



International Organization for Migration (IOM)  
The UN Migration Agency

# MIGRATION HEALTH



MIGRATION HEALTH  
MANAGEMENT

MIGRATION HEALTH  
DIVISION

## Annual Review

# 2016

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

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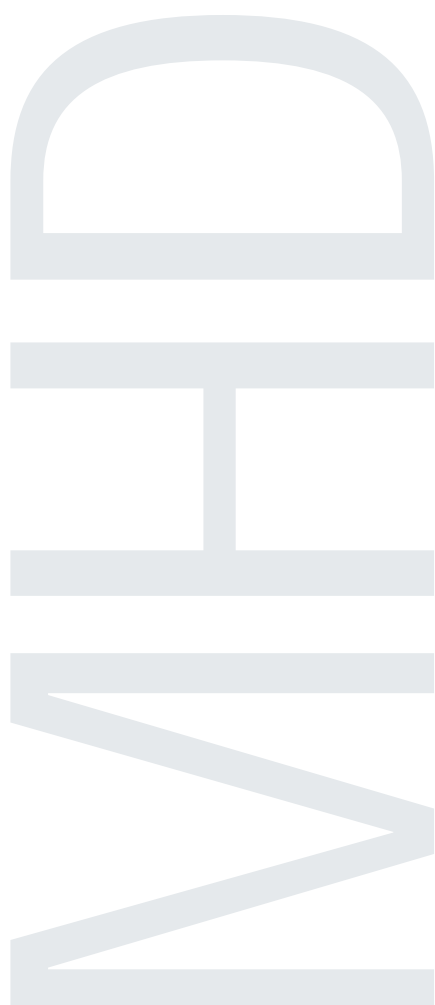
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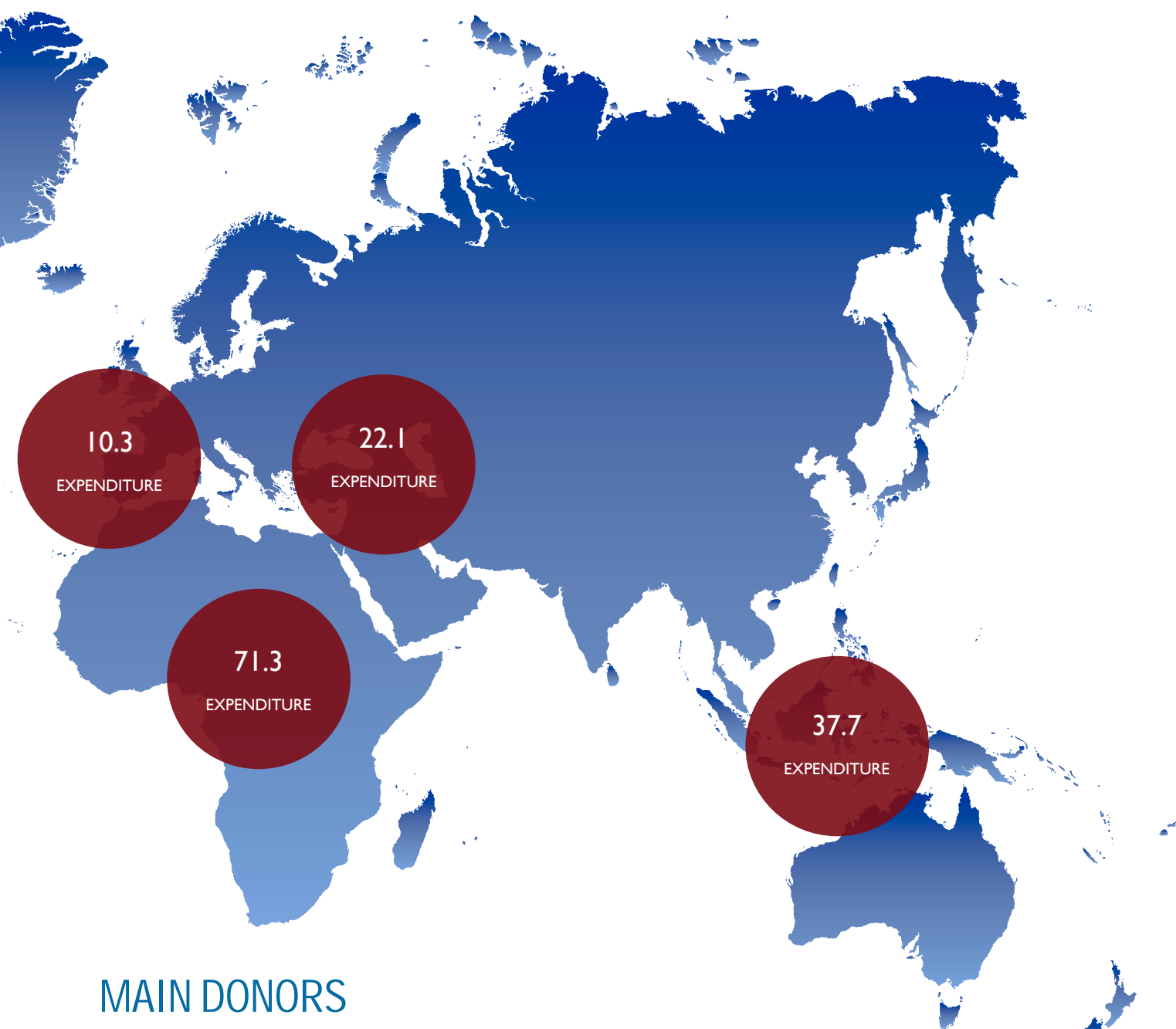
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**Figure I.** Total expenditure by region, 2016 (in millions USD)

# 2016 in numbers





## MAIN DONORS

United States

United Nations

Global Fund to Fight  
AIDS, Tuberculosis  
and Malaria

Australia

Colombia

## 234 PROJECTS ACTIVE IN 2016

28

Migration health assessments and travel health assistance

82

Health promotion and assistance for migrants

124

Migration health assistance for crisis-affected populations

# foreword

Today, more than ever, the plight affecting migrants and refugees has reached the highest levels of diplomacy and has become the central focus in global dialogues. In September 2016, this was evidenced at the Seventy-first United Nations General Assembly (UNGA) High-level Plenary Meeting on Large Movements of Refugees and Migrants. This was the first time the subject had been addressed at such a level by the UNGA. At this Meeting, in the same year that the International Organization for Migration (IOM) celebrated its sixty-fifth anniversary as an intergovernmental organization dedicated to migration management, IOM was inducted into the UN System as the UN migration agency.

Furthermore, the New York Declaration on Refugees and Migrants was adopted, including its annexes on the global compact for safe, orderly and regular migration (hereinafter referred to as the global compact for migration) and on the global compact on refugees, agreements that will be developed within the next two years and that will give States the opportunity to make a crucial contribution to global migration governance. The Declaration, which sets the foundation for the forthcoming compacts, makes reference to health albeit in a fragmented way despite recent renewed international attention to the topic of migration health.

On the margins of the same UNGA Meeting, a side event on health in the context of migration and forced displacement was organized by IOM, the World Health Organization (WHO) and the Office of the United Nations High Commissioner for Refugees (UNHCR), at which IOM Deputy Director General Laura Thompson spoke on how recent discussions on the subject had often only marginally reflected the critical and complex link between health, migration and human mobility.

In October 2016, IOM Director General Ambassador William L. Swing spoke at the World Health Summit seminar, called “Migration and Refugee Health: From Care to Policy”, where he talked about “The Place of Health in the Migrant and Refugee Global Compacts: A Multisector Partnership Agenda”.

In the annual WHO World Health Assembly (WHA), a Technical Briefing for WHO Member States on Migration and Health was organized for the first time in the history of the WHA. Ambassador Swing opened and closed the session, which reviewed the current situation and priorities related to migration and health, country practices, perspectives and lessons learned, as well as implications for the future work of



WHO and partners in relation to migration and health, with an emphasis on the human face of migration.

All of these events are testimony to the increased attention that migration and health have gained in the last year and that the subject is one of interest to many governments. However, despite the increased recognition of the need to adapt policies and programmes, across sectors, to the health challenges brought by global human mobility, the development of functional instruments remains fragmented. This has resulted in migration health often being under-researched and under-funded, and lacking a presence in national health systems and key international dialogues, preventing millions of migrants' access to health services.

In response to the request of the President of Sri Lanka to organize a global consultation on migrant health, which was announced at 106th IOM Council in 2015, IOM organized, in collaboration with WHO and the Government of Sri Lanka, the Second Global Consultation on Migrant Health in February 2017. Building on the accomplishments of the First Global Consultation on Migrant Health in 2010, the Second Global Consultation brought migrant health stakeholders together to share lessons learned, good practices and research in addressing the health needs of migrants; identify priority areas and key policy strategies to reach a unified agenda across regions on the health of migrants, reconciling acute large-scale displacement as well as long-term economic and disparity-driven structural migration; and engage multisectoral partners at the policy level for a sustained international dialogue and an enabling policy environment for change.

The past year has been a busy one for the IOM Migration Health Division (MHD) and has also paved the way for an upcoming year of great ambitions and significant milestones. As the UN migration agency, IOM will continue to have the great responsibility to support Member States and beneficiaries in managing migration. Furthermore, IOM will continue to focus efforts towards assisting Member States and partners for the development of the global compact for migration, which considers the health of migrants, and when relevant, the global compact on refugees, as guided by the Sustainable Development Goals. The MHD will continue to provide governments with technical assistance on migration health policy and development, mainstream the health of migrants into broader governance domains and strengthen partnerships among multisectoral stakeholders.

I am proud to present the *2016 MHD Annual Review*, which highlights some of IOM's activities and achievements in the domain of migration health and offers a glance at upcoming endeavours. My sincere gratitude and admiration go to IOM migration health colleagues around the world, as well as partners and Member States, whose persistence and dedication to the well-being of migrants and communities are improving lives and enabling IOM to advance the agenda of migrant health for the benefit of all. We hope you enjoy the read!



**Davide Mosca**

Director, Migration Health Division  
IOM

# list of acronyms

ADB	Asian Development Bank
ADL	activities of daily living
ADR	assisted discharge and referral
AIDS	acquired immune deficiency syndrome
BCC	behaviour change communication
CA	change agent
CBO	community-based organization
CDC	Centers for Disease Control and Prevention (United States)
CEBS	community event-based surveillance
CHV	community health volunteer
CHW	community health worker
CIPA	Community Initiative for the Prevention of HIV/AIDS
CSO	civil society organization
CXR	chest X-ray
DOH	Department of Health (Philippines)
DOT	directly observed treatment
DST	drug susceptibility testing
EU	European Union
EVD	Ebola virus disease
FSW	female sex worker
GBV	gender-based violence
GCM	Global compact for safe, orderly and regular migration
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHSA	Global Health Security Agenda
GMS	Greater Mekong Subregion
HAP	health assessment programme
HBMM	Health, Border and Mobility Management
HIV	human immunodeficiency virus
HP	health promoter
ICD	International Classification of Diseases
IDC	immigration detention centre
IDP	internally displaced person
IEC	information, education and communication
IMS	immunization management system
IOM	International Organization for Migration
IP	implementing partner
IRU	Injury Rehabilitation Unit
JUNIMA	Joint UN Initiative on Migration and Health in Asia
KAP	knowledge, attitudes and practices
LLIN	long-lasting insecticidal net
MDR	multidrug-resistant
MHA	migration health assessment
MHC	mobile health clinic

MHD	Migration Health Division (IOM)
MHI	migration health informatics
MHPSS	Mental health and psychosocial support
MiMOSA	Migrant Management Operational Systems Application
MIPEX	Migrant Integration Policy Index
MMP	migrants and mobile population
MMT	mobile medical team
MoES	Ministry of Education and Science (Georgia)
MoH	Ministry of Health
NCD	non-communicable disease
NGO	non-governmental organization
NFI	non-food item
NOFSW	national organizations of female sex workers
NTP	national tuberculosis programme
OFDA	(USAID) Office of US Foreign Disaster Assistance
PDMP	pre-departure medical procedures
PEC	pre-embarkation check
PEOC	prefectural emergency operational centre
PHAMESA	Partnership on Health and Mobility in East and Southern Africa
PHC	primary health-care centre
PAHO	Pan-American Health Organization
PHR	personal health record
PoC	protection of civilians
PoE	point of entry
PRM	Bureau of Population, Refugees, and Migration (United States)
RRR	relief, recovery and reconstruction
SDG	Sustainable Development Goal
SRHR	sexual and reproductive health and rights
STI	sexually transmitted infection
TB	tuberculosis
ToT	training of trainer
UHC	Universal Health Coverage
UMN	undocumented Myanmar nationals
UN	United Nations
UNGA	United Nations General Assembly
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WASH	water, sanitation and hygiene
WHA	World Health Assembly
WHO	World Health Organization
WHODAS	WHO Disability Assessment Schedule



A photograph showing a healthcare worker administering a vaccine to a baby held by a woman in a blue headscarf. Another woman in a patterned headscarf stands behind them, holding a document. The scene is set in a clinical or community health center.

# **Part I: Emerging themes in migration and health**



## MIGRANT HEALTH AND THE SUSTAINABLE DEVELOPMENT GOALS

### “Remember the migrants”: Leaving no one behind in the era of Sustainable Development Goals

Following the close of the Millennium Development Goals (MDGs) in 2015, the United Nations General Assembly (UNGA) adopted an ambitious global agenda for sustainable development through the 17 Sustainable Development Goals (SDGs). This post-MDG agenda provides an innovative and broad framework to address the health of migrants, one that encourages the engagement and collaboration of multisectoral and regional stakeholders to work towards achieving the SDG targets. In addition, by promoting social inclusion, the UN 2030 Agenda for Sustainable Development aims to cultivate societies that are more equitable.



To improve child health and maternal care in Somalia, IOM runs mobile health centres across the country. © IOM 2014/ Mary-Sanyu Osire

Although there is no explicit mention of the health of migrants in the newly-adopted SDGs, the Agenda introduces one overarching component that allows for the integration of efforts to promote the health of migrants throughout the SDGs: *Leave no one behind*. The UN 2030 Agenda for Sustainable Development adopts a human rights approach that puts people, particularly the disenfranchised, at the centre of its objectives.

Migration is a social determinant of health that can impact the health and well-being of individuals and communities. The migration process can expose migrants to health risks, such as perilous journeys, psychosocial stressors and abuses, nutritional deficiencies and changes in lifestyle, exposure to infectious diseases, limited access to prevention and quality health care, or interrupted care. Migration also has the potential to improve the health status of migrants and their families, by providing an escape from persecution and violence, by improving socioeconomic status, by offering better education opportunities, and by increasing purchasing power for left-behind family members, thanks to remittances.

### The Goals

The SDGs explicitly acknowledge the development potential created by migration through SDG 10, which aims to “[facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies]”. Migrants contribute to the development of countries of origin, transit, and destination with their intellectual, cultural, human and financial capital, as well as through their active participation in society. Being in good health is a prerequisite to being a productive contributor to the social and economic development of society.



Delivering medical equipment in Myanmar. © IOM 2016

SDG 3, “Ensure healthy lives and promote well-being for all”, addresses the right to health, a right that all human beings have, including migrants regardless of their legal status. Target 3.8, “Achieve universal health coverage”, in particular urges that all members of society are accounted for in financial risk protection schemes and have access to quality, affordable and equitable healthcare services. In addition to SDGs 3 and 10, the health of migrants can be traced throughout the Sustainable Development Agenda. Several goals and targets have significant impact on the health and well-being of migrants, highlighting the multisectoral relevance of the health of migrants and the cross-cutting nature of the subject. Target 1.5, for example, addresses the need to “strengthen resilience of the poor and most vulnerable to economic, social, and environmental shocks and disasters”, a population which often includes migrants. Furthermore, implementing social protection systems that are inclusive of migrants and address portability of entitlements in health can increase migrants’ access to affordable health services and avoid excessive out-of-pocket health expenditures. Other targets, such as 5.2, which calls for the “eliminat[ion] of all violence

against women and girls”, and SDG 8 on “decent work and economic growth”, recognize the risks migrants may be exposed to throughout the migration process. Target 11.1 calls for “access to adequate housing and basic services”, recognizing the importance for all to have access to basic health services, including migrants, many of whom live in slums in urban settings, as well as refugees who live in camps or cities. The importance of “protect[ing] labour rights and promot[ing] safe and secure working environments for all workers, including migrant workers” is directly stated by Target 8.8, emphasizing the need to address the health needs and promote decent work of migrant workers, particularly women migrants with “irregular” status, and those who are exposed to health risks due to poor working and living conditions. As migrants inherently connect sectors, countries and communities, Target 17.16 is vital as it calls for the utilization of multisectoral and international partnerships to achieve the SDGs.

The health of migrants can be traced in at least 8 of the 17 SDGs (see Figure 2). Migrant-specific health vulnerabilities can be addressed through the achievement of these goals and targets.

**Figure 2.** Tracing migrant health in the SDGs





## IOM activities towards the SDGs

IOM's Migration Health Division (MHD) has been working with Member States towards achieving the SDGs. In Sudan, for instance, IOM supports a mobile health clinic that addresses sexual and reproductive health needs, including maternity, infant feeding and HIV/AIDS prevention services (Target 5.6). In Myanmar, health workers were trained to identify migrants with tuberculosis (TB) and to refer them for treatment, while X-ray screening, treatment, and health education sessions were provided to migrants and host community members (Target 3.8). In East and Southern Africa, IOM contributes to the improved standard of physical, mental and social well-being of migrants by responding to their health needs throughout all phases of the migration process and by addressing the public health needs of host communities using IOM's network of partners (Target 17.16).

## Multisectoral responses

Enhanced multisectoral partnership and coordinated efforts are needed to ensure that migrant health is addressed throughout the migration cycle, as well as efforts to develop migration-sensitive health systems that respond to increasingly diverse population health

profiles and needs. Furthermore, the involvement of migrants and migrant organizations through participatory consultations and engagement is crucial to the development of policies and programmes that address the health needs of migrants, as is the collaboration of multilateral and multiregional groups. For example, the Joint UN Initiative on Migration and Health in Asia (JUNIMA) is a coordination mechanism that brings governments, civil society organizations, regional associations, development partners, and UN agencies together to develop and promote policies, build partnerships, share information, and support action on disease prevention, treatment, care and support services for migrant populations in Asia.

There are numerous avenues to address migrant health through the implementation of the SDGs. In response to the call to "leave no one behind", governments and humanitarian and development actors should integrate the health needs of migrants into global and national plans, policies, and strategies across sectors and across borders in accordance with the 17 SDGs and their respective targets. Unless the health of migrants is addressed through their inclusion into health systems and health system responses, sound public health practice, universal health coverage and the SDGs will be unattainable.



IOM Egypt organized a community event to celebrate the International Migrants Day. © IOM 2016

## PROMOTING MIGRATION HEALTH IN THE ERA OF THE GLOBAL COMPACTS FOR MIGRATION AND REFUGEES

Desperate large-scale, conflict-driven human displacement and irregular migration flows have crystalized in the international attention as defining features of contemporary human mobility, overshadowing the otherwise positive and diverse reality of migration. The positive reality is one that recognizes that migration is one of humanity's most traditional poverty reduction strategies, as well as a vital developmental and societal enriching factor for both countries of origin and destination.

The cumulative volume of refugees, asylum seekers and irregular migrants moving in large mixed flows – the main topic of the Seventy-first UNGA High-level Plenary Meeting on Large Movements of Refugees and Migrants in September 2016, where the New York Declaration on Refugees and Migrants was adopted – represents but a fraction of the estimated 1 billion people on the move, either across national borders as international migrants (244 million) or within the borders of their own country as internal migrants (740 million). The health needs of a population of this size is an indicator of the relevance of the issues as a global theme, especially when one considers that migrants may face challenges and obstacles to accessing health care, public entitlements and services that are comparable to those enjoyed by the resident population, due to administrative, economic, cultural, linguistic and social barriers, which the realization of migrant-sensitive health systems could overcome. In fact, it has been repeatedly demonstrated that the upfront costs of investing in migrants' health are largely compensated for by the longer-term public health benefits of integration, as healthier migrants are better able to contribute to economies and societies.

Despite this, the health of migrants has remained a neglected theme, exemplified by its omission from the New York Declaration and the main elements to be included in the global compact for safe, orderly and regular migration (hereinafter referred to as the global compact for migration), as defined in Annex II of the Declaration. This omission is not limited to the health sector, but extends to the various platforms that have addressed the governance of migration in multilateral forums.

### The current migration governance climate

Rather than an oversight or question of interpretation, the absence of a comprehensive reference to the health of migrants in several global frameworks for international cooperation might be a hint of the divisive discourse that exists in societies in relation to the integration of non-citizens. The polarization of the current political debate on immigration has widened to encompass the domain of health policy and the debate around the health of migrants. Indeed, despite global declarations of commitments to realize universal health coverage (UHC) and to “leave no one behind”, what ultimately determines the level of access migrants have to health care today and, more generally, the health outcomes of migration is the legal status that migrants hold in society.

It is estimated that the number of migrants in irregular situations has grown to more than 50 million worldwide, partly as a result of restrictive immigration laws and insufficient channels for orderly and regular migration, and exacerbated by the emergent waves of xenophobia and discrimination, and general resistance to adapting policies to the changing demographic trends and population dynamics. Moreover, it must be recognized that crises are increasing in frequency and duration and that globalization has brought with it new realities that impact human mobility, including the relative ease of travel, global digital connectivity, imbalances in the supply and demand of jobs between regions, and growing disparities within and between countries, to mention but a few.

These many elements have resulted in a shift in the nature of forced migration and irregular migrant flows from aspiration to desperation, with more migrants and displaced persons embarking on perilous journeys, often exposing themselves to the hazards during the migration cycle that may exacerbate their vulnerability to ill health and that have rendered the context in which migration occurs today as an important determinant of health. Increasingly, migrants face the risk of death and trauma along the route, exposure to

communicable diseases, risk of non-communicable diseases, mental health and psychosocial disorders, gender-based violence and sexually transmitted diseases. These health issues have been recognized as a priority for the health sector, yet often fail to explicitly recognize migrants and displaced persons as populations of concern, leaving migrants unprotected and in vulnerable situations.

## Migration and health as a global agenda

Countries in different regions of the world have promoted a health equity agenda for migrants and displaced populations regardless of their legal status. A common factor seems to be an understanding that the realization of national health goals cannot be achieved without the inclusion of migrants and that health represents a fundamental aspect of human rights that extends beyond issues of nationality. Few countries, however, have scaled up their capacity and invested in their response to new or prospective health needs related to migration flows; nor have many countries put in place mechanisms to enhance multisectoral collaboration, cross-sector policy coherence and multistakeholder partnership, which are fundamental to the ability to consistently address migrants' health needs and determinants of health. In most instances, this has been due to the presence of political sensitivities and lack of readiness to commit financial resources, as well as a general political climate in which migration has catalysed divisive elements of society.

The issue of migrant health can no longer be ignored. It must take its place within the global health agenda, as well as within the global migration and socioeconomic development agenda, owing to its relevance in an increasingly interconnected world where, from a purely public health point of view, individual health security and global health security are interdependent. Furthermore, being and staying healthy is a fundamental prerequisite for successful integration and the ability of migrants to contribute to the prosperity of societies of origin and destination. This is in everyone's interest, as migration and human mobility are indisputably megatrends of the twenty-first century.

## Migrant health shortcomings of the New York Declaration

The European–Mediterranean migration crisis, with its outrageous loss of human lives and untold human suffering, not to mention the profoundly divisive debate on migration it has engendered, has challenged principles of protection and humanitarian values regarding refugees and asylum seekers that have long been considered as inalienable. Moreover, it has influenced the UNGA's discussion on large influxes of migrants and has precipitated an entrenchment of the contentious divide between “refugees” and “migrants” along different regimes of protection regulated by national laws and international instruments. Indeed, the New York Declaration called for the elaboration of two separate global compacts, one for refugees, led by the Office of the United Nations High Commissioner for Refugees (UNHCR), and one for migrants, led by Member States. Such a marked divide should, however, have little bearing on health issues.

Unfortunately, the New York Declaration did not address internally displaced persons (IDPs), internal migrants, the majority of migrant workers in a regular situation or other mobile groups; consequently, this omission has influenced other processes, and risks turning back the clock of a discussion that, at the time of WHA Resolution 61.17 Health of Migrants (2008), was intentionally comprehensive. Resolution 61.17 looked at human mobility as a determinant of health whatever the category of migrant, and aligned its actions with the principle of “health for all”, with no discrimination. This is reflected in the New York Declaration's encouragement among States to address common issues, such as the health-care needs of both groups, through “people-centered, sensitive, humane, dignified, gender-responsive” and comprehensive approaches.

It was in this perspective that the Second Global Consultation on Migrant Health, held in Sri Lanka in February 2017, was titled “Resetting the Agenda”. It aimed to reconcile large-scale, crisis-driven influxes of migrants and refugees with structural, disparity-driven migration as two complementary aspects of a migration health agenda that holistically responds to gaps in health promotion and health service delivery in societies increasingly characterized by diversity and human mobility.

The fact that a theme of such relevance has never been presented and discussed by the UNGA is, per se, of concern; there is no current platform for migrant health that informs and is informed by the UN System, a fact that possibly explains the absence of migrant health within the themes selected in New York for the consultations on the global compact for migration. Yet modalities for such leadership that would facilitate the mainstreaming of migrant health within other migration, global health and development platforms for dialogue have not yet materialized.

### Looking ahead to future steps

Advancements in the migrant health agenda will not be accomplished within the health sector alone, but will require progressive and incremental realizations within other sectors, such as migration governance, labour, education, justice, social protection, humanitarian action and others, and by mainstreaming the health of migrants within relevant national, regional and international platforms of negotiations. This will require high-level advocacy and support, including resources and means to monitor progress and to take stock of results.

It is hoped and expected that the global compact for migration will recognize and include health as a core domain for actionable commitments and implementation, including dedicated financing facilities to support continuous evidence generation and sharing of good practices, and to support capacity development locally and internationally. It is imperative to concurrently address issues of access to adequate health care, and the removal of obstacles and other hampering factors that act as determinants of migrants' ill health. The task has thus far proved complex and lacking in political and financial support; therefore, it is important to capitalize on the growing momentum that the topic has been gaining.

In the past, the UN Secretary General appointed special envoys on health issues to support the use of diplomacy to advance health themes of global interest that have an impact on health security, economy, issues of stigma and discrimination, and a need for resource mobilization. All these attributes are applicable to migration and health, including the sensitivity of a divisive topic that is often hard to address within country dialogues. It is vitally important to enhance specific intersectoral solutions both locally and globally, but so far, a convening capacity has been lacking and actions have remained fragmented.

The global compact for migration provides Member States with a unique opportunity to reshape the global governance of migration management, and health must be included. IOM will endeavour to mainstream the health of migrants within the global compacts, in cooperation with the World Health Organization (WHO) and partners, and stands ready to work alongside Member States to better respond to the health needs of millions of migrants on their migration journeys, and to make health systems more migration-inclusive for the benefit of all.









# Part II: The Migration Health Division's highlights of activities, 2016

## MIGRATION HEALTH ASSESSMENTS AND TRAVEL HEALTH ASSISTANCE

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

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

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

Travel health assistance is a related service that addresses individual health and safety and manages conditions of public health concern as individuals move across geographical, health system and epidemiological boundaries. Within health assessment programmes

(HAPs), preembarkation checks (PECs) and pre-departure medical procedures (PDMPs), including stabilization treatment, are performed to assess migrants’ fitness to travel and provide necessary interventions where needed and ensure continuity of care. Migrants who need medical assistance and care during travel are escorted by health professionals. Pre-departure treatment, vaccinations and other public health interventions are tailored to meet the needs of migrants and communities.

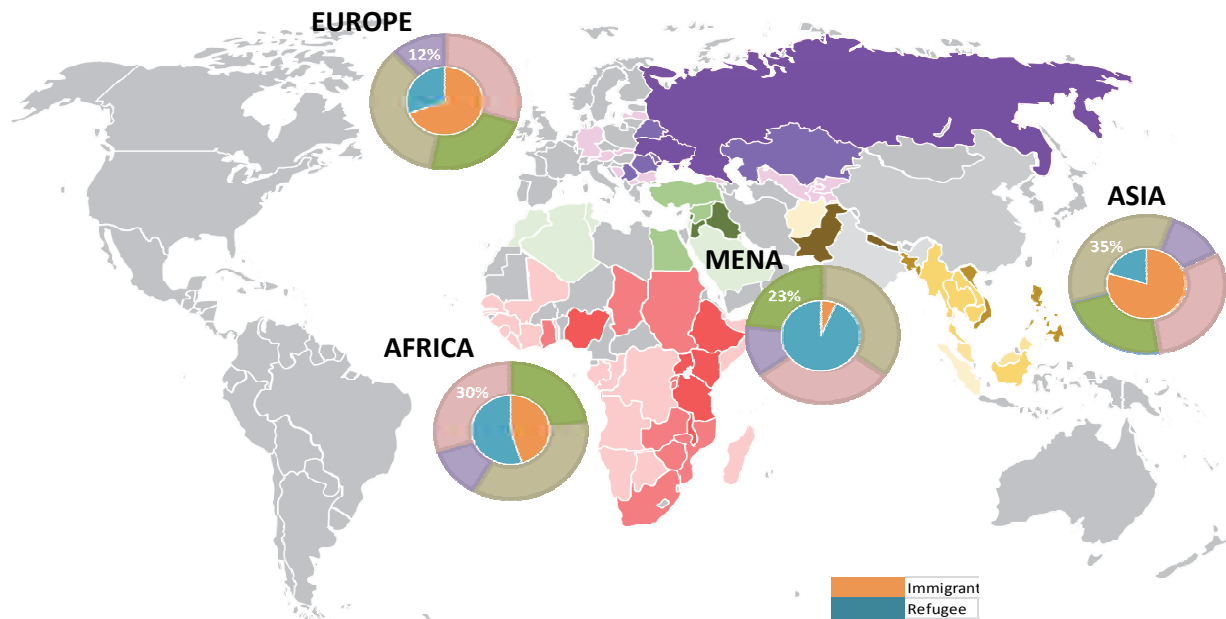
MHAs serve an important purpose in the prevention and control of communicable diseases prior to a migrant’s departure and travel. MHAs may include some or all of the following components:

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



### IOM health assessment programme global presence

**Figure 3.** In 2016, IOM provided 440,935 MHAs at over 60 clinics worldwide. 12 per cent of these health assessments were conducted in the European region, 35 per cent were conducted in the Asia/Pacific region, 30 per cent were conducted in the sub-Saharan Africa region, and 23 per cent were provided in the Middle East and North Africa region.



**Figure 4.** IOM health assessment programme's key figures in 2016.



AS OF 2016



169 physicians

433 other health staff

245 nurses

over 60 clinics

## Profile of IOM health assessment programme beneficiaries, 2016

In 2016, IOM conducted more than 440,000 health assessments among migrants, covering both immigrants (51.5%) and refugees (48.5%) in more than 80 countries. The majority of the assessments were conducted in Asia (35.2%), followed by Africa (29.6%), the Middle East (22.8%) and Europe (12.4%) (see Figure 3 on page 22 and Table 1 in Annex 2).

This represents a steady growth in the number of global health assessment activities conducted by IOM over the last five years. Minimal changes in the number of assessments for immigrants were noted across all regions from 2015 to 2016. However, there was a marked increase in the number of health assessments done for refugees in 2016, primarily in the Middle East and North Africa region as a result of the surge in resettlement of Syrian refugees. The number of health assessments for refugees in Asia dropped slightly, as resettlement operations in that region are slowly winding down (see Figures 12a, 12b, 13a, 13b in Annex 2).

In 2016, the top countries of destination for migrants assisted by IOM were the United States (43.3%) and the United Kingdom (22.6%). Slightly over half of migrants screened were female (52.6%) (see Figures 14a, 14b, 15a, 15b in Annex 2). Overall, the population of migrants screened in 2016 had a median age of 24 years, but

refugees were generally younger, with a median age of 19 years, while the median age of immigrants screened was 26 years. The majority (64.7%) were below the age of 30.<sup>1</sup> Age distribution between immigrants and refugees, as well as regions, is presented in the annexes (see Figures 16-19 in Annex 2).

### Immigrants (various categories)

In 2016, major locations where immigrants were examined (i.e. locations with more than 10,000 health assessments) included Ho Chi Minh City, Viet Nam; Manila, Philippines; Moscow, Russian Federation; Nairobi, Kenya; Lahore, Pakistan; and Kathmandu, Nepal. Health assessments were carried out at the request of countries such as the United Kingdom (39.7%), the United States (26.6%), Canada (20.4%) and Australia (10.3%).

### Refugees for resettlement (urban and camp-based)

In 2016, major locations where refugees were assessed (i.e. locations with more than 10,000 health assessments each) included Beirut, Lebanon; Amman, Jordan; Nyarugusu, United Republic of Tanzania; and Baghdad, Iraq. Refugee health assessments were carried out at the request of multiple resettlement countries, with the top three being the United States (61.1%), Canada (18.5%) and Australia (9.9%).

### Syrian refugee health profile, 2016

In 2016, IOM health assessment programmes in the Middle East and North Africa (MENA) region saw a surge in the number of Syrian refugees. While the increase in caseload began in 2015, the numbers more than doubled over the course of 2016, brought about by an increasing number of countries seeking to resettle Syrian refugees (32 countries of destination in 2016 compared to 15 in 2015). IOM provided health assessment services for Syrian refugees primarily in Lebanon (42.7%), Jordan (34.3%), Greece (9.3%), and Turkey (5.8%). About 33 per cent of the health assessments were provided to children under 10 years of age, while the elderly (aged 60 years and above) accounted for only 3 per cent of the total.

Less than one percent of the Syrian refugees were found positive for TB (n=5), HIV (n=17), syphilis (n=16), and hepatitis B (n=175). In addition to a lower burden of TB and HIV in the MENA region

compared to the sub-Saharan Africa and Southeast Asia regions, among the potential reasons for the low detection of infectious diseases in this population is the large proportion of children that underwent health assessments in 2016. The conditions that were identified in this population were primarily non-communicable. 544 Syrians required medical assistance during travel and were provided with a medical escort; the escorted refugees had a variety of medical conditions, including respiratory, neurologic, psychiatric and cardiovascular disorders.

Nutritional surveillance of children aged 6 to 59 months (n=10,911) revealed a low prevalence of acute (<5%) and chronic (<20%) malnutrition, with about 10 per cent in the overweight or obesity categories. Children who were severely malnourished were referred to UNHCR for proper care and treatment.

<sup>1</sup> Estimates for age and sex distribution in 2016 were calculated based on data from 440,892 health assessments among migrants.

In order to manage the increased caseload, IOM operations in the region expanded both staffing and clinic capacity. New Migration Health Assessment Clinics were set up in Turkey and Egypt, where capacity prior to the resettlement surge had been relatively modest. During the initial phase of the resettlement surge, IOM medical staff from around the world were deployed to the region to bolster the ability of the existing operations to respond to both the increase

in caseload and the increased complexity of the operations. Many of the new destination countries that began resettling Syrian refugees in 2016 were relatively new to refugee resettlement, and not all had pre-existing health assessment protocols. Enhanced coordination and collaboration with new resettlement partners was necessary to establish new protocols and systems to ensure that refugees could travel promptly and safely.

### Patient story: From the Syrian Arab Republic to Greece and beyond

When the family of five decided to leave war-torn Syrian Arab Republic for a safer and more peaceful future, they put their lives at risk and spent their savings to embark on a precarious journey into the unknown. However, the family's endeavour was cut short, as they found themselves stranded at the makeshift camp in Idomeni, in northern Greece, after European borders closed in March 2016. It was the place and time in which the ordeal of one of the family's children, Shady, began.

As most children staying at the camp in Idomeni, Shady played with his friends around the railway tracks, unaware of the dangers involved. One day, disaster struck, as the boy was electrocuted at high voltage, leaving 60 per cent of his body with severe burns. It was the beginning of an arduous process, as the treatment of his injuries was long and painful, with multiple skin transplants and immobilization in a bed surrounded by curtains. And while the scars on Shady's body will most likely be temporary, it is often the mental trauma that is the most difficult to heal. After months in hospitals across Greece and numerous operations, Shady and his family finally received some good news: the family's asylum application had been approved and soon they would relocate to another European state.

IOM undertook the complex task of transporting Shady from Greece to his new home, as part of the implementation of the relocation programme from Greece to other EU Member States for beneficiaries in clear need of international protection. After all the hardship they had been through, Shady and his family simply wanted to relocate as soon as possible. With the consent of Shady's physicians, a major coordination process took place between health institutions in Greece and the receiving country,

IOM, governmental migration agencies, airports and airlines to ensure Shady's safe travel. Numerous visits and meetings with Greek surgeons about necessary transplantations and coordination on the departure date ensued, followed by the preparation of Shady's transportation, including arrangements for an ambulance and a stretcher, with the relevant airport authorities. Direct contact was established between the sending and receiving hospitals, and an IOM doctor and an interpreter accompanied Shady as medical escort to his final destination. When all the necessary medical and other arrangements were completed, Shady and his family were able to finally complete their journey to a new life.



Shady and his family depart from Greece with IOM's assistance.  
© IOM 2016



## IOM tuberculosis detection and control

In 2016, the majority of migrants examined by IOM underwent TB screening prior to their migration. IOM MHAs took place mostly in countries classified as intermediate- or high-TB-burden countries. Overall, the TB detection rate in 2016 was 185 per 100,000 health assessments; there were 176 cases per 100,000 refugee health assessments and 194 per 100,000 immigrant health assessments. Of the 816 total active TB cases in 2016, 615 (75.4%) were confirmed by culture and 201 (24.6%) were diagnosed based on clinical and radiological findings (see Tables 3 and 4 in Annex 2).

Compared to 2015 detection rates, the observed overall active tuberculosis case detection rate for refugee health assessments was lower in 2016 ( $p < 0.001$ ). While detailed statistical analyses are outside the scope of this

report, likely reasons for the lower observed detection, especially for refugee health assessments, includes changes in population groups examined in key locations.

## Radiological services in tuberculosis diagnostics

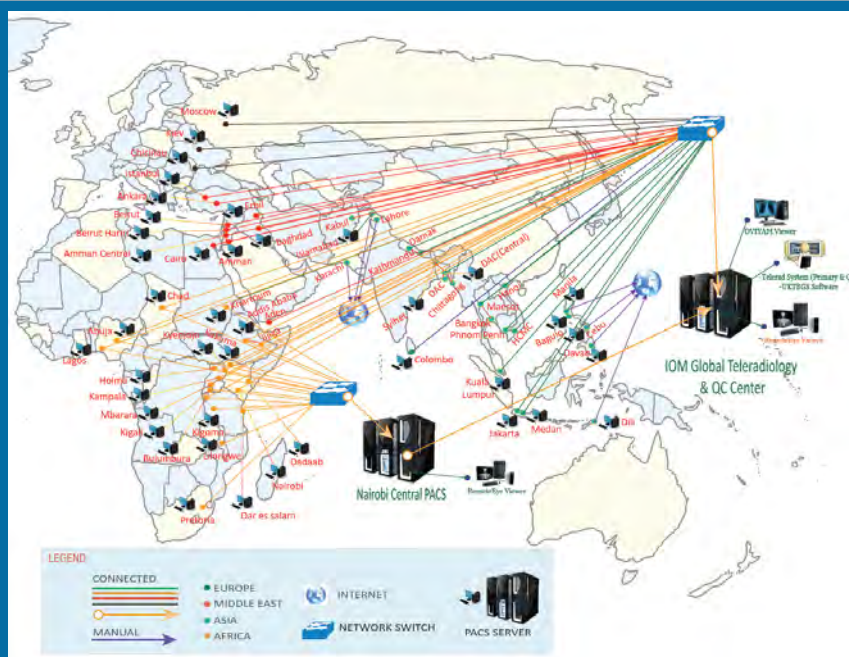
Radiological investigations are the cornerstone of TB detection in MHAs. IOM performed more than 331,000 radiological investigations in 2016, resulting in the identification of 15,998 (4.8%) abnormal chest X-rays (CXR) requiring further laboratory investigations. The prevalence of CXR abnormalities suggestive of TB varied in major IOM screening programmes, with the highest prevalence found among refugees in Thailand (18.5%) and Nepal (17.7%) and the lowest prevalence found among immigrant populations in Jordan (1.6%).

### Teleradiology

The IOM Global Teleradiology and Quality Control Centre (hereinafter referred to as the Teleradiology Centre), based in Manila, Philippines, was established in June 2012 to meet the increasing expectations and requests from major government partners in relation to radiological interpretation within the framework of IOM health assessment programmes. The Teleradiology Centre, which has expanded steadily in the years since, works to standardize IOM

radiological procedures and optimize the quality of chest X-ray (CXR) interpretations through the provision of primary X-ray reading services, quality control and analysis of CXR readings, preparation of radiology guidelines and training materials, and provision of technical radiology-related support to IOM field operations, such as establishing X-ray units, purchasing X-ray machines and hiring radiology staff. The Teleradiology Centre provides real-time

**Figure 5.** IOM global PACS connections, as of December 2016.



services through the global picture archiving and communication system (PACS), as well as through the use of the medical digital image (DICOM) viewing software and CXR reporting Web applications.

In 2016, the Teleradiology Centre successfully completed 112,050 teleradiology primary X-ray readings. From the Teleradiology Centre's inception in 2012 until the end of 2016, a total of 217,196 CXRs were read. These services are provided on behalf of refugees and immigrants bound for Canada, Australia, the United States, the United Kingdom, New Zealand, Malaysia, and European countries, such as Germany, Belgium, Spain, Ireland and Italy, as well as other countries. The majority of CXRs read in 2016 were for Canada ( $n=52,210$ , 46.60%), followed by Australia ( $n=20,701$ , 18.47%) and the United States ( $n=17,586$ , 15.69%).

A total of 4 non-IOM panel sites were supported with teleradiology primary reading services in 2016. Three of the non-IOM locations were located in the Philippines. In 2016, the Teleradiology Centre started to provide the service for the fourth non-IOM site, Stamford Medical in Dili, Timor-Leste. Overall, a total of 14,103 CXRs were read across the 4 non-IOM locations.

In 2016, the Teleradiology Centre installed local PACS and connected to Teleradiology PACS for 11 additional locations, bringing the total number of connections to 55 locations.

A significant aspect of the Manila Teleradiology Centre's work revolves around quality control and quality assurance systems, which entails directly assisting the quality of the radiology service of field missions; monitoring and maintaining the quality of the radiology reading at the Teleradiology



The Nairobi Regional Teleradiology Centre team, with colleagues from the Manila Global Teleradiology Centre. ©IOM 2016

Manila, and running Global Teleradiology Quality Control programmes to optimize radiology services in HAPs globally.

In 2016, the overall agreement on normal/abnormal findings was 86.32 per cent, with a range from 76.24 to 100, and an overall kappa of 0.56. The overall TB agreement was 98.24 per cent and with a TB kappa of 0.88.

In addition to QC service provision, the Global Teleradiology Centre in Manila conducts research and analysis of its quality control program. IOM presented its findings at the annual Intergovernmental Panel Physicians Association (IPPA) Training Summit in 2016, and won the scientific poster award for its poster presenting the results of its radiology TB screening CXR inter-reader agreement analysis.

In November 2016, IOM opened a second teleradiology centre as a regional hub in Nairobi, Kenya. Similar to the Global Teleradiology Centre in Manila, the Nairobi hub aims to optimize the quality of radiology services in IOM Health Assessment Programmes through different activities including primary CXR reading, teleradiology quality control, confirmatory/second opinion CXR readings and technical guidance on different radiology-related matters. The hub supports all IOM field missions in sub-Saharan Africa, and receives support as needed from the Manila Global Teleradiology Centre.

The opening of the regional hub is a significant step in increasing health assessment efficiency and value, particularly in remote field locations where radiology skills and expertise is not always available.



IOM's Global Radiology Coordinator presenting the IOM poster on the results of its radiology TB screening CXR inter-reader agreement analysis during the 2016 Intergovernmental Panel Physicians Association Training Summit. © IOM 2016

## Laboratory services in tuberculosis diagnostics

For persons with presumptive TB based on abnormalities detected during the physical and X-ray examinations, the next step is sputum smear microscopy and culture tests. This is followed by microbiological identification and drug susceptibility testing (DST) for positive culture specimens. Over the last few years, the use of molecular methods such as GeneXpert MTB/RIF has also been phased into many IOM health assessment locations.

In 2016, TB laboratory diagnostics were performed as part of 15,669 health assessments, for both refugees and immigrants, with a total of 15,295 undergoing both sputum microscopy and culture testing. Overall, 615 refugees and immigrants (or 139 per 100,000 health assessments) had positive sputum culture results. DST results were obtained for 84.2 per cent of cases with positive culture results, of which, 21 per cent (n=59) were found to be resistant to one or more first-line anti-TB drugs, and 2.3 per cent were found to be multidrug-resistant (MDR) (n=12).<sup>2</sup> There was also one case (0.2%) of extensively drug-resistant (XDR) TB (see Table 5 in Annex 2).

## Tuberculosis treatment in IOM health assessment programmes

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

In 2016, IOM centres provided DOT for 439 (53.8%) patients with active TB, while the rest were referred for treatment. IOM uses a variety of modalities to follow up and monitor migrants treated at distance (including those referred to other facilities for treatment), such as video DOT, telephone follow-up, regular contact with the treating facility, and periodic evaluations at the IOM clinic, where possible.

IOM clinics also provided directly observed preventive therapy for cases with latent tuberculosis infection in selected locations. Drugs were procured in collaboration with the NTPs in respective countries.

## United Kingdom Tuberculosis Detection Programme

On behalf of the United Kingdom, IOM implements the United Kingdom Tuberculosis Detection Programme, one of the activities with the highest number of IOM-assisted immigrants since 2006. The purpose of the Programme is to screen visa applicants (those who apply to stay in the United Kingdom for six months or more) for infectious pulmonary TB. Treatment for positive cases is provided either by IOM in partnership with NTPs or through a referral system. From the initial

11 clinical sites in 8 countries that IOM operated during the pilot phase of the Programme, the Programme expanded to 56 sites in 40 countries.

In 2016, IOM provided 90,250 health assessments for UK-bound immigrants; 44.5 per cent of these visa applicants were rejoining family members in the UK, while 31.5 per cent were applying for student visas. Most applicants were between the ages of 15 and 35; slightly over half were female. Radiological investigations yielded a total of 1,548 CXRs (1.7%) suggestive of active TB. Overall, among the population screened, there were 95 active TB cases (with a detection of 105 cases per 100,000 health assessments), either microbiologically confirmed or diagnosed clinically (see Table 6 in Annex 2). Most of the active TB cases were in migrants applying to rejoin family members (56.8%), while approximately 18 per cent were in migrants applying for work visas. Approximately half of the TB cases were young adults between the ages of 25 and 34.

## Pre-departure immunizations

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

<sup>2</sup> Three of the MDR tuberculosis cases were confirmed using the molecular line probe assay.



By late 2016, this programme had been implemented in over 20 countries across Asia, Africa, former Soviet Union countries, and IOM Emergency Transit Centres in Europe. Since starting the full-scale vaccination programme against 11 vaccine preventable diseases in 2013, IOM has vaccinated close to 230,000 refugees from about 30 countries, with over 1 million vaccine doses administered. The 11 vaccine-preventable diseases included diphtheria, *Haemophilus influenzae* type b infection, hepatitis B, measles, mumps, pertussis, polio, rotavirus infection, rubella, pneumococcal infection and tetanus.

Through the implementation of this programme, which is funded by the PRM and the CDC, IOM was able to develop significant capacity in multiple countries under technical advisory from the CDC and in partnership with UNICEF, UNHCR, WHO and national immunization programmes. As a result of the programme, documented coverage rates of the most important vaccines significantly increased, especially for refugee populations over 5 years old, not covered by the traditional immunization programmes.

In addition to the US Refugee Vaccination Programme, IOM also provides vaccinations to refugees and immigrants travelling to other destination countries. In 2016, IOM provided over 62,000 doses of vaccines to 25,928 migrants, mainly travelling to Australia (56.4%) and the United Kingdom (31.0%).



The Refugee Vaccination Team, which consists of CDC, PRM and IOM staff, won the 2016 CDC Honor Award for Excellence in Partnering (International Category) for its accomplishments over the last five years. The CDC Honor Awards ceremony is an annual event and represents the CDC's highest honors for public health achievements. © IOM 2016

## DNA sampling services

IOM provides DNA sampling services mainly for family reunification purposes, as required by certain immigration authorities. In 2016, the majority of DNA sample collections were provided in Kenya (23.2%), Pakistan (20%), Viet Nam (11.8%) and Bangladesh (9.7%). A total of 12,226 samples were collected on behalf of 24 countries of immigration (see Figure 20a, 20b in Annex 2).

## Managing data through health informatics systems

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

The Migrant Management Operational Systems Application (MiMOSA), which is IOM's Web-based migrant management software, was used in 40 IOM offices as of 2016 for capturing data on health assessment and pre-departure medical procedures. Throughout the year, the MHI team supported the development of updated releases of the MiMOSA software, providing functionality enhancements, such as the automation of requests for repeated medical examinations once expiration dates of previous exams have been reached, and the design of a completely new pre-departure surveillance module for the recording and monitoring of certain clinical conditions, such as infectious diseases and acute health problems, of refugees who are about to travel to the United States.

The MHI team also developed an enhanced version of the immunization management system (IMS), an interface linked to MiMOSA for tracking inventory levels, stock movement and lot details, and extended its functionality to include the transfers of vaccine lots from one location to another, and generation of inventory and consumption reports.

The MHI team continued to develop its medical data warehouse and business intelligence tools, envisaged to become the central repository and new reporting platform for health assessment data in IOM. Major achievements in 2016 include the design and implementation of dimensional data cubes for ICD-10 coded medical records, TB detection data combined from multiple databases, nutrition surveillance and migrant demographics.

## IOM contributes to the integration of newly arrived migrants and refugees in the EU Member States' health systems

In February 2016, in line with the European Agenda on Migration, which foresees supporting the capacity of European Union (EU) Member States to provide health care to newly arrived migrants and refugees, and facilitating the use of a unified tool for health assessment at the EU level, the MHD in the IOM Regional Office in Brussels launched the “Re-Health project – Support to Member States under particular migratory pressure in their response to health related challenges”.

Co-funded under the EU's Third Health Programme (2014–2020) by direct grant agreement awarded to IOM by the European Commission (EC) Directorate General for Health and Food Safety (DG SANTE), through the Consumers, Health, Agriculture and Food Executive Agency (CHAFAEA), Re-Health aims to improve the capacity of EU Member States under particular migratory pressure to address the health-related issues of migrants arriving at key reception areas, facilitating follow-up and continuity of care, and ensuring that data are maintained in an electronic database platform so as to be available during transit and at destination countries.

The Re-Health project is based on formative work undertaken by IOM in the Regional Office in Brussels and at Headquarters, also supported by DG SANTE, to respond to the need to foster appropriate health-care provision to migrants and to harmonize post-arrival health assessment practices within the EU. IOM initially developed

a tailored Handbook for Health Professionals, and based on this, the personal health record (PHR) was produced with support from the EC and with contribution from the European Centre for Disease Prevention and Control (ECDC). The PHR helps to reconstruct the medical history of arriving migrants, establishing their health status and medical needs. It provides an opportunity to record provision of treatment, including vaccinations, and to offer counselling and health education services. The PHR is also a personal document that migrants and refugees can keep with them.

Within the framework of the Re-Health project in 2016, IOM developed an electronic version of the PHR (e-PHR) and an online platform to facilitate data entry, analysis and transfer within and between EU Member States. The electronic health database is based on the experience of IOM in health assessments and medical data management. The Web-based platform is intended to serve as a standard instrument for the assessment of the health status of refugees and migrants arriving in the EU/European Economic Area; functionalities include the online registration of accredited medical facilities and staff, registration of migrants and recording of bio information, data capture of medical exam and test results, and printing of the PHR in paper form.

More information about the project can be found on the website: <http://re-health.eea.iom.int/>.



## HEALTH PROMOTION AND ASSISTANCE FOR MIGRANTS

### AMERICAS

#### Regional Programme

*“Transwomen without borders against transphobia and HIV/AIDS” in Argentina, Belize, the Plurinational State of Bolivia, Chile, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Panama, Paraguay and Uruguay*

Transgender people in Latin America and the Caribbean region are disproportionately affected by HIV/AIDS compared to other key populations. They have an HIV prevalence rate between 26 per cent and 35 per cent, and a life expectancy between 35.5 and 41.25 years, with HIV/AIDS as the main cause of death. This is triggered by various problems that give rise to the exclusion and marginalization of the population, including a lack of access to and acceptability in health services that consider the specific needs of transgender people, the high levels of stigma, discrimination and violence, and a lack of legislation that respects gender identity.

In this context, the National Trans Organization of Paraguay held two inter-institutional meetings jointly with the Human Rights Commission of the Honorable Chamber of Senators of Paraguay and with the participation of authorities and representatives from the Ministries of Health, Education, and Justice, the National Police, and the Human Rights Prosecutor, among others. Training workshops for health-care personnel were developed in eight countries, with 200 participants in total. The main goal of these workshops was to reduce manifestations of discrimination towards transgender persons in public and private health services. Two educators, who were transwomen themselves, taught the workshops. The women had previously attended a regional workshop of trainers for health services.

The RedLacTrans Regional Coordinator, along with the National Referrals of Costa Rica, Ecuador, Panama, and Paraguay, were all invited to participate in the

21st International AIDS Conference (AIDS 2016) held in Durban, South Africa, on 16–22 July 2016. The event was held by the Living 2016 Partnership, in conjunction with the International AIDS Society. The Ministry of Public Health and Social Welfare of Paraguay approved Resolution 695, which states that health establishments would use the social names of transpersons both in their treatment and documentation, including medical records. Additionally, analytical studies were carried out in the 13 countries on the following topics: degree of transpersons’ awareness of rights and mechanisms of complaints, policies that determine access to health for the transgender population and the status of each country in relation to the fulfilment of human rights towards transpersons.

*“Sex workers in Latin America and the Caribbean working to create alternatives that reduce their vulnerability to HIV: A regional strategy” in Argentina, Belize, the Plurinational State of Bolivia, Chile, Colombia, Costa Rica, Dominican Republic, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Paraguay and Peru*

Eight proposals for changes on current regulation, or for the creation of new regulations regarding sexual workers, were presented at the provincial (i.e. Entre Ríos province, Argentina) or national spheres (i.e. Chile, Colombia and Honduras). Additionally, Guatemala’s Ministry of Labour approved the Autonomous Sexual Workers Union Act. In Chile, a governing agreement by which health and police agents could request a health card to verify the last date of STI/HIV health controls was successfully repealed.

Ten national organizations of female sex workers (NOFSWs) presented funding proposals to national, regional or international donors and received additional funding, resulting in new projects for advocacy and capacity-building in policy development, gender-sensitive perspective, human rights promotion, access to health and HIV prevention in Argentina, Belize, Chile, Colombia, Dominican Republic, El Salvador,

Guatemala, Honduras, Panama, Peru and Paraguay. Additionally, almost 40,000 female sex workers, both new and returning, have been contacted with services provided by the NOFSW of the RedTraSex, including legal assistance, judicial facilitation, condom and lubricant provision, capacity-building, health promotion and health-care access activities, medical appointment support, visits to sexual workplaces and work conditions control.

To sensitize health workers in local health-care centres and hospitals, awareness workshops with at least 50 health-care staff were held by NOFSWs in 14 countries, and guides containing good practices to provide health care to female sexual workers were distributed. The overall goal being to improve health-care quality provided to female sexual workers that tend to be stigmatized and discriminated against by health professionals and staff in general. Agreements were made between health-care centres and NOFSWs in 13 countries to implement good practices in regard to sex workers' health-care attention.

## National Projects

### *Argentina migrant workers face exploitation and serious health consequences, according to report*

A study released on 29 July 2016 by IOM and the London School of Hygiene and Tropical Medicine offered new insight into the experiences of migrants in situations of labour exploitation, including trafficked persons, in the commonly underregulated sectors of textile, mining and construction.

The study, *Labour Exploitation, Trafficking and Migrant Health*, was based on 71 in-depth interviews with men and women who had worked or had been trafficked in the textile, mining, and construction sectors in Argentina, Peru and Kazakhstan. The harm and health consequences for the migrant workers were documented. The research found that people in situations of extreme exploitation, such as labour trafficking, faced not only occupational health risks but also harm due to their terrible living conditions.

Those interviewed for the study were commonly recruited by family and community networks. They often travelled for work, either within their own country or internationally, as part of a general strategy to improve their lives. Most had little or no information about the conditions of the work before they travelled

and some were deceived or misled, particularly those who ended up in trafficking situations. The study also showed that migrants faced grueling hours, risky conditions, and had to learn on the job how to use machinery, chemicals and other dangerous materials. Many were hurt while working and few were able to get medical care. The study showed that people identified as trafficked worked longer hours, experienced more violence, had less freedom of movement, and were more likely to be deceived by recruiters. The research also showed that the larger population of migrant workers lived and worked in similar conditions, with similar health risks and consequences, even if not identified as trafficked.

The study had implications for policymakers, donors and service providers, and included concrete recommendations. The recommendations were primarily addressed to the Ministry of Health, the Ministry of Labour, the private sector and future researchers. They included suggestions like funding health outreach initiatives in locations with high migrant populations, strengthening the capacity of labour inspectors to monitor workplaces and recognize health and safety violations, and carrying out longitudinal research to identify migrants' long-term health needs.

Perhaps the study's most important contribution was sharing the stories of the people themselves. The research voiced the experiences of victims of trafficking and migrant workers who had suffered under unthinkable conditions. Worldwide, people are trafficked into many different kinds of exploitation, including sexual exploitation and forced labour. While the majority of victims identified worldwide continue to be those in sex trafficking, labour exploitation is of growing concern. Since 2010, the majority of the victims of trafficking assisted by the IOM Global Assistance Fund, which has helped more than 70,000 people, have been trafficked into labour exploitation.

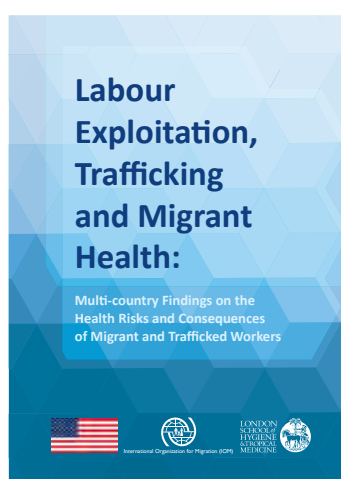
### *Institutional capacity-building in health and migration for the Chilean health system*

In Chile, there were two principal challenges facing the Ministry of Health regarding health and migration. One had to do with the capacity of the health system, both public and private, to tend to the migrant population. This included the internal migrant population within the country, consisting of migratory flows from one region to another, from city to city, from urban to rural areas and vice versa, as well as the migrant populations coming from neighbouring countries or countries far

away. The other challenge was how to transmit, by way of health policies, certain perspectives that are structural for migrants. It was a challenge that went beyond individual health care. It was a collective issue concerning the health of all communities made up of migrants and people who had lived in the country for many years; how to integrate as a community for the well-being of all.

In this background, IOM Chile has continued to engage in several migration health capacity-building activities with the Ministry of Health. IOM organized the Second National Health Ministry Conference on Immigrants and Health on 14–15 January 2016. In July 2015, the Ministry of Health signed a cooperation agreement with IOM for the purposes of jointly developing studies and research efforts, conducting workshops and training activities, preparing and disseminating joint publications, and exchanging information and literature. In addition to the 18 municipal governments that comprise the Inter-municipal Panel for Migrants and Refugees, a forum established and led by the IOM Mission in Chile since 2014, the impact of these initiatives supports 171 officials from 29 health service divisions in the country's 15 regions.

**Figure 6.** “Labour Exploitation, Trafficking and Migrant Health: Multi-country Findings on the Health Risks and Consequences of Migrant and Trafficked Workers”.



The training and awareness-raising process for health officials and workers consisted of: capacity-building related to health service human resources, the adoption of a cultural change perspective and attitude (especially the addressing of new health policy paradigms), a renewed State public function and other factors within the sphere of the Ministry of Health. This training and effort to raise awareness also aimed for the standardization of services and care models at the national level to ensure an efficient and comprehensive response to the migrant population.



### *Fighting tuberculosis in Colombia*

The highest incidence of TB in Colombia occurs in the dispersed, rural regions of the Pacific coast of the country where access to health-care services is the most difficult, coverage is low and poverty indicators are higher than the national average. Since 2011, IOM and FONDADE, Colombia's development agency, have implemented programmes in hard-to-reach areas of the Pacific coast in 46 high-priority municipalities, funded by the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM). The GFATM project aimed to improve TB detection, treatment, control and prevention in the region. The interventions targeted populations who were socially vulnerable, were victims of human rights violations due to armed conflict, or were forced to migrate due to the political and social contexts. IOM implemented five comprehensive interventions: improve TB diagnosis and treatment through community DOT and community health workers (CHWs), strengthen TB/HIV and MDR-TB collaborative activities, support health system strengthening through policy, training,



and coordination between institutions, improve TB awareness through CHWs in the areas with a high TB burden, and develop and implement a national monitoring and evaluation plan for NTP.

A key strategy of this ongoing project in Colombia has been the model of CHWs, who have been playing a vital role in the detection, treatment and follow-up of TB patients. Each city in the country was provided with one CHW who was supervised by a local nurse. The most important requirement was that the community from which the CHW was chosen recognized and respected the CHW, and that they understood the cultural and societal norms of their area. After the

selection of the CHWs, they received technical training on how to identify TB symptoms, collect samples and perform the sputum examination. Their training also included basic infection control. The project encouraged the formation of community groups and support groups that included current and former TB patients, as well as their families, which allowed individuals to share their testimonies. An important objective of the involvement of the communities and their leaders was to reduce the stigma associated with TB and especially TB/HIV co-infection. The CHWs did this through community workshops that addressed the issues of discrimination, which in turn increased social support for TB patients.

### Case study

Karen Rivas is a 29-year-old woman that works as a Community Health Worker (CHW). In 2008 she started to experience symptoms such as weight loss, loss of appetite, fever and diarrhoea. She was given multiple tests in her home municipality of Quibdó in the department of Chocó, but the sputum smears came back negative. After almost a year of testing, she was sent to the city of Medellin in another department called Antioquia where she was finally diagnosed with smear-positive pulmonary TB. She soon left to go back to her hometown because she was verbally abused and humiliated by the other patients in the institution where she was receiving treatment. Because she left without notifying the authorities, she never found out that she was resistant to all of the medications she was taking.

Karen continued to receive treatment in Quibdó, but her symptoms never improved. When she was diagnosed with BK+ TB, she went for a new appointment once again in Medellin. The

secretary of the health department told the infectious disease specialist in Antioquia of Karen's drug resistance and that she had been uninformed of her diagnosis because she had left without notice. It took two years for Karen to be cured because she had to continuously alter her medication due to drug resistance and a lung lobectomy.

Due to the hardship she faced during her treatment because of lack of food, Karen decided to start supporting other TB patients. She knew that people healed more quickly when they were supported, accepted and cared for emotionally, and she became the strongest leader in the department of Antioquia, even while she was still receiving treatment. When Phase II of the Global Fund project was started, Karen became the CHW for the city of Medellin for community directly-observed treatments (DOTs). She accompanied more than 20 patients and their families to help them through their sickness, the stigma and discrimination.

## AFRICA

### Regional Programmes

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

Since 2013, IOM has received funding from the Government of Sweden to implement the second phase of the Partnership on Health and Mobility in East and Southern Africa, from 2014 to 2017. PHAMESA II is implemented in 11 countries – namely, Botswana, Kenya, Lesotho, Mauritius, Mozambique, Namibia, South Africa, Swaziland, the United Republic of Tanzania, Uganda and Zambia. The overall goal of PHAMESA II has been to contribute to the improved standard of physical, mental, and social well-being of migrants and migration-affected populations, enabling them to substantially contribute to the social and economic development of their communities. PHAMESA II responds to the public health needs of migrants and communities affected by migration, and works to ensure the development and implementation of migration-inclusive, human rights- and evidence-based policies and legal frameworks, practices, and programmes at the regional, national and local levels to support equitable access to services that improve health for all.

#### *Inclusive policy and legal frameworks*

As a result of IOM's sensitization and technical support, the following national and regional programmes included migration and health in their strategic plans for 2016: the Busia County HIV/AIDS Strategic Plan in Kenya, the National HIV Social and Behaviour Change Communication Strategy for Fishing Communities, the National Action Plan for HIV and Mobility for the Ministry of Works in Uganda, HIV/AIDS Strategic District Investment Plans for three migrant-populated border districts in Zambia, and the South West Indian Ocean Islands Regional Migration and Health Strategy for 2016–2018.

To promote inclusive policy and legal frameworks, IOM strengthened the capacity of over 470 policymakers and other stakeholders in Kenya, Namibia and Zambia who are capable of influencing policy. The capacity strengthening aimed to enhance the ability of policymakers and stakeholders to develop migrant-inclusive policies or influence the revision of existing policies. South Africa convened a national consultation on migration health to give recommendations for improving the status of migration health in the country

and the region. IOM also provided training and technical support on developing national migration policies to government officials in Botswana, Mauritius and Uganda. In an effort to improve accountability on the ground, IOM initiated migration-responsive community paralegal initiatives in Kenya, South Africa and Zambia.

Additionally, IOM worked to strengthen partnerships with the United Nations, governments and civil society organizations. As a result of this effort, migrant health was included in the United Nations and the Government of Kenya Joint Programme on Gender-based Violence. Also, migrant-responsive HIV prevention, care and treatment interventions were included in the revised Kenya–United Nations Joint Programme on HIV (2014–2018); an implementing partners (IPs) agreement with AMREF Health Africa to provide clinical and health promotion services at the Eastleigh Community Wellness Centre was signed; and in partnership with UN joint team partners, Nairobi County and civil society organizations, HIV testing of 10,208 “boda-boda” (motorcycle taxi) riders was carried out.

#### *Migration-sensitive health services*

IOM and its implementing partners (IPs) reached a total of 148,744 beneficiaries and 42,463 reproductive-aged individuals with community health education. This was done through health promotion activities that included door-to-door outreach, small group interventions, and outreach in schools and communities. IOM and its IPs also trained and mentored 2,028 change agents, 1,264 health workers and 1,065 individuals from key stakeholder organizations on the provision of migration-sensitive services. Change agents became resourceful members of their communities by engaging with the project in learning about health and migration.

In Ressano Garcia, Mozambique, school-based change agents conducted 35 health talks with 815 students from grades 8 to 12, while 60 health talks and lectures were conducted in Xai-Xai reaching over 1,895 students combined. Health promotion activities targeted beneficiaries with health awareness messages that enabled them to make choices that improved their well-being. Topics included HIV and migration; HIV testing, prevention and treatment; male circumcision; early marriage; pregnancy in adolescence; gender roles; sexual and reproductive health and rights (SRHR); and alcohol and other drugs. At a youth counselling centre in a secondary school in

Ressano Garcia, change agents counselled students – both males and females – on HIV prevention methods, unwanted pregnancy, and contraception among other relevant sexual and reproductive health matters.

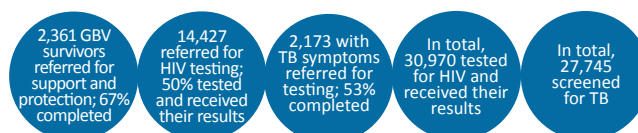
In Kenya, IOM improved capacity of health workers and change agents to deliver migrant-sensitive services. Seventy-nine change agents, among them 15 migrants, were trained as community health volunteers (CHVs), peer educators and community paralegals. In addition, 69 representatives of stakeholder organizations, including Ministry of Health (MoH) departments and 31 health facility staff, were trained on migration-sensitive services in Busia and Nairobi Counties. Over 14,203 persons from a catchment population of about 56,000 were reached with health information on HIV, TB, malaria, reproductive health, maternal and child health, immunization, water, hygiene and sanitation as a result of community mobilization by change agents. Among individuals reached, 4,292 (30%) were migrants. Change agents referred 2,154 individuals for various health services, out of whom 1,623 (75%) received services at the referral destination. Migrants comprised about 25 per cent of those referred as well as those who received services at the referral destination. Through sports, 170 migrant and host community youths were reached with HIV and reproductive health information and HIV testing in Eastleigh, Nairobi. During the sports campaign, 75 youths were tested for HIV. With IOM support, Busia County stakeholders also established a technical working group to address migration health issues at the border, and drafted a terms of reference for the cross-border health committee in Busia.

There were 59 community-led initiatives overall addressing various social determinants of health. These initiatives demonstrated the beneficiaries' willingness and ability to address their identified needs. For example, in Kenya's Eastleigh neighbourhood, communities made a decision to have a cleanup exercise as a way of addressing one of the visible problems of environmental hygiene. In Lesotho's Litjotjela community council, community members, with the help of change agents, set up a community policing committee to address the issue of crime. In Uganda, the Ani Yali Amanyi group in Rakai set up a community-led savings and loans scheme to help improve the livelihoods of vulnerable migrants in the community.

IOM and its IPs also made many referrals for health services. A total of 14,580 individuals were referred to health and other services in 2016; 49 per cent were confirmed to have completed the referral. A total of

2,361 survivors of gender-based violence (GBV) were identified and referred for support and protection; 67 per cent were confirmed to receive the services. A total of 14,398 individuals referred for HIV testing; 50 per cent were reported to complete the referral. IOM and its IPs referred 2,173 people for TB testing; 53 per cent were confirmed to complete the referral. Referral completions have continued to be a challenge because of the mobile nature of migrants and structural barriers such as long distances to facilities, which made follow-up difficult. At times, beneficiaries also chose to go to service points that were not in their catchment area for anonymity. To address this, in some settings when a referral was made, the client was assigned a change agent, who would accompany the person making sure s/he would receive the desired service. Overall, 30,279 individuals were voluntarily tested for HIV and received the results, and 27,745 were screened for TB.

**Figure 7.** Number of test and referrals .



### Multi-country/Multisectoral partnerships

IOM provided technical support to a total of 23 partner initiatives. For example, in Uganda, the Community Initiative for the Prevention of HIV/AIDS (CIPA), in collaboration with government health workers, conducted the "Moonlight HIV Testing Outreach" in which CIPA staff offered HIV testing services to sex workers and their clients at night in selected hotspots. In October 2016, IOM and Makerere University piloted the postgraduate training on migration health with 29 participants from across East, Southern and Central Africa. IOM also signed a cooperation agreement with universities in South Africa, the United Republic of Tanzania and Zambia.

Through continued advocacy and engagement with regional and global health partners, IOM secured EUR 11.1 million (USD 11.9 million) from the Netherlands for a four-year project addressing sexual and reproductive health and rights (SRHR) in migration-affected areas in Southern Africa. The project, SRHR Knows No Borders: Improving SRHR-HIV Outcomes for Migrants, Adolescents and Young People and Sex Workers in Migration-Affected Communities in Southern Africa, will run from 2016 to 2020. It will cover six countries, namely, Lesotho, Malawi, Mozambique, South Africa, Swaziland and Zambia.





IOM participates in the plenary session during the signing of the cooperation agreement between IOM and the Embassy of the Netherlands in Maputo, Mozambique. © IOM 2016

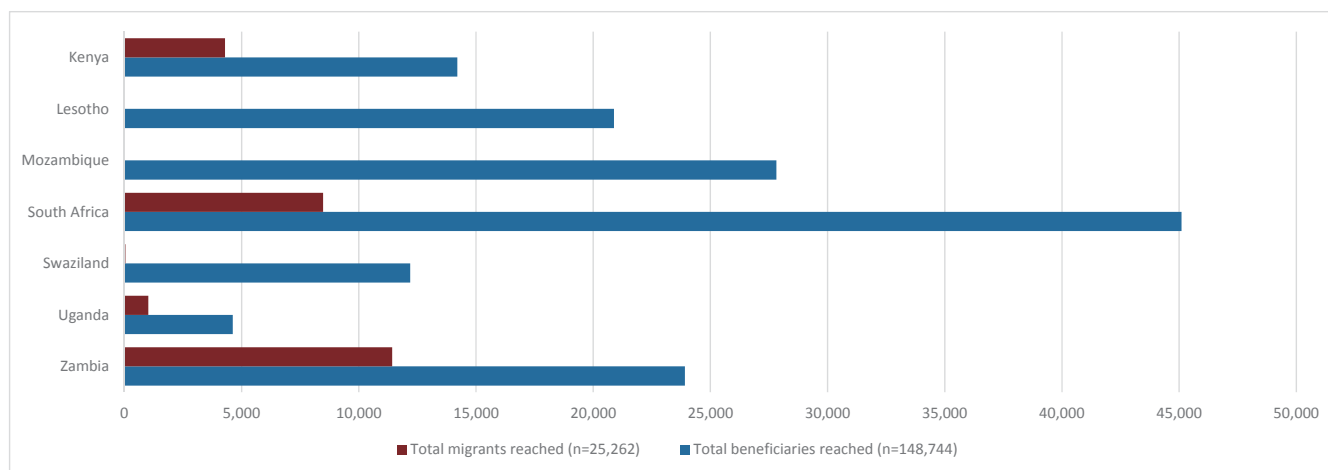
In Kenya, IOM assisted its community partner Arrow Africa to secure USD 10,000 from AidsAlliance for a project on key populations (i.e. lesbian, gay, bisexual, transgender/transsexual, intersex, queer/questioning their gender or sexuality (LGBTIQ)) in Nairobi's Umoja area. In Uganda and Zambia, IOM was awarded USD 402,633 and USD 205,000, respectively, as part of

a larger United Nations Joint Team project. Also, in Uganda, IOM assisted its IP, CIPA, to secure USD 93,750 from the **Determined, Resilient, Empowered, AIDS-free, Mentored and Safe (DREAMS)** programme, which is funded by a combination of donors including the Bill & Melinda Gates Foundation, Girl Effect, Johnson & Johnson, Gilead Sciences and ViiV Healthcare.

### Community mobilization and education

PHAMESA II's overall target was to reach 750,000 individuals with comprehensive education to improve health literacy and knowledge of health-related rights and available services. This target has been surpassed, with 916,645 reached since 2014. In 2016, PHAMESA II reached 148,744 individuals. Of these people, 17 per cent were recorded as migrants, although spaces in which the programme operates have much higher migrant populations. Figure 3 shows the distribution of people reached per country in 2016. In addition, 42,463 reproductive-aged individuals were reached with sexual and reproductive health and rights (SRHR) information specifically, with a total of 113,840 reached since 2014.

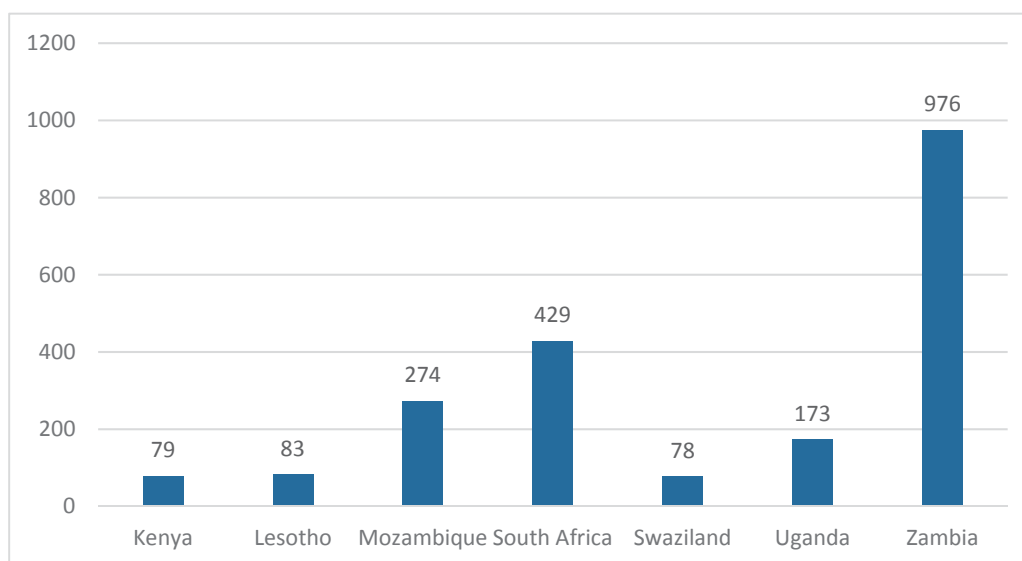
**Figure 8.** Total beneficiaries and migrants reached per country through PHAMESA in 2016.



### Capacity-building of change agents

Change agents have been key resources in improving community knowledge and attitudes towards health, and creating demand for services. Through its implementing partner (IPs), IOM provided training and continuous support to change agents to facilitate community education and engagement. Training

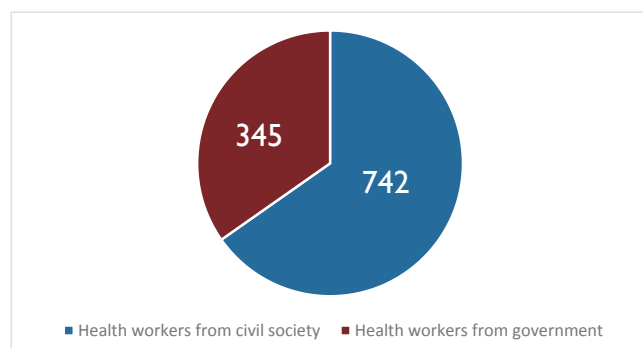
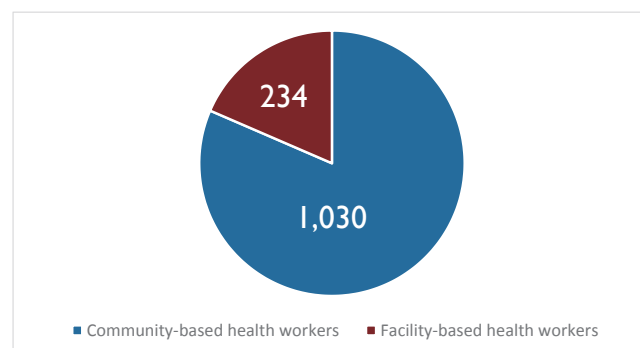
addressed the facilitation of group processes and informing on Sexual and Reproductive Health, HIV, TB, migration health and gender. As shown below, in 2016, IOM trained 2,092 change agents (55.2% women) who had been active in the programme and conducted health promotion activities in their communities; 3,596 had been trained in total since 2014.

**Figure 9.** Total number of active change agents in PHAMESA in 2016.

### Capacity-building of the health workforce

Poor understanding of the effects of migration on community health and negative attitudes from service providers towards marginalized groups are barriers to equitable access and use of health and related services in migration-affected areas. In 2016, IOM, with its implementing partner (IPs), continued to sensitize the community- and facility-based health workforce and other service providers on the importance of providing equitable services that are tailored to the needs of vulnerable migrants and their host communities.

The importance of migration-sensitive services cannot be overemphasized. The ability of service providers to relate with migrants in a sensitive and responsive manner has had a direct influence on the health-seeking behaviour migrants adopt. Since 2014, IOM has been building the capacity of 2,648 health workers from community-based organizations (CBOs) as well as health facilities serving migration-affected communities (surpassing the target of 1,400), including 1,264 in 2016.

**Figure 10.** Total number of health workers in key stakeholder organizations trained on migration and health in 2016.**Figure 11.** Total number of community- and facility-based health workforce members trained on migration and health in 2016.

Training addressed migrant health vulnerabilities, migrants' right to health, migration-sensitive service provision among other topics. In some cases, training also covered important topical issues. In Kenya, for example, in addition to training 31 health facility staff in migrant-populated counties (Busia and Nairobi) on

migration-sensitive services, IOM and its IP sensitized 20 health workers on responsive health services specific to yellow fever in Kamukunji subcounty, Nairobi, in response to yellow fever outbreak potential following an outbreak in Southern Africa and a global vaccine shortage.

### The active role of change agents in Lebire, Lesotho

Change agents in the three community councils of Hleoheng, Maputsoe, and Litjotjela have played a significant role in strengthening the links between communities and health centres by creating demand for health services and facilitating referrals. Continuous health education provided by change agents has also increased community members' knowledge of priority diseases and other health concerns. Reports from health centres indicate that change agents were instrumental, particularly in the uptake of HIV counselling and testing (HCT). Community members agreed:

*"I have now tested for HIV after one woman who described herself as a change agent visited my house and provided some information on HIV. The information gave me power and enthusiasm to know my health status. Earlier I was very reluctant to test and I have realized that was mainly because I did not have sufficient knowledge on issues around HIV."* –Community member, Litjotjela Community Council

Health centres noted how change agents worked in close collaboration with community members while conducting TB and HIV mobilizations. The change agents were effective because of this extensive community engagement, and having councillors and chiefs as change agents facilitated the successful execution of some interventions.

*"Change agents are making our work easier; our health outreaches are more successful because they are very instrumental in mobilizing the community for health services."* –Nursing officer, Mositi Health Centre

Change agents also worked with health centres to address retention in care for clients with TB and HIV.

*"It was very difficult to track patients who were lost to follow up because of limited resources and the communities are very big. With change agents in communities, the work is much easier and patients are tracked and retained into care. Change agents have contributed to reduction of loss to follow up."* –Nursing officer, Linotsing Health Centre, Lesotho

The links established by change agents between communities and health centres have made health services more accessible to community members. Accurate health information exchange between the health centres and communities occurs more rapidly and effectively, and change agents are now recognized as an integral part of the health structure.

Change agents have also gone beyond basic health services in addressing the social determinants of health. In Hleoheng Community Council, daily living conditions, such as the lack of access to clean water, were determined to be barriers to health. Change agents brought together community members, the Councillor and the Chief, and have been mobilizing funds to replace old pipes and unprotected wells. In another community in Litjotjela, change agents formed a community policing committee to respond to high levels of GBV, and the police provided training around relevant topics. The committee prompted the arrest of three men suspected of committing sexual assault in the community, and has been recognized as playing a crucial role in curbing violence and other criminal activities in its particular community.



### Sylvia Mphuti, a.k.a. Mother Theresa

A champion of humanity, Sylvia Theresia Mphuti is dedicated to providing nursing services to the community of Orlando, Komatipoort, South Africa. Sylvia has been Chief Nurse at the local clinic for 18 years and says that it has been a fulfilling journey. The Orlando community accommodates a great number of migrant workers, predominately from Mozambique and Zimbabwe. Masisukumeni Crisis Centre has played a critical role in Sylvia's work, and through the partnership they established years

ago, dealing with migrants has proved less complicated. "We've done many campaigns with the ladies from Masisukumeni, raising awareness on issues of HIV/AIDS, domestic violence, human trafficking and migrants' rights. They also visit our clinic regularly to educate patients and have one on one counselling sessions," she says. She shares that patients who might be victims of domestic violence relate better to change agents. "Patients ask about the change agents even on days when they not in the clinic."



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## A collaborative approach to integrating migration health into university training programmes: IOM Uganda's experience

Promoting migration health in policy and practice can contribute to a reduction of the burden of disease; enhance integration and social stability, as well as social and economic development and communities; can ultimately contribute to poverty reduction. To achieve these outcomes, individuals working in the domains of migration and/or health, such as immigration officials, health-care providers and public health professionals, as well as the private sector and development, humanitarian, and civil society actors, must have multidisciplinary understanding of critical migration health issues.

IOM, with Makerere University School of Social Sciences, Kampala, jointly developed a curriculum for a migration health training course beginning in 2014, following the earlier incorporation of migration health into existing courses at the university. The training was the first multidisciplinary, university-based programme in the region devoted to systematically studying migration health and developing more effective strategies to address it using a human rights-based, public health approach. It has targeted in-service and pre-service practitioners from training institutions, civil society, policymakers and other practitioners in East Africa. The curriculum was validated through a training of trainers that aimed to finalize the curriculum while building the capacity of the university academic staff. In October 2016, the training



Participants during the IOM migration health training held at Makerere University in October 2016. © IOM 2016

was rolled out to the general public, especially to benefit the high-migration districts of Uganda and other institutions involved in relevant work. The course is jointly taught by experts in migration health from IOM and Makerere University and other collaborating institutions.

The training serves as a core pillar for the proposed establishment of the Regional Centre for Migration and Health Studies at Makerere University, which will be implemented as a joint venture with IOM. It has attracted significant demand in the region, with interest for further support by the development partners beyond PHAMESA II. Advocacy is ongoing for other schools within Makerere, such as Law, Women and Gender Studies, Psychology, and Public Health, to integrate migration health studies into their curricula as well.



Participants during the IOM migration health training held at Makerere University in October 2016. © IOM 2016

## National Projects

### *“Healthy Holidays” campaign boosts access to HIV testing and tuberculosis screening in Gaza, Mozambique, 2016–2017*

For the past century, thousands of men have been leaving their homes in the southern Mozambique province of Gaza to seek employment in South Africa’s mines. Often, several generations of the same family would become migrant mineworkers, spending months on end in South Africa and returning home only for the Christmas and Easter holidays. They worked long hours in confined, humid and poorly ventilated conditions, which further increased the risk of TB and other lung diseases. In addition, prevalence of HIV/TB co-infection among mineworkers in South Africa has been one of the highest in the world, which calls for the need to implement awareness-raising and prevention campaigns among both migrant mine workers and their communities of origin.

In three sites—Chicumbane Hospital, the Association of Traditional Healers (AMETRAMO) and the Employment Bureau for Africa (TEBA)—the third edition of the “Healthy Holidays” campaign targeted

mineworkers returning home for the holidays, their families and other community members affected by migration. From 19 December 2016 to 5 January 2017, the campaign provided TB screening and testing, HIV voluntary counselling and testing, family planning services, blood pressure monitoring, blood glucose control and legal counselling on possible compensation to mineworkers who had contracted TB as a result of working in mines.

This was the first time IOM partnered with the private sector (TEBA) in the campaign and it helped the project reach a larger audience of mineworkers. Moreover, upon discussion with local authorities concerning the activities of the campaign, child birth registration services were included. These services targeted unregistered mineworkers’ children and added a more holistic approach to the campaign.

### *Cold chain and vaccine management launched in Lower Juba, Somalia*

The goal of this project was to establish and manage a cold chain and vaccine management hub on behalf of UNICEF, the Ministry of Health and other health partners in the Lower Juba region of Somalia. It ensured the availability of vaccines and immunization supplies to enable timely routine and campaign immunizations in the region. In order to cover the vast region, IOM established regional and subregional cold chain hubs in Kismayo and Dhobley, and achieved the following:

- Four districts within the regions, namely, Kismayo, Afmadow, Badhadhe and Jammame, were supplied with vaccines.
- 26 health facilities (19 maternal and child health centres, 4 hospitals and 3 nutrition stabilization centres) were given weekly supplies.
- A weekly expanded programme on immunization and vaccine management supervision was maintained at the facility level to ensure the quality and efficacy of the vaccines.
- Cold chain equipment and inventory in the cold rooms were well maintained with regular monitoring of the cold chain management and vaccine stocks.



A migrant mineworker being screened for TB during the “Healthy Holidays” Campaign in Xai-Xai and Chicumbane, Gaza province, Mozambique. © IOM/Sérgio Esperança 2016



### Projects to prevent HIV/AIDS launched in South Sudan

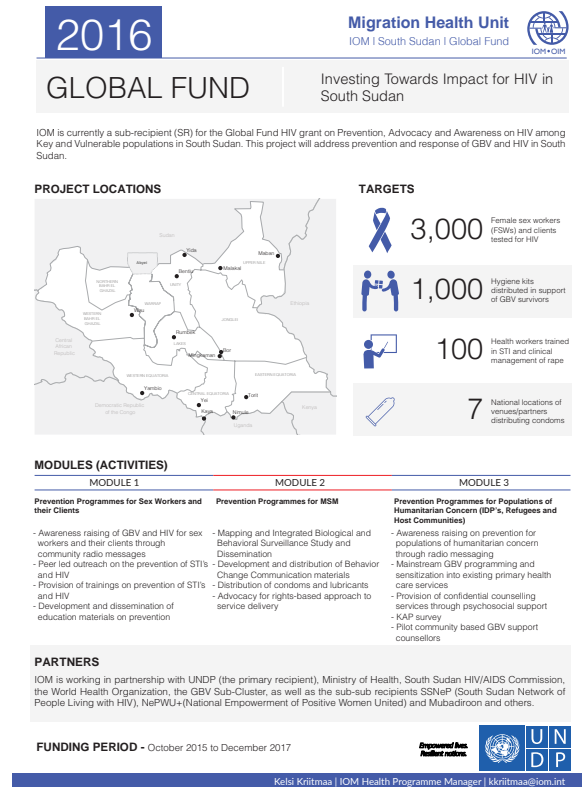
IOM contracted four implementing partners (IPs), working with the Networks of People Living with HIV/AIDS, female sex workers (FSWs) and clients of FSWs. Activities conducted with the IPs included the following:

- 32 outreach sessions on awareness and prevention of HIV and sexually transmitted infections (STIs), and dissemination of information about reproductive health were conducted, targeting key populations.
- Condom distribution points were mapped and established for easy accessibility for key populations, and a total of 37,361 condoms were distributed.
- Five training sessions were conducted for peer HIV counsellors consisting of key populations within the communities. Counsellors trained were from Wau, Yambio, Juba, Kajokeji and Torit.
- A total of 6,192 people in protection of civilian (PoC) sites or IDPs were reached with messages on HIV, STIs and reproductive health. 26 people in PoCs or IDPs have been referred for STI management, 905 have been counselled or tested for HIV, and 1,871 have received and collected condoms.
- IOM also recruited a consultant to develop a package of services for men who have sex with men. The draft tools and protocol was developed and forwarded for approval in early 2017.

IOM conducted an assessment of health facilities within refugee camps and PoC sites, which covered HIV services, the type of services available including HIV testing and treatment, and for which populations those services were provided. It also included sexual reproductive health including gender-based violence (GBV) services and referrals, and the capacity of health workers in regard to HIV and GBV. Based on the findings of the assessment, IOM has been planning to develop evidence-based interventions for refugees and IDPs in camp-based settings in South Sudan.

IOM is also working with vulnerable populations in South Sudan to reduce the risk of transmission of

**Figure 12.** Total number of health workers in key stakeholder organizations capacitated on migration and health in 2016.



HIV/AIDS and increase access to treatment, care and support services. With support from the GFATM, IOM's prevention programmes have aimed to reduce the prevalence and incidence of HIV in South Sudan among key populations that are more vulnerable to the disease. As part of the prevention programme, IOM trained 177 peer counsellors to conduct outreach activities and to encourage uptake of key HIV prevention, treatment, care, and support activities within communities.

On 12 January 2016, in a World AIDS Day event in Juba sponsored by the Ministry of Health, the South Sudan AIDS Commission, IOM, the United Nations and partner agencies, local actors used theatrical performances and songs to demonstrate the damage that discrimination can cause to those affected by the disease and the critical steps each individual can take to prevent infection of HIV/AIDS. Through a consultative process with partners and other stakeholders, IOM has also been developing a revised national behavioural change communication strategy

and education materials aimed at improving HIV and AIDS awareness and knowledge.

At the UN PoC sites in Bentiu, Malakal and Wau, health staff have been offering prevention of mother-to-child transmission of HIV by testing pregnant women for HIV and providing antiretroviral treatment for those who test positive. With antiretroviral treatment, prevention of mother-to-child transmission interventions can reduce the risk of transmission to an unborn child from 45 per cent to 5 per cent. Through existing mental health and psychosocial support programmes in these sites, IOM has been linking people living with HIV and survivors of GBV with trained counsellors and support groups.

Sitting with six other women at a prevention of mother-to-child transmission support group in Bentiu, singing while they embroider and bead necklaces, one expectant mother living with HIV said: "When I'm alone, I feel stress. I rarely get time to myself but I am happy spending time with others in this group to share our stories and support each other."

IOM's humanitarian health and mental health and psychosocial support programmes in South Sudan have been supported by USAID's Office of US Foreign Disaster Assistance, the Government of Japan and the Italian Agency for Development Cooperation.

### *IOM responds to malaria upsurge in Bentiu, South Sudan*

IOM scaled up resources to respond to an upsurge in malaria cases at the UN PoC site in Bentiu, South Sudan. During the first two weeks of June, malaria cases more than doubled, accounting for at least 50 per cent of all health consultations at IOM's two primary health-care clinics in the site and its mobile clinic in nearby Bentiu town. The increase was attributed to the start of the rainy season, which led to stagnant bodies of water and increased the spread of vector-borne diseases.

IOM deployed 40,000 additional rapid diagnostic test kits for malaria to Bentiu, as well as additional anti-malarial medications. In coordination with the Health Cluster, IOM began registering all households in the site to receive mosquito nets to prevent malaria transmission. Through health and hygiene promoters, IOM reached the community with key information on how malaria presents and where to get early treatment and prevention. Malaria was the number one leading disease in the PoC site. All persons with fever were

advised to come for early testing and treatment to reduce mortality and disease burden.

IOM continues to provide safe drinking water to more than 43,300 IDPs at the site on a daily basis, as well as maintains sanitation facilities and conducts regular waste disposal. As camp manager of the site, IOM has also ensured the timely coordination of humanitarian assistance and response to IDP needs. The crisis in South Sudan has displaced more than 2.4 million people and left an estimated 6.1 million people in need of protection and humanitarian assistance. IOM has continued to provide multisectoral assistance to displaced and vulnerable populations across the country, both in PoC sites and remote locations, as part of an effort to reach 5.1 million people with life-saving aid.

### *Tuberculosis and migration in Zimbabwe*

Of the 22 countries designated by WHO as high-TB-burden countries, Zimbabwe ranks seventeenth with an estimated TB incidence rate of 562/100,000. The TB epidemic in Zimbabwe is fueled by the severe parallel HIV pandemic (adult HIV prevalence rate of 15.2%), making TB the second leading cause of death. The TB mortality rate (excluding HIV+TB) is 33/100,000, increasing four-fold among patients with both TB and HIV (132/100,000). Seventy per cent of people living with TB in Zimbabwe also have HIV. The country's NTP has continuously striven to reduce transmission of the disease and mortality rate by breaking the chain of transmission and through free TB diagnosis in national laboratories. Zimbabwe has a low national case detection rate, currently pegged at 46 per cent; however, the country also has a low coverage of TB diagnostic services, with only two TB laboratories offering TB sputum culture microscopy. The other available laboratory facilities are scarce and only conduct smear microscopy, which cannot detect drug resistance and has a lower sensitivity, especially in cases of TB/HIV co-infection.

Zimbabwean migrants often lack access to these facilities due to the migratory nature of their work. When cross-border Zimbabwean migrants live in neighbouring countries such as Botswana and South Africa, they are particularly hard to reach. In many cases, presumptive TB cases of this group are initiated on TB treatment without the requisite diagnostic tests and with poor follow-up due to their mobility patterns.

Efficiently monitoring TB incidence and prevalence in this population requires innovative approaches and

active case finding. With support from TB REACH, several new interventions were designed by IOM. These interventions included systematic TB screening for irregular Zimbabwean migrants deported from South Africa and Botswana, improved access to TB screening and treatment services for migrants and host communities through the establishment of mobile clinics along the transport corridor and outreach activities, and increasing awareness of TB and HIV/AIDS among migrants and high migrant-sending communities through door-to-door TB health messaging conducted by CHWs. It also involved the distribution of educational videos for display on buses, in schools, and in shops, and the use of m-health technology, which employs cell phones to transmit results to patients and to provide them with new information. Nine months into implementing the interventions, 20,445 people had been screened in 2016. A total of 3,593 people had been reported to have presumptive TB, and 113 of them were positive TB cases. 96 cases were recorded, which is a 20 per cent significant change from baseline to the intervention period.

## ASIA

### Regional Programmes

#### *IOM Regional Office for Asia and the Pacific hosts the Secretariat of Joint UN Initiative on Migration and Health in Asia (JUNIMA)*

JUNIMA is a regional coordination mechanism that contributes to regional health security by bringing together governments, civil society organizations, regional associations, development partners and UN agencies. The goal is to effectively advocate, promote policies, share information, and support action on the right to health and access to prevention, treatment, care, and support services for migrant populations affected by TB, HIV, and malaria in Asia.

The biannual JUNIMA Steering Committee Meetings were held in February and September in Bangkok, and convened all 25 member organizations to discuss the work of JUNIMA, migration health programmes in the region and the strategic direction of JUNIMA. The membership grew in 2016 to include UNICEF and the Mekong Migration Network, while the South Asian Association for Regional Cooperation (SAARC) Secretariat on migration health was engaged to work towards JUNIMA membership. IOM, as the JUNIMA Secretariat, along with 2016 co-chairs, ILO and CARAM

Asia, continued to engage with stakeholders and donors during the course of the year. An example of this engagement is the contribution to regional policy and coordination discussions for malaria and the development of proposals for a regional memorandum of understanding on migrant and mobile populations and health security in the Greater Mekong Subregion (GMS).

In addition to facilitating partner dialogue, the IOM Secretariat also supports opportunities for knowledge-sharing. The IOM Regional Office for Asia and the Pacific supported and presented at the International Conference on AIDS in Asia/Pacific in Bangladesh in May 2016. A multilingual advocacy document on the importance of migrant inclusion in health security dialogues was also developed for government members and was translated into all GMS languages.



A migrant mineworker being screened for TB during the “Healthy Holidays” Campaign in Xai-Xai and Chicumbane, Gaza province, Mozambique. © IOM/Sérgio Esperança 2016

#### *Addressing malaria among migrants and mobile populations and host communities in Greater Mekong Subregion countries (Cambodia, Lao People’s Democratic Republic, Myanmar and Thailand)*

Migrants and mobile populations (MMPs) are recognized by governments and WHO as key affected populations in an effort to eliminate malaria in South-East Asia’s GMS, which experiences the highest rates of malaria within the Asia/Pacific region.

Due to the emerging resistance of the malaria parasite to artemisinin, the key medicine used to treat malaria in this region, the policy for malaria in the Asia/Pacific has moved from the control to the elimination of malaria. Any regional elimination efforts however would need to view all of the populations of GMS, regardless of their migrant states, as potentially vulnerable to malaria and therefore would need to commit to providing continuous, coordinated and



comprehensive malaria services to all populations throughout the region, rather than a piecemeal approach to local populations. IOM has conducted malaria activities in all five GMS countries focusing on increasing knowledge of barriers for MMPs and increasing access to malaria services. IOM has been working with Ministries of Health, WHO, and partners to promote awareness and inclusion of migrants within national and regional malaria elimination efforts.

**Cambodia (Donor: ADB).** IOM Cambodia has been implementing a project funded by the Asian Development Bank (ADB) focusing on piloting worksite malaria systems for migrant workers in private-sector worksites in north-west Cambodia. The project will mobilize, train and equip malaria volunteers from a range of worksite locations and promote testing and treatment in line with national guidelines as well as promote vector control/prevention strategies. IOM will also conduct a situational analysis on the internal, cross-border migration cycle to understand the human mobility and hard-to-reach population movement mechanisms in Oddor Meanchey province. In the project selected districts IOM will develop standard operation procedure to improve management and accountability of malaria operations for MMPs for volunteer-based diagnosis and referral for treatment services.

**Lao People's Democratic Republic (Donor: ADB).** IOM in the Lao People's Democratic Republic (hereinafter referred to as Lao) is also currently funded by ADB to establish malaria systems in private-sector worksite locations in peri-border locations. IOM has been supporting the Lao Ministry of Health's efforts to eliminate the spread of drug-resistant malaria, specifically by tackling a key driver of the current malaria outbreak in Lao; the limited access of MMPs in southern Lao to malaria prevention, testing and treatment. Without engaging MMPs, particularly those in private-sector projects, and increasing their access to prevention, testing and treatment, it would be difficult to reverse the current outbreak. Research on the malaria situation among MMPs and mapping of health-service facilities for MMPs in target areas was conducted in October 2016. Following this research, the project will deploy a mix of interventions and innovations – migration mapping, behaviour change, surveillance, testing and treatment – targeting MMPs.

**Myanmar (Donors: GFATM, ADB).** IOM has been directly implementing malaria prevention and control activities in Mon and Kayin states since 2006, and further expanded these services in 2016. Activities included

training and providing support to malaria volunteers for case detection and treatment, distribution of long-lasting insecticidal nets (LLINs), health education and social mobilization for communities, referral of severe cases for hospitalization and treatment, and surveillance and management for malaria resistance. In 2016, IOM distributed 73,704 long-lasting, insecticide-treated mosquito nets; conducted 59,731 malaria tests at the community level; diagnosed and treated 646 malaria cases; and trained and supported 190 community-based malaria volunteers.

**Thailand (Donor: GFATM).** As part of the GFATM project, IOM, in collaboration with the American Refugee Committee (ARC), worked in 11 provinces to support strategies related to: behaviour change communication (BCC) and advocacy for increased awareness of self-protection; vector control and personal protection; health systems strengthening; and monitoring and evaluation. The activities conducted included: community mapping of migrant households; distribution of LLINs, hammock nets and insect-repellant skin lotion; and implementation of awareness-raising campaigns. Activities included interactive small group sessions, home visits, and distribution of multilingual comic books, posters, flip charts, board games and radio broadcasts. Key achievements from October 2011 through December 2016 included the distribution of 100,480 LLINs to migrant populations and ethnic minorities in 1,765 villages. BCC capacity development was conducted for 97 field staff and 56 migrant health workers. Additionally, BCC activities reached over 460,000 migrants in communities, households, and workplaces through radio broadcasts covering 77 districts, peer visits to 529 diagnosed *Plasmodium falciparum* positive cases, and joint "World Malaria Day" yearly campaigns, which were conducted in identified hotspots in targeted provinces.

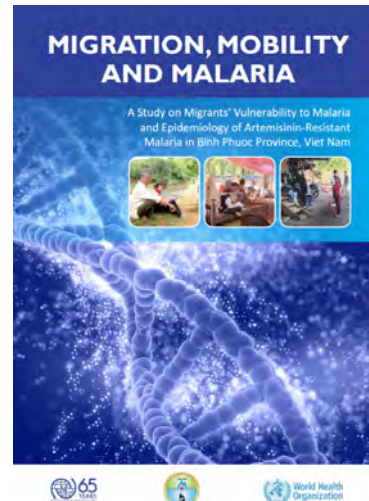
**Viet Nam (Donor: IOM Development Fund).** In partnership with WHO and the National Institute of Malariology Parasitology and Entomology in Ho Chi Minh City and the Ministry of Health, IOM conducted a study on migration and malaria, titled "Migration, Mobility and Malaria – A Study on Migrants' Vulnerability to Malaria and Epidemiology of Artemisinin-Resistant Malaria in Binh Phuoc Province, Viet Nam". The study aimed to provide additional data on and analysis of human and other factors related to exposure to and infection with malaria, prevention of malaria, and the spread of resistance to malaria treatments. The study involved a large-scale knowledge, attitudes and practices (KAP) household

survey, and a smaller in-depth study to show mobility patterns and allow a comparative analysis of migrant types. The research proposed recommendations for targeted interventions addressing the nexus between mobility and the spread of malaria, particularly in border areas. In launching the study, IOM and partners co-organized a workshop called “Information and Experience-sharing on Recent Malaria Research, Control and Prevention Targeting Mobile and Migrant Populations”, which brought together local-, provincial- and national-level malaria and health experts to discuss the findings of the research, and recommendations for malaria prevention and control, and policy within the region.



Dr. Montira Inkochasan, from IOM RO Bangkok, presented the bilingual information, education and communication (IEC) materials on malaria and MMPs. 18 Nov. 2016, Siem Reap. © IOM 2016

**Figure 13.** “Migration, Mobility and Malaria: A study on Migrants’ Vulnerability to Malaria and Epidemiology of Artemisinin-Resistant Malaria in Binh Phuoc Province, Viet Nam.” The study provides an in-depth analysis of malaria vulnerability among MMPs.



Participants at the Consultative Workshop on Improving Access to Malaria Prevention, Testing and Treatment among Migrant and Mobile Populations in Siem Reap, Cambodia. © IOM/Chhya Chhin 2016

## Malaria Prevention, Testing and Treatment for Mobile and Migrant Populations in Myanmar

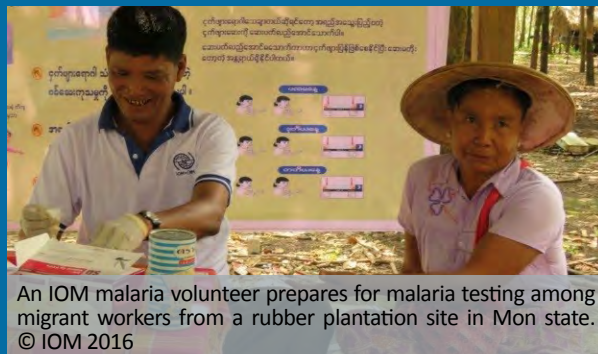
Rubber plantations are an important part of Myanmar's economy, found mostly in the south-eastern part of the country and along the border with Thailand. They need to be constantly manned to keep rubber production going. Migrant and seasonal workers from around the country set camps in the middle of the plantations, having to work through the night and early morning across hundreds of acres of land. As such, their chances of falling ill with malaria soar.

U Tin Naing Soe is a migrant worker in the Kwali camp of Kyat Hto township. However, he now has an additional role in his community: "I am the rapid diagnostic test provider of the camp," he says proudly. "I have been trained to conduct malaria testing for everyone in the community who feels sick or has a fever, and if the result is positive for malaria I can administer treatment. I also report any malaria cases to the Township Community Project Assistant from IOM, so they can share malaria case data accordingly with health authorities".

IOM's project for detecting and treating malaria in high-risk communities is funded by the GFATM. The GFATM has been one of the implementing agencies working across the country on malaria-related projects. The National Malaria Control Programme (NMCP), WHO and other partners have been instrumental in ensuring that malaria funds are secured and distributed efficiently, to achieve the objective of a malaria-free Myanmar by 2030.



IOM malaria volunteer provides health education to migrant workers at rubber plantation site in Mon State. © IOM 2016



An IOM malaria volunteer prepares for malaria testing among migrant workers from a rubber plantation site in Mon state. © IOM 2016

Myanmar has achieved impressive results in the fight against the disease. In the past decade, the number of malaria deaths has dropped steadily year by year from 1,707 in 2005 to just 37 in 2015 (over 98% reduction over 10 years), reflecting major improvements in access to early diagnosis and appropriate treatment. Still, pockets of high-risk areas remain. MMPs have been one of the most high-risk population groups for malaria in Myanmar. Since the country has been moving towards elimination, strategies and interventions have focused on early detection and treatment for MMPs are especially important. In order to bring the number of cases down to zero, an effective coordination among all partners is required. The new Myanmar Malaria National Strategic Plan for 2016–2020, developed by the NMCP with technical assistance from WHO, will be the master plan guiding all malaria activities across the country for the next five years.

For U Tin Naing Soe and his fellow camp-dwellers, a good Malaria programming means being able to get accurate information, diagnostic opportunities and treatment for malaria as soon as they are needed. As he delivers his health information session on the risks and prevention of malaria across the camp, there is a concrete hope that soon the threats of malaria infection will only be a memory in all areas across Myanmar.



## National Projects

### *Promoting comprehensive sexual and reproductive health and rights for internal migrants and internally displaced populations living in urban slums in Sylhet City, Bangladesh*

The Government of Bangladesh National Urban Health Strategy has identified sexual and reproductive care and awareness as a key focus area for urban health systems in Bangladesh. IOM supported the development of a strategic plan of action on sexual and reproductive health and rights for Sylhet City Corporation (SCC) to strengthen the institution's commitment toward the comprehensive integration of SRHR into the National Urban Health Strategy. A baseline survey, which included a KAP survey, was conducted, and needs assessment and findings were shared among relevant governments and other stakeholders. The survey showed that the lack of knowledge on available SRH services is the most common healthcare access barrier. In addition, a large portion of the population is illiterate so outreach workers need to be trained on how to disseminate messages more effectively to this population. The survey also indicated that in order to improve the quality of SRH services, there is a need to invest in refresher training for health-care providers, strengthen the monitoring and oversight systems, and upgrade facilities with proper equipment for SRH. Based on this, a training module on quality and comprehensive SRH clinical services was developed for urban settings, adapting the existing training modules of Marie Stopes Bangladesh and other similar organizations.



An outreach worker conducts an awareness-raising session for an adolescent group on SRHR in Sylhet City, Bangladesh. © IOM 2016

The project also employed community outreach workers who were trained to facilitate group awareness sessions on SRHR for slum-dwellers, using tailored IEC materials. A total of 13,391 sessions for 154,325 participants (42,200 male and 112,125 female) were conducted during the year. Furthermore, twenty primary health-care centres and comprehensive reproductive health-care centres were upgraded with the necessary medical and logistic supplies, and a well-coordinated referral mechanism for comprehensive and quality SRH care was established for the slum-dwellers in SCC.

**Figure 14.** “Baseline Survey Report: Promoting comprehensive sexual and reproductive health rights for internal migrants and internally displaced populations living in urban slums of Sylhet city of Bangladesh.”



### *Strengthening the integration of quality and comprehensive health services into the government health-care system for survivors of human trafficking and abuse in six upazilas of Jessore and Satkhira districts in Bangladesh*

This programme strengthened referral mechanisms for trafficked persons for various services including health, social and legal support in Bangladesh. In 2016, a total of 405 survivors of trafficking were identified and physically reached by the community coordination team members and outreach workers. Among them, 313 (77%) were identified to have physical and psychosocial needs. Out of the 288 survivors that accepted referral cards from IOM to health services, 265 survivors (92%) received health-care services from the six upazila (subdistrict) health complexes. Moreover, 25 survivors were provided with secondary and tertiary medical care through a referral mechanism and financial support.

A total of 83 community health-care providers from four upazilas were provided with training using the “IOM international guideline for health-care providers on caring for trafficked persons”. Additionally, 10

refresher training sessions were held in 2016 with a total of 100 health service providers, including doctors, nurses, family welfare visitors and sub-assistant community medical officers from two upazilas. Understanding the importance of training both male and female health practitioners, IOM made every effort to ensure a gender balance in each of the provided training. During the project, a sustainable, comprehensive and quality health-care service was incorporated into the government health-care system for survivors of human trafficking.

Furthermore, the project fostered an empowering environment for survivors of human trafficking in the community through sensitization and social mobilization. In 2016, a total of 160 women survivors of human trafficking were supported through the formation of social action learning groups. The goal of the learning groups was to enhance women's self-esteem and social empowerment through their participation in the periodic problem-solving meetings. Moreover, 23 community-based outreach workers from six upazilas conducted a total of 3,556 awareness sessions to increase sensitization on human trafficking. The issues that were discussed included the social and health consequences, health rights of survivors of human trafficking and available service facilities to the vulnerable populations in the community. A total of 62,817 men and women were reached through these group awareness sessions.

### *Improving health education and availability of health care for the asylum seekers and refugees in Malaysia*

Since July 2013, IOM has been implementing a pilot health project to provide asylum seekers and refugees in Malaysia with basic primary health care, early diagnosis and referrals for treatment, and medical triage for emergencies. In close coordination with UNHCR, Malaysian health authorities, non-governmental organizations (NGOs) and community organizations, the project provided health assessments to about 2,500 individuals in 2016. Among those presented with medical conditions, the top three morbidities identified were infectious diseases (including TB), musculoskeletal and connective tissue disorders, and nutritional disorders.

A total of 9,397 refugees and asylum seekers, 58.6 per cent male and 41.4 per cent female, were assessed and counselled in the health clinic refurbished and operationalized for this project. A total of 4,940 applicants with medical conditions, predominately with nutritional disorders (20.4%), infectious diseases

including pulmonary TB (19.3%), and musculoskeletal and connective tissues disorders (16.4%), were identified and referred for additional examinations and treatment by specialists. Seventy-seven emergency cases were initially attended in the clinic and referred to the hospitals and NGOs for further evaluation and management. The medical team also provided assistance for one child who was born in the clinic. A total of 130 individuals with beriberi were examined and assisted with treatment, with referral for specialized medical care and follow-up. A total of 375 individuals with complex medical conditions were examined and special medical assessment forms and psychological assessment forms were completed for UNHCR for their follow-up with special resettlement arrangements and/or addressing refugees' and asylum seekers' needs. In early 2016, IOM assisted in producing an animated insurance promotion video which targeted illiterate refugees, particularly the Rohingya population. The refugee medical insurance promotion video is now available in five languages: Rohingya, Burmese, Arabic, Tamil and English.



Health assessment at the IOM clinic in Kuala Lumpur. © IOM 2016

Twenty-nine children with malnutrition and anemia were identified and assisted with nutrition counselling, vitamin supplements, deworming, PaediaSure food supplement, and monthly reassessment and monitoring. More than 75,200 multilingual educational materials, such as leaflets and brochures, with information about communicable diseases, prevention, hygiene and other medical conditions were distributed. Ten health education sessions and

outreach activities were carried out, focusing on hygiene education, TB screening and awareness, nutritional assessment and deworming. These included the provision of hygiene and first aid kits for the refugee community centres and schools.

### **Strengthening maternal, newborn and child health in Myanmar**

With funding from 3MDG in 2016, IOM worked in Myanmar to strengthen the health and community-based systems in Ayeyarwaddy Delta and Kayah state, which promoted and delivered quality maternal, newborn and child health care. Ayeyarwaddy Delta and Kayah state are very remote and present numerous challenges to the delivery of health services, such as geographical constraints, language barriers and the rural population's socioeconomic status. As a result, there has been poor early health-seeking behaviour and people have tended to arrive at clinics only when their conditions have severely deteriorated, leading to avoidable mortality. Through this project, IOM used a community-based approach, collaborating directly with the township health departments and jointly implementing the maternal, newborn and child health activities in Bogale township (population: 327,979),

Mawlamyinegyun township (population: 302,013), and Kayah state (population: 292,353).

In 2016, IOM supported the referrals of close to 4,000 emergency obstetric care patients, more than 1,800 emergency cardiovascular care patients, and other emergency patients to the hospitals in the Delta and Kayah state. As part of IOM's commitment to durable solutions and sustainability, the project also focused on building the capacity of the township health departments in planning, supervision, outreach activities and management of the township health system. IOM, with this funding from 3MDG, piloted the migrant-friendly Maternal Voucher Scheme project in Myanmar as part of efforts to encourage underserved migrant women to seek maternal and child health-care services early and frequently. Through a migrant mapping exercise, the project had identified the Kadon Kani area in 2015 as a migrant dense area, which included 30 villages and the town of Kadon, and had a total population of 25,223 people. In collaboration with local authorities and health providers, the scheme supported 34 pregnant women and 23 under-five children among the local migrant population in order to promote access to maternal and child health services in rural and subrural health facilities.

### Health Education in Ta Gon Taing Rural Health Centre

San Ei Nwe, a 16-year-old mother, actively shared her experience with peer groups about birth spacing, the risk of unwanted pregnancy and teenage pregnancy. Last year, she almost lost her life in a high-risk-induced abortion. She had refused to attend antenatal care visits for several reasons including her socioeconomic status, limited health education and illiteracy. However, she changed her mind when a health assistant from Ta Gon Taing Rural Health Centre conducted a BCC session in her local village of Kan Pyat. Basic health staff and IOM staff provided counselling on the risk factors of unwanted pregnancy and teenage pregnancy, and encouraged all participants to seek antenatal care. San Ei Nwe learned about the dangers of teenage pregnancy, started attending antenatal care services, and immediately sought care at Ta Gon Taing Rural Health Centre when her labour pain started. Seeking health care early was critical for her as she eventually was referred to Mawlamyinegyun Hospital and delivered her baby on the way to the hospital.



San Ei Nwe. © IOM Myanmar 2016

She recalled her experience, *“At first, I was seeking service to conduct induced abortion and didn't want to deliver that child. The health assistant encouraged and counselled me about the risk of unwanted pregnancy and teenage pregnancy. I dare not take antenatal care and dare not deliver at Mawlamyinegyun Hospital because I have many social problems, and my family is very poor.”*



### *Philippines Department of Health, IOM facilitate a migrant health conference*

The Philippines Department of Health (DOH), in collaboration with IOM, held the Second National Conference on Migrant Health on 17 June 2016 in Pasay City, Philippines, to bring together government officials, academic experts, and representatives from international organizations, NGOs, civil society organizations, migrant associations and the private sector to discuss migration health in the country. The 2016 theme was “Advancing the Health of Migrants through Multisectoral Collaboration”. During the conference, IOM affirmed its commitment to working with governments and multisector partners. It is looking forward to working more closely with the DOH, its Bureau of International Health Cooperation, and other relevant units towards technical guidance, policy advocacy and practical solutions that advance the health of migrants.

The National Centre for Mental Health and the Philippine Migrant Health Network are sustained products of the DOH–IOM Joint Project on Migration Health, which has sought to map the status of migration health in the Philippines. The findings of the project have laid the foundation for the development of policies, programmes and activities in the area of migration health in the country.

## **EUROPE**

### **Regional Programmes**

#### *EQUI-HEALTH*

The Equi-Health action project (“Fostering Health Provision for Migrants, the Roma and Other Vulnerable Groups”) was launched by IOM in February 2013, from a direct grant agreement between DG SANTE and IOM within DG SANTE’s Public Health Programme 2012. The project has focused on three distinct areas: (a) migrant health at the southern borders of the EU; (b) Roma health, nationals and migrants; and (c) migrant health in the EU/EEA. Equi-Health has also worked within national legal and policy frameworks and has conducted country reviews under the Migrant Integration Policy Index (MIPEX) framework. The project has had two main objectives: (a) promoting appropriate health care provision to migrants at the southern borders of the EU, thereby increasing public health safety in the EU in the longer run; and (b) reaching the aims of Europe 2020 Strategy on

reducing health inequalities with focus on migrants, the Roma and other vulnerable ethnic minority groups.

### *Training on migration health for health professionals and law enforcement officers in Greece<sup>3</sup>*

IOM and the Department of Sociology of the National School of Public Health in Greece co-organized a training on migration health for health professionals and border/law enforcement officers in Greece. Participants were mainly health providers, of whom 63 per cent were female and 37 per cent were male. The training increased the participants’ understanding of the health-related border policies and procedures, the health challenges faced by migrant populations, and the importance of appropriate and timely referrals to health authorities. The implementation of the training courses in different key locations in Greece allowed the training of more than 334 health professionals and law enforcement officers, mainly from local hospitals, first reception centres and NGOs, as well as volunteers and officials from the Greek Army, the Greek police, and the Greek Coast Guard.

### *Fostering health provision for migrants, the Roma and other vulnerable groups*

Within the Equi-Health Project, IOM Lisbon organized three last training sessions on migration and health for health professionals and administrative personnel, which took place at the beginning of 2016 in Lisbon. In total, the three sessions gathered 87 delegates, who participated in multidisciplinary groups consisting of medical doctors (public health and general and family medicine), nurses, front-desk administrative staff, psychologists, social workers, health services management staff and representatives from the local health authorities. As in previous training sessions (2014–2015), having a mixed-profile group proved to be constructive, allowing different professionals to exchange views and perspectives, discuss and share work-related experiences, and put forward suggestions to improve health services capacity to address migrants’ health needs. Training modules for health professionals were developed as a set of training materials on migration and health including information on health and mobility, social determinants of health, mental health and intercultural competence.

<sup>3</sup> [http://equi-health.eea.iom.int/images/Trainings/REPORT\\_Trainings\\_Greece.pdf](http://equi-health.eea.iom.int/images/Trainings/REPORT_Trainings_Greece.pdf)

### *Equi-Health final dissemination conference in Lisbon, May 2016<sup>4</sup>*

The joint conference of the Equi-Health “Fostering Health Provisions for Migrants, the Roma and Other Vulnerable Groups” and “Adapting European Health Systems to Diversity (ADAPT) projects, co-organized by IOM and COST Action IS1103 ADAPT, took place on 11 May 2016 in Lisbon, Portugal. The conference presented the results of research on health-care policies concerning migrants in 38 mainly European countries, as well as advocated policy change across Europe to improve access to appropriate health-care services for migrants in an irregular situation.

The partnership between IOM and ADAPT resulted in the inclusion of a health strand in the fourth edition of MIPEX, which also involved collaboration with the Migration Policy Group. The health strand is a questionnaire designed to supplement the existing seven strands of MIPEX, which, in its latest edition (2015), monitors policies affecting migrant integration in 38 different countries. The questionnaire measures the equitability of policies relating to four issues: (a) migrants’ entitlements to health services; (b) accessibility of health services for migrants; (c) responsiveness to migrants’ needs; and (d) measures to achieve change.<sup>5</sup>

Another outcome was the development of consensus recommendations on access to health services for migrants in irregular situations. These presented an overview of expert opinions on the health-care needs of such migrants, the diverse arguments for



IOM Lisbon organized a training session on talking about vulnerable groups on 1–3 February 2016. © IOM 2016



IOM Lisbon held a training session on role-playing on 15–17 February 2016. © IOM 2016

improving their access to care and the issues involved in providing adequate services. The recommendations included the following points:

- The principle of universal and equitable health coverage should be applied to all persons residing de facto in a country, regardless of their legal status.
- More prominence should be given to the health-related rights of irregular migrants and more legal action should be undertaken to defend these rights.
- Governments should take into consideration the increasing amount of evidence that restricting access to primary care in fact costs more money than it saves.
- Reporting of irregular migrants by health workers or service provider organizations to police or immigration authorities should be explicitly prohibited.
- Increased research efforts are needed to gain the following knowledge about irregular migrants: the health problems for which they are particularly at risk, their help-seeking behaviour, and the health risks affecting them, among other topics.
- National governments, intergovernmental organizations, NGOs, civil society organization, public health experts, and researchers must join forces and present a united front in support of the health-related rights of irregular migrants.<sup>6</sup>

<sup>4</sup> [http://equi-health.eea.iom.int/images/Evaluation\\_Report\\_Lisbon.pdf](http://equi-health.eea.iom.int/images/Evaluation_Report_Lisbon.pdf)

<sup>5</sup> [https://publications.iom.int/system/files/mrs\\_52.pdf](https://publications.iom.int/system/files/mrs_52.pdf)

<sup>6</sup> [http://equi-health.eea.iom.int/images/Expert\\_consensus\\_Recommendations.pdf](http://equi-health.eea.iom.int/images/Expert_consensus_Recommendations.pdf)

### *Training on migration health for health professionals in Heidelberg, Germany, November 2016*

IOM delivered a two-day training course to improve the knowledge of health professionals about the public health implications of migration and to strengthen the responsiveness of health services to migrants' specific needs. The training course was based on the IOM Equi-Health project training materials, previously developed within the project as a set of interactive educational materials on migration and border management including information on migration, health, and cultural competence for health professionals and law enforcement officers. The materials have been previously used in Equi-Health implemented activities, including regional peer reviews, training of trainers, and rollout sessions on migration and health.

The two sessions allowed participants, mostly health professionals including medical practitioners, health students, public health practitioners from the University of Heidelberg as well as representatives from local health authorities, to explore several important concepts on health care and health mediation for migrants and refugees. Topics included an overview of the global and EU migration trends, key concepts in public health and migration, mental health and psychological aspects of migration, occupational health, vulnerable groups, and communicable and non-communicable diseases.

### *Regional pilot intervention on health mediation and the Roma –fourth study visit in Seville, June 2016<sup>7</sup>*

IOM carried out study visits to EU Member States implementing the Roma health mediation programmes with the objective of learning from individual programme experiences. The fourth and last study visit took place in the district Polígono Sur in Seville, Spain, on 5–8 June 2016. It was co-organized by IOM and the Centre of Community Research and Action at the University of Seville, in collaboration with Oficina de la Comisionada del Plan Integral del Polígono Sur and Universidad Pablo de Olavide. The visit was conducted within the framework of the Equi-Health project's Roma health governance in Polígono Sur, which had the objective of promoting Roma health governance in at-risk local context by embedding Spain's National

Roma Integration Strategy (NRIS) into local policies, rendering them Roma sensitive. The desired outcomes of the project were: building Roma capacity for health governance into the Integral Plan of Polígono Sur, adopting an intersectional and intersectoral approaches and ensuring Roma sensitivity in health initiatives, ensuring transparent and empowering evaluation processes in the initiatives and addressing institutional discrimination.

### *4 national local consultative committee meetings on health mediation in Bulgaria<sup>8</sup>*

Four roundtables titled "Health Mediation in Bulgaria: Opportunities and Perspectives" were jointly organized by IOM and the National Network of Health Mediators Association. The goals of the meetings were to disseminate the activities and results from the Equi-Health project – the Roma Health Component – at a local level, and to present the work of the health mediators as part of the NRIS health component activities for implementation. In November 2016, IOM also launched within the framework of the IOM's Equi-Health project "Fostering Health Provision for Migrants, the Roma and Other Vulnerable Groups", the Euro Health Mediators portal, the online platform of the European Network of Community Health Mediators, created as part of the regional intervention on health mediation and the Roma (<http://eurohealthmediators.eu/>).<sup>9</sup> The online platform serves as a tool for communication, and was developed in partnership with the Federal Public Service for Health (Belgium); the National Network of Health Mediators (Bulgaria); the National Institute for Public Health (Romania); Coalition for the Study of Health, Power, and Diversity (CESPYD) at the University of Seville and the Catalanian Public Health Agency (Spain); the Association for Culture, Education and Communication (Slovakia); and Association pour l'Accueil des Voyageurs (France). It will increase the visibility of the work of health mediators and promote different health mediation models in the EU, as well as provide an opportunity for the harmonization of training programmes and the implementation of joint training programmes and exchanges. The platform is open to all mediation programmes in Europe and provides them with a database for exchange of promotion materials, videos and handbooks translated into multiple languages, as well as link with other EU/regional initiatives on health and mediation.

<sup>7</sup> [http://equi-health.eea.iom.int/images/Pics\\_Roma/Fourth\\_Study\\_Visit\\_Report\\_Final.pdf](http://equi-health.eea.iom.int/images/Pics_Roma/Fourth_Study_Visit_Report_Final.pdf)

<sup>8</sup> [http://equi-health.eea.iom.int/images/Pics\\_Roma/IOM\\_Report\\_Meetings\\_EN\\_final.pdf](http://equi-health.eea.iom.int/images/Pics_Roma/IOM_Report_Meetings_EN_final.pdf)

<sup>9</sup> <http://eurohealthmediators.eu/>



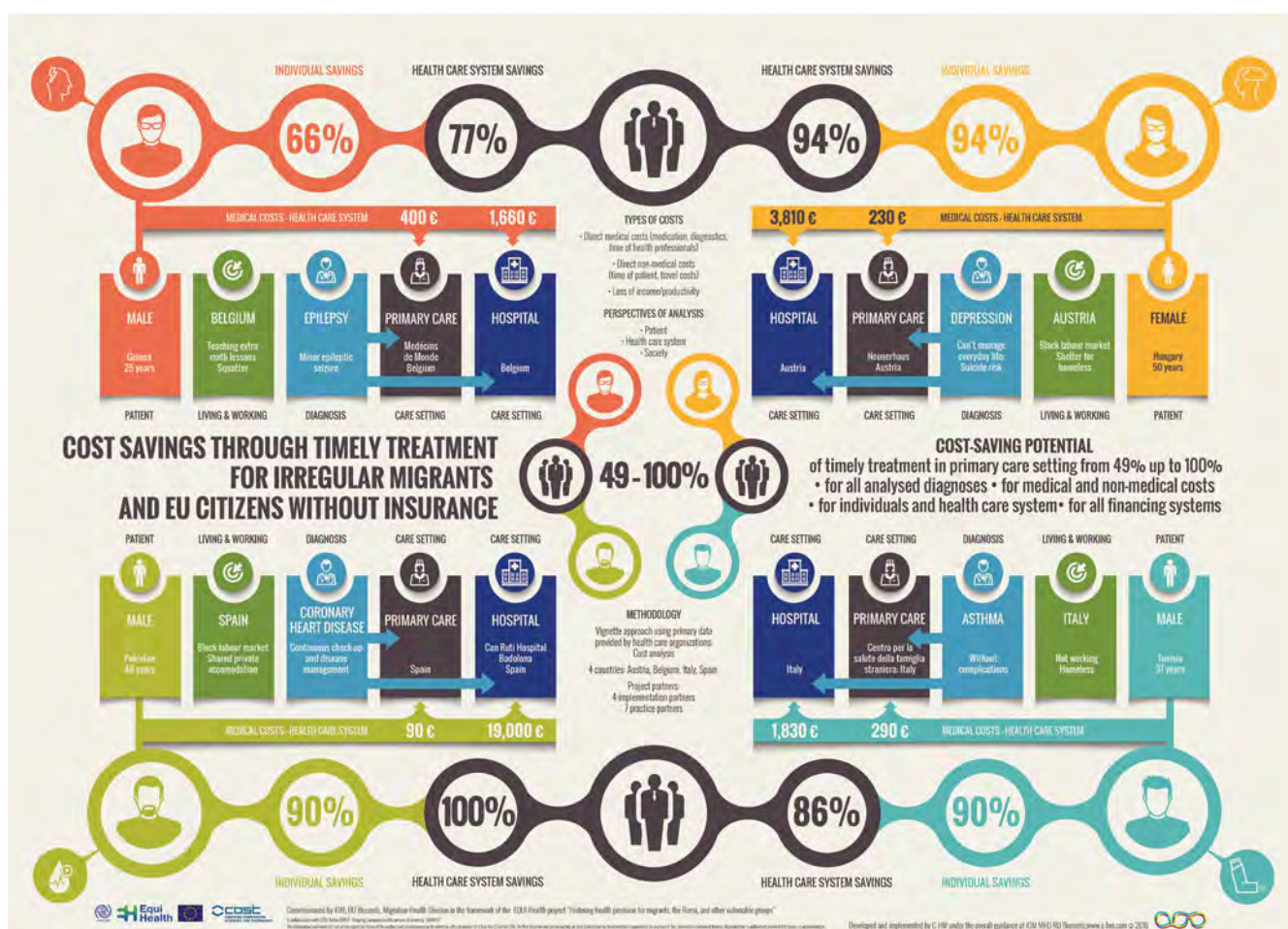
*Thematic study on cost analysis of non-provision of health care to irregular migrants and ethnic minorities including the Roma<sup>10</sup>*

IOM published in 2016 an infographic illustrating the additional costs to the health system that can be incurred when entitlement is limited to emergency care for migrants. Such restrictions place people beyond the reach of prevention programmes and obstruct their access to care in the early stages of illness, when treatment tends to be cheaper and more effective. The main argument for improving access to health care for marginalized groups has always been based on human rights and principles of equity. However, in recent years, more attention has been paid to the economic costs of limiting coverage for these groups. Irregular

migrants, those who cannot afford health insurance and those who may lack the necessary documentation (e.g. the Roma), are routinely excluded from all but emergency care in Europe and beyond. Such policies are often defended on economic grounds, but as the infographic illustrates, they may increase rather than decrease health-system costs.

The results presented in the infographic were taken from the thematic study titled “Cost Analysis of Health-care Provision for Migrants and Ethnic Minorities”, designed and carried out by the Center for Health and Migration in 2014–2015, in close cooperation with IOM as well as primary health-care and hospital service providers in Austria, Belgium, Italy and Spain.

**Figure 15.** Infographic on costs of exclusion from health care.



Source: <http://equi-health.eea.iom.int/images/Inforgraphicdescriptionfinal.pdf>

<sup>10</sup> <http://equi-health.eea.iom.int/images/TSummarypolicybrief.pdf>

### *“Towards an Effective Migrants’ Right to Health in Central Asia: Assisting Governments in Enhancing the Provision of Health Services for Migrants” in Kyrgyzstan, Kazakhstan and Turkmenistan*

The IOM mission offices in Kyrgyzstan, Kazakhstan and Turkmenistan launched the regional project “Towards an Effective Migrants’ Right to Health in Central Asia: Assisting Governments in Enhancing the Provision of Health Services for Migrants”, implemented by IOM and funded by the IOM Development Fund. The main objective was to strengthen migrants’ right to health by increasing the availability and accessibility of health services for migrants in Central Asia through the development of comprehensive and evidence-based migration health policies and legislation, in line with international norms and standards. This objective will be realized by conducting a comprehensive assessment of current legislative and policy frameworks related to migrants’ right to health, as well as conducting advocacy and capacity-building activities with key government officials from relevant ministries and agencies. The project will also study the migration behaviour of health professionals and students in Central Asia in order to understand the pull and push factors influencing the regional distribution of health professionals.

The project will culminate in a Central Asian regional workshop on migration health to be held in Almaty, Kazakhstan, in June 2017, where the assessment’s results will be presented and discussed by a range of government and non-governmental stakeholders. The workshop will represent a unique opportunity for participants to exchange information, experience and ideas on migration health issues in Central Asia. Participants will also be exposed to international experience and the most effective practices in that area. Policy-oriented recommendations aimed at the enhancement of frameworks allowing migrants to benefit from health care services will be formulated jointly by participating stakeholders; concrete paths for their implementation will be discussed.

## **National Projects**

### **Slovenia**

#### *Migrant and refugee emergency field response*

Between January and March 2016, 99,187 migrants and refugees entered Slovenia as part of the Eastern

Mediterranean migration route. IOM responded to the need for a permanent presence of medical staff in the reception centre for migrants and refugees in Dobova at the Slovenia–Croatia border. Following an agreement with the Ministry of Health of Slovenia, on 27 January 2016, a partnership agreement was signed with organizations WAHA International and Zavod Krog to implement joint medical assistance in the field. This partnership, which has pooled the available resources of all three organizations, has enabled partners to guarantee 24/7 medical assistance in the train station where migrants and refugees arrive from Croatia.

The IOM field team, which included a psychologist, two social workers and an interpreter of Arabic, provided emergency psychosocial support to migrants and refugees in both centres in Dobova and Šentilj (at the Slovenia–Austria border) during January–March 2016. The team also identified vulnerable groups for referral to other agencies working in the field, most notably medical assistance from IOM, WAHA and Zavod Krog, as well as specialized care within Slovenian hospitals. The IOM psychosocial team provided assistance in two safe spaces for mothers and children to address the needs of vulnerable persons at the train station and in Dobova accommodation centre. The safe places were separated into two sections – the first was dedicated to breastfeeding mothers and their children, and for the provision of primary care to infants by pediatric nurses. The other section enabled children to engage in play time in a safe, warm area. Both Dobova–Livarna and Dobova train station safe places engaged qualified medical staff including pediatric nurses and were operational 24/7.

In February 2016, the number of migrants and refugees arriving in Slovenia decreased to approximately 200–350 migrants per day due to the introduction of daily quotas of admitted migrants. This also decreased the number of medical interventions at the field medical unit in comparison to previous months. In February 2016, the IOM team treated 44 patients: 19 were female, and 25 were male. Fourteen patients were under the age of 10. The patients mostly had milder health difficulties or suffered from a deterioration of a chronic disease, none were in a life threatening situation. On average the psychosocial team targeted up to 70 beneficiaries with individual care daily.

#### *Training on cultural mediation*

IOM conducted two training sessions on intercultural competencies for public service providers, on 2 and 3 June 2016 in Maribor and 9 and 10 June 2016 in

Ljubljana. The aim of the training sessions was the development and strengthening of intercultural competences and skills among professionals who had been in regular contact with asylum seekers and beneficiaries of international protection, including health professionals. The practical sessions covered the fields of education, health and social care, which were identified as key areas that support the integration of refugees. In total, 65 participants attended the training courses.



The five-day training on cultural mediation took place in Ljubljana on 25–29 July 2016. The training programme was divided into two parts, with the first focusing on the role, aims and ethical considerations of the cultural mediator's profession. The second half of the sessions was dedicated to analysing the practical aspects of cultural mediation in health-care settings. A separate session was specifically devoted to assisting vulnerable groups and the particular concerns associated with providing care to unaccompanied migrant children, victims of trafficking and other persons in need of specialized assistance. Fourteen participants with diverse backgrounds and linguistic skills participated in the full training course and explored the role and importance of a cultural mediator in facilitating the communication and understanding between individuals, groups and/or communities, with a specific focus on health-care institutions. The training involved presentations, practical demonstrations, video materials, working groups and role plays.

## Azerbaijan

### *Training on border management and migrants' health*

On 10–12 February 2016, IOM Azerbaijan organized a training on border management and migrants'

health in the framework of the EU-funded project "Consolidation of Migration and Border Management Capacities in Azerbaijan". The project is co-funded by BP and its co-ventures. The intensive three-day programme was attended by 33 officials from the State Border Service, State Migration Service and State Customs Committee.

The training was based on IOM's global experience in developing border health and migration health programmes at points of entry and in cross-border settings. The training aimed to do the following: (a) outline the domestic and international legal frameworks pertaining to the health of migrants; (b) examine the core competencies of border officials in the prevention and control of public health events of international concern; and (c) increase the capacities of officials in responding to the psychosocial and mental health aspects of MMPs. The interactive training was tailored to address the specific needs identified within Azerbaijan, as well as in the cross-border regions. The participants also explored the need to strengthen technical capacities on the nexus of migration, health and border management.

### *Training of trainers on caring for trafficked persons*

The IOM mission office in Azerbaijan organized a training of trainers (ToT) for health-care professionals focused on building capacities in identifying, referring and caring for trafficked persons. Held on 22–24 November 2016, in Baku, Azerbaijan, the ToT was attended by up to 30 professionals from Women's Consultation Clinics, Republican Clinical Hospital, Children's Clinical Hospital, a psychological health centre, a victim assistance centre, and State and civil society shelters for trafficked persons. The ToT was organized in partnership with the Victims Assistance Service under the Ministry of Labour and Social Protection of Population of Azerbaijan. The participants in the training included different types and levels of health providers such as psychologists, gynaecologists, infectious disease specialists and pediatricians. The training was also attended by the representatives of civil society organizations that provide social, legal, psychological and shelter services to trafficked persons. The ToT was organized within the framework of the project "Enhancing Cooperation Measures to Effectively Combat Trafficking in Persons through Capacity-building and Technical Assistance in Azerbaijan: Phase VI", which is funded by the US Department of State Bureau of International Narcotics and Law Enforcement Affairs (INL). In the framework



of the previous phase of the project, two IOM publications, *Caring for Trafficked Persons: Guidance for Health Providers* and *Caring for Trafficked Persons: Guidance for Health Providers – Training Facilitator's Guide*, were translated from English into Azerbaijani, and printed. As a next step after the organization of ToT in Baku, cascade training sessions will be organized outside the capital cities in the regions to reach out and capacitate the health-care providers located in the provinces.



A ToT for health-care professionals on building capacities in identifying, referring and caring for trafficking persons was held on 22–24 November 2016, in Baku, Azerbaijan. © IOM 2016

## Georgia

### *Raising awareness of the dangers of drug abuse among at-risk vulnerable groups in Georgia*

Comprehensive dialogue with the Ministry of Education and Science (MoES) of Georgia was initiated by IOM, which was successfully concluded by the final clearance of the survey design aimed at measuring the impact of the psychoactive substances' primary prevention campaign. IOM was granted permission by the MoES to enter seven randomly selected secondary schools located in three target regions of Georgia. To ensure high visibility and sustainability of the project, its activities were mainstreamed within the 2017–2018 National Action Plan on Combatting Drug Abuse. A total of 26 officials were reached and engaged in 2016. A good cooperation rapport was established with local self-governing structures in all target regions of the project by hosting official project launch meetings in Tbilisi, Poti, Anaklia, Zugdidi and Mestia, which laid solid foundations for the successful implementation of the campaign throughout 2017.

IOM Georgia gave a presentation concerning the INL-funded information campaign project during the two-day regional workshop titled "A Platform for Sharing the Knowledge, Experience and Practices on

Migration, Health and Substance Abuse", which took place in Ashgabat, Turkmenistan, on 5–6 December 2016. The regional workshop was organized by IOM Turkmenistan with the support of the US Department of State's INL office in Turkmenistan. Representatives of law enforcement agencies and public international organizations in Turkmenistan who attended the regional workshop showed interest in IOM Georgia's experience in the area of primary prevention, and expressed their willingness to share their experience of the project once the campaign was piloted and respective IEC materials were produced and disseminated.

### *IOM and partners combat HIV/AIDS and tuberculosis among migrants in South Caucasus*

IOM Georgia has launched a regional two-year project "Enhancing Mechanisms for Prevention, Detection and Treatment of HIV/AIDS and Tuberculosis (TB) among Migrant and Mobile Populations in the South Caucasus Countries". It will be implemented in close collaboration with the IOM mission offices in Armenia and Azerbaijan, and with national authorities and partners in the three South Caucasus countries. The launch took place during the World AIDS Day national conference in Tbilisi, Georgia, which was hosted by IOM Georgia, in cooperation with the Ministry of Labour, Health and Social Affairs and the National Center for Disease Control and Public Health (NCDC).



A World AIDS Day national conference was held on 1 December 2016, in Tbilisi, Georgia. © IOM/Nino Shushania 2016

IOM and national actors in the region have recognized that while migration itself does not cause disease, mobile populations are at greater risk of HIV infection throughout the entire migration process. The lack of access to health-care facilities and prevention measures has posed risks for both migrants and local communities. In fact, health inequities, inadequate social protection, human rights violations, stigmatization and discriminatory policies have

increased the vulnerability to HIV infection for all. In Armenia, Azerbaijan and Georgia, IOM will cooperate with government institutions in charge of HIV/AIDS and TB surveillance to ensure the capacity-building of relevant national authorities and facilitate the progress of cross-border referral mechanisms, as well as the elaboration of migrant-sensitive and inclusive health-care policies. A regional health promotion campaign targeting MMPs to raise awareness of HIV/AIDS and TB, focusing on preventive screening and treatment adherence, will also be conducted.



IOM officials raise their hands up for HIV to join the World Aids Day 2016 campaign in Georgia. © IOM 2016

### ***IOM, partners, address non-communicable diseases prevention and control in Georgia***

IOM Georgia, in coordination with the Non-communicable Diseases Department of the NCDC as well as with WHO, organized a meeting to present the migrant-inclusive Country Strategy on Non-communicable Diseases (NCDs) and its corresponding Action Plan for 2016–2020, on 17 November 2016, in Tbilisi, Georgia. The Action Plan of the Strategy will be shared with other countries in the region to serve as a model. It addresses the entire population of Georgia, including the over 300,000 IDPs. The number of migrants in Georgia has been increasing due to globalization, and they are the most vulnerable and susceptible to NCDs. Therefore, they should have the same level of access to health-care and preventive measures that the NCDC provides in collaboration with IOM, to ensure their overall health contributes to the development and socioeconomic progress of the country.

### ***Migration and tuberculosis: Cross-border tuberculosis control and care in the Central Asian region (Astana, Kazakhstan, 7–8 December 2016)***

The second high-level meeting on TB control among migrants took place on 7–8 December 2016, in Astana,

Kazakhstan. The meeting was organized by global health education and humanitarian assistance organization Project HOPE, with the participation of the Ministry of Health and Social Development of Kazakhstan, IOM, WHO, the GFATM and USAID. There has been a consistent trend towards reducing morbidity, prevalence, mortality and disability from TB in Kazakhstan. One of the challenges to the implementation of the anti-TB campaign was the country's limited access to quality TB care for external migrants.

Representatives of international organizations such as STOP TB Partnership, WHO, Project HOPE, IOM, representatives of foreign ministries and other foreign government agencies, NGOs, chiefs of clinics and TB dispensaries gathered to discuss the progress of TB control among migrants and to develop an action plan/road map for the next 12-month period. Special attention has been given to points such as migration and TB in the global context, collaboration between IOM and Project HOPE in the framework of the project “Addressing Cross-border TB, M/XDR-TB and TB/HIV among Labour Migrants in the Republic of Kazakhstan”, and the non-use of international recommendations in the activities connected with migration and health undertaken by the State bodies of Kazakhstan. The meeting provided an important opportunity to discuss the activities carried out to help control TB among migrants, take stock of the progress achieved and plan the next steps through the action plan/road map.



A high-level meeting on migration and tuberculosis, organized by Project HOPE, the Ministry of Health and Social Development, and the National Center for Tuberculosis Problems, was held on 7–8 December 2016, in Astana, Kazakhstan. © IOM 2016

### ***Tajik–Afghan integration, resilience and reform-building project***

In 2016, IOM built the capacity of the local NGOs in Gorno-Badakhshan Autonomous Oblast by providing three training sessions that reached the staff of seven local NGOs, namely: Kuhi Pomir, Epidemiolog, Rushdi Ishkoshim, Amina, Rahnamoi Muhojir, Nuri Shavkat and Nurovar. Trained NGO staff

improved their knowledge of and skills in community mobilization for TB prevention, finding people with presumptive TB symptoms, referral for TB diagnostic, and developing cooperation and partnership with relevant health facilities and domestic migration service providers. NGO partners conducted an informational campaign and active-TB detection among migrants and their families in the cross-border communities with Afghanistan. Two NGOs – Nuri Shafkat in Vanj and Rahnamoi Muhojir in Shughnan/Khorog – also reached Afghans living and working in Khorog and at cross-border markets. Training and monitoring of the TB-related activities implemented by NGOs were conducted jointly with health and migration authorities. A technical working group was established from the specialists of the Tajik Ministry of Health and Social Protection; the Tajik Ministry of Labour, Migration and Employment; and the Afghan Ministry of Public Health for the development new informational and educational materials.

Since September 2014, IOM has been part of the five-year (1 September 2014–30 September 2019) USAID TB Control Program in Tajikistan in which Project HOPE (People-to-People Health Foundation, Inc., USA) is the lead implementing agency in two Central Asian republics: Tajikistan and Uzbekistan. Both countries have high TB, drug-resistant TB and/or TB-HIV burdens. During year two (September 2015–2016), IOM enhanced the capacity of the multisectoral team, which consisted of health specialists, representatives of migration service providers and community leaders. Through multisectoral cooperation, 92 per cent of the beneficiaries who were referred for a TB test completed one. Fifty-six TB cases were detected, including 36 among migrants, as a direct result of the IOM efforts within USAID TB Control Program. The results exceeded the targeted 24 TB cases for year 2. Extended outreach work through a well-developed volunteer network, free access to X-ray diagnostic during public events, and social support to TB patients by providing food and livelihood support significantly improved migrants' access to TB services. Advanced training sessions on community mobilization for TB prevention among migrants and psychosocial support for TB patients were conducted for the 40 outreach workers and volunteers. Three new modules on developing skills for psychosocial support for TB patients, community mobilization and peer education among migrants were provided to the migration health department of the Republic Healthy Lifestyle Promotion Centre to be used during relevant training sessions.

## Turkmenistan

Within the framework of the project “Phase 2: Contribute and Extend the Drug Reduction Efforts among Internal and International Migrants in Turkmenistan”, three training sessions with the theme “Migrants’ Right to Health: Comprehensive Approach to Protection of Migrants’ Health including Prevention of Substance Abuse among Migrants” were successfully conducted in the velayats (provinces) of the country. These training sessions strengthened the knowledge and understanding of the representatives of relevant law enforcement agencies and public organizations of Turkmenistan’s Lebap, Mary, Ahal, Balkan and Dashoguz velayats about migrants’ right to health and protection of migrants’ health, including prevention of substance abuse. Overall, 18,000 copies of leaflets as information materials in Turkmen, Russian and English were disseminated among the target population, particularly among mobile groups and migrants, by public organizations and NGOs. The information campaign aimed to increase awareness of the harmful effects of drug use and the existing treatment and referral system that internal and international migrants can access in Turkmenistan. A two-day regional workshop on migrants’ right to health was organized on 5–6 December 2016, in Ashgabat, Turkmenistan, for health workers, representatives of relevant law enforcement agencies and public organizations in Turkmenistan. This regional workshop was the most significant regional capacity-building activity within the project. It facilitated the discussion on preventing substance abuse among youth and mobile groups of the population, including migrants and refugees.



An information campaign on the harmful effects of drugs and substance use among migrant youth in Lebap region was launched in October 2016. © IOM 2016



## MIDDLE EAST AND NORTH AFRICA

### Regional Programmes

#### *Promoting health and well-being among migrants in Egypt, Libya, Morocco, Tunisia and Yemen*

A significant number of people migrate through Egypt, Libya, Morocco, Tunisia, and other countries in the region such as Yemen, towards neighbouring countries or EU Member States. Although at the outset most migrants regard these countries as transit countries, in a considerable number of cases they become de facto destination countries. This is because many migrants are unable to pursue further travel due to lack of resources. Due to poor living conditions, compounded by limited access to preventive health care, they can be faced with serious health problems. In light of this, IOM has been implementing this regional project in order to support the respective host governments in migration management. Special focus is placed on promoting health and well-being among migrants transiting through Egypt, Libya, Morocco, Tunisia and Yemen.

#### Egypt

In 2016, 341 migrants received medical assistance through IOM doctors, and a total of 400 families received humanitarian assistance through the distribution of non-food item (NFI) kits, covering personal and housing hygiene items for families in need. A total of 700 individual NFI kits were distributed among detainees in the North Coast region of Egypt. In addition, more than 700 migrants were informed about diabetes and were encouraged to participate in a free blood glucose screening offered by the Arabic Association for the Study of Diabetes and Metabolism through an event to commemorate the World Health Day. Additionally, 21 peer educators were trained on migrant health issues, who disseminated this information to the broader migrant community while referring migrants to relevant public health services. In celebration of the International Migrants Day, medical screenings and growth percentile checks were conducted for 250 migrant youth. During this event, children also received necessary vitamins and nutritional supplements. To cater for the high number of attendees, pediatricians ran three separate clinics during the event.

#### Libya

In Libya, IOM was able to conduct rapid needs assessments inside the detention centres and provide assistance based on assessment outcomes. IOM Libya has been providing medical and humanitarian assistance to migrants, especially in detention centres across the country. On a daily basis, IOM has been distributing NFIs including hygiene kits, mattresses, pillows, blankets and clothing. In 2016, humanitarian assistance was provided to 1,309 migrants in detention centres and within host communities. Medical staff from IOM Libya's partner organization conducted 256 medical sessions for migrants in nine targeted detention centres through the project's medical assistance fund. A total of 4,399 migrants received medical services during these visits in 2016. Through the humanitarian assistance fund, IOM also has also provided assistance to migrants through repatriation and reintegration. So far, three migrants have been provided repatriation assistance with a medical escort, returning to Uganda, Bangladesh and the Gambia.

#### Morocco

A three-day training for peer educators was carried out in Rabat on 26–28 April 2016. Twenty-six peer educators were trained on various topics relating to migration and health. These topics included the international and national legal frameworks for migration and health, the interaction of migrants with the national health system and how to resolve difficulties in this regard, the identification of vulnerable groups, the provision of psychosocial support by peer educators, the promotion of preventive measures in community health and encouragement of practical life skills for CHWs.

The participants were selected from various community organizations in Rabat, Oujda and Tangier that work on migration issues. The Ministry of Health of Morocco and representatives from the national disease control programmes were also in attendance. The training was highly interactive and provided a space for sharing experiences, exchanging good practices and lessons, asking for advice and receiving support. It also enabled the creation of a network among peer educators. Following the training, two meetings with peer educators were held in the cities of Rabat and Oujda. The objective of these meetings was to establish a working relationship with peer educators, to present the tools for monitoring and data collection and to agree on plans for activities

to raise awareness. They were also asked to identify and collect information about the focal points in their various health facilities to establish a referral network and support for migrants in partnership with the Ministry of Health.

## Tunisia

IOM provided 138 migrants with health services assistance. Seventy-five benefited from medical assistance, both directly (medical consultations, diagnosis, therapeutic management, etc.) and indirectly (public health services). Additionally, 11 people benefited from psychological assistance under this project in Tunisia. Humanitarian assistance was provided to 82 migrants through food and hygiene kit distribution or accommodation through civil society partners and organizations. Furthermore, seven migrants received voluntary return assistance; two were assisted by an IOM escort.

A training workshop on health and migration was held in June for a group of young peer educators. Twenty peer educators from civil society and from organizations working with migrants were present. Their role was to educate migrants on their right to health and on prevention of health problems related to the conditions of migration. They also organized awareness activities on health and migration and referred migrants to adequate public health services.

A global partnership agreement was signed between IOM Tunisia and CARITAS on 19 June 2016, and another global agreement with Amal, a Tunisian association that supports unmarried mothers, was signed on 25 November 2016, as part of an effort to improve migrants' access to health care and to strengthen partnerships with organizations and civil society for more effective medical and humanitarian assistance. Other agreements are underway with other local organizations working with migrants and vulnerable people (e.g. Beity and Human Rights Observatory) and with Ministry of Health institutions.

## Yemen

A key activity for Yemen in 2016 was the launch of a patrolling mobile health clinic (MHC) in Shabwah (located in the south of Yemen), a governorate that has recently emerged as a new main entry point for migrants. As an urgent response to the recent increase in the number of newly arriving migrants in that area, on 18 July 2016, IOM launched an MHC consisting of one physician, one nurse, one translator

and one protection staff to do daily patrols along the coastal areas. The MHC aimed to reach newly arriving migrants in situations of vulnerability and provide them with essential and life-saving health and other humanitarian assistance.

The medical assistance included referral services for those recognized by the IOM health team as severe medical cases. Those cases were referred to the nearest available government hospital for urgent secondary and tertiary health services. In addition to the medical evaluation, treatment and medical referral services provided by the IOM health team, 1,551 food items were distributed to migrants assisted during the daily patrolling of the mobile team. A three-day training for 30 health practitioners was conducted in Sana'a on 8–10 August 2016. The participants were selected from the main public hospitals, health centres, health programmes and relevant NGOs. The training covered various topics relating to trafficking and health, including the concept of trafficking in persons and its various expressions, the health consequences of human trafficking, the rights and obligations of migrants, the role of health providers and cooperation, and possibilities to increase the protection of vulnerable migrants.

## *Enhancing tuberculosis prevention, diagnosis and treatment among Syrian refugees in Lebanon and Jordan*

IOM's programme for TB screening and treatment among Syrian refugees in Jordan and Lebanon, supported in 2015–2016 through a GFATM grant, provided critical services to the Syrian refugee population who otherwise had no clear mechanism for access to TB treatment.

In 2016, 12.6 per cent (58/460) of TB cases in Jordan and 21.7 per cent (146/672) of TB cases in Lebanon were among Syrian refugees. In 2015, treatment completion rates were 94.8 per cent (55/58) in Jordan and 87.1 per cent (122/140) in Lebanon. In Jordan, in 2016, half (29/58) of all cases resided in camps, though only about 22 per cent of Syrian refugees were living in camps during that time. Based on the WHO 2015 data on Syrian TB incidence estimate of 20/100,000 and refugee population estimates of 682,816 (Jordan) and 1,174,830 (Lebanon), case detection rates among Syrian refugees in 2015 were 46.1 per cent and 59.6 per cent, respectively.

IOM supported improvements in the NTP TB systems as well. This support was reflected in extensive salary

support for NTP employees, especially in Lebanon, and training of TB laboratory technicians, as well as in material support for upgrades to provincial and national laboratories, X-ray machines, laboratory diagnostics, and computerized and standardized data management. Support also included the provision of additional staff including doctors, nurses, laboratory technicians, radiology technicians, DOT workers and data management workers. Such improvements, while benefiting refugees, also benefit the entire national TB system.

## Jordan

### *Training non-governmental organizations/ community-based organizations*

The IOM medical team worked with seven NGOs/CBOs that implemented TB awareness activities and work in and outside of the refugee camps. IOM trained 74 health workers on TB activities within these organizations. Three TB awareness sessions targeting refugees were jointly conducted by partner

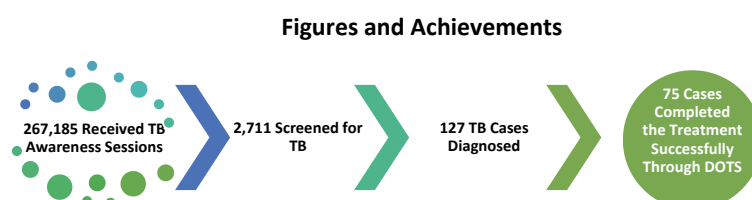


A workshop for health providers of primary health centres in Zarqa was held in October 2016. © IOM 2016

organizations and IOM, and all sessions were held outside of refugee camps in different governorates. During the awareness activities, the IOM medical team distributed TB leaflets and used posters and a PowerPoint presentation to share basic information about TB (e.g. what TB is, how it transmits, how it can be treated, where to go for treatment and contact information on relevant services).

Highlights from Jordan in 2016 are illustrated in the below summary (see Figure 16).

**Figure 16.** Enhancing tuberculosis prevention, diagnosis and treatment among Syrian refugees and migrants in Jordan: figures and achievements, 2016.



INDICATOR	TOTAL	FEMALES	MALES
Number of Syrian refugees and migrants attending awareness sessions	267,185	161,133 (56%)	125,045 (44%)
TB Screening Number of Syrian refugees and migrants screened for TB	2,711	1,310 (48%)	1,401 (52%)
Number of notified incident TB cases among Syrian refugees and migrants	127	59 (46%)	68 (54%)
Proportion of incident TB cases among Syrian refugees and migrants on DOT	120/127 94%	-----	-----



## Community Health Workers

Sixteen CHWs were assigned to facilitate TB awareness sessions, active case finding and treatment follow-up in different governorates. They were also tasked with liaising, engaging and making follow-ups with the partner health organizations on a regular basis to make sure they integrated TB awareness and screening within their routine activities. This scaled up referrals of presumptive TB cases to the nearest Ministry of Health/NTP Chest Disease Centre or IOM medical team. To ensure maximum effectiveness, the majority of the CHWs (10) were selected from the Syrian refugee community. Most of them had a medical or paramedical background. A total of 115,169 (58% female and 42% male) Syrian refugees were reached and sensitized on TB. Of those, 75,031 (65%) were located outside of refugee camps, and 40,138 (35%) were inside of camps.



A TB awareness campaign in hard-to-reach areas in Um Alqoteen, Mafrq, was launched in November 2016. © IOM 2016

## Mobile X-ray screening in refugee camps, hard-to-reach areas and industrial cities

During the project period, the Ministry of Health/NTP mobile digital radiology unit, with the support of the IOM medical team, went to refugee camps, hard-to-reach communities and industrial cities with a portable X-ray van to conduct chest X-ray screenings. Presumptive TB cases gathered in a pre-announced, designated public place, camp or industrial city. They were selectively identified by symptom screenings performed by the IOM medical team and through the medical register of health facilities and factory clinics in the industrial cities. Some were also referred by the NGO partners, camp health facilities, local CHWs, or local Ministry of Health and private health facilities.

The individuals with abnormal chest X-ray findings suggestive of TB were further assessed with sputum bacteriological investigations (e.g. smear, gene Xpert, culture and drug susceptibility testing (DST)). Each mobile team consisted of one radiology technician, one driver from the NTP, one IOM doctor or nurse, and one CHW.



Of the 10 X-ray screening sessions, five sessions were conducted inside the camps (Za'atri and Azraq camps) and five sessions were conducted outside the camps in the hard-to-reach areas in Amman, Irbid and Ramtha, and industrial areas in Irbid. Altogether, 349 refugees and migrants had X-ray screening sessions, on average 35 X-ray screenings per session, and 15 per cent (52) of screened refugees had an abnormal X-ray reading (infiltration, cavities, etc.). To intensify active TB case findings, several X-ray screening sessions were conducted during the grant period in hard-to-reach areas including border areas and informal tented settlements (e.g. Jordan valley) for the Bedouin and other mobile populations, temporary harvesters, and communities with high numbers of refugees and migrants.



## Enhancing tuberculosis prevention, diagnosis and treatment for Syrian refugees and other vulnerable populations affected by the Syrian crisis in Lebanon

The overall goal of this project was to contribute to the reduction in susceptible and resistant TB transmission, morbidity, and mortality among Syrian refugees residing in Lebanon through targeted mechanisms for screening, preventing disruptions, and sustaining the delivery of TB treatment and associated services until TB no longer poses a threat to public health (see Figures 10 and 11). IOM has been increasing the NTP's

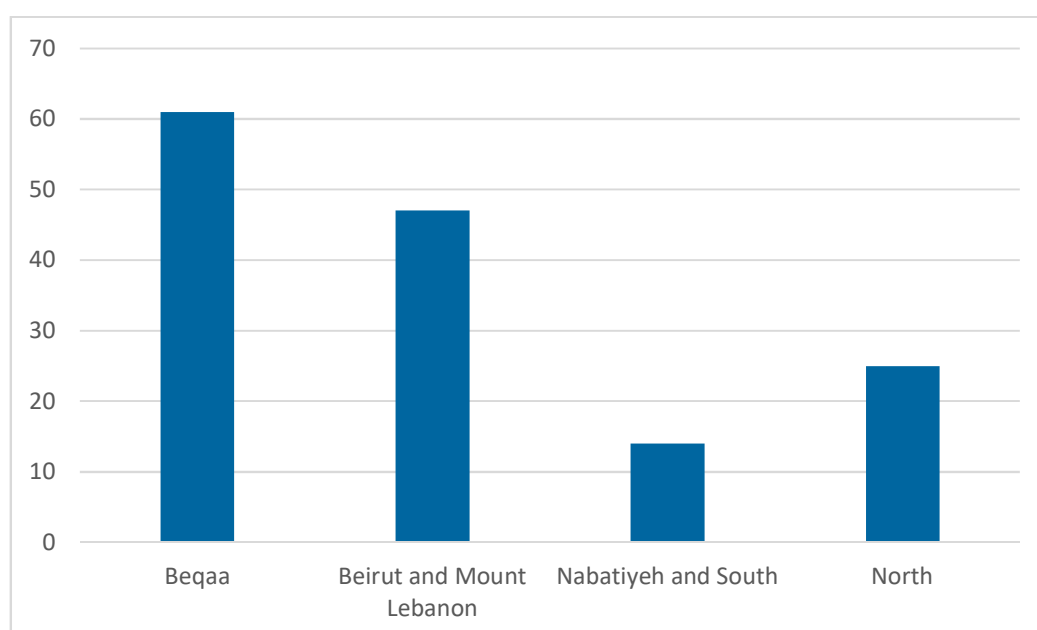
existing capacities through the provision of essential diagnostic equipment (e.g. Xpert, kits and microscopes) and advanced diagnostics, TB drugs (first- and second-line drugs) and additional staff (e.g. doctors, nurses, laboratory technicians, radiology technicians, DOT workers, and staff handling data management, monitoring and evaluation). IOM has also been working to raise awareness about TB and promote active case findings in informal refugee settlements and hard-to-reach areas through CHWs. Primary health-care providers have been trained in several refugee hosting areas to define modalities for referral of presumptive

TB cases for TB screening, and three X-ray machines have been installed in three different TB centres. IOM has facilitated referrals and diagnostic tests and has conducted diagnostic investigations including chest X-ray, direct sputum smears and cultures, GeneXpert and DST. All confirmed TB cases were started on TB treatment which followed the DOT strategy for all smear positive cases not admitted or after discharge from the sanatorium. Additionally, transportation and financial support with subsidized amounts were provided to the most vulnerable Syrian TB patients.

**Figure 17.** Enhancing tuberculosis prevention, diagnosis and treatment among Syrian refugees and migrants in Lebanon: figures and achievements, 2016.

INDICATOR	TOTAL	FEMALES	MALES
Number of Syrian refugees and migrants attending awareness sessions	56,915	29,966 (52.65%)	26,949 (47.34%)
TB screening: number of Syrian refugees and migrants screened for TB	124,647	63,783 (51.17%)	60,864 (48.83%)
Number of notified incident TB cases among Syrian refugees and migrants through screenings	20	10 (50%)	10 (50%)
Proportion of incident TB cases among Syrian refugees and migrants on DOT	14/20 (70%)	–	–

**Figure 18.** Geographic distribution of 147 notified TB cases among Syrian refugees identified across Lebanon who received treatment, 2016.







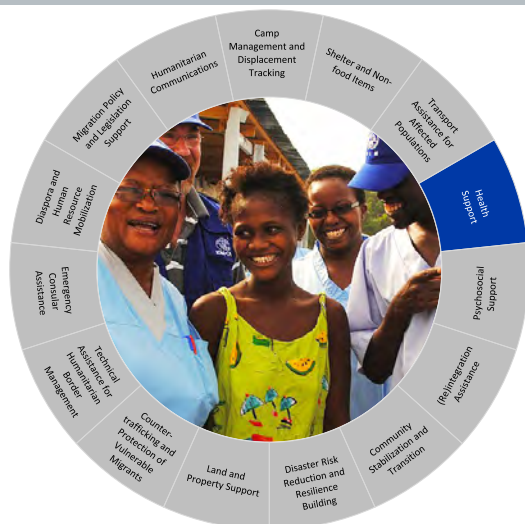


## MIGRATION HEALTH ASSISTANCE FOR CRISIS-AFFECTED POPULATIONS

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

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

**Figure 19.** Health support within IOM's Migration Crisis Operational Framework. © IOM



### CENTRAL AND NORTH AMERICA AND THE CARIBBEAN

#### Cholera in Haiti



**8,574**

Direct Beneficiaries

**7,000** Suspected cholera cases managed  
**1,574** IDP Patients in Medical Treatment



**500,000**

People sensitized about cholera



**50**

Cholera Facilities supported



**241**

Responses to cholera alerts



**697**

Medical professionals trained

Haiti has long struggled with the country's weak health system, which was further debilitated by the 2010 earthquake and subsequent cholera outbreaks. Cholera, an acute diarrheal infection, still poses a serious threat in Haiti, where only 28 per cent of the population has access to improved sanitation, while 35 per cent continues to practice open defecation in rural areas.<sup>11</sup> Hurricane Matthew in 2016 further affected the vulnerable population, and Haiti saw an increase of 50 per cent in reported cholera cases in the most affected areas.<sup>12</sup>

In the face of this challenge, IOM supported Haiti's Ministry of Health through the IOM Cholera

<sup>11</sup> WHO and UNICEF, Progress on Sanitation and Drinking Water: 2015 Update and MDG Assessment (Geneva, WHO, 2015).

<sup>12</sup> WHO, "Haiti hurricane Matthew 2016" (2016). Available from [www.who.int/emergencies/haiti/en/](http://www.who.int/emergencies/haiti/en/)

Programme to reinforce monitoring, first-line treatment and referral systems. In particular, IOM managed 7,000 cholera suspected cases and 1,574 IDP patients in medical treatment, totalizing 8,574 direct beneficiaries in 2016. IOM deployed 10 mobile teams for rapid response operation, following 241 cholera alerts to support cholera response in five departments. IOM also supported 50 cholera structures with medical and non-medical items and trained 697 medical professionals. Furthermore, IOM sensitized 500,000 people through mass and door-to-door educational activities.

IOM has worked closely with the Ministry of Health and local communities, including voluntary committee leaders, in responding to and preventing cholera outbreaks. Rapid response operation combined with community outreach activities remained an effective approach in controlling the outbreaks in highly vulnerable areas.

## MIDDLE EAST AND NORTH AFRICA

### Syrian Arab Republic



**51,105**

IDPs and Host Community Members Assisted in the Syrian Arab Republic

**43,794**

Primary Health Consultations for Refugees and vulnerable migrants in Turkey

**36,398**

Primary Health Care Beneficiaries in Lebanon



**22,761**

Syrian Refugees Assisted through Routine Immunization Activities in Jordan



**12,593**

Syrians and host community members received mental health and psychosocial services in Lebanon



**98,582**

Displaced Syrians, Lebanese Returnees and vulnerable Lebanese attended health education and awareness sessions in Lebanon

The state of the Syrian Arab Republic remains extremely challenging in the sixth year of the conflict. Almost half of the population of the Syrian Arab Republic faced forced displacement, including 4.7 million into neighbouring countries and 6.23 million internally.<sup>13</sup> As the conflict continues, displacement has become increasingly dynamic as widespread violence, a deteriorating economy and foreign incursion have forced Syrians to flee multiple times. IOM has responded to this crisis from within the Syrian Arab Republic, as well as from within neighbouring countries.

In the Syrian Arab Republic, a total of 51,105 IDPs and host community members received IOM's health assistance. IOM supported people with disabilities through the distribution of wheelchairs, crutches and hearing aids, and by supporting the manufacturing of artificial limbs. IOM also provided glucometers with strips and kidney dialysis kits. Additional medical equipment was donated to primary health-care centres (PHCs) using the Inter-Agency UN convoys modality.

Additionally, IOM provided support to health services and health infrastructure. IOM assisted nine remaining dentists in Aleppo City through the provision of a mobile dental clinic and critical dental supplies covering five months of dental treatment for about 5,000 patients.

In Turkey, IOM provided primary health consultations to about 43,800 refugees and vulnerable migrants at a primary health clinic in Istanbul in partnership with the Doctors Worldwide Turkey. IOM also supported over 12,000 Syrian refugees' access to health through the transportation service provided between Adiyaman camp and hospitals.

In Jordan, IOM strengthened routine immunization activities for 22,761 Syrian refugees by reaching every community in high-risk areas and Za'atari camp in Jordan. IOM Jordan also contributed to the control of highly contagious diseases transmission (e.g. measles and polio) among 34,171 Syrian refugees inside the camps. IOM provided emergency vaccinations against polio and measles to children under 15 and awareness-raising for families in Rabaa al-Sarhan, routine vaccinations inside Za'atari camp in accordance with the national routine immunization schedule in Jordan.

<sup>13</sup> United Nations Office for the Coordination of Humanitarian Affairs, Humanitarian Needs Overview; Damascus, Syria (2017).

In Lebanon, IOM provided health education and awareness sessions to 98,582 displaced Syrians, Lebanese returnees and vulnerable Lebanese. IOM Lebanon also provided essential primary health-care services, including maternal health and NCD services through PHCs to 36,398 beneficiaries. IOM also provided psychosocial support to 12,593 Syrian refugees and members of host communities in Bekaa and south of Lebanon.



A pediatrician examines a Syrian boy at a primary health clinic in Fatih, Istanbul, with support from IOM. © IOM Turkey 2016

In Egypt, IOM assisted in the renovation and expansion of a medical centre in Cairo, which provides free and low-cost medical services for Syrians and host communities, to serve more than 3,000 a year.

Additionally, medicines have been provided to support local NGOs' initiative of conducting medical convoys to serve both Syrians and host communities. IOM also directly provided medical support through its health unit.

## Iraq



**292,246**  
Clinical consultations



**5,853**  
Children screened for visual acuity



**46,545**  
Individuals assisted through risk communication and health promotion

In addition to the 3.3 million Iraqis who have been already displaced across the country since 2014, the health needs of both IDPs and host communities have been exacerbated due to the recent displacement of about 100,000 individuals fleeing from the military operations to retake ISIL-occupied areas in the Mosul corridor.

After fleeing their homes, many displaced Iraqis have undertaken demanding journeys, walking for hours or days, with varying degrees of immediate medical needs after having lived in ISIL-occupied areas where there is limited access to health services.



IOM has provided eye-care health activities for vulnerable communities in northern Iraq. A total of 5,853 children (3,391 boys and 2,462 girls) were screened for visual acuity. Thanks to cooperation from a Japanese company Fuji Megane, 1,053 children received spectacles to correct their vision. © IOM 2016

IOM medical teams provided primary health consultations in Dibaga camps and Gwer camp, Erbil; Al-Qayara Airstrip emergency site, Ninewa; Dibis and Mama checkpoints, Kirkuk; and at Shaqlawa complex, Al-Alam camp, Dream City, Silo and Hajaj camps, Salah al-Din. IOM also provided health screenings to IDPs at Mama checkpoint, Kirkuk. Countrywide, IOM's health teams have provided about 30,000 medical consultations per month. The most common health



problems encountered include upper respiratory infections, urinary tract infections, diarrhoea, skin diseases, hypertension and diabetes. The patients needing specialized care were transferred to hospitals, many by ambulance.

IOM Iraq plays a vital role in providing emergency health services. It has operated 24 emergency health medical units in Iraq. In 2016, IOM Iraq has provided a total of 292,246 clinical consultations among IDPs and host communities, and over a half of them (55%) were women (117,073) and girls (43,976). IOM teams have worked in hard-to-reach areas, including Rutbah near Jordan and Kilo 18 camp in Anbar.

## Libya



**4,791**

Individuals received direct medical assistance

**2,181**

Feminine hygiene kits distributed



**3**

Fully equipped medical clinics established at disembarkation points

In 2016, IOM continued to support medical staff visits and provide services in detention centres in Libya. By the end of the year, a total of 4,791 direct medical consultations were provided (of which 3,852 were to males) in such centres. Additionally, IOM distributed 2,181 feminine hygiene kits to targeted girls and women, as well as provided information and education about feminine hygiene and reproductive health.

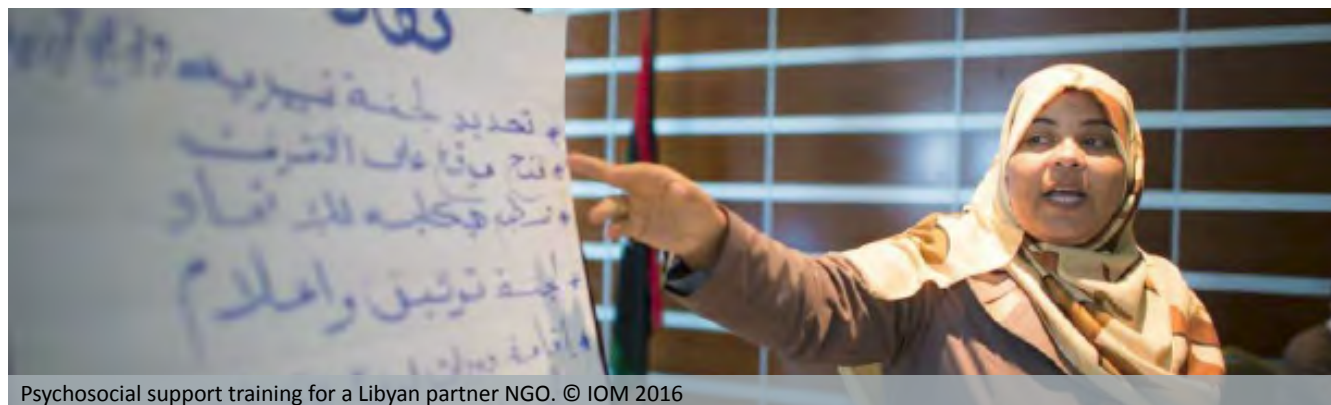
Through the project “Direct Assistance to Migrants Rescued at Sea and Tracking Displaced Populations



Hygiene kits distribution at Misrata detention centre in Libya. © IOM 2016

Inside Libya” funded by the United Kingdom Department for International Development, IOM was able to improve medical clinics in four detention centres in Libya (Shahat, Misrata, Al Zawya Abu Essa and Abu Salim), and establish three fully equipped medical clinics at disembarkation points for migrants rescued at sea in Tripoli, Garaboli and Zlitan. During this project, IOM also delivered hygiene kits and NFIs to 4,000 migrants in 12 detention centres and 5 surrounding communities.

In May 2016, due to poor hygienic conditions and an outbreak of scabies among detainees, IOM launched disinfection and fumigation operations in detention centres in Abu Salim (with 400 detained migrants) and Al-Qweaa (with 350 detained migrants) in May 2016. This action resulted in the immediate improvement in living and health conditions for the detainees in the centres. During these interventions, IOM, through the Detention Task Force co-led with UNHCR, coordinated the efforts of other UN agencies and several local and international NGOs. IOM also sponsored a training session on conducting health-care screenings at disembarkation sites, on 19–21 July 2016, in Tunis. Attendees included 29 representatives from Libya’s Directorate for Combatting Illegal Migration, Libyan Coast Guard, health officials and other government representatives. The training was provided by IOM, WHO, Libya’s Ministry of Health, and the NGO International Medical Corps.



Psychosocial support training for a Libyan partner NGO. © IOM 2016

## Sudan


**52,232**

Primary health care consultations to IDPs and host community members


**15,735**

Immunization Beneficiaries


**220**

Health workers trained

40 Doctors and medical assistants

40 Midwives

140 Community health care workers


**12,696**

Individuals assisted through clinical management of acute malnutrition


**4**

Mobile clinics


**3,759**

Households reached through risk communication and health promotion activities

Health systems in Sudan remain overstretched and struggle to meet the needs of vulnerable groups including IDPs. In line with the 2016 Humanitarian Response Plan for Sudan, IOM provided a total of 52,232 primary health-care consultations to IDPs and host community members (26,901 females and 25,331 males), as part of the minimum basic health package that includes management of communicable and non-communicable diseases, basic maternal and child care, and health promotion on various health topics. These consultations were provided through IOM managed clinics (fixed and mobile), located in El Sereif IDP camp, South Darfur; in Allait, Al Sayah, Gallab and Abbassi IDP camps, North Darfur; in Alfirmous, East Darfur; and in Muli, West Darfur. In addition, IOM provided training courses for 40 midwives and 40 doctor/medical assistants on updated treatment protocols about infectious diseases with special attention to STIs and management of HIV/AIDS. Furthermore, 140 CHWs were trained in general health; covering topics

including the importance of safe drinking water, good practices in personal hygiene and food handling, awareness of water-borne diseases, correct water storage practices and the importance of immunization as a prevention against infectious diseases. Additionally, IOM Sudan provided vaccinations to a total of 15,735 people in 2016, including 10,745 children, who were vaccinated through routine expanded programmes on immunization and against polio.

As part of the emergency response to the outbreak of severe malaria, 20 CHWs were trained on prevention and treatment protocols and integrated vector management (IVM) activities such as house-to-house fog spraying, vector surveillance, vector source reduction and mechanical larvae control, reaching 3,759 households in El Sereif, South Darfur. IOM also mobilized 8,596 IDPs and members of the surrounding community to participate in these vector and source reduction activities.

Finally, IOM established an outpatient nutrition centre in Umbaru, North Darfur, which has assisted 1,657 IDPs and host community members with 1,016 children under 5 years of age screened for malnutrition. IOM delivered a number of training and awareness programmes on health and nutrition. Sixty CHWs were trained on specific nutrition-related topics, 330 caregivers undertook promotion activities on infant and young child feeding, while three peer learning groups have been formed and six sessions have taken place.



IOM health staff outside of an IOM managed clinic in Sudan.  
© IOM 2016

## Yemen



**4,791**

Individuals received direct medical assistance

**2,181**

Feminine hygiene kits distributed



**3**

Fully equipped medical clinics established at disembarkation points

Nearly two years since the conflict escalated, the humanitarian situation in Yemen has continued to deteriorate because of damage to infrastructure and the disruption of basic services. It is estimated that over 2 million people are internally displaced due to the conflict,<sup>14</sup> and over half of the population has no access to health-care services.<sup>15</sup>

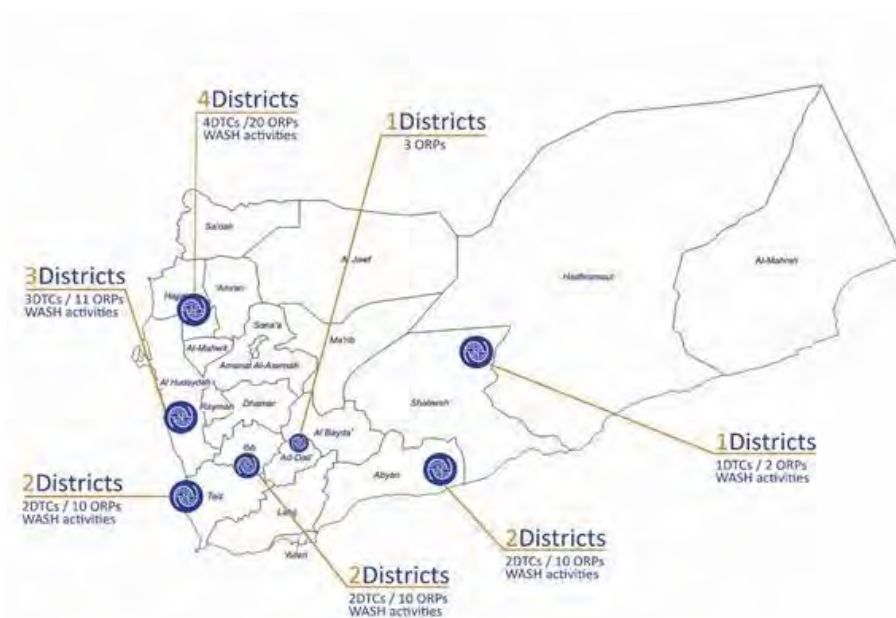
Since January 2016, IOM has been providing health-care services including emergency and primary health care to IDPs and other conflict-affected people in

Aden, Abyan, Al-Dhalea, Hajjah, Hodeidah, Sa'adah, Shabwah and Taizz governorates. IOM mobile health clinics provided 231,028 medical consultations, including reproductive health care, health education, immunization, and mental health and psychosocial support, of which 75,173 were for women and 112,630 were for children.

Furthermore, IOM supported the operation of two public hospitals: 22 May Hospital in Aden and Alrazi Hospital in Abyan. IOM provided medical equipment, medicines and health-care workers to the two hospitals, and 46,135 IDPs and conflict-affected people received health services through these hospitals.

IOM also provided nutrition support, vaccination and health promotion activities to a total of 16,913 IDPs and host community members. IOM operated two outpatient therapeutic programme (OTP) clinics in Ahwar District in Abyan governorate; it also provided nutrition support, maternal and child health services, immunization and reproductive health care. In 2016, IOM conducted community management of acute malnutrition to a total of 1,752 moderate acute

**Figure 20.** Geographic coverage of IOM's cholera response activities in Yemen (2016).



Source: IOM Yemen from 29 August 2016.

<sup>14</sup> The Task Force for Population Movement (TFPM) co-led by IOM and UNHCR, "DTM Yemen – TFPM 12th Report – January 2017. Available from [www.globaldtm.info/dtm-yemen-tfpm-12th-report-january-2017/](http://www.globaldtm.info/dtm-yemen-tfpm-12th-report-january-2017/)

<sup>15</sup> WHO, "Health situation in Yemen and WHO response since March 2015", 25 April 2017. Available from [www.who.int/hac/crises/yem/yemen-infographic2.pdf?ua=1](http://www.who.int/hac/crises/yem/yemen-infographic2.pdf?ua=1)



malnutrition cases and 799 severe acute malnutrition cases among children under the age of 5 years. Additionally, IOM provided treatment to 8,365 children under 5 years old under the Integrated Management of Childhood Illness Programme. IOM also provided reproductive health care to 3,135 women.

## Response to cholera outbreak

In the wake of cholera outbreak in Yemen, the IOM Yemen health team drew up plans to control the outbreak. It targeted migrants in the three main cities of Sana'a, Aden and Hodeidah, where they commonly get stranded and where IOM has facilities to provide the most vulnerable with humanitarian assistance, including emergency health care.

IOM procured and distributed medicines, medical supplies, and water, sanitation and hygiene (WASH) supplies, and set up cholera treatment centres for the isolation and management of infected cases. Referral of severe cases to the public hospitals has been arranged with the health authority. IOM also conducted awareness-raising activities, using promotional materials in local languages.

In collaboration with Ministry of Public Health, WHO, UNICEF and other partners, IOM took part in outbreak response for migrants and the local community.

## CENTRAL AND WEST AFRICA

### Ghana



- 4** Points of entry supported through baseline assessments and consultations
- 3** Land points of entry
- 1** International airport



- 3** Districts supported through participatory mobility mapping exercises

Since the Ebola virus disease (EVD) epidemic in the region, IOM Accra has been implementing the project of the Global Health Security Agenda (GHSa), which pursues a multilateral and multisectoral approach to strengthen global- and national-level capacity to prevent, detect and respond to infectious diseases threats, with support from the US CDC. The project

aims to respond to the mobility dimensions of disease outbreaks and other health emergencies through the IOM Health, Border and Mobility Management (HBMM) framework.

In 2016, the GHSA project strengthened the Government of Ghana's capacity in preparing for and responding to infectious disease outbreaks. The project increased the Government's capacity to detect, report and respond to public health emergencies at three land points of entry (PoEs) – namely, Aflao, Akanu and Paga – and at the Kotoka International Airport, through a baseline assessment and consultations. The project supported them to develop their first drafts of Public Health Emergency Response Plans.



Stakeholders meet at the land point of entry, Paga. © IOM Ghana 2016

Through this project participatory mobility mapping exercises (identification of priority areas) were conducted in the three districts as well as in the Sekondi-Takoradi Metropolis. The project also supported Ghana Health Service and the School of Public Health to jointly develop/update the existing community event-based surveillance (CEBS) training curricula and tools for community volunteers.

The project also strengthened public health information-sharing and capacities to respond across the Ghana–Togo and Ghana–Burkina Faso borders. These activities have contributed to strengthening event-based surveillance systems in border regions and to building the capacity in identifying potential events of concern for public health and health security.

## Guinea



**31,442**

Primary health care consultations to IDPs and host community members



**241**

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



**14**

Points of Entry supported through the development of standard operating procedures

**4**

Cross-border meetings held to share epidemiological information between Guinea and neighbouring countries



**24**

Health screening posts made operational



**28**

Emergency Operations Centres provided with logistical support to improve operational capacity

**13**

Border Posts rehabilitated



**5,540**

Training Beneficiaries, including:

**204** Health staff trained on emergency health management across 38 health districts

**266** Security and health staff at PoEs trained on detecting epidemic prone diseases and the usage of personal protection equipment

The EVD epidemic declared in March 2014 severely affected the Guinean health system. Nearly two years after the crisis, the signs of the impact remain visible despite all the efforts deployed by the Government of Guinea, the international community and the Government's partners to reestablish the access to basic health services.



Distribution of office supplies to the PEOCs of Fria, Guinea. © IOM 2016

To support the Government of Guinea in its efforts to stop the spread of the disease, IOM implemented a programme from December 2014 to June 2016 to strengthen the operational and technical capacities of the health districts. Through this programme, IOM provided: adequate workspaces by rehabilitating 28 health facilities in 5 municipalities in Conakry; IT equipment, communication kits and office supplies to improve the logistical capacity of the health facilities to carry out operational processes; equipment for 28 prefectural emergency operational centres (PEOCs), including fuel-powered generators with fuel

supply, office materials and hygiene kits to PEOCs to improve their operational capacity; development and implementation of a health emergency management training programme for health workers and other staff members involved in the response, and training to 204 health staff on emergency health management across 38 health districts; 3 technical assistants to strengthen the capacity of the National Agency for Health Security and set up an emergency operational centre at the national level.

Guinea faced the most important epidemic outbreak of Ebola in its history between 2014 and 2016. The WHO emergency committee raised an alert regarding the risks of the international spread of the epidemic. One of the identified challenges was regarding surveillance and control given the high population mobility and internal or cross-border movement of infected travellers. Since official posts are easily diverted by the communities, fishermen and others, health surveillance at PoEs must be supplemented by CEBS, taking into account the specificities of the concerned communities.

The CEBS model and the strengthening of the primary health-care system are aligned with IOM's strategic guidelines on HBMM and fully in line with the post-Ebola strategy developed by the Guinean authorities. HBMM takes into account all aspects of human mobility and supports the strengthening of national

health systems, border management capacities, and also the mapping of mobility patterns on both sides of the borders. In all these situations, the communities, mainly those living along the borders, play a key role in the efforts launched to prevent, detect and respond to any public health emergency, particularly those linked to EVD.



Participatory mapping exercise conducted as part of IOM's population mobility mapping. © IOM Guinea 2016

In 2016, 24 health screening posts were made operational through the HBMM framework, and 13 border posts were rehabilitated. Standard operating procedures (SOPs) were developed and validated through workshops for 14 PoEs, and 266 security and health staff at PoEs were trained on detecting epidemic-prone diseases and the usage of personal protection equipment. There were also 14 simulation exercises conducted at PoEs for public health emergencies, and 4 cross-border meetings were held to share epidemiological information between Guinea and neighbouring countries Liberia and Sierra Leone. Moreover, in the 12 zones supported by IOM (which included 10 prefectures – namely, Boké, Boffa, Dubréka, Forécariah, Kindia, Guéckédou, Macenta, Yomou and Lola – and 2 communes, namely, Kaloum and Matoto), 389 suspected and confirmed cases of EVD, measles, yellow fever and poliomyelitis were detected as part of the implementation of CEBS. Community agents reported 264 of these cases, while health facilities reported 125, highlighting the role of community agents in improving the surveillance system at the sub-prefectural level.

IOM conducted 241 participative mapping workshops with 3,615 key informants, chosen by local authorities and community leaders, which resulted in the identification of 5,462 vulnerable sites, 571 health facilities and 595 PoEs. During the EVD resurgence in the district of Kambia, Sierra Leone, in January 2016, data collected through public health risks mapping supported the response and mitigated the risk of EVD spreading along the border. During the EVD resurgence in Forest region (14 March–6 April 2016), IOM mapped

the border regions with the implementation of 3 participatory mapping workshops that involved 30 key informants through the identification of 75 vulnerable sites. The analysed data was shared with the National Coordination of the Fight against Ebola (CNLE, now National Agency for Public Health Security (ANSS)), to aide the emergency response in the affected areas.

## Liberia

During the Ebola outbreak, IOM, funded through USAID's Office of Foreign Disaster Assistance (OFDA), supported enhanced surveillance in the border regions in Liberia. The activities reinforced CEBS in the 8 border counties and 2,972 communities, and screening processes at 72 PoEs in counties bordering Guinea and Sierra Leone. Implemented through local NGOs, the project trained 2,989 CHVs covering 2,972 communities. The project supported the transition in CEBS activities from emergency response to an integrated part of the larger surveillance system, and assisted the establishment of a regular reporting system for the Ministry of Health at both local and central levels on a weekly basis. PoEs in counties bordering Guinea and Sierra Leone. Implemented through local NGOs, the project trained 2,989 CHVs covering 2,972 communities. The project also supported the transition in CEBS activities from emergency response to an integrated part of the larger surveillance system, and assisted the establishment of a regular reporting system for the Ministry of Health at both local and central levels on a weekly basis.



Clinicians provide initial treatment at the withholding center in a health facility during a county-level simulation exercise in Bomi, Liberia. © IOM Liberia 2016

IOM contributed to strengthening the capacity of the Ministry of Health and county health teams to quickly and effectively respond to a disease epidemic in Liberia. IOM was the lead in five counties, and



the regional case management coordinator for the western region (Grand Cape Mount, Gbarpolu and Bomi) and the south-eastern region (Grand Gedeh, River Gee and Maryland).

IOM established rapid response teams at the county and district levels in five counties (Gbarpolu, Bomi, Grand Gedeh, River Gee and Maryland) and trained district rapid response teams and county rapid response teams in these counties. Furthermore, IOM carried out county- and district-level simulation exercises in the five counties and supported county health teams to develop county- and regional-level referral documents and ambulance plans.



Community drill in Bambuta, Liberia. © IOM Liberia 2016

## Nigeria



**99,133**

Individuals assisted through mental health and psychosocial support



**10**

Mental health and psychosocial support resource centers established

IOM Nigeria provided mental health and psychosocial support (MHPSS) to displaced and affected populations in north-east Nigeria in 2016, assisting 99,133 individuals. IOM also trained 78 PSS mobile team members and established 10 MHPSS resource centres through a project funded by GIZ.

## Sierra Leone



**200,000+**

Travelers screened across 7 established flow monitoring points



**49,758**

Beneficiaries of social mobilization and risk communication, including 47,358 community members sensitized on essential family health practices



**4,858**

Health workers received training



**15**

Chiefdoms supported through Community Event Based Surveillance



**13**

Health facilities supported through the renovation and construction of Water, Sanitation and Hygiene infrastructure

Sierra Leone continued to advance the GHSA in 2016 through the programmatic framework of HBMM. Through the second phase of the HBMM project funded by OFDA, IOM established 7 flow monitoring points at PoEs (sea, land and air) that screened over 200,000 travellers. In 2016, IOM also received funding from the Government of Japan to strengthen Sierra Leone's capacity to prevent, detect and respond to epidemic-prone communicable diseases. The project focused on Koinadugu and Bombali Districts, where IOM conducted population mobility mapping exercises in seven chiefdoms to assess the health vulnerability of their border communities, and constructed or refurbished infrastructure at five PoEs. Additionally, 282 CHWs were trained on CEBS, while 51 health staff, including rapid response teams, were trained on infection prevention and control. Additionally, 47,358 community members, including 32,431 women, were sensitized on essential family health practices.

Over the course of 2016, IOM Sierra Leone reached a total of 49,758 individuals through social mobilization and risk communication activities; supported 13 health facilities through the renovation and construction of WASH infrastructure, as well as trained personnel on infection prevention and control; and supported 15 chiefdoms through CEBS, during which 2,021 CHWs were trained.

## SOUTHERN AFRICA

### Democratic Republic of the Congo



7

Points of Entry supported for Yellow Fever outbreak response



3

Population mobility mapping exercises conducted, including at the national level



115

Border health staff trained on Integrated Disease Surveillance and Response (IDSR) and yellow fever control

The Democratic Republic of the Congo declared a yellow fever outbreak in April 2016. The IOM mission in the Democratic Republic of the Congo has implemented yellow fever outbreak response activities at border spaces. Border spaces include the general geographical area surrounding border crossing points, which may constitute a space of vulnerability for disease transmission given high population movement and large congregation points within and through the area. These include vector control, risk communication and capacity strengthening for border health management through provision of necessary equipment and materials and field staff training.

IOM organized five training sessions in the affected and high-risk provinces of Kongo Central, Kwango, Kasai and Lualaba along Angola borders. A total of 115 border health staff (45 women, 70 men) at the Ministry of Public Health have been trained on integrated disease surveillance and response and yellow fever control.

IOM supplied necessary medical and operational equipment and materials to the selected seven main border posts. The equipment has been used for verification of travellers' vaccination status, referral of suspected cases, and provision of first aid for the sick cross-border travellers and neighbouring communities.

IOM has deployed risk communication staff at selected border posts and assisted to scale up risk communication activities and community sensitization at the border posts and neighbouring communities. With the risk communication flyer, IOM provided cross-border travellers with information on risk of yellow fever transmission and prevention practice at the individual level as well as contact information of

medical services. In corroboration with District Health and the partners of the respective health zones, IOM also conducted sensitization activities in the communities of border spaces.

Furthermore, IOM has introduced and rolled out population mobility mapping exercise at the national level. Through population mobility mapping, information about population mobility can be gained and that are at risk of public health threats can be identified and prioritized. National-level participatory mapping exercise was carried out with 20 key informants who have expert knowledge on mobility and/or public health from the ministries, WHO, UNHCR and donors including the US CDC. Based on history of infectious disease outbreaks, capacity of the health system, and the status of the hygiene and sanitation system in place, the national-level exercise has gained an overview of the population flow and has identified areas that are vulnerable to public health threats. From the qualitative and quantitative data gathered and information analysis, the exercise has identified vulnerable territories that need to be prioritized.

## EAST AFRICA AND THE HORN OF AFRICA

### Somalia



229,415

Direct Medical Consultations

581

Cases Referred



25,661

Children under the age of 5 received immunization assistance



13

Locations supported through IOM managed clinics



95,945

Health promotion beneficiaries

Somalia still suffers from the aftermath of a prolonged civil war, and IOM plays a vital role in providing life-saving primary health care to vulnerable populations, including IDPs and affected host communities. In addition to providing emergency care, the interventions contribute to the longer-term sustainability of quality health care through activities including maintenance

and critical repairs of health facilities, capacity-building for health workers, health promotion and community mobilization. In 2016, IOM trained 95 health-care workers, and a total of 229,415 beneficiaries were assisted through direct medical consultations at IOM-managed clinics (fixed and mobile). The clinics are based in 13 locations across the country.

The services, provided as part of the minimum basic health package, included outpatient treatment of acute and chronic communicable and non-communicable diseases; basic maternal care such as antenatal care and the promotion of safe pregnancies and deliveries; child health services, including screening and community-based management of malnutrition and immunizations; and facilitation of referrals. Additional activities included community mobilization, activities in response to public health threats, health workers' training and health promotion campaigns.

IOM also responded to measles outbreak, which affected more than 541 children in Kismayo in 2016. Through TV and radio, IOM, the Government of Somali and health partners disseminated a series of public health messages about measles. In addition, IOM-trained CHWs conducted house-to-house visits with BCC tools designed to achieve improved health-seeking behaviours and immunization of vaccine-preventable diseases.

## South Sudan



**229,415**

Direct Medical Consultations

**581**

Cases Referred



**25,661**

Children under the age of 5 received immunization assistance



**7**

IOM-operated static clinics



**889**

Suspected cases screened for TB

**119** TB cases diagnosed

**60** Individuals successfully completed treatment and cured

**51** Cases confirmed to be HIV positive and initiated on antiretroviral medication

By the end of 2016, IOM had operated seven static clinics across South Sudan, including in Wau town displacement sites, the Bentiu and Malakal PoC sites, as well as in and around Renk, Upper Nile. Community outreach and facility-based health education sessions were a successful strategy in 2016, particularly on HIV/AIDS and TB awareness, prevention of sexual violence and GBV, communicable diseases, and proper sanitation and hygiene. In Malakal, IOM held 881 health education sessions for 58,504 beneficiaries, with campaigns and sessions addressing the specific needs of women and girls in safe spaces using trusted community members.

### Born in Conflict

On 4 August, baby Lisa was born at the IOM temporary clinic on the grounds of the Wau Cathedral. Lisa's mother and her family had been sheltering in the site for over a month after heavy fighting broke out in Wau town in late June, displacing as many as 80,000 people. At the time of Lisa's birth, more than 10,000 IDPs were sheltering and seeking protection at the Cathedral.



IOM temporary Clinic in Wau Cathedral. 3,979 births were attended to by skilled birth attendants across the network of six IOM maternal healthcare clinics in 2016. © IOM 2016

When the mother arrived on the day of Lisa's birth, midwives quickly went into action to ensure the delivery was safe for both mother and child. She had visited the clinic in the days before going into labour to receive a prenatal care consultation with IOM midwives, which included blood pressure monitoring, dispensing of supplements and malaria prophylaxis. After giving labour, Lisa's mother was transferred to a recovery tent, where a midwife ensured she was comfortable and monitored the baby and the mother's health. Lisa's mother also attended postnatal sessions with IOM which includes breastfeeding education sessions.



IOM started a TB screening, testing and treatment programme in Bentiu PoC site in February after identifying the rise in TB and HIV/AIDS related mortalities in the site. A total of 889 suspected cases were screened using sputum smear microscopy testing. Of 119 cases testing smear positive (13% positivity rate), 60 individuals successfully completed the 6-month course of treatment by the end of 2016 and were confirmed to be cured. All TB confirmed cases were also tested for HIV, with 51 cases confirmed to be HIV positive and initiated antiretroviral medication. Supplementary nutrition support is also provided for all TB clients with support from World Food Programme.

In 2016, South Sudan experienced multiple infectious diseases outbreaks, including cholera, malaria and measles. In the midst of the Juba crisis, and with hundreds of humanitarian workers having been relocated from the country, on 18 July the Ministry of Health issued a cholera alert. In coordination with the Ministry of Health, the Inter-Agency Standing Committee Health Cluster and WHO, IOM initiated a rapid response, including deploying geospatial information specialists to map cholera hotspots and managing a cholera treatment unit at the Tonpging transit site. IOM health teams provided cholera case management services and referred 79 severe cases to the Médecins Sans Frontières (MSF) Cholera Treatment Centre. IOM also managed oral rehydration points (ORPs) in three health clinics, including one 24-hour ORP. By the end of December, 2,238 suspected cholera cases had been reported in 8 states.

## ASIA AND THE PACIFIC

### Bangladesh



**173,134**

Direct Medical Consultations



**80,673**

Immunization Beneficiaries



**8**

Health facilities supported in 2 sub-districts of Cox'

**5**

Community health facilities upgraded and equipped with medical instruments, medicines and other supplies



**3**

Mobile medical teams deployed to provide services in new settlements



**953**

Deliveries supported directly by IOM medical teams

Under the framework of the National Strategy on Myanmar Refugees and Undocumented Myanmar Nationals (UMNs) in Bangladesh adopted by the Government of Bangladesh in 2013, IOM was given a mandate to provide direct health-care services and coordinate health services offered to the UMN population and vulnerable host communities in Cox's Bazar District. IOM continues to coordinate the provision of health services in collaboration with other international and national NGOs, such as Bangladesh Red Cross, WHO, UNICEF, UNHCR, United Nations Population Fund (UNFPA), Action Contre la Faim (ACF), MSF and Handicap International in Cox's Bazar.

IOM's health interventions have been set up within existing government health facilities. In 2016, IOM's medical teams provided access to primary and reproductive health-care services to 132,000 UMNs and 500,000 host community members, through 8 supported health facilities in 2 sub-districts of Cox's Bazar. A total of 173,134 medical consultations were provided, of which 62 per cent were to female patients, with patients receiving treatment services and free medicine.

Additionally, 5 community health facilities were upgraded and equipped with medical instruments, medicines and other supplies. Delivery services were introduced in these supported facilities, and the IOM medical teams directly assisted in 953 deliveries, while 1,987 patients were managed in higher-level centres. Ukhia Upazila Health Complex was also upgraded, including an expansion of services and improved infrastructure in its laboratory, operation theatre and delivery rooms, as well as the establishment of an X-ray facility, which has been fully functional since January 2016. Thanks to such upgrades, 372 general surgeries, including Caesarean section operations, were performed. A 10-bed standalone clinic was also constructed in Leda makeshift settlement, providing access to services to a population of 23,000. The clinic provides basic maternity and integrated childhood care.

IOM partnered with two local NGOs – Mukti-Cox's Bazar and Bangla German Shampreeti – for outreach activities in the makeshift settlements and among vulnerable host communities. Female health promoters are the nucleus of this programme. These health promoters conduct daily visits to households in their assigned blocks in the settlements, and provide basic first-aid care and psychosocial counselling to pregnant women and their families, as well as refer families with children under the age of 5 to vaccination centres. They act as a primary link in the referral pathway and interact closely with the clinical teams in the health facilities, as well as with block representatives in the settlements and other members in the communities.

In each coverage area and settlement, a community emergency health action team has been formed, consisting of community members who act as first responders when emergency needs arise. In addition to these teams' awareness-raising activities, they actively encourage and refer pregnant women to have their deliveries in the clinic, in coordination with the health promoters and coordinators of Bangla German Shampreeti. Since October, IOM intensified outreach activities for the newly arrived UMN in Teknaf with psychological first-aid and emergency first-aid care.

In addition, IOM deployed three mobile medical teams (MMTs) to provide services in new settlements in Kutupalong Extension, Balukhali, and adjacent areas. These MMTs provide consultations to the newly arrived UMN with free medicines. The health promoters visit households and provide information on good health and hygiene practices. Cases that require additional

assistance are referred to the MMTs. In turn, the MMTs refer cases that require assistance beyond their capacity to higher-level facilities by ambulances.

## Myanmar



**2,235**

Beneficiaries received emergency referral support



**18**

Health facilities, including 5 hospitals and 13 rural health centres, supported with medical and non-medical supplies



**6,824**

Beneficiaries reached through awareness-raising activities on antenatal and postnatal care, sexual and reproductive health, gender-based violence, and other health topics

Rakhine state suffers from extreme poverty and underdevelopment, and is one of the poorest, most remote and most densely populated parts of Myanmar. The area severely lacks access to health care and food, leading to high levels of morbidity and mortality. Most women give birth at home, and access to emergency obstetric care is severely limited. In Rakhine, under-5 mortality rate (U5MR) is estimated at 70.2 per 1,000 live births, which is higher than the national-level U5MR of 52 per 1,000 live births.

IOM assisted a total of 2,235 beneficiaries (1,588 females and 647 males) with emergency referral support in township and station hospitals, and supported 5 hospitals (2 township hospitals and 3 station hospitals) and 13 rural health centres with medical and non-medical supplies. IOM further equipped these health facilities with resources to provide emergency health-care services to vulnerable populations.

In collaboration with UNFPA, IOM provided 100 basic health-care staff with sexual and reproductive health kits and 200 IDPs with reproductive health kits. Two township medical officers attended the early warning alert and response system training, and eight health workers were trained on the minimum initial service package for reproductive health and clinical management of rape. IOM also conducted awareness-raising activities on antenatal and postnatal care, SRH and GBV, and other health topics for 6,824 beneficiaries.

## Healthy Children, Informed Communities



Chit Su Oo and her mother. ©IOM 2016

Before, Chit Su Oo's mother could not go to a hospital when her baby was ill, as she did not have enough money. She was also afraid of hospitalization due to the lack of knowledge on health care. After attending the IOM outreach sessions on danger signs relating to illness of under-5 children, she came to understand the importance of early referrals and treatment. She received IOM's emergency referral support when her baby was sick, and was very happy and thankful to IOM.

## Nepal



**100**  
Patients admitted to the Injury Rehabilitation Unit

**16**  
Individuals assisted for discharge, follow-up, and referral to local health facilities or safe return to their communities via assisted discharge and referral services through 27 events of assistance



**3,365**  
Internally displaced persons received mental health and psychosocial support services across 13 temporary settlements



**20-bed**  
Injury Rehabilitation Unit operated



**10,644**  
At-risk individuals screened for TB

**1,000** Individuals with symptoms tested for TB

**29** Active TB cases detected and referred for treatment

**2,294** Individuals received assistance for respiratory problems

In 2016, IOM continued its health response to people affected by the 2015 earthquake through the Relief Recovery and Reconstruction (RRR) programme. As part of the RRR's health component, IOM assisted in patient discharge and referrals to facilitate the provision of essential care. IOM provided patient transport to ensure follow-up and the provision of rehabilitation care, a key element in preventing life-long disabilities among the injured. Key achievements included assistance to 16 individuals through 27 events of assistance for discharge, follow-up, and referral to local health facilities or safe return to their communities through the assisted discharge and referral (ADR) services.

In close cooperation with the Ministry of Health, IOM also continued to operate the 20-bed Injury Rehabilitation Unit (IRU) in Chautara, Sindhupalchowk District, to provide step-down care, including intensive physiotherapy, medical, nursing care, psychosocial support, and safe shelter for patients with earthquake-related injuries and disabilities. IOM worked together with WHO and Injury and Rehabilitation Sub-cluster members to establish the IRU as a "demonstration site" for step down care at the district level. In 2016, a total of 100 patients were admitted to the IRU and the facility also provided 264 sessions of psychosocial support, with counselling provided to all 100 patients.

In temporary settlement sites, the IOM medical teams, in cooperation with camp management committees, assisted vulnerable populations, including pregnant women, people living with disabilities or chronic illnesses to access health services. The IOM teams assessed 368



IDPs based on vulnerability criteria, and assisted 151 IDPs on 276 different occasions through follow-ups, discharge and referrals to local health facilities, and safe return to their communities. The teams also conducted a total of 71 needs assessments across 53 IDP camps in 9 earthquake affected-districts. Based on the information collected, the public health team provided 63 sessions of health and hygiene promotion activities to sensitize 1,713 individuals on preventive actions for diseases caused by poor hygiene and sanitation; diseases associated with the winter and overcrowding; vector-borne diseases; and vaccine-preventable diseases. Along with the ADR and health promotion activities, IOM Nepal distributed over 8,000 insecticide-treated mosquito nets in IDP sites to prevent mosquito-borne illnesses.

IOM Nepal continued providing MHPSS services to IDPs in 13 temporary settlements until September

2016, providing direct assistance to 3,324 individuals through stress relieving group activities and to 41 individuals through individual counselling sessions.

In 2016, IOM continued supporting the NTP to restore respective services in affected districts, including tracing of patients whose treatments were disrupted due to the earthquakes. A total of 10,644 (5,072 males and 5,572 females) at-risk individuals residing in temporary sites were screened for TB based on symptoms, and follow-up services were provided. Over 1,000 individuals with TB symptoms were tested for TB and a total of 29 active TB cases were detected and referred for treatment. In addition to these screenings, individuals suspected of having TB were managed for any respiratory problems with chest camps, with a total of 2,294 individuals receiving this assistance.

### Harka Maya Thami's Road to Recovery



Harka Maya Thami is being carried by her daughter-in-law to the IRU for rehabilitation. © IOM 2016

While conducting a community field assessment in her village, the IRU community outreach team first met Harka Maya Thami, a 57-year-old lady from the remote Piskar village of Sindhupalchowk District, lying on her bed. She had fractured her left leg during the 2015 earthquake in Nepal, and was found buried inside a collapsed house along with her 11-month-old granddaughter, only to be rescued after laying there unconscious for an hour. Upon her rescue, she was transported to Kathmandu for further treatment, where she was operated on and managed, before being discharged. She received no further follow-ups after returning to her village.

At the time of her assessment, Harka Maya Thami was both physically and psychologically fragile. She was first assessed by the district triage focal

point for eligibility and later by a physiotherapist to recommend the type and duration of rehabilitation that would be required. After being admitted to the IRU, she received intensive rehabilitation services for 96 days, which included physiotherapy, nursing, medical and psychosocial services. Upon her admission, she also underwent the disability assessment by WHO Disability Assessment Schedule (WHODAS), with a score of 76 at the time. She was then provided with various training, including on activities of daily living as well as gait training. After such training sessions, she gradually recovered and her WHODAS score at the time of discharge improved to 48.

She walked by herself out of the IRU to return home on 6 April 2016. Grateful for the services provided at the facility, she said that she is alive because she met the God that day.



Harka Maya Thami exercises for her ADL training physiotherapy. © IOM 2016

## Thailand



**542**

Medical consultations in 20 locations across 11 provinces



**439**

Beneficiaries of IOM's immunization programme

IOM Thailand provided health examinations and medical assistance through 542 consultations (412 for Myanmar Muslims and 130 for Bangladeshis) in 20 locations across 11 provinces in Thailand. In addition, IOM nurses based in Songkhla, Phang-Nga, Ranong and Surat Thani provided weekly on-site basic health-care services for the beneficiaries in immigration detention centres (IDCs), shelters for children and families, and welfare protection centres for victims of trafficking. The immunization programme, including tetanus-diphtheria (TD); measles, mumps and rubella (MMR); hepatitis B (HBV); and diphtheria, tetanus and pertussis (DTP), as well as deworming treatment, was provided to a least 439 beneficiaries.

In promotion of personal hygiene and health education, IOM staff, in coordination with the relevant authorities of the IDCs, welfare protection centres for victims of trafficking, and shelters for children and families, organized health education sessions for beneficiaries on a weekly basis in Phang-Nga, Ranong, Songkhla and Surat Thani provinces. The sessions included dental hygiene, muscle relaxation, first aid, exercise activities, oral dehydration and education on tobacco harm.

In 2016, depression and frustration among beneficiaries were identified, resulting from prolonged detention and uncertainties regarding their future. The condition of stress and depression among detainees is a concern particularly for those in the IDCs. For security reasons, detainees have limited access to regular outdoor activities compared to those in the shelters. Therefore, IOM's psychosocial activities in 2016 were conducted mainly in the shelters, including shelters for children and families, and welfare protection centres for victims of trafficking. As the number of detainees has decreased and the local authorities are able monitor the detainees, IOM plans to extend its psychosocial activities to IDCs, shelters, and welfare protection centres in Ranong, Songkhla, Surat Thani and Phang Nga.

## A Healthy Return Home

Faruq, a 56-year-old Bangladeshi, returned to Bangladesh in 2016.

"My dream was to earn money in order to continue my children's education and enable them to pursue higher education, which is impossible for me to achieve as a simple farmer in a village, since I do not own any land. My neighbour and



The IOM medical team conducts health assessments in Phang Nga, Thailand. © IOM 2016

I started travelling together from our village and we followed the broker's instructions. We arrived in Thailand nine days later, where the broker



Health assessments are also conducted by the IOM medical team in Pathum Thani, Thailand. © IOM 2016

made a phone call to my wife to pay money to the agent in Bangladesh.

When I was caught by the Thai police about 22 months ago, I was in a very weak and sick condition. IOM's coordination with other agencies to facilitate family phone calls helped to reduce high levels of stress I had been experiencing, especially now that I am getting old and have hypertension disease. IOM also provided me with regular medication, essential vitamins for my recovery and hygiene materials in order to keep me healthy, and also assisted me greatly with my desire to go back home."



## SOUTH-EASTERN EUROPE

### Serbia and Bosnia and Herzegovina

In 2016, ongoing work to enhance the capacities of the Ministry of Defence and the Ministry of Health of Bosnia and Herzegovina, and the Ministry of Health and Social Welfare of Serbia continued to facilitate the provision of a systematic response to mental health issues of current and discharged personnel of the Armed Forces of Bosnia and Herzegovina, as well as in the context of their participation in peacekeeping missions. This action was initiated by relevant Bosnia and Herzegovina authorities, facilitated by IOM and supported by the Nordic Baltic Initiative countries.

Using international models developed and applied by Nordic Baltic Initiative countries, a process was initiated to support the Ministry of Defence to design and implement a systematic and sustainable response to address the potential negative impacts of past and present conflict-related experiences on the mental health and psychosocial well-being of new recruits, discharged and active duty staff of the Ministry of Defence, as well as those involved in peacekeeping missions and their family members.

These peacekeeping missions include around 670 members of the Armed Forces of Bosnia and Herzegovina that have participated in peacekeeping missions in Afghanistan and Iraq, as well as the UN Missions in Congo and Eritrea. The system established through this intervention was embedded within the human resources management system of the Ministry of Defence and linked to the existing civilian network to ensure self-sustainability and cost effectiveness and to avoid duplications. In 2016, the system was also presented in 19 centres for mental health to raise awareness of the mental health difficulties faced by the military personnel.

In 2016, IOM supported the development and approval of SOPs for the psychologists from the Ministry of Defence and the Armed Forces of Bosnia and Herzegovina, and organized two study visits to Norway for the psychologists from the Ministry of Defence and the Armed Forces to learn about the work of military psychologists in Norway in the selection of soldiers, officers and pilots. Ministry of Defence/Armed Forces psychologists also conducted 6 workshops, reaching over 3,000 members of the Armed Forces of Bosnia and Herzegovina.



Psychological selection of officers and noncommissioned officers, September 2016. © IOM / Vesna Lezaja 2016



# annexes

## ANNEX I: MIGRATION HEALTH RESEARCH 2016 AT A GLANCE

Aims	Examples of research impact in 2016
<p>The Migration Health Research Unit of the Migration Health Division (MHD) aims at:</p> <ul style="list-style-type: none"> <li>• providing technical support and assistance to advancing migration health research projects across the three programmatic pillars of IOM health, and promote interdisciplinary research at the nexus of health and migration;</li> <li>• promoting evidence-based public health practice and support MHD knowledge management practice by: building a repository (knowledge hub) containing programme data, technical reports and policy briefs harnessed through applied research and/or programmatic reports; providing regular updates of scientific publications/high-quality evidence reviews relevant to MHD programmes; and undertaking staff training and capacity-building; and</li> <li>• harnessing meaningful and sustainable research collaborations with academic institutions and scholars that are guided by principles of participation, ethics and interventional research that will enrich health programmes/interventions and ultimately promote health of migrants.</li> </ul>	<ol style="list-style-type: none"> <li>1. <i>Migration, Mobility and Malaria: A Study on Migrants' Vulnerability to Malaria and Epidemiology of Artemisinin-Resistant Malaria in Binh Phuoc Province, Viet Nam</i> (IOM, Hanoi, 2016)</li> </ol> <p>This first comprehensive baseline data on migrants' vulnerability to malaria in Viet Nam underlines the need for specific strategies to address malaria vulnerability among mobile and migrant populations.</p> <ol style="list-style-type: none"> <li>2. Managing tuberculosis among labour migrants: Exploring alternative organizational approach", <i>International Journal of Migration, Health and Social Care</i>, 12(4):278–287</li> </ol> <p>This article reviews the results of a survey and of legal provisions concerning access to insurance and medical care among migrants in the Russian Federation and some other countries. Because of this, coverage of voluntary medical insurance for migrants in the Russian Federation is currently being established to include tuberculosis.</p> <ol style="list-style-type: none"> <li>3. <i>Summary Report on the MIPEX Health Strand and Country Reports</i> (IOM, Geneva, 2016)</li> </ol> <p>This report provides comprehensive and standardized data on policies concerning migrants' access to health services and the quality of these services in 38 countries, which paved the way for the improvement of migrants' access to health services</p> <ol style="list-style-type: none"> <li>4. <i>Recommendations on Access to Health Services for Migrants in an Irregular Situation: An expert Consensus</i> (IOM, Brussels, 2016)</li> </ol> <p>This paper reflects the consensus that was developed during a series of joint international meetings from 2012 to 2016, attended by experts on migration, health policy, human rights law, health economics and epidemiology, as well as by representatives of intergovernmental and civil society organizations concerned on migrant health.</p>

Highlights	2016 in numbers
<p>Key activities include:</p> <ul style="list-style-type: none"> <li>• Provision of technical advice on the preparation of research proposals, curricula, study tools, and scientific and full reports;</li> <li>• Launch of the Migration Health Research Bulletin, which aims at advancing evidence-based policy and practice;</li> <li>• Technical review and development of the conceptual framework of the Second Global Consultation on Migration Health, held in February 2017 in Colombo, Sri Lanka;</li> <li>• Support for the establishment of the Migration Health and Development Research Initiative (MHADRI) in partnership with academic and other relevant institutions – a global network of scholars devoted to advancing migration health research.</li> </ul>	<p><b>44</b> publications were produced by IOM</p> <p><b>13</b> studies were published in scientific journals</p> <p><b>22</b> requests on project development, research guidelines, reporting, partnerships, and curriculum review were addressed and supported</p> <p><b>2</b> issues of MHD's first ever Health Research Bulletin</p>



## IOM publications, guidelines and tools in 2016

1. IOM, *Baseline Survey Report for the Project Promoting Comprehensive Sexual and Reproductive Health Rights for Internal Migrants and Internally Displaced Populations Living in Urban Slums in Sylhet City of Bangladesh* (IOM, Dhaka, 2016).
2. IOM, *Health, Border & Mobility Management: IOM's Framework for Empowering Governments and Communities to Prevent, Detect and Respond to Health Threats along the Mobility Continuum* (IOM, Geneva, 2016).
3. IOM, *Informe Regional sobre Determinantes de la Salud de las Personas Migrantes Restornadas o en Tránsito y sus Familias en Centroamerica* (IOM, San Jose, 2016).
4. IOM, *MRS No. 52 - Summary Report on the MIPEX Health Strand and Country Reports* (IOM, Geneva, 2016). Available from <https://publications.iom.int/books/mrs-no-52-summary-report-mipex-health-strand-and-country-reports>
5. IOM, *Recommendations on access to health services for migrants in an irregular situation: an expert consensus* (IOM, Brussels, 2016). Available from <http://equi-health.eea.iom.int/index.php/9-uncategorised/336-expert-consensus>
6. IOM and Stop TB Partnership, *TB REACH Case study - TB and Migration: Cambodia, June 2016* (IOM, Phnom Penh, 2016).
7. IOM, World Health Organization, and Institute of Malariology, Parasitology and Entomology in Ho Chi Minh City, *Migration, Mobility and Malaria: A Study on Migrants' Vulnerability to Malaria and Epidemiology of Artemisinin-Resistant Malaria in Binh Phuoc Province, Viet Nam* (IOM, Hanoi, 2016). Available from <http://publications.iom.int/books/migration-mobility-and-malaria-study-migrants-vulnerability-malaria-and-epidemiology>
8. IOM Regional Office for European Economic Area, the EU and NATO. *MIPEX Health Strand Country Report: Austria* (IOM, Brussels, 2016). Available from [http://equi-health.eea.iom.int/images/MIPEX/AUSTRIA\\_MIPEX\\_Health.pdf](http://equi-health.eea.iom.int/images/MIPEX/AUSTRIA_MIPEX_Health.pdf)
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10. IOM Regional Office for European Economic Area, the EU and NATO. *MIPEX Health Strand Country Report: Bosnia and Herzegovina* (IOM, Brussels, 2016). Available from [http://equi-health.eea.iom.int/images/MIPEX/BiH\\_MIPEX\\_Health.pdf](http://equi-health.eea.iom.int/images/MIPEX/BiH_MIPEX_Health.pdf)
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13. IOM Regional Office for European Economic Area, the EU and NATO. *MIPEX Health Strand Country Report: Cyprus* (IOM, Brussels, 2016). Available from [http://equi-health.eea.iom.int/images/MIPEX/CYPRUS\\_MIPEX\\_Health.pdf](http://equi-health.eea.iom.int/images/MIPEX/CYPRUS_MIPEX_Health.pdf)
14. IOM Regional Office for European Economic Area, the EU and NATO. *MIPEX Health Strand Country Report: Czech Republic* (IOM, Brussels, 2016). Available from [http://equi-health.eea.iom.int/images/MIPEX/CZECH\\_REPUBLIC\\_MIPEX\\_Health.pdf](http://equi-health.eea.iom.int/images/MIPEX/CZECH_REPUBLIC_MIPEX_Health.pdf)
15. IOM Regional Office for European Economic Area, the EU and NATO. *MIPEX Health Strand Country Report: Denmark* (IOM, Brussels, 2016). Available from [http://equi-health.eea.iom.int/images/MIPEX/DENMARK\\_MIPEX\\_Health.pdf](http://equi-health.eea.iom.int/images/MIPEX/DENMARK_MIPEX_Health.pdf)
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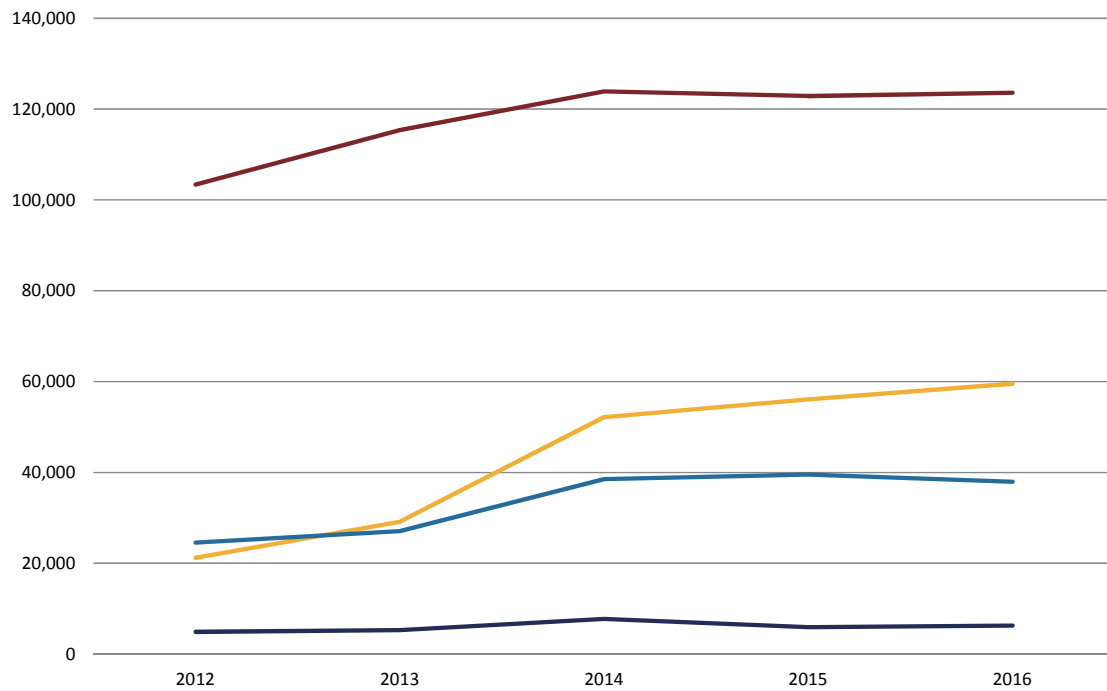


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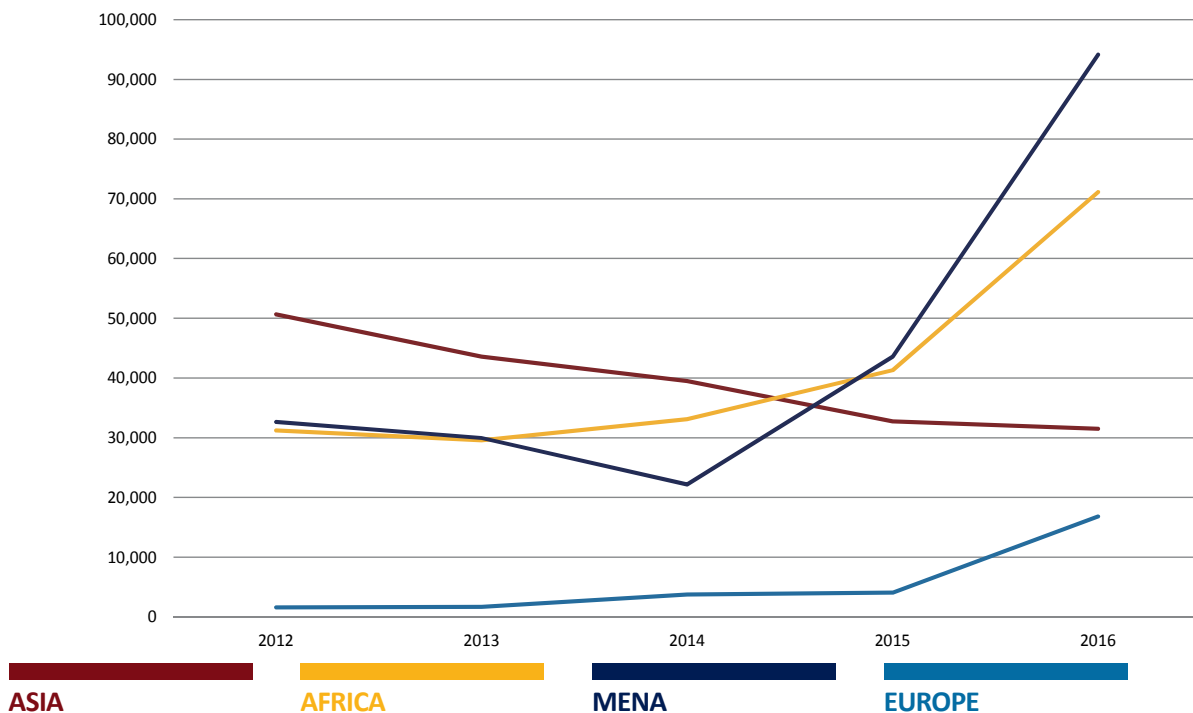


## ANNEX 2: HEALTH ASSESSMENTS AND RELATED SERVICE DELIVERY IN NUMBERS, 2016

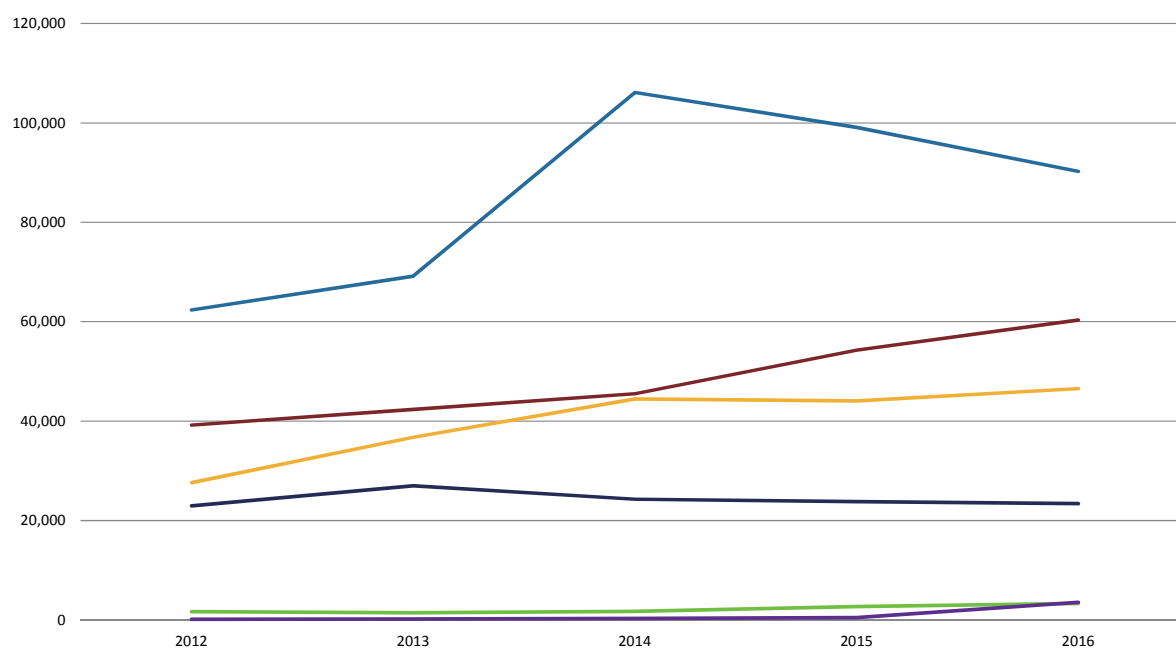
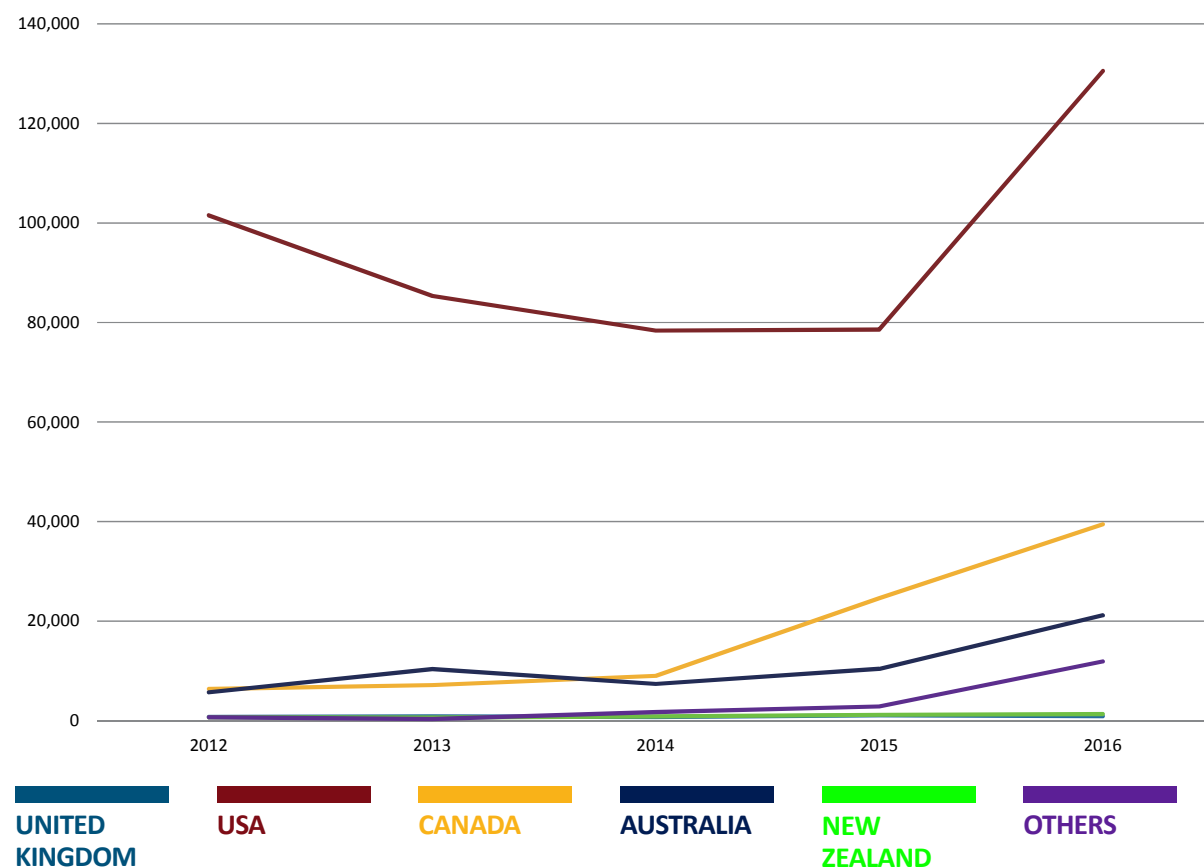
**Figure 21a. Health assessments of immigrants by region of exam, IOM, 2012–2016**

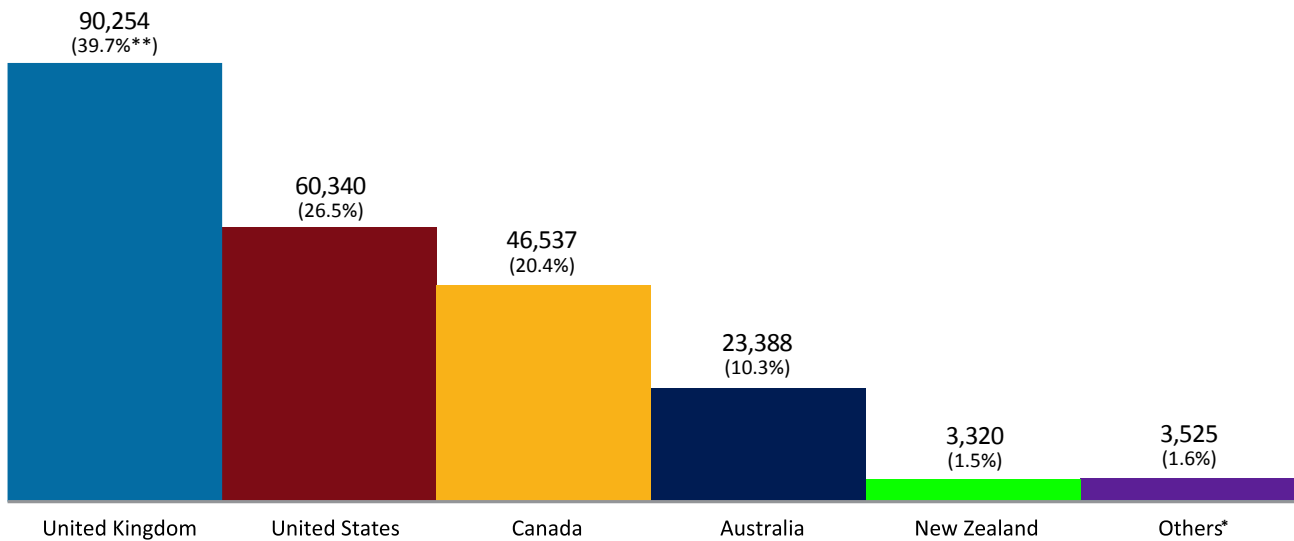


**Figure 21b. Health assessments of refugees by region of exam, IOM, 2012–2016**



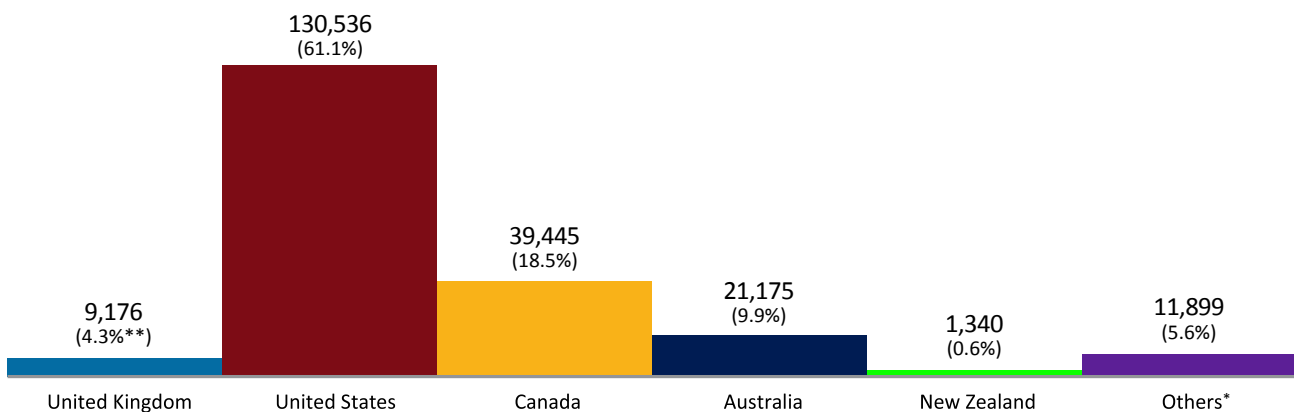


**Figure 22a. Health assessments of immigrants by country of destination, IOM, 2012–2016****Figure 22b. Health assessments of refugees by country of destination, IOM, 2012–2016**

**Figure 23a. Distribution of immigrant health assessments by country of destination, IOM, 2016**

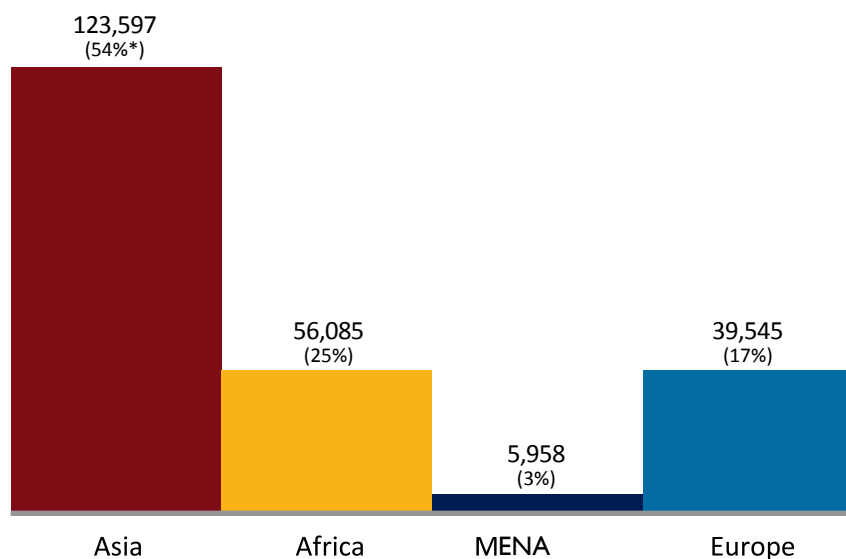
\* Top other destination countries (top 3) for immigrants are Belgium, Malaysia and Germany.  
 \*\* Percentages are based on total number of immigrants examined.

**TOTAL NUMBER OF HEALTH ASSESSMENTS = 227,364**

**Figure 23b. Distribution of refugee health assessments by country of destination, IOM, 2016**

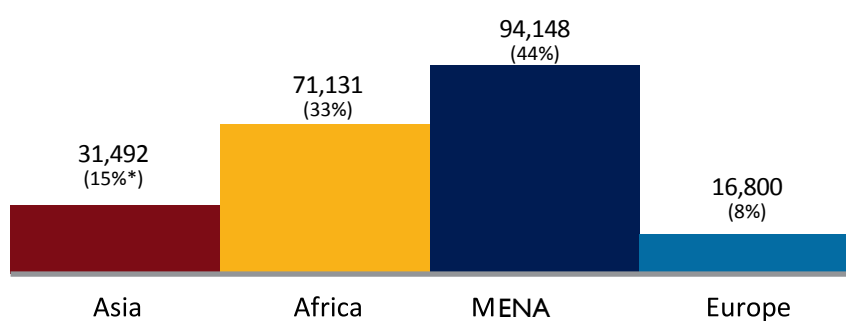
\* Top other destination countries (top 5) for refugees are Germany, Austria, Ireland, Denmark and Italy.  
 \*\* Percentages are based on total number of refugees examined.

**TOTAL NUMBER OF HEALTH ASSESSMENTS = 213,571**

**Figure 24a. Distribution of immigrant health assessments by region, IOM, 2016**

\* Percentages are based on total number of immigrants examined.

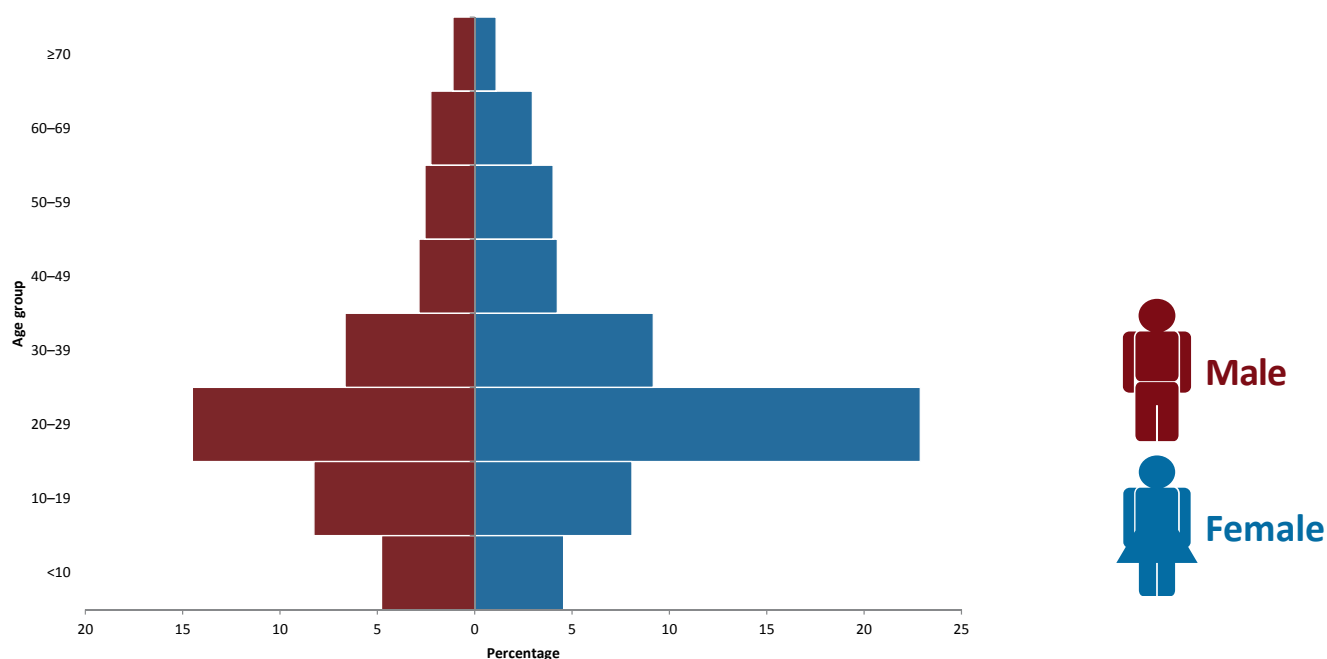
**TOTAL NUMBER OF HEALTH ASSESSMENTS = 227,364**

**Figure 24b. Distribution of refugee health assessments by region, IOM, 2016**

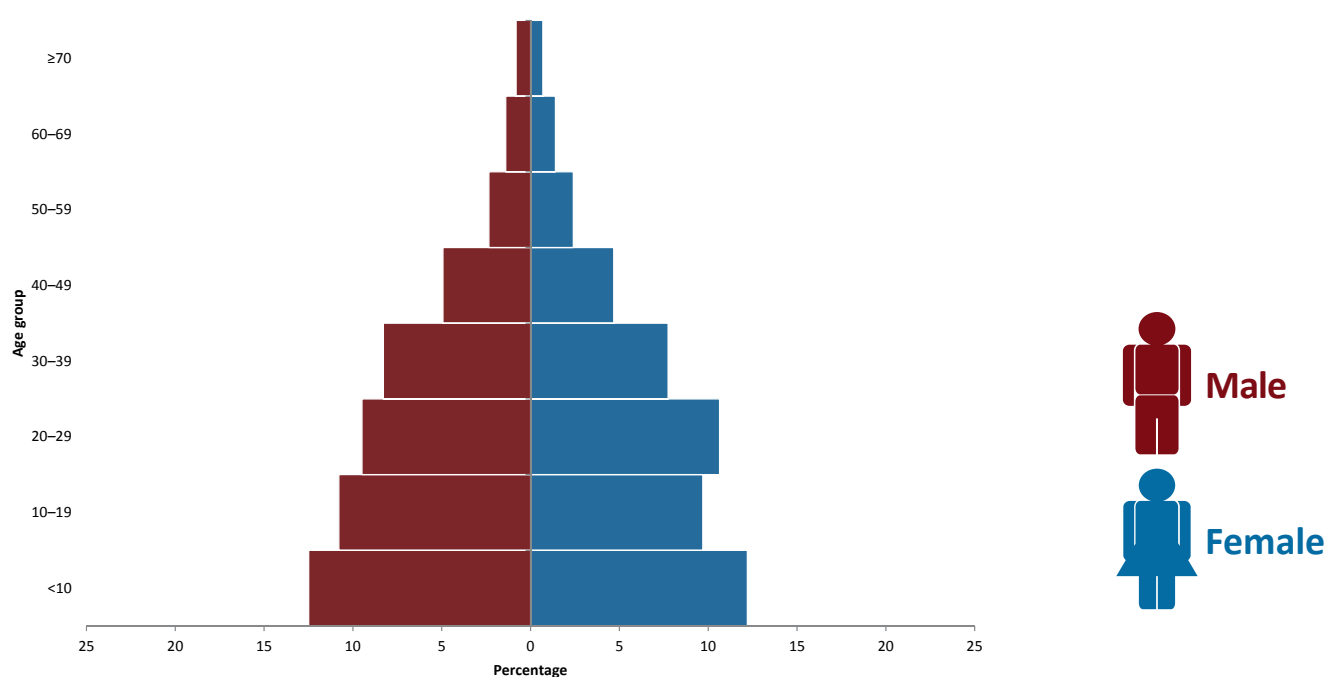
\* Percentages are based on total number of refugees examined.

**TOTAL NUMBER OF HEALTH ASSESSMENTS = 213,571**

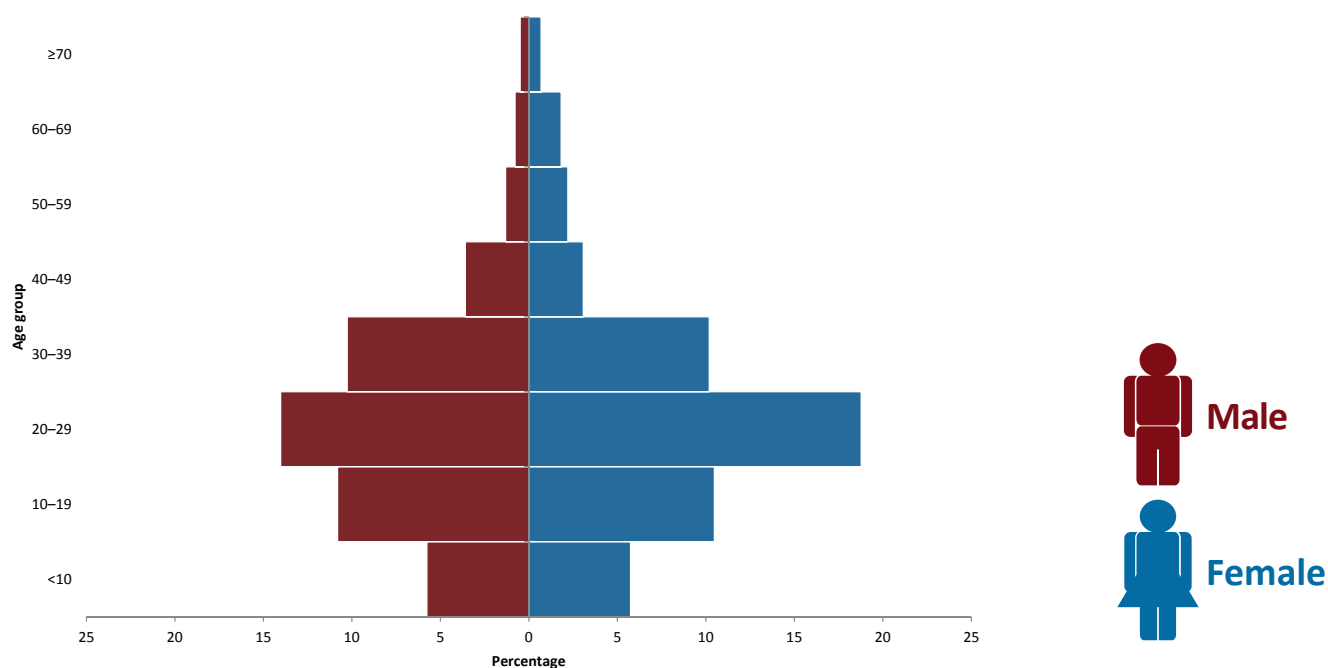


**Figure 25a. Distribution of immigrant health assessments by sex and age, Asia, IOM, 2016**

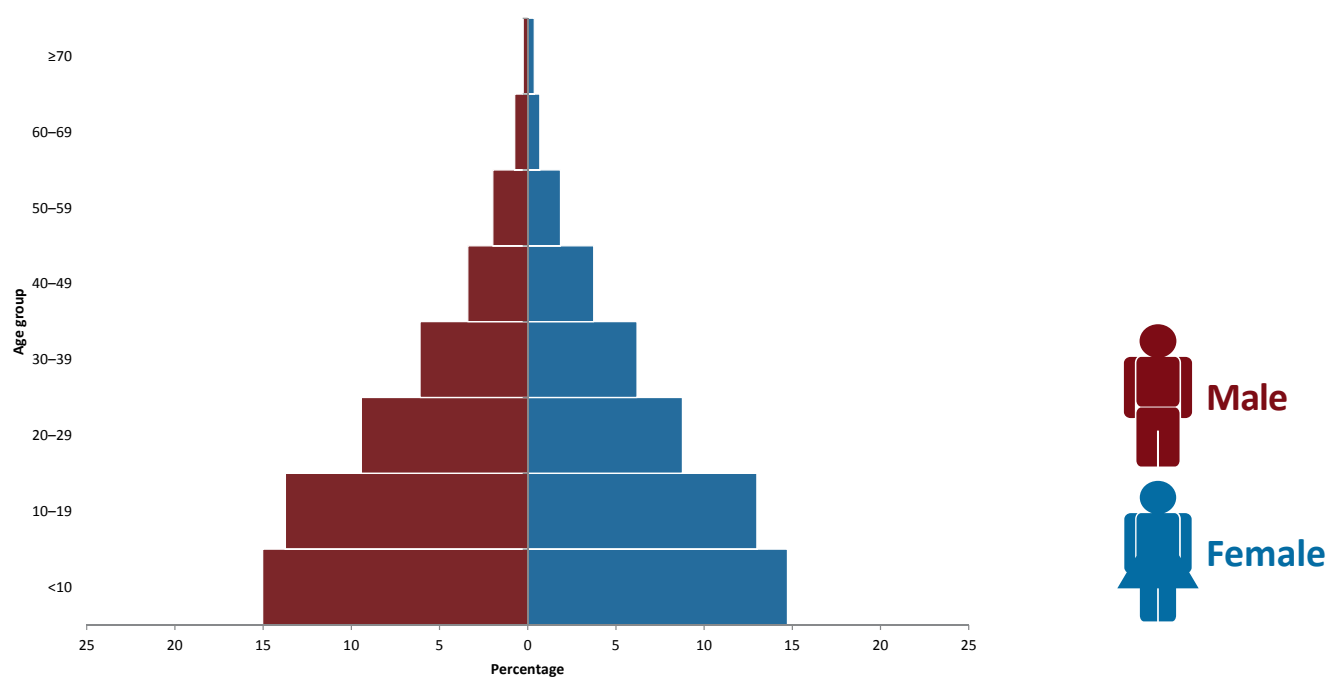
**TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG  
IMMIGRANTS IN ASIA = 123,597**

**Figure 25b. Distribution of refugee health assessments by sex and age, Asia, IOM, 2016**

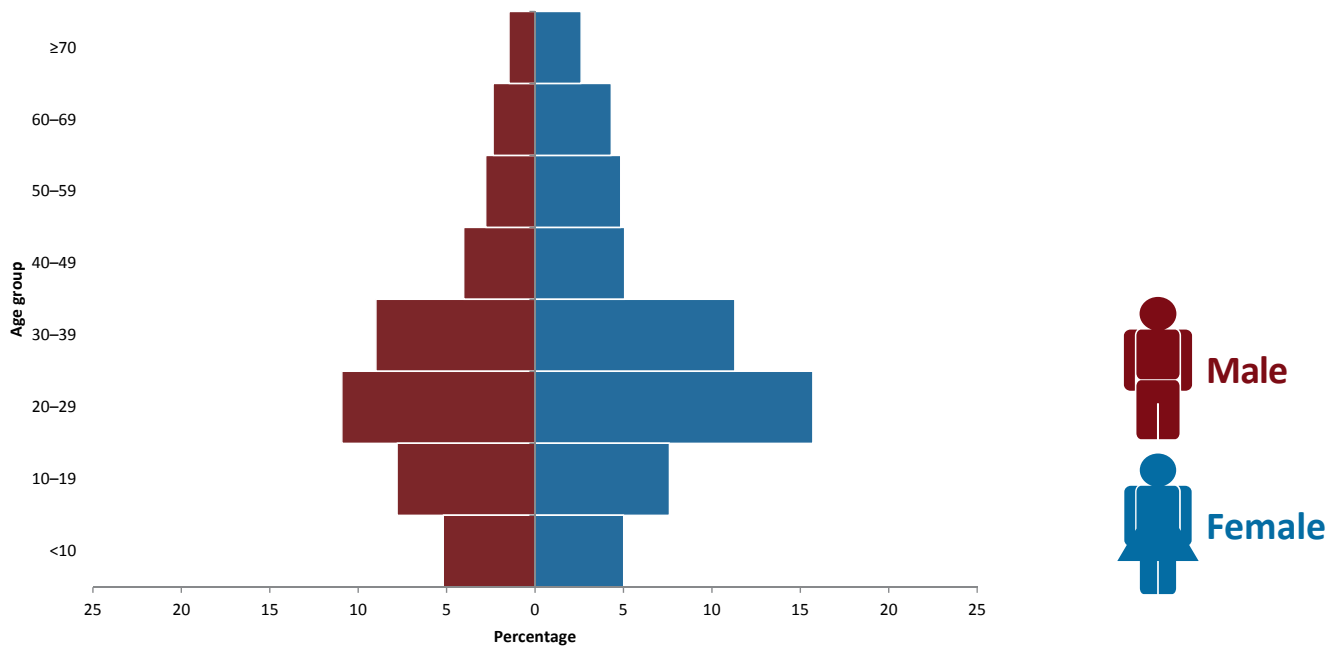
**TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG REFUGEES  
IN ASIA = 31,492**

**Figure 26a. Distribution of immigrant health assessments by sex and age, Africa, IOM, 2016**

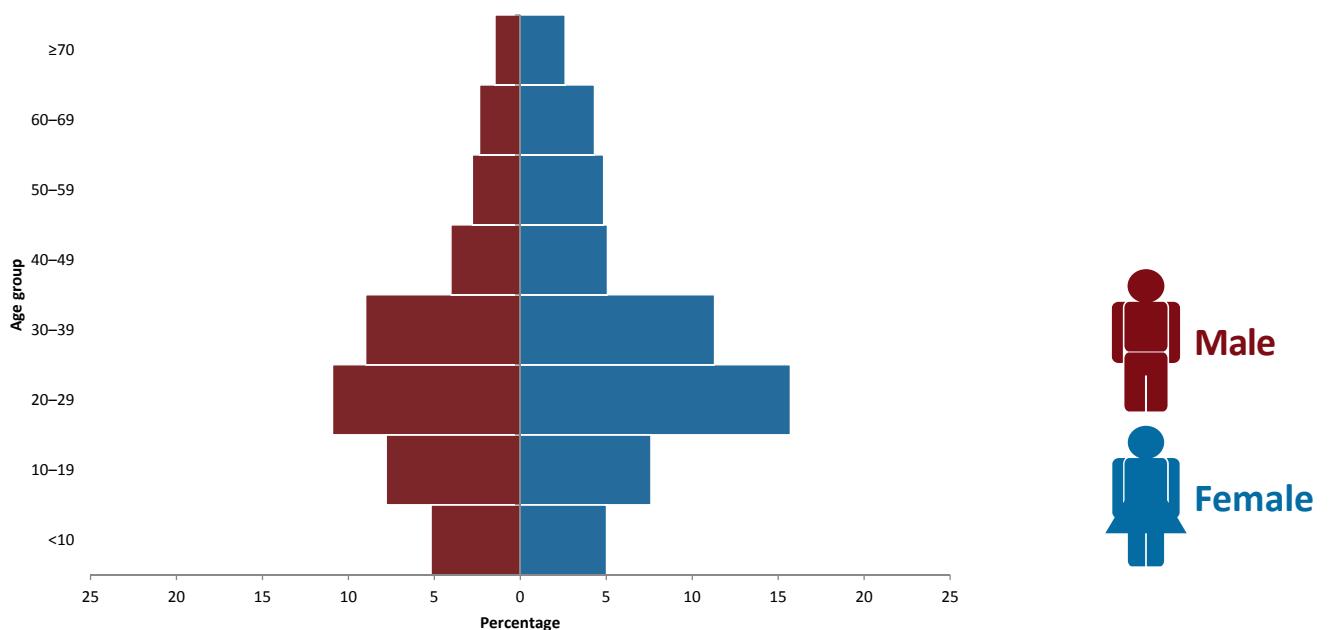
**TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG IMMIGRANTS IN AFRICA = 59,537**

**Figure 26b. Distribution of refugee health assessments by sex and age, Africa, IOM, 2016**

**TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG REFUGEES IN AFRICA = 71,131**

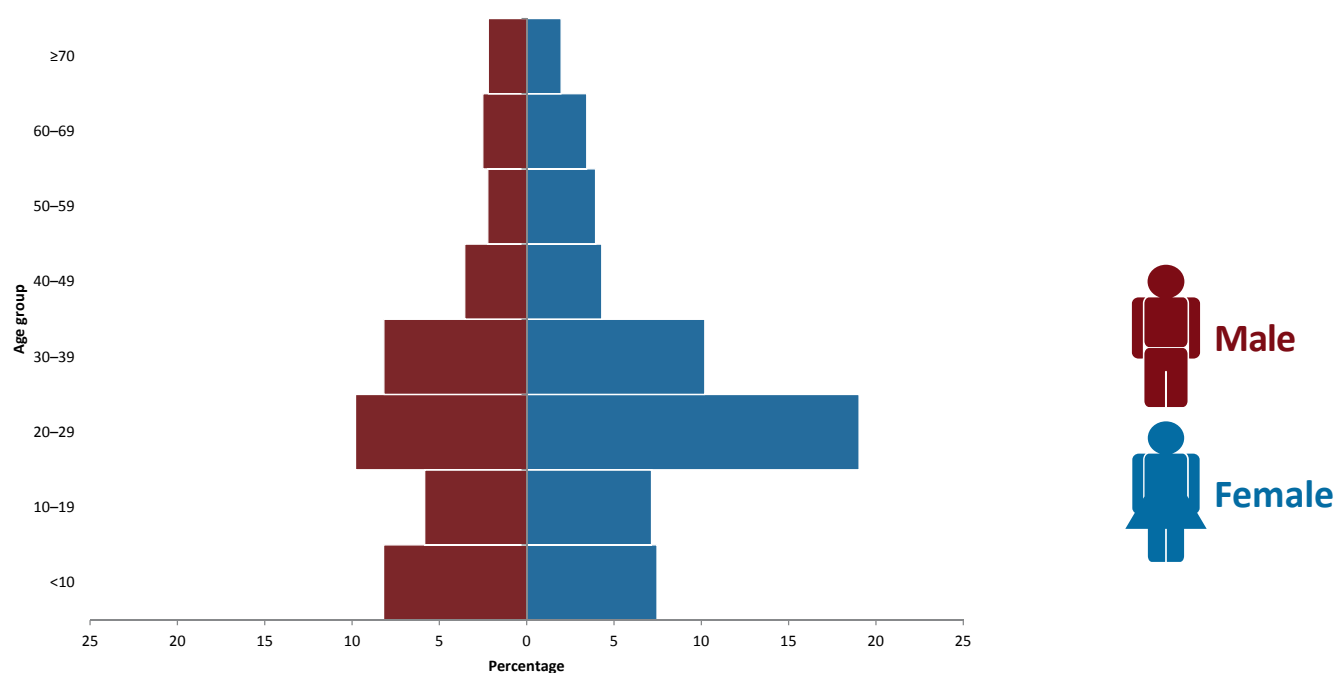
**Figure 27a. Distribution of immigrant health assessments by sex and age, Europe, IOM, 2016**

**TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG IMMIGRANTS  
IN EUROPE = 37,946**

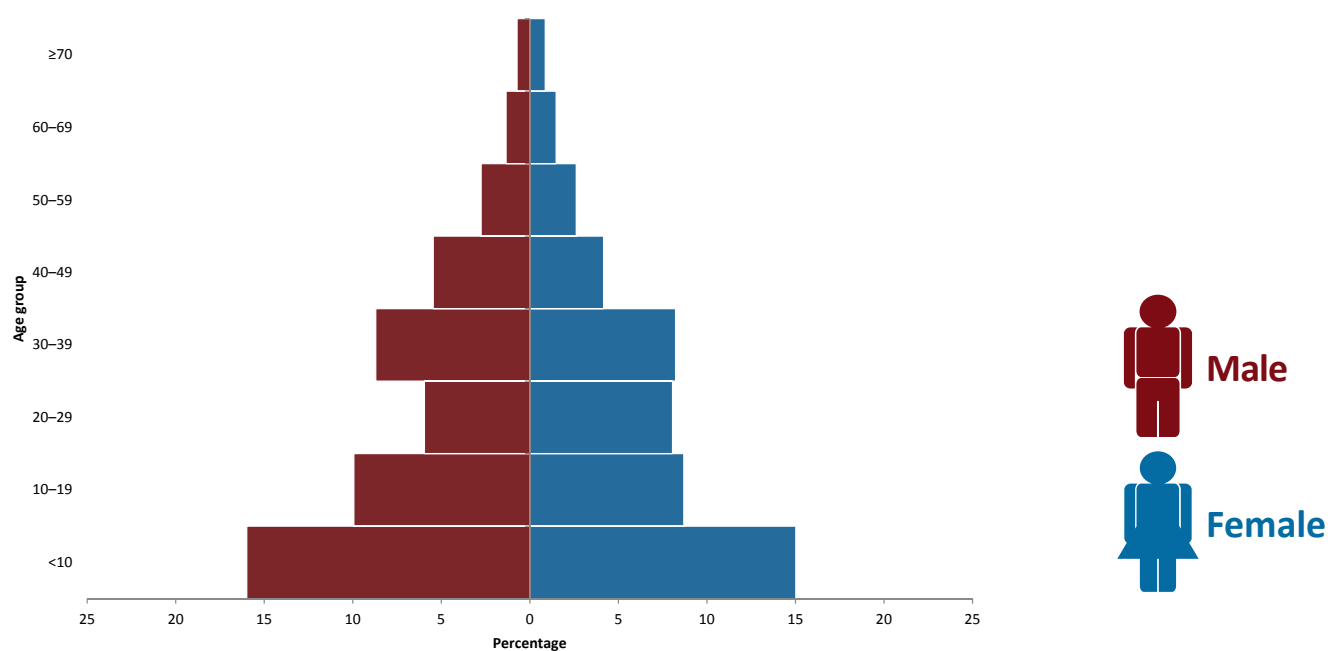
**Figure 27b. Distribution of refugee health assessments by sex and age, Europe, IOM, 2016**

**TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG REFUGEES  
IN EUROPE = 16,800**

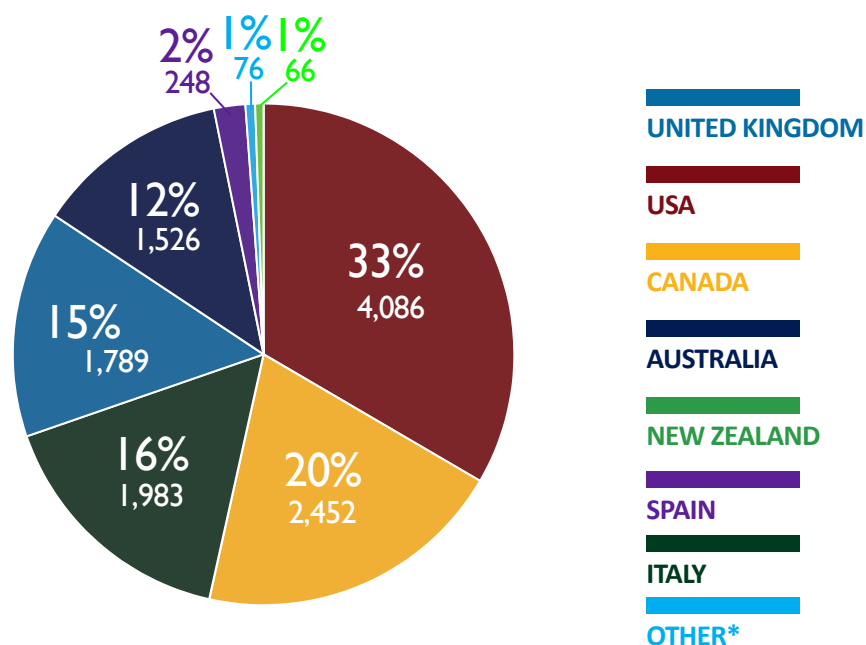


**Figure 28a. Distribution of immigrant health assessments by sex and age, Middle East, IOM, 2016**

**TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG IMMIGRANTS  
IN THE MIDDLE EAST = 6,284**

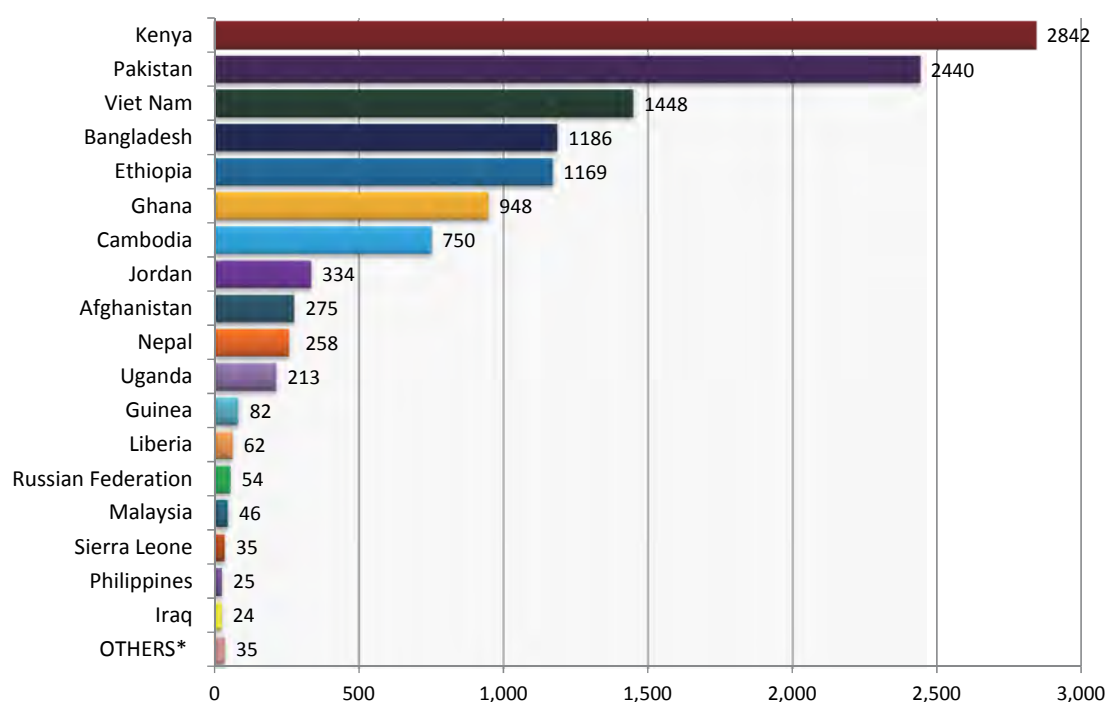
**Figure 28b. Distribution of refugee health assessments by sex and age, Middle East, IOM, 2016**

**TOTAL NUMBER OF HEALTH ASSESSMENTS AMONG REFUGEES  
IN THE MIDDLE EAST = 94,148**

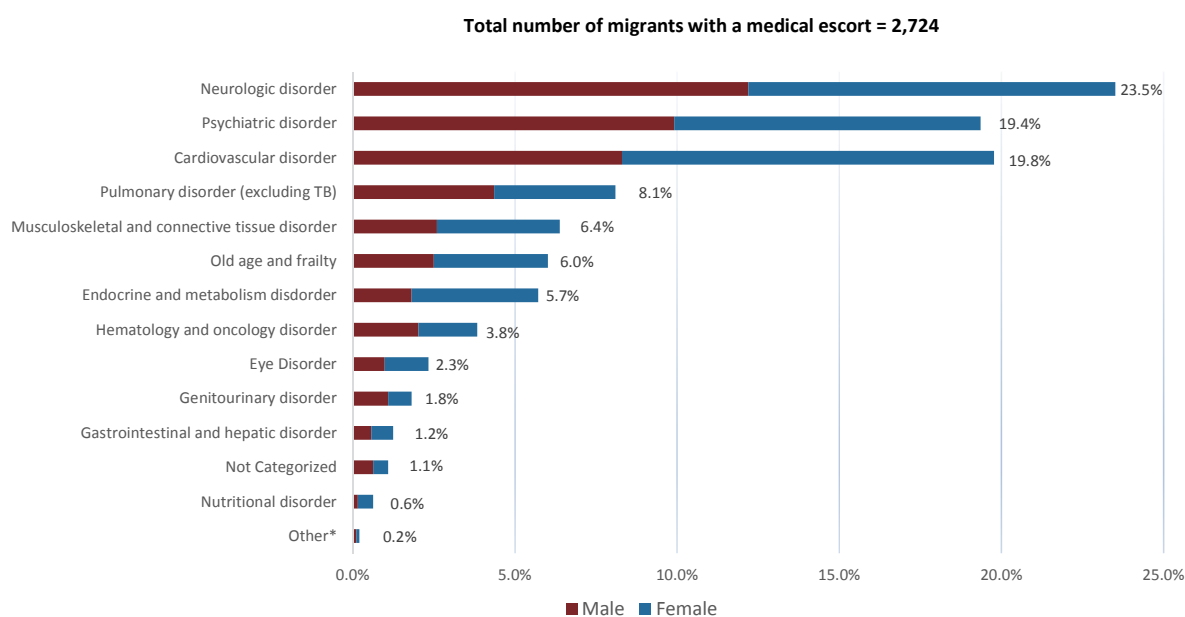
**Figure 29a. DNA sample collection services by country of destination, IOM, 2016**

\*Other destination countries includes Ireland and Norway.

**TOTAL NUMBER OF DNA SAMPLES COLLECTED = 12,226**

**Figure 29b. DNA sample collection services by country of sample collection, IOM, 2016**

\*Others: Ukraine (13), Togo (8), Thailand (6), Republic of Moldova (4), Serbia (2) & Syrian Arab Republic (2).

**Figure 30. Pre-travel medical conditions of all escorted migrants, IOM, 2016**

\*"Other" includes gynecologic disorder, injuries or poisoning, ENT disorder, and not categorized condition.

\*\*Percentages are based on total number of medical conditions (1,364).

**Figure 31. Number of migrants travelling with medical escorts by country of destination, IOM, 2016**



**Table I. IOM health assessments by country of health assessment, country of destination and migrant category, 2016**

Country of Health Assessment	Country of Destination							
	Australia		Canada		New Zealand		United Kingdom	
	Immigrant <sup>a</sup>	Refugee <sup>a</sup>	Immigrant <sup>a</sup>	Refugee <sup>a</sup>	Immigrant <sup>a</sup>	Refugee <sup>a</sup>	Immigrant <sup>a</sup>	Refugee <sup>a</sup>
Afghanistan	523	44	1,081	20	75	0	739	622
Bangladesh	1,504	0	509	0	96	0	4,845	0
Cambodia	1,556	0	352	0	487	0	152	0
Indonesia	0	161	0	107	0	28	0	0
Malaysia	0	829	0	210	0	508	0	0
Myanmar (Burma)	0	0	0	0	0	0	465	0
Nepal	618	493	125	116	1	3	3,724	0
Pakistan	6,996	995	10,992	1,299	740	15	19,161	0
Philippines	0	0	8,993	0	0	0	5,948	0
Sri Lanka	0	0	247	0	0	0	2,889	0
Thailand	122	1,355	86	305	268	110	6,201	0
Viet Nam	3,899	0	5,898	0	331	0	2,578	0
<b>Asia</b>	<b>15,218</b>	<b>3,877</b>	<b>28,283</b>	<b>2,057</b>	<b>1,998</b>	<b>664</b>	<b>46,702</b>	<b>622</b>
Algeria	0	0	0	0	0	0	0	0
Bahrain	0	0	0	0	0	0	0	0
Egypt	0	62	0	730	0	0	0	793
Iraq	385	1,084	283	507	73	0	1,538	406
Israel	0	0	0	0	0	0	0	0
Jordan	221	6,137	323	7,754	52	4	99	716
Kuwait	0	0	0	0	0	0	0	0
Lebanon	0	8,305	179	18,880	0	641	2	4,708
Morocco	0	0	0	0	0	0	0	0
Oman	0	0	0	0	0	0	0	0
Qatar	0	0	0	0	0	0	0	0
Saudi Arabia	0	0	0	0	0	0	0	0
Syrian Arab Republic	107	418	258	30	13	1	0	137
Tunisia	0	0	0	0	0	0	0	0
Turkey	0	0	0	2,002	0	0	0	1,132
United Arab Emirates	0	0	0	0	0	0	0	0
<b>Middle East</b>	<b>713</b>	<b>16,006</b>	<b>1,043</b>	<b>29,903</b>	<b>138</b>	<b>646</b>	<b>1,639</b>	<b>7,892</b>
Angola	0	0	0	12	0	0	525	0
Botswana	0	16	0	9	0	0	235	0
Burundi	42	172	648	61	2	8	0	239
Cameroon	0	0	0	196	0	0	582	0
Chad	0	0	4	31	0	0	0	0
Congo	0	5	0	5	0	0	0	0
Côte d'Ivoire	0	0	0	0	0	0	159	0
Democratic Republic of the Congo	0	1	0	2	0	0	224	0
Djibouti	0	0	0	156	0	3	0	0
Ethiopia	715	106	1,808	807	141	1	1,460	0
Gabon	0	0	0	0	0	0	0	0
Gambia	0	0	0	0	0	0	685	0
Ghana	208	59	997	54	43	0	3,683	0
Guinea	6	8	0	0	0	0	0	0
Kenya	2,293	636	1,344	1,151	100	17	2,056	419
Liberia	0	0	0	22	0	0	0	0
Madagascar	0	0	0	0	0	0	27	0
Malawi	0	23	0	106	0	0	286	0
Mali	0	0	0	0	0	0	0	0
Mauritania	0	0	0	0	0	0	0	0
Mozambique	0	12	0	41	0	0	71	0
Namibia	0	10	0	62	0	0	141	0
Nigeria	622	0	1,973	0	29	0	10,545	0
Rwanda	5	4	10	19	0	0	146	0
Senegal	0	0	0	0	0	0	154	0
Sierra Leone	0	0	0	1	0	0	564	0
Somalia	1	0	22	0	1	0	0	0
South Africa	0	8	0	496	0	0	6,519	0
Sudan	0	0	4	2,505	0	0	2,270	0
Togo	0	0	0	42	0	0	0	0
Uganda	376	160	877	909	25	1	1,432	0
United Republic of Tanzania	4	42	2	444	0	0	634	0
Zambia	0	30	0	68	0	0	436	0
Zimbabwe	0	0	0	207	0	0	1,666	0
<b>Africa</b>	<b>4,272</b>	<b>1,292</b>	<b>7,689</b>	<b>7,406</b>	<b>341</b>	<b>30</b>	<b>34,500</b>	<b>658</b>
Armenia	0	0	0	0	0	0	0	0
Austria	0	0	0	0	0	0	0	0
Azerbaijan	0	0	0	0	0	0	0	0
Belarus	119	0	336	0	35	0	282	0
Bosnia and Herzegovina	231	0	127	0	2	0	0	0
Bulgaria	0	0	342	0	0	0	0	0
Georgia	0	0	0	0	0	0	0	0
Germany	0	0	0	0	0	0	0	0
Greece	0	0	0	0	0	0	0	4
Kazakhstan	279	0	681	0	141	0	1,768	0
Kyrgyzstan	0	0	0	0	0	0	0	0
Latvia	0	0	0	0	0	0	0	0
Malta	0	0	0	0	0	0	0	0
Republic of Moldova	0	0	0	0	0	0	0	0
Romania	34	0	1,050	0	6	0	57	0
Russian Federation	129	0	1,195	0	20	0	0	0
Serbia	1,160	0	1,716	68	411	0	3,697	0
Slovakia	290	0	277	0	98	0	0	0
Tajikistan	0	0	0	0	0	0	0	0
The Former Yugoslav Republic of Macedonia	256	0	72	0	41	0	0	0
Ukraine	656	0	3,724	11	87	0	1,609	0
Uzbekistan	0	0	0	0	0	0	0	0
UNSC resolution 1244-administered Kosovo	31	0	2	0	2	0	0	0
<b>Europe</b>	<b>3,185</b>	<b>0</b>	<b>9,522</b>	<b>79</b>	<b>843</b>	<b>0</b>	<b>7,413</b>	<b>4</b>
<b>Worldwide</b>	<b>23,388</b>	<b>21,175</b>	<b>46,537</b>	<b>39,445</b>	<b>3,320</b>	<b>1,340</b>	<b>90,254</b>	<b>9,176</b>
	44,563		85,982		4,660		99,430	

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

Country of Destination							
United States		Other <sup>b</sup>		Total		Grand Total	
Immigrant <sup>a</sup>	Refugee <sup>a</sup>	Immigrant <sup>a</sup>	Refugee <sup>a</sup>	Immigrant <sup>a</sup>	Refugee <sup>a</sup>	No.	%
0	0	0	0	2,418	686	3,104	2.0
5,007	0	400	0	12,361	0	12,361	8.0
2,832	2	21	0	5,400	2	5,402	3.5
0	1,149	0	0	0	1,445	1,445	0.9
0	7,238	0	28	0	8,813	8,813	5.7
0	0	0	0	465	0	465	0.3
7,445	8,819	0	0	11,913	9,431	21,344	13.8
0	1,798	16	0	37,905	4,107	42,012	27.1
0	2	2	0	14,943	2	14,945	9.6
0	54	10	0	3,146	54	3,200	2.1
0	5,119	7	34	6,684	6,923	13,607	8.8
15,643	29	13	0	28,362	29	28,391	18.3
30,927	24,210	469	62	123,597	31,492	155,089	35.2%
0	20	0	0	0	20	20	0.0
0	19	0	0	0	19	19	0.0
0	3,955	0	0	0	5,540	5,540	5.5
1,474	11,928	0	16	3,753	13,941	17,694	17.6
0	108	0	0	0	108	108	0.1
1,271	19,889	0	127	1,966	34,627	36,593	36.4
0	200	0	0	0	200	200	0.2
0	0	6	1,480	187	34,014	34,201	34.1
0	99	0	0	0	99	99	0.1
0	66	0	0	0	66	66	0.1
0	33	0	0	0	33	33	0.0
0	2	0	0	0	2	2	0.0
0	0	0	0	378	586	964	1.0
0	4	0	0	0	4	4	0.0
0	0	0	1,443	0	4,577	4,577	4.6
0	312	0	0	0	312	312	0.3
2,745	36,635	6	3,066	6,284	94,148	100,432	22.8%
0	3	0	0	525	15	540	0.4
0	59	0	0	235	84	319	0.2
1	1,709	0	3	693	2,192	2,885	2.2
0	306	0	0	582	502	1,084	0.8
0	1,184	0	0	4	1,215	1,219	0.9
0	72	0	0	0	82	82	0.1
0	0	0	0	159	0	159	0.1
0	21	0	0	224	24	248	0.2
0	511	0	0	0	670	670	0.5
4,369	6,951	0	15	8,493	7,880	16,373	12.5
0	6	0	0	0	6	6	0.0
0	4	0	0	685	4	689	0.5
28	174	212	0	5,171	287	5,458	4.2
0	14	0	0	6	22	28	0.0
7,854	18,124	8	12	13,655	20,359	34,014	26.0
0	2	0	0	0	24	24	0.0
0	0	0	0	27	0	27	0.0
0	693	0	0	286	822	1,108	0.8
0	6	0	0	0	6	6	0.0
0	39	0	0	0	39	39	0.0
0	83	0	0	71	136	207	0.2
0	410	0	0	141	482	623	0.5
0	28	0	0	13,169	28	13,197	10.1
7	4,481	0	0	168	4,504	4,672	3.6
0	4	0	0	154	4	158	0.1
0	0	0	0	564	1	565	0.4
0	0	0	0	24	0	24	0.0
0	1,780	0	0	6,519	2,284	8,803	6.7
0	772	0	0	2,274	3,277	5,551	4.2
0	0	0	0	0	42	42	0.0
253	10,216	0	0	2,963	11,286	14,249	10.9
3	12,281	0	0	643	12,767	13,410	10.3
0	1,385	0	0	436	1,483	1,919	1.5
0	397	0	0	1,666	604	2,270	1.7
12,515	61,715	220	30	59,537	71,131	130,668	29.6%
0	47	0	0	0	47	47	0.1
0	81	0	0	0	81	81	0.1
0	30	0	0	0	30	30	0.1
1,141	175	3	0	1,916	175	2,091	3.8
0	0	0	0	360	0	360	0.7
0	0	0	0	342	0	342	0.6
0	8	0	0	0	8	8	0.0
0	1	0	0	0	1	1	0.0
0	0	0	8,739	0	8,743	8,743	16.0
0	79	7	0	2,876	79	2,955	5.4
0	0	0	0	35	0	35	0.1
0	69	0	0	0	69	69	0.1
0	8	0	0	0	8	8	0.0
0	543	0	0	0	543	543	1.0
1,620	582	0	0	2,767	582	3,349	6.1
0	166	0	0	1,344	166	1,510	2.8
4,532	732	2,669	2	14,185	802	14,987	27.4
259	2	151	0	1,075	2	1,077	2.0
0	27	0	0	0	27	27	0.0
0	0	0	0	369	0	369	0.7
6,601	5,144	0	0	12,677	5,155	17,832	32.6
0	49	0	0	0	49	49	0.1
0	233	0	0	0	233	233	0.4
14,153	7,976	2,830	8,741	37,946	16,800	54,746	12.4%
60,340	130,536	3,525	11,899	227,364	213,571	440,935	100%
190,876			15,424		440,935		440,935

**Table 2. Tuberculosis detection among all migrants, IOM selected operations, 2016**

Country of Health Assessment (HA) <sup>b</sup>	Total HAs	Active TB			TB detection <sup>a</sup> per 100,000 HAs		
		Lab <sup>c</sup>	Clinical <sup>d</sup>	Total	Lab <sup>c</sup>	Clinical <sup>d</sup>	Total
Africa							
Burundi	2,885	10	0	10	347	0	347
Cameroon	1,084	1	0	1	92	0	92
Chad	1,219	2	1	3	164	82	246
Ethiopia	16,373	11	6	17	67	37	104
Ghana	5,458	-	2	2	-	37	37
Kenya	34,014	90	20	110	265	59	323
Malawi	1,108	-	-	-	-	-	-
Nigeria	13,197	4	-	4	30	0	30
Rwanda	4,672	3	-	3	64	-	64
South Africa	8,808	7	-	7	80	-	80
Sudan	5,551	-	1	1	0	18	18
Uganda	14,249	27	-	27	189	0	189
United Republic of Tanzania	13,410	19	2	21	142	15	157
Zambia	1,919	3	-	3	156	-	156
Zimbabwe	2,270	2	-	2	88	-	88
Middle East							
Egypt	5,540	2	-	2	36	-	36
Iraq	17,694	3	-	3	17	-	17
Jordan	36,589	4	1	5	11	3	14
Lebanon	34,205	1	1	2	3	3	6
Turkey	4,577	2	-	2	44	-	44
Asia							
Afghanistan	3,140	-	-	-	-	-	-
Bangladesh	12,361	12	-	12	97	-	97
Cambodia	5,402	22	3	25	407	56	463
Indonesia	1,445	-	1	1	-	69	69
Malaysia	8,813	44	26	70	499	295	794
Nepal	21,344	121	4	125	567	19	586
Pakistan	42,012	45	-	45	107	-	107
Philippines	14,945	62	83	145	415	555	970
Sri Lanka	3,200	2	-	2	63	-	63
Thailand	13,607	35	7	42	257	51	309
Viet Nam	28,391	56	41	97	197	144	342
Europe							
Belarus	2,091	-	-	-	-	-	-
Greece	8,743	1	-	1	11	-	11
Kazakhstan	2,955	1	-	1	34	-	34
Republic of Moldova	3,349	-	1	1	-	30	30
Romania	1,510	-	-	-	-	-	-
Russian Federation	14,987	6	1	7	40	7	47
Serbia	1,077	-	-	-	-	-	-
Ukraine	17,832	10	-	10	56	-	56
All Regions							
Other countries <sup>e</sup>	8,950	7	-	7	78	-	78
Total	440,935	615	201	816	139	46	185

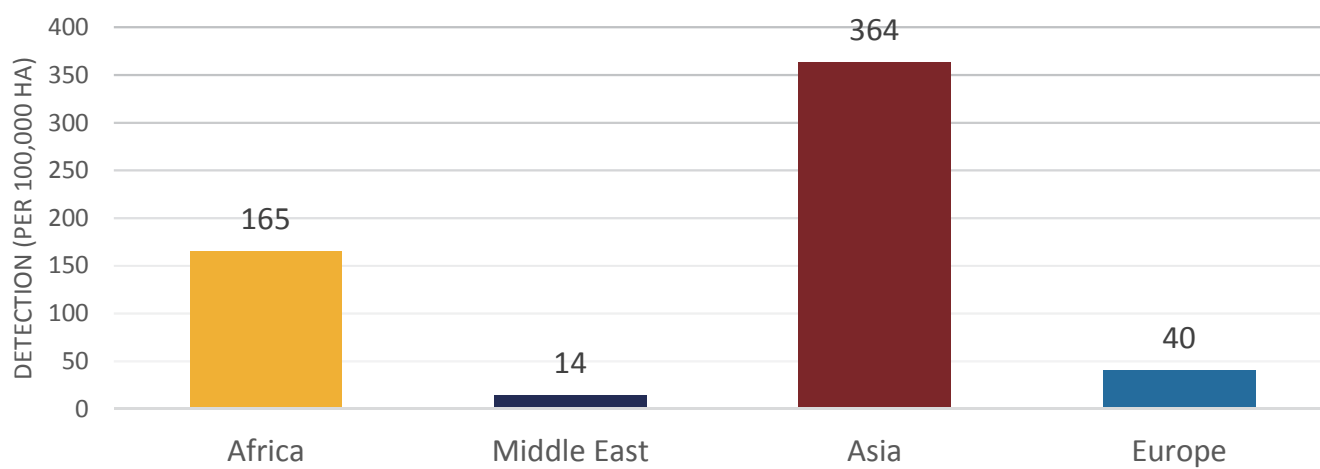
<sup>a</sup> Calculation of TB case detection is done using total numbers of active TB cases (laboratory confirmed or clinically diagnosed TB) as numerator and total HAs as denominator. HAs include repeat medical examinations when the migrant undergoes more than one screening process to meet immigration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

<sup>b</sup> IOM selected operations include locations with more than 1,000 assisted immigrants.

<sup>c</sup> "Lab" refers to TB cases confirmed by sputum culture.

<sup>d</sup> "Clinical" refers to TB cases diagnosed based on clinical or radiological findings.

<sup>e</sup> Refers to IOM operations with 1,000 or less assisted migrants.

**Figure 32. Tuberculosis detection among all migrants, IOM, 2016**



**Table 3. Tuberculosis detection among all immigrants, IOM selected operations, 2016**

Country of Health Assessment (HA) <sup>b</sup>	Total HAs	Active TB			TB detection <sup>a</sup> per 100,000 HAs		
		Lab <sup>c</sup>	Clinical <sup>d</sup>	Total	Lab <sup>c</sup>	Clinical <sup>d</sup>	Total
Africa							
Ethiopia	8,493	3	0	3	35	0	35
Ghana	5,171	0	1	1	0	19	19
Kenya	13,655	38	9	47	278	66	344
Nigeria	13,169	4	0	4	30	0	30
South Africa	6,519	1	0	1	15	0	15
Sudan	2,274	0	1	1	0	44	44
Uganda	2,963	0	0	0	0	0	0
Zimbabwe	1,666	1	0	1	60	0	60
Middle East							
Iraq	3,753	0	0	0	0	0	0
Jordan	1,966	1	0	1	51	0	51
Asia							
Afghanistan	2,418	0	0	0	0	0	0
Bangladesh	12,361	12	0	12	97	0	97
Cambodia	5,400	22	3	25	407	56	463
Nepal	11,913	36	0	36	302	0	302
Pakistan	37,905	36	0	36	95	0	95
Philippines	14,943	62	83	145	415	555	970
Sri Lanka	3,146	2	0	2	64	0	64
Thailand	6,684	8	0	8	120	0	120
Viet Nam	28,362	56	41	97	197	145	342
Europe							
Belarus	1,916	0	0	0	0	0	0
Kazakhstan	2,876	1	0	1	35	0	35
Republic of Moldova	2,767	0	1	1	0	36	36
Romania	1,344	0	0	0	0	0	0
Russian Federation	14,185	4	1	5	28	7	35
Serbia	1,075	0	0	0		0	0
Ukraine	12,677	7	0	7	55	0	55
All regions							
Other countries	7,763	7	0	7	90	0	90
Total	227,364	301	140	441	132	62	194

<sup>a</sup> Calculation of TB case detection is done using total numbers of active TB cases (laboratory confirmed or clinically diagnosed TB) as numerator and total HAs as denominator.

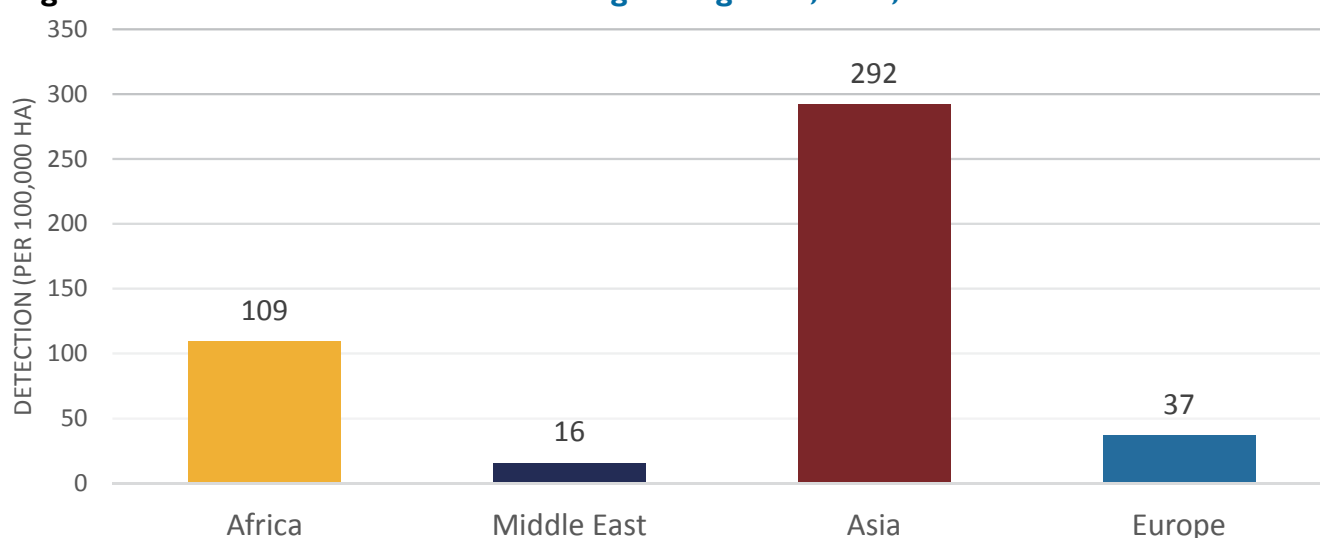
HAs include repeat medical examinations when the migrant undergoes more than one screening process to meet immigration health requirements or other related reasons.

<sup>b</sup> IOM selected operations include locations with more than 1,000 assisted immigrants.

<sup>c</sup> "Lab" refers to TB cases confirmed by sputum culture.

<sup>d</sup> "Clinical" refers to TB cases diagnosed based on clinical or radiological findings.

<sup>e</sup> Refers to IOM operations with 1,000 or less assisted migrants.

**Figure 33. Tuberculosis detection among immigrants, IOM, 2016**

**Table 4. Tuberculosis detection among refugees, IOM selected operations, 2016**

Country of Health Assessment (HA) <sup>b</sup>	Total HAs	Confirmed TB cases			TB detection detection <sup>a</sup> per 100,000 HAs		
		Lab <sup>d</sup>	Clinical <sup>e</sup>	Total	Lab <sup>d</sup>	Clinical <sup>e</sup>	Total
Africa							
Burundi	2,192	6	-	6	274	-	274
Chad	1,215	2	1	3	165	82	247
Ethiopia	7,880	8	6	14	102	76	178
Kenya	20,359	52	11	63	255	54	309
Rwanda	4,504	3	-	3	67	-	67
South Africa	2,284	6	-	6	263	-	263
Sudan	3,277	-	-	-	-	-	-
Uganda	11,286	27	-	27	239	-	239
United Republic of Tanzania	12,767	17	2	19	133	16	149
Zambia	1,483	3	-	3	202	-	202
Middle East							
Egypt	5,540	2	-	2	36	-	36
Iraq	13,941	3	-	3	22	-	22
Jordan	34,623	3	1	4	9	3	12
Lebanon	34,018	1	1	2	3	3	6
Turkey	4,577	2	-	2	44	-	44
Asia							
Indonesia	1,445	-	1	1	-	69	69
Malaysia	8,813	44	26	70	499	295	794
Nepal	9,431	85	4	89	901	42	944
Pakistan	4,107	9	-	9	219	-	219
Thailand	6,923	27	7	34	390	101	491
Europe							
Greece	8,743	1	-	1	11	-	11
Ukraine	5,155	3	-	3	58	-	58
All regions							
Other countries <sup>f</sup>	9,008	10	1	11	111	11	122
Total	213,571	314	61	375	147	29	176

<sup>a</sup> Calculation of TB case detection is done using total number of active TB cases (laboratory confirmed or clinically diagnosed TB) as numerator and total HAs as denominator.

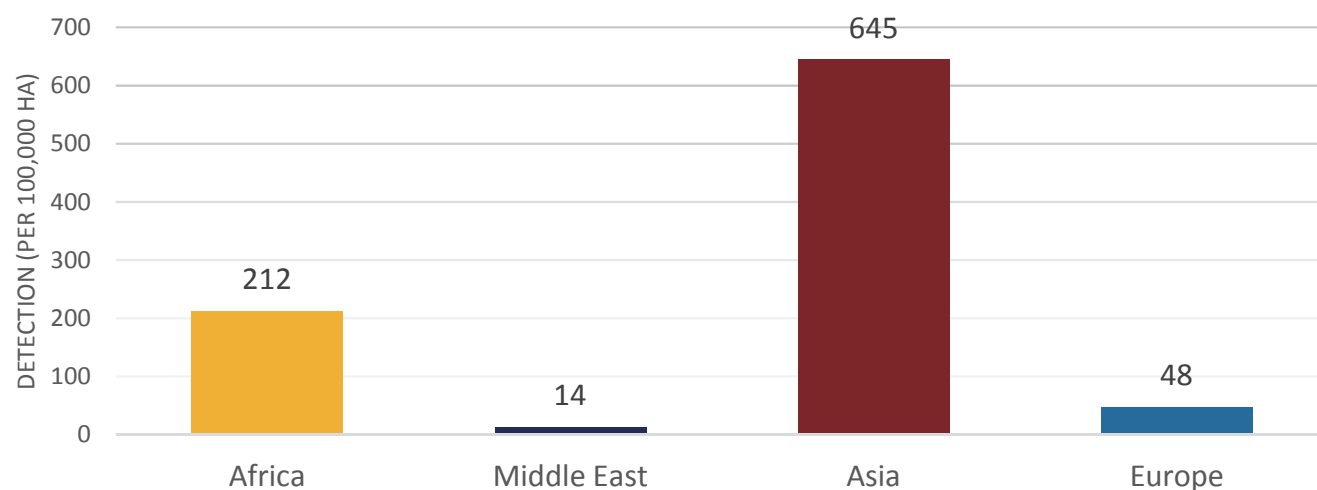
HAs include repeat medical examinations when the migrant undergoes more than one screening process to meet immigration health requirements or other related reasons.

<sup>b</sup> IOM selected operations include locations with more than 1,000 assisted refugees.

<sup>c</sup> "Lab" refers to TB cases confirmed by sputum culture.

<sup>d</sup> "Clinical" refers to TB cases diagnosed based on clinical or radiological findings.

<sup>e</sup> Refers to IOM operations with 1,000 or less assisted refugees.

**Figure 34. Tuberculosis detection among refugees, IOM, 2016**

**Table 5. Drug susceptibility testing results among cases with *Mycobacterium tuberculosis* (MTB) growth on culture, IOM, 2016**

DST	Number	%
Pansusceptible <sup>a</sup>	446	86.1
Monoresistant <sup>b</sup>	47	9.1
Polyresistant <sup>c</sup>	12	2.3
MDR TB <sup>d</sup>	12	2.3
Extensive drug resistant TB <sup>e</sup>	1	0.2
<b>Total</b>	<b>518</b>	<b>100.0</b>

<sup>a</sup> Susceptible to all first-line anti-TB drugs.

<sup>b</sup> Resistant to one first-line anti-TB drug only.

<sup>c</sup> Resistant to more than one first-line anti-TB drug (other than both isoniazid and rifampicin).

<sup>d</sup> Resistant to at least both isoniazid and rifampicin.

<sup>e</sup> Resistant to any fluoroquinolone and to at least one of three second-line injectable drugs, in addition to multidrug resistance.

Sources of notes:

WHO. (2013). Definitions and Reporting Framework for Tuberculosis – 2013 revision (Updated December 2014).

Available at [www.who.int/tb/publications/definitions/en/](http://www.who.int/tb/publications/definitions/en/)

**Table 6. Tuberculosis detection by country of exam, United Kingdom Tuberculosis Detection Programme, 2016**

Country of exam	Total exams	Active TB <sup>a</sup>
Afghanistan	739	0
Angola	525	0
Bangladesh	4,845	3
Belarus	282	0
Botswana	235	0
Cambodia	152	0
Cameroon	582	0
Congo, Democratic Republic of the	224	1
Côte d'Ivoire	159	0
Ethiopia	1,460	1
Gambia	685	0
Ghana	3,686	1
Iraq	1,538	0
Jordan	99	0
Kazakhstan	1,768	1
Kenya	2,056	5
Madagascar	27	0
Malawi	286	0
Mozambique	71	0
Myanmar	465	0
Namibia	141	0
Nepal	3,724	11
Nigeria	10,545	4
Pakistan	19,161	18
Philippines	5,948	32
Republic of Moldova	57	0
Russian Federation	3,695	0
Rwanda	146	0
Senegal	154	0
Sierra Leone	564	0
South Africa	6,519	1
Sri Lanka	2,889	2
Sudan	2,270	1
United Republic of Tanzania	634	2
Thailand	6,201	7
Uganda	1,432	0
Ukraine	1,609	0
Viet Nam	2,578	4
Zambia	436	0
Zimbabwe	1,666	1
<b>Total</b>	<b>90,250</b>	<b>95</b>

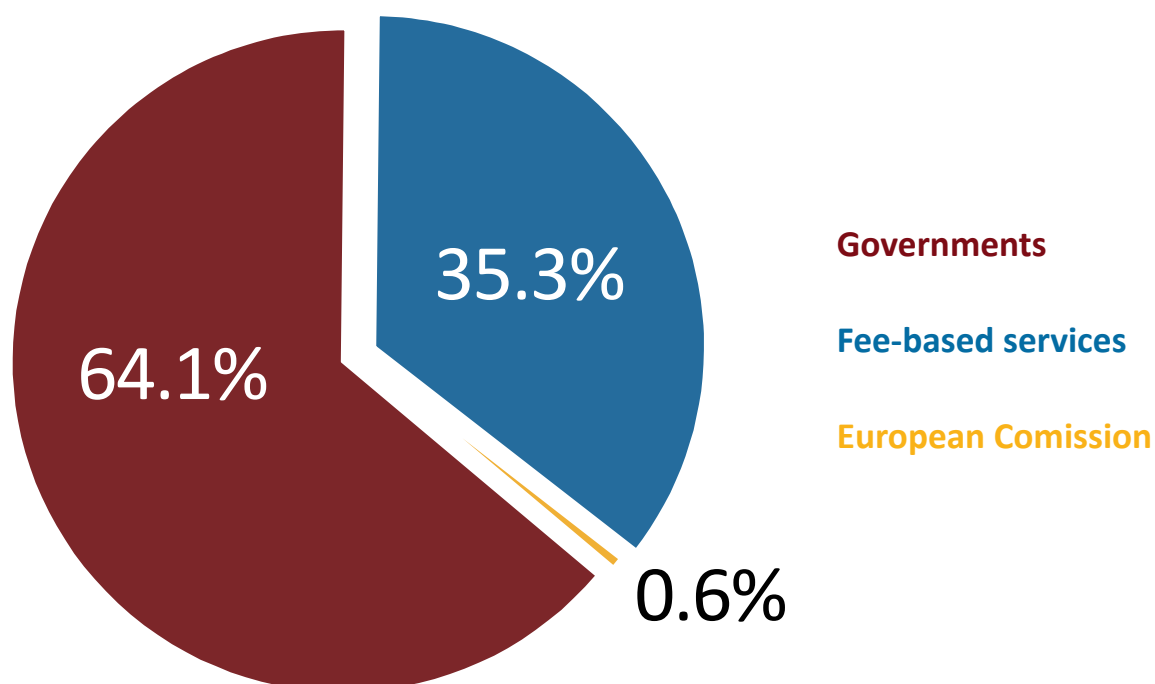
<sup>a</sup> With or without bacteriological confirmation

## ANNEX 3: FINANCIAL REVIEW 2016

**Table 7A Migration Health Assessments and Travel Health Assistance expenditure by funding source, 2015–2016**

Funding source	2016 Expenditure		2015 Expenditure		Increase/(Decrease)	
	(In USD)	%	(In USD)	%	(In USD)	%
Governments	54,326,571	64.07%	39,955,937	60.90%	14,370,634	35.97%
Fee-based services	29,960,253	35.33%	25,656,902	39.10%	4,303,351	16.77%
European Commission	506,457	0.60%	-	0.00%	506,457	-100%
Migration Health Assessments and Travel Health Assistance	84,793,281	100%	65,612,839	100%	19,180,443	29.23%

### FUNDING SOURCES FOR MIGRATION HEALTH ASSESSMENTS AND TRAVEL HEALTH ASSISTANCE, 2016

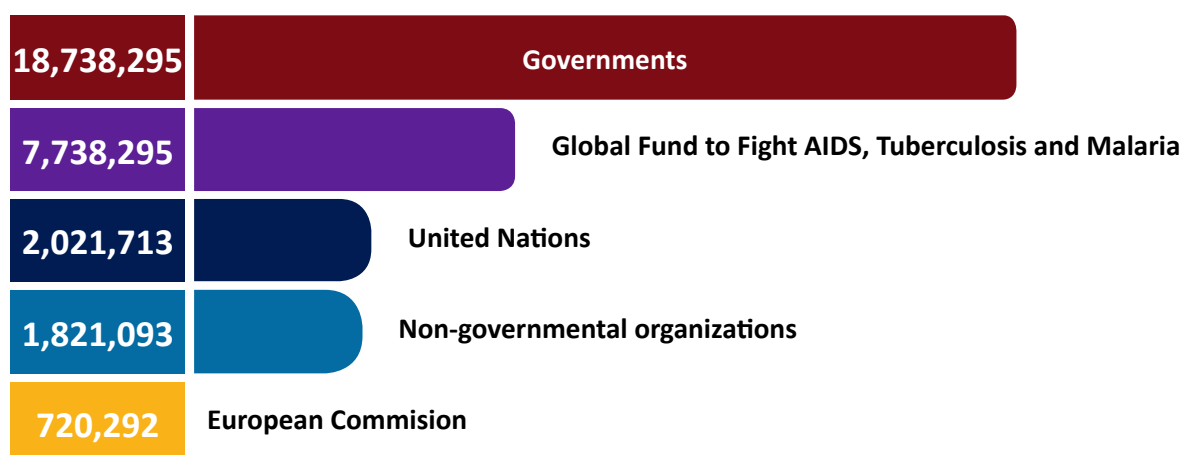




**Table 7B. Health Promotion and Assistance for Migrants expenditure by funding source, 2015–2016**

Funding source	2016 Expenditure		2015 Expenditure		Increase/(Decrease)	
	(In USD)	%	(In USD)	%	(In USD)	%
Governments	18,782,437	59.52%	10,438,518	50.66%	8,343,920	79.93%
United Nations	2,021,713	6.41%	1,482,029	7.19%	539,684	36.42%
Non-Governmental Organizations	1,821,093	5.77%	1,474,836	7.16%	346,257	23.48%
Global Fund to Fight AIDS, Tuberculosis and Malaria	7,738,295	24.52%	5,900,206	28.63%	1,838,089	31.15%
European Commission	720,292	2.28%	719,978	3.49%	314	0.04%
Asian Development Bank	265,740	0.84%	(2,142)	-0.01%	267,881	-12507.13%
IOM	175,015	0.55%	561,274	2.72%	(386,259)	-68.82%
Universities	30,964	0.10%	23,835	0.12%	7,129	29.91%
Private sector	(0)	0.00%	6,517	0.03%	(6,518)	-100%
<b>Health promotion and assistance for migrants</b>	<b>31,555,549</b>	<b>100%</b>	<b>20,605,051</b>	<b>100%</b>	<b>10,950,498</b>	<b>53.14%</b>

## TOP FIVE FUNDING SOURCES FOR HEALTH PROMOTION AND ASSISTANCE FOR MIGRANTS, 2016



**Table 7C. Migration Health Assistance for Crisis-affected Populations expenditure by funding source, 2015–2016**

Funding source	2016 Expenditure		2015 Expenditure		Increase/(Decrease)	
	(In USD)	%	(In USD)	%	(In USD)	%
Governments	31,878,809	68.77%	50,183,999	77.41%	(18,305,190)	-36.48%
United Nations	9,646,616	20.81%	9,868,596	15.22%	(221,980)	-2.25%
Global Fund to Fight AIDS, Tuberculosis and Malaria	2,173,759	4.69%	2,126,225	3.28%	47,534	2.24%
European Commission	992,972	2.14%	1,251,781	1.93%	(258,809)	-20.68%
Universities	73,673	0.16%	53,633	0.08%	20,040	37.37%
Non-governmental organizations	1,586,845	3.42%	1,281,151	1.98%	305,693	23.86%
Private sector	-	0.00%	92	0.00%	(92)	-100.00%
IOM	-	0.00%	64,588	0.10%	(64,588)	-100.00%
Migration Health Assistance for Crisis-Affected Populations	46,352,674	100%	64,830,065	100%	(18,477,391)	-28.50%

## TOP FIVE FUNDING SOURCES FOR MIGRATION HEALTH ASSISTANCE FOR CRISIS-AFFECTED POPULATIONS, 2016



Figure 35. Migration Health Division expenditure by programmatic area, 2001–2016

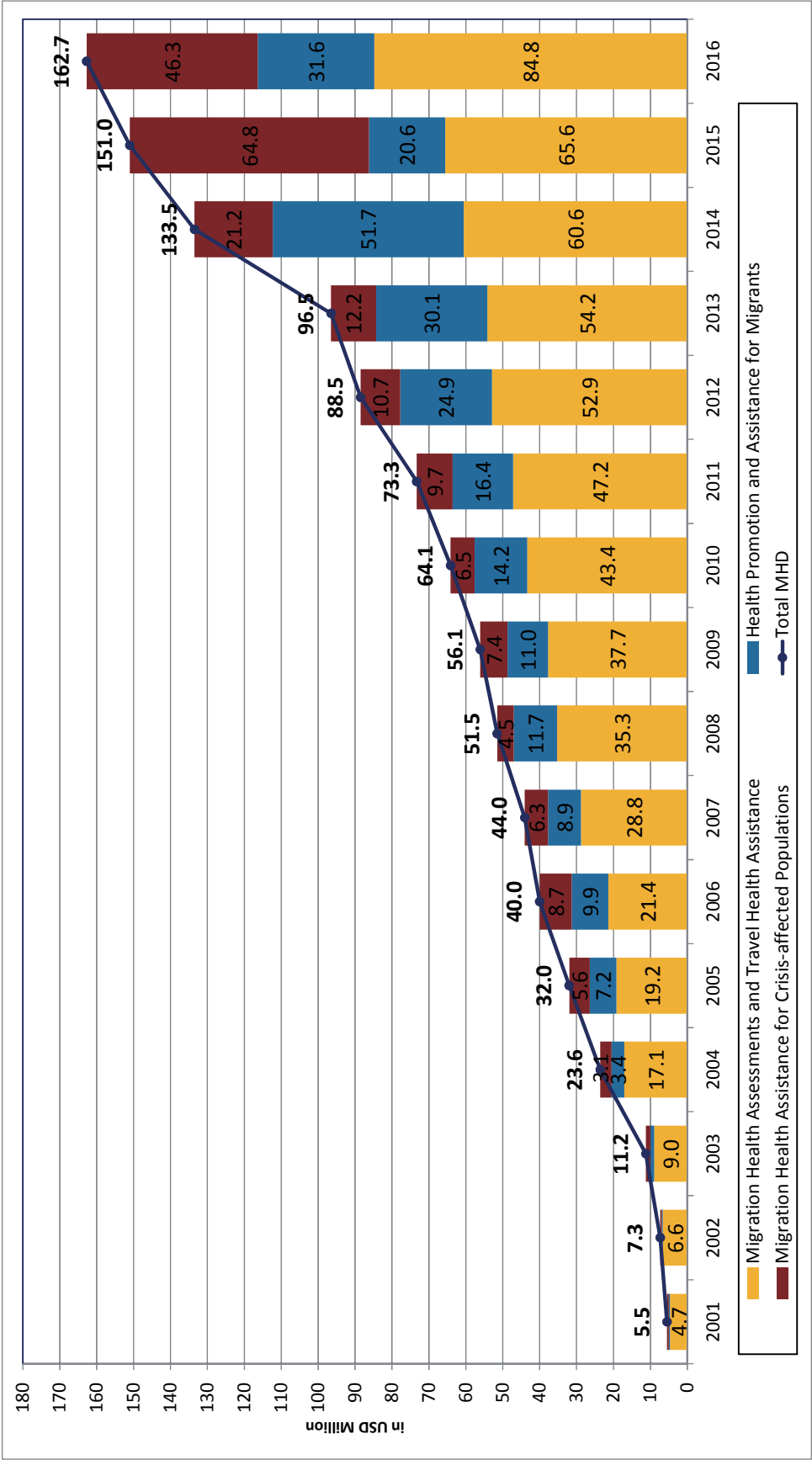


Figure 36. Migration Health Division expenditure by region and programmatic area, 2012–2016

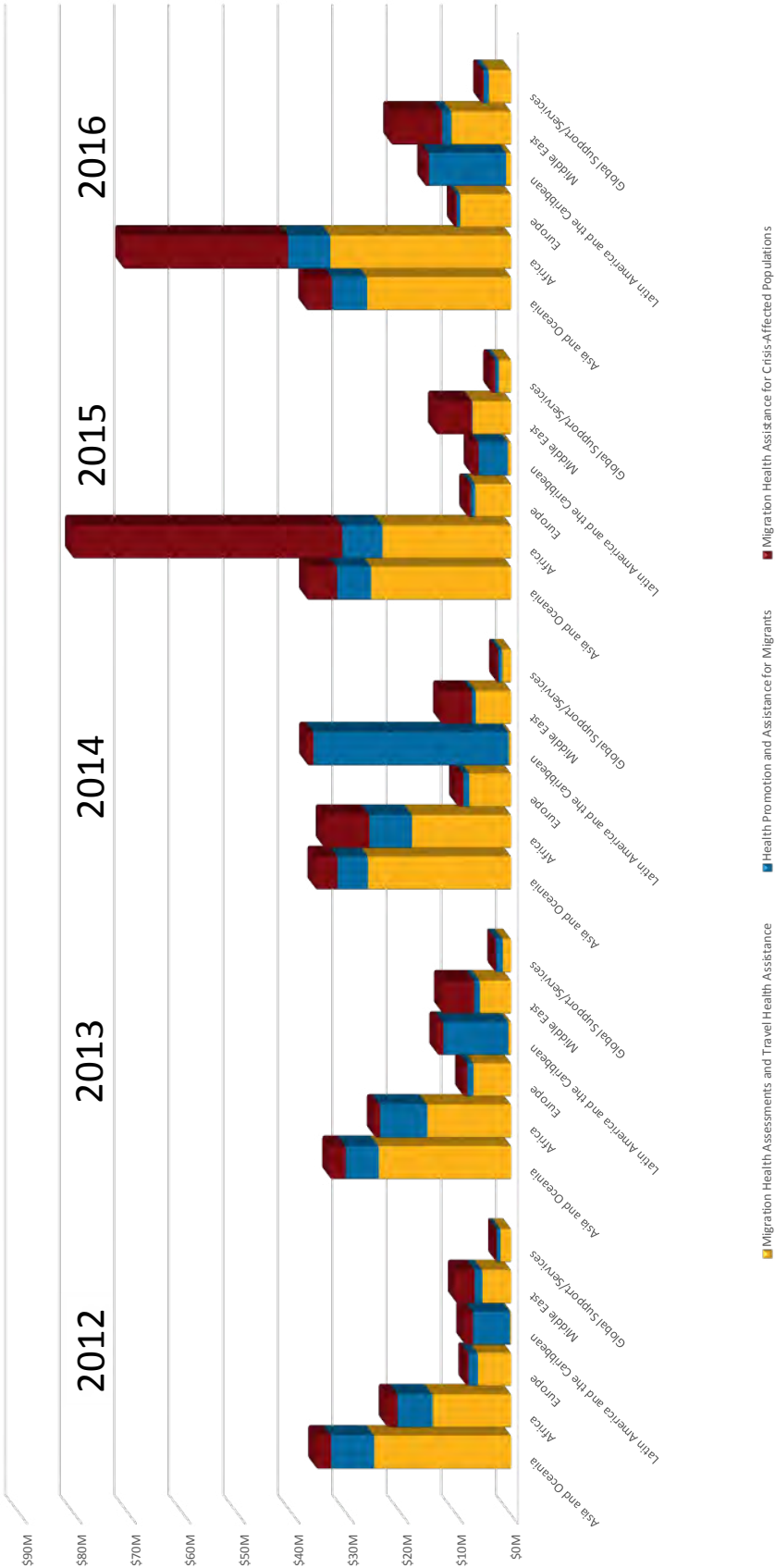
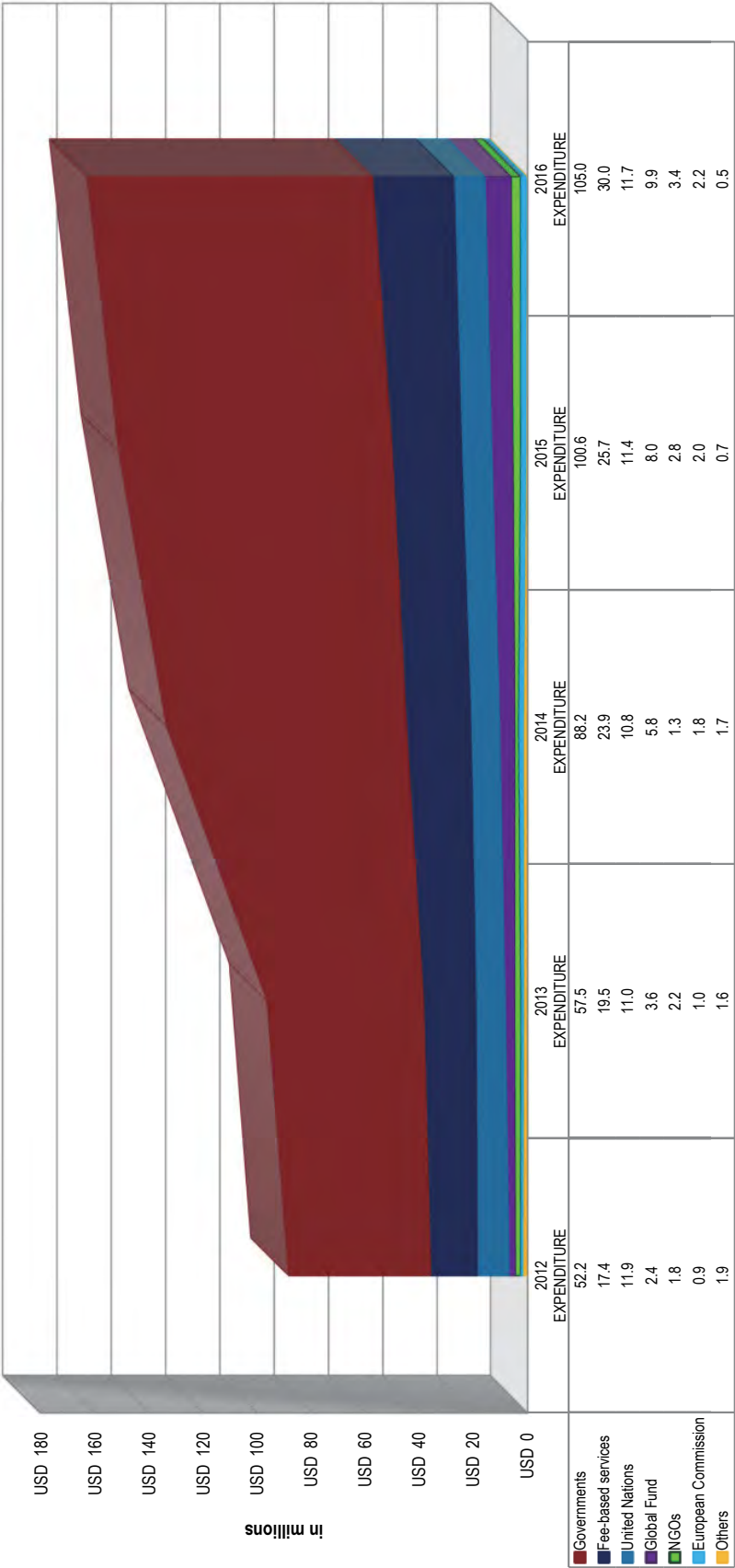




Figure 37. Migration Health Division expenditure by funding source in USD millions, 2012–2016



## ANNEX 4: LIST OF ACTIVE MHD PROJECTS, 2016

### A. Migration Health Assessments and Travel Health Assistance

- Health Assessments for Refugees in Africa going to the United States
- Health Assessments for Refugees in Europe going to the United States
- Health Assessments for Refugees in Middle East-North Africa going to the United States
- Health Assessments for Refugees in Southeast Asia going to the United States
- Health Assessments for Refugees in Southwest Asia going to the United States
- Health Assessment for Refugees going to Australia
- Pre-Departure Health Assessments for Refugees going to Australia
- Tuberculosis Detection Programme for Immigrants going to United Kingdom
- Global Health Assessment Programme for Immigrants going to Australia
- Global Health Assessment Programme for Immigrants going to Canada
- Global Health Assessment Programme for Immigrants going to New Zealand
- Global Health Assessment Programme for Immigrants going to the United States
- Global Health Assessment Programme for Immigrants going to Other Countries
- Harmonization of Protocols for Tuberculosis Diagnosis and Treatment of the Bhutanese Refugees in Nepal
- Medical Examinations, Tuberculosis Treatments, and Certain Vaccinations for Bhutanese Refugees going to Canada
- Enhancing Infectious Disease Surveillance and Mental Health of Refugee and Mobile Populations in East Africa
- Health Assessments for Syrian Refugees going to Australia
- Expanded Vaccination and Presumptive Treatment for Refugees going to the United States
- Enhancing the Overseas Health Assessment and Management of Refugees going to the United States
- IOM Radiologic Interpretation and Quality Control Center
- Supporting Member States under particular migratory pressure in their response to Health Related Challenges (Re-HEALTH)
- Providing Complementary Actions to Support the Relocation of Asylum Seekers selected by the Italian Government

### B. Health Promotion and Assistance for Migrants

- Migration Health Research
- Scaling up of HIV Prevention and Care Interventions for Migrants and Affected Communities in South Africa
- HIV/AIDS National Capacity Building and Awareness Raising Activities among Mobile Populations in Bosnia and Herzegovina
- Strengthening STOP TB Strategy in 46 High-Priority Municipalities of Colombia
- Containment of Artemisinin Resistance and Moving Towards Elimination of Plasmodium Falciparum in Thailand

- Strengthening Government's Capacity of Selected South Asian Countries to Address the Health of Migrants through a Multi-Sector Approach in Bangladesh, Nepal and Pakistan
- Partnership on Health and Mobility in the Mining Sector of Southern Africa
- Partnership on Health and Mobility in East and Southern Africa, Phase 2
- Fostering Health Provision for Migrants, the Roma and Other Vulnerable Group's
- UN Joint Programme on Gender Based Violence - Capacity Building on Gender and Migration in Zambia
- Strengthening Health System Response Capacity in support to the Kédougou Medical Authorities in Senegal
- Joint UN Programme of Support to AIDS in Uganda
- Mobilizing Medical Diaspora Resources for Lesotho in South Africa
- Strengthening the Capacity of the Governments of El Salvador, Nicaragua Honduras and Guatemala to Address the Health of Migrants through a Multi-sector Approach
- Addressing HIV and STI Vulnerabilities among Transnational Migrants in Algeria
- Reducing Latin America Sex Workers' Vulnerability to HIV
- Training Packages for Health Professionals to Improve Access and Quality of Health Services for Migrants and Ethnic Minorities, including the Roma
- Early and Improved Case Detection of TB through the Use of Genexpert Technology in Nepal
- Improving Health Education and Availability of Health Care for Asylum Seekers and Refugees in Malaysia
- TB Control and Early Detection among Migrants and Migration Affected Communities in the Provinces of Matebeleland South in Zimbabwe
- Health Promotion among Key Populations in the Mining and Logging Sector of Guyana
- Vulnerability and Socio-economic Integration of Asylum Seekers and Refugee in the Lazio Region in Italy
- Contributing to Reducing Drugs Use and Abuse among Internal and International Migrants in Turkmenistan
- Development of Financing Mechanisms to Support the Implementation of the Draft Framework for Mobile Populations and Communicable Diseases in the Southern African Development Community (SADC) Region
- Responding to Migrants' Vulnerability to Malaria and Understanding the Migration and Epidemiology of Artemisinin-Resistant Malaria in Binh Phuoc Province of Viet Nam
- Maternal, Newborn and Child Health Services in Kayah State in Myanmar
- HIV and TB Integrated Biological and Behavioural Study (IBBS) for Migrant Mine Worker Communities of Origin in Lesotho, Mozambique and Swaziland
- Providing Support for the Implementation of the Training, "Stigma, Discrimination, and Human Rights Related to Health and Migration" in the Caribbean
- Realization of the Technical Secretariat of the Country Coordinating Mechanism Colombia of the Global Fund to Fight AIDS, Tuberculosis and Malaria
- USAID TB Control Program in Tajikistan
- Strengthening the Integration of Quality and Comprehensive Health Services into Government Health Care System for Survivors of Human Trafficking and Abuse in Jessore and Satkhira Districts in Bangladesh
- Strengthening Local Authorities and Community-based Actors' Capacity to Prevent the Spread of Ebola Virus Disease in West Africa
- Child Care Services and Psychosocial Assistance at the Bangkok Immigration Detention Centre in Thailand
- Community-based TB Awareness, Detection, Diagnosis and Treatment in Mobility-Impacted Communities in Mon and Kayin States in Myanmar
- Targeted HIV Prevention and Community-based Diagnosis, Treatment and Care and Support in Mobility-Impacted Communities in Mon and Kayin States in Myanmar

- Community-based Malaria Prevention, Detection and Treatment in Mobility-Impacted Communities in Mon and Kayin States in Myanmar
- Towards the Strengthening of a Bi-national Agenda on Migrant Health in the Tacna-Arica and Antofagasta Regions in Chile
- Supplementary Feeding for Vulnerable HIV and TB Patients in IOM's Integrated Migration Health Programme of South-East Myanmar
- Ebola Virus Disease Preparedness, Risk Reduction and Response among Migrants, Mobile Population and Border Communities in Ghana
- Promoting Comprehensive Sexual and Reproductive Health Rights for Internal Migrants and Internally Displaced Populations Living in 756 Urban Slums in Sylhet City of Bangladesh
- Promoting Health and Well Being among Migrants Transiting through Morocco, Egypt, Libya, Tunisia and Yemen
- Cross Border Health Integrated Partnership Project in Kenya
- Contribute and Extend Drug Reduction Efforts among Internal and International Migrants in Turkmenistan
- Promoting and Integrating Inclusive and Migrant Friendly Health Assessment Services in the National Health System of Sri Lanka
- Addressing TB, MDR/XDR-TB and TB-HIV among Migrant Workers in Kazakhstan
- Intercultural Competence Training of Trainers and Roll out Training Sessions for Health Professionals in Lazio, Lombardia and Campania in Italy
- Mapping and Size Estimation of Key Populations in Somalia
- Institutional and Community Strengthening for the Implementation of the Public Health Plan 2012/2021 in Colombia
- Cold Chain and Vaccine Management in Lower Juba Region of Somalia
- Infectious Disease Health Services for Refugees and Asylum Seekers in Europe
- Supplementary Feeding for Vulnerable HIV and TB Patients in South Eastern Myanmar
- Strengthening the National Strategy for the Prevention of the Re-Introduction of Malaria in Paraguay (Certification Process of Malaria Free Country)
- Hosting the Somali Global Fund Steering Committee Secretariat in Somalia
- Stop TB Partnership working with IOM on Migrants and Mobile Populations
- Promoting Respect for the Human Rights of Trans People in Latin America and the Caribbean, to contribute to better access to Comprehensive Health and response to HIV/AIDS
- Reducing HIV/AIDS in South Sudan
- Regional Capacity Development and Technical Assistance on Malaria and Communicable Disease Control among Mobile and Migrant Populations in Cambodia
- Regional Capacity Development and Technical Assistance on Malaria and Communicable Disease Control among Mobile and Migrant Populations in Lao PDR
- Awareness Raising on the Dangers of Drug Abuse among At-Risk Vulnerable Groups in Georgia
- Increasing Access to Malaria Prevention, Testing and Treatment for Mobile and Migrant Populations in Myanmar
- IOM's Support to the Italian Programme for Assistance and Health Monitoring at Sea of Rescued Migrants
- Establishing a Migration Health Unit within the Ministry of Health and Sports in Myanmar
- Technical Support to Global Consultation on Migrant Health in Sri Lanka
- Promoting Psychosocial Services and Assistance for Vulnerable Migrants in Morocco
- Technical Support and Capacity Building to Improve Cross Border TB Control and Care of Tajik Migrant Workers



- Enhancing Tuberculosis Prevention, Diagnosis and Treatment among Syrian Refugees and other Vulnerable Migrant Population in Jordan and Lebanon
- Towards an Effective Migrants' Right to Health in Central Asia: Assisting Governments in Enhancing the Provision of Health Services for Migrants in Kyrgyzstan
- Enhancing Mechanisms for Prevention, Detection and Treatment of HIV/AIDS and Tuberculosis Among Migrant and Mobile Populations in the South Caucasus Countries
- Maternal and Neo Natal Child Health Project in Rakhine State in Myanmar
- Sexual and reproductive health and rights (SRHR)/HIV Knows No Borders: Improving SRHR/HIV Outcomes for Migrants, Adolescents and Young People and Sex Workers in Migration-Affected Communities in Southern Africa
- Development and Implementation of a Central American Joint Initiative on the Health of Migrants
- Integrated HIV and Sexually Transmitted Infections Biological and Behavioral Surveillance Study in Key Populations in Somalia
- Strengthening Government Capacity in the Development and Implementation of National Strategic Action Plan on Migration Health in Nepal

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

- Psychosocial Counselling and Support Services to Conflict-affected Persons in Nepal
- Psychosocial Support to Crisis-affected, Displaced and Migrant Youth and their Families in Syria and Neighboring Countries
- Swedish Medical Teams and Medical Emergency Assistance in Bosnia and Herzegovina and Kosovo
- Psychosocial Capacity Building for Medical and Social Service Providers in Chad
- Building the Capacities of Institutions to Address Mental Health Issues Amongst Defence Personnel in Bosnia and Herzegovina
- Strengthening Community-based Systems for the Delivery of Quality Maternal, Neonatal and Child Health Care and Developing Methods for reaching Mobile and Hard-to-Reach Populations in Myanmar
- Building Capacities of Local, Community-based Civil Society Organizations in Providing Psychosocial Support in Libya
- Strengthening the Capacity in Responding to Outbreaks of Cholera in the Artibonite and North-West Departments of Haiti
- Emergency Response Addressing the Critical Needs of IDPs Fleeing Violence throughout Iraq
- Rapid Revitalisation of Health Systems in Areas Affected by Typhoon Haiyan in the Philippines
- Provision of Life-saving Humanitarian and Protection Assistance for Vulnerable and Destitute Migrants throughout Yemen
- Health Assistance to Displaced Persons and Host Communities and Support to National Health Systems in Lebanon
- Psychosocial Support to Conflict-affected Populations Living in UNMISS Protection of Civilian Sites in South Sudan
- Psychosocial Support and Community Mobilization for Conflict-Induced Displaced Populations in the North East Nigeria
- Ebola Crisis Response in Liberia
- Expanding Emergency Psychosocial Support for Conflict-Induced Displaced Population in Maiduguri Camps in Nigeria
- Training Academy for Frontline Ebola Response Practitioners in Sierra Leone
- Scaling Up Provision of Life-saving Health Services in Bentiu, South Sudan

- Rehabilitation and Equipping of Provincial Emergency Operations Centers to Support the Coordination of the Ebola Response in Conakry, Guinea
- Sustaining Life-saving Primary Health Care Services and Provision of Rapid Response and Psychosocial Support for Vulnerable IDPs, Returnees and Affected Host Communities in Upper Nile, Unity, and Jonglei States in South Sudan
- Strengthening Community Social Mobilization for the Prevention and Control of Ebola Virus Disease in Kono, Moyamba and Bombali Districts in Sierra Leone
- Strengthening Infection Prevention and Control and Response Capacities at Selected Points of Entry and Border Areas to Prevent Further Spread of Ebola Virus Disease in Mali and Guinea
- Mobile Clinical Infection Prevention and Control Training for Ebola Treatment Facility Frontline Practitioners; and Academy Training for Clinicians Providing Non-Ebola Health Care Services in Sierra Leone
- Provision of Measles and Polio Immunization for Newly Arrived Syrian Refugees at Raba'al-Sarhan Transit Center in Jordan
- Enhancing Tuberculosis Prevention, Diagnosis and Treatment among Syrian Refugees in Jordan
- Enhancing Tuberculosis Prevention, Diagnosis and Treatment among Syrian Refugees and Other Vulnerable Populations Affected by the Syrian Crisis in Lebanon
- Life-Saving Cholera Prevention, Rapid Response, and Treatment for the Most Vulnerable IDPs Remaining in Camps in Port-au-Prince Metropolitan Area and for Border Communities in Haiti
- Non-Communicable Diseases Guidelines and Health Records for Refugees in Lebanon
- Improved Access to Ebola Virus Disease Prevention and Reduced Risks of Transmissions among Migrants and Border Communities in Guinea and Selected Neighboring Countries
- Rehabilitation of Azzan Hospital, Capacity Building and In-Kind Grants Support for Vulnerable Households in Conflict-Affected Areas of Rudum, Rawdah, Mayfa'a and Habban Districts of Shabwah Governorate in Yemen
- Improving Lifesaving Capacities, Health Care Access and Protection of Vulnerable Migrants and Surrounding Host Communities in Djibouti
- Emergency Health Assistance to Displaced and Affected Populations in Syria
- Provision of Life Saving Psychosocial Support and Reinforcement of Community-based Protection Mechanisms Targeting Expelled Burundian Migrants from Tanzania
- Grant Management for Local NGOs Responding to the Ebola Virus Disease Outbreak in Guinea
- Health and Humanitarian Border Management Phase II in Sierra Leone
- Capacity Building for Ebola-Focused Health and Humanitarian Migration Management in Cote d'Ivoire
- Health and Humanitarian Border Management in Guinea
- Ebola Virus Disease Preparedness, Risk Reduction and Response among Migrants, Mobile Population and Border Communities in Ghana
- Medical and Psychological Assistance for Internally Displaced Persons in Ukraine
- Strengthening Routine Immunization Activities through Reaching Every Community, in the High Risk Areas and Za'atari Camp in Jordan
- Capacity Reinforcement for Response to Cholera Outbreaks in Upper Artibonite and South East Departments and Coordination of Humanitarian Response to IDPs in Haiti
- Enhancing the Psychosocial Well-Being of Internally Displaced Persons and Conflict-Affected Populations in South Sudan
- Assistance to Stranded Migrants in the Andaman Sea and Bay of Bengal
- Enhancing Screening and Surveillance Capacity at Borders and in Border Communities – Ebola Crisis Response in Liberia
- Humanitarian Assistance to Stranded Migrants in Indonesia, Thailand and Malaysia

- Provision of Life-Saving Primary Health Care to Migrants Including Internally Displaced Persons, Returnees, Pastoralists and Host Communities in Mogadishu, Kismayo, Dhobley and Ceel Waaq in Somalia
- Emergency Humanitarian Aid for Rohingya and Special At-Risk Groups in Thailand
- Supporting the Government of Guinea-Bissau to Implement the National Ebola Preparedness Plan, Health and Humanitarian Border Management in selected areas in Tombali and Bijagos Islands in Guinea-Bissau
- Strengthen Infection Control and WASH Infrastructure in Government Hospitals in Sierra Leone
- Recovery Phase: Step Down Care Facility for Earthquake Affected Patients and their Families in Sindupalchowk, Nepal
- Responding to Humanitarian Needs of Migrants in Yemen
- Ensure Adequate and Rapid Response to Cholera Alerts and Outbreaks by the Health Sector in Haiti
- Health and Humanitarian Border Management Support to the Republic of Sierra Leone Armed Forces in Kambia and Port Loko in Sierra Leone
- 115 Call-back System: Implementing a System and Framework Designed to Measure Qualitatively and Quantitatively the Response by Government and Partners to Alerts Generated by the 115 Call Center in Guinea
- Providing Primary Health Care in Shamlapur and Leda Make-shift Camps and Host Communities of Teknaf Upazila in Bangladesh
- Support to Emergency Health Referrals in Northern Rhakine State in Myanmar
- Improved Access to Lifesaving Emergency Health Care Services on Maternal, Newborn and Children in Somalia
- Enhancing Conflict Affected Communities' Access to Health and Psychosocial Support throughout War-Torn Yemen
- Reduction of Morbidity, Mortality and Suffering, Improve Health of IDPs, Host Communities and Vulnerable Families Living in Conflict Areas by Providing Access to Life-Saving Healthcare through Expansion of Primary, Maternal and Child Healthcare in Iraq
- Treatment of Acute Malnutrition in Conflict Affected Areas in Yemen
- Psychosocial Support to Refugees, IDPs and Other Vulnerable Groups in Far North Cameroon
- Direct Psychosocial Support for the Affected Persons such as IDPs, Returnees, Host Community Members and TCNs in the Region of Lac in Chad
- Global Health Security Partner Engagement: Expanding Efforts and Strategies to Protect and Improve Public Health Globally
- Mental Health and Psychosocial Support, and Resilience Building for Conflict-Induced Displaced Populations in the North East of Nigeria
- Rollout of the Essential Package of Health Services in Kismayo District, Lower Juba Region of Somalia
- Response to the Epidemic of the Ebola Virus Disease in Mali
- Identification and Formal Registration of Returnees Stranded in Informal Settlements and Provision of Cholera Response in Anse-à-Pitres in Haiti
- Epidemic Preparedness and Response Consortium in Liberia
- Assistance to Stranded Migrants in Aceh and North Sumatra in Indonesia
- Prevention and Continuity of Care and Treatment of Tuberculosis among IDPs in KRI and Kirkuk and Some Central Governorates in Iraq
- Countering Epidemic-Prone Diseases along Borders and Migration Routes in Guinea
- WASH and Health Emergency Response for AWD/Cholera Affected Communities in Kismayo in Somalia
- Strengthening Health System Capacity, Preparedness and Resilience in Sierra Leone
- Provision of Life-Saving Primary Healthcare Services to the Drought Affected Populations in Somalia
- Provision of Primary Healthcare Support for Displacement Affected Populations across Iraq
- Enhancing Tuberculosis Prevention, Diagnosis and Treatment among Syrian Refugees in Jordan

- Contributing to Improving Deteriorating Health Status among Displaced Ethiopian Migrant Population across Djibouti and Health Assistance to Affected Host Community
- Humanitarian Assistance for Myanmar Muslims from Rakhine State and Special At-Risk Groups in Thailand
- Lifesaving Primary Health, Child Health, Women's and Reproductive Health Care for IDPs and Host Communities in Anbar, Iraq through Mobile Medical Teams
- Psychosocial Support for Affected Population in the North East of Nigeria
- Integrated Response to Emergency Health Needs of Conflict-Affected Populations in Western Equatoria, Western Bahr el Ghazal and Upper Nile States in South Sudan
- Life-Saving Emergency Assistance to Migrants, IDPs and Other Conflict-Affected Populations in Yemen
- Providing Health and Nutrition Services to Returnees and Host Communities in Umbaru, North Darfur to facilitate Recovery, Return and Reintegration
- Provision of Integrated Lifesaving Primary Healthcare Services to IDPs and their Host Communities in Kismayo in Somalia
- Yellow Fever Outbreak Response at Priority Border Spaces between DRC and Angola
- Humanitarian Assistance for Myanmar Muslims from Rakhine State and Special At-Risk Groups in Thailand
- Lifesaving Health Assistance and Prevention, Detection and Response to Disease Outbreaks for IDPs and Host Communities in Wau, Western Bahr el Ghazal in South Sudan
- Psychosocial Support Services for the Conflict Affected Population in Wau, South Sudan
- Cholera Emergency Response targeting People living along the Southern axis of the Ubangui Bangui-Mongoumba River and the Internally Displaced People of Bangui in Central African Republic
- Provision of Lifesaving Primary Health Care Services through Semi-static and Mobile Clinics in Renk County, Upper Nile as well as Flexible Rapid Response Teams for Vulnerable IDPs, Returnees and Affected Host Communities in South Sudan
- Providing Sexual and Reproductive Health Care Services for Crisis Affected Populations in Paukdaw and Buthidaung Township, Rakhine State in Myanmar
- Primary Health Care Support for Crisis Affected Communities in Lebanon
- Provision of Integrated Life-Saving Primary Healthcare Services to Internally Displaced Persons and their Host Communities in Daynille District in Banadir in Somalia
- Provision of Urgent Health Services to Displaced and Conflict Affected Population in Syria
- IOM National Ebola Training Academy – Phase II: Establishment of Infection Prevention Control Short Course Departments and Mobile Training in Sierra Leone
- Healthcare Assistance to IDPs and Conflict-Affected Communities in Yemen
- Promoting the Psychosocial Wellbeing of Persons Affected by Crisis in Burundi
- Provision of Critical Primary Health Care including the Minimum Initial Service Package for Reproductive Health in Crisis to recently Arrived Undocumented Myanmar Nationals living in Kutupalong, Shamlapur and Leda Makeshift Settlements and within the Host Communities of Teknaf and Ukhiya Upazilas, Cox's Bazar in Bangladesh
- Global Health Security Partner Engagement - Expanding Efforts and Strategies to Protect and Improve Public Health Globally
- Enhancing Health Responses through the Provision of Comprehensive Primary Health Care and Cholera Response in High Risk Regions of Grand-Anse and South Departments in Haiti
- Responding to Health Needs of Internally Displaced Persons and Returnees Affected by Conflict in Northern Mali through Mobile Clinics



## BY IOM'S SIDE

Thanks to our major partners in 2016

**GOVERNMENTS** • Australia • Canada • Colombia • Finland • Germany • Italy • Japan • Netherlands • New Zealand • Sweden • Thailand • United Kingdom • United States of America • **INTERGOVERNMENTAL ORGANIZATIONS, FUNDS AND OTHER ENTITIES** • Central Emergency Response Fund • Common Humanitarian Fund for Sudan • European Commission • United Nations Children's Fund • United Nations Development Programme • United Nations Office for Projects Services • United Nations Office for the Coordination of Humanitarian Affairs • World Health Organization • **NON-GOVERNMENTAL ORGANIZATIONS** • AmeriCares • ANESVAD Foundation • Global Fund to Fight AIDS, Tuberculosis and Malaria • International Rescue Committee • Project HOPE

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

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

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

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



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