International Organization for Migration (IOM)
The UN Migration Agency

MIGRATION HEALTH

MIGRATION HEALTH DIVISION

MIGRATION MANAGEMENT

Annual Review 2015

IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental organization, IOM acts with its partners in the international community to: assist in meeting the operational challenges of migration, advance understanding of migration issues, encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

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DEPARTMENT OF MIGRATION MANAGEMENT

Migration Health Division

Annual Review 2015

MHD

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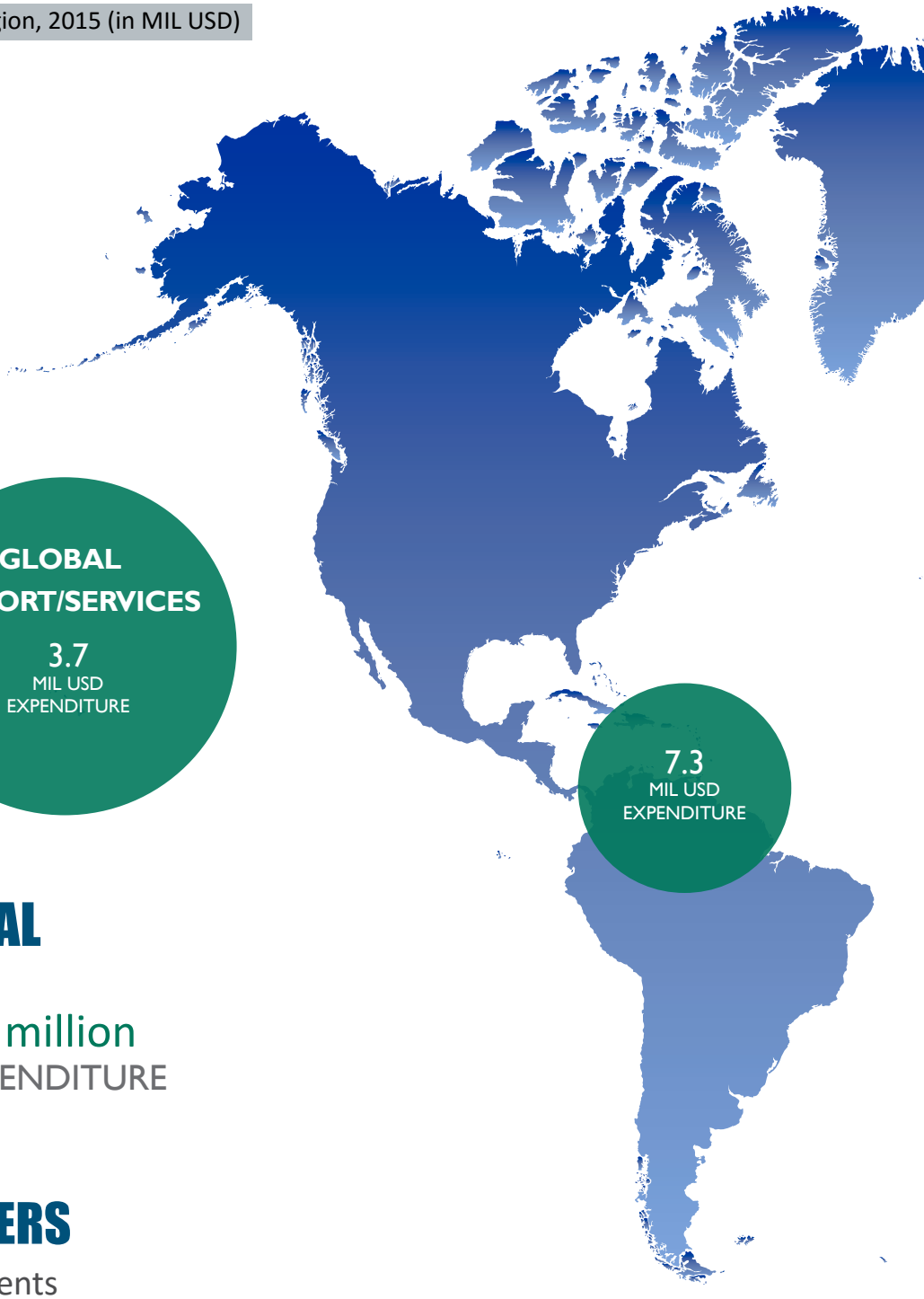


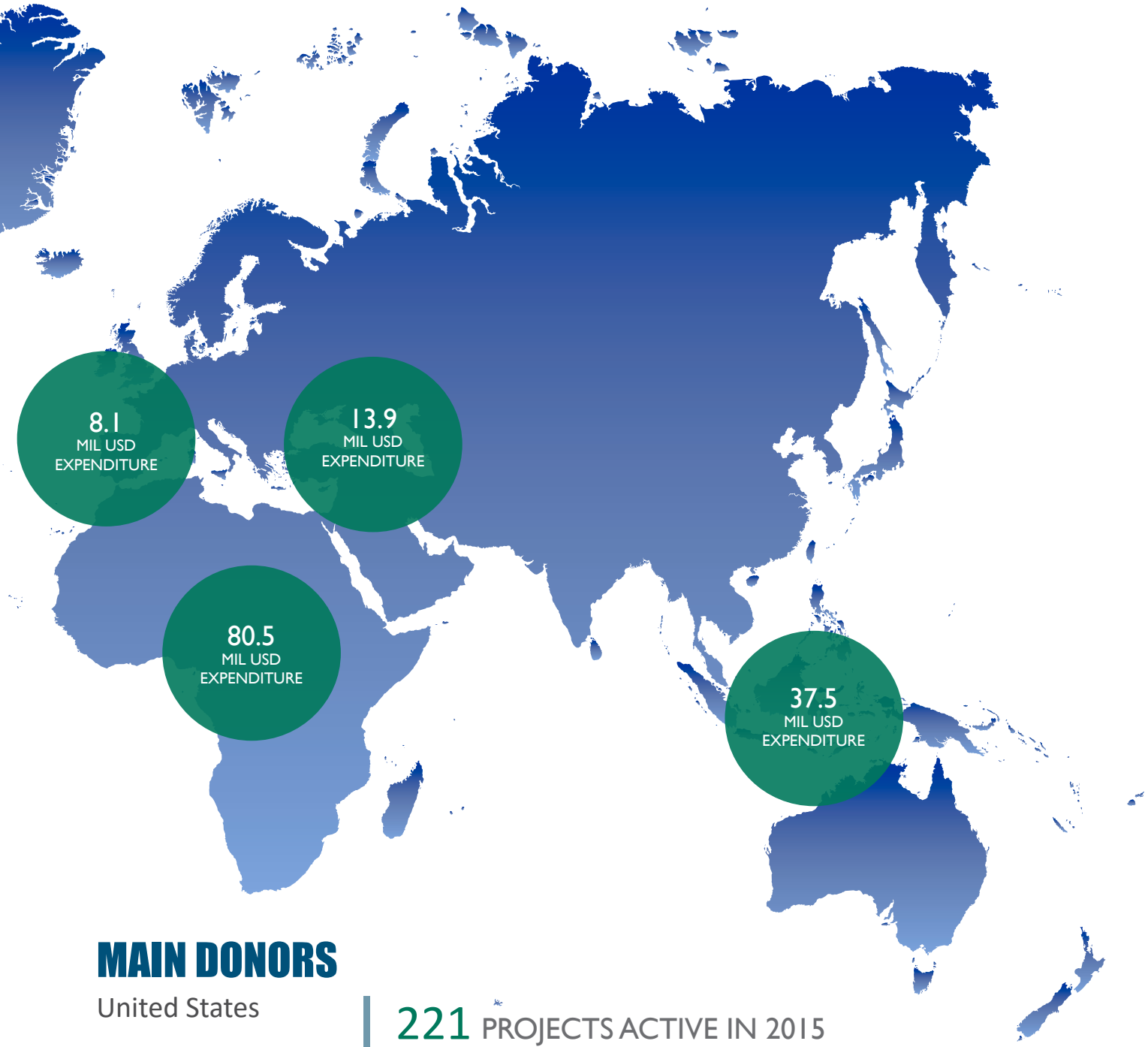
2015 in numbers

IN TOTAL

151 million
USD EXPENDITURE

PARTNERS

Governments
United Nations
Non-governmental organizations
European Commission
Universities



MAIN DONORS

United States

United Nations

Global Fund to Fight AIDS, Tuberculosis and Malaria

Australia

Sweden

221 PROJECTS ACTIVE IN 2015

24 Migration health assessments and travel health assistance

114 Migration health assistance for crisis-affected populations

83 Health promotion and assistance for migrants

foreword

With more than 1 billion migrants across the globe, the link between migration, human mobility and health is an evolving domain of critical importance, bridging aspects of public health and health security, human rights and equity, and human and societal development. Today, more than ever before, migration and population mobility can be considered as a social determinant of health. Many irregular migrants pay the ultimate price, losing their lives crossing seas, deserts and dangerous border areas to escape wars, poverty and land degradation.

Yet these deaths represent only one aspect of a complex and multifaceted issue, one that is compounded by the current backdrop of restrictive and isolationist migration policies, terrorism and anti-migrant rhetoric. These elements contribute to the persistent denial of migrants' rights, discrimination and abuse against migrants, and insufficient access for many non-nationals to equitable health and social services. As a result, migrants and mobile populations, and consequently societies at large, are more vulnerable to disease and ill health. This ultimately impacts public health and greater socioeconomic development.

From a global health security perspective, the recent Ebola virus disease outbreak in West Africa is testimony to the fact that human mobility is a key factor in the spread of pandemics and outbreaks, and that migrant sensitive surveillance mechanisms are essential for effective disease control measures. From a sustainable development perspective, it is widely acknowledged that migration carries significant development potential, owing to migrants' intellectual, cultural, social and financial capital and their active participation in societies of origin and destination. Being and staying healthy is a fundamental precondition for migrants to work, be productive and contribute to the social and economic development of their communities of origin and destination. Nevertheless, discussions on ways to promote this idea as part of a "shared prosperity and shared responsibility" approach with regard to migration and development have not yet gained much momentum in relevant global debates. Globalization, the speed of travel and a changing security landscape present new challenges for global health that require greater attention to the health risks associated with migration and population mobility, both within and across national borders. These challenges require innovative, systematic, evidence-based, multidisciplinary and multi-country responses.

The year 2015 marks a milestone in the International Organization for Migration's (IOM) efforts to advance

the agenda of migrant health for the benefit of all. We have observed an increase in the attention of governments to the themes of migration and human mobility within the global health debate, as well as within the debates on global health security, universal health coverage and the right to health, and in the 2030 Sustainable Development Goals. At the 106th IOM Council meeting, held in November 2015, a document cataloguing IOM's decades-long efforts to advance the agenda of migrant health was submitted to IOM Member States. A high-level panel on migration, human mobility and global health was organized as well, which, along with the Council document, served to draw attention to the unfinished agenda of migrant health, which has been missing from the international health arena since the First Global Consultation on Migrant Health, jointly organized by IOM, the World Health Organization (WHO) and the Government of Spain in 2010. It is now time to reset the Migrant Health Agenda and take stock of recent experiences, new needs and challenges in the era of global human mobility. A Second Global Consultation is jointly planned by IOM, WHO and Government of Sri Lanka for early 2017, which will hopefully represent a new milestone in building technical and policy partnership towards realizing equity in health for migrants and mobile populations.

Based on the Organization's unique understanding of and exposure to the determinants and patterns of migration, its multidisciplinary nature and its solution-oriented approach, IOM's core health activities have, for decades, included advocacy for migration-sensitive health policies, as well as monitoring, supporting and improving the health and well-being of migrants through services and programmes. With migration and human mobility becoming a growing global trend, and an increased focus on ensuring healthy lives and well-being for all observed within the post-2015 development agenda, IOM finds itself well placed to assume an important and multifaceted role in the field of migration health by enhancing partnerships and further building momentum in this area. The adoption of the New York Declaration during the 2016 UN General Assembly High-Level Summit on Large Movements of Migrants and Refugees provided the scope for an improved international response to global migration, using a more humane and better-coordinated approach. Within this context, it will be necessary to ensure that the achievement of equitable health for migrants is part of future political commitments on protecting the rights of refugees and migrants, saving lives and contributing to sustainable and inclusive development.

Over the course of 2015, IOM staff in countries around the world provided governments with technical assistance on migration health policy and development, mainstreaming the health of migrants into broader governance domains, and strengthening partnerships among multisectoral stakeholders. IOM also provided a wide range of health services for both migrants and host communities, often in challenging contexts such as low-resource or conflict- or disaster-affected areas. I am proud to present the *2015 MHD Annual Review*, which offers a snapshot of IOM's activities and achievements in migration health, and a glance at upcoming endeavours. My heartfelt appreciation goes to IOM migration health colleagues around the world, whose persistence and dedication to the well-being of migrants and communities is improving lives and enabling IOM as a whole to move forward the unfinished agenda of migrant health for the benefit of all. Happy reading!

Davide Mosca
Director, Migration Health Division
IOM

list of acronyms

AIDS	acquired immune deficiency syndrome
BCC	behaviour change communication
CDC	Centers for Disease Control and Prevention (United States)
CERF	Central Emergency Response Fund
CSO	civil society organization
CXR	chest X-ray
DOT	directly observed treatment
DST	drug susceptibility testing
ETU	Ebola treatment unit
EVD	Ebola virus disease
FSW	female sex worker
GBV	gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHSA	Global Health Security Agenda
GMS	Greater Mekong Subregion
HAP	health assessment programme
HBMM	Health, Border and Mobility Management
HIV	human immunodeficiency virus
ICASA	International Conference on AIDS and Sexually Transmitted Infections in Africa
IDC	Immigration Detention Centre
IDP	internally displaced person
IHR	International Health Regulations
IOM	International Organization for Migration
JUNIMA	Joint UN Initiative on Migration and Health in Asia
MDR	multidrug-resistant
MHA	migration health assessment
MHD	Migration Health Division (IOM)
MHI	migration health informatics
MHPSS	Mental health and psychosocial support
MiMOSA	Migrant Management Operational Systems Application
MIPEX	Migrant Integration Policy Index
MMN	Mekong Migration Network
MMP	migrants and mobile population
NCD	non-communicable disease
NGO	non-governmental organization
NTP	national tuberculosis programme

OCV	oral cholera vaccine
OFDA	Office of US Foreign Disaster Assistance
PDMS	pre-departure medical screening
PEC	pre-embarkation check
PHAMESA	Partnership on Health and Mobility in East and Southern Africa
PEC	primary health-care centre
PHEIC	public health emergency of international concern
POE	point of entry
PoC	protection of civilian
RRT	rapid response team
SADC	Southern African Development Community
SADCD	Southern African Development Community Declaration on TB in the Mining Sector
STI	sexually transmitted infection
TACAIDS	Tanzania Commission for AIDS
TB	tuberculosis
UHC	Universal Health Coverage
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNHCR	United Nations High Commissioner for Refugees
UNMs	Undocumented Myanmar nationals
UNMISS	United Nations Mission in South Sudan
USAID	United States Agency for International Development
WASH	water, sanitation and hygiene
WHA	World Health Assembly
WHO	World Health Organization

Part I: Emerging themes in migration and health

ADVANCING THE UNFINISHED AGENDA OF MIGRANT HEALTH FOR THE BENEFIT OF ALL

2015 Milestone Events

2015 has been a year of great achievements, as well as a year of a collective awakening to the urgent need to advance the migrant health agenda. The International Organization for Migration's (IOM) Director General, Ambassador William Lacy Swing, noted that "the year 2015 has been, in every sense of the word, the 'Year of the Migrant'". The record numbers of refugees and migrants entering Europe made migration into a defining issue, one that dominated media headlines and political debates around the world. In this context of unprecedented migrant flows and high media visibility, IOM's efforts to promote the migrant health agenda resonated with both partners and Member States.

Several benchmark events provide a foundation for the promotion of the migrant health agenda. In 2008, the World Health Assembly Resolution (WHA 61.17) on the Health of Migrants was adopted and in 2010, the World Health Organization (WHO), IOM and the Government of Spain jointly organized the first Global Consultation on Migrant Health. The 2010 Consultation identified an operational framework that offers governments and stakeholders a way to frame and measure their progress in ensuring migrants' health. Core recommendations called for multisectoral partnerships based on system-wide approaches, as well as inter-country collaboration. Since then, some governments and agencies have made considerable progress. Such initiatives deserve wider visibility and dissemination to ensure that remaining gaps can be addressed effectively. Much more can be done to continue mainstreaming migrant-sensitive policies that promote the health of migrants throughout the migration cycle.

In order to highlight good practices and innovative approaches on migrant health in urban settings, IOM's International Dialogue on Migration Conference on Migrants and Cities hosted a high-level panel session, "Migrants and Cities: Partnerships in Health", in October 2015. The panel addressed the importance of ensuring access to migrant-sensitive health services for a positive migration outcome and contribution to the socioeconomic development of urban areas. The session looked specifically at matters, such as data collection on migration and social status, special concerns for migrant women and for refugees in urban settings, and how to foster inter-city dialogue on health service provision for migrants. The session provided a unique opportunity for leaders of cities and organizations to share their experiences, good practices and challenges related to the health of migrants in urban settings.[1]

IOM sought to bring further attention to the health of migrants by presenting a document, *Advancing the Unfinished Agenda of Migrant Health for the Benefit of All*, to its Members States during the 106th IOM Council. Building upon the 2004 Council document, Migrant Health for the Benefit of All, this document reviewed the current status of the migration and health agenda, the nature and scope of IOM's engagement in health, and IOM's expertise and role in national, regional, global and multisectoral response activities concerning health, mobility and public health emergencies. It mapped the evolution of migrant health activities within IOM and proposed a way forward, with the intention to initiate a discourse towards further mobilizing the IOM membership and partners to build a more effective and structured means of leadership and partnership to advance the unfinished agenda of migrant health for the benefit of all.

A high-level panel on migration, human mobility and global health was also organized during the 106th session of the IOM Council. The high-level panel, composed of representatives from the Governments of Greece, Thailand, Finland and Sierra Leone,

[1] Twenty-fifth International Dialogue on Migration: Conference on Migrants and Cities, IOM, 2016.

the Director Generals of WHO and the European Commission's Health and Food Safety Directorate General, was chaired by IOM's Director General and introduced by the President of Sri Lanka. The session highlighted the clear links between global health goals, human and population mobility, human and health security, and foreign policy and how universal healthcare, Health in All Policies, equity and integration are effective responses to a successful migration outcome that need to be more widespread.

The panel session responded to the expressed interest of IOM's Member States to better understand the linkages between health and migration, and served to advance a multisectoral dialogue on the theme. During the session, the IOM Director General noted that "modern migration trends and globalization have brought us all new challenges within the health sector, challenges that require innovative solutions and new partnerships". A main conclusion of the session was indeed that, to properly address the challenges related to the topic, a new mindset vis-à-vis health and equity in our globalized and interconnected world is required, as well as strong leadership across all sectors and across all borders. It will require an innovative, systematic, multidisciplinary and multisectoral approach, of which partnerships and diplomacy are prerequisites.

To further address and explore these issues, IOM and WHO will co-organize a Second Global Consultation on Migrant Health, an event which President Maithripala Sirisena of Sri Lanka generously offered to host during his intervention at the 106th IOM Council. This second global consultation would offer Member States and partners a meaningful and sustained platform for multisectoral dialogue and political commitment towards enhancing and mainstreaming the health of migrants.

The year 2015 has been marked by significant milestones in the sphere of migrant health. Health is a basic human right and an essential component of sustainable development; being and staying healthy is a fundamental precondition for migrants to work, to be productive and to contribute to the social and economic development of their communities of origin and destination. These milestones, along with upcoming ones, are important markers on a road map that will guide IOM and the international community towards the 2030 Sustainable Development Goals (SDGs) and towards promoting a unified agenda on the health of migrants for the benefit of all.

IOM's Director General addresses Member States during the High-Level Panel on Migration, Human Mobility and Global Health at the 106th Session of the IOM Council. © IOM 2015

IOM ADVANCING THE GLOBAL HEALTH SECURITY AGENDA

Figure 2. The global aviation network
Source: Taken from A.M. Kilpatrick and S.E. Randolph, "Drivers, dynamics, and control of emerging vector-borne zoonotic diseases", The Lancet, 380:1946–55 (2012).

As the world becomes more interconnected with unprecedented migration and human mobility, a health threat present in the most remote corner of the world has a real probability of becoming a health threat to the rest of the world. Through globalization, trade and travel, infectious diseases now spread faster and farther, while at the same time, most countries are not prepared to face such threats. Moreover, health threats posed by infectious diseases cause severe setbacks in hard-earned progress towards development, as demonstrated most recently by the Ebola outbreak in West Africa (2014–2015), which resulted in a loss of over USD 2.2 billion in economic development across Guinea, Liberia and Sierra Leone.

Consequently, in February 2014, the governments of more than 30 countries launched the Global Health Security Agenda (GHSA) with the goal of creating a world safe and secure from health threats through stronger collective prevention, detection and response capacities. To date, close to 50 countries have committed to the Agenda. The GHSA directly supports the implementation of the International Health Regulations (IHR 2005), a legally binding instrument, which mandates that all 195 signatory State Parties achieve the required capacities to "prevent, protect against, control and provide public health response" to health threats, particularly those with potentials for international spread. A core element of the IHR is public health measures required at points of entries (POEs), including airports, seaports and ground crossings, meant to prevent the international spread of diseases.

With migration and human mobility at the core of the Organization's mandate, IOM approaches prevention, detection and response to health threats from a human mobility perspective. From one case in the remote forest region of Guinea, Ebola spread to 10 countries across three continents as a result of human mobility. While far-flung air travel extended the global spread of Ebola, the traditional movement of people

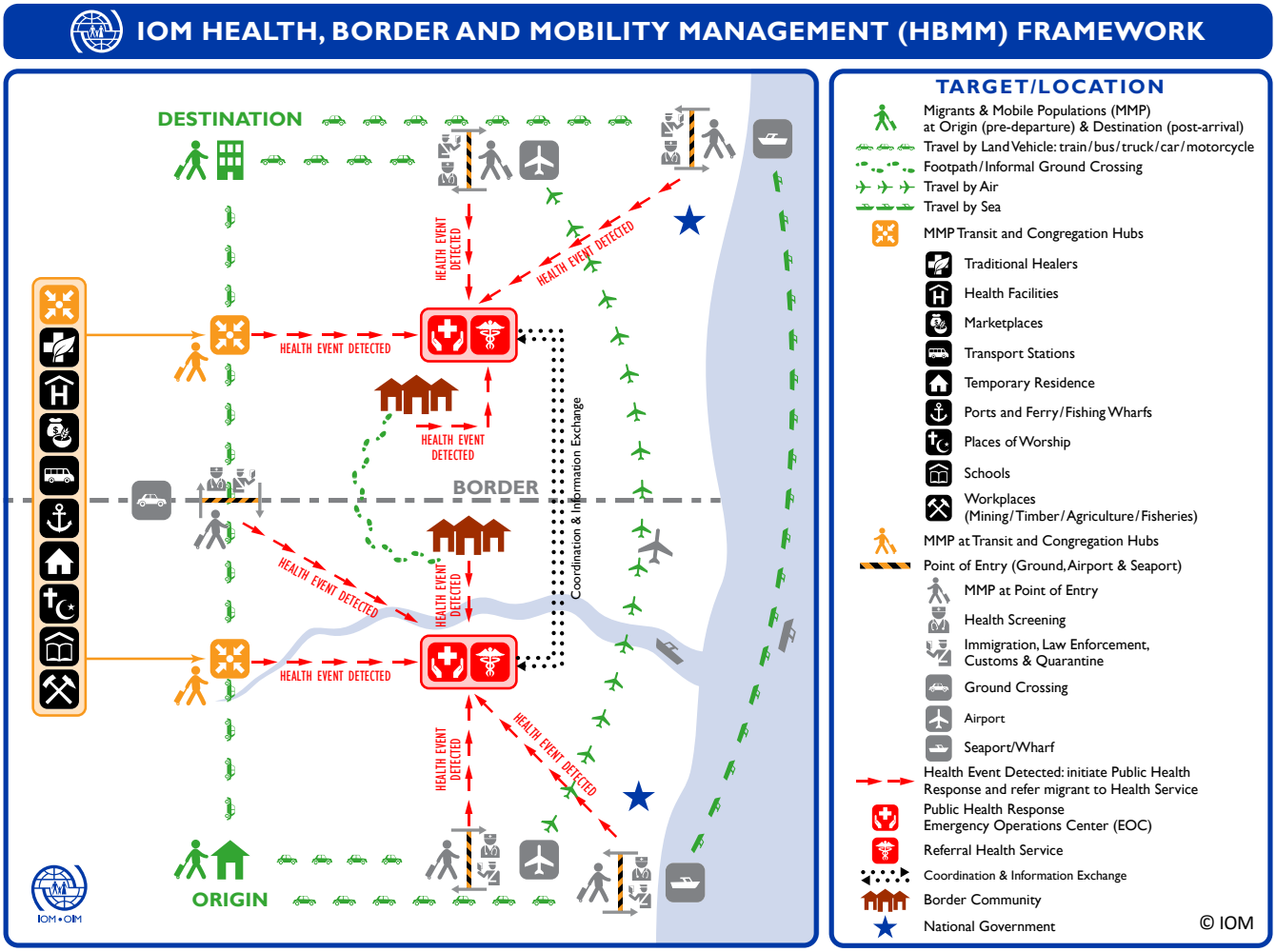
in the West African subregion, carried out as part of their daily lives and livelihoods, caused the prolonged transmission of the virus in Guinea, Liberia and Sierra Leone.

The IHR puts a pronounced emphasis on public health measures at POEs. However, the reality of human mobility goes far beyond these border crossings. In fact, borders should be seen as spaces, not just as lines dividing countries, nor as points of crossing. In many parts of the world, communities living around international border lines share familial and social ties across the border; for them, these administrative lines are meaningless, and international movement is a common part of daily life.

IOM's Health, Border and Mobility Management Framework

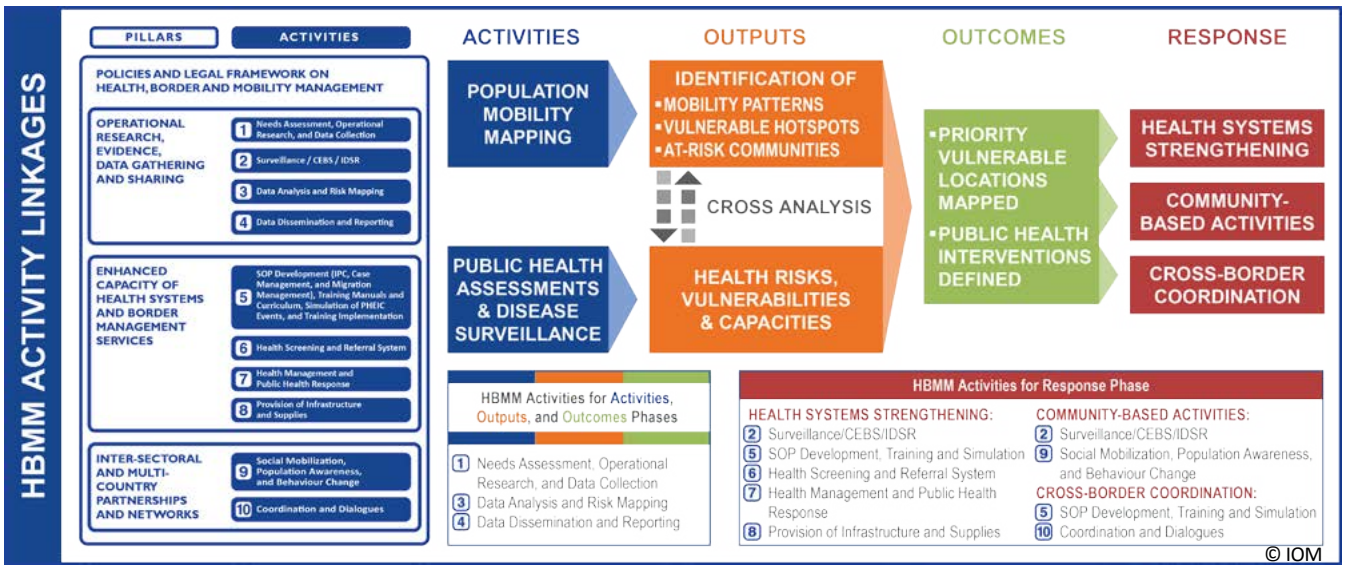
Throughout 2015, IOM took part in the review process of the implementation of the IHR in response to the Ebola outbreak in West Africa. IOM's contribution was consistently articulated through the concept of border spaces and the importance of integrating cross-border mobility dynamics into efforts for prevention, detection and response to health threats. The Report of the Review Committee, delivered at the 2016 World Health Assembly, acknowledged these aspects of global health security, and consequently, its recommendations explicitly stated the need for WHO and governments to work with IOM, notably in building country capacities for preparedness, by addressing the migration and human mobility dimension of prevention, detection and response to health threats.

Figure 3. IOM's human mobility continuum



Health, Border and Mobility Management (HBMM) endeavours to build human mobility-competent health systems that are essential for global health security. Such systems are responsive to the dynamics of human mobility and are inclusive, ensuring Universal Health Coverage (UHC), which leaves no one behind, not even migrants and mobile populations (MMPs), regardless of their status. UHC is a fundamental dimension of both individual and collective health security and an essential feature of resilient and sustainable health systems. HBMM unifies border management, human and health security, which ultimately supports the implementation of the IHR 2005. Implementing HBMM based on primary healthcare achieves equity in health and renders health systems better able to prevent, detect and respond to epidemic and endemic infectious diseases.

Figure 4. IOM Health, Border and Mobility Management activity linkages



IOM and US Centers for Disease Control and Prevention Partnership for Global Health Security Agenda

In September 2015, IOM entered into a formal agreement with the United States' Centers for Disease Control and Prevention (CDC) to implement a set of activities aimed at building the capacities of six West African States to better prevent, detect and respond to the prevailing threat of Ebola, as well as other communicable diseases and health threats. From 29 September 2015 to date, IOM has worked with the Governments of Ghana, Guinea-Bissau, Guinea, Liberia, Senegal and Sierra Leone, as well as CDC and WHO counterparts in each of these countries, in three priority areas: (a) POE capacity development, according to the IHR; (b) border health risk mitigation through strengthened surveillance, incorporating a strong human mobility perspective; and (c) bilateral and regional IHR coordination.

Population mobility mapping with national and local stakeholders, such as this exercise held in Kambia, Sierra Leone, enables IOM and partners to identify and prioritize locations at higher risk of public health threats, in order to deliver more targeted and evidence-informed public health interventions. © IOM 2015

Preparedness and response plans and capacities of authorities at points of entry are evaluated and reinforced, through simulation of public health emergency events, Lungi Airport, Sierra Leone. © IOM 2015

IOM staff interact with travellers to collect mobility pattern and volume data on mobile devices, raise awareness about infectious diseases, and institute effective infection prevention and control in Kourémalé, Mali. © IOM 2015

Part II: The Migration Health Division's highlights of activities, 2015

MIGRATION HEALTH ASSESSMENTS AND TRAVEL HEALTH ASSISTANCE

The Migration Health Assessments and Travel Health Assistance Unit (also referred to as the Health Assessment Programme Unit) contributes to global migration health priorities through the provision of comprehensive health services for migrants and the promotion of safe, dignified and healthy migration.

What are IOM migration health assessments and why are they important?

Migration health assessments (MHAs) are among the most well-established migration management services offered by IOM. At the request of receiving country governments, IOM provides an evaluation of the physical and mental health status of migrants for the purpose of assisting them with resettlement, the obtainment of temporary or permanent visas, international employment or enrolment in specific migrant assistance programmes. Reflecting differences in immigration and public policies and practices, there is a diverse range of health assessment requirements among receiving countries. These requirements may be specific to certain diseases of public health concern such as tuberculosis (TB), as in the case of the United Kingdom Tuberculosis Detection Programme. Requirements may also be more general in nature, or include additional interventions such as vaccinations. But despite differences in health assessment requirements among countries, one thing remains constant: the need to ensure that the migration process does not endanger the health of migrants or host communities.

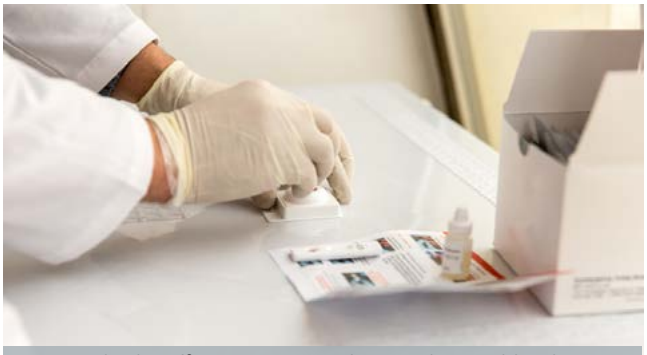
MHAs have many benefits, including the early detection and treatment of conditions of individual and public health concern, safer travel and the prevention of negative health events during travel or on arrival at host communities. Additionally, they serve to protect the health of both migrants and host communities and reduce the expected demand for domestic health and social services. MHAs also serve to allow refugee resettlement agencies to adequately prepare for the arrival of refugees by providing them with important medical information in advance. MHAs are coherent with the IOM goal of "healthy migrants in healthy communities" and, as such, positively impact on migrants' capacity to integrate fully into receiving societies.

Travel assistance is a related service that addresses individual health and safety and manages conditions of public health concern as individuals move across geographical, health system and epidemiological boundaries. Within health assessment programmes (HAPs), pre-embarkation checks (PECs) and pre-departure medical screenings (PDMSs) are performed in order to assess migrants' fitness to travel and provide medical clearance. These measures also ensure that migrants are referred to appropriate medical services once they arrive at 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.

Refugees in the United Republic of Tanzania prior to their departure for resettlement in Australia. © IOM

MHAs serve an important purpose in the prevention and control of communicable diseases prior to a migrant's departure and travel. MHAs may include some or all of the following components:

- Review of medical and immunization history;
- Detailed physical examination and mental health evaluation;
- Clinical or laboratory investigations (e.g. serological tests, radiological screening, chemical analysis of blood or urine);
- Referral for consultation with a specialist;
- Pre- and post-test counselling;
- Health education;
- PDMS;
- Administration of vaccines;
- Provision of, or referral for, directly observed treatment (DOT) for some conditions (for example, intestinal and other parasitic infestations, TB, malaria and sexually transmitted infections (STIs));
- Detailed documentation of findings, preparation of required immigration health forms and documents and confidential transfer of relevant information or documentation to appropriate immigration or public health authorities;
- Fitness-to-travel assessments (PECs);
- Public health surveillance and outbreak management in camps, transit centres and other temporary settlements; and
- Provision of medical escorts and special arrangements for travel.



IOM medical staff in Amman, Jordan conducts a blood test to screen for diseases such as syphilis and HIV. © IOM

Profile of IOM health assessment programme beneficiaries, 2015

In 2015, IOM conducted more than 346,000 health assessments among migrants, covering both immigrants (64.9%) and refugees (35.1%) in more than 80 countries. The majority of the assessments were conducted in Asia (45%), followed by Africa (28.8%), Middle East (13.7%) and Europe (12.6%) (see Table 6 on page 102 in Annex 2). This represents a modest but steady growth in the number of global health assessment activities conducted by IOM over the last five years. Compared to 2014, the number of assessments done among refugees in Asia dropped slightly in 2015, while there was a marked increase in health assessments provided in the Middle East region. Minimal changes were noted in the number of assessments for immigrants in all regions, with highest changes noted in Africa. The number of United Kingdom-bound immigrants dropped slightly in 2015 compared to the previous year, whereas for refugees, there was a distinct increase in the number of assessments for those bound to Canada in 2015 (see Figure 15, Figure 16, Figure 18 and Figure 20 on page 91 – page 96 in Annex 2).

In 2015, the top countries of destination for migrants assisted by IOM were the United States (38.4%) and the United Kingdom (29.8%). Slightly over half of migrants screened were female (53%), and comparable sex distributions were observed regardless of the type of migrant (see Figure 17 on page 93 in Annex 2). Overall, the population of migrants screened in 2015 had a median age of 24 years, but refugees were generally younger with a median age of only 19 years while immigrants had a median age of 26 years. Majority (65.2%) was below the age of 30.[2]

There was a slight variation in age distribution between immigrants and refugees. Minor regional differences in age distribution were also observed within similar categories of migrants (see Figure 20 on page 96 in Annex 2).

[2] Estimates for age and sex distribution in 2015 were calculated based on data from 346,139 health assessments among migrants.

IOM medical staff in Rwanda provides medical screening for refugees preparing to be resettled to a third country. © IOM

Immigrants (various categories)

In 2015, major locations where immigrants were examined (that is, locations with more than 3,000 annual health assessments) included Ho Chi Minh City, Viet Nam; Lahore, Karachi, Mirpur and Islamabad in Pakistan; Manila, Philippines; Dhaka and Sylhet in Bangladesh; Kathmandu, Nepal; Nairobi, Kenya; Kyiv, Ukraine; Moscow, Russian Federation; Bangkok, Thailand; Addis Ababa, Ethiopia; Phnom Penh, Cambodia; Abuja, Nigeria; Chisinau, Republic of Moldova; Colombo, Sri Lanka; and Accra, Ghana. Health assessments were carried out at the request of countries, such as the United Kingdom (44.2%), the United States (24.2%), Canada (19.6%) and Australia (10.6%).

Refugees for resettlement (urban and camp-based)

In 2015, major locations where refugees were assessed (that is, locations with more than 3,000 annual health assessments each) included Baghdad, Iraq; Kuala Lumpur, Malaysia; Addis Ababa, Ethiopia; Amman, Jordan; Mae La Camp in Thailand; Kakuma Camp in Kenya; Beldangi II and Sanischare camps in Nepal; and Damascus, Syrian Arab Republic. More than 2,000 annual health assessments each were done at the Beldangi I and II extension camps in Nepal; Islamabad, Pakistan; Mbarara refugee camp in Uganda; and in Nairobi, Kenya. Refugee health assessments were carried out at the request of multiple resettlement countries, with the top three being the United States (64.6%), Canada (20.2%) and Australia (8.6%). Other countries of destination for refugees included Austria, Belgium, Denmark, Ethiopia, Germany, Ireland, Italy, Japan, Kenya, New Zealand, Netherlands, Norway, Republic of Korea, Spain, Sweden, Tajikistan and the United Kingdom. The refugees examined by IOM resided in both camp (for example, Nepal) and urban settings (for example, Jordan).

The impact of the Syrian refugee crisis: increased refugee resettlement from the Middle East

In the latter half of 2015, several traditional resettlement governments increased their Syrian refugee intake in light of the ongoing refugee crisis. Canada pledged to welcome 25,000 Syrian refugees to Canada by the spring of 2016, while the United Kingdom, Australia and others also increased their Syrian refugee intake substantially. From approximately 1,600 health assessments for Syrian refugees in 2014, IOM scaled up to over 24,000 health assessments for Syrian refugees in 2015, the bulk of which were provided over the span of three months. On behalf of receiving countries, IOM provided pre-departure resettlement services and managed movement operations; the health component of these services included pre-departure health assessments, PECs and medical movement assistance.

IOM health assessments among Syrian refugees in 2015 were provided primarily in Lebanon (53%) and Jordan (41.3%). Approximately 5 per cent of the health assessments were performed in Egypt, Iraq and Turkey. Sixty-four per cent of the pre-departure health assessments for Syrian refugees were on behalf of the Government of Canada, while other top countries of destination included Australia (9.8%), the United Kingdom (9.9%) and the United States (10.3%). Over a quarter of the caseload was composed of children aged 10 years or younger, while the elderly (aged 60 years and above) accounted for only 3.4 per cent of the total. Nearly half of the caseload was comprised of female refugees.

The 2015–2016 Syrian resettlement "surge" was a remarkable example of a "whole-of-IOM" effort. Skilled medical and other staff joined the surge from missions around the world, working around the clock and in close partnership with the relevant governments, United Nations High Commissioner for Refugees (UNHCR) and other implementing partners to accomplish the resettlement objective.

Speaking of the resettlement surge to Canada, an IOM doctor in Amman explained, "We initially planned to conduct fit-to-travel assessments to see if individuals were healthy enough to travel, and figure out if they have any medical necessities that stretch beyond what is normally required for healthy individuals while travelling. That [was] expanded to include a full physical examination, blood tests and chest X-rays (CXR). To do all of this for everyone was very challenging, but once we began to work with the families and saw how excited they were to go to Canada, it became immensely rewarding work. You truly feel the effort you are putting into this work is paying off."

IOM medical staff from missions around the world came together to support the 2015 resettlement surge in Jordan and Lebanon. © IOM 2015

IOM tuberculosis detection and control

TB detection and control continues to be an important public health concern for both sending and receiving countries, as well as migrants and their families. IOM contributes to cross-border TB detection and control by screening migrants for active TB prior to resettlement. Within its TB screening programmes, IOM provides a wide range of TB-related services, including physical examination, radiological investigation, the tuberculin skin test, sputum smear and culture, drug susceptibility testing (DST), contact tracing, health education and DOT. TB treatment is provided either directly by IOM or through a referral system, in partnership with national TB programmes (NTPs).

In 2015, as a core component of health assessments, the majority of migrants examined by IOM underwent TB screening prior to their migration. IOM MHAs took place mostly in countries classified as intermediate or high TB burden countries. Overall, the TB detection rate in 2015 was 269 per 100,000 health assessments; specifically, there were 261 cases per 100,000 refugee health assessments and 273 per 100,000 immigrant health assessments. Of the 930 total active TB cases in 2015, 616 (66.2%) were bacteriologically confirmed and 314 (33.8%) were diagnosed based on clinical and radiological findings (see Table 7 on page 104 and Table 8 on page 105 in Annex 2).

In 2015, the detection of active TB was slightly higher among immigrants; immigrant health assessments were more likely (with a ratio of 1.04) to yield active TB detection than refugee health assessments.

Compared to 2014 detection rates, the observed overall active TB case detection rates for refugee health assessments appeared lower in 2015 (while those for immigrants slightly increased). While detailed statistical comparative analyses are outside the scope of this report, likely reasons for the lower observed detection, especially for refugee health assessments, could include changes in population groups examined in key locations and a possible increase in the proportion of repeated medical examinations in 2015 compared to 2014; due to resettlement visa regulations, refugees often have to undergo repeated medical examinations to ensure their health status and confirm treatment and certification.

Radiological services in tuberculosis diagnostics

Along with clinical signs and symptoms, radiological investigations are important for the diagnosis of TB. IOM performed more than 271,000 radiological investigations in 2015, resulting in the identification of 12,204 (4.5%) abnormal CXR and further laboratory investigations. The detection of CXR abnormalities suggestive of TB varied in major IOM screening programmes, with the highest detection rates found among refugees in Nepal and Thailand (17,846 and 16,217 per 100,000 health assessments, respectively) and the lowest detection rates found among immigrant populations in the Middle East (overall detection 426 per 100,000 health assessments; 212 per 100,000 health assessments in Iraq and 965 per 100,000 health assessments in Jordan).

An IOM radiologist at the Manila Teleradiology Centre remotely reads and interprets a CXR. © IOM

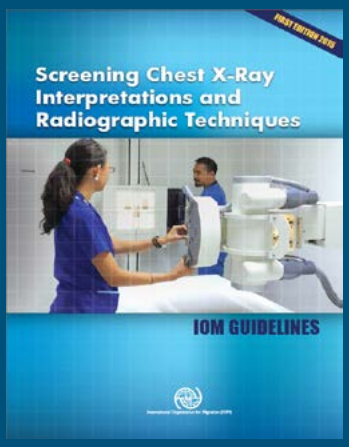
The IOM Global Teleradiology and Quality Control Centre, based in Manila, Philippines, was established in June 2012 to meet the increasing expectations and requests from major government partners in relation to radiological interpretation within the framework of IOM Health Assessment Programme. The Teleradiology Centre, which has expanded steadily in the years since, works to standardize IOM radiological procedures and optimize the quality of CXR interpretations through the provision of primary X-ray reading services, quality control and analysis of CXR readings, preparation of radiology guidelines and training materials, and provision of technical radiology-related support to IOM field operations, such as establishing X-ray units, purchasing X-ray machines and hiring radiology staff. The Centre provides real-time service through the Global Picture Archives and Communication System (PACS), as well as through the use of the medical digital image (DICOM) viewing software and CXR reporting Web applications.

Recently, concurrent with the success of the Centre's service provision, partner governments have requested enhanced services, such as reading CXRs for external non-IOM panel sites, providing radiology training to non-IOM panel physicians, capacity-building for local radiologists, regular data reporting, increased quality control services and greater coverage of IOM CXR caseloads. By the end of 2015, the Centre had networked the teleradiology PACS system to 45 field locations.

Over the course of 2015, IOM completed more than 50,000 primary CXR readings and rolled out primary reading support to six additional IOM locations: Kampala, Uganda; Ho Chi Minh City, Viet Nam; Kuala Lumpur, Malaysia; Phnom Penh, Cambodia; Addis Ababa, Ethiopia; and Beirut, Lebanon. This brought the total number of supported locations to 21, covering HAPs for Canada, Australia, Germany, United States, United Kingdom and New Zealand.

The Centre also supported several IOM Missions in the Middle East region through the rapid set-up and provision of teleradiology primary reading services to respond to the unprecedented surge in Syrian refugee resettlement in late 2015 and early 2016. It was an important element of the success of the resettlement surge.

In 2015, the Centre established an innovative global quality control programme with auto-sampling and auto-image transfer systems, which involves a radiologist who reviews cases with significant disagreement; experts from the CDC provide a third opinion, if needed. The Teleradiology Centre rolled out its quality control programme to seven IOM field locations with a US programme in 2015, sampling a total of 4,742 CXRs from the seven locations; the quality control programme then read and analysed 3,476 cases and provided biannual reports on the results, including the Kappa agreement level, to the field locations. The quality control programme helped to assess and identify gaps in radiologic techniques and radiologists' reporting, as well as data management, and allowed for the provision of expert feedback and recommendations for further optimization of the radiology service in IOM field operations. The Centre plans to further expand the quality control programme to more HAPs and field locations in 2016. The global teleradiology team has additionally been providing second opinion CXR reading services for different IOM field operations when they have queries on the first reading.



Guidelines developed by IOM's Global Teleradiology Centre in Manila.

Available at: http://publications.iom.int/system/files/pdf/screening_chest_xray_interpretations.pdf

IOM teleradiology workshop in 2015. © IOM

The Centre updated its IOM Guidelines on Screening CXR Interpretations and Radiographic techniques, which was published in both print and e-book formats. The guidelines are believed to be a useful handbook for radiologic technologists, radiologists and panel physicians working in HAPs.

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In addition to its regular service provision, the Centre also provided three major radiology trainings in 2015 in several locations around the world, targeting panel physicians, radiologists, radiographic technologists, radiology support staff and medical information technology colleagues. The trainings focused on

screening CXR approach, radiographic techniques and teleradiology systems and techniques, and trained over 160 participants.

Additionally, the Centre conducted Web-based trainings for first-time teleradiology users for all locations that starting using the teleradiology services in 2015, as well as on-site training at the Centre in Manila for visiting staff.

As part of the plan to expand the network of IOM teleradiology support and services, the Centre has been working to establish a second teleradiology centre in Nairobi, Kenya. The nascent teleradiology centre in Nairobi has already been networked to 15 IOM field operations in Africa. The Nairobi centre is expected to be fully operational by end of 2016.

Laboratory services in tuberculosis diagnostics

For persons with presumptive TB based on abnormalities detected during the physical and X-ray examinations, the next step in IOM's TB detection programme is sputum smear microscopy and culture tests. This is followed by microbiological identification and DST for positive culture specimens. Over the last few years, the use of GeneXpert has also been introduced in many IOM screening locations at the request of resettlement countries.

In 2015, tuberculosis laboratory diagnostics were performed for 12,235 health assessments. TB laboratory diagnostics include sputum smear microscopy and sputum culture examinations; nearly all (96.2%) specimens underwent both smear and culture testing. Overall, 616 refugees and immigrants (or 178 per 100,000 health assessments) were confirmed with active TB by positive sputum culture results, out of which 520 (84.4%) were referred for DST. Of this figure, 13 per cent of cases (n=68) were found to be resistant to one or more anti-TB drugs, and 3.1 per cent was found to be multidrug-resistant (MDR) (n=16). The application of this diagnostic test helped clinics to better align their treatment protocols, improving the overall performance of TB treatment programmes (see Table 9 on page 106 in Annex 2).

IOM laboratories closely collaborate with national and supranational laboratories, as well as with the Global Laboratory Initiative.

Tuberculosis treatment in IOM health assessment programmes

Another important element of the IOM health assessment services is the provision of TB treatment to migrants, which is undertaken in close collaboration with NTPs and in accordance with international protocols. IOM runs several certified DOT centres in locations in Africa and Asia.

In 2015, IOM centres provided DOT for 404 (43.4%) patients with active TB, while the rest were referred for treatment. In addition, IOM clinics also provided directly-observed preventive therapy for cases with latent TB infection in selected locations. Drugs were procured in collaboration with NTPs in the respective countries.

For United States-bound refugees on TB treatment, IOM performs routine monitoring of treatment outcomes in coordination with the CDC, using a set of predefined TB laboratory and treatment performance indicators.

IOM Patient Stories: In pursuit of happiness

Dr Damaris Miriti consulting with a TB patient at the MDR-TB clinic in Dadaab. © IOM

"I long for the day my country will be stable, I wish for peace, stability. I wish for the day children and their parents and grandparents can come out to the streets to sing and dance without fear of the militia or the army beating and killing us," John stated in a pensive tone of voice. "I am extremely happy to get this opportunity to start afresh in the United States of America, after all that I have gone through. I never thought I would see this day," he continued.

John arrived in Nairobi, Kenya, in August 2010 by way of the Kenya–Uganda border. Prior to this, he had lived in Mbarara, in the western region of Uganda. When he arrived in Nairobi, he was received by a Kenyan acquaintance who immediately took him to the suburb of Kasarani. "Here I met many of my countrymen who lived here as refugees, and I was happy," he explained. "Although I did not speak or understand Kiswahili, most of the people there understood English. I felt at home and safe."

Once in Kenya, John registered as a refugee with UNHCR. In 2012, John received a call from IOM requesting him to come for a pre-departure resettlement health assessment, a standard part of the resettlement process. He took this as a sign that he was about to start a new journey, a new chapter in his life. Filled with confidence, he made his way to the Migration Health Assessment Centre in Nairobi. He felt strong and healthy, and that nothing was going to deter him from achieving his goals.

When his X-ray results came back, however, they revealed scars on his lungs, and his sputum tested positive for MDR-TB. "I saw death staring at me in the eye," John recounted. "I thought to myself, this is it, finally; the devil has caught up with me. I thought of all I [had been] hoping to achieve, and now this. I honestly regretted wanting to go abroad; had I not been to IOM, I would not have known about all this."

John did not show the typical signs of suffering from TB, as he was not coughing and had no fever. He had, however, lost his appetite and had consequently lost weight, something he had mistakenly associated with stress.

This marked the beginning of a more than two-year journey in IOM's MDR-TB clinic in Dadaab. Through the support of the team at the clinic, John was able to successfully finish his treatment and proceed with his resettlement process.

A Doctor's Diary: Dr Damaris Miriti

John receiving instructions on his departure schedule from an IOM operations officer. © IOM

After more than 15 years of engaging with TB care, both in the public and private sector, I have had many heart-rending moments. I am grateful for those who have succeeded in their treatment, to be able to share experiences that provide encouragement. John was a source of encouragement for me personally, and for the IOM team at large, to continue our diligent service to migrants, especially those who encounter seemingly insurmountable challenges. At the start of my journey with John, which spanned over two years, I met a pleasant and positive young man. He had to move to the Dadaab refugee camp due to lack of social support in Nairobi. He started treatment for MDR-TB following his diagnosis by IOM; a few months into treatment, however, IOM had to bring in support from our psychiatrist and counselling team. John was experiencing ill mental health, an adverse side effect of some of his TB medications. He consequently had to stop treatment for a month before he was again well enough to resume an adjusted regimen of medication.

But as this storm settled, another was brewing. Severe gastric-related adverse side effects soon brought his treatment to another halt. John could barely swallow anything, neither food nor medicine, despite his efforts, and he subsequently lost more weight. IOM staff and other patients in the ward supported John with encouragement and specially cooked meals to help him absorb the necessary nourishment and to keep his spirits up.

On my next visit and review, John had successfully completed his full course of prescribed MDR-TB therapy, was cured and had regained weight – a strong and cheerful man met me on that day. John's experience demonstrates how patient-centred care and psychosocial support is a vital component of the TB care package. John, fully healed, departed for a new life in Denver, Colorado, United States, in July 2015.

United Kingdom Tuberculosis Detection Programme

On behalf of the United Kingdom, IOM implements the UK TB Detection Programme, one of the activities with the highest number of IOM-assisted immigrants since 2006. The purpose of the programme is to screen visa applicants (those who apply to stay in the United Kingdom for six months or more) for infectious pulmonary TB. DOT for positive cases is provided either by IOM in partnership with NTPs, or through a referral system. From 2005 to 2012, IOM ran a pilot version of the programme in eight countries, namely Bangladesh, Cambodia, Ghana, Kenya, Pakistan, Sudan, Thailand and the United Republic of Tanzania. Upon successful completion of the pilot phase in mid-2012, the United Kingdom announced that it would progressively expand the programme to over 60 countries worldwide. Over the course of 2013–2014, IOM worked intensively to assist the United Kingdom with the implementation of the programme. From the initial 11 clinical sites in 8 countries that IOM operated during the pilot phase of the programme, the programme had been expanded to 56 sites in 40 countries.

In 2015, of the total 99,099 health assessments done for this programme, the majority of visa applicants undergoing TB screening fell under visa categories "settlement and dependents" (45.5%) and "students" (33.6%). The bulk of the applicants belonged to the 20- to 39-year-old age group; slightly more than half (56.3%) were female migrants. Radiological investigations yielded a total of 1,903 CXRs (2.1%) suggestive of active TB. Overall, there were 182 active TB cases (with a detection of 184 cases per 100,000 health assessments), either microbiologically confirmed or diagnosed clinically (see Table 10 on page 106 in Annex 2). Of this figure, the majority (62.1%) were those in the "settlement and dependent" visa category, while about 17 per cent were in the "student" visa category. Approximately 47 per cent of the TB cases were in the 25 to 34-year-old age group.

Pre-departure Immunizations

IOM conducts a variety of pre-departure immunization activities. Within the context of the US Refugee Admissions Program, IOM has been working with CDC, the US State Department's Bureau of Population, Refugees and Migration and national immunization programmes to develop and implement a vaccination programme for United States-bound refugees since 2012. The programme aims to introduce vaccinations early in the resettlement process to ensure that refugees arrive in the United States protected against many of the common vaccine-preventable diseases.

By the end of 2015, this programme had been implemented in over 12 countries, with the United Republic of Tanzania, Indonesia and Chad expected to start in early 2016. Overall, from the programme's start at the end of 2012, more than 130,000 refugees received one or more vaccines as per the programme's vaccination schedule and over 800,000 doses of vaccines documented. As part of the programme, IOM successfully piloted global vaccine procurement from UNICEF and other sources, established cold chain protocols and infrastructure, as well as integrated testing for Hepatitis B in all programme locations, with over 42,000 refugees tested in 2015.

Table 1. Expanded health assessment vaccination and presumptive treatment activities

Region	Country	Expanded vaccination	Hepatitis B testing
Africa	Ethiopia	17-Nov-13	26-Dec-14
	Kenya	15-Sep-13	15-Jan-15
	Uganda	20-Aug-14	1-Jan-15
	Rwanda	10-Nov-15	10-Nov-15
Asia	Malaysia	15-Sep-13	2-Jun-14
	Thailand	17-Dec-12	8-Dec-13
	Nepal	17-Dec-12	7-Jan-14
Europe and Former Soviet Union	Belarus	1-Jan-16	1-Jan-16
	Republic of Moldova	1-Jan-16	1-Jan-16
	Kazakhstan	1-Jan-16	1-Jan-16
	Russian Federation	1-Jan-16	1-Jan-16

Table 2. Vaccination coverage, 2013–2015 combined (including re-medicals)

Country	Project start	Examined	Full schedule	Total vaccines	Total doses
Ethiopia	17-Nov-13	17,599	13,209	52,751	107,966
Kenya	15-Sep-13	22,644	18,131	67,735	157,208
Malaysia	15-Sep-13	36,227	28,627	104,567	227,749
Nepal	17-Dec-12	23,560	23,560	72,068	133,878
Thailand	17-Dec-12	24,383	24,383	74,849	152,442
Uganda	20-Aug-14	6,300	4,373	16,008	34,104
Total		130,713	112,283	387,978	813,347

An IOM nurse vaccinates a young refugee against vaccine-preventable diseases in Nairobi, Kenya. © IOM 2011

IOM-CDC Cooperative Agreements: Strengthening prevention and control of infectious diseases, including vaccine-preventable diseases, in United States-bound refugee populations

Following an assessment of refugee camps in several countries in the previous years, a number of gaps in health assessment and support of United States-bound refugees were identified and new protocols explored with the help of the CDC-IOM Cooperative Agreement. These activities included the following components:

- Anemia screening for children below 5 years of age, as well as pregnant women. Anemia is common among refugees and often caused by nutritional deficits, such as iron deficiency. Iron deficiency anemia frequently affects children under the age of 5, when it can be detrimental to cognitive development. Anemia in pregnant women or women of childbearing age is also an issue of global concern. The UNHCR has designated anemia as a "very serious" problem among children and women worldwide, and has recently developed a strategic plan for its treatment and control among refugees. The testing aims to identify etiologies of anemia in this refugee population in an effort to treat these and improve health before resettlement.

- Anthropometric assessment of children below 5 years old, estimating three key indicators for protein-energy malnutrition as recommended by WHO, UNHCR, CDC and World Food Programme, namely weight-for-height or wasting, height-for-age or stunting, weight-for-age or underweight. Child malnutrition, both undernutrition and over-nutrition, are global problems that impact on survival, incidence of acute and chronic disease, healthy development, and the economic productivity of individuals and societies. Among refugee children aged 6–59 months, malnutrition is a critical public health concern due to the subsequent increased morbidity and mortality in this age group and the food insecurity facing refugee populations worldwide. Those presented with malnutrition (-2 z-score and below) undergo anemia screening. In addition, they are provided with nutritional counselling, supplementation and referred for pediatric consultations.

- Blood lead testing for children under 5 years old. Lead is a metal found in the environment, which can have bad effects on nearly every part of the body, especially for children. It can cause problems with learning and behaviour. At very high levels, lead can cause seizures, coma and death. High lead levels have been found in refugee children living in the United States and in host countries like Thailand. Those who are diagnosed with elevated lead level are offered counselling and education about the condition, while those with high levels are referred to a specialist for further evaluation and/or in-patient care prior to resettlement to the United States.

- Additional medical investigations have been conducted for refugees with splenomegaly to better understand the underlying etiologies of this condition, which is prevalent in selected refugee groups in Uganda. The refugees underwent ultrasound, blood, urine and stool testing. During the study period, a total of 974 refugees from the Kyangwale refugee settlement were assessed for splenomegaly, 145 (14.9%) of which were identified with palpable splenomegaly and enrolled in the evaluation. All assessed refugees received the required initial treatment and were referred for further management to resettlement and overseas health facilities.

DNA Services

IOM provides DNA sampling services for family reunification purposes, as required by certain immigration authorities. In 2015, the majority of DNA services were performed in Kenya (26%), Viet Nam (22.9%), Ethiopia (12.5%), and Bangladesh (10.3%) (see Figure 21a on page 100 in Annex 2).

Outbreak Surveillance and Response

IOM performs both active and passive surveillance for outbreaks of communicable diseases in refugee camps and transit centres in countries, such as Jordan, Kenya, Nepal, Thailand, the United Republic of Tanzania and in some locations in Europe and Central Asia.

Children in Kenya undertaking pre-departure procedures as part of the US refugee resettlement programme. © IOM

IOM response to the measles outbreak in Kyrgyzstan, February–March 2015

On 7 February 2015, IOM received a notification from the CDC on a confirmed case of measles among refugees who arrived in the United States from Kyrgyzstan and a request to suspend refugee movements out of Bishkek in accordance with the "Interim recommendations regarding measles among United States-bound refugees in Kyrgyzstan", which was provided by the CDC. The request came after a 9-month old refugee who arrived in Atlanta on 4 February 2015 was diagnosed with measles. According to the estimates of CDC, WHO and national authorities, the outbreak of measles in Kyrgyzstan affected about 2,000 residents of the country, mostly unvaccinated children and adults.

IOM implemented a series of response measures through medical facilities in Bishkek, including the following:

- Vaccination of refugees in the immediate resettlement pipeline, organized in Bishkek through partnership with the Kyrgyz National Immunization Programme; measles-mumps-rubella (MMR) vaccines were provided by the State's vaccination facilities free of charge. As recommended by the CDC, this action targeted all non-pregnant United States-bound refugees from Kyrgyzstan, between 6 months and 58 years of age. In total, 67 individuals were vaccinated against measles, most of whom received two doses of the MMR vaccine.
- Appropriate vaccination information was sent to the Kyrgyz State Health Authority; and
- Additional training was delivered to physicians in Bishkek on pre-departure medical examinations in accordance with CDC recommendations.

Close cooperation and support provided by the local health authorities in Kyrgyzstan helped to rapidly implement CDC-recommended measures and resume resettlement.

Nutrition Profiling

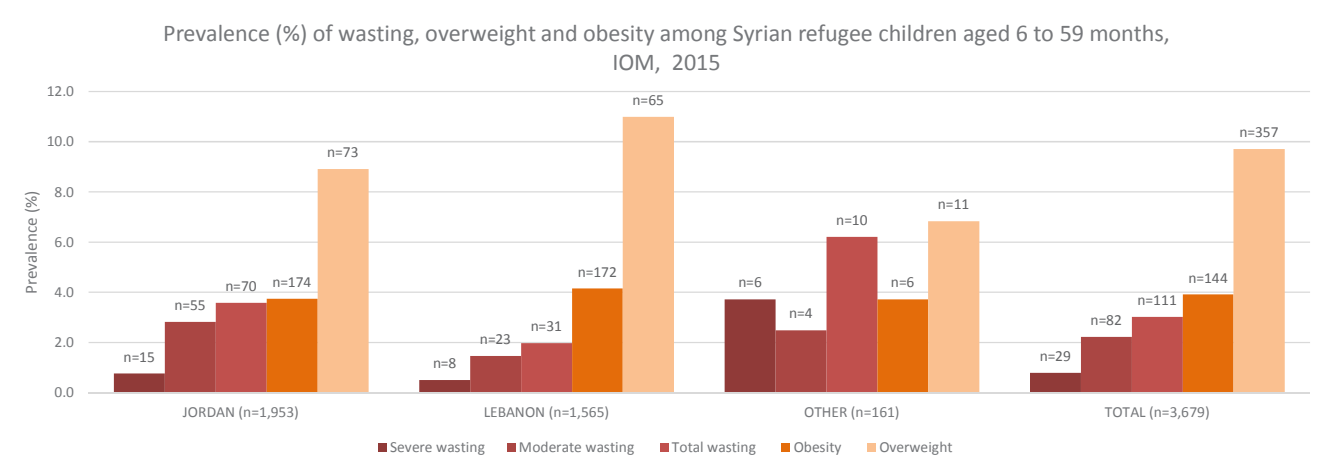
IOM uses available anthropometric indices from refugee health assessments to estimate malnutrition. For children, prevalence levels of wasting and stunting are estimated. Wasting (low weight-for-height) generally indicates recent or severe weight loss, while stunting (low height-for-age) indicates prolonged or repeated undernutrition.

A total of 3,679 Syrian refugee children aged 6 to 59 months were examined in 2015, mainly in Jordan (53.1%) and Lebanon (42.5%), with a small portion in neighbouring countries. The majority of children were aged between 24 and 59 months (70.5%).

Overall, there was low prevalence of malnutrition: 111 children (3%) had moderate or severe wasting, while 320 children (8.7%) had moderate or severe stunting. The prevalence of wasting in Jordan and Lebanon was low, while the level in neighbouring countries was moderate. Among the severely wasted children (n=29), more than half (n=18, 62.1%) were aged 24–59 months and were mainly boys (n=18 62.1%). Overweight and obesity status (high weight-for-height) was noted among 501 (13.6%) children.

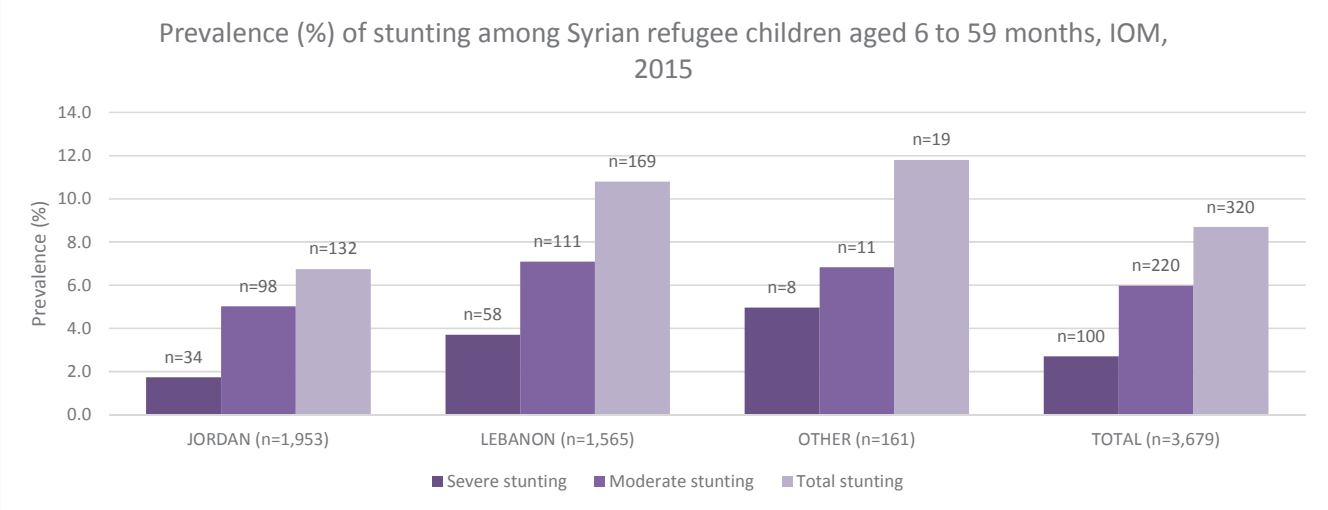
IOM doctors detecting children with severe malnourishment refer them to UNHCR, which undertakes to ensure follow-up care through interventions such as the provision of supplemental nutrition or food vouchers.

Figure 5. Prevalence of wasting, overweight and obesity among Syrian refugee children, aged 6 to 59 months, IOM, 2015



Source: IOM.

Figure 6. Prevalence of stunting among Syrian refugee children, aged 6 to 59 months, IOM, 2015



Source: IOM.

Managing and sharing data through health informatics systems

Migration health informatics (MHI) has transformed the way migrant health data are generated, reviewed and processed by systematically applying new technologies and computer science to global information service provision in IOM resettlement and immigration programmes. MHI also helps MHD to decrease processing time and conserve resources, integrate all migration health activities at the country level, and standardize and centralize data collection among IOM Country Offices, thereby creating a repository of migrant health information at the IOM global organizational level.

The Migrant Management Operational Systems Application (MiMOSA), which is IOM's Web-based migrant management software, was used in 37 missions as of 2015 for capturing data on health assessment and pre-departure medical procedures. In 2015, the MHI team supported the development of updated releases of the MiMOSA software, providing functionality enhancements, such as enabling CXR links to view X-ray images within MiMOSA, an updated medical profile management, and a completely new module for managing the patient capacity of IOM clinics with an enhanced appointment scheduling system.

MHI further developed specialized operational medical data management tools, such as the IOM Immunization Management System, an interface for tracking vaccine inventory levels, stock movement and lot details.

Additional effort was put into the extension and enhancement of the Web-based HAP statistical reporting mechanism (HAPSTAT Plus) that represents a substantial improvement to data quality control and validation activities of field operations using MiMOSA for medical record data entry. Additionally, MHI has finalized the medical escorts report and, as an important step toward automated data validation and submission, has developed a US-focused TB indicator report.

To train MHD focal points in the usage of the Web reports, MHI held the first "HAPSTAT Plus" workshop at the IOM Manila Administrative Center in Manila, Philippines in December 2015, during which considerable progress was made in streamlining data validation processes and paving the way for more timely reporting of migrant health information.

The MHI team initiated work on a data repository that is based on modern data warehouse and business intelligence technology and which will become the new reporting platform for medical data. It is envisaged that the medical data warehouse will be linked to other IOM corporate data and information sources, so that IOM will be in a better position to undertake secondary analyses of current and historical operational data, update findings and identify trends in changing population groups of examined migrants at the global level.

MHI also enables the exchange of information between IOM and its partner agencies, improving IOM's capacity to deliver cost-effective and timely services and ensuring the consistency and completeness of data. Support to continuity of healthcare provision through the electronic transmission of relevant data is currently being provided for US-bound migrants through the MiMOSA–Electronic Data Notification interface, which is constantly being enhanced and further developed to meet US Centers for Disease Control and Prevention requirements and expectations.

Participants of the first global HAPSTAT workshop in Manila. © IOM 2015

HEALTH PROMOTION AND ASSISTANCE FOR MIGRANTS

The Health Promotion and Assistance for Migrants programme area of MHD caters its strategy and activities to the needs of migrant populations and the changing requirements of Member States to address health of migrants. IOM projects in this area provide access to high quality health services for migrants and undertake a substantial amount of operational research to promote evidence-based migration health policies. Technical support and national capacity-building efforts are included in this work area to support Member States in their efforts to better manage migration health challenges. IOM missions carry out various activities to assist governments in addressing migration and mobility-related health challenges by strengthening national health systems and ensuring that migrants have equitable access to health services. Migrant beneficiaries of this area of work include workers, undocumented migrants, trafficked persons, seasonal and otherwise temporary cross-border migrants, and displaced populations. Partners include governments, non-governmental organizations (NGOs), UN agencies, including WHO, civil society groups and academic agencies, among others.

This section provides selected highlights in this programme area from 2015, presenting them by region and highlighting both regional initiatives and individual country activities.

AMERICAS

Regional Programme

Dialogue on the Health of Migrants in Central America

The Central American region is considered one of the most important migration corridors of the world. Apart from being transit and destination countries, El Salvador, Guatemala, Honduras, and Nicaragua are countries of origin and return, with social and family dynamics closely linked to the migration process. As migration is a social determinant of health, a socio-epidemiological profile and accurate information to show its link with health outcomes are essential, generating the necessary evidence to facilitate dialogue and decision-making to improve the health conditions of migrants and communities.

Through the project "Capacity-building of the governments of El Salvador, Honduras, Nicaragua, and Guatemala to address the health of migrants from a multisectoral approach", funded by the IOM Development Fund, investigations were carried out in the four countries, revealing the vulnerabilities related to health in the migration cycle and their impact on the well-being of the families left behind, as well as the health of returnees. This research provides elements of interest, including morbidity and migration, health and self-care, suitability of the existing health service offerings, risk perception and STIs, including HIV/AIDS, among others. The project was ongoing from 2013 to 2015, and was finalized, published, and presented in December 2015.

Among the many results achieved, an epidemiological profile was constructed for each of the countries. Overarching trends showed that healthy young people tend to be the ones migrating and highlighted the multiple vulnerabilities linked to social, working and living conditions that are experienced en route and influence migrants' health.

The studies also found that returnees' risk of getting sick raises gradually in the various phases of the migration cycle. During the return phase, migrants can often bring with them a great epidemiological burden, pathologies and effects of lived experiences, and take these vulnerabilities and risks with them back to their communities of origin. Infectious and non-infectious diseases, as well as chronic non-communicable diseases, were found to be among the concerns for returning migrants.

The study conducted in Honduras identified four priority health issues among its migrant population. These included the following: (a) communicable diseases, including TB and sexually transmitted

diseases; (b) non-communicable diseases, including cardiovascular disease, which is caused by poor nutritional status and lack of physical activity; (c) somatic disorders related to stress, including pain and ulcers; and (d) psychological disorders, such as depression, anxiety and low self-esteem.

These priority concerns were echoed in the other country reports, as well. In Guatemala, it was found that the most common causes of disease burden for returned migrants were hypertension and diabetes, with 56 per cent and 37 per cent, respectively. The reports on El Salvador and Honduras found similar trends, while also noting that the number of migrants who suffered from HIV/AIDS or other sexually transmitted diseases was greatly elevated upon return to country of origin as compared to the number before migration. The report on El Salvador found that among migrants interviewed who were in the country with irregular status, only 15 per cent had been tested for HIV, despite 94 per cent reporting that they had access to basic medical care in the country. The analysis on Honduras indicated that migrants vulnerable to disease before migration would be more likely to transmit diseases upon return to communities of origin because of lost access to medical care during the migratory process.

The studies also highlighted that among the families remaining in the community of origin, there is a special vulnerability. The burden of sickness associated with the emotional process of stress or migratory grief is substantially higher than that among those families who did not have an absent member due to migratory processes. A greater impact of migration on the mental health of fragmented family members, especially women left behind in the community, was observed.

After the completion of the exploratory investigations, the results were presented both to the relevant national officials in each country and at a regional dialogue held in San Salvador in July 2015. As a final activity, and based on the gathered information, country dialogues were carried out in all four countries, led by the Ministry of Health of each country with the support of the governmental migration offices, IOM, government agencies, civil society and other partners. As a result, an action plan was developed with specific measures to strengthen the capacity regarding health and migration.

National Projects

Joint programme to improve the human security of Ngäbe and Buglé temporary migrants in Costa Rica and Panama

According to International Labour Organization figures, of the coffee pickers in the Coto Brus and Los Santos regions along the southern border of Costa Rica, a large proportion are indigenous Ngäbe and Buglé migrants (85% and 58% respectively) from Panama. Close to 19,000 Ngäbe and Buglé persons migrate to Costa Rica every year, representing one of the principal sources of labour for the coffee harvest and production of bananas. They are the poorest and most marginalized migrants in the country. As part of an effort to strengthen community and regional structure, including inter-institutional networks, indigenous orientation centres and the recipient communities of the migrant population, IOM has been engaged with the programme titled “Joint Programme to Improve the Human Security of Ngäbe and Buglé Temporary Migrants in Costa Rica in Panama” since 2013.

The project strengthened the relevant institutions on migration health issues and supported migrants by through awareness-raising activities and the organization of cultural, health and entrepreneurial fairs. In the final year of implementation of this project, the efforts and activities were focused on achieving an institutional commitment at the national level to allow for the consolidation and sustainability of the Joint Programme results. Five inter-institutional networks were strengthened and over 800 public officials were sensitized and trained on the needs facing migrant populations. Additionally, three Indigenous Orientation Centres are operating in Costa Rica, and two have been opened in Panama. Over the course of the project, more than 66,000 migrants received necessary services and orientations.

Characterization of migratory flows of migrants and the labour market between Colombia and Chile

Growing out of a project that characterized the migratory flows of the labour market between Colombia and Chile, an initiative between the two governments was developed in order to strengthen the Binational Agenda on the Health of Migrants in the Tacna, Arica and Antofagasta regions. The cooperation agreement was signed on 9 July 2015 and aimed at strengthening the institutional capacity of the Chilean Ministry of Health in migration management in the field of public health.

Primary areas of focus included an analysis of the knowledge and behaviours surrounding STIs among the migrant population, an evaluation of the socio-epidemiological profile among undocumented migrants, an evaluation of the availability, access and responsiveness of the health systems for migrant populations and the identification of particular risks and vulnerabilities associated with female migration. To date, a system to allow for the exchange of doctors and medical personnel between Chile and Colombia has been established, with the preparation of terms of reference and determination of specific medical workforce needs by region. Additionally, a socioepidemiological profile of disease burden has been completed, with a particular focus on the prevalence of HIV/AIDS and other STIs among the migrant population.

Characterization of migratory flows of migrants and the labour market between Colombia and Chile

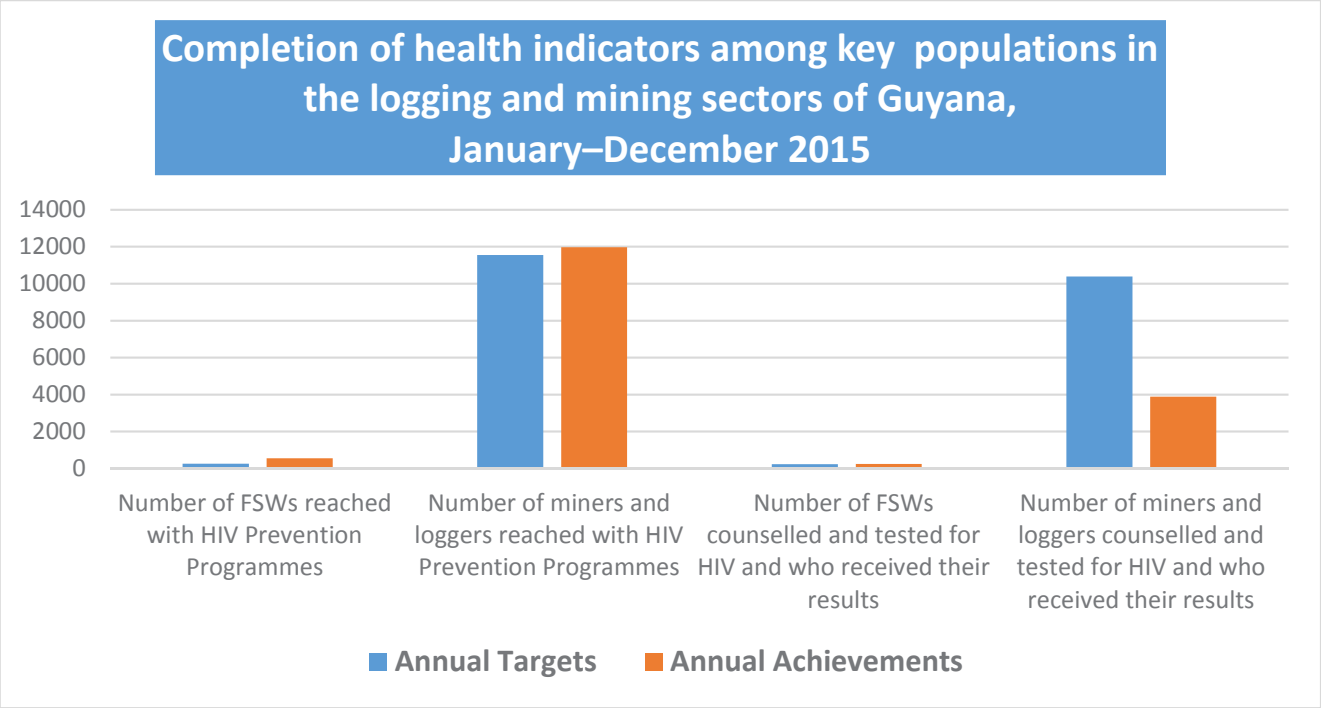
The Health Promotion Among Key Populations in the Logging and Mining Sectors of Guyana project – developed in collaboration with Guyana's Health Ministry and funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria – is a programme that aimed to contribute to improved access to healthcare and testing for mobile populations, including sex workers, miners, loggers, and other affected individuals and communities in the country.

There are an estimated 20,000 Brazilian migrants living and working in Guyana. Many are miners, loggers, and sex workers, among other livelihoods. The project focused on a community-based approach by creating strong partnerships with local authorities on HIV/AIDS, sexual reproductive health and other vulnerabilities faced by mobile populations. The HIV prevention behaviour change communication (BCC) and HIV counselling and testing among loggers,

Table 3. Project components targeting logging and mining communities of Guyana, "Health Promotion among Key Populations in the Mining and Logging Sector of Guyana", July 2014 to December 2016

Component 1	Research and information dissemination	Qualitative survey on HIV/AIDS awareness and service provision among sex workers, loggers and miners and mobile populations Draft protocol with the National AIDS programme manager for review and discussion
Component 2	Culturally appropriate HIV/AIDS service delivery and capacity-building	Greater awareness and access to HIV/AIDS services and information by sex workers, loggers and miners Increase awareness of local and governmental organizations providing health-care services to key populations
Component 3	Partnership and networking	Greater collaboration among key stakeholders and partners to manage health vulnerabilities among key populations Mobile consular services available to 9,000 Brazilian migrants within the four regions

Figure 7. Completion of health indicators among key populations in the logging and mining sectors of Guyana, 2015



Source: IOM.

miners and female sex workers (FSWs) were carried out in four administrative regions of Guyana.

The project was comprised of three components, as indicated in Table 3 on page 36, and the evaluation was guided by four primary indicators (a) number of FSWs reached with HIV prevention programmes; (b) number of miners and loggers reached with HIV prevention programmes; (c) number of FSWs counselled and tested for HIV and who received their results; and (d) number of miners and loggers counselled and tested for HIV and who received their results.

IOM also trained 89 stakeholders, including government and civil society organizations (CSOs) in three regions of Guyana on "Health, Mobility and Vulnerability", "Stigma, Discrimination and Human Rights" and "Community Mobilization, Networking and Referrals." Sixteen health workers in the four regions also received specialized training to strengthen their capacity to deliver HIV prevention programmes.

AFRICA

Regional Programmes

Strengthening local authorities and community-based actors' capacity to prevent the spread of Ebola virus disease in West Africa.

Following the outbreak of the Ebola virus disease (EVD) in March 2014 and the subsequent elevation to a Public Health Emergency of International Concern (PHEIC), IOM responded to the increased needs for prevention, promotion, and border security through a project in Côte d'Ivoire, Ghana and Senegal.

The project objective was to strengthen the response capacity of preparation for the EVD for local authorities and community stakeholders in Senegal, Ghana and Côte d'Ivoire in accordance with the standard operating procedures established by the health ministries of the three countries. As part of this project, IOM supported border health surveillance by strengthening the capacity of border health staff and law enforcement to identify and refer suspect EVD cases to the appropriate personal protection equipment, and infection prevention and control procedures. The programme also supported community mobilization and preparedness by capacitating community health workers and community leaders and traditional practitioners on EVD identification and prevention measures. Specific goals of the project were as follows: (a) identifying hard-to-reach populations; (b) enabling border officials to effectively screen and identify Ebola cases; (c) equipping community health workers with the skills and knowledge to conduct awareness-raising activities to outreach populations; (d) making EVD prevention kits and culturally sensitive information, education and communication materials widely available to target population; and (e) implementing an effective monitoring system across all of the target countries.

To this end, several activities were accomplished across the region. In Senegal, through the training of community health workers, the main projects consisted of the organization of community activities (educational talks, home visits and radio programmes) and promotion of three key practices to significantly reduce the risks of EVD: (a) handwashing with soap; (b) access to adequate household sanitation; and (c) treatment, handling and hygienic storage of water and food. Assessments were carried out in the other two countries, identifying the primary challenges and the influence of migration and human mobility on the ultimate outcomes. Among these were activities of cataloguing movement of international travellers via land and air crossings, and the characterization of priority populations including fisher folks, foreign students and refugees.

Migration and health strategy for South-West Indian Ocean

In February 2015, IOM, in support to the Indian Ocean Commission (IOC), facilitated a regional meeting of representatives from the Comoros, Madagascar, Mauritius, Seychelles and the French island of La Réunion (as an Observer) to draw up the first migration and health regional strategy. The strategy aims to improve the management of the health of migrants and migration-affected communities in the IOC region by establishing a list of priority actions to implement by 2017. In particular, it will focus on the following: (a) enhancing capacities of Member States to develop evidence-based action on migration and health; (b) promoting availability and access to migrant-sensitive health services; (c) facilitating and strengthening coordination and multisectoral partnerships on migration and health; and (d) advocating for dedicated national and regional programmes on migration and health.

PHAMESA (Partnership on Health and Mobility in East and Southern Africa)

The Partnership on Health and Mobility in East and Southern Africa (PHAMESA II) is a programme designed to contribute to an improved standard of physical, mental and social well-being for migrants and migration-affected communities, enabling them to substantially contribute towards the social and economic development of their communities. To achieve this goal, PHAMESA responds to the public health needs of migrants and communities affected by migration, and aims to support the development and implementation of migration-inclusive, evidence-based policies and legal frameworks, practices and programmes at regional, national and local levels to support equitable access to services that improve health for all. Through PHAMESA, IOM implements an integrated package of interventions that addresses not only direct health needs, but also social determinants of health at individual, institutional and structural/normative levels. As a regional programme, PHAMESA addresses region-wide factors that impact the health of migrants and migration-affected communities throughout the different phases of the

migration process, at policy and programmatic levels in a coordinated manner. In line with this partnership, several activities at country level were carried out over the course of 2015.

Decentralized Planning for HIV and AIDS Response in Zambia

IOM and the Government of Zambia launched HIV strategic investment plans for three border districts in the country aimed at guiding the national response to "A Nation Free from the Threat of HIV". The three districts (Sesheke, Kazungula and Chililabombwe) serve as gateways into the neighbouring countries of Namibia, Botswana, and Democratic Republic of the Congo.

According to the 2013–2014 Zambia Demographic and Health Survey, Zambia's HIV prevalence among mobile men who spent nights away from home for various reasons was at 15.1 per cent, compared to the national prevalence of 11.3 per cent for all men. Similarly for women, the prevalence was 17.3 per cent among those who had spent nights away from home, compared with the national average of 15.1 per cent. The strategic plans developed have been aligned to the National HIV and AIDS Strategic Framework (2014–2016) and focused on high-impact interventions including key populations. The plans have a strong shift towards "leaving no one behind" and seek to strengthen mechanisms to address "hard-to-reach" populations, including MMPs. Through these plans, the districts under the leadership of the National AIDS Council aim to make significant inroads in reaching the national vision of "A Nation Free from the Threat of HIV".

Evidence-based programming in Namibia

In order to assist the Government of Namibia in evidence-based policy and programming, IOM focused on generating migration health data through the inclusion of indicators and customized analysis. In this perspective, a secondary review of migration indicators of the Demographic Health Survey, Census and Ministry of Health and Social Services registers was conducted, as well as a field survey to analyse the impact of migration on health in selected areas. The findings of the assessment prompt for action to develop a National Migration and Health Strategy (expected in 2016). Furthermore, IOM Namibia influenced the inclusion migration indicators in the Social Welfare Information System and advocated with the Directorate Social Welfare Services, within the Ministry of Health and Social Services, in order for migration and health to be incorporated in the client intake form used by the social workers at regional level.

IOM Mozambique's TB and HIV active case detection in mineworker communities of origin

In Mozambique, TB and HIV are principal public health concerns. The 2014 TB incidence in the country was 544/100,000 habitants (WHO, 2014), while the estimated mortality rate in TB/HIV patients is also extremely high at 134/100,000 habitants (WHO, 2014). Mozambique is also burdened with a high HIV prevalence of 11.5 per cent (INSIDA, 2009), being one of the 10 countries most affected by HIV/AIDS in the world. In 2009, the first national prevalence survey – INSIDA – found Gaza and Maputo provinces to have the highest prevalence of HIV in the country, with 25.1 per cent and 19.8 per cent, respectively. The two provinces are mainly mineworker-sending provinces. The Mozambican Mine Workers Association claims that as many as 40,000 Mozambicans, retrenched from the contracted mining system, have returned to their communities of origin under precarious circumstances. The Employment Bureau for Africa, the primary mine recruitment agency, estimated that 39,500 Mozambicans were contracted to the mines through formal mechanisms, with another 40,000 Mozambicans working in non-licensed mines or through subcontracts.

Because of these disproportionate statistics, in 2015, IOM Mozambique and its partners worked to reduce the prevalence and impact of TB and HIV among migrant mineworkers and in their communities of origin. The campaigns focused on TB and HIV education and sensitization, along with paralegal counselling on rights at the Ressano Garcia Border, the busiest border in the southern region. It also offered TB screening and testing and HIV testing in migrant communities of origin, focusing on the districts in Gaza where the highest proportion of migrant mineworkers reside. A survey of mineworkers was also conducted about a pilot cross-border TB treatment project in order to gain feedback about potential treatment mechanisms.

At the Ressano Garcia border post, 6,113 people were reached with TB information. In addition to TB education, 40,258 condoms were distributed to those who asked for them. In Chibuto and Xai-Xai districts, 2,406 people were screened for TB, and 84 had TB symptoms and gave sputum samples. Four people

Miner workers in Mozambique. © IOM Mozambique

were found to be TB positive and were referred to the nearest clinic to start treatment. During the campaign, in both districts, 1,269 people were tested for HIV, out of which 89 tested HIV positive. These cases were also referred to the nearest clinic to start antiretroviral therapy.

IOM Zimbabwe enhancing TB case detection through TB REACH programme

Zimbabwe has a low coverage of TB diagnostic services, with only two TB laboratories offering TB sputum culture microscopy. The other scantily available laboratory facilities merely conduct sputum smear microscopy, which has a lower sensitivity, especially in cases of TB/HIV co-infection and is unable to detect MDR-TB. None of these facilities are often accessed by Zimbabwean migrants due to their transient behaviour and movements back and forth between neighbouring countries. These migrant populations have less access to the existing network of health facilities and diagnostic services because of distance between the health facilities and the main road network, attitudes of health workers, lack of time, opportunity cost and lack of flexibility in the health system to provide migrant-friendly health services. In addition, poverty and poor understanding of TB disease increases the likelihood that migrants neglect to seek early treatment. In many cases, suspected TB cases are initiated on TB treatment without the requisite diagnostic tests and with poor follow-up, particularly among migrant populations who are a particularly hard-to-reach group because of their unpredictable mobility patterns.

IOM, in collaboration with the Stop TB Partnership and funded by TB REACH, carried out a TB detection project in Zimbabwe between 1 June 2014 and 1 December 2015. The overall objective was to increase detection of TB cases by at least 30 per cent among irregular Zimbabwean migrants returned from South Africa and Botswana and communities they interact with in Matebeleland South Province. The interventions under this proposal contributed towards increased access to early TB case detection, rapid diagnosis and improved treatment outcomes through systematic TB screening and by strengthening existing government TB services. In order to achieve this objective, four GeneXpert machines were installed, with which over 27,000 irregular Zimbabwean migrants deported from South Africa and Botswana were screened for TB and more than 250 confirmed cases were identified. To better strengthen the systems in place, 158 community health workers were trained in six out of seven districts

in the country, and formative research was conducted about the knowledge, attitudes, and practices on TB among irregular Zimbabwean migrants.

South Africa

In partnership with the South African National AIDS Council, IOM conducted a review and documentation of emerging and good practices on HIV/AIDS/STI and TB programming in the commercial agricultural, forestry and fishery sectors. The process culminated in a policy review and development of guidelines for strengthening the HIV/AIDS/STI and TB response in the sector.

On the ground, IOM worked with local implementing partners to roll out the community capacity enhancement (CCE) dialogues in the farming communities and urban informal settlements in Limpopo, Gauteng and Kwazulu Natal provinces. The CCE dialogues gave communities a platform to reflect on their situations and talk seriously about their issues. In these dialogues, barriers to social and behaviour change were appraised through a structured engagement process, and innovative solutions to address these were explored and implemented. Some of the success stories included improved access to TB and antiretroviral treatment in these hard-to-reach communities, strengthened collaboration with local municipalities and departments of health, as well as improved social cohesion.

In addition, the Waterberg district municipality, where IOM implemented TB/HIV interventions in the mining communities, launched a migrant health forum. This is the third forum of its kind to be launched since the implementation of migration health projects. The forum brought together government, the private sector and CSOs, including migrant communities, to respond to health issues in the context of migration in a coordinated and collaborative manner. As a result of these initiatives, IOM supported the profiling of undocumented adolescents in their last year of high school in Ehlanzeni district of Mpumalanga province. Given their undocumented status, a considerable number of students go through schooling without any identity documents. These students are not able to receive their high school completion certificates, and the district executive mayor was concerned about the consequences this would have on their futures, as well as the social and health vulnerabilities it created in this group of young people. Over 1,000 students were assessed in order to understand the circumstances behind their undocumented status. This exercise served as an advocacy mechanism to give a voice to this issue and rally support from different stakeholders and government agencies.

HIV/AIDS and STIs among locals and migrants in Dar es Salaam Port

A groundbreaking qualitative research study commissioned by IOM in partnership with the South African Development Community (SADC) and the support of Tanzania Commission for AIDS (TACAIDS) revealed that key populations working around the port have a higher risk of contracting HIV/AIDS and STIs due to the complexities of sexual networks within their environment. The study was launched in partnership with the TACAIDS in September 2015 in Dar es Salaam. The report comprises one of four studies carried out in the SADC region with the aim of contributing to the reduction of HIV incidence and impact of AIDS among migrant and mobile workers and their families, and the communities with which they interact in selected port regions in Southern Africa. The study, which was the first of its kind to include personnel in four of the largest ports within the SADC region showed evidence to suggest that sedentary populations (such as food traders, police officers and port officials) who engage in commercial and transactional sexual relationships were becoming “high-risk” populations. According to Joint United Nations Programme on HIV/AIDS (UNAIDS), an estimated 1.4 million Tanzanians were living with HIV in 2015. Dar es Salaam is among the top 10 African cities with high prevalence rate of HIV at 6.9 per cent. The majority of new infections in the United Republic of Tanzania were occurring in stable heterosexual relationships (38.8 %), followed by casual heterosexual sex (28.9 %), and clients of sex workers (8.7 %). The national HIV response in the United Republic of Tanzania reached out to commercial sex workers with research and programming, but very little support was offered to migrants, making this an essential complementary programme.

Health, mobility and HIV prevention in the United Republic of Tanzania on World AIDS Day

In the United Republic of Tanzania, HIV/AIDS remained the number one cause of mortality, and to mark World AIDS Day 2015 on 1 December, IOM organized two events to target drivers of the epidemic.

During the first two days of December, IOM staff and volunteers from the Youth of United Nations Association of Tanzania distributed over 1,000 packages to bus drivers and travellers at Ubungo Bus Station. Ubungo is the central bus station of Dar es Salaam and the transportation link to most large urban areas, such as Arusha, Kilimanjaro, Morogoro and Dodoma regions. The packages contained pamphlets providing information on HIV/AIDS and other sexually transmitted diseases in Kiswahili, and World AIDS Day 2015 key rings and condoms donated by Population Services International (the United Republic of Tanzania). The advocacy event was designed to raise awareness of the scale of the HIV problem and provide information on measures to control the spread of the disease. Ubungo was targeted based on the findings of a 2014 IOM study, "Health Vulnerabilities of Mobile Populations and Affected Communities at the Port of Dar es Salaam, Tanzania". The study highlighted the HIV vulnerability of mobile populations and surrounding communities on transport corridors, due to high levels of concurrent sexual partnerships and low rates of condom use. On 2 December 2015, IOM also facilitated a round-table discussion on HIV/AIDS at the Muhimbili University of Health and Allied Sciences to increase the awareness of the disease among Tanzanian youth.

Action plan to fight TB in the Tanzanian mining sector

IOM, in close collaboration with the Ministry of Health and Social Welfare of the United Republic of Tanzania, hosted a series of meetings in June and July 2015 to discuss findings from a baseline assessment to evaluate current practices among small-scale miners in Kahama, Geita and Merarani mining areas and to formulate plans to control TB in the United Republic of Tanzania. The meetings aimed at supporting the implementation of the 2012 Southern African Development Community Declaration on TB in the Mining Sector (SADCD). The SADCD affirmed the Member States' commitment to the elimination of TB and pledges to improve practices related to health and safety in the mining sector. Under the auspices of PHAMESA, IOM assists the Technical Working Group on TB/HIV Control to plan and execute interventions related to TB control in mines across the country. Mining company representatives supported an initiative to increase the number of GeneXpert machines (a machine that can diagnose TB) to enable the rapid identification and treatment of TB in mining settings. Among the recommendations discussed were the following:

(a) Construct health facilities at sites that currently do not have health facilities to increase access to health services, including construction of toilets for public and community use;

(b) Review, strengthen and mainstream policies and guidelines for the mining sector to incorporate TB and silicosis control measures;

(c) Strengthen diagnostic TB services by building the capacity of the health-care workers to perform smear microscopy and support provision of TB supplies and reagents; and

(d) Review recording and reporting tools to incorporate the occupation of TB patients to adequately assess the magnitude of the condition specifically among miners.

Technical support to the Government of Uganda and academia

During 2015, IOM conducted operations research aimed at generating evidence to inform migration health policy and programming. These included studies on HIV vulnerability in mining and other extractive industries in Uganda, mapping of all the health facilities along the transport corridor, and a rapid assessment on Access to Healthcare for Urban Migrants in Kampala. The results of these studies helped to identify programming gaps and to inform the planning and development of migration-responsive interventions within the urban setting of Kampala, mining and transport sectors. Based on this research, IOM Uganda also provided technical support to the finalization of the National Migration policy, which was due for the Ugandan Cabinet's approval. To enhance collaboration with governments, the studies were conducted in collaboration with the Ministry of Works and Transport, Ministry of Energy and Mineral Development and Makerere University.

IOM also continued its engagement on service delivery. IOM built the capacity of health workers in the provision of migration-friendly health services, targeting private and government health facilities in the districts of Rakai, Kiryandongo, Gulu and Lyantonde. The trainings aimed to equip health workers with knowledge and skills necessary for provision of migration-sensitive family planning, HIV care and treatment services. The training targeted sex worker peer educators and health workers in a comprehensive HIV care package, including the elimination of mother-to-child transmission. In total, IOM trained 216 participants in five separate training sessions. The trainers were drawn from IOM and the Uganda Ministry of Health AIDS Control Programme.

Migration health promotion initiatives in Kenya

Health promotion interventions addressed health needs of migrants in two spaces of vulnerability, mainly transport corridors and urban settings. In 2015, activities were implemented to contribute to the achievement of all four PHAMESA outcomes.

One key result on monitoring migrant health was the inclusion of two migration variables – nationality and duration of stay at current residence for over 30 days – in the ongoing TB survey tools. This was achieved through advocacy and technical assistance to the TB survey technical advisory committee. The plan was to ensure that the final report highlighted relevant needs of migrants to inform TB programming in Kenya.

Another important priority was to advocate for inclusion of migrants in health and other relevant policies, and the operationalization thereof. In 2015, IOM signed a memorandum of understanding with the Ministry of Health in Kenya. It defined the terms of engagement with the Ministry of Health on migration health, including technical support for policy development and service delivery.

IOM donates back packs to the Head of the National TB Programme for the National TB Survey. © IOM

IOM Kenya facilitated migrants' access to health services and built capacity for migrant-sensitive health services. Key strategies included targeting BCC, mobilizing community using change agents and training healthcare workers and community health volunteers. IOM sensitized 20 healthcare workers from various health facilities in Kamukunji sub-county in Nairobi to migrant-sensitive services and gender-based violence (GBV) in the context of migration and human trafficking.

As a result, over 176,564 individuals were reached with health education on HIV/AIDS, sexual, reproductive health and rights, including GBV, TB, maternal, newborn, child and adolescent health, hygiene and sanitation, and disease outbreaks in Nairobi. Further, IOM's financial and technical support enabled the sub-county's Ministry of Health health management team to control a cholera outbreak in the Nairobi–Kamukunji area. In addition, the Ministry of Health achieved its polio immunization targets for Eastleigh North division, which is predominantly migrant-populated.

IOM supported the review of the sexual and GBV curriculum for training health-care workers, by including a module on human trafficking. The curriculum was used to train 25 health workers (doctors, nurses, pharmacists and laboratory staff) in Busia County. Finally, IOM led the revision of the

terms of reference of the urban refugee forum in Nairobi County to include all migrant categories and supported the convening of an expanded cross-border committee on health in Busia County.

IOM participated in the development of the joint programme on GBV and identified migration health-related priorities to be addressed. In addition, IOM facilitated the inclusion of HIV prevention, care and treatment interventions that benefited migrants in the final Kenya UN Joint Programme on HIV (Kenya JP-HIV: 2014–2018). The Kenya JP-HIV provided a framework for the UN's support to the national HIV response, and was strategic to IOM both for the integration of migrants' needs in national HIV priorities and for resource mobilization.

National Projects

IOM South Sudan improving access to TB and HIV services in protection of civilian sites in South Sudan

Among displaced populations in South Sudan, TB and HIV/AIDS is the second leading cause of death (WHO, 2015). Furthermore, the populations in the camps housing internally displaced persons (IDP) and in protection of civilian (POC) sites in many ways reflect the reality of populations outside the POC sites, indicating the potential for a much larger problem. The living conditions in POC sites and IDP camps – especially overcrowding, frequent mobility leading to inconsistent access to health and inadequate funding for TB and HIV activities – have contributed to the problem. In this regard, the IOM Migration Health Unit has been on the front line to initiate TB and HIV testing and DOT for treatment of TB within and outside of Bentiu POC site, which had a population of over 140,000 people in 2015. The national prevalence of HIV was estimated to be 2.6 per cent, while TB testing in Bentiu POC since had shown a prevalence of 16 per cent.

IOM Migration Health Unit marked the 2015 World AIDS Day by raising awareness within the community on the burden of HIV and the services available within the POC. Through a number of trainings, the Migration Health Unit increased the national staff capacity on TB and HIV to ensure all staff provide high-quality services to clients at IOM facilities. The Migration Health Unit planned to increase the coverage of TB/HIV services offered by extending the same services to displaced populations in other counties.

Health for development in Somalia: Steps ahead in health system strengthening

While Somalia still faced emergencies and crises with over 4.9 million people in need of life-saving services, IOM had been closely partnering with the federal government, as well as regional State governments, in particular the Ministries of Health, for health system strengthening. This was done in line with achieving national and international goals such as the SDGs and Universal Health Coverage, and at the same time, making emergency and humanitarian health responses more effective and efficient.

Since one of the leading causes of death among children in Somalia is vaccine-preventable diseases, IOM also partnered with UNICEF on a project titled "Cold Chain and Vaccine Management in Lower Juba" to manage two cold chains in Jubaland in Somalia where vaccination coverage is low. The project contributed to effective cold chain management and vaccination distribution to partners to cover hard-to-reach populations such as pastoralists. Additionally, IOM in Somalia addressed the social determinants of health through non-health projects, such as shelter, water, sanitation and hygiene (WASH), protection, livelihood, improving availability of resources to meet daily needs (such as safe housing), access to educational, economic and job opportunities, improved public safety through solar lantern distributions, and social mobilization for stigma reduction towards survivors of GBV.

IOM provides childhood vaccinations. © IOM

The growing migration health needs of complex migration in Burundi

In 2015, IOM established the medical health clinic dedicated to conducting medical screening for the resettlement process of refugees and self-paying migrants in Burundi. According to the framework of the IOM mental health and psychosocial services the Country Office also established eight "centres d'ecoutes" (listening centres). IOM Burundi continued to work with the National Public Health Institute to support a three-year psychiatric training track that was established in 2014 with assistance from an IOM Development Fund project that funded the return of Burundian mental health professionals to the country from abroad.

IOM Burundi furthermore leveraged its engagement in the psychosocial sector focusing on the Tanzanian border provinces of Rutana, where IOM was the only presence among the UN agencies, and in Makamba. Over 3,000 persons, notably returnees and expelled migrants, displaced and host populations, were assisted on psychological needs. This was done in close collaboration with Healthnet TPO with whom IOM commenced a partnership in Burundi based on its global agreement.

Conferences

ICASA International Conference on AIDS and STIs in Africa

The International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA) is a major international AIDS conference that takes place in Africa, alternating between Anglophone and Francophone African countries. The 2015 ICASA was held in Harare, Zimbabwe, between 29 November and 4 December. IOM Migration Health colleagues from East and Southern Africa took active part in the 2015 conference through the presentation of posters and satellite sessions. Additional research was shared focusing on equitable health-care access for migrants, technology for migrant health monitoring, and mapping of HIV services.

Second African Conference on Key Populations in the HIV Epidemic

The African Conference on Key Populations in the HIV Epidemic was held in Dar es Salaam, the United Republic of Tanzania, between 16 and 18 December 2015. The event was jointly organized by Muhimbili University of Health and Allied Sciences, the University of Oslo, the National AIDS Control Programme (United Republic of Tanzania) and the Tanzania Commission for AIDS, with support from the Research Council of Norway, UNAIDS, and United States Agency for International Development (USAID). Around 200 participants attended the event, including governments, academia, NGOs, civil society representing key populations, international organizations (UNAIDS, WHO, IOM) and donors (USAID).

IOM organized a round-table discussion and four oral presentations representing IOM studies on topics related to the particular vulnerabilities that migrants face, including the implementation of rapid health assessments among migrant populations in Somalia and Djibouti, and case studies of risk factors among populations in Uganda and Zambia.

ASIA

Regional Programmes

Joint UN Initiative on Migration and Health in Asia

The Joint UN Initiative on Migration and Health in Asia (JUNIMA) is a regional coordination mechanism that contributes to regional health security by bringing together governments, CSOs, regional associations, development partners and UN agencies. The mission is to effectively advocate, promote policies, share information, build partnerships, and support action on the right to health and access to HIV, TB and malaria prevention, treatment, care, and support services for migrant populations in Asia. JUNIMA's vision is for all migrants and their families to have equal access to healthcare throughout the migration process and to live healthy, productive lives. The IOM Migration Health Division at the Regional Office for Asia and the Pacific was voted into the role of Secretariat in December 2014, and officially served as the Secretariat starting in January 2015.

Under this framework, in May 2015, on the occasion of the International Day of Action for Women's Health, the Mekong Migration Network (MMN), a JUNIMA member organization, launched the qualitative research report titled *Self-Care & Health Care: How migrant women in the Greater Mekong Subregion take care of their health*. This research involved MMN and their network of CSOs and research institutes in the Greater Mekong Subregion (GMS) conducting qualitative interviews with 114 migrant women in all six countries (Cambodia, China, Lao People's Democratic Republic, Myanmar, Thailand and Viet Nam).

This research activity was conducted through a Grant Agreement with the United Nations Development Programme, as part of the Asian Development Bank funding to support the GMS-MOU Joint Action Programme on HIV and Population Mobility. The findings provided key information to understand the behaviour of migrant women before and during the process of accessing health services in the GMS. Additionally, this report highlighted the main factors associated with these attitudes and practices. The provided recommendations are valuable for guiding policy and programming efforts in the region for key stakeholders, including specific recommendations for governments in the GMS to help improve migrants' access to health services. A full report is available online in English and PDF format at: www.mekongmigration.org/Self-Care%20and%20Health%20Care_final.pdf.

JUNIMA also collaborated with the Asia-Europe Foundation to jointly organize a one-day round-table meeting on migration and healthcare, held in Bangkok under the title of "Migrants and Healthcare: Socioeconomic Approaches and Strengthening Partnerships". The sessions analysed the socioeconomic benefits of investing in migrants' health and discussed how strengthening multisectoral partnerships at national, regional and global levels helps to advocate for policies that support migrants' access to health.

An additional activity undertaken in liaison with the JUNIMA collaboration was a multisectoral "Regional Workshop on Migrants' Health", jointly organized and funded by the Thai Ministry of Foreign Affairs, the Ministry of Public Health of Thailand and IOM, in August 2015 in Bangkok. This was followed by a study visit to Samut Sakhon Provincial Hospital to learn about the public health services available for migrants. The objective of the workshop was to share experiences and good practices in exploring ways to strengthen access to and ensure sustainable and inclusive health services for migrants. The workshop served as an important opportunity for stakeholders from 23 countries across Asia, Europe, the Americas and Australia, including international development partners and civil societies, to raise and address salient issues related to migration and their health

Figure 8. "Self-Care and Health Care: How migrant women in the Greater Mekong Subregion take care of their health" research report
Source: The Mekong Migration Network.

challenges. The workshop concluded with seven recommendations at the regional and international level, which were relevant to the work of JUNIMA, including the promotion of bilateral agreements to ensure social protection of migrants, promoting multisectoral collaboration, encouraging legal channels of migration, and maximizing the use of existing regional mechanisms to address migrant health.

National Projects

Baseline assessment of the health vulnerability of migrants in Bangladesh, Nepal and Pakistan

In order to strengthen the capacity of government agencies in Bangladesh, Nepal, and Pakistan in addressing the health needs of inbound and outbound migrants using a multisectoral approach, IOM supported a project to produce a baseline assessment of the health vulnerability of migrant populations. The study employed a mixed-methods approach, involving over 1,200 structured interviews of both inbound and outbound migrants in three countries, as well as dozens of focus group discussions and key informant interviews with representatives of particular sectors of interest.

Key findings of the studies included the high costs of healthcare and language barriers as key reasons why migrants fail to seek appropriate healthcare while abroad. The main recommendations from the three countries studied included the following: (a) the need for governments to ratify global migration-related conventions; (b) incorporate addressing the health needs of migrants as an essential and non-negotiable component in bilateral labour agreements; (c) identify gaps and reform national policies related to migration and health; and (d) develop a regulatory mechanism to effectively monitor the activities of recruiting agencies and health assessment centres that perform mandatory health assessments.

In March 2015, a regional consultation on migration health was held in Dhaka to share the study's findings and exchange experiences and best practices among the participating countries. The specific objectives of the regional consultation included building mutual understanding and consensus of existing gaps, identifying priority actions to address migration-related health challenges in the South Asian region and identifying core elements to guide the development of national strategic action plan for Bangladesh, Nepal, and Pakistan in addressing the health issues and concerns of migrants. Following the regional consultation, the three countries of focus provided technical and coordination support to develop a National Strategic Action Plan on Migration Health.

Promoting the health of left-behind children of Asian labour migrants

Although migration has become an important issue on the global stage, less research has been dedicated to the health consequences for those family members who are left behind. In September 2015, IOM published a policy brief titled "Promoting the Health of Left-Behind Children of Asian Labour Migrants: Evidence for Policy and Action" based on a desk review of available literature on the topic to further contribute to the discussion and make recommendations to be incorporated into policy.

Unlike the common perception that remittances indirectly improve health, studies conducted in Indonesia, the Philippines, Thailand and Viet Nam have shown that migration has a mixed impact on the mental and physical health of children left behind. This outcome depends on a number of factors related to the migration experience: the characteristics of the child, household and society, such as age, gender, size of the home, availability of resources and time since migration. Though it is difficult to generalize, the outcomes for children could include limited access to nutrition, illness and psychosocial disorders, such as depression and isolation. However, results show that the impact on health of children left behind varies from country to country. In countries such as the Philippines where migration is "normalized", there was less of a negative impact on the health of children left behind.

Given that data, a policy brief was constructed to contribute to the discourse on the topic. Key recommendations of the brief included the following: (a) increase research, particularly to understand the long-term impact on the health of children left behind; (b) expand programmes focusing on migrant health to cover migrant families and provide preventive healthcare; and (c) ensure, through effective partnerships, the creation and maintenance of awareness-raising programmes. Based on this research, the Second National Symposium on Migration Health and Development was held in Sri Lanka, resulting in the draft of the National Coordinated Care Plan in Sri Lanka. Free online access to the publication can be found at: https://publications.iom.int/system/files/pdf/mpi_issue_no_14.pdf.

TB treatment and care for migrants in Myanmar

TB elimination efforts implemented through IOM in Myanmar included community-based awareness-raising, identification and diagnosis, counselling and medicine adherence support throughout the course of treatment, both for individuals and communities. TB is consistently identified as a disease that disproportionately affects low-income and migrant populations due to susceptibility of transmission and infection because of poor living, working, and transit conditions, and exclusion from health education and health services because of legal status, cost, distance, language or discrimination. IOM projects work to address these vulnerabilities and health system risks on all levels – including individual risk factors, social barriers and economic costs. In specific efforts to address each of these branches and consider this disease from a national as well as a cross-border perspective, IOM Myanmar continued its work on the programme "Community-Based TB Awareness, Detection, Diagnosis and Treatment in Mobility Impacted Communities", funded through the Global Fund, which had been ongoing since 2011.

In collaboration with the National TB Programme in Myanmar, IOM provides TB services in seven migration-affected townships in Mon and Kayin states, as well as Yangon region in Myanmar. IOM's approach uses community structures and village-based mobility working groups to identify, recruit, and train outreach health workers. These health workers conduct health education in the community and in migrant-specific settings (e.g. worksites such as rubber plantations), refer symptomatic patients for testing and diagnosis, undertake contact tracing, encourage and refer TB patients for HIV testing and treatment if needed, and support patients with TB to stay on treatment through directly-observed therapy with counselling to migrant patients, especially on the importance of continuing medication while moving from place to place.

IOM and the NTP jointly conduct active case finding for TB in locations where there may be "hidden" TB using data collected by outreach health workers and township-level health staff. In 2015, IOM launched the **M**igrant **O**ut**RE**ach with **H**ealth **E**ducation and **A**ccess to **L**ab Diagnosis for **T**B and **H**IV in **Y**angon (MORE HEALTHY) Bus, which is a mobile active case finding service that targets migration hotspots in peri-urban areas within the outskirts of Yangon and provides on-the-spot X-ray screening for migrants and host communities.

During 2015, IOM supported 7,809 migrants and host community members to access diagnostic or treatment services. Through this support, 2,099 new TB cases were detected, including 144 cases detected in four months through IOM's newly established accelerated case finding mobile team in Yangon. One hundred twenty-three community health workers supported by IOM were trained and actively involved in TB case finding and/or treatment activities. Seven hundred seventy-six health education sessions were held, reaching over 7,625 migrants and host community members.

MORE HEALTHY bus used for health education in Myanmar. © IOM

IOM outreach health worker visits Aye Aye daily to observe her taking her treatment, check for any side effects, arrange support for follow-up appointments, and provide support. © IOM

Aye Aye's native region is the Ayeyrewady Delta in Southern Myanmar, where she used to work as a rice paddy field labourer together with her husband. With their two children growing older, having no paddy field of their own, and the ongoing economic impacts of the disastrous Cyclone Nargis in 2008 still being felt, Aye Aye and her family were moving further into debt with limited income generation activities. They decided to move to Yangon to get better job opportunities in whatever way they could. Migration, particularly to urban areas, is increasingly seen across the country as a livelihood strategy.

Aye Aye, her husband and their children moved from a rural area in Myanmar's south to the urban city of Yangon. Aye Aye took care of her family as best as she could, and also sometimes got work as a day labourer. Ever since living in a shanty next to the concrete works, she has had trouble with her lungs. Living in cramped and crowded conditions like those in the hostel where 11 of the 12 rooms are full with families can make transmission of TB easier. For several months, Aye Aye was experiencing subtle symptoms, such as mild fever, loss of appetite, occasional coughing and weight loss. Although she did not feel well, neither did she have enough money to go to a local health centre and pay a doctor for diagnosis and medicine.

In 2015, IOM's TB Active Case Finding Team (known as MORE HEALTHY) conducted a mobile clinic session near Aye Aye's home on the outskirts of Yangon where many migrants live. She heard about it from the local authorities, including that the service was free of charge and would be coming to her so would be easy to access. At the mobile clinic, Aye Aye listened to health education from IOM's outreach workers. She was seen by an IOM doctor together with local health staff of the Ministry of Health and had a digital X-ray done on the spot, which showed signs consistent with TB. IOM supported her by providing referral for sputum testing, accompanying her to go to the National TB Programme clinic to get medicine, and counselling and HIV testing as well. With a diagnosis of pulmonary TB, she needed to take medicine every day for at least six months. IOM staff supported her along the way, including providing initial counselling and daily observation of her taking her treatment, regularly checking for any side effects or problems, supporting her to attend outpatient appointments, and performing other necessary tests.

Within a few weeks, her fever had gone, and she began feeling better. Her appetite returned and she was able to get some much-needed sleep. Three months after her diagnosis, she was already feeling like a younger person. She encouraged her family and neighbours to also attend the IOM clinic for screening and even provided health education to her friends and family.

HIV vulnerability and service availability in mobility settings of Myawaddy and Kawkareik, Myanmar

Published in 2015, this study assessed HIV vulnerabilities and access to HIV health-care services among key affected populations – namely migrants, FSWs, men who have sex with men and people who use drugs – that live or work along the East-West Economic Corridor between Myawaddy and Kawkareik in Kayin state, Myanmar, as well as the impact of economic development and increased interconnectivity of these factors. The findings aimed to be used as an evidence base to develop HIV prevention and control policies, plans and programmes within the target area.

Using a mixed-methods approach of mapping, key informant and focus group qualitative interviewing, and quantitative survey data, a total of 58 individuals were sampled in the qualitative data analysis, and an additional 400 individuals were sampled through qualitative surveys. The study exposed the complexity of mobility patterns within this border area. The conclusions were largely centred on the difficulty of providing health interventions among such a mobile population. The recommendations of the study were as follows: (a) improving the HIV knowledge and attitudes towards HIV among migrants; (b) maximizing the accessibility of condoms and promoting condom usage; (c) enhancing health and HIV services; (d) improving the quality of HIV and health services; (e) strategizing HIV and health communications, and BCC; (f) strengthening networking and collaboration within health sectors; (g) maintaining evidence-based planning and interventions; and (h) monitoring the impacts of HIV and mobility.

Interviews with migrants in Binh Phuoc Province, Viet Nam. © IMPE Ho Chi Minh City

WHO-IOM joint study on migrants' vulnerability to malaria and epidemiology of artemisinin-resistant malaria in Binh Phuoc Province, Viet Nam

In close collaboration with the Institute of Malariology, Parasitology and Entomology in Ho Chi Minh City, IOM and WHO conducted a joint study on malaria vulnerability and MMPs in the border province of Binh Phuoc in Viet Nam from December 2014 to August 2015, using a knowledge, attitudes, and practices survey methodology and GPS technology for tracking mobility patterns. This study highlighted significant gaps between the different groups of MMPs and between the MMPs and the local population in terms of knowledge, exposure and access to malaria service. This was the first study of its kind in Viet Nam. The final report on the study will be published in July 2016. IOM and WHO seek to replicate this study in other parts of Viet Nam.

Interviews with migrants in Binh Phuoc Province, Viet Nam. © IMPE Ho Chi Minh City

Partnership for containment of artemisinin resistance and moving towards the elimination of plasmodium in Thailand

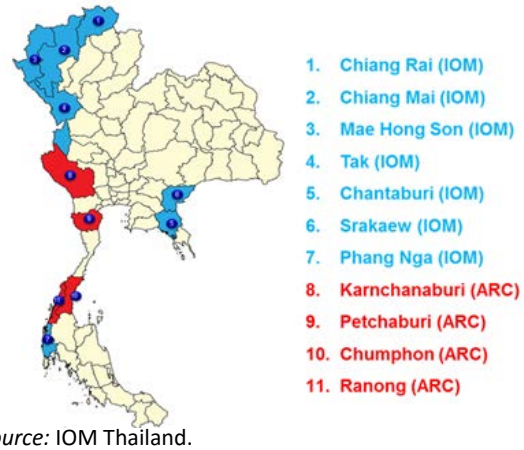
In Thailand, with support from the Global Fund, IOM has been providing malaria services to migrant populations and host communities along the border provinces of Chiang Mai, Chiang Rai, Mae Hong Son, Tak, Kanchanaburi, Phetchaburi, Chumphon, Ranong, Phang Nga, Chantaburi and Sa Kaeo since 2011.

During the period from October 2011–October 2015, in association with our Global Fund Recipient partner, ARC, IOM implemented activities in 11 provinces. 70,236 long-lasting insecticide nets were distributed to migrant populations and ethnic minorities in 1,000+ villages. On an annual basis, BCC capacity development was provided for 34 field staff and 56 migrant health workers. BCC activities were conducted through various channels, such as radio broadcasts that covered 77 districts and joint World Malaria Day yearly campaigns conducted in hotspots of 11 provinces.

Overall, BCC activities reached a total of 356,429 migrants in communities, households and workplaces, with peer visits to 291 diagnosed *Plasmodium falciparum* positive cases.

Repellent lotions distributed to Burmese women working in rubber plantation at Bangkrung, Kuraburi district, Phang Nga province, Thailand. © IOM 2015

Figure 9. Map of malaria intervention provinces in Thailand



Source: IOM Thailand.

Early and improved tuberculosis case detection through the use of GeneXpert technology in Nepal

IOM Nepal continued to implement the TB REACH project, which was funded by Stop TB Partnership. The overall goal of the project was to increase TB case detection in the Eastern Development Region and two districts of the Central Development Region of Nepal through the use of GeneXpert technology. The project was implemented in close collaboration with the National TB Programme.

The specific objectives of the project were to increase the sensitivity of laboratory testing through the use of point-of-care GeneXpert instruments, strengthen referral systems from the peripheral-level microscopy centres to GeneXpert Centres and improve early and active case detection of TB through active case finding in private hospitals and health-care facilities.

In 2015, over 17,000 people with high suspicion of TB were tested with GeneXpert, resulting in the detection of 2,712 MTB positive cases. This included 170 Rifampicin-resistant cases indicating drug-resistant TB. Over 80 per cent of them were enrolled in the treatment. Likewise, a total of 149,370 outpatient department cases attending the private hospitals and health facilities were screened for TB; 15,995 were identified of having TB symptoms; 15,983 were tested for TB; a total of 1,158 were diagnosed of having active TB; and 903 were enrolled in the treatment. TB screening activities were implemented in four selected districts that were highly affected by the earthquake. During the reporting time, the activities were implemented in six IDP sites, reaching a total of 1,875 people screened for TB. A total of 244 TB

symptomatic people were identified, and 183 were tested for TB. Four people were diagnosed as having TB.

TB screening chest camp in Nepal. © IOM 2015

Improvement of health education and care for refugees and asylum seekers in Malaysia

IOM began to implement a pilot health project in July 2013 that sought to provide asylum seekers and refugees in Malaysia with basic primary healthcare, early diagnosis and referrals for treatment, and medical triage for emergencies. IOM was in close coordination with UNHCR, the Malaysian health authorities, NGOs and community organizations on the implementation of project activities.

In 2015, the project provided medical examinations to about 5,000 individuals. Among those who presented with medical conditions, the top three morbidities identified were infectious diseases (including TB), musculoskeletal and connective tissue disorders, and nutritional disorders. While being assessed, 38 individuals presenting with emergency medical needs were sent to the nearest hospital for further care.

Furthermore, the project assisted a total of 79 beriberi cases in 2015 by providing essential medicines and supplies, including vitamin B1 and multivitamins, for treatment and prophylaxis of nutritional deficit. Severe cases were provided with injectable medications, and a few were in need of admission. The majority of the beriberi cases were among children 10 to 19 years old (49.4%).

The project also aimed to mitigate health risks and reduce preventable morbidity, mortality and disability through cultural- and language-appropriate hygiene promotion and health education activities. The health education sessions conducted sought to raise awareness among refugees and asylum seekers on hygiene, TB prevention, and nutrition. More than 58,000 health education materials were disseminated to the target audiences.

Health of Filipino migrants

The Philippines' Department of Health (DOH) – Bureau of International Health Cooperation, together with IOM, developed three key pillars for advancing the health of Filipino migrants. These pillars, collectively called as the "I^3" – which stand for Internal, Inter-Agency and International – were conceptualized on 12 February 2015 during a consultative meeting between IOM and the DOH.

Additionally, the Philippines' DOH, through technical advisory and support from IOM, conducted a Strategic Planning Workshop for the Migration and Health Network in May 2015 in Tagaytay City. Objectives included the following: (a) review of the network's mandate, vision, mission, and objective; (b) identification of future activities and programmes, priority projects, and development activities; and (c) charting of the Migration and Health Network directions. After the workshop, a draft Strategic Plan was developed for revision, which was to be presented once more to the workshop participants for finalization, and later to the Migration and Health Network for approval.

EUROPE

Regional Programmes

EQUI-HEALTH

The EQUI-HEALTH (Fostering health provision for migrants, the Roma and other vulnerable groups) IOM direct agreement with the European Commission Directorate-General for Health and Food Safety (DG SANTE) has been ongoing since 2013. The project focuses on three distinct areas: (a) migrant health at the southern borders of the European Union; (b) Roma health, nationals, and migrants; and (c) Migrant health in the European Union and European Economic Area. EQUI-HEALTH also works within national legal and policy frameworks and conducts country reviews under the Migrant Integration Policy Index (MIPEX) framework (see text box below). The project has two main objectives: (a) promoting appropriate health-care provision to migrants at the southern borders of the European Union, thereby increasing public health safety in the European Union in the longer run; and (b) reaching the aims of Europe 2020 Strategy on reducing health inequalities, with a focus on migrants, Roma and other vulnerable ethnic minority groups (http://equi-health.eea.iom.int/).

EQUI-HEALTH study visit to Spain to monitor the health of the Roma population, June 2016. © IOM 2016

European Union Borders

In order to increase understanding of the needs and priorities for improving migrant health in detention and border facilities in Southern European Union States, several activities were completed in 2015. Actions were taken to strengthen the capacity of law enforcement authorities and health-care providers to promote access to and support the delivery of appropriate healthcare throughout the reception process. Based on the consultations and needs identified during the fieldwork, as well as prior IOM work on health and border management, training

Figure 10. EQUI-HEALTH project areas and countries, 2015

Migrant health at Southern European Union borders:

- Bulgaria
- Croatia
- Greece
- Italy
- Malta
- Spain
- Portugal

Migrant health sector:

- European Union
- European Economic Area

Roma health:

- Belgium
- Bulgaria
- Croatia
- Czech Republic
- Italy
- Romania
- Slovakia
- Spain

modules were developed and a number of regional and national activities were held in order to enhance the capacity of public health authorities, law enforcement services, and health-care providers.

Specific target groups were health professionals and law enforcement officers working at the "front lines". The approach included training of trainers and roll-outs. Trainings were practical and interactive, and the learning objectives were split into three general modules with subunits (see Table 4 below):

In each country, the material was translated and adjusted according to the needs, and IOM worked closely with national experts from the field to make the training as relevant as possible to the specific situations. By the end of 2015, training sessions were conducted in Italy, Croatia, Malta, Portugal, and Greece. Italy trained a total of 300 health professionals; Croatia trained 62 health professionals and law enforcement officers; Malta trained 169 health professionals; and Portugal trained 131 health professionals. Greece conducted a training of trainers with 20 health professionals and law enforcement officers.

Roma Health

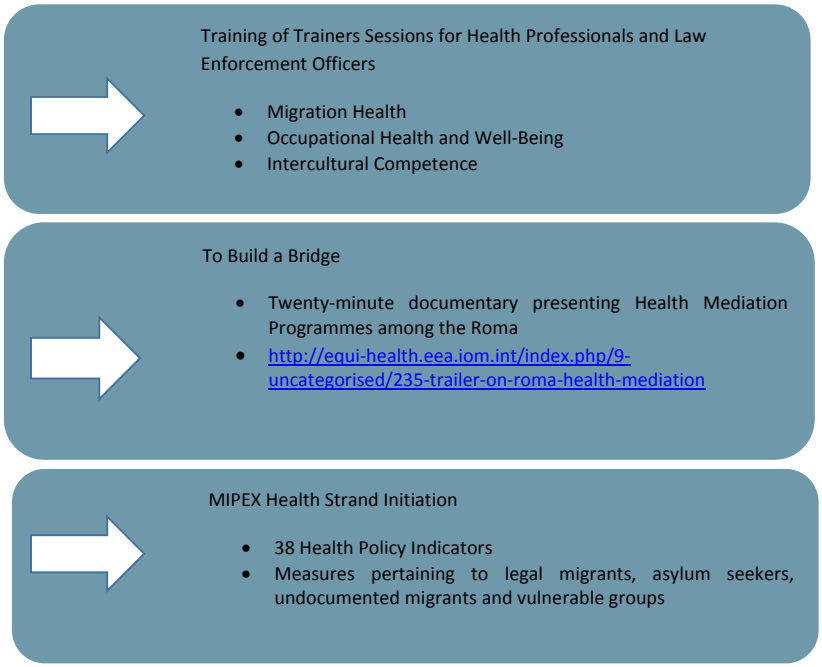
On Roma health, the EQUI-HEALTH project objective is to support national authorities in monitoring, sharing and strengthening national approaches to Roma health within the European Union. In June 2015, a twenty-minute documentary was launched, which was filmed during an exchange of experiences during field visits in Bulgaria, Belgium, and France. The objective was to present at European Union and national levels the added value of health mediation programmes and to advocate for their sustainability (http://equi-health.eea.iom.int/index.php/9-uncategorised/235-trailer-on-roma-health-mediation).

Furthermore, the development of a web-based communication platform to facilitate exchanges between health mediators in Europe, as part of the European Union Community Health Mediation Network promoted by IOM, was initiated in 2015. Planning of the platform and further joint work was done during a study visit that took place in Romania from 2–4 July 2015. The study visit included a workshop in Bucharest that showcased presentations of different

Table 4. EQUI-HEALTH Migration Health Training Modules

Module I – Migration Health	Module II – Occupational Health and Well-Being	Module III – Intercultural Competence
• Global and European Trends of Migration • Migration Health • Public Health Ethics	• Communicable and Non-communicable Diseases, Socioeconomic and Cultural Factors • Occupational Health: well-being at workplace • First Aid • Psychosocial Aspects of Migration • Caring for Vulnerable Groups • Coping with Grief (Added recently to address the current situation especially in Greece)	• Introduction to Intercultural Competence • Communication Skills • Intercultural Mediation in Health Care

Figure 11. EQUI-HEALTH Work



mediation programmes in Europe, followed by visits to two Roma settlements.

In 2015, IOM continued synergies with all related actors: the European Union Agency for Fundamental Rights, the Interagency Coordination Initiative on Roma Health, led by WHO Europe "Scaling up action towards Millennium Development Goals 4 and 5 in the context of the Decade of Roma Inclusion and European Union National Roma Integration Strategies", and the COST-ADAPT Working Group on Roma health and other relevant initiatives in the field, such as the Council of Europe Ad-Hoc Committee of Experts on Roma and Traveller Issues (CAHROM). IOM presented the EQUI-HEALTH project and its achievements in respect to Roma health at the Ninth Plenary Session of the Council of Europe (CoE) CAHROM in Strasbourg (May 2015), where the CoE noted, "IOM reports and projects will be duly taken into consideration in the process of preparation of the first CAHROM thematic visit on health to Bulgaria in 2015 that will be organized under the Bulgarian presidency of the CoE". IOM was also invited to present EQUI-HEALTH work during the thematic visit to Bulgaria in November 2015.

Migrant health in the European Union/ European Economic Area

The third priority of the IOM/European Commission EQUI-HEALTH initiative is supporting the development of a harmonized European Union approach for access to and appropriate provision of healthcare for migrants and ethnic minorities. Within this scope of work, the MIPEX health strand covering 38 migrant health policy indicators was officially launched in July 2015.

MIPEX is a unique tool that measures policies to integrate migrants in all European Union Member States, as well as traditional immigrant destinations, including Australia, Canada, Iceland, Japan, Republic of Korea, New Zealand, Norway, Switzerland, Turkey and the United States. The index includes overall 167 policy indicators developed across 8 programmatic areas: (a) labour market mobility; (b) education; (c) political participation; (d) access to nationality; (e) family reunion; (f) health; (g) permanent residence; and (h) anti-discrimination.

Following the publication, MIPEX 2015 results, rankings and country comparisons were discussed and will continue to be, especially those related to health in 2016 at national and European Union-level events, where 31 country analytical reports will be finalized. The health policy indicators cover measures pertaining to legal migrants, asylum seekers and undocumented migrants, and include special provisions for vulnerable groups. There are four overall components of health that are scored across countries and various migration categories, as shown in the Table 5 on page 56.

Table 5. Four components of health, MIPEX 2015

Entitlement to Health Services	Health Entitlements for Legal Migrants Health entitlements for asylum seekers Health entitlements for undocumented migrants Administrative discretion and documentation for legal migrants Administrative discretion and documentation for asylum seekers Administrative discretion
Policies to Facilitate Access	Information for service providers about migrants' entitlements Information for migrants concerning entitlements and use of health services Information for migrants concerning health education and promotion Provision of cultural mediators or patient navigators to facilitate access Obligation and sanction for assisting undocumented migrants
Responsive Health Services	Availability of qualified interpretation services Requirement for culturally competent or diversity sensitive services Training and education of health service staff Involvement of migrants in information provision, service design and delivery Encouraging diversity in the health service workforce Development of capacity and methods
Measures to Achieve Change	Collection of data on migrant health Support for research on migrant health Health in all policies approach Whole organization approach Leadership by government Involvement of migrants and stakeholders

European Centre for Disease and Prevention Control (ECDC) "Infectious Disease Health Services for Refugees and Asylum Seekers in Europe"

In December 2015, IOM was selected as the lead partner and project manager to oversee the overall project implementation, as well as the financial and administrative management of the ECDC tender "Infectious disease health services for refugees and asylum seekers in Europe". The objective of the scoping study is to collect information on the availability and provision of communicable diseases services to refugees and asylum seekers in Europe. Activities will include a desk review, interviews with stakeholders, field visits to a minimum of one European Union Member State, and establishment of synergies with the EQUI-HEALTH European Commission co-funded action.

National Projects

Addressing migration-related health issues of Turkmenistan

The twelve-month project, "Addressing Migration-Related Health Issues of Turkmenistan", funded by the IOM Development Fund, yielded the results expected; additionally, as the result of the one-day high-level round table on migration and health, the national counterparts' knowledge and skills on international migration and health issues were increased. The study visit to Portugal reinforced capacity of the national counterparts on comprehensive approach to migration and health issues, as well as on Portuguese migrant-sensitive health policies and programmes. The visit allowed Turkmen officials to learn from Portugal's best practices and strengthen their technical capacity to develop an operational action plan on migration and health. The two-day working meeting on migration and health identified migration and health priorities for Turkmenistan in line with WHA Resolution 61.17 on the Health of Migrants.

The Bureau of International Narcotics and Law Enforcement Affairs funded project titled "Contributing to reducing drug use and abuse among internal and international migrants in Turkmenistan" aimed to contribute to collaborative efforts of the drug reduction programme in Turkmenistan through preventing substance abuse, and identifying and referring drug users among international and internal migrants. These efforts strengthened the capacity of health workers, relevant law enforcement agencies, and local authorities to prevent substance abuse among migrants, as well as to identify those who are drug addicts by utilizing international standards and practices. Awareness-raising campaign activities implemented within the project increased the awareness of international and internal migrants of the harmful effects of drug use and abuse and brought attention to the availability of treatments.

Scientific workshop: Tajikistan

In October 2015, IOM partnered with the French Institute for Central Asian Studies, the French Ministry of Education and Research, and UN Women to hold the regional scientific workshop "Migration and Healthcare in Central Asia", which took place in Dushanbe, Tajikistan. This event brought together professionals from Tajikistan, Kyrgyzstan, Kazakhstan, Russian Federation and France to explore the relationship between migration and access to healthcare in Central Asia and the Russian Federation. Discussions highlighted regional migration patterns, migrants' health-care needs, and their strategies in obtaining medical services in host countries, as well as the impact of stigmatization and cultural stereotypes on the delivery of medical help. Economic aspects of healthcare for migrants received special attention with presentations addressing issues, such as contributions of migrants to maintaining public health in Tajikistan and the equity effect of remittances on migrant families' access to healthcare.

Scientific Workshop on Migration and Healthcare in Central Asia held in Tajikistan in partnership with French Institute for Central Asian Studies. © IOM

Access of migrants to TB and HIV care in Tajikistan

Although the overall TB morbidity rate in Tajikistan has decreased over recent years, the proportion of TB cases among migrant workers has increased, especially for TB and HIV co-infection and MDR-TB.[3] Therefore, a vulnerability analysis among migrants to define barriers that hinder their access to TB and HIV services was conducted in 2015. This study, "Situational analysis of the access of migrants and members of their families to comprehensive TB, MDR-TB and HIV services", was conducted by IOM in coordination with Ministry of Health of the Republic of Tajikistan within

[3] Z. Abdullaev, Presentation of the Deputy Director of the Tajik National Center on Population Protection from TB, Dushanbe, 29–30 September 2015.

the framework of USAID TB Control Programme, which was implemented by the Project Hope (www.projecthope.org/where-we-work/europe-eurasia/tajikistan.html). This assessment included a review of international and national legal frameworks and their practical implementation. It also provided information on the existing networks, coordination mechanisms, and partnerships at the national and international levels. This report included analysis of the migrants' health monitoring systems and the quality of services provided to migrants in medical facilities.

Preliminary findings suggest many barriers to accessing needed healthcare for migrants with socially important diseases, such as TB, ranging from culturally appropriate health systems to political and policy level. Access of the internal migrants to TB services should be included in the agenda of the discussions on coordination and management of issues in TB services in Tajikistan. Additionally, referral and data exchange mechanisms between the State employment agency, clinical expert commissions, and primary healthcare should be a key part of pre-departure examinations and monitoring of the migrant's health upon return.

Increasing participation of regional health systems and ensuring coordination between countries of origin, transit, and destination would be an essential step to better managing the transmission of the disease among mobile populations. The final report highlights the need for partnerships and multi-country coordination to address health issues, improved health monitoring for migrant populations, the establishment and support of migrant-sensitive health-care systems, and policy and legal frameworks for each of the involved countries and regions of origin, transit and destination.

MIDDLE EAST AND NORTH AFRICA

Demographic and socioeconomic trends, conflict and, in some cases, climate change are among the factors that influence migration and potential migrants' decisions to leave their countries of origin in the Middle East and sub-Saharan Africa, in order to attempt dangerous journeys in search of security and better opportunities. They migrate through Egypt, Libya, Morocco, Tunisia, Yemen, and other countries in the region towards neighbouring countries or European Union Member States. Although at the outset, most migrants regard these countries as transit countries, in many cases, they become de facto destination countries. This is because many migrants are unable to pursue further travel due to lack of resources.

In light of this, IOM started the implementation of a regional project to support host governments in migration management. The project, called "Promoting health and well-being among migrants in Egypt, Libya, Morocco, Tunisia, and Yemen" was implemented in coordination with governmental institutions, NGOs, and UN agencies, including UNHCR, WHO, United Nations Population Fund, UNICEF, and UNAIDS, in order to support the governments of Egypt, Libya, Morocco, Tunisia, and Yemen in migration management, with a focus on promoting the health and well-being among migrants transiting through these countries. Funded by the Ministry of Foreign Affairs of Finland, this project was launched in November 2015 at a regional seminar in Rabat, Morocco, and will run through the end of 2017.

MIGRATION HEALTH ASSISTANCE FOR CRISIS-AFFECTED POPULATIONS

Since its establishment, IOM's health activities have evolved and expanded in response to the changing needs of migrants, as well as the context in which migration occurs. As a formal partner of the WHO, and as a member of both the Inter-Agency Standing Committee's Global Health Cluster, and more recently, the Global Outbreak Alert and Response Network, IOM is an increasingly key player in responding to humanitarian and public health emergencies, as well as supporting health system recovery and resilience. In addition to being an essential part of IOM's humanitarian mandate, health support in emergencies is recognized by the IOM Migration Crisis Operational Framework as being one of the 15 sectors of assistance to address before, during and after crises.

IOM's health response to humanitarian and public health emergencies aims to alleviate suffering, save lives, and protect human dignity, while also upholding IOM's commitment to humanitarian principles and protection mainstreaming. IOM's Migration Health Assistance for Crisis-Affected Populations programming encompasses the various stages and typologies of crises, throughout all the phases of the migration cycle and the mobility continuum.

Figure 12. Health Support within IOM's Migration Crisis Operational Framework

© IOM

Nurse Celestine Olale administers medicine to patients at the mobile clinic in Zameyan Town. © IOM

CENTRAL AND NORTH AMERICA AND THE CARIBBEAN

Cholera in Haiti

4,224
Suspected cholera cases managed

277,467
People sensitized about cholera

Cholera Facilities
9 Repaired
40 Supported

329
Responses to cholera alerts

690
Professionals trained

169 Brigadiers
20 Hygienists
211 Focal Points
290 Nurses

Haiti remains fragile, as the least developed country in the Western hemisphere. Only half of the population has access to healthcare, 26 per cent has access to sanitation, and over 40 per cent continue to practice open defecation in rural areas. Cholera remains a very serious threat for the most vulnerable Haitians. Since its introduction to Haiti in 2010, the disease has overrun national healthcare capacity, rapidly spreading throughout the 10 departments; it has resulted in 738,000 suspected cases and 8,964 deaths, as of April 2015.

IOM supports the Government of Haiti, along with local and international partners, in a range of cholera health response initiatives. In particular, IOM backed the ten-year National Plan for the Elimination of Cholera in Haiti by the Government of Haiti's Ministry of Public Health and Population. The plan outlines the intention to build rapid emergency response capacity to survey and investigate reported cases, distribute cholera kits, transport cholera patients and reinforce capacity of Ministry staff at the departmental level. Additionally, since 2014, IOM has worked closely with the Ministry to integrate cholera response into primary healthcare provision.

In line with the National Strategy for the Eradication of Cholera, IOM maintains surveillance, treatment and prevention activities in an effort to decrease morbidity and mortality rates, particularly in light of contamination associated with seasonal flooding and deteriorating WASH conditions in the remaining camps. In 2015, IOM managed 4,224 suspected cholera cases in 48 camps or communities through 10 mobile teams in 4 departments. IOM also repaired 9 cholera structures and supported 40 others, training 169 brigadiers, 20 hygienists, 211 focal points and 290 nurses. IOM also sensitized 277,647 people on cholera and responded to 329 alerts.

MIDDLE EAST AND NORTH AFRICA

Crisis in the Syrian Arab Republic

42,560
Individuals assisted in primary healthcare centres

Medical Distributions
2,380 Wheelchairs
20 Crutches
600 Diabetic kits
190 Hearing aid devices
5 Under-knee prosthetic limbs

The humanitarian situation in the Syrian Arab Republic remains extremely challenging. In the fifth year of the conflict, there are more than 3 million Syrian refugees in the region. In addition, over 50,000 Syrians have sought asylum in more than 90 countries outside the region. Inside the Syrian Arab Republic, an estimated 10.8 million people are in need of humanitarian assistance, including some 6.5 million IDPs. The health infrastructure in the Syrian Arab Republic has been severely damaged.

In 2015, IOM expanded primary healthcare centres (PHCs) from five governorates to seven, assisting an estimated 42,560 beneficiaries. The provision of diabetic kits (including a diabetic measure device and extra strips) were

IOM-established Primary Healthcare Centre in Homs city and supported it with all needed medical supplies, equipment and items targeting people in need. © IOM

distributed and benefited 600 individuals who needed immediate assistance in three governorates. Additionally, IOM Damascus supported people with disabilities through the installation of under-knee prosthetic limbs for five amputees in one governorate. IOM also provided wheelchairs to 2,380 individual beneficiaries in nine governorates, crutches to 20 individual beneficiaries in one governorate, and hearing aid devices to 190 individual beneficiaries in seven governorates.

Under the programme "Psychosocial support to crisis-affected, displaced and migrant youth and their families in the Syrian Arab Republic and neighbouring countries", funded by Italy, several psychosocial support activities were implemented inside the Syrian Arab Republic since 2013, and new activities were implemented throughout 2015. In particular, in July 2015, 15 psychosocial professionals and activists working inside the Syrian Arab Republic with different NGOs and CSOs graduated from the second edition of the Executive Master degree in "Psychosocial Support and Dialogue", organized by IOM in collaboration with the Lebanese University in Beirut.

Additionally, in June 2015, IOM conducted a comprehensive evaluation of the capacity-building activities conducted in the Syrian Arab Republic during the period from May 2013 to December 2014. The trainings targeted IDP shelter managers, front-line workers, psychosocial practitioners, psychosocial experts and sport coaches working with differently abled people and orphanage care-givers. A total of 1,369 professionals and volunteers were reached through the trainings and evaluation results indicated that they served to enhance the capacity of various actors to mainstream mental health and psychosocial support (MHPSS) considerations in their work. Additionally, the trainings also succeeded in better equipping psychosocial professionals in the country for the enormous challenges posed by the needs of the population. However, high turnover of shelter managers and front-line workers could hamper long-term benefits from the trainings. For trainees who were already trained in conflict mediation at the community level, it was suggested that the training provided should also be reinforced with in-service and on the job components.

Vulnerable children with disabilities receive mobility items (crutches and wheelchairs). © IOM

Under the same programme, a "self-help" booklet for Syrian men was compiled in 2014 on how to react to emotional consequences of crisis situations, in coordination with the Syrian Red Crescent. In 2015, more than 8,000 copies of the booklet were printed and distributed in Lebanon, Turkey, Iraq, Egypt, and the north of the Syrian Arab Republic. Additionally, electronic copies were distributed to several partners worldwide, and the booklet has also been included in the multi-agency guidelines on the provision of MHPSS support to migrants on the move in Europe. Under the same programme, a "self-help" booklet for Syrian men on how to react to emotional consequences during crisis situations was compiled in 2014, in coordination with the Syrian Arab Red Crescent. In 2015, more than 8,000 copies of the

At the age of 10, a girl should be riding a bike and enjoying her childhood – instead, ten-year-old Samar is physically disabled with a divorced mother. In June 2012, the armed conflict hit the area – Samar's father disappeared and Samar's family were displaced from Al Haffah (far east of Lattakia) to Al-Raml Al-Janoubi neighbourhood (East Lattakia). Now, Samar, her mother, sister, grandmother, uncle and her uncle's wife are living in a rented room for USD 54.50 per month. "Samar gets sad every time she sees her neighbours' children going to school; her uncle stopped carrying her to school anymore because


Samar received a wheelchair courtesy of IOM. © IOM

she gained weight," Samar's grandmother said. On 10 November 2015, IOM provided Samar with a wheelchair to help her go back to school. Her uncle's wife showed her gratitude to IOM and said: "I am really happy for her, she can go back to school now."

booklet were printed and distributed in Lebanon, Turkey, Iraq, Egypt and the north of the Syrian Arab Republic from Turkey. Additionally, electronic copies were distributed to several partners worldwide, and it has also been included in the multi-agency guidelines on the provision of MHPSS support to migrants on the move in Europe.

Lebanon

5
Primary Healthcare Centres supported

55,898
Consultations provided

317
Patients received minor surgeries

3,453
Patients received lab test services

4,975
Patients received diagnostic imaging services

5,978
Antenatal care visits

5,412
Children vaccinated

24,000
Syrians and host communities received mental health and psychosocial services

5,039
People attended health education sessions

97,758
People received TB awareness information

137,635
Individuals screened for TB

- 140 TB cases diagnosed
- 1 MDR-TB case diagnosed
- 2,986 TB diagnostic tests and follow-up services delivered

In 2015, IOM Lebanon provided essential primary healthcare services to Syrian refugees, Lebanese returnees and host community members through existing primary healthcare facilities to improve healthcare access among populations in hard-to-reach areas in Lebanon and the Syrian Arab Republic. With IOM supporting three existing PHCs in South Lebanon and two PHCs in Bekaa, 55,898 consultation services were provided, 3,453 patients benefited from laboratory diagnostic services, 4,975 patients had access to diagnostic imaging services, and 317 patients were able to obtain minor surgery. In addition, this initiative was also able to provide vaccinations for 5,412 children, antenatal care services for 5,978 pregnant women, and health education sessions attended by 5,039 individuals.

Since September 2014, IOM – in collaboration with Johns Hopkins University as the research lead, and Sana, an organization hosted by the Massachusetts Institute of Technology – launched a research project that aimed to develop, implement and evaluate the effectiveness of non-communicable diseases (NCDs) treatment guidelines and health intervention in primary healthcare settings in crisis contexts. The research study focused on patient and provider compliance, control of disease, quality of care, and health outcomes among Syrian and Lebanese patients with hypertension and type 2 diabetes. In 2015, 1,016 patients were enrolled in the study, and 23 physicians, 23 nurses, 1 pharmacist and 1 health coordinator were trained on newly developed NCD guidelines. The mHealth application for management of NCDs would be rolled out in February 2016.

In part as a result of overstretched capacity within the Lebanese health system, including the National Tuberculosis Programme, an increase in TB cases was observed, including cases of MDR-TB, which is difficult to treat and represents a major public health concern. IOM, with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria and in coordination with partners, implemented an emergency TB project that aimed to reduce TB transmission, morbidity, and mortality among Syrian refugees and local communities. Activities included providing TB diagnostics and treatment services, improving knowledge of the TB epidemic, coordinating the TB response, enhancing service delivery and human resources, and raising awareness of TB among target populations. Working closely with the NTP, IOM started a nationwide screening campaign for active TB in major informal settlements and collective shelters in four governorates. During the campaign,

137,635 individual beneficiaries were screened, 97,758 individual beneficiaries were provided with TB awareness by community health volunteers, and 2,986 diagnostic tests and follow-up services were covered, among which 140 cases of active TB, including 1 MDR-TB case, were diagnosed. Additionally, 79 TB-related hospital admissions for Syrian refugees were covered by the project grant.

In 2015, with funding from Italy, Kuwait, and the United States, IOM continued to implement direct psychosocial support activities in Lebanon, largely as a follow-up to previously launched initiatives. In particular, IOM continued to provide financial, logistical, and technical support for the activities of the Dari Recreational and Counselling Centre for Families in Baalbeck and for a psychosocial mobile team in the south of Lebanon.

The Dari Recreational and Counselling Centre was established by IOM in 2007 to serve Lebanese returnees after the war with Israel. It has since become an independent centre run by a local NGO in coordination with the regional social development centre. Since 2013, IOM has supported the centre to expand and reinforce its counselling, recreational, cultural, and psychosocial activities for various groups to include newly arrived Syrian refugees and Lebanese returnees.

Starting in June 2013, IOM has deployed a psychosocial team to provided direct psychosocial support to affected Syrians families living in collective shelters in the south of Lebanon. The team visits various shelters on a daily basis and consists of a psychologist, a social worker, an educator, and music and art animators. By the end of 2015, IOM's MHPSS activities were able to reach a total of 24,000 Syrians and host community members in Lebanon.

Ibrahim is a 30-year-old Syrian refugee residing in Debeyeh, Mount Lebanon. He left his home country in 2012 with his parents and wife after a year of struggling to survive inside the Syrian Arab Republic.

Ibrahim was a university student, but he found himself responsible for his family and wife after the Syrian crisis started. He quit his education and tried different kinds of basic jobs to cover the necessities of life. He lived with his family in a small house for which he could barely afford the rent.

In 2015, Ibrahim started losing weight dramatically and had episodes of severe coughing, but did not have enough money to seek medical care. Ibrahim slowly became alienated from his neighbours, due to his illness. After continuous failed attempts to diagnose his case, he became pessimistic and started to face problems at his workplace. He finally visited a physician who referred him to the NTP centre, based on his symptoms. Once he approached the centre, he was examined by the NTP physician and finally received the necessary diagnostic tests for both himself and for his close contacts, through IOM coverage with support from the Global Fund. His TB diagnosis was confirmed and Ibrahim started his TB treatment regimen directly. By the time he completed the six-month treatment, his health status had improved significantly. After being cured, Ibrahim was able to find a new job and live safely with his family.

Ibrahim said: "I returned back to life after a bitter journey with the disease. I feel safe in my current country of residence – Lebanon."

Ibrahim after completing his TB treatment. © IOM

Iraq Crisis

152,849 Medical consultations

9 Mobile medical teams

4 Static medical clinics

12,489 Migration health assessments

3 Migration health assessment centres

800 Suspected cases screened for TB

350 Cases received follow-up care

over 10,000 Individuals received mental health and psychosocial services

16,700 IDPs and refugees attended TB awareness sessions

In addition to supporting returnees and the host communities, the ongoing conflict in Iraq continues to overstretch the capacity of the national health system, which is not able to meet the health needs of its approximately 3.2 million IDPs. Due to the limited primary healthcare services available, lack of sufficient and trained health personnel, destroyed or inadequate healthcare infrastructure and lack of medicines and medical supplies, there is an urgent need to support the capacity of Iraq's Ministry of Health to ensure adequate health coverage for all vulnerable populations and to manage the impact on public health in the country. For most IDPs, living conditions are meager, with many living together in cramped temporary informal settlements and camps. These communities face poor hygiene and sanitation, limited access to adequate PHC services, including maternal and child health, inadequate nutrition, and lack of preventive and curative healthcare for communicable diseases. Areas of return, especially those that are newly liberated, face similar challenges with communities and returnees unable to address their health needs.

IOM Medical Team assessing old age women in Christian Ashur Charity Duhok district. © IOM

Erbil Zytoon Area TB Awareness Session. © IOM

In conflict-affected areas within the Kurdistan region of Iraq, the project "Provision of Psychosocial Support and Winterization Non-food Items to Recently Displaced IDP Minorities in the North of Iraq", funded by the United States, allowed IOM to provide services to IDPs in the targeted area, in particular to those minorities that had become a target for the Islamic State of Iraq and the Syrian Arab Rebublic, or ISIS, including Yazidi and Christian populations. Through the establishment and deployment of psychosocial mobile teams and several trainings provided to front-line workers and psychosocial support paraprofessionals, the project was able to reach more than 10,000 individuals with recreational, cultural, psychosocial, counselling, and referral activities, as well as psychiatric consultations and follow-up for people with pre-existing or emerging mental disorders.

In coordination with the Iraqi and Kurdistan Region of Iraq's Ministries of Health, and in partnership with the Health Cluster and WHO, IOM supported a coordinated response to strengthen existing PHC and referral services and to prevent, diagnose, and

IOM Medical Team assessing old age women in Christian Ashur Charity Duhok district. © IOM

facilitate the treatment of infectious diseases. With close to 100 staff, including 38 doctors, 26 nurses and 17 community health workers, IOM managed and developed the capacity of nine mobile medical teams and four static clinics in eight governorates. Each included one to two doctors, several nurses, and community health workers who would conduct PHC consultations, including maternal and child services, communicable disease screening and awareness, and refer and transport patients to specialized services. In 2015, IOM provided medical consultations to a total of 152,849 beneficiaries.

In northern and central Iraq, IOM supported Iraq's NTP services by providing transportation and follow-up for suspected cases, early detection and screening, DOT, psychosocial support, awareness-raising, training, contact tracing of positive TB cases, and capacity-building of NTP centres. TB awareness-raising sessions were offered to more than 16,700 IDPs and refugees; more than 800 suspected cases were screened and more than 350 cases were provided with care. In all governorates, IOM simultaneously supported health promotion by raising awareness on communicable diseases and immunization campaigns.


Diabetic patient examined at Ninawa Shekhan camp. © IOM

Under the framework of IOM's Migration Health Assessment Programmes, IOM Iraq partnered with the Iraqi Ministry of Health and other service providers to provide health services, including medical examinations, immunizations, pre-departure fitness-for-travel checks, and health-related travel assistance, including medical escorts. Such medical services were delivered through three Migration Health Assessment Centres managed by IOM, with a capacity of 13 doctors, 9 nurses and 9 data processing assistants.

Libya Crisis

284
Patients examined in 3 detention centres, through November and December 2015

IOM supports local medical staff visits, once a week in three detention centres in Libya. From November to December 2015, a total of 284 patients were examined; common conditions included upper respiratory tract infections, headaches, abdominal pain, common colds and skin sensitivity. The nationality of the patients varied widely and included countries such as Nigeria, Gambia, Ghana, Mali, and Somalia.

In 2015, with funding support from the European Commission and in coordination with the Ayadian Association for Social Solidarity and the Multakana Centre in Tripoli, among other partners, IOM organized psychosocial support activities, such as individual consultations for IDPs and migrants in the Benghazi and Tripoli areas. Activities included sport competitions, cultural events, and multicultural banquets, as well as individual and group consultations for IDPs and migrants in detention centres. In addition, psychosocial support components were added to the relevant trainings for CSOs tasked with identifying and responding to the needs of the most vulnerable.

Sudan Crisis

51,688
Vulnerable individuals received medical assistance

12,346
Individuals attended community mobilization campaign events

22,898
Community members reached through health promotion activities

8,482
Community health worker and promoters trained

50
Healthworkers trained on hygiene, safe water, psychological first aid, and reproductive health

6,414
Under-5s vaccinated (EPI)

2,347
Under-5s received polio vaccination and Vitamin A supplementation

4,354
Measles outbreak immunizations

2,469
Antenatal care visits

264
Births assisted

720
Pregnant and lactating women received one-month supplementary nutritional feeding support

13,000
Community members received malaria awareness and health education information

600
Mosquito nets distributed

300
Households fogged

2
Mobile clinics

In July 2015, with funding from the Government of Japan, a mobile clinic was opened in Sayah-Melit, North Darfur, to provided needed health services as a result of intertribal fighting that led to a high influx of IDPs. In conjunction with the El Sereif clinic established in 2014, IOM provided minimum basic health packages, including the treatment of communicable and non-communicable diseases, referrals, and, maternal and child care. By the end of 2015, IOM had conducted over 24,000 medical outpatient consultations and facilitated 85 referrals to hospitals. For healthcare provided to children, 736 cases of malnutrition were identified and treated through the Outpatient Therapeutic Programme or community-based management for acute malnutrition and 6,414 children under 5 years old were vaccinated according to the Expanded Programme on Immunization schedule. Regarding maternal care, 2,469 antenatal care visits were provided, and the clinic in South Darfur recorded 264 births assisted by skilled attendants. In addition, 720 pregnant and lactating women in Zamzam, North Darfur, received assistance through a one-month supplementary nutritional feeding programme.

To respond to the 2015 outbreak of measles and severe malaria in Darfur, IOM assisted three states through the following: (a) training 40 key community members on prevention and vector control, signs and symptoms, and treatment; (b) distributing 600 mosquito nets to the most vulnerable households; (c) supplementing 5,125 households with vector surveillance equipment; (d) conducting fog spraying in over 300 households; (e) promoting awareness and health education about malaria to over 13,000 community members; and (f) directing a 10-day measles vaccination campaign where 4,354 individuals were immunized. Additionally, in order to increase vaccination coverage, 2,347 children under 5 received polio vaccines and vitamin A supplements by means of a house-to-house campaign.

In coordination with HelpAge International, IOM conducted a one-month project with activities specifically aimed at improving healthcare access for older persons. These activities included training of medical staff in geriatric care, rehabilitating senior citizen social centres, providing age-adapted hygiene kits and emergency drugs, conducting home visits, and delivering hygiene sessions. As a result of this project, 800 older IDPs in selected camps were able to benefit from these activities.

With a goal of focusing on health promotion and building staff capacity, a total of 8,482 community

House-to-house inspection for eradication of malaria vector breeding sites, El Sereif, South Darfur. © IOM

health workers and promoters were trained on a wide variety of health topics, such as food and personal hygiene practices, safe water, prevention of infectious diseases, such as cholera and malaria, mid-upper arm circumference screening for malnutrition, and community-based management of malnutrition. In February 2015, a six-day training course on Prevention of Mother-to-Child Transmission of HIV/AIDS for IDP midwives, a four-day peer education on HIV/AIDs for IDP youth, and a three-day psychological first-aid training was conducted and delivered in Zam Zam camp, North Darfur. In June, a programme conducted in collaboration with SNAP-STATE NATIONAL AIDS PROGRAMME also included a mobile volunteer counselling and testing, in which a total of 105 individuals participated. To encourage community mobilization, IOM steered a five-day campaign targeting women and children to raise awareness on reproductive health, feminine hygiene, immunization, and prevention of infectious diseases. The campaign included discussion groups to identify key issues affecting women, promotion of good nutrition practices, and house-to-house health promotion. At the end, the campaign managed to reach 4,491 women, 1,391 men, and 6,464 children.

Yemen Crisis

101,497
Individuals received direct health assistance

1,355
Individuals received post natural disaster health assistance

3,933
Evacuees checked for fitness-to-travel

191
Medical escorts provided

Yemen continues to face complex humanitarian situation characterized by ongoing insecurity, localized conflicts, water scarcity, and the extreme poverty of growing numbers of the population. These challenges are exacerbated by rising prices and economic difficulties that contribute to reduced access to food and safe water, basic services, and livelihood opportunities. Yemen's malnutrition levels are among the highest in the world. The number of IDPs as a result of recent conflicts rose significantly over the course of 2015 to 2.5 million people. In addition, Yemen hosts over 272,949 refugees and asylum seekers.

In 2015, IOM Yemen's Migration Health teams delivered direct health assistance to over 100,000 individuals across eight governorates, including vulnerable migrants, IDPs, conflict-affected populations, populations affected by the cyclones in Socotra Island, and Yemeni returnees. This was in accordance with five areas of IOM service delivery in Yemen: (a) health assistance to migrants; (b) healthcare to Yemeni host communities; (c) health assistance to IDPs and other conflict-affected populations; (d) medical screening and travel assistance during the evacuation of third-country nationals; and (e) health assistance to Yemeni returnees.

In late October and early November 2015, Yemen was struck by two tropical storms which mainly affected Socotra Island in the Indian Ocean and other governorates, including Hadramout, Shabwah, and Abyan. In response to these storms, IOM Yemen deployed a health team consisting of five health workers – one physician, one nurse, one midwife, one health promoter, and one psychological counsellor – to Socotra Island to assist in providing emergency health services, as well as primary healthcare for IDPs and cyclone-affected populations. During the reporting period, IOM Yemen's health team provided health assistance to 1,355 individuals. This included 432 medical consultations and 67 reproductive health services to women, among which were 36 pregnant and 41 lactating women. In addition, 28 individuals were provided with MHPSS, while an estimated 775 individuals were provided with health awareness sessions.

As part of a project aiming to provide life-saving assistance to vulnerable migrants in Yemen, IOM Yemen conducted a training on first aid that targeted local authorities and host communities who could be the first respondents to injured or sick migrants. The trainings were conducted in four governorates and reached around 500 individuals, including 378 men and 118 women. In addition, training was organized for government health workers to provide them with the knowledge and skills that would enable them to provide culturally sensitive health services to trafficked migrants. Furthermore, IOM conducted two trainings for physicians and nurses in the community on the management of acute malnutrition, also training psychologists on clinical counselling and psychotherapy.

Following the start of the conflict in late March, IOM Yemen conducted evacuation operations to assist stranded migrants who were unable to return home. Between April and September, IOM Yemen's Migration Health teams screened a total of 3,933 evacuees to assess their medical fitness for travel. Among the evacuees were 191 medical cases that were provided with healthcare before their departure; IOM also provided medical escort services for all medical cases to ensure a safe journey.

On 16 March 2015, a 25-year-old Ethiopian male, Ebrahim Sufyan, was brought to the Immigration Passport and Naturalization Authority in critical condition, seeking help from IOM clinic.

Ebrahim had gotten his medical condition two months earlier. He had entered Yemen after a long, risky and very difficult journey from Ethiopia to Djibouti and then by sea to Yemen, hoping that he would be able to work and earn money to improve his life. However, he ended up doing difficult work on farms in Rada'a Governorate under very tough conditions, including long working hours, exposure to chemical products (insecticides) without proper safety measures, poor nutrition and little access to health services. During this challenging period, he felt unsafe, frustrated and disappointed with his situation.

His situation deteriorated to the point that Ebrahim found himself with a marked disability, with generalized paralysis, such as the loss of most sensory and motor functions in his four limbs, his sphincter, and in his speech and vision for about one month. He was unable to take care of himself.

IOM's health team took Ebrahim to a clinic where he was provided essential healthcare, following which he was immediately transferred to a hospital for further evaluation and a specialist's advice. In the hospital, he was admitted to the intensive care unit (ICU), and following laboratory diagnostic tests and radiological investigations, the neurologist diagnosed him with acute disseminated encephalomyelitis syndrome, a rare complex neurological disease with a high mortality rate. He was kept in the ICU for one month and then transferred to the medical ward under medical monitoring and close observation for about six months.

Under this care, Ebrahim's medical condition improved gradually, with a noticeable improvement in his speech, motor functions, vision and mobility. He was eventually discharged to a foster family with instructions for medication, physiotherapy, bladder care and regular specialist visits. IOM continued to provide health support to Ebrahim, including the provision of around-the-clock care by two caretakers, who accompanied the patient in two shifts. When the Ebrahim felt better and was declared fit for travel, he requested IOM to provide him with assisted voluntary return services.

However, due to the crisis in Yemen, the airports had been closed and it was not possible to repatriate him immediately. After signing a declaration form, IOM transferred Ebrahim, along with other migrants with medical conditions, to Hodeidah governorate, accompanied by a medical escort. IOM health staff in Hodeidah admitted Ebrahim to the Migrants Response Point and continued providing health and nursing care. IOM arranged Ebrahim's return to Ethiopia with the Ethiopian Embassy and Migration Authority, and issued Ebrahim the necessary travel documents. After coordinating with the IOM Migration Health teams in Djibouti and Ethiopia, Ebrahim was finally evacuated from Hodeidah to Ethiopia by sea.

IOM team doing anthropological measurements at Jehaf District Aldhalea Governorate. © IOM


IOM Physician examining IDP in Socotra Island. © IOM

CENTRAL AND WEST AFRICA

Ebola Crisis in West Africa

The 2014–2015 EVD outbreak in Guinea, Liberia, and Sierra Leone – which also affected the neighbouring countries of Nigeria, Senegal and Mali – was unprecedented in its scale and impact in terms of human loss, economic drain, and delayed development for countries within the region. The EVD outbreak of 2014-2015 in West Africa was declared a PHEIC on 8 August 2014 and was, in fact, two crises in one:

(a) A crisis of a virulent, epidemic disease with more than 28,600 infected persons and over 11,300 deaths, including 513 deaths of healthcare workers;[4] and

(b) A crisis of systems that were unable to address the challenges of EVD in health services and public health, consequentially crippling other governmental systems, including education, food security, finance, and more.

IOM's early response efforts comprised the following: (a) managing three Ebola treatment units (ETUs) in Liberia and supporting return to normal primary healthcare services; (b) supporting the prefectural emergency operation centres in Guinea to facilitate regional incident management and build capacities to support future incident management and critical "all hazards" disaster risk reduction; and (c) managing a national training academy in Sierra Leone, coaching front-line Ebola responders in infection prevention and control, self-protection and clinical care. Although IOM's position during the acute phase of the response was to respond to "urgent health and operational gaps in order to save lives", the Organization soon aligned its EVD response across the three affected countries and neighbouring "ring" countries by implementing the HBMM framework. At the centre of this framework is the realization that, by better understanding population mobility, more targeted and evidence-informed responses could be mounted at critical locations along human mobility pathways. Enhancing national capacities to better prevent, detect, and respond to any future disease outbreaks and other health threats along such pathways is also emphasized.

Through its efforts to map mobility dynamics in the subregion, IOM became increasingly recognized as a technical health partner, able to address a major knowledge gap: mobility and its related spaces of vulnerabilities vis-à-vis disease transmission. The notion that a better understanding of human mobility is crucial for the prevention, detection and response to health threats, including communicable diseases, gained momentum, which IOM, due to the nature of its mandate, was a good position to act upon.

Ebola Survivor adds his handprint to the "Survivor Wall" at the Ebola Treatment Unit in Tubmanburg, Liberia. © IOM

[4] **WHO Situation Report data, as of 13 December 2015.**

Liberia

3
Ebola treatment units managed by IOM
- 185 Patients triaged
- 133 Patients admitted
- 28 Patients tested positive for Ebola
- 12 Patients survived Ebola

528
Medical ETU clinicians trained on infection prevention and control and waste management
- 437 Liberian national staff
- 91 Foreign medical team members

Developed the Safe and Quality Health Services training package

612
Clinicians trained

1,147
Non-clinicians trained

7
Flow monitoring points established to support health screening and disease surveillance and analyse mobility flows and patterns

18
Border Posts rehabilitated to strengthen infectious disease surveillance, preparedness and response

316
Teachers and parents trained by IOM social mobilization teams to promote WASH among students in 63 schools

120
Hand washing facilities fabricated and installed

50
Latrines rehabilitated

38
Hand pumps repaired

In 2015, the strengthening of EVD response through the operations of ETUs, including three managed by IOM Liberia, and the deployment of Foreign Medical Teams had effectively contributed in maintaining zero new cases. In addition, IOM conducted active case finding at 7 marketplaces, 7 border crossing points, 11 in-county checkpoints, and through mobile clinics that reached 80 communities, surpassing the original target of 30 communities. IOM ambulances and mobile teams supported rapid referral of cases to ETUs and IOM teams identified and referred 16 suspected cases to County Health Teams and health facilities.

Prior to beginning work in IOM-managed ETUs, IOM trained all 437 Liberia National Staff and 91 Foreign Medical Team members working on ETU clinical care on infection prevention and control and waste management, in accordance with WHO/Ministry of Health protocols and by MOH/WHO approved trainers. In IOM-managed ETUs, 185 individuals were triaged and 133 admitted patients were provided with systematic treatment and clinical care. Twenty-eight patients tested positive for EVD, 12 individuals were discharged as survivors, and 15 patients died – a survival rate of 46 per cent. There were zero reported cases of EVD among healthcare workers in IOM-managed ETUs in Liberia and IOM met the target of 100 per cent of patients receiving care and treatment.

Furthermore, as a result of the high infection rate and mortality from EVD reported among the Liberian health workforce, IOM contributed to the technical team that developed the SQS training package for local clinicians and non-clinicians, which included four modules: (a) Infection Prevention and Control; (b) Clinical Skills; (c) Psychosocial Support; and (d) Surveillance. 612 clinicians received the four-day training and 1,147 non-clinicians (including WASH, waste management, and security workers) received a two-day training.

By mid-2015, as the outbreak approached its end, IOM gradually transitioned into development work that involved consolidating and building on the strong emergency response during the EVD outbreak. Starting in March 2015, IOM supported health screening and surveillance efforts at border points and within border communities through the multi-partner Border Coordination Group and provided direct support to Grand Cape Mount, Grand Bassa, and Bomi County Health Teams. Other activities included the following: (a) ensuring continuity of care for affected communities by providing

clinical trainings and supporting access to existing healthcare and referral services; (b) performing needs assessments and gap analyses to assess border and community health to enable border health authorities to respond and mitigate the risk of re-importation of Ebola into Liberia; (c) establishing health screening points at various internal checkpoints inside Liberia; (d) monitoring mobility flows at seven points around Liberia; and (e) rehabilitating border posts at 18 POEs to Côte d'Ivoire along the border with Liberia and Guinea.

In addition, with funding from USAID's Office of US Foreign Disaster Assistance, IOM trained key immigration and health actors at prioritized border posts and checkpoints to improve efficiency and quality of entry and exit health screening procedures. This support improved infection prevention and control standards, provided isolation spaces, facilitated health referrals and aided reporting to the national disease surveillance structure. Through local organizations, IOM also provided training, tools, and monitoring to enable border and vulnerable migrant communities to sustainably conduct community events-based surveillance and systematically report for prompt public health responses.

Figure 13. Location of the ETUs in Liberia

© IOM

Apart from supporting the EVD response, IOM also conducted WASH activities by working with local contractors to upgrade WASH facilities in schools. This included 38 hand pump repairs, 120 handwashing facilities fabricated and installed, and 50 latrines rehabilitated, including roofing, and repairs to damaged infrastructure. Furthermore, IOM social mobilization teams trained 316 teachers and parent representatives from 63 schools to promote WASH among students.

Social Mobilization

In the context of the regional response to the Ebola epidemic, IOM staff in Liberia's Grand Cape Mount County, bordering Sierra Leone, focused on promoting health and safety along the official and unofficial border crossing points. At six different crossing points, the team offered on-site training to border officials and community volunteers to ensure correct health screening and safe practices in order to reduce the risk of cross-border transmission of Ebola.

Education on Social Mobilization in Liberia using a graphic story. © IOM

In support of these efforts, the social mobilization team equipped community health volunteers in bordering Tewor and Porkpa districts to be able to increase awareness and engagement in cross-border surveillance within their communities.

Working with a targeted edition of the "Spread the Message, Not the Virus" graphic story, the team trained 26 community health volunteers to use the story as a means to communicate key messages through interpersonal reading sessions. Sessions targeted key community leaders and reached a large number of households. The same graphic story was shared with local journalists through Interviews as a possible tool for mass communication in line with the information needs of Liberia's readers and listeners.

Sierra Leone

10
Flow monitoring points established to support health screening and disease surveillance and analyse mobility flows and patterns

100
Airport personnel tested through health emergency simulation exercises at Lungi International Airport

8,244
Medical practitioners trained on Ebola clinical care and infection prevention and control at the Ebola National Training Academy

630
Community volunteers and Ebola survivors trained as Social Mobilizers on infection prevention and control and general health education

1,250,071
Individuals reached through social mobilization activities to promote Ebola awareness and effective infection prevention and control

over 1,400
Ebola frontline health workers across 10 districts readied for rapid-deployment, mobile training teams

130
Cultural burial liaisons trained and certified to perform safe and dignified burials

26
Health facilities strengthened with Infection Prevention and Control and WASH infrastructure

Flood Emergency Distributions

80 Mattresses
200 Blankets
100 Tarps

Under the programmatic framework of HBMM in eight West African countries, health screening points were established at international airports and points of entry/exit and at various internal checkpoints in Sierra Leone. Mobility flows were also monitored at 10 designated points around Sierra Leone. Previously affected by Ebola, the capacity of border health and non-health staff were strengthened to identify and refer suspected EVD cases with the appropriate personal protection equipment and infection prevention and control procedures.

On 2 January 2015, a case of Ebola was confirmed among airport workers, raising the risk of disease spreading between workers and travellers. With an estimated 1,500 people working in the airport, the main health threat arose from airport staff moving in and out of hotspots to their workplace. Additionally, a recent increase in Ebola cases in Sierra Leone's Port Loko District, notably among the approximately 85,000 inhabitants of Kaffu Bullom Chiefdom near the airport, has led to increased scrutiny of procedures for airport workers. The Chiefdom was placed under quarantine, and IOM supported the Ebola prevention and control work in the area, as well as the delivery of two dedicated ambulances to assist the airport with any suspected cases.

To face the challenge of airport workers' movements and the prospect that more flights and airlines would operate at the airport in the future, IOM plotted six possible response scenarios to run consecutively to test the operation of various airport agencies in simulated health emergencies. On 12 January, IOM implemented an emergency simulation exercise at Sierra Leone's Lungi International Airport with about 100 participants ranging from medical screeners, port health, cleaners, army, police, and Westminster Aviation Security Services, a private airport security provider, to test and improve the entry and exit health screening process and general health security throughout the airport. From this exercise, gaps in the health defence systems were highlighted and targeted for further training to improve airport security. Following this exercise, IOM, together with the British Army, CDC, WHO and Lungi International Airport, developed and implemented Airport Standard Operating Procedures for travellers and employees, which included screening and health monitoring, a management action flowchart, and staff information posters. This information was updated daily and IOM assisted the airport in investigating the

intelligence and implementing home quarantine for 21 days.

Managed by IOM since December 2014, the Ebola National Training Academy provided modular EVD clinical care, infection prevention and control, and personal protective equipment training for front-line Ebola and non-Ebola medical practitioners. Its curriculum included a three-day module on donning and doffing of personal protective equipment, proper handwashing techniques, preparation of chlorine solution, spill cleanup, and information on managing Ebola infection, as well as a two-day practical component that took place in a mock ETU simulating various scenarios at each stage. Since 1 December 2014, the academy certified 8,244 individuals (7,705 national and 539 international). In addition, over 1,400 national and 24 international EVD front-line health workers across 10 districts were ready for rapid deployments as mobile training teams, following a request by the Ministry of Health.

Over 8,000 health personnel trained at the National Training Academy in Sierra Leone. © IOM

30,000 travellers screened at Lungi International Airport in Sierra Leone since November 2014. © IOM

After assessing gaps in services, IOM launched two social mobilization programmes to fight Ebola in the Northern Bombali and Eastern Kono districts of Sierra Leone. Funded by the Office of US Foreign Disaster Assistance and implemented in close cooperation with World Hope International and Wellbody Alliance, it supported the social and mobilization pillar at the District Ebola Response Centres in Bombali to align with current epidemiological and transmission trends through training and revamping social and behavioural change messaging campaign. There were 630 volunteers, community leaders and Ebola survivors who were trained on effective infection prevention and control measures and messaging on general health education, and over 1 million individuals were reached by social mobilization activities.

In response to a flood emergency, infection prevention and control and WASH infrastructure were strengthened in five public and 21 private health facilities; 80 mattresses, 200 blankets, and 100 tarps were distributed and Infection Prevention Control (IPC) and health education was conducted. Additionally, 130 representatives from secret societies in Bombali district were certified as cultural burial liaisons to perform safe and dignified burials, and community mobilization was implemented in the districts of Western Area, Bombali, and Kono.

Guinea

26
Ebola screening and flow monitoring checkpoints opened

83
Fever cases identified by flow monitoring agents

5
Reports produced to profile human mobility patterns and trends through analysis of flow monitoring data

3
Participatory mapping exercises conducted to map public health risks and identify priority areas at greater risk to the spread of infectious diseases.

239,836
People screened and sensitized to Ebola at health screening / flow monitoring checkpoints

20,000
Illustrated exercise books distributed to community health workers

30
Emergency operations centres rehabilitated and equipped

11
Points of Entry renovated to include isolation rooms

3
Border Posts rehabilitated

over 500
Workers trained in health screening

242
Community volunteers trained in health screening at 15 sea border points of entry

28
Emergency operations centres provided with material support, including: generators, laptops, printers, routers, office furniture, hygiene kits, and office supplies

Guinea, one of the three countries hardest hit by the Ebola outbreak, struggled to contain the spread of the virus. In mid-May 2015, a new EVD outbreak was declared in Boké Prefecture, a region bordering Guinea-Bissau. IOM, in collaboration with the US CDC, conducted an assessment in Boké Prefecture to assess the capacity of regional and local authorities to respond and halt the spread of EVD. At the request of the National Ebola Operations Coordination, IOM and the CDC sent a Cross-Border and Health assessment team on a joint exploratory mission to Boké Prefecture to identify needs and the capacity of the local authorities in EVD outbreak management at POEs. From 18 to 21 May 2015, the team visited two seaports in Kamsar and Kanfarande, and one land border post in Kandiafara. The team also met with local authorities from the Prefecture Emergency Operations Centre, as well as with medical officials. As a result of the assessment, the Prefecture and National Ebola response authorities requested that IOM and CDC provide technical and material support in setting-up roadside health checkpoints around Kamsar. They assessed that health checkpoints were needed at the main border POEs and that epidemiological surveillance capacities in the prefecture needed to be strengthened by training health personnel on infection prevention and control measures. They also identified the need to organize patient triage based on a set of symptoms that suggest possible EVD in order to increase the capacity of health facilities to differentiate EVD cases from other cases.

With support from the Government of Japan, IOM worked to minimize cross-border Ebola transmission within Guinea, Mali, Côte d'Ivoire and Senegal, donating materials, such as tents, separation corridors, thermoflashes, tables, chairs, soap, chlorine, handwashing stations, and other related materials, for the opening of 26 Ebola screening checkpoints along the coastal areas of Guinea. Forty motorbikes were also donated to seven district health authorities in the same areas to support community surveillance activities, and trainings were organized for health workers, volunteers, and port authorities.

Under the HBMM programme, IOM supported the creation of a cross-border Ebola response group between Sierra Leone and Guinea by drafting a cross-border response strategy, the road map for surveillance at POEs, and a cross-border operational plan for Forecariah-Kambia. The objectives of the response group were as follows: (a) to strengthen Guinea's health screening at land and sea borders and monitor traveller movements to reduce the epidemiological

risk; (b) to strengthen the health system at the borders; (c) to develop an atlas of public health vulnerability and risk at border areas; (d) to sensitize communities on Ebola and other epidemic-prone diseases; and (e) to implement a community event-based surveillance system. As a result, over 500 workers were trained in health screening; 242 community volunteers were trained in health screening at 15 sea border POEs; 239,836 individuals were screened and sensitized on the Ebola disease; and 83 fever case alerts were identified by the flow monitoring agents. Additionally, 11 POEs were renovated with isolation room and 3 border health posts were rehabilitated; public health risks were mapped over 3 participatory mapping exercises; 20,000 illustrated exercise books were distributed to community health workers; and a mini-series on Ebola and other epidemic-prone diseases, as well as a prevention song, was created. IOM also extended support to Ebola survivors and granted 53 survivors up to USD 600, provided funding to community micro-projects and trained 14 workers on community dialogue.

Participation of the Prime Minister in the health screening procedure (handwashing, temperature monitoring), prefecture of Forécariah. © IOM

Families came from all around for the weekly market in this Sierra Leonean village. At the flow monitoring point, all travellers were required to perform health screening procedures (handwashing and temperature monitoring). When one child was detected with a high temperature, response measures were immediately activated - she was isolated and the investigation team was alerted. When the team arrived, the child was brought to the ETU where tests were performed, but fortunately she tested negative for Ebola; the high temperature was determined to have developed from flu.

Under the development of health emergency management and infrastructure in Guinea, 22 out of 33 prefectures were renovated or built to provide logistical support to prefectural emergency operational centres. This also included THE capacity-building of health officials in health emergency management and the deployment of technical assistants in prefectural emergency operational centres. By the end of 2015, 30 emergency operation centres were rehabilitated and equipped, 28 emergency operation centres were provided with logistical support, 8 national staff were trained-as-trainers in health emergency management, and 300 national staff of 33 prefectures and 5 communes of Conakry were trained in health emergency management.

Participatory mapping in Dubreka. © IOM

Ghana

8,000
Posters on infection prevention and control distributed

20,000
Health declaration forms printed and distributed at select entry points

40
Government officials attended 2-day workshop on EVD prevention and control

During the Ebola outbreak, although 132 suspected cases in Ghana had all proven negative, Ghana was a hub for various movements to and from the region, and received approximately 13 per cent of passengers who embark on planes from three EVD affected countries – Liberia, Sierra Leone and Guinea. To enhance prevention of possible EVD spreading across Ghana, proactive measures had to be put in place to build the capacity of some key actors and focused mainly on building capacity for border health surveillance and protection from suspected EVD cases, and conducting information outreach on EVD to raise community awareness of infection prevention and control.

In cooperation with WHO and Ghana Health Service, IOM conducted assessments on EVD infection prevention and control measures at select entry points and health facilities and donated 8,000 posters and 20,000 bilingual (English/French) health declaration forms to Ghana Health Service for use at all major POEs. In January 2015, IOM – in collaboration with the Port Health Authorities at the Tema and Takoradi seaports – organized a two-day workshop for 40 government officials (Port Health Authority, Ghana Immigration Service, Customs Excise and Prevention Services) on EVD prevention and control workshop.

With funding from the Government of Japan, IOM launched a project to provide operational support and technical guidance to Ghana Health Service and Ghana Immigration Service to strengthen EVD surveillance at Kotoka International Airport in Accra, Tema and Takoradi seaports and the Elubo land border. The project assisted border officials to conduct EVD surveillance and protect themselves through provision of protective equipment and isolation tents. This project also provided trainings on EVD-related screening and infection control procedures. To prepare for future health crises, session also focused on migration and the right to health, health-related border policies and procedures, and health-related vulnerabilities in the migration process. Health Declaration Forms were distributed and administered at border points, and information outreach activities were conducted to support community leaders in awareness-raising efforts.

Côte d'Ivoire

18
Border Posts rehabilitated at select Points of Entry

Under the HBMM project, EVD preparedness activities in Côte d'Ivoire included the training of border personnel, surveillance, and the reinforcement of community engagement, as well as rehabilitating border posts at 18 POEs, along the border with Liberia and Guinea.

Mali

18
Ebola screening and flow monitoring checkpoints established

428
Individuals trained in Ebola sensitization and community mobilization

Since 18 January 2015, Mali was declared Ebola-free. However, according to the IHR guidelines, countries were required to quickly determine the necessary preventive measures to avoid the spread of Ebola at national and international level. Consequently, the Ministry of Health of Mali established "sanitary cordons" at the main border entry points to ensure epidemiological surveillance of border communities previously affected by the Ebola epidemic. At each border point, there were medical agents and security forces (police, national guards and customs); awareness-raising about EVD was provided for the health and security forces through sensitization and community mobilization training.

Since November 2014, with funding from Office of US Foreign Disaster Assistance and the Government of Japan, IOM has been implementing activities aimed at strengthening monitoring mechanisms and preventing Ebola at major border points. Under the HBMM activities for Mali, health screening points

were set up at various internal checkpoints around Mali. From 10 to 17 September 2015, IOM collaborated with the International Medical Corps to conduct EVD sensitization and community mobilization training sessions in the three regions. These sessions were attended by 428 people representing the security forces, medical agents, and IOM field staff. The objectives of the sessions were: (a) to provide an initial training of trainers on the modes of transmission, symptoms, and prevention measures, good individual and collective hygiene practices, and appropriate attitudes in times of epidemics; (b) to involve the security forces and health agents for change of behaviour towards associated risks linked to EVD and to clarify their respective roles in the communities; (c) to teach participants the proper techniques of organizing and facilitating training sessions and animation; and (d) to update the IOM Flow Monitoring Points agents on information related to EVD.

Central Africa Crisis

Cameroon

3,074
Medical consultations

110
Cases referred

over 1,000
Participants attended training on proper hygiene

The civil conflict that affected various areas of Central African Republic in 2014 has led to massive displacement internally and to surrounding countries, widespread violence, especially GBV, and dramatic community divides. IOM, funded by the Central Emergency Response Fund (CERF), aimed to provide emergency health and protection assistance to stranded third-country nationals and migrants in Cameroon fleeing the crisis in the Central African Republic. Implemented in the towns of Kentzou and Garoua Boulai within the Eastern region, key activities included health triage, consultation, and referral services. From May 2014 to October 2015, the IOM medical team in Kentzou and in Garoua Boulai conducted 3,074 medical consultations of individuals from Mali, Chad, Niger, Nigeria, Senegal, Libya, Liberia, Burkina Faso, and Benin, identifying cases of malaria, intestinal parasites, respiratory infections, and STIs. Among them, 110 individuals were referred to Médecins Sans Frontières for further medical follow-up, and 45 cases were referred to the local hospitals. In the same period, over 1,000 participants were trained on how to maintain proper personal hygiene, as well as to maintain clean clothing.

Nigeria

In the first quarter of 2015, IOM, with support from France and Germany, conducted an initial psychosocial needs assessment of IDPs in Adamawa state, in northeast Nigeria. To conduct the assessment, psychosocial mobile teams made up of a total of 40 participants representing IDPs, staff from the Ministry of Women Affairs and Social Development, the Ministry of Health and the national and State emergency management agencies, were created and trained on key issues related to MHPSS in emergency settings, including sexual and gender-based violence, protection mainstreaming, and psychological first aid. After the training, the teams visited IDP camps to conduct one-on-one and group interviews with IDPs, camp management, and community leaders. Findings from the assessment provided a clear understanding of the psychosocial need among individuals, families, and the community of those who were displaced and affected by the Boko Haram insurgency, which left thousands dead and close to 1.5 million people displaced in Nigeria's six northeastern states. Furthermore, the assessment supported the creation of different tailored psychosocial activities according to the identified needs and the inputs received from the beneficiaries.

Additionally, nine psychosocial mobile teams, each comprising a counsellor, a nurse, an educator, and a community mobilizer were deployed to formal and informal IDP camps and settlements. The teams, comprised of resources from both the IDP and the host community, offered an array of activities, including identification of basic needs, recreational and livelihood activities, family counselling, child-friendly spaces, peer-to-peer support, and referral. A team was also deployed to Chibok to support the family of kidnapped girls and the communities at large. The teams were supervised by both an international clinical psychologist and an international counsellor, and received one week of additional training per month.

EAST AFRICA AND THE HORN OF AFRICA

Somalia

IOM lead in cholera emergency response and stakeholder coordination

266
Acute watery diarrhoea and suspected cholera cases treated at 2 community oral rehydration centres

1,092
Households reached through health and hygiene promotion

5,000
Households received hygiene kits

2
Main water sources chlorinated

over 1,000
Donkey cart drums chlorinated

In late April 2015, the number of acute watery diarrhoea and suspected cholera cases in the Kenyan–Somali border town of Dhobley in the Lower Juba region of Somalia started to increase rapidly. IOM responded by launching mass health and hygiene promotion via community hygiene promoters and dispatched a mobile outreach team to provide oral rehydration salts treatment in the most affected areas. IOM also collected four samples from suspected cholera cases for laboratory testing at CDC in Dadaab, Kenya, of which two confirmed positive for Vibrio Cholera 01 Ogawa. By 17 May, 5 people had died and a total of 129 patients were admitted at Dhobley General Hospital for treatment.

As co-chair of Somalia's Health Cluster, IOM took the lead in the emergency response, as well as stakeholder coordination to contain the disease. By 18 May 2015, IOM had: (a) treated a total of 266 cases at two of its community oral rehydration centres; (b) collaborated with partners to chlorinate two main water sources and over 1,000 donkey cart drums; (c) conducted health and hygiene promotion with 1,092 households; and (d) provided critical care medicine and rapid test kits to Dhobley General Hospital to treat severe cases. In addition, IOM coordinated with local partners in the strategic distribution of hygiene kits for 5,000 households throughout the affected area.

South Sudan Crisis

213,047
Individuals provided with health consultations in Malakal and Bentiu

193,551
Individuals reached with health education

6
Mobile rapid response team missions

over 11,000
Health consultations provided

248,000
Vaccinations administered

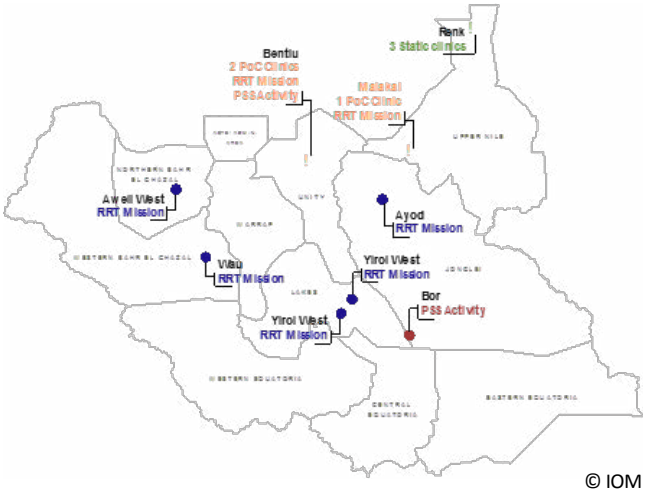
25,682
Individuals provided with psychosocial support services in conflict-affected areas

80
Mobile psychosocial support team members deployed in Bentiu and Bor

More than two years into the conflict in South Sudan, violence, access constraints, and food insecurity continue to drive increased needs and displacement across the country. Since December 2013, the crisis has forced more than 2.3 million people from their homes, including 1.66 million people displaced internally and 647,800 others who have fled to neighbouring countries. Of these, more than 216,000 people sought refuge at six UN Mission in South Sudan (UNMISS) POC sites, predominantly in Bentiu, Unity State; Malakal, Upper Nile State; and in Juba, Central Equatoria State.

Humanitarian needs remain immense, particularly in conflict-affected areas. In September, an estimated 3.9 million people – 34 per cent of the population – faced severe food insecurity and malnutrition, a figure 80 per cent higher than during the same time in 2014. According to the October–December Infection Prevention and Control analysis estimates, 40,000 people in Unity state were likely to face famine conditions in the absence of an immediate scale-up of humanitarian assistance. In 2015, the number of people sheltered at POC sites at UNMISS bases in

Figure 14. Map of service provision by IOM South Sudan's Migration Health Unit in 2015



© IOM

Bentiu and Malakal increased dramatically; in March, the combined figure for these two sites was 70,000, and as of December 2015, it had reached 184,800. Most IDPs indicated either conflict or food insecurity as their reasons for fleeing to the sites; however, it is misleading to attribute the huge influx to only one or the other. Protection concerns and food insecurity are intricately linked as conflict prevents civilians from producing food and precludes humanitarians from delivering assistance in a consistent manner.

In 2015, IOM South Sudan provided more than 200,000 consultations across six static clinics in the Unity and Upper Nile states, and deployed six mobile rapid response teams (RRT) missions in Jonglei, providing more than 11,000 health consultations. To mitigate possible risk of outbreaks, IOM and its partners organized five mass measles vaccination campaigns undertaken by the RRT, two rounds of the oral cholera vaccine (OCV) in Bentiu POC site, two rounds of OCV in the Malakal POC, and one round of polio vaccination in Renk county. As a result of these campaigns, a total of 248,000 people were vaccinated in the Unity and Upper Nile states.

Mother and child at the Cholera Treatment Centre at Juba Teaching Hospital, July 2015. © IOM

On 3 December 2015, IOM officially opened a PHC clinic[5] in sector two of the Malakal POC site. The clinic had a dedicated five-bed maternity ward capacity that could accommodate general PHC consultations, routine Expanded Programme of Immunization, and reproductive healthcare, including antenatal and postnatal care, family planning and prevention of mother-to-child transmission of HIV.

Opening of the new IOM Primary Healthcare Clinic in Malakal POC Site, December 2015. © IOM

Additionally, there was also a handover of an IRC clinic in Bentiu sector 3 to IOM, the construction of a new TB laboratory in Bentiu POC that allowed the initiation of TB testing and treatment for the population, and the commencement of reproductive health services, including facility-based births, in Renk County.

In 2015, thanks to initial funding from the protection cluster to the project "Enhancing the psychosocial well-being of internally displaced persons and conflict affected populations", Italy continued funding from June 2015 to support IOM's role in addressing MHPSS needs among IDPs based in Bor and Bentiu POC sites. IOM provided capacity-building for stakeholders by facilitating Psychological First Aid trainings and MHPSS mainstreaming workshops for Camp Coordination and Camp Management actors. Additional trainings were provided to local NGOs in conflict-affected areas outside the POCs. In addition, psychosocial support services were provided in Bor and Bentiu by MHPSS mobile teams comprised of personnel with relatable backgrounds chosen from among the POCs inhabitants trained in dedicated workshops and in service by IOM experts.

[5] This clinic was subsequently burned down in the February attack in Malakal, and rebuilt by IOM and reopened in April 2016.

ASIA AND THE PACIFIC

Bangladesh

6
Medical teams deployed

102,470
Patients received direct healthcare services

1,652
Patients received referral care services

100
Surgical operations performed

8,168
Mothers received obstetric care

74%
Pregnant women received at least one antenatal care service

Under the framework of the National Strategy on Myanmar Refugees and Undocumented Myanmar Nationals (UMNs) in Bangladesh adopted by the Government of Bangladesh in 2013, IOM was given a mandate to provide direct healthcare services and coordinate health services offered to the UMN population and vulnerable host communities in Cox's Bazar District, in collaboration with other international and national NGOs.

IOM's health interventions were set up within existing government health facilities and activities focused on strengthening the capacity of government health infrastructure. This included the deployment of six medical teams comprised of doctors, nurses, and paramedics, provision of essential medicines, medical equipment and trainings, and refurbishing and upgrading three health facilities. In addition, basic primary healthcare was provided directly to both UMNs and vulnerable local populations, and outreach activities were carried out regularly.

Between January and December 2015, 102,470 patients received direct healthcare services from IOM's medical teams. There were 100 surgical operations performed, 8,168 mothers received obstetric care and 74 per cent of pregnant women received at least one antenatal care in the outreach catchment areas. At secondary and tertiary medical facilities, 1,652 patients received referral care services. Additionally, IOM organized community-based awareness events on health issues regarding maternal and child health, sexual and reproductive health, and communicable diseases. At the end of 2015, this programme was able to directly reach 473,425 people through 14,448 awareness events.

Myanmar

971
Individuals in 2 townships able to rely on emergency referrals, due to the support of transportation, meals, living expenses, and treatment costs

Referral Mechanism Training

105
Village health workers trained

132
Basic healthcare staff trained

87
Basic healthcare staff trained on safe motherhood

In the wake of Cyclone Komen in late July 2015, Myanmar was highly affected by flooding, flash floods, and landslides in several parts of the country after heavy monsoon rains. As a result, more than 5.4 million people were affected, with over 476,000 houses damaged or destroyed in 12 states and regions.

For communities living in hard-to-reach areas of northern Rakhine state, the lack of access to specialized healthcare services in hospitals and bigger health facilities could be life-threatening, even more so for pregnant women, mothers, and children, when complications during pregnancies or birth that are not promptly addressed could lead to death. To address this issue, IOM, with funding support from UN CERF, aimed to provide effective referral services to the most vulnerable households, with a goal of reducing excess mortality and morbidity in remote areas of Northern Rakhine state.

In conjunction with the Township Health Department and the State Health Department, IOM worked to support health system strengthening and to improve access to healthcare for all communities. In accordance with IOM's conflict sensitivity strategy, IOM facilitated access to services for all residents, irrespective of their

Nini and her baby received emergency referral support from IOM's CERF-funded project. © IOM Myanmar

Nini, a 20-year-old pregnant woman from one of the villages in Buthidaung, was one of these people. Last February, she went into labour and had complications. There was no available health staff in her village, and one volunteer who had attended IOM's training referred her to Buthidaung Hospital. Despite the difficulties in reaching the hospital, which was located more than ten miles from her village, she was admitted in time and stayed in the hospital for nine days. Mother and baby were discharged in good health due to the timely support received.

religious beliefs or displacement status. To date, a total of 971 people in Buthidaung and Pauktaw townships were able to rely on emergency referrals due to the support for transportation, meals, living expenses, and treatment costs.

In addition, to ensure that the referral mechanism worked smoothly and in a timely way, IOM provided training support to the monthly Continued Medical Education training for 87 basic healthcare staff on safe motherhood and to 105 village health workers and 132 basic healthcare staff on the referral mechanism. IOM also supported the provision of basic medical equipment and supplies, and preparedness for addressing to emergency medical needs at station and village level.

Nepal

506
Individuals assisted for discharge, follow-up, and referral to local health facilities or safe return to their communities via assisted discharge and referral services

20-bed
Injury Rehabilitation Unit established and operated

16,000
Individuals received counselling sessions and recreation activities

4,033
Individuals at risk of TB screened

317
Individuals tested for TB

3
Active TB cases referred for treatment

Two devastating earthquakes struck Nepal in April and May 2015, causing nearly 9,000 deaths, over 22,000 injuries, and over 2.8 million displaced. Many sought refuge in displacement sites within the affected districts that were usually overcrowded, thus increasing potential exposure to various health concerns. At both displacement sites and in the communities, the health needs of affected populations were significant, with approximately 70 per cent of health facilities destroyed or severely damaged, and very limited access to health services.

In the immediate aftermath of the earthquakes, IOM initiated the Relief, Recovery, and Reconstruction Programme, a core area of IOM's relief strategy, to provide emergency life-saving health assistance. Achievements included providing assistance to over 500 individuals through 2,039 events of assistance for discharge, follow-up, and referral to local health facilities or safe return to their communities through the Assisted Discharge and Referral Service established by IOM, and establishing and operating a 20 bed Injury Rehabilitation Unit in Chautara, Sindhupalchowk district to provide step-down care, including intensive physiotherapy, nursing care and psychosocial support for patients with earthquake-related injuries and disabilities to 19 patients. A total of 75 staff and volunteers from different site management agencies and committees were trained on conducting health and hygiene promotion sessions

to increase understanding of public health concerns and to mitigate against exposure to health risks in displacement settings.

Regarding MHPSS, over 16,000 individuals in 13 displacement sites received individual, family, or group counselling sessions, as well as recreational activities that aimed to promote positive coping mechanisms among earthquake-affected populations. To properly manage the spread of TB in Nepal after the earthquake, 4,033 individuals at risk of contracting TB were screened, 317 individuals tested and a total of three active cases were referred for treatment. Additionally, IOM also supported the National Tuberculosis Programme to restore TB active case finding services in earthquake-affected districts.

Assisting earthquake injured individuals to go home

Mr Nath is a permanent resident of Nuwakot district, Taruka Village, located 2.5 hours from Kathmandu. He is a farmer by trade and relies on his crops to feed his family. On 25 April 2015, while Mr Nath was in his home, he felt the ground shake and attempted to run out of his house. He was unable to make it out in time and was buried under rubble from a collapsing wall. Community members came to his rescue, and he was sent to the Bir Hospital Trauma Centre in Kathmandu where he was diagnosed with a pelvic fracture with hemoperitoneum and multiple other injuries.

Mr Nath being transported on the way home by IOM and community members. © IOM

After receiving treatment at the health facility, Mr Nath was discharged. Although he desperately wanted to go back home, he did not have funds to pay for the travel. Mr Nath was connected with IOM and offered transportation assistance free of charge back to his home.

On 11 June 2015, IOM and Mr Nath left Kathmandu for Nuwakot district by vehicle; however it was not possible to reach his village due to landslides that prevented access. IOM and community members therefore carried Mr Nath for 20 minutes by stretcher in order to reach his village.

Upon arrival in his village, Mr Nath was greeted by family members and his entire community. After being welcomed back, IOM provided Mr Nath and his family members with guidance on nutrition and sanitization to care for his injuries.

Philippines

157,777
Individuals provided with health assistance

30
Health facilities refurbished or constructed

Starting in November 2013, when Typhoon Haiyan devastated several locations in the Philippines, killing more than 6,300 people, IOM Philippines has operated Typhoon Haiyan Response projects with a focus on revitalizing existing health systems that were severely disrupted and enhancing local capacities for health support, including psychosocial support, to become more resilient in the event of future disasters. Health activities within these projects focused on two regions and covered six provinces. In addition, IOM increased emergency health support in response to armed conflict in Maguindanao (Mindanao). The health component of the Maguindanao conflict response focused on the provision of psychosocial support to affected populations, mainly IDPs staying in the displacement sites, due to the nature of the crisis.

In 2015, IOM provided health assistance to a total of 157,777 individuals, including the following: (a) 129,526 individuals who benefited from various direct health support services ranging from consultations, maternal and child health, immunizations, referrals, and dental support; (b) 3,652 individuals who benefited from psychosocial support either through direct assistance or training for health professionals and community service providers; (c) 396 individuals who benefited from other capacity-building activities, largely on primary healthcare; and (d) 23,630 individuals who benefited from community health outreach activities. During the same period, 30 health facilities, such as rural health clinics, hospitals and bunkhouse health posts, were either refurbished or constructed.

Psychosocial support activities from the project "Philippines: Mental Health and Psychosocial Support in Region VI" was launched to enhance MHPSS services in the areas affected by the typhoon. The project utilized a multi-tiered approach to address the second and third layers of the Inter-Agency Standing Committee pyramid of MHPSS interventions. The approach included the following: (a) a community-level training of trainers for midwives on the normal emotional consequences of such events and coping mechanisms; (b) a training on basic MHPSS for community leaders and service providers; (c) a training of trainers for doctors and nurses on basic psychological skills; and (d) an intensive supervisory training to enhance the quality of services carried out by those who had been previously trained on MHPSS.

The Man in the Blue Vest[6]

It is five in the morning. Women ride on tricycles on their way to the marketplace. Men stretch their muscles as they get ready for another day of hard work.

Formerly an emergency room nurse in one of the province's hospitals, Jerry Tagle, a nurse working in the IOM-supported Rural Health Unit in Cuartero, Capiz, traded his white uniform for a blue vest. As he makes his way to the Rural Health Unit, he is greeted by peoples' smiles. In the Rural Health Unit, working side by side with another IOM nurse and a physician, Jerry fights the good fight. With every patient seen, assessed, diagnosed, medicated, and managed, he knows he is making a difference - or at the very least, an impression in the lives of the people.

He goes about his daily routines with an enviable deftness, his dedication to his work driven further by his capability to assist in providing the poorest members of the population with access to free healthcare, which includes not only consultations but also medicine, diagnostic exams and at times, hospital referrals for life-saving procedures. With more than five years of nursing experience under his belt, he faces each day with confidence, but ends each shift with the life lessons learned from the valuable patient interactions he has throughout the day.

[6] www.iom.int/sites/default/files/country/docs/IOM-Philippines-StoriesofHealthandHealing_2015.pdf

Thailand

1,057
Beneficiaries received humanitarian medical assistance in 19 provinces across 9 cities

In 2015, IOM provided humanitarian medical assistance to 1,057 beneficiaries in 19 provinces across 9 cities in Thailand. Assistance included health examinations at all locations for Myanmar Muslims from Rakhine state and Bangladeshis, detained in the aforementioned locations nationwide. Weekly health check-ups by IOM nurses and periodic assessments by IOM medical teams were also provided, as well as vitamin injections, medical supplies, immunizations, and screening for communicable and non-communicable diseases. IOM also supported Immigration Detention Centres (IDCs) with basic medication and first-aid kits to meet the immediate needs of detainees. Pregnant detainees received regular medical check-ups, antenatal and postnatal care at local hospitals, as well as from IOM nurses. Notably, IOM also facilitated intracranial surgery for one beneficiary found to have had a cerebral infarction. Additionally, health screenings comprising of lab and CXR screenings were conducted under the resettlement programme for Myanmar Muslims from Rakhine state.


Immunizations as part of health support, Ranong, 2015. © IOM

The project "Child Care Services and Psychosocial Assistance at the Bangkok Immigration Detention Centre" was a continuation of a United States-funded project related to IOM's support to foreign detainees, especially children, women and some men as permitted by the officials at IDC in Bangkok. In the context of this project, IOM offered detained children the opportunity to participate in daily educational and


Nurul. © IOM

Nurul was 19 years old when he was discovered to be in miserable mental and physical condition during an IOM refugee resettlement health assessment on 19 August 2015. He had been severely beaten and after his arrival in Thailand, brain injuries, including hemiplegia and hemiparesis, were discovered, affecting the left side of his body. He could neither walk nor speak, and had difficulty swallowing. IOM provided a medical examination, as well as support from a physiotherapist and an ophthalmologist, both of whom recommended magnetic resonance imaging and cranial surgery in December 2015. After a substantial medical examination with the cooperation of the IOM medical team and the intensive care of IOM Emergency and Post-Crisis Operations staff, Nurul underwent cranial surgery on 5 December 2015. He was released from the hospital on 8 March 2016 after a lengthy recovery and IOM appointed a physiotherapist to visit him on a weekly basis. IOM diligently followed up and ensured that his needs, such as extra nutritional support, were fulfilled.

IOM staff visited him on 23 May 2016 for the last time before he departed for resettlement in the United States. During this final visit, he was found to be in good spirits and very happy and excited to be resettled to the United States, asking many questions about his future medical care and also expressing his desire to pursue an education. Nurul has since departed for the United States.


Cooking activities, Ranong, 2015. © IOM

recreational activities designed to promote a child's physical and mental development. Supplementary food and hygiene kits and psychosocial support were also provided and a psychologist assigned by IOM visited the centre an average of 14 times per month. In addition, IOM recognized the importance of exposing children to positive environmental, social and cultural conditions in order to develop their physical and mental well-being. Therefore, outdoor activities and visits to parks were also included in the programme.

Vanuatu

In March 2013, a cyclone ripped through the Pacific archipelago and cut off some of the most inaccessible islands from the outside world. To step up health assistance to displaced communities in the post-disaster context, IOM continued its mission to Vanuatu and worked alongside the National Disaster Management Organization to provide targeted health assistance to displaced families in Vanuatu, conduct PDMS, and provide measles vaccinations for children under 5 years old.

Following the disaster crisis, IOM assisted the Vanuatu authorities with the registration of 37 households on the devastated Mataso Island in the Sheffa Province and performed fit-to-travel health checks of residents prior to their evacuation to the capital Port Vila. Additionally, IOM medical staff referred 46 patients and ensured that vulnerable patients do not face additional transport costs to return home, and where possible remained accessible to outpatient care. IOM also supported the Ministry of Health to conduct public health assessments and event-based surveillance monitoring in evacuation centres to monitor public health risks and to ensure that any issues would be identified at the earliest possible stage.

EUROPE

Serbia and Bosnia and Herzegovina

Following the devastating floods in this region, IOM, with UN CERF and European Union funding, was able to provide psychosocial support to vulnerable returnee and IDP families. Due to existing structural obstacles that limited access to such support, for example, due to a lack of public transportation, lack of insurance, and general poverty, activities in the project focused on providing adequate health and psychosocial support to persons in rural areas and on enhancing capacities to deliver inclusive services to the most vulnerable returnees and IDPs in targeted localities.

IOM undertook assessments in different municipalities in order to identify health and psychosocial support needs of families, particularly for elderly and disabled IDPs and returnees, and to detect existing capacity and relevant gaps. Direct psychosocial support was provided to IDPs in targeted localities, especially to vulnerable returnees and IDPs, and capacity of Social Welfare Centres in relevant municipalities was enhanced.

Serbia and Bosnia and Herzegovina

In 2015, ongoing work to enhance the capacities of the Ministry of Defence, the Ministry of Health of the Federation of Bosnia and Herzegovina, and the Ministry of Health and Social Welfare of Republika Srpska continued to facilitate the provision of a systematic response to mental health issues of current and discharged personnel of the Armed Forces of Bosnia and Herzegovina. This action was initiated by the relevant Bosnia and Herzegovina authorities and was facilitated by IOM and supported by the Nordic Baltic Initiative countries.

Using international models developed and applied by Nordic Baltic Initiative countries, a process was initiated to support the Ministry of Defence to design and implement a systematic and sustainable response to address potential negative impacts of past and present war-related experiences on the mental health and psychosocial well-being of active and discharged Ministry of Defence duty staff, as well as those involved in peacekeeping missions. The system established through this intervention was embedded within the human resources management system of the Ministry of Defence and linked to existing civilian network to ensure self-sustainability, cost-effectiveness and avoid duplications.

In 2015, five psychologists were included in the structure of the Ministry of Defence, following an appropriate period of training. An awareness brochure was also finalized and printed with the narrative "Stigma – de-stigmatisation of persons with mental disorders". The brochures were distributed to soldiers who attended four workshops on the topic in Banja Luka barracks, Tuzla barracks, and Capljina barracks.

annexes

ANNEX 1: INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM) PUBLICATIONS, GUIDELINES AND TOOLS ON MIGRATION AND HEALTH, 2015

IOM internal publications, guidelines and tools

1. IOM, *An Assessment of Psychosocial Needs and Resources in Yola IDP Camps: North East Nigeria* (IOM, Geneva, 2015). Available from https://nigeria.iom.int/sites/default/files/newsletter/Yola%20Assessment%20Report%20MHPSS%202015.pdf

2. IOM, *Condición de salud, acceso a los servicios e identificación de factores de riesgo y vulnerabilidades asociados a la migración en Honduras* (IOM, San José, 2015).

3. IOM, *Estudio Exploratorio: Condición de salud, acceso a los servicios e identificacion de riesgos y vulnerabilidades asociados a la migración en El Salvador* (IOM, San José, 2015).

4. IOM, *Health Vulnerabilities of Migrants from Bangladesh: Baseline Assessment* (IOM, Dhaka, 2015).

5. IOM, *Health Vulnerabilities of Migrants from Pakistan: Baseline Assessment* (IOM, Islamabad, 2015).

6. IOM, *Health vulnerabilities of mobile and migrant populations in selected ports of South Africa - Regional Synthesis Report* (IOM, Pretoria, 2015).

7. IOM, *National Strategic Action Plan on Migration Health 2015–2018* (IOM, Dhaka, 2015).

8. IOM, *Perfil de la salud de las personas migrantes en Nicaragua* (IOM, Managua, 2015)

9. IOM, *Preparing for Return* (IOM, Dublin, 2015). Available from http://health.iom.int/sites/default/files/Publications/IOM%20Ireland%20Preparing%20for%20Return%20Booklet.pdf

10. IOM, *Self-Help Booklet for Men facing Crisis and Displacement* [Arabic] (IOM, Beirut, 2015). Available from http://health.iom.int/sites/default/files/Publications/Self%20help%20booklet-Arabic%20Final.pdf

11. IOM, *Self-Help Booklet for Men facing Crisis and Displacement* [English] (IOM, Beirut, 2014). Available from http://health.iom.int/sites/default/files/Publications/Self%20help%20booklet-%20Final%2010%20March%202015.pdf

12. IOM, *Stories of Health & Healing* (IOM, Makati City, Philippines, 2015). Available from www.iom.int/sites/default/files/country/docs/IOM-Philippines-StoriesofHealthandHealing_2015.pdf

13. IOM, *Voices from Bor: Reflecting on a mental health and psychosocial support project at the Bor protection of civilians site in South Sudan* (IOM, Juba, 2015). Available from http://health.iom.int/sites/default/files/Publications/Voices%20from%20Bor_Electronic_double%20spread.pdf

14. IOM Regional Office for Asia and the Pacific, *Migration Health Division: Third and Fourth Quarterly Reports 2014*, Issue nos. 16 and 17, Jul–Dec 2014 (IOM, Bangkok).

15. IOM Regional Office for Asia and the Pacific, *Migration Health Division: First Quarterly Report 2015*, Issue No. 18, Jan–Mar 2015 (IOM, Bangkok).

16. IOM Regional Office for Asia and the Pacific, *Migration Health Unit: Second Quarterly Report 2015*, Issue no. 19, Apr–Jun 2015 (IOM, Bangkok).

17. IOM Regional Office for Southern Africa, *IOM eNews Partnership on Health and Mobility in East and Southern Africa (PHAMESA)*, no. 2, July 2015 (IOM, Regional Office for Southern Africa, Pretoria). Available from www.iom.int/sites/default/files/mission_newsletter/file/PHAMESANewsletter_July2015.pdf

18. IOM Regional Office for Southern Africa, *IOM eNews PHAMESA e-Newsletter no. 5*, October 2015 (IOM Regional Office for Southern Africa, Pretoria). Available from www.iom.int/sites/default/files/mission_newsletter/file/PHAMESANewsletter_October2015.pdf

19. IOM Regional Office Pretoria, *Mapping the Basotho Health Professionals in the Diaspora (SA, UK, USA): A needs assessment of human resources in the Lesotho health sector* (IOM, Pretoria).

20. IOM and FLACSO Guatemala, *Estudio Exploratorio: Condición de salud, acceso a los servicios e identificación de riesgos y vulnerabilidades asociados a la migración en Guatemala* (IOM, San José).

21. IOM and London School for Hygiene and Tropical Medicine, Labour Exploitation, *Trafficking and Migrant Health: Multi-country Findings on the Health Risks and Consequences of Migrant and Trafficked Workers* (IOM, Geneva, 2015). Available from http://publications.iom.int/system/files/pdf/labour_exploitation_trafficking_en_0.pdf

22. IOM, UNHCR and MHPSS.net, *Mental Health and Psychosocial Support for Refugees, Asylum Seekers and Migrants on the Move in Europe: A multi-agency guidance note, December 2015* (IOM, Geneva). Available from http://health.iom.int/sites/default/files/pdf/MHPSS-refugees-asylum-seekers-migrants-Europe-Multi-Agency-guidance-note.pdf

IOM external publications, guidelines and tools

1. Abubakar, A. et al.
2015 The First Use of the Global Oral Cholera Vaccine Emergency Stockpile: Lessons from South Sudan. *PLOS Medicine Journal*, 12(11). Available from http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001901

2. Cookson, S. et al.
2015 Impact of and response to increased tuberculosis prevalence among Syrian refugees compared with Jordanian tuberculosis prevalence: case study of a tuberculosis public health strategy. *Conflict and Health*, 9(18). Available from www.conflictandhealth.com/content/pdf/s13031-015-0044-7.pdf

3. Sergevey, B. et al.
2015 Labor migrants in St. Petersburg: disease awareness, behavorial risks and counseling by health professionals in building up prevention against TB, HIV and associated infections. *Journal of Public Health*, 23(4): 213–221. Available from http://link.springer.com/article/10.1007/s10389-015-0669-4

4. Siriwardhana, C. et al.
2015 Common mental disorders among adult members of "left-behind" international migrant worker families in Sri Lanka. *BMC Public Health*, 15:299.

5. Wickramage, K., C. Siriwardhana and S. Peiris
2015 Promoting the health of left-behind children of Asian labour migrants: evidence for policy and action. *IOM and Migration Policy Institute (MPI) Issue in Brief*, 14. Available from http://publications.iom.int/system/files/pdf/mpi_issue_no_14.pdf

ANNEX 2: SERVICE DELIVERY IN NUMBERS, 2015

Figure 15a. Health assessments of immigrants by region, IOM, 2009–2015

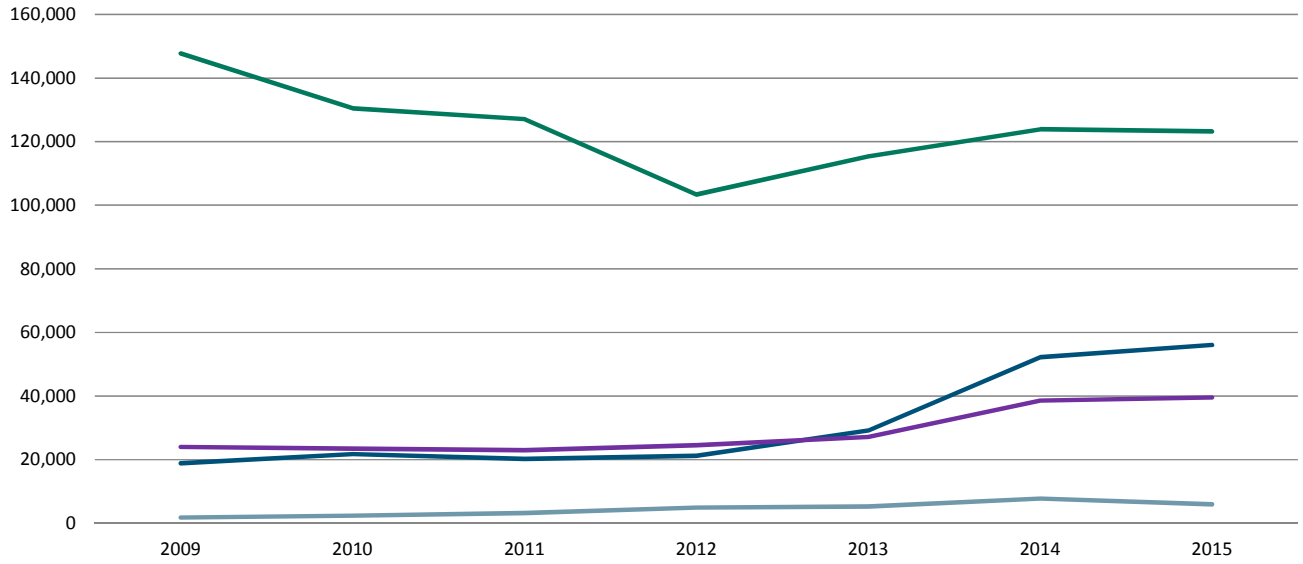


Figure 15b. Health assessments of refugees by region, IOM, 2009–2015

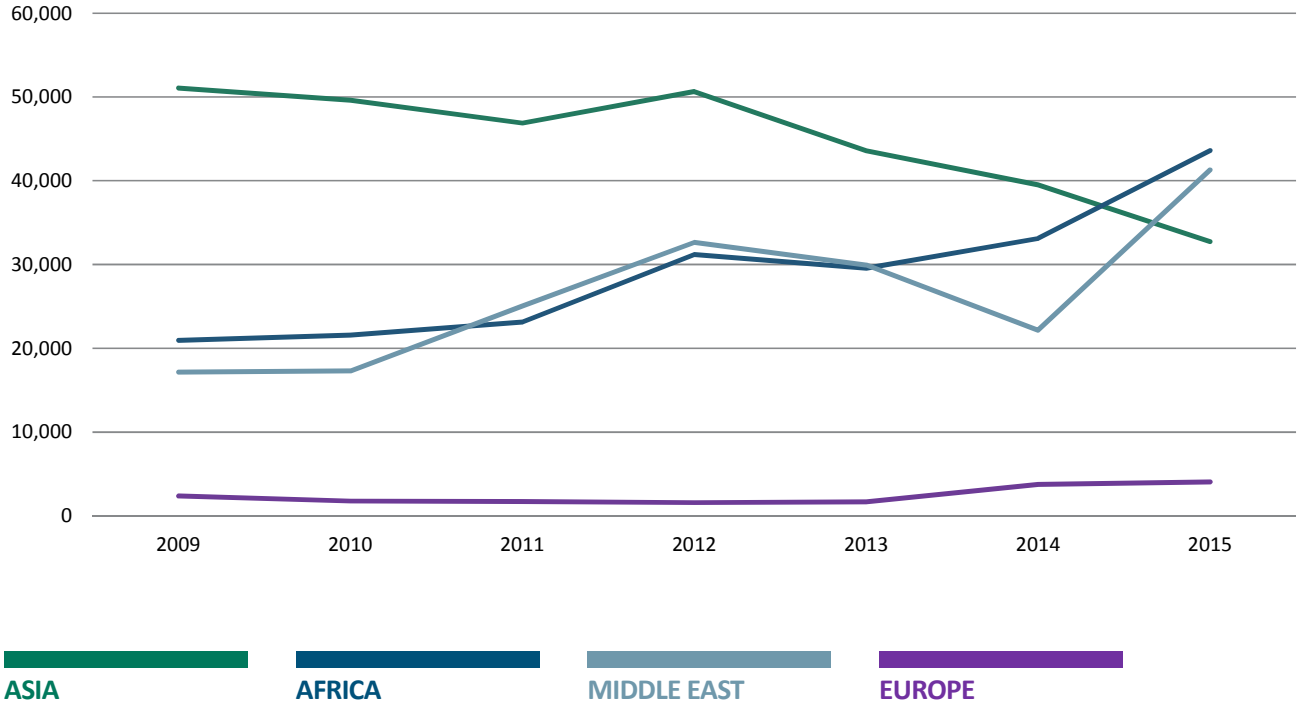


Figure 16a. Health assessments of immigrants by country of destination, IOM, 2009–2015

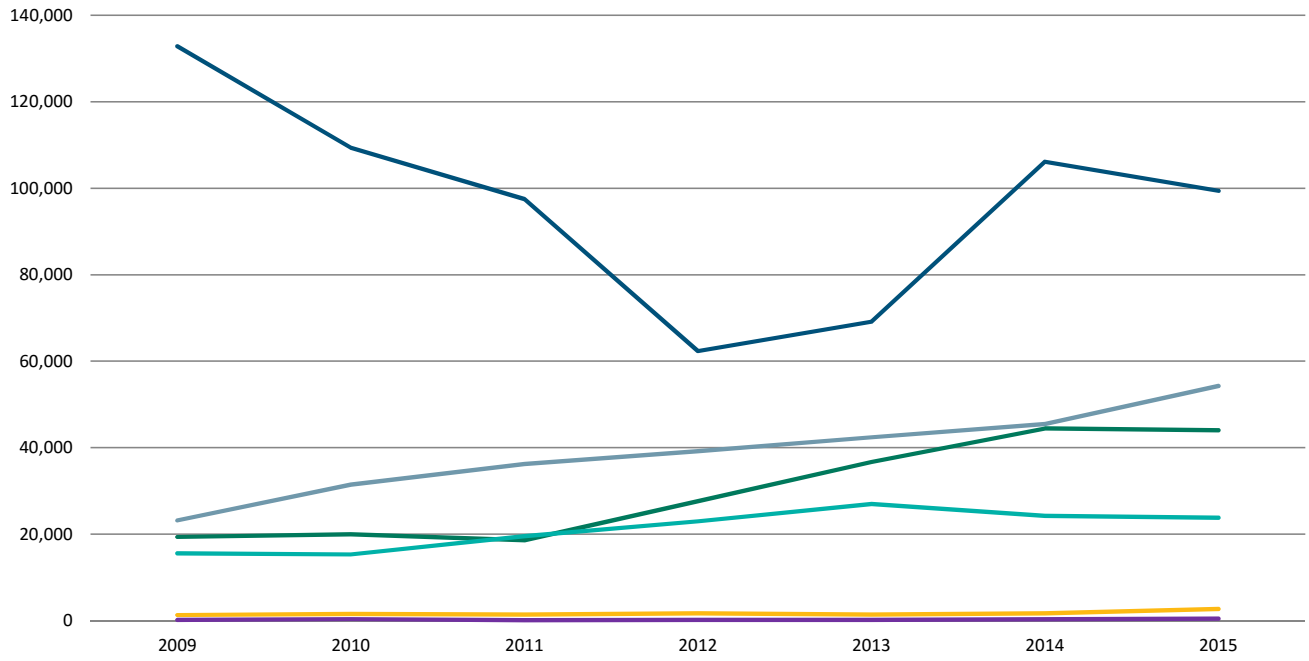


Figure 16b. Health assessments of refugees by country of destination, IOM, 2009–2015

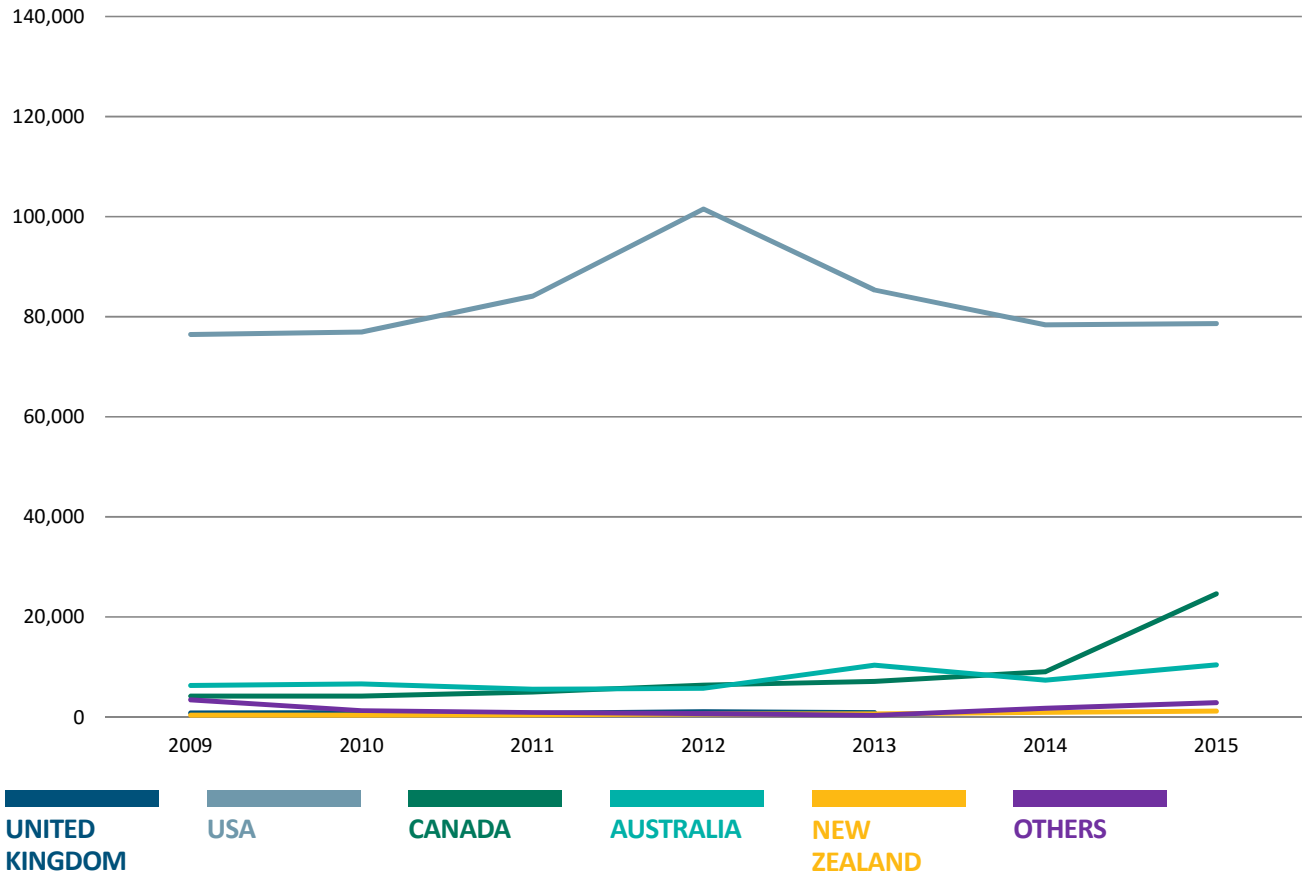


Figure 17a. Distribution of immigrants by sex, IOM, 2015

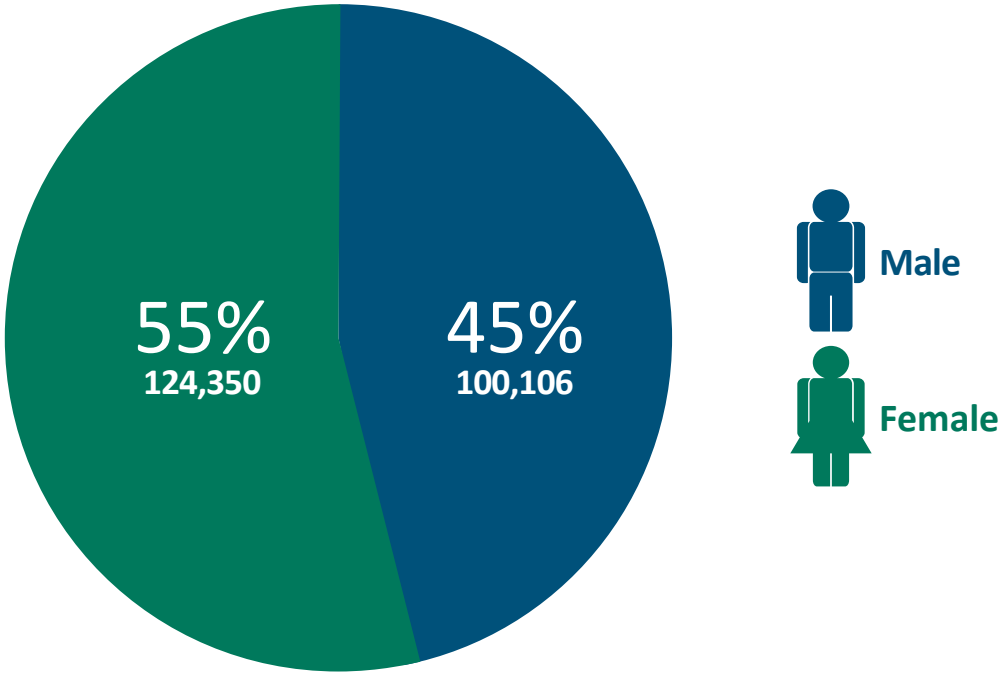


Figure 17b. Distribution of refugees by sex, IOM, 2015

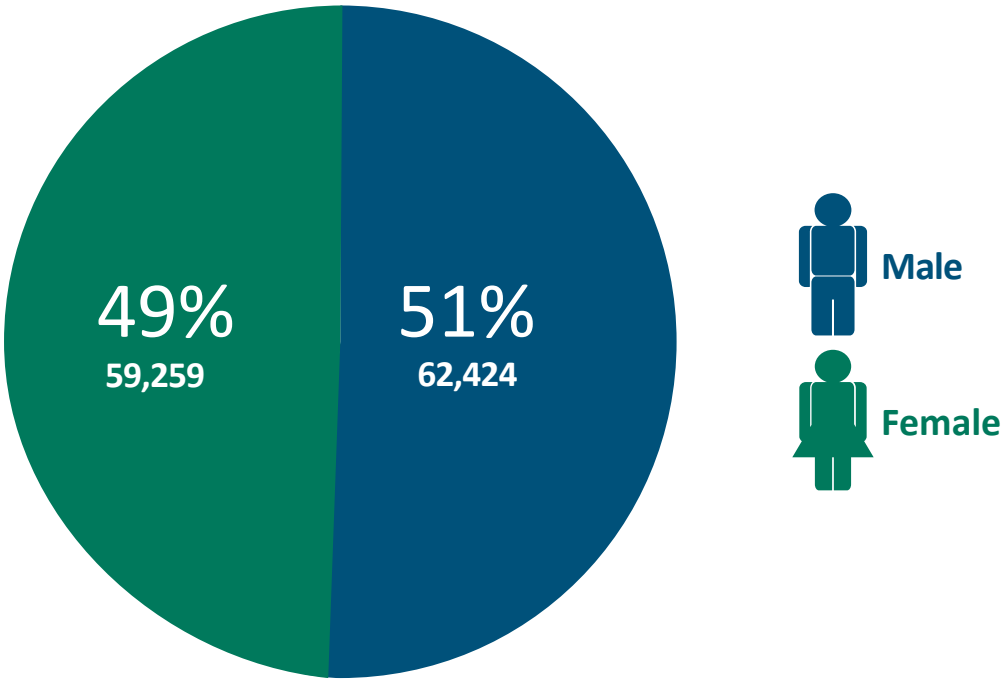
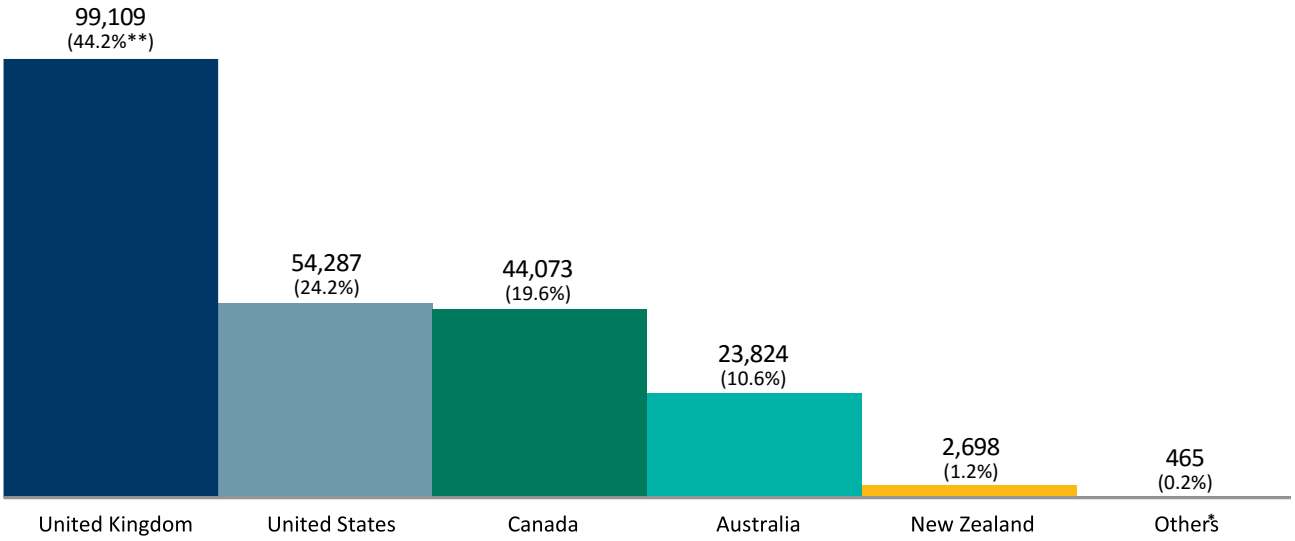


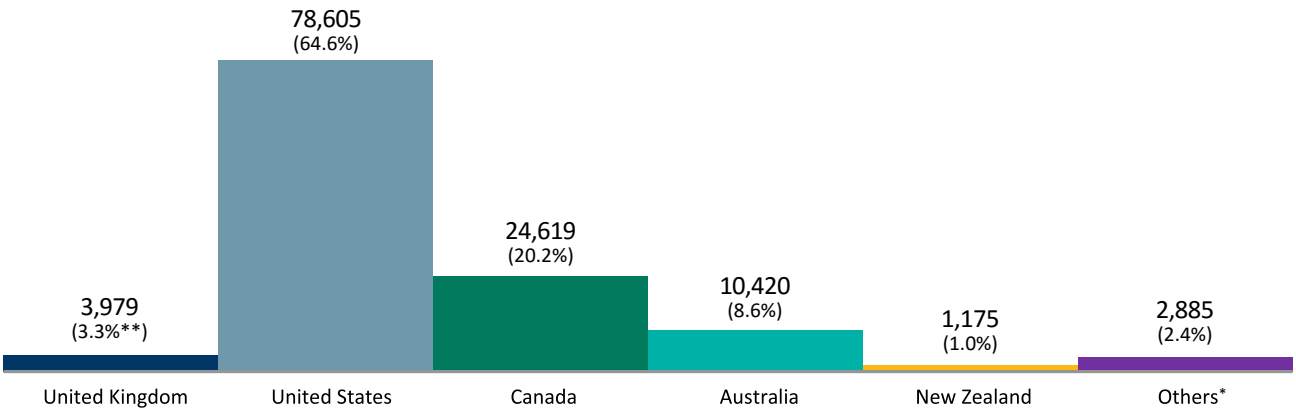
Figure 18a. **Distribution of immigrants by country of destination, IOM, 2015**



* *Top other destination countries (top 3) for immigrants are Belgium, Malaysia and Germany.*
** *Percentages are based on total number of immigrants examined.*

TOTAL NUMBER OF HEALTH ASSESSMENTS = 224,456

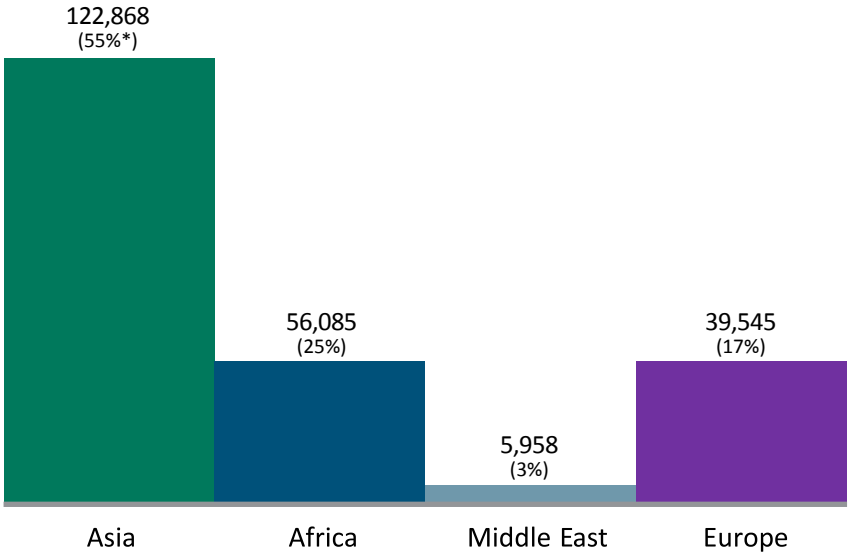
Figure 18b. **Distribution of refugees by country of destination, IOM, 2015**



* *Top other destination countries (top 5) for refugees are Germany, Austria, Ireland, Denmark and Italy.*
** *Percentages are based on total number of refugees examined.*

TOTAL NUMBER OF HEALTH ASSESSMENTS = 121,683

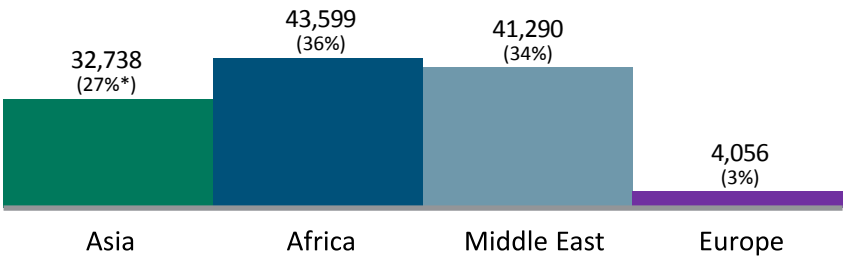
Figure 19a. Distribution of immigrants by region of health assessment, IOM, 2015



*Percentages are based on total number of immigrants examined.

TOTAL NUMBER OF HEALTH ASSESSMENTS = 224,456

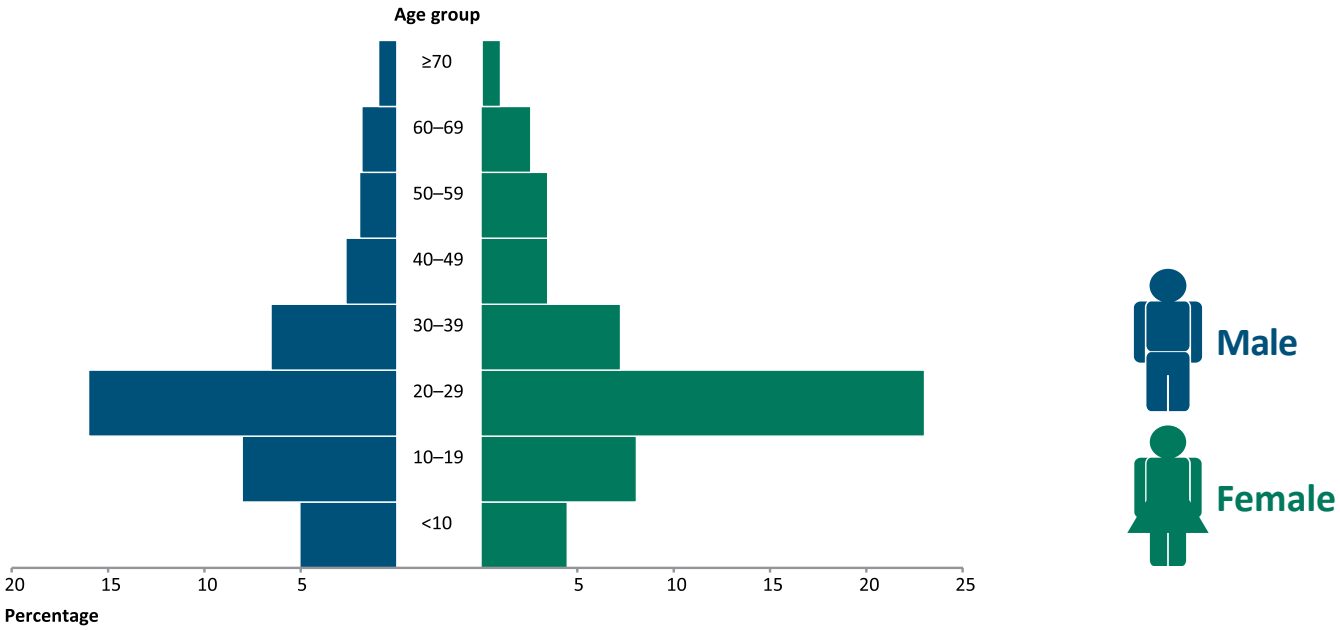
Figure 19b. Distribution of refugees by region of health assessment, IOM, 2015



*Percentages are based on total number of refugees examined.

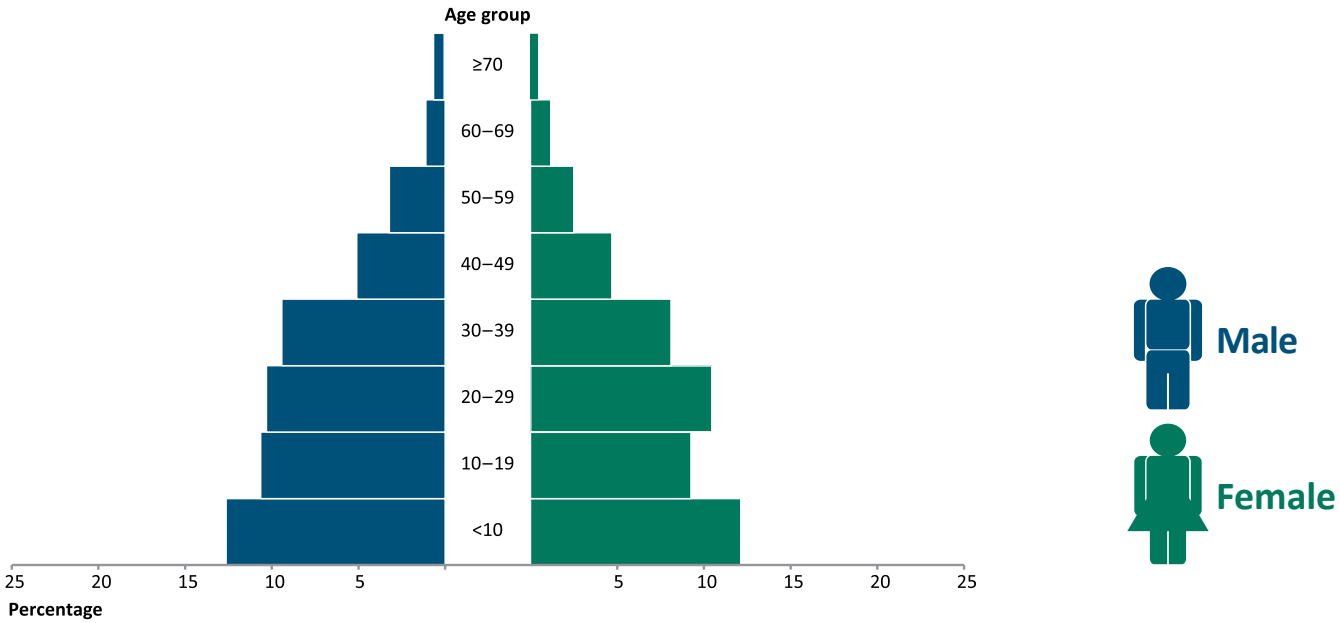
TOTAL NUMBER OF HEALTH ASSESSMENTS = 121,683

Figure 20a. Distribution of immigrant health assessments by sex and age, Asia, IOM, 2015



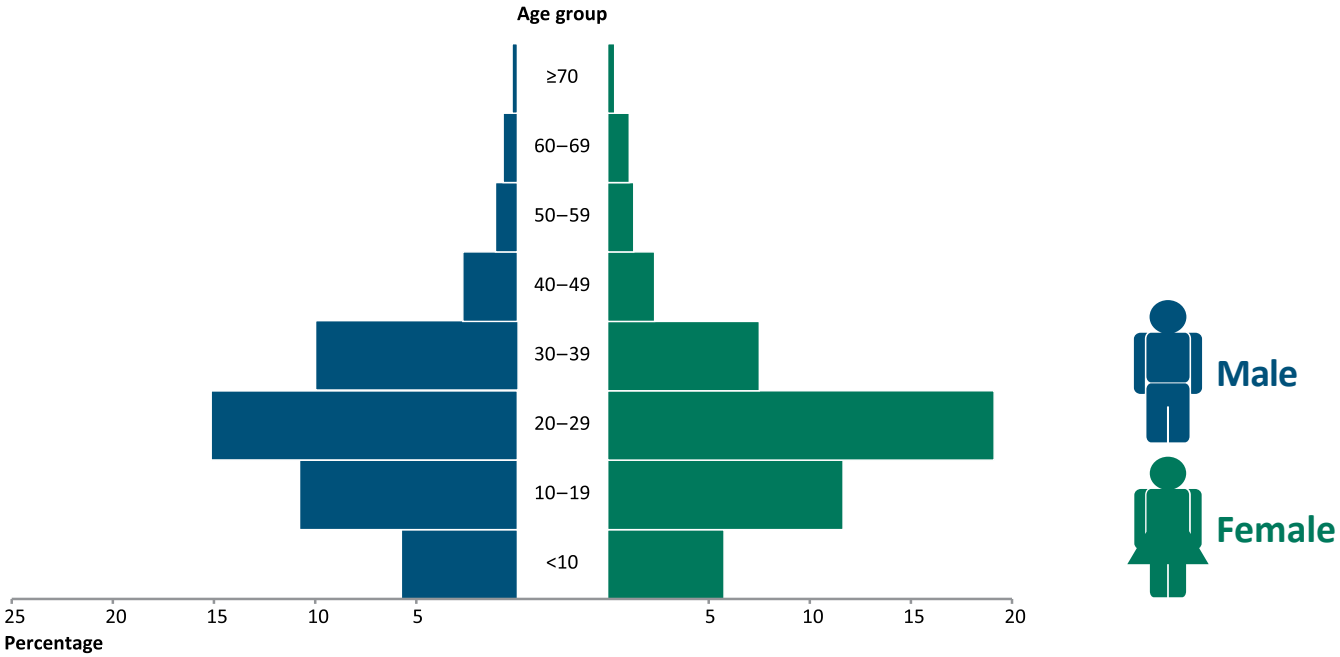
TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG IMMIGRANTS IN ASIA = 122,868

Figure 20b. Distribution of refugee health assessments by sex and age, Asia, IOM, 2015



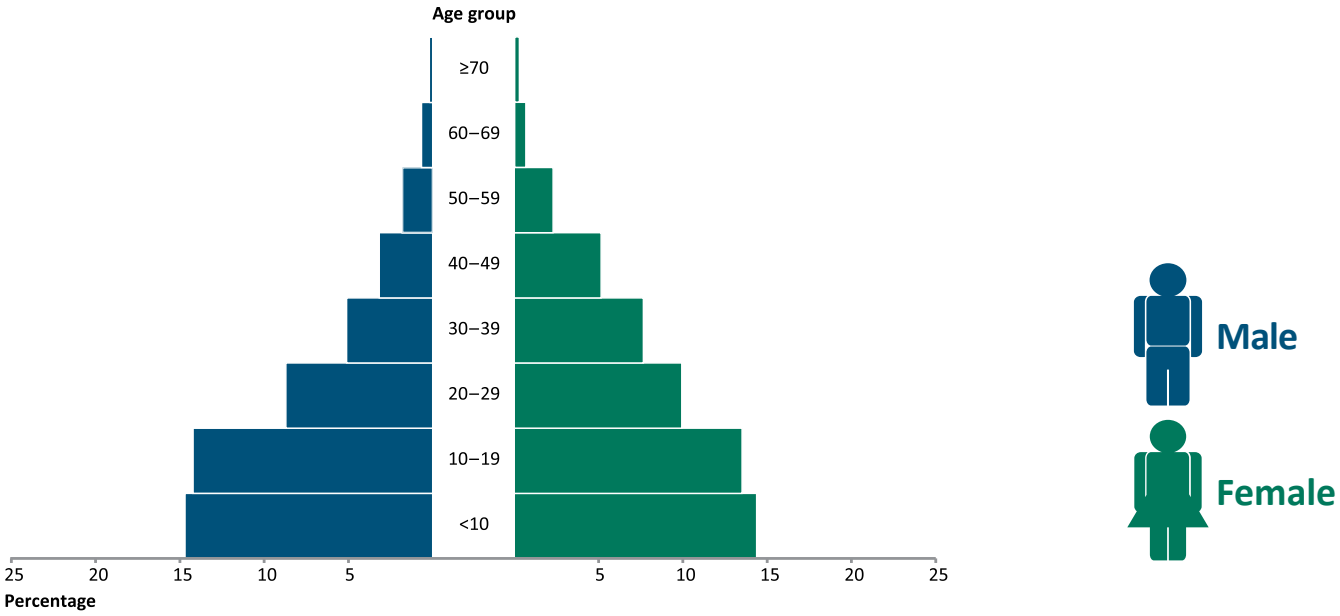
TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG REFUGEES IN ASIA = 32,738

Figure 20c. Distribution of immigrant health assessments by sex and age, Africa, IOM, 2015



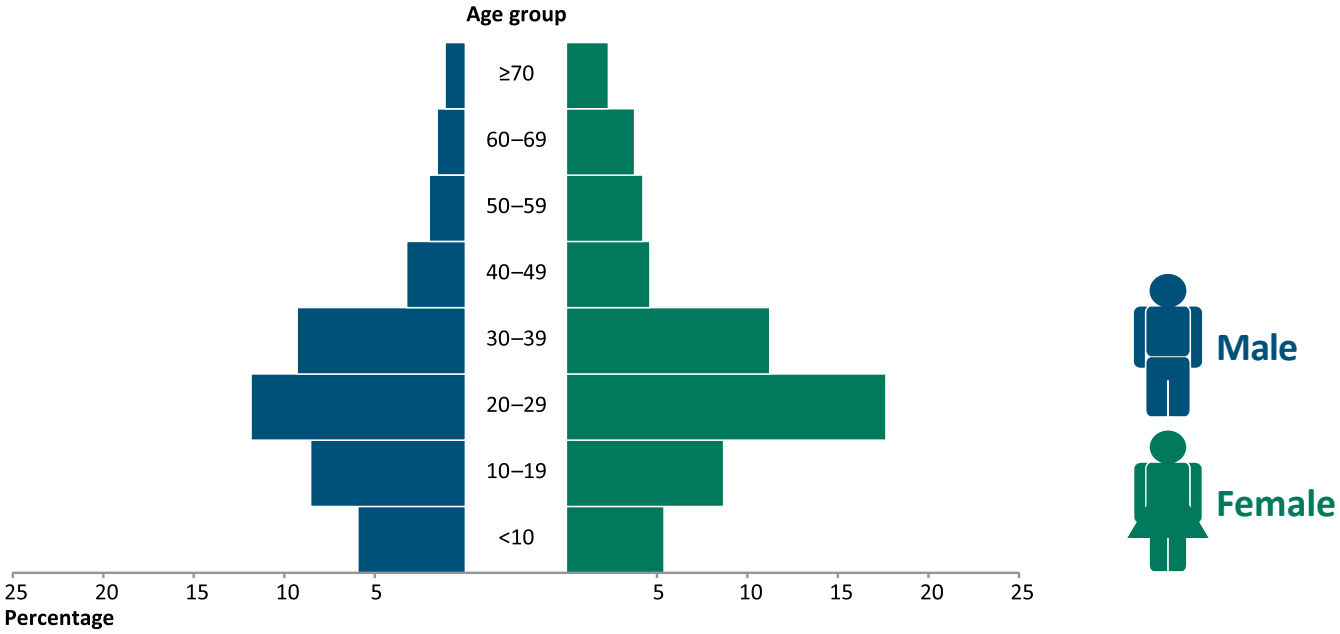
TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG IMMIGRANTS IN AFRICA = 56,085

Figure 20d. Distribution of refugee health assessments by sex and age, Africa, IOM, 2015



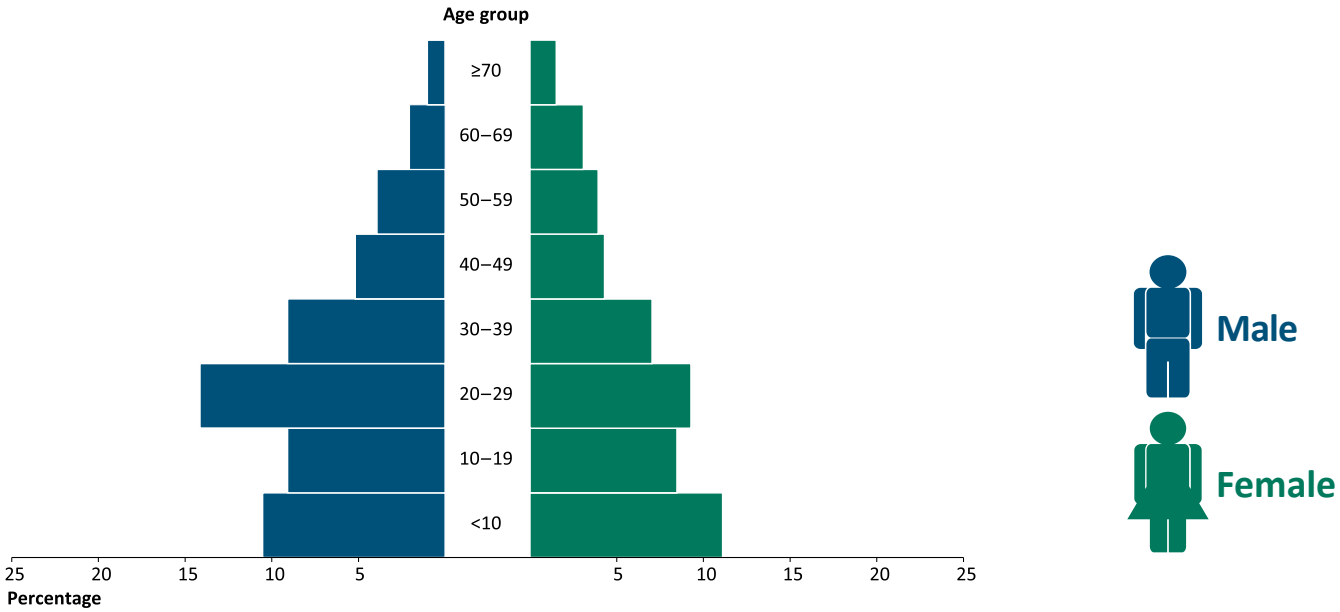
TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG REFUGEES IN AFRICA = 43,599

Figure 20e. Distribution of immigrants health assessments by sex and age, Europe, IOM, 2015



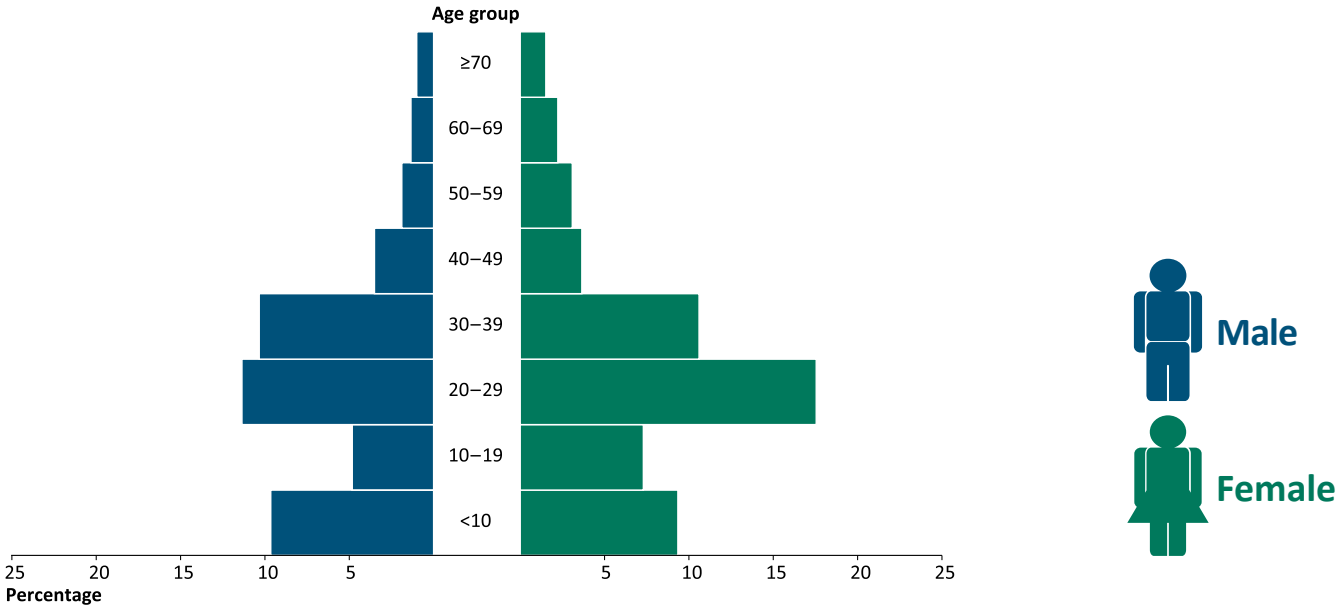
TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG IMMIGRANTS IN EUROPE = 39,545

Figure 20f. Distribution of refugees health assessments by sex and age, Europe, IOM, 2015



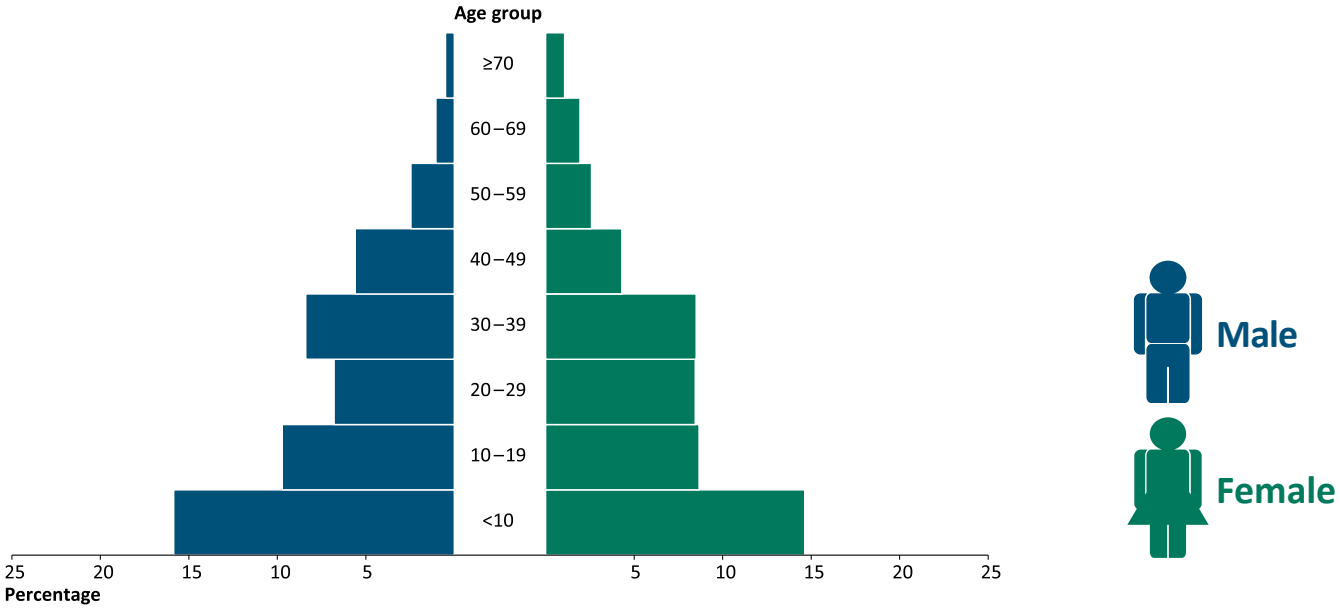
TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG REFUGEES IN EUROPE = 4,056

Figure 20g. Distribution of immigrants health assessments by sex and age, Middle East, IOM, 2015



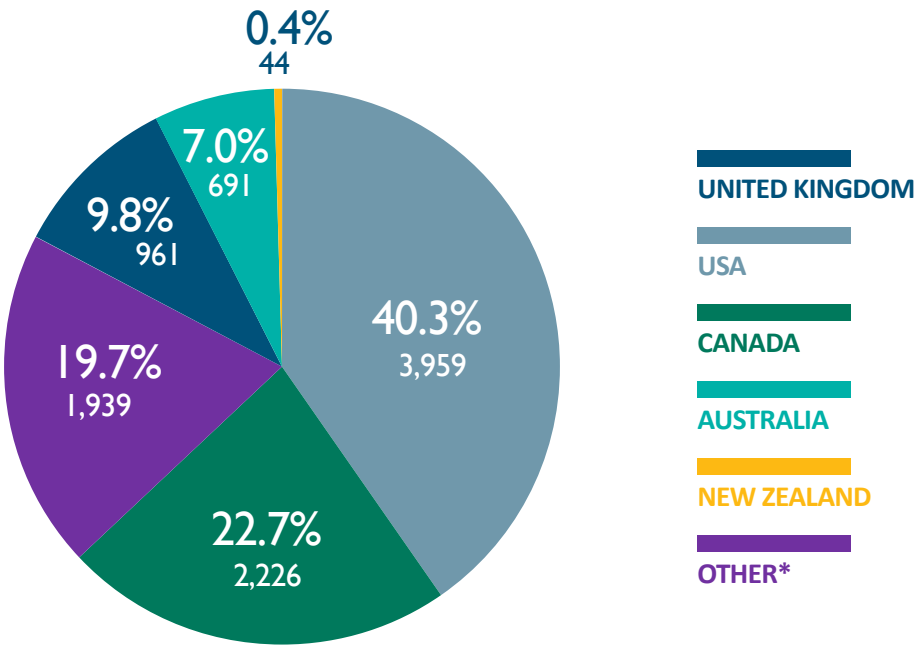
TOTAL NUMBER OF HEALTH ASESSMENTS AMONG IMMIGRANTS IN THE MIDDLE EAST = 5,958

Figure 20h. Distribution of refugees health assessments by sex and age, Middle East, IOM, 2015



TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG REFUGEES IN THE MIDDLE EAST = 41,290

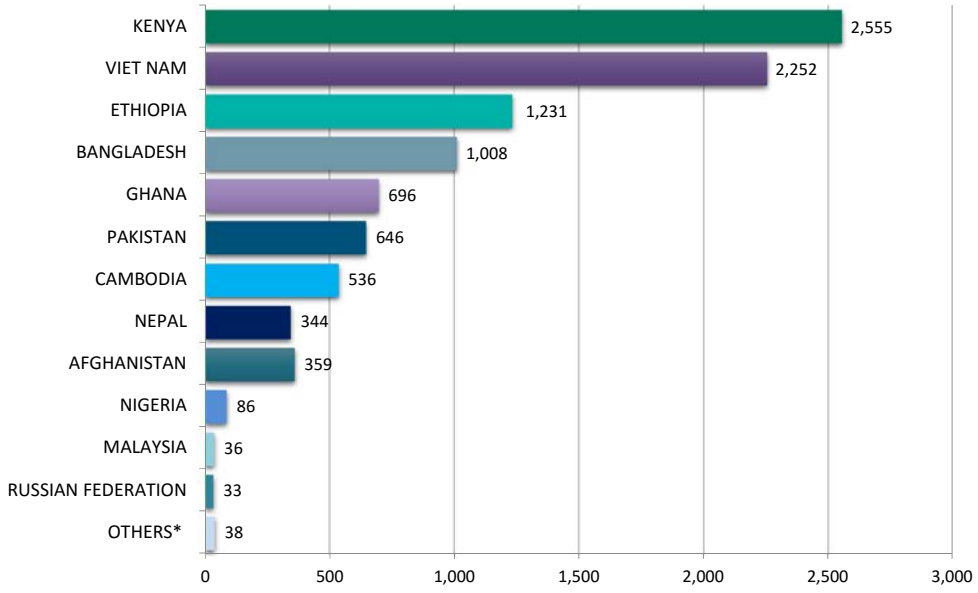
Figure 21a. IOM-assisted DNA services (sampling) by country of destination, IOM, 2015



*Other (destination countries) includes Italy, Ireland and Norway.

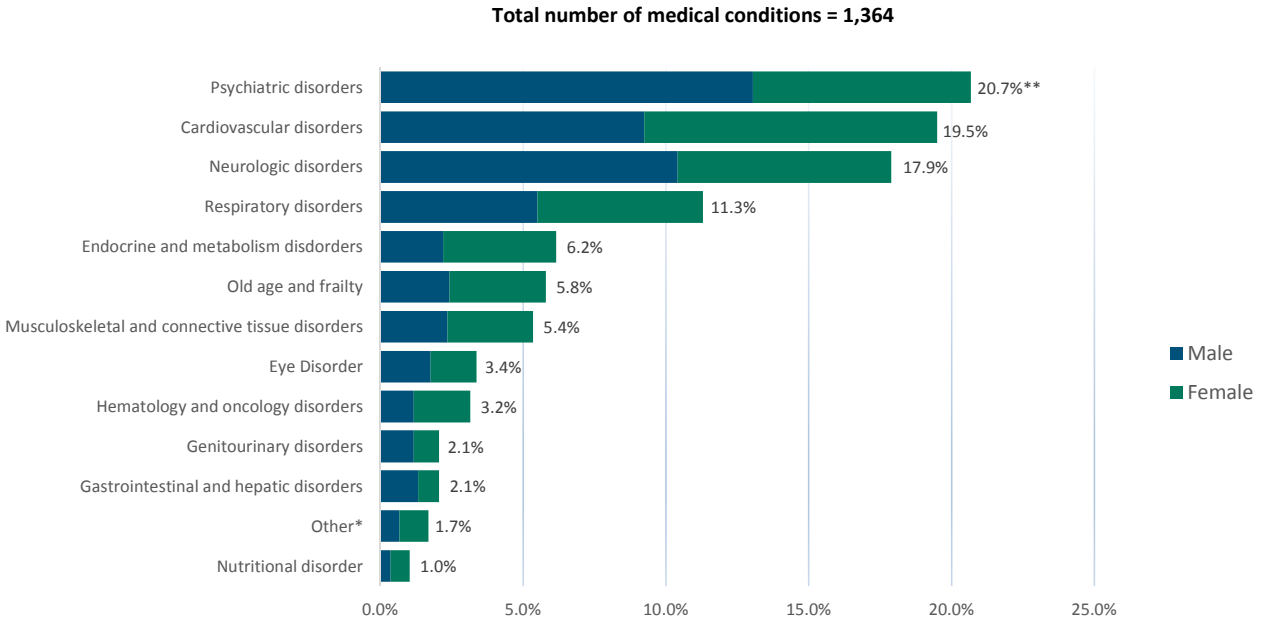
TOTAL NUMBER OF IOM-ASSISTED DNA SERVICES = 9,820

Figure 21b. IOM-assisted DNA services (sampling) by country of exam, IOM, 2015



*Others: Egypt (13), Philippines (5), Lebanon (4), Republic of Moldova (4), Serbia (2), Liberia (2), Thailand (2), Ukraine (2), Syrian Arab Republic (2), Kazakhstan (1) and the former Yugoslav Republic of Macedonia (1).

Figure 22. **Pre-travel medical conditions of all escorted migrants, IOM, 2015**



*"Other" includes gynecologic disorder, injuries or poisoning, ENT disorder, and not categorized condition.
**Percentages are based on total number of medical conditions (1,364).

Table 6. IOM health assessments by country of origin, country of destination and migrant category, 2015

Country of Health Assessment	Country of Destination							
	Australia		Canada		New Zealand		United Kingdom	
	Immigrant[a]	Refugee[a]	Immigrant[a]	Refugee[a]	Immigrant[a]	Refugee[a]	Immigrant[a]	Refugee[a]
Afghanistan	494	53	704	20	87	9	507	619
Bangladesh	1,779	0	675	0	101	0	5,535	0
Cambodia	1,331	0	484	5	421	0	148	0
Indonesia	0	132	0	77	0	96	0	0
Malaysia	0	1,172	0	151	0	261	0	0
Myanmar (Burma)	0	0	0	0	0	0	403	0
Nepal	343	575	88	461	0	11	4,869	0
Pakistan	8,815	1,176	12,573	763	618	373	22,365	0
Philippines	0	0	6,927	1	0	0	4,980	0
Sri Lanka	0	0	0	0	0	0	3,426	0
Thailand	43	921	216	652	71	295	6,545	0
Viet Nam	3,716	0	4,589	0	250	0	2,774	0
Asia	**16,521**	**4,029**	**26,256**	**2,130**	**1,548**	**1,045**	**51,552**	**619**
Algeria	0	0	0	0	0	0	0	0
Bahrain	0	0	0	0	0	0	0	0
Egypt	0	0	0	0	0	0	2	151
Iraq	712	56	313	6	73	0	1,768	368
Israel	0	0	0	0	0	0	0	0
Jordan	231	1,983	324	7,373	78	4	112	576
Kuwait	0	0	0	0	0	0	0	0
Lebanon	0	2,104	101	9,594	0	109	1	1,157
Morocco	0	0	0	0	0	0	0	0
Oman	0	0	0	0	0	0	0	0
Qatar	0	0	0	0	0	0	0	0
Syrian Arab Republic	119	188	448	409	19	8	0	133
Turkey	0	0	0	0	0	0	0	350
United Arab Emirates	0	0	0	0	0	0	0	0
Middle East	**1,062**	**4,331**	**1,186**	**17,382**	**170**	**121**	**1,883**	**2,735**
Angola	0	0	0	0	0	0	837	0
Botswana	0	4	0	62	0	0	297	0
Burundi	4	22	132	534	1	0	0	196
Cameroon	0	0	0	182	0	0	657	0
Chad	0	2	0	234	0	0	0	0
Congo	0	1	0	14	0	0	0	0
Democratic Republic of the Congo	9	5	40	47	0	1	333	0
Côte d'Ivoire	0	0	0	106	0	0	213	0
Djibouti	3	0	0	55	0	3	0	0
Ethiopia	862	548	1,821	827	82	5	1,201	0
Gabon	0	0	0	0	0	0	0	0
Gambia	0	0	0	0	0	0	734	0
Ghana	188	33	840	130	23	0	3,730	0
Guinea	0	0	0	0	0	0	0	0
Guinea-Bissau	0	0	0	10	0	0	0	0
Kenya	1,759	826	1,156	933	62	0	2,098	429
Liberia	0	3	0	1	0	0	0	0
Madagascar	0	0	0	3	0	0	40	0
Malawi	0	299	0	88	0	0	235	0
Mali	0	0	0	0	0	0	0	0
Mauritania	0	0	0	0	0	0	0	0
Mozambique	0	0	0	74	0	0	61	0
Namibia	0	14	0	91	0	0	117	0
Nigeria	2	48	1,748	20	0	0	13,242	0
Rwanda	0	0	0	2	0	0	162	0
Senegal	0	8	0	0	0	0	117	0
Sierra Leone	0	0	0	0	0	0	552	0
Somalia	0	0	2	57	0	0	0	0
South Africa	0	6	0	448	0	0	5,797	0
Sudan	0	0	0	35	0	0	1,894	0
United Republic of Tanzania	4	19	0	393	0	0	658	0
Togo	0	0	0	43	0	0	0	0
Uganda	431	210	692	545	4	0	1,448	0
Zambia	0	12	0	76	0	0	383	0
Zimbabwe	0	0	0	0	0	0	1,604	0
Africa	**3,262**	**2,060**	**6,431**	**5,010**	**172**	**9**	**36,392**	**625**
Armenia	0	0	0	0	0	0	0	0
Azerbaijan	0	0	0	0	0	0	0	0
Belarus	102	0	322	0	25	0	305	0
Bosnia and Herzegovina	245	0	207	0	11	0	0	0
Bulgaria	0	0	419	0	0	0	0	0
Georgia	0	0	0	0	0	0	0	0
Germany	0	0	0	0	0	0	0	0
Kazakhstan	182	0	608	10	92	0	2,135	0
Kyrgyzstan	0	0	0	0	0	0	0	0
Latvia	0	0	0	0	0	0	0	0
Malta	0	0	0	0	0	0	0	0
Republic of Moldova	56	0	1,213	0	20	0	113	0
Romania	102	0	1,339	1	25	0	0	0
Russian Federation	1,046	0	1,963	69	390	0	4,684	0
Serbia	366	0	558	0	79	0	0	0
UNSC resolution 1244-administered Kosovo	16	0	124	0	1	0	0	0
Slovakia	0	0	0	0	0	0	0	0
Tajikistan	0	0	0	0	0	0	0	0
The former Yugoslav Republic of Macedonia	420	0	187	0	36	0	0	0
Ukraine	444	0	3,260	17	129	0	2,042	0
United Kingdom	0	0	0	0	0	0	0	0
Uzbekistan	0	0	0	0	0	0	0	0
Europe	**2,979**	**0**	**10,200**	**97**	**808**	**0**	**9,282**	**0**
Worldwide	**23,824**	**10,420**	**44,073**	**24,619**	**2,698**	**1,175**	**99,109**	**3,979**
	34,244		**68,692**		**3,873**		**103,088**	

[a] *Immigrants moved on a voluntary basis. Refugees were displaced on an involuntary basis and fall under the definition of the 1951 UN Convention.*
[b] *Other destination countries (top five) include Germany, Belgium, Austria, Denmark and Ireland.*

Country of Destination							
United States		Other[b]		Total		Grand Total	
Immigrant[a]	Refugee[a]	Immigrant[a]	Refugee[a]	Immigrant[a]	Refugee[a]	No.	%
0	0	0	0	1,792	701	2,493	1.6
3,773	0	87	0	11,950	0	11,950	7.7
2,006	0	0	0	4,390	5	4,395	2.8
0	194	0	19	0	499	499	0.3
0	12,818	0	0	0	14,421	14,421	9.3
0	0	0	4	403	0	403	0.3
7,054	5,686	1	0	12,355	6,737	19,092	12.3
0	0	1	0	44,372	2,312	46,684	30.0
0	1	0	0	11,907	2	11,909	7.7
0	0	0	0	3,426	0	3,426	2.2
0	6,116	3	64	6,878	8,048	14,926	9.6
14,065	13	1	0	25,395	13	25,408	16.3
26,898	24,828	93	87	122,868	32,738	155,606	45.0%
0	14	0	0	0	14	14	0.0
0	82	0	0	0	82	82	0.2
0	528	44	561	46	1,240	1,286	2.7
809	8,324	0	1,051	3,675	9,805	13,480	28.5
0	152	0	0	0	152	152	0.3
802	4,209	0	254	1,547	14,399	15,946	33.7
0	176	0	0	0	176	176	0.4
0	0	2	754	104	13,718	13,822	29.3
0	25	0	0	0	25	25	0.1
0	20	0	0	0	20	20	0.0
0	34	0	0	0	34	34	0.1
0	0	0	0	586	738	1,324	2.8
0	420	0	0	0	770	770	1.6
0	117	0	0	0	117	117	0.2
1,611	14,101	46	2,620	5,958	41,290	47,248	13.7%
0	4	0	0	837	4	841	0.8
0	89	0	0	279	155	434	0.4
9	1,678	0	95	146	2,525	2,671	2.7
1	237	0	0	658	419	1,077	1.1
0	937	0	0	0	1,173	1,173	1.2
0	238	0	0	0	253	253	0.3
0	36	0	0	382	89	471	0.5
0	0	0	0	213	106	319	0.3
0	374	0	0	3	432	435	0.4
2,703	6,485	0	60	6,669	7,925	14,594	14.6
0	14	0	0	0	14	14	0.0
0	0	0	0	734	0	734	0.7
22	57	165	0	4,968	220	5,188	5.2
0	9	0	0	0	9	9	0.0
0	0	0	0	0	10	10	0.0
6,499	9,079	0	18	11,574	11,285	22,859	22.9
0	27	0	0	0	31	31	0.0
0	0	0	0	40	3	43	0.0
0	543	0	0	235	930	1,165	1.2
0	1	0	0	0	1	1	0.0
0	7	0	0	0	7	7	0.0
0	174	0	0	61	262	323	0.3
0	311	0	0	117	450	567	0.6
0	31	4	0	14,996	51	15,047	15.1
0	3,625	0	0	162	3,635	3,797	3.8
0	0	0	0	117	0	117	0.1
0	2	0	0	552	2	554	0.6
0	0	0	0	2	57	59	0.1
1	1,380	0	0	5,798	1,834	7,632	7.7
0	587	0	0	1,894	622	2,516	2.5
0	4,480	0	0	662	4,892	5,554	5.6
0	97	0	0	0	140	140	0.1
424	4,004	0	1	2,999	4,759	7,758	7.8
0	757	0	0	383	845	1,228	1.2
0	459	0	0	1,604	459	2,063	2.1
9,659	35,722	169	173	56,085	43,599	99,684	28.8%
0	38	0	0	0	38	38	0.1
0	43	0	0	0	43	43	0.1
1,572	119	1	0	2,327	119	2,446	5.6
0	0	0	0	463	0	463	1.1
0	0	0	0	419	0	419	1.0
0	23	0	0	0	23	23	0.1
0	1	0	0	0	1	1	0.0
0	51	0	0	3,017	61	3,078	7.1
0	114	0	0	0	114	114	0.3
0	3	0	0	0	3	3	0.0
0	499	0	0	0	499	499	1.1
2,029	278	0	0	3,431	278	3,709	8.5
0	120	0	0	1,466	121	1,587	3.6
5,511	502	23	5	13,617	576	14,193	32.6
329	0	133	0	1,465	0	1,465	3.4
208	0	0	0	349	0	349	0.8
0	116	0	0	0	116	116	0.3
0	12	0	0	0	12	12	0.0
0	0	0	0	643	0	643	1.5
6,470	2,025	0	0	12,348	2,042	14,390	33.0
0	1	0	0	0	1	1	0.0
0	9	0	0	0	9	9	0.0
16,119	3,954	157	5	39,542	4,056	43,601	12.6%
54,287	78,605	465	2,885	224,456	121,683	346,139	100%
132,892		3,350		346,139		346,139	

Table 7. Tuberculosis detection among immigrants, IOM selected operations, 2015

Country of Health Assessment (HA)[b]	Total HAs	Active TB			TB detection[a] per 100,000 HAs		
		Lab[c]	Clinical[d]	Total	Lab[c]	Clinical[d]	Total
Africa							
Ethiopia	6,669	2	1	3	30	15	45
Ghana	4,968	-	2	2	-	40	40
Kenya	11,574	23	6	29	199	52	251
Nigeria	14,996	10	1	11	67	7	73
South Africa	5,798	3	-	3	52	-	52
Sudan	1,894	-	-	-	-	-	-
Uganda	2,999	3	1	4	100	33	133
Zimbabwe	1,604	-	-	-	-	-	-
Middle East							
Iraq	3,675	1	-	1	27	-	27
Jordan	1,547	-	-	-	-	-	-
Asia							
Afghanistan	1,792	5	-	5	279	-	279
Bangladesh	11,950	8	-	8	67	-	67
Cambodia	4,390	19	1	20	433	23	456
Nepal	12,355	42	1	43	340	8	348
Pakistan	44,372	43	-	43	97	-	97
Philippines	11,907	58	191	249	487	1,604	2,091
Sri Lanka	3,4256	-	-	-	-	-	-
Thailand	6,878	10	2	12	145	29	174
Viet Nam	25,395	132	36	168	520	142	662
Europe							
Belarus	2,327	-	-	-	-	-	-
Kazakhstan	3,017	1	-	1	33	-	33
Republic of Moldova	3,431	-	-	-	-	-	-
Romania	1,466	-	-	-	-	-	-
Russian Federation	13,617	2	1	3	15	7	22
Serbia	1,465	-	-	-	-	-	-
Ukraine	12,348	4	-	4	32	-	32
All Regions							
Other countries[e]	8,596	3	-	3	35	-	35
Total	**224,456**	**369**	**243**	**612**	**164**	**108**	**273**

[a] *Calculation of TB case detection is done using total numbers of active TB cases (laboratory confirmed or clinically diagnosed TB) as numerator and total HAs as denominator. HAs include repeat medical examinations when the migrant undergoes more than one screening process to meet immigration health requirements or other related reasons.*
[b] *IOM selected operations include locations with more than 1,000 assisted immigrants.*
[c] *"Lab" refers to TB cases confirmed by sputum culture.*
[d] *"Clinical" refers to TB cases diagnosed based on clinical or radiological findings.*
[e] *Refers to IOM operations with 1,000 or less assisted immigrants.*

Table 8. Tuberculosis detection among refugees, IOM selected operations, 2015

Country of Health Assessment (HA)[b]	Total HAs	Confirmed TB cases			TB detection detection[a] per 100,000 HAs		
		Lab[d]	Clinical[e]	Total	Lab[d]	Clinical[e]	Total
Africa							
Burundi	2,525	1	2	3	40	79	119
Chad	1,173	-	1	1	-	85	85
Ethiopia	7,925	9	3	12	114	38	151
Kenya	11,285	17	6	23	151	53	204
Rwanda	3,635	4	1	5	110	28	138
South Africa	1,834	4	1	5	218	55	273
United Republic of Tanzania	4,892	4	-	4	82	-	82
Uganda	4,759	10	-	10	210	-	210
Middle East							
Egypt	1,240	-	-	-	-	-	-
Iraq	9,805	2	2	4	20	20	41
Jordan	14,399	1	-	1	7	-	7
Lebanon	13,718	-	-	-	-	-	-
Asia							
Malaysia	14,421	87	40	127	603	277	881
Nepal	6,737	59	-	59	876	-	876
Pakistan	2,312	8	-	8	346	-	346
Thailand	8,048	28	12	40	348	149	497
Europe							
Ukraine	2,042	2	-	2	98	-	98
All regions							
Other countries[f]	10,933	11	3	14	101	27	128
Total	**121,683**	**247**	**71**	**318**	**203**	**58**	**261**

[a] *Calculation of TB case detection is done using total number of active TB cases (laboratory confirmed or clinically diagnosed TB) as numerator and total HAs as denominator. HAs include repeat medical examinations when the migrant undergoes more than one screening process to meet immigration health requirements or other related reasons.*

[b] *IOM selected operations include locations with more than 1,000 assisted refugees.*

[c] *"Lab" refers to TB cases confirmed by sputum culture.*

[d] *"Clinical" refers to TB cases diagnosed based on clinical or radiological findings.*

[e] *Refers to IOM operations with 1,000 or less assisted refugees.*

Table 9. DST results among cases with Mycobacterium tuberculosis (MTB) growth on culture, IOM, 2015

DST	Number	%
Pansusceptible/Pansensitive[a]	423	81.3
Monoresistant[b]	56	10.8
Polyresistant[c]	12	2.3
MDR TB[d]	16	3.1
Extensive drug resistant TB[e]	1	0.2
Contaminated/Missing	12	2.3
Total	**520**	**100.0**

[a] *Susceptible to all first-line anti-TB drugs.*
[b] *Resistant to one first-line anti-TB drug only.*
[c] *Resistant to more than one first-line and anti-TB drug (other than both isoniazid and rifampicin).*
[d] *Resistant to at least both isoniazid and rifampicin.*
[e] *Resistant to any fluroquinolone and to at least one of three second-line injectable drugs, in addition to multidrug resistance.*

Sources of notes:
WHO. (2013). Definitions and Reporting Framework for Tuberculosis – 2013 revision (Updated December 2014).
Available at www.who.int/tb/publications/definitions/en/ (accessed July 2016).

Table 10. Tuberculosis detection by country of exam, UK TB Detection Programme, 2015

Country of exam	Total exams	Active TB[a]	Detection per 100,000 exams (95% CI)
Afghanistan	507	2	394 (0 - 940)
Angola	837	0	0 (0 - 0)
Bangladesh	5,535	3	54 (0 - 116)
Belarus	305	0	0 (0 - 0)
Botswana	279	0	0 (0 - 0)
Cambodia	148	0	0 (0 - 0)
Cameroon	657	0	0 (0 - 0)
Congo, Democratic Republic of the	333	1	300 (0 - 888)
Côte d'Ivoire	213	0	0 (0 - 0)
Ethiopia	1,201	1	83 (0 - 246)
Gambia	734	1	136 (0 - 403)
Ghana	3,723	2	54 (0 - 128)
Iraq	1,768	1	57 (0 - 167)
Jordan	112	0	0 (0 - 0)
Kazakhstan	2,135	1	47 (0 - 139)
Kenya	2,098	4	191 (4 - 377)
Madagascar	40	0	0 (0 - 0)
Malawi	235	0	0 (0 - 0)
Mozambique	61	0	0 (0 - 0)
Myanmar	403	1	248 (0 - 734)
Namibia	117	0	0 (0 - 0)
Nepal	4,869	29	596 (379 - 812)
Nigeria	13,242	10	76 (29 - 122)
Pakistan	22,365	19	85 (47 - 123)
Philippines	4,980	75	1506 (1168 - 1844)
Republic of Moldova	113	0	0 (0 - 0)
Russian Federation	4,684	0	0 (0 - 0)
Rwanda	162	0	0 (0 - 0)
Senegal	117	0	0 (0 - 0)
Sierra Leone	552	0	0 (0 - 0)
South Africa	5,797	3	52 (0 - 110)
Sri Lanka	3,426	0	0 (0 - 0)
Sudan	1,894	0	0 (0 - 0)
United Republic of Tanzania	658	13	1976 (912 - 3039)
Thailand	6,545	3	46 (0 - 98)
Uganda	1,448	0	0 (0 - 0)
Ukraine	2,045	0	0 (0 - 0)
Viet Nam	2,774	12	433 (188 - 677)
Zambia	383	0	0 (0 - 0)
Zimbabwe	1,604	1	62 (0 - 185)
Total	**99,099**	**182**	**184 (157 - 210)**

[a] *With or without bacteriological confirmation*

ANNEX 3: FINANCIAL REVIEW

Table 11. MHD Expenditures by Donor, 2014–2015

Table 11a. Migration Health Assessments and Travel Health Assistance

Funding source	2015 Expenditure		2014 Expenditure		Increase/ (Decrease)	
	(In USD)	%	(In USD)	%	(In USD)	%
Governments	39,995,937	61%	36,636,176	60.48%	3,319,761	9%
Fee-based services	25,656,902	39%	23,901,905	39.45%	1,754,997	7%
Non-Governmental Organizations	-	-	42,805	0.07%	(42,805)	-100%
Migration Health Assessments and Travel Health Assistance	65,612,839	100%	60,580,886	100%	5,031,953	8%

FUNDING SOURCES FOR MIGRATION HEALTH ASSESSMENTS AND TRAVEL ASSISTANCE, 2015

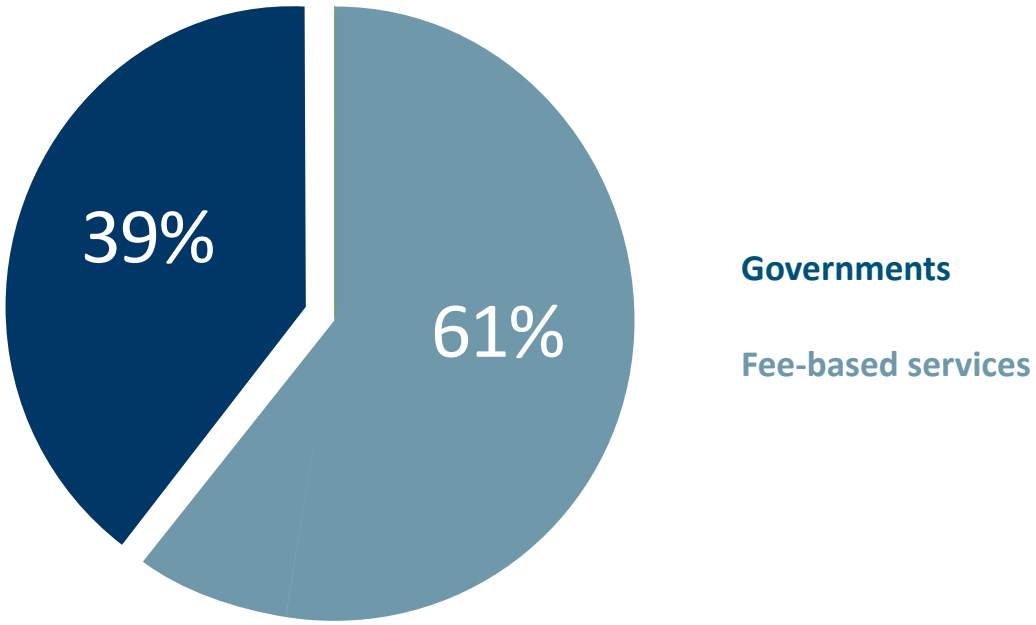


Table 11b. Health Promotion and Assistance for Migrants

Funding source	2014 Expenditure		2013 Expenditure		Increase/ (Decrease)	
	(In USD)	%	(In USD)	%	(In USD)	%
Governments	10,438,518	50.66%	41,620,514	80.56%	(31,181,996)	-74,92%
United Nations	1,482,029	7.19%	2,072,921	4.01%	(590,892)	-28.51%
Non-Governmental Organizations	1,474,836	7.16%	713,037	1.38%	761,799	106.84%
IOM	561,274	2.72%	573,409	1.11%	(12,134)	-2.12%
European Commission	719,978	3.49%	738,254	1.43%	(18,276)	-2.48%
Global Fund to Fight AIDS, Tuberculosis and Malaria	5,900,206	28.64%	5,757,299	11.14%	142,907	2.48%
Universities	23,835	0.12%	-	-	23,835	100.00%
Asian Development Bank	(2,142)	-0.01%	168,262	0.33%	(170,404)	-101.27%
Private sector	6,517	0.03%	20,873	0.04%	(14,355)	-68.77%
Health promotion and assistance for migrants	20,605,051	100%	51,664,567	100%	(31,059,516)	-60.12%

TOP FIVE FUNDING SOURCES FOR HEALTH PROMOTION AND ASSISTANCE FOR MIGRANTS, 2015

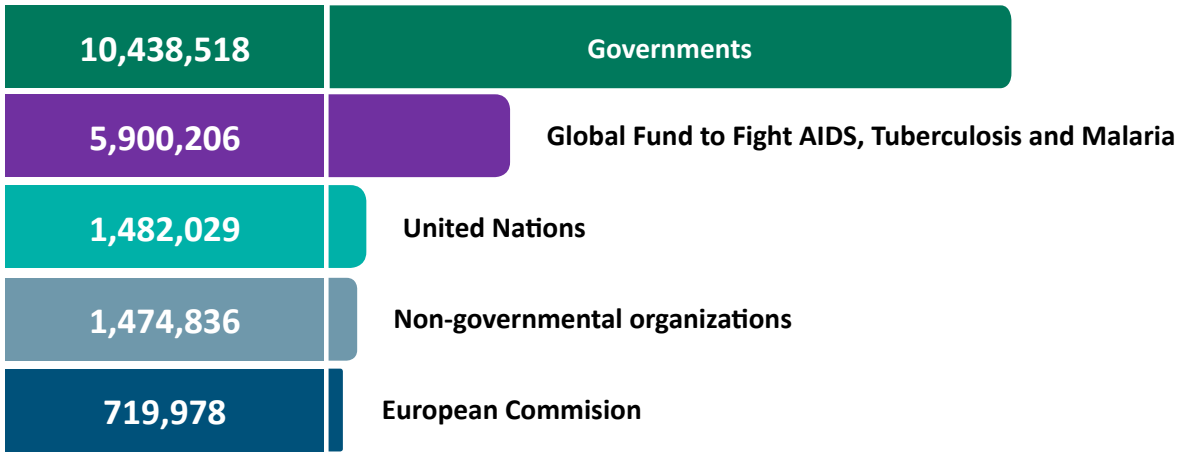


Table 11c. Migration Health Assistance for Crisis-affected Populations

Funding source	2015 Expenditure		2014 Expenditure		Increase/ (Decrease)	
	(In USD)	%	(In USD)	%	(In USD)	%
Governments	49,756,229	76.75%	9,988,972	47.03%	39,767,257	398.11%
United Nations	9,868,596	15.22%	8,716,371	41.04%	1,152,225	13.22%
Global Fund to Fight AIDS, Tuberculosis and Malaria	2,126,225	3.28%	-	-	2,126,225	100.00%
European Commission	1,251,781	1.93%	1,053,226	4.96%	198,555	18.85%
Universities	481,403	0.74%	856,541	4.08%	(384,138)	-44.38%
Non-Governmental Organizations	1,281,151	1.98%	538,439	2.54%	742,712	137.94%
Private sector	92	0.00%	39,086	0.18%	(38,994)	-99.76%
IOM	64,588	0.10%	35,412	0.17%	29,176	82.39%
Migration Health Assistance for Crisis-Affected Populations	64,830,065	100.00%	21,237,047	100.00%	43,593,019	205.27%
Grand Total	151,047,955	100.00%	133,482,499	100.00%	17,565,455	13.16%

TOP FIVE FUNDING SOURCES FOR MIGRATION HEALTH ASSISTANCE FOR CRISIS-AFFECTED POPULATIONS, 2015

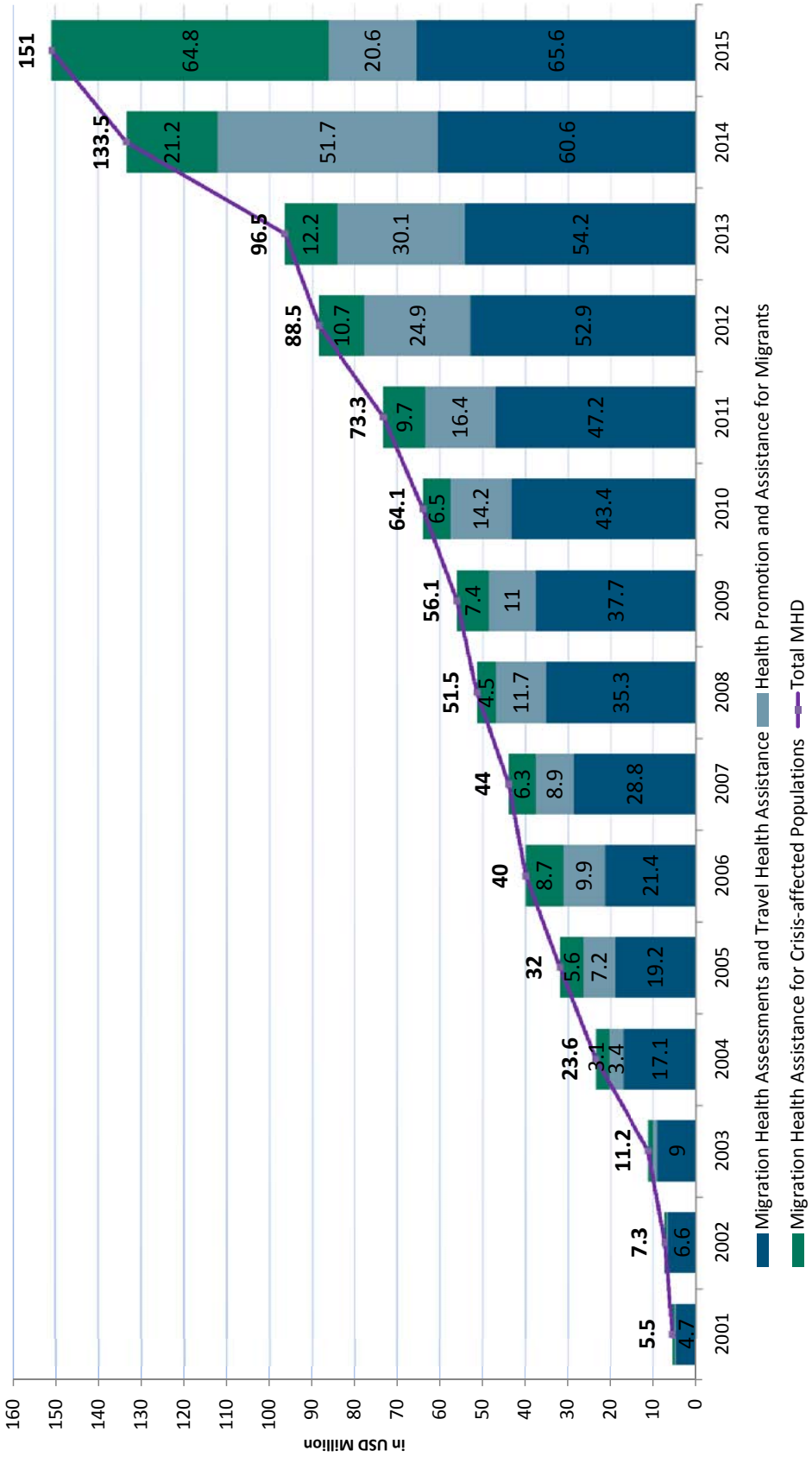


Figure 23. MHD expenditure by programmatic area, 2001–2015

Figure 24. MHD expenditure by region and programmatic area, 2011–2015 (in USD)

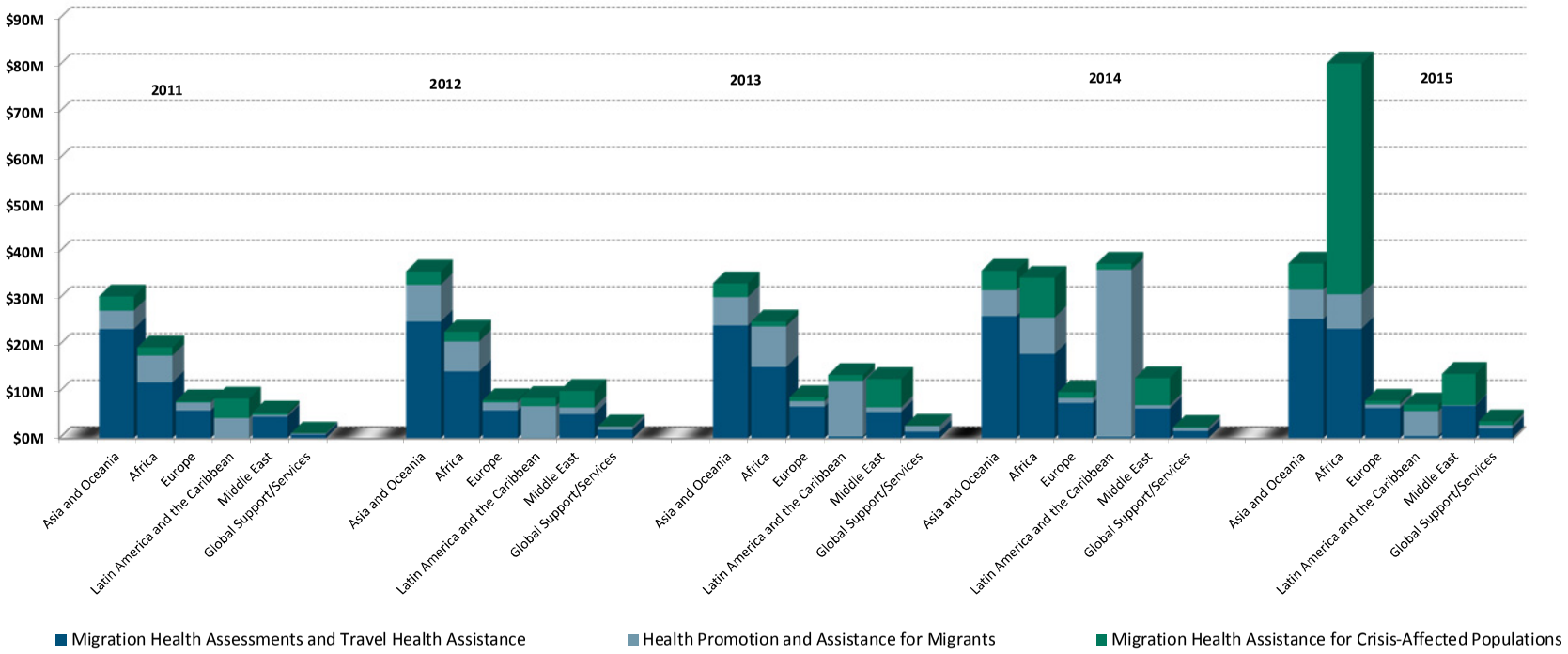
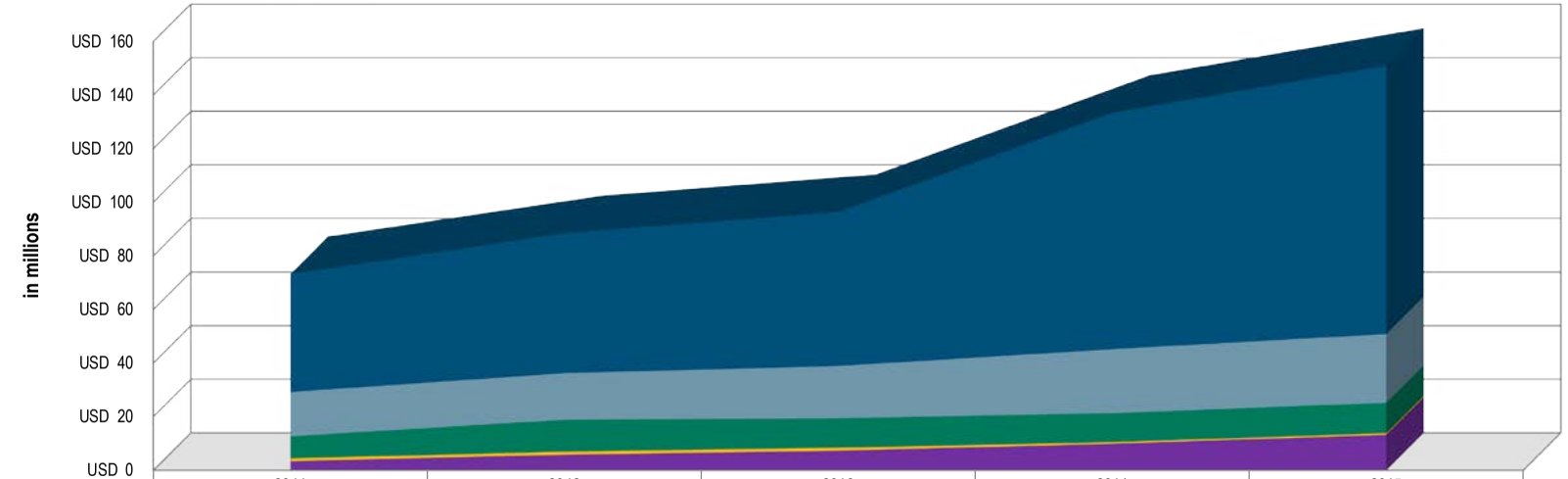


Figure 25. MHD expenditure by funding source, 2011–2015



	2011 expenditure (USD millions)	2012 expenditure (USD millions)	2013 expenditure (USD millions)	2014 expenditure (USD millions)	2015 expenditure (USD millions)
Governments	44.0	52.2	57.5	88.2	100.2
Fee-based services	16.6	17.4	19.5	23.9	25.7
United Nations	8.2	11.9	11.0	10.8	11.4
IOM	1.1	1.2	1.2	0.6	0.6
Other	3.4	5.8	7.3	9.9	13.3

BY IOM'S SIDE

Thanks to our major partners in 2015

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Established in 1951, the International Organization for Migration (IOM) is the principal intergovernmental organization in the field of migration.

IOM is dedicated to promoting humane and orderly migration for the benefit of all. It does so by providing services and advice to governments and migrants. IOM's mandate is to help ensure the orderly and humane management of migration; to promote international cooperation on migration issues; to aid in the search for pratical solutions to migration problems; and to provide humanitarian assistance to migrants in need, be they refugees, displaced persons or other uprooted people. The IOM Constitution gives explicit recognition of the link between migration and economic, social and cultural development as well as respect for the right of freedom of movement of persons.

IOM works in the four broad areas of migration management: migration and development; facilitating migration; regulating migration; and addressing forced migration. Cross-cutting activities include: the promotion of international migration law, policy debate and guidance, protection of migrants' rights, migration health and the gender dimension of migration.

IOM works closely with governmental, intergovernmental and non-governmental partners.

IOM • OIM

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