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WHITE PAPER

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# Infectious Disease: Stigmatization of Refugees and Vulnerable Migrants

## Project Summary and Meeting Report

**Henry J. Leir Institute**

The Henry J. Leir Institute at The Fletcher School, Tufts University focuses on the security and protection of individuals and communities while promoting peace and sustainable development. To achieve this, the Leir Institute catalyzes collaboration between and creates synergies among the fields that place people at the center of concern: conflict resolution, human rights, humanitarian studies, and political and economic development. Our research, education, and policy engagement emphasize the following principles: protection and promotion of the rights of at-risk populations, empowerment of people, and promotion of responsible government and institutional practices.

**For more information on the research project, please contact Ian.Johnstone@tufts.edu or Nahid.Bhadelia@bmc.org.**

**DR. NAHID BHADELIA**

Assistant Professor, Boston University School of Medicine and Director of Infection Control and Medical Response at National Emerging Infectious Diseases Laboratory; Adjunct Assistant Professor, Fletcher School of Law and Diplomacy, Tufts University

**IAN JOHNSTONE**

Dean *ad interim* and Professor of International Law, Fletcher School of Law and Diplomacy, Tufts University

The stigmatization of people on the move on the basis of potential risk for infectious disease is one manifestation of a larger backlash against refugees and migrants. Public health policies instituted by some countries towards incoming refugees and migrants (as defined in the accompanying white paper) can have the unintended consequence of increasing this stigma. There is an urgent need to examine this phenomenon and assess its impact to help highlight areas of programmatic and policy innovation. The important public health elements of infectious disease surveillance and access to preventive services need to be designed and implemented in such a way as to reduce stigma. Additionally, legal and policy instruments need to be identified that can protect refugees and migrants from unfair stigmatization. This paper is a culmination of a project examining these issues through a white paper[1] based on literature review and a working group meeting of subject matter experts from relevant international and intergovernmental organizations in November 2018 in Geneva, Switzerland.

## Background

For the purposes of the current discussion, stigma is defined as 'a powerful discrediting and tainting social label that radically changes the way individuals view themselves and are viewed as persons.'[2] It is a mark of disgrace or shame, a form of stereotyping that engenders fear and prejudice, which in itself does harm to migrants, and can translate into harmful policies. The white paper examined the real versus perceived risks of infections originating from refugee and migrant communities. Our literature review revealed several factors that place refugees and vulnerable migrants

1 Nahid Bhadelia and Ian Johnstone, "Infectious Disease: Stigmatization of Refugees and Vulnerable Migrants", Henry J. Leir Institute Background Paper, The Fletcher School, Tufts University (November 2018).

2 Alonzo A.A. and Reynolds N.R. (1995). "Stigma, HIV and AIDS: an exploration and elaboration of a stigma trajectory", *Social Science and Medicine,* 41 (3), 303–315.

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at higher risk for both acquisition of infectious diseases and worse outcomes in their aftermath. These populations tend to:

- originate from areas where public health infrastructure and disease surveillance may be scarce or debilitated or their prior access to health care limited;
- reside for prolonged periods in crowded conditions during migration;
- suffer from poor access to nutrition and poor living conditions, reducing resilience to infections
- endure disruption of on-going treatment due to the *ad hoc* nature of care received (for reasons described in accompanying white paper).

Importantly, studies have failed to demonstrate that these groups pose any additional risk of transmission of communicable diseases to the host populations.

The exaggeration of the threat of transmission of communicable diseases has been an element of anti-immigrant movements and can result in public and institutional stigma that significantly impacts refugees and migrants in negative ways. Such stigma can impede the ability of these groups to gain asylum, access health and human services, and access broader economic, education and social opportunities. It can also have indirect impact on wellbeing and mental health. The language and scope of national policies and practices can further stigmatize migrants, refugees and asylum seekers when they include practices such as detention at arrival, linkage of infectious disease screening to asylum status, and discrimination at the point of service access. Additionally, screening for infectious diseases can further isolate refugees and vulnerable migrants when it is not logistically friendly, culturally appropriate, human rights compliant and focused mainly on the needs of the receiving country rather than the health needs of the individual.

Some aspects of existing international law can serve to protect against stigma, most notably the right to health and related rights in the International Covenant on Economic, Social and Cultural Rights (ICESCR) and Constitution of the World Health Organization. The Committee on Economic and Social Rights has made clear that migrants' enjoyment of the right to health without discrimination "should not depend on the legal status of the persons concerned." In addition, the International Health Regulations impose an obligation that they be implemented "with full respect for the dignity, human rights and fundamental freedoms of persons" (Article 3(1)), and provisions on medical exams requiring that they be minimally intrusive and conducted only with informed consent (Article 23). Article 23 of the Convention and Protocol Relating to the Status of Refugees stipulates that refugees lawfully staying in the territory of a party to the Convention are entitled to "the same treatment with respect to public relief and assistance as is accorded to their nationals," which includes health care. Various non-binding instruments also provide guidance, including most recently the Global Compact on Refugees, , the Global Compact for Safe, Orderly and Regular Migration, and the WHO's "Framework of Priorities and Guiding Principles to promote the health of refugees and migrants."

## Working group meeting summary

At the working group meeting (attendee list in appendix), the discussion centered around number of broad themes.[3]

First, it was emphasized that more research was needed on the extent to which refugees and vulnerable migrants are stigmatized, by whom and why. Is the stigma similar to what is faced by members of the host population thought to be carriers of infectious disease? After all, there is a long history of stigmatization and exclusion (for example, quarantines) in dealing with infectious disease.

A second theme concerns the relationship between the problem of stigmatization for infectious disease and other forms of anti-refugee and anti-migrant sentiment. Already branded as criminals, terrorists and job-stealers, adding infectious disease compounds the problem. Moreover, what may be a kernel of genuine (if unfounded) fear among the host population can be exploited by populist politicians. They use the excuse of disease to close borders, to deport or detain migrants, to prevent them from attending schools and to deny other social services.

3 See Bhadelia and Johnstone, *supra* note 1, for the questions that were used to stimulate discussion at the workshop.

These political actors feed off and amplify the fears of local populations

A third theme is the extent to which refugees and vulnerable migrants have particular health needs, distinct from the host population. Do we need differentiated policies for them? If the answer is yes, care must be taken to ensure that special measures do not themselves stigmatize by signaling that refugees/migrants are more likely to spread infectious disease than others. Moreover, government policies that seem to favor refugees and vulnerable migrants (such as vaccinations for all) may be resented by local populations.

The fourth theme concerns the role of intergovernmental organizations (IGOs) and of international law. The workshop was designed specifically to consider how the policies and practices of IGOs could impact the problem of stigmatization as perpetrated by national and local governments and other domestic actors, while also serving public health goals. In that connection, it considered whether recent normative developments make this an opportune moment to advance an anti-stigmatization agenda. The two global compacts, as a first step for building momentum, may be useful to prevent further back-sliding on protecting the rights of vulnerable migrants and refugees.

Within and beyond those four broad themes, the following points emerged from the meeting:

- There is tension between the importance of surveilling and diagnosing infectious diseases among vulnerable populations as a means of defining the magnitude of problem, while simultaneously ensuring that such project activities do not further characterize refugees and vulnerable migrants as the sources of communicable diseases. Surveillance and testing allow for assessment of the problem, which in turn allows for allocation of resources, but these activities must be balanced with the right messaging.
- There is a need for early integration of refugees and migrants into national health systems rather than providing that care in parallel systems and sites which might result in stigmatization and/or delay in treatment. Such integration would require national health systems to uphold the human rights standard of non-discriminatory access to health based on nationality or legal status. Analysis of how this can be done while still meeting the unique needs of these groups is necessary.
- Legal and policy instruments only go so far in affording protection against stigma. More novel interventions that improve surveillance program execution are needed, including training staff in improved sensitivity to these issues and addressing practical hurdles of language and cultural barriers.
- In addition to policy instruments, the provision of legal services can ensure that vulnerable individuals receive appropriate access to care and are not discriminated against. Such legal assistance programs are generally on a volunteer basis; more funding and resources should be allocated to ensure they are more permanent and pervasive.
- Programming should highlight commonalities among refugees, migrants and host populations. Cultural tools such as support for artists and campaigns to address xenophobia can build a new narrative on migration.
- Refugee and migrant voices should be included in discussions on policies and programs. They can help to guide more focused research and effective programming.
- Immigration detention centers collect data that reflect national policies in practice. Better national evaluation of this data can help identify where human rights violations are occurring.
- Certain infectious diseases have a long history of stigmatization, such as tuberculosis and HIV/AIDS. There may be vulnerable subpopulations within the refugee and migrant populations such as men who have sex with men, people who inject drugs, and sex workers that are already stigmatized. Health programming needs to establish greater trust to reach those subgroups.

## Recommendations

As noted above, the workshop was designed to consider how the policies and practices of inter-governmental organizations (IGOs) can help to overcome the problem of stigmatization. The principal role of the IGOs is as advocates and influencers as opposed to the actual implementers of programs. They can set standards, and both pressure and help governments to meet those standards.

a) **Draw on international law and non-binding instruments as advocacy tools.** IGOs ought to use existing international, human rights, refugee and health law to push for appropriate law, policies and practices at the national level. They should also draw on the two global compacts in advocacy efforts, as well as the Sustainable Development Goals, especially SDG 3 (ensure healthy lives and promote well-being for all at all ages).

b) **Pursue both long- and short-term counter-stigmatization strategies.** The long-term, overarching goal is to strengthen and render more resilient national health care systems for the benefit of both host and migrant populations. Accordingly, refugees and migrants should be included in 'healthcare for all' strategies and programs. Yet the long-term aspiration of universal access to adequate health care must not be an excuse for neglecting more short-term solutions to the problem of stigmatization.

c) **Refugee application outcomes should not be linked to infectious disease screening and health services access.** Linking asylum status approval (and the threat of deportation) to infectious disease surveillance hinders public health goals. Health care professionals must be able to operate independently from immigration authorities.

d) **Deliver health services to migrants and refugees in a culturally sensitive way.** IGOs, working with NGOs and governments, should develop sensitization-training programs for front-line health professionals and community health workers. Holistic health screening rather than for infectious disease only can reduce the possibility of stigmatization.

e) **Raise awareness among local officials and community leaders as well as central governments.** Overcoming the stigma associated with infectious disease requires creative education and communication efforts at all levels. For example, school officials have an especially important role to play in stemming fears that migrants and refugee children will infect children in the host population. The same is true for local media.

f) **Seek to crystallize widely accepted norms through practice.** The strategy of IGOs should be not to make new law, but to act on the basis of existing norms and law in support of vulnerable migrants and refugees. Activities engaged in or promoted by international organizations can give content to and thereby 'harden' soft law, such as the right to "the enjoyment of the highest attainable standard of physical and mental health." These activities may include the production of guidelines,[4] a more proactive role in human rights bodies, advocacy with governments, and support to non-governmental organizations.

4 Global Migration Group, "The Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations" is an example. https://www.ohchr.org/en/issues/migration/pages/vulnerablesituations.aspx.

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**Geneva Workshop**
**Tuesday, 27 November 2018, 14:00 – 17:00**

## Participant List

Nahid Bhadelia, Assistant Professor, Boston University School of Medicine and Director of Infection Control and Medical Response at National Emerging Infectious Diseases Laboratory

Gian Luca Burci, Adjunct Professor of International Law, Geneva Graduate Institute, former WHO Legal Counsel

Ann Burton, Chief, Public Health Section, Office of the UN High Commissioner for Refugees

Paola Botta, Associate Expert in Migration and Human Rights, Office of the UN High Commissioner for Human Rights

Manuel Carballo, Executive Director, International Center for Migration, Health and Development

Michael Flynn, Executive Director, Global Detention Project

Lasha Goguadze, Senior Health Officer, International Federation of Red Cross and Red Crescent Societies

Ian Johnstone, Dean *ad interim* and Professor of International Law, Fletcher School of Law and Diplomacy, Tufts University

Susana Martinez Schmickrath, Lead for Inter-Agency Collaboration,World Health Organization

Ryan Morhard, Project Lead, Global Health and Healthcare Industries, World Economic Forum

Michaela Told, Deputy Director and Executive Director, Geneva Graduate Institute Global Health Center

Alice Wimmer, Migration Health Officer, International Organization for Migration

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