Community, Rights and Gender Barriers Relating to Tuberculosis Prevention and Control among Migrants and Mobile Populations in the Greater Mekong Subregion

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Community, Rights and Gender Barriers Relating to Tuberculosis Prevention and Control among Migrants and Mobile Populations in the Greater Mekong Subregion

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Foreword

We are pleased to present this report, *Community, Rights and Gender Barriers Relating to Tuberculosis Prevention and Control among Migrants and Mobile Populations in the Greater Mekong Subregion*. This document features a comprehensive review and analysis undertaken in partnership with the Regional Coordinating Committee (RCM) and the Country Coordinating Mechanisms (CCM) of target countries in the subregion to understand the unique challenges and barriers faced by their migrants and mobile populations in accessing effective tuberculosis (TB) prevention and control services.

This work could not have been accomplished without the generous cooperation and insights of various stakeholders throughout the Greater Mekong Subregion. We extend our profound gratitude to the RCM for the project, "Tuberculosis Elimination Among Migrants 2022–2024" (TEAM2), as well as TEAM2 sub-recipients, and the CCMs and national TB programmes of target countries – who have all provided insightful and valuable inputs.

The engagement of these key players has not only enriched our understanding of the public health challenges in the subregion but also highlighted the collaborative spirit that is essential for addressing them. Their contributions reflect a shared commitment to overcoming barriers and enhancing the health and well-being of migrants and vulnerable populations.

It is through our collective efforts that we can continue to make strides in the fight against TB and improve health outcomes for all, regardless of migration status and especially those who are most at risk.

Thank you to all who have played a part in bringing this important work to fruition.

Dr Patrick Duigan
Regional Migration Health Advisor
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Acronyms

CRG	community, rights and gender
DOTS	directly observed treatment, short-course
FEW	female entertainment worker
FSW	female sex worker
GBV	gender-based violence
GMS	Greater Mekong Subregion
HICS	Health Insurance Card Scheme (Thailand)
HIV	human immunodeficiency virus
IBBS	integrated bio-behavioural surveillance
IDP	internally displaced person
IOM	International Organization for Migration
MDR-TB	multidrug-resistant tuberculosis
MMPs	migrants and mobile populations
MoU	memorandum of understanding
MSM	men who have sex with men
NSP	National Strategic Plan for Tuberculosis (Myanmar)
NTP	National Tuberculosis Program (Cambodia); National Tuberculosis Control Programme (Lao People's Democratic Republic); National Tuberculosis Control Program (Thailand)
PLHIV	people living with HIV
S&D	stigma and discrimination
TB	tuberculosis
UHC	universal health coverage
WHO	World Health Organization

Glossary[1]

Community, rights and gender (CRG) assessment. CRG assessment is a qualitative research tool that prioritizes the experiences and participation of communities affected by HIV, tuberculosis (TB) and malaria, including key and vulnerable populations.[2] Key and vulnerable populations are groups at higher risk of HIV, TB and malaria that lack access to health services due to biological, behavioural, social and/or structural factors.[3] Since 2017, Stop TB Partnership has been supporting countries in rolling out assessment tools to identify gaps in the data on key and vulnerable populations for TB, human rights and gender barriers to accessing TB services and subsequent solutions to address inequalities to accessing TB prevention, treatment, care and support services.

Country of destination. A country that is the destination for a person or group of persons, irrespective of whether they migrate regularly or irregularly.

Country of origin. A country of nationality or former habitual residence of a person or group of persons who have migrated abroad, whether regularly or irregularly.

Country of transit. A country through which a person or a group of persons pass on any journey to the country of destination, or from the country of destination back to the country of origin or habitual residence.

Cross-border health (or border health). A term referring to the system comprising of health-care markets, regulatory environments, health laws, environmental factors, and health-care consumer and individual behaviours (risky and protective) that shape the health of migrant and non-migrant populations living in a region intersected by the geopolitical boundaries of two or more nations.

Crossing point. A place authorized by the competent authorities for crossing an international border (for persons or goods) or officially designated by the legal framework of the State as an official entry to or exit from the State.

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1 Definitions are taken from the IOM *Glossary on Migration* (IOM, 2019a) unless otherwise stated.

2 Citro et al., 2021.

3 Stop TB Partnership, 2017.

Documented migrant worker. A migrant worker authorized to enter a country to stay and engage in a remunerated activity.

External stigma (see also internal stigma). With regard to HIV or TB, this happens when other people perceive or treat a person living with HIV or TB differently on the basis of their HIV or TB status.[4]

Greater Mekong Subregion (GMS). The Greater Mekong Subregion (GMS), or just "Greater Mekong", is a transnational region of the Mekong River basin in South-East Asia that comprises Cambodia, China (specifically Yunnan Province and Guangxi Zhuang Autonomous Region), the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam.[5] (This report covers only Cambodia, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam.)

Human rights. Universal legal guarantees protecting individuals and groups against actions and omissions that interfere with fundamental freedoms, entitlements and human dignity.

Internal migrant. Any person who is moving or has moved within a State for the purpose of establishing a new temporary or permanent residence or because of displacement.

Internal stigma (or self-stigma). With regard to HIV or TB infection, this happens when a person living with either disease internalizes negative attitudes that may be associated with the infection and accepts these as applicable to themselves.[6]

Internally displaced person (IDP). A person who has been forced or obliged to flee or leave their home or place of habitual residence, particularly as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights, or natural or human-made disasters, and who have not crossed an internationally recognized State border.

International migrant. Any person who is outside a State of which they are a citizen or national, or, in the case of a stateless person, their State of birth or habitual residence. The term covers those who intend to move permanently or temporarily, those who move in a regular or documented manner, and migrants in irregular situations.

4 Global Network of People Living with HIV (GNP+), 2020:6.

5 Asian Development Bank, 2023.

6 GNP+, 2020:6.

Irregular migrant. A person who moves or has moved across an international border and is not authorized to enter or stay in a State, pursuant to the laws of that State and/or international agreements to which that State is a party.

LGBTQI+. An inclusive acronym for groups and identities sometimes also grouped as "sexual and gender minorities". Specifically, these are individuals who identify as lesbian (L), gay (G), bisexual (B), transgender (T), intersex (I) and queer (Q), among others (+).[7]

Migrant. Any person who is moving or has moved across an international border or within a State, away from their habitual place of residence, regardless of their legal status, whether the movement is voluntary or involuntary, the cause(s) for the movement and the duration of the stay.

Multidrug-resistant tuberculosis (MDR-TB). Multidrug-resistant TB (MDR-TB) is TB that does not respond to at least two drugs, namely isoniazid and rifampicin – the two most powerful anti-TB drugs.[8]

Refugee. A person who, owing to a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion, is outside the country of their nationality and is unable or, owing to such fear, unwilling to avail for themselves the protection of that country; or who, not holding any nationality and being outside the country of their former habitual residence as a result of such events, is unable or, owing to such fear, unwilling to return to it.

Undocumented migrant. A non-national who enters and/or stays in a country without the appropriate documentation.

7 United Nations, 2023.

8 World Health Organization (WHO), 2018.

Executive Summary

Tuberculosis (TB) continues to be a significant global health concern, with the World Health Organization reporting an estimated 10.6 million new cases and 1.6 million deaths in 2021, predominantly in Africa and South-East Asia. Migrants are particularly vulnerable to health inequities due to inadequate social protection, discrimination, human rights violations and stigmatization. TB is a social disease, and migration, as a social determinant of health, may increase TB-related morbidity and mortality among migrants and surrounding communities. It is understood that many migrants face various barriers to accessing TB detection and treatment services in countries across the Greater Mekong Subregion (GMS). Language barriers, lack of knowledge about TB, fear of deportation, stigma and discrimination are some of the major factors that contribute to low TB case detection and poor treatment adherence among migrants and mobile populations.

The Global Fund Strategy 2023–2028 underscores the importance of human rights, gender equality, community engagement and addressing the social determinants of TB for quality TB services. However, there is a significant lack of data and research on TB infection among migrants in the GMS, restricting the development of responsive guidelines and policies. Therefore, further analysis of available evidence and research relating to the community, rights and gender (CRG) dimension of TB infection among migrants in the GMS is needed to ensure that TB programmes in the subregion are more responsive to the needs and rights of affected communities, contributing to the elimination of TB among migrants and the broader population. A few smaller-scale studies have been conducted among migrants in the subregion and given that their scope is often limited, their generalizability cannot be easily assumed. Similarly, specific information regarding the gender, human rights, and stigma and discrimination (S&D) dimensions of TB infection among migrants in the GMS is lacking. However, studies on the gender, human rights and S&D dimensions or aspects of HIV, conducted among people living with HIV (PLHIV) and other key and vulnerable populations in the GMS, are reviewed, and potential implications for TB programmes identified. These studies highlight the importance of addressing gender inequalities, protecting human rights and combating stigma and discrimination to improve the overall response to TB, including among migrant populations. This report reviews existing and accessible studies on the CRG dimension of TB infection among migrants in the GMS and

categorizes the available information, remarking on country-specific situations (i.e. contexts) in terms of TB burden, key and vulnerable populations, gender- and human rights-related barriers to accessing TB services, and TB-related stigma and discrimination.

In GMS countries, migrants constitute a key population at risk of TB due to various factors, including precarious living and working conditions, limited access to health-care services, language barriers and increased likelihood of disrupted continuity of care. Thailand, the major destination country for the other countries in the subregion, is estimated to have around 5 million migrants. These migrants are characterized as suffering from crowded living conditions, having poor health-seeking behaviours, experiencing stigma and discrimination, and facing language barriers to their access to TB prevention, diagnosis and treatment.

Gender is another factor to consider when addressing the issue of TB infection among migrants, as women are often at a disadvantage due to their social and economic circumstances. Women migrants face additional challenges, including limited access to reproductive health-care services, cultural and social norms that hinder them from seeking medical care, and greater vulnerability to gender-based violence. This review highlights significant gender disparities in TB detection and treatment among migrants. It emphasizes the need for gender-sensitive interventions that address the unique needs of women migrants, including reproductive health-care and empowerment programmes to enhance their health-care decision-making abilities. Limited legal protections, discrimination and inadequate access to health-care and social services violate the rights of migrants, impeding their ability to seek timely and appropriate TB care.

After a review of relevant documents, this report proposes a set of recommendations to address the aforementioned issues that could be considered at both the subregional and country levels: (a) strengthening cross-border collaboration to harmonize health and migration policies; (b) promoting the sharing of best practices; and (c) helping develop cross-border mechanisms for enhanced TB detection and treatment, as well as more efficient cross-border referral systems. Further, data collection efforts to disaggregate TB data by migration status are crucial, and countries should invest more efforts and resources in CRG studies on the subject of migration and TB. Comprehensive TB awareness and education campaigns are essential to increasing knowledge about symptoms, prevention and available services. These campaigns should be designed to reach both migrants and the general population and consider their respective specific contexts. To improve access to TB services, it will be important to provide information

materials in multiple languages, interpretation services and/or health-care professionals who are trained to effectively communicate with migrant populations in their native languages. It will also be important to develop and implement gender-sensitive approaches that address the unique needs of women migrants, which include reproductive health-care and empowerment programmes. Since there is limited data on TB among migrants in the GMS, it will be crucial to conduct further research and collect data to inform targeted interventions and policies for this vulnerable population. Additionally, efforts should be made to strengthen legal frameworks and policies that protect the human rights of migrants, including their right to access health care regardless of legal status.

CHAPTER ONE

Introduction

1. INTRODUCTION

1.1. Tuberculosis in the Greater Mekong Subregion

Tuberculosis (TB) remains a significant global health issue, particularly in low- and middle-income countries. It is the thirteenth leading cause of death worldwide and the second-deadliest infectious disease, following COVID-19. Factors such as poverty, overcrowding and limited access to health care contribute to high TB transmission rates, especially among vulnerable populations, including migrants, internally displaced persons (IDPs) and refugees. In the Greater Mekong Subregion (GMS), these vulnerable groups typically experience higher TB infection and exposure due to overcrowded living and working conditions, increased vulnerability to HIV, malnutrition, and substance use induced by marginalization and social exclusion. Delays in TB diagnosis among migrants are frequently associated with health-care access difficulties, lack of education, poor health-seeking behaviours and inimical cultural beliefs, TB stigma, and the marginalization of migrants.

Social barriers play a significant role in TB management among migrants and mobile populations (MMPs), who often lack access to accurate information on TB prevention, transmission and latent infection due to language barriers and cultural beliefs that inhibit health-seeking behaviour. Stigma-related fear, unawareness of their health service entitlements, low health-related spending capacity relative to household income, and migrant-unfriendly health services all contribute to migrants' reluctance to seek care or adhere to treatment.

Among GMS countries, Myanmar has the highest TB incidence (360 per 100,000 population), followed by Cambodia (288 per 100,000 population) and Viet Nam (173 per 100,000 population). Thailand and the Lao People's Democratic Republic each have a TB incidence of 143 per 100,000 population. Thailand, Viet Nam and Myanmar are on the World Health Organization's (WHO) global list of 30 high-TB-burden countries, with Thailand and Myanmar also featuring on the WHO list of 30 high-TB/HIV-burden countries. Notably, Thailand transitioned out of the list of 30 countries with high burdens of multidrug-resistant-TB (MDR-TB) in 2021, while Viet Nam and Myanmar remained on it.[9]

[9] WHO, 2022a.

Table 1. **Total population and TB burden in GMS countries, 2021**

Country	Total population (in millions)[a]	Estimated new TB infections[b]	Estimated TB incidence per 100 000 population[b]
Cambodia	16.59	50 000	288
Lao People's Democratic Republic	7.42	11 000[c]	143[c]
Myanmar	53.80	194 000	360
Thailand	71.60	105 000	143
Viet Nam	97.47	172 000	173

Sources: [a] World Bank, 2022a (Projections are based on the latest available national census figures for each country: Cambodia, 2019; Lao People's Democratic Republic, 2015; Myanmar, 2014; Thailand, 2022; Viet Nam, 2019).

[b] WHO, 2022a (all countries except Lao People's Democratic Republic).

[c] WHO, 2022c.

Progress towards TB elimination and TB control and prevention efforts in the GMS have been significantly impacted by the COVID-19 pandemic. Health-care resources have been largely diverted towards combating COVID-19, leading to disruptions in routine health-care services and setbacks in TB programmes. Travel restrictions and lockdowns imposed to control the spread of COVID-19 have further hindered patients' access to health-care facilities, as well as interrupting supply chains for essential TB medicines and diagnostics. In addition, the deployment of health-care workers to manage the pandemic has similarly shifted attention away from TB, resulting in delays in case detection, contact tracing and treatment initiation.

Overall, the situation in GMS countries is further aggravated by widespread poverty, high HIV prevalence in some areas, limited health-care access, and dynamic and widespread cross-border migration. The additional burden of COVID-19 has created a major setback in TB control and prevention efforts in GMS countries. The consequences of these setbacks will likely continue to be felt for the foreseeable future. The pandemic has underscored the need for resilient and flexible health-care systems capable of managing multiple health crises simultaneously. It also highlighted the importance of avoiding the neglect of one health issue while addressing another.

1.2. Migration in the Greater Mekong Subregion

According to the latest estimates, there are approximately 281 million international migrants worldwide, accounting for 3.6 per cent of the global population.[10] This means that 1 out of 7 people globally is on the move, either internationally or within their own countries. Determining the exact number of migrants in the GMS is challenging due to the spontaneous and often irregular nature of migration, not to mention the typically sparse data collection, with the international migrant population in the subregion estimated to be around 5 million. Thailand is the primary destination country for migrants, mainly from neighbouring countries, such as Myanmar, Cambodia and the Lao People's Democratic Republic, due to its comparatively stronger economy and employment opportunities.[11] Apart from this figure, there are internal migrants and other mobile populations who may also face numerous challenges related to their legal status.

Ascertaining the number of undocumented migrants in the GMS is difficult due to a variety of factors. Despite Thailand having established memorandums of understanding (MoUs) with its neighbours Cambodia, the Lao People's Democratic Republic, Myanmar and Viet Nam, providing legal channels for migrants to access job opportunities, a significant proportion of migrants still enter the country through irregular channels. The high costs, time-consuming procedures and complex processes associated with legal channels often deter migrants from utilizing them.[12] As a result, estimating the number of undocumented migrants is difficult. At any rate, it is estimated that Thailand alone is home to approximately 1.5 million undocumented migrants from neighbouring countries.[13] It is important to emphasize that this figure is only a rough estimate, owing to the lack of precise data and the dynamic nature of migration flows in the subregion.

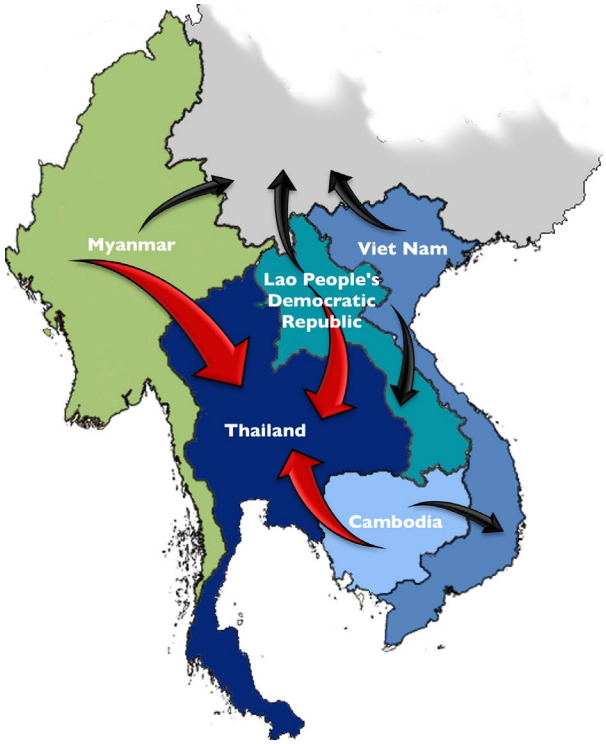
10 IOM, 2021a.

11 Mekong Migration Network, 2023.

12 United Nations Thematic Working Group on Migration in Thailand, 2019.

13 Suphanchaimat et al., 2017.

Figure 1. **Common international routes in the Greater Mekong Subregion**



Source: Prepared by the IOM Regional Office for Asia and the Pacific – Migration Health Unit.

Note: This map is for illustration purposes only. The boundaries and names shown and the designations used on this map do not imply official endorsement or acceptance by the International Organization for Migration.

The GMS sees a significant volume of intraregional (in addition to international) migration, which is unevenly distributed due to inconsistent and unequal economic development in recent years. The majority of intraregional migrants often hold low-skilled jobs and are undocumented; as such, migration itself is a social determinant of health, with migrants potentially facing various health problems related to the migration process. Under normal circumstances, migration is not a risk to health per se; however, conditions surrounding the migration process can increase individuals' vulnerability to ill health. To be specific, migration-related risk factors are often linked to the legal status of migrants, which, in turn, determines their level of access to health and social services. The migration landscape in the GMS is complex and fluid, with people constantly moving across borders for various reasons, including economic opportunities, conflict and climate change. Migrants in the GMS represent a key, high-risk group that faces severe difficulties in accessing health care due to their legal status. This underscores the urgent need for comprehensive and inclusive health policies that recognize the unique challenges faced by this group, and the importance of addressing these issues in efforts to achieve health equity and universal health coverage (UHC).

Table 2. **International migrant population estimates for GMS countries, 2020**

Country	Estimated population
Cambodia	79 341
Lao People's Democratic Republic	48 731
Myanmar	76 446
Thailand	3 632 496
Viet Nam	76 767

Source: United Nations Department of Economic and Social Affairs (DESA) Population Division, 2021.

1.3. Tuberculosis and migration

MMPs, including but not only refugees and asylum-seekers, are among the groups most affected by TB worldwide. According to WHO, in 2020, migrants and refugees accounted for an estimated 11 per cent of the global TB burden.[14] However, this figure is likely an underestimate, as many countries do not systematically collect data on TB among the migrant or non-national population. The COVID-19 pandemic has profoundly impacted the mobility of migrants across GMS countries due to travel restrictions and border closures. These disruptions have hindered access to TB screening, diagnosis and treatment services for all, leading to an overall decline in TB case detection rates, including among migrants. This has also led to delayed diagnoses, more missed cases and increased risks of transmission.[15]

It is estimated that one third of TB cases are "missed" by health-care systems, with many of these cases occurring among vulnerable populations that are hard to reach or have difficulty accessing public health services, including migrants and refugees, alongside children and people living with HIV (PLHIV).[16] There is an urgent need for increased efforts to enhance service availability for these populations to ensure fewer missed cases.

1.4. Gender and tuberculosis

Gender is another critical factor to consider when addressing the issue of TB infection among migrants. Gender-specific factors must be taken into account in relation to migrants' access to health-care services, as well as to disease transmission and elimination among this population.[17]

[14] WHO, 2022a.

[15] Teo et al., 2021.

[16] Centers for Disease Control (CDC), 2016.

[17] The Global Fund, 2023a.

Women migrants are often at greater risk of contracting TB due to their social, cultural and economic circumstances. These circumstances may include limited access to health care and a greater likelihood of experiencing gender-based violence (GBV), driven by certain sociocultural gender norms.[18] Cultural norms and practices may also affect women's ability to seek TB care and adhere to treatment. Thus, addressing gender-specific needs and challenges is essential in designing and implementing effective TB prevention and control strategies for migrants. This includes ensuring that TB services are accessible and culturally appropriate for both male and female migrants, and that interventions account for gender-specific barriers and challenges. By doing so, migrants, particularly women, are prevented from experiencing difficulties in accessing and completing TB care. Different ideas about masculinity and femininity exist in GMS countries and significantly influence how men and women access health-care services.

1.5. Human rights and policy

Ensuring access to health care is a fundamental human right applicable to all individuals, including MMPs, irrespective of their legal status or nationality. This right must be acknowledged and prioritized, including in the context of TB elimination efforts. Presently, global strategies for combating TB predominantly focus on biomedical and public health interventions.[19] These conventional approaches pervade global and national TB programmes and research, which often overlook social, economic and structural determinants that contribute to the disease's spread and the emergence of drug resistance. Consequently, addressing the broader factors driving the TB epidemic is essential for comprehensive and effective response.

The UHC principle underscores the importance of ensuring that everyone has access to quality health services without incurring financial hardship. The degree to which UHC is implemented for MMPs in GMS countries, however, varies. While some of these countries have taken steps to extend health-care services to MMPs, challenges persist. For example, migrants often encounter barriers, such as language difficulties, discrimination and lack of documentation, which impede their ability to access health care even when services are made available. In some cases, migrants may be required to pay out of pocket for health-care services, often rendering necessary care unaffordable. These challenges obstruct full enjoyment of the right to access health care, undermining efforts to achieve UHC and TB elimination.

[18] Beia et al., 2021.

[19] Citro et al., 2016.

Currently, no unified policy or legal framework specifically targets TB among MMPs in the GMS as a whole (although there are MoUs between some GMS countries on conducting health check-ups, including TB screening, among migrants). The absence of a dedicated, comprehensive policy framework, combined with insufficient coordinated action and inadequate resources, poses a significant challenge to cooperation across the subregion and the harmonization of TB elimination approaches. This lack of a unified approach across countries hinders efforts to ensure migrants' access to health services and address TB among this population. Developing a policy framework for the GMS that acknowledges the unique health-care needs of migrants and guarantees their inclusion in TB prevention, diagnosis and treatment efforts is crucial for effective cooperation and progress towards TB elimination in the subregion. To holistically support this goal, the framework should consider, alongside biomedical interventions, key policy-level components that address the stigma and discrimination (S&D) and community, rights and gender (CRG) dimensions of TB infection.

1.6. Stigma and discrimination

TB-related stigma and discrimination against migrants in the GMS is a significant barrier to effective TB control. Such stigma and discrimination lead to fears of job loss and/or decreased income, deterring individuals from seeking diagnosis and treatment. Such fear is amplified by the reality that stigma can emanate from various sources, including communities, health-care workers and employers. Deep-rooted stigmas and stereotypes, often fuelled by pre-existing biases, cultural beliefs and historical stereotypes about migrants and TB, significantly influence perceptions and attitudes towards TB in migrant communities. These perceptions are further complicated by the diversity of languages and cultural norms in the GMS, which can hinder effective communication and understanding among migrants, local communities, employers and health-care providers. This complexity can ultimately obstruct the delivery of health-care services and the diffusion of accurate information about TB.

The impacts of stigma and discrimination can be further associated with other factors. Access to health care is often limited, especially for undocumented migrants, aggravating the risk and exacerbating the consequences of TB. Fear and misinformation lead to the exclusion and isolation of and discrimination against migrants, perpetuating negative attitudes and further marginalizing these populations. The negative portrayal of migrants with TB in the media can further perpetuate stigmas and biases, reinforcing discriminatory attitudes in wider society. Concerted efforts are needed to address these numerous barriers and may include comprehensive public education campaigns, strengthening health-care systems and creating supportive legal and policy environments that promote equitable access to health-care services.

1.7. Purpose of the report

The Global Fund Strategy 2023–2028[20] is a bold initiative aiming to hasten the end of HIV, TB and malaria while constructing resilient and sustainable health-care systems. Running from 2023 to 2030, the strategy underscores the importance of equity, sustainability, programme quality and innovation. It is dedicated to addressing gender- and human rights-related barriers to health service access, leveraging the fight against HIV, TB and malaria to build more inclusive, resilient and sustainable health-care systems. As regards TB specifically, the strategy focuses on comprehensive, quality services that are human rights-based, gender-responsive, people-centric and integrated into health and community systems.

One of the significant programmes under this strategy is "Tuberculosis Elimination Among Migrants 2022–2024 (TEAM2)",[21] funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria ("the Global Fund"), with the IOM Regional Office for Asia and the Pacific as the principal recipient. The project spans five GMS countries – Cambodia, the Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam – and aims to reduce the TB burden among MMPs. It especially targets missing cases, thereby diminishing TB transmission, incidence and mortality. The project acknowledges the substantial barriers migrants, particularly the undocumented and irregular, encounter when accessing health-care services, including TB prevention, diagnosis and treatment. An important aspect of the project is engaging communities, including migrants and other key populations, in the design and delivery of TB services. The project also emphasizes the promotion of human rights and gender equality in TB programmes for migrants – by addressing stigma and discrimination, ensuring accessible and responsive services for all genders and encouraging the significant participation of affected communities.

Understanding CRG-related barriers to health services, particularly TB elimination in the GMS, is critical to ensuring that TB programmes are increasingly responsive to the needs and rights of affected communities. This report, developed under the project, TEAM2, aims to enhance understanding of CRG and S&D considerations. This knowledge can be applied and used more broadly, informing other partners' and stakeholders' TB programming in the subregion.

[20] The Global Fund, 2023b.

[21] IOM, 2023a.

1.8. Objectives

The primary objectives of this report are as follows:

(a) Provide an overview of key CRG and S&D concerns in the context of TB infection among migrants in the five GMS countries;

(b) Identify CRG gaps and needs in the GMS to support further design and planning for future CRG assessments and inclusion of MMPs as beneficiaries in TB elimination activities;

(c) To offer GMS-wide and country-level recommendations on how to strengthen CRG-sensitive service provision and policy for TB among migrants and reduce TB-related stigma and discrimination against MMPs.

CHAPTER TWO

Methodology

2. METHODOLOGY

2.1. Methodology

This report consists primarily of a review of published documents, in print or online, on the CRG and S&D dimensions of TB (and HIV) infection among migrants in the GMS. The review methodology is described in detail below.

(a) **Online search of published literature.** The approach to reviewing relevant literature involved conducting an online search using specific keywords. Relevant literature was identified based on these search terms and reviewed to provide the specific context of TB among migrants in the GMS through insights into the relationship between migrants and TB, the impact of stigma and discrimination related to TB, and gender- and human rights-related barriers to migrants' access to TB services. The list of reviewed literature, disaggregated by topic, is shown in Table 3.

Table 3. **Literature reviewed, by search term**

Country	Studies referenced for each topic
Cambodia	TB and migrants: 5 studies TB, gender and key populations: 6 studies TB- and HIV-related stigma, discrimination and human rights: 4 studies TB and HIV co-infection: 7 studies
Lao People's Democratic Republic	TB and migrants: 2 studies TB, gender and key populations: 4 studies TB- and HIV-related stigma, discrimination and human rights: 4 studies TB and HIV co-infection: 3 studies
Myanmar	TB and migrants: 4 studies TB, gender and key populations: 5 studies TB- and HIV-related stigma, discrimination and human rights: 3 studies TB and HIV co-infection: 4 studies
Thailand	TB and migrants: 8 studies TB, gender and key populations: 6 studies TB- and HIV-related stigma, discrimination and human rights: 7 studies TB and HIV co-infection: 6 studies
Viet Nam	TB and migrants: 3 studies TB, gender and key populations: 6 studies TB- and HIV-related stigma, discrimination and human rights: 4 studies TB and HIV co-infection: 5 studies

(b) **Review of unpublished literature.** This includes: (i) annual reports of national TB programmes, shared by key informants following interviews; (ii) the TEAM2 funding request proposal to the Global Fund; (iii) IOM reports; (iv) slide presentations from subregional consultation meetings organized by TEAM2; and (v) the response to the Global Fund Technical Review Panel by the Regional Coordinating Mechanism.

(c) **Consultations with representatives of subrecipients under the TEAM2 project.** All subrecipient organizations under the TEAM2 project were contacted, and their representatives were consulted (virtually) for this report. It should be noted that IOM country offices are among the subrecipients of TEAM2 in Cambodia, Thailand and Viet Nam.

Table 4. **Subrecipient institutions consulted for the report**

Subrecipient institution	Date of consultation
Shoklo Malaria Research Unit, TB Program, Mae Ramat, Tak Province, Thailand	6 April 2023
IOM Cambodia[a]	10 April 2023
World Vision Thailand	10 April 2023
Department of Disease Control, Ministry of Public Health, Thailand	12 April 2023
National Lung Hospital, Viet Nam	18 April 2023
World Vision, Myanmar	9 May 2023
IOM Viet Nam[a]	10 May 2023
Community Health and Inclusion Association (CHIAs), Lao People's Democratic Republic	11 May 2023

Note: [a] The IOM Regional Office for Asia and the Pacific is the principal recipient of the TEAM2 grant, with IOM country offices in Cambodia, Thailand and Viet Nam as subrecipients.

2.2. Definition of "migrant"

For the purposes of this report, it is important to clarify that while there is no universally agreed-upon legal definition of "migrant", a definition provided by IOM is used:

> A migrant is any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of the person's legal status, whether the movement is voluntary or involuntary, what the causes for the movement are and what the length of the stay is.[22]

Furthermore, it is worth noting that the term "migrant" is used differently in various contexts. For instance, in Thailand, "migrant" typically refers to a cross-border migrant from a neighbouring country. However, in Cambodia, the Lao People's Democratic Republic, Myanmar and Viet Nam, it more likely refers to an internal migrant or a return migrant (one who crosses borders to stay in another country for work, eventually returning to their home country). Lastly, it is recognized that the term "migrant" may not fully cover the entire spectrum of individuals on the move. For this reason, either "migrants" or "mobile population" (or "migrants and mobile populations (MMPs)") may be referenced in this report, with the two terms used interchangeably.

[22] IOM, 2016.

2.3. Limitations

Data related to migration in the GMS. There is a significant challenge in estimating the current number of migrants in the GMS due to the scarcity of recent data. The most recent estimates available at the time of this report's writing are from 2018, before both the COVID-19 pandemic and the military coup in Myanmar. The absence of a recent formal census and published data results in a significant lack of information regarding the specific breakdown of migrants by country of origin, ethnicity and gender. Consequently, the true extent of migration in the GMS following the said events remains uncertain and challenging to ascertain.

Lack of documentation on TB-related stigma and discrimination. This review is limited by the scarcity of documented evidence specifically pertaining to TB-related stigma and migration. Existing literature predominantly focuses on HIV-related stigma and discrimination, leaving a notable gap in our understanding of the unique challenges faced by individuals affected by TB in the GMS.

Limited data on TB among migrants in the GMS. The lack of comprehensive data related to TB among migrants in the GMS hampers understanding of the disease's prevalence and incidence, as well as the specific challenges faced by this population. Furthermore, information related to CRG dimension of TB among migrants is scarce.

Limited CRG data. Only one country in the GMS (i.e. Cambodia) had conducted a comprehensive and formal CRG assessment at the time of this report's writing, limiting the availability of comparative data and insights across countries. The lack of standardized assessments hinders the ability to identify common challenges and develop strategies coordinated across the subregion.

Reliance on existing literature and absence of primary data. This review primarily relies on the analysis of existing literature on the situation of TB (e.g. in terms of prevalence, incidence and HIV co-infection) among migrants in the GMS and the CRG and S&D dimensions of TB infection among this population. As no primary data was collected, for example, through direct interaction with migrants diagnosed and treated for TB, valuable insights into the challenges faced by migrants in accessing TB services in GMS countries may be lacking.

Only the five GMS countries covered by the TEAM2 programme – namely Cambodia, Myanmar, the Lao People's Democratic Republic, Thailand and Viet Nam – are evaluated in this report.

CHAPTER THREE

Findings

3. FINDINGS

3.1. Overview

Cross-border mobility in the GMS is highly dynamic, characterized by varying migration patterns and levels among and within countries. Migrants in the GMS encounter numerous challenges to accessing TB and other health services. In addition, they also face non-health-related migration issues that must be considered through a CRG lens. These challenges often stem from a complex interplay of legal, social, economic and cultural barriers. Understanding these country-specific challenges is crucial for developing comprehensive strategies to address the health needs of migrants in the GMS.

Existing strategies for preventing and controlling TB encompass various methods: directly observed treatment, short-course (DOTS); contact tracing, vaccination, health education, infection control measures and infection surveillance; environmental controls, such as ventilation and airflow management in areas with high TB burden; use of protective equipment; and promoting health education, including respiratory hygiene and cough etiquette. However, these strategies often fall short when it comes to effective implementation of TB care for marginalized groups. Migrants in the GMS often lack access to these crucial services, and inadequate implementation of TB control methods, in particular, presents a significant challenge to achieving TB control targets in the subregion.

To ensure the success of TB control efforts in the GMS, it will be essential to develop and implement targeted interventions that address the unique needs of MMPs as regards TB services and the barriers they face when accessing them. Listed below are some of the most common challenges faced by MMPs across the GMS as regards TB – challenges that are largely related to barriers to accessing health services in general. Further details and country-specific examples are provided in the country profiles.

Language barriers. Migrants' limited access to health-care services, including TB prevention, case-finding and care, can often be attributed to language barriers and migrants' lack of awareness of available services. Migrants may struggle to communicate with health-care providers due to language differences, which can hamper their ability to express their symptoms, understand medical advice and effectively navigate the health-care system. Moreover, the lack of culturally sensitive services and the inadequate availability of migrant-friendly health-care facilities contribute to gaps in the delivery of TB detection, diagnosis and treatment services to migrants. Migrants may also have limited knowledge about TB preventive measures, health-

seeking behaviours related to TB prevention and early symptom recognition, and where to go to access TB services. This knowledge gap can lead to delayed (or foregone) diagnosis and treatment, inadvertently contributing to increased risks of TB transmission in certain areas with larger migrant communities, such as those along borders.

Lack of health insurance and identification. Many migrants in the GMS lack health insurance coverage and/or proper identification documents, further impeding their access to health-care services. Without valid documentation, migrants may find themselves ineligible for subsidized (if available) or affordable health care. Indeed, the widespread perception among migrants that health care is largely inaccessible to those who lack proper documentation can deter them from seeking necessary care in the first place. Additionally, insufficient health-care infrastructure, particularly in rural and/or remote areas, where migrants may be concentrated, coupled with limited service availability (e.g. only during standard daytime working hours), can exacerbate these challenges.

Immigration status and legal barriers. Legal barriers and immigration status often restrict a migrant's access to public services, including health care. A migrant may not speak the local language and/or be unfamiliar with the local health-care system, struggle to navigate it effectively or face discrimination while trying to do so. Furthermore, a migrant, especially if without proper documentation, may fear that attending clinics or travelling to health facilities could bring them to the attention of authorities, posing a risk of deportation.

Economic constraints on migrants. Economic constraints and precarious living conditions pose additional challenges to migrants, who often suffer from low wages, exploitative working conditions and unstable employment, limiting their financial capacity for health care, including insurance services. Financial strain can make it difficult for them to access the necessary TB diagnosis and treatment services.

Health of migrants. MMPs have the fundamental right to both full physical and mental health. Focusing on migrants' health issues is significant, as it directly impacts various development outcomes for countries. However, this focus is often not prioritized and, in some cases, disregarded altogether. Migrants play a crucial role in meeting the labour demands of higher-income nations, bolstering economies through trade activities and tax contributions, and sending remittances to their countries of origin. Furthermore, the health of migrants has a considerable impact on general or overall public health. Effectively including migrants in public health preparedness and response efforts and ensuring their full inclusion in health-care systems contribute not only

to their health but that of the broader population as well. Therefore, prioritizing migrants' health not only upholds their rights but also helps boost the overall well-being and resilience of communities. It is therefore crucial to ensure that TB services are accessible to and culturally appropriate for all populations, including migrants, to reduce the overall TB burden in the GMS.

3.2. Country profiles

This section presents a comprehensive overview of the migration situation, including the challenges faced by migrants, and the burden of TB in each country covered in this study. Additionally, it highlights the specific burden of TB among MMPs, identifies key and vulnerable populations at higher risk of TB, and describes gender- and human rights-related barriers to accessing TB services. As direct evidence pertaining to TB are not always available, this report draws from relevant studies of similar programmes, such as HIV-related stigma and discrimination, for their implications for and to inform TB programmes. This examination aims to gain a deeper understanding of the unique challenges to and opportunities for improving TB control and care among migrants in individual GMS countries.

3.2.1. Cambodia

3.2.1.1. Migration context

Cambodia has traditionally been a migrant-sending country, with internal migration being more prevalent than international migration. Migrant workers in Cambodia typically engage in various professions, including construction, garment manufacturing, agriculture, domestic work and the service industry. The United Nations Department of Economic and Social Affairs (DESA) – Population Division reported in 2021 that there were 79,341 international migrants living in Cambodia, primarily from Viet Nam (49.3%) and Thailand (41.7%), out of a total population of 16.59 million.[23] Over 20 per cent of this population are considered "mobile populations", which include international migrants, internal migrants and returnees. Cambodia has witnessed a notable increase in the number of international migrants, particularly from China and the Republic of Korea, seeking employment and investment opportunities. COVID-19 has also had substantial effects on migration patterns in Cambodia, with at least 110,000 return migrants from

[23] DESA Population Division, 2021.

Thailand and Viet Nam in 2020 alone, as reported by IOM Cambodia.[24] It is essential to note that this figure may not capture all forms of migration, as it may exclude some undocumented migrants, irregular migrants and/or unregistered refugees. Migration patterns have since relatively stabilized, but the effects of these pattern changes may not be well understood for some time to come.

3.2.1.2. Burden of tuberculosis

Cambodia was removed from the WHO list of the top 30 high-TB-burden countries in 2021, marking the promising progress in TB control made by the country. Nevertheless, Cambodia's TB burden remains high, and the country was included in the new WHO global TB watch list for 2021–2025. The incidence of TB in Cambodia was estimated at 288 cases per 100,000 population in 2021, accounting for approximately 48,000 new cases in that year.[25] The incidence of MDR-TB is 1.9 per cent among new cases and 12 per cent among re-treatment cases.[26] In 2019, the National Center for Tuberculosis and Leprosy Control (CENAT)) of Cambodia (which runs the National Tuberculosis Program (NTP)) reported 30,017 TB case notifications, although the estimated TB burden in the country was significantly higher, at approximately 52,000.[27] Despite significant successes in TB control over the years, a considerable gap in case detection persists in Cambodia, mainly due to challenges to accessing remote and marginalized populations, as well as limited health-care infrastructure and diagnostic capabilities.[28]

TB poses a significant public health challenge in Cambodia due to a confluence of contributing factors. These include a high prevalence of HIV, with an estimated 74,000 persons infected with HIV in 2021,[29] constrained health-care infrastructure, inadequate resources for TB control programmes, substandard living conditions, and insufficient awareness and education about TB among people with TB and the general population.[30] The scarcity of health-care facilities and professionals in the country, particularly in rural areas with limited access to services, complicates the diagnosis and treatment of TB cases. These challenges lead to delays in diagnosis and treatment, consequently increasing the risk of TB transmission and adversely affecting patient outcomes.

[24] IOM, 2020a.
[25] USAID, 2022.
[26] Ibid.
[27] USAID, 2020.
[28] CDC, 2016.
[29] AIDS Data Hub, 2021a.
[30] Ma et al., 2022.

Considering the critical nature of TB as a public health concern in Cambodia, concerted, sustained and sustainable efforts are necessary to address the issue effectively. While the Government and international organizations have initiated various measures to combat TB, more work is required to achieve the objective of eliminating TB as a public health problem in the country. The National Strategic Plan to End Tuberculosis 2021–2030[31] serves as a comprehensive blueprint for addressing TB in Cambodia throughout the decade. The Strategic Plan, which aligns with Cambodia´s National Strategic Development Plan 2019–2023[32] and the End TB Strategy[33] of WHO, prioritizes interventions that have the most significant impact on TB case notification, treatment of drug-resistant TB and management of TB–HIV co-infections. The plan seeks to build upon the progress made in TB control over the recent years and expedite efforts and work towards eradicating TB as a public health threat by 2030.

Access to TB services should be taken into account within the broader health-care system framework, and achieving UHC for migrants in Cambodia still presents some challenges, even as efforts have already been made to improve access to health care for this population. Cambodia has taken steps to extend health-care services to migrants, in recognition of their right to health as a human right. In 2021, for example, a national policy has been endorsed that specifically targets MMPs in the country that aims to facilitate their enhanced inclusion and access to health care.[34] The policy highlights the importance of promoting migrants' health and well-being, reducing the risk of communicable disease transmission, and providing appropriate health education and information. It emphasizes the importance of addressing the unique health-care needs of MMPs, ensuring equitable access to health-care services, including preventive, curative and rehabilitative care.

For many international migrants in Cambodia, lack of official documentation is a primary barrier to the access to social and health protection schemes and other health-care and social services. Language barriers, limited awareness of available services, and discrimination can also hinder migrants' ability to fully benefit from initiatives towards UHC. Migrants in Cambodia often face difficulties navigating the health-care system and encounter challenges to accessing affordable and quality health-care services. As such, implementing and ensuring UHC for migrants in Cambodia will require continued efforts to address these barriers and promote equitable access to health care for all, irrespective of migration status.

[31] Government of Cambodia, National Center for Tuberculosis and Leprosy Control (CENAT), 2021.

[32] Government of Cambodia, 2019.

[33] WHO, 2023a.

[34] IOM, 2022.

3.2.1.3. Tuberculosis among migrants

Comprehensive data on the prevalence of TB among migrants in Cambodia is scarce. While a few fragmented studies offer insight, albeit limited, on the TB burden among migrants, nationally disaggregated data on this population remains unavailable.

A total of 15,034 Cambodian migrant workers were screened for TB by IOM Cambodia in Poi-Pet, at the Thai–Cambodian border, from January 2020 to November 2021.[35] Of this number, 1,519 underwent TB testing, with 342 testing positive for the disease. This shows an alarmingly high positivity rate of 22.5 per cent among those tested. Additionally, between 2019 and 2020, the United Nations Office for Project Services successfully implemented a multi-country grant project for TB prevention among migrants in the GMS. The effort identified 278 cases of TB among migrants in Cambodia.[36] It is essential to recognize that while activities under formal agreements (i.e. MoUs) or funded programmes are able to produce data on results of TB testing conducted among MMPs, data from the NTP is not disaggregated by migration status.

While the Ministry of Health runs services at the Poi-Pet Transit Center, which receives migrants returning from Thailand, such as providing TB screening and managing TB case referrals from Thailand, Cambodia still lacks a comprehensive migrant health policy, resulting in undocumented migrant workers or displaced persons potentially falling through the cracks. For instance, the ministry estimates that 2,000–3,000 new cases of TB among Cambodian migrant workers in Thailand in 2017 went unreported to the NTP of Cambodia.

3.2.1.4. Key and vulnerable populations for tuberculosis

Migrants in Cambodia are among vulnerable populations that may face unique barriers to accessing TB prevention, diagnosis and treatment services. Other key and vulnerable populations for TB include PLHIV, senior citizens and prison inmates. The weakened immune systems of PLHIV, in particular, increase their susceptibility to TB and exacerbate disease severity. In 2021, there was an estimated 74,000 PLHIV in Cambodia, with only 62,636 identified.[37] Certain populations experience a higher incidence of HIV, including women providing "entertainment services" (4.9% incidence),[38] men who have sex with men (MSM) (4.0% incidence) and transgender women

[35] Sovuthy, 2022.

[36] Funding request application submitted by TEAM2 to the Global Fund for "Tuberculosis priority in the Greater Mekong region among migrants and mobile populations, 1 January 2022 to 31 December 2024".

[37] AIDS Data Hub, 2021a.

[38] Phalkun, 2022. (Also, note that this statistic for female entertainment workers (FEWs, also lumped into the category of female sex workers (FSWs)) is from 2021, while the statistics for men who have sex with men (MSM) and transgender women (TGWs) are from 2019. Additionally, the FEW data (2021) is from 9 provinces, while the MSM/TGW data (2019) are from 13 provinces, with only 8 provinces in common.)

(TGWs) (9.6% incidence)[39] – all of whom are typically more vulnerable to TB. These populations also have high HIV incidence rates, presenting a substantial risk factor for co-infection with TB, which contributes to the country's TB burden. The prevalence of HIV among TB patients in Cambodia is 1.7 per cent.[40]

Factors such as stigma and discrimination, as well as inadequate awareness and health literacy, can hinder these populations from accessing TB diagnosis and treatment services. Addressing these challenges necessitates targeted interventions that cater to each group's very specific needs. Such interventions would involve, for example, enhancing migrant TB screening and treatment services at border crossings and improving access to TB diagnosis and treatment in prisons and rural health-care facilities.

3.2.1.5. Gender-related barriers to accessing TB services

Women comprised 51 per cent of the total population of Cambodia and represented 45 per cent of new TB cases detected in the country in 2021.[41] Gender differences can significantly impact not only the risk of contracting TB but also access to TB services, including testing. Due to gendered barriers to education and health information, women may be less likely to access information about TB and related services.

An integrated bio-behavioural surveillance (IBBS) study conducted among female entertainment or sex workers (FEWs or FSWs) in Cambodia in 2022 revealed a 4.9 per cent HIV prevalence in this group. Additionally, 6.5 per cent reported having been physically forced to have sex; 10.4 per cent had experienced violence from sex/intimate partners; and 17.7 per cent had avoided health care due to stigma and discrimination.[42] In these contexts of violence, stigma and discrimination, FEWs/FSWs, MSM and transgender women have also demonstrated higher TB prevalence.[43]

No known studies have been conducted to specifically assess gender-related barriers to accessing TB services in Cambodia. However, studies on gender-related barriers to accessing HIV services among key populations in Cambodia suggest that similar disparities may exist with regard to TB services. Such studies highlight potential implications for TB programmes, emphasizing the importance of addressing gender inequalities in health care, protecting human rights and

39 Phalkun, 2020.
40 WHO, 2022b.
41 CENAT, 2017.
42 Phalkun, 2022.
43 Ibid.; Phalkun, 2020.

combating stigma and discrimination. Thus, insights from HIV studies can inform efforts to improve gender equity and access to TB services for all, including key and vulnerable populations. Further research is necessary to better understand and address the gender dynamics impacting TB service delivery in Cambodia.

3.2.1.6. Human rights-related barriers to accessing TB services

While there are no known published studies conducted in Cambodia specifically assessing human rights-related barriers to TB services, there have been research into key and vulnerable populations for HIV that have identified various human rights barriers these groups face when accessing HIV services.

IBBS studies conducted among MSM and TGWs (2019) and among FEWs/FSWs (2022) in Cambodia have identified significant human rights-related barriers to accessing HIV services that these population groups encounter. The studies show that these groups often receive differential treatment from health-care workers and often have fears of judgment and mistreatment that discourage them from seeking HIV services in the first place. Such treatment violates their human rights by creating a substantial barrier to essential health-care services. Additionally, the studies found that these populations often face various forms of domestic violence and GBV from sex/intimate partners, clients (in the case of FEWs/FSWs and TGW sex workers) and even the police.

The IBBS studies,[44] while focused on HIV/AIDS, yielded findings that have implications for TB services. The findings underscore the need to train and sensitize health-care providers on providing non-judgmental and inclusive care – not only TB and HIV services, but all types of health-care services – for all populations, including MSM, TGWs and FEWs/FSWs. In addition, the findings highlight the necessity of public health interventions that address the root causes of human rights-related barriers to these populations' access to TB services and efforts to increase awareness and knowledge of TB and HIV services.

3.2.1.7. TB-related stigma and discrimination

Although no known published studies have specifically assessed TB-related stigma and discrimination against migrants in Cambodia, a few studies have explored these issues within the general population.

[44] Phalkun, 2020 and 2022.

In a 2019 study conducted in Cambodia, over half of TB patients reported experiencing self-stigma, with a significant difference in levels observed between those who live in rural areas and those who live in urban areas.[45] A later study showed that such stigma often resulted in delays in seeking diagnosis and treatment services.[46] In the People Living with HIV Stigma Index 2.0 ("PLHIV Stigma Index 2.0") study, conducted in Cambodia in 2018, 75 per cent of men and 72 per cent of women reported concealing their HIV status from others.[47]

There have been numerous proactive efforts by organizations such as IOM Cambodia, which has provided village health support group volunteers with education on TB and training that covers topics such as health education of migrants during TB screening, including on how to address stigma and discrimination, alongside advice and support on treatment adherence for TB patients in their communities. However, significant challenges remain. The persistence of stigma, particularly among employers, discourages migrants from undergoing TB and further diagnostic testing. The continuing stigma underscores the need for targeted, community-specific interventions to address migrant patients' misconceptions and fears.

The above-mentioned findings suggest that disease-related stigma and discrimination, including within the health-care system itself, create an environment of fear and mistrust among migrants in Cambodia, including those affected by TB. If migrants feel that seeking TB services may expose them to stigma or mistreatment, they might be reluctant to access necessary health care, including TB screening, diagnosis and treatment. This reluctance can lead to delayed diagnosis, poor treatment adherence and, collectively, increased TB transmission among migrants and within host communities.

The 2019 IBBS study found HIV prevalence rates of 4.0 per cent among MSM and 9.6 per cent among TGW respondents.[48] Various IBBS studies among transgender individuals in Cambodia revealed numerous experiences of discrimination, ranging from being ignored by others or unable to express oneself freely, to being subjected to GBV, including domestic violence.[49]

A scoping review of the HIV epidemic in Cambodia[50] and PLHIV Stigma Index 2.0 study[51] provide valuable insights into HIV-related stigma and discrimination in Cambodia. While these studies focus on stigma towards PLHIV from the general population (i.e. public stigma), they have

45 Teo et al., 2020.
46 Teo et al., 2021.
47 Cambodian People Living with HIV Network (CPN+), 2019.
48 Phalkun, 2020.
49 de Lind et al., 2021.
50 Ibid.
51 CPN+, 2019.

crucial implications for the NTP, including in relation to MMPs. Considering the common and overlapping S&D issues faced by PLHIV and people living with TB, collaboration between the national TB and HIV programmes is essential. By working together, the NTP and other disease programmes can share best practices and resources for addressing stigma and discrimination and develop coordinated strategies for promoting stigma reduction among various key and vulnerable populations, including migrants.

3.2.2. Lao People's Democratic Republic

3.2.2.1. Migration context

When people from the Lao People's Democratic Republic migrate abroad, they do so primarily to neighbouring countries, especially Thailand, in search of better economic opportunities. The Lao People's Democratic Republic serves mainly as a source country of migrants, with some Vietnamese workers using it as a transit point to Thailand. Limited job prospects, insecurity, low wages, poverty and lack of education are the main factors driving migration out of the country. The number of Lao migrants leaving the country, officially reported at 277,845 in 2018, has been increasing annually.[52] However, this figure may not capture all migrants, including those who are undocumented. The Government provides reintegration programmes for returnee migrants, offering job training, financial aid and health care. At any rate, further efforts are needed to support returnees, especially in remote areas, and ensure their successful reintegration into their communities.

3.2.2.2. Burden of tuberculosis

TB is a major public health problem in the Lao People's Democratic Republic. An estimated 11,000 people were newly infected with TB in 2021 (143 per 100,000 population).[53] The incidence of MDR-TB is 0.67 per cent among new cases and 11 per cent among re-treatment cases.[54] TB is a leading cause of death in the Lao People's Democratic Republic, with an estimated 2,000 deaths (27 per 100,000) due to TB in 2021, excluding PLHIV.[55] Additionally, TB is a significant problem

52 IOM, 2021b.
53 WHO, 2022a; World Bank, 2022b.
54 WHO, 2022c.
55 Ibid.

among PLHIV, with an estimated 6 per cent of TB cases co-infected with HIV.[56] The burden of TB is around 5 to 10 times higher among the elderly and those living in rural areas in the Lao People's Democratic Republic, emphasizing the importance of equity and access within the public health system.[57] A primary challenge for the National TB Control Programme (NTP) of the Lao People's Democratic Republic is the lack of quality TB services in hard-to-reach communities due to access barriers and limited availability of services provided by the primary health-care network.[58]

The country has made progress in addressing the TB epidemic in recent years. One action it has taken is implementing the WHO-recommended DOTS strategy for TB control, which includes providing free TB diagnosis and treatment, promoting community-based care, and strengthening TB surveillance and monitoring. However, challenges remain, such as limited resources for TB control, inadequate access to TB diagnosis and treatment in some areas, and the emergence of drug-resistant TB.

3.2.2.3. Tuberculosis among migrants

TB is a significant health concern among both international and internal migrants in the Lao People's Democratic Republic. Migrants are at a higher risk of contracting the disease due to several factors, such as overcrowding, poor living conditions, malnutrition and limited access to health-care services. The incidence of TB in the Lao People's Democratic Republic among the general population is estimated at 143 per 100,000 people,[59] (disaggregated data for migrants has become available in the country's District Health Information System 2.0 (DHIS2) since 2019). The actual burden of TB among migrants is likely higher due to poor living conditions, difficulties in accessing health-care services and under-reporting.

Despite several initiatives implemented by the Government to address TB infection among migrants, more needs to be done to ensure that they, including the unregistered or undocumented, have access to TB prevention and treatment services. This may require strengthening health-care systems and addressing the underlying social determinants of health, such as poverty and poor living conditions, which increase the risk of TB among migrants. Foreigners are not covered by national health insurance in the Lao People's Democratic Republic, except for TB (for which everyone in the country is covered), and are thus required to pay full medical costs themselves.

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56 Ibid.

57 Government of the Lao People's Democratic Republic, National Tuberculosis Control Programme (NTP), 2020.

58 Funding request application submitted to the Global Fund from the Lao People's Democratic Republic for TB and HIV for 1 January 2021 to 31 December 2023.

59 WHO, 2022a.

Migrants report facing several barriers to accessing health services, such as language and, as mentioned, financial obstacles. In addition, cross-border migrants and internal migrants who originate from other provinces within the Lao People's Democratic Republic are required to pay any unsubsidized medical expense (or portion thereof), with TB services free of charge according to the National TB Policy. At district hospitals, which can offer more comprehensive services than community hospitals, both internal and international migrants are excluded from national health insurance coverage and required to pay the full cost of services.[60]

3.2.2.4. Key and vulnerable populations for tuberculosis

The National Tuberculosis Strategic Plan for 2021–2025 of the Lao People's Democratic Republic emphasizes the importance of addressing the needs of key and vulnerable populations as part of the country's efforts to control TB.[61] The plan recognizes that certain groups, such as PLHIV, prison inmates, MMPs, ethnic minorities and household contacts of people with TB, are at a higher risk of developing TB and experiencing poor TB treatment outcomes.

The situation of TB among the prison population in the Lao People's Democratic Republic is not well documented, and there is very limited data available on the prevalence and incidence of TB in prisons. PLHIV, estimated at 15,000 in 2021, with only 11,803 actually diagnosed, are another key and vulnerable population for TB in the country.[62] In the same year, 610 new TB cases were estimated among PLHIV in the country.[63] As regards HIV among other population groups: the prevalence of HIV was 3.1 per cent among transgender people in Vientiane and Savannakhet in 2012; 8 per cent among MSM in Vientiane (2020); and 2.2 per cent among FSWs in Vientiane (2020).[64]

The National TB Strategic Plan for 2021–2025 aims to reduce the TB burden among MSM, TGW and FSW populations through targeted interventions, such as integrated TB–HIV services, expanding TB screening and treatment in prisons, strengthening surveillance systems for MMPs, improving access to TB services for ethnic minorities, and increasing TB awareness and education for household contacts. By addressing the specific needs of these populations, the National TB Strategic Plan hopes to make significant progress towards ending the TB epidemic.

60 Government of the Lao People's Democratic Republic, NTP, 2020.
61 Teo et al., 2021.
62 AIDS Data Hub, 2021b.
63 WHO, 2022c.
64 UNAIDS, 2021.

3.2.2.5. Gender-related barriers to accessing TB services

Several gendered human rights-related barriers can serve to limit access to TB services in the Lao People's Democratic Republic. By preventing contact with the health-care system, these barriers contribute to the under-reporting of TB cases among both general and key populations.

The overall lifetime prevalence of physical violence by a husband or sex/intimate partner among ever-partnered women in the Lao People's Democratic Republic has been reported at 11.6 per cent.[65] In addition, women, including migrant women, face multiple gender-related barriers that can restrict their access to TB services. For example, traditional gender norms often assign caregiving responsibilities to women, including taking care of children and elderly family members, which restrict their physical mobility and make it difficult for them to access TB services, particularly if these services are located further afield. Balancing their caregiving responsibilities with their own health needs can result in delays in seeking TB care, hindering timely diagnosis and treatment.[66]

Addressing gender-related barriers to the access to TB services needs a multisectoral approach involving collaboration among various stakeholders, including government agencies, civil society organizations and international organizations. This collaboration shall aim to ensure that migrant women have access to TB services without discrimination and stigma. Potential strategies may involve promoting gender equality and empowerment, improving access to information and education, and ensuring that TB services are culturally appropriate and sensitive to the needs of migrant women. There is no available information on similar initiatives that target the LGBTQI+ population in the Lao People's Democratic Republic.

3.2.2.6. Human rights-related barriers to accessing TB services

The exclusion of internal migrants from national health insurance schemes in the Lao People's Democratic Republic, as stipulated in the National TB Strategic Plan,[67] raises significant human rights concerns. Access to affordable and comprehensive health care is a fundamental human right, and denying migrants this right undermines their well-being and perpetuates health inequalities. By requiring all migrants (including internal migrants) to pay the full amount for health-care services, they face financial barriers that hinder their ability to access necessary TB care. This exclusion exacerbates the vulnerabilities of internal migrants, who often face

[65] Government of the Lao People's Democratic Republic, National Commission for the Advancement of Women, 2015.

[66] Luxembourg Development Cooperation Agency, 2021.

[67] Teo et al., 2021.

socioeconomic challenges and may have limited financial resources. Beyond this, there is no available and accessible information specifically on human rights-related barriers to accessing TB services in the Lao People's Democratic Republic.

3.2.2.7. TB-related stigma and discrimination

People in the Lao People's Democratic Republic who have TB or are at risk of contracting it may face various S&D issues, which can limit their access to TB services. No TB stigma assessment has not been conducted in the Lao People's Democratic Republic to date, leaving a gap in the understanding of the actual burden of TB-related stigma and discrimination.

The PLHIV Stigma Index study (2012) conducted in three provinces in the Lao People's Democratic Republic offers some parallels that could be relevant to the country's TB programmes. The study demonstrated the prevalence of stigma and discrimination against PLHIV, the most common form of which was being gossiped about because of their status (reported by 23% of respondents). High levels of self-stigma were also reported by the study's PLHIV respondents, with 22 per cent forgoing the usual social gatherings and 13 per cent isolating from family and/or friends.[68] The study further revealed that 36 per cent of respondents avoided going to health clinics because of their HIV status.[69] The fear of stigma and discrimination might similarly deter key and vulnerable populations from seeking TB services.

Collaborations between the NTP and civil society organizations in the Lao People's Democratic Republic on TB detection and treatment have highlighted specific challenges faced by migrant workers, with persistent stigma and discrimination from employers identified as a significant issue. Migrants are often forced to stop working when they test positive for TB due to stigma built into company regulations. The current national policy on the protection of migrants with TB is inadequate, posing a substantial problem for migrant workers losing their source of income, which can subsequently affect their ability to continue TB treatment.

These findings underscore the urgent need for the NTP to address stigma and discrimination as a serious issue affecting health-care access in the country, including for TB services. The programme should consider implementing stigma reduction interventions, such as training health-care workers to provide non-discriminatory care and increasing community awareness and education to reduce HIV- and TB-related stigma and discrimination. Simultaneously, it is

[68] UNAIDS and Lao National Network for People Living with HIV and AIDS, 2012.

[69] Government of the Lao People's Democratic Republic, NTP, 2020.

crucial to improve existing protective policies for migrant workers diagnosed with TB. These steps should be implemented alongside efforts to increase access to health insurance for all migrants, whether internal or international, in the country. It is paramount that TB services are accessible, culturally appropriate and sensitive to the needs of migrants, and that health-care providers and workers are trained to deliver care without stigma and discrimination.

3.2.3. Myanmar

3.2.3.1. Migration context

Myanmar is the most ethnically, linguistically and religiously diverse nation among GMS countries. While being predominantly a source country for migrants, Myanmar also has migrants making up an estimated 25 per cent of its population, including approximately 9.39 million internal migrants and 4.25 million international migrants,[70] according to the latest available census data. It is estimated that there are 1.4 million Myanmar migrants in Thailand alone.[71] Many migrants on the Myanmar–Thailand corridor are processed at checkpoints that lead into special economic zones in the Thai border provinces of Tak, Kanchanaburi and Ranong. Factors driving migration from Myanmar include widespread poverty, lack of livelihood opportunities, insecurity, human rights violations and displacement caused by commercial and military development projects.[72]

The COVID-19 pandemic has exacerbated the situation, with many migrants losing their jobs and struggling to access health care and other essential services. As such, and also because of the military coup, the aforementioned numbers may have changed (more recent national estimates remain unavailable). The Office of the United Nations High Commissioner for Refugees reports that there were 1.1 million refugees and asylum-seekers from Myanmar in neighbouring countries as of 31 December 2022. Similarly, as of 1 May 2023, the total estimated number of IDPs in Myanmar had reached 1.8 million.[73]

[70] Government of Myanmar, 2014.

[71] Ibid.

[72] Parmar et al., 2019.

[73] Office of the United Nations High Commissioner for Refugees, 2023.

3.2.3.2. Burden of tuberculosis

Myanmar has made significant progress in the fight against TB but continues to have a high burden of the disease, including drug-resistant TB and TB–HIV coinfection. In 2021, it was estimated that 194,000[74] people were living with TB in Myanmar, with an incidence of 360 per 100,000 population,[75] and that 36,400 individuals lost their lives to the disease.[76] Of these, an estimated 4,400 were PLHIV.[77]

All countries in the GMS have intensified efforts to eliminate TB, and Myanmar stands out as the only country in the WHO South-East Asia region to achieve its 2020 milestone targets, even as it remains on the WHO list of 30 high-TB-burden countries. These targets include a 20-per-cent reduction in TB incidence from the 2015 baseline, in line with the WHO End TB Strategy, which itself is aligned with Target 3.3 under Sustainable Development Goal 3, which aims to epidemics of communicable diseases, including TB, by 2030.[78]

The most recent iteration of Myanmar's National Strategic Plan (NSP) for TB covers 2021 to 2025 and aligns with the End TB Strategy. This plan sets ambitious targets for TB prevention, diagnosis and treatment, including a 50-per-cent reduction in TB incidence by 2025 from the 2015 baseline. Key strategies involve strengthening TB surveillance, enhancing access to diagnostics and treatment, and addressing social determinants of TB, such as poverty, malnutrition and tobacco use. The plan recognizes the particular importance of engaging key populations, such as PLHIV, prisoners and migrants, while emphasizing the need to tackle TB-related stigma and discrimination. The NSP has identified several challenges to TB services' ability to reach migrants in Myanmar.[79] It is important to note, however, that the political coup and change of government in Myanmar has caused, alongside security issues, severe disturbances at all levels of the public health system, such as hospital closures, drug shortages and human resource shortages affecting numerous health posts at all levels – all of which cause challenges for many national and international actors trying to implement life-saving programming.

[74] WHO, 2022f.
[75] WHO, 2022a.
[76] WHO, 2022d.
[77] WHO, 2022a and 2022f.
[78] WHO, 2023b.
[79] Government of Myanmar, Ministry of Health and Sports (MOHS), 2020.

Table 5. **Challenges to TB services' ability to reach migrants in Myanmar**[80]

Key population	Challenges to service reach
International migrants	• Access to care dependent on the nature of migrant workers' employment contracts, work permits and/or insurance coverage • Problems with medical follow-ups on TB patients after completion of DOTS • Unrecorded or double-recorded TB treatment • Lack of migrant-specific data to inform decision-making • Absence of systematic referral mechanisms • (For undocumented migrants) Fear of deportation, which discourages migrant workers from completing treatment or from seeking TB care in the first place
IDPs	• Problems with access to health centres due to armed conflict, displacement, marginalization of ethnic minority groups and underdevelopment of their communities • Restrictions on movement (other than those in the previous bullet point) that prevented patients from reaching health facilities or other services • Weak infection surveillance and weak infection prevention measures

3.2.3.3. Tuberculosis among migrants

The national TB prevalence survey in Myanmar does not specifically report TB cases among migrants. The lack of data notwithstanding, TB prevalence among migrants might be higher than that of the general population due to their poor living conditions and restricted access to health-care services.

The Government of Myanmar has implemented several initiatives to address TB infection among migrants and internally displaced populations in the country. The NTP has developed a comprehensive strategy to provide TB diagnosis and treatment services to all individuals, including migrants, refugees and IDPs. This includes ensuring that TB services are available in all parts of the country, particularly in areas with high numbers of migrants and IDPs. The NTP has also established partnerships with civil society organizations and other stakeholders to enhance outreach and awareness-raising activities for these populations. Moreover, the Government is implementing initiatives to improve living conditions and provide better access to basic services, such as water and sanitation, to address underlying social determinants of TB infection among migrants and IDPs. However, challenges remain in ensuring that TB services are accessible to all, especially those in remote and conflict-affected areas, and in addressing the social and economic factors that contribute to the risk of TB among these populations.

[80] Ibid.

3.2.3.4. Key and vulnerable populations for tuberculosis

The NSP for TB 2021–2025 identifies several groups as key and vulnerable populations for TB in Myanmar, including the elderly (aged 50 or older), prison inmates, urban-congested and peri-urban populations, people who use/inject drugs, high-risk workers, ethnic minority groups, migrants and IDPs. TB is a significant public health concern in Myanmar, particularly among key and vulnerable populations. The NSP acknowledges the importance of addressing these populations' needs and incorporates specific strategies to reach them. These strategies include improving access to TB services, enhancing TB prevention and control activities, providing targeted health education and awareness-raising initiatives, promoting community involvement and strengthening cross-country collaboration and participation in TB care and prevention. Addressing the needs of key and vulnerable populations is essential for achieving Myanmar's national goal of TB elimination by 2035.

The NSP identifies several key and vulnerable populations for TB in Myanmar, such as the elderly (aged 50 and older), prison inmates, urban-congested and peri-urban populations, people who use/inject drugs, high-risk workers, ethnic minority groups, migrants and IDPs. However, there is a lack of additional available information such as the estimated number of individuals in each of these populations, the burden of TB among them and specific behaviours that put them at risk of contracting TB. Furthermore, as the CRG assessment has not yet been conducted in Myanmar, obtaining further details about these key and vulnerable groups remains challenging. Addressing these knowledge gaps is crucial for tailoring effective and targeted interventions for TB control in the country.

3.2.3.5. Gender-related barriers to accessing TB services

Migrants and IDPs in Myanmar face various human rights- and gender-related barriers when trying to access TB services. Limited access to health-care facilities, language barriers and discrimination pose significant challenges for these groups. Women may encounter additional barriers due to cultural norms and social expectations that restrict their mobility (thus their ability to physically access services) and health decision-making power. It should be noted that conflict and displacement can intensify risks and challenges related to TB, particularly for those residing in camps or overcrowded environments. To address these challenges, the Government of Myanmar and its partners are working to expand access to TB services in conflict-affected areas, enhance the quality and availability of interpretation services, and combat stigma and discrimination through awareness-raising activities and community engagement.[81] However,

[81] Government of Myanmar, MOHS, 2020.

more efforts are needed to ensure that all individuals, including migrants and IDPs, can access TB services without fear of discrimination, arrest or deportation.

A study highlights the significant impact of gender on the clinical course of HIV infection in Yangon, Myanmar.[82] Globally, prevailing concepts of masculinity have been seen to contribute to many men being less likely than women to seek health care, undergo HIV testing, and initiate and adhere to antiretroviral therapy (ART), resulting in considerably higher mortality rates among men. Similar concepts of masculinity exist in Myanmar and significantly influence how men access health care. Although gender has been linked to poorer outcomes in men living with HIV in the country, the independent influence of gender to clinical outcomes is not fully understood.

Young women in Myanmar may be more likely to access the health-care system and be routinely screened for HIV, including as part of antenatal and obstetric care. Conversely, marginalized populations, such as MSM, who may be less inclined to seek health care due to fears of discrimination and stigmatization in a country where same-sex intercourse remains illegal, could face barriers to accessing TB services, leading to delayed diagnosis and increased transmission risks.[83] These gender disparities in health-seeking behaviours may also be observed with TB services.

3.2.3.6. Human rights-related barriers to accessing TB services

The prevalence of human rights-related barriers to accessing TB services in Myanmar is not well documented, and it is essential to recognize and address such barriers for all population groups, particularly those who are vulnerable and marginalized. The recent political upheaval and ongoing situation in Myanmar following the coup have only exacerbated human rights issues across the country, including those related to health-care and TB services. Disruptions in health-care infrastructure, limited access to essential services and restrictions on movement have heightened the challenges faced by individuals seeking TB diagnosis and care. Addressing the human rights implications arising from the political crisis is paramount to safeguarding the health and well-being of all individuals impacted by TB in Myanmar.

According to UN Women, 17.3 per cent of women in Myanmar have experienced physical and/or sexual intimate partner violence.[84] The Independent International Fact-Finding Mission on Myanmar reported in September 2018 that rape and other forms of sexual violence have

[82] Nyein et al., 2021.

[83] Veronese et al., 2020.

[84] UN Women, 2023.

been particularly severe and recurring features of the targeting of civilian populations in different states of Myanmar since 2011.[85] The Independent International Fact-Finding Mission on Myanmar reported in September 2018 that rape and other forms of sexual violence have been particularly severe and recurring features of the targeting of civilian populations by security forces in different states of the country since 2011.[86] GBV poses a significant barrier to accessing TB services and infringes on the human rights of women and other marginalized populations. It can result in physical and psychological trauma, as well as stigma and discrimination, deterring individuals from seeking TB diagnosis and treatment. Addressing GBV is crucial for ensuring equal and safe access to TB services and protecting human rights.

3.2.3.7. TB-related stigma and discrimination

Stigma and discrimination related to TB poses significant challenges in Myanmar. Individuals with TB often experience stigma and discrimination within their communities, workplaces and even their families, which can cause them to delay seeking care and treatment, impacting their mental health and well-being. Additionally, there is stigma associated with being a migrant or IDP in Myanmar, which can further exacerbate the issue for those affected by TB. NTP in Myanmar is working to address stigma and discrimination through community awareness-raising campaigns and training programmes for health-care providers. However, much work remains in terms of improving social attitudes towards TB and vulnerable populations affected by the disease, and specific information regarding TB-related stigma and discrimination is not readily available. Insights from available data or strategies pertaining to HIV-related stigma and discrimination in the country may offer valuable insights and potential implications for the TB programme.

The PLHIV Stigma Index 2.0 study was conducted in Myanmar in 2023 by the Myanmar Positive Group (MPG), with results available by the end of the year. The first PLHIV Stigma Index study, conducted in 2010 by MPG, assessed S&D levels experienced by PLHIV in the country. The study report revealed that 45 per cent of respondents were aware of friends gossiping about them because of their HIV status, and over 20 per cent of female PLHIV respondents reported being verbally insulted, harassed or threatened within the 12 months Prior to the study. The report also showed that a large number of respondents were grappling with emotional problems and internal stigma resulting from their HIV-positive status. Over 60 per cent felt ashamed, 35 per cent felt they deserved some kind of punishment and 25 per cent felt suicidal because of their HIV status.[87] Another study conducted in Myanmar echoed these findings, indicating

[85] United Nations, 2019.

[86] Ibid.

[87] Myanmar Positive Group and Myanmar Marketing Research and Development, Ltd, 2010.

that PLHIV faced mistreatment, such as being segregated into separate hospital waiting areas or wards, due to their HIV status.[88]

The 2010 PLHIV Stigma Index study has significant implications for national TB programmes, particularly concerning migrants and TB–HIV co-infection. Given the close link between TB and HIV, reducing HIV-related stigma and discrimination could also contribute to improved TB prevention and treatment outcomes. One key implication of the study for the NTP is the need to enhance collaboration between TB and HIV programmes. This could involve jointly planning and implementing activities that address HIV-related stigma and discrimination while also improving access to TB and HIV services for migrants and other vulnerable populations. Furthermore, it emphasizes that deep-rooted stigmas cannot be overlooked in the fight to eradicate TB.

3.2.4. Thailand

3.2.4.1. Migration context

According to the United Nations Thailand Migration Report 2019, approximately 4.9 million migrants resided in Thailand in 2018, with the majority (3.9 million) originating from the GMS.[89] These migrants constituted about 8 per cent of Thailand's population and were employed across various sectors, including construction, manufacturing and agriculture. Given its central location in the GMS, Thailand has become a preferred destination for migrants from neighbouring countries. The largest group of migrants and refugees in Thailand comes from Myanmar, many of whom reside in Thai provinces bordering Myanmar, although a number also reside in Bangkok. Although migration has brought significant economic benefits to Thailand, numerous migrants continue to face challenges that include, among others, discrimination, limited access to health care and education, and workplace exploitation.

Migrants entering Thailand from GMS countries can be broadly categorized as either documented or undocumented. A documented migrant possesses proper legal documents, such as a passport, visa and/or work permit, while an undocumented migrant lacks one or more of these. Both

[88] Huang et al., 2021.

[89] IOM, 2019b.

groups, however, may encounter difficulties in accessing health-care, education, legal and other essential services in Thailand, with undocumented migrants facing additional barriers due to their legal status. Documented migrants from GMS countries who are legally employed in Thailand are eligible to enrol in the Health Insurance Card Scheme (HICS) administered by the Ministry of Public Health. The health insurance card offers four aspects of health-care benefits: medical treatment, health promotion, disease surveillance, and disease prevention and control.[90]

Thailand's HICS is often regarded as an example for other countries in the GMS. The HICS benefit package is comprehensive, covering outpatient and inpatient treatment, health promotion and disease prevention services, and includes HIV/AIDS treatment and other high-cost care. HICS is self-funded by migrants, who are expected to pay an annual premium of either THB 1,600 (if they have registered with the One-Stop Service, which was launched to expedite the documentation of migrants) or THB 2,200 (if they have not). As of 2016, only 1.45 million migrants were enrolled in HICS, and while participation in the scheme is supposed to be compulsory for all migrants, many migrants fail or do not wish to register. There currently is no law or regulation that penalizes migrants who fail or refuse to sign up for HICS or employers who leave migrant employees uninsured. As such, HICS is only "semi-compulsory". In actual practice. Policymakers and decision-makers must recognize that a migrant's employment status is often dynamic, and lack of portability of health insurance schemes presents a challenge to migrants and their continuity of care.

3.2.4.2. Burden of tuberculosis

TB poses a significant public health challenge in Thailand, resulting in a high burden of disease and mortality, with the World Health Organization (WHO) estimating that Thailand had 103,000 cases of TB and TB incidence of 143 per 100,000 population in 2021. In 2021, an estimated 103,000 individuals in Thailand were living with TB, of which only 72,000 were notified by the National Tuberculosis Control Program (NTP). This indicates the existence of approximately 31,000 unreported TB cases. Among the total estimated cases, 68 per cent were male; 31 per cent, female; and 1 per cent, children. In the same year, there were 11,400 TB-related deaths in Thailand, with 1,700 of these deaths occurring among PLHIV.[91] Although Thailand was removed from the WHO list of 30 countries with high burdens of multidrug- and rifampicin-resistant TB in 2021, it continues to be on the WHO list of 30 high-burden countries for TB and TB–HIV.[92]

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[90] Interview with Kesanee Sriruksa, Public Health Officer, Senior Professional Level, Office of the Global Fund Project Administration, Department of Disease Control, Ministry of Public Health, Nonthaburi, Thailand, 25 April 2023.

[91] WHO, 2022g.

[92] WHO, 2022a.

To mitigate the TB burden in Thailand, several measures are being implemented, including expanding access to TB diagnostic tests and treatment, enhancing cross-border cooperation with neighbouring countries, raising TB awareness and promoting prevention among high-risk populations, and strengthening TB–HIV collaboration. These efforts aim to reduce the prevalence and impact of TB in Thailand, focusing particularly on vulnerable populations.

3.2.4.3. Tuberculosis among migrants

TB is a significant health burden among migrants in Thailand. According to WHO, Thailand has one of the highest TB burdens in the Asia–Pacific region, and migrants in the country are at an increased risk of TB due to factors such as poor living and working conditions, malnutrition and limited access to health care.

Research in Thailand indicates that TB rates are higher among migrants compared to the general population. For example, a study conducted in Tak Province, along the border with Myanmar, found a high burden of both TB and MDR-TB among migrants compared to the general population, with TB diagnosed in 65 per cent and MDR-TB in 70 per cent of non-Thai individuals.[93] Children among MMPs also bear a substantial burden of TB. A retrospective analysis of routine programmatic data on children of migrants aged 15 years or younger on the Thai–Myanmar border found a high proportion of childhood TB (17.3%, or 398 out of 2,304) among all diagnosed TB cases.[94]

Thailand collects and disaggregates cases based on migration status: In 2020, the total number of "non-Thai" TB cases treated in Thailand was 3,190, most coming from nationals of Cambodia and Myanmar. The Division of Tuberculosis of the Ministry of Public Health of Thailand has identified Bangkok, Samut Sakhon, Tak, Chiang Mai, Samut Prakan, Chonburi, Chiang Rai, Kanchanaburi, Phuket and Nonthaburi as the top ten provinces in terms of new and relapse TB cases among the non-Thai population.[95]

Thailand Operational Plan to End TB 2017–2021 proposes several activities under its Strategy 1 (Expedite TB case-finding to ensure full coverage through TB screening among at-risk populations, including migrants), which aims to improve TB prevention and control measures, as well as promoting early TB detection and treatment, among MMPs.[96] Overall, TB is a significant

[93] Hemhongsa et al., 2008.

[94] Carroll et al., 2022.

[95] Government of Thailand, Ministry of Public Health (MOPH) Division of Tuberculosis, 2021.

[96] Government of Thailand, MOPH, 2016.

health burden among migrants in Thailand, and there is a pressing need to improve access to TB prevention, diagnosis and treatment services for this population. Coordinated response from government, civil society and international organizations will be required to address the underlying social and economic factors that contribute to TB infection among migrants.

It is important to note that under HICS, eligible migrant workers must clear a health examination, as stipulated by the Ministry of Public Health. Documented migrant workers, under MoUs between Thailand and other GMS countries (e.g. Thailand and Myanmar, Thailand and Cambodia, and Thailand and the Lao People's Democratic Republic), also undergo TB screening at post-arrival and reintegration centres. Additionally, documented migrant workers undergo annual health examinations, ensuring treatment if found to be infected with TB. Undocumented migrants and displaced populations in the country are also provided with mobile outreach services for TB, including TB screening (using X-ray, Xpert MTB/RIF assay,[97] microscopy, sputum smear and drug susceptibility testing, in line with national protocols)[98] and treatment or treatment referral if found to be TB-positive.

Table 6. **Summary of TB services for documented versus undocumented migrants in Thailand**

Target population	Available TB services
Documented migrant workers	TB screening at post-arrival and reintegration centres, with linkage to treatment (under MoUs with Cambodia, the Lao People's Democratic Republic and Myanmar) Annual health examination, ensuring treatment of migrants with TB Linkage of TB screening for documented migrants to the National TB Information System (NTIP)
Undocumented migrants and displaced populations	Mobile outreach services, including regular screening (using X-rays, Xpert MTB/RIF assay, microscopy, sputum smear and drug susceptibility testing, in line with national protocols) Information on TB and HIV services at drop-in centres

3.2.4.4. Key and vulnerable populations for tuberculosis

Thailand's Operational Plan to End TB 2017–2021[99] identifies prisoners, migrants, displaced and stateless individuals, people residing in detention centres, and PLHIV as key and vulnerable populations for TB. Note that Thailand's Operational Plan to End TB 2023–2027 is in the draft stage and, as such, has not yet been publicly disseminated.

[97] Xpert MTB/RIF is a test that simultaneously detects *Mycobacterium tuberculosis* complex and resistance to rifampicin.

[98] Government of Thailand, MOPH, 2016.

[99] Thailand's Operational Plan to End TB 2023–2027 is in the draft stage and, as such, has not yet been publicly disseminated.

Thailand has a sizeable prison population. According to the National Prison Administration of Thailand, there were 262,319 prisoners, of whom 3.5 per cent were foreign, as of January 2023.[100] Thai prisons house large numbers of former and current drug users, who face disproportionate burdens of both TB and HIV. In fiscal year 2021, 2,961 prison inmates were diagnosed with TB.[101] Overcrowded prisons in Thailand create favourable conditions for TB transmission, and, as such, the burden of HIV and MDR-TB among inmates is high. Further, the TB burden among PLHIV in Thailand is also high. According to the WHO Global TB Report 2022, Thailand is a high-TB- and high-HIV-burden country. An estimated 8,900 PLHIV[102] were coinfected with TB in Thailand out of 490,362 PLHIV.[103] Despite the availability of effective ART, TB remains the leading cause of morbidity and mortality among PLHIV in Thailand.

Key and vulnerable populations, such as migrants, prisoners and PLHIV, face a higher risk of TB due to various factors. Migrants, including undocumented immigrants and refugees, encounter challenges to accessing health-care services, including TB diagnosis and treatment, due to their legal status and language barriers. Overcrowded and poorly ventilated prison settings also contribute to the high prevalence of TB among prisoners in Thailand. PLHIV are at an increased risk of TB due to their weakened immune systems, and TB is a leading cause of death among PLHIV in the country.

To address these challenges, the Government of Thailand has implemented interventions such as providing free TB diagnosis and treatment for migrants, increasing TB screening and treatment in prisons, and implementing joint TB–HIV activities for PLHIV. However, sustained efforts will be required to improve TB control and prevention strategies among these key and vulnerable populations in Thailand.

3.2.4.5. Gender-related barriers to accessing TB services

Despite notable progress made towards gender equality in Thailand, persistent gaps continue to exist,[104] particularly in the context of TB services. While the country has successfully expanded women's economic opportunities through investments in girls' education, challenges remain in female representation at the highest levels of decision-making. Additionally, unimproving rates of GBV impede women's voice and agency, with over 16 per cent of married or cohabitating

[100] Birkbeck, University of London – Institute for Crime and Justice Policy Research, 2023.
[101] Government of Thailand, MOPH, 2021.
[102] WHO, 2022g.
[103] UNAIDS, 2022.
[104] Paweenawat, 2011.

Thai women experiencing domestic violence.[105] Concerningly, TB diagnosis patterns reveal a gender disparity, with more men diagnosed with TB than women, at a ratio of 1.3, indicating an inequitable distribution of TB services.[106] Addressing these gender-related barriers is crucial to ensuring comprehensive and effective TB services in Thailand, fostering a more inclusive and equitable health-care system for all.

Gender-related barriers to accessing TB services also exist, with women migrants in Thailand experiencing unique difficulties. Cultural norms often prioritize male health needs over those of women and may pose barriers to health-care availability for women migrants. These gender-related barriers prevent women migrants from accessing TB services, resulting in delayed diagnosis and treatment of the disease among this particular demographic.

3.2.4.6. Human rights-related barriers to accessing TB services

Migrants working in Thailand may face various human rights and gender-related barriers to accessing TB services. Discrimination based on ethnicity, nationality and immigration status can limit access to health services and affect their willingness to seek care. Language barriers can further complicate communication with health-care providers, who may only speak Thai, or Thai and English, leading to miscommunication and misunderstanding. Migrants in Thailand also often work under difficult conditions, sometimes for more than eight hours per day, and they are paid, on average, significantly less than the minimum wage, according to a two-year study by the Mekong Migration Network.[107]

There is an urgent need to ensure that TB services in Thailand are accessible, affordable and culturally sensitive to migrants from the GMS to address human rights and gender-related barriers relating to TB access and service provision. A starting point towards achieving this goal is providing information and education on TB prevention and treatment in languages understandable to migrants. Moreover, health-care providers should be trained to recognize and address the diverse needs of MMPs, including those working in the informal sector. To reduce the TB burden among migrants in Thailand, it will also be crucial to address underlying structural factors that contribute to their vulnerability, such as labour rights abuses.

105 World Bank, 2023.

106 Raks Thai Foundation and Health Management Support Team, 2023.

107 *Radio Free Asia*, 2020.

Thailand adopted a national code of conduct on HIV prevention and management in the workplace in 2021, and its Department of Labour is compiling relevant ministerial regulations and related HIV laws to be disseminated to the private sector, promoting non-discriminatory business practices.[108] Thailand is dedicated to fostering inclusive and supportive work environments for all employees, including migrants, by implementing a more equitable code of conduct. This compassionate initiative seeks to diminish stigma and discrimination surrounding TB among migrants, encouraging early diagnosis and improving access to essential TB prevention and care services.

While known to occur, deportation from Thailand is typically regarded as a last resort and only pursued when all other measures have been exhausted or if an individual poses a significant public health risk. The Government of Thailand decides on deporting an individual with extensively drug-resistant TB on a case-by-case basis, depending on several factors such as the severity of their illness and the potential risk to public health. However, a stakeholder interviewed for this report mentioned anecdotal cases of increased loss to follow-up for MDR-TB cases diagnosed by the NTP.[109]

3.2.4.7. TB-related stigma and discrimination

Stigma and discrimination associated with TB remain a significant challenge in Thailand. Despite numerous organizations and efforts by the NTP to increase public awareness of and, therefore, reduce TB stigma, many individuals with TB continue to encounter discrimination in their personal and professional lives. Information specific to TB-related stigma and discrimination against migrants in Thailand is limited. However, the PLHIV Stigma Index study provides valuable insights into preventing TB-related stigma and discrimination against migrants. Studies focusing on stigma and discrimination associated with TB in the broader population are also informative.

A study examining patients, family members and health-care providers' experiences and perceptions of TB stigma in a northern province of Thailand revealed that TB-related stigma is pervasive in Thai society.[110] This stigma causes the public to avoid TB patients and discriminate against them, which, in turn, causes reluctance among patients to disclose their TB status. Stigma also impacts individuals' willingness to participate in TB contact investigations, especially in non-household settings where they interact with others, such as workplaces and schools. Consequently, there is an urgent need to address TB stigma in Thailand and create strategies

[108] Office of the United Nations High Commissioner for Human Rights, 2022.

[109] In-depth virtual interview with representatives of World Vision Thailand, 20 June 2023.

[110] Ngamvithayapong-Yanai et al., 2019.

to increase community involvement in TB control. In a 2020 survey conducted by BE Health Association in four Bangkok high schools, 57.1 per cent of 630 respondent students acknowledged the high levels of TB stigma and discrimination in the city.[111]

The first PLHIV Stigma Index study conducted in 2010 revealed that 34.33 per cent of respondents had experienced being refused or prevented from joining social or community activities because of their HIV status.[112] The study identified various drivers of stigma and discrimination, including fear of HIV transmission, misconceptions about HIV and discriminatory attitudes among health-care professionals. PLHIV Stigma Index 2.0 implementation in Thailand, from 2022 to 2023, with the support of the Thai Network of People Living with HIV (TNP+) and the Thai PLHIV Stigma Index Task Force Committee, provides further insight.[113]

Recent reports from TEAM2 subrecipients in Thailand reveal that stigma and discrimination have discouraged suspected TB cases from participating in chest X-ray (CXR) screening. Misperceptions among camp residents that X-rays lessen life expectancy are prevalent, with many also fearing that they might discover they have TB through CXR, leading to their ostracization within the community. Self-stigma thus prevents diagnosis, as migrants fear seeking medical services at hospitals. Panic sets in with the fear of community hatred should they be diagnosed with TB, especially as migrant workers with TB are often expelled from workplaces (employers reason out that TB is an airborne disease) and even deported from the country. Migrants are often forced to resign without treatment or compensation. Thus, migrants with TB face double the stigma, as they are seen as inferior because of their migration status and ostracized for having TB.

These findings have crucial implications for the NTP of Thailand, particularly in terms of diagnosing and treating TB among vulnerable and key populations, including migrants. The study underscores the importance of addressing stigma and discrimination towards PLHIV and TB patients, as these can adversely impact their access to health-care services, such as TB diagnosis and treatment. The NTP should ensure non-discrimination and absence of stigma in health-care settings for all patients. Collaborative work with organizations that understand the needs and experiences of PLHIV and TB patients can aid in developing and implementing interventions to address stigma and discrimination.

111 Moonsarn et al., 2023.

112 Thai Network of People Living with HIV/AIDS, 2010.

113 Visit www.stigmaindex.org/country-reports/#/m/TH for more information on the ongoing PLHIV Stigma Index 2.0 implementation.

3.2.5. Viet Nam

3.2.5.1. Migration context

Viet Nam shares its borders with the People's Republic of China to the north, the Lao People's Democratic Republic and Cambodia to the west and is flanked by the South China Sea to the east and the Gulf of Thailand to the south-west. In recent years, the country has experienced an increase in the number of immigrants. Primarily a country of origin rather than destination, approximately 100,000 Vietnamese workers leave each year to work in other countries. According to the IOM report, "Situation Analysis of Migrant Health in Viet Nam", there were 76,104 international migrants in Viet Nam in 2019.[114]

Migrants in Viet Nam face various challenges. One specific issue of concern is the situation of undocumented migrants. These individuals may encounter additional difficulties in accessing health care, education and other basic services. They may also be more vulnerable to exploitation and abuse. Another challenge is discrimination and social exclusion, including of migrants, particularly those from neighbouring countries such as Cambodia and the Lao People's Democratic Republic, due to factors like nationality, ethnicity and language. These barriers can make it difficult for migrants to integrate into Vietnamese society and access employment and other opportunities.[115]

Viet Nam has expanded access to social protection systems based on a "life cycle approach", with its goal of achieving universal coverage focused on vulnerable groups such as migrants, older persons, vulnerable women, ethnic minorities and people in difficult-to-access rural areas. Although a social health insurance scheme was introduced for all residents in Viet Nam in 1992, low health insurance coverage among vulnerable populations remains an issue, leading to high out-of-pocket spending on health-care services. In 2009, Viet Nam scaled up the programme and began implementing universal health insurance for all residents, initially focusing on the poor and near-poor, as well as the informal sector. As of 2020, government-sponsored health insurance covered 91 per cent of Vietnamese.[116]

[114] IOM, 2020b.

[115] Integral Human Development, 2023.

[116] Vu and Haley, 2023.

3.2.5.2. Burden of tuberculosis

TB poses a significant public health challenge in Viet Nam, which has a high burden of both new TB and multidrug-resistant TB (MDR-TB). According to WHO, there were an estimated 169,000 new TB cases in Viet Nam in 2021, resulting in an incidence rate of 173 cases per 100,000 population.[117] WHO also reported that 4.3 per cent of the country's TB cases in 2021 were MDR-TB (i.e. any of various forms of TB that are resistant to at least two of the most potent first-line anti-TB drugs), including it on a list of 30 countries worldwide with high burdens of MDR-TB.[118] TB is a leading cause of illness and death in Viet Nam, particularly among vulnerable populations such as PLHIV, migrants and those living in poverty. Additionally, TB can have substantial economic impacts on individuals and families, such as lost income and elevated health-care costs.

The Government of Viet Nam has taken measures to address the country's TB burden, including expanding access to TB diagnosis and treatment services, intensifying efforts to identify and treat MDR-TB cases, and reinforcing TB prevention and control programmes. Nevertheless, there remains a need for further efforts to tackle the TB burden in the country, particularly among vulnerable populations, and address the issue of MDR-TB.

3.2.5.3. Tuberculosis among migrants

Approximately 76,000 international migrants were reported to be residing in Viet Nam in 2019.[119] Most were in cities and industrial zones, where they have limited access to health-care services and experience social exclusion – factors that may increase the risk of TB infection, disease and transmission.

There is limited data available on the burden of TB specifically among this population, as many of them are undocumented or are working in the informal sector. At any rate, migrants are widely considered to be a vulnerable population (i.e. having increased risk) for TB, and that they may also be facing challenges to accessing TB diagnosis and treatment services. Targeted efforts are needed to improve health-care access and confront the social and economic factors that elevate their risk of TB.

117 WHO, 2022e.

118 Birkbeck, University of London – Institute for Crime and Justice Policy Research, 2023.

119 DESA Population Division, 2021.

A study conducted by IOM in 2021 in border cities of Viet Nam and Cambodia identified structural, financial and cognitive barriers to the diagnosis and treatment of TB among cross-border migrants (Table 7).[120]

Table 7. **Barriers to TB diagnosis and treatment of cross-border migrants in Viet Nam**[121]

Categories	Specific barriers
Structural barriers	Limited health communication programmes Unideal location of health-care facilities Lack of language interpreters Excessive waiting times at health facilities Lack of guidance from health-care providers
Financial barriers	Lack of health insurance Financial burden on cross-border migrants Out-of-pocket costs associated with TB diagnosis and treatment Lack of legal documents
Cognitive barriers	Lack of knowledge about TB Discrimination against migrants

The Government of Viet Nam has made efforts to control TB among MMPs in the country through various strategies such as improving access to health-care services, implementing targeted screening and treatment programmes, and working with international partners. However, further efforts are needed to address the high burden of TB among migrants and other vulnerable populations.

3.2.5.4. Key and vulnerable populations for tuberculosis

The National Strategic Plan (NSP) for TB Prevention and Control of Viet Nam for the period 2021–2025 identifies migrants, prisoners, PLHIV, children and miners as key and vulnerable populations for TB. The plan recognizes that these populations are at a higher risk of TB and require targeted interventions to ensure that they receive appropriate screening, diagnosis and treatment services.

Children are an important vulnerable population that is not adequately reached by the NTP of Viet Nam. Although children should comprise approximately 10 per cent of total notifications, the proportion of children diagnosed with TB in Viet Nam is less than 2 per cent. PLHIV are

120 IOM, 2021c.

121 Government of Viet Nam, Ministry of Health, 2020.

another key and vulnerable population for TB in Viet Nam, especially given that TB is the most common opportunistic infection among PLHIV in Viet Nam, but TB–HIV collaboration is weak.

Prisoners are also a key and vulnerable population for TB in Viet Nam, as congregate settings have very high TB prevalence. According to the Department of Prison Management of the Ministry of Public Security of Viet Nam, there were 125,697 prison inmates in Viet Nam in mid-2019. In 2018, there were 130 prisoners living with HIV across Dong Nai Province of Viet Nam, and they had difficulty in accessing basic HIV and other health services.[122]

Overall, the NSP on TB Prevention and Control 2021–2025 represents a comprehensive and ambitious plan for TB prevention and control in Viet Nam, with a focus on improving access to TB diagnosis and treatment services, addressing TB in vulnerable populations, and strengthening TB surveillance and monitoring efforts.

3.2.5.5. Gender-related barriers to accessing TB services

In Viet Nam, gender- and human rights-related barriers can significantly impact TB prevention, diagnosis and treatment efforts. According to a nationwide study on violence against women conducted in 2019, nearly two thirds (62.9%) of women have ever experienced at least type of violence (physical, sexual, economic and/or psychological) in their lifetime from an intimate partner, with 31.6 per cent experiencing such violence within 12 months prior to the study.[123] GBV, including intimate partner violence and sexual violence, may also prevent individuals from seeking health care and other services. There is not much publicly accessible current literature on issues relating to the subject of TB and gender.

A 2014 joint review of the health sector response to HIV in Viet Nam, published by WHO, found that FSWs and female drug users reported physical and sexual violence as core issues that must be addressed to create a supportive environment for effective HIV prevention services. These women typically experience regular physical and sexual violence from their clients, primary sexual partners and managers of the establishments where they work.[124] These findings highlight the need to address, more broadly, the GBV and sexual abuse experienced by Vietnamese women in general. Limited access to health-care services, particularly for women and marginalized populations, can hinder access to TB prevention, diagnosis and treatment services.

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122 *Vietnam+*, 2018.

123 Government of Viet Nam, Ministry of Labor, Invalids and Social Affairs; Government of Viet Nam, General Statistics Office; and United Nations Population Fund, 2019.

124 WHO Regional Office for the Western Pacific, 2016.

3.2.5.6. Human rights-related barriers to accessing TB services

Various HIV key and vulnerable populations have been shown to experience different forms of human rights-related barriers to accessing HIV services. However, no studies in the literature have examined how human rights-related barriers impact access to TB services, specifically, for different key populations in Viet Nam.

It will be essential to adopt rights-based approaches to TB prevention and control in Viet Nam, to address these barriers. This entails advocating for community-based approaches that engage women and marginalized populations, addressing stigma and discrimination, promoting gender equity and social inclusion, and strengthening health-care systems to improve access to TB services for all.

3.2.5.7. TB-related stigma and discrimination

There is a lack of information on TB-related stigma and discrimination in Viet Nam. To date, no study on this subject has been conducted in the country. However, several PLHIV Stigma Index studies have been undertaken in Viet Nam, including in 2012, 2014 and 2021, which have some implications for TB programmes.

In the 2021 PLHIV Stigma Index study conducted in Viet Nam, 12.9 per cent of respondent PLHIV reported experiencing stigma or discrimination due to their HIV status in the previous 12 months. This study also found high levels of internalized stigma, with 37 per cent reporting feelings of guilt, 42 per cent reporting feelings of worthlessness, 41 per cent reporting feelings of shame, and 39 per cent feeling "dirty" because of their HIV status.[125] These findings suggest that stigma and discrimination against PLHIV are prevalent in both community and health-care settings in Viet Nam.

It Is crucial to address stigma and discrimination towards PLHIV, especially among key populations such as MSM, PWID and FSWs, who are particularly vulnerable to HIV-related stigma and discrimination. Efforts to engage these populations in HIV prevention and care should also be expanded to include TB prevention and care. By creating an enabling environment that reduces stigma and discrimination, migrants and individuals in these populations are more likely to seek early TB care, leading to improved case detection rates and better treatment outcomes. Additionally, extending efforts to include TB prevention and care within the scope of

[125] Vietnam Network of People living with HIV, 2020.

interventions targeting key populations can bring significant benefits to overall NTP outcomes. Some individuals in these populations may be co-infected with both TB and HIV, and by providing comprehensive care that addresses both infections, overall health outcomes can be improved.

Stigma and discrimination can discourage people from seeking testing and treatment, leading to delayed (or foregone) diagnosis and increased transmission. Addressing stigma and discrimination is, therefore, essential for effective TB control and can be done by developing and implementing strategies such as education and awareness campaigns, sensitization and training of health-care providers, engagement of affected communities, peer support and community mobilization, all of which should take into account the experiences and needs of key populations.

CHAPTER FOUR

Conclusion and Recommendations

4. CONCLUSION AND RECOMMENDATIONS

4.1. Conclusion

This report has examined documents pertaining to the CRG aspects of TB infection among migrants in the GMS. It highlights the pressing and interlinked issues of TB, gender, human rights, and stigma and discrimination faced by migrants. This report underscores the urgent need to address the common yet contextually unique challenges and vulnerabilities experienced by migrants in accessing TB services and support. By acknowledging the intersection of gender, human rights and TB, GMS countries can develop targeted interventions that promote increasingly equitable access to quality care and challenge stigma and discrimination, in order to safeguard the rights and dignity of migrants (and communities) affected by TB. Through collaborative efforts and a rights-based approach, GMS countries can work towards a future where all migrants, regardless of status, have equal access to TB prevention, treatment and support services, free from discrimination and stigma.

The following section provides a breakdown of recommendations as regards CRG and TB for the GMS as a whole, as well as the individual countries therein. Note that this list is not exhaustive but provides a few key suggestions that could be considered.

4.2. General recommendations

After careful consideration of the findings from available literature, the following recommendations are presented for the GMS as whole:

(a) Research on the barriers experienced by cross-border MMPs in accessing TB diagnosis and treatment services in the GMS remains limited. To acquire a deeper understanding of these barriers, a study encompassing all GMS countries should be conducted, alongside more data collection efforts at the national and local levels. This study will provide valuable insights into the specific challenges and barriers faced by migrants from a cross-border perspective, enabling policymakers and health-care providers to develop targeted interventions and policies that improve migrants' access to TB services. Therefore, GMS countries should collaborate and allocate resources to address this critical knowledge gap, promoting equitable access to TB diagnosis and treatment services for cross-border MMPs through a CRG lens. Scarcity of CRG data at the national and subregional levels hinders the development of subregional and national guidelines and policies for TB control among migrants in all countries.

(b) Each country (barring Cambodia, which has already conducted one) should consider rolling out national CRG assessments that would link to the subregional assessment.

(c) At present, no GMS-wide TB framework exists that addresses TB among MMPs. Relevant stakeholders, including international organizations, should advocate for the development of a comprehensive regional TB framework specifically targeting MMPs in the GMS. This framework should emphasize collaboration, information-sharing and coordinated efforts among GMS countries to enhance surveillance, early detection and treatment of TB among migrants, while ensuring the integration of critical CRG aspects.

(d) Migrants often experience difficulties accessing TB services in their destination countries due to language barriers. To alleviate this issue, host countries should produce information, education and communication (IEC) materials in the languages most spoken by migrants in the GMS, and these should be rolled out at the national level to all partners working on the TB response. By doing so, host countries can effectively convey critical information about TB prevention, alongside available services, while emphasizing the importance of early diagnosis and treatment. These materials should be culturally appropriate, easily accessible and tailored to the specific needs and concerns of migrants. Furthermore, collaboration between host countries, migrant communities and relevant stakeholders is crucial for developing and disseminating these materials. It is important to involve community leaders, migrants' organizations and language interpreters in the IEC development process to ensure the materials' accuracy, cultural sensitivity and relevance.

(e) The national TB programmes of all countries in the GMS should collect data disaggregated by migration status to support the development of evidence-based guidelines and policies for TB control among MMPs. This data should be shared, and mechanisms should be established to enhance the cross-border sharing of key migration and public health data, including TB data.

(f) National TB programmes should implement programmes that are human rights-based, gender-sensitive and responsive to inequity analyses and include activities aimed at reducing stigma and discrimination against people with TB and those affected by TB. The NTPs are to monitor their achievements in this regard with key aligned targets.

(g) National HIV programmes in the GMS currently conduct periodic surveys and assessments, such as the PLHIV Stigma Index studies and the IBBS survey. By including a few additional questions related to TB in these studies, in consultation

with the national HIV programmes themselves and/or technical partners, further information on TB can be obtained. Therefore, concerned stakeholders should advocate for the inclusion of TB-related questions in the HIV studies planned by national HIV programmes in the different GMS countries.

4.3. Country-specific recommendations

In addition to recommendations for the GMS as a whole, each country in the subregion is urged to take specific steps, which are laid down in this section.

4.3.1. Cambodia

(a) The integration of TB screening of key populations into existing HIV programmes should be further pursued. Doing so could help address intersecting risk factors and the co-occurrence of TB and HIV among these populations, as well as promoting more comprehensive and efficient health-care services overall.

(b) The ongoing Safe Migration training programme for migrants travelling from Cambodia to Thailand is currently limited to the Poi-Pet Transit Center. To enhance its impact, the programme should be expanded to include a broader range of migrant categories and could be implemented in other key checkpoints and/or border crossings.

(c) Health-care providers should receive training on providing unbiased and inclusive care for all populations. This should include the delivery of both TB and HIV services to MSM, TGWs and FEWs.

(d) Given the shared challenges of stigma and discrimination faced by individuals living with TB and HIV, collaboration between TB and HIV programmes will be essential. By pooling resources and sharing best practices, the NTP and other disease-focused health programmes of Cambodia can develop coordinating strategies to reduce stigma among different key and vulnerable populations, including migrants.

(e) The Government of Cambodia should ensure that enough resources are allocated for the proper implementation of the national migrant health policy (which it endorsed in January 2021), which specifically addresses the needs of undocumented migrant workers and displaced persons.

4.3.2. Lao People's Democratic Republic

(a) The true extent of the TB situation among migrants in the Lao People's Democratic Republic remains unclear due to a lack of studies estimating the TB burden among this population. The Ministry of Health should conduct more research to estimate

the impact of TB specifically on migrants. This would involve collecting and analysing data that identifies and disaggregates TB cases among MMPs. Understanding the actual extent of the TB situation among migrants can lead to more targeted interventions and effective resource allocation.

(b) TB diagnosis and treatment in the Lao People's Democratic Republic are provided free of charge to everyone in the country, including migrants. Both international migrants and Lao internal migrants are not covered by national health insurance; as such, they bear full medical costs for almost everything else. The Government should address this barrier to health care and include international migrants in national health insurance coverage.

(c) The Government should prioritize initiatives aimed at improving language support services and financial assistance programmes to alleviate language and financial barriers that hinder migrants' access to health-care services and promote more equitable and affordable health care.

(d) The NTP should take further proactive measures, such as public awareness campaigns, community engagement, health-care worker sensitization and media engagement, to address TB-related stigma and discrimination.

4.3.3. Myanmar

(a) Myanmar currently lacks updated data on the number of migrants in the country. Such data and other migration-related information could significantly better inform targeted TB programmes and interventions, ensuring that the health needs of migrants are adequately addressed and TB control efforts are effectively implemented. The country should conduct comprehensive surveys or assessments that specifically target MMPs, gathering data to determine TB prevalence, as well as information on treatment access and health-care utilization by these groups.

(b) Stigma and discrimination against key and vulnerable populations in health-care settings likely affect access not only to HIV services but also TB services and remains an issue in Myanmar. By fostering a supportive and non-judgmental environment, Myanmar can improve access to comprehensive health care (including TB services) for key populations, enhancing TB control and prevention efforts.

(c) The country should strengthen collaboration between its TB and HIV programmes by developing and implementing joint activities. These initiatives should aim to address TB- and HIV-related stigma and discrimination while improving access to TB and HIV services for migrants and other vulnerable populations.

4.3.4. Thailand

(a) While HICS is intended to be compulsory for all migrants, some migrants fail or refuse to register under the scheme. There are penalties for non-compliance by either migrants or their employers. Policymakers in Thailand should consider enacting and enforcing regulations that make HICS compulsory for all migrants, with penalties for non-compliance by both migrants and their employers. Additionally, measures should be taken to improve the portability of health insurance schemes for migrants, allowing continuity of care despite changes in employment status.

(b) The Government should further strengthen and expand initiatives to improve health-care access for migrants, including undocumented immigrants. This may involve addressing legal barriers and providing language support services. Integrating TB and HIV services and ensuring their availability and accessibility to migrants should be prioritized to reduce the TB burden among this population.

(c) Currently, international migrants diagnosed with extensively drug-resistant TB (XDR-TB) and reported to authorities are subject to deportation from the country on a case-by-case basis. The Government should develop and implement a policy that ensures individuals diagnosed with XDR-TB are not deported but, instead, are enrolled in appropriate treatment and care programmes. This will prevent these TB cases from being lost to follow-up and, rather, ensure continuity of care for TB cases, contributing to improved treatment and public health outcomes.

4.3.5. Viet Nam

(a) To date, the literature lacks studies that specifically examine how gender- and human rights-related barriers impact key populations' access to TB services in Viet Nam. The Government should consider conducting studies to assess these barriers and which will provide valuable insights into the specific challenges and vulnerabilities faced by different key populations.

(b) Viet Nam should conduct studies on TB-related stigma and discrimination, particularly against key populations and migrants, as there is a dearth of information on this subject. These studies will serve to inform the development of targeted interventions designed to address stigma and discrimination.

(c) By integrating TB prevention and care into existing HIV programmes for key populations (including migrants), Viet Nam could promote comprehensive care for individuals co-infected with TB and HIV, leading to improved health outcomes and a more effective TB control programme.

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