

# MIGRATION HEALTH

REPORT OF ACTIVITIES 2010



***Special 60th Anniversary Edition***  
**Health of Migrants in an Increasingly  
Globalized World**



# Migration is About Health

**Health issues** cut across the entire migration process in countries of origin, transit, destination and return. Improving migrants' access to health care and promoting their well-being contribute to creating prosperous, cohesive and healthy environments. To maintain the health of migrants and their families is to uphold a basic human right; it is also in the best interests of all countries and communities.

IOM assists Member States in addressing health-related aspects of migration. Its programmes are implemented in over 50 countries and provide health services that are accessible and equitable to vulnerable migrants, and host communities alike. Activities cover migration health assessments and health promotion and a broad range of health topics such as psychosocial support, sexual and reproductive health, tuberculosis and HIV/AIDS.



International Organization for Migration (IOM)

Migration for the Benefit of All

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# List of Acronyms

AIDS	Acquired Immunodeficiency Syndrome
AMDA	Association of Medical Doctors of Asia
AU	African Union
CAAP	Central Asia AIDS Control Project
CCCM	Camp Coordination and Camp Management
CDC	Centers for Disease Control and Prevention
CIC	Citizenship and Immigration Canada
CIS	Commonwealth of Independent States
CoAg	Cooperative Agreement
CXR	Chest X-Ray
DNA	Deoxyribonucleic Acid
DOT	Directly Observed Treatment
DST	Drug Susceptibility Testing
EAC	East African Community
ECDC	European Centre for Disease Prevention and Control
EEA	European Economic Area
EPSCO	Employment, Social Policy, Health and Consumer Affairs Council
EU	European Union
GBV	Gender-Based Violence
GFATM	Global Fund to Fight AIDS, TB and Malaria
GFMD	Global Forum on Migration and Development
HAP	Health Assessment Programme
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
IBBS	Integrated Biological and Behavioural Surveillance
IDP	Internally Displaced Person
IGAD	Intergovernmental Authority on Development
ILO	International Labour Organization
MARP	Most-at-Risk Population
MDG	Millennium Development Goal
MDR-TB	Multidrug-Resistant Tuberculosis
MHD	Migration Health Division
MHPSS	Mental Health and Psychosocial Support
MOH	Ministry of Health
MOPH	Ministry of Public Health
NACC	National AIDS Control Council

NGO	Non-Governmental Organization
NTP	National TB Programme
PDMS	Pre-Departure Medical Screening
PEC	Pre-Embarkation Check
PLHIV	People Living with HIV
PRM	United States Bureau of Population, Refugees and Migration
RTCC	Regional Training Coordination Centre
SHAPE	Strengthening Serbia's Human Capital through the Active Involvement of Young People
STI	Sexually Transmitted Infection
TB	Tuberculosis
UKTBDP	United Kingdom Tuberculosis Detection Programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
WASH	Water, Sanitation and Hygiene
WHA	World Health Assembly
WHO	World Health Organization
WMR	World Migration Report

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# Foreword

It is a distinct pleasure for me to present to you the International Organization for Migration (IOM) report, *Health of Migrants in an Increasingly Globalized World: Special Edition of the Migration Health Division's (MHD) Annual Report for 2010*. This latest offering illustrates IOM's growing multidimensional migration health activities and global partnerships.

This year, IOM celebrates the sixtieth anniversary of its founding in 1951, when the Provisional Intergovernmental Committee for the Movement of Migrants from Europe (PICMME) was created following the Second World War. In the 60 years that have followed, the Organization has become the leading international agency working with governments and civil society to advance migration management in accordance with human dignity and the well-being of the world's 214 million international migrants. The increase in the range and complexity of migration activities in the last six decades is reflected in IOM's membership, which currently stands at 132 Member States; an annual budget of more than USD 1.4 billion; and staff of 7,500 people serving in 460 locations around the globe.

Migration is an integral feature of the global economy and there is growing acknowledgement on the part of governments and other actors that migrant remittances and labour – skilled and unskilled – are desirable and needed to encourage economic growth and prosperity. At the same time, however, the current political climate is characterized by a public wave of anti-migrant sentiment in parliaments, state houses and the media. The positive contributions to our societies and economies of the overwhelming majority of migrants are unfortunately often overshadowed, or forgotten altogether.

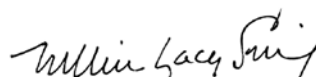


**William Lacy Swing, Director General, International Organization for Migration, on a field visit in Colombia.**

Marginalizing populations such as migrants from having access to health and other social services is a violation of human rights and negatively affects the public health and economic well-being of the host society. Improved working conditions for migrants, greater protection, and better access to health care contributes to a healthier environment on which to build prosperous societies.

No single government or organization can manage migration in isolation. Partnerships are essential in the new age of human mobility. Since 1951, IOM has been working closely with a variety of different partners to reduce the potential health risks of human mobility to both migrants and destination countries and communities. This Annual Report highlights these partnerships and illustrates the activities of different organizations in the migration health field. We are honoured to have the contributions of some of our partners in this special edition of the 2010 MHD Annual Report.

We will all need to work in concert to realize migration's full potential to advance human and societal development – while severely limiting any negative effects of migration on development.

  
**William Lacy Swing**  
Director General

# Introduction

As IOM celebrates sixty years of assisting migrants and governments in addressing migration-related health challenges worldwide, this report presents the highlights of IOM's health activities in 2010, as well as views from important IOM partners and leading health entities on a range of migration health topics. In doing this, we believe that the complexity and cross-cutting nature of migration health is better reflected. We are very grateful to governments, agencies, professionals and institutions at the international, regional and national levels who have accepted our invitation this year, and have given voice to the legitimate aspiration of millions of migrants worldwide to greater equity in health.

Migration is humanity's oldest manifestation of an individual's desire for development, dignity and a decent life – even if it means doing the dirty, difficult and dangerous jobs that domestic workforces often shun. This increasingly implies braving perilous journeys and enduring harsh living and working conditions or limitations in accessing health care brought about by crises and global economic downturns. This all too often results in severe negative health outcomes for migrants, and even the loss of lives.

Health is a critical asset for migrants and their families, and the negative health outcomes of migration not only have an effect on the individual migrant or cause a possible social and economic burden on host communities, they may also have repercussions for families left behind, or the wider community in the country of origin. This calls for joint efforts between countries of origin and destination to agree on a broad concept of “shared prosperity and shared responsibility” around migration. It also calls for collaborative efforts between different sectors within countries to address the determinants of migrants' health, which are often found outside the health sector itself.



**Dr. Davide Mosca, MHD Director, speaks at the first National Consultation on Migration Health in Kenya. (Photo: Celeste Hibbert)**

Yet multisector dialogue, policy coherence, and financial investment towards the promotion of health is often not an easy target to achieve; this is all the more the case when societal obligations towards non-citizen beneficiaries or diasporas, which may be seen as enjoying better life standards abroad, is not widely felt. Pursuing greater equity in health for migrants ultimately means investing in health for social cohesion, economic development, public health and human security, and as such, it bridges human rights, development and public interest. There is no better or more rewarding challenge.

Since my appointment as Director of IOM's Migration Health Division in 2008, I have been asking myself and colleagues the question:

“Are we making a difference in the lives of the people we serve?”

Reading the contributions of the various organizations and colleagues in this report, I am comforted by the knowledge that migration health is slowly gaining ground at the global level, and that IOM, while humbled by its task, is nevertheless proudly playing its role in contributing to making this happen! Amongst the major



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benchmarks of the year 2010, I think it is important to mention the *Global Consultation on Health of Migrants: The Way Forward*, co-organized by WHO and IOM and hosted by the Government of Spain in Madrid. The Consultation's outcomes have provided the operational framework for the implementation of the *Sixty-first World Health Assembly Resolution on the Health of Migrants (WHA61.17)*. The operationalization of the Resolution has been a matter of debate in various national and regional fora, where it has been collaboratively promoted by IOM, WHO and other partners throughout the year. Many more countries have engaged in new policies and programmes that promote access to health for migrants, irrespective of their legal status. Migration is increasingly recognized as a social determinant in the health of migrants and communities, and health aspects have been included into global and regional debates on migration and development, such as the *Global Forum on Migration and Development (GFMD) in Puerto Vallarta, Mexico*, and other various relevant regional consultative processes.

IOM's migration health activities have grown tremendously over the last years, both in volume and in complexity, as globalization has made the world increasingly mobile and connected. Until the early 1980s, the majority of health activities carried out by IOM concerned the health assessments of refugees bound for resettlement, a traditional, yet evolving, core area of focus since the Organization's inception. However, as new global migration health challenges emerged, IOM's work evolved accordingly. Currently, new IOM health programmes aim to respond to a wide range of health

challenges in different migration and displacement contexts, as will be highlighted later in this report.

Finally, my sincere gratitude and appreciation goes to the dedicated staff of IOM, in the present and in the past, for their dedication and commitment to addressing and pursuing the health of migrants worldwide. This report shows the fruits of our constant efforts to improve the lives of migrants and the communities that host them. IOM will continue to address migration health challenges and identify opportunities to make a difference in the lives of migrants and those affected by migration, while upholding partnership as the factor that allows this work to progress.

For healthy migrants in healthy communities!



**Dr. Davide Mosca**

Director, Migration Health Division

Department of Migration Management

# Part I – Health of Migrants in an Increasingly Globalized World



**Madrid, Spain, 2010. Global Consultation on Health of Migrants: The Way Forward.** Standing from left to right: Brian Gushulak, Harald Siem. Sitting from left to right: Danielle Grondin, Davide Mosca, Janet Hatcher-Roberts. (Photo: Jacqueline Weekers)

## Interview with five IOM health directors reflecting on 25 years of migration health



*In your opinion how has the global landscape of migration and health changed over the last 20 years?*

**Harald Siem.**<sup>1</sup> As early as 1990, IOM and WHO were already collaborating on migrant health issues, and, in the same year, they jointly organized the first conference on migrant health. The conference, which was held in Geneva, brought together 185 participants from 42 countries and more than 50 technical and policy papers were presented.

The agenda of the conference reflected the themes of the time, namely the resettlement of refugees and the admission conditions imposed by immigrant countries.

HIV, leprosy, hepatitis, tuberculosis and mental health were dominant themes. This relatively narrow perspective on the phenomenon was expanded in a second conference the following year in Brussels, where a much broader policy approach was taken. With these two conferences, IOM Medical Services became a key part of the growing international debate on migration and health, and, in 1994, IOM, working in close collaboration with WHO and the University of Geneva, established the International Centre for Migration and Health (ICMH)<sup>2</sup> with a mandate to develop, compile and provide stakeholders such as governments, United Nations agencies and NGOs with research findings and policy documentation.

Since then global attention to migrant health has developed significantly and a vast new area of clinical and social epidemiology has emerged around the theme. Research is now ongoing in many parts of the world on topics such as how the socio-economic and health background of migrants and the conditions under which they move interplay to affect their health in the countries they resettle in.

This interest in the social determinants of the health of migrants is opening up new avenues of understanding the ways in which health and disease are affected and how access to care varies not only among migrants but also among the host populations. It is equally facilitating a new debate about culturally sensitive, non-discriminatory care that places a high value on the ways in which communication between health care providers and clients could and should be improved.

Migrant health issues are also increasingly being taken up by medical and nursing schools and by public health training programmes at both undergraduate and graduate levels. In many parts of the world, hospitals are also beginning to examine their routines and procedures with respect to migrants and other minority groups that in the past have been taken for granted, despite their different backgrounds, needs and capacities to utilize health care services.

This is all to say that **today the complexity of migrant and minority health issues has finally found its place in the language of health**

<sup>1</sup> Dr. Harald Siem, Senior Adviser at the Department of Global Health at the Norwegian Directorate of Health, Director of IOM Medical Services, 1988–1996.

<sup>2</sup> IOM separated from the ICMH in 2004, when IOM Medical Services was established as the Migration Health Department.

**research and health care planning. When I look back over the last 20 years, I realize that a page has been turned.**

*How do issues of health and migration affect each other in contemporary society?*

**Brian Gushulak.**<sup>3</sup> In the world today, health and migration are related on several levels. The volume of modern migration alone is an important indicator of the global importance of the health of those moving across and between borders. Considered as a nation, migrants comprise the fifth largest country in the world. Migration, travel and mobility are fundamental components of both the current and future human condition. Population mobility will influence, guide and support economic and social development, security, and the greater integration of global processes in origin, transit and destination countries. **The healthier migrants are and remain, the more efficient and balanced the future of our integrated and globalized world will be.** Maintaining and ensuring the health of migrants, their families and those who live and work with them is, and will continue to be, an important aspect of health and health care at the national and international level.

*How would you position the health of migrants agenda within the context of contemporary global health goals?*

There are two major global health goals that have direct relevance for the health of migrants. Firstly, one of the major pillars of contemporary global health approaches is the reduction in disparities that create and sustain adverse health outcomes. Migrant communities often experience the consequences of health disparities, both positive and negative, that result from conditions at their point of origin. Others experience adverse health outcomes during transit or after their arrival. Improving the health of migrants and reducing migration-related disparities in health outcomes should become an integral component of programmes attempting to manage disparity at the regional and global level. Secondly, programmes designed to manage or mitigate the global spread of diseases of international importance often include components focused on mobile populations. Ensuring that the medical, social and community needs of migrants are met during global disease control activities is an equally important aspect of the migration health agenda.

*Globally, what is the biggest challenge to ensuring the health of migrants today?*

**Danielle Grondin.**<sup>4</sup> During my tenure as Director of Migration Health at IOM, we put emphasis on understanding the benefits of investing in health and considering the health of migrants as an integral part of migration management. Economic, social and public health studies support investing in and managing migration health, for example, showing that poor health reduces GDP per capita by reducing both labour productivity and the relative size of the labour force. Migrants in good health would enjoy raised life expectancy and be more productive. Enjoying physical, mental and social well-being, migrants can more easily seize opportunities to participate positively in their communities. Investing in migration health also means better global public health. **Integration, understood as autonomous participation and contribution to society, and an indicator for successful migration outcome, calls for a comprehensive interpretation of migration health beyond infectious disease control towards inclusion of chronic non-communicable conditions, mental health concerns, and health and human rights issues.** A failure to recognize these benefits could lead to a higher level of disease among migrants, including mental and social ill-being, reduced individual incomes and less positive community involvement. And IOM has continued its work in this regard.

*How can we, the international community, deal with that challenge?*

By considering the health of migrants as an integrated part of migration management, the international community could create a platform for dialogue and information sharing, bringing migration and health stakeholders together, with a commitment to build or strengthen multilevel and multisectoral partnerships; contribute to public education by developing understanding through research and analysis for the development of evidence-based policy formulation and management strategy in migration health, bridging source, transit, destination and return countries/regions; and by monitoring public health surveillance, data systems, and policymaking worldwide to create a positive synergy that will magnify social and economic gains for all.

<sup>3</sup> Dr. Brian Gushulak, Consultant, Migration Health Consultants Inc., Director of IOM Medical Services, 1996–2001.

<sup>4</sup> Dr. Danielle Grondin, Director-General - Health Branch, Citizenship and Immigration Canada, Director of IOM Migration Health Department, 2001–2007.

*If you could change one thing to secure good health among migrants, what would it be?*

**Janet Hatcher-Roberts.**<sup>5</sup> Global political recognition and commitment that securing the health of migrants is a critical public health challenge that needs to be addressed by governments and societies. These public health realities formed the basis for the Resolution on the Health of Migrants, which was endorsed by the Sixty-first WHA in May 2008. Since the adoption of this resolution, as WHO points out in the 2010 progress report, the global economic crisis has contributed to increasing unemployment, falling wages and poorer working conditions which have had an inequitable impact on migrants. This economic crisis has also augmented unauthorized migration flows, placing many more migrants in a vulnerable situation, particularly with regard to their inability to access health services. In addition, the growing economic crisis, natural disasters, armed conflict and food insecurity have increasingly displaced millions of people whose health is threatened.

We need to ensure that governments provide universal access to essential preventative and public health services for all migrants, regardless of status. We also need to make sure that health professionals who interact with migrants in countries that absorb migrants are better prepared and trained to identify, treat and manage their health problems. Development of evidence-based guidelines for health professionals which specifically address those issues relevant to migrants is essential. Initiatives such as the Canadian Refugee and Migrant Health initiative, which has sought to develop such guidelines and thus key benchmarks for provision of care, are an important next step for comprehensive and harmonized responses. Coupled with these types of initiatives is the need for data for baseline and progress monitoring and evaluation, which currently is a significant gap.

*Which actors can play a significant role in protecting migrants' health and how?*

It is critical, given the multidimensional challenges to migrants and their health, that responses go beyond those found solely within the health care system. This requires a health systems approach that not only secures access to health services but also reaches out across other sectors, outside of the health care sector. This requires coordination and collaboration that promotes cohesive policies and programmes outside the health care system which address the inequities of migrants.

**Maintaining and sustaining the health of migrants requires not only political commitment from all sectors (health, education, environment, finance and foreign affairs, to name a few) but also non-governmental actors (civil society) and the private sector.** These players need to be supported by mechanisms, infrastructure and the political will to work together to not only protect but also maintain and promote the health of migrants now and in the future.

*In your view, what are the key words that describe efforts to achieve and ensure migrants' health in the twenty-first century?*

**Davide Mosca.**<sup>6</sup> I will use the IOM Migration Health Division's (MHD) slogan to elucidate the vision and purpose underlining the advancement of this agenda: "Healthy migrants in healthy communities!". This vision, which upholds social integration and equity, reflects the long-standing health policy concept of "Health for All" that has been popularized since the 1970s by WHO in the promotion of global health, human dignity and enhanced quality of life. I want to recall here the words of former WHO Director-General Halfadn Mahler, who, in defining "Health for All" in 1981, said: "Health is to be brought within reach of everyone in a given country. And by 'health' is meant a personal state of well-being, not just the availability of health services, a state of health that enables a person to lead a socially and economically productive life." Ultimately, migration is about the enhancement of one's capability to ensure for self and loved ones longer and healthier lives that enable the expression of one's full potential and participation in the life of the community. In this sense, the removal of obstacles to health for migrants should be regarded as a fundamental objective not only of economic and human development through migration, but also of social stability and cohesiveness. Yet the realization of "Health for All" remains a far-off objective, and the challenges ahead are many and increasingly complex. **The ongoing financial crisis and the growth of anti-migrant sentiments that threaten to aggravate the societal perception of any positive contributions from migrants both increase the vulnerability of migrants and reinforce the importance of protecting their right to health and the commitment to effective respect of human dignity and well-being of all migrants.**

<sup>5</sup> Janet Hatcher-Roberts, Executive Director of the Canadian Society for International Health, Director of IOM Migration Health Department, 2007–2008.

<sup>6</sup> Dr. Davide Mosca, Director of IOM Migration Health Division since 2008.





IOM is committed to the health of migrants. (Photo: IOM)

Furthermore, as the agreed time frame for the achievement of Millennium Development Goals (MDGs) approaches, the compelling question is, “how much have we progressed in respect of the health of migrants and other mobile, marginalized or hard-to-reach populations that often fall through the cracks of policies and monitoring systems?” I think that there is a need to review and adapt health strategies and systems, including primary health care, in light of the growing mobility of populations brought about by globalization and the consequent diversity existing in our societies. Echoing WHO Director-General Margaret Chan, who, in her opening remarks at the Sixty-fourth World Health Assembly, urged us to “remember the people” and to give priority to the health needs of the vulnerable and marginalized, I would add “don’t forget the migrants.” **Since we look at migration as a social determinant of the health of migrants, political will across sectors is paramount, particularly among non-health sectors, where the conditions surrounding present-day migration and mobility, which have direct or indirect impacts on the health of people, are determined.** An important step for IOM will be to advocate for the inclusion of health in the migration and development debate at the UN High-Level Dialogue in 2013. Such a step would not only reinforce the intersection of migration, health and development, it would also increase awareness of the close linkages between the health of migrants and their ability to contribute to the socio-economic development of both their host and origin countries, thus emphasizing their role as crucial actors in the development process.

*How do you see the relationship between migration, mobility and health unfolding over the next 20 years?*

Migration has always been a characteristic of human societies, and one that has probably always been pregnant with health challenges. The twentieth century has seen the rapid expansion and increased complexity of global migration trends; and, as put in evidence by Organisation for Economic Co-operation and Development (OECD) studies, though the forces that will shape migration in the next 20 years – economic, geopolitical, social, demographic, technological and environmental – all carry significant levels of uncertainty, it is very likely that migration flows will keep rising, or will at least remain constant with the trends of the last 30 years. This means a continuing build-up of migratory pressures, though with significant regional differences. Many countries previously confronted with migration issues on a marginal level will need to put policies in place for the effective monitoring and management of immigration, emigration and internal migration. The health sector is no exception. We believe that responding constructively and sympathetically to the health needs of migrants, irrespective of their legal status, correspond with the same imperatives we all sustain in embracing Global Health and Millennium Development Goals. This, of course, also makes a lot of sense from a public health perspective, especially when one considers that, in many parts of the world, there is reversed progress towards meeting the health needs of people and disparities and inequities are on the rise; well, migration bridges these disparities. Societies are meant to become more diverse, and the health sector needs to face this reality. Migrant-inclusive health policies and migrant-friendly services are needed to overcome barriers and marginalization for the best health interest of all. Also, considering the increasingly circular nature of migration and the creation of a transborder space of common interest, **countries of origin and destination should collaborate in jointly promoting the health of migrants in a concept of “shared prosperity and shared responsibility” that values migration, values health, and values people.**





**Dr. Margaret Chan,**  
Director-General,  
World Health Organization

## The health of migrants

Recent events have heightened public and political awareness of the plight of migrants, as measured by their increasing numbers, their special needs, including for refuge and health care, and the pressures that cause them to leave their homes. These pressures have been multiplied and amplified in a world of radically increased interdependence.

Globalization of the labour market encourages many individuals to leave home in the quest for a better life elsewhere. In the past, the majority of migrant workers were men. Today, nearly as many women and even children are becoming international labour migrants, making them especially vulnerable to human trafficking.

As we have witnessed just this year, many migrants flee their homes because of conflict or civil unrest, often overburdening neighbouring countries with their immediate needs for shelter and health care. As the climate gradually warms, other so-called “environmental refugees” are displaced by floods or leave when food crops fail and livestock die during times of prolonged drought. As we have also witnessed this year, substantial population displacements can place a huge burden on the international humanitarian community. The causes of all these trends are deep-rooted and difficult to reverse.

For WHO, an especially difficult problem has been the discrimination against migrants seen in countries that associate migration with the spread or reintroduction of infectious diseases, including tuberculosis, also in its multidrug-resistant forms, HIV/AIDS, and polio. WHO and its Member States are increasingly aware of the dangers of such attitudes and the need to develop policies that fight discrimination, encourage the inclusion of migrants in societies, and promote equal access to social services.

In 2008, a report to the World Health Assembly on the health of migrants set out four principles that should guide policies for meeting the health needs of migrants through a public health approach. These principles aim to ensure fair access to health services, protect the fundamental right to health of migrants, put life-saving measures in place when migration results from conflict or disasters, and guard against adverse health consequences associated with the stresses that often accompany migration. An associated resolution asked WHO to promote the health of migrants on the international health agenda in collaboration with other relevant international organizations.

WHO has enjoyed a long and fruitful collaboration with the International Organization for Migration. Our shared agenda is well-reflected in the theme chosen to celebrate IOM’s sixtieth anniversary: Health of Migrants in an Increasingly Globalized World.

Let me join others in congratulating IOM for 60 years of dedicated service, at practical, policy and advocacy levels, in managing migration for the benefit of all. Given the conditions in our increasingly globalized world, this work is bound to grow in complexity, requiring cohesive and forceful action from multiple sectors. Rest assured that WHO will be a steadfast partner, now and well into the future.

Ensure fair access to health services, protect the fundamental right to health of migrants, put life-saving measures in place when migration results from conflict or disasters, and guard against adverse health consequences associated with the stresses that often accompany migration.

**Dr Margaret Chan**  
Director-General  
World Health Organization



**Michel Sidibé,**  
Executive Director,  
Joint United Nations  
Programme on HIV/AIDS

## Migration and HIV

This year marks 30 years of AIDS – 30 years since the virus was first reported; 30 years which have changed the course of history.

It has been an unprecedented journey. AIDS, which was once a little known and little understood disease, progressed rapidly to the very top of political agendas, infecting 60 million people, affecting many millions more.

The scale and nature of the disease prompted a global movement of unprecedented scale, involving people from all walks of life and from every sector of society. This worldwide reaction and mobilization has enabled significant results to be achieved. New HIV infections have fallen by 20 per cent in the last 10 years, deaths have reduced by 20 per cent over the last five years, and over 6.5 million people are now receiving life-saving antiretroviral treatment.

But this progress is still overshadowed by today's realities. Thirty-three million people around the world are living with the virus, millions are in urgent need of treatment, and there are still major barriers preventing access to life-saving HIV services for people in need.

Achieving the UNAIDS vision of zero new HIV infections, zero discrimination and zero AIDS-related deaths will not be possible, unless people have universal access to HIV prevention, treatment care and support services.

One area which requires global attention is scaling up access to HIV services for migrants and mobile populations. There are close to 200 million migrants around the world today. This is one in every 35 people.

Migrants are people on the move for a vast array of reasons – either to find work, flee from conflict, seek a better life or reunite with families. The journeys they take can lead them to the very margins of society, without access to services that protect their safety and health.

As people embark on a migratory journey, they leave behind their families, social networks, communities and the institutions they rely on for support. The social norms, once so familiar at home, no longer apply to their new surroundings and the long periods spent away from home can lead to risk behaviour and render migrants vulnerable to HIV.

Migrating women are particularly affected. Many become employed in the manufacturing, domestic service or entertainment sectors, sometimes without legal status and with little access to health services. They are often susceptible to exploitation and physical and sexual violence, in some cases by their employer, and have few alternative employment opportunities.

Women left behind are also at risk. Not only are they faced with the same economic challenges which contributed to their husband's departure, they may also have new challenges to confront. The women who stay behind may be forced to exchange sex for food and money. They may also be at risk if their returning husbands were exposed to HIV during their migratory journeys.

Discrimination also remains a major challenge. Laws and policies which prevent people living with HIV from entering a country are discriminatory and have no place in today's globalized world. In the last few years, UNAIDS has championed the removal of all restrictions preventing people living with HIV from entering or remaining in a country.

HIV programmes need to be designed and implemented to reach migrant workers and their families. If migrants stay healthy, they can make an active contribution to economic growth and become an integral part of their new societies.

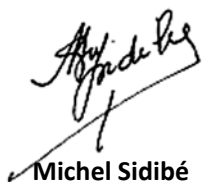
**Laws and policies which prevent people living with HIV from entering a country are discriminatory and have no place in today's globalized world.**

The human rights and health rights of migrants must be respected. UNAIDS will continue to work closely with IOM and other partners to improve access to HIV services for migrants and mobile populations.

### UNAIDS and IOM

UNAIDS has worked with IOM since 1996 to enhance social protection for migrants affected by HIV. Under a renewed agreement signed in January 2011, UNAIDS and IOM are focusing on stopping violence against migrant women and girls, reducing stigma and discrimination, and removing punitive laws, policies and practices related to HIV and population mobility that block effective responses to HIV.

In addition, UNAIDS and IOM are strengthening technical support to help governments, regional institutions and civil society reduce vulnerability to HIV among mobile and migrant populations. The two organizations will also continue cooperation on research to deepen understanding of HIV and population mobility.



**Michel Sidibé**  
Executive Director  
Joint United Nations Programme on HIV/AIDS



**Maria do Céu Machado,**  
High Commissioner for  
Health, Government of  
Portugal

## Migrant health in Portugal: Practices and challenges<sup>7</sup>

Migrant health is a critical issue and strategies must address inequities and differences in health status and access, as well as ensure migrants' rights in health and social protection.

In recent years, several migrant-friendly policies have been implemented in Portugal: in 2001, a legal diploma was issued granting migrants access to universal health care services regardless of their legal status (Ministry of Health, 2001); an integrated, multisectoral programme was developed, encompassing labour and professional training, housing, education and health as areas for action; and, more recently, the II National Plan for Immigrant Integration (2010–2013) was put into practice (Ministers Council, 2010).

"Health and Migration" was the main health theme during the Portuguese Presidency of the EU in 2007, when the conference "Health and Migration in the EU: Better Health for All in an Inclusive Society" was held (Fernandes et al., 2009). An important World Health Assembly resolution on the health of migrants came out of this multi-stakeholder meeting, underlining the importance of establishing partnerships, networks and multi-country frameworks for action in this area. These are vital for ensuring there are minimum standards for access of migrants to health care and sound public health policies and practices.

<sup>7</sup> This article was prepared by Maria do Céu Machado, High Commissioner for Health, and Sílvia Machaqueiro, Technical Advisor to the Office of the High Commissioner for Health.

Some of the areas that admittedly will need investment in the future are research in migrants' health for further understanding of their needs and the challenges which accompany the migration process.

As a Ministry of Health institution, the Office of the High Commissioner for Health has also collaborated closely with IOM since its membership of the Organization in 1975. This translated, for instance, in the organization of a meeting on migrant health held in Lisbon in September 2009, for instance, within the scope of the Assisting Migrants and Communities (AMAC) project. The discussion was centred on eight thematic background papers, one of which was written by the Office of the High Commissioner for Health in partnership with the New Lisbon University (Machado et al., 2009).

The IOM office in Lisbon also promotes several initiatives and projects in areas like migration and development, migration policy and research, in cooperation with the EU and different Portuguese institutions and organizations (e.g. Portuguese Institute for Development Assistance (IPAD), Immigration and Borders Service (SEF), ACIDI, Commission for Citizenship and Gender Equality, and Gulbenkian Foundation).<sup>8</sup>

At the European level, Portugal has often been ranked highly regarding its integration policies and equity mechanisms, as a result of its great progress in securing long-term residence for migrants, addressing specific employment situations, granting common citizenship, education policies, political opportunities and anti-discrimination laws.<sup>9</sup>

Some of the areas that admittedly will need investment in the future are research in migrants' health for further understanding of their needs and the challenges which accompany the migration process thorough monitoring of migrants' health as a greater knowledge base for policymaking; shared responsibility of the central and local governments, civil society, etc. in promoting migrants' social inclusion and equal access to opportunities.

Finally, it must be emphasized that cooperation within and among countries is an essential aspect in addressing migrant health, not only with regard to irregular migration and its regulation, but also concerning good practice sharing and strengthening of international dialogue.



**Maria do Céu Machado**  
High Commissioner for Health  
Government of Portugal

<sup>8</sup> IOM online. Available at [www.iom.int](http://www.iom.int).

<sup>9</sup> Migrant Integration Policy Index (MIPEX). Available at [www.mipex.eu](http://www.mipex.eu).



**Dr. José Martínez Olmos,**  
Secretary-General of  
Health, Ministry of Health,  
Social Policy and Equality,  
Government of Spain

## Investing in universal access to health

Health is a right and equity is a matter of social justice. In an increasingly globalized world, many persons leave their countries in search of new opportunities, a fact that unequivocally supports economic growth and cultural enrichment. No need to look far; everyone of us knows someone (children, friends or relatives) in our immediate circle who now lives in another country and, in fact, any one of us may initiate a migratory movement at any time. Unfortunately, on other occasions, migration is not a choice: wars and environmental disasters (earthquakes, hurricanes and tsunamis) force many persons to leave their countries and change their lives.

Whatever the motivation to initiate a migration process is, health should not cease to be a right for all persons.

The main features of our National Health System are universal coverage and public financing. It ensures health care coverage for the migrant population in the same conditions as those for Spanish citizens. In this regard, Article 12 of the Spanish Organic Law 4/2000 on the Rights and Freedoms of Foreigners in Spain and their Social Integration states that whatever their legal situation might be, immigrant pregnant women, children and persons, in the event of serious illness, accident or any emergency situation, are also entitled to care.

In this sense, during the Spanish Presidency of the European Union in the first half of 2010, “Innovation in Public Health: Monitoring Social Determinants of Health and Reducing Health Inequalities” was one of the priorities of the Ministry of Health, Social Policy and Equality.

The document *Moving Forward Equity in Health: Monitoring Social Determinants of Health and Reducing Health Inequalities* was produced as a technical support for this priority. Some areas addressed in greater depth

Whatever the motivation to initiate a migration process is, health should not cease to be a right for all persons.

are social exclusion and structural health inequalities. There is a specific section on migrants and ethnic minorities, which had the valuable collaboration of the International Organization for Migration (IOM); therefore we would like to publicly express our gratitude for their efforts and their continued commitment to migrant populations.

During the Spanish Presidency of the EU, we also strived to ensure health care for all children and women during pregnancy. The Conclusions of “Equity and Health in All Policies: Solidarity in Health”, adopted at the EPSCO Council of Ministers on 8 June 2010, urges Member States thereto in articles 47 and 48.

We should advocate that all countries invest in facilitating universal access to health systems (health promotion, disease prevention and care services), adapting them to the needs of the population. Thus, they will provide equal treatment and will not generate health inequalities. Professionals should also be trained to be sensitive to differences and to jointly reflect on the importance of addressing more structural determinants of population health and recognize the limitations of the health system.

In these times of crisis, policies that guarantee basic rights such as health should be further strengthened, and other governance sectors concerned should be involved, always taking into account equity as a cross-cutting issue. Investment in health is cost-effective, and, in times of crisis, its maintenance should remain a priority and, we reiterate, a right and a matter of social justice.

**Dr. José Martínez Olmos**  
Secretary-General of Health  
Ministry of Health, Social Policy and Equality  
Government of Spain





**Enrique V. Iglesias**  
Secretary General,  
Ibero-American

## Health and the Social Protection of Migrants in Ibero-America

In the Montevideo Summit 2006, the heads of state and government in the Ibero-American region thoroughly discussed the central subject of the meeting: migration and development. After the debate, they reached a consensus and adopted the Montevideo Commitment on Migration and Development; a document which established a plan to address this topic in Ibero-America.

Although the Commitment respects the sovereign power of the countries to authorize the entry, stay and residence of foreign people into their territory, it also focuses on migrants and lays down the framework for the protection and promotion of their human rights with the ultimate goal of formulating and designing public policies on this matter.

Health, as an integral and multidimensional concept, and understood not only as the absence of disease or infirmity but also as the complete state of physical, mental and social well-being, is a fundamental human right, irrespective of a person's ethnicity, sex, religion and origin. It is a basic condition for the fulfilment of other social goods and a determining factor for social cohesion, since there is evidence proving that inequality in terms of health leads to inequality in terms of income.

In most Ibero-American countries, the right to health is included in their political constitutions. However, save for a few exceptions, health systems in the region are characterized by a high degree of segmentation and fragmentation as well as a significant access deficit, which especially affects the underprivileged and vulnerable groups such as migrant populations.

In the Ibero-American region, the right to health protection is usually associated with diverse – often overlapping – criteria such as citizenship, work relation, population groups, territory and user condition. As a consequence, people who are working in the informal sectors of the economy, for example as independent, domestic, temporary/seasonal and irregular workers, are excluded from accessing health care.

Even when countries guarantee the provision of health care for all people within their territory, regardless of their socio-economic status, most provide only emergency care to irregular migrants, which limits the preventive effectiveness of care and increases the overall costs attributable to illness. Furthermore, it is not unusual for migrants to choose to not receive sanitary services, in spite of having access, out of fear of being denounced to authorities and/or deported. As a result of the vulnerability associated with being a migrant, this population suffers higher health risks than the local population.

Migrating women, compared to migrating men, are increasingly suffering from a particularly vulnerable situation. In transit, cases of sexual abuse and violence are widespread and the possibility of falling into the hands of the mafia and human trade organizations is a harsh reality. In their country of destination, migrant women usually assume occupations within the informal sector that may exclude them from health coverage, even if they are suffering from psychosomatic illnesses resulting from stress, loneliness and structural violence.


It seems that we are facing a vicious circle, which contributes to high costs for people and governments. Therefore, it is important to maintain efforts aimed at raising awareness about migrants' unprotected health situation and posing the question for consideration among Ibero-American countries.

**As a result of the vulnerability associated with being a migrant, this population suffers higher health risks than the local population.**

Encouraged by the World Health Assembly Resolution 2008, which promotes the adoption of public health policies that are sensitive towards the situation of migrants, Ibero-America has taken a few steps along that path, and during the Twentieth Summit of Mar del Plata in Argentina, 2010, the heads of state and government formally incorporated the matter of migration and health into the Ibero-American agenda on migration and development. Also, the Ibero-American Forum on Migration and Development in El Salvador in 2010 and the subsequent Seminar on Social Protection in Latin American Migrant Health and Reproductive Health, organized the same year in Madrid, proposed, among other things, health of migrants to be included in universal social protection schemes.

Ibero-America relies on an unprecedented instrument in favour of the social protection of migrants and the promotion of their human rights. The Ibero-American Agreement of Social Security grants financial security to migrants throughout their various countries of residence, such as portable pension benefits and, when needed, disability and survivor pensions. This agreement promotes the possibility for two or more countries, through mutual agreement, to broaden their objective scopes of application and offer additional services. This may be an important milestone on the road towards strengthening the social protection of migrants in the region. However, this should be approached in a modulated and progressive manner according to the capacity of health systems in each country and to the will and decision of the latter.

Thus conceived, the Ibero-American Agreement of Social Security will be an essential guideline in the construction of a space of social dialogue and interaction, a practical achievement that will benefit the inhabitants of all of our 22 countries. It is achievements like this one which, added together, solidifies the concept of an Ibero-American community.

  
**Enrique V. Iglesias**  
 Secretary General  
 Ibero-American



**Beatriz Londoño Soto**  
 Vice Minister of Health  
 and Welfare, Ministry of  
 Social Protection  
 Republic of Colombia

## The importance of providing psycho-social support to internally displaced individuals and victims of war

Two migratory phenomena currently affect the population of Colombia: internal displacement due to armed conflicts, and internal displacement due to the winter weather emergencies, which also result in the aggravation of the conditions of already displaced individuals. As of March 2011, 3,700,381 persons were registered as internally displaced in the country (Sistema de Información para la Población Desplazada, 2011), while 3,590,630 individuals have been affected by the winter weather emergencies (Dirección de Gestión de Riesgo de Colombia, 2011).

The consequences of these two phenomena are diverse. The psychosocial impact is profound for all and has affected several generations, but different populations have been differently affected. In accordance with our constitutional mandate, and following the relevant requirements of both the Comisión Interamericana de Derechos Humanos and of the Honourable Corte Constitucional de Colombia, the Ministerio de la Protección Social has placed the mitigation of the suffering of the affected individuals; the restoration of fundamental rights, and hence, of dignity and integrity; and the integral reparation of the damage at the core of its response strategy.

Law 387, passed in 1997, grants juridical status to those individuals who are displaced due to violence, and it gave rise to the establishment of the National System for Integrated Attention to the Displaced Populations (*Sistema Nacional para la Atención Integral de la Población Desplazada*), which includes the Ministerio de la Protección Social. Within this framework, this Ministry created in 2004 the Guidelines for Psychosocial

The psychosocial impact is profound for all and has affected several generations, but different populations have been differently affected.

Interventions among Victims of Violence and Forced Displacement (*Lineamientos de intervención psicosocial con víctimas de la violencia y el desplazamiento forzado 2004–2014*). The guide is used by the government to determine an appropriate state response for each displacement context and in different types of violations of fundamental rights, promoting an interdisciplinary, inter-institutional and intersectorial approach. The same year, the Honourable Corte Constitucional de Colombia divulged the sentence T-025/04, which determined displaced populations to be in a situation of unconstitutionality (*estado de cosas inconstitucional*). Later on, thanks to the relevant implementation acts, it stressed the importance of looking at the different impacts of the conflict on diverse populations and ordered the creation of a psychosocial support programme, validating the strategy proposed by the Ministerio de la Protección Social. This strategy has been implemented from 2006, focusing on the reconstruction of social identities, social management and local initiatives for social inclusion.

In 2010, the Honourable Corte Constitucional de Colombia, with the sentence T-045, ordered the Ministerio de la Protección Social to “design and implement those health protocols, programmes and policies that are necessary to respond to the specific necessities of the armed conflict’s victims...especially in relation to their psychosocial recovery” (Honourable Corte Constitucional de Colombia, 2004). As a consequence, a protocol for psychosocial response and a guide for community mental health interventions for armed conflict victims were developed and are being implemented in 2011. Currently, the programme is being piloted in 17 particularly affected municipalities.

The winter weather emergencies, on top of the material losses, alter family systems, break the social texture and exacerbate human vulnerability, since the affected individuals are often previous victims of forced displacement. In addition to reconstruction efforts, there is also a need to enhance national prevention and

preparedness planning so that the focus on immediate responses does not overlook more durable solutions and preparedness needs.

Colombia is firmly tackling the situation of displaced populations through the consolidation of a national policy framework for a differential and integrated response with a psychosocial focus, which is being led by the Ministerio de la Protección Social. The major task ahead for the country is to determine which institutional rules will be operationalized under the Victims Act (*Ley de Víctimas*), which is the result of a national agreement between different social and political actors. This issue currently has the attention of Congress and is expected to be promulgated within the near future.

**Beatriz Londoño Soto**

Vice Minister of Health and Welfare  
Ministry of Social Protection  
Republic of Colombia

# Migration, Health and Development in Sri Lanka – A Case Study




## Advancing the WHA Resolution on the Health of Migrants via an inter-ministerial process driven by the Ministry of Health



Sri Lanka is going through a major post-war developmental transition. Migration is already a significant feature of the Sri Lankan society and economy in terms of the numbers involved and contribution to our gross domestic product and foreign exchange earnings, especially by our migrant workers. All types of migration are increasing with rapid development and with urbanization. Migration is important in relation to Sri Lanka's vision of becoming a vital hub in the global and regional economy articulated in the catchy and emotive idea of Sri Lanka turning into the "Wonder of Asia". Despite the many positive effects of migration on our society and economy, we must ensure balance of the negative impacts of migration with the benefits. This will depend on protecting the health and well-being of migrant populations, their families and the host populations.

The tireless efforts of my ministry in collaboration with other government ministries, and with support from the International Organization for Migration, has resulted in Sri Lanka developing a national migration health policy and designing programmes to benefit all migrant populations in the country.

  
**Maithripala Sirisena**  
Minister of Health  
Sri Lanka



The Government of Sri Lanka has been working in close partnership with the International Organization for Migration (IOM) since 2009 to ensure better health outcomes for the three flows of migrant populations (inbound, outbound and internal) and the families left behind.



Led by the Ministry of Health, a Migration Health Development programme was launched in 2009 involving 12 key government ministries. The inter-ministerial coordination mechanism has achieved remarkable progress within a short duration. The Migration Health Task Force (MHT), with technical focal points from each key agency, meets regularly to discuss programme implementation, and high-level policy decisions are taken by the National Steering Committee on Migration Health (NSC) chaired by the Secretary of Health. Supported by IOM, a secretariat within the Ministry of Health (MOH) acts as the permanent coordinating hub. Through this coordination framework, Sri Lanka has proactively responded to its emerging migration health-related challenges, such as health services provision for returning refugees and the health assessments of resident visa applicants to the country.

Health is a fundamental human right and one that is critical for human development, and central to the Millennium Development Goals. A new aspect of the ongoing debate on migration is the exclusion of many migrants from essential social services in receiving countries, particularly health services. Concern in connection with access to health services for migrants on the part of many receiving states formed the basis of the Resolution on the Health of Migrants.

This resolution was endorsed by the Sixty-first World Health Assembly in May 2008, which was chaired by Sri Lanka. Following the adoption of this resolution, Sri Lanka is spearheading a multi-stakeholder and evidence-based process towards developing a national policy on migration health, with assistance from IOM. We hope that this model could be emulated by other countries in addressing this important issue.



**Dr. Palitha Kohona**

*Permanent Representative of Sri Lanka to the United Nations (Sixty-fifth Session, UN General Assembly)*



As the former chairman of the Executive Board of the World Health Organization and the former president of the World Health Assembly, I recollect with pleasure my efforts to adopt and catalyze into action the World Health Assembly Resolution on the Health of Migrants. I am proud that Sri Lanka has taken the lead in this endeavour and the Ministry of Health is now working within an inter-ministerial process to facilitate not only intersectoral dialogue, but also the development of a migration health policy and action for the betterment of migrants' health. I acknowledge the tireless efforts of the Ministry of Health and the International Organization for Migration in pursuing the migration health agenda forward, providing technical guidance and facilitating the process. One salient point is to recognize the importance of dialogue with all stakeholders nationally, regionally and globally. Health of migrants can be achieved only by formulating a pragmatic policy framework within the country, addressing regional and global commitment.



**Nimal Siripala De Silva**  
Minister of  
Irrigation & Water  
Resource Management  
former Minister of Health



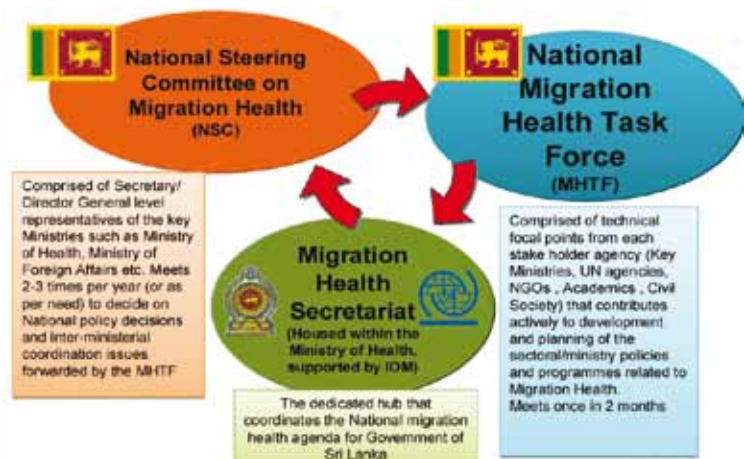
It is important to note that Sri Lanka's migration health development agenda is not only limited to policy development. The process is a dynamic one, and has already resulted in practical intersectoral action to address current national issues. Programmes developed since the inception of the process include: a health assessment programme for returning refugees, new inclusions for yellow fever reporting at point of embarkation and the need for a visa health assessment as per the request of the Department of Immigration and Emigration.



**Dr. Susie Perera**  
Director, Policy Analysis and  
Development, Ministry of Health  
Focal Point, Migration Health Development Programme



## Inter-ministerial and inter-agency coordination framework for migration health development in Sri Lanka



With funding from IOM's 1035 Facility to catalyze this important technical cooperation strategy, IOM supports the Ministry of Health's Migration Health Strategy through the following broad areas of work:

1. Enhancing the technical capacity of MOH to integrate migration health in the national, regional and global agendas;
2. Developing a national migration health policy for Sri Lanka with an evidenced-based research agenda;
3. Managing various migration health challenges that are emergent from the migration, health and development process in-country (e.g. responding to returning refugees from India);
4. Developing and enhancing technical cooperation on health assessment and health promotion for mobile at-risk populations and migrants.

The key features of the **migration, health and development programming** in Sri Lanka are: i) an inclusive and participatory "whole of government" approach that covers all three migrant typologies (inbound, outbound, internal) and families left behind; ii) the involvement of a range of government stakeholders in a participatory process via a dedicated hub within the Ministry of Health for coordination and knowledge transfer; and iii) the adoption of a national migration health research agenda to generate empirical evidence for policy and programme development. IOM and the Government of Sri Lanka have also embraced a pragmatic approach to migration health programming that is responsive to emerging needs in the country (e.g. visa health process), while at the same time engaging in regional and global partnerships for effective intergovernmental collaboration (e.g. Colombo Process, Global Forum on Migration and Development).





**Hon. Beth Mugo,**  
**Minister for Public**  
**Health and Sanitation,**  
**Government of Kenya**

## Migration of health workers from Kenya

Kenya's economy has grown steadily in the past decades and so has the government's absolute budgetary allocation to the health sector, though it still falls short of the Abuja declaration target of 15 per cent allocation of the annual budget to health. Human resource capacity development has been carried out mainly through the Ministries of Education and Higher Education, Science and Technology. There has also been substantial contribution by the country's development partners, whose presence has accelerated the development of human resource capacity in many sectors of the economy.

Over the years, the health sector has also emphasized the professional development of health workers. This is done through mentorship, refresher training, in-service courses and further studies. The ministry, through the Public Service Commission, has continued to review and improve the terms and conditions of service for health workers, with a view to attracting and retaining requisite human resource within the Public Service. A substantial amount of research exploring the push and pull factors for health workers' migration from Kenya has been conducted in recent years. IOM has contributed significantly to this process. Various reports and recommendations have been made and the government has implemented some of them while working out modalities for comprehensive action on others.

One big dilemma for the government is that, though a large number of health workers are trained, it is difficult to get health workers to work in hard-to-reach areas. We therefore have a situation where there are many qualified health workers but a deficiency of staff in hard-to-reach areas. Moreover, about 50 per cent of Kenya's qualified health workers have migrated in search of employment and better working conditions in other countries.

One big dilemma for the government is that, though a large number of health workers are trained, it is difficult to get health workers to work in hard-to-reach areas.

The Joint Commission of Cooperation (JCC) Kenya, along with other governments, has managed to bring together the health sector and other government sectors such as labour to address the dynamics of demand and supply in the human resource for health. Among the interventions that the JCC is working on include bilateral country agreements that will enable Kenya to export health workers through the Ministry of Labour on a contract basis. This system has been and continues to be beneficial to Member States in that:

- Kenya and the receiving states share and strengthen good diplomatic ties;
- It is an attractive big employment opportunity for Kenyan health workers;
- Kenya can recall its health workers back home whenever the government can absorb them into the health system;
- Kenya, through the receiving state, ensures that the working conditions of Kenyan health workers are decent;
- The receiving states will formally access qualified skilled Kenyan health workers when required; and
- Kenya and the receiving state's health workers will have an opportunity to share best practices on various health issues.

So far there are a number of such bilateral agreements between Kenya and other African states already in existence. There is great need for better cooperation between Kenya and the more developed economies of the West since most of Kenya's health workers individually migrate to these countries. These countries should support Kenya in the training of these health workers to ensure that the curriculum matches international standards, so that when already licensed Kenyan health workers migrate to their countries, they are not subjected to further examinations.

I recognize and appreciate the support and contribution that IOM has continued to make towards the health of migrants in this country.

**Hon. Beth Mugo, EGH, MO**  
**Minister for Public Health and Sanitation**  
**Government of Kenya**



**Dr. David Nabarro,**  
Senior UN System  
Coordinator for Avian and  
Human Influenza and  
UN Special Representative  
on Food Security and  
Nutrition

## Pandemic preparedness for migrants and mobile populations

Over the past decades, migration has become increasingly intricate. Elements such as natural and man-made disasters, civil unrest, climate change, and food insecurity have served as “push factors” for migration at various times. These population movements have long been associated with the spread of communicable diseases.

Mechanisms like the International Health Regulations and intergovernmental and multisectoral cross-border collaborations have been important for the prevention and control of disease spread, particularly when linked to the movement of people. Furthermore, critically important has been the willingness and capacity of governments to respond to the humanitarian, health and social needs of migrants.

The UN System and Partners Consolidated Action Plan for Animal and Human Influenza, originally developed in 2007, recognizes the need to strengthen the capacity for pandemic preparedness in refugee and migrant communities. Work outlined in the UNCAPIH<sup>10</sup> was undertaken through collaborations with humanitarian health and non-health stakeholders in both the public and private sectors. The Action Plan focuses on five priorities:

- Healthy livestock production systems and animal health services capable of responding to highly pathogenic avian influenza;
- Functioning human public health systems (that can detect, respond to and contain serious infections, including avian and pandemic influenza);
- Social mobilization activities that include communication for behaviour change;

The inclusion of migrants’ needs in all preparedness plans – especially those for disease pandemics – is key to limiting potential economic and human losses and increasing the efficiency and effectiveness of such a response.

- Crisis preparedness efforts that include contingency planning for influenza pandemics;
- Institutional arrangements for co-coordinated financial and technical support for effective national implementation of integrated influenza programmes.

Migration-related issues were, and continue to be, recognized as cross-cutting factors in all the five priority areas.

Over the last four years, Member States, the International Organization for Migration (IOM) and other partners have worked within the framework of the UN System Influenza Coordination to develop and implement migrant-friendly communication strategies, contingency plans and operational continuity for public health emergencies. Partners have advocated for the inclusion of migrants’ needs in national pandemic contingency plans, and for migrants to have access to health and social services irrespective of their immigration status – particularly during a public health crisis such as a pandemic.

With the emergence of the novel Influenza A Virus H1N1 in 2009, many national authorities worked with these partners to scale up implementation of national plans to cope during the influenza pandemic. Many lessons have been learned as a result of this work, particularly with reference to migrants. For example, governments that had not included a migration component in their national preparedness plans were challenged when coping with mobile population needs during the pandemic.

As the risk of an influenza pandemic continues, so should our efforts to ensure we are fully prepared. The inclusion of migrants’ needs in all preparedness plans – especially those for disease pandemics – is key to limiting potential economic and human losses and increasing the efficiency and effectiveness of such a response.

**Dr. David Nabarro**

Senior UN System Coordinator for Avian and Human Influenza and UN Special Representative on Food Security and Nutrition

<sup>10</sup> The UN Consolidated Action Plan on Avian and Human Influenza.



**Ann Pawliczko,**  
**Emerging Population Issues**  
**Advisor, United Nations**  
**Population Fund**

## Addressing the challenges of migration and health<sup>11</sup>

There are concerns among policymakers and health authorities about the infectious diseases that migrants might bring into a country. However, we should have the same concerns about the health conditions of migrants. Population movements often make migrants more vulnerable to health risks. Access to appropriate and affordable health care services can be a particular challenge for many migrants, including the young, the elderly and women who are more vulnerable to abuse, violence, exploitation and discrimination. Of particular concern are the many young women who fall prey to traffickers and are afraid to seek medical treatment, including reproductive health care.

### Addressing the sexual and reproductive health needs of migrants

The sexual and reproductive health needs of migrants are usually not adequately addressed. UNFPA experience has shown that key components of an all-inclusive response to addressing these needs include: comprehensive information and services, including contraception; assisted deliveries; pre- and post-natal care; STI/HIV prevention; prevention of mother-to-child transmission and anti-retroviral therapy; and services to address violence against women. Services should be client-friendly, age- and gender-appropriate, and take into account cultural and linguistic differences.

Among the main challenges to comprehensively address the sexual and reproductive health needs of migrants are: 1) an irregular status and no access to health insurance; limited access to public services, services that are usually obtained privately, including from traditional

practitioners, with concomitant risks; 2) negative service provider attitudes; stigma and discrimination towards migrants in general, and HIV-positive, AIDS victims and sex workers in particular, 3) services for migrants which tend to focus on prevention and treatment for sexually transmitted infections (STIs) and HIV only.

Many developing countries do not have the capacity and resources to provide the necessary services to meet the health needs of migrants. This is especially true when they are faced with sudden large forced migration flows which put additional burdens on local services.

UNFPA is working to address the many challenges of meeting the health needs of migrants. Among the good practices identified by UNFPA to address the sexual and reproductive health needs of migrants are:

- Provision of free services for documented and undocumented migrants;
- Culturally sensitive service provision, including information, education and communication (IEC) and services provided in migrant languages; services available at migrant-friendly times; mobile services for those working remotely;
- Integration of sexual and reproductive health information and services into workplaces, particularly factories;
- Support to migrant networks to promote sexual and reproductive health information through peer approaches.

### UNFPA activities at the country level

A good example of activities in this area comes from Latin America and the Caribbean, where UNFPA and its partners developed a strategic axis for the promotion of the human rights of young people and migrant women and for strengthening programmes for sexual and reproductive health care, including HIV/AIDS, and gender violence in five national borders. This initiative is being implemented in 10 countries: Guatemala–Mexico, Colombia–Ecuador, Argentina–Bolivia, Costa Rica–Nicaragua and Haiti–Dominican Republic. Binational studies involving five national borders were published and a regional study was developed, comparing state-of-the-art analysis, sociodemographic data, legal and regulatory framework as well as main actions by organizations and health services working with migrants at the borders. The project included a study with scientific evidence and solid arguments on the cost for receiving countries of not providing for the sexual and reproductive health needs of migrants. An assessment of the situation regarding the right to reproductive health for migrants is being conducted in three border areas, as well as the systematization of the international, regional and national frameworks in this area. Work has begun in the Mexico–Guatemala border, laying the

<sup>11</sup> This article was prepared by Ann Pawliczko. Special thanks to Jose Miguel Guzman, Jennifer Butler, Sonia Martinelli Heckadon, Sabrina Juran and colleagues from UNFPA Country Offices who provided information.

UNFPA experience has shown that key components of an all-inclusive response to addressing these needs include: comprehensive information and services, including contraception; assisted deliveries; pre- and post-natal care; STI/HIV prevention; prevention of mother-to-child transmission and anti-retroviral therapy; and services to address violence against women.

groundwork for the implementation of databases with alternative sources on health of migrants, integrating data available in the health sector as well as generating innovative information from rapid surveys at the border. A reproductive health and gender-based violence prevention care model was designed, tested and evaluated for the Mexico–Guatemala border, generating information and experience that will be replicated in other national borders, taking into account the specific conditions of migrant populations and services available in each situation.

In other regions, a number of UNFPA Country Offices are also undertaking or supporting activities to promote migrant health. For example, in Kosovo, migration data from the UNFPA-supported Demographic Health Survey

and the Socio-Economic and Health Status of Migrants facilitated awareness-raising and policy dialogue to improve the health of migrants. In Papua New Guinea, UNFPA supported the preparation of a radio drama by the Population Media Centre that focuses on the different MDGs and relevant population issues, in particular the effects of international migration, urbanization, and health issues such as HIV and reproductive health.

There is an urgent need to promote migrant-sensitive health policies and equitable access to health information, disease prevention and care for migrants. National health systems must reach out to migrants and address their special vulnerabilities and health care needs, taking cultural, linguistic, age and gender needs into account. Health service providers who work with migrants must be sensitized and properly trained to understand and address their needs. The World Health Assembly Resolution on the Health of Migrants pointed out that “Member States have a need to formulate and implement strategies for improving the health of migrants” (WHA61.17).

**Ann Pawliczko**  
Emerging Population Issues Advisor  
United Nations Population Fund



This sign at a border area between Mexico and Guatemala provides information on HIV/AIDS prevention to migrants. (Photo: UNFPA)



UNFPA counselling on reproductive health issues for women at the border of Haiti and the Dominican Republic. (Photo: UNFPA)





**Brahm Press,**  
Board of Director and  
Convener of the Task Force  
on Migration, Health and  
HIV, CARAM Asia



**Mohammad Harun  
Al Rashid, Regional  
Coordinator, CARAM Asia**

## Asian migrant workers' health rights – not excess baggage

There are 61 million Asian migrant workers abroad – half are women and many have gone to the Middle East. They build high-rises, harvest rubber, process food, make cheap goods and clean houses from Singapore to Dubai. Their families go into debt to send them abroad in hopes that the remittances will improve their lives. Yet, while migrant workers are an essential component of the economies of both origin and destination countries, they are only wanted for their labour.

Coming from conditions of poverty, receiving countries see migrants as a health threat and have imposed restrictions accordingly. Migrants are required to undergo mandatory health testing as a condition for receiving a work permit and entry visa. Once they are in the destination country, they must undergo this testing again and when they renew their documents. Used solely as a screening tool, this testing violates basic health rights. There is no information provided on the conditions tested; migrants are not informed of the results, only whether they are “fit” or “unfit”; and even though HIV is tested, there is no confidentiality, no counselling and no referral for treatment.

Although migrants arrive “fit”, they may not be prepared for the health threats they face in the destination country. They commonly work in “dirty, dangerous and difficult” jobs, are forced to live in cramped, unsanitary quarters, and made to work in excess of standard hours without proper rest. The lack of HIV prevention information and reproductive health services leaves migrants, away from home and lonely, vulnerable to risks related to sexual behaviours. When a migrant undergoes health testing and is found to be with an “exclusionary” condition, which includes tuberculosis, HIV, STIs and pregnancy,

**Migrants need appropriate and accessible health services that include sexual and reproductive health.**

they may be summarily deported even though they were evidently infected in that country.

The fact that migrants are deported for a health condition is appalling. The way they are deported is shocking. Commonly a migrant will be confined and then expelled from the country without even being informed of the reason. They are then returned home humiliated and hopeless, and those infected with HIV may unwittingly infect their spouse. Others may avoid home altogether out of fear of bringing shame upon the family. Rather than invest in providing migrants with appropriate health services, destination countries rely on testing and deportation. They reject the migrant’s contribution to the economy and push the disease burden back onto the poorer country.

Through its regional research and work with migrants, CARAM Asia has been advocating for migrants’ health rights for over 12 years. Still, there are many obstacles remaining that undermine Asian migrant workers’ health. Namely, migrants need appropriate and accessible health services that include sexual and reproductive health; policies on mandatory health testing and related deportation need to be lifted; and labour standards and basic rights need to be upheld for all migrant workers. There have also been advances in promoting migrants’ health that need to be pursued. Non-governmental organizations (NGOs) in origin countries have started providing health and HIV prevention information in pre-departure training; HIV prevention programming for migrants is being implemented in some destination countries, and the issue of mandatory HIV testing has been raised among governments at the regional level through multi-stakeholder dialogues. To make meaningful improvements in migrants’ health and rights, it will take ongoing advocacy supported by evidenced-based research and the direct participation of migrant workers and their communities.

**Brahm Press**

Board of Director and Convener of the Task Force on Migration, Health and HIV  
CARAM Asia

**Mohammad Harun Al Rashid**

Regional Coordinator, CARAM Asia





**Dr. Sophia Kisting,**  
**Director, ILO**  
**Programme on HIV/AIDS**  
**and the World of Work**

## **The protection of human rights in the context of migration, mobility, and HIV and AIDS**

At the outset, we would like to salute the International Organization for Migration (IOM) for its commitment and dedication to facilitate HIV prevention, treatment, care and support services to migrant and mobile populations. We greatly value our collaboration and look forward to many more years of an effective partnership beyond the significant sixtieth-year celebration of the IOM.

HIV and AIDS have been with us for 30 years now. It is a time to celebrate our collective achievements but it is also a time to reflect, to remember and to honour the millions who cannot be with us. It provides us with the opportunity to rededicate our efforts for the greater protection of human rights and it challenges us to build stronger partnerships to help address the major problems faced by migrant and mobile populations and those affected by conflict. We have seen some successes for the 215 million international and between 600 and 700 million internal migrants, but access to health services and the extension of social protection remain formidable challenges. At least 22 countries still deport people living with HIV (PLHIV) and 47 countries, territories, and areas impose some form of restriction on the entry, stay and residence of PLHIV.

As an integral part of its normative functions, the ILO has developed international instruments on labour migration for decades. Recommendation 200, the first International Labour Standard on HIV and AIDS and the world of work, was adopted by governments, employers and workers in June 2010. It specifically calls for HIV testing and disclosure of HIV-related information not to be required for purposes of migration by countries of origin, of transit or of destination. Recommendation 200 has been included in the UN Declaration of Commitment at the UN High-Level Meeting in New York in June 2011.

**Build stronger partnerships  
to help address the major  
problems faced by migrant and  
mobile populations and those  
affected by conflict.**

This is an important milestone and the commitment by UN Member States for the implementation of the Declaration will contribute towards the greater protection of human rights for migrant and mobile populations.

The programmes of ILO/AIDS engage with international as well as internal labour migrant and mobile workers. We collaborate with IOM and UNAIDS, and engage with a wide range of stakeholders, including Ministries of Labour and Foreign Affairs, National AIDS Commissions, recruitment agencies, employers, trade unions and networks of people living with HIV for the extension of effective HIV prevention, treatment, care and support services.

For international migrants, our focus is on including HIV and AIDS in policy dialogue between key stakeholders as well as between sending and receiving countries. In Indonesia, our efforts contributed to the commitment of national authorities to increase the quality of services at all stages of the migration process. Considering the critical need to address the gender dimension, we helped to ensure the involvement of the Gender-Based Violence Commission and the Ministry of Women's Employment. Similarly in Sri Lanka, ILO/AIDS has developed a strong pre-departure HIV training programme, involving recruitment agencies and government officials. Community-based organizations actively look up returnee migrants and their families and offer them information and refer them to services where indicated.

Over 42,000 mobile transport workers, including long-distance truck drivers, have been reached at hotspots along key cross-border routes in the transport corridors between South Africa, Zimbabwe, Malawi and Mozambique. Information and training on HIV have been offered to cross-border institutions such as customs agencies and other regulatory bodies, as well as transport companies. In the all-important maritime sector, we are working closely with IOM and other partners to help address HIV-related challenges.

In China, the "Hometown Fellow" campaign reached approximately 40 million internal migrant workers with anti-stigma and anti-discrimination messages during

their journey between their homes and construction sites, demonstrating the effectiveness of public–private partnerships. In India, we have engaged with trade unions amongst the internal migrant workers. The ILO model of intervention through trade unions in the extensive construction sector is to be replicated in five economic sectors under the Global Fund grant that the Ministry of Labour and Employment has received in India under the Global Fund Round 9.

We look forward to further strengthening of the much valued collaboration with IOM and other partners to enable us to work with greater urgency towards reaching both the UNAIDS goal of zero new infections, zero discrimination and zero AIDS-related deaths and the Millennium Development Goals by 2015.

  
**Dr. Sophia Kisting**  
 Director

International Labour Organization's Programme on HIV/AIDS and the World of Work



**Dr. Mario Raviglione,**  
**Director, Stop TB**  
**Department, World Health**  
**Organization**

**Dr. Dennis Falzon,**  
**Medical Officer,**  
**Stop TB Department,**  
**World Health Organization**

## TB and migration in an increasingly globalized world

Driven by disasters, violence, and economic disparities, internal and international human migration has increased worldwide in recent years (UNDP, 2009; UN DESA, 2009). Many temporary migrant workers travel regularly within their country or abroad. Every year, more than 5 million people cross international borders to go and live in a developed country (UNDP, 2009).

The threat of immigration to tuberculosis (TB) control has concerned high-income countries for a long time (Rieder et al., 1994). TB is directly transmissible and can cause severe illness and death. Very little of the global TB burden occurs in high-income countries – where incidence is generally  $<10/10^5$  population – with the vast majority being concentrated in lower-income countries (WHO, 2010a). Over one half of TB patients in Australia (Australian Government Department of Health and Ageing, 2009), Canada (Public Health Agency of Canada, 2010), the United States (CDC, 2010) and many Western European countries (European Centre for Disease Prevention and Control et al., 2011) are foreign in origin, with most having migrated from high TB prevalence countries. Such migrants are at risk of developing TB after moving to lower prevalence settings, particularly in the first years post-arrival (Zuber et al., 1997; Lillebaek, 2002). Mass, short-term labour migration may be fuelling high TB rates even outside high-income settings, such as in southern Africa (Rees et al., 2010), where TB incidence reaches  $1,000/10^5$  (WHO, 2010a). Internal migration in China has been reported to increase TB prevalence in areas of resettlement (Jia et al., 2008).

**Given the global nature of TB and its lack of respect for country borders, the importance of information sharing and international coordination cannot be overemphasized.**

Foreign patients may face barriers to care in the host country as a result of inadequate knowledge of TB and health services, language limitations, fear of immigration authorities, unemployment and lack of money or health care coverage. Loss to follow-up is frequent in TB patients of foreign origin (Manissero et al., 2010). Irregular migrants may avoid public health services, resulting in missed or delayed treatment (Achkar et al., 2008). TB patients from certain geographical areas are more likely to be HIV-infected (Long, 2010), harbour drug-resistant TB strains (Falzon et al., 2006) or present unusual clinical features (Kherad et al., 2009) than indigenous patients, thus complicating diagnosis in host countries.

In 2008, the World Health Assembly approved a Resolution promoting migrant-sensitive health policies (WHO, 1991). Two years later, the World Health Organization (WHO), the International Organization for Migration (IOM) and the Government of Spain held a global consultation on migrant health, recommending four thematic areas for action (WHO et al., 2010b). These areas conform to the sound principles for the protection of vulnerable populations and the promotion of human rights espoused by WHO's Stop TB Strategy (Raviglione et al., 2006):

- i. Monitoring migrant health: information is necessary to monitor TB care and plan health services. Data about patient origin are needed to identify inequalities in access to care. Spatial information can profile "hotspots" of TB for targeted action (Jia et al., 2008).
- ii. Policy and legal framework: migrants need to appreciate the regulatory framework within which TB control operates. Policies on TB screening and contact tracing have to respect cultural differences.
- iii. Migrant-sensitive health systems: the health provider has to ensure that TB care is delivered in an ethical manner which facilitates access and does not discriminate against the sick person

(Tala, 1994; Heldal et al., 2008). Screening needs to be coupled with a treatment plan for patients detected with TB (Klinkenberg et al., 2009). The use of direct observation of treatment and enablers may help adherence (CDC, 1992).

- iv. Partnerships, networks and multi-country frameworks: permit a broader exchange of technical information (Veen et al., 2011). At times, they may even facilitate the follow-up of individual patients crossing borders. The need for stronger links between the states and industry in providing cross-border continuity of care has been recommended (Park et al., 2009).

Given the global nature of TB and its lack of respect for country borders, the importance of information sharing and international coordination cannot be overemphasized.



**Dr. Mario Raviglione**  
Director, Stop TB Department  
World Health Organization



**Dr. Dennis Falzon**  
Medical Officer, Stop TB Department  
World Health Organization



**Dr. Stanley Sonoiya,**  
**Principal Health Officer,**  
**East African Community**

## **EAC and IOM partnership in the East African Region**

An interview with Dr. Stanley Sonoiya, Principal Health Officer, East African Community (EAC), about EAC's ongoing partnership with IOM.

*What are some of the East African Community's regional health priorities?*

Our key priorities include strengthening capacities in cross-border disease surveillance, managing the migration of health workers, and HIV/AIDS prevention. We have already developed a strategy on disease surveillance, with a list of priority conditions that are covered under the East African Integrated Disease Surveillance Network. We aim to identify outbreaks and deal with them swiftly. Various viral haemorrhagic fevers such as yellow fever, polio and other vaccine-preventable diseases are of particular concern.

With the free movement of people under the newly established "East African Community Common Market Protocol", including the right to employment, regional policies are needed to fill human resource gaps in the health sector by making intraregional deployment of health workers a win-win situation for both sending and receiving States.

Transborder HIV programming needs to be scaled up, with a common package of comprehensive services that prioritize prevention. We need to reach key populations in fishing communities, in One-stop Border Posts, and along regional transport corridors.

*Why is transborder collaboration and partnership so important among the EAC Partner States?*

Aspects of health cannot be solved solely by individual countries. Populations are increasingly moving across borders, so standardized protocols on regional cooperation are needed for diagnosis, referral, health promotion and disease surveillance.

With the Customs Union and Common Market already achieved in the EAC region, the free and continuous movement of people across borders calls for strengthened cooperation among the Partner States on health-related issues.

*What is the biggest health challenge or risk among mobile populations and migrants in the East African Community?*

I would say HIV and tuberculosis (TB). Although epidemiological data is lacking, we believe that there may be higher HIV prevalence in "risk zones" along regional transport corridors stemming from transactional sex. The prevalence of HIV is particularly high among fishing communities and migrant plantation workers, partly as a result of the nature of their work, which demands that they are away from home for long periods of time, and hence the likelihood of engaging in unprotected sex with multiple concurrent partners, which may in turn contribute a significant number of new HIV infections.

With TB, mobile populations can have trouble accessing diagnosis and treatment services. TB treatment is often lengthy, and if incomplete, drug resistance can occur, which poses a real challenge to health systems.



Populations are increasingly moving across borders, so standardized protocols on regional cooperation are needed for diagnosis, referral, health promotion and disease surveillance.

*How are EAC and IOM working to improve the health of mobile populations and migrants in East Africa?*

EAC and IOM are currently implementing a memorandum of understanding that was jointly signed on 5 June 2006, and which covers various areas of mutual interest, including development of a regional migration policy, capacity-building of immigration officers and other issues. With health, IOM is assisting in two main ways. Firstly, as a technical agency, IOM is facilitating the gathering of data, assisting with regional coordination, providing ongoing specialized technical advice, and working to develop a regional strategy aimed at preventing HIV along transport corridors. Secondly, governments have specifically requested assistance from IOM, as an implementing partner, to scale up comprehensive HIV programming in border areas, including One-stop Border Posts, which fast-track the various clearance procedures of immigration, customs, and health at border sites.

*What has been the foremost success of EAC and IOM's joint regional collaboration?*

Two important meetings and field visits took place on 26–30 June 2011 and were considerable milestones cementing EAC's relationship with IOM. The first meeting took place between the Republic of Rwanda and the United Republic of Tanzania at the proposed Rusumo One-stop Border Post. The second meeting was between the United Republic of Tanzania and Burundi at Kabanga and Kobero border post. During both visits, EAC and IOM collaborated to bring together over 40 national government delegates from all five East African Community Partner States to jointly assess the health programming needs of the Kagera River

Basin trans-boundary region. Several local government and civil society representatives participated. The recommendations of Partner States in the official meeting report were clear on the need for strengthening health systems in these border areas and other major regional transport corridors linking the East African Community Partner States and neighbouring countries, including ports, harbours and island maritime routes.

*With regional integration, how do you see the relationship between mobility and health unfolding over the next 10 years in East Africa?*

We anticipate an inevitable increase in intraregional mobility. Cross-border movements will be made much easier through the internationalization of the East African Community passport, and the use of national identity cards for local cross-border travel. People will be free to establish businesses and homesteads in neighbouring countries and infrastructure will rapidly expand. All of this means an increase in the transborder movement of people along corridors and across borders, so we need to focus urgently on implementing the related health priorities as described above.

For more information on the East African Community, please visit: [www.eac.int](http://www.eac.int).



**Snezana Samardzic Markovic, Minister of the Ministry of Youth and Sport, Department for Youth, Republic of Serbia**

## Use of psychosocial approach in strengthening active participation of young people in Serbia

Young people in Serbia belong to a very sensitive group which needs specific support since they face various social barriers that prevent them from full involvement in social circles and hamper the full development of their potential. Not only does modern society make individuals adapt, fast and easily, to the changeable requirements of the world around them, it also enables them to know and to handle those changes. The young are expected to develop skills and abilities so that they can take an active part in all fields of social activity.

In Serbia, there has not been for a long time an institutional, strategic and legal framework for engaging the national policy for young people. The situation substantially changed on 15 May 2007 with the passage of the Law of the Ministries, which resulted in the establishment of the Ministry of Youth and Sport. The care of young people became one of the priorities of the national policy. Something that must not be neglected is that this institutional fact itself was changed due to the zeal of young people, who wanted their own ministry, support for their ideas, and acknowledgement of their role in society.

Through numerous research, consultations, 167 round tables, 7 regional conferences and 3 central conferences, 16,000 young people, 47 NGOs, 18 ministries and innumerable experts took an active part in the establishment of the National Strategy for Young People and the Action Plan for its implementation. And then, within a year, on 9 May 2008, the Government of Serbia adopted the National Youth Strategy.

Subsequently, the Fund for Young Talents was established in 2008 and, to date, more than 5,300 young students have been supported. Within the Fund, the Center for Career Guidance and Counseling has been established as well, and more than 1,000 young talents have been involved in the Center's services.

When making the Law of the Young, the Ministry of Youth and Sport chose the longer path – consulting those to whom the law would apply, nourishing young people's trust in institutions and setting up two-way communication between young people and local authorities.

The problem of activism, i.e. qualitative leisure time, is something that young people defined as one of the priorities during the work on the National Strategy for Young People. Led by the desire to contribute to putting all the possibilities offered to the young together, increase access to information, and stimulate people from different backgrounds to use given opportunities, the Ministry of Youth and Sport continually supports and finances projects aimed at: social inclusion; psychosocial strengthening of the young; equal prospects for all young people; health care and the promotion of healthy lifestyles; and the involvement of the young and raising their capacity, i.e. encouraging them to be proactive in all spheres of social life. The Ministry strongly supports the creation of youth companies; it keeps record of the reporting in the media; and it organizes activities where young people are active participants and promoters of human rights awareness, millennium objectives, the environment, healthy lifestyles, peer education and informal education.

Proactive young people represent the first priority of the National Strategy for Young People. This is why the Ministry of Youth and Sport initiated the

The psychosocial approach in working with young people was the method that contributed to the increased motivation and creativity of the young and thus their engagement in the local community.

establishment of local youth offices (the exact number is 120), thus making young people a strategic priority in the development of most regions in Serbia. These offices are places where young people can go and say what bothers them; where they will be listened to and given the opportunity to institutionally change their surroundings. This is the right place where they can get informed about the ways of having active and qualitative free time, sports, nourishing healthy and safe lifestyles, youth exchanges, sustainable development and all other fields in compliance with the National Strategy for Young People.

The project “Strengthening Serbia’s Human Capital through the Active Involvement of Young People (SHAPE)”, carried out by IOM in cooperation with the Ministry of Youth and Sport and 10 municipalities in Serbia, has had significant success in the process of engaging the young to join and contribute to the work of youth offices in 10 target municipalities. This project made a visible step forward in engaging young people in carrying out local youth policies, in promoting local development as a means to prevent brain drain – this especially refers to the promotion of involvement in cultural and social life, better information about existing programmes, cultural integration, joint voluntary actions at the local level, as well as connecting young people from different towns and youth offices from the target municipalities. The psychosocial approach in working with young people was the method that contributed to the increased motivation and creativity of the young and thus their engagement in the local community. In less than two years, more than 3,200 young people from 10 target municipalities have been strengthened through workshops especially organized according to the expressed needs and priorities of the young.

The Ministry of Youth and Sport, within the celebration of the European Year of Volunteering and International Year of the Young, carries on with its support for the active involvement of young people by financing youth voluntary actions aimed at the improvement of life in local communities.

In January, the Ministry of Youth and Sport marked the start of the European Year of Volunteering by awarding prizes for the best voluntary actions held in 2010 within the campaign “Youth rules!”. This year the ministry will support 139 juvenile voluntary actions with an aggregate sum of around 13 million Serbian dinar.

Young people are the largest resource of this society. The young are creative; they get things going; they find nothing difficult. Young people learn and continually improve their knowledge and skills; they are eager to learn something new and different. Young people must be given a hand in the process of changing their environment, because when they change something, they change it for the better.

  
**Snezana Samardzic Markovic**

Minister, Ministry of Youth and Sport  
Department for Youth  
Republic of Serbia



**Dr. Jose Angel Cordova Villalobos, Secretary of Health, Government of Mexico**

## The role performed by institutions in the protection and care of the health needs of Mexicans abroad – either in regular or irregular immigration status

Mexico is a country with more than 12 million people migrating every year to pursue their dream of a better life, either internally or externally; for example, our own Chiapas population migrating to border towns such as Tijuana or our fellow neighbours from Central and South American countries transiting through Mexico to reach the United States.

At this infinite crossing, the Government of Mexico recognizes that health is a priority to fully develop the physical, social and cultural rights of migrants and their families and mitigate factors that threaten individuals and public health.

As a response, the Government of Mexico, through the Ministry of Health, has established a Programme of Action on Migrant Health (2007–2012), which sets out various activities aimed at protecting the health of migrants and their families in countries of origin, transit and destination, through the development of specific strategies for binational collaboration for the promotion and provision of health care. Among the most prominent programmes of the Comprehensive Strategy for Migrant Health are the *Ventanillas de Salud*, the Repatriation of Mexicans with Grave Illness, the *Vete Sano Regresa Sano* (“Go Healthy, Return Healthy”), the Binational Health Week and the Commission on US–Mexico Border Health (USMBHC).

Furthermore, given the migratory trends over the past two years, especially with regard to migrants returned by the US border patrol, the Mexican government has recently prompted new programmes for migrant health care and their families, including prevention and health promotion outreach to migrants in places of deportation,

along the border cities of northern Mexico, through the Mexico–Guatemala Health Commission; and surveys on the use of, and access to, health services among migrants in southern and northern Mexico. The government has also increased access to community health centres as well as provided preventive and health promotion services through the implementation of call centres.

All the actions of the various programmes are aimed at improving access to health services among migrants and their families, focusing mainly on promoting healthy lifestyles in order to enable a better quality of life. The Strategy therefore identifies a number of priority issues such as HIV and AIDS, tuberculosis, hepatitis, chronic degenerative diseases (diabetes, hypertension and nutritional status), obesity and mental health (domestic violence, alcohol and illicit drug use).

More importantly, the *Ventanillas de Salud* programme has been the most successful programme and it is unique worldwide for its characteristics. With a goal to strengthen bilateral health cooperation with the United States, it has, since 2002, established a number of information centres in the United States to increase awareness and access to health services among the migrant population. The *Ventanillas de Salud* programme operates within the Consulates of Mexico in the United States and is currently implemented in 45 *Ventanillas de Salud* information points, with an additional five being rolled out between July and August 2011, thus reaching the goal of 50 *Ventanillas de Salud* as committed by the Federal Government: one in each of the consulates to provide daily and timely access to quality community health centres and cultural sensitivity for migrants and their families.

Protecting the health of migrants and their families in countries of origin, transit and destination, through the development of specific strategies for binational collaboration for the promotion and provision of health care.

**Dr. Gudelia Rangel Gomez**

Coordinator of the Comprehensive Strategy for the Migrant Health Secretary

On behalf of

**Dr. Jose Angel Cordova Villalobos**

Secretary of Health  
Government of Mexico





**Dr. Mubashar Sheikh,**  
Executive Director, Global  
Health Workforce Alliance

## **International migration of health personnel: Moving from global dialogue to national action**

The challenge of international brain drain of health personnel clearly highlights how the health of nations is closely interlinked at the global level.

The international labour market for health workers is such that developed countries with strong purchasing power outbid poorer countries and attract their health workers, exacerbating the challenges of already weak health systems.

The overall shortage of health personnel, estimated at 4.3 million health workers, is concentrated in 57 priority countries that have too few health workers to deliver even essential health services. Migration is not the only problem: the global shortage vastly exceeds the number of health workers who have migrated overseas, and is compounded by inequitable distribution within countries and uneven performance.

International migration and these other challenges are underpinned by common structural constraints: limited training capacity, weak management systems and poor working conditions, including inadequate financial and non-financial incentives, conspire to determine poor morale and high attrition of health workers, leading them to migrate to the private sector, to urban areas, or overseas.

Recognizing the need for balancing international labour markets in favour of retention in low- and middle-income countries, health personnel migration has always been a priority for the Alliance. At the First Global Forum on Human Resources for Health in 2008, the Alliance adopted the Kampala Declaration and Agenda for Global

The international migration of health workers from poor to rich countries is one of the issues that most clearly highlight some of the inequality challenges posed by globalization in the early twenty-first century. Fortunately, there now seems to be the political will to address this problem, and the Code provides a useful framework to guide such action.

Action, which advocated the development of a global code of practice on international recruitment of health personnel.

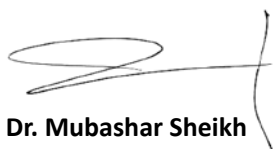
After years of policy dialogue, supported by the Alliance's advocacy efforts, in 2010 the World Health Assembly adopted a voluntary code of practice on the international recruitment of health personnel (the Code), which calls upon Member States, recruiters and relevant stakeholders to cooperate in the ethical management of health professionals' migratory flows.

The Code is a historic milestone in tackling migration challenges, but its adoption is not an end target on its own. Countries should now put in place the required regulatory, governance and information mechanisms to support its implementation – a call that was reinforced by the Second Global Forum on Human Resources for Health, held in 2011 in Thailand.

The challenge now is to move from global dialogue to national action, through initiatives such as:

- planning for self-sufficiency (all countries should train sufficient health workers to address their needs);
- developing and implementing coherent policies to assist health worker retention within countries;
- building capacity to implement bilateral agreements on international recruitment of health personnel;
- monitoring the migratory flows of the health workforce to inform policy decisions.

Finding sustainable solutions to the health workforce crisis is in the best interests of developing and developed countries alike, for reasons that go from health security to human development more broadly. The international migration of health workers from poor to rich countries is one of the issues that most clearly highlight some of the inequality challenges posed by globalization in the early twenty-first century. Fortunately, there now seems to be the political will to address this problem, and the Code provides a useful framework to guide such action.



**Dr. Mubashar Sheikh**  
Executive Director  
Global Health Workforce Alliance



**Professor Orago addresses crowds at the opening of the Busia Wellness Centre, a free health care clinic launched in partnership with IOM that targets hard-to-reach populations on the Kenyan/Ugandan border.**

## HIV and mobility in Kenya

Interview with Professor Alloys S. S. Orago, Director of Kenya's National AIDS Control Council (NACC).

*What are some of Kenya's priority areas regarding HIV?*

The first priority would be related to implementation of the new Kenya Constitution, which devolves government more to the local level. There is an increase in the number of constituencies, which requires additional human resource capacity. A national strategic plan that integrates HIV interventions into the general health care system is also key. The second priority is Kenya's vast number of mobile populations; developing HIV prevention programmes becomes a challenge because these populations are constantly on the move and hard to reach with services.

One thing that makes me extremely happy is that we are doing a midterm review of our strategic plan. At the end of the midterm review process, we will have a very comprehensive document that identifies gaps and thus facilitates advocating for improved service delivery.

*What are NACC's key focus areas?*

The focus is now largely on HIV prevention. We have to look at our programmes more comprehensively, and provide information on sexuality, rights and reproductive health.

Developing HIV prevention programmes becomes a challenge because these populations are constantly on the move and hard to reach with services.

We are working to more closely engage people who are infected and affected with HIV, and we also need to empower women, as we know that the HIV epidemic in sub-Saharan Africa is disproportionately feminine. Women and girls must be empowered to say no to sex, to participate in decision-making, be financially independent, and be equipped with HIV knowledge. Many women have transactional sex because they come from a very poor background and will sell their bodies for food and clothing.

*How are partnerships impacting on better border management or transborder collaboration?*

I think we have had very good partnerships with many players, particularly through the regional initiatives. However, I think more needs to be done on the Kenyan/Somali/Ethiopian borders. I would be going flat out to look for partners that we can work with on people who are coming into Kenya from these border posts. I look forward to enhanced partnerships between countries themselves and our development partners to ensure that services are provided for mobile populations.

*What are the biggest health challenges or risks among mobile populations?*

We need to come up with a policy framework on how to programme for key populations whose activities or lifestyles go against the norm – for example, sex workers, truck drivers and drug users – and not just people who inject. There are parts of this country where HIV affects people because of alcohol consumption, particularly among young people. How do we engage young people who use drugs? How can we de-stigmatize homosexuality? All of these populations must have access to services because they are a part of a chain. We

are also very interested in making sure that transport corridors are fully covered, because those are the catchment areas where we find such populations.

*How has your partnership with IOM contributed to NACC?*

Our partnership with IOM has contributed significantly to NACC because of the comparative advantage that IOM has with migrant populations, and the fact that IOM came on board at a very critical time when, for example, the Great Lakes Initiative on AIDS (GLIA) was coming to an end; we did not see how we were going to continue without IOM. However, the demand is outstripping our ability to cope, so we appeal for IOM to look for extra resources. We are also very interested in the technical assistance that IOM provides; for example, they allow an IOM staff member to work within our offices and programmes. We would like to see a bigger presence of technical partners.

We would also like to see more of IOM in our programming, even in terms of technical experts that we are going to work with and resources, because, you know, you can plan, but without resources you cannot implement.

*What motivated you to work in the field of HIV and for NACC?*

We must be able to make a real difference. I have lost relatives myself, and subsequently it has given me extra responsibilities in terms of looking after other family members. I look forward to a situation where we can keep parents alive for a long time through treatment and proper nutrition. My greatest motivation is to make a difference for people who are vulnerable, or who are likely to get infected.



In 2010, IOM upgraded a wellness centre in Busia on the Kenyan/Ugandan border, targeting sex workers and their clients. (Photo: Celeste Hibbert)



**Dr. Pablo Ortiz Roses**  
 Director, Health Region of Coto  
 Brus, Social Security System  
 Costa Rica

## Improving the health of indigenous labour migrants in Costa Rica

*Finca Sana* was an initiative developed by IOM jointly with the Costa Rican Department of Social Security, Coto Brus Health Region (located in the south of the country). From the beginning, the project aimed at improving the health and working conditions of the Ngäbe-Buglé indigenous population, who travel every year from Panama to Costa Rica to work with the coffee harvest. These migrants normally remain in Costa Rica for a six-month period. The primary concern was that access to health services was very limited on the Panamanian side of the border due to this population's living conditions. Thus, a strategy was devised to supply primary health care on coffee farms in Costa Rica that the migrants could access during the months they are staying at the farms for work.

This ensured that, during the period when the Ngäbe-Buglé remain in Costa Rica, they have access to basic health care services and can also improve their living conditions at the coffee farms, hence relying on the minimum conditions that, as workers, they should have in their workplace.

This project reduced the cases of preventable diseases and lowered child mortality in both the mobile and resident populations, as well as granted education on health promotion topics that could be applied in Panama and Costa Rica. Additionally, there was an explicit need to raise awareness among employers – in this case among coffee growers – of the fact that their foreign employees deserve the same assistance and support as national employees to avoid discrimination due to their ethnic origin.

In addition, it was emphasized that the houses of the labour migrants during harvest season should at least have drinkable water, an appropriate place to cook according to custom, and enough bathrooms for the workers residing on each of the farms.

At first, it was difficult to promote a change of attitude among the coffee growers but, in time, we progressively achieved the goal of encouraging them to invest more in improving their farms. Likewise, the coffee growers allowed mobile health teams to visit the farms outside working hours so as not to interfere with work, thus achieving a strategic public/private alliance between the health structure and the coffee growers. Also, these actions implied greater investments in health staff in order to meet the demand for assistance, and ultimately translated into benefits for the whole mobile population.

The Ngäbe-Buglé population even expressed that the reason they come to Costa Rica each year is because they know that they can rely on these services free of charge and receive health education – something that is not very common in their original communities. This, in turn, results in increased well-being for their whole family, thanks to a joint effort that only required small resources and was achieved through the *Finca Sana* project.

**Foreign employees deserve the same assistance and support as national employees to avoid discrimination due to their ethnic origin.**

**Dr. Pablo Ortiz Roses**  
 Director, Health Region of Coto Brus  
 Social Security System, Costa Rica





**Dr. Martin S. Cetron,**  
**Director of the Division**  
**of Global Migration and**  
**Quarantine, US Centers**  
**for Disease Control and**  
**Prevention**

## Public health and the role of overseas health assessments

Today there are over 43 million people displaced from their homes worldwide. More than 16 million of those are refugees who may have little chance of returning to their home countries because of ongoing conflicts or the continued fear of persecution. Each year the United States provides resettlement opportunities for approximately 70–90,000 of the world's most vulnerable refugees through a programme that seeks to provide protection, ease suffering, and resolve the plight of persecuted and uprooted people around the world on behalf of the American people. Health is fundamental to successful resettlement of refugees. The administration of health services and support to resettling refugees involves multiple organizations and government agencies. Close coordination is essential through the continuum of their resettlement journey that begins in a camp or country where they initially sought a safer haven, through their acceptance and ultimate transportation into more permanent community integration in another country. This journey can take weeks to years, adding to the complexity of health support services needed and overall resettlement planning.

Through its regulatory authorities, the Division of Global Migration and Quarantine (DGMQ) of the US Centers for Disease Control and Prevention (CDC) develops guidelines and monitors the implementation of overseas health assessments that refugees receive prior to resettlement in the United States. Overseas assessments are essential to detect conditions, such as tuberculosis, that may require treatment prior to travel. They also serve as an opportunity to detect other infectious diseases or gaps in prevention services where earlier health interventions would result in significant health benefit to both the refugee and the receiving community.

Over the last 20 years, CDC and the US government have partnered with the International Organization for Migration (IOM) to help meet the challenging overseas health screening and treatment needs of US resettlement-bound refugees with the goal of integrating healthy people into healthy communities. The groups worked together to address large-scale refugee resettlement and outbreak responses for Somalia Bantu refugees in Mombasa, Kenya in 1998 and the mass emergency migration of ethnic Albanians during the Kosovo conflict in 1999. We continue to work closely in the ongoing resettlement process for the large numbers of refugees that reside in the Dadaab and Kakuma camps in Kenya, the Burmese refugees in camps on the Thailand border, and the Bhutanese refugees in Nepal.

This partnership has also helped prevent and control outbreaks of cholera, measles, mumps, rubella, and varicella; public health actions that not only directly improve the health of refugees, but also avoid delays in the resettlement process and protect the welcoming communities. Public health surveillance and other population health profile evaluations have identified conditions, such as malaria or intestinal parasite infections, which affect sizeable proportions of refugee populations. Treating these conditions prior to departure improves the health of the refugee, prevents further spread, yields substantial cost savings and strengthens the resettlement programme by easing refugees' integration into the receiving US community. IOM has partnered with CDC to demonstrate the overwhelming benefits of good health screening and earlier public health and medical interventions overseas; sparing thousands of

Overseas assessments are essential to detect conditions, such as tuberculosis, that may require treatment prior to travel. They also serve as an opportunity to detect other infectious diseases or gaps in prevention services where earlier health interventions would result in significant health benefit to both the refugee and the receiving community.

lives, alleviating suffering, and saving millions of dollars. In contrast to prior paradigms based upon screening for exclusion and inadmissibility, this twenty-first century approach to migration health promises transformational changes in refugee resettlement aimed towards successful community integration of healthier refugees. I congratulate IOM on its sixtieth anniversary and look forward to an ongoing partnership that promotes safety and health in a world where global migration continues to bring together people and communities, new and old.



**Martin S. Cetron, MD**

Director, Division of Global Migration and Quarantine  
US Centers for Disease Control and Prevention



**Dr. Chanvit Tharathep,**  
Director of the Department  
of Health Service Support,  
Ministry of Public Health,  
Government of Thailand

## Healthy migrants, healthy Thailand

### Background

In 2010, Thailand registered more than 1,168,824 migrant workers from Myanmar, Lao People's Democratic Republic and Cambodia for permission to work in the country. It has been estimated that for every registered migrant, there are two or more undocumented migrants in Thailand. Mainly, the porous border and the disparities in the socio-economic and health conditions between Thailand, Myanmar, Lao People's Democratic Republic and Cambodia are factors influencing this migration flow.

Every year, the Government of Thailand (GoT), through cabinet-approved policy and regulation, addresses illegal migration by offering migrants and their employers the opportunity to legalize their immigration status by registering for a work permit. Illegal migrants are registered by the Ministry of Interior; and they receive a physical check-up and a health insurance card from the Ministry of Public Health (MoPH) before they can be granted a work permit by the Ministry of Labour. For migrants, the health examination is part of the process to maintain public health and safety for a "Healthy Thailand".

### Goal

The goal of "Healthy Thailand" cannot be achieved with unhealthy migrants. In 2010, the MoPH's health examination classified migrants into a healthy group, a curable group (0.8-1.2%), and a prohibited group (<0.01%) for those who were diagnosed as very sick to work. Pregnant women migrants found positive for HIV were given anti-retroviral medicines to prevent transmission of HIV to the fetus. Pulmonary tuberculosis and syphilis, the most common disease conditions found among the curable group, were treated and followed

## The goal of “Healthy Thailand” cannot be achieved with unhealthy migrants.

up. Like the 30 Baht Scheme for the Thai people, the health insurance benefit package for registered migrants supports their utilization of outpatient, inpatient, and health promotion and disease prevention services provided by contracted hospitals.

The MoPH, together with intergovernmental and non-governmental organizations, supported the provision and accessibility of health services to difficult-to-reach migrants in Thailand. The network's migrant health strategies are to: (1) increase migrants' access to health and medical services, especially for specific health problems such as HIV/AIDS; (2) adopt a more inclusive approach in the public health service delivery system to migrants; (3) provide health care security for migrant workers; (4) promote migrant self-care and participation; and (5) strengthen health care management and information systems for migrants. In line with these strategies, migrant health workers and volunteers successfully bridged health services to the migrant community, improving health outcomes for the migrant population from 2004 to 2008.

### Challenges

The government's policy that swings between security and economy annually influences the ratio of unregistered and registered migrants. Consequently, if there are more unregistered migrants, diseases such as pulmonary tuberculosis, syphilis, leprosy, malaria and elephantiasis, which were found to be common during the health examination of migrants, will not be detected and appropriately managed. Diarrhoea, influenza and dengue haemorrhagic fever, diseases which are more difficult to eradicate among unregistered migrants, will be harder to control. Also, limited revenues from registration and health insurance will reduce support for environmental and sanitation services from local authorities.

### Opportunities

A policy that addresses the health of migrants can support both economic- and security- centred policies. However, the health service system needs a longer-term migrant health policy to accurately determine and quantify its

targets and build and institutionalize its interventions to appropriately and adequately deliver the needed services that will control, if not mitigate, the transmission of diseases in its communities. Unfortunately, an annual allocation of migrants for registration does not produce consistent data for the health sector to plan and budget for its intervention ahead of time. Through experience, the participation of migrants as migrant health workers and volunteers facilitates better access to the health services of the government. Intersectoral coordination among relevant ministries of the government, including non-governmental stakeholders, is needed to provide comprehensive and effective services. Lastly, the strategies and approaches have to be adaptable to address the different context and environment of each province in Thailand.



**Dr. Chanvit Tharathep**

Director, Department of Health Service Support  
Ministry of Public Health  
Government of Thailand



Cathy Zimmerman,  
Researcher and Founding  
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Medicine

## Women at risk in migration: Protecting the invisible

Women make up approximately half of the world's international migrants and an unknown, but probably similar, proportion of internal migrants (United Nations Population Division, 2009). A central question for our research group, the Gender Violence & Health Centre at the London School of Hygiene & Tropical Medicine, and for others concerned about migrant women is "how do women fare in these journeys and how can we best protect them?"

To broach these questions, let us start with some facts:

- Recent estimates indicate that approximately 49 per cent of all international migrants are women (United Nations Population Division, 2009).
- Violence against women is prevalent globally, with the World Health Organization's Multi-Country Study on Domestic Violence finding that the lifetime prevalence of physical or sexual partner violence varied from 15 per cent to 71 per cent in the 10 countries studied (Garcia-Moreno et al., 2006).
- Women are increasingly migrating independently for work opportunities rather than as dependents or for family reunification. This change in female migration patterns has been identified as the "feminization of migration" (Piper, 2003).
- With new forms of independent female migration comes both increased risk as well as potential empowerment (Zimmerman et al., 2011).

- The commitment to protect women and girls from human trafficking and female refugees from sexual violence has been highlighted in international instruments (United Nations, 2000; United Nations Security Council, 2008).
- Research continually demonstrates strong associations between violence against women and severe and enduring health problems and disability (Watts and Zimmerman, 2002; Campbell et al., 2002; Heise et al., 1994).

The challenge to learning about protecting women in migration, however, is the absence of epidemiological evidence about female migrants. To date, we cannot answer questions such as how migration influences women's health and well-being; whether migrant women experience more or less violence than non-migrating women; or what are the patterns of vulnerability versus empowerment. With such large numbers of women migrating to seek job opportunities, greater equality and a better future, in addition to the thousands fleeing war, political crises and environmental degradation, these questions are pressing.

Although trafficking of women has received significant attention because of the extreme nature of the violence, evidence is still scarce on the health consequences for trafficking survivors and intervention opportunities for those still in trafficking situations. Similarly, rape in war has received considerable policy-level rhetoric, but there remain few surveys exploring, for example, refugee or asylum-seeking women's exposure to sexual and other forms of violence (e.g. domestic violence, sexual coercion, physical abuse) or their broader health needs.



Our research centre has worked for a number of years now with anti-trafficking groups, including the International Organization for Migration, to carry out research on the health of trafficked persons, and with refugee rights groups to investigate violence and health among asylum-seeking women. We are regularly surprised about the dearth of research-based evidence on the health of these vulnerable women.

As a researcher, I, of course, will always plead for better data on migrant women's health, including sex-disaggregation of all migration statistics, and evidence-informed policies. Yet, at the same time, I do not believe that we need to wait for this evidence to take action. States can and should immediately begin to live up to international rhetoric by instituting policies that recognize that women comprise half of the globe's large and growing mobile population. By implementing strategies and legislation that ensure women's legal and equal rights and non-discriminatory health and other support services for all migrants, we can move one step closer to protecting both the health of migrants and our global health.

To date, we cannot answer questions such as how migration influences women's health and well-being; whether migrant women experience more or less violence than non-migrating women; or what are the patterns of vulnerability versus empowerment.

### **Cathy Zimmerman**

Researcher and Founding Staff Member of the Gender Violence & Health Centre  
London School of Hygiene & Tropical Medicine



Sudan, March 2010. IOM doctor consults a family in Source Yubu IDP camp in Southern Sudan. (Photo: Siv Steffen Nygaard)



Sudan, 2010. IOM midwife measures blood pressure of a pregnant woman in Ezo IDP camp. (Photo: Siv Steffen Nygaard)



2010. Education session for children, Cite la joie camp, Carrefour.

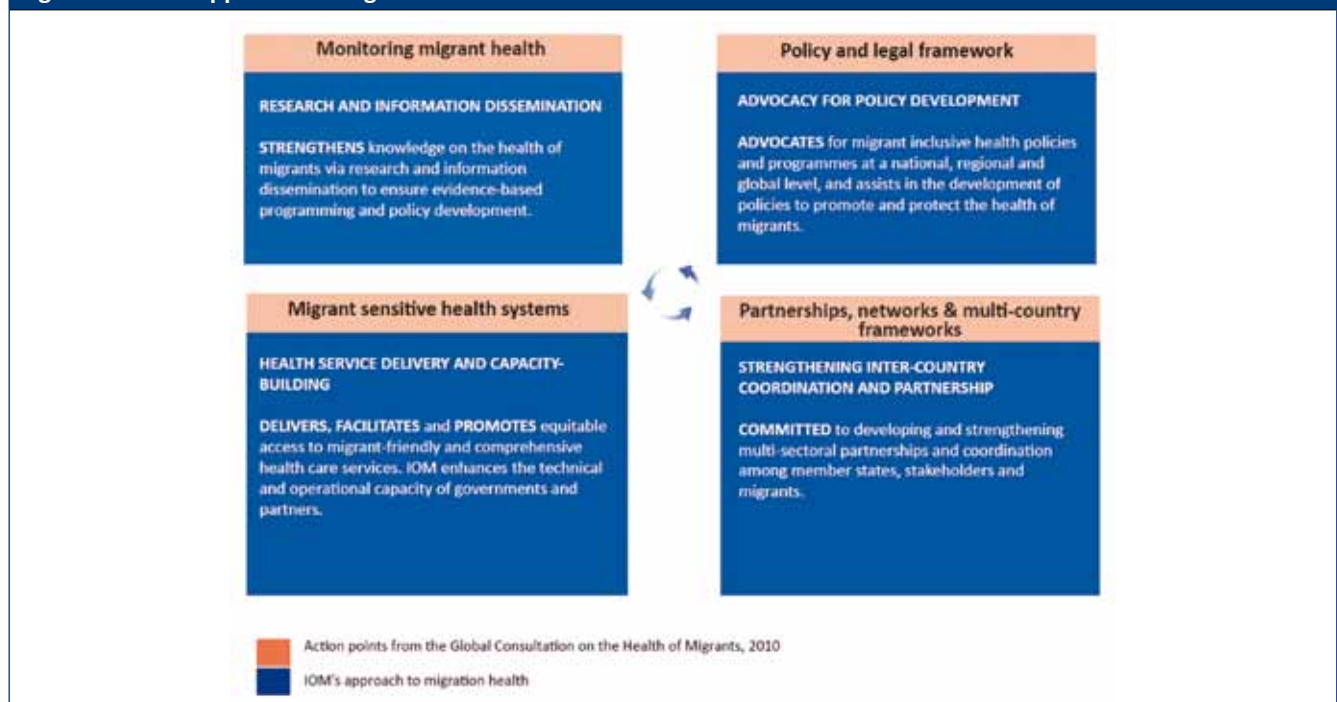
# Part II – The Migration Health Division – Highlights of IOM Activities, 2010

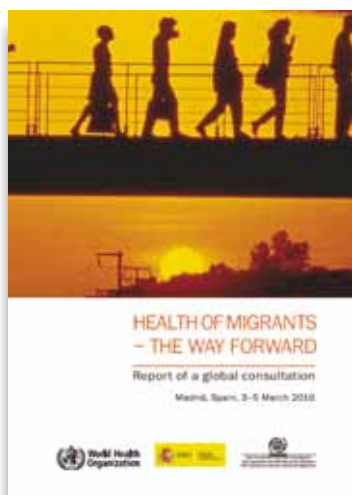
## Summary

The year 2010 has been an enriching and eventful year in the field of global migration health. Among the major benchmarks of the year was the *Consultation on the Health of Migrants* held in Madrid in March and organized by IOM and WHO together with the Government of Spain. The Consultation acted as a platform to prepare Member States for the Sixty-third World Health Assembly Meeting in May 2010, when the WHO Director-General was called to report on the progress of implementing *Resolution 61.17 Health of Migrants* adopted by the World Health Assembly (WHA) in 2008. It brought together approximately 100 participants from all geographical regions representing various arms of governments, NGOs (Platform for International Cooperation on Undocumented Migrants (PICUM), Médecins Sans Frontières (MSF)), international organizations (UNICEF, UNHCR, ILO, UNAIDS, the International Federation of Red Cross and Red Crescent Societies (IFRC)), regional organizations (European Commission, African Union

(AU), Southern African Development Community (SADC), Ibero-American Secretariat), academics and experts, as well as associations representing health professionals and migrants. The consultation identified four basic building blocks to serve as an operational framework for implementing the Resolution, including: monitoring migrant health, migrant-sensitive health systems, policy and legal framework, and partnership, networks and multi-country frameworks. A series of agreed upon actions within these building blocks will assist all stakeholders to coordinate and harmonize initiatives focused on enhancing the health of migrants. This framework was jointly presented by IOM and WHO at the Sixty-third WHA and will hopefully serve as a basis for future progress reports on the implementation of this important Resolution. The four basic blocks identified in Madrid are synergetic with IOM's strategies in managing and promoting migration health, as outlined in Figure 1.

Figure 1 : IOM's approach to migration health





The consultation report offers a summary of issues discussed at the consultation and presents an outline for an operational framework to guide action by key stakeholders. For more info see <http://publications.iom.int>.

In the experience of IOM, advocacy for policy change needs to primarily address the multisectoral nature of the migration and health agenda by including a health focus within the migration and development debate as well as a migration focus within global health goals. In September 2010, IOM, together with other members of the *Asia-Pacific Regional Thematic Working Group* on International Migration, including Human Trafficking, organized the *Asia-Pacific Regional Preparatory Meeting to the Global Forum on Migration and Development* (GFMD) in Bangkok. One of the four thematic topics of the round table discussions was migration and health. Participants included delegates from 31 governments in the Asia-Pacific region representing labour, foreign affairs, and immigration/interior. At the conclusion of the meeting, the delegates adopted an “outcome document” which included a number of recommendations to address health challenges in the context of migration and development strategies. This document was submitted at the Fourth Meeting of the GFMD, held in Puerto Vallarta, Mexico, in November 2010. Similarly, the topic was also included into the debate of the *Second Ibero-American Forum on Migration and Development* in July, and conclusions were reported to the Fourth GFMD.



Bangkok, Thailand, 2010. **Nanda Krairiksh** (Chief, Programme Management Division, ESCAP) with the country and government representatives present during the Asia-Pacific Regional Preparatory Meeting to the 2010 Global Forum on Migration and Development.

## IOM's Vision on Migration Health

Migrants and mobile populations benefit from an improved standard of physical, mental and social well-being, which enables them to substantially contribute towards the social and economic development of their home communities and host societies.

## IOM's Objectives on Migration Health

1. To ensure the right to health of migrants;
2. To avoid disparities in health status and morbidity among migrant populations;
3. To reduce excess mortality and morbidity among migrant populations;
4. To minimize the negative health outcomes of migration.

Due to IOM's initiative and in partnership with WHO, health was included for the first time on the agenda of the Fourth GFMD in Puerto Vallarta, in Mexico. Specifically, health was discussed during the session “Reducing the Costs of Migration and Maximizing Human Development”. The forum recommended Member States to “assess cost effective health care models for various types of migration scenarios”. Contributions to the GFMD came also from the *High-Level Multi-Stakeholder Regional Dialogue on Health Challenges for Asian Migrant Workers* held in Bangkok, Thailand, in July 2010, and organized by IOM together with UNDP, WHO, UNAIDS, ILO and the Joint Initiative on Mobility and HIV/AIDS (JUNIMA). The event provided an important opportunity for government representatives from various ministries, including health, labour and foreign affairs from 13 countries across South and South-East Asia, including 11 Member States of the Colombo Process, to discuss health challenges related to labour migration. The meeting concluded with a set of joint recommendations to address the identified health challenges. IOM has been advocating for the inclusion of these recommendations in the Dhaka Declaration concluding the Fourth Ministerial Colombo Process meeting (held in April 2011 in Dhaka, Bangladesh).

**Developing and strengthening multisectoral partnerships** is key to promote and implement migration health initiatives. The Partnership on Health and Mobility in East and Southern Africa (PHAMESA) is an example of a regional partnership between IOM, Regional Economic Communities, National AIDS Councils, Ministries of Health, other ministries, private sector companies, unions, United Nations partners and international and local NGOs. PHAMESA comprises a number of projects, which, together with the various partners, seek to provide migrant-friendly services, generate data on migrant health issues and advocate for migrant-inclusive health policies and programmes.





Bangkok, Thailand, 2010. **Andrew Bruce** (IOM), **Zafar Ahmed Khan** (Ministry of Expatriates' Welfare and Overseas Employment, Bangladesh), and **Gwi-Yeop Son** (UNDP) during the Closing Panel of the Regional Dialogue on the Health Challenges for Asian Labour Migrants.

**Research and information dissemination** are critical components in monitoring the health of migrants and support the implementation of the WHA Health of Migrants Resolution. During 2010, IOM conducted research on HIV and migration in the European context and produced the report *Improving HIV data comparability in migrant populations and ethnic minorities in the EU/EEA Countries*, which is forthcoming as part of the ECDC migrant health series (2009–2011), see <http://ecdc.europa.eu> > Publications > Technical Reports. In Somalia, IOM led the first ever biological and behavioural surveillance survey in the country among mobile female sex workers to provide policymakers with data and recommendations on how to address HIV among marginalized and mobile populations, see <http://nairobi.iom.int>.

A fundamental concept in order to advance the migration health agenda is to **build the capacity of national health delivery systems**. At the national level, IOM delivered migration health services by developing the technical capacity of its implementing partners to more effectively accommodate the health needs of migrants, thus supporting the establishment of migrant-friendly health systems. For example, in South Africa, IOM assisted a programme to provide sustainable HIV prevention and care services to farm workers. Since 2009, IOM has been implementing the *Ripfumelo HIV Prevention and Care Project*, which targets 20,000 seasonal, temporary and permanent farm workers, some of whom are undocumented migrants. The project is being implemented on 81 farms where 197 farm workers have been trained as change agents/peer educators to promote safer sexual behaviour and information about testing and treatment to date. Similarly, in 2010, IOM continued to provide technical support to the Government of Sri Lanka to strengthen its migration

health strategy. The Migration Health Development programme, led by the Ministry of Health, utilizes an inclusive, participatory and multisectoral approach that addresses all migrant typologies and involves a range of government stakeholders. The migrant health programme seeks to respond to emerging needs within the country, while at the same time engage in regional and global partnerships for effective intergovernmental collaboration.



Colombo, Sri Lanka, 2010. **Hon. Nimal Siripala De Silva**, Minister of Health and the Executive Chair of WHA 2009, inaugurating the National Migration Health Stakeholder Meeting in Colombo which brought together more than 12 government ministries, United Nations agencies, academics and civil society groups.



Colombo, Sri Lanka, 2010. The first National Migration Health Task Force Meeting on Migration Health Policy Development for Sri Lanka.

In 2010, IOM also continued to present and share technical expertise at meetings to promote and protect migration health issues at the global level. In preparation for and during the Sixty-third WHA, IOM was actively involved in the development of the WHO *Global Code of Practice on the International Recruitment of Health Personnel* (WHA 63.16), which was adopted during the 2010 WHA. Upon request from the European Union (EU) and the African Union, IOM provided technical briefings on the issue of health worker mobility to Member States that were actively involved in the drafting of the Code. The Code will be instrumental in providing ethical guidelines to support the sustainable development of the national health sectors in addressing the shortage of health personnel in developing countries due to migration; this is an issue of priority for health systems.



Recognizing that health issues can affect all migrants and that health serves as a catalyst for fostering positive migration outcomes, migration health applies to various domains of the Organization's work and, as such, is linked to the IOM 12 Point Strategy of 2007. IOM's migration health work encompasses the three programmatic areas of migration health assessments and travel health assistance, health promotion and assistance for migrants and migration health assistance for crisis-affected populations. Together, these areas complement each other and provide a holistic approach to migration health in order to contribute to the implementation of the WHA Health of Migrants Resolution.

- **Migration Health Assessments and Travel Health Assistance:** At the request of resettlement country governments, migration health assessments are provided to refugees and immigrants prior to departure to their countries of destination. The main objectives of this global programme are to reduce and better manage the public health impact of population mobility on the host communities of receiving countries, to facilitate the integration of migrants into host communities through the detection and management of health conditions in a cost-effective manner, and to provide information on the medical conditions of migrants. As a result of health assessment programme activities, IOM contributes to evidence-based migration health policies through the confidential sharing of medical data with resettlement country governments and through the exchange of epidemiological data with partners at international and national levels. IOM also contributes to health service delivery and capacity-building through collaboration with National TB Programmes (NTPs); training for national laboratory technicians, physicians and nurses; and the provision of TB, HIV and maternal and child health (MCH) services for both migrants and host communities.
- **Health Promotion and Assistance for Migrants:** Activities within this area support the establishment of migrant-friendly health systems; advocate for migrant-inclusive health policies and programmes at national, regional and global levels; and strengthen multisectoral partnerships within and among Member States, stakeholders and migrants. Furthermore, critical research is undertaken to produce evidence-based data on the health of migrants to policymakers and ensure informed migration health programming. This is done by building the technical and operational capacity of partners from the health and non-health sectors and the public and private domains, as well as migrants and host communities themselves. In doing so, multisectoral partnerships on migration health are developed, which is instrumental in advocating for the health of migrants while ensuring

the sustainable delivery of comprehensive quality health services throughout the migration cycle.

- **Migration Health Assistance for Crisis-affected Populations:** The main focus of this programme area is to complement IOM emergency and post-emergency programmes in the health sector by assisting governments and affected communities in emergency preparedness, during, and in the aftermath of, emergencies or crisis situations. It does so through managing health and psychosocial issues related to population displacement, facilitating health referral mechanisms, and arranging mobile health clinics and medical evacuations for individuals who cannot be cared for locally when health facilities are overstretched or have been destroyed. IOM ensures that mechanisms are in place to address public health concerns, continuity of care, as well as promotion of health and well-being enabling conditions in situations of displacement and assisted movements.

In addition, IOM accounts for three cross-cutting issues that in various ways affect the health and well-being of migrants:

- **Mental Health and Psychosocial Support:** IOM works with partners and key stakeholders to strengthen the capacity of psychosocial services offered to vulnerable migrants. IOM is also a member of the Inter-Agency Standing Committee (IASC) Working Group on Mental Health and Psychosocial Response in Emergency, and has provided psychosocial support to and created capacity-building initiatives for crisis-affected populations in emergency and post-emergency situations since 1998.
- **Emerging and Re-emerging Diseases:** Increasing population mobility can play a role in the transmission of emerging and re-emerging diseases. To address this issue, IOM works in close partnership with its Member States and other stakeholders to facilitate health access to migrants and host communities. IOM also conducts capacity-building activities through workshops on health promotion and behaviour change for health and community workers who interact with migrants.
- **HIV and Population Mobility:** IOM addresses HIV risks and vulnerabilities during all phases of the migration cycle. HIV prevention and research are key activities. IOM also provides direct HIV services to migrants in selected sites, including voluntary HIV testing and counselling for migrants and their communities, and treatment services including anti-retroviral therapy.

In 2010, total expenditure for migration health operational programmes amounted to USD 64.1 million,

representing an increase of 14 per cent (USD 8 million) from USD 56.1 million in 2009. The increase was brought about primarily by health assessment programmes in the context of resettlement, particularly the United States Refugee Programme (USRP) in Africa and Asia, as well as by global health assessment programmes for migrants bound for Australia, the United Kingdom and the United States.

In terms of the distribution of activities and expenditures by region in 2010, Asia and Oceania had the largest activity under migration health assessments and travel health assistance. Africa, however, had the largest expenditure under health promotion and assistance for migrants, as well as migration health assistance for crisis-affected populations.

Below follow highlights from IOM's health activities carried out globally within the different health areas and cross-cutting topics during 2010.

## Migration Health Assessments and Travel Health Assistance

Migration health assessments are among the most well-established migration management services offered by IOM. Health assessments provide the opportunity to promote the health of migrants through the initiation of preventive and curative interventions for conditions that, if left untreated, could have a negative impact on the migrant's health and/or on the public health of the host communities. Travel health assistance is a health assessment-related service offered to address individual health and safety, and to manage conditions of public health concern as individuals move across geographical, health system and epidemiological boundaries. Within health assessment programmes (HAPs), pre-embarkation checks (PEC) and pre-departure medical screenings (PDMS) are performed in order to assess a migrant's fitness to travel or to provide medical clearance. These measures also ensure that migrants are linked to and given appropriate referrals to medical services once they arrive in their destination countries. Migrants who need medical assistance and care during travel are escorted by health professionals to avoid complications during transit. Pre-departure treatment, vaccinations and other public health interventions are also tailored to meet the needs of migrants and immigration authorities.

HAPs represent the largest activity of IOM's Migration Health Division (MHD) in terms of migrants served, staff concerned and operational costs. Over the past decade, the HAP has experienced considerable growth. From 2001 to 2010, the number of health assessments

provided for both refugees and immigrants nearly tripled, reaching over a quarter of a million assisted beneficiaries in 2010, in over 50 countries. The total number of IOM health assessments performed over the last 10 years is more than 1.5 million.

## Types of services

### Health assessments

Upon request from receiving-country governments, IOM provides an evaluation of the physical and mental health status of migrants for the purpose of resettlement, international employment, enrolment in specific migrant assistance programmes, or for obtaining a temporary or permanent visa. Reflecting national differences in immigration and public policies and practices, there is a diverse range of health assessment requirements, the most common being the need to ensure that the migration process does not endanger the health of the migrant or the host population. These requirements may be specific to certain diseases of public health concern, such as screening for tuberculosis in the *United Kingdom Tuberculosis Detection Programme* (UKTBDP), or they may be broader, as in other resettlement and immigration programmes. Health assessments involve a medical examination, a review of the migrant's medical history, preventive and/or curative treatment, counselling and health education, and final preparation of required immigration health forms. IOM provides treatment of international standard, or facilitates access to treatment through referrals, to refugees and immigrants found to have certain conditions of significant health concern by destination-country governments.

In 2010, almost 270,000 health assessments were performed for migrants, including both immigrants (178,000 or 66%) and refugees (90,000 or 34%) in almost 60 countries, with a majority of the assessments conducted in Asia (67%). Health assessments were carried out at the request of resettlement countries such as the United Kingdom and the United States, which were major countries of destination (41% and 40% of migrants, respectively). Other countries of destination include Australia, Canada and New Zealand, among others. IOM also managed and supervised nearly 15,000 health assessments conducted by non-IOM panel physicians, mostly upon the request of the United States for quality control purposes. Detailed tables and graphs on services and beneficiary profiles can be reviewed in Annex 1, "Service Delivery in Numbers, 2010" (see Table 2 and Figures 8 and 9). The results of the laboratory screening for tuberculosis, HIV, syphilis, and malaria are also presented by region and sex in Annex 1, under "Salient findings from migration health assessment programmes" (see Table 3).

### **Pre-departure services and travel assistance**

Pre-departure medical procedures comprise a range of services that are meant to ensure that people travelling under the auspices of the Organization travel in a safe and dignified manner, are fit to travel, receive appropriate assistance when necessary, and do not pose a hazard to other travellers, personnel or receiving communities. Procedures such as pre-embarkation checks (PEC) and pre-departure medical screenings (PDMS) are performed within a 72-hour window prior to departure in order to assess a migrant's fitness to travel, to provide medical clearance and to notify receiving countries about any last minute change in health conditions. Pre-embarkation checks, typically referred to as 'fitness-to-travel checks', are conducted either on the day before travel or the day of travel itself. More comprehensive procedures, such as the PDMS, are conducted up to 3 days prior to departure and may include a physical examination, a re-screening for certain diseases such as tuberculosis, testing and treatment for parasites and malaria, and immunizations for vaccine-preventable diseases. In the event that a significant medical condition is identified, passengers may be delayed or excluded from travelling until treated. In 2010, IOM performed pre-departure medical procedures for the majority of departing refugees. These measures additionally serve to ensure that migrants are linked to and given appropriate referrals to medical services once they arrive in their destination countries. Migrants who need medical assistance and care during travel are escorted by health professionals to avoid complications during transit. In 2010, IOM provided group and individual medical escorts to about 1,500 refugees with a variety of medical conditions, such as cardiovascular, neurologic, respiratory and psychiatric disorders (see Figure 15).

### **M-assessments and other services**

The M-assessment service is unique to the Canadian immigration medical process, which consists of two separate components: the immigration medical examination (IME) conducted by designated medical practitioners, and the immigration medical assessment (IMA), which is an admissibility assessment conducted by Canadian medical officers. Citizenship and Immigration Canada (CIC) has designated significant portions of the IMA role to IOM designated medical practitioners at IOM's operations in Bucharest, Kiev, Moscow and Nairobi, which conducted over 12,000 M-assessments in 2010. IOM assesses a range of migrants based on admissibility categories that account for the migrant's future demand on health or social services, and the degree of risk to the public health and safety of receiving communities.

Upon the request of the United States Bureau of Population, Refugees and Migration (PRM), IOM supervises a network of non-IOM panel physicians in several countries, using its experience with the United

States Health Assessment Programme to ensure the quality of medical screenings, including the clinical, radiological and laboratory aspects. IOM supervised and monitored more than 12,000 health assessments in 2010, mainly in Africa and the Middle East.

IOM also provides DNA testing services in order to meet the demand of immigration authorities to prove family links among immigration applicants. IOM has established a mechanism for the confidential collection of bio-samples, management of relevant files, shipment of samples along a control chain to designated laboratories, and counselling for applicants. In 2010, DNA services were offered in several countries, with the majority of tests performed in Viet Nam, Kenya, Ethiopia, Cambodia and Ghana (see Annex 1, Figures 16a and 16b).

## **Public health activities in the context of the health assessment programme**

While public health activities have been a recognized part of MHD's HAP services for several years, there has been a recent shift in the approach of some resettlement countries, denoting a progressive change in attitude regarding the role of health assessments in migration health. Health assessments have traditionally been approached with the primary intention of reducing the risk of importation of infectious diseases and other conditions of public health concern, thereby reflecting the concept of "admissibility" as expressed by the legislation and technical instructions (TIs) of receiving country governments. However, it was later acknowledged that certain conditions that affect the health of migrants, such as malaria and intestinal parasites, were not addressed by TIs. In the United States, for example, this realization prompted the US Centers for Disease Control and Prevention (CDC) to request the inclusion of presumptive treatments in the standard package of health assessment services. The addition of expanded diagnostics for tuberculosis and other preventive and public health measures, such as vaccination, outbreak management and certain pre-departure procedures, further evidenced the shift in the approach of the CDC from exclusionary practices to a more comprehensive public health approach that addresses refugee health needs early in the resettlement process. In addition, the collection and analysis of aggregate data from health assessments provide resettlement countries with valuable information on the health profiles of migrants, enabling better migration management. These approaches allow for the bridging of health management systems between source, transit and destination communities.

Several public health aspects are already integrated into HAP, such as population health profiling, prevention

activities, diagnostics and screening, case management and treatment, and outbreak management. Other activities are covered through the CDC-IOM Cooperative Agreements, which involve substantial US-bound refugee populations in East Africa, Nepal and Thailand, as well as other mechanisms, such as partnerships with National TB Programmes, the Global Fund and the STOP-TB Partnership.

### **Tuberculosis prevention and control**

Three quarters of the migration health assessments performed by IOM took place in high TB-burden countries, as defined by the WHO 2010 Global TB Control Report.

Services included physical examinations, radiological investigations, tuberculin skin tests, sputum smears and cultures, drug susceptibility testing (DST) and health education and counselling. Directly-observed treatment (DOT) was provided either by IOM or through a referral system, in partnership with National Tuberculosis Programmes (NTP).

Health assessments in 2010 were carried out in almost 60 countries worldwide and resulted in the detection of about 900 cases of active pulmonary tuberculosis <sup>12</sup> (340 per 100,000).

The prevalence among the refugee population was 4.7 times higher than that of the immigrant population, at 700/100,000 compared with 150/100,000. Regional variation within the refugee population was also significant, with the highest rate of 1,000 per 100,000 in Asia and the lowest rate of 100 per 100,000 in Europe. Variation among immigrants, however, follows a different pattern, with prevalence ranging from the maximum of 230 per 100,000 in Africa to 40 per 100,000 in Europe.

In addition, IOM identified 12,000 cases from among both refugees and immigrants that were suggestive of past or non-active TB infection (5,100/100,000), and data were made available for post-arrival follow-up.

### **TB diagnostics - Radiology**

Along with clinical signs and symptoms, radiological investigations are the first and most crucial step in the diagnosis of TB. By the end of 2010, most of the major IOM screening locations had switched to digital X-ray processing, by upgrading their existing set-up or establishing partnerships with external providers that have digital facilities. This move has enabled IOM's medical operations to improve the efficiency, safety and quality of health assessments through improved imaging

and faster communications. In 2010, IOM performed more than 231,000 radiological investigations, most of which were digital (77%) and accessible via a network of picture archiving and communications systems (PACS). While this system is in the process of elaboration, IOM health assessment programmes have started to benefit from the new technology by bringing a pool of experienced IOM radiologists to perform diagnostics and quality control reviews in all screening locations connected via teleradiology bridges. The transition to a digital system will also help IOM missions to fulfil current and future requirements of resettlement countries by integrating digital radiology into the resettlement information flow and the health information systems of resettlement country governments (e.g. E-Health for Australia and pending systems for Canada and the United States).

### **TB diagnostics - Laboratory**

IOM has constantly endeavoured to strengthen and update its TB laboratory diagnostic capabilities, in line with developments in the field. In operations around the world, IOM now implements sputum culture examinations for TB screening and detection, based on revised instructions from resettlement countries that follow international standards in TB prevention and control. The addition of sputum culture examinations has further enhanced the accuracy of TB screening resulting in increased case detection. It can be inferred that this has reduced morbidity and mortality among individual migrants, while simultaneously limiting TB disease transmission and the health care burden in resettlement countries. All IOM laboratories are closely collaborating with national and international standardized laboratory networks in the respective countries, through implementation of internal quality control procedures and participation in external quality assurance programmes.

Building on a large body of experience in TB diagnostics and treatment, IOM continued improvements in TB laboratory diagnostic services in 2010 by establishing and upgrading laboratory facilities in various locations. To expand IOM's diagnostic capacity, new laboratories were established in Kuala Lumpur, Malaysia, while partner laboratories were upgraded in Ho Chi Minh City, Viet Nam and Dhaka, Bangladesh. In order to keep pace with cutting-edge technological developments, most of the IOM laboratories are now equipped and certified to provide DST and molecular diagnostic capabilities, thereby enabling the timely provision of appropriate treatment for migrants.

<sup>12</sup> Condition diagnosed by either laboratory confirmation or clinical and radiological findings





Damak, Nepal, 2010. Sputum specimen processing in a TB laboratory at IOM Nepal. (Photo: Raymond Zanda)

In keeping with its approach of working closely with NTPs, IOM continues to be a key partner in capacity-building of local and national TB laboratories in various countries. In 2010, IOM helped to build the capacity of national TB laboratories in Kenya, Nepal, Pakistan, Thailand and Viet Nam. In Pakistan, the IOM laboratory partnered with the National Reference Laboratory to strengthen their human resource capacity to conduct line probe assays, a technique that has been applied by IOM since 2009. In Nepal, the IOM laboratory features modern diagnostic modalities, including liquid cultures and rapid molecular tests, which enable the identification of drug-resistant TB within two hours. IOM Nepal works closely with its local refugee health partner, an NGO called AMDA (Association of Medical Doctors of Asia), to provide technical training in TB diagnostics (sputum smears, cultures, DST and rapid molecular assays) to their laboratory staff.

### GeneXpert and IOM TB Diagnostics

GeneXpert is a new rapid, fully automated DNA molecular TB test that improves TB case detection and management by providing a highly accurate diagnosis in a single two-hour test that detects *M. tuberculosis* in sputum specimen of smear-negative and multidrug-resistant tuberculosis (MDR-TB) cases. In 2010, WHO officially endorsed and strongly recommended the new rapid test for an expected threefold increase in the diagnosis of patients with drug-resistant TB, and a twofold increase in the number of TB/HIV cases diagnosed in areas with high rates of TB and HIV, when compared to microscopy. Single-centre studies reviewed by WHO reveal a lack of cross-reactivity with non-tuberculous mycobacteria in this test, which correctly detects TB and rifampicin resistance in the presence of mixed susceptible DNA. With results available in about two hours, this cartridge-based automated nucleic acid

amplification test has minimal biosafety or training requirements, and is suitable for use outside of conventional laboratory settings, such as at the point of care.

In accordance with a continuing commitment to upgrading laboratory diagnostics in TB, IOM plans to improve case detection and TB treatment by using GeneXpert in its country operations. IOM facilities in Cambodia, Ethiopia, Nepal and Thailand will implement WHO TB REACH projects utilizing this new technology, with the aim of increased case detection and treatment among vulnerable and hard-to-reach mobile populations. Through these projects, IOM will build additional in-country TB capacity by establishing a referral system of specimens and patients to the diagnostic centres equipped with GeneXpert, and contributing evidence on the effectiveness and suitability of GeneXpert testing to improve TB case finding.

### TB treatment

The health assessment services offered by IOM are not limited to the screening and detection of TB, but extend to the provision of treatment to refugees as well, in line with national and global standardized regimens. In 2010, about 1,000 migrants were referred for TB treatment, which was provided by either IOM or its partner TB clinics. In order to provide the best possible treatment, IOM uses DST for culture-positive samples in order to align the protocols to patients' susceptibility to TB drugs. In IOM TB treatment Programmes in 2010, seven per cent of patients with available data on DST had mono-resistance to either isoniazid or other first-line TB medication, while multidrug resistance was revealed in 2 per cent of the patients; 1 per cent of the cases were poly-resistant.

Several IOM operations around the world, including those in Ethiopia, Jordan, Kenya, Malaysia, Nepal, Thailand and, recently, Bangladesh have created and maintained certified DOT centres that provide TB treatment to migrants in close collaboration with NTPs and in accordance with international protocols. Monitoring of TB treatment programmes is performed in coordination with CDC, using a set of predefined TB laboratory and treatment performance indicators.

IOM is constantly strengthening its capabilities for high-quality TB case management services for migrants. For example, in Pakistan, IOM clinics have started to provide systematic case management to all migrants detected with active TB; case management consists of documented counselling, support in treatment, and free

screening for close contacts of the TB-positive person. In 2010, IOM DOT clinics in Addis Ababa and Shire (northern Ethiopia) became Multidrug-Resistant satellite clinics in Ethiopia. Efforts and deliberations are underway to establish a TB and MDR-TB Treatment Centre, Radiology and Laboratory units and an MDR-TB isolation ward in Dadaab, Kenya to serve refugees and local communities by 2011.

### Collaboration with National TB Programmes

In its countries of operation, IOM collaborates closely with NTPs, WHO and other agencies to provide technical assistance to governments aiming to intensify their national TB control efforts. IOM contributes to increased case finding and treatment among vulnerable and hard-to-reach populations through the case detection and treatment components of its migrant health assessment programmes.

In Kenya, well-established migration health assessment programmes have opened the door for enhanced collaboration with national TB and HIV/AIDS programmes and relevant United Nations agencies, notably UNHCR and WHO. In 2010, IOM successfully registered and ran four different TB DOT Centres in Kenya, in cooperation with the National Ministry of Public Health and Sanitation. In Bangladesh, IOM initiated discussions with the National TB and Leprosy Programme in the Ministry of Health on the IOM clinic's engagement in curative TB actions. The Dhaka sub-office is currently working to establish a TB treatment section, which will be incorporated into the NTP and opened for access to the general population, if a sustainable mechanism for such assistance is identified.

### UK Pre-departure Tuberculosis Detection Programme (UKTBDP)

In 2005, in response to an increasing incidence of tuberculosis in the UK, the Government of the United Kingdom, with IOM as the implementing partner, designed and launched a pre-departure TB detection programme to screen visa applicants planning to stay in the UK for six months or longer for infectious pulmonary tuberculosis. The programme was launched in eight countries: Bangladesh, Cambodia, Ghana, Kenya, Pakistan, Sudan, Tanzania and Thailand, which cover seven additional neighbouring countries. The selection of these countries was based on a variety of factors, including a high burden of TB, based on World Health Organization (WHO) prevalence estimates.

From October 2005 to December 2010, IOM assessed nearly 482,000 UK visa applicants, with 325 confirmed cases of infectious TB, based on laboratory findings. More than 50%, or 178, confirmed TB cases belonged to the 'student' visa category. The initial programme protocol required chest X-rays (CXR) for all applicants, followed by sputum smear examination for those with signs of active TB disease on the CXR. In November 2007, the protocol was expanded to require comprehensive bacteriological screening, specifically the routine inclusion of sputum cultures. With the introduction of cultures to the amended protocol, two additional cases were detected for every case diagnosed using the initial protocol, as revealed by the TB prevalence estimates of 38 and 91 per 100,000 populations under the respective initial and amended protocols (see Table 1). Individuals who were found to have infectious tuberculosis were referred for treatment in line with National TB Programme (NTP) standards. Upon successful completion of treatment, applicants were able to be re-screened before proceeding with their visa application.

**Table 1: Prevalence of infectious TB cases by country according to protocol, UKTBDP, October 2005–December 2010**

Country	Initial protocol			Amended protocol		
	Tested	TB cases	Prevalence (CI95%)*	Tested	TB cases	Prevalence (CI95%)*
Bangladesh	37,465	24	64 (38–90)	110,763	97	88 (58–118)
Cambodia	120	0	-	342	1	292 (0–1258)
Ghana	20,707	0	-	8,024	3	37 (11–64)
Kenya	4,613	11	238 (98–379)	8,249	10	121 (21–222)
Pakistan	125,983	27	21 (13–30)	110,270	38	34 (24–45)
Sudan	3,573	1	28 (0–83)	1,077	0	-
Thailand	16,682	18	108 (58–158)	25,451	91	358 (267–448)
United Republic of Tanzania	6,693	1	15 (0–44)	1,934	3	155 (0–249)
<b>Total</b>	<b>215,836</b>	<b>82</b>	<b>38 (30–46)</b>	<b>266,110</b>	<b>243</b>	<b>91 (79–104)</b>

\* Confidence Interval

Health education and counselling was provided for all applicants assisted within the programme. Cases confirmed for infectious TB were advised referrals for treatment. In addition to detection of infectious TB, cases with CXR signs suggestive of active TB, but without bacteriological confirmation, received recommendations to seek healthcare assistance upon arrival in the UK.

In 2010, IOM Thailand conducted client satisfaction surveys for this programme throughout the year. 8,009 visa applicants participated in these anonymous surveys, which demonstrated not only 92% overall client satisfaction, but similar levels of satisfaction in response to each inquiry presented in the survey, including the open-ended questions. In Pakistan, in order to improve the quality of service provision, IOM relocated its Lahore and Islamabad clinics to safer, more easily approachable and client-friendly locations. An e-mail appointment system and a local website to assist beneficiaries were also introduced as part of IOM's migrant-friendly client services.

### Health service delivery and capacity-building

IOM health assessment programmes contribute to improved health service delivery at various locations through projects that target refugee communities, as well as other migrants and host populations in surrounding communities. In 2010, one such project was implemented in Nepal with funding from PRM and Citizenship and Immigration Canada (CIC). IOM Nepal, in consultation with UNHCR and the NTP, implemented a project that harmonizes TB case detection and treatment protocols for Bhutanese refugees, irrespective of their resettlement status, i.e. whether they are already in the resettlement pipeline or they are awaiting interviews by a resettlement country and are therefore considered "non-resettlement" cases. This project was implemented in coordination with AMDA, which provides health care and basic hospital care in the refugee camps. Through this project, IOM is building AMDA's capacity in TB detection and treatment, in part by training laboratory microscopy technicians, as well as training AMDA physicians and DOT staff to address different aspects of TB diagnosis, treatment and contact management. Prior to this project, AMDA followed NTP protocols of passive TB screening and treatment, which resulted in an underestimation of infectious TB prevalence in the camps, delayed detection of MDR-TB, occasional unnecessary treatment and risk of relapse among treated refugees. IOM and AMDA have now developed guidelines for the referral of refugees for TB screening and have conducted orientation sessions for health care providers in camps.

In 2010, 1,102 "non-resettlement" refugees were screened for TB by the IOM laboratory with sputum

smears and culture exams. Case finding of bacteriologically confirmed pulmonary TB in camps, calculated as the sum of resettlement and non-resettlement cases for the mid-year population of such camps, was 301 per 100,000. IOM provided all necessary first-line drugs and some of the second-line drugs for treatment of patients with mono- and poly-drug resistant TB. IOM provided complete monitoring of refugees on treatment with medical examinations, laboratory and radiological tests and specialist consultations, as needed. Patients with MDR-TB and highly infectious pan-susceptible TB were isolated at the "Magic Mountain" Isolation Centre (MMIC).



Damak, Nepal. IOM's **Magic Mountain Tuberculosis Treatment Centre**. Patients with drug-resistant forms or highly infectious TB stay at the Centre until they become non-infectious.

This initiative, the harmonization project, exemplifies the commitment to ensure that all refugees receive the same high standard of TB evaluation and treatment regardless of whether they have been accepted for immigration. Expanding case detection from smear to case detection, which includes culture and susceptibility testing, benefits the full community of refugees as well as the surrounding community in Nepal. Since resettling and non-resettling refugees mix freely and refugees also interact with the surrounding eastern Nepal community, this step also has an important positive impact on health in Nepal.

Evaluation of the TB harmonization project in IOM Nepal, August 2009, by Advisory Council for the Elimination of Tuberculosis, US Centers for Disease Control and Prevention and Citizenship and Immigration Canada.

Another relevant example of strengthened health service delivery by IOM for migrants and host communities comes from Kenya, where IOM runs a comprehensive TB, HIV and basic maternal and child health clinic in Eastleigh, a Nairobi district heavily populated by migrants from Somalia, Ethiopia, Eritrea and Sudan. Known as the *Eastleigh Community Wellness Centre*, it is a health clinic that meets the specific needs of migrants and their host community without discrimination. The clinic also offers a space for capacity-building of health care providers and community dialogue around health



and social issues. The clinic is supported by provincial health authorities, national TB and HIV programmes, the Kenyan Expanded Programme for Immunization and CDC, and runs in cooperation with national partners. Through a research collaboration with CDC, IOM conducted a health utilization survey (HUS) among migrants in Eastleigh between July and August 2010 to assess the utilization of health care by migrants for acute illnesses in children and adults, including pneumonia, diarrhoea, fever and maternal and child health issues. Preliminary findings indicated that about 75 per cent of Eastleigh residents with any one illness sought some kind of health care, with the majority seeking care either at a private health care provider or buying medication over the counter. Reasons why some migrants did not seek health care included expense concerns (45.3%) and the belief that they were not sick enough (34.4%). These findings indicate the need to engage with private health facilities for systematic disease surveillance in this setting.

A young, female Somali who was unsuccessfully treated for TB by a private health care provider in Nairobi came to the IOM Eastleigh Community Wellness Centre, where she received treatment for multidrug-resistant tuberculosis. Thankful for the service she received, she comments (2010):

*I am very thankful to the International Organization for Migration in Nairobi for taking me through this long period of treatment and for being by my side; when things started to get tough, IOM staff supported and counselled me. My brother in the United States could never have afforded to buy these drugs for me for such a long period of time, as he is still supporting his family in America and my family here in Eastleigh. I really thought the daily injections would never end, but thank you IOM for making me strong to sustain the difficulties of this treatment.*

### Population profiles

IOM health assessment programmes generate an extensive repository of information on medical and public health conditions for various key refugee groups being resettled to countries such as the United States, Canada, Australia and New Zealand, among others. Secondary analysis of this programmatic data can generate significant insights into the prevalent morbidities, risk factors, potential health care needs and imminent public health impact of resettlement on host communities and countries. Timely health information on several refugee groups assisted by IOM is not otherwise readily available in literature. With this background, IOM has initiated a project to analyse medical and public health data on



Eastleigh, Nairobi, Kenya, 2010. Former Executive Director of the UNODC **Antonio Mario Costa** and Hollywood actor **Nicolas Cage** talking to urban migrant-beneficiaries of the IOM TB/HIV comprehensive care programme at the IOM-run Wellness Centre in the Nairobi suburb of Eastleigh. (Photo: Matama Lillian)

existing and emerging refugee groups assisted at key locations, such as Iraqi (Jordan and Iraq), Somali (Kenya and Eritrea), Bhutanese (Nepal) and Eritrean (Ethiopia) refugees. The data sources and methods used in this project include: the assignment of codes from the International Classification of Diseases rev.10 (ICD-10) to health assessment data using specially designed software; the review and analysis of data obtained from IOM's Significant Medical Conditions (SMC) forms, which document medical resettlement needs, such as needs for post-arrival medical follow-up, medication and treatment, and other relevant sociodemographic information. The resultant profiles, which will be produced on a periodic basis by IOM, will contain refugee population descriptions, prevalence of significant medical conditions, top ICD-10 disease groups and top diseases in each of the prevalent groups, with a special emphasis on children under age 5, mental health and infectious diseases, as well as assistance and medical follow-up needs for each group. This information will be of value to refugee health coordinators, local community health care providers in host communities, other resettlement agencies and public health organizations, such as the CDC, which are engaged in refugee health programmes.

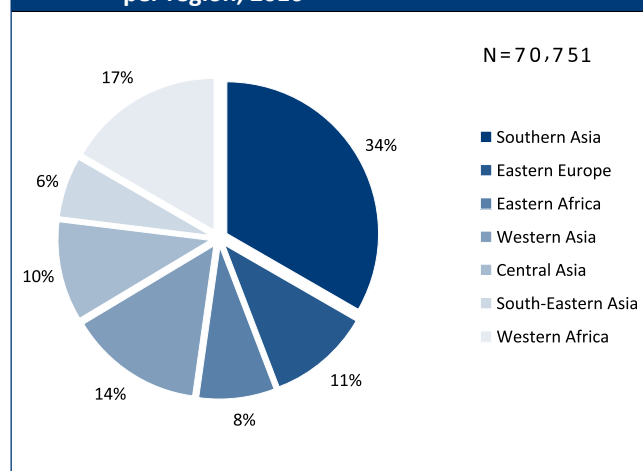
### Resettlement/follow-up needs

Aiming at the seamless transition of refugees with significant medical conditions through the process of resettlement and successful integration in the receiving society, IOM documents refugees' post-arrival needs and shares them with resettlement agencies in the country of destination. This service enables IOM to fulfil its mission to assist Member States in the orderly and humane management of migration by meeting both the needs of the governments of resettlement countries and those of migrants. As a result of this assessment in 2010,



about 12 per cent of the US refugees were found to have significant medical conditions that would merit special accommodation, assistance, schooling and employment needs upon arrival in the United States. The prevalence of significant medical conditions requiring special attention upon arrival varied, depending on refugees' country of origin (Figure 2), from 6 per cent in South-Eastern Asia to 30 per cent in Southern Asia. Based on an analysis of the medical follow-up needs of refugees in the United States, an estimated 30 per cent of the caseloads examined in 2010 required further medical assistance following arrival to the United States, with most migrants (17%) needing follow-up within one month after arrival.

**Figure 2: Distribution of significant medical conditions per region, 2010**



## Surveillance

IOM conducts a range of surveillance activities among refugees bound for resettlement, as well as the refugee population level in camps and other communities. Surveillance data is obtained from a variety of sources, including camp clinics, referral hospitals, partners such as WHO and UNHCR, and IOM pre-departure health assessments. IOM conducts routine or ad hoc surveillance in many camp locations, as well as enhanced surveillance during outbreaks.

In Nepal, for example, IOM conducts regular surveillance activities using several mechanisms, including: daily active surveillance in Damak and at the Kathmandu transit centre; information gathered through the camp clinics and selected referral hospitals in the area; the WHO Vaccine Preventable Disease Surveillance Bulletin; the UNHCR Health Information System report; and the Health Management Information System report of the District Public Health Office; as well as daily surveillance of audio, visual, paper-based and Web-based sources. The main aim of the surveillance is to

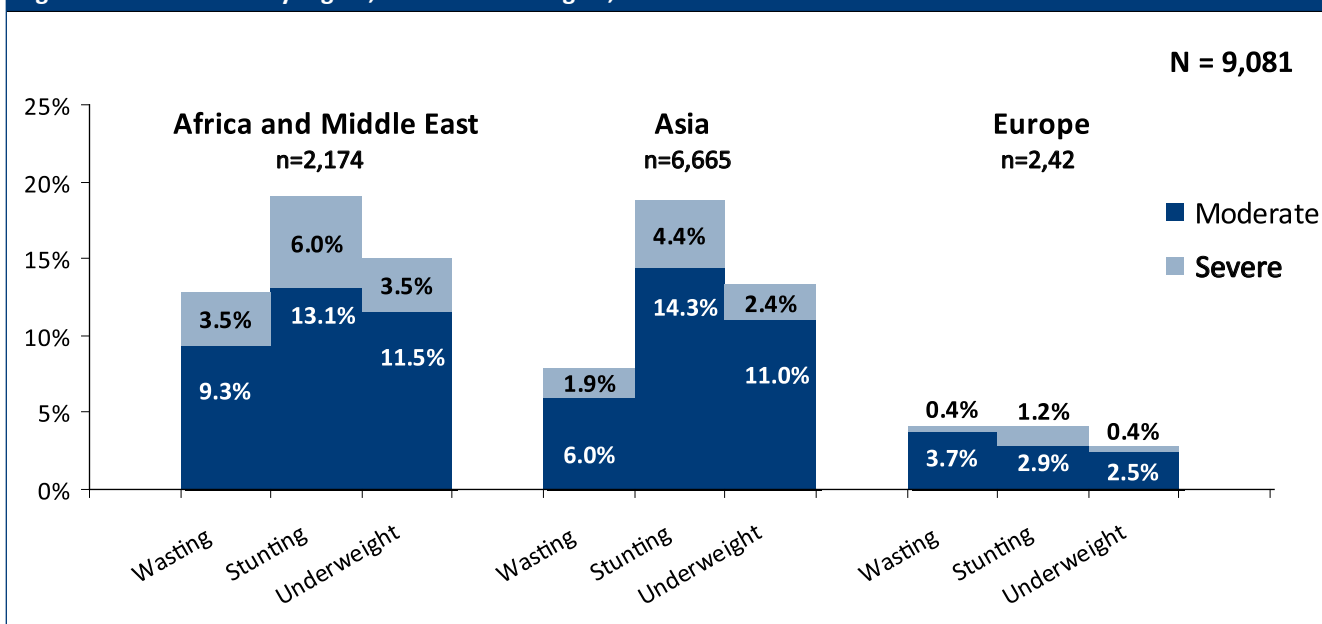
detect communicable disease outbreaks in refugee settlements and surrounding communities as early as possible, to initiate outbreak response and to prevent the exportation of communicable diseases to the country of destination.

Once an outbreak is suspected, information is shared with the concerned authorities and partners, including UNHCR and AMDA, and additional information is sought. If an outbreak is confirmed, concerned stakeholders within IOM and authorities in the resettlement countries are informed; the affected cases are put on hold; active surveillance is put in place; and mechanisms of outbreak response are activated through UNHCR and AMDA. Standard operating procedures and related instruments for communicable disease surveillance and nutritional analysis have been developed.

## Nutritional surveillance

As a component of efforts to strengthen camp surveillance systems, IOM uses data from IOM-assisted refugee health assessments to estimate childhood malnutrition and to refer malnourished children to appropriate feeding programmes. Childhood malnutrition refers to malnutrition affecting children aged 6 months to 59 months. The overall distribution of malnutrition, including wasting, stunting and underweight status, among under-five refugees in 2010 by region is presented in Figure 3. To estimate acute malnutrition, IOM employs the WHO weight-for-height indicator to measure wasting (low weight-for-height). This is considered the best indicator of acute malnutrition and a strong predictor of mortality among children under five. In 2010, the combined prevalence of moderate and severe wasting among under-five refugees assisted by IOM suggests high (12.8%), medium (7.9%), and low (4.1%) levels of acute malnutrition for refugee children from Africa and Middle East, Asia and Europe, respectively. Follow-up activities to IOM nutritional surveillance are undertaken in collaboration with local UNHCR offices and other partners. For example, in Nepal, IOM produces monthly lists of malnourished children, which is shared with AMDA, World Food Programme and UNHCR for provision of supplementary or therapeutic feeding, as necessary.

**Figure 3: Malnutrition by region, children under age 5, 2010**



## Health Education

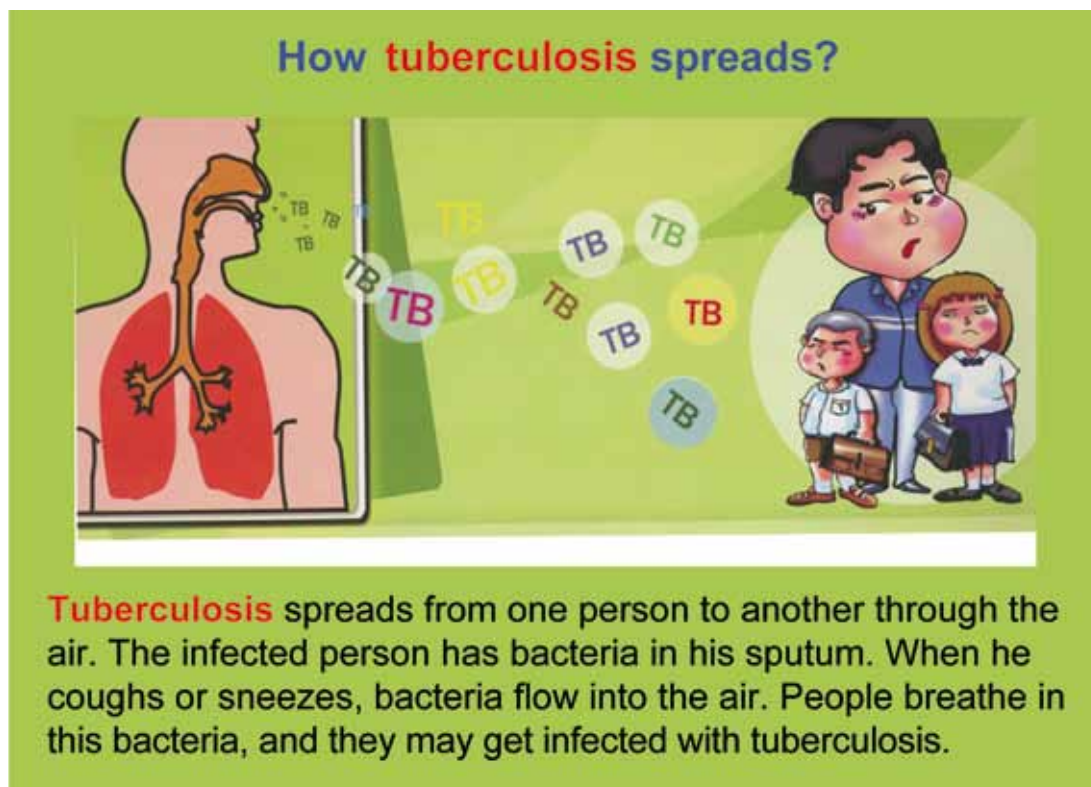
Health education has long been an area of interest for the IOM health assessment programme. Health assessments provide an opportunity to disseminate relevant health information to a captive audience. Such health information is an important element in the preventive approach to disease reduction and the promotion of better health for migrants.

Accordingly, IOM provides a variety of health education services, employing both passive and active methods. For example, IOM clinics use different media to promote awareness about conditions of interest, including flip charts, videos, leaflets and brochures, wall posters and magazines. Often, these materials are developed in conjunction with local hospitals, agencies or ministries of health, and are translated into local languages. Other health education activities include pre- and post-test counselling (for HIV, tuberculosis and others), as well as additional health counselling for certain conditions as needed, information campaigns and

presentations, and training for local agencies. IOM clinics also provide briefings for migrants concerning available health services, such as vaccinations, and certain conditions of interest.

The UKTBDP is one example of an area where IOM has developed a variety of health education materials, with the aim of informing migrants about the disease and its mode of transmission, and empowering them to seek health care upon arrival in the UK should they suspect a need.

In addition to services offered in IOM clinics, in 2010, HAP began to explore the possibility of collaborating with cultural orientation programmes in the context of refugee resettlement. Such orientation classes provide an opportunity for the inclusion of health education in an engaging environment, directly prior to refugee resettlement.



Thailand. TB leaflet used in IOM clinics. (Credit: Ministry of Health, Thailand)

### CDC–IOM Cooperative Agreements

In 2007, the US Centers for Disease Control and Prevention entered into a partnership with IOM, through the mechanism of a Cooperative Agreement (CoAg). The goal of the CoAg was to prevent the disruption of resettlement activities due to unmanaged outbreaks of infectious diseases, to protect public health in the United States against importation and spread of communicable diseases, and to reduce the financial burden on the US health system through improved diagnostics and prevention of communicable diseases, rapid response to outbreaks and epidemics, and improvement in the transmission of health data from IOM to CDC.

Over the course of the ensuing four years, the CDC–IOM CoAg covered the most substantial US-bound refugee populations in East Africa, Nepal and Thailand. The CoAg enabled a wide spectrum of public health activities, such as strengthening camp surveillance systems in locations with large USRP movements and setting up a preparedness system for outbreaks of vaccine-preventable diseases, as well as providing recommended

vaccinations to US-bound refugees, enhancing laboratory capacities for diagnostics of communicable diseases and improving data collection and transmission on the health of refugees.

In 2010, activities under the CoAg included: surveillance for communicable diseases, particularly in Nepal, where active surveillance was conducted both during health assessments and at the Kathmandu Transit Centre; surveillance for malnutrition; dissemination of health education materials in local languages; genotyping for tuberculosis in Nepal; outbreak response activities in both Nepal and Kenya; and the procurement and provision of vaccinations.

## Health informatics systems and data management

Migration health informatics (MHI) has been transforming the way migrant health data are documented, assessed and treated, systematically applying new technologies and computer science to global service provision in the IOM resettlement and immigration programmes, helping MHD to decrease processing time and resources, integrate all migration health activities at the mission level, and standardize and centralize data collection between IOM missions, creating a repository of migrant information at the organizational level.

Supported by the Migrant Management Operational Systems Application (MiMOSA) and the UK TB Global Software, which together cover more than 80 per cent of the assisted migrants, the centralized data collection system helps IOM to analyse and understand patterns of morbidity related to migration health, aggregate data and ensure quality control in services and timely reporting to health regulatory agencies in receiving countries. This, in turn, allows IOM and partner organizations to tailor screening tools for different epidemiological contexts, thereby enabling receiving governments to provide more rational screening protocols as well as better integration services for migrants.

Additionally, MHI enables information exchange between IOM and its partner agencies, improving their capacity to deliver cost-effective and timely services and ensuring the consistency and completeness of data. Such continuation of health care provision through the electronic transmission of relevant data is currently being provided for the CDC, with medical data for more than 164,000 refugees transmitted since the launch of the interface in 2008.



Bangkok, Thailand. Digital radiology at IOM Bangkok. (Photo: Siam Karnchanasai)

The recent development of digital X-ray technologies at IOM missions required MHI support in facilitating the storage, archiving and distribution of digital images, and integrating them into the overall health assessment data management framework. This was achieved by creating a network of picture archiving and communications systems and linking them to existing health information systems. An additional benefit of this technology is the electronic transmission of radiological images across geographical locations (teleradiology) for the purposes of interpretation and consultation. This significantly enhances MHD's quality control procedures by optimizing the use of resources through the delivery of radiological knowledge and skills to locations where this expertise is otherwise unavailable, or by enabling a single radiologist to simultaneously provide services to several IOM locations.



Dhaka, Bangladesh. Debriefing and health education session for clients of the UKTBDP at IOM.



# Health Promotion and Assistance for Migrants

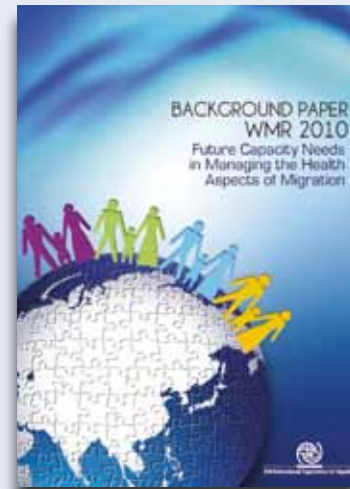
IOM's work in the area of health promotion and assistance for migrants aims to ensure the provision of equitable access to quality health services for migrants and mobile populations, including migrants in irregular situations, such as trafficked persons and stranded migrants, as well as labour migrants and host communities. IOM's strategy, based on the *WHA Resolution on the Health of Migrants*, is to build the capacity of all partners, including those from health and non-health areas, public and private sectors, migrants and host communities, to ensure the sustained delivery of high-quality and comprehensive health and psychosocial services throughout the migration cycle and to provide evidence for policy.

Working in partnership with all relevant sectors such as health, immigration, welfare, labour, youth, social affairs and migration, IOM develops collaborative strategies that benefit both migrants and the communities in which they live by strengthening migrant-sensitive health systems. Furthermore, IOM actively strives to engage with migrant communities and civil society in order to develop culturally and linguistically appropriate and rights-based policies and programmes. IOM believes that building broad partnerships is a key component in the overall strategy to address the health needs of migrants and their host communities. The section below highlights just a handful of the 130 projects under health promotion and assistance for migrants implemented in 2010.



Vienna, Austria, 2010. The IOM Satellite Session "Spaces of Vulnerability" at the International AIDS Conference explored research, lessons learned, and the way forward to reducing HIV vulnerability and risk behaviours among populations living and working in spaces of vulnerability. For more info see [www.iom.int>migration health>hiv and population mobility](http://www.iom.int>migration%20health%20hiv%20and%20population%20mobility).

## Background Paper for the World Migration Report 2010



In 2010, MHD wrote one of the background papers, *Future Capacity Needs in Managing the Health Aspects of Migration*, for IOM's annual World Migration Report (WMR). To align with the capacity-building general theme of the WMR, the background paper looked into the different capacities needed of governments and societies in order to promote health care equity in increasingly diverse societies characterized by high levels of migration and mobility. The background paper stresses that the key issue is how to strengthen health systems within and between countries so as to promote the health of migrants. Minimum standards in accessing health should be defined for all migrants, weighing the rights and dignity of migrants in light of the best interests of the host society, and the costs and benefits of inclusive approaches. ([www.iom.int>publications](http://www.iom.int>publications))

## Europe

In 2010, IOM strengthened its collaboration with the *European Centre for Disease Prevention and Control* (ECDC), including providing advice on emergency and public health risks. This collaboration is one of many strategic partnerships IOM has entered to enhance the capacity to monitor and report on migration health. IOM conducted research and produced the report *Improving HIV data comparability in migrant populations and ethnic minorities in the EU/EEA Countries for ECDC*, which is forthcoming as part of the ECDC migrant health series (2009–2011). The report is

the result of an extensive review of European literature on HIV and migration, expert consultations and a survey among selected experts from governments, relevant international organizations, NGOs, academic institutions and other key stakeholders. The main recommendations include the need for multisectoral approaches and collaboration on migration health in order to address existing research gaps in the field of migration and HIV and AIDS. Furthermore, the report recommends that common research indicators for migration health be developed for use by different European countries to enable comparison and systematic analysis in future research and programming.

### Mental Health and Psychosocial Response

Over the course of 2010, the *Mental Health, Psychosocial Response and Intercultural Communication Unit* provided support to various IOM divisions and field missions in the development of related guidelines and training tools. Most notably, this included a training in Psychosocial Support to Trafficked and Exploited Children for government and NGO officials in Senegal, a module on Psychosocial Protection to Victims of Trafficking in East and Southern Africa for government officials of nine countries in the region, and training in the Psychosocial Needs and Well-being of Migration Professionals for government officials and third-sector care workers in Estonia. Two comprehensive manuals for psychosocial support to victims of trafficking were developed in Thailand and South Africa, and an assessment on mental health gaps was published in Cambodia.

As part of the *Increasing Public Health Safety alongside the New Eastern European Border Line* (PHBLM) project, IOM produced a migrant health database template, guidelines for health-related border management and training materials on migration and health for health professionals and border officials. Evidence generated from the assessment of conditions at checkpoints and places of detention in Hungary, Poland, and Slovakia was used in developing these materials. On the basis of the PHBLM project, IOM has taken part in the revision of the EU External Borders Agency–Frontex Common Core Curriculum (CCC) for the training of border guards, including a section on first aid and occupational health.



The guidelines from the PHBLM project have been designed primarily to support the capacity of border management personnel to handle migration health concerns and public health risks related to migration. For more info see [www.iom.int/migrationhealth](http://www.iom.int/migrationhealth) Increasing Public Health Safety Alongside the New Eastern European Border Line.

To further strengthen its relations with the Ministry of Health and promote the health of migrants, IOM Moldova, in partnership with the Moldovan Ministry of Health, developed a database for Moldovan health workers. This database enables authorities to collect and analyse data on human resources and to monitor the migration of health professionals out of the Republic of Moldova. The database was developed as part of the IOM-funded project *Managing the Impact of Migration on the Health Care System of Moldova* and aims to mitigate the negative impact of the outflow of skilled health workers from the Republic of Moldova on the Moldovan health care system. Moreover, IOM Moldova, again in partnership with the Moldovan Ministry of Health, implemented an information campaign called *Stay Healthy, Wherever You Are!*, which targets potential migrants and their families through wide distribution of information materials and broadcasting of video and audio materials on television and national radio.



Moldova, 2010. Information materials from the campaign were distributed in schools during seminars, in public health centres and hospitals and at checkpoints in Moldova.

IOM conducted several health promotion activities for asylum-seekers and refugees in Europe during 2010 to further support the implementation of the *WHA Resolution on the Health of Migrants*. In Finland, for example, IOM implemented a health promotion project called *Terve tulevaisuus – Health material for refugees, asylum-seekers and health professionals*, which included a resource package (consisting of a DVD, a handbook and handouts) designed to promote access to health care for refugee and asylum-seekers in Finland. The resource package provides information to refugees and asylum-seekers about their rights to health services, helping them to better understand and appropriately make use of the Finnish health care system. The materials are designed to be used widely in reception centres, at private and municipal health care facilities, and as a part of various training events.



Finland, 2010. The text version of the DVD “*Terve tulevaisuus – Health material for refugees, asylum-seekers and health professionals*” can be downloaded in Finnish, English, Arabic, Dari and Somali at [www.tervetulevaisuus.fi](http://www.tervetulevaisuus.fi).

In Poland, IOM worked to establish migrant-friendly health systems by implementing the project *Campaign to improve medical services for asylum seekers in Poland with the support of the National Refugee Fund from the European Commission*. The project sought to improve the quality and efficiency of medical services provided to asylum-seekers in Poland through raising awareness of prevention and treatment of communicable diseases and reproductive health, medical care during pregnancy and child care among asylum-seekers, as well as through increasing the intercultural competences of medical staff.

The project *Enhancing Vulnerable Asylum-Seekers Protection in Europe* was implemented in four European countries (Italy, UK, Netherlands and Greece) and had a particular focus on psychosocial and mental health during the reception phase of the asylum-seeking process. The project involved the exchange of information and best practices at local, national and international levels through the organization of 20 field research studies, four local stakeholders’ round tables,

three transnational steering committee meetings and a final EU-wide conference, held in Rome in July 2010. In addition, a three-day innovative training of trainers programme was developed and tested for a wide range of professionals working or in contact with vulnerable asylum-seekers and refugees in all stages of the asylum procedure. After the training package was tested, the training materials, along with additional resources and a discussion group, were launched ([www.evasp.eu](http://www.evasp.eu)). The assessment and training tools are now being piloted in the UK by the Medical Foundation and the Refugee Council and in Italy by the NGO Connecting People in a selected number of centres.

### IOM Builds Advocacy, Capacity and Partnerships in Europe

As part of the Migration Health Strategy, IOM sets out to do advocacy and capacity-building and build partnerships around the crucial issues of migration and health, notably with regional and international organizations and IOM Member States. In 2010, in Europe and Central Asia, IOM continued to work closely, through consultation processes and joint initiatives, with: EU institutions; governments in the region, in particular those holding the EU Presidency; the Council of Europe; and regional mechanisms such as the Northern Dimension Partnership for Public Health and Social Wellbeing (NDPHS) and the South Eastern Europe Health Network (SEEHN), as well as WHO Euro, many United Nations agencies, notably UNAIDS and UNFPA, and other organizations such as the European Observatory on Health Systems and Policies and the European Public Health Association. In particular, IOM has been one of the authors of the expert report *Moving forward Equity in Health*, annexed to EU Council Conclusions on Equity and Health (June 2010). IOM is also a member of, and has contributed research evidence and expertise to, the EU Working Group on the European Workforce for Health and the EU HIV/AIDS Think Tank, as well as to the work of the ECDC.

Health promotion and protection projects were also implemented for various labour migrant groups in Europe. In Norway, IOM empowered Polish construction workers by providing them with accurate information about their rights and duties as employees, including occupational health and health care. This was implemented in partnership with the *Carpenter and Construction Workers Union* in Oslo and the *Polish–Norwegian Association* in Stavanger. The programme activities included training seminars as well as distribution of relevant information by trained resource persons in the Stavanger area, in addition to the information provided at the project website.



To support health and social protection schemes for labour migrants, since these are critical components for their well-being, IOM, within the framework of a regional Central Asia migration programme, conducted a poll among 1,297 migrant workers on voluntary medical insurance in Russia, Tajikistan and Kyrgyzstan. The data was collected following the Russian national health insurance system's abolishment of compulsory coverage of labour migrants temporarily staying in Russia. It revealed that the majority of labour migrants from Tajikistan and Kyrgyzstan were interested in being covered by a voluntary medical insurance during their stay and work in Russia if it could be provided at a low and affordable fee.

In Serbia, IOM continued to work together with the Ministry of Youth and Sport and municipal governments on a project called *Strengthening Serbia's Human Capital through the Active Involvement of Young People* (SHAPE), which focuses on increasing the participation of youths in democratic processes and counteracting brain drain through community-based activities for young people and their organizations. These activities also aim at enhancing inter-ethnic and sociocultural cohesion in communities, thus increasing well-being and stabilization among young people and community members.



The logo of "Strengthening Serbia's Human Capital through the Active Involvement of Young People" project. For more info see <http://www.iomyouth.rs/index.php/en/programs>.

## Africa

In the African region, IOM, in collaboration with different stakeholders, organized a number of national consultations on migration health in countries such as South Africa, Mozambique and the United Republic of Tanzania to develop and strengthen multisectoral partnerships among relevant stakeholders to advocate

for the inclusion of migration in health policies and programming as part of supporting the implementation of the *Health of Migrants Resolution* (WHA 61.17). For instance, in South Africa, in collaboration with the National Department of Health, the Forced Migration Studies Programme of the University of Witwatersrand and UNAIDS, IOM organized the consultation *Realizing Migrants' Right to Health in South Africa*. In Mozambique, the meeting *HIV Dynamics and Responses in the Road Transport Sector* was organized by IOM in partnership with the Ministry of Transport, ILO and UNAIDS; and IOM Tanzania worked with the Ministry of Home Affairs and the Tanzania Commission for AIDS to arrange the consultation *Migration and HIV in Tanzania among Uniformed Personnel, Mobile Populations and Border Communities*. All three consultations brought together key players from government; civil society, including migrants' associations; and members of the international community to discuss migration health challenges and identify priorities for action, which are currently being implemented. These action plans will be instrumental in monitoring migration health and forming partnerships to promote the health of migrants in these countries. For consultation reports see <http://iom.org.za> > Publications > Migration and Health.

### IOM Press Briefing Note 1/10/2010

#### Zambian Government Launches HIV and AIDS Policy for the Transport Sector

The Zambian government's Ministry of Communication and Transport (MCT) is today launching its new HIV and AIDS policy for the transport sector in Zambia.

Following more than two years of extensive collaboration with IOM through its regional *Partnership on HIV and Mobility in Southern Africa Programme* (PHAMSA), the National AIDS Council (NAC), and partners from the public and private sectors, the new policy aims to provide guidelines and strategic direction for the coordination, implementation, monitoring and evaluation of all workplace programmes in the transport and related sectors, according to Professor Geoffrey Lungwangwa, Minister of Communications and Transport.

With a national HIV prevalence rate of 15.2 per cent among people aged 15–49 years, the Zambian government has highlighted mobility as one of the six key drivers of the HIV epidemic in the country and, in response, has established a national campaign to initiate, revitalize and scale-up innovative HIV prevention programmes for mobile populations.



The HIV and AIDS Policy for the transport sector is designed to help meet this goal, as well as to assist the government in reaching its Millennium Development Goal of arresting and continuing to reverse the spread of HIV in the country by 2015.

The new policy targets people who are employed in building, maintaining and operating transportation and related infrastructures, including railways, roads, airlines and maritime services.

“This policy is a great achievement for the Zambian government and is expected to have a significant positive impact on the lives of migrants, both in Zambia and beyond,” said IOM Chief of Mission in Lusaka, Dr. Andrew Choga.

Similarly, IOM co-organized and provided technical support for a high-level meeting in Djibouti in September 2010, in partnership with UNAIDS, the Intergovernmental Authority on Development (IGAD) and the Government of Djibouti. The aim of this meeting was to establish a multi-country HIV programme response for key population groups such as sex workers and their mobile clients and other vulnerable populations, including irregular migrants and refugees. Approximately 30 governments participated, and the President of Djibouti and the Executive Director of UNAIDS were also in attendance. A Declaration of Commitment for Mobility, Migration and HIV Vulnerability of Populations along the Ports of the Red Sea and the Gulf of Aden was signed by IGAD, as well as by Red Sea and Gulf of Aden countries. A call for action for an International Conference on Port Mobility, Migration and Vulnerability to HIV was also signed. As part of IOM’s approach to migration health, this Declaration will be used to advocate for migrant-inclusive health policies and migrant-friendly health services.



Tanzania, 2010. IOM, together with the Ministry of Home Affairs, produced four short movies as part of the awareness-raising campaign on HIV and mobility in the country focusing on fishing communities, truck drivers, uniformed border personnel and seafarers. (Photo: Real2Reel 2010). For videos see <http://www.iom.int/jahia/Jahia/video-vault>.

## From PHAMSA to PHAMESA

In 2010, the Swedish International Development Agency (Sida) approved the extension of PHAMSA (Partnership on HIV and Mobility in Southern Africa) to PHAMESA (Partnership on Health and Mobility in East and Southern Africa) for about USD 9 million. From 2010–2013, PHAMESA seeks to contribute to the improved standard of physical, mental and social well-being of migrants and their families by responding to their health needs, as well as the health needs of host communities, using IOM’s network of regional and country missions and partnerships with regional economic communities, National AIDS Councils, ministries of health, ministries of sectors dealing with mobile and migrant workers, private sector companies, unions, United Nations partners, and international and local NGOs.

The programme will assist countries in East and Southern Africa in managing migration health and addressing vulnerability to ill health, including HIV and its impacts, through the following components: 1) service delivery and capacity-building; 2) advocacy for policy development; 3) research and information dissemination; 4) regional coordination; and 5) governance and control.

In 2010, reports from several IOM health-related research projects in sub-Saharan Africa were released. In Somalia, IOM Hargeisa, funded by the Global Fund to Fight AIDS, TB and Malaria (GFATM), was invited to lead the first ever biological and behavioural surveillance survey in the country among mobile female sex workers. The study was successfully implemented by IOM in partnership with WHO, the Somaliland National AIDS Commission (SOLNAC), and the Andrija Stampar School of Public Health in Zagreb, Croatia. Based on the study findings, IOM and its partners recommended strengthening the combination of HIV prevention interventions, focusing on HIV testing, risk reduction, awareness-raising and availability of condoms, in order to effectively reach highly marginalized female sex workers.

## IOM on the Ground in Limpopo Province, South Africa<sup>13</sup>

The post-election violence in Zimbabwe in 2008 and the subsequent collapse of the economy resulted in the displacement of hundreds of thousands of migrants spilling into neighbouring countries. Many

<sup>13</sup> The story was collected by an IOM Migration Health Information Officer from Pretoria through telephone interview.

of these migrants sought economic opportunities and asylum in South Africa. The town of Musina in Vhembe District, as the gateway to South Africa, played host to thousands of Zimbabwean migrants during this period. The situation was worsened by the outbreak of cholera that started in Zimbabwe but later spread to Vhembe District, claiming many lives. Access to health care services, food and shelter became expensive commodities.

IOM, with funding from OFDA/USAID, provided non-food items (comprising of water buckets, jerry cans, water purification materials and hygiene packs) to more than 13,000 migrant farm workers. IOM also initiated the establishment of a coordination forum that brings together government departments, international organizations, non-governmental organizations and civil society in the comprehensive management of the humanitarian response. This forum evolved into the current Migrant Health Forum.

Below is a partner's account of IOM and the Migrant Health Forum:

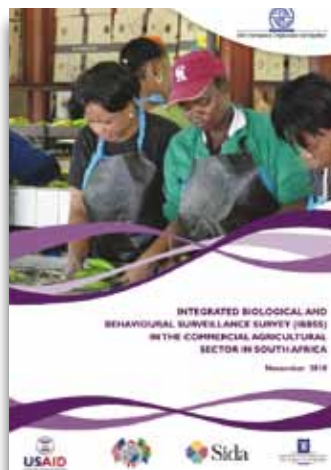
*We first met with IOM in 2008 during the cholera outbreak in Zimbabwe, which spread to our district here in Musina. Following the cholera experience, the Limpopo Office of the Premier, Vhembe District Municipality and IOM initiated a Migrant Health Forum (MHF) to bring together all stakeholders to coordinate health interventions. These stakeholders include international organizations, local non-governmental organizations and local government departments like the police, the defence force and the health department.*

*IOM is the secretariat of this forum and they really are the engine that runs this machine. They have been with us since 2008, offering advice and assistance on implementation of programmes. They are approachable and always ready to help. Without IOM, things would be chaotic. There would be no Migrant Health Forum, and*

*we really need this forum because it promotes accountability. Stakeholders must account for their departments. Working in close coordination and communications with IOM has been and still is a good experience.*

- Alex NemaKonde  
Chairperson, Migrant Health Forum,  
Vhembe District

In order to increase knowledge on the health of migrants, IOM has conducted a number of surveys and research. In South Africa, IOM conducted an Integrated Biological and Behavioural Surveillance Survey (IBBS) to map HIV prevalence among 2,810 farm workers at 23 commercial farms. The farms are located near the Mozambique and Zimbabwe borders, which many workers cross regularly to commute between their home country and their workplace. The study found an overall HIV prevalence of 39.5 per cent among farm workers, which is significantly higher than the national rate of 17.8 per cent. The results have been used to inform policymakers and health workers to design better targeted prevention and treatment programmes.



A report based on an Integrated Biological and Behavioural Surveillance Survey of more than 2,800 farm workers on 23 commercial farms in the Limpopo and Mpumalanga provinces of South Africa. See <http://iom.org.za> > Publications > Migration and Health.



Limpopo Province, South Africa. Alex NemaKonde (far left) during a field visit at Alicedale Farm with migrant workers. (Photo: Gaone Dixon)

In Kenya, IOM completed an HIV IBBS survey among migrant female sex workers in Nairobi, in partnership with the University of Manitoba, Ministry of Public Health and Sanitation, the National AIDS Control Council, UNAIDS and UNFPA (funded by UNAIDS and the Joint UN Programme of Support on HIV/AIDS in Kenya). The study has resulted in a pilot project, implemented by IOM and its partners, UMA Community Based Organization and the National Organization of Peer Educators (NOPE), that is directly reaching the study population with a three-pronged “combination prevention” package that includes access to health services, behaviour change, and structural components such as social support and community advocacy on gender and protection issues. The IBBS found an HIV prevalence of 23.1 per cent among migrant female sex workers, which is on par with the rate for Kenyan female sex workers, but much higher than levels in the general population. HIV knowledge was low among migrant female sex workers, with just 18 per cent knowing that a healthy-looking person can have HIV, and a quarter not knowing that condom use protects against HIV. Just over half had ever had an HIV test, which shows the inadequate reach of health services. Within seven months, the pilot intervention has assisted a total of 1,275 individual sex workers. A total of 653 sex workers are enrolled in the comprehensive programme, and 224 have accessed HIV counselling and testing.

*Due to stigmatization, many female sex workers fear to declare they are engaged in sex work and therefore rarely access health services. This is much worse for migrant female sex workers due to social exclusion. Consistent advocacy and assurance of confidentiality are keys to improving the situation. This pilot project has been greatly welcomed by the women since they can access essential services in a friendly environment.*

- Maurine Achieng, social worker, National Organization of Peer Educators

### Scale-up of Combination HIV Prevention along Transport Corridors in East Africa

Today, transport corridors are an increasingly important aspect of economic development, particularly with the independence of landlocked South Sudan and as the East African Community Partner States are implementing a Common Market Protocol. Countries have identified a persistent gap in effective HIV prevention programming along corridors, and recognize the urgent need for national and regional scale-up of targeted intervention that reach vulnerable women and men. IOM is thus supporting the governments of Kenya

and Uganda, and the EAC Secretariat to undertake gap analyses, implement pilot activities, and bring partners together to develop national and regional strategies. This process will in turn facilitate resource mobilization for the implementation of a harmonized combination prevention package at the national, bilateral and regional levels.

*Some men refuse to wear a condom. Some already have HIV, so they just don't care.*

- A 19-year-old Ugandan female sex worker in a Kenyan truck stop

*We want to see clinics peppered all along the transport corridor, but this can only be achieved with coordinated partnership.*

- Professor Alloys Orago, Director, Kenya National AIDS Control Council

### HIV Service Delivery along Transport Routes in Uganda

As one step in the process of assisting partners in Uganda to develop and scale up a targeted HIV combination prevention package along highway corridors, IOM partnered with UNAIDS and the Amalgamated Transporters and General Workers' Union (ATGWU) to support three private health clinics at truck stops along the Kampala–Juba highway between May and August 2010.

The aim of the project was to assess effective modes of HIV service delivery targeted at vulnerable populations in Kigumba, Bweyale and Karuma. Each clinic received a regular and sufficient supply of free condoms and HIV testing kits, and was supported to conduct mass mobilization campaigns to encourage key populations, including female sex workers, traders and truckers, to utilize available HIV services. IOM and its partners have documented the pilot as an effective model that can be brought to scale.

*In Karuma, people were forgetting about the dangers of HIV and were engaging in unprotected sex. Some non-governmental organizations conduct outreach activities [sic], but this is only done once in a month and many people do not go for testing. IOM's HIV counselling and testing is open any time so now many community members are getting to know their status.*

- Opio Severino, Council Chairman, Karuma, Uganda





Uganda, 2010. The correct and consistent use of condoms is central to behaviour change for HIV prevention. (Photo: Anne Musisi)

## Middle East

In the Middle East, IOM continued to implement activities as part of its Migration Health Strategy during 2010. In Egypt, IOM worked in partnership with the Egyptian Ministry of Health and health care providers to enhance access to primary health care for Iraqi nationals and other migrants residing in Egypt. Activities included provision of direct health services to migrants, training of health practitioners and organizations on migrants' health, and the formation and training of community health volunteers. These community health volunteers are migrants, who have been trained in basic health care in order to conduct home visits to migrant families lacking access to health services. About 150 governmental and non-governmental organizations, health practitioners and policymakers participated in relevant training sessions and workshops, and 1,500 migrants participated in *Health in Motion* events focused on promoting exercise, well-being and hygiene care. Moreover, over the course of 2010, 35 Iraqi women were trained as community health volunteers and regularly conducted home visits to around 500 families. This volunteer service, which included antenatal care, services for malnourished children and socio-economic assistance, directly assisted 968 people.



Cairo, Egypt, 2010. Clowns entertain migrant children during a programme at the **Health in Motion** event, which was jointly organized by IOM and Caritas in Cairo. (Photo: Ahmed Rady)



Cairo, Egypt, 2010. An Iraqi community health volunteer shows her IOM certificate at the closing event of the **Enhancing Access to Primary Health Care for Iraqis** project. (Photo: Ahmed Rady). For more info see [www.iom.int](http://www.iom.int) >Migration Health> Health Promotion for Migrants> Selected projects.



*"The benefits of being a community health trainer have been many," Ines explains as she cradles her daughter Amna on her lap. "I no longer feel like I am a second-class citizen [in Egypt] and I have learned about many issues like the flu, hygiene, basic health and tuberculosis. I am able to share this information with others and because of it, I feel better about myself because I know I am adding value to the community."*

- Ines, migrant participant in IOM Egypt's Community Health Volunteer Programme

## Latin America and the Caribbean

In Latin America, IOM has active health programmes in Colombia, Guyana and Costa Rica. In Colombia, IOM completed the project *Prevention of Gender-Based Violence for Communities along the Colombian Border with Panama, Venezuela and Ecuador*. As part of this project, capacity was built among local stakeholders, including health workers, teachers and police, in the area of prevention, detection and response to gender-based violence (GBV), particularly with regard to spouse/partner violence, inter-family and sexual violence. In addition, five health centres were equipped with the forensic toolkits necessary to provide appropriate medical assistance to victims of GBV. In Guyana, IOM carried out a desk review of national policies, existing studies and research on the links between migration, HIV,



STIs, TB and malaria as part of a new HIV programme with funding from UNAIDS. The project generated evidence on prevalence, policies and programme evaluation on HIV, STIs, TB and migrant populations in Guyana, with the further objective of developing a more comprehensive HIV prevention project among mobile populations.

In Costa Rica, IOM's regional office conducted training on migration health in Central America as part of the project *Migrant Sexual and Reproductive Health and Gender Violence Prevention*, together with UNFPA and Agencia Española de Cooperación Internacional Para el Desarrollo (AECID). IOM developed a one-day course with two modules designed not only to sensitize and inform officials from Ministries of Health and Migration Offices on Health and Migration to promote the establishment of migrant-sensitive health services, but also to develop capacity within other ministries in contact with migrants and mobile populations to address health issues. This included a review of basic concepts that are relevant to migration health, an overview of regional and national migration demographics, an introduction to common migration myths, and the perspective of migration as a social determinant of health.

Furthermore, to improve access to health services among cross border and internal migrants in the region, IOM collaborated with Social Security authorities in Costa Rica to reach populations from Nicaragua and indigenous migrants from Panama that live and/or work in the country. Health promotion information was targeted to people as they passed along migration routes in Costa Rica. Workshops with cultural advisors on farms and other areas with high migrant populations were also conducted about pandemic preparedness and other health information.



Costa Rica, 2010. Workshop about the importance of hand-washing and keeping clean environmental conditions with migrant indigenous Ngäbe Bugle from Panama who work in coffee farms in Costa Rica. (Photo: Luis Solano)

## Asia and Oceania

In Asia, IOM implemented a number of health projects related to labour migration. In Cambodia, IOM, in collaboration with the Cambodian Ministry of Labour

and Vocational Training, developed a pre-departure manual for labour migrants bound for the most common destination countries (Thailand, Malaysia and Kuwait). The manual addresses different health aspects, including sexual and reproductive health; informing prospective labour migrants not only about the general topic, but also about specific health conditions that are prevalent in the destination countries.

To prevent HIV among Bangladeshi migrant workers, IOM, in collaboration with Family Health International (FHI), initiated and established pre-departure and return programmes for Bangladeshi migrant workers. Although the national HIV prevalence is low, risk factors exist for labour migrants residing in other countries and for their families left behind. IOM developed and strengthened the capacity of local government staff from the Ministry of Health and Family Welfare working in migrant-dense areas to provide basic information on HIV to labour migrants and their families through an established pre-departure programme. A referral system for voluntary counselling and testing (VCT) and STI services was also developed in the targeted areas.



Comilla District, Bangladesh, 2010. Training of peer educators (returnee migrants) of a partner organization on HIV and migration issues in the district. (Photo: Saiful Islam)



Bangladesh, 2010. Outreach worker in Bangladesh educating potential migrant workers on HIV prevention at a marketplace. (Photo: Saiful Islam)

In line with the operationalization of the WHA Health of Migrants Resolution, IOM endeavours to establish and maintain partnerships with key stakeholders from different sectors as well as develop and strengthen their capacities to address migration health. In Dushanbe, Tajikistan, IOM opened the Regional Training Coordination Centre (RTCC) on Migration and HIV in March 2010. It was established within the framework

of the regional project “HIV Prevention among Labour Migrants in Central Asian Countries”. The RTCC provides training for government officials (medical staff, customs and border officials), as well as journalists, religious leaders and representatives of NGOs from the Central Asia region. The training provided by the RTCC is based on migration and HIV modules developed by IOM in the framework of the Central Asia AIDS Control Project (CAAP). The modules reflect differences in the migration environment, legislative frameworks, epidemiological situations, and social and cultural traditions in Central Asian countries. Linked to the RTCC, a regional NGO network was also established and aims to carry out HIV awareness-raising activities for migrants and their families.

### **IOM and the Global Fund to Fight AIDS, TB and Malaria (GFATM)**

IOM is increasingly recognized as a key partner at the country level for preventing and responding to AIDS, TB and malaria among vulnerable mobile populations as part of GFATM-funded programmes. In Somalia, for example, as a sub-recipient of an HIV grant, IOM provides community-based HIV prevention and stigma reduction to at-risk adolescent and youth mobile populations. IOM works in partnership with UNICEF, the Somali AIDS Commissions and local implementing partners to increase HIV awareness among vulnerable migrant population groups, including displaced and mobile populations such as sex workers, truck drivers, uniformed service providers, vulnerable youth and women. Furthermore, IOM works to build the capacity of NGOs to effectively coordinate and manage HIV and to decrease HIV-related stigma among key stakeholders, including religious leaders. In 2010, about 90 youth were trained as peer educators and it is estimated that the programme reached about 1,900 youths. Roughly 60 outreach sessions were conducted in 36 schools and youth centres, reaching more than 2,400 most-at-risk populations (MARPs) and exceeding the GFATM target of 1,000 MARPs for 2010. The MARPs reached included mobile population groups such as sex workers, port workers, internally displaced persons (IDPs), migrants, truck drivers, tea sellers, and people in uniformed services.

Additionally, in Tajikistan, IOM has managed the project “*Community mobilization for HIV prevention among labour migrants and their families*” jointly with UNDP, since 2005, with funds from the GFATM. This project aims to reduce HIV prevalence among labour migrants and their families through capacity-building and raising awareness of STIs and HIV prevention. The project has activities in 35 districts

of Tajikistan in close cooperation with the Ministry of Health, the Migration Service Department under the Ministry of Internal Affairs, the Ministry of Labour and Social Protection, local governmental authorities, the primary health care system and local NGOs. Activities in 2010 built upon manuals developed and translated within a previous CAAP supported by the World Bank and the documentary *Har yaki mo* (Every one of us) developed in Tajik and Russian by the GFATM project, along with other promotional materials for radio and television.

## **Migration Health Assistance for Crisis-Affected Populations**

Persons fleeing from an unexpected humanitarian crisis, such as a natural disaster or a sudden onset or protracted conflict, may have increased exposure to health risks due to the nature of their movement. Forced to move, resource-poor mobile and displaced populations often lack access to life-saving and primary health care services, which are critical for the reduction of excess mortality and morbidity during and after movement. For IOM, ensuring and providing access to health care services through a continuity of care approach within an integrated humanitarian response is fundamental.

IOM’s work in health is guided by evidence-based best practices, lessons learned from the field, and international policies, including the Sixty-first World Health Assembly Resolution on the Health of Migrants (WHA 61.17). The Resolution, adopted in May 2008, encourages WHO Member States, partner agencies and key stakeholders to work alongside IOM to “promote migrant-inclusive health policies and practices [and] to promote equitable access to health promotion and care for migrants.” As a call to action, the resolution promotes Member States, partners and key stakeholders, including IOM, to engage with the Global Health Cluster and its work in collaboration with other partners such as national governments, United Nations agencies, civil society and donors, to reduce preventable mortality, morbidity and disability during and after crisis situations.

Contributing to collective efforts to mitigate the burden of disease, IOM works to strengthen and support existing national health systems and infrastructure by providing technical guidance to respond to urgent needs during and after emergencies. Furthermore, IOM has the flexibility and capacity to provide on-site health services in situations where the local health system is non-

existent or unable to meet the demands of the displaced population and the surrounding host community. In such situations, IOM works closely with governments to establish transitional or temporary health posts and mobile outreach clinics to serve as a mechanism for increasing the community's access to health services until a medium-term to permanent solution can be identified and established.

In addition to participating in the Global Health Cluster, IOM is the Camp Coordination and Camp Management (CCCM) Cluster lead in natural disasters, such as in the case of the earthquake in Haiti and the massive floods in Pakistan during 2010. Within this role, IOM's health team partners to facilitate access to health care services through safe transportation to and from hospitals and clinics, travel assistance and transitional shelter referrals, and reintegration of displaced persons to their community of choice.

#### **IOM Health Response in Emergency and Post-crisis Contexts**

- Primary health care provision and community health revitalization
- Medication evacuation and health rehabilitation
- Travel health assistance
- Health referrals, facilitated hospital discharge and assisted returns

#### **Cross-cutting Issues**

- Mental health and psychosocial services
- Environmental health, water and sanitation
- Pandemic preparedness and response
- HIV and TB in emergencies

## **The Haitian earthquake health emergency response**

Already the poorest country in the Western hemisphere, the 7.0 magnitude earthquake that struck Haiti on 12 January 2010 worsened the fragile government and economy and left nearly 1 million people stranded and homeless. In the immediate aftermath of the earthquake, IOM health teams, in coordination with the UN Health Cluster, were dispatched to assist in life-saving efforts.

With IOM as the CCCM lead, IOM's health team was uniquely placed to partner and create synergies among IOM programmes in order to bridge critical gaps in public health, environmental health and psychosocial support. Furthermore, with more than 50 years of experience in logistics and movement assistance IOM led the facilitated movement and referral response

for earthquake victims and vulnerable groups. IOM provided patient transport and assistance services to government- and NGO-run hospitals and health clinics to assist in the return of vulnerable patients and families and improve their access to appropriate health care and rehabilitation support.

*100% friendly and collaborative.*

*The service [provided by IOM] was good – it was very hot, busy and with bad conditions at the hospital – was happy to come to the camp.*

*I had nothing – my house collapsed, I was grateful for everything they [IOM] did. Very good service.*

Comments from Haitian patients stating overall satisfaction after being assisted by IOM's Facilitated Discharge and Referral and Assisted Return Services.

With so many Haitians left homeless by the earthquake, hospitals became a shelter for both the injured and non-injured. The transportation service provided by IOM assisted in the decongestion of overcrowded hospitals and the appropriate placement of patients in camps linking them with available follow-up health services in the community. Linking patients with available health services in the community is a central component of IOM's continuity of care approach. By the end of 2010, over 2,500 patients and their family members have been assisted with discharge and return services from 16 main health care service providers in Haiti.

*[The work of IOM is] Essential – couldn't function without them and without IOM we would have many patients still here on our door, with tents throughout our hospital.*

Comments from health care service providers stating overall satisfaction after being assisted by IOM's Facilitated Discharge and Referral and Assisted Return Services

Furthermore, IOM, in collaboration with the Ministry of Public Health and Population, the University of Haiti-Faculties of Ethnology and Human Sciences, local NGOs and the IASC Mental Health and Psychosocial Support (MHPSS) partners, began providing psychosocial assistance to earthquake-affected populations in February. The Emergency Psychosocial Assistance Project supported more than 160,000 direct beneficiaries living in priority locations in Port au Prince. Activities included community mobilization, arts-based workshops, psychological first aid, discussion groups, counselling sessions and identification and referral of people with pre-existing disorders and those in severe distress. Moreover, IOM co-chaired with UNICEF the Inter-agency Technical Working Group on MHPSS, which was tasked



with mapping, harmonizing and guiding MHPSS services and mainstreaming psychosocial considerations within other cluster policies.

## 2010 Activities Related to the Emergency Psychosocial Assistance Project in Haiti

### Cross-cutting Issue: Environmental Health, Water and Sanitation in the Aftermath of the Haiti Earthquake

In an emergency setting with a large displacement of people, environmental health concerns, particularly access to clean water, sanitation and hygiene, are critical in order to decrease the risk of infection, toxic poisoning and injuries. In Haiti, IOM water, sanitation and hygiene (WASH) teams built and maintained WASH facilities in IDP sites through the installation of water points, hand-washing stations and construction of latrines with de-sludging services. Additionally, approximately 40,000 gallons of drinking water were delivered to IDP sites daily, along with water purification tablets and soap. IOM WASH teams also conducted 507 hygiene promotion activities in the camps and surrounding areas, which included hygiene kit distribution, training of trainers, and the facilitation of community and school sensitization activities and action groups.

- 863 humanitarian workers trained on psychosocially aware provision of humanitarian services; the “Do not harm” principles based on IASC Guidelines for Mental Health and Psychosocial Support in Emergency Settings;
- 238 humanitarian workers trained in psychological first aid and psychosocial response in emergency settings (including specialized training in systemic and family counselling approach and ethnosystemic narrative approach).



Haiti, 2010. IOM co-chairs the Inter-Agency Mental Health and Psychosocial Support Working Group in Haiti, providing secretariat support and leading inter-agency assessment.



Haiti, 2010. An IOM nurse transferring a patient to a Haitian Red Cross ambulance. IOM's Assisted Discharge and Referral project partners with Haitian Red Cross for emergency and ambulance transport.



Haiti, 2010. An IOM national physician assesses amputees and others with earthquake-related injuries in terms of their options and needs for returning to their homes or to camps following discharge from hospital. IOM assisted all of these patients to return to either their homes or to managed camps and linked them with rehabilitation support upon discharge.



Haiti, 2010. Recreational activity for children.



## Haiti: Cholera Response

Within 10 weeks after the initial confirmed case of cholera in Haiti on 21 October, the outbreak had spread country-wide. As the CCCM lead and in close collaboration with the Government of Haiti and the Ministry of Health, IOM began a 3 x 3 approach focusing on direct service delivery of cholera response activities across the country through the support of local, national and international partners. IOM focused interventions on the key service areas of awareness, prevention and first-line treatment and referral activities in three main geographic areas, including IDP sites, vulnerable rural communities and around main border-crossing areas with the Dominican Republic.

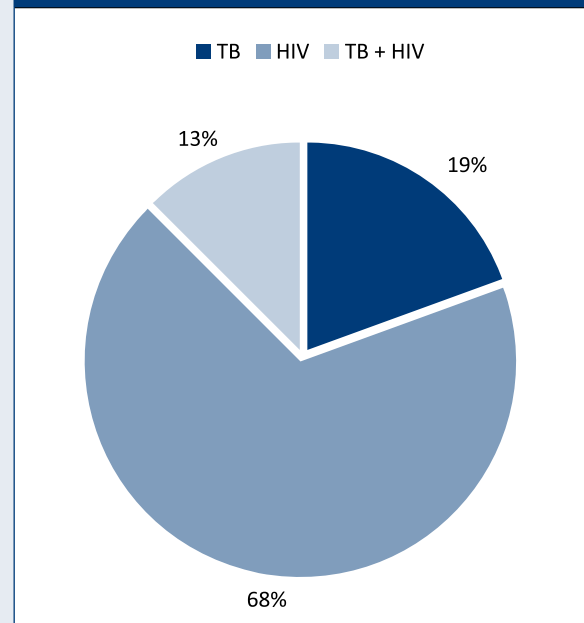
Specifically, IOM's health unit trained 593 brigadiers and camp community members in cholera awareness, prevention and treatment. The training, in line with the Ministry of Public Health and Population's (MSPP) Community Brigade Strategy, enabled the establishment of more than 120 oral rehydration posts in camps. These posts offered first-line oral rehydration solution (ORS) treatment, referral to cholera treatment units and centres when necessary, disinfection activities for positive cases, and community education about cholera and the appropriate response. IOM collaborated closely with the Ministry of Health by directly and indirectly supporting new community cholera workers through training conducted following the Ministry of Health curriculum and the supervision of newly trained workers in the field. As a key partner in the Health Cluster, IOM worked with the Pan American Health Organization (PAHO) and WHO to map cholera treatment facilities, provide cholera prevention items, coordinate psychosocial response and technical support, and assist in facilitated discharge and health referrals for cholera patients to and from health care services.

IOM's psychosocial teams worked with IDP populations to investigate, address and provide support to the population at large, tackling issues of prevention, myths and misperceptions and fears. In the fall of 2010, under IOM technical leadership, a document providing recommendations for cholera prevention workers was shared with local and international agencies on the most appropriate ways to deal with common myths and misperceptions surrounding cholera.

## Cross-cutting Issue: HIV and TB in Emergencies

In collaboration with UNAIDS, IOM Haiti worked to mainstream HIV considerations in CCCM, as well as provided direct support and services for camp populations living with HIV and/or TB. These services included assisted referral and discharge support, training of condom focal points in camps, mapping of camps and TB facilities, and case finding and diagnosis support for TB and TB/HIV cases in camps.

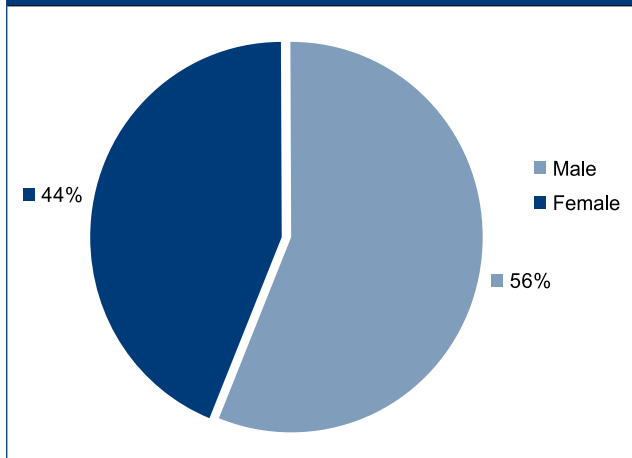
**Figure 4: TB and HIV patients from Haiti Referral Project, percentage by vulnerability, 2010**



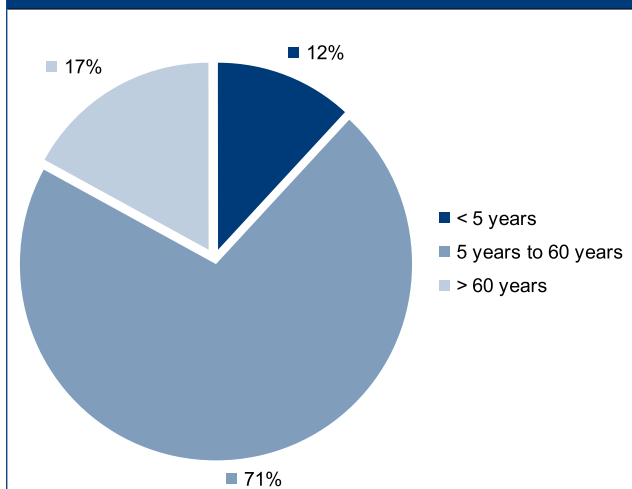
## Massive flooding in Pakistan

The massive flooding from heavy monsoons in late July through August placed approximately a fifth of Pakistan's total land area underwater and displaced a large portion of the population. The IOM Pakistan health team supported the Pakistani Ministry of Health in the four worst-affected districts: Muzaffargarh and Rajanpur in Punjab province, and Thatta and Dadu in Sindh. IOM provided emergency health care services to more than 90,000 IDPs and assisted nearly 1,000 severely ill patients in accessing specialized health services in tertiary-care facilities which were, in some instances, up to 200 km away. The health teams also contributed to malaria control efforts by mobilizing community health educators and distributing of 10,000 bed nets. As part of primary health care provision, IOM supported vaccination services by providing 5,000 VeroRab vaccines in the affected districts.

**Figure 5: Percentage of gender-disaggregated beneficiaries from Assisted Referral Services in Pakistan, 2010**



**Figure 6: Percentage of age-disaggregated beneficiaries from Assisted Referral Services in Pakistan, 2010**



IOM's work in health referrals was particularly important in Pakistan, where health teams established an innovative telemedicine network. The programme focused on building the capacity of local area clinics to refer patients to regional hospitals. This expansion of the existing telemedicine network was piloted in South Punjab, allowing flood-affected areas to improve access to quality specialized health care at virtually no cost. For example, IOM clinics in Mithan Kot, Lahore and Karachi formed partnerships with Holy Family Hospital and Sheik Zaid Hospital in Rahimyar Khan to facilitate consultations for flood-affected patients by specialists such as radiologists, dermatologists, and ear, nose and throat (ENT) specialists. Thanks in part to close collaboration with the Ministry of Health in Pakistan, donors and stakeholders, IOM health teams were able to assist vulnerable individuals and families affected by the historic flood through both primary health care interventions and facilitated health referrals.

### IOM Pakistan: Health Referrals Through Innovative Means

Poor and malnourished after the floods affected her district of Rajanpurt, a 55-year-old woman came to the IOM clinic in THQ Kot Mithan with a high-grade fever, cough, and shortness of breath. The doctors immediately stabilized her using available tools, oxygen therapy and intravenous antibiotics. Knowing that they did not have the facilities to assist her further, IOM doctors, using the new, innovative approach of telemedicine, referred the woman to DHQ hospital in Rajanpur. At the hospital, pathological tests and a chest X-ray were completed, which confirmed the diagnosis and allowed the doctors to prescribe the correct treatment.

It was this facilitated health referral which saved her life. When asked how she had come to know about the IOM clinic, she replied: "My neighbour who suffered from a similar illness told me that there is very good medicine available at the IOM clinic that could heal me." She was so thankful to the clinic and the doctors. "You are doing a great job for the community, especially for poor ones," she said.



Punjab, Pakistan, 2010. A doctor on IOM's mobile medical team in Punjab provides primary health care to a flood victim. (Photo: Marco Bottelli)



Punjab, Pakistan, 2010. Forty-seven-year-old **Sadiq Hussain** (right) talks to an IOM doctor (left). IOM's mobile medical team in Punjab provided primary health care to flood victims in remote areas. (Photo: Marco Bottelli)

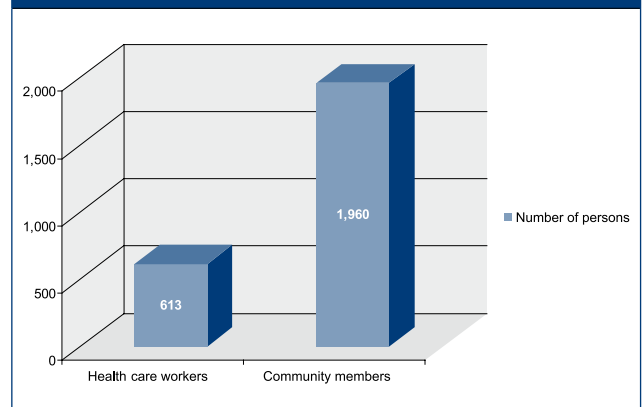
## Health system strengthening in post-conflict Sri Lanka

IOM's Emergency Response Programme in Sri Lanka involved both emergency humanitarian action and interventions aimed at facilitating post-conflict health systems recovery. Since the end of the conflict in May 2009, IOM Sri Lanka, in partnership with the Ministry of Health, has provided emergency health care services to over 285,000 conflict-displaced people in northern Sri Lanka. In 2010, IOM played a continuing role in providing primary health care-related interventions in areas of return and in IDP camps. IOM's support to the returnee process includes: ambulance care across four post-conflict districts; mobile clinics with IOM-supported MOH medical staff providing primary health care services; disease surveillance and response programmes; a vector control programme; health worker transportation to remote settings; provision of short-term consultants to disaster response units; accommodation for staff at IDP settings; and training and management of a large network of health volunteers under the auspices of the MOH. In 2010, IOM began restoring peripheral hospitals to functional status in conflict-affected areas in the north by strengthening laboratory support and emergency rooms at referral centres, providing necessary medical supplies and equipment, and providing transport for medical specialists to resource-poor districts on a short-term basis. Under the directive of the MOH, IOM established a temporary rehabilitation hospital unit at Menik Farm IDP camp for civilians injured during the conflict, and also provided psychosocial support and health promotion programmes to raise awareness of vector-borne dengue fever.

*IOM immediately mobilized in the aftermath of the conflict, setting up primary health care services, supporting MOH's vertical programmes and also medical referral services in the IDP camps in Menik Farm. I am happy to say that IOM continued to support us in the next phase when the war-displaced population was resettling into their places of origin after the land mines were cleared and roads were rebuilt. IOM supported my unit with consultants and hire vehicles and worked in close partnership with us to restore and strengthen the war-damaged health system in the north. IOM restored rural hospitals to functional status, strengthened public health laboratories, and revitalized emergency rooms and premature baby units at referral hospitals. Without IOM's support, the health system, and thus the population, would certainly have suffered. As the Secretary of Health to Northern Province, I am privileged to work with such a dynamic organization.*

- Mr. R. Raveendran, Northern Secretary of Health,  
Ministry of Health, Government of Sri Lanka

**Figure 7: Number of persons trained by IOM Sri Lanka, 2010**



Sri Lanka, 2010. IDP children inside the community centre at Zone 4 in Menik Farm supported by IOM.



Sri Lanka, 2010. MHD Director **Dr. Davide Mosca** visited the dormitory refurbished and supported by IOM for health personnel working in Menik Farm.



## Long-term assistance provided in protracted civil conflict in Colombia

Over the past decade, IOM Colombia has worked to develop and implement a comprehensive plan of direct assistance for people internally displaced due to civil conflicts and unrest. This direct assistance plan includes a broad range of services such as income generation, vocational training and capacity-building, shelter and education. To complement this overall response, IOM also provides psychosocial and health services, as well as a focus on health system strengthening activities. For instance, in January 2010, the health team launched a pilot psychosocial project that sought to strengthen individual, family and collective well-being and resilience. This project was particularly unique because it aimed to provide more than just social services, focusing also on the emotional, relational and cultural needs of the individuals and the community. In 2010, the pilot directly assisted 5,000 families in 35 municipalities throughout Colombia. Its success led to the inclusion of psychosocial indicators in the overall monitoring system. In line with IOM global policies, guidelines for case management and follow-up were established and government officials and carers received training on psychosocial responses to displacement.

### Cross-cutting Issue: Pandemic Preparedness and Response

In 2010, IOM strengthened national capacity to meet the needs of migrants during a pandemic. This was done by strengthening national pandemic and disaster management plans and advocating for the implementation of plans at the district level and the inclusion of migrant needs. For example, IOM Nicaragua, in collaboration with UNFPA, organized a binational meeting to advocate for the inclusion of migrant needs into national pandemic preparedness plans and to discuss a coordinated response. Additionally, IOM focused on raising awareness through pandemic preparedness and social mobilization activities for migrants, civil society and national agencies. In Egypt, seven awareness-raising sessions on pandemic preparedness were conducted, reaching at least 150 migrants. Furthermore, IOM trained 280 migrant community leaders in Lebanon and Egypt on the reduction of influenza-like illnesses.

### Cross-cutting Issue: Mental Health, Psychosocial Response and Intercultural Communication

This year, IOM strengthened its role within the Inter-Agency Standing Committee (IASC) Reference Group on Mental Health and Psychosocial Support in Emergency Settings. In particular, IOM collaborated on the drafting of the IASC guidance note for the Haiti emergency and co-chaired the IASC Mental Health and Psychosocial Technical Working group for Haiti, together with UNICEF. IOM's experts peer-reviewed several inter-agency tools, including the new Psychological First Aid Guidelines, making sure that intercultural and migrant specific considerations were included. Moreover, IOM took the lead in mainstreaming the relevant IASC guidelines within the activities and tools of the Global Camp Coordination and Camp Management Cluster, resulting in two presentations to the Global Cluster and a plan of action, which was included in the work plans of both the CCCM cluster and the MHPSS group.

Over the past year, IOM established partnerships and secondment agreements with the Centre for Trauma, Asylum and Refugees of the University of Essex in the UK; the Traumatic Stress Service of the Maudsley Hospital-King's College in London; the Trans-cultural Therapy Foundation in Rome, Italy; the Foundation Minkowska in Paris, France; the Faculties of Human Sciences and Ethnology of the University of Haiti; and the Scuola Superiore Sant'Anna in Pisa, Italy. Presentations on the mental health of migrants and crisis-affected populations were held, inter alia, at the Geneva Health Forum, the Congress of Transcultural Psychiatry, the Conference Performance with a Purpose at the University of London and in several relevant academic courses.

In 2010, the Mental Health, Psychosocial Response and Intercultural Communication Section provided support to various IOM departments and field missions in the development of related guidelines and training tools. For instance, IOM's Rapid Psychosocial Assessment Tools in Emergency, Early Recovery and Return was published in English, translated into French and Spanish, and was finalized and tested in Haiti, the Democratic Republic of the Congo, Kenya and Pakistan. Furthermore, an additional handbook containing 12 training modules on emergency psychosocial assistance was also finalized in Lebanon in English and Arabic.

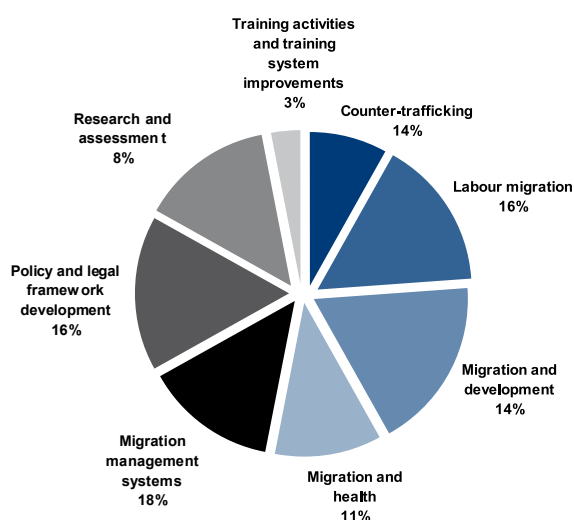


# IOM's 1035 Facility and Health

IOM's 1035 Facility (Support to IOM developing Member States and Member States with economies in transition) continues to be a responsive and flexible funding mechanism to address the capacity-building needs of Member States. It is designed to allocate resources (up to USD 5.5 million in 2010) towards the many significant migration-related needs of Member States. Among these is the need to respond and manage the health related aspects of migration. For this reason, the 1035 Facility has contributed, since 2001, to a number of migration health projects in a variety of Member States. From 2001 to the end of 2010, the 1035 Facility has contributed up to USD 2,101,000 (nominal) towards health migration projects.

The kinds of health projects that have been supported by the 1035 Facility have included projects specifically dealing with HIV/AIDS and reproductive health, and projects addressing technical cooperation and capacity support in the area of migration and health. Other themes covered included communicable diseases, education/improvement of health knowledge and improving health care systems, services, access and counselling.

Percentage distribution of 1035 Facility allocations per project category, 2010



## **“Enhancing the Capacity of the Ministry of Health to Assist Victims of Trafficking in Egypt” (2009)**

1035 Facility funding: USD 200,000

The goal of this still-ongoing project is to help Egypt's Ministry of Health enhance protection for victims of trafficking by providing comprehensive medical and psychological support to victims.

So far, the project has, among other things, set up a trafficking victims support unit which has established standard health treatment and testing protocols for victims of trafficking. Fifteen doctors and nurses at the National Bank Hospital in Maadi, Cairo have been trained in applying these protocols. The victims support unit is already equipped and nearly in operation. Twenty-five victims have been screened and once the victims support unit is fully operational, IOM will begin referring victims there for assistance.

In April, the UN Special Rapporteur on Trafficking in Persons, Dr. Joy Ngozi Ezeilo, visited Egypt to assess the situation of human trafficking in Egypt, including a visit to the victims support unit, using the opportunity to highlight the importance of providing medical care to victims of trafficking.

## **“A Pilot Project for the Construction of an Intersectoral Response to Sexual and Reproductive Health” (2002)**

1035 Facility funding: USD 48,233

This 1035 Facility project for Colombia in the area of health, with emphasis on STDs/HIV/AIDS, was developed in order to check the methodologies and instruments outlined in an earlier pilot project proposal which was presented by the Government of Colombia to the Global Fund but which was, unfortunately, not funded.

The objective was, therefore, to improve the development of a subsequent project proposal, by means of various technical adjustments, with the intention of once again presenting it to the Global Fund, this time with confidence that it would be approved.

The adjustments to the subsequent proposal were made by implementing the earlier-proposed pilot project with 1035 seed funding, while evaluating and analysing the whole project process, the methodologies and their results.

The project activities involved, among other things, the creation of partnerships between the private and public sectors in order to educate communities on HIV/AIDS through the efforts of peer educators.

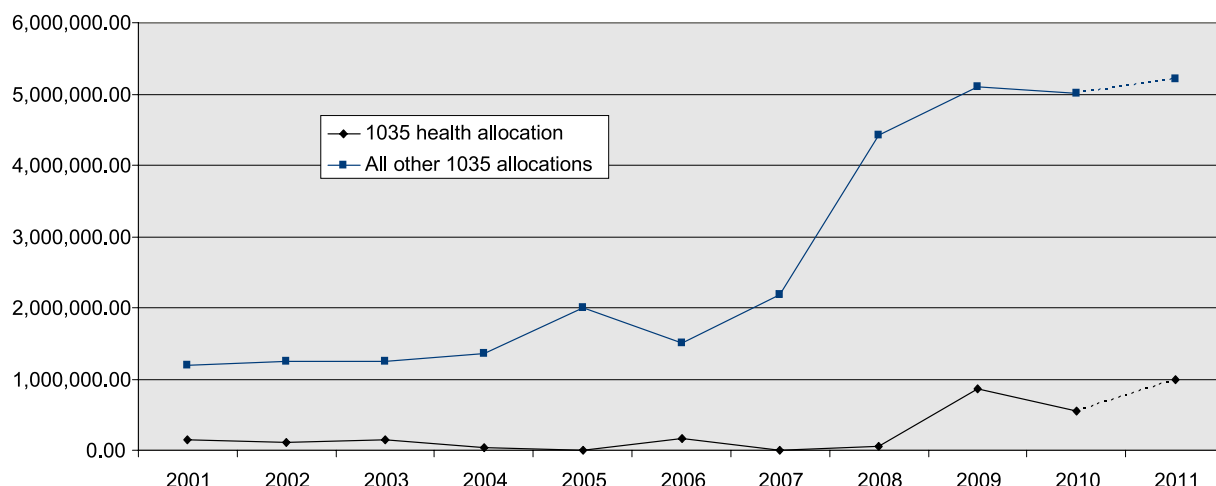
In the end, the Global Fund approved the subsequent, improved, project proposal presented by Colombia, awarding the project with a budget of USD 8,768,000 for a period of four years.

As an IOM official said that the time, this project serves as a “striking example of successful application of the 1035 Facility.”



HIV/AIDS peer educators.

### 1035 health project allocations compared to all other allocations, 2001–2010 (with 2011 est.)



#### **“Facilitation of the Recruitment and Placement of Foreign Health Care Professionals to Work in the Public Sector Health Care in South Africa: Assessment” (2006)** 1035 Facility funding: USD 69,925

The project was a preliminary assessment phase of a subsequent envisaged programme that aims to strengthen the capacity of public sector health care services in South Africa by facilitating the recruitment and placement of foreign health care professionals.

The interest and availability of health professionals from the Netherlands, the United Kingdom and the United States to work in the public health sector in South Africa were assessed by means of a mapping exercise of relevant institutions and associations.

The human resource shortages in the South African public sector health care desperately called for improved capacity for the successful delivery of quality health care services, particularly to underserved areas. The project thus aimed to help fill this human resources gap.

A second aspect of this project was to provide information to the general public in South Africa, as well as to create a network of relevant stakeholders on issues pertaining to health worker migration in South and Southern Africa, which is still ongoing.



Seafarers.



Educational materials for seafarers.

#### **“Seafarers Health Education Counselling (SHEC) – Building the Capacity of Diagnostic Clinics” (2004)**

1035 Facility funding: USD 49,180

This project improved the capacity of Philippine diagnostic clinics in the area of so-called “voluntary confidential counselling and testing”, thereby contributing to the enhancement of the clinics’ provision of HIV and STI education, specifically aimed at persons in the seafaring profession.

Diagnostic clinics were provided with training on pre-/post-test counselling on HIV and provided with educational materials – which, among others, included a well-received comic book based on the actual experiences of seafarers – for distribution among target groups, in diagnostic clinics and other appropriate venues.

In addition, this project actively involved persons living with HIV, specifically seafarers, in peer education and monitoring activities. In all, about 240 seafarers were counselled by 11 peer counsellors, either in groups or individually.

Through all of this, the project built upon existing best practices and developed a new model that could be scaled up in future similar interventions worldwide.

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# Annex 1: Service Delivery in Numbers, 2010

## Migration Health Assessments and Travel Health Assistance

### Service delivery and beneficiary profiles

**Table 2: IOM health assessments by country of origin, country of destination and migrant category, 2010**

Country of IOM health assessment	Country of destination					
	Australia		Canada		New Zealand	
	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees
Afghanistan	118	10	154	117	21	9
Bangladesh	524	121	79	3	0	6
Cambodia	1,621	0	572	4	717	0
Indonesia	52	582	106	0	1	0
Kazakhstan	136	0	623	97	10	0
Kyrgyzstan	0	1	0	0	0	0
Malaysia	0	381	0	131	0	197
Nepal	0	1,396	0	1,336	0	139
Pakistan	5,581	1,047	1,510	46	24	0
Thailand	0	1,124	0	110	0	0
Uzbekistan	0	0	0	0	0	0
Viet Nam***	2,501	0	3,064	0	141	0
<b>Asia and Oceania</b>	<b>10,533</b>	<b>4,662</b>	<b>6,108</b>	<b>1,844</b>	<b>914</b>	<b>351</b>
Angola	0	0	0	0	0	0
Bahrain	0	0	0	0	0	0
Benin	0	0	28	6	0	0
Botswana	0	0	0	0	0	0
Burkina Faso	0	1	0	0	0	0
Burundi	0	0	10	64	0	0
Chad	0	5	0	0	0	0
Côte d'Ivoire	0	0	0	0	0	0
Democratic Republic of the Congo	0	0	0	6	0	0
Djibouti	0	4	6	27	0	0
Eritrea	48	32	48	177	0	0
Ethiopia	275	105	1,590	342	0	7
Gabon	0	0	0	0	0	0
Gambia	0	0	0	0	0	0
Ghana	105	60	147	17	1	0
Guinea	7	155	87	0	0	0
Iraq	333	143	41	0	61	0
Jordan	61	142	0	0	3	0
Kenya	1,291	418	680	636	84	0
Liberia	17	0	0	44	0	0
Malawi	0	0	0	0	0	0
Mozambique	0	0	0	0	0	0
Namibia	0	0	0	0	0	0
Nigeria	0	0	8	20	0	0
Republic of the Congo	0	0	7	0	0	0
Rwanda	33	83	2	6	0	0
Senegal	0	0	0	0	0	0
Somali Republic	0	0	0	1	0	0
South Africa	0	0	0	0	0	0
Sudan	0	0	1	0	0	0
Syrian Arab Republic	1	285	40	486	0	0
Togo	0	5	0	0	0	0
Uganda	140	294	99	159	2	19
United Republic of Tanzania	16	196	7	52	0	0
Zambia	0	0	0	0	0	0
Zimbabwe	0	0	0	0	0	0
<b>Africa and the Middle East</b>	<b>2,327</b>	<b>1,928</b>	<b>2,801</b>	<b>2,043</b>	<b>151</b>	<b>26</b>
Belarus	74	0	409	0	19	0
Bosnia and Herzegovina	132	0	173	38	1	0
Bulgaria	0	0	464	0	0	0
Croatia	141	0	65	0	11	0
FYROM***	173	0	193	0	5	0
Republic of Moldova	51	0	1,981	0	8	0
Romania	121	0	1,525	0	25	0
Russian Federation	997	0	1,739	287	303	0
Serbia	392	0	412	0	9	0
UNSC resolution 1244-administered Kosovo	26	0	293	0	6	0
Ukraine	353	0	3,775	0	81	0
<b>Europe and the Commonwealth of Independent States</b>	<b>2,460</b>	<b>0</b>	<b>11,029</b>	<b>325</b>	<b>468</b>	<b>0</b>
<b>Worldwide</b>	<b>15,320</b>	<b>6,590</b>	<b>19,938</b>	<b>4,212</b>	<b>1,533</b>	<b>377</b>
		21,910		24,150		1,910

\* Immigrants moved on a voluntary basis

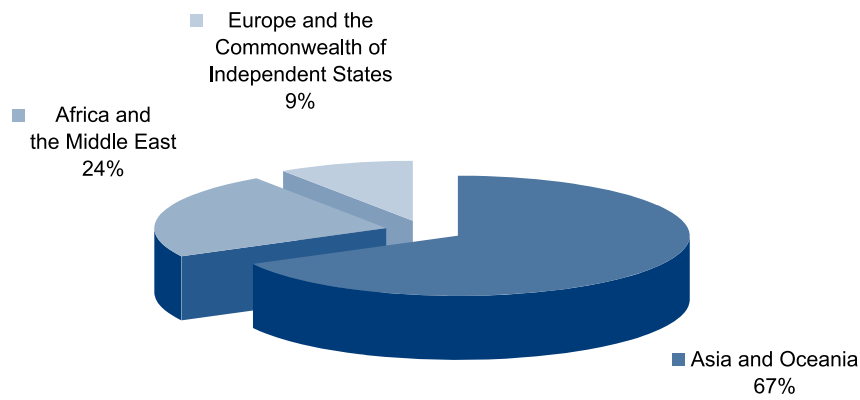
\*\* Refugees were displaced on an involuntary basis and fall under the definition of the 1951 UN Convention

\*\*\* In addition, IOM Viet Nam conducted health assessment for 281 humanitarian resettlement cases bound for the United States

\*\*\*\* The former Yugoslav Republic of Macedonia

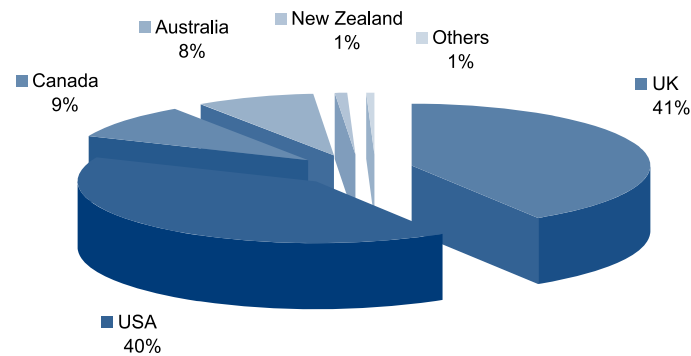
Country of destination									
UK		USA		Other		Total		Grand total	
Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees		
0	0	0	0	0	0	293	136		429
23,879	113	0	280	0	0	24,482	523		25,005
115	0	1,525	6	1	0	4,551	10		4,561
0	0	0	0	0	0	159	582		741
0	0	33	90	0	0	802	187		989
0	0	14	119	0	0	14	120		134
0	0	0	11,096	0	100	0	11,905		11,905
0	117	1,764	15,073	0	210	1,764	18,271		20,035
68,157	0	0	0	0	0	75,272	1,093		76,365
7,809	0	0	15,162	0	42	7,809	16,438		24,247
0	0	5	62	0	0	5	62		67
0	0	9,600	0	0	0	15,306	0		15,306
99,960	230	12,941	41,888	1	352	130,457	49,327		179,784
0	0	0	1	0	0	0	1		1
0	0	0	90	0	0	0	90		90
0	0	0	0	0	0	28	6		34
0	0	0	20	0	0	0	20		20
0	0	0	0	0	0	0	1		1
0	0	0	39	0	0	10	103		113
0	0	0	11	0	0	0	16		16
0	0	0	1	0	0	0	1		1
0	0	0	0	0	0	0	6		6
0	0	0	360	0	0	6	391		397
0	0	0	0	0	0	96	209		305
0	0	409	6,254	0	221	2,274	6,929		9,203
0	0	0	0	0	0	0	0		0
0	0	0	0	0	0	0	0		0
4,331	0	46	275	0	0	4,630	352		4,982
0	0	0	106	0	0	94	261		355
0	5	151	9,465	0	0	586	9,613		10,199
0	124	1,450	6,072	240	109	1,754	6,447		8,201
3,067	244	6,932	6,572	0	108	12,054	7,978		20,032
0	0	0	0	0	0	17	44		61
0	0	0	136	0	0	0	136		136
0	0	0	193	0	0	0	193		193
0	0	0	30	0	0	0	30		30
0	0	0	0	0	0	8	20		28
0	0	0	0	0	0	7	0		7
0	124	0	317	0	0	35	530		565
0	0	0	1	0	0	0	1		1
0	0	0	0	0	0	0	1		1
0	0	0	678	0	0	0	678		678
983	0	0	0	0	232	984	232		1,216
0	158	0	0	0	232	41	1,161		1,202
0	0	0	0	0	0	0	5		5
0	0	173	516	0	0	414	988		1,402
1,017	0	5	1,817	0	0	1,045	2,65		3,110
0	0	0	285	0	0	0	285		285
0	0	0	90	0	0	0	90		90
9,398	655	9,166	33,329	240	902	24,083	38,883		62,966
0	0	31	73	0	0	533	73		606
0	0	0	0	0	4	306	42		348
0	0	0	0	0	0	464	0		464
0	0	0	0	0	0	217	0		217
0	0	0	0	0	0	371	0		371
0	0	320	212	0	0	2,360	212		2,572
0	0	0	0	0	0	1,671	0		1,671
0	0	3,281	697	8	5	6,328	989		7,317
0	0	178	0	121	0	1,112	0		1,112
0	0	0	0	0	0	325	0		325
0	0	5,540	458	0	0	9,749	458		10,207
0	0	9,350	1,440	129	9	23,436	1,774		25,210
109,358	885	31,457	76,657	370	1,263	177,976	89,984		267,960
110,243		108,114		1,633		267,960			(268,241)***

**Figure 8: IOM health assessments by region of origin, 2010**



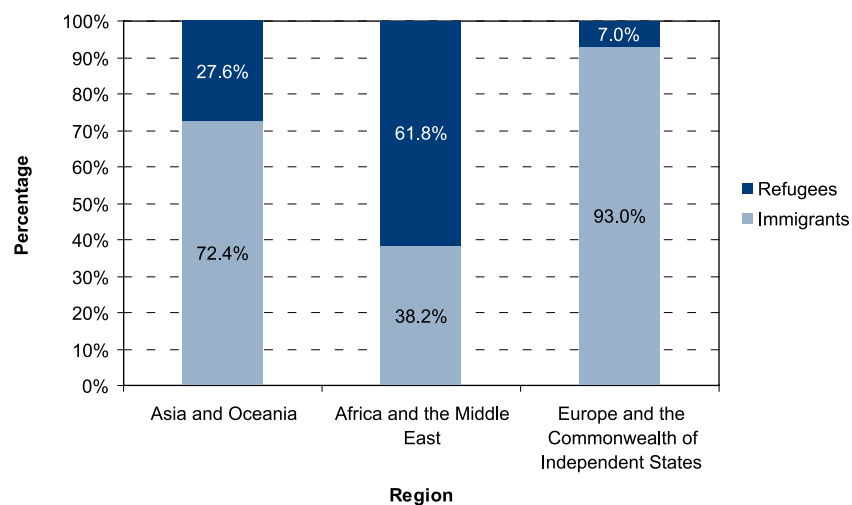
**Individuals assessed = 268,241**

**Figure 9: IOM health assessments by country of destination, 2010**



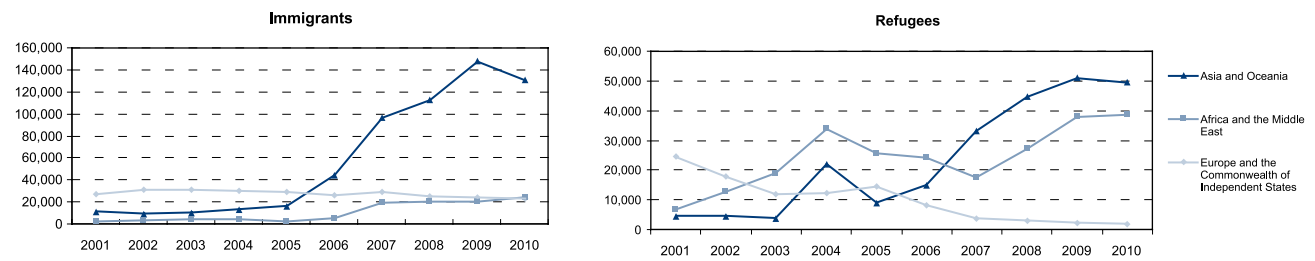
**Individuals assessed = 268,241**

**Figure 10a: Immigrants and refugees examined by region of origin, 2010**

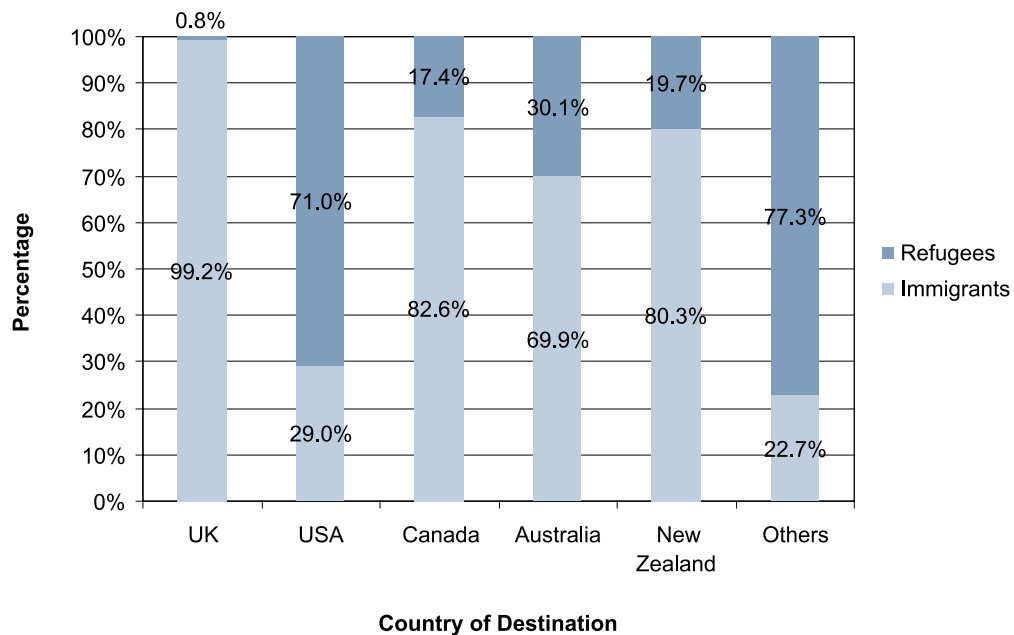




**Figure 10b: Immigrants and refugees examined by region of origin, 2001–2010**



**Figure 11a: Immigrants and refugees examined by country of destination, 2010**



**Figure 11b: Immigrants and refugees examined by country of destination, 2001–2010**

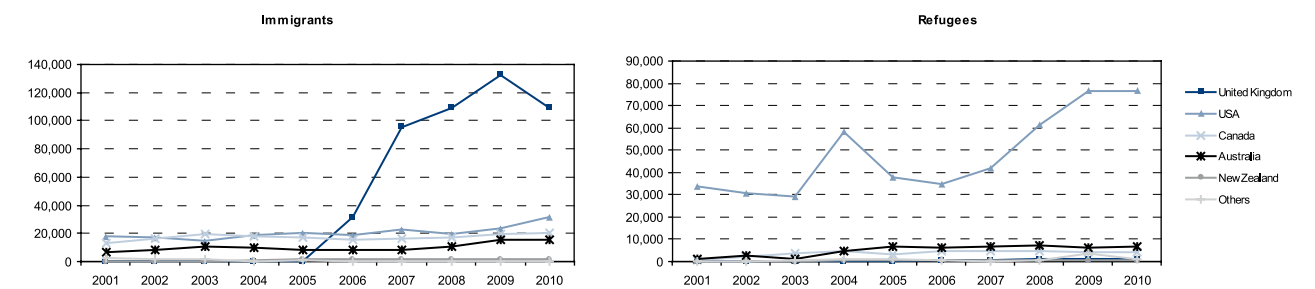


Figure 12: IOM health assessments by region of origin, 2001–2010

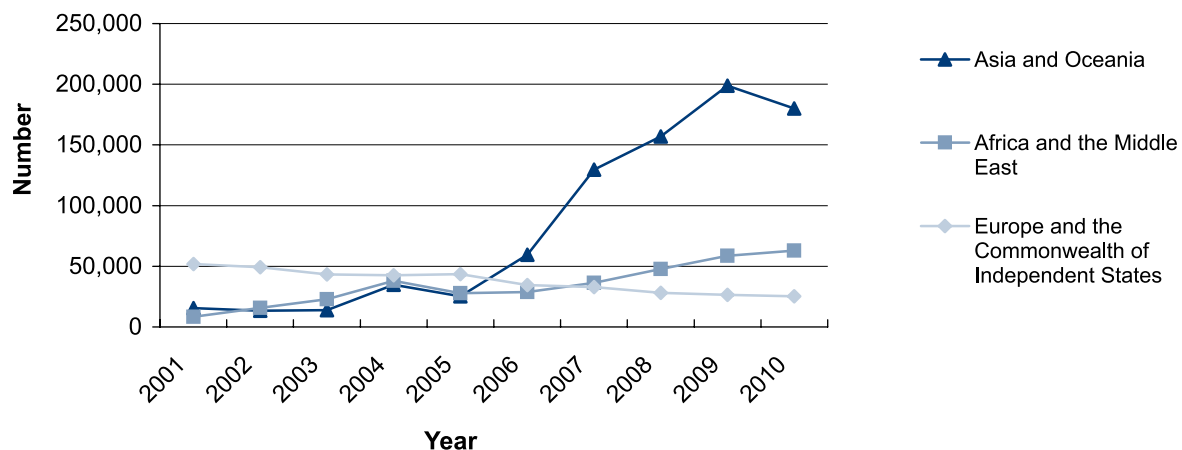


Figure 13: IOM health assessments by country of destination, 2001–2010

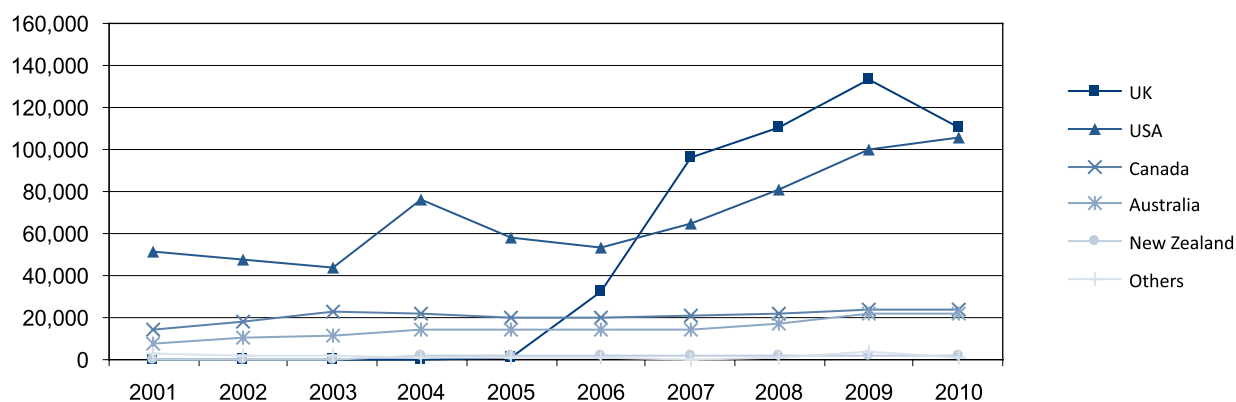
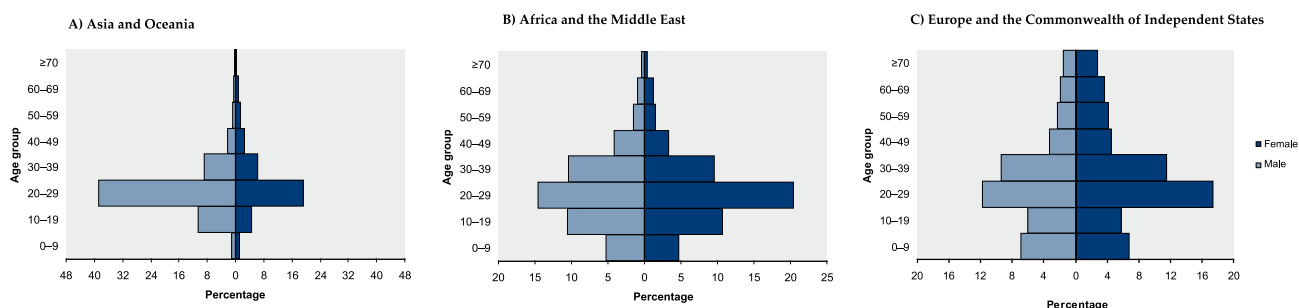
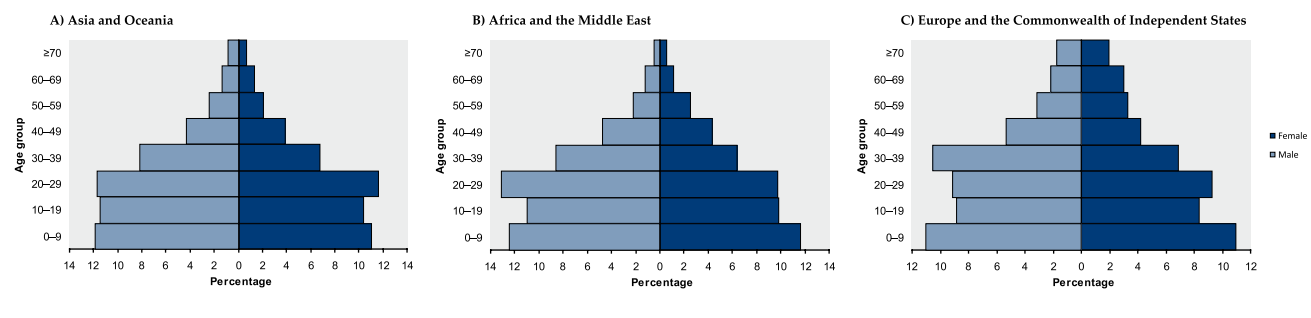


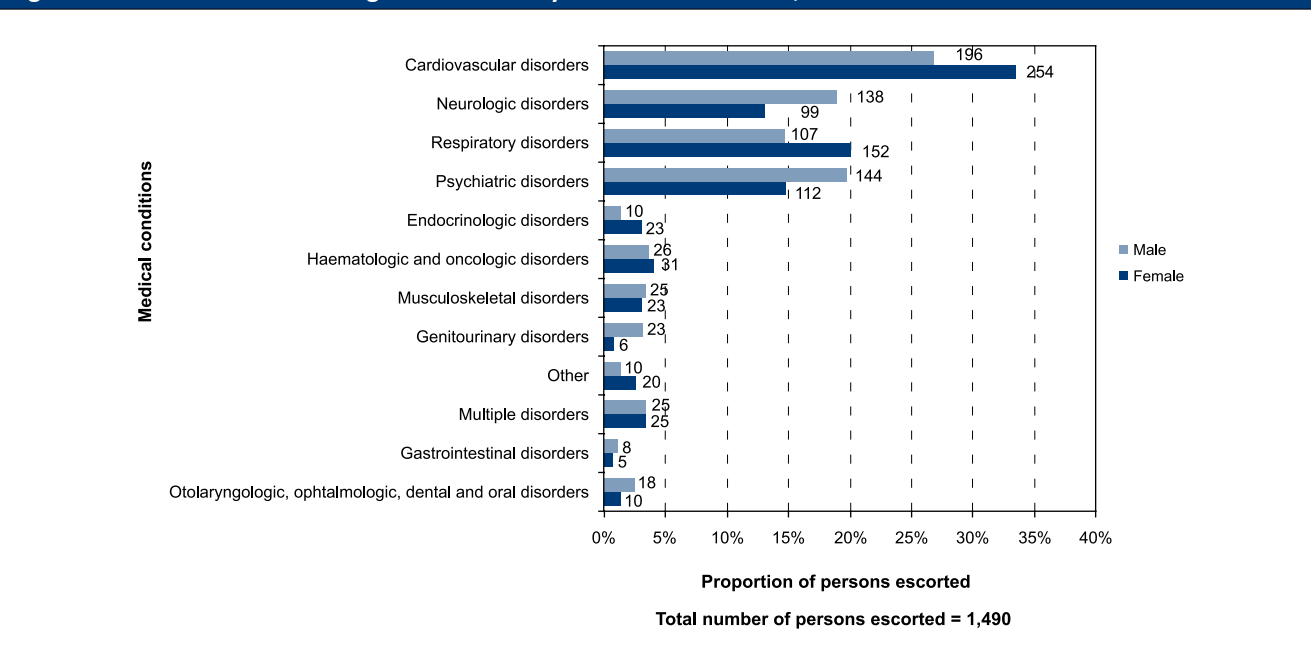
Figure 14a: Sex and age distribution of immigrants, 2010



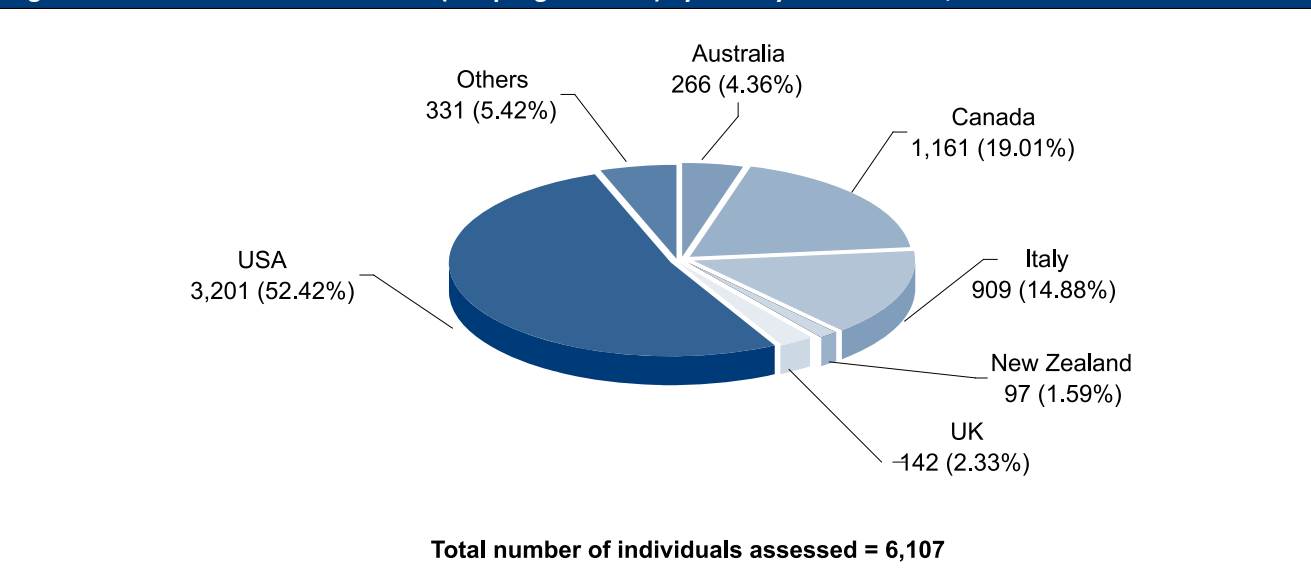
**Figure 14b: Sex and age distribution of refugees, 2010**



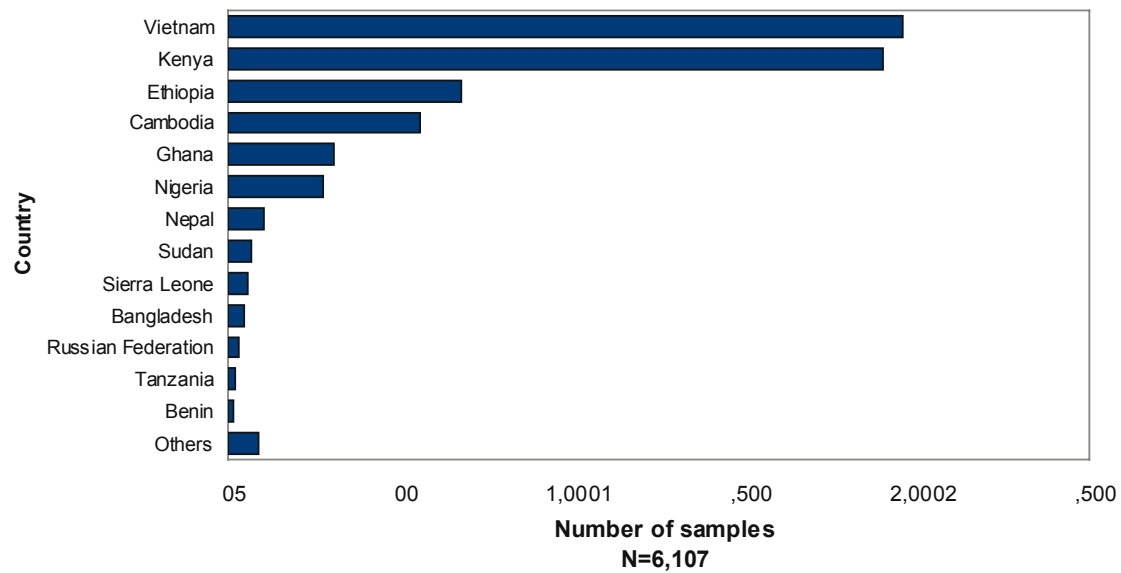
**Figure 15: Main conditions of migrants assisted by IOM medical escorts, 2010**



**Figure 16a: IOM-assisted DNA services (sampling and tests) by country of destination, 2010**



**Figure 16b: IOM-assisted DNA services (sampling and tests) by country of service, 2010**





# Salient findings from migration health assessment programmes

**Table 3: Screening for TB, HIV, syphilis and malaria – Positive findings by sex and region of origin, 2010**

Screening/ Region	Asia and Oceania		Africa and the Middle East		Europe and CIS		Total	
Tuberculosis								
Total screened	180,065		62,966		25,210		268,241	
Positive*	697	0.39%	191	0.30%	12	0.05%	900	0.34%
- male	426	(0.39%)	119	(0.37%)	7	(0.06%)	552	(0.36%)
- female	271	(0.38%)	72	(0.24%)	5	(0.04%)	348	(0.30%)
HIV								
Total screened	17,359		12,023		11,245		40,627	
Positive	140	0.81%	232	1.93%	12	0.11%	384	0.95%
- male	82	(1.02%)	79	(1.31%)	5	(0.10%)	166	(0.87%)
- female	58	(0.62%)	153	(2.55%)	7	(0.11%)	218	(1.01%)
Syphilis								
Total screened	49,537		36,101		18,371		104,009	
Positive	143	0.29%	224	0.62%	20	0.11%	387	0.37%
- male	89	(0.37%)	123	(0.64%)	8	(0.10%)	220	(0.43%)
- female	54	(0.21%)	101	(0.60%)	12	(0.11%)	167	(0.32%)
Malaria								
Total screened	2,977		3,361		0		6,338	
Positive	2 (0.67%)		189 (5.62%)		0		191 (3.01%)	

\* Cases referred for TB treatment (based on either microbiological confirmation or clinical findings).

## Health Promotion and Assistance for Migrants

**Table 4: Number of health promotion and assistance for migrants projects, 2009–2010**

Thematic area	Region	2009	2010
Population mobility and HIV	Africa	29	31
	Middle East	0	0
	Latin America and the Caribbean	1	2
	Europe	9	11
	Asia and Oceania	19	16
	Multiregional	3	1
Other health promotion projects	Africa	6	8
	Middle East	2	2
	Latin America and the Caribbean	8	7
	Europe	21	25
	Asia and Oceania	14	14
	Multiregional	10	14
Total all regions		122	131

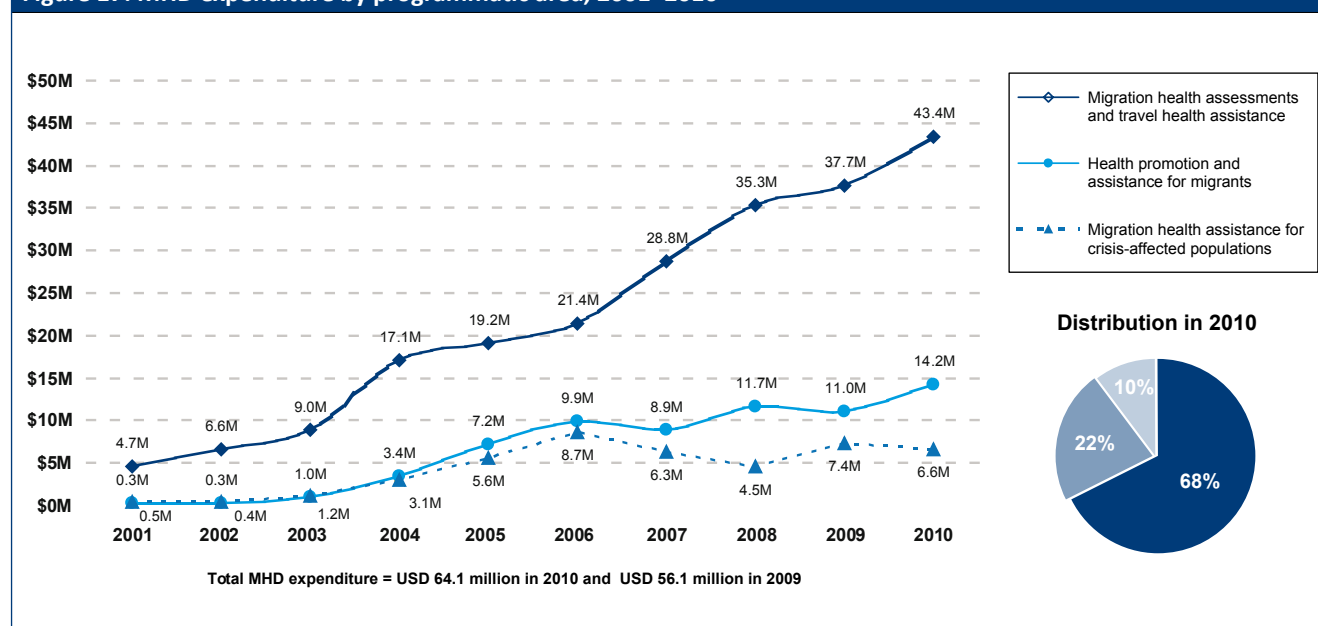
# Migration Health Assistance for Crisis-Affected Populations

**Table 5: Number of health assistance in crises projects, 2009–2010**

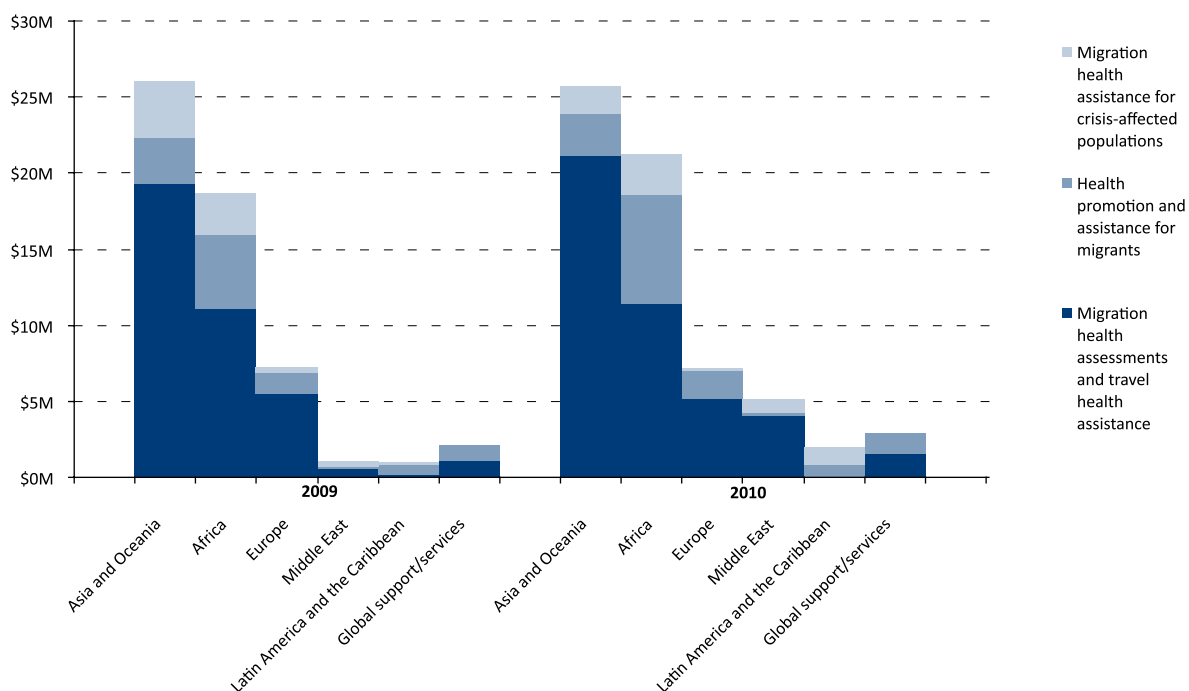
Thematic area	Region	2009	2010
Emergency health response	Africa	7	10
	Middle East	1	1
	Latin America and the Caribbean	4	8
	Europe	2	1
	Asia and Oceania	10	17
	Global support/services	0	1
	<b>Sub total</b>	<b>24</b>	<b>38</b>
Cholera response/ Environmental health	Africa	10	7
	Middle East	0	0
	Latin America and the Caribbean	0	1
	Europe	0	0
	Asia and Oceania	0	0
	Global support/services	0	0
	<b>Sub total</b>	<b>10</b>	<b>8</b>
Mental health and psychosocial response	Africa	1	1
	Middle East	2	3
	Latin America and the Caribbean	0	0
	Europe	1	1
	Asia and Oceania	3	2
	Global support/services	0	0
	<b>Sub total</b>	<b>7</b>	<b>7</b>
<b>Total all regions</b>		<b>41</b>	<b>53</b>

## Expenditure 2010

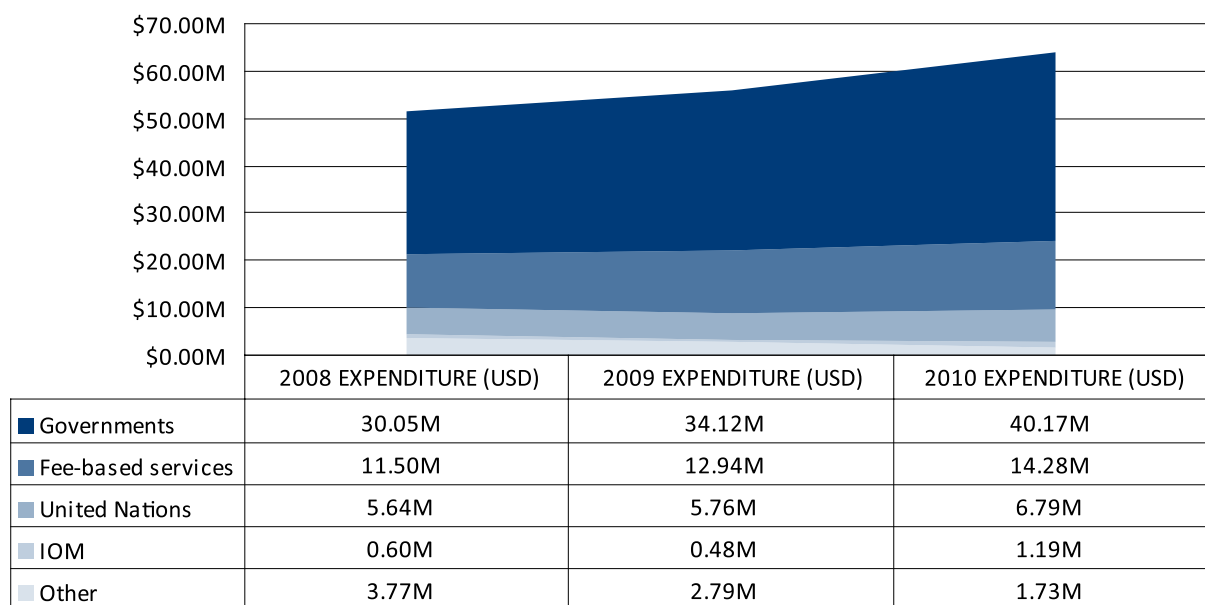
**Figure 17: MHD expenditure by programmatic area, 2001–2010**



**Figure 18: MHD expenditure by region and programmatic area, 2009–2010**



**Figure 19: MHD expenditure by funding source, 2008–2010**



**Table 6: MHD expenditure by donor, 2009-2010**

**A) Migration Health Assessments and Travel Health Assistance**

FUNDING SOURCE	2010 EXPENDITURE		2009 EXPENDITURE		Increase/ (Decrease)
	(In USD)	%	(In USD)	%	
<b>Governments</b>	<b>29,106,173</b>	<b>67</b>	<b>24,721,957</b>	<b>66</b>	<b>4,384,215</b>
USA	24,777,138	85	20,330,784	82	4,446,354
Australia	3,957,962	14	3,836,561	16	121,400
Canada	371,073	1	554,612	2	(183,539)
<b>Fee-based Services</b>	<b>14,272,130</b>	<b>33</b>	<b>12,924,852</b>	<b>34</b>	<b>1,347,278</b>
<b>United Nations</b>	-	-	13,524	0	(13,524)
United Nations High Commissioner for Refugees (UNHCR)	-	-	10,728	79	(10,728)
International Labour Organization (ILO)	-	-	2,796	21	(2,796)
<b>Migration Health Assessments and Travel Health Assistance</b>	<b>43,378,302</b>	<b>100</b>	<b>37,660,333</b>	<b>100</b>	<b>5,717,969</b>

**B) Health Promotion and Assistance for Migrants**

FUNDING SOURCE	2010 EXPENDITURE		2009 EXPENDITURE		Increase/ (Decrease)
	(In USD)	%	(In USD)	%	
<b>Governments</b>	<b>7,464,100</b>	<b>53</b>	<b>4,696,969</b>	<b>43</b>	<b>2,767,132</b>
Sweden	3,403,659	46	1,546,291	33	1,857,367
USA	1,883,405	25	1,742,177	37	141,228
Kazakhstan	905,605	12	64,008	1	841,597
United Kingdom	625,253	8	399,430	9	225,823
Italy	338,367	5	368,037	8	(29,670)
Switzerland	130,395	2	287,562	6	(157,167)
Norway	92,593	1	77,821	2	14,772
Poland	34,568	0	-	0	34,568
Germany	32,677	0	-	0	32,677
Angola	29,623	0	123,635	3	(94,012)
Hungary	19,009	0	26,623	1	(7,614)
Croatia	12,330	0	51,713	1	(39,382)
Canada	-	0	157	0	(157)
Netherlands	-	0	(4,818)	0	4,818
Guatemala	(19,662)	0	-	0	(19,662)
Colombia	(23,722)	0	12,722	0	(36,444)
Belgium	-	0	1,611	0	(1,611)
<b>United Nations</b>	<b>4,653,056</b>	<b>33</b>	<b>4,591,491</b>	<b>42</b>	<b>61,565</b>
United Nations Office for Project Services (UNOPS)	1,069,670	23	921,268	20	148,401
United Nations Development Programme (UNDP)	1,000,105	21	891,592	19	108,514
Central Fund for Influenza Action (CFIA)	982,525	21	1,689,283	37	(706,758)



FUNDING SOURCE	2010 EXPENDITURE		2009 EXPENDITURE		Increase/ (Decrease)
	(In USD)	%	(In USD)	%	
United Nations Children's Fund (UNICEF)	583,645	13	93,688	2	489,957
Joint United Nations Programme on HIV/AIDS (UNAIDS)	512,844	11	462,559	10	50,285
United Nations Trust Fund for Human Security (UNTFHS)	186,398	4	-	0	186,398
United Nations Population Fund (UNFPA)	144,791	3	118,243	3	26,548
United Nations One Fund	92,293	2	-	0	92,293
United Nations Development Fund for Women (UNIFEM)	44,210	1	-	0	44,210
World Food Programme (WFP)	33,783	1	33,219	1	564
World Health Organization (WHO)	2,792	0	320,620	7	(317,828)
United Nations Office on Drugs and Crime (UNODC)	-	0	59,051	1	(59,051)
International Labour Organization (ILO)	-	0	1,968	0	(1,968)
<b>IOM (including IOM 1035 Facility)</b>	<b>1,189,501</b>	<b>8</b>	<b>491,764</b>	<b>4</b>	<b>697,737</b>
<b>European Commission</b>	<b>650,108</b>	<b>5</b>	<b>911,605</b>	<b>8</b>	<b>(261,496)</b>
<b>Non-Government Organizations</b>	<b>191,341</b>	<b>1</b>	<b>139,236</b>	<b>1</b>	<b>52,104</b>
Family Health International	71,918	38	38,022	27	33,896
CARE	54,816	29	77,854	56	(23,038)
Ethno-Medizinisches Zentrum Verein	44,054	23	-	0	44,054
Chemonics International Inc.	14,801	8	-	0	14,801
Defense for Children International	5,752	3	3,345	2	2,407
International Transport Workers Federation	-	0	20,000	14	(20,000)
SIDACTION	-	0	15	0	(15)
<b>World Bank</b>	<b>25,704</b>	<b>0</b>	<b>51,771</b>	<b>0</b>	<b>(26,067)</b>
<b>Universities</b>	<b>18,864</b>	<b>0</b>	<b>26,421</b>	<b>0</b>	<b>(7,556)</b>
University of Pecs (Hungary)	18,864	100	26,421	100	(7,556)
<b>Asian Development Bank</b>	<b>779</b>	<b>0</b>	<b>15,200</b>	<b>0</b>	<b>(14,420)</b>
<b>Private Sector</b>	<b>(2,950)</b>	<b>0</b>	<b>78,602</b>	<b>1</b>	<b>(81,552)</b>
Kellogg Foundation	-	0	72,342	92	(72,342)
Azienda ULSS 20 Verona	-	0	6,260	8	(6,260)
Fondazione Benni	(2,950)	100	-	0	(2,950)
Other	296	0	33,308	0	(33,012)
<b>Health Promotion and Assistance for Migrants</b>	<b>14,190,800</b>	<b>100</b>	<b>11,036,366</b>	<b>100</b>	<b>3,154,435</b>

### C) Migration Health Assistance for Crisis-Affected Populations

FUNDING SOURCE	2010 EXPENDITURE		2009 EXPENDITURE		Increase/ (Decrease)
	(In USD)	%	(In USD)	%	
<b>Governments</b>	<b>3,597,102</b>	<b>55</b>	<b>4,696,362</b>	<b>64</b>	<b>(1,099,260)</b>
USA	1,893,235	53	1,217,414	26	675,821
Netherlands	365,998	10	-	0	365,998
Australia	360,158	10	250,600	5%	109,558
United Kingdom	355,544	10	1,720,138	37	(1,364,593)
Sweden	292,568	8	1,010,150	22	(717,581)
Switzerland	258,356	7	-	0	258,356
Denmark	31,975	1	-	0	31,975
Belgium	50,025	1	106,835	2	(56,810)
Poland	(126)	0	159,120	3	(159,246)
Colombia	(10,632)	0	232,105	5	(242,737)
<b>United Nations</b>	<b>2,205,568</b>	<b>34</b>	<b>1,155,462</b>	<b>16</b>	<b>1,050,106</b>
Central Emergency Response Fund (CERF)	1,135,576	51	947,922	82	187,653
United Nations Office for Project Services (UNOPS)	541,435	25	-	0	541,435
Common Humanitarian Fund for Sudan (CHF)	248,688	11	138,874	12	109,814
United Nations Children's Fund (UNICEF)	201,337	9	6,757	1	194,580
United Nations Development Programme (UNDP)	70,889	3	-	0	70,889
World Health Organization (WHO)	7,644	0	54,367	5	(46,723)
Joint United Nations Programme on HIV/AIDS (UNAIDS)	-	0	7,542	1	(7,542)
<b>Private Sector</b>	<b>318,941</b>	<b>5</b>	<b>36,716</b>	<b>0</b>	<b>282,226</b>
ExxonMobil Foundation	234,384	73	-	0	234,384
Foundation D'Harcourt	66,176	21	-	0	66,176
CREADEL – Liban	18,382	6	-	0	18,382
Fondazione Moncalme	-	0	36,716	100	(36,716)
<b>Non-Government Organizations</b>	<b>272,046</b>	<b>4</b>	<b>330,777</b>	<b>4</b>	<b>(58,730)</b>
Methodist Committee on Relief	191,814	71	-	0	191,814
AmeriCares	80,232	29	216,180	65	(135,948)
Save the Children	-	0	114,596	35	(114,596)
Universities	167,824	3	-	0	167,824
University Hospital in Linkeoping	167,824	100	-	0	167,824
<b>World Bank</b>	<b>11,550</b>	<b>0</b>	<b>1,162,949</b>	<b>16</b>	<b>(1,151,399)</b>
<b>IOM (including IOM 1035 Facility)</b>	<b>8,957</b>	<b>0</b>	<b>-</b>	<b>0</b>	<b>8,957</b>
<b>Migration Health Assistance for Crisis-Affected Populations</b>	<b>6,581,988</b>	<b>100</b>	<b>7,382,265</b>	<b>100</b>	<b>(800,277)</b>

# Annex 2: IOM Publications and Guidelines on Migration and Health

## A) Internal publications, guidelines and tools

1. Elmi, H. et al. (2010) *Sexual and Gender-based Violence (SGBV) and HIV Assessment among Vulnerable and Displaced Women in Somaliland in Non-Camp Settings*. IOM, Nairobi.
2. International Organization for Migration (2010) *An Assessment of Health Vulnerabilities among Internal Labour Migrants in Northern Mozambique's Cashew Industry*. IOM, Pretoria, [http://iom.org.za/site/index.php?option=com\\_docman&task=doc\\_details&gid=178](http://iom.org.za/site/index.php?option=com_docman&task=doc_details&gid=178)
3. International Organization for Migration (2010) *An Assessment of Health Vulnerabilities among Migrant and Non-Migrant Workers in the Ports of Maputo, Beira and Nacala, Mozambique*. IOM, Pretoria, [http://iom.org.za/site/index.php?option=com\\_docman&task=doc\\_details&gid=178](http://iom.org.za/site/index.php?option=com_docman&task=doc_details&gid=178)
4. International Organization for Migration (2010) *Assessment on the Psychosocial Needs of Haitians Affected by the January 2010 Earthquake*. IOM, Port Au Prince.
5. International Organization for Migration (2010) *Background Paper WMR 2010: Future Capacity Needs in Managing the Health Aspects of Migration*. IOM, Geneva, [http://publications.iom.int/bookstore/index.php?main\\_page=product\\_info&cPath=37&products\\_id=637](http://publications.iom.int/bookstore/index.php?main_page=product_info&cPath=37&products_id=637)
6. International Organization for Migration (2010) *Background Paper WMR 2010: The Future of Health Worker Migration*. IOM, Geneva, [http://publications.iom.int/bookstore/index.php?main\\_page=product\\_info&cPath=37&products\\_id=636](http://publications.iom.int/bookstore/index.php?main_page=product_info&cPath=37&products_id=636)
7. International Organization for Migration (2010) *Bangkok Statement on Migration and Development: Outcome Document of the Asia-Pacific Regional Preparatory Meeting for the Global Forum on Migration and Development 2010*. IOM, Bangkok, <http://www.iom.int/jahia/webdav/shared/shared/mainsite/events/docs/Bangkok-Statement-on-Migration-and-Development-2010.pdf>
8. International Organization for Migration (2010) *Guidelines for Border Management and Detention Procedures involving Migrants: A public health perspective*. IOM, Brussels, <http://www.iom.int/jahia/webdav/shared/shared/mainsite/activities/health/Guidelines-Border-Management-and-Detention-Procedures-Public-Health-Perspective.pdf>
9. International Organization for Migration (2010) *Integrated Biological and Behavioural Surveillance Survey (IBBSS) in the Commercial Agricultural Sector in South Africa*. IOM, Pretoria, [http://iom.org.za/site/index.php?option=com\\_docman&task=doc\\_details&gid=173](http://iom.org.za/site/index.php?option=com_docman&task=doc_details&gid=173)
10. International Organization for Migration (2010) *Migration and Health in SADC: A review of the literature*. IOM, Pretoria, [http://iom.org.za/site/index.php?option=com\\_docman&task=doc\\_details&gid=179](http://iom.org.za/site/index.php?option=com_docman&task=doc_details&gid=179)
11. International Organization for Migration (2010) *Migration and Health in South Africa: A review of the current situation and recommendations for achieving the World Health Assembly Resolution on the Health of Migrants*. IOM, Pretoria, [http://iom.org.za/site/index.php?option=com\\_docman&task=doc\\_details&gid=170](http://iom.org.za/site/index.php?option=com_docman&task=doc_details&gid=170)

12. International Organization for Migration (2010) *Migration and HIV/AIDS in Thailand: Triangulation of biological, behavioural and programmatic response data in selected provinces*. IOM, Bangkok.
13. International Organization for Migration (2010) *National Consultation Migration and HIV in Tanzania: Uniformed Personnel, Mobile Populations, and Border Communities - Meeting Report*. IOM, Dar es Salaam.
14. International Organization for Migration (2010) *Policy Analysis and Programme Response on Trafficking in Persons and HIV in Women and Girls in Indonesia*. IOM, Jakarta, <http://www.iom.or.id/reports.jsp?lang=eng>
15. International Organization for Migration (2010) *Regional Assessment on HIV-prevention Needs of Migrants and Mobile Populations in Southern Africa*. IOM, Pretoria, [http://iom.org.za/site/index.php?option=com\\_docman&task=doc\\_details&gid=160](http://iom.org.za/site/index.php?option=com_docman&task=doc_details&gid=160)
16. International Organization for Migration (2010) *Regional Workshop on HIV Responses for Mine Workers, Their Families and Affected Communities in Southern Africa*. IOM, Pretoria, [http://iom.org.za/site/index.php?option=com\\_docman&task=doc\\_details&gid=175](http://iom.org.za/site/index.php?option=com_docman&task=doc_details&gid=175)
17. International Organization for Migration (2010) *Somali HIV & Mobility Research and HIV Hot-Spot Mapping Toolkit for Hard-to-Reach Populations, 2008-2010*. CD-ROM. IOM, Nairobi.
18. International Organization for Migration and Ministry of Communications and Transport of the Republic of Zambia (2010) *HIV and AIDS Policy for the Transport Sector in Zambia*. IOM, Lusaka, <http://www.iom.org.za/mwg-internal/de5fs23hu73ds/progress?id=46lfdgwkhI>
19. International Organization for Migration and Ministry of Health of the Republic of Moldova (2010) *Moldovan Migrants Health: Impact of the socio-economic welfare*. IOM, Chisinau.
20. International Organization for Migration, Pepperdine University and Royal University of Phnom Penh (2010) *Mental Health in Cambodia: A qualitative evaluation*. IOM, Phnom Penh.
21. Navarro, B. et al. (2010) *Training Modules on Migration and Health for Border Officials*. IOM, Brussels, <http://www.iom.int/jahia/webdav/shared/shared/mainsite/activities/health/Cuaderno-Officials-ISBN.pdf>
22. Navarro, B. et al. (2010) *Training Modules on Migration and Health for Health Professionals*. IOM, Brussels, <http://www.iom.int/jahia/webdav/shared/shared/mainsite/activities/health/ISBN-Cuaderno-Professionals.pdf>
23. Samuilova, M. et al. (2010) *Increasing Public Health Safety alongside the New Eastern European Border: An overview of findings from the situational analysis*. IOM, Brussels, <http://www.iom.int/jahia/webdav/shared/shared/mainsite/activities/health/PHBLM-SAR-Public-Report-2010.pdf>
24. Taephant, N. (2010) *IOM Training Manual on Psychosocial Assistance for Trafficked Persons*. IOM, Bangkok.
25. Testa, A. (2010) *Somali HIV Hot-Spot Mapping: Exploring HIV Vulnerability among Populations at Increased Risk, 2008*. IOM, Nairobi.
26. Testa, A. and K. Kriitmaa (2010) *HIV & Syphilis Integrated Biological and Behavioural Surveillance (IBBS) Survey among Female Sex Workers in Hargeisa, Somaliland, 2008*. IOM, Nairobi.

## B) External publications, guidelines and tools

1. Benedict, R. et al. (2010) Better health for all in Europe: Developing a migrant sensitive health workforce. *Eurohealth*, 16(1): 17–19, <http://www.euro.who.int/en/home/projects/observatory/publications/eurohealth/migration-and-health-in-the-european-union>
2. Benedict, R. et al. (2010) Social exclusion and structural health inequalities. In: *Moving Forward Equity in Health: Monitoring social determinants of health and the reduction of health inequalities*. Ministry of Health and Social Policy of Spain, pp. 39–47.
3. Davies, A. et al. (2010) Migration: A social determinant of migrants' health. *Eurohealth*, 16(1): 10–12, <http://www.euro.who.int/en/home/projects/observatory/publications/eurohealth/migration-and-health-in-the-european-union>



4. Gorbacheva, O. et al. (2010) Prevalence of bacteriologically confirmed pulmonary tuberculosis in the Bhutanese refugees in Nepal: Results of active case finding. *International Journal of Infectious Diseases*, 14(1): 150.
5. Kriitmaa, K. et al. (2010) HIV prevalence and characteristics of sex work among female sex workers in Hargeisa, Somaliland, Somalia. *AIDS*, 24: S61–S67, [http://journals.lww.com/aidsonline/Abstract/2010/07002/HIV\\_prevalence\\_and\\_characteristics\\_of\\_sex\\_work.8.aspx](http://journals.lww.com/aidsonline/Abstract/2010/07002/HIV_prevalence_and_characteristics_of_sex_work.8.aspx)
6. Mishra, A. K. et al. (2010) Varicella (Chickenpox) outbreak in Bhutanese refugee camps in Eastern Nepal. *International Journal of Infectious Diseases*, 14(1): 134.
7. Pace, P. (2010) What can be done in EU Member States to better protect the health of migrants? *Eurohealth*, 16(1): 5–10. (<http://www.euro.who.int/en/home/projects/observatory/publications/eurohealth/migration-and-health-in-the-european-union>)
8. Peiro, M. and R. Benedict (2010) Migrant health policy: The Portuguese and Spanish EU Presidencies. *Eurohealth*, 16(1): 1–4, <http://www.euro.who.int/en/home/projects/observatory/publications/eurohealth/migration-and-health-in-the-european-union>
9. Samuilova, M. et al. (2010) Mapping EC-funded initiatives on health and migration in Europe. *Eurohealth*, 16(1): 26–28, <http://www.euro.who.int/en/home/projects/observatory/publications/eurohealth/migration-and-health-in-the-european-union>
10. Schininà, G. et al. (2010) Psychosocial response to the Haiti earthquake: The experiences of International Organization for Migration. *Intervention*, 8(2): 158–164, [http://journals.lww.com/interventionjnl/Abstract/2010/07000/Psychosocial\\_response\\_to\\_the\\_Haiti\\_earthquake\\_\\_the.9.aspx](http://journals.lww.com/interventionjnl/Abstract/2010/07000/Psychosocial_response_to_the_Haiti_earthquake__the.9.aspx)
11. UNDP, IOM, WHO, UNAIDS, JUNIMA, and ILO (2010) *Regional Dialogue on the Health Challenges for Asian Labour Migrants: Meeting Report*, Bangkok, Thailand, 13–14 July 2010. UNDP Asia-Pacific Regional Centre, <http://mnlintranettest:8091/jahia/webdav/shared/shared/mainsite/events/docs/health/Regional-Dialogue-Migrant-Health-Meeting-Report.pdf>
12. World Health Organization, Ministry of Health and Social Policy of Spain, and International Organization for Migration (2010) *Health of Migrants: The Way Forward - Report of a Global Consultation*. Madrid, Spain, 3–5 March 2010. World Health Organization, [http://www.iom.int/jahia/webdav/shared/shared/mainsite/events/docs/consultation\\_report\\_health\\_migrants\\_colour\\_web.pdf](http://www.iom.int/jahia/webdav/shared/shared/mainsite/events/docs/consultation_report_health_migrants_colour_web.pdf)





“Health is a status of physical,  
mental and social well-being”

Health in Motion Programme.  
Cairo, Egypt, 2010. Young Iraqi  
refugee participating in a psycho-  
social animation workshop.  
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