REVIEW

Leprosy among migrant workers: ensuring proper treatment

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Since 1982 using freely available multiple drug therapy (MDT), over 15 million people have been cured. The World Health Organization in 1991 set its goal as ‘the elimination of leprosy as a public health problem by the year 2000'. The elimination goal of less than one case per 10,000 population was reached at a global level by the year 2000 and all but a small number of countries had achieved the target by 2005. According to official reports received during 2011 from 130 countries and territories, WHO released the following statistics about leprosy: the global registered prevalence of leprosy at the beginning of 2011 stood at 192,246 cases, while the number of new cases detected during 2010 was 228,474 (excluding the small number of cases in Europe) out of them 8,495 cases registered in Eastern Mediterranean with a prevalence rate of (0.15) and 4,029 new cases detected in 2009 with a detection rate of (0.70).

WHO’s Global Leprosy Strategy for 2011–2015 adopted by 44 National Leprosy Programme managers in New Delhi, India in April 2009 focused its attention much more towards reducing the burden of leprosy and ensuring the quality and sustainability of control activities. It highlighted increasing migrant populations as workers and marginal populations living in slums, the diversity of health care providers and lack of coordination among them. The major focus within urban areas however, should be on improving the health services for marginal people living in the slums and migrant workers inside the same country who do not have the same conditions of life as in their native residence. The promotion of human rights and social justice in dealing with people affected by leprosy remains vital in addressing the persistent problems of stigma and discrimination suffered by people affected by leprosy and their families.

DEFINITION OF A MIGRANT

Migrant workers are those populations, who left their native countries or residence, because of poverty, inflation, low income, methods of living (nomads) or political instability, to live and work in other countries or areas to support their families in their native residence. Migrant workers can also be those people moved inside their own country from one region to another with the same suffering as, or not less than, the migrant workers migrating outside their countries. Migrant workers can be legal travelers with valid visas or illegally smuggled
to better-off countries; they can be migrant or immigrants according to the time and type of residence period in the target countries.

SOCIAL, PSYCHOLOGICAL AND PHYSICAL CONDITIONS OF MIGRANT WORKERS

The migrant workers in their new residences are subjected to different conditions that affect their health situation including poor levels of hygiene, unsanitary working and living conditions, nutritional and structural barriers to health services. Add to these materialistic problems; the psychological suffering, emotional well being and unacceptable human rights. In addition to the loneliness, homesickness and low social integration the migrants suffer in their new communities; there is also a social belief that migrant workers bring with them diseases from their countries of origin into the countries they work in; this belief led some countries to control the migrants rather than control the diseases.

When it comes to health problems with diseases accompanied by stigma migrant workers suffer more than physical health problems, they are also subjected to isolation, ostracism and in some countries termination of their contracts of work and even deportation. The stigma itself creates psychological barriers among these workers preventing them from seeking medical help or exposing themselves to such measures.5

MIGRANT WORKERS IN THE EASTERN MEDITERRANEAN REGION (EMR)

In the EMR states most of these workers are living in the Gulf countries, but not exclusively as all the countries of EMRO have internal or external migrant workers. The migrant workers’ situation in EMR countries is insecure. This varies from one country to another according to the legal situation and the legalisation of health services in the country concerned. Migrant workers suffer poor working and living conditions and the health services are often not easily affordable. In most of the gulf countries migrants workers will be immediately deported when they recognised as leprosy patients.5

LEGALISATION OF MIGRANT WORKERS

In the report of The Tenth Meeting of WHO Technical Advisory Group (TAG) on Leprosy Control hold in New Delhi, India, on 23rd April 2009 the following declaration was issued “A leprosy patient’s infectiousness is related to the size of the bacillary population in the body. It has been shown that a single dose of rifampicin decreases the load of viable bacilli to such low levels that it is no longer possible to cultivate the organism in an animal model. In public health terms, it is reasonable to conclude that infectiousness becomes unlikely after starting multidrug therapy (MDT)”.6

The recommendations of the programme managers meeting on leprosy elimination, Beirut, Lebanon, 15–16 December 2010 stated that member states should guarantee that once leprosy cases are diagnosed, they should receive free treatment regardless of their nationalities, as long as they reside in the country. However official regulation against migrants and immigrant workers are based on outdated public health beliefs about leprosy and other communicable diseases.7 In many countries leprosy is still regarded as a notifiable disease, the identification of which can have a direct impact on the rights of migrant workers and potential immigrants.8
In some countries, policies are in place citing leprosy as grounds for refusal of visas and for the inadmissibility of migrants or immigrants to these countries included Barbados, Hungary, Iraq, Namibia, the Philippines, Russia, Taiwan, Thailand, South Africa, the United Arab Emirates, United Kingdom and USA. In spite of the International Convention on the protection of the Rights of All Migrant Workers and their families RE (45/158) these workers still are suffering from neglect, abuse and cruelty. When a migrant worker is diagnosed with leprosy that will be their last day at work, as they immediately isolated and deported from the host country in most member states of the region.

Leprosy, among other neglected diseases mentioned in Factsheet 31 for the office of the United Nations High Commissioner for Human Rights and World Health Organization must enjoy the right to health as any other patient. The General Assembly of UN in 21st December 2010 adopted in the 65th session, agenda item 68 (b) Resolution 65/215. Titled: - Elimination of discrimination against persons affected by leprosy and their family members, in summery (persons affected by leprosy and their family members should be treated as individuals with dignity and are entitled to all human rights and fundamental freedoms under customary international law, relevant conventions and national constitutions and laws.)

NATIONAL LEPROSY CONTROL PROGRAMMES, MARGINAL AND MIGRANT WORKERS IN EMR

The National Leprosy Control Programmes in EMR started as early as the 1980s and have accomplished good results in controlling leprosy in the region since then. All countries in the region reached the elimination goal at country level but some countries like Yemen, Sudan, South Sudan, and Egypt still have endemic leprosy at the sub-regional level. In spite of these successes in leprosy control apart from SAPEL initiatives in Sudan; Somalia and Yemen, there are few reports published about leprosy control activities for marginal or migrant workers in the region.

Marginal populations like Akhdam in Yemen, Falattah in Sudan, Khudarys in KSA, many marginal people living in slums located in the poor belt surrounding Cairo, gypsies and nomads in other Arabic countries living in slums, and in refugee camps have the same situation as migrant workers with low accessibility to health services. Migrant workers and marginal populations must be given an equal chance for health services in all the countries of the world, if leprosy patients are discovered among them they must have the right to be treated and given the same care as given for any ordinary person suffering from other diseases. Refugees are victims of war or natural disasters are other groups who also share the same population characteristics of marginal and migrant workers; therefore leprosy control activities have to give them special attention. Neglecting treatment of leprosy affected people among migrant workers will lead to an increase in the backlog of leprosy cases.

TREATMENT OF LEPROSY AMONG MIGRANT WORKERS

Leprosy in migrant workers can be one of the following:

(1) Patients registered for treatment that migrate to other country or location without completing their MDT - continuation of MDT if within the time of treatment or repeat the full course of MDT if a defaulter.
(2) A new migrant worker discovered during the routine health check up for employment or by health providers as they come for other health problems - routine MDT treatment according to leprosy classification.

(3) A patient discovered in migrants workers camp or in marginal dwellings during rapid skin diseases survey - the usual MDT course and care.

(4) A defaulter from treatment because of migration - treat as usual for defaulter.

(5) A deported leprosy patient returning back to their country because leprosy discovered by the authorities in the migration country - treatment according to the calculation of time when they stopped MDT.

In some situations of migrant workers with leprosy or patients living in unstable areas or nomads vulnerable for frequent change of their residence, a self-supervised treatment in the form of blister packs must be given in enough quantities till the next MDT distribution points, a method used before in SAPEL initiatives in some EMR states like Yemen, Somalia and Sudan. In this situation patients must be provided with information about drug administration, side effects and where to report when complications develop.

Conclusion

Fortunately or unfortunately there is no free significant migrant worker movements between countries in the EMR, neither is there high prevalence of leprosy in the countries of the region. However the migrant worker movements are substantial inside the territories of the same country and between countries which is a challenge for the national leprosy control managers to ensure regular MDT for their leprosy patients. Information and dissemination of updated information on infectivity and treatment of leprosy especially for health authorities in areas where migrant workers exist is crucial so that ‘discovered’ patients and their families, who were historically ostracized from their communities, are dealt with humanitarian respect and to ensure that they receive the proper treatment without interruption of their work. Leprosy programme workers must use new communication techniques such as SMS to notify their colleagues in other areas about patients transfer to ensure continuation of MDT treatment.

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5 Personal Communication.


9 http://www.smhf.or.jp/e/news/033_08.html

10 International Convention on the protection of the Rights of All Migrant Workers and their families RE (45/158) http://www2.ohchr.org/english/law/cmw.htm


13 http://www.emro.who.int/rd/annualreports/1999/chapter5.htm