From Disease to Pandemic

Amy Lieberman

World Policy Journal 2013 30: 78

DOI: 10.1177/0740277513506384

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AMY LIEBERMAN

MANGALSEN, Nepal—Most locals walk here, journeying hours or days to reach a smattering of tea shops and convenience stores or an ammonia-washed health clinic. Outsiders access the western Nepali district of Achham either by helicopter or the single road clinging precariously to the rocky corners of the Himalayan Mountains. People in Achham have no choice but to eat the little that sprouts from their stubborn land. Here, many know HIV only as "Bombay disease," a seemingly mysterious illness that began to weaken and kill in Achham when men started migrating to India for short-term, low-wage jobs more than a decade ago.

Two women fix their eyes on their small children when they speak with a visitor outside a local health clinic for people living with HIV/AIDS. Even one and two years after their diagnoses, they say it's difficult to accept their HIV-positive status. They've never left Achham, though their husbands traveled to India several times. Both men succumbed to AIDS complications a few years ago, dying in Achham before they ever told their wives they were infected with the virus.

On the road that leads to Mangalsen, teenage boys and men crowd together on top of trucks that flash neon images of Hindu gods. The trucks emit low, muffled coughs that burst into roars as they pop from behind the road's veiled bends, tumbling down to the porous India border, where they will join 1.5 to 2 million Nepali migrants working jobs in manual labor.

Those returning from Mumbai make up one of Nepal's highest risk groups for HIV infection—a rate more than five times the national average. Barring any intervention, by 2015 it is thought that 7,000 recently returned Nepali migrants will live with HIV in places like Achham in far western Nepal, while 12,000 more Nepali migrants infected with the virus will live in India.

While low-skilled labor migrants typically embark on their travels abroad healthy and fit, they are then prone to falling ill during their arduous journeys, working in hazardous situations and living in poor conditions. At this point, there also develops the increased possibility of inaccessible or unaffordable health services in a foreign country. Moreover, such migrants are more likely to engage in sexual behavior, as anonymous outsiders away from home and their families, which places them at risk for a sexually transmitted infection like HIV. Such a collision of factors presents a dangerous public health scenario, afflicting people regardless of citizenship and national borders.

GHETTOIZING IMMIGRANT POPULATIONS OR BARRING THEM ENTIRELY IN A FUTILE ATTEMPT TO CONTAIN DISEASES IS MISGUIDED.

One non-governmental organization has started a regional pilot intervention project to prevent cross-border transmission of HIV between India and Nepal. In early 2013, the international humanitarian group CARE cross-linked public pharmaceutical services for 22 Nepali migrants living with HIV in India. They can now access the same line of government-provided antiretroviral treatment in either country.

Amy Lieberman is a journalist based in New York, reporting from the United Nations as well as Latin America, South Asia, and Southeast Asia.

If successful, the project would push the governments of India and Nepal to begin more cross-border health interventions, says Prabodh Devkota, who is leading the CARE pilot project known as EMPHASIS, or Enhancing Mobile Population Access to HIV/AIDS Services.

"In the last 25 years, we have been trying to work toward something like this and to facilitate this sort of process, to make the flow between the different government systems more systematic," Devkota says. "This could save the lives of hundreds of thousands of people." The project has the distinct potential to scale up and reach more people, but Devkota notes the considerable time it took to make these services available to only 22 people, a number he concedes some might consider minimal. "It took us more than three years just to achieve this, so you must consider the intensity, the investment, and the whole mechanism of the system that has been required to reach these people. There's a huge possibility of scaling this up. But it completely depends on the people in the governments. As a project, we have limitations. We are only covering two districts in Nepal, so it depends on the institutional support we are receiving."

The expansion of promising, though small-scale, initiatives like this—a rarity in the field of international development and migration projects—depends on political will. With today's large-scale movement of vast populations, disease spreads quickly, and it is increasingly urgent for governments to claim responsibility for a threat that is not contained within their borders. Political leaders need to collaborate and pledge, on national and regional levels, to include non-citizens like labor migrants as inclusive recipients of the same health services and basic rights their own citizens enjoy. This shift may run counter to the flow of popular opinion, but ghettoizing immigrant populations or barring them entirely in a futile attempt to contain diseases is misguided and ignores the reality of global migration. It also puts the rest of the population at risk.

Economic globalization is facilitating the flow and building the appetite for the world's 87.5 million labor migrants, especially in countries with fast-growing economies and aging populations. This market demand—and, perhaps, a better understanding of the links of international migration to social and economic development in low-income countries—is now slowly moving migration onto the international policy agenda in certain high-level circles at the United Nations. Identifying transmission systems and negotiating agreements to establish a more health-conscientious brand of migration could help confine outbreaks of transmittable diseases to small pockets of migrants before they can mushroom into pandemics.

LAISSEZ-FAIRE TREATMENTS

Yet the issue of health—access to education, services, treatment, and a quality of life that can prevent migrants from getting sick with a transmittable illness—remains largely absent from regional and international agreements and discussions on migration. It is unlikely to surface as a priority any time soon, international experts on health and migration say, given the predominant, though inaccurate, conviction that migrants bring disease to a new country rather than acquiring them there and returning home to spread the contagion.

"We talk about global health care and everybody seems to agree on the principles, but when it comes to migrants, you see the sensitivity the issue raises. People say, 'Oh, now we are talking about migrants'," says

Davide Mosca, the Geneva-based director of the International Organization for Migration's Department of Migrant Health. "No one shares the responsibility. We talk about migration, but not about health. It's too sensitive." Indeed, the Geneva-based World Health Organization (WHO), the United Nations body that should monitor and police this growing crisis, refuses even to discuss the issue publicly.

Talk of migration often makes politicians balk, given the impact the typically unpopular policy issues may have on their political future. The public often fears migrants spread disease and pose excessive burdens on government-supported health care. "Because of this stigma, it is unpopular for politicians to stand for migrants' rights, including health. There is a deliberate tendency to avoid any explicit promotion of inclusive policies and practices," says Mosca. The alternative, and generally accepted model, is simply to exclude migrants from countries' public health systems, or to restrict their access.

John Monterona, a Filipino migrant worker and advocacy organizer in Saudi Arabia, considers himself among the lucky few out of the 1.2 million Filipino workers in the Gulf kingdom. The 38-year-old has risen in the ranks in his construction engineering work and is now a schedule analyst. He spends his days at construction sites tracking and monitoring the step-by-step progress of each project on a computer, to make sure work remains on schedule. He lives alone in a small studio apartment in Jeddah, where he has his own bathroom, kitchen, and the privacy to call his family back home. But when Monterona first began his work as a migrant in the early 2000s in Qatar, he experienced a far less appealing lifestyle that is the norm for many of his Filipino co-workers.

"Compare what I have now to a four-by-four room jam packed with seven or eight people with the beds all stacked together with industrial workers sleeping like fish in a can," the former secondary school teacher says. "The ratio could be one toilet for 20 people. There's no ventilation, and the heat is unbearable in the summertime. It's very easy to become sick." Colds, diarrhea, high fevers, and the flu are all common among the tight-knit Filipino community in Saudi Arabia, Monterona says. A handful of Filipinos have also been diagnosed with H1N1.

"MIGRANTS ARE A VULNERABLE PART OF THE POPULATION WITH VERY LIMITED ACCESS TO THE HEALTH CARE SYSTEM."

Monterona himself counts three times in the past six years that he has been struck with a debilitating flu. Once, for two weeks, he could not kick the virus. Sickness is a constant source of anxiety for Monterona, who gasps and then chuckles nervously at any mention of HIV and AIDS.

Migrant workers in Saudi Arabia can be jailed or deported if they test positive for HIV. Foreign workers in Saudi Arabia also know the risk of having their contracts, which typically run for about two years, terminated early if they do not clear one of the routine physical and mental health checks they must pay for.

Monterona says he's fortunate that his bouts of flu never hit during his health checks, including his initial one in the Philippines before he left for Saudi Arabia. Though Monterona has a master's degree in public administration, his monthly salary of about $370 as a teacher in Manila was not enough to support his three school-aged children, his wife, and himself back home.

He plans to continue working abroad, perhaps move on to a job in Africa, at least until his youngest child, age 5, graduates from university. He isn't sure what his family would do if he, like some former co-workers and friends, got sent home because of illness.

"Let us say there are about 4,200 Filipinos leaving the country per day just to find work abroad," Monterona says. "There is no job security, and 11 million are underemployed or unemployed. The Philippines has become a peddler for cheap human labor." As regional director for the migrant rights network and advocacy group Migrante-Middle East, Monterona is lobbying the Filipino government to send a medical representative to Saudi Arabia, just as it sent a police attaché in 2009 to serve as a legal point of reference for migrants.

"If the Filipino government put more pressure on the Saudi government to provide for the needs of our workers on site and at their homes, then I think the Saudi government would be forced to respond squarely and this could be done at a high diplomatic level," Monterona says.

Yet that method of diplomacy has been tried before, and met little success. The Philippines has tried to negotiate a model recruitment agreement with Saudi Arabia that would include human rights guarantees and health provisions, and for Saudi Arabia to enforce it, recalls François Crépeau, the UN special rapporteur on the human rights of migrants. "Saudi Arabia said, 'Get lost. We'll find our workers somewhere else.' Some 30,000 Filipino workers saw their contracts not renewed, because Saudi Arabia thought the authorities were way too insistent on their rights," Crépeau says.

BEATING MISPERCEPTIONS

Tackling the issue of cross-border migration and health first involves clarifying and reformulating, on a broad public scale, dominant misperceptions about migrants. When they begin their journeys, migrants are almost always healthy. Otherwise it would be difficult to undertake the long trips to reach a new country or to clear government and company-mandated health checks, like Monterona has done. "Pretty much the common myth is refugees and migrants are carriers of disease and burdens on the health care system," says Steve Kraus, the director for the UNAIDS regional support team for Asia and the Pacific. "The reality is that they are young and healthy. They don't start off as unhealthy populations."

Across seven migrant detention centers in Greece, which hold 40 to 500 detainees, Médecins Sans Frontières migrant expert Ioanna Kotsioni most often treats respiratory infections and skin infections. Many migrants, estimated in Europe to top 4 million, live in poor conditions, in concentrated and small spaces. Kotsioni observes, "A lot of these infections would be preventable if the living conditions would be improved."

The majority of the detained migrants in Greece, most recently hailing from Syria and Afghanistan, are rarely repatriated back to their countries, Kotsioni says. Once released from detention and living again among the general population in Greece, staying healthy can be a challenge, particularly since the financial crisis hit Greece in 2010. People cannot pay for medical treatment or are afraid to seek health care, for fear of being identified and detained. Migrant communities, according to Mosca from the International Organization for Migration, demonstrate a higher prevalence of communicable diseases, including sexually transmitted infections and viruses like HIV, compared to non-high risk populations in their residence countries. "Migrants are a vulnerable part of the population with very

limited access to the health care system, so clearly this falls as a risk for public health," Kotsioni says. "It doesn't necessarily mean you will get big outbreaks of infectious diseases. But it is a concern."

Mosca cautions against generalizing about the vulnerability of migrant populations. "When we talk about migrants, any statistic gives opportunity for misperception and misrepresentation," Mosca says. "However, our impression is most of the migrants become infected after they migrate."

Tola Moeun provides legal and health support to about 800 returned Cambodian migrant workers each year from the Phnom Penh office of her organization, the Cambodian Legal Education Center. About half of the Cambodian workers the center services are women—often young, uneducated rural women who spent time working as domestic workers in Malaysia. The other half are men—equally poor and uneducated, who gained their experience abroad working on boats as fishermen in Thailand, Indonesia, or sometimes South Africa. Most Cambodian former migrant workers are sick when they return to their home country, says Moeun. Women are often afflicted with some form of mental illness, like trauma or depression, while men often come back with malaria or typhoid.

"All of the fishermen get sick, and they will not receive any sort of treatment working on the boats," Moeun says. Thai authorities deport around 100,000 Cambodian migrant workers per year, according to the UN Inter-Agency Project on Human Trafficking. In Thailand, Moeun says, the fishermen only have access to medical care if and when they disembark from the boat. They can remain at sea for weeks or months, even up to a year or more, at a time. Workers then will not see any of their accumulated pay. Once the boat docks, workers may have the chance to visit a local hospital and pay their own way for treatment, but some sick Cambodian workers balk at this opportunity.

"The problem they have is the language," Moeun says. "They do not speak Thai, for the most part. That makes it very hard for them to seek out medical care." Back in Cambodia, only some of the fishermen will find their way to Moeun and receive the treatment her center offers in partnership with the UN and the International Organization for Migration. Cyclical movements of migration are common, as fishermen who fell sick abroad and had negative, even frightening experiences, find there are still few job opportunities for them at home.

GOVERNMENTS ARE INDIVIDUALLY AND COLLECTIVELY RECOGNIZING A RESPONSIBILITY TO PROVIDE FOR THE HEALTH OF FOREIGN MIGRANTS IN THEIR COUNTRIES.

CONVENTIONAL SOLUTIONS?

At the end of April, 45 member nations convened at the United Nations for a five-day session known as the Commission on Population and Development—a lead-up to a high-level dialogue on migration in October. But representatives butted heads, according to civil society observers, with the sexual and reproductive health rights of migrants emerging as a specific point of contention. The nations were unable to agree on a consensus document, adopting instead a tepid statement with few concrete recommendations.

So far, 46 countries have ratified the International Convention on the Protection of the Rights of All Migrant Workers. The 23-year-old agreement has support

from governments like the Philippines and Mexico, both large exporters of migrants, but not from the richer countries that receive migrants.

These host governments are turned off by the convention's lack of distinction between documented and undocumented migrants, Crépeau says. "They have not signed it, and if you ask them why, they will say that it doesn't concern them, and they don't want that kind of framework. It acknowledges that irregular migrants have rights. That is completely unpalatable to most global North countries at the present."

THE WHOLE ISSUE OF MIGRATION IS DEFINED BY NATIONAL BORDERS, AND THERE IS A SORT OF SPECIAL CONNECTION TO NATIONAL SOVEREIGNTY.

The convention grants migrant workers and their families the right to emergency medical care and says that states should ensure that working and living conditions offer a standard of "fitness, safety, health, and principles of human dignity." The convention is the strongest international policy tool out there when it comes to labor migration and health. It still hasn't been enough. "This convention hasn't changed anything," Crépeau says.

A few court rulings from the European Court of Human Rights offered varied indications on whether governments, which have not ratified the UN migrants' convention, violate the European Convention on Human Rights when they deport a migrant who is sick with a communicable and potentially fatal disease. In 1997, the court ruled that the United Kingdom did violate the convention when it ordered the deportation of an AIDS-sufferer and migrant back to his native St. Kitts in the late stages of illness, potentially subjecting the person to inhuman or degrading treatment. But in 2006 and 2008, the court ruled against the cases of two migrants, Algerian and Ugandan nationals living with Hepatitis C and AIDS, and in the favor of France and the United Kingdom.

"The international framework is not there and that is why we have started, very cautiously, to see how we can promote this dialogue," says Bela Hovy, chief of migration at the UN Department of Economic and Social Affairs. Hovy is organizing a high-level dialogue on international migration and development, slated to coincide with the launch of the General Assembly session in September at UN Headquarters in New York. Health will factor into the portion of the government talks that focus on the rights of migrants, Hovy says. But the event—a follow-up from the first and last international high-level event on migration that happened in 2006—is considered a cautious second step to continue the con-

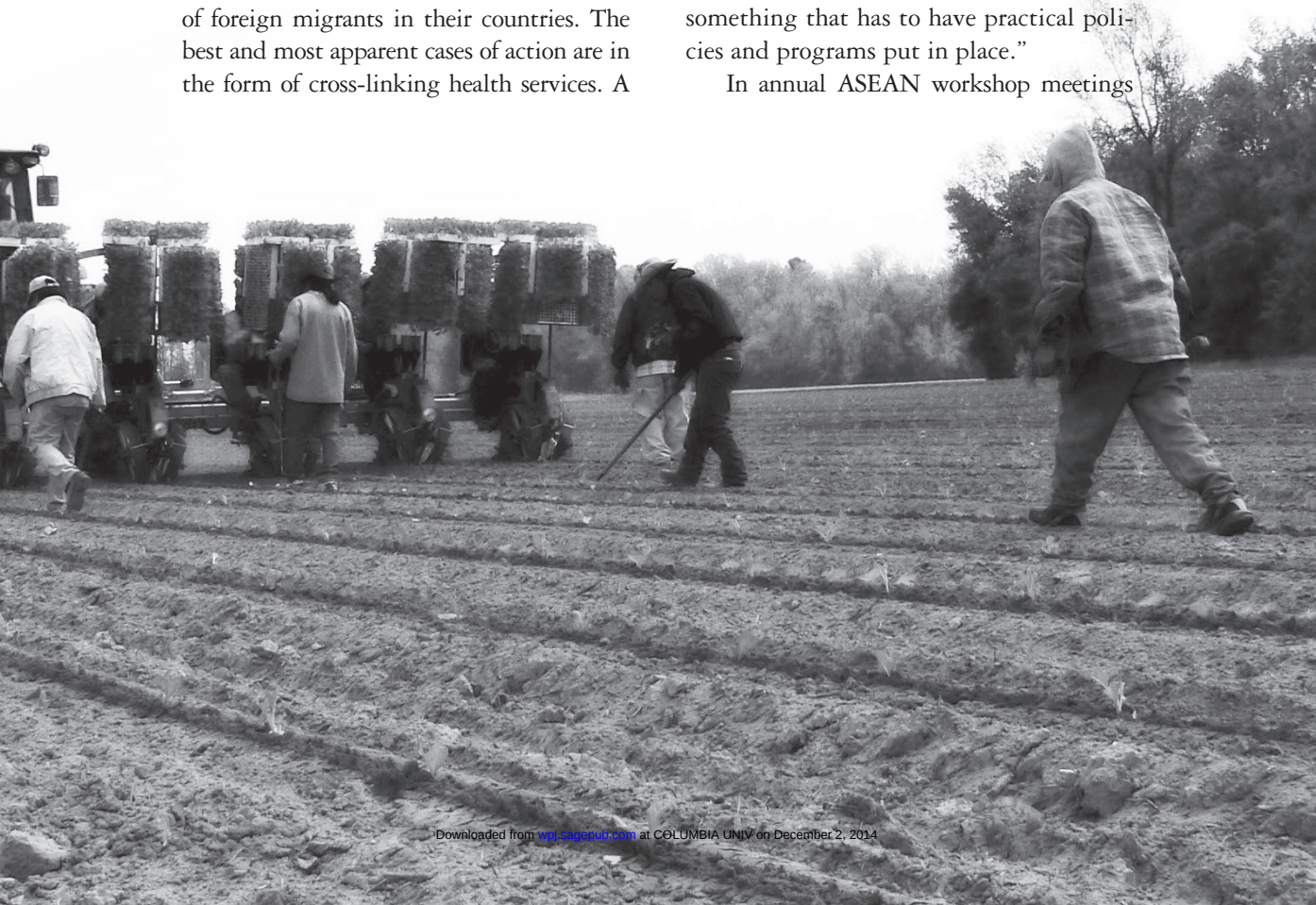
versation, but not necessarily to make any firm decisions or sign any agreements.

Though the understanding that migration can have benefits for both receiving and sending countries is becoming generally accepted, Hovy says, governments appear hesitant to hash out talks within the confines of the United Nations. One alternative could be the Global Forum on Migration and Development—a government-led initiative that has held annual meetings in different countries around the world since 2007. "It's outside the UN, to make sure it is as informal as possible, not driven by the agenda of the UN, but by the member states themselves, and has attracted 150 countries each year," says Hovy.

It's at the regional and national level where progress appears to be taking some form, where governments are individually and collectively recognizing a responsibility to act on the need to provide for the health of foreign migrants in their countries. The best and most apparent cases of action are in the form of cross-linking health services. A joint government and United Nations consultation in Thailand in 2012 etched out a national plan that would provide treatment for all people in Thailand living with HIV and would link treatment plans across countries, similar to the CARE program in India and Nepal. Cambodia, Laos, China, Myanmar, Thailand, and Vietnam have signed a memorandum of understanding to reduce HIV vulnerability among migrant populations by increasing access to prevention and treatment services.

The 10 countries that make up the Association of Southeast Asian Nations (ASEAN) are unique in that they all receive and send migrants internationally, says Kraus, of UNAIDS. This is prompting a shift in addressing cross-border movements and health. "In the past, it was seen as a thing that is dangerous, unhealthy, and has to be controlled," Kraus says. "Now they are talking about it as part of globalization, as something that has to have practical policies and programs put in place."

In annual ASEAN workshop meetings



NEIL SMITH

on migration and health during the past two years, governments have discussed eliminating all HIV-related travel restrictions in the region. Fourteen countries, including Jordan, Russia, the Bahamas, and Singapore, now prohibit foreigners from entering the country for any period of time if they are carrying HIV. Twenty-one countries prohibit entry for long-term stays, more than 90 days, while 27 others potentially can or will deport foreigners identified as living with HIV. In practice, these regulations look different around the world. In Singapore, only foreigners who want to stay for more than 30 days must undergo HIV testing, though technically no foreigner living with HIV is allowed to enter the country. Doctors in Singapore are also required to report a foreigner's HIV status to the authorities, which can then deport that individual.

WITHOUT ANY INTERVENTION, THE PREVALENCE OF HIV CASES IN WESTERN NEPAL WILL CONTINUE TO RISE AMONG MIGRANT COMMUNITIES.

Hungary does not have HIV entry restrictions, but it requires foreigners to inform the government if they are infected with HIV/AIDS, tuberculosis, Hepatitis B, syphilis, or typhus. Failure to do so—as well as failure to receive treatment for these illnesses—could result in deportation. In Hungary, migrants with an irregular status only have access to emergency health care that they must pay for. The same holds for migrants in 10 other countries in the European Union. A number of countries, including the United States, China and Namibia, began lifting their entry bans on people living with HIV in 2010, amid criticism and in the face of research that the travel restrictions have no known public health benefits.

In 2012, government representatives from Asia considered eliminating health barriers for migrants and discussed coordinating with governments from South Asia and the Arab Gulf States, where the noncitizen population, typically from Southeast and South Asia and Africa can range from 25 percent of the total population in Saudi Arabia to 90 percent in the United Arab Emirates and Qatar.

Yet the national dialogue remains stilted and disconnected. "Some think migrants are intrinsically healthy, and others think migrant populations are carriers of disease and they are just going to be a burden on the health care system," Kraus says.

Since last February, law enforcement agencies and departments of social development from South Africa and Zimbabwe have been meeting every other month to talk about solutions to irregular migration and its health challenges. The International Organization for Migration, which facilitated these talks, is also aiming to link all Southern African countries through a health and migration program, Partnership on Health and Mobility in East and Southern Africa. The organization wants to improve migrants' access to health care services and turn HIV-risks of labor migration into a pressing national and regional policy issue. These regional initiatives could be replicated on a larger scale but would require the participation of more states, which is difficult to enforce without their full cooperation.

Taking the issue to the United Nations is not always the answer, as demonstrated by the hands-off approach member-nations have used in dealing with the migration convention. "People are suspicious of these supranational bodies," says Scott Blinder, the deputy director of the Migration Obser-

vatory, a research unit at Oxford Institute. "The whole issue of migration is defined by national borders, and there is a sort of special connection to national sovereignty, and it seems like something that needs to be done at the national level."

WHO'S ON FIRST?

The World Health Organization, the International Labor Organization, or the independent International Organization of Migration, could create tailored health contracts for execution at the national level, but there remains the question of application and enforcement. The WHO declined to comment for this article. Its spokesman, Gregory Hartl, says the topic of migration and the risk of cross-border transmission of communicable diseases does not fall within its purview—despite the threat of rapid spread of diseases carrying pandemic potential through migrating populations. "People move around and migrate all the time and are transported by different methods, on planes and whatever else," he says lightly. "It is a lot easier now to move from one place to another but this is not something that we would look at as a differentiable issue."

There exists a final viable option for governments to improve labor migrants' access to health services and prevent the risk of migrants becoming sick with a transmittable illness—addressing the issue on both national and international scales. When the United Nations' eight poverty Millennium Development Goals, known as the MDGs, expire in 2015, they will be succeeded by a new development agenda, which, unlike the MDGs, will not just apply to developing countries. In June, UN Secretary-General Ban Ki-moon's 27-person panel on the post-2015 development agenda released a report recommending a framework with 12 goals. Some are extensions of the MDG's targets, like ending poverty and achieving gender equality, but others, like creating good and decent jobs and ensuring healthy lives, are new. The June report said to meet these new goals—reducing HIV/AIDS, tuberculosis, and malaria and decreasing maternal mortality ratios—universal access to basic health care is absolutely necessary.

The General Assembly had passed a similar resolution in December 2012 that recommended governments begin the policy and financial transition to universal health coverage for all. The historic resolution encourages member states to recognize the links between universal health coverage and foreign policy issues.

This could allow piecemeal progress to become more uniform, more cross-linking treatment programs to launch, working and living conditions for migrants to improve, and more governments to lift travel and entry bans on people living with HIV or other communicable diseases.

The depth of the fallout for failing to pursue this connection and these channels on an international scale is not appreciated. Without any intervention, the prevalence of HIV cases in western Nepal will continue to rise among migrant communities. The flow of international migrants leaving the mountains of Nepal for Mumbai offers a tiny ripple in a whirlpool of global labor migration. Young, healthy people leave their families behind for the distant promise of higher-paying jobs. In exchange, they experience difficult journeys and often challenging working and living conditions that expose them to communicable diseases. When these people return home, whether by force or choice, they risk transmitting illnesses to their families and communities. This issue defies national borders and so must the prevention and the cure. ●