

MIGRATION HEALTH



Report of IOM Activities 2011



International Organization for Migration (IOM)
Organisation internationale pour les migrations (OIM)
Organización Internacional para las Migraciones (OIM)

Migration is

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

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



International Organization for Migration (IOM)

Migration for the Benefit of All

contents

List of Acronyms	2
List of Figures and Tables	4
Foreword by the Director of the Department of Migration Management	5
Introduction by the Director of the Migration Health Division	6
Part I Emerging Themes in Migration and Health	8
Non-Communicable Diseases and Migration	9
Social Determinants of Health and Migration	13
Libya Crisis – IOM Health and Psychosocial Response, 2011	16
Part II The Migration Health Division's Highlights of Activities, 2011	20
Migration Health Assessments and Travel Health Assistance	24
Health Promotion and Assistance for Migrants	42
Migration Health Assistance for Crisis-Affected Populations	61
Annex 1: IOM Publications, Guidelines and Tools on Migration and Health	73
Annex 2: Service Delivery in Numbers, 2011	76



List of Acronyms

AIDS	Acquired immunodeficiency syndrome
ARRA	Administration for Refugee and Returnee Affairs
ASEAN	Association of Southeast Asian Nations
BE&O	Bureau of Emigration and Overseas Employment
BHS	Barangay health station
CCCM	Camp Coordination/Camp Management
CDC	Centers for Disease Control and Prevention
CHV	Community health volunteer
CHW	Community health worker
CIC	Citizenship and Immigration Canada
CoAg	Cooperative Agreement
DNA	Deoxyribonucleic acid
DOT	Directly observed treatment
DST	Drug susceptibility testing
EU	European Union
GAM	Global acute malnutrition
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HAP	Health assessment programme
HIV	Human immunodeficiency Virus
IASC	Inter-Agency Standing Committee
IDP	Internally displaced person
IEC	Information, education and communication
IIRHWG	Intergovernmental Immigrant and Refugee Health Working Group
ILO	International Labour Organization
IOM	International Organization for Migration
LTBI	Latent tuberculosis infection
MDG	Millennium Development Goal
MDR	Multidrug-resistant
MHA	Migration health assessment
MHD	Migration Health Division
MHF	Migrant Health Forum
MHI	Migration health informatics

MHU	Migration Health Unit
MOH	Ministry of Health
MOPHP	Ministry of Public Health and Population
NCD	Non-communicable disease
NGO	Non-governmental organization
NTC	National TB Centre
NTP	National tuberculosis programme
OTA	Onward transportation assistance
PDMS	Pre-departure medical screening
PEC	Pre-embarkation check
PFA	Psychosocial first aid
PRM	United States Bureau of Population, Refugees and Migration
SADC	Southern African Development Community
SGBV	Sexual and gender-based violence
SMC	Significant medical condition
STI	Sexually transmitted infection
TB	Tuberculosis
TCN	Third-country national
THA	Travel health assistance
TTC	Technical training centre
UKTBDP	United Kingdom Tuberculosis Detection Programme
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USRAP	United States Refugee Admissions Programme
VCT	Voluntary counselling and testing
WHA	World Health Assembly
WHO	World Health Organization
YAHAN	Youth AIDS and HIV Network
YRC	Yemeni Red Crescent Society

List of Figures and Tables

- Figure 1: NCD risk factors and migration
Figure 2: Migration as a social determinant of health, modified from the WHO model
Figure 3: Operational framework on migration health (Global Consultation on the Health of Migrants, Madrid, 2010)
Figure 4: MHD expenditure by programmatic area, 2001–2011
Figure 5: MHD expenditure by region and programmatic area, 2009–2011
Figure 6: MHD expenditure by funding source, 2009–2011
Figure 7: IOM health assessments among immigrants and refugees by region of origin, 2007–2011
Figure 8: Immigrants and refugees examined by country of destination, 2007–2011
Figure 9a: Sex and age distribution of immigrants from Asia and Oceania, 2011
Figure 9b: Sex and age distribution of immigrants from Africa and the Middle East, 2011
Figure 9c: Sex and age distribution of immigrants from Europe and the Commonwealth of Independent States, 2011
Figure 10a: Sex and age distribution of refugees from Asia and Oceania, 2011
Figure 10b: Sex and age distribution of refugees from Africa and the Middle East, 2011
Figure 10c: Sex and age distribution of refugees from Europe and the Commonwealth of Independent States, 2011
Figure 11: Main conditions of migrants assisted by IOM medical escorts, 2011
Figure 12: IOM-assisted DNA services (sampling and tests) by country of destination and country of service, 2011
Figure 13: Wasting among refugee children under age 5 in seven countries, 2011
Figure 14: Stunting among refugee children under age 5 in seven countries, 2011

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- Table 1: Prevalence of infectious TB cases by country, 2011, UKTBDP
Table 2: Top 10 disease conditions (ICD-10) among Iraqi refugees (n=13,637) screened in Iraq and Jordan, 2010
Table 3: Top 10 disease conditions (ICD-10) among refugees (n=8,817) screened in Malaysia, 2011
Table 4: MHD expenditure by donor, 2010–2011
Table 5: IOM health assessments by country of origin, country of destination and migrant category, 2011
Table 6: TB detection among refugees, IOM major operations, prevalence per 100,000
Table 7: TB detection among immigrants, IOM major operations, prevalence per 100,000
Table 8: DST results among cases (n=602) with *Mycobacterium tuberculosis* (MTB) growth on culture, IOM, 2011
Table 9: TB treatment outcomes among migrants on ongoing treatment, 2011

Foreword by the Director of the Department of Migration Management

It is my pleasure to present to you the Annual Report 2011 of IOM's Migration Health Division (MHD), one of the four divisions that make up the Department of Migration Management (DMM). It summarizes the main activities and results of MHD's work in 2011 and highlights how IOM addresses migration-related health challenges in various parts of the world with a range of different partners.

Despite the fact that health is a migrant's main asset and the leading factor for determining whether the migration experience will be positive or negative for the migrant, his/her family and the countries of origin and destination, health – as an essential contributor to development – is often overlooked in migration management frameworks and discussions. To overcome this challenge, IOM works hard to facilitate and strengthen intersectoral dialogue and partnerships between the various actors that deal with migration and health to ensure the health and well-being of migrants throughout the migration process. Some of these approaches are described in this report.

Addressing the health needs of migrants is a smart choice on all levels: individual, local and national. At the individual and local levels, addressing the health needs of migrants improves migrants' health, protects the health of the public and facilitates integration, while at the national level, such efforts have been shown to contribute significantly to social and economic development.



Therefore, IOM sees management of the health-related aspects of migration as an integral part of comprehensive migration management, without which migration would not be effectively contributing to development. We hope that this report will enable readers to get better acquainted with the Organization's work in the field of health. As with all our undertakings, we wish that this work will ultimately be of benefit to millions of migrants around the world and the countries working with us to effectively manage migration.

A stylized, handwritten signature in black ink, appearing to read 'Irena'.

Irena Vojáčková-Sollorano
Director, Department of Migration Management

Introduction by the Director of the Migration Health Division

It is with great pleasure that I present this Annual Report 2011 on the activities of IOM's Migration Health Division (MHD). The year 2011 was a memorable one, as IOM celebrated its 60th anniversary. MHD issued a special 60th anniversary edition of its Annual Report 2010, *Health of Migrants in an Increasingly Globalized World*, which included the views of important IOM partners and leading health entities on a range of migration and health topics. This reflects our appreciation for our partners and highlights the value of partnership to achieve substantial results.

2011 saw important initiatives across the three pillars of MHD's work. The health assessment and travel assistance programme area focused particular attention on the issue of post-arrival integration. Through its work implementing public health activities in the pre-departure setting, such as vaccination programmes, health education and prevention initiatives, disease control and mental health services, MHD supports and facilitates the integration of refugees and immigrants resettling in both receiving communities and host health-care systems. The programme also worked to improve the transfer and exchange of important information among resettlement partners in order to facilitate the smooth reception and integration of refugees upon arrival in the domestic setting. This illustrates the role that comprehensive pre-departure health assessment programmes can have as a tool for improving the integration of prospective migrants. IOM also worked at strengthening partnership and cooperation with health systems in countries that host refugees, particularly in the domain of tuberculosis control.

IOM responded to many crises over the course of 2011, the most substantial of which was the response to the crisis in the Middle East and North Africa, or Libya crisis. The MHD migration health assistance for crisis-affected populations programme was active in the IOM response, which focused on the evacuation and repatriation of third-country nationals. MHD carried out a variety of health and psychosocial-related activities in



Libya, as well as in neighbouring countries such as Chad, Egypt and Niger. This experience highlighted the extreme vulnerability of migrants caught in crisis and displacement situations. Migrants assisted by IOM, particularly low-skilled migrants and domestic workers, showed the effects of having had limited access to health care and general social protection, which was exacerbated by the protracted crisis. Tuberculosis, as well as mental health and psychosocial concerns, was the focus of IOM's attention in this context.

In considering the major benchmarks of the global health agenda in 2011, I think it important to mention two major events: the United Nations General Assembly High-level Meeting on the Prevention and Control of Non-communicable Diseases, which took place in New York in September; and the World Conference on Social Determinants of Health, held in Rio de Janeiro in October. In the context of its health promotion and assistance for migrants programme area, MHD participated in both events, as well as in the processes that led up to them. At the latter event, MHD was accompanied by IOM Director General, William Lacy Swing, who participated in a high-level round table and advocated on behalf of migrants and migration. Both events were the result of long processes of effort and advocacy. The global health debate is increasingly recognizing the critical importance of addressing non-communicable diseases and social determinants of health in order to improve equity in health and access to needed health care. Disappointingly, however, the declarations stemming from these events neglected to mention migrants among the vulnerable groups, which illustrates the sensitivity

still evoked by the topic of migration and migrants, even when the discourse is centred on shared values of equity and public health. A long road of advocacy work and evidence-based policy change still remains to be travelled in this domain.

IOM's vision on migration health is grounded on the premise that migrants and mobile populations that benefit from an improved standard of physical, mental and social well-being substantially contribute towards the social and economic development of their home communities and host societies. IOM's work is focused on promoting access to health information and services at all stages of the migration process, including where migrants live and work. Unfortunately, many migrants face barriers to accessing services, particularly the most vulnerable migrants, such as informal workers, irregular migrants and migrant victims of violence or exploitation.

Going forward, there is a pressing need for increased government and public recognition of migrants' contribution to societies, as well as the inclusion of migrant health in the migration and development debate. Moreover, we must continue to integrate migration health into the global health debate, and encourage the implementation of the World Health Assembly resolution on the

health of migrants at the country level. Migrant-inclusive health policies and intersectoral policy coherence are needed to address inequalities and vulnerabilities affecting migrants and to ensure that migrants are able to lead healthy lives and contribute as productive members of society.

I would like to extend my sincere thanks and appreciation for the tireless efforts and commitment of IOM staff in the Field and at Headquarter to address the health of migrants at all stages of the migration process. This report provides an overview of the work carried out by IOM and its partners around the world in the past year. Looking forward, IOM will continue to work in partnership to address migrants' health needs and to promote equal access to health for all.

For healthy migrants in healthy communities!



Dr. Davide Mosca

Director, Migration Health Division
Department of Migration Management

Part I

Emerging Themes in Migration and Health



Ngabe Buglé kids in Costa Rica. ©IOM 2011.

Non-Communicable Diseases and Migration

Non-communicable diseases result in a huge global disease and death burden

In 2008, non-communicable diseases (NCDs) accounted for over 60 per cent of global deaths, and the burden from diseases like cardiovascular diseases, diabetes, chronic respiratory diseases and cancers is projected to further increase. Nearly 80 per cent of NCD deaths occur in low- and middle-income countries, and by 2030, NCDs may become the leading cause of death even in the African region. A large proportion of the mortality and morbidity burden from NCDs can be removed by controlling four key risk factors: tobacco use, harmful alcohol use, physical inactivity and unhealthy diet.

The Sixty-sixth United Nations General Assembly Political Declaration calls upon Member States to act on non-communicable diseases

A High-level Meeting of the United Nations General Assembly on the prevention and control of NCDs was held in New York in September 2011. In the resulting declaration, government heads and representatives acknowledged the global burden of NCDs and its threat to social and economic development worldwide. The assembly also recognized the important role of the international community in assisting Member States in generating an effective response to NCDs, which are caused or influenced by behavioural, social, economic and environmental factors. These factors are particularly relevant to the raised vulnerability of migrants to NCDs.

Selected **commitments to action from the United Nations General Assembly Political Declaration 2011** relevant to the NCD–migration health nexus:

“... recognize the importance of universal coverage in national health systems, especially through primary health care and social protection mechanisms to provide access to health services for all...”

“... promote access to comprehensive and cost-effective prevention treatment and care for the integrated management of non-communicable diseases...”

“... strengthen country-level surveillance and monitoring systems... and include monitoring exposure to risk factors, outcomes, social and economic determinants of health, and health system responses.”

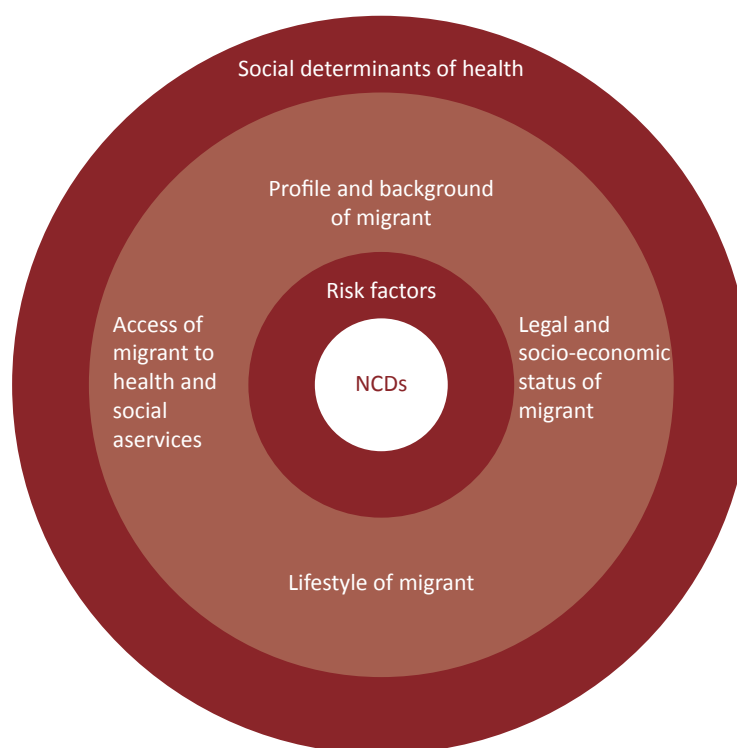
The migration and NCD nexus

With 5–10 million people crossing international borders each year, migration can have an impact on migrants' vulnerability to NCDs. Migrants are often exposed to stress related to acculturation, which can trigger unhealthy lifestyle changes, and unfavourable socio-economic situations that limit availability and access to health services.

A study of South Asian migrants in Europe on the relationship between the social determinants of health, migration and NCD risk factors found that migrant health risks can also be dependent on age, gender, nationality, social strata, occupational group, personal medical history and prior exposure

to NCD-related risk factors. For instance, cultural barriers, particularly in Asian societies, prevent women from engaging in sports in public facilities. Findings from developed countries revealed that South Asian migrants undertake half the amount of daily physical activity and show higher levels of central obesity compared to the host population. The reported prevalence of type 2 diabetes was higher among migrant South Asians, compared to those in their homeland and their host populations in the United Kingdom, Europe, Norway, Canada, the United States and Singapore; this is partly attributed to the acquisition of a “Western” lifestyle. Traditional beliefs also influence the health-seeking behaviour of migrants.

Figure 1: NCD risk factors and migration



Poor socio-economic situations, such as low educational attainment, difficult working conditions, lack of gainful employment, and low income also contribute to increased vulnerability to NCDs and decreased quality of life. The World Health Organization (WHO) *Global Status Report on Non-communicable Diseases* (2010) stated that **vulnerable and socially disadvantaged populations are affected disproportionately by NCDs**, since poverty exposes them to more risk factors; in turn, resulting NCDs lead to catastrophic spending and impoverishment. The high cost of NCD diagnosis and treatment places a burden on migrants who often **do not have access to health insurance and social services**. Migrants regularly have lower levels of education, economic status, prevalence of vigorous activity, and health care utilization. In view of these, higher NCD mortality and morbidity among migrants can be expected. Conversely, risk factors can be reduced through improved living conditions and **lifestyle changes after migration**. This was shown by an age-period-cohort analysis of Chinese migrants in Hong Kong from 1976 to 2005, which revealed an increase in male mortality from ischaemic heart disease and female mortality from hormone-driven (breast and ovarian) cancers.

A **migrant's legal status** may affect health outcomes, as migrants in irregular status not

only experience difficulties in accessing health and social services, but also tend to live and work under unfavourable circumstances. In Europe alone, where an estimated 5–8 million undocumented migrants reside, lack of health information, poor health-seeking behaviour and poor access to health services prevail, largely due to irregular migrants' fear of being discovered and deported. Other deterrents to irregular migrants' access to health and social services include low health literacy, language barriers, high cost of treatment and discrimination. As of March 2004, approximately 10.3 million undocumented immigrants were estimated to be living in the United States, of which 57 per cent were Mexicans. Upon assessing health services access and use among 505 Mexican-born undocumented immigrants in New York City, researchers reported that only 10.5 per cent of the respondents had health insurance coverage, 13.0 per cent received emergency health care, and 36.5 per cent had access to a regular health provider.

The way forward

Future NCD policies and programmes should include migrants and build on key policy landmarks, such as the 2008 World Health Assembly (WHA) resolution on Prevention and Control of Non-communicable Diseases: Implementation of the Global Strategy (WHA 61.14) and the resolution

on the Health of Migrants (WHA 61.17), the WHO *Global Status Report on Non-communicable Diseases 2010*, and the Sixty-sixth United Nations General Assembly Political Declaration of the High-level Meeting on the Prevention and Control of Non-communicable Diseases. Strategies for the prevention and control of NCDs to include migrants as a vulnerable group must not only look at genetic susceptibility and major disease risk factors, but also consider migrants' background, lifestyle, socio-economic and legal status, and health-seeking behaviour, which all have implications on health status.

The International Organization for Migration (IOM) recommends multisectoral action by four key stakeholder groups to address the vulnerabilities and needs of migrants with regard to NCDs:

Governments should be encouraged to adopt transnational approaches to NCD prevention and control that enable migrants to receive cross-border care, such as transferable treatment schemes and harmonized treatment protocols.

Health policymakers and public health planners should review the NCD epidemiological profiles of migrants' countries of origin and support migrant-friendly health services in public health programmes and medical interventions, particularly those on tobacco control, alcohol use reduction, promotion of healthy lifestyle and other cost-effective strategies to reduce risk factor levels. NCD programmes and services should also

be culturally and linguistically appropriate to the epidemiological profiles of migrants.

Health care providers should develop sociocultural competence to minimize discrimination and xenophobia, and apply multilingual and culturally sensitive information, education and communication (IEC) strategies to improve health literacy on NCDs among migrant populations.

Researchers should investigate modifiable risk factors such as diet, physical activity, alcohol consumption and socio-economic status among migrant populations, by using representative sample sizes and standardized data collection methods.

Civil society institutions and non-governmental organizations (NGOs) can advocate for the inclusion of NCDs in the national and local political agenda. As providers of prevention and treatment services for NCDs, they are capable of filling health service delivery gaps left by government and private sectors.

The **corporate sector** should collaborate with governments in advocating healthy lifestyles by promoting a healthy diet through reduced-salt, low-fat and low-sugar products and responsible marketing. Companies should also ensure the health and well-being of their employees through workplace health promotion and targeted NCD prevention schemes.

At the United Nations High-level Dialogue on Non-communicable Diseases in 2011, IOM proposed the following:

1. Monitoring and surveillance of NCDs, risk factors and determinants should include data on internal and international migrants.
2. National health systems strengthening for NCD prevention and control should include investment in migrant-sensitive health systems with culturally competent health services and personnel. Financing schemes for essential NCD health care interventions should respect a rights-based approach to migrants' access to health insurance, services and treatment.
3. Appropriate schemes should be implemented for retention of skilled health care workers within countries, in line with the WHA Global Code of Practice on International Recruitment of Health Personnel.
4. Implementation of cost-effective population-wide interventions for NCD risk factors should ensure coverage of migrants through promotion of health literacy, awareness and improved access to health-promoting environments.
5. Stronger partnerships should be fostered between health and non-health migration-relevant sectors such as labour, immigration and border agencies. Similarly, partnerships between public and private sectors, as well as governmental and civil society groups should be fostered to overcome barriers to NCD treatment and care faced by migrants.

IOM and the Ministry of Health of Georgia detect high burden of non-communicable diseases and risk factors in migrant communities

In Georgia, where about 70 per cent mortality is attributable to cardiovascular diseases, the health care system is challenged to provide prevention and control services for NCDs. Out-of-pocket payments for diagnostics and continued treatment become a burden for poor households, and often drive others towards poverty. Medical insurance in Georgia does not fully cover treatment of NCDs, and the primary health care system is not fully engaged in NCD prevention, surveillance and management.

Harsh socio-economic conditions, a stressful environment and extreme poverty may increase the NCD burden faced by vulnerable population groups such as migrants. Given the lack of

disaggregated data on migrants' health, there is limited empirical evidence on their NCD risk-factor prevalence, health-seeking behaviours, and access to health care services. In light of the need to gather and interpret disaggregated data on migrants, IOM Georgia, in cooperation with the Ministry of Labour, Health and Social Affairs of Georgia, the National Centre for Disease Control and Public Health, and Kurta Hospital Ltd, started a study among various migrant groups residing in Georgia, including returned migrants, victims of trafficking, internal forced migrants and foreign migrants. The study involves: 1) a comprehensive survey on health care access, health-seeking behaviours and NCD risk factors among migrant populations; and 2) dissemination of generated findings and recommendations on migrant-friendly health care delivery and NCD control to various stakeholders.

Among the internal forcefully displaced migrants residing in eight settlements in Georgia in 2011, preliminary findings reveal a **high prevalence of NCD risk factors**.

- 20 per cent smoke tobacco.
- 86 per cent drink (i.e. drank alcohol in the past 30 days).
- 100 per cent eat less than five servings of fruit and/or vegetables on average per day.
- Mean BMI: 27 kg/m².
- 35 per cent are overweight.
- 25 per cent are obese.
- 54 per cent have an elevated blood pressure (SBP \geq 140 and/or DBP \geq 90mmHg or currently on medication for raised BP).

Analysis of the spread of NCDs is mainly based on the data provided by the National Centre for Disease Control and Public Health (NCDC). These data do not reflect some underreported cases from private clinics and self-treatment cases. In addition, health information systems do not provide for disaggregated data on the health of diverse migrant populations residing in Georgia, which is considered to be the primary obstacle to migrant-friendly health care planning and delivery.

In light of this, it is essential to advance awareness of the health conditions that affect migrants in Georgia, the key risk factors for these negative health outcomes, how migrants utilize available health services and how affordable are these services.

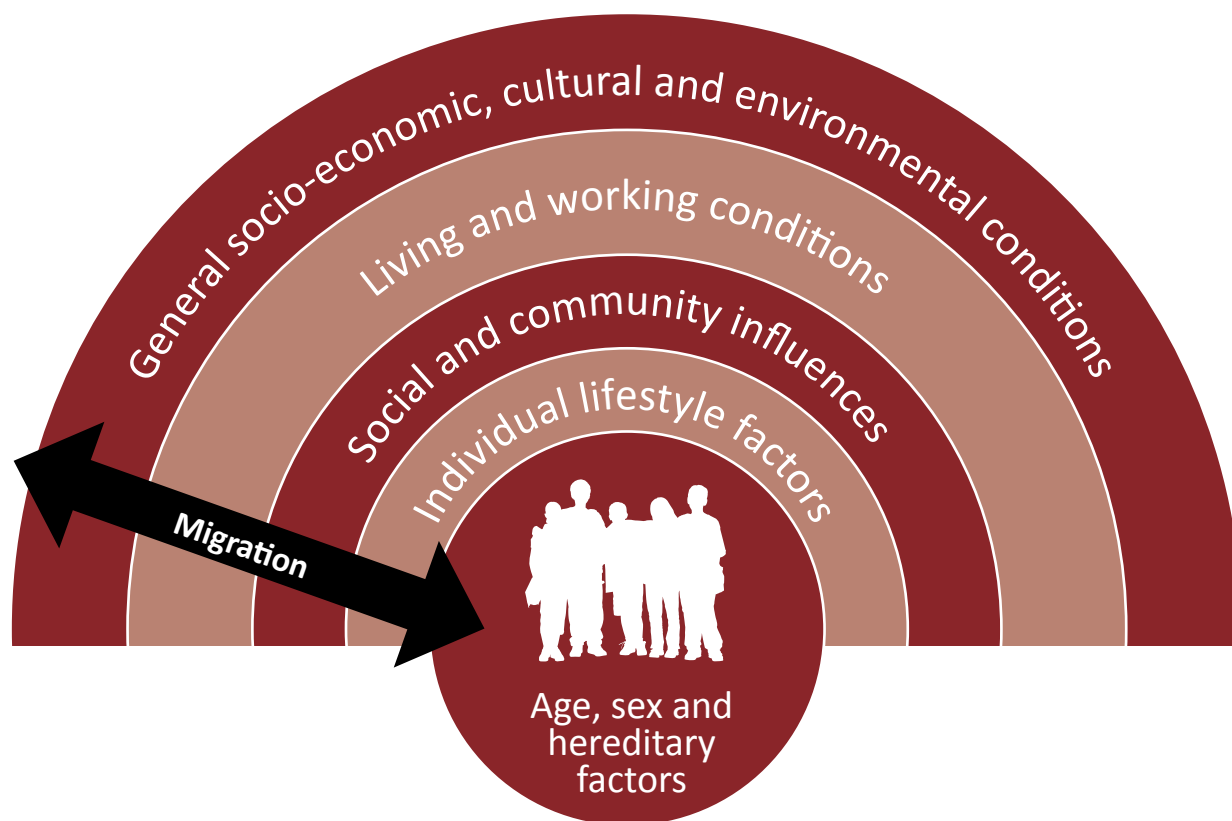
Taking into consideration all the issues pointed out by the migrant health survey is of great significance.

- **Lela Sturua, MD PhD MPH**

Head, Non-communicable Diseases Department
National Centre for Disease Control and Public Health

Social Determinants of Health and Migration

Figure 2: Migration as a social determinant of health, modified from the WHO model



Migration is a social determinant of health

A person's upbringing, education, economic status, employment, physical and cultural environment, and health systems are collectively referred to as social determinants of health. Such circumstances, which are often determined by the distribution of money, power and resources at national, regional and local levels, alter an individual's health status along with age, sex, heredity and lifestyle. Social determinants of health give rise to health inequities, which are unfair and avoidable disparities in health outcomes between countries and populations.

Throughout the entire migration process – from origin, transit, destination to return – migrants encounter legal, social, cultural, economic, behavioural and communication barriers that render them more vulnerable to disease. With migration as a cross-cutting social determinant of health, **several factors contribute to poor health outcomes among migrants** (see Figure 2):

- **Individual lifestyle factors**, namely low educational attainment, low socio-economic status, smoking, alcohol and drug abuse, irregular migration status, low health literacy and poor health-seeking behaviour;
- **Social and community influences** such as separation from family, anti-migrant sentiment in the host community and the lack of migrant-inclusive services;
- **Living and working conditions** like limited supply of, or access to, clean water and sanitation, unavailability of safe housing, unfavourable work conditions and lack of gainful employment;
- **General socio-economic, cultural and environmental conditions**, for example, the lack of legislation to ensure migrants' access to health and social services, effective policies to protect labour migrants' rights and welfare, and laws penalizing discriminatory practices.

In addition, social exclusion, discrimination, xenophobia, conflict and political instability

exacerbate poor health outcomes. Women who migrate as main income-earners are also exposed to exploitation, gender discrimination, low wages, and sexual, physical and psychological violence. With over 1 billion migrants worldwide, one in seven people are more likely to be ill due to these factors, and yet also at a social disadvantage due to persistent health inequities in their host countries.

Improving migrants' health would benefit not only the migrants themselves, but their home and host countries as well. In 2010, the World Bank reported that official remittances alone amounted to more than USD 440 billion, clearly depicting the positive contribution of migrants to national and global economies. The International Labour Organization (ILO) estimates that the number of economically active migrants in 2010 was 105.4 million, and together with their migrant family members, they account for nearly 90 per cent of the total number of international migrants.¹ Beyond economic gains, migrants also contribute to social development, as their remittances are commonly spent by their families on education and health care. Ensuring migrants' health would minimize public health risks to host communities, decrease losses in productivity due to illness, and lessen the financial burden on individuals and on host countries.

"Missing" migrants in the global discourse on social determinants of health.

In October 2011, the Government of Brazil and WHO hosted the World Conference on Social Determinants of Health in Rio de Janeiro. Comprised of members of government, ministers, the academe, United Nations organizations and civil society, the delegates reaffirmed that "health inequities within and between countries are politically, socially and economically unacceptable... and that the promotion of health equity is essential to sustainable development and to a better quality of life and well-being for all, which in turn can contribute to peace and security". Although emphasis on the global action for "health for all" has been made, **migrants' health remains to be formally acknowledged** in national policies and mainstreamed into programmes and research.

Migrants, as all humans, are entitled to good health as a basic human right, and continuing to neglect migrants' access to health and social services would contradict the principles of public

health. This right to health is guided by four interrelated essential components,² namely:

- **Availability**, the physical presence of a sufficient quantity of health facilities, goods and services;
- **Accessibility**, in its four dimensions of non-discrimination, physical accessibility, economic accessibility or affordability, and information accessibility;
- **Acceptability**, wherein health facilities, services and goods are culturally appropriate and respectful of medical ethics;
- **Quality**, wherein health facilities are medically and scientifically appropriate and of good quality within the economic possibilities of the country.

The Rio Political Declaration further states that "good health requires a universal, comprehensive, equitable, effective, responsive and accessible quality health system". To achieve health equity, the responsibility must be shared by all sectors of government, all segments of society, and all members of the international community.

We need more inclusive policies and health systems that guarantee "health for all" as a means to work towards the achievement of international development commitments, such as the MDGs.

- William Lacy Swing
Director General,
International Organization for Migration
Opening Statement at the World Conference
on Social Determinants of Health
October 2011

IOM and the Ministry of Health of Cambodia identify socio-economic factors linked to irregular migration and related health issues in border areas

In 2011, IOM and the Ministry of Health of Cambodia conducted a situation analysis of the health status of Cambodians who migrated in irregular status to Svay Rieng and Banteay Meanchey, provinces bordering Viet Nam and

¹ ILO, 2010.

² Office of the United Nations High Commissioner for Human Rights and World Health Organization, 2008.

Thailand, respectively. Various socio-economic, demographic and health-related variables of persons with a history of irregular migration were compared with those of people living in these provinces who did not migrate.

Individual-level demographic factors were found to be associated with irregular migration; for example, in the border provinces, persons with a history of irregular migration were more likely to lack primary and secondary education, as compared to those who did not migrate. The lack of formal education and skills reduces the likelihood of migrants obtaining decent jobs, and also creates challenges in health care access and health education.

Several socio-economic factors were found to influence decisions and conditions related to cross-border migration. The three major “push” factors for irregular migration are: (i) the lack of ownership of agricultural land as a stable source of employment, income and subsistence; (ii) household indebtedness for basic living needs such as health care; and (iii) insecure employment and low income.

In terms of health risks during and post-migration, their lack of documented status makes cross-border migrants particularly vulnerable to occupational and other health risks, without much protection or access to health services.

Garment workers returning home from work at local factories on the border in Svay Rieng Province. © IOM 2011.



The way forward

With migration itself as a strong determinant of physical and mental health, migrants' health is a human rights and social equity issue. Multisectoral action at individual, societal and general socio-economic levels is needed to promote and protect migrants' health.

National policies and laws must ensure that migrants have access to health promotion, prevention, care and treatment regardless of immigration status. **Health in All Policies** as well as intersectoral cooperation and action can be effective approaches to ensure accountability for health in other migration-related sectors such as immigration, labour and finance.

National governments should ensure that migrant-inclusive policies and programmes are implemented at the regional and local levels, using a multisectoral approach and minimizing social exclusion, stigmatization, discrimination and marginalization of migrant populations.

Health and social services must be responsive to the particular needs of male and female migrants. Health care providers must be culturally competent to recognize and manage reproductive and sexual health issues. Medical education programmes should include cultural and linguistic competence in the curriculum.

Migrants must participate in policy design, health service delivery, monitoring and evaluation and feedback systems to ensure awareness and acceptability of current health care and preventive services.

Libya Crisis – IOM Health and Psychosocial Response, 2011

*I still walk towards the south,
When the wind blows some dreams on
the empty streets,
Pavements offering a bed from
nightmares and promises of a sunny day.*

(From the poem “Will they be
walking the same road next year?”
by **Ghazi Gheblawi**,
Libyan author and doctor)

Libya and the migration crisis

The first part of the year 2011 will be remembered in world history as the “Arab Spring”. The series of protests and demonstrations across the Middle East and North Africa ultimately resulted in authoritarian regimes being forced from power in several countries across the region. As part of this regional upheaval, in February 2011, smoldering civil unrest in Libya erupted into armed conflict between the pro-Gaddafi forces and the rebels of the National Transitional Council.

Prior to the onset of the crisis, Libya is estimated to have hosted over 1.8 million migrant workers, owing to the Libyan economy’s heavy reliance on migrant labour from sub-Saharan Africa, Asia and Europe. The massive outflow of Libyan nationals and hundreds of thousands of migrants escaping violence in the country is considered to be one of the largest migration crises in modern history (IOM, 2012). Migration flows consisted of migrants from neighbouring countries who were crossing the border to get to their countries of origin (Chad, Egypt, Niger and Tunisia), as well as migrants who were crossing the Libyan border to reach countries other than their countries of origin. The latter group of migrants, referred to as third-country nationals (TCNs), represented over 120 nationalities.

As part of the coordinated humanitarian response to the Libya crisis, IOM reinforced its presence within Libya, including Benghazi, and established operations at the country’s border with Tunisia,

Egypt, Niger and Chad four days after the beginning of the conflict. While providing practical protection through humanitarian evacuation and transportation assistance, IOM ensures that people travel in a safe and dignified manner, are fit to travel, receive appropriate assistance when necessary, and do not pose health hazards to other travellers, personnel or receiving communities.

One of IOM’s key responses to requests from several of its Member States was the evacuation and repatriation of TCNs. Of the over 790,000 migrants fleeing Libya, more than 25 per cent received assistance from IOM to evacuate and return to their countries of origin. Evacuations were carried out through sea evacuations from Misrata and Tripoli to safer Benghazi, convoy and air transportation from Sebha to Chad, and charter flights from Tripoli; as well as bus transportation from Tripoli to Ras Ajdir in Tunisia, from Benghazi to Salloum in Egypt and onward to several sub-Saharan and Asian capitals. Before departure, IOM conducted pre-embarkation health checks to ensure migrants’ fitness to travel.

During the Libya crisis, IOM carried out many health-related and psychosocial activities in Libya and its neighbouring countries of Egypt, Chad and Niger. These activities include:

- Conducting rapid pre-embarkation health checks to ensure the fitness to travel of departing migrants and families;
- Providing facilitated health care referrals and continuity of care upon arrival at the destination;
- Providing medical escorts when necessary for at-risk migrants who are travel-ready to return home;
- Providing mental health referrals and direct psychosocial support through counselling and the creation of safe spaces for women and children;
- Facilitating psychosocial first aid training for humanitarian actors;
- Supplying meals and nutritional supplements to migrants awaiting repatriation;

- Building local capacity for travel health and psychosocial assistance;
- Liaising and coordinating with national health systems, national Red Crescent Societies and health cluster partners;
- Supporting and building the capacity of local health systems in Tunisia in TB diagnostics, case management and treatment;
- Providing travel health and transportation assistance for the medical evacuation of critically ill and wounded Libyans from Misrata and Tripoli to Benghazi.

Health challenges in Libya

The crisis in Libya resulted in massive numbers of war-related injuries, disabilities and deaths. At the peak of the armed conflict, the Libyan health care system was facing major interrelated health system challenges. The conflict severely disrupted health care access and referrals to primary, secondary and tertiary care. As the Libyan health sector was particularly reliant on migrant workers, the rapid departure of skilled health professionals and unskilled migrant health workers created a critical capacity vacuum in general health and specialized care. The remaining medical staff, which was already dealing with a lack of medical supplies and non-functional medical equipment, was overstretched beyond its capacity to care for the critically injured and acutely and chronically ill people in need of continuing care. In some cases, medical evacuation was the only way to save the life of a vulnerable individual.

Ahmed is one patient IOM will never forget. He was born in war-torn Misrata, in north-west Libya. At just 18 days old, living in a region under siege, Ahmed was on life support in an incubator, suffering from acute gangrenous enterocolitis – severe inflammation of the colon and small intestine. As Ahmed needed urgent care, we evacuated him and his mother to Benghazi, Libya's second-largest city. It was a huge challenge for us, as the sea trip was 19 hours, and he was the first patient in need of neonatal intensive care we ever had in Libya; it was highly complex in terms of available equipment, functioning facilities and security – but we managed to stabilize Ahmed's health, and now he no longer needs his incubator.

- Dr. Mohamed Refaat
IOM Cairo

Health response in neighbouring countries

Egypt

Egypt was the destination of a large proportion of migrants escaping Libya. Altogether, over 260,000 TCNs and over 200,000 Egyptians had crossed the border from Libya to Egypt by the end of 2011. Many of them sought food, water and shelter in Salloum, at the Egyptian/Libyan border. IOM was one of the first organizations to arrive in Salloum and provide emergency assistance. By 24 February, IOM had emergency response physicians, nurses and trained psychosocial counsellors to assist migrants in need of health care and psychosocial services. An IOM-managed health clinic at the border offered daily consultations. In close collaboration with the Egyptian Ministry of Health and Population and other partners, IOM provided health care to more than 34,500 TCNs stranded on the Salloum border. The Organization assisted those who set off on their next journey from Salloum and conducted pre-departure



The IOM health team at the health clinic in the Salloum border. © IOM 2011.

health checks to ensure the fitness to travel of TCNs and their families who found their way into Egypt. IOM also arranged referrals for ambulance services to nearby health facilities for those who needed medical care before travel; it also assigned medical escorts to accompany returning migrants in need of health assistance during their journey home.

Tunisia

As of 31 December 2011, Tunisia had received more than 208,400 TCNs, making it the largest recipient of migrants escaping Libya. Many of these migrants stayed at a transit camp in Choucha near the southern Libyan–Tunisian border of R'as Ajdir while waiting for repatriation assistance. The IOM Choucha Health Unit streamlined health care and referrals for TCNs transiting in Choucha camp and those scheduled for repatriation. The Organization collaborated with the Medenine regional public health system and Tunisia Military Hospital authorities to ensure the best possible care for migrants in need of medical attention. IOM provided assisted transportation services to Choucha camp health partners, providing one ambulance and two fitted vehicles to transport migrants to and from camp health clinics and local hospitals in the Medenine region.



Follow-up care for a migrant with a fractured upper arm before repatriation conducted by the IOM medical team in Choucha camp. © IOM 2011.

IOM worked closely with the Medenine Regional Hospital to facilitate TB screening and case management for migrants who were undergoing pre-departure fitness-to-travel health checks prior to repatriation. Altogether, 70 individuals were examined, of which 30 were diagnosed with TB. The individuals diagnosed with TB were provided with medications and monitoring at the camp, as well as nutritional supplements at the later stages of the crisis. When leaving the camp, after having been declared non-infectious, the individuals diagnosed with TB were provided with a month's supply of drugs, a medical report and advice to contact a health care provider upon return to their countries of origin.

Chad

From March to December 2011, approximately 65,000 migrants arriving from Libya were registered in Chad. IOM health and psychosocial teams provided post-arrival assistance and psychosocial support for returning Chadians largely at way stations along the Libya–Chad border and in N'Djamena, ensuring care and referral to local health facilities before onward transportation to their communities of origin. Additionally, the humanitarian response in Faya, Abeche and Mao included an outreach component to support local hospitals, which were providing free medical care to returnees, along with food and medication. A cholera epidemic was then affecting most regions of the country and the areas of extreme outbreak corresponded to areas of high return. As part of the assistance provided to returnees from Libya, IOM established a cholera awareness-raising campaign. It distributed soap and information brochures and provided a briefing to all returnees transiting in N'Djamena.

Niger

Over 85,000 Nigeriens and TCNs had crossed the border to Niger by the end of 2011. IOM provided assistance (accommodation, food, travel health assistance, health referrals, and transport by road and air) for vulnerable Nigeriens and TCNs in transit in Dirkou, Arlit, Agadez and Niamey. IOM partnered with WHO and identified health partners for those migrants in need of further medical assistance.

A pregnant woman living in deplorable conditions was evacuated by IOM from Sebha to N'Djamena on 28 July 2011. Upon arrival in N'Djamena, the woman went into labour and was immediately transported to the hospital. She gave birth to her first child the following day. Relieved to have returned to Chad unharmed after witnessing violence and experiencing personal loss, the woman named her son "Miracle".

Lessons learned and way forward

The Libya crisis represented a migration crisis, a situation different from the refugee and internal displacement situations more familiar to the humanitarian community. Large-scale forced migration across country borders, such as that witnessed during the Libya crisis, poses specific challenges to humanitarian and migration crisis health responses, especially to continuity of patient care. This kind of situation emphasizes the need for coordination between health partners and governments, not just in-country, but also across country borders. Ideally, these health linkages as to prevention and treatment across borders between and among partners and other stakeholders would be established prior to a crisis situation, in order to allow smooth activation of the collaboration in the event of large-scale forced migration.

When the country of return is struggling with poverty and health care system constraints, as was the case for countries in sub-Saharan Africa which were the destinations of many returnees, even primary medical care might not be available upon return. These situations raise questions on the ethical justification for returning people to

countries where their lives are endangered due to lack of appropriate care. Support for development and capacity-building in these countries may ultimately be the way to sustainable improvement, but in the short-term, alternative humane options for returns to unfavourable situations should be discussed.

Health information management is also a big challenge during a migration crisis. When pursuing lifesaving evacuations and providing repatriation assistance to up to thousands of people daily, data collection may not be seen as a necessary or feasible part of lifesaving humanitarian response. However, adequate data collection and analysis is essential as a means to ensure adequate and targeted health response; it is also a tool for detecting and addressing possible public health threats. New, innovative data collection methods applicable to assistance in rapid large-scale movements would be welcomed to improve health information management in migration crises.

One distinct characteristic of the Libya crisis was the repatriation of a large number of migrant workers whose contributions had been essential to the health sector and many other sectors of society. Now that the conflict is over, the time has come to revitalize the health sector through capacity-building support for Libyan health professionals and facilitating the return of migrant health labour. The title of the poem by Libyan author Ghazi Gheblawi asks: "Will they be walking the same road next year?" Perhaps, over time, we will see migrant workers returning to Libya to help its health sector to thrive, to pursue their dreams and, along with Libyans, to fill the empty streets with life.

Part II

The Migration Health Division's Highlights of Activities, 2011



In 2011, IOM continued to work systematically at implementing the migration health operational framework, which stems from the WHA resolution on the Health of Migrants (2008), and the IOM–WHO Global Consultation on the Health

of Migrants (2010). The work of the Migration Health Division is guided by this widely supported conceptual framework, lending it policy legitimacy and coherence.

Figure 3: Operational framework on migration health (Global Consultation on the Health of Migrants, Madrid, 2010)

Monitoring migrant health <ul style="list-style-type: none"> • Develop health information systems; collect and disseminate data. • Assess and analyse migrants' health. • Disaggregate information by relevant categories. 	Policy and legal frameworks <ul style="list-style-type: none"> • Promote migrant-sensitive health policies. • Include migrant health in regional/national strategies. • Consider the impact of policies in other sectors.
Migrant-sensitive health systems <ul style="list-style-type: none"> • Strengthen health systems; fill gaps in health service delivery. • Train health workforce on migrant health issues. • Raise cultural and gender sensitivity. 	Partnerships, networks and multi-country frameworks <ul style="list-style-type: none"> • Promote dialogue and cooperation among Member States, agencies and regions. • Encourage a multisectoral technical network.

Activities in migration health, 2011

The types of migration health activities carried out by IOM in 2011 in support of the above-mentioned conceptual framework are explained in the following sections. Further details on selected IOM projects in 2011 are presented, along with the three main programmatic areas of health assessments, health promotion and health assistance for crisis-affected migrants.

A) Monitoring migrant health

In 2011, IOM continued to develop and implement migration health research projects and strengthen mechanisms for migration health data collection and analysis. In addition, health was integrated as a key thematic area within the guidance package for developing Migration Profiles. These profiles are seen as a policy instrument to strengthen governmental capacity for effective migration

management. IOM recommended that Member States include the health sector in inter-ministerial working groups set up to develop the Migration Profiles. A set of health indicators was included in the new Migration Profile template to assist stakeholders in studying the impact of migration on health.

B) Migrant-sensitive health systems

In 2011, IOM remained active on several fronts in facilitating migrants' access to health services and health service delivery to migrants, in such varied contexts as resettlement, immigration, humanitarian emergencies and general migration management. With regard to IOM's global health assessment programme (HAP), around 270,000 health assessments were performed among refugees and immigrants in 2011. IOM's operations were upgraded to digital X-ray processing, enabling

telerradiology and the implementation of a new e-Health system for Australia-bound refugees and visa applicants, which will soon cover Canada-bound refugees and migrants as well.

In line with its role in the global health cluster, IOM integrated health within its humanitarian response to several emergencies in 2011. For example, IOM ensured that migrants and displaced communities affected by social and political unrest in Yemen and Libya had access to travel health assistance and direct and follow-up medical care, particularly in transit countries like Chad, Egypt and Tunisia, including some health assistance upon arrival home. The psychosocial needs of migrants were addressed during the North Africa crisis both in transit areas and in countries of destination like Chad and Niger.

Psychosocial programmes were established in response to the conflict in Côte d'Ivoire and the earthquake in Turkey, and IOM continued to offer such programmes in Haiti in support of the relocation process.

As part of health promotion initiatives, 43 new projects on health promotion and assistance for migrants were started in 2011 in several countries, including Colombia, Egypt, Georgia, Jordan, Myanmar, Thailand, Turkey, Yemen and Zimbabwe. In partnership with host governments and WHO, new TB case detection and management projects for hard-to-reach migrant populations were started in Cambodia, Myanmar, Nepal and Thailand, using GeneXpert technology.

IOM and the Global Fund to Fight AIDS, TB and Malaria (GFATM) signed two new grant agreements to implement disease prevention and control projects in 2012 for migrant populations in South America. In Argentina, IOM was the principal recipient for a regional project on HIV/AIDS, whereas in Bogota, IOM was the principal recipient for a TB control project. In Myanmar, as a sub-recipient of the GFATM, IOM began new projects on HIV, TB and malaria in 2011.

C) Policy and legal frameworks

In 2011, IOM continued advocacy with key policymakers at the national and regional levels to promote migrants' access to health services. Through these initiatives by IOM and other partners, some positive outcomes were noted. For example, in Europe, in March 2011, the European Parliament adopted a resolution on "Reducing health inequalities in the European Union (EU)", which calls upon Member States to

tackle health inequalities in access to health care for undocumented migrants. This was a significant step forward in ensuring equitable access to health care for all, with no discrimination based on the administrative status or financial resources of migrants. IOM believes that the text carries an important message from the EU to national decision makers and will have a positive impact on the rights and health of undocumented migrants. Furthermore, in November 2011, the Committee of Experts of the Council of Europe adopted Recommendation CM/Rec (2011)13 on mobility, migration and access to health care. IOM believes that this Recommendation will support the Council of Europe, its Member States and its partners in their collective efforts to acknowledge and adequately address issues of mobility, migration and health, and ultimately promote migrants' health in the European region.

Given the critical burden of NCDs worldwide and the likely vulnerabilities of migrants to NCDs and risk factors, IOM presented official statements on migration and NCDs at the First Global Ministerial Conference on Healthy Lifestyles and Non-communicable Disease Control in Moscow in April 2011 and the World Health Assembly in May 2011. In April 2011, the Fourth Colombo Process Ministerial Meeting was organized in Dhaka, Bangladesh, with the theme "Migration with dignity" focusing on multiple aspects related to labour migration that impact on the rights, welfare, dignity and well-being of migrant workers. Through the advocacy efforts of IOM and its partners, health was included as a recommendation in the final Dhaka Declaration (see <http://colomboprocess.org/images/docs/dc2011/dhaka%20declaration.pdf>): "To promote the implementation of migrant-inclusive health policies to ensure equitable access to health care and services as well as occupational safety and health for migrant workers (Art 1.8)".

D) Partnerships, networks and multi-country frameworks

In 2011, IOM strengthened and expanded partnerships in the area of migration and health, and facilitated integration of health in several key regional dialogues and networks on migration.

In January, IOM Director General William Lacy Swing and Joint United Nations Programme on HIV/AIDS (UNAIDS) Executive Director Michel Sidibé signed the revised IOM-UNAIDS cooperation agreement (see IOM website, www.iom.int), which was then disseminated to UNAIDS and IOM offices in the field. In June 2011,

Ambassador Swing took part in a side session on Migration and HIV at the United Nations General Assembly High-level Meeting on AIDS in New York organized jointly by IOM, UNAIDS, ILO and the United Nations High Commissioner for Refugees (UNHCR) (see IOM website www.iom.int). Migrants and migration are explicitly mentioned in the 2011 Political Declaration on HIV/AIDS. IOM's collaboration with WHO continued as WHO became the sixteenth member of the Global Migration Group and invited IOM to a high-level panel at the World Conference on Social Determinants of Health in Rio de Janeiro in October 2011. IOM also continued to participate actively in the Health Cluster chaired by WHO to coordinate the health response in countries facing humanitarian emergencies. IOM strengthened its collaboration with regional health bodies, most notably through an agreement with the West African Health Organization on an operational plan to address migration health (2011–12), as well as a TB control agreement with the WHO Regional Office for the Western Pacific Region. An important partner in IOM's health activities in the context of the refugee resettlement programme and other areas of migration health is the Centers for Disease Control and Prevention (CDC) in the United States. In 2011, the IOM Director General went on his first visit to CDC and held meetings with the CDC Director and other senior staff.

IOM continued efforts to expand its health partnerships by engaging with the private sector. For example, in Mozambique, with funding from a large recruitment company dealing with migrant labour, IOM carried out capacity-building activities to implement and monitor community-based responses to HIV/AIDS in mine worker-sending communities.

Reflecting the high value of academic institutions to IOM, the Organization continued to work closely with a number of academic partners, including the University of Geneva (Department of Sociology), the School of Public Health at Johns Hopkins University (Baltimore), the London School of Hygiene and Tropical Medicine (London), the Migration Research and Training Centre (Seoul), the United Nations Research Institute for Social Development (UNRISD), and the Center of Expertise on Migration and Health at the University of California (Berkeley).

In February 2011, IOM organized the first residential winter school in "Psychosocial Interventions in Emergency Displacement" for 30 professionals from IOM, other international

organizations, governmental partners and NGOs. The project was a collaboration between IOM and the Sant'Anna Academic School in Pisa, the Centre for Trauma, Asylum and Refugees at the University of Essex, the United Nations Children's Fund (UNICEF), the Traumatic Stress Service of King's College in London and technical NGOs.

Budget for migration health activities, 2011

In 2011, total expenditure for migration health operational programmes amounted to USD 73.3 million, representing an increase of USD 9.2 million (14%) from USD 64.1 million in 2010. The increase occurred across all three programmatic areas, of which USD 3.8 million was attributable to migration health assessments and travel health assistance largely due to refugee and immigration health assessments for the United States and the United Kingdom TB detection programmes; USD 3.2 million, to migration health assistance for crisis-affected populations as a result of the cholera outbreak in Haiti; and USD 2.2 million, to health promotion and assistance to migrants mainly due to new projects in the African region and Colombia (see Annex 2).

In terms of the distribution of activities and expenditures by region, Asia and Oceania had the largest activity under migration health assessment and travel health assistance. Africa, however, had the largest expenditure under health promotion and assistance for migrants, while the Americas and the Caribbean had a notable increase in migration health assistance for crisis-affected populations, because of cholera prevention and response efforts in Haiti.

IOM and migration health: The way forward

Health continues to be a key thematic function of IOM's migration management portfolio. In recognition of the importance of healthy migrants in healthy communities, IOM issued a press release dedicated to the health of migrants during International Migrant Day 2011 (see IOM website, www.iom.int). In his message, the IOM Director General gave a call to action: "It is now time for countries to be bold, to take action and uphold a tenet they ascribe to – the right to health for all". In 2012, it is important to better document good practices and identify practical implementable models, and strengthen support to IOM beneficiaries including migrants, Member States and other partner agencies working towards more migrant-inclusive health policies and programmes.

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, as well as through research and information on the determinants of the health of migrants. The Unit advocates for policy revisions, provides technical expertise to strengthen the capacity of local health systems, and promotes and strengthens intercountry dialogue and coordination.

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

Migration health assessments are among the most well-established migration management services offered by IOM. Upon request from receiving-country governments, IOM provides an evaluation of the physical and mental health status of migrants for the purpose of resettlement, international employment, enrolment in specific migrant assistance programmes, or obtaining a temporary or permanent visa. Reflecting national differences in immigration and public policies and practices, there is a diverse range of health assessment requirements – the most common of which is the need to ensure that the migration process does not endanger the health of the migrant or the host population. These requirements may be specific to certain diseases of public health concern, such as screening for tuberculosis in the United Kingdom Tuberculosis Detection Programme (UKTBDP). Requirements may also be broader, as is the case with other resettlement and immigration programmes.

IOM MHAs aim to protect the health of migrants and communities along the migration continuum, from the pre-departure phase to the travel phase, and finally upon arrival at the country of destination. Over the years, MHAs have evolved and increased in scope, adopting a more public health-oriented approach, where public health and medical interventions prior to departure aim to contribute to the successful community integration of migrants at the destination.

Health assessments provide an opportunity to promote the health of migrants through the initiation of preventive and curative interventions for conditions that, if left untreated, could have a negative impact on a migrant's health and/or on the public health of his/her host community. Migration health assessments have many benefits, including the early detection and treatment of conditions of individual and public health concern, safe travel and the prevention of negative health events during travel or on arrival. Additionally, health assessments serve to protect the health of both migrants and host communities and reduce expected demand for domestic health and/or social services. In the case of refugee resettlement, MHAs also serve to allow resettlement agencies to adequately prepare for refugees by providing important medical information prior to their arrival. Migration health assessments are coherent with IOM's goal of promoting "healthy migrants in healthy communities" and, as such, positively impact on migrants' capacity to integrate fully in receiving societies.

Travel health assistance is a health assessment-related service to address individual health and safety and manage conditions of public health concern as individuals move across geographical, health system and epidemiological boundaries. Within HAPs, pre-embarkation checks (PECs) and pre-departure medical screenings (PDMS) are performed in order to assess a migrant's fitness to travel or 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.



IOM-assisted refugee family resettling from Thailand to the United States. © IOM.

IOM's approach to migration health assessments

IOM HAP is accountable to partner Member States for adapting MHA requirements according to the changing migratory patterns and epidemiological profiles of migrants and communities. In light of this, IOM utilizes a risk- and evidence-based approach to advise on migration health assessment requirements. This risk-based approach also incorporates fundamental public health and human rights principles that aim to uphold the well-being of migrants.

IOM HAP's primary stakeholders are the migrants it serves, IOM Member States and the international health community. The Organization is accountable to its stakeholders for delivering MHA services that are technically sound and accurate, uphold national and international health legislation, are delivered in a timely and efficient manner, and are beneficial, accessible and equitable for migrants. Specifically, IOM is accountable for delivering MHA services which respect fundamental global health principles and strategies and the dignity and self-determination of migrants, and are administered by technically

competent and qualified personnel who adhere to established ethical standards.



An IOM staff member gives a TB awareness class to a group of Burmese refugees. © IOM.

IOM HAP upholds the Millennium Development Goals and recognizes the intricate link between health and development. Specifically, HAP promotes the health of migrants throughout the migration continuum by identifying and addressing pre-departure determinants of migrants' ill health, minimizing health risks during transit, and facilitating access to health services upon arrival. As a result of these efforts, migrants are more capable of contributing to the social and economic development of both countries of destination and origin.

Profile of IOM HAP beneficiaries, 2011

In 2011, IOM conducted around 270,000 health assessments for migrants, covering both immigrants (64%) and refugees (36%), in more than 60 countries. The majority of the assessments were conducted in Asia (64%), followed by Africa and the Middle East (27%) (see Table 5, Annex 2). This represents a modest but steady growth in global health assessment activities conducted by IOM over the last five years. Among refugees, those coming from Africa and the Middle East

for resettlement to the United States increased notably since 2010, while among immigrants, a slight decrease in number can be seen since 2009, as the number of UK-bound immigrants particularly from Asia also decreased (Figures 7 and 8, Annex 2). In 2011, most migrants were bound for the United States (44%) and the United Kingdom (36%). More than half of the migrants screened were males and a similar sex distribution was observed regardless of the type of migrant (i.e. refugee, student or immigrant). Overall, the population of migrants screened in 2011 was young, with an average age of 26.6 years and with 69 per cent below the age of 30.³

There is a slight variation in the age distribution between immigrants and refugees. At least half of the immigrants screened were between the ages of 20 and 29, with very few children (i.e. beneficiaries less than 10 years old) or adults in the older age group (i.e. 60 years and above). Refugees, on the other hand, generally consisted of a younger population, with 66 per cent of assisted refugees below 30 years old and nearly 25 per cent below 10 years old (see Figures 9 and 10, Annex 2).

IOM also managed and supervised more than 14,000 health assessments conducted by non-IOM panel physicians, mostly at the request of the United States, for quality control purposes.



A Bhutanese refugee girl waiting for her turn for health assessment before third-country resettlement, Damak, Nepal. © IOM.

³ Estimates for age and sex distribution were calculated based on data from 269,924 migrants as 302 migrants had no data on age and other demographic information.

Refugees for resettlement (urban and camp-based)

In 2011, major locations where refugees were examined (i.e. over 3,000 people per location) included Baghdad, Kuala Lumpur, Amman and Addis Ababa; the Sanischare, Beldangi and Khudunabari camps in Nepal; and the Mae La and Mae La Oon camps in Thailand. Refugee health assessments were carried out at the request of

resettlement countries such as the United States (87%), Australia (6%) and Canada (5%), which were the top three countries of destination in 2011. Other countries of destination for refugees included New Zealand and several Scandinavian nations. The refugees examined by IOM resided in both camp settings (e.g. Nepal) and in urban settings (e.g. Jordan).



Burmese refugee candidates for resettlement to a third country waiting for health assessments at Mae Sot's Pawo Hospital in Thailand. © IOM.

Immigrants (various categories)

In 2011, major locations where immigrants were examined (i.e. over 4,000 per location) included Karachi, Lahore, Mirpur and Islamabad in Pakistan; Ho Chi Minh City; Nairobi; Dhaka and Sylhet in Bangladesh; Kyiv; Bangkok; Moscow; Kathmandu; Phnom Penh; and Accra. Immigrant health assessments were carried out at the request of countries such as the United Kingdom (56%), the United States (21%), Australia (11%) and Canada (11%).

I. Migrant-Sensitive Health Systems

Migration health assessments 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;
- Pre-departure medical screenings;
- Administration of vaccinations;
- Provision of, or referral for, directly observed treatment (DOT) for some conditions (e.g. intestinal and other parasitic infestations, TB, malaria, sexually transmitted infections);
- Detailed documentation of findings, preparation of required immigration health forms and documents, confidential transfer of relevant information or documentation to appropriate immigration or public health authorities;

- Fitness-to-travel assessments or PECs;
- Public health surveillance and outbreak management in camps, transit centres and other temporary settlements;
- Provision of medical escorts/special health accommodations for travel.

In particular, IOM has significant experience in diagnostics and treatment, or referral for treatment, of pulmonary TB.

IOM tuberculosis services

TB prevention and control continues to be an important public health concern for both sending and receiving countries, as well as for migrants and their families. IOM contributes to cross-border TB prevention and control by screening for active TB prior to resettlement. Within its TB screening programmes, IOM provides a comprehensive range of TB-related services, including physical examinations, radiological investigations, tuberculin skin tests, sputum smears and cultures, drug susceptibility testing (DST) and DOT. TB treatment is provided either directly by IOM or through a referral system, in partnership with national tuberculosis programmes (NTPs).

In 2011, as a core component of health assessments, almost all migrants examined by IOM underwent TB screening prior to their migration or resettlement. IOM's migration health assessments took place in more than 60 countries worldwide, mostly in countries with a high prevalence of active TB (>40 per 100,000 population). Among migrants assessed, about 12,400 were referred for further laboratory investigations, resulting in the detection of 727 cases (or 269 per 100,000 migrants⁴) of microbiologically confirmed TB (sputum smear and/or culture-positive results). In addition, 28 migrants were diagnosed with pulmonary TB and referred for treatment based on advanced clinical findings.

The overall prevalence of active TB,⁵ including all cases referred for TB treatment, in the migrant population assisted by IOM in 2011 was 280 per 100,000 migrants, or 755 TB cases. The prevalence of active TB was higher among refugees, with 466 TB cases per 100,000 population, than among immigrants, with 176 per 100,000 population. Refugees were almost three times more likely (prevalence ratio = 2.64) to be detected with active

TB as compared to immigrants. Investigation into the causes of this difference is beyond the scope of this report; however, the difference may be connected to poorer health and nutritional status and the living and socio-economic conditions of refugees.

As shown in Tables 6 and 7, active TB case detection was highest in refugee populations in Asia, ranging from 501 per 100,000 in Thailand to 1,004 per 100,000 in Nepal. The lowest figures were observed in Europe and Middle East migrant groups. It is important to note that the prevalence of latent TB infection was also high in several populations, particularly among refugees in Malaysia (25%) and Uganda (19%). Determining the prevalence of latent TB (in the form of inactive pulmonary TB lesions) is also essential for organizing proper follow-up in the country of destination. In 2011, migrant populations from Malaysia, Nepal and Thailand had the largest proportion of cases with X-ray findings suggestive of inactive TB.

Radiological services in tuberculosis diagnostics

Along with clinical signs and symptoms, radiological investigations are important in order to diagnose TB. More than 230,000 radiological investigations were performed by IOM in 2011, resulting in the identification of around 12,400 migrants (5.4%) as TB suspects and referrals for these migrants to undergo further TB laboratory investigations. The prevalence of X-ray findings suggestive of TB varied in major IOM screening programmes, with the highest prevalence found among Bhutanese and Burmese refugees in Nepal and Thailand (14,129 and 18,259 per 100,000, respectively) and the lowest prevalence found among immigrant populations in the Middle East (193 and 435 per 100,000, respectively, in Jordan and Iraq).

Digital radiology

In order to improve the efficiency, safety and quality of X-ray diagnostic services, more than 80 per cent of IOM screening locations have progressively switched to digital X-ray processing, by upgrading their existing set-up or establishing partnerships with external providers that have digital facilities. Teleradiological systems, currently under development as part of IOM HAPs, are also expected to help address the main challenges of initial TB diagnostics, such as the quality of

⁴ The denominator used in this section is the total number of migrants who underwent TB screening by IOM in 2011 (i.e. 269,924).

⁵ Definition: Cases referred for TB treatment (based on either microbiological confirmation (727) or clinical findings (28)).

X-ray reading and the lack of skilled radiologists in many remote locations.

In 2011, IOM started piloting the teleradiology approach by connecting radiologists from Nepal, Kenya and the Russian Federation via a network of IOM picture archiving and communication systems (PACS) and a specially developed teleradiology software system. This pilot initiative is expected to increase IOM's capacity to provide remote reading of X-ray images worldwide, as well as to establish an X-ray quality control and monitoring system within MHD health assessment programmes.

Laboratory services in tuberculosis diagnostics

For TB suspects identified based on abnormalities detected during physical and X-ray examinations, the next step in IOM TB detection programmes is sputum smear microscopy and/or culture tests. This is followed by microbiological identification and DST for positive culture specimens. Over the last few years, sputum culture examinations for all TB suspects referred for laboratory diagnosis have been introduced in most IOM screening locations, due to requests from resettlement countries and updated international standards in TB prevention and control.

In 2011, around 12,400 TB suspects, both refugees and immigrants, underwent laboratory diagnostics, either sputum smear microscopy and/or sputum culture examinations. Depending on receiving-country protocols and the IOM location for the health assessment examination, a total of 8,898 individuals underwent both smear and culture testing. Overall, 727 refugees and immigrants were diagnosed with infectious pulmonary TB, based on positive sputum microscopy and/or culture results from IOM or partner laboratory services. Sputum culture testing resulted in the detection of an additional 443 active TB cases that sputum smear testing alone would have missed.

Drug susceptibility testing (DST) was conducted for 97 per cent of all cases with *Mycobacterium tuberculosis* growth (n=621) in TB cultures. Of this figure, 14.4 per cent of cases (n=87) were found to be resistant to one or more anti-TB drugs, and 1.8 per cent were found to be multidrug-resistant (MDR) (n=11). These findings helped clinics to better align their treatment protocols, improving the overall performance of TB treatment programmes (see Table 8 in Annex 2 for details).

To further enhance the accuracy of TB screening and support treatment services offered worldwide, IOM has improved its laboratory services by closely collaborating with national and international standardized laboratory networks and piloting new methods such as molecular TB diagnostics.



Technicians make TB smear evaluations using microscopes at the IOM microscopy laboratory in Mae Sot Pawo Hospital, Thailand. © IOM.



A technician manipulates samples of TB culture in a growing machine at the IOM TB laboratory in Mae Sot Pawo Hospital, Thailand. © IOM.

Tuberculosis treatment in IOM health assessment programmes

The final step in IOM health assessment services includes the provision of treatment to migrants, which is undertaken in close collaboration with NTPs and in accordance with international protocols. IOM runs several certified TB treatment centres in locations in Africa and Asia that offer DOT; in 2011, IOM centres started TB treatment for 419 (71%) of the active cases referred for treatment. In addition, IOM clinics also started directly observed preventive therapy for 25 cases with latent TB infection. Drugs were procured in collaboration with NTPs in the respective countries.

For migrants 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. In 2011, TB treatment cure or treatment completion was achieved among 406 patients (64%) in IOM DOT programmes, while 202 migrants remained in treatment by the end of the year (see Table 9, Annex 2).



An IOM nurse with patients living at the Magic Mountain Tuberculosis Treatment Centre, Damak, Nepal. © IOM.

United Kingdom Tuberculosis Detection Programme (UKTBDP)

One of the projects of IOM HAP with the highest number of assisted migrants is the pre-departure TB detection programme that the United Kingdom government runs, with IOM as the implementing partner. 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. The programme currently operates in eight countries: Bangladesh, Cambodia, Ghana, Kenya, Pakistan, Sudan, the United Republic of Tanzania and Thailand.

In 2011, IOM assessed nearly 98,000 United Kingdom visa applicants, which included visa categories such as “students” (63.4%) and “settlement and dependents” (31.6%). Radiological investigations indicated 1,202 cases of active TB (1.2%) and 2,131 cases of inactive TB (2.2%). Overall, 85 individuals (with a prevalence of 87 cases per 100,000) were found to have infectious TB, as confirmed by microbiological findings. Fifty-six confirmed cases of infectious TB (more than 65%) involved those in the “student” visa category.

Table 1: Prevalence of infectious TB cases by country, 2011, UKTBDP

UKTBDP site	Total screened	Prevalence per 100,000 (95% CI)
Bangladesh	15,660	77 (33–120)
Cambodia	86	0 (0–0)
Ghana	3,966	50 (0–120)
Kenya	2,631	76 (0–181)
Pakistan	66,292	81 (60–103)
Sudan	925	0 (0–0)
Thailand	7,095	197 (94–301)
United Republic of Tanzania	816	123 (0–363)
Total	97,471	87 (69–106)

Pre-departure services and travel assistance

Pre-departure medical procedures comprise a range of services to ensure that people travelling under the auspices of IOM do so in a safe and dignified manner, are fit to travel, receive appropriate assistance when necessary, and do not pose health hazards to other travellers, personnel or receiving communities.

Services in this category include PDMS, PECs or fitness-to-travel checks, medical escorting and THA (e.g. special travel arrangements, such as provision of wheelchairs, stretchers or oxygen supply). Other pre-departure activities include vaccination and immunization campaigns and presumptive treatment for conditions such as malaria and parasites.

These pre-departure services are offered in addition to core MHAs, which often take place several months prior to departure. Not only do these pre-departure services complement the MHA by providing additional health measures (e.g. immunizations for vaccine-preventable diseases), they also ensure that a migrant’s health condition has not changed in the often several-month period between the initial health assessment and

actual departure. PDMS and some immunization activities may take place up to several weeks prior to departure, while PECs generally take place one to three days prior to departure.

In 2011, IOM performed almost 70,000 pre-departure medical procedures for the majority of departing refugees. In the event a significant medical condition (SMC) is identified, passengers may be delayed or excluded from travelling until they are treated. For instance, among refugees bound for Australia, an important component of PDMS is screening for malaria. In 2011, out of approximately 6,500 refugees screened, 49 (0.74%) were found to have malaria. Accordingly, treatment was provided for positive detected cases, while in other operations, presumptive anti-malaria treatment was given for all refugees departing from malaria-endemic countries in Asia and Africa.

Refugees who need medical assistance and care during travel are escorted by health professionals to avoid complications during transit. In 2011, IOM provided group and individual medical escorts to approximately 1,200 refugees with a variety of medical conditions, such as cardiovascular,

neurologic, respiratory and psychiatric disorders (see Figure 11, Annex 2).

Pre-departure immunization

In close collaboration with CDC and the United States Bureau of Population, Refugees and Migration (PRM), IOM conducts a variety of pre-departure immunization activities. Within the context of several CDC–IOM Cooperative Agreements, IOM has been providing immunization services for US-bound refugees since 2007. These services include the development of a vaccination procurement and storage system, cold chain and shipment arrangements, education and awareness-raising, and immunization coverage. Under these Cooperative Agreements, in 2011, vaccination activities were implemented in Kenya, the United Republic of Tanzania and Ethiopia against measles-mumps-rubella (MMR), yellow fever, meningitis, polio, hepatitis A and B, pneumococcal disease, DTP, human papilloma virus (HPV) and varicella (chicken pox).

The Cooperative Agreements have also supported mass immunization campaigns and regular immunization days at the IOM clinic in Eastleigh, Nairobi to address outbreaks of measles and polio. These immunization days cover refugees who live in the urban areas of Nairobi. During these activities, IOM provides logistical support to the Kenya Ministry of Health. The CDC–IOM Cooperative Agreements also support the capacity of IOM to conduct awareness-raising activities for the community, to store vaccines and, in agreement with the National Immunization Programme, to provide immunization for hard-to-reach refugee populations.

In addition to the immunization activities conducted in the context of the CDC–IOM Cooperative Agreements, IOM increasingly carries out immunization activities for both refugees and immigrants in a variety of operations. For example, oral polio vaccines and MMR vaccines are included in the list of recommended vaccines for US-bound refugees. In 2011, more than 100,000 migrants were vaccinated prior to departure. Common vaccines given included MMR, DTP, hepatitis B and chicken pox vaccines.

Pre-departure treatment activities

In the Africa region, IOM provides resettling refugees with deworming treatment, prophylactic treatment for malaria and pre-departure presumptive treatment for schistosomiasis. Pre-departure presumptive treatment for

schistosomiasis was instituted throughout IOM's operations in Africa as of January 2009. IOM mobile teams cover small caseload locations within the continent. In 2011, all refugees bound for the United States (6,361) received pre-departure medical screening and treatment. A total of 5,759 refugees were provided with presumptive treatment for schistosomiasis (91% coverage), while 6,227 refugees received presumptive treatment for malaria (98% coverage). In addition, 6,090 refugees received deworming treatment before departure (96% coverage).

Significant medical conditions and follow-up needs

In an effort to bridge the gap between the phase prior to resettlement and the phase following arrival in the country of destination, IOM facilitates the integration of resettling refugees into the destination country health system by increasing the flow of important information to domestic refugee resettlement agencies. IOM documents the post-arrival needs of US-bound refugees in the SMC form. This form is then made available to US resettlement agencies to enable them to adequately prepare for the needs of refugees upon arrival.

Post-arrival needs have an impact on the reception and placement of refugees in the final destination. Such needs may include special accommodation, schooling and/or employment requirements, needs for additional personal care and follow-up for prescription medication or treatment.

As a result of an assessment in 2011, IOM noted that approximately 15 per cent of refugees had significant medical conditions (SMCs) that would require health related follow-up or special accommodation and assistance upon arrival in the United States, primarily due to vision (2.9%), hearing (1.5%) and mobility (1.8%) concerns. Additionally, there was a need for special schooling and employment considerations upon resettlement due to the presence of moderate to severe mental conditions (0.7%) among refugees.

DNA testing

IOM also provides DNA testing services for family reunification purposes, as required by certain immigration authorities. IOM has established a system for the confidential collection of DNA samples, storage, testing and appropriate counselling for applicants. In 2011, the majority of tests were performed in Kenya, Viet Nam, Ethiopia and Cambodia (see Figure 12, Annex 2).

II. Monitoring Migrant Health

Increasing knowledge on the health of refugees and immigrants

Health assessment programmes generate valuable information on the health status of refugee and immigrant populations that are in the process of resettlement or migration prior to their departure from their countries of origin or countries of transit (e.g. countries where refugee camps are located). Secondary analysis of HAP data can provide significant insights into the prevalent morbidities, potential health care needs and imminent public health impact of resettlement on host communities and countries.

Refugee health profiles: ICD coding

In the past year, IOM launched a project to ensure that health information on several refugee groups it has assisted is readily available in literature. By coding data using the International Classification of Diseases Rev. 10 (ICD-10), and using data

from IOM's SMC forms and other relevant sociodemographic information, IOM can analyse medical and public health information on existing and emerging refugee groups at key locations.

Most recently, such analyses were conducted for IOM-assisted refugees examined in Jordan and Iraq in 2010 and in Malaysia in 2011. The resulting profiles captured population descriptions, the prevalence of SMCs, the top ICD-10 disease groups and the top diseases in each of the prevalent groups. IOM placed special emphasis on children under age 5, mental health and infectious diseases, and assistance and medical follow-up needs for each group.

As shown in Table 2, morbidity among Iraqi refugees examined in Iraq and Jordan in 2010 can be attributed to several risk factors and conditions related to NCDs, such as obesity, essential hypertension, non-insulin dependent diabetes mellitus and asthma.

Table 2: Top 10 disease conditions (ICD-10) among Iraqi refugees (n=13,637) screened in Iraq and Jordan, 2010

ICD-10 disease condition	Number	Prevalence (%)
Low vision	1,381	10.1
Obesity	1,102	8.1
Essential (primary) hypertension	1,058	7.8
Non-insulin dependent diabetes mellitus	284	2.1
Other disorders of teeth and supporting structures	279	2.0
Asthma	212	1.6
Disorders of lipoprotein metabolism and other lipidaemias	198	1.5
Dental caries	141	1.0
Bronchitis, not specified as acute or chronic	135	1.0
Presence of other devices*	132	1.0

Note: * "Presence of other devices" is under the main chapter "Factors influencing health status and contact with health services". "Other devices" indicates the presence of an artificial eye, limb, dental prosthetics, spectacles and contact lenses, external hearing aids and intrauterine contraceptive devices.

On the other hand, for Burmese refugees examined in Malaysia in 2011, common morbidities found were communicable diseases such as respiratory TB, HIV infection and mycobacterial or Non-Tuberculous Mycobacterium (NTM) infections. For adult refugees in both settings, problems with low vision were noted. Iraqi refugees under age 5 examined in Jordan and Iraq in 2010 (14% of the overall population) predominantly had strabismus, asthmatic disorders, bronchitis and

atopic dermatitis. Burmese refugees under age 5 (n=1,465; 16.6%) examined in Malaysia in 2011 predominantly had inactive respiratory TB, congenital malformations of the cardiac septa and newborn respiratory distress. High levels of malnutrition among Burmese children examined in Malaysia were also noted, with a prevalence of moderate to severe wasting of up to 12 per cent (based on recommended standards by WHO).

Table 3: Top 10 disease conditions (ICD-10) among refugees (n=8,817) screened in Malaysia, 2011

ICD-10 disease condition	Number	Prevalence (%)
Latent TB*	429	25.8
Respiratory TB, not confirmed bacteriologically or histologically	767	8.7
Blindness and low vision	226	2.56
Essential (primary) hypertension	182	2.06
Asymptomatic human immunodeficiency virus (HIV) infection status	114	1.29
Infection due to other mycobacteria	74	0.84
Obesity	63	0.71
Respiratory TB, bacteriologically and histologically confirmed	52	0.59
Complications and ill-defined descriptions of heart disease	43	0.49
Other disorders of conjunctiva	36	0.35

Note: * n=1,666.

IOM Refugee Health Profiles aim to be of value to refugee health coordinators, local community health care providers in host communities, and other resettlement agencies and public health organizations engaged in refugee health programmes.

Nutrition Surveillance Profiles

IOM uses data from refugee health assessments to estimate childhood undernutrition and refer children to appropriate feeding programmes. The prevalence of undernutrition is usually expressed in terms of two indicators: wasting (weight-for-height) is indicative of recent and severe weight loss, while stunting (height-for-age) is the result of chronic suboptimal nutrition and health conditions.

A total of 7,101 refugee children aged 6 months to 59 months assisted by IOM in Ethiopia, Iraq, Jordan, Kenya, Malaysia, Nepal and Thailand were included in the nutrition surveillance analysis for 2011.

The nutrition surveillance analysis revealed an overall prevalence of undernutrition in this group, with a medium prevalence of wasting and a low prevalence of stunting, in accordance with the classification criteria for population-level analysis on nutrition (WHO, 1997).

In terms of wasting, global acute malnutrition was found in 7.5 per cent of the refugee children, with the level of severe acute malnutrition in this group at 2.4 per cent (see Figures 13 and 14 in Annex 2). Stunting or chronic malnutrition was found in 19.7 per cent of the children, with 5.9 per cent suffering from severe chronic malnutrition.

A high prevalence of wasting was observed in urban locations in Iraq and Malaysia, and several camps in Ethiopia, Kenya and Nepal. Camps in Thailand that have hosted displaced refugees for several decades showed a high prevalence of stunting.



A young Burmese refugee is weighed during a medical screening at Mae Sot Pawo Hospital, Thailand. © IOM.

Outbreak surveillance and response

IOM performs both active and passive surveillance for outbreaks of communicable diseases through its health assessments in refugee camps in locations such as Nepal, Thailand, Kenya and the United Republic of Tanzania.

In early 2011, refugee camps in Damak, Nepal experienced an outbreak of varicella (chicken pox). Immediately following notification of the outbreak, daily surveillance measures were put into place in NGO-run refugee camp clinics. The resettlement process for cases identified by IOM's daily active surveillance and refugee camp clinics was kept on hold in order to prevent possible transmission of the disease during processing and travel.

During the outbreak, a total of 56 cases were identified by camp clinics, the IOM Damak health facility and the Kathmandu Transit Centre. Of these cases, 19 (involving a total of 81 family members) were in the midst of the resettlement process. Flights were delayed for two of these cases (involving a total of six refugees).

In response to the outbreak, IOM and other stakeholders in the camps and in the Kathmandu Transit Centre intensified their efforts to educate refugees diagnosed with varicella and their families on the importance of isolation, hygiene and sanitation. Additionally, vaccinations for varicella were provided to refugees bound for New Zealand and Canada. As a result of these comprehensive measures, there were no imported cases of varicella reported by the resettlement countries.

Conducting studies on specific issues

"Who am I?" An Assessment of Psychosocial Needs and Suicide Risk Factors among Bhutanese Refugees in Nepal and after Third-Country Resettlement

In 2010, reports of disproportionately high numbers of suicides among Bhutanese refugees resettled in the United States and in camps in Nepal came to the attention of humanitarian and governmental agencies. The anecdotal nature of the reports, which were based mainly on media accounts, and the superficial nature of the proposed explanation to the phenomenon, highlighted the need to investigate the issue and, upon confirmation of the data, to develop a series of recommendations to prevent further suicides.



Who Am I - An Assessment of Psychosocial Needs and Suicide Risk Factors among Bhutanese Refugees in Nepal and after Third-Country Resettlement. © IOM.

With these general aims, in January 2011, IOM, in coordination with UNHCR and PRM, conducted a three-week assessment of psychosocial well-being and suicide risk factors among Bhutanese refugees in Nepal and those resettled in the United States.

The specific objectives of the rapid appraisal study were to confirm the magnitude of suicides among Bhutanese refugees in camps and upon resettlement; identify risk categories and factors; investigate possible cultural explanatory systems for suicide; investigate whether the general levels of distress in camps could create an environment for suicide; investigate the possible coexistence of mental health problems in those who attempted or committed suicide; conduct a review of psychosocial and mental health services provided to the refugee population; and observe refugee resettlement processes in order to identify gaps and possible improvements which might prevent or mitigate mental uneasiness, including suicide.

The assessment team was comprised of an IOM psychosocial expert, a consultant psychiatrist, an epidemiologist and two translators (a public health specialist and a psychosocial counsellor). The assessment consisted of data collection and statistical analysis; interviews with families among the general population of the camps; focus group discussions with adolescents, women and the elderly; interviews with individuals who attempted suicide; post-mortem interviews with families of individuals who committed suicide; and interviews and focus group discussions with stakeholders.

From 2004 to 2011, there were 67 certified suicides and 64 certified attempted suicides in the Bhutanese refugee camps in Nepal. Since 2007, there have been 12 cases of Bhutanese refugee suicides upon resettlement to a third country. While suicide attempts were more common among women (59.7%), more men actually succeeded (56.7%). Refugees who had experienced gender-based violence or who were in highly vulnerable families were more prone to attempt or commit suicide. Those with a history of mental illnesses in the family were 1.9 times more likely to commit suicide than those with none, although this association was not statistically significant.

Interviews with 16 individuals who attempted suicide revealed that refugees with untreated mental disorders or a history of alcohol abuse or suicide in the family were most at risk. Most suicides were impulsive acts (14 out of 16 cases)

and were carried out by hanging. The most commonly cited factors related to the suicides were social stressors. Mental disorders such as depression (6/16), bipolar disorder (2/16) and psychosis (2/16) were also noted. Alcohol abuse was reported in 8 out of 16 cases. Suicide is a crime under Nepalese law and is viewed negatively by many religions, often resulting in the under-reporting of cases. A difference in outlook towards suicides was observed, however, between older and younger generations in the camps. To the older generation, suicide was a sin and provoked fear or judgement, whereas for the younger generation, it was an understandable response to current predicaments.

In summary, the results highlight that, in camps, victims of gender-based violence and individuals living in highly vulnerable families are more likely to commit or attempt suicide. As such, these categories should be prioritized in any envisaged suicide prevention initiatives.

A report was published based on the findings of the assessment, with both immediate and mid-term recommendations for mental health and psychosocial activities in refugee camps, as well as upon refugees' arrival in the United States. Recommendations include the organization of training for medical providers, the establishment of protocols for the identification and management of refugee families with risk factors for depression, and the organization of suicide prevention campaigns in camps.

The full report can be accessed at the IOM website: www.iom.int.

IOM [helps] refugees for resettlement in third countries. People who already reached there are doing [well]. It is good for future of our children. Here [in refugee camps] we have no future.

- Refugee in IOM Damak

Vitamin B12 deficiency study among Bhutanese refugees

Post-resettlement routine medical examinations by physicians in US resettlement states detected refugees with haematologic and neurologic disorders that were traced to

vitamin B12 deficiency. These cases were reported by examining physicians and state health departments to CDC, which initiated an investigation to evaluate vitamin B12 deficiency among Bhutanese refugees. Sera from overseas medical exams, post-arrival exams in three state health departments (Minnesota, Utah and Texas), and medical records and interviews at a health clinic in St. Paul, Minnesota were evaluated. Vitamin B12 deficiency, defined as serum vitamin B12 concentration <203 pg/mL, was found in 64 per cent (63/99) of serum bank specimens, 27 per cent (17/64) of post-arrival medical screenings, and 32 per cent (19/60) of Bhutanese refugees examined at the St. Paul clinic. Vitamin B12 deficiency was found in all age groups, and was highest in: the >50 age group (23/25, 92%) in CDC's migrant serum bank samples; the 30 to 49 age group (7/16, 44%) in the three-state sample; and the 15 to 29 age group (8/18, 44%) in the St. Paul sample. Although the deficiency may be multifactorial, the cause is thought to be the diet consumed by these refugees for nearly two decades in Nepal, which lacked meat, eggs and dairy products, the major dietary sources of vitamin B12.

Managing and sharing data/health informatics systems and data management

Migration health informatics (MHI) has transformed the way migrant health data are documented, assessed and treated, systematically applying new technologies and computer science to global 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 mission level, and standardize and centralize data collection between IOM missions, creating a repository of migrant information at the organizational level.

The main highlights of MHI in 2011 include the development of the Migrant Management Operational Systems Application (MiMOSA) and the UK TB Global Software, covering operational, monitoring and reporting activities in HAPs for more than 80 per cent of assisted migrants. Additionally, more IOM missions started using the e-Health system for migrants bound for Australia, eliminating the need to process paper-based health examination reports, and allowing HAP operations to record a visa applicant's health information, including digital chest X-rays, electronically.

Additionally, MHI enables the exchange of information between IOM and its partner agencies, improving their capacity to deliver cost-effective and timely services and ensuring the consistency and completeness of data. Such continuation of health care provision through the electronic transmission of relevant data is currently being provided for CDC, with medical data for more than 210,000 refugees transmitted since the launch of the interface in 2008.

In relation to digital radiology and teleradiology, MHI provided support in facilitating the storage, archiving and distribution of digital images, integrating them into the overall health assessment data management framework for IOM missions in Afghanistan, Bangladesh, Bangkok, Jordan, Kenya, Malaysia, Nepal, the Russian Federation, Ukraine and Viet Nam.

Other MHI initiatives this year, developed upon request of internal and donor communities, included a Web-based compendium of IOM HAPs, as well as the Global Incident Management System, which is capable of recording, tracking and aggregating incidents in health assessment activities.

III. Policy and Legal Frameworks

Inter-Agency Meeting on the Public Health Aspects of Resettlement

In June of 2011, IOM participated in an inter-agency meeting on the public health aspects of refugee resettlement, hosted by UNHCR. The purpose of the meeting was to foster increased understanding and awareness of each agency's activities in refugee camps, particularly those with resettlement populations. The meeting was attended by participants from the CDC, PRM, UNHCR, IOM and the US Mission in Geneva.

Several areas of importance were identified during the meeting, including further work needed in the areas of information management, resettlement policy, TB policy, planning and preparation of medical cases, drug management, operational enhanced surveillance and program evaluation, and new methods for data collection in non-camp settings.

Intergovernmental Immigrant and Refugee Health Working Group (IIRHWG)

From 31 October to 4 November 2011, IOM participated in the eighth annual Intergovernmental Immigration and Refugee

Health Working Group Conference in Sydney, Australia. This working group is composed of the Five Country Conference (FCC) partners: Australia, Canada, New Zealand, the United Kingdom and the United States.

The main theme of the eighth annual conference was the business benefits of increased network alignment among IIRHWG countries, as well as the expansion of their TB networks. IIRHWG countries are increasingly looking to cooperate and pool expertise and resources in shared activities.

As in previous years, IOM's participation provided an opportunity for IIRHWG countries to learn about achievements, challenges and trends in IOM activities in 2011. The conference also provided an opportunity for IOM to receive feedback from its partner countries and to engage in constructive discussions on issues of common interest.

IV. Partnerships, Networks and Multi-Country Frameworks

Collaboration with national tuberculosis programmes (NTPs)

Malaysia

IOM has been working to strengthen collaboration with the NTP of Malaysia to eliminate TB among the migrant population. In 2011, IOM provided DOT to identified refugees with active TB disease and shared related data with the NTP. MDR-TB

cases revealed during IOM health assessments were also communicated and treated under the NTP, in close collaboration with IOM. CDC authorized IOM's TB laboratory to conduct TB testing for all immigrants to the United States from Malaysia.

Ukraine

HAP programmes in Ukraine use NTP's services for the treatment of migrants with active TB. For the US Refugee Programme, IOM Kyiv nurses provide training for NTP staff administering TB treatment to migrants in TB dispensaries. In addition, IOM assists with obtaining supplies of first-line TB drugs, in accordance with WHO standards.

Pakistan

IOM Pakistan continued to strengthen its collaboration with the National TB Control Programme in 2011 through joint capacity-building workshops for laboratory technicians from various districts. The capacity-building workshops focused on training district lab technicians on the latest techniques for culturing and DST for *Mycobacterium tuberculosis*. Three such training sessions were hosted by IOM Pakistan in its Islamabad laboratory, with the participation of 8 to 12 colleagues on average from the Pakistan NTP. There were also discussions with the Pakistan NTP to develop a memorandum of understanding (MOU) on joint collaboration for future project development and enhance the existing referral system for clients diagnosed with TB.



Mr. Sajid, an IOM microbiologist, giving hands-on training to colleagues from the National TB Programme. © IOM.



Hands-on training on sputum culturing at IOM's Islamabad laboratory, courtesy of IOM laboratory technician Mr. Aziz. © IOM.

Bangladesh

In 2011, IOM Dhaka's MHD Health Assessment Centre was recognized by the NTP of Bangladesh as an official DOT centre. IOM Dhaka started DOT treatment for its first TB patient on 17 August 2011. The DOT centre is open every day of the week in order to ensure that patients take their TB medication under observation. Records are kept of the patients' attendance for treatment.

M-assessments for Canada

As a result of IOM's strong partnership with Citizenship and Immigration Canada (CIC), in addition to the provision of MHAs for both

immigrants and refugees bound for Canada, several IOM migration health processing sites have been entrusted with admissibility determinations (or "M-assessments"), a function normally reserved for CIC Regional Medical Officers. M-assessments entail an assessment of a migrant's admissibility or inadmissibility, judged according to his/her potential impact on the public health or public safety of the receiving community, or whether a health condition may create excessive demand for health/social services.

In 2011, around 13,000 M-assessments were an ongoing activity in IOM Moscow, Kyiv, Nairobi and Bucharest.



IOM medical staff observes a patient taking his TB treatment medication. © IOM.

CDC–IOM Cooperative Agreements

In 2005, to allow for increased pre-departure public health prevention activities, IOM and CDC entered into a cooperative agreement. The CDC–IOM Cooperative Agreements (CoAgs) are CDC-funded public health initiatives within the context of the United States Refugee Admission Program (USRAP). Started in 2007, they emphasize overseas refugee health, public health and the importance of sharing data.

The overall goals of the CoAgs are to: prevent the disruption of resettlement activities (i.e. movement delays or cancellations due to outbreaks), protect public health in the United States against the importation and spread of communicable diseases, reduce the financial burden on the US health system through improved diagnostics and prevention of communicable diseases, enable a rapid response to outbreaks and epidemics, and improve the transmission of health data from IOM to CDC.

In fiscal year 2011, the CoAgs funded 12 modules in Africa and Asia and had access to over USD 1 million.

IOM Director General visits CDC headquarters for the first time in September 2011

On 26 September 2011, IOM Director General William Lacy Swing and MHD Director Davide Mosca traveled to the CDC headquarters in Atlanta, Georgia to meet with the Director of CDC, Dr Thomas Frieden. The visit was a courtesy meeting in recognition of the strong partnership between the two organizations. The objective of the meeting was to acknowledge the long-standing collaboration between CDC (in particular the Division of Global Migration and Quarantine) and IOM in the provision of overseas health assessments, for both resettlement of refugees and immigration to the United States, and to renew IOM's commitment to collaborating with CDC to enhance overseas HAPs and address the public health and refugee health aspects of the resettlement programme.

IOM Global Meeting on Resettlement Services, September 2011

In September 2011, MHD participated in the First IOM Global Meeting on Resettlement Services. The aim of this meeting was to bring together a select multidisciplinary team of IOM resettlement service practitioners, along with other colleagues from Headquarters and the Field, to engage in strategic discussions on how IOM could best position itself toward an effective, coherent and

programmatic focus on resettlement services. MHD was represented by HAP colleagues at the global, regional and country levels. The Global Meeting on Resettlement Services aimed to take stock of what IOM is currently doing in refugee resettlement, map the way forward in line with the strategic objectives of the Organization and consider how resettlement fits within the new Organizational structure. The meeting also aimed to identify strengths, weaknesses, opportunities and threats to the Organization in delivering consistent, high-quality resettlement services across its global platform.

Establishment of new migration health assessment operations

Zarzis, Tunisia

In the first half of 2011, PRM requested IOM MHD to establish MHA capacities for the USRAP in Tunisia, near the border with Libya, where the Choucha camp is located. IOM MHD, in cooperation with the IOM Mission in Tunisia and the regional USRAP hub in Amman, Jordan, responded to this request by preparing a mission plan and appropriate budget for the project, which is to begin in fiscal year (FY) 2012.

In setting up the MHA operation in Zarzis, approximately 80 km away from the Choucha camp, MHD was able to build upon existing capacities from the emergency evacuation operation in Tunisia, which was established following the crisis in Libya. The development of an MHA operation in Tunisia is a good example of IOM's ability to make a smooth transition from an emergency operation to a health assessment operation in Tunisia.

Pretoria, South Africa

In 2011, IOM South Africa opened its first medical health assessment centre, which provides medical assessments, pre-departure medicals and fitness-to-travel checks for USRAP. The centre handles UNHCR-referred refugees, mostly those who had been victims of xenophobic attacks. These vulnerable cases have no other local alternative other than resettlement to a third country as the most durable solution.

National-level partnerships for capacity-building

In addition to its global-level partnerships, IOM HAP operations also engage in country-level partnerships that enable IOM to contribute to local capacity-building.



An IOM doctor attends to a family at IOM South Africa's new health assessment centre. © IOM.

Capacity enhancement of the tuberculosis laboratory of the largest Ministry of Health hospital in southern Viet Nam

In coordination with CDC, IOM Viet Nam lends its technical expertise and training support to the TB laboratory of Cho Ray Hospital, the largest tertiary hospital attached to the Ministry of Health (MOH) in the southern region of Viet Nam. This partnership between the MOH hospital and IOM is instrumental in upgrading the level of TB culture examinations and maintaining the integrity and the quality of examinations performed in the TB laboratory. In 2011, the TB laboratory began to perform drug-sensitivity testing on second-line TB drugs, in addition to tests that had been implemented the year before, namely sputum smear for acid fast bacilli (AFB), sputum culture and DST for first-line TB drugs.

Enhancing diagnostics of communicable diseases in Thailand

To enhance the diagnostic capabilities of NGO-run camp laboratories that perform microscopic detection of infectious TB cases within the camps, a Microscopy Enhancement Training Course was conducted at eight camps and one IOM Thailand laboratory. Prior to the development of the training curriculum and materials, a pre-training survey of all sites was done to determine site-specific needs and NGO laboratory staff skill levels, and the capacity of individual camp sites to host a three-day event. Training materials developed and provided included a training course handbook and lecture notes. Additional laboratory supplies provided to each camp laboratory included quality control (QC) slides, Ziehl Neelsen staining reagents, and Proficiency Testing slide panel sets.

Health Promotion and Assistance for Migrants

In support of IOM's vision of "healthy migrants in healthy communities", regional and national activities were undertaken in 2011 in line with IOM's strategic objectives on migration health. These activities contribute to IOM and partner efforts to achieve their migrant health goals of strengthening governmental and non-governmental capacity to address migration-related health challenges and promote social integration and health equity. The following sections provide a summary of activities carried out by various IOM Missions under the programmatic area of health promotion and assistance for migrants along these four strategies.

I. Monitoring Migrant Health

Timely research on pertinent migration health topics, dissemination of findings and strengthened information systems on migration health assist policymakers and implementing agencies. Research priorities at the national and regional levels are typically determined through situational analyses of migrant health needs and health policy gaps. The highlights of IOM's activities in 2011 to strengthen monitoring of migration health are described in this section.

Funded by IOM Development Fund and Fundacion ANESVAD in April 2011, IOM, in cooperation with the London School of Hygiene and Tropical Medicine (LSHTM), began the implementation of the project, "Study on Trafficking, Exploitation and Abuse in the Mekong Subregion (STEAM)". STEAM is a 30-month research project that will generate evidence on the physical and mental health consequences of trafficking and the associated health care needs of trafficked persons. This evidence will be used to enhance care and support for trafficked persons in the Mekong subregion, through strengthening of relevant health policies and services. Participants in this research project include trafficked men, women and children receiving post-trafficking services from governmental and non-governmental service providers in Cambodia, Thailand and Viet Nam. In June 2011, the project established research teams, consisting of IOM field teams and selected governmental and non-governmental project partners to provide post-trafficking

services to trafficked persons. A research planning meeting was held to finalize study methods and tools, including questionnaires, consent forms and data collection methods. Tools and guidance documents were translated into related languages in the region. The project identified five shelters in Thailand, 11 shelters in Cambodia and seven shelters in Viet Nam to participate in the research. From August to October 2011, a series of training activities were conducted at all three project sites for interviewers, interpreters and staff of service providers, followed by pilot-testing of the questionnaire with trafficked persons in the shelters. The fieldwork then started in October in Cambodia and a total of 99 trafficked persons were interviewed at the end of 2011. Thailand and Viet Nam interviewed only six and eight trafficked persons, respectively, since the fieldwork in these two countries could be conducted only in December 2011. Fieldwork is expected to continue at various sites in the three countries until February 2013.

A new project was started by IOM Jordan upon the request of the Jordanian Ministry of Health, to address the health of labour migrants in Jordan. This project involves a study to generate data on the health status, health care access and health-seeking behaviours of diverse migrant groups residing and/or working in the country. A total of 1,234 (mostly labour) migrants were interviewed, including Egyptians, Iraqis, Sri Lankans, Indonesians and Filipinos, at three study locations in the country (Amman, Irbid and Aqaba). The findings of the study, as well as other relevant global and national knowledge on the health of migrants, will be presented and discussed during a national consultation on the health of migrants in 2012, when priority actions will be agreed upon to strengthen Jordanian health systems to better address the health of labour migrants in the country.

To assist the Government of Tajikistan in developing an evidence-based migration health policy and better manage migration-related health challenges, IOM started a research project in 2011 on the health needs and access to health care of rapidly growing migrant communities in Tajikistan. The research findings will be useful in building the capacity of government and non-governmental

partners to address the health needs of migrants and the public health needs of migrant-hosting communities by promoting migrant-sensitive health services.

Upon the request of the Bureau of Emigration and Overseas Employment (BE&O) of the Government of Pakistan, IOM conducted research on the HIV-related risks and vulnerabilities faced by Pakistani temporary contractual workers who work in the Middle East. Results showed that migrants are often mistreated and exploited at health centres where medical screenings take place. They may not have sufficient legal cover, protection or safeguard against violation of human rights with regard to ensuring voluntary counselling and testing at the medical centres, prevention of fraudulent and exploitative practices like declaration of fake results, lack of linkages with treatment centres for TB and HIV. Contrary to internationally established norms, pre-test and post-test counselling is not being offered at Gulf Cooperation Council (GCC)-approved medical centres. Several outbound migrants may receive false positive diagnoses, thereby undermining the credibility of HIV testing in Pakistan. Similarly, returnee migrants with HIV may be diagnosed late, posing a risk of transmission to family members. The research also found high

levels of ignorance and limited coordination among overseas employment promoters, medical screening centres, BE&O offices and various government agencies at airports with regard to migrant workers' health issues, including HIV. These findings were shared and discussed at a national consultation with various stakeholders, including representatives from the Ministry of Health and the National AIDS Control Programme, to agree on priority actions. Identified priorities include the capacity-building of government and non-governmental partners, especially the Gulf Cooperative Council Approved Medical Centres Association's (GAMCA) medical centres, to address the HIV prevention, care and support needs of prospective and returnee migrants. In response to the identified gaps and needs, IOM and its partners developed and disseminated migrant-sensitive behaviour change communication (BCC) materials on health challenges during the various stages of the migration cycle, as well as a Training Module for Briefing Officers to be used by the orientation and briefing centres of the BE&O.

As part of the Joint United Nations HIV/AIDS Team in Costa Rica, IOM led a research study on knowledge, attitudes, practices and behaviour related to HIV among the Ngabe Buglé population



Indigenous cultural advisors during training with culturally appropriate flipchart. © IOM 2011.

from Panama, who work as temporary migrants on coffee plantations in Costa Rica. The findings showed poor knowledge about HIV and limited access to information, which increases this group's vulnerability. The research findings serve as important evidence for stakeholders and call for a more inclusive approach from health authorities, including the development of health promotion materials that are linguistically and culturally appropriate.

In order to sensitize counterparts, donors and other stakeholders concerned with the health of migrants in Nicaragua, IOM collected and analysed data on the health conditions of migrants, their access to institutional services and general information about the migration situation in the country. The resulting Migration Health Profile was distributed to governmental institutions, donors and counterparts as a tool for advocacy.

Southern African Development Community (SADC) Port and Health research

In 2011, SADC requested IOM to conduct a study to address the gap in research on health vulnerabilities among sex workers, truck drivers and seafarers in selected port communities of southern Africa. The research consists of two components: 1) strategic information to strengthen the evidence base for future interventions in HIV prevention, treatment, care and support to address the specific needs of the said vulnerable groups; and 2) information dissemination and regional coordination in order to reinforce information-sharing, networks and partnerships for better coordination of health and HIV response in port settings. It is anticipated that the research findings will provide evidence on the nature and dynamics of health vulnerabilities among the targeted communities and provide guidance on existing and future policies and programmes.

IOM advocated for the inclusion of migration and mobility-related indicators in the Kenya AIDS Indicator Survey (KAIS) for 2012, such as country of birth, country of nationality, length of stay in Kenya and reason for moving to Kenya. This is the first time that such indicators have been included in national HIV-specific surveillance. Survey results will provide HIV information disaggregated by migrant status, which is needed for advocacy and for planning appropriate interventions for HIV prevention, treatment and care.

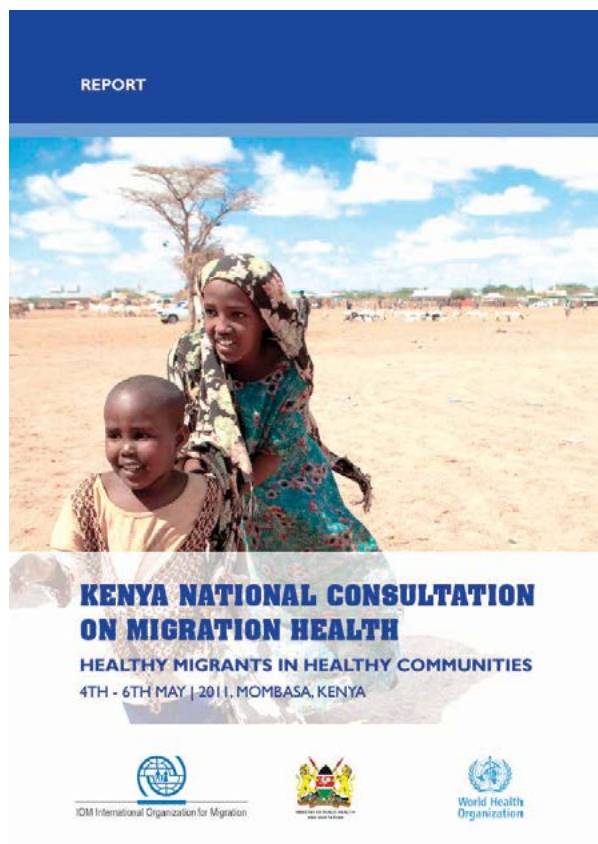
In 2011, IOM finalized a three-year research project on the Mobility of Health Professionals (MoHProf). Conducted by multiple partners in 25 countries, the study assessed health worker mobility to, from and within the EU. The findings of this research project, based on quantitative and qualitative data, were presented at the international conference "Ensuring Tomorrow's Health: Workforce Planning and Mobility" in Brussels on 7–9 December, which IOM organized together with the European Observatory on Health Systems and Policies and the Centre for Health Services and Nursing at the Catholic University Leuven. Approximately 100 participants from five continents shared findings and experiences and discussed recommendations for further action at the European Commission and global levels. Joint recommendations from the three large research projects will be further finalized and disseminated among key stakeholders in the EU.

The First Global Conference on the Psychosocial Effects of Globalization on Mental Health met in Lyon, France in October 2011. Mental health professionals and civil society representatives from all over the world discussed the impact of globalization on human beings and their societies, in emergency and non-emergency settings. IOM presented its poster "Human resources in psychosocial response: The experience of West African irregular migrants returning to West Africa" and is now using the professional network it developed during the conference to strengthen community-based migration-specific psychosocial programmes in West and Central Africa.

II. Policy and Legal Frameworks



IOM hosted Kenya's first ever National Consultation on Migration Health. © IOM 2011.



This consultation report provides a summary of the issues discussed and includes an action plan that outlines priority activities that need to be considered and implemented by the Government of Kenya and stakeholders.

National Consultation on Migration Health in Kenya

The Kenyan Ministry of Public Health and Sanitation, in partnership with IOM, WHO and other partners, hosted a National Consultation on Migration Health in Mombasa on 4–6 May 2011. The Consultation aimed to operationalize WHA resolution 61.17 on the Health of Migrants and reach consensus on the way forward for securing quality and equitable health services for migrants and mobile populations in Kenya.

“I want to urge all of you to think of migrants and mobile populations as people who deserve to live healthy lives among us. We must welcome and accommodate them in our laws, policies, and health care systems. We are a country that runs ahead of others, and it is our duty to show strong leadership in the area of migration health,” stated Honourable Beth Mugo, Kenya’s Minister for Public Health and Sanitation.

Speaking at the consultation, Dr. Abdoulie Jack, WHO’s Country Representative in Kenya, called for multisectoral collaboration in addressing migration health issues. “The

health of migrants is by no means just the business of the health sector, or an agency like the World Health Organization; indeed, the management of migration health requires close cooperation and collaboration among sectors, and related institutions involved in the migration process,” he stated.

The Ministry of Public Health and Sanitation and its partners will continue to implement recommendations formed at the national consultation, including the mainstreaming of migration health into all legislation, policies, programmes and strategies, supporting the development of a national forum for coordinating migration health, and strengthening partnerships for developing and implementing a national plan of action.

Action on migration health is achieved through policy changes and sustained political and financial commitment, and both are influenced by advocacy. Advocacy is essential to influence policy change, and build sustained political and financial commitment to migration health action in countries. IOM’s advocacy efforts should

be teamed with direct technical assistance to governmental and non-governmental stakeholders for the development of migrant-inclusive health policies as well as “healthy” migration policies in other sectors such as labour and immigration.

In 2011, IOM Sri Lanka continued to work with the Government of Sri Lanka, through the IOM Development Fund project “Technical Cooperation on Strengthening Migration Health Management in Sri Lanka”. This project has enhanced the capacity of the government to effectively manage various migration health challenges and promote the health and well-being of various categories of Sri Lankan migrants, as well as the families they left behind. Among the most significant contributions of this project were the provision of technical and financial support to the Ministry of Health in establishing a fully functional inter-agency coordination framework, the identification of policy and service gaps for Sri Lankan migrants and mobile populations, the launch of a migration research agenda and migration health website, ongoing consultations to initiate development of the national migration health policy in a comprehensive evidence-based approach, and advocacy in support of the 2008 WHA resolution on the health of migrants.



The governor of Sri Lanka's Northern Province lights the traditional oil lamp during the National Scientific Symposium on Migration Health in Colombo on 13 October 2011. © IOM 2011.

With technical and financial support from UNAIDS, IOM launched a project in 2011 to reduce the vulnerability of Bangladeshi female labour migrants to sexually transmitted infections (STIs) including HIV, by developing the capacity of the trainers at technical training centres (TTCs) under the Bureau of Manpower Employment and Training (BMET) in providing HIV and reproductive health information to potential female labour migrants. A comprehensive study was first conducted to identify risk factors and community-based HIV awareness activities. As a part of policy advocacy, booklets (with written and pictorial messages) on HIV and women-specific health issues were developed and distributed to potential and returnee migrant workers in the community. Technical assistance was provided to the trainers at TTCs in the form of day-long training on health risks related to the migration cycle, reproductive health issues for women migrant workers, and available HIV prevention services and care. This integrates health and HIV issues with other skill-building courses, such as those on housekeeping and garment trade. A comprehensive training manual on HIV and migration issues was developed in the local language for this endeavour and is under production. This project complements another IOM project with Family Health International (FHI), which focuses on reducing the risk of HIV infection among returning migrant workers and their families through community-based awareness programmes and capacity-building of government health and family planning field staff.

Dhaka Declaration

In April 2011, the Fourth Colombo Process Ministerial Meeting was held in Dhaka, Bangladesh. The theme was “Migration with Dignity”, focusing on all aspects related to labour migration that impact on the rights, welfare, dignity and well-being of migrant workers. Through the advocacy efforts of IOM and its partners, health was included as a recommendation in the final Dhaka Declaration: “To promote the implementation of migrant-inclusive health policies to ensure equitable access to health care and services as well as occupational safety and health for migrant workers (Art. 1.8)”.

With financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria, IOM and its partners are sensitizing vulnerable populations on HIV prevention, sexual and gender-based violence and the right to health. In 2011, over 300 peer educators were trained across Somalia to target at-risk populations, including port workers, truck drivers and female sellers of khat (an herbal stimulant). IOM also partnered with the Youth AIDS and HIV Network (YAHAN) in Somalia to provide a space where HIV positive men and women can share their experience and advocate for stigma reduction. Known as the Network for People Living with HIV in Puntland, members are slowly gaining the confidence to discuss their HIV status. The YAHAN director asserted that the forum restores the members’ dignity and gives them a new sense of community. In temporary shelters and IDP camps, where sexual and gender-based violence are common, IOM is collaborating with We Are Women Activists in empowering vulnerable displaced and migrant women through training on microfinancing models. Although programming and research have helped identify target populations and programmatic gaps, there is a need for targeted male- and female-friendly services, combining biomedical interventions and behavioural change, as well as activities to address determinants of risk behaviour and service access.

I find it hard to tell people my status. I hope one day our voice will be heard... Only God can kill me, not this HIV. I know my status, so now the only problem I have with my life is stigma.

When the nurse discovered I was HIV positive, she was too ashamed to call me back to the hospital. Instead, she told members of my community. I was immediately disowned. My neighbours forced me to leave my house – they thought I could infect them. They thought I had a ‘killer disease.’ Now I live alone; I am isolated.

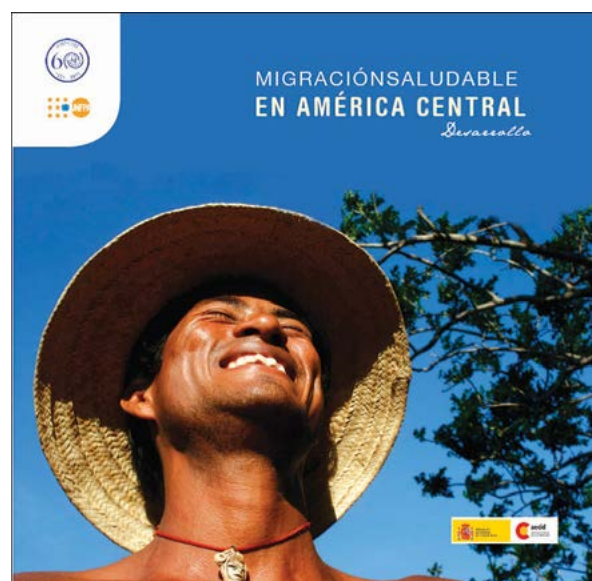
- HIV-positive migrant in Somalia

In Uganda, hotspots for unsafe health practices have emerged along the transport corridors, including trade routes that link Uganda with Kenya, Rwanda and South Sudan. These routes

are characterized by key populations at risk of HIV infection, due to engagement in transactional sex, including female sex workers (FSW) and their clients who comprise truckers, road construction workers and members of the host communities. Through the joint efforts of IOM Uganda, Makerere University, the Uganda AIDS Commission, the Ministry of Works and Transport, the Ministry of Health and UNAIDS, the strategic framework for the national “Combination HIV Prevention along the Transport Corridors in Uganda (CHIPS for Transport Corridors)” was developed to strengthen the national HIV response and promote combination HIV prevention as the preferred approach to service provision hotspots and host communities.

IOM participated in a Government of Thailand workshop addressing malaria prevention and control for high-risk populations along the Thai border on 21–22 April 2011 in Bangkok. Along with representatives from WHO, Thailand’s Ministry of Public Health and Bureau of Vector-Borne Disease, and NGOs working along the Thai border in the area of malaria and donor organizations, IOM discussed the importance of proactive collaboration of all sectors across ministries and countries for the health of border populations, and the need for stronger collaboration to address

the potential emergence of artemisinin-resistant malaria in Thailand and other Greater Mekong Subregion countries.



A photographic manual depicting images related to migration health issues in Central America was designed as an instrument for advocacy. High-quality photos and easy-to-read concepts are included to inform and sensitize about migration as a social determinant of health for migrants. This photographic manual was distributed to partners across the region, with a first edition of 1,000 copies. © IOM.



IOM is working with the Government of Kenya to harmonize the response to HIV throughout the transport corridors. © IOM 2011.

Also in 2011, IOM assisted Kenya's National AIDS Control Council (NACC) and National AIDS and Sexually Transmitted Infections Control Programme (NASCOP) to facilitate the development of a national strategy on HIV combination prevention along transport corridors, through an inclusive process with validation from all stakeholders. This strategy aims to harmonize the response to HIV throughout transport corridors, identify gaps in existing response, prioritize structural interventions needed and provide a means for resource mobilization for sustainable programming. Based on this strategy, minimum bio-behavioural health service delivery packages will be developed that are intended to ensure that services along the corridor are gender-sensitive and in-line with the mobile nature of the target population.

The Migrant Health Forums in South Africa

South Africa hosts an increasingly diverse migrant population comprising 3 per cent of the nation's total population. These migrants are a mix of asylum-seekers and documented or undocumented migrants who come from Zimbabwe and other countries in the SADC region and the Horn of Africa. In response to the growing need to address migrants' health needs, the city of Johannesburg initiated a Migrant Health Forum (MHF) as a venue to identify challenges and gaps, advocate to the government and ensure that migrants have access to basic health care services. International organizations, academia, migrant groups and religious sectors participated in the MHF in Gauteng.

Following this example, IOM conducted a seminar in Musina in 2009 that led to the establishment of an MHF in partnership with the Office of the Premier and the Vhembe District Municipality. The MHF in Vhembe is a key coordination forum where local and provincial governments obtain technical advice on migration health issues. The highlights of the Vhembe District MHF, facilitated by IOM, are:

- a site visit to Alicedale Farm in December 2010, for participants to better understand the experience of farm workers and the physical and systematic challenges of operating farms, and overall, to highlight the positive impact of agriculture on local economies;

- a seminar on sexual and gender-based violence (SGBV) on 23 March 2011 that targeted law enforcement officers in and around Musina, providing information on migration and vulnerability;
- the development of an SGBV task team along the border with Zimbabwe, one of the key recommendations of the SGBV seminar at the 4 May 2011 meeting, and following endorsement to the Province of Limpopo Director General; and
- the development and endorsement of Standard Operating Procedures (SOP) for the Management of Deportees by the MHF Task Team in the latter half of 2011, to ensure that individuals in possession of valid documentation legalizing their stay in South Africa are not deported.

III. Migrant-Sensitive Health Systems

To improve migrants' accessibility to health services, health systems must be strengthened, with consideration to the specific needs of migrants and recognizing the responsibilities and skills of health professionals and institutions. Capacity-building should address factors such as cultural sensitivity, linguistic competence, non-discriminatory regulations, community participation and engagement of migrants and migrants' associations, in order to ensure migrant-friendly care.

In Myanmar, IOM and its partners are implementing three large projects to reduce TB, HIV and malaria-related morbidity and mortality among vulnerable migrants and members of migration-affected communities in Mon and Kayin states. These projects, which are financially supported by the GFATM, aim to strengthen malaria control efforts in selected source communities and institutions through improved free TB and malaria diagnostic and treatment, improved access to free voluntary confidential counselling and testing (VCCT) for HIV, treatment for opportunistic infections (OI), antiretroviral therapy (ART), and care and support for infected patients and their families. A combination of approaches and techniques were employed, including community-based outreach and education, peer educator facilitation, mobile clinics, workplaces, central service provision and capacity-building of local public and private health staff and facilities. With the financial support of WHO's Stop TB Partnership, IOM and its partners have started implementing community-based



IOM mobile clinic offers maternal and child health services in Mon State, Myanmar. © IOM 2011.

quality TB control interventions in the Bogale Township, in the Ayeyarwady Region. This involves facilitating access to and providing free diagnosis

of TB, and monitoring treatment among the general population as well as among vulnerable migrants and migration-affected communities.

In eastern Myanmar, IOM currently targets destination sites, such as rubber plantations, gold mines and rock quarries, for internal migrants. These areas are also source communities for migrants travelling to other countries, and are therefore a key focus area for the control of communicable diseases. IOM is collaborating to build the capacity of government and communities in strengthening health systems. The programme model involves capacitating malaria volunteers and 100 village mobility working groups (comprising community leaders and employers) to support service delivery, referral, awareness-raising, peer support groups, and participatory action sessions among vulnerable migrants. In partnership with the World Food Programme, IOM is providing food assistance to persons living with HIV, TB patients, and vulnerable mothers and children. Achievements from 2007 to 2011 include the distribution of 100,000 long-lasting impregnated bed nets and the provision of over 115,000 malaria microscopy and rapid diagnostic tests. About 55,700 persons were identified positive and received treatment per national guidelines through mobile malaria clinics and fixed microscopy sites, and 6,000 persons were treated for TB. Furthermore, 100,000 long-lasting impregnated bed nets and 1.3 million condoms were distributed. IOM will start working in other destination sites, starting with the major crossing between Thailand and Myanmar at Myawaddy Township in the Kayin state of Myanmar in 2012.

"I came to Kenya from Tanzania for a better life but I have been sitting on this stool for 20 years selling sex." © IOM 2011.



In partnership with Kenya's National AIDS and Sexually Transmitted Infections Control Programme, IOM supported two community-based organizations (CBOs) to implement a "Combination HIV Prevention Pilot Project" for migrant female sex workers. The project, which ended in December 2011, offered HIV-prevention services, life skills and psychosocial support. A drop-in centre which offered friendly services for both migrants and the host community was opened. It provided a space for community dialogue around health and social issues, including: advocacy for mitigation of sexual and gender-based violence; HIV counselling and testing; screening for sexually transmitted infections; behavioural change

communication; social support; and referral of patients for TB/STI/HIV services, basic primary health care, and reproductive health services. In an effort to overcome language barriers, IOM and its partners provided language classes and translation services at the centre. As a result of this programme, IOM and its partners raised the profile of migrants within the Government of Kenya's Ministry of Public Health and Sanitation and among other stakeholders. The centre also served as a platform for piloting start-up activities to reduce disparities in health service access – a key objective of the Kenya National Health Sector Strategic Plan II – and should, through lessons learned, inform scale-up of services in larger Nairobi.



IOM's Wellness Centre at the Kenya/Uganda border received a donation of HIV testing kits from UNFPA. © IOM 2011.

Busia Trailer Park Wellness Centre and Clinic

IOM and Kenya's National AIDS Control Council launched a free health care clinic in Busia targeting vulnerable populations on the Kenyan/Ugandan border. Located at the heart of Busia's trailer park, the health care clinic opened to the public on 25 March 2011.

The Busia Trailer Park Wellness Centre and Clinic targets vulnerable populations such as

truck drivers, civil servants and female sex workers who, due to their social environment, are particularly vulnerable to engaging in risky sex, and subsequently, to HIV.

The health needs of female sex workers and clients are currently not being adequately met in Kenya. A majority of health care clinics operate at inopportune times for people who need to access services in such remote locations and at odd hours. The Busia Trailer

Park Wellness Centre and Clinic will provide free TB, malaria and HIV counselling and treatment, and nurses are available 24 hours a day. Busia's town council has also embraced the new centre and generously donated the land on which the clinic sits.

Professor Alloys Orago, the Director of the National AIDS Control Council stated: "This is just the beginning; partnering with IOM and the Kenya's National AIDS and Sexually Transmitted Infections Control Programme, we aim to pepper the entire northern transport corridor with free health care clinics specifically designed for hard-to-reach populations."

"We see the Busia Trailer Park Wellness Centre and Clinic as a first step," said Greg Irving, IOM Health Programme Officer. "We need to focus more on prevention; behavioural and clinical services must be put in place and scaled up to secure meaningful impact for migrants and mobile populations who are currently not being catered for by health services. Strengthened partnerships, capacity-building, accountability, coordination and financial commitment will ultimately prevent new HIV infections."

The Busia Trailer Park Wellness Centre and Clinic already triggered a cross-border meeting between Kenyan and Ugandan government officials. The meeting led to the strengthening of existing relationships and provided an opportunity to highlight common health care challenges between the two countries. Participants agreed on a way forward in jointly tackling identified challenges, and decided to work towards offering a common health care package.

Through local partnership and with funding from the GFATM, IOM reached 5,110 people through its HIV prevention programmes in Somalia, including 1,297 internally displaced persons (IDPs) and migrants in 2010–2011. This led to an increase in voluntary counselling and testing (VCT) among key populations, namely sex workers and their clients. This is a promising observation in a country where the epidemic is still highly concentrated among key populations and where VCT uptake is extremely low. IOM trained a total of 181 youth peer educators in life skills (including HIV prevention, gender norms, and sexual and reproductive

health and rights) and peer education, resulting in training workshops for community leaders and women's groups. In addition, IOM trained 16 women's advocates and 60 vulnerable women on gender, HIV/AIDs and gender-based violence. These are considerable achievements in Somalia, where the culture remains extremely conservative and the rights disparity between women and men is immense.



© IOM 2011.

IOM's contribution to the national AIDS response is indispensable. Through their consistent and quality technical assistance, scientific research and effective capacity-building of the national partners, I believe that Somalia is now better focused than ever on targeting HIV programmes at the priority populations... Yet, we are still in great need of resources as well as assistance in order to scale up the current implementation of Combination HIV Prevention. We need a greater role for IOM in the national [AIDS] response.

- Dr. Abdirahman Saeed Mohamoud
Executive Director, Puntland AIDS
Commission

Starting 2011, IOM implemented activities aimed at decreasing the vulnerability of mobile populations in Bosnia and Herzegovina (BiH) to HIV/AIDS. These activities were carried out as part of a GFATM-supported project implemented by the United Nations Development Programme (UNDP) and its partners, with the active participation of local and international stakeholders in the field of HIV/AIDS in BiH. These include institutions that are essential to developing policy, civil society actors that reach out to the general public and assist people living with HIV/AIDS, and mass media

that communicate information on HIV/AIDS to the general public. This project builds the capacity of local actors, including NGOs, to strengthen HIV prevention responses among mobile populations. A voluntary confidential counselling and testing campaign is being implemented in border-crossing areas for mobile populations. The project also strengthens networks between BiH institutions at the national and local levels, and between institutions and NGOs in BiH and other countries in South-East Europe.



Village health volunteers and health centre staff received training on TB mass screening during the pilot phase in Paksong District, Champasak Province in March 2011. © IOM 2011.



Mass screening training for village health volunteers and health centre staff in Phonethong District, Champasak Province in August 2011. © IOM 2011.

Funded by WHO's Stop TB Partnership and TB REACH, IOM started implementing a one-year collaborative project in 2011 with the National TB Centre (NTC) and the Ministry of Health (MOH) in Lao People's Democratic Republic to improve TB diagnostics, detection and treatment among hard-to-reach populations, including ethnic communities, remote populations, and internal and cross-border migrants in two provinces along the Lao–Thailand border, namely Savannakhet and Champasak. The project aims to facilitate the NTC's TB control efforts through active TB mass screening, strengthened capacity of NTC staff, improved referral systems, and greater public awareness of TB via targeted information education campaigns. The target groups are among the most affected by TB, yet face multiple barriers to accessing TB services due to their mobility, poverty, cultural and language differences, poor infrastructure and geographical isolation. In 2011, a number of training activities were held, including microscopy training on TB diagnosis for 28 laboratory technicians, and a training of trainers on active mass screening process for 17 TB health staff at the national, provincial and district levels. In addition, 76 workshops were conducted by district TB managers for 1,628 health staff (including health centre staff and village health volunteers). Participants were trained on project aims, mass screening methodology, how to administer TB screening questionnaires, collecting sputum, and delivering samples. Also in 2011, mass screening tools were developed, including a Symptomatic Health Screening form and a Head of Household Interview form. In addition, to raise awareness of

TB among migrant and Lao populations, the project conducted 15 outreach events and awareness-raising campaigns in communities at cross-border checkpoints along the Lao–Thai and Lao–Viet Nam border and other locations where potential Lao and Vietnamese migrants are found, such as bus stations and markets. During these events, over 19,000 IEC brochures in different languages were disseminated to inform target populations on TB. As a result of this project, 290,868 people were screened for TB in 2011, resulting in the detection of 7,082 suspected cases, the collection of 2,896 sputum samples and the identification of 111 smear-positive cases.

Despite having a comprehensive national TB programme and full DOT coverage, there are still areas in Thailand, such as the northern and north-eastern border provinces, where access to, or uptake of, TB services is limited. In 2011, IOM started a project that aims to address bottlenecks related to TB screening and diagnosis in 58 of the poorest, high TB burden districts in seven provinces in northern and north-eastern Thailand. Increased detection of TB and MDR-TB is being achieved through active case finding and treatment referral strategies such as the use of GeneXpert, a rapid diagnostic tool with high sensitivity; building networks of community health workers and community health volunteers (CHWs and CHVs) to raise TB awareness; and strengthening referral systems and case reporting using CHW networks and working groups. In 2011, IOM finalized project partners at the provincial and district levels and established testing centres.



Meeting with Ngabe Buglé leaders and government officials. © IOM 2011.

In 2011, IOM worked with government officials from Panama and Costa Rica, the United Nations Population Fund (UNFPA) Panama and leaders of indigenous communities to strengthen health units close to the border area along the migration route, where many migrants move, especially the indigenous population Ngabe Buglé. IOM has provided the units with medical equipment and technical support so they are able to deliver better health services to migrants along the migration route.

IOM scaled up the response to the increasing needs of vulnerable migrants transiting through Egypt and Yemen in 2011. It provided direct medical and socio-economic assistance to migrants, strengthened the capacity of the government and NGOs to offer migrant-friendly health care services, and assisted governments and NGOs to provide comprehensive assistance to the most vulnerable groups, namely trafficked persons and unaccompanied minors. Through the implementation of these activities, there is increased recognition of the problem and a willingness by government and civil society partners to improve the health and well-being of migrant communities, especially in urban settings such as Cairo, at the Yemen border, and in detention facilities in Egypt.

A training curriculum was developed, implemented and validated in 2011 in Guatemala,

Costa Rica and Nicaragua to train government officials from Ministries of Health and Migration Offices in Central America on key migration health issues. The curriculum, which was adapted for the specific context in each country, focused on the health aspects of migration and aimed to strengthen migrant-friendly services and establish new partnerships.



Migration Health Workshop with government officials validating methodology and manuals in Nicaragua. © IOM 2011.

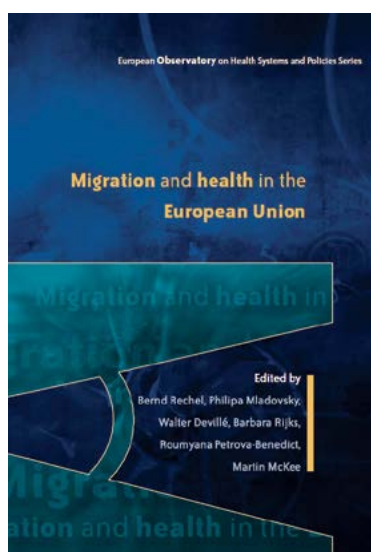


Migration Health Workshop with government officials validating methodology and manuals in Guatemala. © IOM 2011.

IV. Partnerships, Networks and Multi-Country Frameworks

Going beyond collaboration with the health sector, intercountry partnerships should use a multisectoral approach and coordinate with local affairs, foreign affairs, labour, social welfare/protection, community groups, private sector, academia, civil society groups and the media. Multi-stakeholder national working groups should be created to operationalize migration health strategies and mobilize resources for programme implementation and monitoring. Active international partnerships should be promoted through regional consultative and coordination mechanisms, in particular between countries of origin and destination, engaging such stakeholders as employers and trade unions.

In November 2011, the Committee of Ministers of the Council of Europe from 47 Member States adopted the extensive recommendations to Member States on mobility, migration and access to health, drafted by the Council of Europe Expert Committee over 2009–2010, in which IOM was a contributing member. The preamble acknowledges IOM's work in the lead-up to the recommendations and their adoption: "Noting the relevance of the International Organization for Migration's contribution to the field, in particular the publications *Migration and the Right to Health: A Review of European Community Law and Council of Europe Instruments* (2007), *Migrant Health for the Benefit of All* (2004) and the Concluding Statement of the European Union-level Consultation on Migration Health, 'Better Health for All' (2009)."



This book explores the different aspects of migration and health in the European Union and how they can be addressed by health systems.

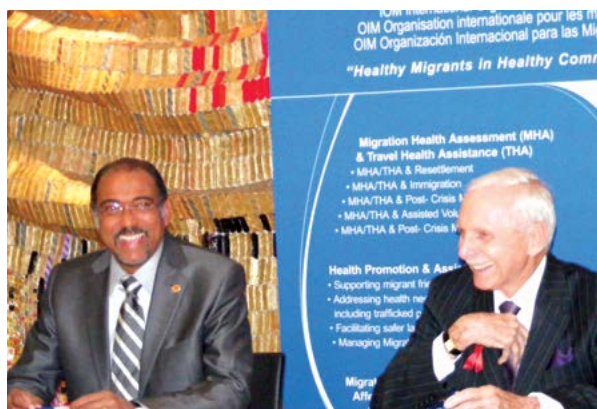
In collaboration with the European Observatory on Health Systems and Policies and the European Public Health Association (EUPHA), IOM developed a publication entitled *Migration and Health in the European Union*, which gives comprehensive information on different aspects of migration health, and how these can be addressed by health systems.

IOM's Regional Office in Brussels was invited by Prolepsis (Institute of Preventive Medicine, Environmental & Occupational Health, Greece) to take part in an international conference on "Good Practices in the Sectors of Health, Welfare and Social Security" on 27–28 June in Athens. The conference covered the topics of migration, health and social care in an EU policy framework; the role of civil society and good practices to promote migrants' integration; and improving the use of health services, welfare and social inclusion. The objective of the conference was to encourage communication and networking and improve cooperation between relevant stakeholders at the European and national levels. Around 100 representatives from international organizations, academia, EU Member States, civil society, and the European Commission participated in the meeting. IOM shared findings, experiences and good practices on migration health in the EU region, and many of IOM's partners, including WHO, Prolepsis, ACIDI (Portugal) and the Centre for Health and Migration (Nowhereland project), highlighted their appreciation for the partnership with IOM.

Developing joint approaches on cross-border tuberculosis control and care in Europe

IOM was invited by the WHO Regional Office for Europe (WHO EURO) and the European Centre for Disease Control (ECDC) to contribute to the development of a "Minimum package for cross-border TB control and care in the WHO European region: A Wolfheze consensus statement", which was discussed at the yearly National TB Coordinator meeting in May 2011. This series of workshops focused on the management and coordination of TB control efforts in countries with high TB prevalence in Central and Eastern Europe and Central Asia. The fifteenth workshop included a session on cross-border care, with the objective of updating participants on TB and migration in the region, achieving consensus on the finalization of the concept paper and its implementation, and agreeing on priorities for further collaboration and coordination. The manuscript has been submitted for publication to the European Respiratory Journal in 2012.

On 10 June 2011, representatives of United Nations Member States gathered in New York City to renew and reaffirm their commitment to stop the spread of HIV, by signing the Declaration of Commitment on HIV/AIDS, entitled “Global Crisis – Global Action”. In partnership with UNAIDS, ILO and UNHCR, IOM organized a side event to raise awareness among Member States to continue addressing HIV vulnerabilities related to population mobility, including forced displacement, economic migration and discrimination. IOM Director General William Lacy Swing, who was part of the panel, underscored the importance of action on barriers faced by migrants in accessing health and HIV services, in light of migration trends and their impact on global health policy.



UNAIDS Executive Director Michel Sidibé and IOM Director General William Lacy Swing sign a new cooperation agreement to overcome HIV-related challenges faced by many migrants. © IOM 2011.

IOM and UNAIDS have renewed their commitment to overcome HIV-related challenges faced by many migrants by signing a new cooperation agreement in January 2011. The agreement seeks to integrate human rights and the needs of migrants and mobile populations into national and regional HIV responses and ensure universal access to HIV prevention, treatment, care and support. Both organizations will also continue cooperation on research to deepen understanding of HIV and population mobility. This agreement replaced the 1999 Cooperation Framework, which was updated in 2002.

As a member of the Joint United Nations Initiative on Mobility and AIDS (JUNIMA) in Asia, IOM contributed to the High-level Multi-stakeholder Dialogue on Migrant Health and Access to HIV Prevention, Treatment, Care and Support in the ASEAN (Association of Southeast Asian Nations) Region, which took place in Bangkok on 29–30 November 2011. To address challenges and opportunities for migrants and improve their

access to health and HIV services, 41 government representatives from the ministries of health, labour and foreign affairs of 10 ASEAN Member States (Brunei Darussalam, Cambodia, Indonesia, Lao People's Democratic Republic, Malaysia, Myanmar, Philippines, Singapore, Thailand and Viet Nam), leading civil society organizations and the United Nations family convened to review country- and regional-level commitments and progress and implementation tools, and develop good practices. Among the priorities addressed were: 1) increased involvement of migrant communities, civil society organizations and unions as active partners in bilateral and multilateral agreements, advocacy and service delivery; 2) enhanced collaboration on migrants' health concerns with respect to ASEAN mechanisms, including the ASEAN Intergovernmental Commission on Human Rights; 3) development of standard migrant health indicators and disaggregated data, while ensuring confidentiality and privacy; 4) further study on the costs and benefits of providing migrant-sensitive health services to migrants; and 5) further outreach to undocumented migrant populations to identify effective health interventions. These joint priorities serve as a useful tool for government and civil society representatives in planning and coordination with all stakeholders at the country level.

The transport sector is vital to the development of east and southern Africa. However, HIV continues to impact the sector, as transport workers and communities along transport corridors are affected by the disease, threatening future development. IOM, in partnership with ILO, UNAIDS, the International Transport Workers' Federation (ITF), and the Health Economics and HIV and AIDS Research Division (HEARD) at the University of KwaZulu Natal, held the Subregional Workshop on HIV and AIDS in the Transport Sector in Southern Africa in Johannesburg on 29–30 March 2011. The workshop aimed to review current evidence on HIV and TB in the transport sector, identify research gaps, review and assess the effectiveness of existing policies and programmes, and develop country plans and regional action plans for southern Africa on HIV for all transport sectors. Different stakeholders from the region participated, including transport ministries, National AIDS Councils, civil society, development partners and representatives of employers' and workers' organizations from Botswana, Kenya, Malawi, Mozambique, Namibia, South Africa, the United Republic of Tanzania, Zambia, and Zimbabwe. The participants agreed there is a need for a clear regional transport HIV policy framework from which countries can

develop common initiatives and interventions. Also highlighted was the need for workplace policies as well as the negotiation of collective bargaining agreements with employers to create comprehensive HIV and AIDS workplace programmes. Action plans were developed by the countries represented at the workshop. IOM and ILO, together with other partners, will work with focal points in relevant countries to monitor progress.

From March 2010 to October 2011, IOM implemented, with IOM Development Fund (IDF) support, a capacity-building support project in six West African countries, including Burkina Faso, Guinea, Mali, Mauritania, Niger and Senegal. The objectives of this project were to reinforce technical cooperation between countries in the region and facilitate fundraising for the development of regional initiatives on

migration and health. A literature review was initially conducted to collect available West Africa migration and health-related information. A survey was conducted in the six target countries to assess national and regional policy environments and make recommendations to facilitate the provision of psychosocial support to prevent mental health disorders among irregular migrants – as well as their families – returning to their countries of origin in West Africa. Six country-level reports and a regional synthesis were produced. Other planned activities were not achieved, including the nomination of migration and health focal persons within the ministries of health of targeted countries (except in Senegal), and two regional surveys on: 1) epidemiological surveillance and early response systems at the borders of West African countries, and 2) reduction of truck drivers' vulnerability to HIV and STIs.



Promoting women's leadership in reducing the feminization of HIV/AIDS in the border areas of Senegal. © IOM 2011.

IOM shares data and experiences on mobility and HIV in Africa



IOM satellite session at ICASA 2011 conference. © IOM 2011.

An IOM delegation from East and Southern Africa gathered at Africa's largest conference on HIV and AIDS. The Sixteenth International Conference on AIDS and STIs in Africa (ICASA), held in Ethiopia on 4–8 December 2011, brought together more than 10,000 participants from 103 countries to share information and learn about successes, challenges and innovations in the prevention and control of HIV and AIDS. Participants included scientists, health workers, people living with HIV, policymakers, civil society and NGOs, activists and government representatives.

IOM, together with its regional partners – the Intergovernmental Authority on Development (IGAD) and the Southern Africa Development Community – organized a well-attended satellite session on “East Africa meets Southern Africa: A bi-regional perspective on HIV and migration”.

With increased population mobility brought about by the search for better opportunities or safety, human mobility in East and Southern

Africa impacts on the health of migrants and the public health of host communities and countries. Among other things, the session aimed to increase understanding of the HIV vulnerability of migrants, the mobile populations and communities they interact with, and the various regional responses to address HIV and population mobility in both regions. Apart from the satellite session, IOM was well represented in oral and poster presentations. The Kenya team delivered a presentation on the findings of a response analysis of combination prevention along Kenya's transport corridors, while the Somalia team presented a behavioural survey on youth in Somalia, which was very well received by the participants. The Uganda team had a poster and an oral presentation focusing on: condom knowledge, attitudes and practices among female sex workers and truck drivers in Uganda; HIV risks and vulnerabilities of undocumented migrants in Kampala, Uganda; and sexual risk behaviours, condom use and STI treatment-seeking behaviour among female sex workers and truck drivers along major transport corridors in Uganda.

The first meeting of the Iberoamerican Network on Migration of Health Professionals was held jointly with the fourth Iberoamerican Meeting on the Migration of Health Professionals on 17–18 November 2011 in Uruguay. Funded by the EU as part of the MPDC project related to the Migration of Health Professionals between Latin America and Europe, this was also supported by the Pan American Health Organization (PAHO), the Ministry of Health of Uruguay and the Escuela Andaluza de Salud Publica. IOM was included in the event in part due to its participation in a working group formed in 2006 to tackle this issue. Minister Jorge Venegas, the Minister of Health of Uruguay, opened the event together with a panel of officials that also included IOM Head of Office Alba Goycochea, Ambassador Geoffrey Barrett, Head of the EU Delegation in Uruguay, and the Director of the Pan-American Health Organization in Uruguay, Eduardo Levcovitz. The event emphasized the need to respect the right of health professionals to migrate, while also addressing the impact of their migration.

Organized by the Ibero-American Secretariat and UNFPA, IOM participated in a meeting in Costa Rica on “Social Protection in Health of Migrants in Ibero-America” in December 2011. IOM provided technical support to advance the area of social protection in health for migrants and advocated for the inclusion of social protection in health in the Latin American Multilateral Agreement on Social Security, which has been signed by most countries but is yet to be ratified.

IOM participated in the “Technical Seminar on Preventive Strategies for Social Security Coverage of Vulnerable Populations in Costa Rica and Argentina”, an exchange of best practices and lessons learned between the social security systems of these two countries. Held in San José, Costa Rica on 24–26 August 2011, the seminar was coordinated by the International Social Security Association, and IOM led two presentations on an intercultural approach to indigenous populations and health of migrants in the region.

Migration Health Assistance for Crisis-Affected Populations

The Migration Health Assistance for Crisis-Affected Populations Unit responds to the health and psychosocial needs and vulnerabilities of populations affected by armed conflicts, natural disasters and other crises that result in population movements. As a member of the Global Health Cluster (GHC), Country Health Clusters and the Mental Health and Psychosocial Support Network, and as a partner of health NGOs, the Unit integrates health and psychosocial responses to the overall IOM emergency response. Ensuring access to health for displaced people in the aftermath of a disaster is also an integral part of IOM's role as the Global Camp Coordination/Camp Management Cluster (CCCM) lead in natural disasters.

IOM assists governments and affected communities in emergency preparedness and mitigation during the emergency phase; it also assists in recovery in the aftermath of emergencies. Health assistance for crisis-affected populations includes managing health and psychosocial issues related to population displacement, facilitating health referral mechanisms, establishing mobile or fixed health clinics, and arranging medical evacuations for individuals who cannot be cared for locally when health facilities are either overstretched or have been destroyed. IOM ensures that mechanisms are in place to address public health concerns; the Organization also ensures continuity of patient care and promotion of health and well-being in situations of displacement and assisted movements. The

profile of assisted populations varies: depending on the situation, beneficiaries may be internally displaced people, as in the aftermath of the Haiti earthquake in 2010; migrants, as during the Libya crisis in 2011; or refugees, as in the ongoing IOM projects in Ethiopia and Kenya.

The following sections summarize IOM's key activities in various countries in 2011 as part of the programmatic area of migration health assistance for crisis-affected populations.

I. Migrant-Sensitive Health Systems

Emergency primary health assistance in South Sudan

IOM South Sudan has tracked over 2.8 million South Sudanese returning from Sudan. Many returnees are unable to reach their final areas of destination and are thus provided onward transportation assistance (OTA). From 2005 to December 2011, over 50,000 stranded returnees benefited from this OTA service. IOM medical teams assess each returnee in order to determine their fitness to travel before the OTA convoy departs. They arrange medical escorts for those who might need assistance during the trip back to their preferred communities of return. From August through December 2011, fitness-to-travel medical screenings and medical escorts were arranged for the OTA movements of more than 3,000 returnees.



An IOM medical staff member attends to a patient at Barial Camp, a camp for communities displaced from Abyei after clashes between Sudan Armed Forces and Sudan People's Liberation Army. © IOM 2011.

IOM primary health care activities in South Sudan are mainly focused on providing basic health care for stranded returnees and conflict-affected communities, as well as health services for vulnerable host communities. IOM runs mobile and semi-static health clinics in Western Equatoria, Central Equatoria, Western Bahr el Ghazal and Upper Nile states.

One of the many challenges facing South Sudan is poor health infrastructure in areas of high return and a lack of trained primary health care providers. As part of its reintegration and community stabilization programme, IOM has rehabilitated primary health care units (PHCUs) in Northern Bahr el Ghazal.

In the Upper Nile state, IOM operates a semi-static health clinic on the site of an old gasoline station at the Mina Camp for stranded returnees in the town of Renk.

This camp reached its full capacity in August 2011. At the end of 2011, it hosted over 9,000 stranded returnees. The clinic provides health services to an average of 100 patients per day among returnees as well as members of the surrounding host community who are unable to pay fees charged by the local hospital. From August to December 2011, the IOM clinic in the Renk Mina Camp completed over 11,000 patient consultations, with the most common diagnoses being malaria (approximately 40% of patients tested positive using the Paracheck® dipstick test), upper and lower respiratory tract infections, and parasitic worms. IOM medical teams provide access to medicines and medical supplies and conduct immunizations for vaccine-preventable childhood diseases. Maintaining the cold chain system and a steady supply of medicines presents significant challenges for IOM health staff in these locations.

Pre-departure fitness-to-travel health checks are conducted by the medical staff to assess whether returnees are fit to travel on IOM-organized barges. Medical escorts are arranged for all organized movements.

Drought in Dollo Ado, Ethiopia – the worst in the Horn of Africa in 60 years

The Horn of Africa drought crisis in 2011 resulted in severe lack of food and access to safe water for more than 12.5 million people in the region. IOM's humanitarian response built on existing programmes and robust capacity in the region, including assistance in shelter, transport, food and health care. At the request of the Government of Ethiopia's Administration for Refugee and

Returnee Affairs (ARRA) and UNHCR, IOM provided primary health care services for 3,859 vulnerable refugees in two camps in Dollo Ado, Ethiopia in 2011. The project responds to the continuing unacceptably high rates of mortality and malnutrition in these camps, as well as to concerns over the public health situation and lack of outreach capacity in the refugee community.

Specifically, the project focuses on the following components to reduce preventable morbidity and mortality in the two camps:

- Construction of temporary satellite clinics/health posts to increase access to emergency primary health care;
- Deployment of IOM doctors and nurses to work alongside and provide supportive supervision and capacity-building to ARRA staff in health centres and satellite clinics, in order to ensure increased quality of health care;
- Deployment of medical specialists from Black Lion Hospital to perform specialized consultations and treatment currently not available in the camps, including mental health and psychosocial support, and ophthalmologic and obstetric–gynaecological consultations;
- Contributing to mass immunization campaigns in the camps to prevent the spread of vaccine-preventable diseases, both within the camp population and between the camp population and local communities;
- Contributing to health promotion activities to increase health-seeking behaviour in the camps;
- Contributing to the preparedness and response plan for communicable diseases with public health implications, particularly acute watery diarrhoea (AWD), meningitis and acute viral hepatitis.

Cholera response in Kenya

In 2011, thousands of Somalis fled to Kenya to escape the drought in Somalia. This aggravated overcrowding and other existing conditions in Dadaab camps, which are already hosting large numbers of refugees as a result of the conflict in Somalia, and overstretched their capacity and resources.

IOM's needs assessment in July 2011 indicated gaps in health and psychosocial support, shelter and transportation of new Somali arrivals at border areas, and livelihood support for host communities. At the request of the Kenya Provincial Administration, IOM facilitated the orderly movement of refugees and migrants from the Somalia–Kenya border town of Liboi to



In partnership with Kenya's Ministry of Public Health and Sanitation, IOM's mobile medical rapid response teams reach vulnerable pastoralists in Turkana who are experiencing the worst drought in 60 years and have little or no access to basic health care. © IOM 2011.

Dadaab. Between July and October 2011, over 17,000 drought-displaced refugees were given transportation and THA. Emergency relocation and THA for over 28,000 refugees from Dagahaley refugee camp to the Ifo 2 East camp was also facilitated by IOM teams. IOM also donated drugs and medical supplies to UNHCR in December 2011 to contribute to efforts to stem the cholera outbreak in Dadaab refugee camps.

IOM collaborated with UNHCR and the Kenya Red Cross on prevention, mitigation and medical assistance to refugees at the Ifo 2 East Camp after a cholera outbreak. Patients were treated for watery diarrhoea, respiratory infections, malaria and skin infections. Maternal and child health care, including antenatal checks and immunizations against childhood diseases, were provided. At the Ifo 2 East camp, over 3,000 patients benefited from IOM health programmes until December 2011.



Children are taught by IOM staff how to wash their faces and hands, in order to improve their basic hygiene and prevent water-related diseases. © IOM 2011.

Turkana, nestled in north-west Kenya, was hit hard by drought: two years of scarce rains resulted in the driest season since 1950.

Grace Khaguli, Field Coordinator for IOM's emergency project in Turkana said: "Due to the scale of the drought, water is scarce. This makes people more inclined to drink dirty, unsafe water. The situation is now more critical than ever. The worry is that residents use contaminated water, and the area has very few toilets, which contributes to improper waste disposal. Lack of safe water is the main driver of epidemic waterborne diseases."

"My nine children are consistently suffering from *akirem* (diarrhoea)," said Ereng. Ereng and his children are among the many families who received treatment for diarrhoeal diseases from IOM. In partnership with Kenya's Ministry of Public Health and Sanitation, IOM's mobile medical rapid response teams go to hard-to-reach mobile communities in Turkana. Equipped with rehydration sachets, chlorine water purification tablets, deworming tablets, and essential medications for treating common medical conditions, the teams distribute much-needed medication and conduct mass deworming campaigns.

Small changes can have a big impact, as proven by IOM's health and hygiene promotion talks during mobile team visits to hard-to-reach communities. Sensitive to sustainability and cultural practices, IOM's health promotion campaign complements local knowledge with indigenous solutions. For example, communities are encouraged to wash their hands with ash, a local disinfectant that is free and easily accessible.

Senior elder Echeban Ngelecha, a community leader in Nadapal Village, northern Turkana, said: "In our culture, we divide illnesses into those caused by God and those caused by *Ngidekesiney ka ekapilan* (witchcraft). Thanks to IOM, we are now aware that we can do certain things to prevent illnesses. This partnership needs to be continuous because it takes time to change behaviour, like remembering to use ash when we wash our hands in order to prevent the spread of diseases."

Delivery of lifesaving care for acute malnutrition and improving emergency reproductive health services in Zimbabwe

In 2011, the IOM health team in Zimbabwe focused on improving access to basic social services among high migration-affected communities, including services such as community-based management of acute malnutrition for children under age 5 and emergency reproductive health. IOM's project aimed to offer lifesaving care for acute malnutrition and focused on two objectives: 1) ensuring access to comprehensive Community-based Management of Acute Malnutrition (CMAM) services for more than 2,000,939 people, including 258,121 young children, between March and November 2011, and 2) delivering timely appropriate care to approximately 1,247 children with severe acute malnutrition.

IOM's project on improving emergency reproductive health services for displacement- and migration-affected communities was implemented in two districts. The main objective of the project was to contribute to reducing morbidity and mortality of mothers and newborns, by strengthening reproductive health service provision primarily in rural health facilities. Specifically, the project sought to address the three main delays (delay in deciding to seek appropriate medical help for an obstetric emergency, delay in reaching an appropriate obstetric facility and delay in receiving adequate care when a facility is reached) in accessing health services among mothers and neonates in the two districts.

Stranded migrants and trafficked persons receive emergency health care in Yemen

Yemen is wrestling with many social, political and economic problems that result in extremely precarious living conditions for both the Yemeni population and the country's marginalized migrants. Yemen's health profile is one of the least favourable in the world. This health vulnerability is a result of a combination of factors: lack of access to and limited availability of health care, as well as unmet needs with regard to the basic social determinants of health, such as nutrition, education, and gender disparity. IOM is working continuously to provide health care support and services for stranded migrants who are unable to access the care they need.

Al-Jawf, north-east Yemen, March 2010 to December 2011

Al-Jawf is the third-largest governorate in Yemen and one of the most remote, inaccessible and

impoverished regions in the country. Bordering Sa'ada and sharing strong tribal affiliations, the population of Al-Jawf has been heavily impacted by the ongoing conflict in Sa'ada between the government and Al Houthis. Basic social services, including health care, are almost non-existent in Al-Jawf. The situation has further deteriorated with the successive rounds of conflict between the government and Al Houthis. IOM operated five mobile health clinics in the districts of Barat Al Inan, Khab wa'ash Shaf, Rajooza and Az Zahir, providing basic primary health services and health promotion. Throughout 2011, 21,817 individuals were directly provided with health care. For many of the villages serviced by IOM's mobile health clinic, it was the first time that the population accessed health care and met a medical doctor.

By the end of November 2011, IOM had completed a polio vaccination campaign and the distribution of vitamin A supplementation in three districts of northern Al-Jawf. Of the total number of children under age 5 targeted by the Ministry of Public Health and Population (MOPHP), 92 per cent were covered by the campaign in Al-Humaydat District, followed by 67 per cent in Barat Al-Inan and 43 per cent in Rajuzah.

Additionally, through a household nutrition survey, 936 children under age 5 were measured for age, height and weight in six districts. This survey revealed a global acute malnutrition (GAM) level of 29 per cent, far above the emergency threshold of 15 per cent. Furthermore, in Northern Al-Jawf, the proportion of girls under age 5 suffering from GAM was significantly higher than the figure for boys in the same age group. Of all anthropometric surveys of children under age 5 carried out so far, this gender disparity in the level of malnutrition was only found in Al-Jawf. As the current situation is not foreseen to improve significantly in the near future, the number of children suffering

from malnutrition is expected to rise even more in the coming months, which will ultimately result in higher morbidity and mortality. Traditional attitudes of providing better food and care for men and boys will especially put women and girls at greater risk.

Abyan, south Yemen, September to December 2011

The population of Abyan has been the most impacted by military campaigns and armed insurgencies occurring throughout the country. The battle for control of Zinjibar, Abyan's regional capital, has resulted in the displacement of thousands of families. IOM focused on an estimated 4,262 families (approximately 21,310 individuals) displaced throughout Abyan Governorate. It is the only United Nations-affiliated organization working directly in the governorate.

Responding to the urgent health needs of IDPs and host communities in Abyan, IOM started the operation of its first mobile health clinic in September 2011, providing a range of primary health care services, health promotion and assisted medical referrals. From September to December 2011, IOM reached several villages in the districts of Serar and Rasud and treated 6,508 individuals, the majority of whom were women and children, including 1,035 children under age 5 and 122 pregnant women. The mobile health team also identified and treated 16 cases of suspected measles. Additionally, the IOM Migration Health Unit team carried out a rapid assessment of health facilities in Sarar, Sabah, Rusod and Lawdar, and found that most health facilities were not optimally functioning due to the displacement of health care providers, disrupted supplies of medicines and medical supplies, and the destruction of basic infrastructure. In Sarar, IOM MHU was the only health care provider for the general population and IDPs.



Stranded migrants at the IOM Departure Centre in Haradh City, Yemen. © IOM 2011.

Haradh, north-west Yemen, January to December 2011

Since September 2010, tens of thousands of migrant men, women and children have been stranded in Haradh, a strategic crossing point along the Red Sea on Yemen's north-west border with the Kingdom of Saudi Arabia, as they are turned away at the Saudi Arabian border and many of those smuggled into the country are expelled back to Yemen. From a public health perspective, the complex migration cycle endured by these migrants poses many health risks. The journey across the sea and onward by foot to Haradh is perilous. Of those who survive the journey, many reach Haradh severely dehydrated and malnourished, and often suffering from renal failure. High morbidity and mortality among migrants is compounded by Haradh's harsh climate, with temperatures climbing to over 45 degrees Celsius, the humidity in the summer rising to 100 per cent and periodic tropical storms destroying migrants' makeshift settlements. Frequent summer flooding and winter drought aggravate existing health conditions and further strain overburdened local health facilities suffering from a critical lack of medicines, medical supplies and referral facilities. Haradh has a high prevalence of *falciparum* malaria, and with the current summer temperature, many migrants reach the IOM Departure Centre in a comatose state due to cerebral malaria. Throughout the summer, many were found to be suffering from heatstroke. Both cerebral malaria and heatstroke have irreversible consequences and poor outcomes and frequently result in deaths.

Within the context of providing humanitarian assistance to this extremely vulnerable population, IOM has been operating a fixed clinic at its migrant registration and departure centre in collaboration with the Charitable Society for Social Welfare (CSSW) since January 2011. Under the supervision of an IOM medical staff, two medical doctors and three nurses operate around the clock in shifts, providing emergency medical care, treatment of common ailments, medical referrals, pre-departure health check, and facilitation of vaccination and mosquito spraying in and around the IOM clinic premises, with support from the MOPHP and WHO. From January to December 2011, 16,665 migrants were directly provided with health care, including 447 women and 2,388 children. From January to May 2011, IOM assisted a caseload of approximately 1,000 patients per month; this number doubled in June 2011 due to the extreme summer weather in Haradh. IOM's average monthly caseload since May 2011, when the Organization established a new more

comprehensive medical information system, stands at 1,789 individuals. The most common medical conditions that have been diagnosed and treated since then are diarrhoeal diseases (2,215 cases) and respiratory tract infections (2,037 cases). The incidence of *falciparum* malaria and TB is also high among migrants – 446 and 86 cases, respectively. Measles is also a major communicable disease affecting both adult and child migrants. IOM identified 51 cases of measles until the end of July 2011, when the outbreak was finally contained as a result of continuous vaccination carried out by WHO and MOPHP. Additionally, IOM provided medical care to 262 injured migrants mostly suffering from gunshot wounds and fractures, and 93 surgical cases. In December alone, IOM treated 84 cases of physical trauma.

In June 2011, IOM established a formal cooperation with another implementing partner, the Hajja Branch of the Yemeni Red Crescent Society (YRC) for the provision of residential health care, psychosocial services and safe accommodation to the most vulnerable migrants. Through this cooperation, serious medical cases not requiring hospitalization, cases discharged from hospitals and those requiring specific isolation measures are treated at YRC's Protection Centre. Although the Protection Centre was initially designed to accommodate up to 20 migrants, it has operated beyond its capacity since day one, accommodating as many as 50 migrants on some occasions. The unmet health needs of migrants remain immense and IOM Yemen is continuously seeking additional support.

Preparedness and control of communicable diseases with epidemic and life-threatening potential in IDP settings: Mentawai Islands, West Sumatra Province, Indonesia

On 25 October 2010, Indonesia experienced a 7.7-magnitude earthquake that resulted in a substantial localized tsunami striking South Pagai, Mentawai Islands, West Sumatra Province. IOM implemented a project over a six-month period ending in December 2011 in response to communicable disease outbreaks among the populations displaced by the natural disaster. IOM also provided unified logistics assistance for all humanitarian actors operating in affected areas, as well as health interventions, including medical evacuations, referrals and returns, and community-based psychosocial support in the immediate aftermath of the disaster.

IOM responded to prioritized and verified urgent needs and gaps in local disease surveillance and



IOM provided training for health practitioners from primary health care centres and district health offices on clinical management of communicable diseases and strengthening diseases surveillance. © IOM 2011.

response system by establishing and mobilizing CHV teams in 21 sub-villages across Mentawai Islands, as well as by increasing the capacity of CHVs and the health cadre through training on identification, reporting, responding and clinical management of endemic communicable and life-threatening disease conditions. Community awareness campaigns on prevention and control of communicable diseases were carried out, combined with environmental clean-up campaigns. The community was empowered to protect itself from communicable diseases through material support, such as the provision of impregnated mosquito nets, in collaboration with local health structures.

During project implementation, 189 CHVs were trained on basic case detection, reporting, and referral. Thirty-one professional health workers were trained on clinical management, and 7,707 IDPs (women, 49%; men, 51%; and children under 18 years of age, 25%) benefited from health promotion campaigns on topics such as hygiene awareness, environmental clean-ups, waste management and vector control.

Health projects for conflict- and flood-affected communities in the Philippines

Health assistance to families in conflict-affected areas in Central Mindanao

IOM is providing assistance to communities through repair and refurbishment of barangay health stations (BHS) in the provinces of Maguindanao and North Cotabato, which have been affected by conflict and flooding.

Health interventions in these communities remain critical as local government and humanitarian partner assessments indicate poor health

conditions, for example, fever/flu, waterborne diseases, respiratory tract infections, and a need for urgent response. Needs are still high due to continued displacement, damaged health facilities and overwhelmed health services. From September to December 2011, more than 10,000 individuals benefited from the medical services provided by IOM doctors and nurses

At present, medical services in impoverished communities once affected by conflict and/or flood are very limited. This is aggravated by the shortage of qualified personnel and limited supplies and medicines.

IOM has repaired four BHS that benefit vulnerable communities. Medical equipment, such as examination tables, nebulizers, weighing scales, and medicine cabinets and health kits containing blood pressure metres, thermometers, stethoscopes and other common medical tools were also provided to each BHS.

The project is implemented within the health cluster strategy in conflict-affected areas, and the repair of BHS is IOM's contribution to the bigger programmatic approach of the cluster. Interventions and tasks are distributed among health cluster members and shared out in terms of provision of medicines and supplies and the organization, deployment and capacitating of community mobile health referral teams (CMHRT). IOM works in partnership with the Integrated Provincial Health Office (IPHO) and the Department of Health in the Autonomous Region in Muslim Mindanao (ARMM).

Emergency primary health care assistance to flood-affected families in Central Luzon

IOM Philippines provided emergency health care through the deployment of mobile clinics in the most vulnerable flood-affected communities in the provinces of Bulacan and Pampanga, where houses were flooded for weeks, posing serious health risks to affected families especially the vulnerable population.

The most vulnerable areas were validated by IOM through the help of the regional and municipal offices of the Department of Social Welfare and

Development and all local barangay health units. IOM identified 50 barangays where mobile clinics were deployed all throughout the project. IOM also conducted health sessions and distributed IEC materials in the most vulnerable communities, as well as family health kits to 3,000 families.

This health care assistance was part of an ongoing multisectoral project that IOM is implementing in response to the damage caused by typhoons Nesat and Nalgae in almost 40 provinces in northern Luzon in 2011, especially in Bulacan and Pampanga.



Mobile health clinic in Pampanga, Philippines. © IOM.

Psychosocial support in Pakistan

Emergency primary health care assistance to monsoon flood-affected populations in host communities in Pakistan

IOM health teams provided critical and lifesaving health care services to thousands of families and individuals stranded, displaced and trapped following the heavy rains and flash floods in Sindh and Punjab.

From March to November 2011, 95,000 patients were treated at IOM fixed and mobile clinics at five locations in southern Punjab and southern

Sindh. A total of 624 patients benefited from referral services to tertiary health facilities for lifesaving treatment of complicated, chronic and acute illnesses. Twenty-five thousand patients attended 167 health promotion and disease prevention awareness sessions. An Information Management Cell was established at Director General Health Hyderabad office in support of Health Cluster and Health Early Recovery Working Group activities. Upgrading and equipment work at five IOM clinics was completed. Comprehensive refurbishment and equipment was supplied to People's Maternity Centre Dadu in support of safe delivery services.

As part of the project “Multisectoral Health Response to Disaster-stricken Health System of Punjab and Sindh”, which ran from August 2010 to August 2011, IOM conducted a mental health needs assessment survey in April 2011 in consultation with its global mental health and psychosocial support unit in Geneva, as well as the Departments of Psychology in Bahudin Zikrya University Multan and Sindh University Jamshoro. The psychosocial needs assessment survey was rolled out in four districts of Punjab and Sindh with the help of 16 male and female psychologists trained by IOM.

Residents of severely affected areas, people working in severely affected areas, those who suffered flood-related losses, and those still living in transitional settlements/camps were prioritized as beneficiaries.

The assessment found a near-absence of a mental health and psychosocial support system in flood-affected areas and a paramount need for capacity-building.



Role-playing on psychosocial first aid during the Workshop on Innovative Psychosocial Responses to Disasters – Social Theatre and Movement Therapies. © IOM 2011.



Participants of the Workshop on Innovative Psychosocial Responses to Disasters – Social Theatre and Movement Therapies. © IOM 2011.

Workshop on Innovative Psychosocial Responses to Disasters – Social Theatre and Movement Therapies in Pakistan

The need to build awareness of innovative practices for mental health and psychosocial support (MHPSS) in disaster response was identified at a national workshop held in June 2011 at the WHO Collaborating Centre for Mental Health Research, Training and Substance Abuse at the Institute of Psychiatry (IOP), Rawalpindi General Hospital. In the spirit of humanitarian response, IOM attempted to fill the identified gap by conducting a series of workshops on best practices for MHPSS in disasters, including the use of innovative theatre and movement therapies. The workshop was a collaborative effort between IOM and IOP, and multiple stakeholders, including government institutions, the Armed Forces Institute of Mental Health and civil society organizations actively participated in the workshop.

On the first day, the workshop introduced the basic epistemology of mental health and psychosocial support, as well as the Inter-Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support. The second day of the workshop focused on the theory of psychosocial first aid (PFA) skills and practice sessions on PFA for the participants. The participants were introduced to the theory and practice of social theatre and movement therapies on the third day. The three-day workshop was followed by the National Consultation on Strategy Development on Mental Health and Psychosocial Support for future disasters in Pakistan. The participants were divided into groups and given various components of the mental health response in disasters. The deliberations are being incorporated into the draft document that would be shared with the Health Emergency Preparedness and Response Unit (HEPRU) as well as the health sector led by WHO.

Workshop on shelter security and psychosocial support for victims of trafficking

IOM held a workshop for humanitarian workers active in southern Punjab and Sindh to give them essential knowledge on the psychosocial support needed by victims of trafficking and their health vulnerabilities.

Translation of Psychological First Aid manual

The Psychological First Aid manual, published by WHO in August 2011, was translated into Urdu with funding from the Canadian International Development Agency (CIDA).

II. Monitoring Migrant Health

Monitoring the health of migrants: The Bangladeshi migrant worker experience

Libya hosted thousands of migrant workers, a significant number of which come from Bangladesh, before the civil war in 2011 (for more information on the Libya crisis, see the section on “Libya crisis – IOM health and psychosocial response”). The IOM Dhaka migration health team worked with the operations team to assist in the return and reintegration of Bangladeshi migrant workers from Libya during the 2011 crisis. A migration health physician from IOM Dhaka worked with the health team in Tunisia. Migration health staff also worked as part of a team that received the returnees at the international airport in Dhaka.



Migrant with a fractured leg being assisted off the plane upon arrival in Dhaka. © IOM 2011.

A World Bank-funded project managed by IOM Dhaka in collaboration with the Government of Bangladesh provided reintegration grants for all registered returnees. There were reports of about 63,000 Bangladeshi migrants in Libya. Over 36,500 people, of whom 145 were women, registered with this reintegration programme. The return and registration of thousands of Bangladeshi migrant workers from Libya offered an opportunity to study a topic of global significance: migrants' access to health in their country of destination. During the registration process, qualitative information was collected through focus group and in-depth discussions on migrants' access to insurance and health services during their stay in Libya.

Very few of the migrants had received health information before leaving Bangladesh for Libya, even though all of them had undergone health assessment at a government-approved health centre. The migrants were not informed of the reason why laboratory investigations, X-rays or physical examinations were being performed. None of the migrants reported having access to health insurance, and only a few of the foreign companies provided some basic health services for the migrant workers. Most of the migrant workers preferred to use private health services, even though doing so was more expensive than using government hospitals, since they perceived private health services to be more migrant-friendly. In most cases, migrant workers had to pay for health services, with no hope of reimbursement from their employers. Access to health services was hindered by migrant workers' inability to communicate in Arabic. The migrants reported that they got all their health information from the Bangladeshi television programmes that they regularly watched via satellite in Libya. There were reports of stressful work environments, high use of tobacco and alcohol, and visits to sex workers.

This information indicates that there is a need for: 1) pre-departure health assessments to provide information and obtain consent for investigations from prospective migrants in a language that they understand; 2) employment contracts to include health insurance and access to migrant-friendly health services in destination countries; and 3) continuous health promotion for migrants, instead of this being offered only at the pre-departure stage of migration.

III. Policy and Legal Frameworks

Emergency psychosocial assistance and return and reintegration assistance in Haiti

This project aimed to provide psychosocial support and psychosocially aware humanitarian assistance for earthquake-affected people in support of the reintegration and return process. More than 1,700 earthquake-affected persons returning home or resettled in IOM- or CCCM-identified shelters were assisted through direct psychosocial support, including facilitating referrals to other required services, while facilitating the country's capacity to respond through capacity-building of professionals and general humanitarian workers.

Activities provided by the psychosocial teams included community mobilization and recreational, informal, educational and counselling services in accordance with the IASC Guidelines on Mental Health and Psychosocial Support and consistent with the needs identified through relevant IOM psychosocial assessments in Haiti. In addition to accompanying families during the transition period, IOM engaged in monitoring needs and feelings regarding return and its difficulties, assessing the protective and risk factors of individuals and families facing difficulties to return to their home/shelter, and providing information to communities about positive and effective coping mechanisms. The IOM psychosocial team focused on assessing especially vulnerable individuals, such as pregnant women, individuals with disabilities or pre-existing psychiatric disorders, and elderly people.

Addressing health and psychosocial barriers to return and reintegration of IDPs

In the aftermath of a natural disaster, there may be multiple barriers to accessing health care, as was the case in Haiti in 2011. In Haiti, such barriers included a poorly functioning pre-existing health system, physical barriers due to injury, displacement, destroyed health clinics, lack of knowledge on where care is available, financial barriers to pay for transport to facilities, and fees for service requirements.

Those who remain in IDP camps are often the most vulnerable. Catastrophic health costs/incidents can be significant barriers to successful return/reintegration and can compound vulnerability upon return. This vulnerability can be particularly seen among pregnant, post-partum and lactating women, with significant consequences for mothers, boys and girls.

As efforts by the Government of Haiti and the international community were scaled up to support return and reintegration initiatives, there was a critical need to address health and psychosocial barriers to return in order to assist the most vulnerable and prevent the return process from having negative consequences.



Camp Capva, Cité Soleil, one of the oral rehydration posts established by IOM in camps, vulnerable rural communities and border crossings. © IOM 2011.

A project was designed to complement inter-cluster objectives and initiatives contributing to comprehensive return and reintegration assistance. Assistance was prioritized to support the most vulnerable, including: people living with disabilities (physical, sensorial, mental and intellectual); pregnant, post-partum and lactating women; children under age 5; elderly persons; people with chronic or disabling illnesses, including HIV/AIDS and TB; and acutely ill patients, with a focus on IDP camps targeted for return and resettlement initiatives. More than 1,000 vulnerable individuals were provided with multiple health and psychosocial services in IDP camps.

IV. Partnerships, Networks and Multi-Country Frameworks

Winter school: Psychosocial Interventions in Emergency Displacement

IOM, together with the Scuola Superiore Sant'Anna di Studi Universitari e di Perfezionamento and the Centre for Trauma Asylum and Refugees at the University of Essex, organized the training course "Psychosocial Interventions in Emergency Displacement" in Pisa, Italy on 14–26 February 2011.

The training focused on: 1) the epistemology of mental health and psychosocial responses in emergencies; 2) international standards and global tools; 3) psychosocial approach to emergency humanitarian assistance; and 4) mental health and psychosocial programming in emergencies, with particular reference to IOM approaches and programmes.

The course had a practical orientation and relied heavily on case studies to enhance participants' skills and abilities to effectively provide psychosocial support. Practical exercises included advanced role-playing and simulations. Trainers included experts from IOM, UNICEF, HealthNet TPO (Transcultural Psychosocial Organization), the University of Essex, the Maudsley Hospital, the IASC Reference Group on Mental Health and Psychosocial Services, the War Trauma Foundation, and the Lebanese Centre for Political Studies. Participants included IOM staff from 14 different countries, as well as governmental counterparts and psychosocial staff of WHO, UNIFEM, War Child, Handicap International and several other NGOs.



Lecture during the Psychosocial Interventions in Emergency Displacement training course. © IOM 2011.

Support to DARI recreational and counselling centre for families in Baalbeck, Lebanon

This project supported the sustainability and existing achievements of DARI (Recreational and Counselling Centre for Families in Baalbeck) over a period of one year. Previous funding had facilitated sustainability through capacity-building of the centre's staff and management through training in fundraising/project cycle management, budgeting and administration, notwithstanding activities and social opportunities for the local community. New funding facilitated development of the centre's capacity to continue and advance psychosocial opportunities for the community.

Annex 1: IOM Publications, Guidelines and Tools on Migration and Health

IOM internal publications, guidelines and tools, 2011

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12. International Organization for Migration (2011) *Nutrition Surveillance Reports: Health Assessment Programme (Issue No. 1, Jan–Jun 2011)*. IOM, Manila, http://publications.iom.int/bookstore/free/MHD_NL%20issue1_13sep_FINAL.pdf.
13. International Organization for Migration, et al. (2011) *Key Populations, Key Solutions – A Gap Analysis and Recommendations for Key Populations and HIV in South Africa*. Policy Brief. IOM, Pretoria, http://iom.org.za/web/index.php?option=com_docman&task=doc_download&gid=70&Itemid=11&lang=en.
14. International Organization for Migration and Ministry of Health (2011) *Situational Assessment on the Health of Cambodian Irregular Migrants*. IOM, Phnom Penh.

15. IOM Finland (2011) *Healthy Future DVD*. IOM, Helsinki, www.iom.fi/index.php?option=com_content&view=article&id=112:health-project&catid=41:migration-health&Itemid=119.
16. IOM Finland (2011) *Healthy Future DVD – Handbook for Health Care Professionals* (in Finnish). IOM, Helsinki, www.iom.fi/index.php?option=com_content&view=article&id=112:health-project&catid=41:migration-health&Itemid=119.
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18. IOM- MHD Regional Office Brussels (2011) *Future Development Report: With Migrants for Migrants – Improving HIV Prevention for All*. IOM, Brussels.
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20. IOM-MHD Regional Office Brussels (2011) *National Profile of Migration of Health Professionals – Egypt*. IOM, Brussels.
21. IOM-MHD Regional Office Brussels (2011) *National Profile of Migration of Health Professionals – Ghana*. IOM, Brussels.
22. IOM-MHD Regional Office Brussels (2011) *National Profile of Migration of Health Professionals – Kenya*. IOM, Brussels.
23. IOM-MHD Regional Office Brussels (2011) *National Profile of Migration of Health Professionals – Morocco*. IOM, Brussels.
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28. IOM Regional Office for Asia and the Pacific (2011) *Regional Migration Health Initiatives (Issue No. 4, Jul–Sep 2011)*. IOM, Bangkok.
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34. IOM Sri Lanka (2011) *Key findings of the national research on migration health – Study on Returning Refugees from South India*. IOM, Colombo, [www.migrationhealth.lk/factsheets/Returning%20refugees%20fact%20sheet\(for%20website\).pdf](http://www.migrationhealth.lk/factsheets/Returning%20refugees%20fact%20sheet(for%20website).pdf).

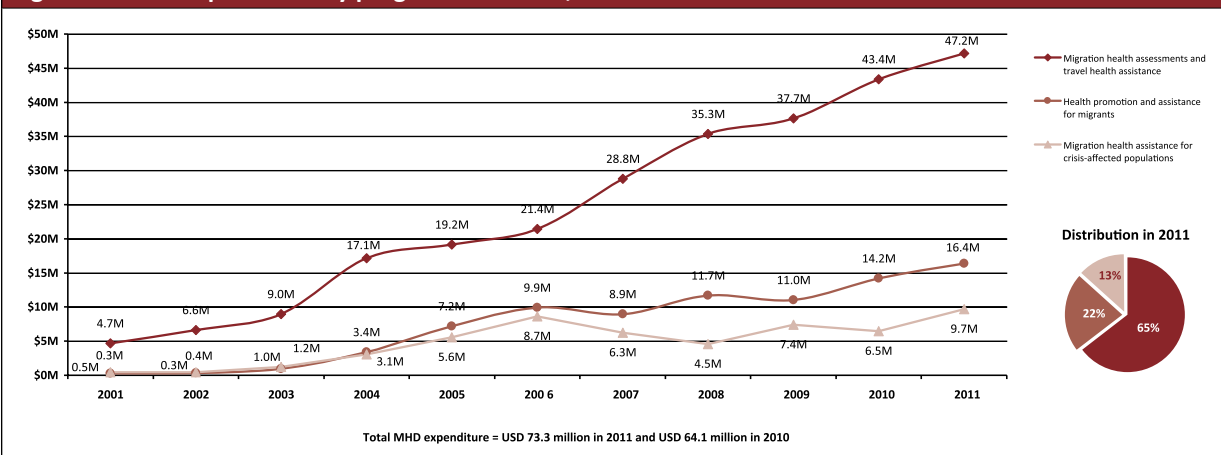
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Annex 2: Service Delivery in Numbers, 2011

Figure 4: MHD expenditure by programmatic area, 2001–2011



Note: Health issues cut across all areas of IOM's work. This figure reflects only purely migration health programmes and projects. It does not include migrant health expenditures which are integrated into other IOM services.

Figure 5: MHD expenditure by region and programmatic area, 2009–2011

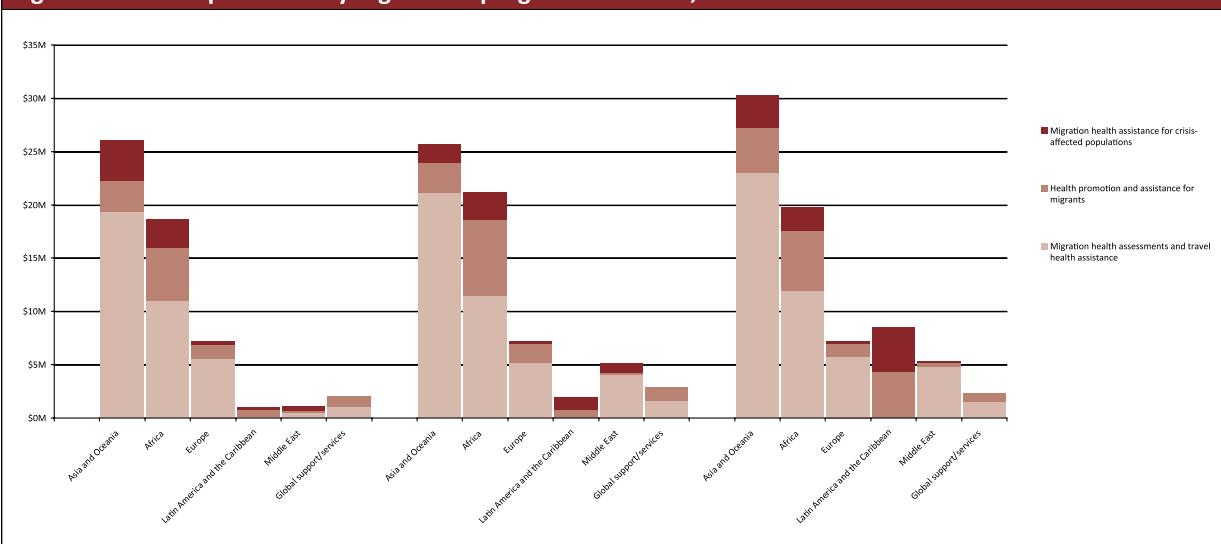


Figure 6: MHD expenditure by funding source, 2009–2011 (in USD)

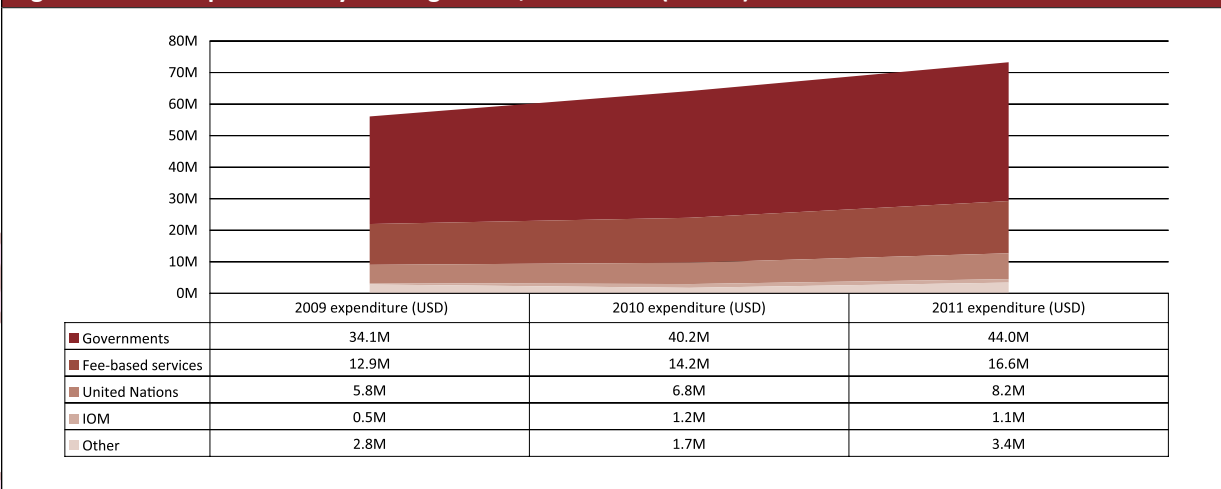


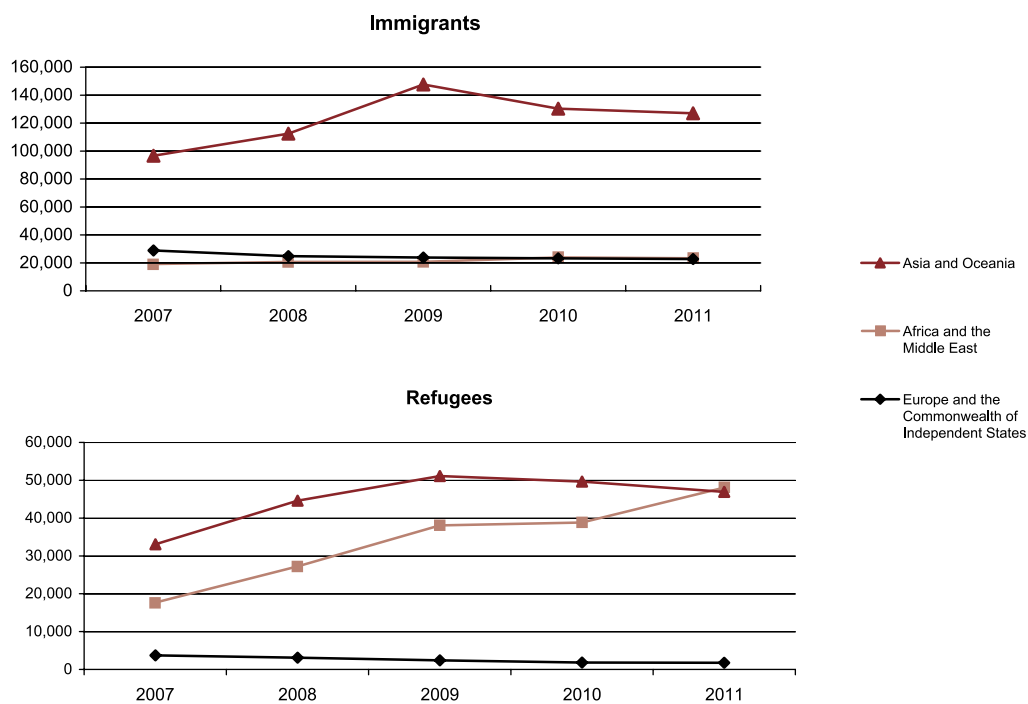
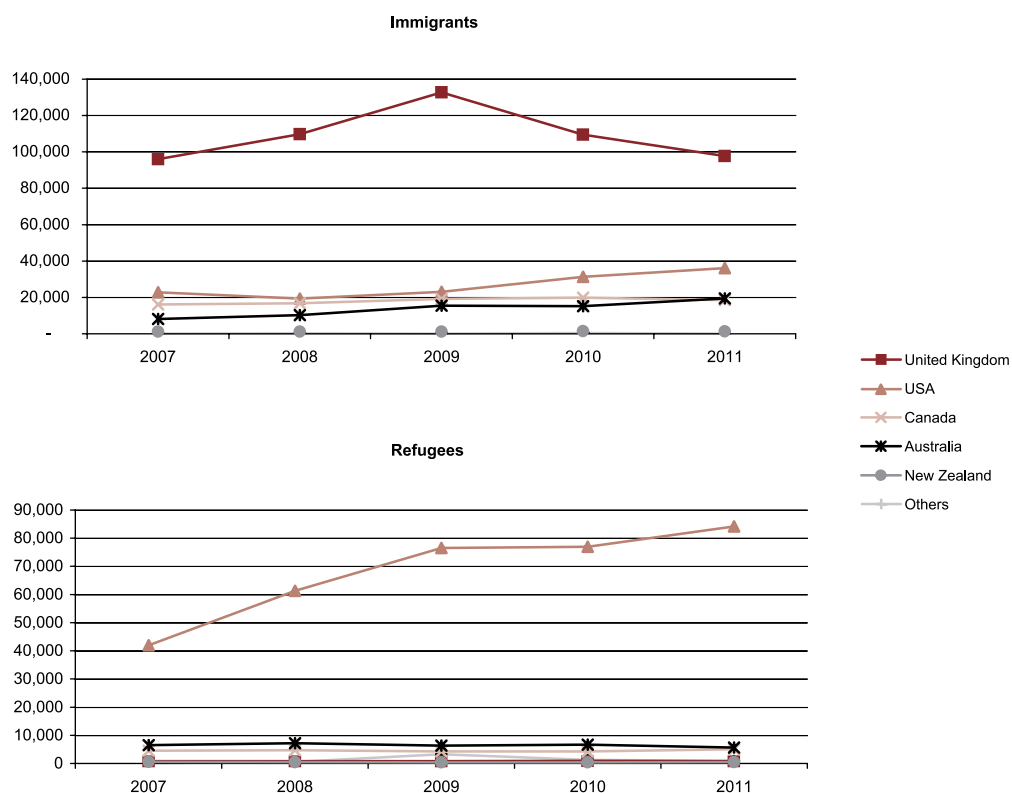
Figure 7: IOM health assessments among immigrants and refugees by region of origin, 2007–2011**Figure 8: Immigrants and refugees examined by country of destination, 2007–2011**

Figure 9a: Sex and age distribution of immigrants from Asia and Oceania, 2011

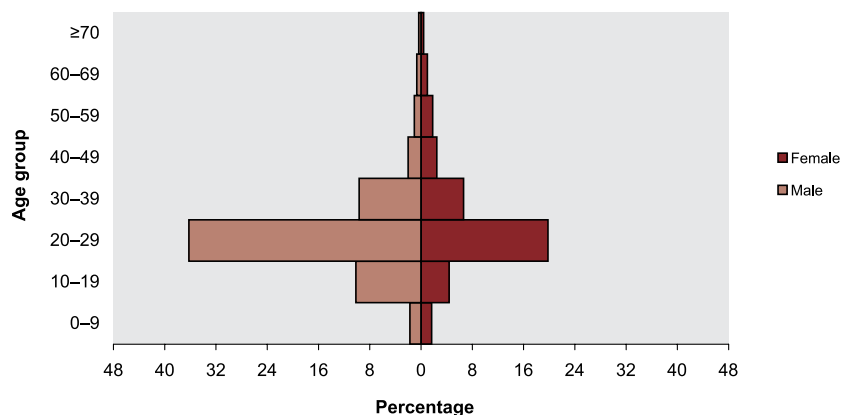


Figure 9b: Sex and age distribution of immigrants from Africa and the Middle East, 2011

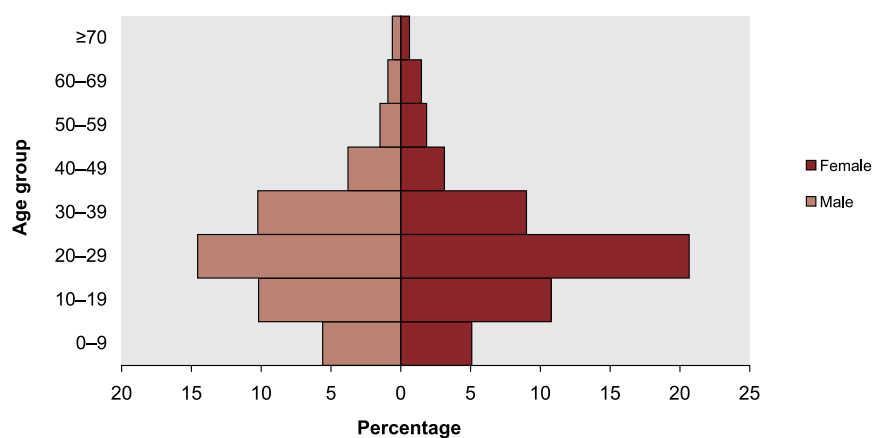


Figure 9c: Sex and age distribution of immigrants from Europe and the Commonwealth of Independent States, 2011

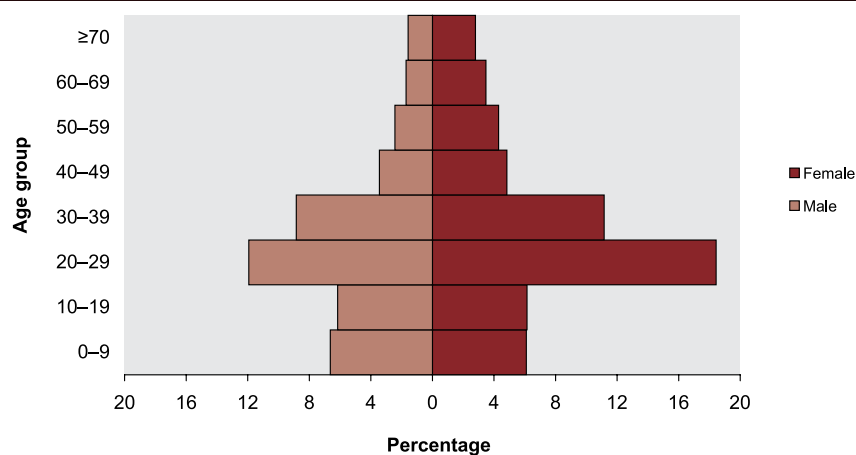


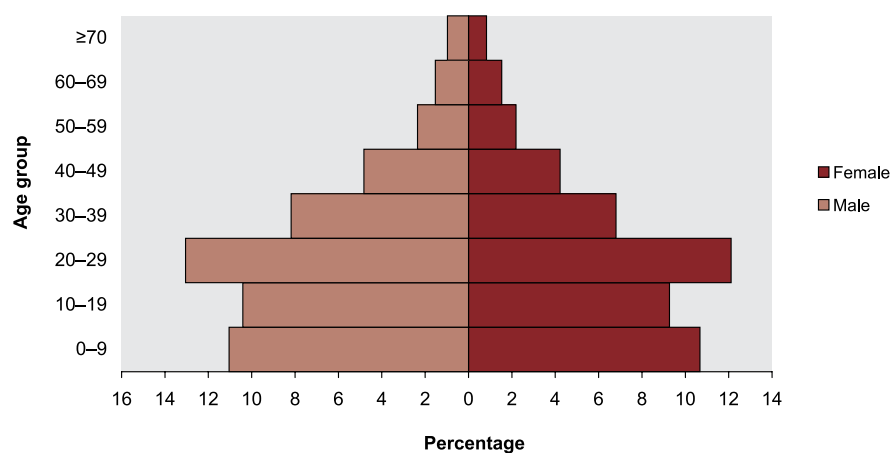
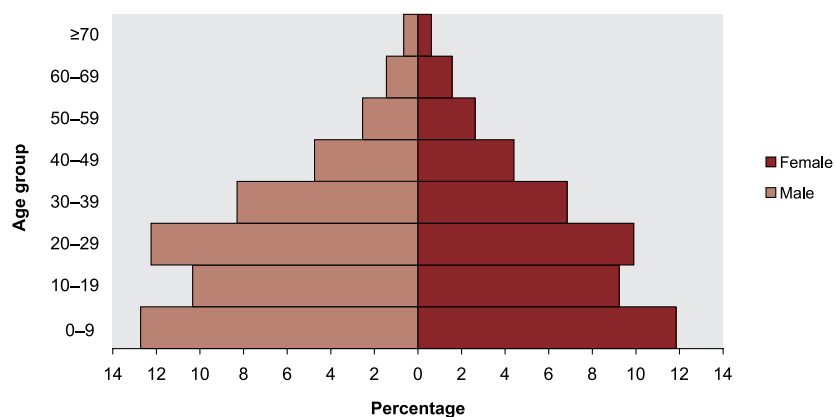
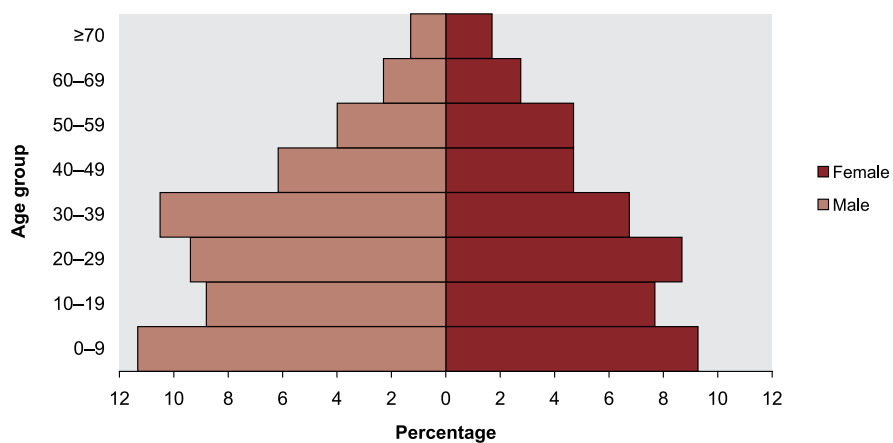
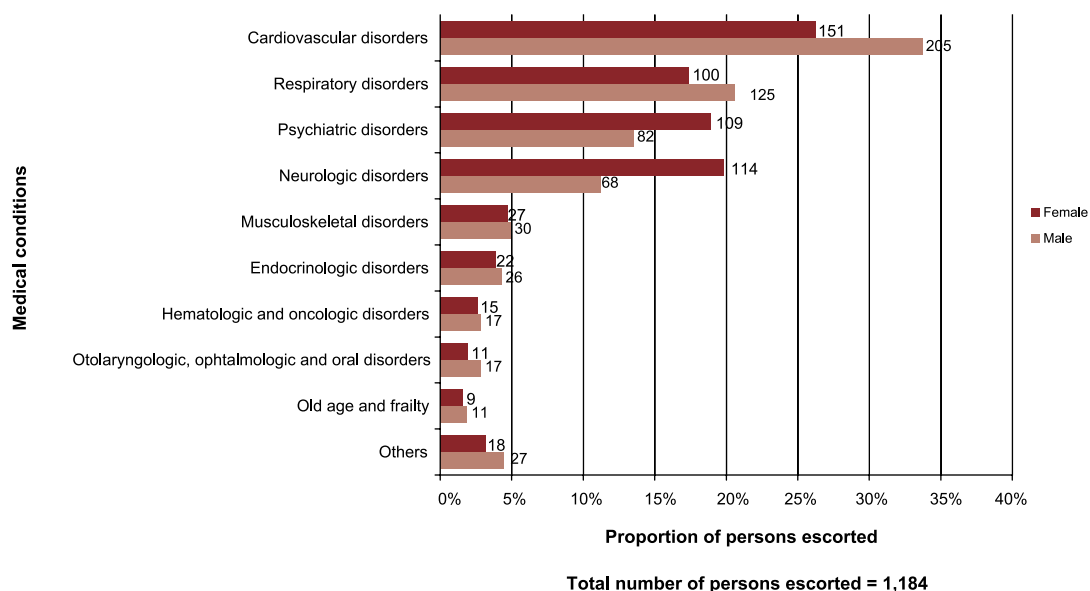
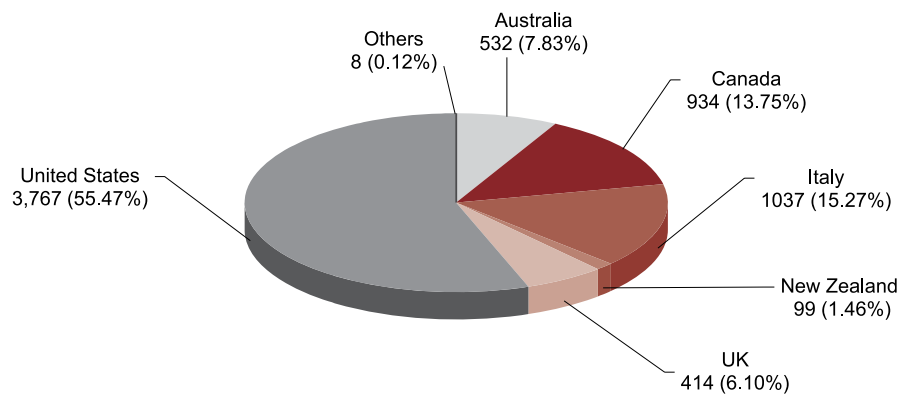
Figure 10a: Sex and age distribution of refugees from Asia and Oceania, 2011**Figure 10b: Sex and age distribution of refugees from Africa and the Middle East, 2011****Figure 10c: Sex and age distribution of refugees from Europe and the Commonwealth of Independent States, 2011**

Figure 11: Main conditions of migrants assisted by IOM medical escorts, 2011**Figure 12: IOM-assisted DNA services (sampling and tests) by country of destination and country of service, 2011**

Total number of samples tested = 6,791

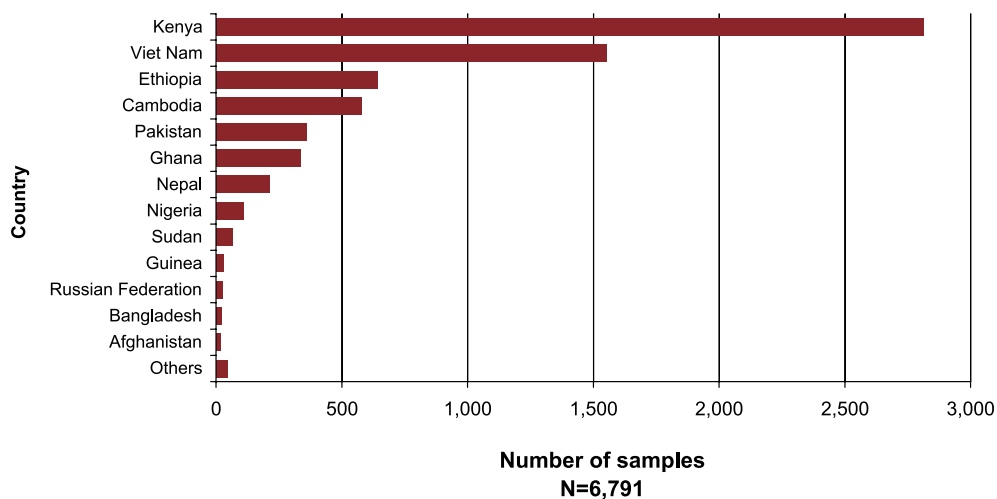
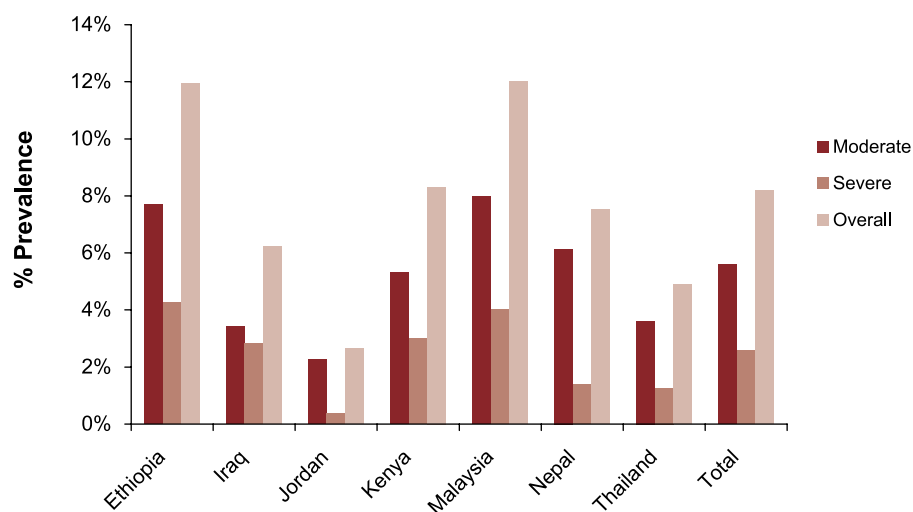
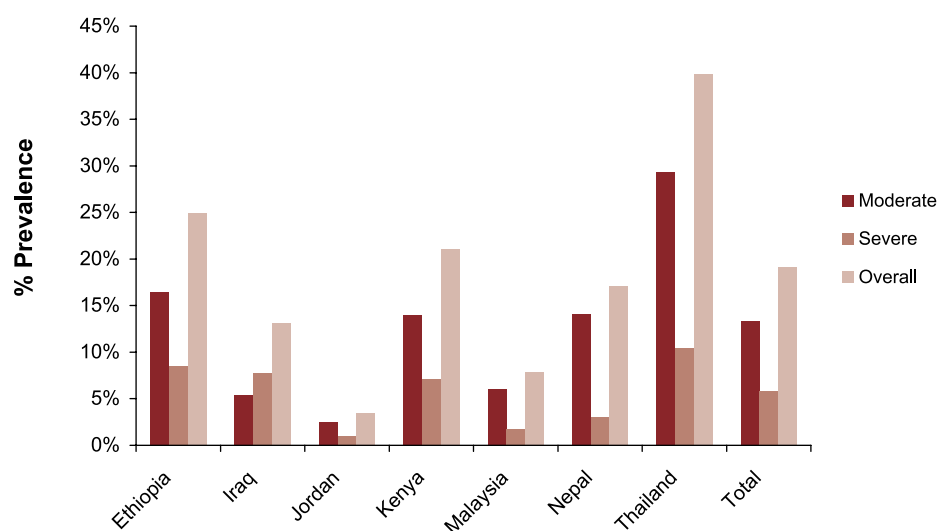


Figure 13: Wasting among refugee children under age 5 in seven countries, 2011**Figure 14: Stunting among refugee children under age 5 in seven countries, 2011****Table 4: MHD expenditure by donor, 2010–2011**

A) Migration health assessments and travel health assistance					
FUNDING SOURCE	2011 EXPENDITURE		2010 EXPENDITURE		Increase/ (Decrease)
	(In USD)	%	(in USD)	%	
Governments	30,596,840	65	29,106,173	67	1,490,667
USA	26,157,713	85	24,777,138	85	1,380,575
Australia	3,918,189	13	3,957,962	14	(39,772)
Canada	520,937	2	371,073	1	149,864
Fee-based services	16,581,574	35	14,272,130	33	2,309,445
Migration health assessments and travel health assistance	47,178,414	100	43,378,302	100	3,800,112

B) Health promotion and assistance for migrants					
FUNDING SOURCE	2011 EXPENDITURE		2010 EXPENDITURE		Increase/ (Decrease)
	(In USD)	%	(In USD)	%	
Governments	7,951,805	49	7,464,397	53	487,408
Colombia	3,414,088	43	(23,722)	0	3,437,811
Sweden	2,175,141	27	3,403,659	46	(1,228,518)
USA	1,856,245	23	1,883,405	25	(27,159)
Finland	215,617	3	-	0	215,617
Italy	158,407	2	338,515	5	(180,108)
Norway	131,009	2	92,593	1	38,416
Poland	32,340	0	34,568	0	(2,228)
UK	2,703	0	625,253	8	(622,550)
Africa	151	0	-	0	151
Angola	-	0	29,623	0	(29,623)
Guatemala	-	0	(19,662)	0	19,662
Hungary	-	0	19,009	0	(19,009)
Japan	(148)	0	148	0	(296)
Germany	(631)	0	32,677	0	(33,308)
Switzerland	(817)	0	130,395	2	(131,212)
Croatia	(2,599)	0	12,330	0	(14,929)
Portugal	(3,170)	0	-	0	(3,170)
Kazakhstan	(26,534)	0	905,605	12	(932,139)
Fee-based services	7,855	0	-	0	7,855
United Nations	4,736,749	29	4,653,056	33	83,693
United Nations Development Programme (UNDP)	1,494,516	32	1,000,105	21	494,411
United Nations Children's Fund (UNICEF)	1,051,451	22	583,645	13	467,806
World Health Organization (WHO)	505,740	11	2,792	0	502,948
United Nations Office for Project Services (UNOPS)	411,524	9	1,069,670	23	(658,146)
Joint United Nations Programme on HIV/AIDS (UNAIDS)	390,692	8	512,844	11	(122,153)
United Nations One Fund	314,475	7	92,293	2	222,182
United Nations Trust Fund for Human Security (UNTFHS)	209,169	4	186,398	4	22,771
Central Fund for Influenza Action (CFIA)	178,519	4	982,525	21	(804,006)
World Food Programme (WFP)	70,791	1	33,783	1	37,007
United Nations TB Reach	62,519	1	-	0	62,519
United Nations Population Fund (UNFPA)	41,569	1	144,791	3	(103,222)
United Nations Development Fund for Women (UNIFEM)	5,785	0	44,210	1	(38,425)
Non-governmental organizations	1,229,945	8	191,341	1	1,038,604
Save the Children	952,561	77	-	0	952,561
Ethno-Medizinisches Zentrum Verein (EMZ)	81,856	7	44,054	23	37,801
Family Health International	73,054	6	71,918	38	1,137
ANESVAD Foundation	55,273	4	-	0	55,273
Consorzio Connecting People	48,242	4	-	0	48,242
TEBA Development	11,402	1	-	0	11,402
World Vision Australia	7,557	1	-	0	7,557
CARE	-	0	54,816	29	(54,816)
Chemonics International Inc.	-	0	14,801	8	(14,801)
Defense for Children International	-	0	5,752	3	(5,752)
IOM	1,094,190	7	1,189,501	8	(95,311)
European Commission	776,645	5	650,108	5	126,537
Global Fund to Fight AIDS, Tuberculosis and Malaria	540,993	3	-	0	540,993
Universities	38,921	0	18,864	0	20,057
The Regents of the University of San Francisco, California	38,921	100	-	0	38,921
University of Pecs (Hungary)	-	0	18,864	100	(18,864)
Asian Development Bank	-	0	779	0	(779)
World Bank	4,939	0	25,704	0	(20,766)
Private Sector	-	0	(2,950)	0	2,950
Fondazione Benni	-	0	(2,950)	100	2,950
Health promotion and assistance for migrants	16,382,041	100	14,190,800	100	2,191,241

C) Migration health assistance for crisis-affected populations					
FUNDING SOURCE	2011 EXPENDITURE		2010 EXPENDITURE		Increase/ (Decrease)
	(In USD)	%	(In USD)	%	
Governments	5,488,665	56	3,597,102	55	1,891,563
USA	3,299,996	60	1,893,235	53	1,406,760
Canada	734,479	13	-	0	734,479
Sweden	687,692	13	292,568	8	395,124
Switzerland	345,154	6	258,356	7	86,798
UK	172,212	3	355,544	10	(183,333)
Germany	135,418	2	-	0	135,418
Netherlands	105,352	2	365,998	10	(260,646)
Denmark	21,598	0	31,975	1	(10,377)
Poland	-	0	(126)	0	126
Australia	(2,480)	0	360,158	10	(362,638)
Belgium	(3,109)	0	50,025	1	(53,135)
Colombia	(7,647)	0	(10,632)	0	2,985
United Nations	3,456,404	35	2,205,568	34	1,250,837
Central Emergency Response Fund (CERF)	1,393,582	40	1,135,576	51	258,007
United Nations Office for Project Services (UNOPS)	1,045,457	30	541,435	25	504,022
United Nations Office for the Coordination of Humanitarian Affairs (OCHA)	583,692	17	-	0	583,692
Common Humanitarian Fund for Sudan (CHF)	358,005	10	248,688	11	109,317
World Health Organization (WHO)	57,125	2	7,644	0	49,482
Joint United Nations Programme on HIV/AIDS (UNAIDS)	20,078	1	-	0	20,078
United Nations Development Programme (UNDP)	(198)	0	70,889	3	(71,087)
United Nations Children's Fund (UNICEF)	(1,337)	0	201,337	9	(202,674)
European Commission	462,826	5	-	0	462,826
Universities	230,703	2	167,824	3	62,879
University Hospital in Linköping	230,703	100	167,824	100	62,879
Non-governmental organizations	62,768	1	272,046	4	(209,278)
AmeriCares	62,768	100	80,232	29	(17,464)
Methodist Committee on Relief	-	0	191,814	71	(191,814)
Private sector	49,755	1	318,941	5	(269,187)
Foundation D'Harcourt	29,145	59	66,176	21	(37,030)
United States Association for International Migration	16,428	33	-	0	16,428
CREADEL – Liban	4,181	8	18,382	6	(14,201)
ExxonMobil Foundation	-	0	234,384	73	(234,384)
IOM	557	0	8,957	0	(8,400)
World Bank	-	0	11,550	0	(11,550)
Migration health assistance for crisis-affected populations	9,751,678	100	6,581,988	100	3,169,690
Grand Total	73,312,133	100	64,151,091	100	9,161,043

Table 5. IOM health assessments by country of origin, country of destination and migrant category*, 2011

Country of IOM Health Assessment	Country of Destination					
	Australia		Canada		New Zealand	
	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees
Afghanistan	226	1	247	317	46	0
Bangladesh	1,012	0	175	0	0	0
Cambodia	1,599	0	551	55	526	0
Indonesia	1	42	17	6	2	0
Kazakhstan	227	0	591	29	62	0
Kyrgyzstan	0	0	0	0	0	0
Malaysia	0	1,171	0	156	0	99
Nepal	67	1,014	0	1,731	0	136
Pakistan	8,637	678	2,650	5	130	0
Thailand	0	627	0	48	0	199
Uzbekistan	0	0	0	0	0	0
Viet Nam**	2,160	0	2,873	0	109	0
Asia and Oceania	13,929	3,533	7,104	2,347	875	434
Bahrain	0	0	0	0	0	0
Benin	0	0	0	4	0	0
Botswana	0	0	0	53	0	0
Burundi	0	3	0	11	0	0
Cameroon	0	0	0	0	0	0
Central African Republic	0	0	0	0	0	0
Chad	0	0	0	0	0	0
Côte d'Ivoire	0	7	1	0	0	0
Democratic Republic of the Congo	7	0	42	70	0	0
Djibouti	0	0	58	24	0	0
Eritrea	26	3	3	7	0	0
Ethiopia	378	206	1,455	247	2	4
Gabon	0	0	0	0	0	0
Ghana	78	21	125	7	1	0
Guinea	33	248	96	51	0	0
Iraq	321	304	107	0	30	0
Jordan	95	80	0	164	14	0
Kenya	1,225	365	563	685	25	8
Lesotho	0	0	0	0	0	0
Liberia	7	0	0	0	0	0
Madagascar	0	0	0	1	0	0
Malawi	0	95	0	0	0	0
Mali	1	0	0	0	0	0
Mozambique	0	0	0	0	0	0
Namibia	0	0	0	0	0	0
Nigeria	2	0	0	4	0	0
Oman	0	0	0	0	0	0
Republic of the Congo	0	0	5	2	0	0
Rwanda	22	113	0	0	0	0
Sierra Leone	0	0	0	1	0	0
Somali Republic	0	0	9	6	0	0
South Africa	0	0	0	0	0	0
Sudan	1	6	0	0	0	0
Syrian Arab Republic	23	401	38	726	0	0
Togo	1	0	0	0	0	0
Tunisia	0	82	0	0	0	0
Uganda	103	57	140	319	0	0
United Republic of Tanzania	106	34	2	110	0	0
Zambia	0	5	0	0	0	0
Zimbabwe	0	0	0	0	0	0
Africa and the Middle East	2,429	2,030	2,644	2,492	72	12
Belarus	82	0	320	0	17	0
Bosnia and Herzegovina	162	0	175	10	0	0
Bulgaria	0	0	388	0	0	0
Croatia	254	0	40	0	8	0
FYROM***	255	0	190	0	20	0
Republic of Moldova	75	0	1,577	0	8	0
Romania	173	0	1,533	0	37	0
Russian Federation	1,310	0	1,395	98	284	0
Serbia	484	0	460	0	27	0
UNSC resolution 1244-administered Kosovo	29	0	246	0	3	0
Ukraine	346	0	2,548	9	88	0
Europe and the Commonwealth of Independent States	3,170	0	8,872	117	492	0
Worldwide	19,528	5,563	18,620	4,956	1,439	446
	25,091		23,576		1,885	

Notes:

* Immigrants moved on a voluntary basis. Refugees were displaced on an involuntary basis and fall under the definition of the 1951 United Nations Convention.

** In addition, IOM Viet Nam conducted health assessments for 114 humanitarian resettlement cases bound for the United States.

***The former Yugoslav Republic of Macedonia.

Country of Destination									
UK		USA		Other		Total		Grand Total	
Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees		
0	0	0	0	0	0	519	318		837
15,660	0	0	0	0	0	16,847	0		16,847
86	0	1,770	5	0	13	4,532	73		4,605
0	0	0	0	0	0	20	48		68
0	0	20	21	1	0	901	50		951
0	0	0	3	0	0	0	3		3
0	0	0	9,625	0	153	0	11,204		11,204
0	91	4,584	17,957	0	276	4,651	21,205		25,856
66,292	0	0	0	0	0	77,709	683		78,392
7,095	0	0	12,271	0	40	7,095	13,185		20,280
0	0	0	5	0	0	0	5		5
0	0	9,678	0	0	0	14,820	0		14,820
89,133	91	16,052	39,887	1	482	127,094	46,774		173,868
0	0	0	44	0	0	0	44		44
0	0	0	5	0	0	0	9		9
0	0	0	49	0	0	0	102		102
0	0	0	95	0	0	0	109		109
0	0	0	121	0	0	0	121		121
0	0	0	67	0	0	0	67		67
0	0	0	210	0	0	0	210		210
0	0	2	0	0	0	3	7		10
0	0	0	0	0	0	49	70		119
0	0	0	361	0	0	58	385		443
0	0	0	0	0	0	29	10		39
0	0	790	6,092	0	236	2,625	6,785		9,410
0	0	0	105	0	0	0	105		105
3,966	0	28	33	0	0	4,198	61		4,259
0	0	0	133	0	0	129	432		561
0	0	736	15,198	0	28	1,194	15,530		16,724
0	28	1,825	7,852	1	3	1,935	8,127		10,062
2,631	506	6,538	8,094	0	1	10,982	9,659		20,641
0	0	0	4	0	0	0	4		4
0	0	0	0	0	0	7	0		7
0	0	0	0	0	0	0	1		1
0	0	0	11	0	0	0	106		106
0	0	0	29	0	0	1	29		30
0	0	0	131	0	0	0	131		131
0	0	0	70	0	0	0	70		70
0	0	0	0	0	0	2	4		6
0	0	0	19	0	0	0	19		19
0	0	0	2	0	0	5	4		9
0	1	0	550	0	0	22	664		686
0	0	0	0	0	0	0	1		1
0	0	0	2	0	0	9	8		17
0	0	0	512	0	0	0	512		512
925	0	0	218	0	0	926	224		1,150
0	111	0	0	0	1	61	1,239		1,300
0	0	0	15	0	0	1	15		16
0	0	0	0	0	0	0	82		82
0	0	3	1,666	0	0	246	2,042		2,288
816	0	6	636	0	0	930	780		1,710
0	0	0	47	0	0	0	52		52
0	0	0	194	0	152	0	346		346
8,338	646	9,928	42,565	1	421	23,412	48,166		71,578
0	0	125	73	0	0	544	73		617
0	0	0	0	0	0	337	10		347
0	0	0	0	0	0	388	0		388
0	0	0	0	0	0	302	0		302
0	0	0	0	0	0	465	0		465
0	0	571	400	0	0	2,231	400		2,631
0	0	0	0	0	0	1,743	0		1,743
1	0	3,616	674	15	11	6,621	783		7,404
0	0	172	0	124	0	1,267	0		1,267
0	0	536	0	0	0	814	0		814
0	0	5,268	429	0	0	8,250	438		8,688
1	0	10,288	1,576	139	11	22,962	1,704		24,666
97,472	737	36,268	84,028	141	914	173,468	96,644		270,112
98,209		120,296		1,055		270,112			(270,226)**

Table 6: TB detection among refugees, IOM major operations,* prevalence per 100,000

Country	Total Refugees	LTBI		CXR TB		Active TB per 100,000		
		No. tested	Positive (%)	No. tested	"Positive (per 100,000)"	"Lab confirmed"	Clinical	Total
Africa								
Ethiopia	6,785	1,991	194 (9.7)	4,515	402 (8,904)	177	44	221
Kenya	9,659	2,896	239 (8.3)	6,697	472 (7,048)	207	0	207
Uganda	2,042	513	97 (18.9)	1,507	74 (4,910)	294	49	343
Middle East								
Jordan	8,127	0	-	5,716	46 (805)	0	12	12
Iraq	15,530	0	-	10,461	45 (430)	13	0	13
Syrian Arab Republic	1,239	0	-	987	-	0	0	0
Asia								
Malaysia	11,204	2,070	524 (25.3)	8,542	915 (10,712)	982	9	991
Nepal	21,205	3,856	385 (10)	16,647	2,352 (14,129)	948	57	1,004
Thailand	13,185	4,338	301 (6.9)	8,374	1,529 (18,259)	432	68	501
Europe								
Russian Federation	783	0	-	754	143 (18,966)	128	0	128
All regions								
Other refugees	6,999	671	53 (7.9)	4,469	272 (6,086)	200	14	214
Total	96,758	16,335	1,793 (11.0)	68,669	6,250 (9,102)	437	29	466

Note: *An IOM major operation is defined as an operation involving more than 1,000 assisted immigrants or refugees.

Table 7: TB detection among immigrants, IOM major operations,* prevalence per 100,000

Country	Total Immigrants	LTBI		CXR TB		Active TB per 100,000		
		No. tested	Positive (%)	No tested	“Positive (per 100,000)”	Lab confirmed	Clinical	Total
Africa								
Ethiopia	2,625	237	19 (8)	1,994	60 (3,009)	190	-	190
Ghana	4,198	3	-	4,146	30 (724)	48	-	48
Kenya	10,982	1,349	199 (14.8)	10,627	422 (3,971)	228	-	228
Middle East								
Jordan	1,935	0	-	1,555	3 (193)	-	-	-
Iraq	1,194	0	-	920	4 (435)	-	-	-
Asia								
Bangladesh	16,847	0	-	16,679	1,282 (7,686)	77	-	77
Cambodia	4,532	190	26 (13.7)	4,138	86 (2,078)	441	-	441
Nepal	4,651	914	49 (5.4)	3,682	270 (7,333)	366	-	366
Pakistan	77,709	0	-	75,402	1,532 (2,032)	72	-	72
Thailand	7,095	0	-	7,033	426 (6,057)	324	-	324
Viet Nam	14,820	1,329	20 (1.5)	12,922	740 (5,727)	918	-	918
Europe								
Republic of Moldova	2,231	8	4 (50)	1,656	135 (8,152)	-	-	-
Romania	1,743	0	-	1,473	81 (5,499)	57	-	57
Ukraine	8,250	0	-	6,577	241 (3,664)	12	-	12
All Regions								
Other immigrants	14,354	3	-	12,939	708 (5,472)	35	-	35
Total	173,166	4,033	317 (7.9)	161,743	6,020 (3,722)	176	-	176

Note: *An IOM major operation is defined as an operation involving more than 1,000 assisted immigrants or refugees.

Table 8: DST results among cases (n=602) with *Mycobacterium tuberculosis* (MTB) growth on culture, IOM, 2011

DST result	No	%
Pansusceptible	502	83.4
Monoresistance	67	11.1
Polyresistance	20	3.3
MDR TB	11	1.8
Failed	2	0.3
Total	602	100.0

Table 9: TB treatment outcomes* among migrants on ongoing treatment, 2011

Country	All treatment outcomes in 2011, n (%)						
	"Cure/Completed"	Default	Ongoing Rx	Change in Dx	Transferred out	Died	Failure
Ethiopia (n=66)	42	0	13	1	7	3	0
Kenya (n=41)	19	1	18	0	1	2	0
Malaysia (n=115)	85	0	28	0	2	0	0
Nepal (n=295)	185	0	101	5	1	3	0
Thailand (n=111)	72	1	36	0	0	2	0
Uganda (n=9)	3	0	6	0	0	0	0
Total (n=637)	406 (63.7%)	2 (0.3%)	202 (31.7%)	6 (0.9%)	11 (1.7%)	10 (1.6%)	-

Note: *Typical treatment outcomes recommended by WHO for TB reporting forms; except for cases from Thailand, Kenya and Uganda, all other cases started treatment before 2011.

About Health



Two young Somali girls wait for their measles vaccination at the Eastleigh Community Wellness Centre in Nairobi, Kenya © IOM 2011.

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The background of the entire page is a solid dark red color. At the top and bottom, there are decorative borders consisting of a dense pattern of concentric circles in a slightly lighter shade of red. A thin white horizontal line is positioned on the right side, just below the top decorative border.

Healthy migrants in healthy communities!

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