

ANNUAL REPORT
2007

Migration Health



IOM International Organization for Migration



mission statement

The Migration Health Department's Mission Statement:

- Promote migrants' health.
- Lead on migration health research, policies and management.

To fulfill its goals, the Migration Health Department endeavours to:

- **Advocate** for migrants' physical, mental and social health.
- **Deliver** high quality and comprehensive health care services to migrants.
- **Provide** capacity building and technical cooperation.
- **Respond** to the changing patterns of mobility and consequent needs in migration health management through migration policy and in collaboration with States and communities.
- **Conduct** research to guide policy makers on migration health issues.
- **Advocate** for comprehensive health policy implementation that benefits both migrants and communities, including policy changes relevant to the various complex patterns of migration.
- **Provide** a forum for dialogue, consultation and learning with counterparts and partners.
- **Promote** cooperation and coordination among stakeholders in migration health issues.

The Migration Health Department is accountable to:

- **Migrants**, for the provision of high quality health services in full respect of their human rights.
- **Governments**, for the provision of advice on emerging migration health issues, including how to manage and research them.
- **Donors**, for service delivery needed and cost-effective services.
- **IOM**, for ensuring the integration of migration health in all relevant areas of its work.

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Cover photo Hazara IDP children in Said Abad, Bamyan District. © IOM 2002 - MAF0129 (Photo by Ferrán García)

Inside front cover photo Bhutanese refugees in Nepal. © IOM 2007 (Photo by Olga Gorbacheva)

introduction

As the new Director of the Migration Health Department (MHD), it is an honor and a privilege for me to present this Annual Report 2007, which consolidates the work of colleagues and friends in the Department and the Organization who, as myself, have enjoyed the inspiring and gentle leadership of my predecessor Janet Hatcher Roberts. Before joining the Headquarters' team in my new role, I worked for IOM as a field-based staff member for 14 years.

Migration, including migrants' health, has been high on the international agenda in 2007, and has been addressed in many fora and venues. For instance, the Portuguese presidency of the European Union (EU) and the 47th Council of Europe Health Ministers recognized as an area of concern, health needs of migrants in Europe, and the consequent challenges for national health care systems. The debate that evolved over the year around this theme was brought forward by the Government of Portugal with the support of a number of countries, and led to a draft Resolution on Migrants' Health to be presented at the World Health Assembly of the World Health Organization (WHO) in 2008. IOM actively contributed to this and other migrant health-related processes emphasizing its experience as an implementing agency, directly delivering health services to migrants in collaboration with a wide range of partners, and bringing the capacity to mainstream health into the multisector migration management platforms in which the Organization is involved.

The Migration Health Department has been increasingly recognizing the need to respond with a multisectoral approach to the health-related challenges posed by migration. Such approach is important to address the underlying social, economical, cultural, structural and environmental determinants of health that result in inequalities and vulnerability to diseases for certain categories of migrants, and to move from a biomedical approach to a preventive and promotional pattern of health interventions integrating the contributions of other sectors. This holistic vision goes hand in hand with IOM's focus on the quality and efficacy of medical services offered to Member States and migrants in the context of resettlement and other travel-related health programmes, with the conviction of the contri-

The Migration Health Department has been increasingly recognizing the need to respond with a multisectoral approach to the health-related challenges posed by migration.

bution these services bring in promoting health of migrants and communities. IOM is exploring opportunities to provide integrated HIV and Tuberculosis (TB) diagnostics for vulnerable mobile populations especially within countries where drug resistant TB is a concern. Addressing the health of migrants and mobile populations can contribute significantly to communicable disease control.

A photograph of a man with a mustache, wearing a patterned shirt, pouring tea from a large, ornate metal kettle into several small glasses. The setting is a rural tea stall with a thatched roof and bamboo walls. The text is overlaid on the left side of the image.

Such approach
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of health...

A successful returnee worker running his own tea stall at a rural Bazar in Sirajganj district, Bangladesh.

© IOM 2007 - MBD0015 (Photo by Bashir Ahmed Sujan)



IOM contributes to Afghanistan's nation-building efforts by addressing the health care and education needs of about seven million Afghans through the construction and refurbishment of 328 schools and 174 health facilities in 23 provinces of the country.

© IOM 2007 - MAF0265 (Photo by Barat Ali Batoor)

HIV, TB, and human mobility have been as usual amongst the top priorities of the Department, as part of its special attention towards emerging, re-emerging or neglected diseases. For instance, IOM has been advocating for migrants' health in the context of the Avian Influenza pandemic preparedness in Asian and African countries.

Many health-related activities, especially those related to crisis-affected populations, have been implemented in an integrated and coordinated way with other IOM Departments. Mental Health and Psychosocial support to individuals and communities for example, has contributed to IOM's community support programmes in Lebanon and Kenya, illustrating IOM's concept of health as a status of physical, mental and social well-being. Such programmes contribute to the increased local capacity and knowledge, in line with our conviction that country leadership and ownership are the best ways to achieve sustainable and durable results. To this end, human capital remains a pillar for the health sector, and the Department has confirmed its commitment to working with the Global Alliance on Health Workforce, WHO, International Labour Organization (ILO) and numerous parties in addressing the critical shortage of health workforce particularly in Africa, and in working with the health diaspora of many countries towards this end.

IOM strongly believes that a better understanding of migration health issues and enhanced partnerships across sectors within governments, and among agencies and communities are essential to turn challenges into opportunities and improve migrant health for the benefit of all. Pursuing the well-being of migrants is not only a matter of basic right to health, but also of benefit to societies: A healthy migrant will be more likely to participate in the socio-economic fabric of the host community, to become autonomous and financially independent, receptive to education and a tolerant partner in his/her community. We hope this Report can help in continuing a constructive dialogue. My deep appreciation goes to all those who have contributed to its preparation and those who with their work have given us proud and hope.

Dr Davide Mosca
Director, Migration Health Department



migration and health

Migration¹ involves a diverse group of people, including regular and irregular migrants, trafficked persons, asylum seekers, refugees, displaced persons, returnees, migrant workers and internal migrants.

IOM's concept of migration health² addresses the physical, mental and social needs of migrants and the public health needs of host and home communities.

With the increase in global mobility, people are traveling rapidly to more destinations either in search of better opportunities or safety. Human mobility today affects not only migration and development policies, but also related policy domains, such as human security and public health. The re-emergence of TB in the so called "developed world", the Severe Acute Respiratory Syndrome (SARS) epidemic, the Avian Influenza and Human Pandemic Preparedness and the high mortality often associated with irregular and forced migration, are a few examples of the critical relation between population mobility and health.

IOM continues to address the health needs of migrant children.

© IOM 2007
(Photo by Olga Gorbacheva)

¹ Migration can be defined as "a process of moving, either across an international border, or within a State. It is a population movement encompassing any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people and economic migrants". Glossary on Migration, International Migration Law Series, IOM, 2004.

² The concept of health follows the widely accepted definition of "health." <http://www.who.int/suggestions/faq/en/index/htm/>

Health issues can affect all migrants and as such potentially cut across all areas of IOM's work. It is therefore the role of IOM's MHD to raise awareness of migration health issues throughout the Organization and to ensure that the health of migrants is addressed in all its activities.

In addition, governments are increasingly recognizing the need for a comprehensive approach to migration health that goes beyond infectious diseases and border control that includes migration-related health vulnerabilities, communicable diseases, mental health, occupational health, health implications brought about by climate change, as well as access to health care and human rights issues. Addressing the health needs of migrants improves migrant health, avoids stigma and long-term health and social costs, protects global public health, facilitates integration and contributes to social and economic development.

Migration Health: A Cross-Cutting Issue for IOM

The provision of quality health assistance for migrants has been a function of IOM since its creation in 1951, starting with the delivery of medical services during the movement of European migrants following the Second World War. Activities have evolved and responsibilities have expanded over the years in response to the changing needs of migrants and governments, and the increased international awareness of the health-related dimensions of migration patterns and trends.

Health issues can affect all migrants and as such potentially cut across all areas of IOM's work. It is therefore the role of IOM's MHD to raise awareness of migration health issues throughout the Organization and to ensure that the health of migrants is addressed in all its activities. MHD staff provides guidance and technical support to IOM field offices to identify appropriate responses to demands concerning migration health, and provides technical back-up for the development, management and oversight of project activities.

IOM's global network of offices and partnerships with governments, civil society and international agencies, allows MHD to respond to the health needs of migrants throughout all phases of the migration process, as well as the public health needs of host communities. MHD contributes to the strengthening of national health systems and the development of evidence-based policies and practices. In particular, MHD's activities can be summarized as follows:

(a) Service delivery and capacity building

The activities of MHD aim at providing access to health services for migrants, especially the most vulnerable, including women and children, those who are forced to move (e.g., refugees, internally displaced persons) or those who are in an irregular situation (e.g., undocumented migrant workers, trafficked persons). Services delivery includes prevention and health promotion, control and management of infectious diseases, chronic diseases, mental health, reproductive health and environmental health. In doing so, MHD heavily emphasizes the need for building local capacity and ownership through training of national staff across relevant sectors, in order to ensure durable solutions in line with national health and migration plans and policies.

(b) Advocacy and policy development

MHD advises partners, governments and IOM staff on best practices in the management of migration health issues and related strategies, as well as policy development. In response to the growing international interest in migration health, MHD provides a forum for dialogue for policymakers, experts and partners with the aim of bridging the gap between migration and health policy, as well as promoting the health of migrants by



A Sri Lankan woman in a camp where IOM provided humanitarian assistance in the post-tsunami period.

© IOM 2006 - MLK0166 (Photo by Olga Gorbacheva)

integrating migrant health concerns into public health, migration and development policies globally.

(c) Research and information dissemination

MHD responds to the needs of governments, partner agencies and civil society for quality information on migrant health. Quantitative and qualitative research data on migrant health are analysed and disseminated for advocacy purposes and to guide policy and programme development and strategies. MHD collaborates closely with renowned universities and partners

to develop and conduct research on a wider range of migrant health topics.

Health Consequences of Migration

Migration may impact on health outcomes, both positively or negatively, just as health status may affect migration outcomes. Therefore, measures to address migration-related vulnerabilities need to be built into migration management strategies.

Migration does not generally pose a risk to health;

Providing access to health services for migrants, especially the most vulnerable, including women and children, is one of the goals of the Migration Health Department.

© IOM 2007 (Photo by Olga Gorbacheva)



however circumstances surrounding the migration process may increase the vulnerability to ill health. This is particularly evident in situations of involuntary migration, such as fleeing natural or man-made disasters, human rights violations, or irregular migration, as well as cases where migrants fall into the hands of traffickers and end up in exploitive situations. Risk factors are often linked to the legal status of migrants, which determines the level of access to health and social services. Other equally important contributing factors include poverty, stigma, discrimination, social exclusion, differences in language and culture, separation from family and socio-cultural norms.

A Multisectoral Approach

Health is influenced by policies in other domains and health has, in turn, important effects on the realization of the goals of other sectors. IOM believes that an open and constructive multisectoral dialogue based on shared and fundamental societal values and principles, such as solidarity, integration, human rights and participation, as well as sound public health principles, can contribute to the improvement of health outcomes for both migrants and host communities. Therefore, IOM encourages governments and partners to cooperation with other sectors such as security, education, labour and social welfare to ensure that migration health is reflected in national plans and strategies.

Strengthening of Health Systems

Migrant-friendly policies should be integrated into existing health systems to prevent stigma and discrimination, and to contribute toward equal access to care and treatment for migrants and mobile populations.

There is a need to secure access to health services for migrants and to address specific vulnerabilities of certain migrant populations in a culturally and linguistically appropriate manner. These measures will contribute toward public health interest because neglecting the health needs of vulnerable groups may translate into considerable health and social costs in receiving communities. It is also important to raise awareness and train a new generation of health professionals in order to understand, study and respond to the health needs of increasingly mobile and multi-ethnic societies. This is an area in which IOM is developing positive partnerships with academic institutions.

Partnerships

IOM carries out its health activities in partnership with intergovernmental organizations,³ government counterparts, national agencies and civil society.

The need for coordinated and sustained action to address migration-related health challenges is increasingly recognized by Member States and collaborating agencies alike.

As an implementing agency, IOM actively contributes toward alleviating migration health concerns by directly delivering health services to migrants in collaboration with a wide range of partners. IOM also has the distinct advantage of being able to provide capacity to mainstream health into the multisectoral migration management platforms in which the Organization is involved.

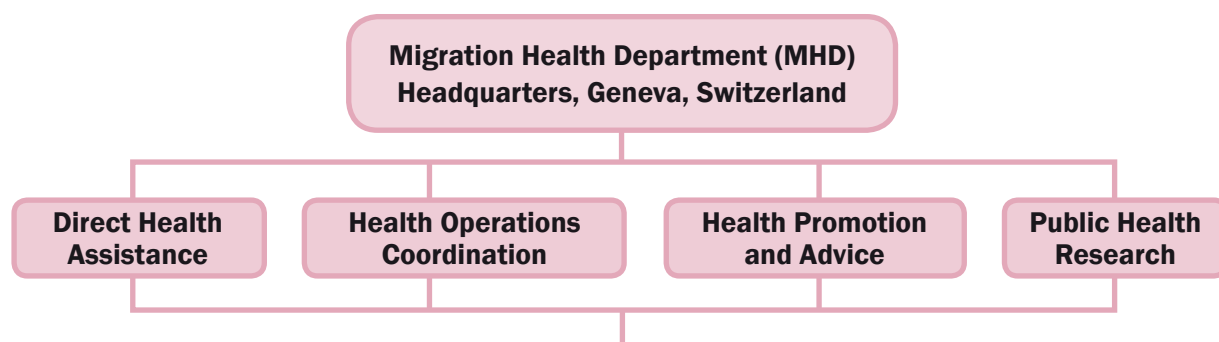


IOM works toward the delivery of important health services to migrants, including children.

© IOM 2007 (Photo by Olga Gorbacheva)

³ IOM has entered into cooperation agreements with, for example, WHO, UNAIDS, UNHCR and UNFPA.

migration health presence and functions in 2007 (Organigram)



Africa & Middle East

Côte d'Ivoire
Abidjan

Ethiopia
Addis Ababa

Ghana
Accra

Guinea
Conakry

Iraq
Baghdad
Basrah

Jordan
Amman

Kenya
Dadaab
Kakuma
Nairobi

Lebanon
Beirut

Nigeria
Abuja

Senegal
Dakar

South Africa
Pretoria

Sudan
Khartoum
Nyala

Uganda
Kampala

United Republic of Tanzania
Dar es Salaam
Kibondo

Zambia
Lusaka

Zimbabwe
Harare

Asia

Afghanistan
Kabul

Bangladesh
Chittagong
Sylhet

Cambodia
Phnom Penh

Indonesia
Banda Aceh
Bantul
Batam
Bireun
Bogor
Calang
Jakarta
Klaten
Kupang

Lao People's Democratic Republic
Vientiane

Malaysia
Kuala Lumpur

Myanmar
Belin
Kyaikmayaw
Mawlamyine

Nauru
Yaren

Nepal
Damak

Pakistan
Islamabad
Karachi
Lahore

Philippines
Manila

Sri Lanka
Colombo

Thailand
Bangkok
Chiang Rai
Kanchanaburi
Lopburi
Mae Hong Son
Mae Sariang

Vietnam
Hanoi
Ho Chi Minh City

Dhaka

Svay Rieng

Lhoksumawe

Makassar

Mataram

Meulaboh

Pontianak

Sukamakmur

Surabaya

Yogyakarta

Kathmandu

Mirpur

Quetta

Nong Khai

Phang Nga

Ranong

Ratchaburi

Samutsakorn

Tak

Europe

Belgium
Brussels

Bosnia and Herzegovina
Sarajevo

Bulgaria
Sofia

Croatia
Zagreb

Italy
Rome

Republic of Moldova
Chisinau

Romania
Bucharest

Russian Federation
Krasnodar
Moscow

Serbia
Belgrade
Pristina

Slovakia
Bratislava
Kosice

Tajikistan
Dushanbe

The Former Yugoslav Republic of Macedonia
Skopje

Ukraine
Kiev

Americas & Caribbean

Colombia
Bogotá

Costa Rica
San José

financial overview

Figure 1 - Expenditures on migration health activities by geographical region, 2007

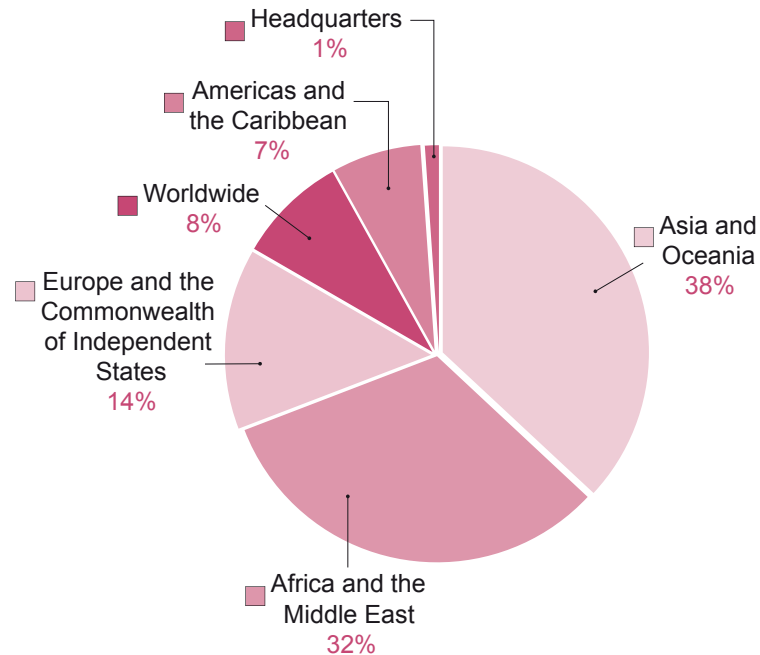


Figure 2 - Expenditures by main areas of work, 2007

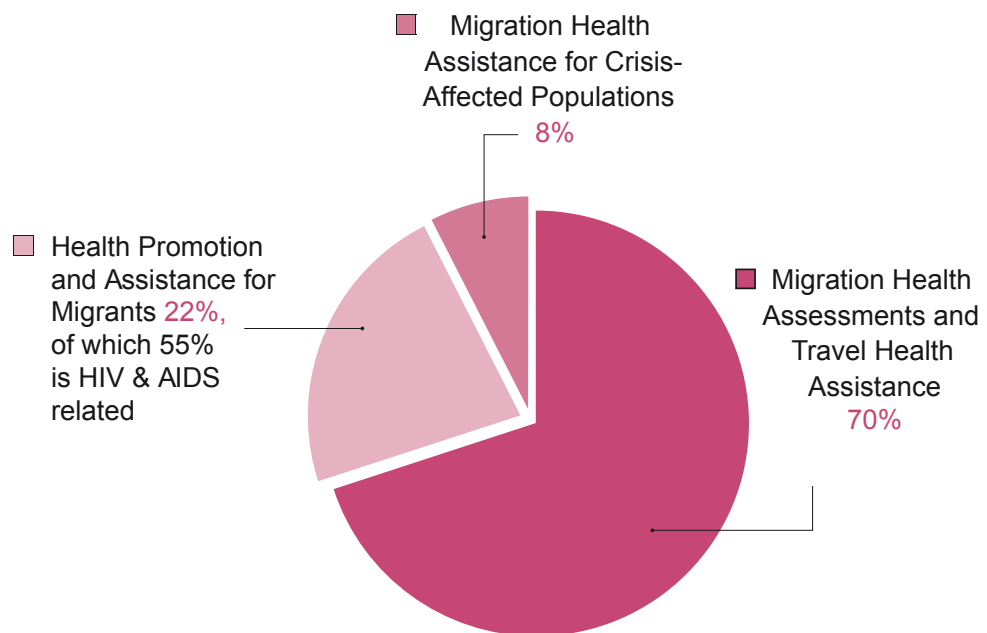


Table 1 - Financial contributions toward IOM Migration Health Department based on expenditures, 2007

FUNDING SOURCE	EXPENDITURE (USD)
Governments	43,069,674
USA	20,437,313
Canada	12,128,229
Sweden	4,312,998
Australia	2,806,698
Norway	569,168
Netherlands	502,616
Japan	470,733
United Kingdom	453,959
Italy	326,534
Switzerland	245,260
Guatemala	227,509
Belgium	224,174
Colombia	155,660
Portugal	87,630
Finland	40,771
New Zealand	37,802
Denmark	16,599
Croatia	15,946
Germany	6,018
Republic of Congo	4,057
Migrants	10,087,301
United Nations	3,518,839
United Nations Population Fund (UNFPA)	933,332
United Nations Development Programme (UNDP)	686,234
United Nations Office for Project Services (UNOPS)	492,424
Central Emergency Response Fund (CERF)	393,115
Common Humanitarian Fund for Sudan (CHF)	335,021
World Health Organization (WHO)	305,440
United Nations Children's Fund (UNICEF)	202,495
Joint United Nations Programme on HIV/AIDS (UNAIDS)	145,683
Central Fund for Influenza Action (CFIA)	20,396
International Labour Organization (ILO)	4,699
Global Fund to Fight AIDS, Tuberculosis and Malaria	2,330,757
IOM*	1,316,548
Discretionary Income	659,640
Administrative Budget	656,909
Non-Government Organizations	938,030
AmeriCares	617,621
Save the Children	224,934
Family Health International	51,679
World Vision	37,035
SIDACTION	6,761
European Commission	596,614
Private Sector	325,323
Esso Exploration Angola (Block 15) Limited	105,596
Standard Chartered Bank	91,959
Rockefeller Foundation	52,922
Kellogg Foundation	46,210
Fondazione Moncalme	14,407
Sasakawa Funds	14,230
Universities	59,921
Geneva University Hospital (Switzerland)	46,388
University of Pecs (Hungary)	13,533
Other	26,470
TOTAL	62,269,478

* Some core functions are funded through the Organization's Administrative part of the Budget or discretionary income.

main areas of work

Migration Health Assessments and Travel Health Assistance

Migration health assessments have traditionally represented the largest activity of IOM's MHD in terms of migrants served, staff concerned, and operational costs.

Migration Health Assessments include:

- health examination of prospective migrants
- pre-departure treatment and referral
- HIV counselling
- health education
- immunizations
- medical escorts and pre-embarkation medical checks
- health informatics services
- laboratory services
- quality assurance
- capacity building
- Deoxyribonucleic Acid (DNA) testing for family reunification

Health assessments of potential migrants are carried out at the request of resettlement countries such as Australia, Canada, New Zealand, the United Kingdom (UK), and the United States of America (USA). These assessments are tailored to fulfill the national immigration requirements of the receiving governments. In countries such as the Russian Federation, MHD acts as an accredited "panel physician" whereby doctors employed by IOM carry out health assessments for countries of immigration. In other instances, like in many sites in Africa, IOM supervises non-IOM panel physicians accredited to carry out health assessments in the receiving country.

The aim of pre-departure health assessments is to reduce and better manage the public health impact of population mobility on communities of receiving

countries, as well as identifying demand on health and social systems, through detection and cost-effective management of health conditions and provision of medical information. In addition, pre-departure health assessments offer an opportunity to promote the health of the migrants assisted, through initiating preventive and curative interventions for conditions that, if left untreated, could have a negative impact on the migrant's health and/or on the public health of the host communities. MHD also offers large-scale pre-departure treatment of high prevalence conditions such as malaria and intestinal parasites, treats migrants with TB, including multi-drug resistant TB following directly observed therapy, and certain sexually transmitted infections (STIs), and provides immunization for preventable infections, as well as pre- and post-test Human Immunodeficiency Virus (HIV) counselling.

Pre-departure embarkation checks are performed for migrants who are to be transported by IOM in order to assess fitness to travel. Migrants who need medical assistance and care during travel are escorted by health professionals.

Profile of Migrants Examined by IOM in 2007

MHD provided health assessment services to 198,935 migrants in 40 countries through its static and mobile health teams (Table 2). IOM also managed and supervised a total of 781 health assessments conducted by non-IOM panel physicians mostly upon request from the USA for the purpose of quality control. More than half of the total number of migrants (127,921 or 64.3%) assessed by IOM in 2007 departed from Asia and Oceania (Figure 3), while the highest percentage of migrants (48.5%) applied for resettlement in the UK (Figure 4). The latter is mainly due to the pre-departure TB detection programme that was implemented in 2005 on behalf of the government of the UK and expanded in terms of numbers of migrants and countries of origins in 2007. A smaller number of the health assessments and "fitness-to-travel" pre-departure checks were provided on request of non-traditional immigration countries, such as the Nordic countries.

Table 2 - IOM health assessments per location of origin, immigrant*/refugee status and destination, 2007**

Location of IOM Health Assessment	Country of Destination															
	UK		USA		Canada		Australia		New Zealand		Other		Total		Grand Total	
	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees
Pakistan	48,130	0	0	0	0	0	0	353	40	1	0	0	48,170	354	48,524	0
Thailand	8,340	240	0	23,325	0	1,911	0	4,003	0	456	0	102	8,340	30,037	38,377	0
Bangladesh	22,181	0	0	0	0	80	0	0	0	0	0	0	22,181	80	22,261	0
Vietnam	0	0	6,321	1,224	2,898	0	2,205	0	133	0	0	0	11,557	1,224	12,781	0
Cambodia	73	0	2,285	79	758	16	1,284	0	602	0	30	0	5,012	95	5,107	0
Indonesia	0	0	0	2	191	18	111	147	9	0	0	0	311	167	478	0
Nepal	0	0	0	313	0	0	0	0	0	3	0	0	0	316	316	0
Afghanistan	0	0	0	0	0	0	52	0	11	7	0	0	63	7	70	0
Nauru	0	0	0	0	0	0	0	7	0	0	0	0	0	7	7	0
Asia and Oceania	78,724	240	8,606	24,943	3,847	2,025	3,632	4,510	795	467	30	102	95,634	32,287	127,921	0
Kenya	3,232	366	120	7,697	246	786	1,323	712	101	42	0	0	5,022	9,603	14,625	0
Ghana	11,040	0	48	760	0	136	0	22	1	0	0	0	11,087	907	11,994	0
Jordan	0	0	0	2,217	0	0	3	9	0	4	0	0	2,230	3	2,233	0
Tanzania	1,912	0	0	16	0	10	0	292	0	0	0	0	1,912	318	2,230	0
Ethiopia	0	0	2	1,523	4	207	4	18	0	16	3	0	1,762	1,775	3,537	0
Guinea	0	0	0	585	0	39	0	339	0	0	0	0	963	963	1,926	0
Sudan	818	0	0	0	0	0	0	0	0	0	0	0	818	0	818	0
Uganda	0	0	0	17	0	130	0	212	0	0	0	0	359	0	359	0
Cote D'Ivoire	0	0	0	338	0	0	0	0	0	0	0	0	338	0	338	0
Somalia	0	0	0	0	0	278	0	0	0	0	0	0	278	0	278	0
Benin	0	0	0	0	0	81	0	161	0	0	0	0	242	0	242	0
Republic of Congo	0	0	0	8	0	55	0	127	0	0	0	0	190	0	190	0
Zambia	0	159	0	0	0	0	0	0	0	0	0	0	159	0	159	0
Gabon	0	0	0	148	0	0	0	0	0	0	0	0	148	0	148	0
Iraq	0	0	0	0	0	0	0	74	0	0	0	0	74	0	74	0
Nigeria	0	0	0	0	0	48	0	0	0	0	0	0	48	0	48	0
Africa and the Middle East	17,002	525	168	13,299	250	1,770	1,330	1,964	102	62	3	0	18,855	17,820	36,675	0
Ukraine	0	23	8,213	820	3,119	0	402	0	90	0	0	0	11,824	843	12,667	0
Russia	0	0	3,500	1,830	1,851	553	1,047	0	237	0	20	0	6,664	2,183	8,847	0
Romania	0	0	0	0	3,449	0	122	0	45	0	0	0	3,616	0	3,616	0
Serbia and Montenegro	0	0	244	0	397	14	511	0	23	0	118	0	1,393	14	1,407	0
FYROM***	0	0	917	0	51	0	239	0	15	0	0	0	1,222	0	1,222	0
Kazakhstan	0	0	119	108	697	65	176	0	18	0	0	0	1,012	173	1,185	0
Moldova	0	0	442	334	276	0	44	0	7	0	0	0	769	334	1,103	0
Bulgaria	0	0	0	0	1,080	0	0	0	3	0	0	0	1,083	0	1,083	0
Belarus	0	0	103	85	660	25	90	0	17	0	0	0	860	110	970	0
Kosovo (Serbia and Montenegro)	0	0	597	1	284	0	45	2	2	0	0	0	878	3	881	0
Bosnia and Herzegovina	0	0	1	0	236	163	285	17	6	0	0	0	528	180	708	0
Uzbekistan	0	0	36	443	14	10	0	0	0	0	0	0	50	453	503	0
Croatia	0	0	0	0	41	0	188	0	18	0	0	0	243	0	243	0
Kyrgyzstan	0	0	0	36	0	39	0	3	0	0	0	0	78	0	78	0
Tajikistan	0	0	0	0	0	26	0	0	0	0	0	0	0	26	26	0
Europe and the Commonwealth of Independent States	0	0	14,172	3,657	12,105	718	3,239	22	478	0	147	0	30,142	4,397	34,539	0
Worldwide	95,726	765	22,946	41,899	16,202	4,513	8,201	6,496	1,376	529	180	102	144,631	54,304	198,935	0
	96,491		64,845		20,715		14,697		1,905		282		198,935			

* Immigrants moved on a voluntary basis **Refugees have been displaced by force and fall under the definition of the 1951 UN Convention

***The Former Yugoslav Republic of Macedonia

Figure 3 - IOM health assessments per region of origin, 2007

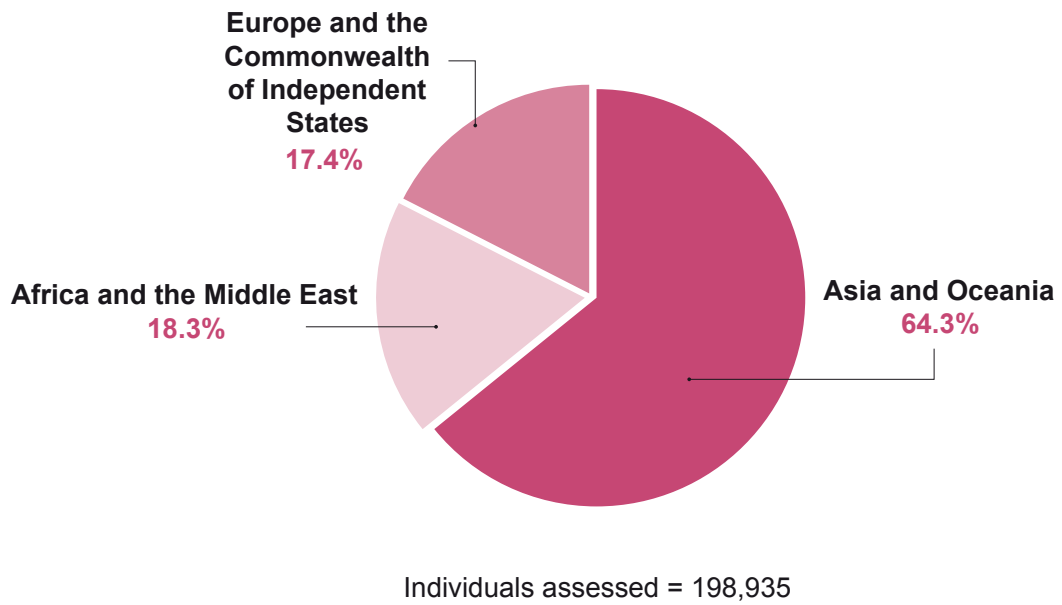
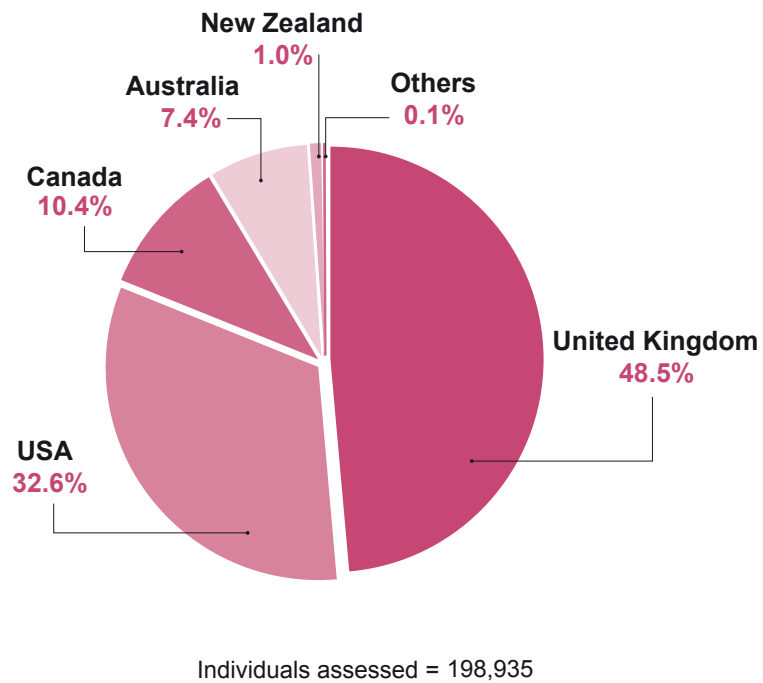


Figure 4 - IOM health assessments per country of destination, 2007





Children and elderly await for their medical examination.

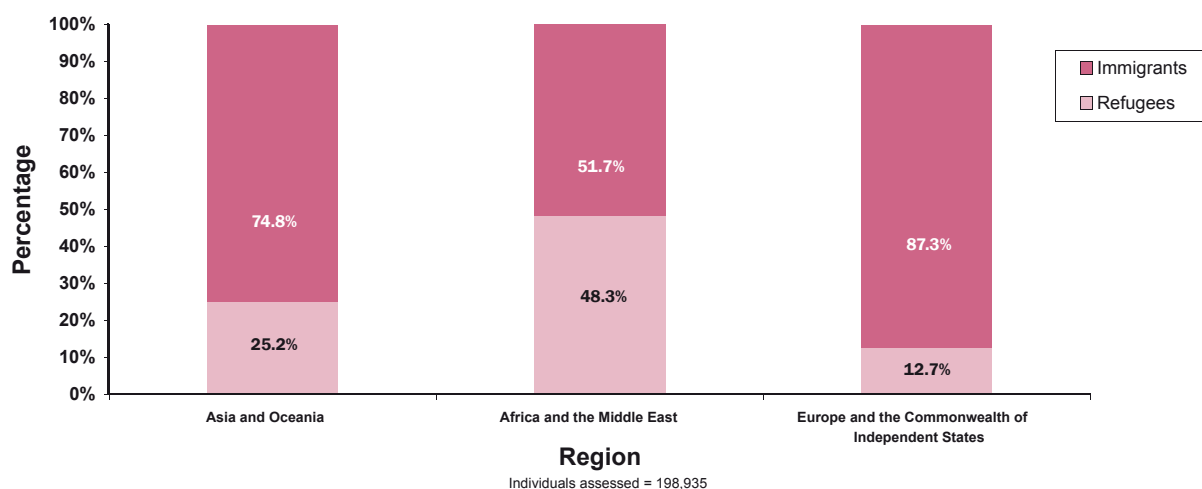
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Refugees and Immigrants

The costs associated with health assessments differ in relation to refugees⁴ and immigrants⁵. Resettlement countries often cover the costs for the majority of refugee resettlements, whereas immigrants pay for the services they receive from IOM.

The proportion of refugees and immigrants assisted by IOM varies over time. In 2001-2003, the IOM-assisted caseload included more immigrants than refugees. In 2004, refugees outnumbered immigrants and from 2005 onwards, the proportion of immigrants significantly increased due to the addition of the UK TB detection programme. In 2007, 72.7% (144,631) of the migrants were self-payers. Figure 5 shows that immigrants are consistently the highest proportion of the IOM caseload in Asia and Oceania (74.8%), Africa and the Middle East (51.7%), and Europe and the Commonwealth of Independent States (CIS) (87.3%). Further, while the highest percentage of migrants going to Australia (55.8%), Canada (78.2%), New Zealand (72.2%), UK (99.2%) and other countries (63.8%) were immigrants, refugees had a higher percentage (64.6%) among the caseloads examined on behalf of the USA (Figure 6).

Figure 5 - Breakdown of immigrants and refugees examined per region of origin, 2007

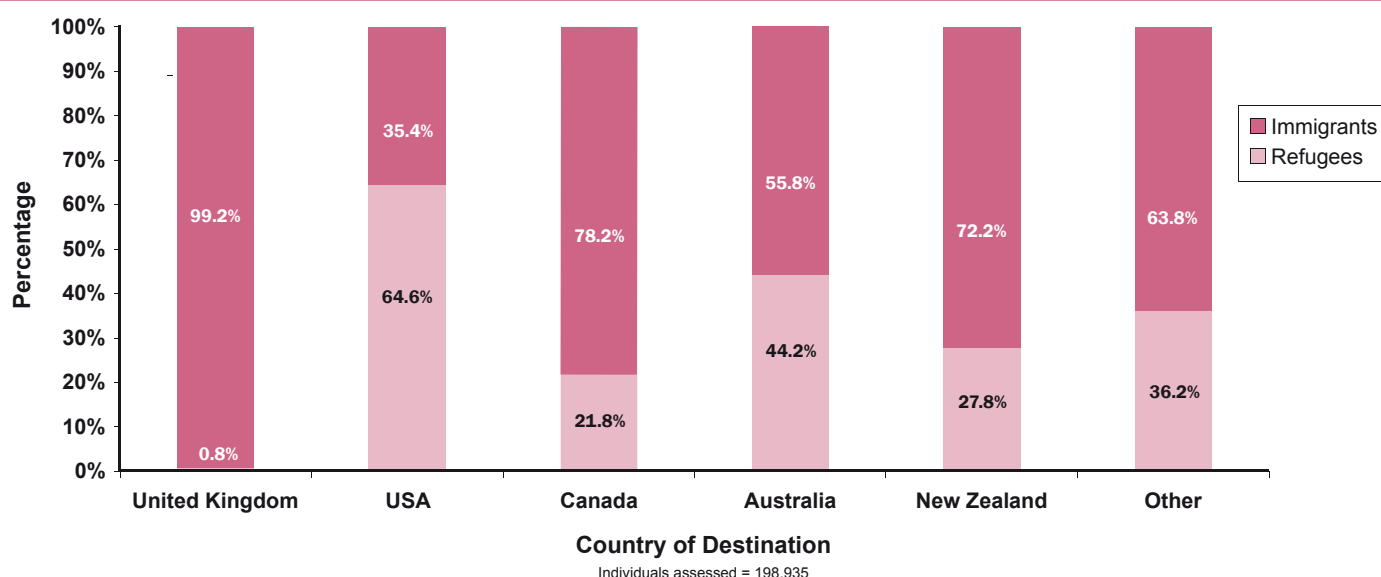


⁴ According to the 1951 UN Convention Relating to the Status of Refugees, a refugee is a person who "owing to a well-founded fear of being persecuted for reasons of race, religion, nationality, membership in a particular social group or political opinions, is outside the country of his nationality, and is unable to or, owing to such fear, is unwilling to avail himself of the protection of that country".

⁵ In this report, immigrants refer to individuals who decided to apply for immigration under the relevant legal provisions of the respective countries, for instance, family reunification cases and certain categories of migrant workers.



Figure 6 - Breakdown of immigrants and refugees examined per country of destination, 2007



Age and Sex

There were more males than females among the 2007 IOM caseload (56.7% and 43.3% respectively). Among both refugees and immigrants, males prevailed in the age categories below 40 years and were outnumbered by females in the age categories above 50 years. With respect to immigrants, the largest difference in the number of males and females was seen in the age category 20-29 years, where males composed 33.3% and females 19.4% of the total immigrant caseload (Figure 7). The same could be observed among the refugee applicants with 11.9% male and 9.6% female in the age category of 20-29 years (Figure 8). Most immigrants fell within the category of 20-29 years (52.7%) while most refugees fell within the category between 10-19 years of age (24.7%). In terms of region of origin and country of destination, most applicants fell within the category 20-29 years of age (Figures 13-21; see Annex).

The mean age of the total population was 26.5 years. Women were on average older than men (27.4 years, versus 25.7 years for men). The mean age of immigrants was 27.6 years, and 23.5 years for refugees. Applicants from the Europe and CIS were slightly older compared with the applicants from Asia, Oceania, Africa and the Middle East (Table 3).

Figure 7 - Sex and age breakdown of immigrants for all regions of origin, 2007

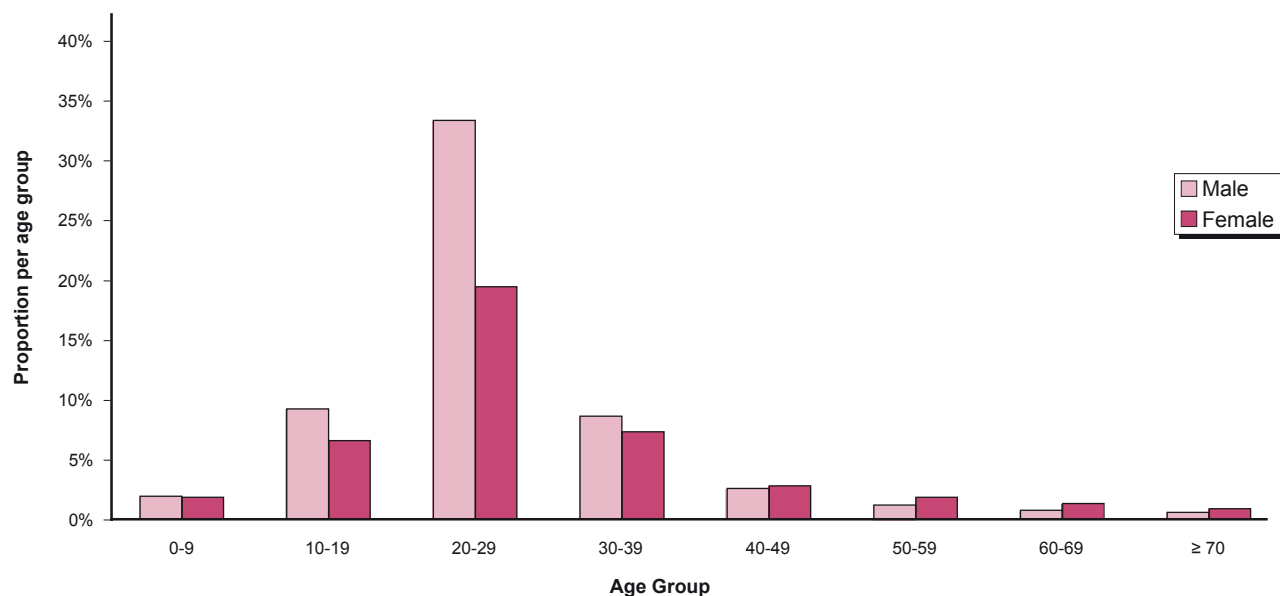


Figure 8 - Sex and age breakdown of refugees for all regions of origin, 2007

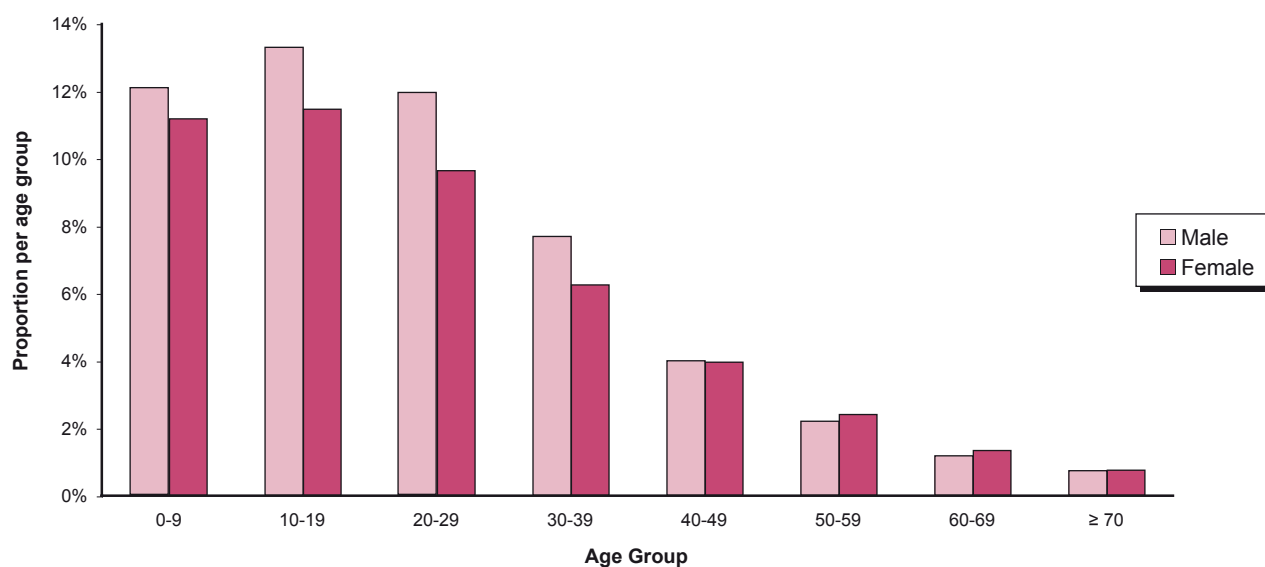


Table 3 - Mean age of the examined immigrants and refugees per sex and region of origin, 2007

REGION	IMMIGRANTS			REFUGEES			GRAND TOTAL
	Male	Female	Total	Male	Female	Total	
Asia and Oceania	25.7	27.8	26.5	23.1	22.7	22.9	25.6
Africa and the Middle East	27.2	26.8	27.0	22.9	24.3	23.6	25.4
Europe and the Commonwealth of Independent States	29.7	32.5	31.2	26.4	28.3	27.4	30.8
TOTAL	26.5	29.0	27.6	23.3	23.7	23.5	26.5

Mean Age: Male 25.7
Female 27.4

Health Conditions of Concern

Following the policies and regulations of the resettlement countries requesting its services, IOM assists in the detection of conditions that may pose a risk to public health (e.g., TB) or an excessive demand on the health and social services of the receiving country. The presence of certain health conditions can exclude an applicant from admission to a receiving country until adequate treatment has been provided. “Waivers” may be granted to some categories of applicants, permitting them to resettle in spite of the presence of an otherwise excludable condition.

IOM helps refugees and immigrants with potentially excludable conditions by giving treatment of international standard for some conditions, or by facilitating access to such treatment, as well as by providing counselling, referral, health education and assistance in obtaining waivers.

“Excludable conditions” vary according to the destination country, but the main conditions of concern include:

- Infectious TB
- HIV infection⁶
- Certain chronic illnesses
- Disorders that pose a safety risk to self and others

Table 4 lists some of the tests performed by IOM during health assessments and shows the number of individuals examined with these tests.

Table 4 - Type of tests performed among applicants, 2007

Tests	Number	Percentage (N = 198,935)
X-rays	177,111	89.0%
HIV	72,158	36.3%
STI	68,106	34.2%
Sputum Smears	9,478	4.8%
Skin Test	7,918	4.0%
Hepatitis B	3,660	1.8%
Sputum Culture	4,932	2.5%
Hepatitis C	1,698	0.9%

⁶ IOM promotes HIV voluntary testing and counselling as opposed to mandatory HIV testing for the purpose of migration, emphasizing the lack of public health relevance of mandatory HIV testing. When carrying out HIV testing for migrants on behalf of countries that require such testing in the context of resettlement, IOM follows a harm reduction model, ensuring that high quality HIV counselling is offered.

Figure 9 shows that only a modest number of those examined by IOM in 2007 (0.8% of all persons tested) had a “potentially excludable condition”. The rates of HIV, TB and syphilis are shown in Table 5. For HIV and TB, the rates were highest in Africa and Middle East (1.3% and 0.6%, respectively). The rates for Syphilis were highest in Asia and Oceania with 0.6%. However, these rates cannot be compared with national rates of the same diseases in the countries from which the IOM caseload departed. There are several reasons why the health profile of IOM-assisted migrants may be different from the profile of the national population of the countries from which they are departing. For example, refugees may have been living in isolated settings, or immigrants may have come from a particular region or from a particular social class. In addition, there may be a form of “pre-selection”: potential immigrants wishing to apply to countries that do not allow entry of people with certain conditions may independently make sure they do not have that condition before they apply for immigration and exclude themselves for application if they do. Thus they would not appear for IOM immigration health assessments.

Figure 9 - Breakdown of healthy individuals and individuals with “potentially excludable conditions”, 2007

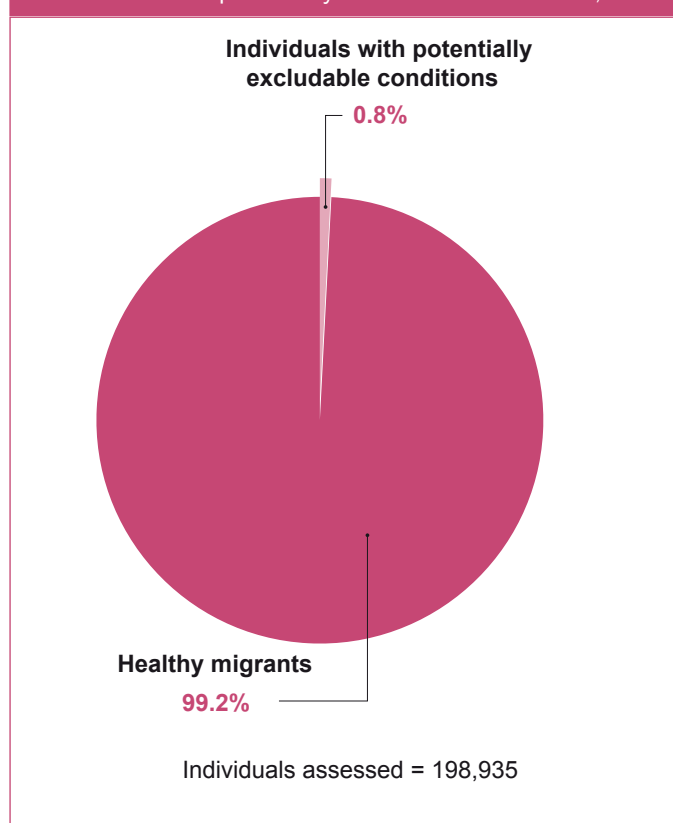


Table 5 - Percentage of positive cases for HIV, Syphilis and Tuberculosis,* per region of origin, sex and average age, 2007

HIV									
Location	Female			Male			Total		
	Positive cases	%	Average age	Positive cases	%	Average age	Positive cases	%	Average age
Asia and Oceania	11	0.1	30.2	19	0.1	33.7	30	0.1	32.1
Africa and the Middle East	82	1.5	30.4	73	1.1	32.5	155	1.3	31.4
Europe and the Commonwealth of Independent States	5	0.0	26.2	7	0.1	28.6	12	0.0	27.6
Syphilis									
Location	Female			Male			Total		
	Positive cases	%	Average age	Positive cases	%	Average age	Positive cases	%	Average age
Asia and Oceania	85	0.7	52.3	95	0.5	52.3	180	0.6	52.3
Africa and the Middle East	24	0.4	35.4	25	0.3	37.4	49	0.4	36.4
Europe and the Commonwealth of Independent States	19	0.1	34.1	17	0.2	32.2	36	0.1	33.2
Tuberculosis									
Location	Female			Male			Total		
	Active cases**	%	Average age	Active cases**	%	Average age	Active cases**	%	Average age
Asia and Oceania	124	0.3	40.6	220	0.3	42.5	344	0.3	41.8
Africa and the Middle East	77	0.5	34.5	104	0.6	37.1	181	0.6	36.0
Europe and the Commonwealth of Independent States	6	0.0	50.4	6	0.0	53.1	12	0.0	51.7

* Once migrants are treated for syphilis and tuberculosis they are no longer excluded. Some categories of migrants can obtain waivers in case of HIV-positive status

** "Active" cases are referred for TB treatment and/or sputum smear positive and/or sputum culture positive.

Children patiently waiting for their health check.

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Health Assessments and Capacity Building

In order to ensure the quality of health assessments, IOM must frequently set up or improve testing facilities and practices. This activity benefits not only potential migrants, but also—directly or indirectly—local communities. IOM continues to:

- contribute to training of local health personnel;
- participate in the dissemination of best practices; and
- establish, equip or upgrade laboratories.

Travel Health Assistance and Pre-Embarkation Services

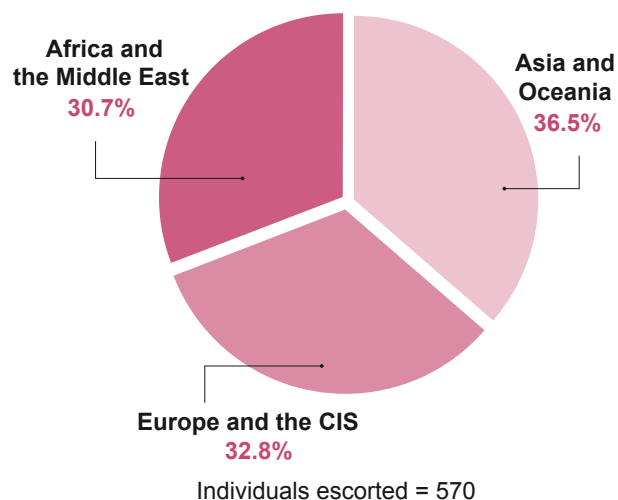
Once migrants have fulfilled the immigration application requirements, many travel to their new country of residence through the transportation services provided by IOM, mainly by air. Individuals in need of assistance by an escorting health professional during transportation are identified at the time of the health assessment to ensure that they travel safely and without undue hardship to themselves or to other travelers. The IOM escorting health professional also ensures that appropriate reporting is used, to refer the migrant to the health and immigration officials, or to family members on arrival at the final destination. Before embarking, migrants undergo a brief health check by a physician or nurse to assess if they are fit to travel.

The figures below include only travel health assistance and pre-departure checks in the context of organized refugee resettlement using air transportation and do not include the figures of similar services provided during mass movements following emergency situations, or assisted voluntary return movements of individuals.

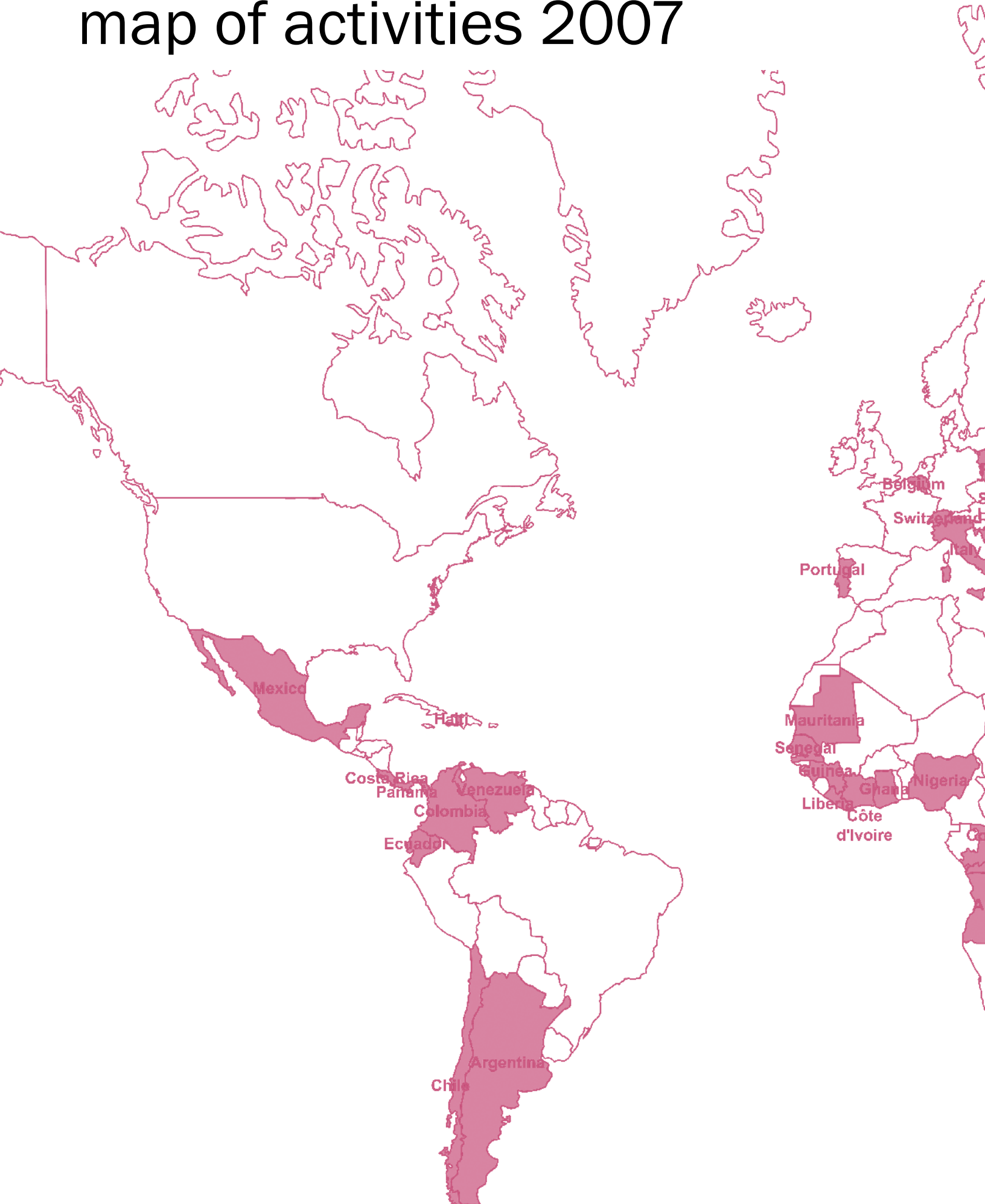
In 2007, escorts accompanied 570 migrants in need of some form of care on the way to their final destination. Most (36.5%) came from Asia and Oceania (Figure 10). Most escorted passengers (34.1% females and 28.8% males) suffered cardiovascular problems (Figure 11). The mean age was similar for both males and females for most conditions, with the exception of gastrointestinal, endocrinologic, and musculoskeletal disorders (Table 6). Females with gastrointestinal and endocrinologic disorders were older (55.6 and 46.1 years respectively) than men (28.9 and 37.3 years respectively). Among those suffering from musculoskeletal abnormality however, males had higher average age (44.7 years) than females (22.4 years).



Figure 10 - Passengers in need of health assistance per region of origin, 2007



map of activities 2007



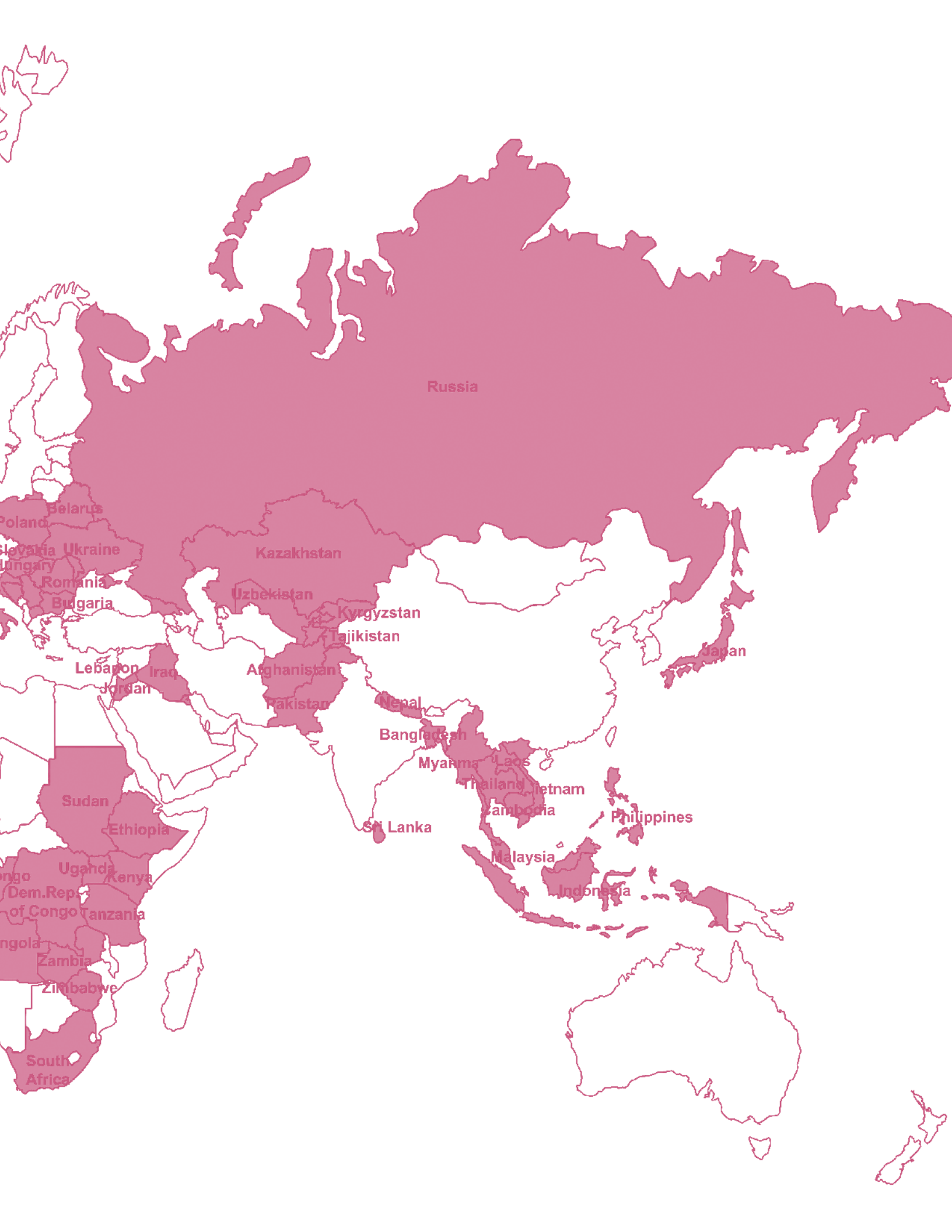
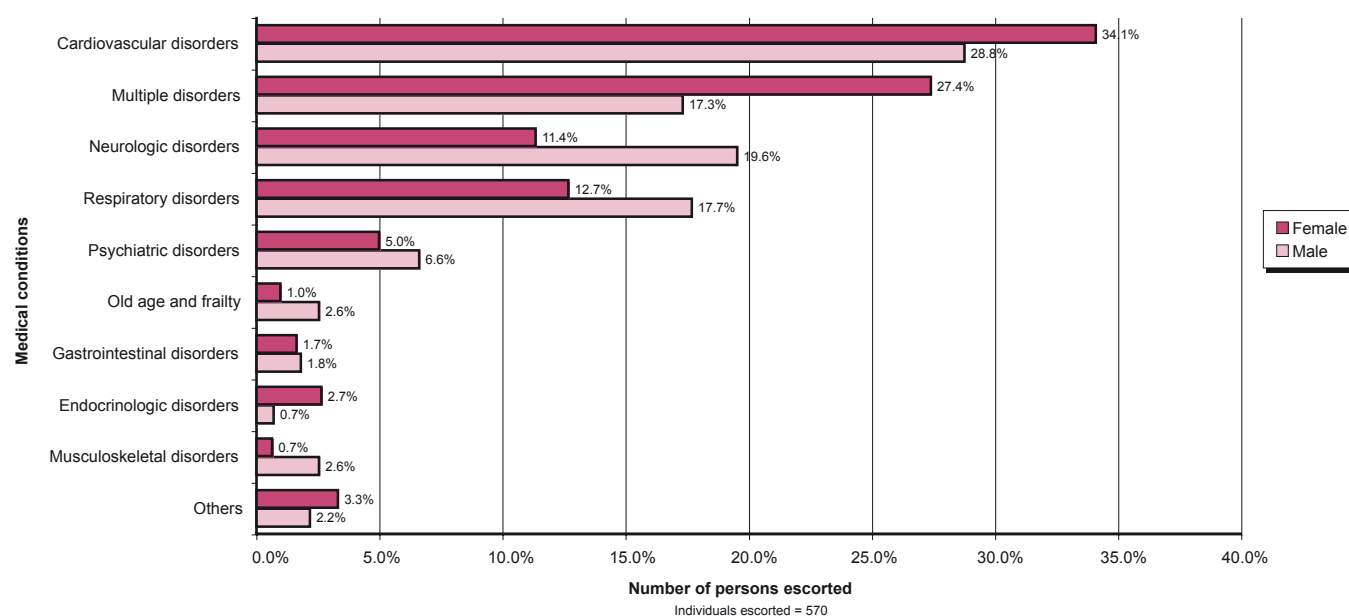




Figure 11 - Main conditions of medically assisted passengers by sex, 2007



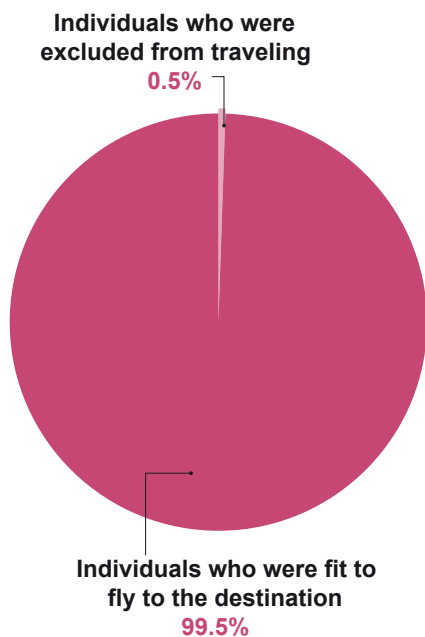
Health Promotion and Assistance for Migrants

Table 6 - Mean age of escorted applicants per medical condition and sex, 2007

Conditions	Mean Age	
	Male	Female
Cardiovascular disorders	55.0	54.9
Multiple disorders	54.7	59.9
Neurologic disorders	26.6	26.9
Respiratory disorders	32.4	38.6
Psychiatric disorders	26.2	27.7
Old age and frailty	75.6	82.2
Gastrointestinal disorders	28.9	55.6
Endocrinologic disorders	37.3	46.1
Musculoskeletal disorders	44.7	22.4
Others	21.0	19.2

Of the 32,489 pre-departure medical checks carried out during the year, only 165 persons (0.5%) were excluded from immediate departure and were provided with an escort for travel at a later stage (Figure 12).

Figure 12 - Distribution of applicants according to the result of pre-embarkation assessment, 2007



Total number of health checks = 32,489

Main factors that may have a negative impact on the health of mobile populations and their access to health services include poverty, lack of legal protection, discrimination, social exclusion and exploitation. On the one hand, MHD services respond to the health needs of migrants and their host communities, covering, inter alia reproductive health, Avian and Human Influenza (AHI) Pandemic Preparedness, mental health, HIV and AIDS prevention, environmental hygiene and health promotion and, on the other hand, build local capacity and find durable solutions for integrating health into local policies and strategies.

Activities under this category cover health services to a wide range of mobile populations, such as migrants in an irregular situation, trafficked populations, internal migrants and migrant workers. This allows IOM to work in collaboration with a wide range of partners, national health authorities, as well as other sectors and civil society. Finally, following the global shortage of health care workers, the migration of health care workers has become an area of increased attention for the Organization.

Population Mobility, HIV and AIDS

In addressing HIV and AIDS, IOM supports a global approach focusing on advocacy, policy guidance and definition of best practices, regional level initiatives and capacity building.

IOM works to prevent and counter the misinformation, misunderstanding and stigmatization that continue to foster the perceived relationship between migration and the initiation and/or propagation of HIV and AIDS. IOM's response to the HIV epidemic addresses migrants throughout all stages of their journey – before they leave, as they travel, in communities and countries where they stay, and after they return home. This often requires going beyond national approaches to develop regional and cross-regional approaches, in particular in cross-border areas.

The Organization's activities are structured under the following strategic objectives:

- decrease risk of HIV exposure among mobile populations and labour migrants;
- advocate for universal access of migrants to HIV care and treatment;

- support governments to manage the health impacts of migration and population movements; and
- address the HIV needs and vulnerabilities of mobile populations in emergency settings.

In 2007, MHD assisted in the project development of and provided country support for HIV-related activities in 22 countries, including Angola, Colombia, Croatia, Ecuador, Mauritania, Myanmar, Nigeria, Tajikistan, Thailand and Zimbabwe. HIV projects constitute the second largest set of activities within IOM's migration health work and they cover a wide range of topics, such as:

- mapping of HIV and AIDS services in Uganda covering 1.5 million IDPs, 107 service providers, and 136 IDP health facilities;
- interventions to prevent HIV, benefiting 411,564 IDPs, and a nationwide mass media information dissemination campaign on cross border mobility in Zimbabwe;
- reducing the HIV vulnerability of labour migrants by implementing HIV prevention projects and research in migrant settings, as well as through the development of policies and regional coordination mechanisms;
- a "Safe Mobility" education video and life skills activities on HIV and AIDS for migrants and people affected by mobility in the Greater Mekong Sub-Region; and
- HIV prevention activities including training of over 2,800 local residents in Ecuador as well as Colombians who have crossed into Ecuador while fleeing violence in their country.

A young Burmese refugee from Mae La camp, Thailand, passing by an IOM billboard.

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EU Partnership Project to Reduce HIV and Public Health Vulnerabilities Associated with Population Mobility

An important focus of the Portuguese EU Presidency in 2007 was "Health and Migration in the EU". Within this framework, the Government of Portugal and IOM developed the EU Partnership Project as a preparatory initiative to the EU National AIDS Coordinators' meeting "Translating Principles into Action in the WHO European Region and EU Neighbouring Countries" of 12-13 October 2007.

The main objectives of the EU Partnership Project were (1) to document the key HIV and mobility-related health vulnerabilities in the EU and (2) to enhance policy dialogue for potential joint actions. In collaboration with national institutions, the research community and non-government organizations, the Project coordinated seven country reports that generated migration and epidemiological profiles for Bulgaria, Germany, Hungary, Italy, Malta, the Netherlands and Portugal.

Review and synthesis of these studies produced a number of good practice examples of regional interest, including the development of National and Local Immigrant Support Centres in Portugal and the establishment of HIV prevention programmes collaborating with ethnic minority communities in the Netherlands. Eleven key issues for EU-level action were further identified, emphasizing the importance of a human-rights based approach to policy on HIV and migration in Europe, the need

for including migrants in National AIDS Strategies, and the benefits of cooperation between health systems of sending and receiving countries.

On the basis of these findings, four key actions were recommended to the EU National AIDS Coordinators' meeting:

- engage the business sector;
- engage migrants to voice their perspective on access to health services with respect to HIV;
- engage in national HIV strategic planning that considers population mobility issues, ensure adequate national HIV surveillance, and translate findings into concerted actions; and
- engage non-health actors, including Labour, Justice, Foreign Affairs, Interior, Education, and Defense.

Over an eight-month period, the Project has contributed a situation analysis in a field in which some countries had limited prior experience. Both the partner consultations and the EU National AIDS Coordinators meeting have provided dialogue opportunities between different EU Member States, while in Bulgaria, the dialogue established through the Project led to the inclusion of migrants and mobile populations as a target group in its 2008-2013 National AIDS Strategy.



HIV Awareness Campaign and Distribution of IEC Materials in Hoedspruit, an agricultural town in South Africa's Limpopo province.

© IOM 2007 - MZA0046 - (Photo by Patrick Cocakynne)

IOM Mapping of HIV Hot-Spots in Somaliland, Puntland, and South-Central Zones of Somalia, August-December 2007

Through the “One-United Nations (UN)” programme of support, IOM Nairobi’s East Africa HIV Research Team partnered with the United Nations Joint Programme on HIV/AIDS (UNAIDS), United Nations Children’s Fund (UNICEF), World Health Organization (WHO), and the three Somali AIDS Commissions to undertake groundbreaking formative research, which aims to:

- identify and document effective and appropriate methods of collecting HIV and sexual behaviour data in the Somali context;
- define the situation of HIV risk and vulnerability among at risk populations in selected HIV hot-spots; and
- establish evidence-based programmes by undertaking the first Somali National HIV Sero-Behavioural Survey.

In disseminating the results, IOM and partner organizations have breached longstanding barriers to openly discuss sensitive issues among target populations and stakeholders. This, in turn, fostered national ownership of the data, which will significantly alter the Somali HIV national response.

A CD-ROM Toolkit and Final Report of the findings has been produced and disseminated. The research has also been featured twice in the Integrated Regional Information Networks (IRIN) press releases. In addition, UNAIDS has initiated a write-up of the study for its “Best Practice” collection.



As part of HIV hot-spot mapping of most-at-risk mobile populations in three Somalia zones, IOM conducted research interviews in Somaliland in September 2007.

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A Zimbabwe-bound bus stops at a service station near Polokwane where passengers buy last minute essentials especially perishables like bread.

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(Photo by Lerato Maduna)

Health and Border Management

Human health measures represent a key component of sound border management policies. Addressing public health concerns, the health needs and rights of migrants, and occupational health of staff are particular challenges for policy makers and require strong collaboration among health care providers, public health authorities, and border officials. The health risks surrounding irregular migration flows are particularly acute as a result of the conditions of the journey and legal status in the receiving country.

IOM provides support to governments and partners aiming to minimize the public health risks posed by irregular migration along border areas and moreover, to improve health care for migrants in border areas by using a human rights-based and a migrant-sensitive approach. In addition, activities strengthen technical capacity of governments in addressing health issues in the context of border management through technical advice and training of immigration officials, border guard staff, and managing officers and health personnel.

Increasing Public Health Safety Alongside the New Eastern European Border Line

The enlargement of the Schengen area brings new migration-related health challenges to the Member States on the eastern EU frontier and highlights the pre-existing gap in migration and health policies in Europe. Health systems and border services need to be prepared to address public health concerns, health needs and human rights of migrants, as well as to ensure staff's occupational health. Responding to these conditions, the "Increasing Public Health Safety Alongside the New Eastern European Border Line" Project was implemented by the IOM Regional Office to the EU in collaboration with IOM offices in Hungary, Poland, Romania and Slovakia.

Since June 2007, this 30-month Project aims to minimize public health risks in the EU, build capacity for border management and health staff, and facilitate appropriate health care to migrants as a fundamental human right. The Project includes the development of a methodology for the analysis and documentation of the current public health situation regarding border management. Based on this comprehensive assessment, the Project will further develop a template for an irregular mi-

grant health database, a set of evidence-based minimum standards for health aspects of border management, a multidisciplinary curriculum for health professionals and border officials, as well as regional training to test these elements as part of a comprehensive and adaptable public health and border management module.

During the initial six months, the Steering Committee and Joint Project Team were constituted and the assessment phase was launched. Joint Project Team members drafted the methodology for the situation analysis (data collection templates, KAP surveys and site checklists) and preliminary retrospective data were collected in the target countries.

Activities have been implemented in association with the University of Pécs, Hungary, and in cooperation with the Governments of Hungary, Poland, Romania and Slovakia, the European Centre for Disease Prevention and Control (ECDC), Frontex and WHO EURO. The Project is co-financed by the European Commission's Public Health Programme 2003-2008 and the Hungarian Ministry of Health.

Reproductive and Sexual Health

Reproductive and sexual health represents important challenges for certain migrant populations. It is particularly challenging for migrants in an irregular situation and migrants who are moved by force, to access reproductive health services, including antenatal care. In addition, these vulnerable groups are often subject to gender-based violence (GBV). Migration also creates situations where cultural and ethnic reproductive and sexual health practices and norms of behaviour may challenge or conflict with those in the host community. One well recognized example is female genital mutilation. Also, access and use of contraception in the new community may differ significantly from patterns and cultural or religious approaches in the country of origin.

In 2007, IOM's work around reproductive health of migrants increased significantly especially within the areas of sexual and gender-based violence (SGBV), in the context of forced and irregular migration. In particular, IOM's counter-trafficking activities heavily emphasized the need to address reproductive health of trafficked persons. Sexual and reproductive health problems, for example STIs, unsafe abortions and unwanted pregnancies, have been associated with the exploitation and abuse suffered by many of IOM's assisted trafficked persons during the trafficking process.

MHD initiated an internal working group on reproductive health composed of migration health professionals located internationally at IOM's country offices and Headquarters. The working group is tasked to develop a concise practical and user-friendly "Reproductive Health Rapid Assessment – Guidance Notes for Field Missions", which will provide directions for field managers working on reproductive health matters.

Examples of IOM's reproductive health-related work include:

- Prevention and responses to reproductive health needs of displaced women in IDP settings in Zimbabwe. Assistance to 200,000 women in displaced situations, identification of rape cases, and community-based prevention through the distribution of information, education and communication materials, spearheading drama groups, peer educations, community reconciliation and persecution of perpetrators.
- Responses to HIV and AIDS and GBV needs of cross border mobile populations and deported



migrants at the South Africa-Zimbabwe border. Based on the Inter-Agency Standing Committee (IASC) guidelines for GBV and HIV and AIDS interventions in emergency settings, the United Nations Population Fund, in collaboration with IOM, developed a strategy to respond to GBV needs of women affected by trafficking or irregular migration at the South Africa-Zimbabwe border, more specifically at the Beitbridge border town.

- A study on counter-trafficking in persons within, through and from Haiti to enhance service provision for victims of trafficking and SGBV.
- A study on sex work and HIV in relation to the presence of international peacekeepers in Somalia. This study will build on an innovative mapping exercise that was recently conducted by IOM.



An open poultry market in Nigeria. In 2007, Nigeria was affected by Avian Influenza prompting IOM to conduct a series of activities in the country aimed at strengthening prevention efforts as part of the organization's global programme, funded by the Japanese government, to counter the spread of Avian Influenza by targeting migrant and mobile populations.

© IOM 2007 - MNG0001 (Photo by Anita Davies)

Avian Influenza and Human Pandemic Preparedness

Many countries have responded to the threat of Avian Influenza, and developed pandemic preparedness and response plans to varying degrees at national and community levels. However, very few countries have developed strategies that address the needs of migrants. In response, IOM continues to collaborate with its Member States through the relevant ministries and Avian Influenza and Pandemic Preparedness Task forces, UN lead agencies, NGOs, civil society and other stakeholders.

A project on Avian Influenza and Pandemic Preparedness for migrants, funded by the government of Japan, was implemented in Indonesia, Kenya, Nigeria and Thailand in 2007.

The project objectives include the following:

- to advocate for migrants whose livelihoods depend on small livestock production (including poultry);
- to ensure that human health services enable migrants to be protected against newly emerging infections, specifically Avian Influenza;
- to establish social mobilization campaigns using effective communications, a range of media, as well as incentives and regulations;
- to encourage migrants and professionals to change livestock rearing practices and promote bio-security; and
- to contribute towards preparation for the maintenance of essential functions for continuity of livelihoods and security, governance and economic systems in the event of a pandemic.

In 2007, IOM was granted access to the UN Central Fund for Influenza Action. This facilitated funding for a project on Avian and Human Influenza Pandemic Preparedness for Vietnamese migrants and Lao host communities. IOM works in collaboration with the Lao People's Democratic Republic (PDR) government through the National Avian and Human Influenza Coordination Office, UN agencies, NGOs and other stakeholders in Lao PDR.

To further promote the needs of migrants on Avian Influenza and Pandemic Preparedness, IOM participated in the Fifth International Conference on Avian Influenza and Pandemic Preparedness in New Delhi, India in December 2007. During this conference, the United States Agency for International Development (USAID) pledged one million dollars to IOM for pandemic preparedness capacity development of migrants and cross border communities.

Managing the Migration of Health Care Workers

Human resources for health are critical to ensure the delivery of quality health services. The global shortage of health workers is aggravated by an unequal distribution of human resources sustained by a steady flow of international, regional and internal migration.

Insufficient supply of health workers is an increasing challenge not only in source countries, that suffer weakening of their health system, but also in receiving countries, facing demographic challenges due to ageing populations.

In the context of the migration of health care workers, the return phase of migration requires special attention. Health workers who are members of the diaspora can be encouraged to contribute towards the strengthening of health systems of their countries of origin through the transfer of knowledge and skills in an organized fashion. Sending and receiving coun-

tries are encouraged to collaborate in addressing the global health workers shortage, particularly in developing countries where human resources are needed to ensure that the set Millennium Development Goals (MDGs) are met.

MHD continues to work with WHO, ILO, and other international and national organizations, professional organizations, and other stakeholders to promote the management of the migration of health workers.

In line with the action points from the IOM International Dialogue on Migration in March 2006, with the theme "Migration and Human Resources for Health: From Awareness to Action," the following activities have been initiated in 2007:

- IOM, in collaboration with WHO, ILO, the East African Community Member States, and other stakeholders, commissioned five studies to address the need for evidence to influence policies on human resources for health in Africa;
- IOM is a member of the Global Health Workforce Alliance (GHWA) and participated in the GHWA activities through membership in the Migration Policy Advisory Council, jointly chaired by the "Realizing Rights, the Ethical Globalization Initiative" and the GHWA, as well as in the Migration Technical Working Group chaired by WHO; and
- MHD is also a member of the strategic advisory group of the International Centre on Nurse Migration.

MHD continues to work with other IOM services in promoting strategies, policies, and research, for ethical management of the migration of health workers. Some of the IOM programmes promoted are the Migration for Development in Africa initiative, Assisted Voluntary Return programmes, Return of Qualified Nationals programmes and other labour migration initiatives.

Managing Human Resources for Health in East Africa

To address the needs and the migration of health workers in East Africa, IOM facilitated the formation of an inter-ministerial and tripartite National Steering Committee (NSC) by the Government of Kenya. This committee is co-chaired by the Ministry of Labour and Human Resource Development and the Ministry of Health. NSC took a multisectoral approach in managing human resources for health and involved members from government agencies such as the Ministry of State for Public Services, Ministry of State for Immigration, Ministry of Education and Ministry of Foreign Affairs. Other stakeholders such as employers and workers organizations, as well as professional organizations also participated.

In recognition of the lack of primary data in the region, the NSC commissioned a Technical Working Group (TWG) to develop a research agenda. Following the recommendations of the TWG, the following studies were conducted in Kenya:

1. Managing the Migration of Human Resources for Health in Kenya: A Policy Review (funded by ILO);
2. Managing the Migration of Human Resources for Health in Kenya: Dynamics, Trends, Magnitude, Data Collection/Management (funded by ILO and WHO); and
3. Managing the Migration of Human Resources for Health in Kenya: The Impact on Health Service Delivery (funded by the Regional Network for Equity in Health in East and

Southern Africa, East, Central and Southern Africa Health Community, and IOM).

IOM, in collaboration with the TWG, organized the First National Stakeholders Human Resources for Health Workshop in Kenya. This workshop titled “Managing the Migration of Human Resources for Health in Kenya” was held on 11-13 November 2007 at Lukenya, 40 kilometers south of the capital city, Nairobi. The workshop was funded by ILO, WHO and IOM.

To further understand the migration of health workers in the East African Region, IOM continues to collaborate with the East African Community and other regional stakeholders to facilitate human resources for health research studies in Uganda and Tanzania.

The results from all the studies emphasized the need for the following, namely:

- capacity building to strengthen the health system;
- development of a functional data management system; and
- the development and implementation of evidence-based human resources for health policies.

The importance of both the financial and non-financial incentives to retain health workers was also highlighted.



IOM medical staff providing oral rehydration to returnee children on their way to Mundiri, Western Equatoria State, Southern Sudan.

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Migration Health Assistance for Crisis-Affected Populations

Emergencies, both natural and man-made (arising from political strife or conflict), cause population movements and often have major consequences on the health of the affected populations. IOM health assistance to crisis-affected populations can be divided to the following three major areas:

Emergency Assistance includes:

- Providing health assistance during rapid mass movement of people to safe areas, identifying and stabilizing medical conditions before the journey, establishing a triage system, providing medical escorts and medical assistance during the journey, and facilitating referral to available health services upon arrival.
- Establishing medical evacuation programmes, in coordination with local authorities and actors in destination communities, when the needs of crisis-affected populations exceed the capacity of the locally available health care system.
- Supporting and assisting inter-agency health contingency planning in emergencies; supporting and implementing health priorities identified, such as vaccination campaigns, vector control, and environmental sanitation.
- Conducting rapid health assessments, including vulnerability and needs assessments, and mapping of displaced populations and potential health service providers in host communities affected by crisis.
- Increasing access to health services for people who have been relocated from high risk to protected areas, by establishing temporary clinics, rehabilitating existing services or setting up mobile health teams.
- Assisting and supporting the Public Health Sector in extending emergency health assistance and improving access to basic health services such as primary care, reproductive health, communicable disease control, immunization, and environmental health and sanitation. Such support targets particularly vulnerable displaced populations, such as unregistered migrants and IDPs, as well as their host communities.

Children in a tent camp in Girdassen, Dohuk governorate in Iraq.

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Women cooking in the communal kitchen area at the International Organization for Migration-run IDP camp in Sri Lanka.

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Early Recovery covers:

- Continuous monitoring of health services availability and access for the migrant populations served by IOM.
- Supporting training of migrant community health workers and volunteers, as well as local health service providers, in rapid health assessments, surveillance, monitoring and provision of basic primary health care services to targeted migrant populations.
- Carrying out needs assessment surveys amongst migrant populations and host populations to identify priority areas for implementing relevant health programmes.
- Rehabilitating or strengthening the capacity of local primary health care services or destroyed specialized services, if needed, to meet the increased demands created by the displaced populations.
- Organizing and operating transit centers for returnees, who were previously displaced due to a crisis situation, to safe and adequate shelter facilities with access to drinking water, food, sanitation facilities and health services.

Reconstruction and Rehabilitation activities involve:

- Building capacities of local human resources for health, and rehabilitation of primary health care services, to assure continued access to curative health care services for both migrant and host communities in order to facilitate reintegration.
- Sensitizing national authorities, employers and health service providers concerning cultural and social diversity, social and health implications of migration and population movement, and migrants' right to health.
- Assisting and supporting the public health sector by coordinating and mobilizing health resources and ensuring that preventive health services and other public health measures also address the needs of migrants and local host communities affected by crisis.
- Mobilization of diaspora health professionals who might assist in developing primary level health services in crisis-affected areas.

At a global level, MHD continued its contributions and participation within the humanitarian reform process through close interaction with the IASC Taskforces on HIV in Emergency Settings and Mental Health and Psychosocial Support in Emergency Settings, Global Health Cluster, and SGBV Working Groups.

Highlights of Migration Health Assistance for Crisis Affected Populations, 2007

Under the Direct Health and Psychosocial Assistance Programme implemented in the Bireuen District in Aceh province, Indonesia, IOM assisted 2,500 (60% were female) conflict-affected persons, of which 23% received mental health care. Also, community leaders and counselors were trained on community mobilization to support the Ministry of Health's Mental Health Plan for Aceh province. IOM also provided clinical educator training for 48 midwives to support 100 village-based midwives in 8 sub-districts of Bireuen in Aceh province, Indonesia, in collaboration with UNICEF and Save the Children. Further, IOM and the Harvard Medical School completed their reference material titled "Psychosocial Needs Assessment of Communities in 14 Conflict Affected Districts in Aceh."

In Sudan, IOM established pre-departure medical screening and vaccination services in 13 IDP and refugee return operations providing services to a total of 52,492 beneficiaries, of which 52% were women; 3,576 received treatment in departure centers and 179 received treatment in local hospitals. All organized convoys were escorted by medical staff and beneficiaries received en route treatment and appropriate vaccination, including measles (10,574), meningitis (17,866) and yellow fever (725) to reduce vulnerability to common communicable diseases. Recognizing the human resource gaps in South Sudan, IOM also identified,

registered and facilitated the reinstatement of 209 IDP health workers in Khartoum IDP camps. This number included two medical assistants, 63 nurses, 19 midwives and 123 community health workers.

In Zimbabwe, IOM worked with its partners to provide health care and treatment for 130,415 beneficiaries of emergency assistance programmes in which key interventions included establishing mobile outreach services; emergency health care to control disease outbreaks; establishing a network of community health volunteers; improving access to clean water and sanitation facilities; and implementing a disease surveillance database and early warning system for mobile and vulnerable populations.

In Lebanon, IOM in collaboration with the Association for the Protection of Children Affected by War, undertook rapid assessments through qualitative interviews among professionals involved in direct assistance to target groups, and delivered training on mental health and psychosocial approaches in emergency contexts for field staff in Lebanon and Syria. In addition, IOM developed and offered a one-year course titled, "Psychosocial Animation in War-Torn Societies" to 30 psychosocial and mental health service providers from 25 national and international institutions and NGOs and also organized the "2nd International Healing the War" Meeting in Geneva on responding to the mental health and psychosocial needs of war-affected populations.



IOM conducts an assessment of the effects of Typhoon Mina (International codename: Mitag) in Catanduanes, in the Philippines' Bicol region.

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2007

Alta Consejería para la Reinserción (ACR) – Centro Mundial para la Solución de Conflictos (CMSC). *Cartilla de Identidad, Duelo y Resiliencia*. OIM, Bogotá.

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acronyms

AIDS	Acquired Immunodeficiency Syndrome
CIS	Commonwealth of Independent States
DNA	Deoxyribonucleic Acid
EU	European Union
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
IDP	Internally Displaced Person
ILO	International Labour Organization
IOM	International Organization for Migration
MHD	Migration Health Department
NGO	Non-Government Organization
NSC	National Steering Committee
SGBV	Sexual and Gender-Based Violence
STI	Sexually Transmitted Infection
TB	Tuberculosis
TWG	Technical Working Group
UK	United Kingdom
UN	United Nations
UNAIDS	United Nations Joint Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
USA	United States of America
WHO	World Health Organization

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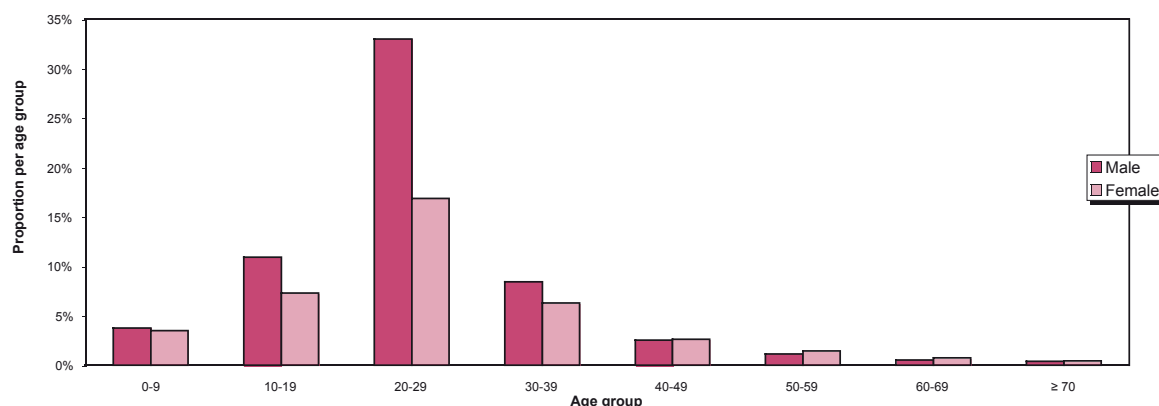


Figure 14 - Africa and the Middle East

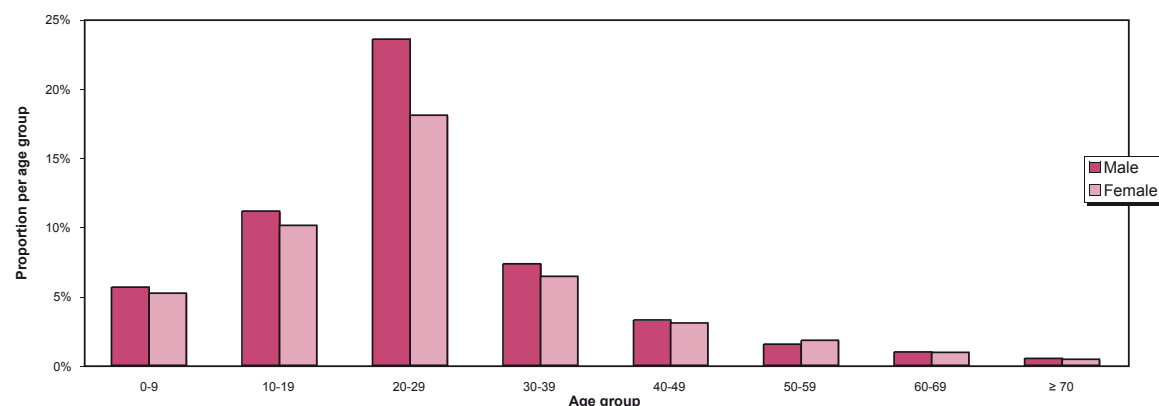
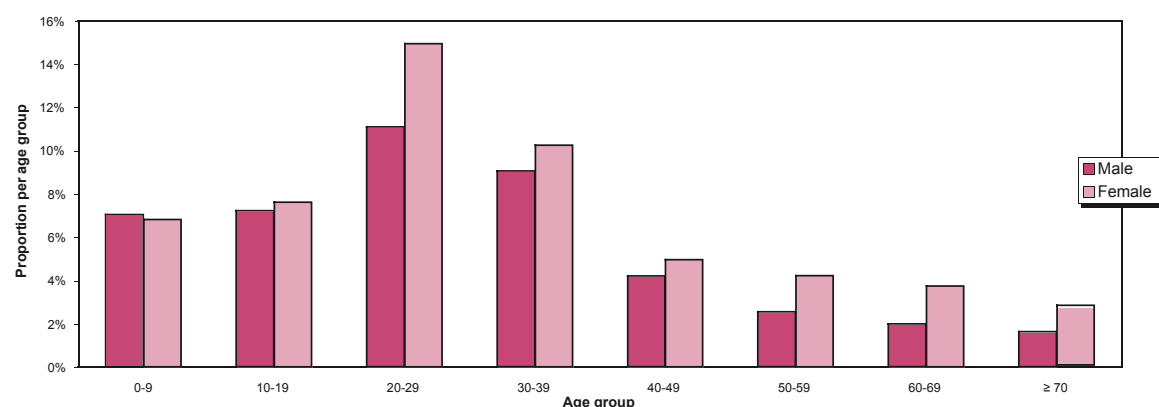


Figure 15 - Europe and the Commonwealth of Independent States



Sex and Age Distribution of All Migrants by Country of Destination, 2007

Figure 16 - United Kingdom

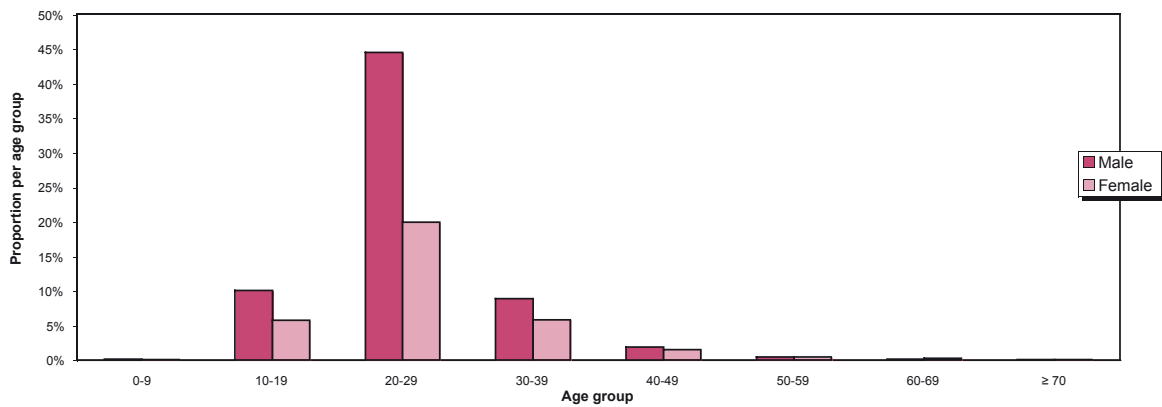


Figure 17 - United States of America

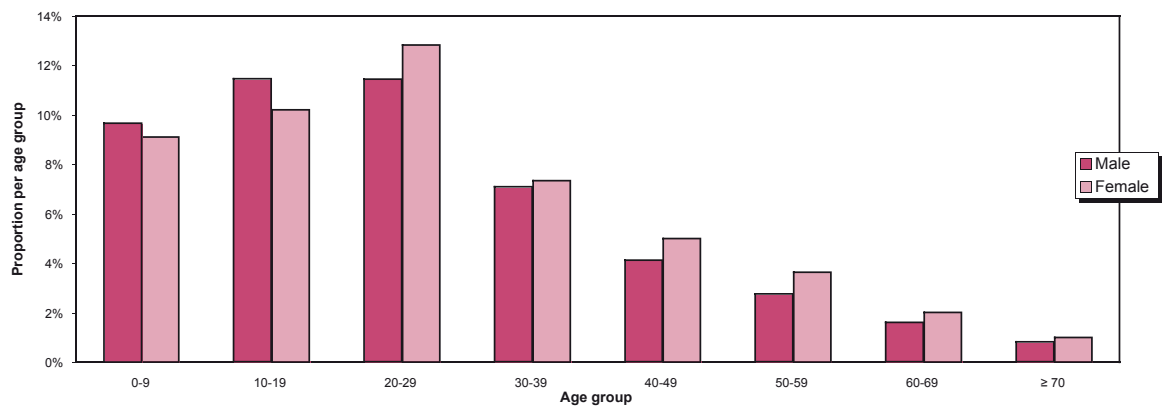


Figure 18 - Canada

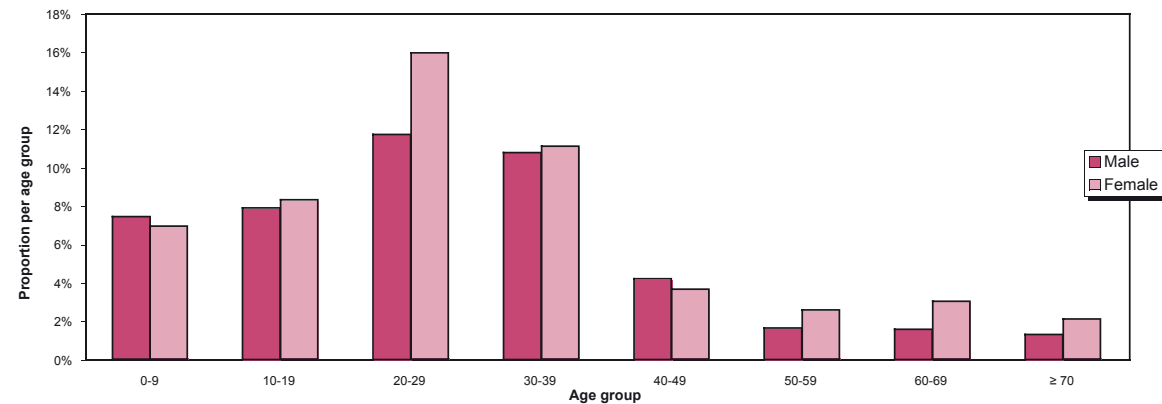


Figure 19 - Australia

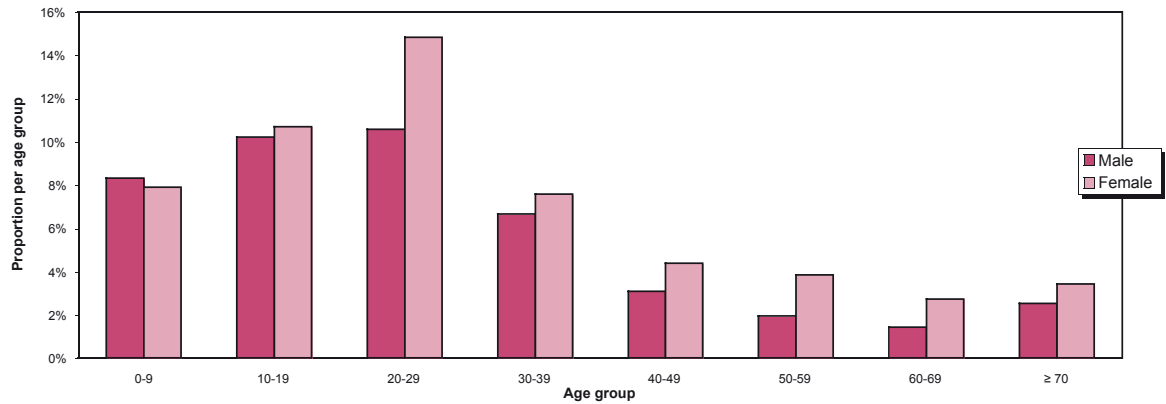


Figure 20 - New Zealand

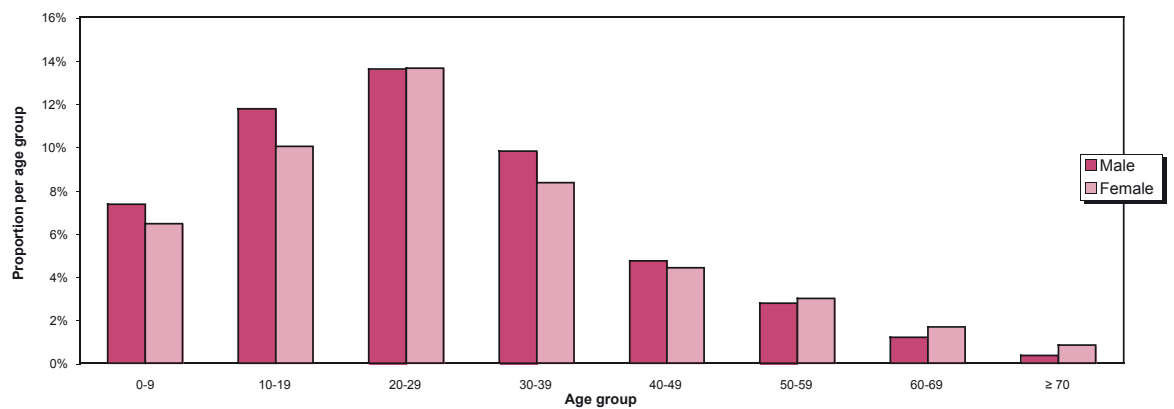
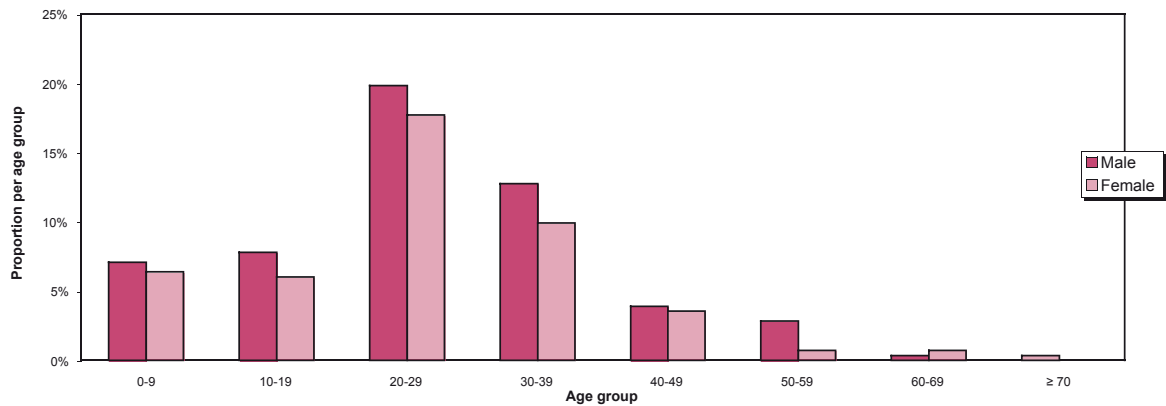


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Families during the trip on the Nile in cabins on the barge. These Dinkas, one of the main tribes in Southern Sudan, were displaced from their homes during the long civil war which ended after a peace deal was signed between the government in Khartoum and the SPLA (Sudanese People Liberation Army).

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Faces of Sri Lankan IDPs in the camps where IOM provided humanitarian assistance in the post-tsunami period.

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



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