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Tuberculosis, human rights and ethics considerations along the route of a highly vulnerable migrant from sub-Saharan Africa to Europe

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SUMMARY

Migrant health is a critical public health issue, and in many countries attention to this topic has focused on the link between migration and communicable diseases, including tuberculosis (TB). When creating public health policies to address the complex challenges posed by TB and migration, countries should focus these policies on evidence, ethics, and human rights. This paper traces a commonly used migration route from sub-Saharan Africa to Europe, identifying situations at each stage in which human rights and ethical values might be affected in relation to TB care. This illustration provides the basis for discussing TB and migration from the perspective of human rights, with a focus on the right to health. We then highlight three strands of discussion in the ethics and justice literature in an effort to develop more comprehensive ethics of migrant health. These strands include theories of global justice and global health ethics, the creation of 'firewalls' to separate enforcement of immigration law from protection of human rights, and the importance of non-stigmatization to health justice. The paper closes by reflecting briefly on how TB programs can better incorporate human rights and ethical principles and values into public health practice.

KEY WORDS: communicable disease; global health justice; migration; stigma; discrimination

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WITH MORE PEOPLE IN MIGRATION today worldwide than at any other time in human history,[1] migrant health is becoming a critical public health issue. A major barrier to migrants' access to health care is their legal status.[2] Although a substantial number of migrants arriving from less industrialized to more stable countries migrate through official channels that involve pre-immigration health screening and/or post-arrival health services, many cross borders without documentation. For example, half of the migrants arriving in Italy using the central Mediterranean over-water route do not apply for asylum upon arrival, and thus stay undocumented.[3]

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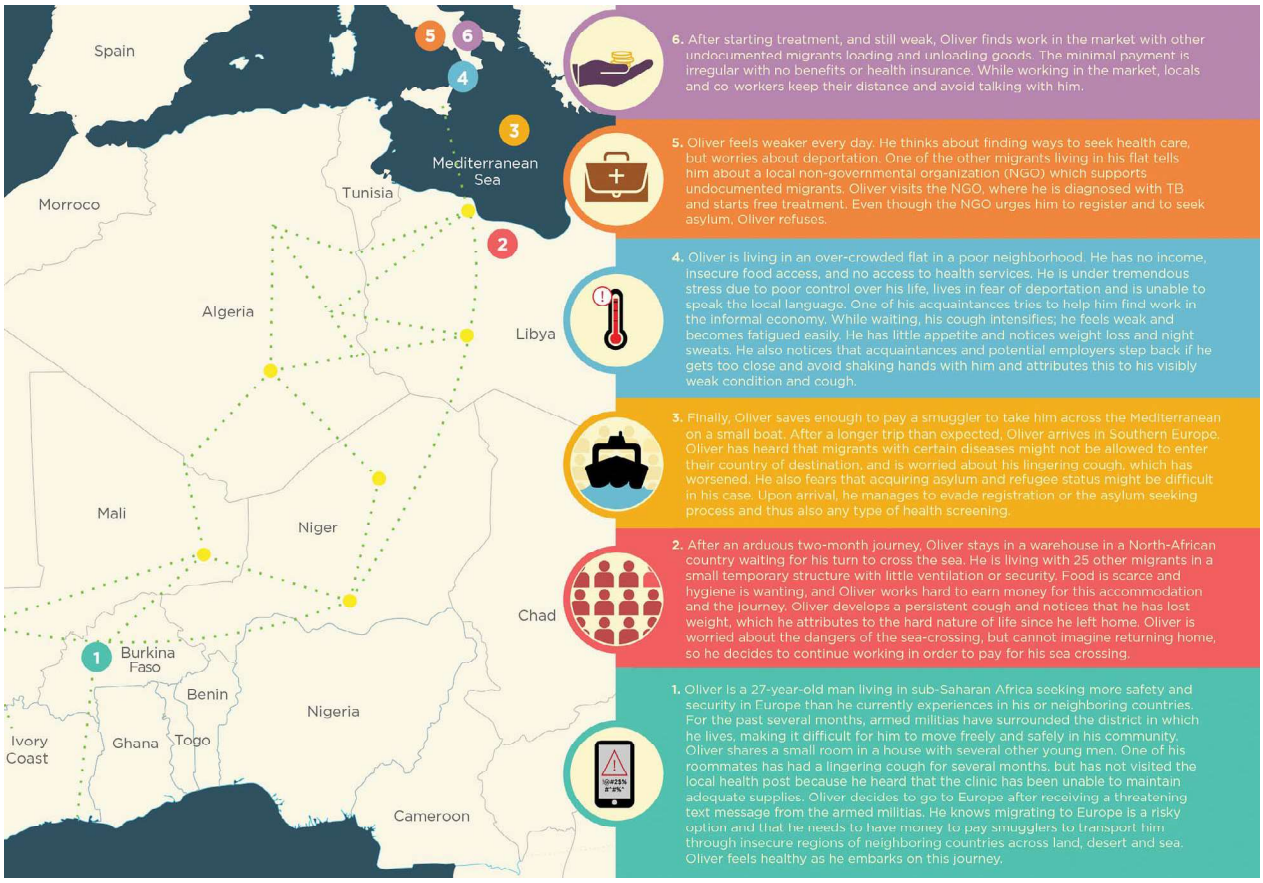

Figure Oliver's journey to Europe: tracing a common route of migration from sub-Saharan Africa to Europe. The map depicts a possible migrant route from sub-Saharan Africa to Europe, and is loosely based on the migrant journeys reported in Patrick Kingsley's book, The new Odyssey.[8] This image can be viewed online in color at http://www.ingentaconnect.com/content/iuatld/ijtld/2017/00000021/00000010/art00005

As we will see in this paper, this group of migrants is highly vulnerable in relation to their health and well-being.[4]

Tuberculosis (TB) in migrants is a challenging issue due not only to the complexities in detection, diagnosis and prolonged treatment, but also to its wider implications in terms of social and political determinants of health, as well as processes of stigmatization and discrimination. Earlier in this State of the Art series, Lönnroth et al. reported that overall TB rates among native-born and foreign-born persons in low-incidence countries have declined since 2009; however, rates among native-born persons have declined faster than among foreign-born persons.[5] Most TB in migrants stems from post-arrival reactivation of remotely acquired latent tuberculous infection, although a portion may have TB due to primary progression of a recent tuberculous infection.[6] Persons with TB who have migrated at some point in their past pose a modest risk of transmission to host-country citizens, although transmission within immigrant communities and workplaces post-arrival has been demonstrated.[6,7]

In the present paper, we trace a commonly used route of a migrant, here called Oliver, from sub-Saharan Africa to Europe (Figure, Table 1).[8] During each phase of the route, we identify situations in which human rights and ethical principles and values might be affected in relation to the provision of TB services. By illustrating the route, we aim to show how all steps are connected, and identify crucial points at which human rights principles and ethical values such as non-discrimination, protection of health and well-being and health justice can be applied in public health programs and policies.

Throughout the paper, we use the term 'migrant' to refer to 'any person who is moving or has moved across an international border or within a country away from their habitual place of residence, regardless of their legal status, whether their decision to move was voluntary or involuntary, the cause for the movement, and the length of stay.'[9] The United Nations Development Programme has noted that 'the proliferation of migration categories obscures rather than illuminates the processes underlying the decision to move, with potentially harmful effects on policy-making.'[10] We agree that a strict line between undocumented migrant and refugee can often not be drawn, as we will see in

Table 1 Summary of a common case of a migrant traveling from sub-Saharan Africa to Europe[8]

Step	Migration phase	General situation	TB status	Ethical and human rights principles
1	In the country of origin/before departure	Oliver lives in poverty in a high TB burden country in sub-Saharan Africa. He and his family feel threatened by terror militia for reasons of faith. Oliver feels healthy and strong	LTBI	Rights to life, food, education and health not protected; no access to education for prevention of communicable diseases and other public health issues*
2	During transit	Oliver lives in a cramped, overcrowded warehouse waiting for smugglers to take him to Europe. He experiences food scarcity and harsh working and living conditions. Oliver has a persistent cough and begins to lose weight	Conversion to active TB; no diagnosis Primary TB transmission possible	No access to primary health care; weak or non-existent health infrastructure; no access to education for diagnosis or treatment of TB disease; no access to safety and security; dire living conditions and food insecurity with detrimental mental and physical health effects
3	At the border	Oliver has heard that migrants with diseases will not be allowed to enter Europe. Oliver arrives in Europe and immediately goes underground to avoid registration, fearing expulsion for health reasons	Active TB; no diagnosis Primary TB transmission possible	Failed efforts by region of destination to convey the message that 1) everyone has the right to seek asylum and therefore the right to seek asylum is independent of health status, and that 2) everyone has a right to health, independent of residential status
4	After arrival	Oliver stays with acquaintances in an overcrowded flat while waiting for a work opportunity. Oliver's cough persists, he starts to feel weaker, loses more weight and starts looking ill. He notices that his potential employers are taking a step back when he approaches them	Active TB; no diagnosis Primary TB transmission possible.	Missed opportunity for country to reach out to newly arrived migrants and inform them about health care options. Because Oliver looks ill and coughs in addition to being an immigrant of lower social status, stigmatization is exacerbated
5	First half year	Oliver feels weaker and looks for health care. He hears of a local NGO that helps undocumented migrants. Oliver receives anti-tuberculosis treatment but refuses to register officially at the immigration office	TB diagnosis; TB treatment begins	Health care system does not ensure universal right to health for everyone in the territory
6	Long-term perspective	Oliver works as an undocumented migrant. He continues to feel reluctance from his co-workers and acquaintances to enter into contact with him, shake his hand, etc. Anti-tuberculosis treatment continues through the NGO	TB is treated	Stigmatization, stereotyping, exclusion. Failure to ensure transition from parallel NGO health program to routine primary health care

* Not limited to potential migrants; the general population in the country also faces these issues. However, these conditions have a special impact on potential migrants, as they 1) can function as additional mobilizing factors, and 2) contribute to systematic disadvantages for the migrants even during and after transit.
TB = tuberculosis; LTBI = latent tuberculous infection; NGO = non-governmental organization.

our case example. By adopting this approach to terminology, we aim to show how ethics and human rights can strengthen public health efforts to address TB among persons in migration, regardless of their reasons for movement or legal status.

At the same time, inclusive treatment of the word 'migrant' does not mean that we should lose sight of the legal protections established for specific groups, such as refugees and asylum seekers, and it does not preclude the possibility of drawing applications of human rights and ethics to more specific categories, such as undocumented migrants, or seasonal workers. Undocumented immigration takes on various forms, including, for example, undocumented entry, fraudulent documentation, or visa violation.[11] The case presented in this paper and subsequent analyses focus on the first form of undocumented immigration.

We chose this particular case scenario for several reasons:

1 Undocumented migrants are among the most vulnerable migrants. Ethics and human rights-based approaches have a special responsibility to identify and focus on vulnerabilities and discuss the issues at stake. Ethics and human rights approaches offer tools to discuss possible vulnerabilities in relation to health and to address health services for this subgroup.
2 The route we chose is underrepresented in the literature on ethics and human rights of migrant health. While health care for undocumented migrants has been discussed, the larger focus taken here, on the entire migration route from sub-Saharan Africa to Europe, with its own particularities, has so far been neglected. Nevertheless, a

substantial number of migrants are currently moving along this route, and understanding their health needs, especially in terms of TB, is of general urgency.

3 With our case selection, we aim to show we are not dealing only with a nationally confined subpopulation with certain health issues that require a domestic response. A significant portion of the migration experience occurs before arrival in a host country, when a migrant is in preparation to depart and in transition.[12] Ethics and human rights reflections should take these phases into account, in addition to considering the experience of being a newcomer to the country of destination. A geographically confined view tends to underestimate the biographical issues that come beforehand, and which motivate a person to migrate, and those that the migrant encounters during the journey. Issues encountered during all stages of the migration experience can define the health and well-being of a person and show where the burdens and challenges lie.

HUMAN RIGHTS PERSPECTIVES ON THE CASE

A human rights-based approach to TB and migration opens several avenues for analysis and action. First, a rights-based analysis starts by examining the concordance between specific laws, policies, and practices related to TB and migration and international and regional human rights law. Second, a rights-based approach seeks to integrate human rights principles such as non-discrimination, participation, accountability, and transparency into migrant health programs. Third, such an approach draws on key elements of the right to health and interrelated rights to define standards for evaluating the success of these programs—standards that can be used in advocacy and litigation to hold governments accountable for meeting their obligations under international law. These obligations are generally understood as encompassing three dimensions: respect, protect, and fulfill. Briefly, the obligation to 'respect' charges governments with not taking any actions that would interfere with rights, including discriminatory policies.[13] 'Protect' requires governments to prevent third parties from violating rights, while the duty to 'fulfill' refers to creating an enabling environment in which individuals can fully exercise their rights.

Examining laws and policies

The human rights standards for the health and protection of migrants are not located in a single treaty, but instead find expression throughout numerous international and regional human rights instruments (Table 2).[14] Central to understanding the individual in our fictive case study, Oliver (see Figure), is the right to health (e.g., Article 12 of the International Covenant on Economic, Social, and Cultural Rights [ICESCR]).[15] ICESCR Article 12 establishes the right of everyone to enjoy the highest attainable standard of physical and mental health and tasks States Parties (i.e., governments that have ratified or acceded to the convention) with upholding the right by taking steps to prevent, treat, and control epidemic diseases and by 'creating conditions which would ensure to all medical service and medical attention in the event of sickness.' Importantly, in General Comment 14, the Committee on Economic, Social, and Cultural Rights (CESCR) states that the right to health extends to the underlying determinants of health, including food, housing, and other socioeconomic factors; access to health-related information; and safe and healthy working conditions.[16]

Throughout his journey, Oliver passed through territories in which governments were unable to fully protect and fulfill his right to health, as well as those in which governments failed to respect the health rights of migrants. In his home country, the rights to life, food, education and health were not protected and there was no access to education for prevention of communicable diseases for the population at large.[17] Oliver experienced severe deprivation in the warehouse in Northern Africa, where his worsening condition went unaddressed. The lack of access to the underlying determinants of health, such as food, shelter, and safe working conditions, for migrants constituted a failure to both respect and protect the right to health.[17] Once he reached Southern Europe, Oliver feared that he would encounter a screening program more oriented toward securing the health of European nationals against 'imported' diseases than toward promoting the health of undocumented migrant newcomers. Even if the country provided for screening, diagnosis and treatment, irrespective of residence status—as many European countries do for asylum seekers and sometimes also for undocumented migrants—Oliver mistrusted and feared the authorities based on, for example, information from fellow migrants. He had heard that persons found to have a communicable disease might face administrative penalties mimicking criminal penalties (e.g., deportation or detention).[18,19] Aware of his poor health, unsure about his chances of acquiring protection as a refugee, and worried about potential state-imposed penalties, Oliver chose to go underground, where he struggled to access medical care. This action was based partly on misinformation about his actual rights and opportunities—many places in Europe (municipalities and/or countries) provide TB services irrespective of residence status—and partly fueled by a general feeling of not being welcome (perhaps based on the observation that many countries seem to place the protection of the nation's citizens over the right to health for immi-

Table 2 International human rights instruments relevant to migration and health*†

Universal Declaration of Human Rights (UDHR)
International Covenant on Economic, Social, and Cultural Rights (ICESCR)
International Covenant on Civil and Political Rights (ICCPR)
International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (ICRMW)
Convention Against Torture (CAT)
International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)
Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)
Convention on the Rights of the Child (CRC)
Convention on the Rights of Persons with Disabilities (CRPD)

* The above treaties enshrine the rights relevant to health and migration. In some cases, the treaty itself may not expressly focus on migrants, but the relevant human rights treaty bodies responsible for monitoring implementation of the rights therein have addressed the issue of migration in general comments clarifying the normative meaning and legal content of the treaty.
† Source: adapted from reference 14.

grants). This resulted in his ultimately becoming an undocumented migrant with very little security and protection, although his chances of obtaining asylum and proper protection might even have been quite high. The phenomenon of immigrants delaying or avoiding treatment or preventive health care due to fear of penalties has already been described and discussed in the literature.[20–22]

Integrating human rights principles

In General Comment 14, the CESCR singles out the principle of non-discrimination as being central to the right to health, and notes that particular attention must be paid to ensuring that health facilities, goods, and services are made accessible to all 'in law and in fact'.[16] In several places, General Comment 14 refers specifically to migration, stating that governments must 'refrain from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers, and illegal immigrants, to preventive, curative, and palliative health services'. While ICESCR Article 2 provides for progressive realization—an acknowledgment that states are at various stages of development and may have resource constraints that preclude them from immediately providing for the full realization of rights—in General Comment 14, the CESCR notes that States Parties hold immediate obligations under the right to health, including 'a guarantee that the right will be exercised without discrimination of any kind'. Moreover, progressive realization does not obviate the obligation of states to take concrete action toward realizing rights or to justify retrogressive measures. Retrogression could occur, for example, if states revise migration policies in ways that limit access to health care for migrants where it once existed, or impose stricter penalties that amplify vulnerability or lead to worse health outcomes by dissuading migrants from seeking care.

In addition to non-discrimination, the participation of individuals in decision making about programs and policies that affect their lives is a core tenet of the right to health; ideally, decisions should be made with the involvement of those who will bear their consequences.[23,24] Upholding the principle of participation may be particularly challenging when working with undocumented migrants, due to the lack of trust, access and language barriers, and the lack of knowledge about their destination's health care system.

The process of incorporating human rights principles into policy and practice encourages health programs to consider the ways in which interventions are implemented, in addition to measuring their outcomes.[25] Programs that adopt rights-based approaches will center on the welfare of persons in migration as an end in itself, rather than treating migrant health only as a means of securing some other goal (e.g., public safety). In Oliver's case, it was not until his friend connected him to the migrant services non-governmental organization (NGO) that Oliver had the impression of encountering a health service that was designed to meet the needs of migrants.

Defining standards

Finally, a rights-based approach will draw on key elements of the right to health to define standards for judging the provision of TB services in the context of migration. The 3AQ (availability, accessibility, acceptability, and quality) framework outlined in General Comment 14 provides a starting point, in specifying that the right to health must contain the following elements in all its forms and at all levels: the 3AQ of health goods and services.[16] Each of these considerations forms a focal point around which to organize for change. The absence or partial fulfillment of these elements characterized Oliver's interaction with health services before his connection to the NGO.

Human rights and international humanitarian law

In upholding obligations under the right to health in the context of TB and migration, governments need not act alone. The CESCR's interpretation of the right to health emphasizes cooperation among states in addressing cross-border health issues, and stresses that '...the economically developed States Parties have a special responsibility...to assist'.[16] This responsibility is closely related to the perspectives of global justice and global health ethics discussed below. In addition, the duty of international assistance demonstrates that the drivers of TB and migration may be beyond the ability of any single state to address at its borders. Often, these conditions stem from situations of conflict covered by international humanitarian law (IHL), which is designed to limit the violence of conflicts and protect the victims of those conflicts.[26] Oliver is a case in point, as he is

affected by armed conflicts—directly, by the threatening messages received in his home country, and indirectly, by the lack of security and health care during his journey through countries in conflict. In all such situations, IHL is applicable. IHL is a set of rules designed to limit the violence of conflicts and protect the victims of those conflicts.[26] As a victim of armed conflict, Oliver is protected by rules stipulated in the Geneva Conventions and their Additional Protocols. For example, Article 3 and Article 14 of Protocol II provide for the protection of objects indispensable to survival, and Article 17 of Protocol II provides for the protection of civilian populations against forced displacement. The 1951 Convention concerns the rights of displaced persons within the host country with respect to legal status, employment, and housing.[27] The applicability of relevant human rights treaties, alongside IHL and the perspective of IHL in the case of migration and TB, is understudied and needs further investigation.

THREE HIGHLIGHTS FROM THE ETHICS AND JUSTICE LITERATURE

Until now, health ethics has mainly focused either on the domestic health of citizens, to seek better health care, or on obligations from high-income countries (HICs) towards low- and middle-income countries (LMICs). A specific ethics of migrant health and well-being that could be applied to Oliver's case is only in its early stages. The existing literature on migrant health ethics has so far focused mainly on the question of access to health care in receiving countries,[28] but ethically relevant issues arise throughout the entire migration route. In line with the human rights perspective, and in an attempt to develop a more specific and comprehensive ethics of migrant health and well-being, we highlight three strands of discussions in the ethics and justice literature that can be derived from Oliver's case and that add weight to arguments for improving health along migration routes typified by Oliver's case.

Acknowledging global justice and global health ethics perspective (relevant for all steps)

The link between global justice theories, global health ethics and resulting obligations is not yet fully developed, but there is increasing interest among scholars of public health ethics and justice.[29–33] Traditionally, social justice theories have focused on the just distribution of goods and resources in the national context. In contrast, theories of global justice, particularly so-called moral 'cosmopolitanism', emphasize the equal moral worth of every human being, independent of their place of birth. These theories identify and trace the existing globalized social connections and resulting obligations between those countries who profit (e.g., from trade structures) and those who are less privileged, even if they are geographically far apart.[32,34,35]

This approach provides direct insights for global health ethics. It can show that a narrow focus on national health care is insufficient, given that global trade, communication, and travel have effectively created a global community. According to this approach, health and well-being should be understood as a global value to be ensured for everyone by a global effort. Nevertheless, even if one does not fully agree with such a cosmopolitan approach, there is a less controversial, minimalist demand that any country's policies and practices must not harm other countries' population health.[31,36] This means that in all policies, even in migration policy, potentially harmful effects on the health outcomes for all those affected—not only domestically, but also globally—should be taken into account (see also the firewall argument below). Beyond this limited demand to avoid harm, theories of global justice and global relational equality increasingly emphasize positive obligations to take action to improve the health of populations in or from LMICs if a country is in a position to do so, and even more so if such a capable country benefits from an existing imbalance of power.[30,36,37]

The approach to global health ethics includes the understanding that one single country should not focus only on those who are in its territory, but that the international community has a short- and long-term responsibility to secure health for all, in every country; in other words, to consider health as a global project.[29,30] The recent response to Ebola shows the importance of such global obligations and that strengthening acute emergency responses to public health crises, as well as long-term strengthening of health systems, infrastructure and social determinants of health in LMICs, should be urgent priorities. The public health ethicist Angus Dawson underscores the global character of health for all and the long-term obligations to establish a functioning public health infrastructure:

> Citizens in these states [*heavily affected by Ebola*] have been failed by global inaction, both before the Ebola outbreak through continuing neglect of the poor public health infrastructure, and since it began.[38]

Regarding Oliver's case, we can see the short- and long-term importance for the international community to strengthen the health systems, infrastructure and social determinants of health in his country of origin, and in the countries he is passing through. This is based on the demands of global justice and the corresponding assignment of responsibilities,[32,33] but such global responsibilities do not necessarily conflict with national interests. On the contrary, global health ethics suggests that the responsibility of one HIC for

its own citizen's health should also encompass efforts to improve the health systems in LMICs to stabilize these regions, reduce migration pressure and reduce the risk of communicable diseases for all.

The lens of global health ethics also reveals the simple, important fact that the same global obligations exist for migrants. Countries—and especially those that have the resources to do so—should consider it their responsibility to create a health care system that allows every person in a given territory to seek health care once she/he has arrived at the country of destination, irrespective of his/her legal status. Details of the scope of health services offered would have to be determined in each country, based on the resources available and on what is included in the regular universal health care package, if one exists.[39,40] There are various ethical arguments that call for equal access to health care for all, i.e., the equal moral worth of every human being, which entails securing for every person the opportunity to live a flourishing life, health as a basic good for a flourishing life, reciprocity, and solidarity.[41–43] Again, such responsibilities to provide universal health care for all people in a state's territory, regardless of their residence and citizenship status, do not necessarily conflict with pragmatic state interests, such as protection of public health, improved health and thus a healthier workforce in the country, or even a reduction in costs for the national health care system.[41–44]

Emphasizing the 'firewall argument' (especially relevant to steps 3–6)

Undocumented migrants are often effectively cut off from the protection of or even from pursuing their basic human rights because they fear negative consequences of making the authorities aware of them. For example, if an undocumented migrant is a victim of violence, he/she might refrain from calling the police for fear of being deported.[45] As a remedy against undocumented migrants being effectively unable to claim their basic human rights, a so-called 'firewall' has been proposed through an interpretation of the ethics of human rights. A thorough description and discussion of the argument can be found in the work of the philosopher Joseph Carens on the ethics of immigration. The important point is, as Carens writes, that it does not make moral sense to formally provide a right under conditions that make it practically impossible to actually pursue this right.[45] There is therefore an ethical obligation to develop mechanisms for the proper protection of basic human rights. Carens describes the firewall as follows:

> Democratic states can and should build a firewall between the enforcement of immigration law, on the one hand, and the protection of general human rights, on the other. We ought to establish as a firm legal principle that no information gathered by those responsible for protecting general human rights can be used for immigration enforcement purposes. (p 133)[45]

Carens engages in a profound discussion of this argument, and characterizes it as 'idealistic in relation to the status quo'. On the basis of examples, he nevertheless describes in detail the feasibility of reasonably effective firewalls if there is the will to implement them.

As described in Oliver's case, studies show that fear of immigration law enforcement is in fact one of the main reasons why undocumented migrants refrain from seeking medical care, even if in principle legal ways to seek health care are available.[46] This has several negative consequences: Oliver does not receive the necessary—but in some European countries even technically available—health care, which creates a risk both to himself and to the people around him. Even if there is contact with the medical system, health care workers might not be able to provide appropriate and effective care because Oliver might not disclose all symptoms due to fear of deportation, resulting in a mistrust of the health system. A firewall would ensure that practitioners of each profession can fulfill their duties without worrying that their actions will interfere with immigration law enforcement.

The firewall argument has been taken up in more detail in the area of migrant health, and is becoming inextricably tied to the acknowledgment and affirmation of human rights. It calls for a separation of immigration law and health care for migrants based on the importance of health, irrespective of the legal residence status of the person.[47,48] As there are fewer feasibility constraints in HICs, these countries have a special responsibility to care for anyone in their territory.[41]

This argument can increasingly be found in official international policy proposals. For example, the report of the UN Secretary General on the Promotion and Protection of Human Rights claims:

> Thus, the absence of firewalls between public services and migration authorities is a vital force in the denial of basic rights (p 7/18).[49]

With utmost clarity, the European Council recently emphasized the need for a firewall:

> It deals exclusively with the question of ensuring access by all persons ... to those human rights which are guaranteed to them in international human rights instruments, in particular as concerns education, health care, housing, social security and assistance, labor protection and justice, while they are within the jurisdiction of a member State. To this end, this GPR [*authors: general policy recommendation*] calls for the creation of effective measures (hereafter 'fire-

> walls') to prevent state and private sector actors from effectively denying human rights to irregularly present migrants by clearly prohibiting the sharing of the personal data of, or other information about, persons suspected of irregular presence or work, with the immigration authorities for purposes of immigration control and enforcement.[50] (p 7)

The firewall argument can be used for different purposes. It can be used to highlight a harmful, non-existent separation of immigration law enforcement and basic human rights. This is, for example, the case in the United Kingdom, the United States, and Australia, where asylum seekers are required to undergo pre-entry TB screening. This requirement denies the right to enter the country and claim asylum in case of untreated, infectious TB.[51–54] Here, the firewall argument helps to argue for a separation in principle. An empirical investigation as to whether it functions would be the second step.

The firewall argument can also be used in less controversial contexts. In continental Europe, where asylum seekers are allowed to enter the country without prior health screening, immigration authorities are interested in finding undocumented migrants and deporting them. In Germany, for example, a law requires public institutions—excluding physicians, but including, for example, social workers who are often involved in organizing access to health care—to denounce all undocumented migrants to the immigration authorities.[55] The firewall argument can be used to discuss potential fundamental moral flaws of legal regulations.

Some European cities, including German cities, have used their autonomy to build firewalls around health provision for undocumented migrants, and to provide secure, free and confidential health care, irrespective of their residential status.[56] Here, too, the demand of the firewall is to investigate whether these options are well communicated to the migrants and whether these firewalls function in practice.

Non-stigmatization as part of health justice theories (especially relevant for steps 4 and 6)

Various studies have shown that TB is stigmatized, which in itself constitutes a moral problem. Stigma can lead to harmful consequences, such as discrimination or negative socio-economic outcomes, or can negatively impact health care-seeking behavior due to diagnostic delays and reduced treatment adherence.[57,58] Studies on stigma often distinguish three levels: individual stigma (e.g., in interactions between two people), institutional or structural stigma (e.g., through institutional practices, rules and policies) and internalized self-stigmatization.[59] Being a migrant can exacerbate stigma in relation to TB on all three levels, as being a migrant strongly correlates with experiencing stigma, prejudices and implicit biases.[60–62]

Stigma and the resulting discrimination also plays an important role in theories of justice and of justice in health. A central concern of such theories is to reach equality in certain areas. In relation to stigma, theories demanding relational or democratic equality, participation and respect for persons are particularly pertinent.[63,64] These theories focus on the quality of interactions between persons and object to discrimination, exclusion, and domination. The central aim is to realize a society of equals in moral worth; stigmatization contradicts this aim.

An especially interesting health justice theory for Oliver's case is Madison Powers and Ruth Faden's theory of social justice in public health and health policy. At the core of their approach lies the assumption that social justice is the foundational moral justification of public health.[61,65–67] Powers and Faden identify six fundamental dimensions of well-being that are essential for any human being at any time: health, personal security, reasoning, respect, attachment and self-determination.[68] Justice in their view requires sufficiency of every dimension. Each dimension of well-being can be influenced by one or multiple social determinants. In Oliver's case, we can detect insufficiency in most or all dimensions of well-being.[69] Here we want to focus on respect, which 'requires an ability to see others as independent sources of moral worth' (p 22).[68] Oliver might experience being 'perceived as being of lesser value because of membership in a particular [...] group, about whom invidious judgments are made'(p 23).[68] Lack of respect, stigmatization and resulting discrimination constitute a serious assault on the person as a morally worthy agent.

According to Faden and Powers, those health inequalities matter most and thus require action most urgently when they co-travel with clusters of disadvantaging determinants that undermine multiple dimensions of well-being.[64,68] As we have seen, stigma in relation to migrant status and TB are part of the clustering of disadvantage that Oliver experiences.[69] If the basic moral task to see others equally as independent sources of moral worth is taken seriously, individual and institutional stakeholders would be responsible in cases such as Oliver's for taking relevant actions to secure non-stigmatization and respect.

Other ethical issues in TB care of migrants

Other ethical issues are of significance in relation to TB and migration. For example, one could discuss the ethical legitimization of migrating or seeking asylum with the primary purpose of seeking TB care. Other questions are, for example, in relation to the case where the patient does not speak the language of the health care providers or does not want to follow

through with isolation or other TB care procedures, because she/he is on the move. Another question is whether compulsory screening at the border is ethically defensible when there is weak evidence that it helps to reduce transmission or improve individuals' health outcomes.[52]

All these issues are highly relevant, but not in Oliver's case, as he stays undiagnosed and untreated for most of the journey. This paper puts special emphasis on this type of problem, as Oliver's story might be representative of many other migrants with TB or other communicable diseases. A different migrant story, one of a migrant who is diagnosed and treated during the journey, will help to identify and address more fields. This shows the importance of continuing to analyze different case studies of migrants affected by TB for their significance as regards ethics and human rights. Ethics discussions in relation to human rights discourses, and vice versa, should focus on these questions much more systematically than is currently done, to provide a sound and appropriate ground for argumentation and for adequate responses in policy and practice.

PUTTING HUMAN RIGHTS AND ETHICS INTO PRACTICE

Implementing the ethical values and human rights, as outlined in this paper in TB and migrant health services, poses a considerable challenge. Countries receiving undocumented migrants should respond to the surge in human mobility through public health policies based on evidence, ethics, and human rights to ensure that migrant health issues are addressed.

The turn toward nationalist dynamics in some Western nations can make the task of affirming ethics and rights in migrant health even more challenging.[70] Policies based on fear, discrimination and exclusion may affect not only the health of migrants, but also that of the of host communities where migrants live and work, or of others in their countries of transit. In this context, it is critical that the TB community stay with the task of upholding ethics and affirming rights. Incremental victories protecting the health and rights of migrants with TB may occur first in individual programs or for individual cases, before building into bigger policies. TB programs and practitioners should build active solidarity and alliances with migrant rights movements and other groups that are defending human rights and working toward global health justice; they also should collaborate with more general anti-discrimination, ethics education, and right to health initiatives. Aligned with others, TB programs can become spaces where alternatives to stigmatizing, de-humanizing, and rights-denying approaches to migrant health are tried and shown to succeed. Ultimately, it is the responsibility of states to uphold their obligations under international human rights law and enact policies that reflect the ethical and moral underpinnings of public health. However, single states acting alone cannot solve a problem as complex in its genesis as migration-associated TB. Cross-border projects are necessary to make progress against the global drivers of TB. Such projects should acknowledge the obligations of international human rights and humanitarian law throughout the migration route, and reaffirm the insight of global health ethics—that health for all is a shared project, and that responsibility increases with the privilege, wealth and advantages that a country holds. In working with peers from other nations, health professionals will be creating the foundation on which approaches to TB and migration based on evidence, ethics, and human rights can be strengthened.

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