



Exploitation, vulnerability to tuberculosis and access to treatment among Uzbek labor migrants in Kazakhstan

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ABSTRACT

In recent years, Kazakhstan has become an important destination for primarily undocumented seasonal workers from Uzbekistan. In a context of high tuberculosis (TB) incidence, TB treatment is provided free for all residents in Kazakhstan, but migrants rarely access these services. This paper reports findings from a qualitative study conducted with migrants, TB patients and health care workers between July and September 2008 to understand the mechanisms that impede migrants' access to care. Findings describe three structural contexts – the employment, legal and health care contexts – which act in concert to render migrants vulnerable to exploitative work conditions and cause a series of barriers to health care. These conditions contribute to increased exposure to TB, heightened risk of reactivation due to weakened immunity, treatment-seeking delays, and increased severity of disease. Seasonal migration patterns also contribute to treatment interruption, which constitutes a risk for the creation of drug resistance. Using the theory of structural violence coupled with the concept of cumulative vulnerability, this paper analyzes how illegality interacts with exploitation and social marginalization to produce vulnerability to TB and restrict access to treatment.

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Introduction

In Eastern Europe and Central Asia, the collapse of the Soviet Union in 1991 marked a pivotal point in the fight against tuberculosis. The period of general upheaval following the transition to capitalism unleashed widespread socio-economic changes, which contributed to a dramatic resurgence of tuberculosis in all countries of the region. In addition to a very high burden of TB, the former Soviet Union is now facing a serious epidemic of drug resistance, with some of the highest rates of multi-drug resistant TB (MDR-TB) in the world (WHO, 2010).

In tandem, the disintegration of the Soviet Union has made the region the site of some of the largest migration flows in the world. Most migration is intra-regional, work-related and short-term, with a main axis of migration linking Central Asia to wealthier Russia and Kazakhstan (IOM, 2008; Mansoor & Quillin, 2006). Due to the development of its oil production and extractive industries, Kazakhstan's booming economic growth has made it the country with the highest earning potential in Central Asia. Since 1999, it has

become a main migration destination for workers from the poorer neighboring republics of Uzbekistan, Kyrgyzstan and Tajikistan. The majority of migrants come from Uzbekistan and most are undocumented seasonal laborers. In a sizeable migrant population, lack of access to treatment – or worse, irregular treatment – could have disastrous consequences for TB control in Central Asia.

In an effort to control tuberculosis, the government of Kazakhstan has extended free TB treatment to all residents. However, anecdotal accounts from health workers suggest that migrants do not access these services. This paper analyzes findings from a qualitative study conducted by Project HOPE¹ in summer 2008 as part of operational research through the Central Asian TB Control Partnership. The study was designed to investigate the mechanisms that impede access to health care in general, and TB treatment in specific, among Uzbek labor migrants in Kazakhstan.

¹ Project HOPE is a US-based non-profit organization working in the health sector in more than 35 countries (see www.projecthope.org). In 2008, Project HOPE was part of the Central Asian TB Control Partnership, a five-year USAID-funded consortium focusing on TB education, laboratory strengthening and improving clinical capacity to diagnose, manage and treat TB in the five Central Asian republics.

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The findings herein describe in turn the three structural contexts – the employment, legal and health care contexts – which impact migrants' lives. Using the theory of structural violence (Farmer, 1999) coupled with the concept of cumulative vulnerability (Muela & Hausmann-Muela, 2011), this paper analyzes how illegality interacts with exploitation and social marginalization to produce vulnerability to tuberculosis and restrict access to care.

Tuberculosis and migration in Kazakhstan

The resurgence of tuberculosis in the former Soviet Union represents a clear illustration of the role of social, economic and political factors in the spread of tuberculosis. Some of the classic risk factors for TB include poverty, homelessness, incarceration, crowding, malnutrition, alcoholism and HIV infection (Lönnroth, Jaramillo, Williams, Dye, & Raviglione, 2009). In the former Soviet Union, the factors that led to the resurgence of TB included economic decline and deteriorating living standards, rising unemployment, decreased nutrition, widespread alcoholism, increased crowding in living conditions, and internal migration within the former Soviet sphere (David, 2008; Toungousova, Bjune, & Caugant, 2006). At the same time, a generalized breakdown of the health care system caused by a decrease in medical personnel, budget cuts of over 60% and shortages of essential drugs led to an increase in TB mortality and set the stage for the emergence of drug resistance (McKee, Healy, & Falkingham, 2002; Toungousova et al., 2006).

Within Central Asia, Kazakhstan and Uzbekistan currently have very high incidence of TB, at 163 per 100,000 and 128 per 100,000 population, respectively (WHO, 2010). Obstacles to effective TB control in these countries include low case detection rates and high treatment default and failure rates (Godinho, Veen, Dara, Cercone, & Pacheco, 2005). Kazakhstan and Uzbekistan have some of the highest rates of MDR-TB in the world, registered at 14% primary resistance among new sputum-smear positive cases (WHO, 2010). Within Uzbekistan, TB incidence in the region of Karakalpakstan is double the national incidence, due to the ecological and socio-economic devastation caused by the Soviet-era desertification of the Aral Sea (Cox & Hargreaves, 2003; Crighton, Elliott, van der Meer, Small, & Upshur, 2003). Concern also has been expressed about the international transmission of MDR-TB strains due to out-migration from this region (Cox et al., 2004).

In 1998, the government of Kazakhstan adopted the WHO-recommended strategy for Directly-Observed Treatment, Short-Course (DOTS), consisting of a standardized regimen of a two-month intensive phase and a four-month continuation phase of treatment. The Central Asian republics inherited a Soviet hospital-based system of health care which includes a highly vertical TB control system consisting of TB dispensaries, TB hospitals and sanatoria, and a weakly-developed network of primary health care (PHC) clinics called polyclinics (*poliklinika*) (David, 2008; McKee et al., 2002). Kazakh residents have residence registration which entitles them to care from the PHC clinic associated with their catchment area. The PHC clinic can make a preliminary diagnosis of TB and refers the patient for confirmation and initiation of treatment to a TB facility. According to the form of DOTS practiced in the region, the hospitalization phase of treatment is delivered in specialized TB facilities and the continuation phase is delivered on an ambulatory basis through PHC facilities. The Sanitary-Epidemiological Service (SES) is responsible for contact tracing, defaulter tracing and disinfection of the source of infection (Ibragimov, Meimanaliev, & Veen, 2007).

In Kazakhstan, TB is classified as a “socially significant disease” and free TB treatment is available to all residents as part of the State Guaranteed Benefit Package. Foreigners and people without

nationality are also eligible for free emergency health care and treatment of socially significant diseases, and can also access basic primary services for a fee (Ibragimov et al., 2007). However, little is known about migrants' access to the health care system and TB treatment in practice.

Estimates of labor migrants in Kazakhstan range from 500,000 according to official statistics to 2.5 million according to the International Organization for Migration (IOM), and more than half of migrants come from Uzbekistan (IOM, 2008; Laruelle, 2008). A study conducted by the IOM among Uzbek migrants estimates that between 200,000 and one million work in the border regions of southern Kazakhstan alone (IOM, 2005). This study found that Uzbek migrants are mostly male seasonal laborers involved in construction, agriculture and trade, and the overwhelming majority are undocumented. The Uzbek government maintains strict control over external labor migration, requiring migrants to go through complicated legal channels to legalize their exit. In reality, very few migrants attempt or manage to go through these channels. In Kazakhstan, migrants are required to obtain a migration card at customs, be hired by employers with a special permit, and legalize their stay through residence registration. In practice, very few employers legalize their migrant employees' status. This policy environment contributes to what the IOM terms a situation of “double illegality,” where migrants may be more vulnerable to exploitation because they are thus removed from the legal protection of both countries. The same study found poor working conditions and high levels of labor exploitation among Uzbek migrants, with up to 71 percent having their passports confiscated and many being confined to the worksite (IOM, 2005).

Current research on migration and tuberculosis

Most of the literature on migration and TB comes from Western, industrialized countries where incidence of TB is typically low, and focuses on differential rates of TB among immigrants from developing countries where TB incidence is higher. Most studies find higher rates of TB among the so-called “foreign-born” (Cain, Benoit, Winston, & Mac Kenzie, 2008; Heldal et al., 2008; Migliori, 2007; Rieder, Zellweger, Raviglione, Keizer, & Migliori, 1994; Watkins & Plant, 2002). Tuberculosis infection includes an asymptomatic latency period which may become reactivated to active disease (Frieden, Sherling, Munsiff, Watt, & Dye, 2003), and it is thought that most cases of TB among migrants are the result of latent infection acquired prior to migration (Watkins & Plant, 2002).

Much less is known about differences in TB rates among migrants transitioning from high-incidence to other high or intermediate-incidence countries, as may be the case in Eastern Europe and Central Asia. In China, studies among internal rural-to-urban migrants have shown treatment-seeking delays for TB and worse TB treatment outcomes in this population than among permanent residents (Long et al., 2008; Wang, Jiang, Abdullah, & Xu, 2007; Wang, Long, Liu, Tolhurst, & Tang, 2008). In Europe, one study on access to TB treatment for migrants found that a large cohort of undocumented migrants represented a significant proportion of TB cases (Heldal et al., 2008).

The same study was not able to obtain information from the former Soviet countries about the TB policy on migrants, so that there continues to be a lack of information on the burden of migrant TB and policies of access to TB treatment in this region (Heldal et al., 2008). One study of Tajik migrants in Russia found that migrants face significant care-seeking delays for TB and treatment barriers (IOM, 2009) but no studies have examined access to care in Kazakhstan. Two studies of TB in Uzbekistan found that unemployment was very high among TB patients and defaulters, and that economic migration was a cause of default in 16

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