



EDITOR'S NOTE ON WORLD TB DAY

by Dr Erick Ventura
IOM's Migration Health Regional Coordinator

TB Migration in Southern Africa



Africa.

The 21st century has been a challenging one in the fight against communicable and infectious diseases. According to the WHO Global Tuberculosis Report 2015, Tuberculosis is now the number one infectious killer, the study revealed that TB is causing more deaths than HIV. Southern Africa has the highest TB incidence rates in the world, averaging at 591/100,000 compared to the global average of 126/100,000. Seven out of the sixteen high burden countries in the world are in East and southern

The mining sector in Southern Africa has particularly been severely affected by TB and HIV and related risks such as silicosis. Swaziland, Lesotho and Mozambique are among the main mine worker sending countries to South Africa.

Every year thousands of men travel from across the Southern African region to work in South Africa's mines and, in doing so, may contract TB as well as HIV and silicosis (a degenerative lung disease linked to exposure to silica dust in gold mines). Silica dust forms part of an ever-present potential hazard for mineworkers resulting in the highest TB incidence rates in the world.

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Mineworkers are particularly vulnerable to TB and silicosis due to exposure to multiple risk factors as a result of their working and living conditions, and their migrant lifestyles. Crowded dormitory-style living conditions and poor housing in informal settlements increase the risk of contracting the airborne disease.

High rates of HIV also increase the likelihood of TB infection; regular movements across borders provide a route for transmission of infections to families and communities in the workers' home countries.

This pattern of mostly male migrants arriving at the mines to work, becoming infected with TB and returning home again – has created an enormous public health crisis throughout the region. Silicosis can take from ten to thirty years to develop after exposure, a large proportion of miners only develop silicosis and TB after they have left mines and returned to their communities, often in a different country. In many cases when miners become sick from TB, HIV or silicosis and/or a combination of the three, they will return or be sent back to communities of origin.

They often receive no compensation from the mining company, have no access to cross-border health referrals and possess no source of income to support themselves and their families while they are out of work receiving treatment. Back in their communities, ex-miners don't always get the treatment they need and often succumb to the bacteria while spreading the disease.

The consequences of this health crisis are broad and have far-reaching effects, not to mention the social and economic impact for the miners' communities are equally devastating. In many instances a job at the mine is a family's only viable economic opportunity. A 'retrenchment' (redundancy), therefore, not only signals a decline in health, it often also means an end to the family's only stream of income.

Treating TB among migrant mineworkers is particularly difficult due to the fact that the treatment must be taken continuously and uninterrupted to avoid developing multi-drug resistant TB. In addition, health systems in the affected countries are not yet harmonized, making it difficult to track and refer patients across provincial and national borders. Responding to HIV and TB within the SADC mining sector requires a regional approach that is cognizant of regional factors that impact on HIV and TB vulnerability, such as bi-lateral and regional agreements and oscillating migration between the different countries, whilst at the same time coupled with a response that addresses the real issues experienced by migration affected communities.

Score Card: TB in Mining in Southern Africa

By David Makapela



IOM Addresses the Health of Migrants in the Southern Africa Mining Sector

IOM in Southern Africa has been involved in creating and maintaining strategic partnerships with the South African Development Community (SADC) in an effort to end TB. IOM was a key partner in the SADC Declaration on TB in the Mining Sector signed in 2012 and A Framework for the Harmonised Management of TB in the Mining Sector which was signed in 2014. These two policy tools led to IOM providing technical assistance in the development of the SADC Code of Conduct (2015) which provided guidelines for the operationalization of the declaration. IOM additionally ensured the inclusion of migrants in the SADC Framework on Population Mobility and Communicable Diseases which aims to improve harmonisation and coordination of responses to improve access to healthcare services. [Read more...](#)

FEATURE STORY

TB Migration in Zimbabwe

By Blessing Kanengoni



Efficiently monitoring TB incidence and prevalence in migrant populations requires innovative approaches and active case finding.

While there is a low national case detection rate, currently pegged at 46%, the Zimbabwe NTP continuously strives to reduce transmission of the disease and mortality rate, through breaking the chain of transmission of infection and through free TB diagnosis at national laboratories.

Of the 22 countries designated by WHO as high TB burden countries, **Zimbabwe ranks 17th** with an estimated **TB incidence rate of 562/100,000**.

However, Zimbabwe has a low coverage of TB diagnostic services with only two TB laboratories offering TB sputum culture microscopy. The other available laboratory facilities are scarce and only conduct smear microscopy which has a lower sensitivity, especially in cases of TB/HIV co-infection and which cannot detect drug resistance. Zimbabwean migrants often lack access to these facilities due to

their transient behavior. When cross-border Zimbabwean migrants live in neighboring countries such as Botswana and South Africa, they are particularly hard-to-reach. This is because of the many challenges they may encounter as they try to access health services. For instance: irregular migrants often avoid using public health facilities in host countries out of fear of being intercepted and deported; long distances between the health facilities and the main road network affects attendance; negative attitudes of health workers can impact turnout; lack of time, the cost of travel and health services, and opportunity cost also have a negative impact. In addition, poverty and a poor understanding of TB disease can cause migrants to put off care seeking. [Read more](#)

WORLD TB DAY STORIES

By Vyona Ooro



JOHN BAHO: A Congolese Refugees Story of Despair and Triumph Over TB

John arrived in Kenya in August of 2010 by road through the Malaba, the Kenya -Uganda border, prior to this he lived in Mbarara located in the Western Region of Uganda. When he arrived in Nairobi, he was received by a Kenyan man who was aware of his arrival

and immediately took him to the suburb of Kasarani. [Read more about John's story](#)



Peter Kago's Story of Triumph over TB

Peter Kago, a Kenyan whose experience with tuberculosis (TB) was a near tragedy. As a teacher at a local primary school, Peter has not been able to engage in his passion for close to two years. He became very ill in 2013. "I lost my voice and therefore I have not been able to teach. My search for

treatment has cost me a lot of money and a misdiagnosis at a private hospital almost led to brain surgery." Peter experienced pain on the left side of his body, describing a "burning sensation," which resulted in many sleepless nights. [Read more about Peter's story](#)



Change Agent's Advocate for Tuberculosis Testing and Treatment in Swaziland Communities

Rosa a 35 year old ex- miner's widow and mother of three has been breastfeeding her six month old baby despite suffering from MDRTB. "I cannot stop breastfeeding my baby, my mother in law forbids me" says Rosa. Change agents who live in the community in Swaziland visited Rosa's homestead to persuade her to change living environment with her children and seek medical attention. [Read more about Rosa's story](#)



Prayer is all we do, God will heal my Son

These are the words echoed by Elphas Dlamini of Matsanjeni community. His son, Bheki Dlamini suffers from MDR-TB and is facing adherence issues especially now that he is back home and under a highly religious environment that does not allow for any drugs to be administered in the body as the beliefs are that, prayer and believing in God is the only solution. [Read more about Bheki story](#)



ABDIKANI YUSUF: A Somali Refugee's Story

In June 2009, Abdikani Yusuf began his journey of hope from Mogadishu to Cape Town, South Africa through Kenya, Tanzania and Mozambique. The three day treacherous journey was nothing he could imagine. [Read more about Yusuf's story](#)

INFOGRAPHIC



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