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Is New Zealand immigration policy a barrier to TB elimination?

Emmanuel Badu, Charles Mpofu, Panteá Farvid

In many high-income countries including Aotearoa/New Zealand, the search for a ‘magic bullet’ to eliminate TB has intensified following the introduction of the WHO’s post-2015 TB strategy, “Towards TB elimination”.¹ The new strategy requires low-incidence countries, defined as countries reporting less than 100 cases per 1,000,000 population² to achieve pre-elimination (defined as less than 10 TB cases, all forms, per 1,000,000 population) by 2035 and subsequent elimination (defined as less than 1 TB case, all forms, per 1,000,000 population) by 2050. While these targets are bold, New Zealand remains far from achieving them. For instance, it has been estimated that an annual rate of decline of about 11% is required to achieve elimination by 2050, which is over three times the rate of decline (3.8%) observed between 2000 to 2012.¹

TB rates have declined to such low levels, 6.7 per 100,000 in New Zealand, that most people are less likely to experience a case of TB in their lifetime. Whereas this is a positive public health outcome, it has contributed to the general societal misconception that TB does not exist and has died out. History has shown that global TB control efforts only intensify when there are periods of a sudden rise in TB incidence, and dwindle when the rates decline.³ This phenomenon, where TB programmes and funding decline with the downward trend of incidence to create a favourable condition for resurgence, has famously been referred to as “the U-shaped curve of concern”.³

Even today, with improvements in diagnostics and several decades after the introduction of the BCG vaccine and anti-TB drugs (perceived as the panacea to the disease), TB continues to affect the lives of many people in the world. In 2015 alone, an estimated 10.4 million people were affected

and 1.8 million died from TB, and yet about four million more people were living with undiagnosed or unnotified TB globally.⁴

Like other low-incidence countries, migration remains the enduring threat to the TB elimination agenda. Foreign-born persons living in these countries contribute the highest proportion of all notified TB cases. For instance, the foreign-born population in New Zealand constitute about a quarter (25.2%; 1,001,787 people) of the population,⁵ yet they report the highest proportion (77.6%) of TB cases.⁶ With migration projected to rise, more deliberate policies to improve migrant wellbeing, and early diagnosis and treatment are warranted.

Thus, the aim of this letter is to add to the knowledge about TB service delivery challenges for the most vulnerable in our society and to increase pressure on policy makers by sharing our findings around a key structural barrier to TB control efforts from a small qualitative study that sought to understand the factors that drive the TB epidemiology in New Zealand. We purposively sampled and interviewed nine key informants (four community leaders, four health professionals and one charitable organisation staff) in Auckland. The methods for this study have been described elsewhere.⁷ Our findings suggest New Zealand immigration policies may be preventing some migrants from accessing and completing TB treatment. Health professionals interviewed in this study were concerned about the lack of clarity and consistency in the implementation of the immigration policy rules as to who gets to stay or leave because of TB. They reported that many of their clients with multi-drug resistance TB have had their applications to stay in New Zealand declined.⁷ This lack of

clarity in how immigration works inhibited health professionals' abilities to offer reliable advice to their clients, which makes some people reluctant to be diagnosed or treated for TB. In many instances, according to the participants, migrants on short-term visas were anxious about their immigration status and less worried about their own health. Participants explained that people who are unfortunate to be diagnosed with TB while they are in New Zealand are often very fearful about what will happen to their immigration status, particularly if they are a visitor or on a short-term permit. Such individuals are often very worried about what will happen if they have to declare to immigration that they have had treatment for TB.

Within the communities, the results suggest a lack of information about healthcare eligibility and free TB services for new migrants. Also, community leaders reported some mistrust for health professionals due to what they perceived as the unknown link or interaction between healthcare providers and immigration New Zealand, which sometimes inhibit some migrants from seeking help.

The study demonstrated that while individual knowledge about symptoms of TB could positively influence health decisions, concerns about one's immigration status has the potential to prevent actual help-seeking behaviour. We note that the prevailing silence and lack of advocacy may reflect the general societal and political disposition towards TB. Unfortunately, this curable disease may remain a silent killer, as the many people affected are the vulnerable and voiceless who have no influence over the agenda setting process.

We recommend: a clear guide for consistent implementation of the immigration New Zealand policy, which should be widely disseminated within migrant communities to diffuse the fear of getting diagnosed with TB; a national TB elimination strategy with specified goals, targets and ring-fenced funding to accelerate the public health action on eliminating TB; and more engagements with the media to influence the national discourse on TB from one of stigma or blame on immigration to that which interrogates how system factors such as the immigration policy may influence TB among migrants.

Competing interests:

Nil.

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