custody, prison or immigration holding facility.”<sup>306</sup> In other cases, the right to detain people who are deemed to be in the country illegally may be based on powers implied in national constitutional or legal frameworks.

While there is overlap between the needs and vulnerabilities of all detained people, whether they are detained for penal, migration or other reasons, there are also unique characteristics of migration detention and its related health needs that warrant the development of law and policy specific to that context. The need to provide for continuity of care throughout the deportation process is one example of why such laws and policies are warranted. But it is not only the unique demands of migration detention that compel the need for law and policy explicitly and specially directed to that context. The fact that most law and policy related to detention has been developed in the context of penal law means that migrants, and the governmental departments charged with matters related to them, slip through the cracks in the legal framework. The experience of South Africa’s Lindela Repatriation Centre is illustrative.

## TB AND THE RIGHT TO HEALTH IN THE LINDELA REPATRIATION CENTRE, SOUTH AFRICA

Over the past twenty years, human rights organizations and the South African Human Rights Commission have repeatedly documented health and other human rights abuses in the Lindela Repatriation Centre outside of Johannesburg, South Africa. These include severely inadequate access to health care services such as TB prevention, testing and treatment. The South African Human Rights Commission has issued several reports detailing such rights violations and making extensive “recommendations” to the Department of Home Affairs requiring action to address them. South African courts have also repeatedly condemned the Department of Home Affairs for failing to comply with court orders related to rights violations in Lindela.<sup>307</sup> Despite this attention, there has been little improvement in the conditions and practices at Lindela. Médecins Sans Frontières/Doctors Without Borders (MSF) highlighted in a June 2018 report that the Department of Home Affairs has for the most part failed to implement the recommendations of a 2014 report from the Human Rights Commission.<sup>308</sup> In particular, there remains no systematic TB or HIV screening, nor is there capacity within the detention center to ensure access to quality health services or measures in place to ensure continuity of treatment between police holding cells and Lindela — a particular concern in the context of TB and HIV.<sup>309</sup> Further, there are inadequate measures in place to ensure continuity of care when detainees are repatriated.<sup>310</sup>

### DOCUMENTATION OF RIGHTS VIOLATIONS RELATED TO HEALTH AT LINDELA

Inadequate access to health services in Lindela has been repeatedly documented over the course of more than 20 years. In 1997, Human Rights Watch found that detainees with septic wounds and undiagnosed illness were refused access to doctors.<sup>311</sup> A 2010 University of the Witwatersrand study found that of those seeking access to health care, 19% were not given access because their requests were ignored or they were given medication or bandages by the Lindela or Bosasa staff; 29% were given pain medication without attempt to diagnose their conditions; and of those on medication, including ARVs, 62% did not have access to their medications while at Lindela.<sup>312</sup> Notably, 54% of those who sought health care did not feel that their condition had been adequately treated.<sup>313</sup> In a 2014 investigation by the South African Human Rights Commission,

Lindela staff reported that only four detainees out of between 1,200 to 1,500 were on treatment for TB, a treatment rate dramatically below any estimation of TB prevalence.<sup>314</sup> In that same investigation, only five out of 109 detainees responding to a survey conducted by the Commission reported having ever been tested for TB.<sup>315</sup> South African courts have repeatedly acknowledged and condemned unlawful conditions of detention in prisons, particularly as they relate to access to TB services.<sup>316</sup>

### LEGAL FRAMEWORK AND THE CURRENT SITUATION

These conditions stand in sharp contrast to South Africa’s legal framework, which guarantees the right of everyone, including migrants, to access to TB and other services.<sup>317</sup> It also contrasts national policy, which prioritizes cross-border collaboration on HIV, TB and STI policy and programming and targets “mobile populations, migrants and undocumented foreigners” for TB interventions.<sup>318</sup>

To date, there are no national guidelines specific to immigration detention in South Africa, with the exception of those set out in Annexure B to the 2014 immigration regulations. Annexure B consists of a single page setting out “Minimum Standards of Detention,” such as the requirements that detainees be provided “an adequate balanced diet,” means to maintain personal hygiene, and “adequate space, lighting, ventilation, sanitary installations and general health conditions and access to basic health facilities.<sup>319</sup> As such, Annexure B provides little more detail on the required conditions of detention than does section 35(2)(e) of the South African Constitution. The Department of Home Affairs maintains that the correctional facilities guidelines on health care apply to immigration detention. However, as shown above, these have not been implemented.

Moreover, there is also no independent institution charged with ongoing oversight over Lindela. Instead, the Judicial Inspectorate for Correctional Services is charged with such oversight over correctional centres. Indeed, migrants receive considerably less protection even than those detained for penal reasons.<sup>320</sup> All court orders and recommendations of the Human Rights Commission should urgently be implemented at Lindela. In addition, regulations and policy tailored to the migration detention context should be developed and implemented, and an independent oversight body with legislated powers and independence should be charged with monitoring and enforcing rights at Lindela.

# 5. ALIGNING NATIONAL LAWS AND POLICIES IN MIGRATION AND TB WITH INTERNATIONAL HUMAN RIGHTS INSTRUMENTS AND SOUND PUBLIC HEALTH PRINCIPLES

Given the degree to which many national legal and policy frameworks are inconsistent with international human rights principles and sound TB control approaches, it is apparent that urgent action is needed. Action is required at national, regional and global levels.

## COUNTRIES SHOULD:

Review and, where needed, revise laws and policies concerning immigration restrictions and deportation to ensure that they are aligned with international human rights and public health recommendations, including WHO guidelines, which provide that TB screening should be conducted solely for the purposes of providing appropriate medical care and never for the purposes of exclusion of entry, stay or residence.

Review and, where indicated, revise national frameworks concerning immigration, deportation and continuity of care and referral systems, in order to ensure that migrants have access to good-quality, affordable TB and other health services throughout the entirety of the migration process.

Review and, where indicated, revise national frameworks to align them with international standards on TB screening and treatment for migrants, including the prohibition on

conditioning immigration status on undergoing TB and other medical interventions.

Review and, where indicated, revise national frameworks and health programs to ensure free or affordable and rights-based TB prevention, diagnostics, treatment, care and support for all migrants and refugees, regardless of immigration status and without adverse immigration consequences.

Identify and effectively address all barriers to health care access confronting migrants, such as language, cultural and information barriers, among others.

Ensure continuity of care and harmonization of treatment for all migrants with TB, including the provision of adequate funding to implement rights-aligned frameworks in law, policy and practice.

Halt the practice of detaining migrants and refugees in correctional facilities, including prisons and police holding cells.

Ensure that legal frameworks clearly provide that immigration detention is only permissible as a last resort, for the shortest period, and solely for legitimate purposes, and that they establish processes to protect this limitation on detention.

Ensure that there is clear provision in law and policy for the right to TB and other health services in the context of immigration

detention and sufficient oversight of migration detention facilities.

Ensure that national TB control frameworks and action plans prioritize sound, rights-based responses to TB among migrants, in line with the principles and action steps outlined in the above-noted actions for countries.

## REGIONAL BODIES SHOULD:

Ensure the development and full implementation in law, policy and practice of frameworks to ensure regional continuity of TB care and harmonization of TB treatment protocols and standards, including full implementation of existing frameworks in SADC and the WHO Euro Region.

## THE GLOBAL COMMUNITY SHOULD:

Substantially elevate within a strengthened TB agenda the priority given to the universal access of migrants to TB diagnosis, prevention, treatment and care at all stages of the immigration process and to the essential need to align laws, policies and practices as they relate to TB and migration with recognized human rights instruments and principles.

Strengthen the routine reporting on human rights issues pertaining to TB and migrants.

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- 227 Constitution of Brazil, arts. 6 and 196-200. Article 196 provides that "health is a right of all and the duty of the National Government and shall be guaranteed by social and economic policies aimed at reducing the risk of illness and other maladies and by universal and equal access to all activities and services for its promotion, protection and recovery."
- 228 Constitution of Cambodia, Section 72 provides "the health of the people shall be guaranteed. The State shall pay attention to disease prevention and medical treatment. Poor people shall receive free medical consultations in public hospitals, infirmaries and maternity clinics." This provision refers to 'the people' while other provisions specifically provide for the rights of 'citizens.' Chapter III provisions are expressly applicable to Khmer citizens, while chapter VI provisions (including the right to health) does not expressly preclude non-citizens overall but do so in certain provisions including Articles 65 and 68 on education. Available at [https://www.constituteproject.org/constitution/Cambodia\\_2008?lang=en](https://www.constituteproject.org/constitution/Cambodia_2008?lang=en).

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- 230 Article 72 provides that citizens are entitled to free medical care, and all persons who are no longer able to work because of old age, illness or a physical disability, the old and children who have no means of support are all entitled to material assistance. This right is ensured by free medical care, an expanding network of hospitals, sanatoria and other medical institutions, State social insurance and other social security systems. Constitution of the Democratic Peoples' Republic of Korea.
- 231 Section 47 provides that the right to health and to [a] secure food supply is guaranteed. Political rights are limited to Congolese citizens; most other rights in the Bill of Rights including the right to health (art. 47) are enjoyed by all, including migrants. Constitution of the Democratic Republic of the Congo, art. 47 available at [https://www.constituteproject.org/constitution/Democratic\\_Republic\\_of\\_the\\_Congo\\_2011.pdf?lang=en](https://www.constituteproject.org/constitution/Democratic_Republic_of_the_Congo_2011.pdf?lang=en).
- 232 Article 28H provides "[e]very person shall have the right to live in physical and spiritual prosperity, to have a home and to enjoy a good and healthy environment and shall have the right to obtain medical care. Constitution of Indonesia, art. 28H.
- 233 Constitution of Kenya, art. 43.
- 234 Article 27 of the Constitution provides that the promotion of health is a matter of state policy, which is not justiciable. This protection is expressly limited to citizens under Article 27. Lesotho Constitution, art. 27.
- 235 Articles 89 and 116 of the Constitution recognize the right to health. Section 89 provides "[a]ll citizens shall have the right to medical and health care, within the terms of the law, and shall have the duty to promote and protect public health."
- 236 Section 367 restricts the right to health to citizens. Constitution of Myanmar, section 367.
- 237 Section 17(3)(c) and (d) of the Constitution provides that the State shall direct its policy towards ensuring that: (c) the health, safety and welfare of all persons in employment are safeguarded and not endangered or abused; and that(d) there are adequate medical and health facilities for all persons, available at <http://www.nigerialaw.org/ConstitutionOfTheFederalRepublicOfNigeria.htm>.
- 238 Section 11 of Article XIII on Social Justice and Human Rights provides that the State shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost; that there shall be priority for the needs of the underprivileged, sick, elderly, disabled, women, and children; and that the State shall endeavor to provide free medical care to paupers.
- 239 Section 41(1) of the Constitution provides that "everyone shall have the right to health protection and medical care" and "medical care in State and municipal health institutions shall be rendered to citizens free of charge at the expense of the appropriate budget, insurance premiums and other proceeds." Available at [https://www.constituteproject.org/constitution/Russia\\_2014?lang=en](https://www.constituteproject.org/constitution/Russia_2014?lang=en).
- 240 There is no constitutional right to health; health is a social objective. Sierra Leone Constitution, section 8.
- 241 Section 27 of the Constitution of South Africa provides that "everyone" has the right to access healthcare services and that "no one" can be refused emergency medical services.
- 242 Chapter III sets forth "rights and liberties of the Thai people" including section 47 which provides "[a] person shall have the right to receive public health services provided by the State" and "an indigent person shall have the right to receive public health services provided by the State free of charge as provided by law." Section 47 also provides that "[a] person shall have the right to the protection and eradication of harmful contagious diseases by the State free of charge as provided by law." Constitution of Thailand, section 47.
- 243 Article 38 of the constitution provides "[t]he citizen is entitled to health care and protection, equal in the use of medical services, and has the duty to practice regulations with regards to prophylactics, and medical examination and treatment." Vietnam Constitution, art. 38.
- 244 While there is no constitutional right to health, Article 112(d) of the Constitution provides as a matter of state policy a nonjusticiable right to 'adequate medical and health facilities for all. n
- 245 Section 76 (1) provides that every citizen and permanent resident of Zimbabwe has the right to access basic health-care services, which include reproductive health-care services; Section 76 (2) provides that every person living with a chronic illness has a right to have access to basic health-care services for the illness; Section 76 (3) provides that no person may be refused emergency medical treatment in any health-care institution. Sub-section one is specifically limited to citizens and permanent residents. Zimbabwe Constitution, section 76.
- 246 In Germany, while the right to health is included in the constitutions of several states, it is not included in the Federal Constitution. Mchale, Fundamental Rights and Healthcare, available at [http://www.euro.who.int/\\_\\_data/assets/pdf\\_file/0004/138163/E94886\\_ch06.pdf](http://www.euro.who.int/__data/assets/pdf_file/0004/138163/E94886_ch06.pdf), at 293.
- 247 Constitution of Spain, art. 43.

- 248 Article 32 of the Italian Constitution provides “[t]he Republic safeguards health as a fundamental right of the individual and as a collective interest and guarantees free medical care to the indigent” and “[n]o one may be obliged to undergo any health treatment except under the provisions of the law.” Constitution of the Italian Republic, art. 32.
- 249 In its preamble, France’s Constitution provides that it shall guarantee to all, notably to children, mothers and elderly workers, protection of their health, material security, rest and leisure.
- 250 Government of the People’s Republic of Bangladesh - Ministry of Health and Family Welfare - Directorate General of Health Services - National Tuberculosis Control Programme (NTP), National Strategic Plan for Tuberculosis Control (2018-2022). Migratory populations are included as special and high-risk populations. At 54, 72, and 82.
- 251 Governo do Brasil - Ministério da Saúde - Secretaria de Vigilância em Saúde - Departamento de Vigilância das Doenças Transmissíveis, Brasil Livre da Tuberculose Plano Nacional pelo Fim da Tuberculose como Problema de Saúde Pública (2017-2020). Available in Portuguese at [http://bvms.saude.gov.br/bvs/publicacoes/brasil\\_livre\\_tuberculose\\_plano\\_nacional.pdf](http://bvms.saude.gov.br/bvs/publicacoes/brasil_livre_tuberculose_plano_nacional.pdf) Vulnerable populations include people living with HIV, people experiencing homelessness, prison populations, health care professionals, and indigenous populations. At 52.
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- 254 Republique Democratique du Congo - Ministere de la Sante et de la Population - Programme National de Lutte Contre la Tuberculose (PNLT), Plan Strategique National de Lutte Contre la Tuberculose (2014-2018). Available in French at <http://snucongo.org/wp-content/uploads/docx/sante/13.pdf>. Refugees are included as an at-risk group. At 5, 22, 27, and 52.
- 255 Federal Democratic Republic of Ethiopia - Ministry of Health, Revised Strategic Plan Tuberculosis, TB/HIV, MDR-TB and Leprosy Prevention and Control (2013/14-2020). Available at <http://ethiopiaccm.org/index.php/events/funding-request-2017/category/7-concept-note-tbhiv?download=22:revised-strategic-plan-tuberculosis-tb-hiv-mdr-tb-and-leprosy-prevention-and-control-2006-2013-ec-2013-14-2020>. While migrants are not mentioned as vulnerable or at-risk populations, the NSP does provide screening for MDR should be enhanced including in “congregate settings (Prison, refugee camps, Internally Displaced populations.” At 79.
- 256 Government of India - Ministry of Health with Family Welfare – Directorate General of Health Services – Central TB Division - Revised National Tuberculosis Control Programme, National Strategic Plan for Tuberculosis Elimination (2017-2025). Available at <https://tbcindia.gov.in/WriteReadData/NSP%20Draft%202020.02.2017%201.pdf>. “Refugees or internally displaced people, illegal miners, and undocumented migrants” are included as “people who have limited access to TB services.” At 45. In addition, refugee camps are congregate settings for vulnerable groups. At 23 and 24.
- 257 Republic of Kenya – Ministry of Health – National Tuberculosis, Leprosy and Lung Disease Program, National Strategic Plan for Tuberculosis, Leprosy and Lung Health (2015-2018). Available at <https://healthservices.uonbi.ac.ke/sites/default/files/centraladmin/healthservices/Kenya%20National%20Strategic%20Plan%20on%20Tuberculosis%2C%20Leprosy.pdf>. Mobile populations, migrants, and refugees are defined as at-risk groups. Specifically, refugees account for 30% of all of the MDR-TB cases notified in Kenya. At 23.
- 258 Republic of Liberia - Ministry of Health, National Leprosy and Tuberculosis Strategic Plan (2014 - 2018). Available at [http://www.lcm.org.lr/doc/TB%20and%20Leprosy%20Strategic%20Plan%202014-2018%20consolidated%20\(1\)%20\(1\).pdf](http://www.lcm.org.lr/doc/TB%20and%20Leprosy%20Strategic%20Plan%202014-2018%20consolidated%20(1)%20(1).pdf). Refugees are included as high-risk groups, but not other migratory groups. At 47.
- 259 República de Moçambique - Ministério de Saúde Direcção Nacional de Saúde Publica - Programa Nacional de Controlo da Tuberculose, Plano Estratégico e Operacional (2014-2018). Available in Portuguese at [http://gard-cplp.ihmt.unl.pt/Documentos/Paises/Mocambique/Plano\\_Estrategico\\_Operacional\\_Tuberculose\\_Mocambique\\_2014-2018.pdf](http://gard-cplp.ihmt.unl.pt/Documentos/Paises/Mocambique/Plano_Estrategico_Operacional_Tuberculose_Mocambique_2014-2018.pdf) Refugees are defined as a high-risk vulnerable groups. At 32, 39, and 42.
- 260 Republic of the Union of Myanmar - Ministry of Health and Sports - National Tuberculosis Programme, National Strategic Plan for Tuberculosis (2016-2020). Available at [http://www.aidsdatahub.org/sites/default/files/publication/Myanmar\\_National\\_Strategic\\_Plan\\_for\\_Tuberculosis\\_2016-2020.pdf](http://www.aidsdatahub.org/sites/default/files/publication/Myanmar_National_Strategic_Plan_for_Tuberculosis_2016-2020.pdf) Migrants and refugees are defined as having disproportionate TB burden, as a high-risk and hard-to-reach population. At 6, 42, 66, and 112.

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- 262 Federal Republic of Nigeria - Federal Ministry of Health - Department of Public Health - National Tuberculosis and Leprosy Control Programme, The National Strategic Plan for Tuberculosis Control (2015-2020). Available at [http://www.health.gov.ng/doc/National%20Strategic%20Plan%20for%20Tuberculosis%20Control%20%20%20%202015\\_2020.pdf](http://www.health.gov.ng/doc/National%20Strategic%20Plan%20for%20Tuberculosis%20Control%20%20%20%202015_2020.pdf). Key affected populations most at risk for TB include migrants, internally displaced people, and nomadic populations. At 2, 5, 7, 49, 76, 79, 91, 93, and 196.
- 263 Islamic Republic of Pakistan - Ministry of National Health Services - Regulations & Coordination Islamabad - National TB Control Program Pakistan, National TB Control Strategic Plan “Vision 2020” (2014). Available at [http://www.ntp.gov.pk/uploads/Vision\\_2020\\_National\\_Strategic\\_Plan.pdf](http://www.ntp.gov.pk/uploads/Vision_2020_National_Strategic_Plan.pdf). Vulnerable populations include slum dwellers, internally displaced people/ refugees and brick kiln workers. At 152. Migrants. At 165.
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