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CASE REPORT

The deportation of two Ethiopian migrant workers with leprosy

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A migrant is defined as a person who lives temporarily or permanently in a country in which they were not born.¹ The International Organisation for Migration estimates that 3% (192 million) of the world's population lives outside the country of their birth.² This figure suggests that one in every 33 people in the world is a migrant. Globalisation, economic necessity, conflict or natural disasters lead to the movement of people.

The proportion of migrants comprising the total population of the six Gulf Cooperation Council (GCC) countries (Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and the United Arab Emirates) ranged from 27.8 to 86.8% in 2010.³ It is estimated that more than a million Ethiopians work outside Ethiopia.⁴ The total workers remittances to Ethiopia was 241.6 million US dollars in 2011.⁵ Many Ethiopians seek employment in GCC countries each year through various regular and irregular means.⁶ An increasing proportion of these migrants are women. Many Ethiopian migrants to GCC countries use private employment agencies having attended pre-orientation sessions organised by the Ministry of Labour and Social Affairs (MOLSA)⁴ and are screened for HIV, tuberculosis and other infectious diseases.

Ethiopia reported 4374 new cases of leprosy to WHO in 2013.⁷ Eighty-eight cases of leprosy, none of which were in children, were reported by the GCC countries.⁷ However the case report of an 8 year old Kuwaiti boy was recently published.⁸ The long incubation period of leprosy results in some individuals from endemic countries developing symptoms after moving abroad.⁹ We report the experiences of two Ethiopians who had migrated to Kuwait to work.

CASE 1

A 29 year old Ethiopian man, GD migrated to Kuwait in September 2010 to work as a cleaner. In December 2011 he noticed a plaque on his left cheek. GD was seen at a hospital

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and prescribed topical treatment. He developed more skin lesions. After seeing a private Sri Lankan dermatologist, GD was diagnosed with leprosy 11 months after he had first sought medical advice. He was not informed of his diagnosis but was sent to another hospital where he was admitted. He was given rifampicin 600mg daily and dapsone 100mg daily for 14 days. He was still not informed what had been diagnosed. He was told to stay in his hospital room which he shared with a man from India.

On the third day following GD's hospitalisation, people wearing masks went to his flat and burnt his clothes and bedding. His three flatmates (all Ethiopian nationals) were taken by these 'officials' to have a clinical examination. GD's passport and outstanding salary were recovered from his employers. At the hospital an individual who did not identify himself wished to take a photograph of GD's face but not his lesions. When GD refused, the man told him the police would be called. GD agreed to the photograph after being persuaded by hospital staff. His fingerprints were taken 2 days later by a uniformed police officer who wore a face mask. His Indian roommate was also fingerprinted, taken from the hospital and did not return. With no official notice GD was taken in a police vehicle to a detention centre and 12 hours later to the airport. Without passing through normal airline and immigration channels he was put directly on a flight back to Ethiopia. On the flight no special precautions were taken. He had had no contact with his embassy and had not had the benefit of an independent Amharic translator.

On his return to Ethiopia GD attended the ALERT Center and was directed to the leprosy clinic where he showed us the short handwritten discharge summary and 52 capsules of rifampicin and 120 tablets of dapsone he had been given. A diagnosis of borderline lepromatous leprosy with associated T1R was made. He was prescribed WHO multibacillary (MB) multi-drug therapy (MDT) and ciclosporin and prednisolone for the reaction. We asked him how he felt about his experience. GD said that at the time he had been very afraid but after returning to Ethiopia he felt angered by the way he was treated which had made him 'feel like an animal'. He had grown up in the area surrounding the ALERT Center and knew that patients with leprosy in Ethiopia were not treated the way he and his flat-mates had been treated in Kuwait. He has now finished both his MDT and his reaction treatment and found work in Ethiopia.

CASE 2

A 25 year old Ethiopian woman TK who is fluent in Arabic, had worked in Kuwait for 3 years as a housekeeper when she noticed two skin lesions on her face which were intermittently red and swollen. In March 2012, a doctor diagnosed an allergy and treated her with topical corticosteroids and oral anti-histamine with no effect. A year later TK noticed another, similar lesion on her back. She was referred to the local hospital where a biopsy was taken in April 2013. A diagnosis of borderline tuberculoid leprosy was made. The bacterial index was zero. TK was informed of the diagnosis and told that she would need to start treatment as an in-patient. She was familiar with leprosy because her father had been treated for the condition when she was a child. Her paternal aunt had also had leprosy and was an active member of the local leprosy patient association in Ethiopia.

TK agreed to start treatment, but refused admission. Information about her employers and previous work history was taken and she was allowed to go home with rifampicin 600mg once a month, dapsone 100mg daily and vitamin B complex.

On arrival at her employer's residence, TK was told by her employer that the hospital had rung and warned her of TK's disease. TK decided that her best option was to return to Ethiopia where she knew how to get help. TK and her employer went the following day to buy a ticket to Addis Ababa, but TK was told by the travel agent that a ticket could not be issued because her name was on some kind of 'alert' list. On the advice of her employer, TK agreed to return to the hospital where she was told that she was highly contagious and that she must be isolated. All her belongings were taken from her and from her place of residence and discarded. She remained in isolation for 4 days before a woman from Indonesia was admitted to the same room.

TK was interviewed by a man in uniform who took all her details and her finger prints. She was warned not to return to Kuwait for the next 6 years. It was explained to her, that her finger prints would alert the authorities if she tried to apply for a work visa within the next 6 years to any of the GCC states. She was told that her employer had purchased her ticket to Addis Ababa and that she was to be expelled from the country. She was taken to the airport and taken directly onto the plane along with two prisoners.

Her main feeling throughout this time was anger that the doctors and the Kuwaiti authorities would treat someone with leprosy in such a manner. This treatment contrasted markedly with that she had seen her own family members receive in Ethiopia. On arrival in Ethiopia she presented to the leprosy clinic at the ALERT Center with a referral letter from Kuwait. A diagnosis of borderline tuberculoid leprosy with Type 1 reaction was confirmed. She has finished a 12 month course of WHO MB MDT and 6 months of prednisolone. Her nerve function remains intact, although her facial patch is highly visible. She is hoping to find work abroad again but in a non-GCC country.

The delay in diagnosis of leprosy is a well-recognised phenomenon in low endemic and non-endemic countries and often affects migrants in these settings.⁹ In Kuwait, foreign nationals diagnosed with leprosy are referred to an infectious diseases hospital to start treatment and then 'sent back to their respective countries' to complete it.¹⁰ In the Farwaniya region of Kuwait between 2003 and 2008, 46 people were diagnosed with leprosy and of these almost 90% were foreign nationals. The authors describe as 'significant' and 'alarming' an almost ten-fold increase in the proportion of Kuwaitis diagnosed with leprosy in their study compared to a previous one with a different methodology published 20 years earlier.¹¹ It was not shown how they arrived at this 'significant' and 'alarming' finding. We feel such language based on dubious statistical methodology is inflammatory and misleading. Leprosy has been a notifiable disease in England and Wales since 1951 and 1533 cases have been reported. There have been no cases of autochthonous transmission to date.¹²

The lack of information and respect accorded these individuals prior to their removal from Kuwait, a member state of the United Nations infringed their human rights, undermining the General Assembly resolution of 2010 and underlining the continued need for lobbying of governments by all those concerned about the welfare of people diagnosed with leprosy.¹³

The early diagnosis of all individuals with leprosy is key, and so health care workers in low prevalence settings need to be educated about the clinical features of the disease and the appropriate management. Information for clinicians should be easily accessible from the appropriate government agencies. A designated clinician with expertise in the diagnosis and management of leprosy should be accessible for advice. The authorities should foster an environment that encourages individuals who suspect they may have a communicable disease to seek advice quickly.

We do not believe that the cases we report are isolated incidents. Draconian policies will make it less likely that people will present early and immigration laws that lead to the deportation of migrant workers with leprosy may infringe human rights. The deportation of individuals who have commenced MDT will have no significant impact in terms of wider public health.¹⁴ There should be a duty of care that ensures individuals are fully informed of their diagnosis and provided with treatment based on established evidence. This should be done in accordance with the principles of confidentiality and respect for individual autonomy.¹⁵

Note: We would like to thank GD and TK for allowing us to report their experiences. The initials of both individuals have been changed.

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