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Commentary

International labour trafficking: A neglected social origin of COVID-19

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COVID-19 and international labour trafficking interact in a complex two-way manner that is mediated by sociobiological factors. In one way, the pandemic magnifies socioeconomic inequalities, such as poverty and unemployment in workers' countries of origin, which heighten the risk of victimisation of workers through labour trafficking [1]. Conversely, labour trafficking serves as a social origin for COVID-19 through a unique set of social disadvantages–i.e., reluctance to seek medical care due to fear of legal prosecution–that make infected workers potential disease vectors which threaten the health of the host country's population. The resurgence of COVID-19 in Thailand substantiates this notion that labour trafficking is a critical but neglected public health issue [2].

Once lauded for achieving a 103-day period of zero domestic transmission after its first surge of COVID-19, Thailand unveiled a new cluster of 2,629 COVID-19 cases (65.7%) among an estimated 4,000 international migrant workers at the country's largest shrimp market between December 20–27, 2020 [3]. Within days, the cluster resulted in the spread of disease to 44 out of 77 provinces. This incident raises the question: What is the mechanism underlying this impactful pathway of disease transmission that harms the public at large? The answer lies at Thailand's border.

Economic hardships abroad and border restrictions in Thailand during the pandemic have contributed to a spike in labour trafficking of international migrant workers. Once victims of trafficking, workers are limited to low-paying labour-intensive jobs which make poor quality housing unavoidable. Furthermore, workers' status due to illegal entry into the country inhibits their ability to access healthcare [4]. Regardless of these specific social contexts, pre-existing disease control measures tend to emphasize biomedical principles including aetiology, diagnosis, prognosis, and treatment [5]. Based on the aetiology of COVID-19, interventions including physical distancing and working from home have been implemented to break the chain of transmission [6]. Mass testing to diagnose infected individuals and prompt treatment to modify prognosis of disease and outbreak in the community have also been key strategies [7]. While these biomedical approaches are assumed to be generalisable to the population at large, they neglect to address the social inequalities of this latent population [8]. Tightly packed living arrangements make physical distancing impractical for victimised workers. These essential workers in the shrimp market lack the privilege to work from home. Working in a foreign country where COVID-19 information is unavailable in their native languages worsens their health literacy and contributes to poor compliance with preventive measures–i.e., not wearing masks. Without lawful documentation, trafficked individuals lack the right to healthcare, making timely diagnosis and treatments impractical. Furthermore, stigmatisation and xenophobia heightened by the outbreak create a hostile environment, which has driven individuals into hiding and contributed to a poor prognosis for the outbreak overall [9]. This was evident in Thailand's recent outbreak when infected migrant workers, 90 percent of whom remained asymptomatic, were left undiagnosed and unknowingly spread the disease.[10] These migrant workers are the backbone of the country's food supply chain and potential vectors of disease. Their public-facing role in shrimp markets requires them to be in contact with middlemen who can become infected and further transmit the disease to others gathering in markets across the country. Altogether, the aforementioned evidence elucidates the mechanism by which labour trafficking gives rise to COVID-19 through sociobiological mediators, such as the occupational health risk of contracting and transmitting the virus, which make compliance to biomedical interventions unfeasible and further contribute to the resurgence.

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Multilevel interventions and intersectoral collaborations would break this pathway between international labour trafficking and COVID-19. Multinational efforts that transcend labour trafficking law reinforcement, and instead strengthen governance of social protection and public health action, would mitigate the vulnerabilities of workers. For those already involved in trafficking, provisional suspension of laws penalising unauthorized international migrant workers and their employers would prevent disease transmission by limiting the movement of potentially infected individuals fearing legal prosecution. Then, to enhance their willingness to cooperate in disease control and preventive measures, interventions should promote non-discrimination, cultural humility, and clear communication–to build trust, mutual understanding, and inclusivity. Considering workers' shared affinity, language, and social network; peer-to-peer communication initiatives–i.e., migrant worker health volunteer programs–would connect community members with health authorities and labour officials that bridge them to necessary health and social services.

Although the pandemic disproportionately affects these victims of labour trafficking, its effect is not merely confined to these individuals. To protect society as a whole, labour trafficking and care for its victims should be addressed as public health priorities to limit transmission of infectious disease through this social mechanism.

Authors' contributions

CR developed the concept for this commentary. SE provided substantial intellectual content towards drafts. Both authors contributed to the writing of the paper and approved its final version.

Declaration of Competing Interest

The authors declare no conflicts of interest.

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