MIGRATION HEALTH

Analysis: HIV prevention along East Africa's transport corridors

An interview with EAC

47,576 health assessments conducted across Africa & the Middle-East

Meet the children of migrant mineworkers in Lesotho

National Consultation on Migration Health in Kenya



IOM International Organization for Migration



The International Organization for Migration's (IOM) Health Division, based in Kenya, is a technical unit for migration health assessments across Africa* and the Middle-East, and health promotion and emergency health activities in East Africa and the Middle-East. IOM delivers and promotes evidence-informed health policies and programmes which are beneficial, accessible and equitable for migrants, mobile populations, and the communities in which they live, or transit.

* Southern Africa and West Africa both have migration health units in Dakar and Pretoria, and are responsible for the technical support and coordination of health promotion and emergency health activities in North, West, Central, and Southern Africa.

Welcome to our first edition of Migration Health

With close to one billion people on the move, human migration is a global phenomenon which deserves global attention. Migration is largely a very positive phenomenon, and is imperative if humanity is to achieve the Millennium Development Goals. However, for some, mobility can negatively affect ones physical, mental, and social well-being. Migration can increase health disparity, as many migrants face obstacles in accessing essential health care; language barriers, a lack of migrant-inclusive health policies, and inaccessibility of services are all factors which undermine the realization of health equity for mobile populations across Africa and the Middle-East, and indeed globally. Our aim is to assist governments to reduce these disparities so that population mobility is a positive phenomenon which leads towards socio-economic development.

Africa and the Middle-East are source, transit and destination locations for various migration flows. These flows are often driven by natural disasters, seasonal variations, climate change, conflict, and/or migrants seeking prosperity elsewhere. Promoting the health of people on the move remains a challenge, and therefore multi-sectoral partnership is required in order to reduce health disparities faced by migrants and other mobile populations.

In this issue we discuss the future of mobility and health with our partner, the East African Community, and take a look at the first ever National Consultation on Migration Health in Kenya. We also examine how we are meeting the needs of stranded migrants along the Republic of Yemen's borders and ask pertinent questions on what needs to be done to stem new HIV infections along East Africa's transport corridors.

As we go to print, the worst drought in 60 years hits the Horn of Africa. In our next issue we will look at how the drought is affecting the lives of thousands, and how the International Organization for Migration (IOM) is providing essential health care.

In just six months, IOM's Health Division conducted one of the first surveys in Somalia on young people and HIV, kick-started the process to tackle HIV in emergencies in Kenya, performed over 47,500 migration health assessments across Africa and the Middle-East, and provided health care for over 5,300 migrants in the Republic of Yemen. Health assessment centres in Ghana and Ethiopia have been revamped and upgraded, and IOM has been supporting the world's newest country – South Sudan – to reach isolated communities through mobile health clinics.

All of this would not have been possible without our partners, who are aligned in IOM's mission, and passion, to ensure healthy migrants live in healthy communities.

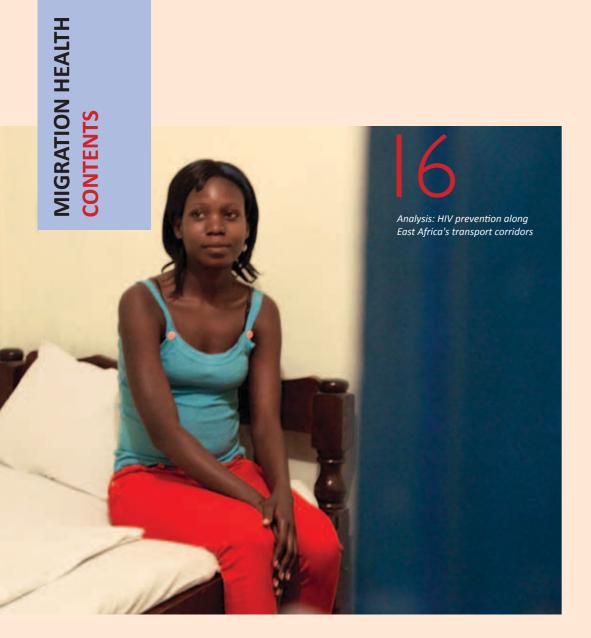
This Migration Health newsletter serves to highlight some of the ways IOM, and our partners, are making a difference.

We hope you enjoy the first edition, and we welcome your feedback.

Dr. Aleksandar Galev

Migration Health Assessment Coordinator for Africa & the Middle-East IOM Coordinating Office for the Horn of Africa, Nairobi, Kenya





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Latest news

Urgent health care scale-up needed for urban migrants in Kenya



"In my house, there are many, many people. The house rents are very high. These are the hardships that cause the spread of various diseases. We do not have the money to access quality health care."

An urban migrant residing in Eastleigh, Nairobi

Scores of urban migrants are living in overcrowded, dark and poorly ventilated apartment blocks or makeshift homes across Kenya, with limited access to health care. Migrants and mobile populations face many obstacles in accessing essential health services due to a number of factors, including irregular immigration status, language barriers, a lack of migrant-inclusive health policies, and inaccessibility of services.

The International Organization for Migration (IOM), in partnership with the Kenyan Government, is offering free TB and HIV diagnosis, treatment, counselling, nutritional support, maternal health care, and routine immunizations for children under the age of five at the IOM Eastleigh Community Wellness Centre, a budding health clinic located in eastern Nairobi. In cooperation with the district health authorities, the clinic meets the needs of migrants and the local community without discrimination. From January to June 2011, over 1,000 clients were assisted with HIV testing and voluntary counselling, 22 patients are receiving TB treatment and 23 patients are being provided with HIV treatment. During the same period, 341 children under the age of five received routine immunization, vitamin A supplements and de-worming.

Yet, more needs to be done to expand the scope of health care offered as key promotive health issues are not being adequately addressed, such as nutrition, immunization, and pre- and postnatal care. IOM is seeking further support to strengthen existing health systems and to expand on community-owned health care packages, this will include maternal child health, primary health care, health promotion and education.



Boosting HIV prevention in Somalia

An estimated 8.1 million people are feeling the impact of poor health systems in Somalia due to ongoing conflict and environmental catastrophe. Trade-driven mobility is also driving a demand for transactional sex in post-conflict Somaliland which can lead to subsequent HIV infections.

Over the last two years, the International Organization for Migration (IOM) has worked closely with Government officials and partners in Somalia to develop and implement community-centred health programmes. By June 2011, IOM had trained 108 peer educators on HIV and gender-based violence education, and had reached out to over 2,270 migrants vulnerable to HIV infection with an awareness-raising campaign. Vulnerable groups targeted include truck drivers, port workers, young people, women and internally displaced persons.

IOM assists 4,400 Ethiopian migrants in the Republic of Yemen

The Yemeni/Saudi Arabian border is synonymous with thousands of African migrants fleeing through the Gulf of Aden into the Middle-East, and on to Europe in pursuit of prosperity and opportunity. With heightened security measures, men, women and unaccompanied minors are often forced to end their journey at the Yemeni/Saudi Arabian border. 52 per cent of vulnerable returnees told the International Organization for Migration (IOM) at the border that they did not have access to primary health care while in transit; 21.5 per cent said they did not have access to clean water, and 88.5 per cent spoke of not having access to adequate food. Swiftly acting to mitigate these health care challenges, IOM provided emergency and primary health care services to migrants, including treatment for respiratory illnesses and psychosocial support. IOM also continues to provide tuberculosis detection and treatment referrals in partnership with national hospitals.



An alarming number of MDRTB cases uncovered in northern Ethiopia

The International Organization for Migration's (IOM) existing health assessment programme in northern Ethiopia's Shimelba refugee camp identified an alarming number of Eritrean migrants infected with a strain of multi-drug resistant tuberculosis (MDR TB). IOM's Health Division alerted all relevant partners: the Tigray Regional Health Bureau, the National TB Programme (NTP) of Ethiopia, the United Nations Refugee Agency, the Administration for Refugee and Returnee Affairs, the World Health Organization, and Centers for Disease Control and Prevention, Atlanta. A joint effort by IOM and Ethiopia's NTP to better understand the situation, uncovered that 3.6 per cent of migrants had infectious TB, and out of these, 16.6 per cent had MDR TB – a serious illness that requires prolonged, expensive and potentially harmful

treatment with five to six different types of drugs. It also requires concerted and rigorous action to trace those who may have contracted MDR TB and prevent further infection.

To counteract this alarming prevalence of MDR TB, IOM is embarking on a project that will trace and identify active TB cases in migrant communities. IOM will treat those infected, and aim to reduce the transmission of the disease, in cooperation with the NTP. It will target over 253,000 migrants, and their host communities in Kebribeyah, Shimelba and Mayaine refugee camps. The project, funded by the "TB Reach" initiative, and entitled Enhancing TB/HIV Detection and Treatment among Migrants and Refugees in Ethiopia, will assist the Ethiopian Government to strenghen their existing health systems.

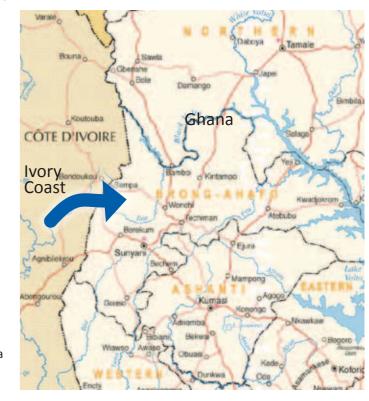
IOM has evacuated over 530 war-affected migrants and internally displaced persons from war-torn Misrata to Libya's second largest city, Benghazi. More than 30 physicians and nurses provided essential and specialized health care.

Ivory Coast crisis: IOM Ghana responds to the health needs of migrants

Widespread violence followed the Ivory Coast's disputed elections in late 2010, resulting in thousands of refugees and asylum seekers pouring into neighbouring Ghana. As the number of migrants soared, the International Organization for Migration (IOM) and partners established reception centres to accommodate an increasing number of new refugee arrivals in Ahafo, western Ghana.

Malaria is endemic in Ghana, and the influx of migrants began at the height of the rainy season causing wide-spread concern. In addition, many migrants fled the Ivory Coast's capital, Abidjan, on foot, which resulted in trauma wounds. Responding to a vast need, IOM in collaboration with the Ghanaian health services, sent in two doctors, a medical assistant, and three nurses to assist migrants reaching the Ivory Coast/Ghanaian border. From January to June 2011 IOM delivered vital medical screenings to over 7,000 refugees and asylum seekers, and treated over 1,790 migrants suffering from malaria, diarrhoeal diseases, respiratory infections and trauma wounds.

IOM and partners set-up an emergency disease surveillance system in order to ensure the early detection of priority diseases such as cholera, measles, polio and yellow fever. Surveillance data was delivered daily to the Ghanaian health authorities to trigger early warning systems and response mechanisms.





Canadian Citizenship and Immigration entrusts migration health assessments in the Middle-East to IOM

For the first time, the International Organization for Migration (IOM) has established partnership with Citizenship and Immigration, Canada and the Canadian Ministry of Public Works and Government Services in the Middle-East. As of January 2011, the humanitarian refugee admissions programme, which mainly assists Iraqi and Palestinian refugees travelling to Canada from the Middle-East will be assisted by IOM's health assessment programmes.

IOM doubles its migration health assessments in Iraq

Iraq, with its complex and often volatile living and working conditions, has seen an unprecedented number of internally displaced persons and refugees. The International Organization for Migration's (IOM) health assessment programme in Baghdad has formulated numerous partnerships to provide an increased scope of services for migrants accepted onto refugee resettlement programmes. With a total of 35 medical staff, several clinics and forged quality control and assurance mechanisms, IOM assessed over 12,000 Iraqi and Palestinian migrants from January to June 2011, which is over double the number of migrants assessed between 2008 – 2010.

Targeting 10,000 displaced persons with health care in Ethiopia

Gambella, a small swampy, mosquito-ridden region in western Ethiopia, is home to over 27,000 displaced people. An International Organization for Migration (IOM) assessment uncovered low health awareness, abandoned health centres and displaced persons travelling over 30 – 40km to the nearest health facility. IOM quickly responded by dispatching two mobile health teams to help deliver essential health services in June. Over 10,000 displaced persons in Gambella and close to 20,000 members of the host community will be benefiting from health care services provided by IOM.



Migrants benefit from upgraded health assessment centre in Ethiopia

The decision to move the International Organization for Migration's (IOM) Migration Health Assessment Centre in Ethiopia from Kasanchis Woreda to more spacious premises along the popular Bole Road paves the way for migrants to receive more comprehensive migration health assessment services. The Migration Health Assessment Centre has four examination rooms, its own pharmacy, a serology laboratory, private counselling rooms and offers directly observed treatment for tuberculosis. The new centre has the capacity to screen over 120 migrants per day.

IOM supports the world's newest country with mobile health clinics

The International Organization for Migration (IOM) has tracked 2.5 million people returning to South Sudan since 2005; most returnees travel south from northern Sudan via barges on the Nile. IOM also works with the Government of Sudan and the Government of South Sudan to perform medical screenings of each returnee involved in IOM/Government movements, and provides medical escort teams to travel with vulnerable returnees on the barges. IOM has currently screened over 15,600 people since January 2011. There are fewer than 100 midwives deployed

within the health care system in South Sudan, which has some of the highest infant and maternal mortality rates in the world. The Ministry of Health in South Sudan has ambitious plans to open a network of primary health care centres – roughly one per 15,000 people – but, at present the country still relies heavily on international assistance. Through its mobile clinics IOM is providing maternal and child health care, health and hygiene education sessions, and emergency health services to 26,842 people in insecure, remote and difficult to access areas in South Sudan.



Health care is provided to over 34,500 evacuees in Republic of Egypt

In February 2011, thousands of women, men and children fled escalating civil violence in Libya and sought food, water and shelter in Salloum, on the Egyptian/Libyan border. The International Organization for Migration (IOM) was one of the first organizations to arrive in Salloum and provide emergency assistance. By 24th February, IOM was present with expert physicians, nurses and trained counsellors to assist in mitigating the health risks posed to migrants fleeing the conflict. In close collaboration with the Egyptian Ministry of Health and Population, and partners, IOM provided health care to more than 34,500 evacuees stranded on the Egyptian/Libyan border. IOM also provided pre-departure health checks for refugees accepted into Egypt, hospital referrals, and medical escorts for returnees. Still based in Salloum, IOM continues to work around the clock delivering psychosocial and medical support to migrants, in an effort to cope with current public and emergency health concerns. One of the major public health concerns, resulting from a of lack safe hygiene, is communicable diseases, particularly in children.

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

Dr. Mohamed Refaat, IOM Cairo, Republic of Egypt



Boosting the health of refugees in remote Chad

Chad, a dry, land-locked country in Central Africa hosts more than 140,000 internally displaced persons and over 200,000 refugees from Sudan and Central African Republic. Despite an untapped wealth of oil and minerals, infrastructure and access to quality health care remains stubbornly low.

In Gore, a town nestled next to the border with the Central African Republic, an International Organization for Migration (IOM) mobile medical team from Ghana successfully conducted migration health assessments for 210 refugees from remote camps in February 2011. Fleeing from northern areas of the Central African Republic, all refugees had been accepted into the United States Refugee Admissions Programme.

As a country struggling with recurring crop failures, Chad has soaring malnutrition rates, so IOM provided nutritional support for all refugees under its care, as apart of a comprehensive health service package.

IOM and Kenyan partners kick-start the process to tackle HIV in emergencies

Often overlooked, and rarely anticipated, HIV remains a critical factor in emergency contexts. In humanitarian emergencies, HIV prevention and treatment commodities are scarce, sexual and gender-based violence often increases, and basic health care services become inaccessible; all of which increases the vulnerability of people living with HIV and AIDS, and aggravates potential of new infections. Through the Joint United Nations Team on HIV and AIDS in Kenya - an initiative to reduce the spread of HIV and improve the quality of life for those infected – the International Organization for Migration (IOM) and partners initiated a workshop to establish a national strategy. The workshop strengthened the capacity of key individuals in non-governmental organizations and Government ministries through a two-day training of trainers course. Over 22 participants were trained on how to prepare for, and handle, HIV prevention in emergencies, and how to ensure the continuity of health systems.



Outreach health workers in Republic of Egypt, Cairo, assist marginalized migrants

The International Organization for Migration (IOM), in partnership with the Egyptian Red Crescent has trained 45 community health volunteers who are working among two of the largest migrant communities – Sudanese and Somali – in Cairo, Republic of Egypt. Many of these migrants do not have legal documentation that authorizes their stay in the country, and as such, often seclude themselves to congested, poorly ventilated shelters. Inaccessibility of services, discrimination and language barriers are all contributing factors to the poor health of migrants. IOM's community health volunteers are deployed into urban migrant communities to highlight what services available to migrants and to provide essential health awareness. Plans are underway to train an additional 75 volunteers who will serve the Ethiopian, Eritrean and Iraqi communities in Republic of Egypt.

IOM and partners call for urgent action against drug resistance on World Health Day

The International Organization for Migration (IOM) joined forces with the Kenyan Government and the World Health Organization on 7th April to mark World Health Day, an international commemorative day to platform pressing global health issues. World Health Day 2011 focused on drug resistance, a serious worldwide health concern whereby antimicrobials are continuously being misused: drugs are shared, patients are self-medicating and buying their medicines directly over the counter, prescriptions are not duly followed, and treatments often go uncompleted.

As an official World Health Day partner in Kenya, IOM asked the international community not to forget the specific health care

needs of migrants and mobile populations. Ashraf El Nour, Regional Representative for IOM Kenya, commented: "Due to a number of social factors, such as immigration status and language barriers, migrants and mobile populations are more likely to self-medicate which often leads to drug resistance. The issue is inequality; such populations are invisible and existing disparities are preventing them from accessing quality health care. We must ensure medical services are 'migrant friendly' to reduce these disparities and to curb drug resistance in Kenya, and indeed, globally. Diagnostic capacities must also be improved and expanded."



A migrant health forum initiated in Limpopo, northern South Africa

"We first met with IOM in 2008 during the cholera outbreak in Zimbabwe, which spread to our district here in Musina [northern town in the Limpopo province]. Following the outbreak, the Limpopo Office of the Premier, Vhembe District Municipality and IOM initiated a 'migrant health forum' to bring together all stakeholders to coordinate health interventions. These stakeholders include international organizations, local non-governmental organizations and local government departments including the police, defence force and the health department. IOM is the secretariat of this forum; they really are the engine that runs this machine. They have been with us since 2008, offering advice and assistance on the implementation of programmes. Without IOM, things would be chaotic. There would be no migrant health forum, and we really need this forum because it promotes accountability. Stakeholders must account for their departments."

Mr. Alex Nemakonde, General Manager, Community Service, Vhembe District Municipality & Chairperson, Migrant Health Forum, Vhembe District

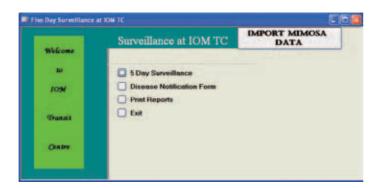
The majority of refugees residing in Kenya live in refugee camps and urban migrant communities. Refugees are faced with an array of medical problems compounded by overcrowded conditions and limited access to health care. Poverty, a lack of health education, and crowded living conditions, makes refugees particularly susceptible to infectious diseases. In 2010, there were a dozen disease outbreaks declared in Dadaab — a region in north-eastern Kenya hosting numerous refugee camps — including cholera, swine flu, measles, viral hemorrhagic conjunctivitis, varicella, meningitis, and pertussis.

Due to frequent disease outbreaks, it has become necessary to implement a disease surveillance system to stem new infections. The International Organization for Migration's (IOM) Health Division has established a surveillance system in Dadaab and Kakuma refugee camps and a subsequent five-day quarantine and surveillance mechanism at its transit centre in Nairobi. In coordination with Centers for Disease Control and Prevention Atlanta (CDC), this system will ensure that migrants who have an infectious condition undergo laboratory investigations and are provided with adequate treatment.

In partnership, IOM and CDC have improved ongoing surveillance systems at IOM's transit centre in Nairobi – a space where refugees reside before travelling on to their new resettlement country. A new database was developed for disease surveillance

in March 2011 so now a wide range of data can be captured, recorded and analyzed including vital signs of illness, fever, clinical signs, symptoms, notifiable conditions, referral and hospitalization records.

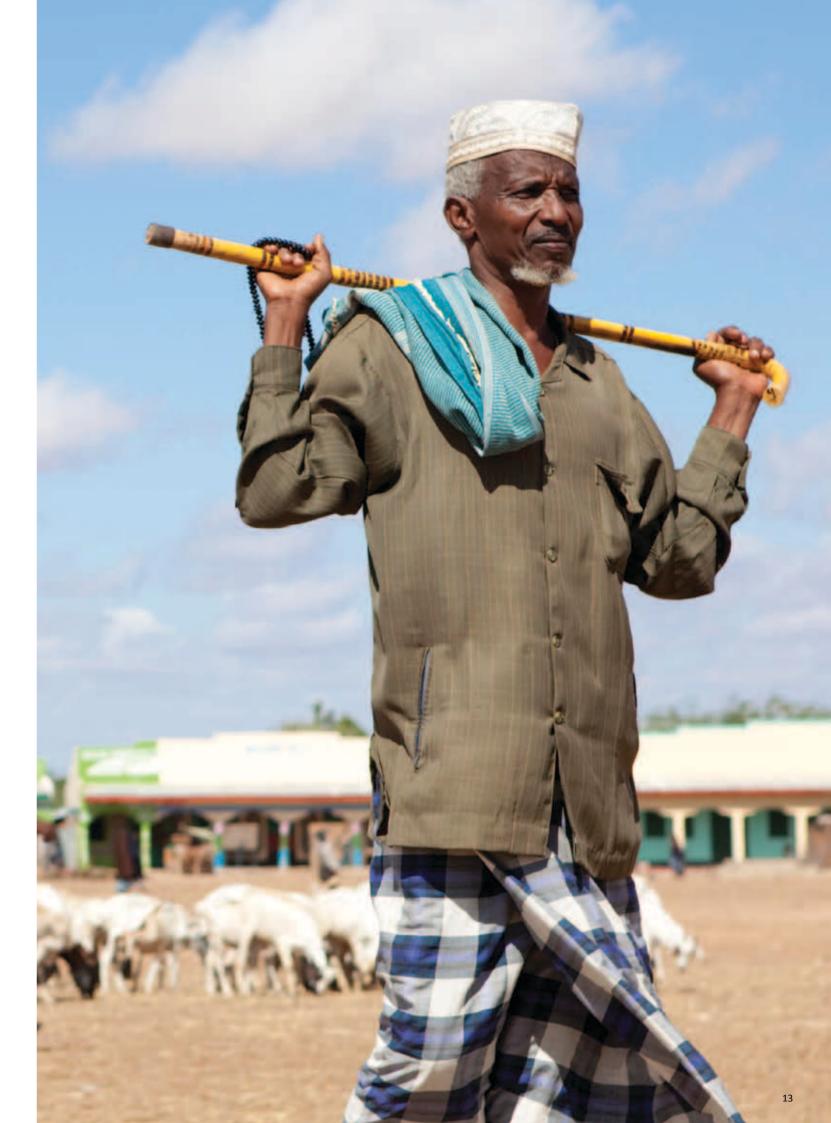
The surveillance system is a fundamental public health tool which reduces the spread of communicable diseases. It also provides vital information and guidance on what type of vaccines need to be administered in refugee camps, and during the pre-departure stages of migration. One result of the surveillance system has been the introduction of a second dose of the measles, mumps and rubella vaccine for refugees departing from Kenya to the United States of America.



IOM provides prophylaxis and immunizations for refugee migrants from Africa to the USA

Through a cooperative agreement with US Centers for Disease Control and Prevention, Atlanta, the International Organization for Migration's (IOM) Health Division administers prophylaxis – a measure taken for the prevention of a disease or condition – and treatment for schistosomiasis, intestinal parasites and malaria for all eligible refugees migrating from Sub-Saharan Africa to the United States of America. Immunizations and prophylactic treatment are benefiting both refugees and immigrants departing Africa and their new host community.

Immunizations for US-Bound Refugees from East / Central / Southern Africa January – June 2011					
	Kenya	Tanzania	Ethiopia	Other countries in East, Central and Southern Africas	Total
Exams/Departures	4,730/874	104/41	3,774/1,103	1,652/334	10,260/2,352
Albendazole	831	38	1,090	327	2,286
Coartem	870	39	1,094	334	2,337
Praziquantel	792	35	1,051	297	2,175
MMR	5,170	74	2,058	0	7,302
Polio	5,301	1	0	0	5,302
Other vaccines	1	0	0	0	1



Talking figures

A round up of our latest figures from January – June 2011

23,896

the number of individual doses of DTP, pneumococcal, meningococcal, hepatitis A and B, rota virus, HPV, varicella, MMR, polio and other vaccines IOM administered in 2011 to immigrants travelling from Kenya to the USA (excluding refugees)



IOM's annual migration health budget in Africa and the Middle-East



47,57 the number of health assessments carried out in Africa and the Middle-East



In an IOM study, 93 per cent of migrant female sex workers interviewed reported having vaginal intercouse for the first time between

5-14 years of age



enrolled in IOM's **HIV Combination Prevention Pilot**



is the number of NGO peer educators in Somalia trained and

sensitized by IOM on health care education and sexual and genderbased violence

In an IOM study on migrant female sex workers in Nairobi, the HIV prevalence was

the number of migrants in detention centres across the Republic of Egypt who have been visited by IOM, given food and basic medication the number of IDPs IOM is targeting with health care via mobile health teams in Gambella, Ethiopia

the number of stranded migrants who were provided with emergency health care in Yemen



Sarah

Sarah Namakula is a 19-year-old female sex worker from Uganda. When her father and mother died, both from AIDS, Sarah travelled across the border to Kenya, where she found sex work her only viable option for survival. Sarah has been working as a sex worker in Busia, a border town between Kenya and Uganda, for the last two years. Her top four clients? Truck drivers, immigration officers, policemen and health workers.

"Some men refuse to wear a condom. Some already have HIV, so they don't care about protection," says Sarah.

Sarah's story is tragically common. Nearly 30 years ago, the HIV epidemic was first identified as a major problem along East Africa's transport corridors. While transport corridors are no longer the primary source of new infections in East Africa, they remain a significant driver of the epidemic. In fact, the Government of Kenya has prioritized populations along transport corridors as "among the most important most-at-risk populations that are not adequately covered by the national HIV prevention strategy."

The phenomenon of 'mobile men with money', socio-economic disparities, and vibrant night life at hot-spots along transport corridors fosters risky sexual behaviours including transactional sex, multiple concurrent sexual partnerships, and inconsistent condom use.

HIV and mobility

The national HIV prevalence in Kenya was estimated at 6.3 per cent in 2009 by the *Kenya National Bureau of Statistics* and 6.4 per cent in Uganda by the *Uganda HIV/AIDS Sero survey 2004/2005*. It has occasionally been misconstrued that mobile populations carry HIV from higher to lower prevalence countries. The reality is that inequitable access to HIV prevention programming, and the social environments in which people live, fosters the spread of HIV; not all migrants are equally vulnerable. Furthermore, women are at the highest risk of infection, and most in need of services, but are frequently overlooked in HIV/AIDS programming.

As just 30.2 per cent* of a sex worker's clientele along transport corridors are truck drivers and their assistants, prevention efforts need to focus on diverse localized clientele at various hot-spots.

Lack of coordination

In a recent response analysis undertaken by Kenya's National AIDS Control Council (NACC) and IOM, 70 per cent of the 600 sex workers and truck drivers interviewed at five Kenyan truck stops along Kenya's main transport corridor had never received any relevant information on HIV at the truck stops. The study also indicates that although numerous agencies are providing various HIV-related services along corridors, the collective impact is minimal. A large number of organizations are involved in HIV prevention programming along transport corridors, yet during five weeks in the field not a single behavioural intervention or HIV counselling and testing campaign was witnessed by the study team. Populations also did not have access to treatment, including prophylaxis for opportunistic infections and anti-retroviral therapy. A similar response analysis was conducted in Uganda in 2009 and also highlighted that programming along transport corridors is misdirected, fragmented, and lacks both scale and intensity.

Bottlenecks to effective HIV prevention programming include a lack of consistent funding, weak coordination and collaboration, and a lack of accountability and quality assurance mechanisms that could ensure effective delivery. Partners lack clear direction on what services to deliver.

The way forward

IOM advocates for a three-pronged combination prevention approach, including:

- clinical services that meet the specific needs of both vulnerable men and women;
- strengthening messaging and intensifying behaviour change communication, and;
- addressing priority structural issues, such as making quality condoms available. National and regional strategies are required, as well as a common minimum service package that all agencies would collaboratively implement.

Professor Alloys Orago, the Director of NACC asserts: "We want to see clinics peppered all along the transport corridors, but this can only be achieved with coordinated partnership."

Uganda AIDS Commission's Namulondo Joyce Kadowe adds: "The country's priority is the prevention of new HIV infections. This will be achieved through HIV prevention that combines biomedical, behavioural and structural interventions including quality equitable care and treatment of those already infected. Trans-border collaboration and partnership is a must, as HIV has no boundaries."

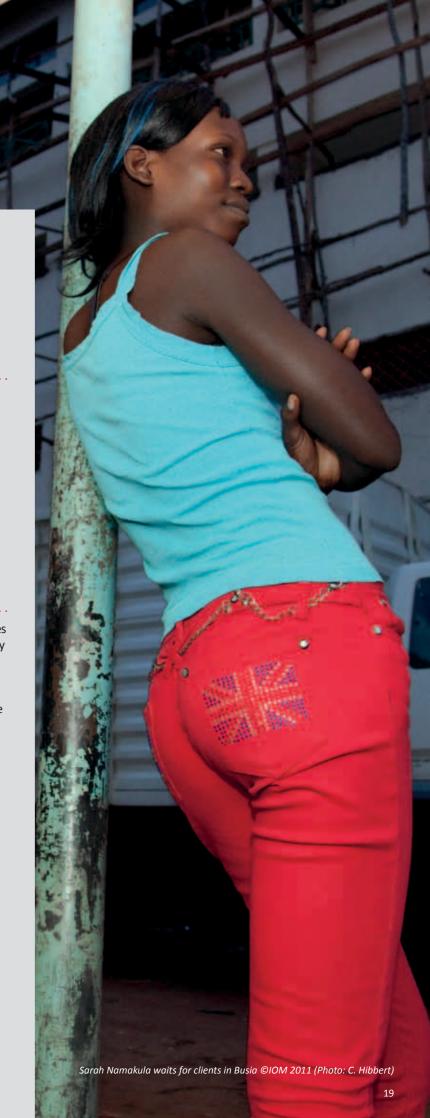
Through an inclusive process, IOM is assisting government partners to achieve meaningful scale-up in Kenya and Uganda.

Kenya

- A national prevention strategy along transport corridors is being developed and will be validated in September 2011;
- IOM has seconded an HIV and mobility consultant to both Kenya's National AIDS Control Council and the Kenyan National AIDS and STI Control Programme to strengthen coordination and capacity building;
- IOM upgraded a health facility in Busia on the Kenyan/Ugandan border in March 2011, targeting sex worker clients.

Uganda

- IOM undertook a study to assess the knowledge, attitudes and practices of sex workers and truckers. Using this study IOM developed a communication toolkit, 30 community health volunteers were trained as peer educators, information education and communication materials were distributed, over 30 condom pick-up points were established and over 12 HIV counselling and testing mass campaigns were conducted;
- IOM is supporting national stakeholders, under the leadership of the Uganda AIDS Commission, to develop a national HIV combination prevention strategy along transport corridors. The strategy is expected to launch in September 2011;
- IOM has seconded an HIV and mobility consultant to the Ugandan Ministry of Works and Transportation to strengthen coordination and capacity building;
- IOM supported the Uganda Ministry of Works and Transport to develop an internal HIV policy and 2011 – 2014 HIV strategy;
- IOM undertook studies to analyze a national HIV response targeting most-at-risk populations at hotspots along transport corridors.



^{*} Hot-Spot Mapping of the Northern Transport Corridor Transport Route: Mombasa – Kampala (Republic of Kenya, 2005)



A day in the life of

Imelda Angelo, a migrant female sex worker

Imelda Angelo is a 43-year-old Tanzanian sex worker living in Nairobi, Kenya. For the last 20 years she has been working for less than one dollar a day. We hear her story...

A man alights at Majengo from the Matatu bus stop. Everyone stares at him; they know he has come here for sex. He manoeuvres around fragile tin houses, dodges the sewage, and walks to where "the women on stools sit." He sees a woman on her stool, walks into her home, and ten minutes later they exchange money. He leaves; she takes a soda, and awaits her next client. That is how life is here.

20 years as a sex worker

Imelda Angelo should know. At the age of 43, she has spent the last 20 years as a sex worker in Majengo, an area in Nairobi heavily populated by Tanzanian migrants. "In Majengo, men know they can get cheap sex. Some girls get a flat rate of 100 KES (\$1), but I have worked for 50 KES," says Imelda. "We have a mixture of clients, but the businessmen from other countries are always the good ones. Lots of our clients do not work; young people around here have nothing to do, no job, no education. They just sit around during the day, or wash cars for a few shillings, and then mug people at night. Those clients have threatened me with a knife, or just abuse me until I have sex with them for free."

Men who have HIV don't care about protection

Following her mother's death, Imelda travelled from Bukoba in Tanzania to look after her younger siblings in Nairobi, Kenya. Arriving in Majengo, Imelda had no money to support her family. Her Tanzanian friends told her the only option was sex work, and at the age of 23, Imelda found herself with her first client.

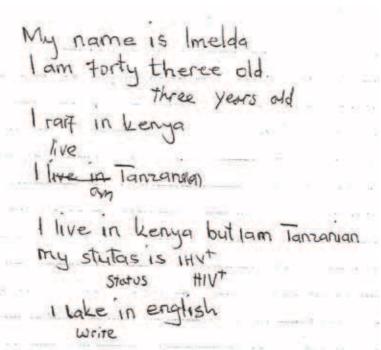
"Men who have HIV don't care about protection," says Imelda. "Men will pierce a condom without you knowing, I don't know why they do it. Maybe it feels better? I was young and didn't know that men were doing this. Men would also pay you more money if you didn't wear a condom. When I was pregnant with my third child, I found out my status. I was HIV positive. A year later, in 2003, I went on ARVs (anti-retroviral treatment for HIV)."

Imelda's husband died from AIDS two years ago: "He was in denial and refused to accept that he was HIV positive. He did not want help, or ARVs. I think that is why he died. We need intensive counselling here in Majengo, we need free condoms, and we need money so we don't have to sit on the stools anymore. Here we must have the highest number of sex workers living positively with HIV in Nairobi. It could be as high as 500."

1,275 female sex workers enrolled

Imelda travels to neighbouring Eastleigh, another urban migrant region in Nairobi, to access services by Uma and the National Organisation of Peer Educators, two community-based organizations supported by the International Organization for Migration. Imelda is one of 1,275 female sex workers enrolled in a pilot urban female sex worker programme where she can now access health education, HIV counselling and testing, free sexually transmitted infection screening, and English language classes. "The programme has given me hope," says Imelda during her English class. "It has helped me to accept my HIV status, and given me the chance to learn English. Most businesses are in English, so only understanding Swahili reduces my chance of getting proper work."

With ongoing support from the pilot programme, Imelda has started her own vegetable stall: "Now my children don't come home from school and ask why I am sitting on a stool anymore. I just wish these services were available in my community so all the other sex workers I know in Majengo can access them easily."







Two minutes with Professor Alloys Orago, Director, National AIDS Control Council of Kenya (NACC)

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

A national strategic plan that integrates HIV interventions into the general health care system is important. We also must address Kenya's vast number of mobile populations.

What are NACC's key focus areas?

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

How do you feel that partnerships are impacting on trans-border collaboration?

I think we have had very good partnerships with many players, particularly through regional initiatives. However, I think more needs to be done on Kenyan/Somali/Ethiopian borders.

What are national priorities for key populations?

We need to come up with a policy framework on how to programme for key populations whose activities, or lifestyles, go against the norm, for example sex workers, truck drivers and drug users – and not just people who inject.

How do you feel your partnership with IOM has contributed to NACC?

Our partnership with IOM has contributed significantly to NACC because of the comparative advantage that IOM has with migrant populations. We are also very interested in the technical assistance that IOM provides, for example, we now have an IOM staff member embedded within our offices and programmes.

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

We must be able to make a real difference. I have lost relatives myself, and subsequently, it has given me extra responsibilities in terms of looking after other family members. My greatest motivation is to make a difference for people who are vulnerable, or who are likely to get infected.

For more information, please visit: www.nacc.or.ke

Southern Africa

The Port of Beira is the second largest port in Mozambique, and serves as a key transportation point for Malawi, Zimbabwe and Zambia. Truck drivers make up the majority of the highly mobile population, with a large proportion of sex workers. IOM conducted research on health and HIV vulnerabilities of port users in Beira, Maputo and Nacala in Mozambique. The study found that port users are vulnerable to HIV, with high levels of multiple partners and transactional sex being recorded. Only 40 per cent of truck drivers reported using a condom during their last sexual encounter and sex workers were not accessing services because they reported a sense of shame, stigma and a fear of losing clients, some of whom are health service providers. With funding from the Southern African Development Community (SADC) HIV and AIDS Special Fund, IOM will undertake further research in the ports of Mozambique, Namibia, South Africa and Tanzania over the next three years to better understand the significance of sea ports as hot-spots, and mobile populations as drivers of the HIV/AIDS epidemic.

 24



Meet the children of migrant mineworkers in Lesotho

The Leribe district lies on the high plains of north-western Lesotho, in the shadow of the Maluti Mountains. Entirely surrounded by South Africa, "The Mountain Kingdom" is one of the most underdeveloped countries in the world, with very few local employment opportunities available to its citizens. Many families have therefore relied on salaries earned by male migrant labourers in the mines of South Africa to augment the often meagre living they make from subsistence agriculture. Agreements between Lesotho and South Africa still allow for the recruitment of Basotho mineworkers to this day and the Employment Bureau of Africa (TEBA) therefore has a widespread presence across the country, including in the Leribe district.

A price to pay

Two young men – who are children of mineworkers – from Leribe talk to the International Organization for Migration (IOM) about their life. While their experiences show that mine labour brings opportunities to the families of such workers, there is also often a price to pay due to the nature of their work.

Ramalumane: A mineworker's son

Ramalumane was born in Leribe district in 1987, the fourth born of six children. His grandparents were poor subsistence farmers in the district but his father went to a mine in Rustenburg, South Africa to earn a living for his family. When Ramalumane was born, his father had already worked in South Africa for several years while his mother remained to raise the children, as well as their crops and livestock. On their small plot of land, perched on the side of a windswept eroded valley, they grew vegetables, potatoes, maize and sorghum, and kept a small number of sheep, goats, cows, pigs and chickens. While he was growing up, Ramalumane's father would only visit home for a weekend every two or three months, apart from his annual month-long leave, which he normally took every July. "I would miss him," says Ramalumane, "but I understood that he had to be away to earn something for us."

My parents were ordering me to work

According to Ramalumane, their mother was quite strict with the children which meant that even though their father was absent they were well-behaved. Because their father was away, the children had to help with running the farm: "When I was growing up, my parents were ordering me to work, which I thought was bad at the time. But now I can see that it was good." he concedes.

Ramalumane recalls that their mother used to correspond often with their father, who would also send letters from time to time. His father also sent remittances which were enough to feed, clothe and school the family, so Ramalumane does not have any complaints about having been the son of a mineworker. He dropped out of school in high school at the age of 17, when he considered himself a man and ready to face the adult world.

Jobs in Lesotho are hard to come by

At first Ramalumane stayed at home to help his mother run the farm while occasionally working the construction sector. Jobs in Lesotho are hard to come by and he says he might have to follow in his father's footsteps and become a mineworker. Despite his humble background and limited education, Ramalumane has big ambitions for his future. "In the future," he says, "I want to see myself somewhere: I want a beautiful home, to be a respectable father and have a car." To achieve this he feels he must go to South Africa.

Mphaka – a deceased mineworker's son

Born in 1984, Mphaka* is the second born of 14 children. He too was born in Leribe district to a mother who remained on the farm while her husband worked on the mines in South Africa. Being strongly traditional, Mphaka's parents did not prioritise education for his sisters, but Mphaka himself only completed two years of high school. Being the oldest son, he was always expected to help his mother run the farm and take care of his younger siblings. He developed a strong sense of duty towards his family, seeing himself as the man of the house in his father's absence. Like Ramalumane, he says that his father looked after the family well, sending money to his mother often and visiting whenever he could.

A strong sense of responsibility

However, his father died in a mining accident when Mphaka was only 21, leaving the family with nothing. Although their

*Name has been changed.



mother would have received a small pension payout from the mine, another arrangement was made. TEBA and the mines have an arrangement that if a worker dies in a work-related accident then a job will be made available to one of his sons, so that the family can continue to benefit from the income stream they have come to rely on. With a strong sense of responsibility for his younger siblings Mphaka was only too keen to step into his father's shoes and become the family breadwinner. "After mourning my father, I was happy to take over his job. I now can send money back home to pay for school for my younger brothers," he says. Mphaka also points out that it is very hard for people to obtain jobs at the mines, so it is a great advantage that he has gained this job, albeit the unfortunate circumstances.

Hoping for marriage

Mphaka's family commitments and the fact that he now has to take responsibility for his younger siblings has meant that he has had to put his own plans on hold. He is still unmarried but has a girlfriend in Lesotho whom he hopes to marry at some point in the future. Because he will have to make the traditional bridewealth payment to her family, he cannot get married soon given that he has to channel most of his earnings to his own family. "I am still preparing for that," he says, and it is clearly his ambition once married to continue with mine labour while his wife performs the role expected of most rural Basotho women, namely to remain at home and raise the children and the crops.

HIV challenges, risks and perceptions

Ramalumane and Mphaka provided some insight into issues faced by young rural Basotho men with regards to relationships and HIV. Ramalumane is still single at the age of 23, but this is clearly not due to any lack of charm, looks or confidence. "I was a charmer at school, and I had no problems attracting girls. I would go straight up to them if I wanted to speak to them," he says unabashedly.

However, he explains why he still prefers to be single: "These girls! You think that you can wait for them, but the next thing you find is that they are taken, and you become stressed. So I will wait until the time is right. I do not want my wife to come and be a burden to my mother. I will wait until I can support her myself."

Ramalumane is equally comfortable and open talking about HIV and the problems that migrant workers face in this regard. He acknowledges that migrants are exposed to fellow workers who misbehave, which puts their health at risk: "If a man gets out of his own home, he becomes attracted to females, unaware that they may be infected, and then he may get HIV." He feels that if he became a migrant worker he would rather abstain from sex until returning home as he wants to protect himself. However, he acknowledges that many men say that it's impossible to go without sex for long periods.

Falimeha HIV outreach project

On the Falimeha HIV outreach project implemented by IOM and TEBA, Ramalumane is convinced that it is having a positive impact. He says that people are becoming better educated and changing their behaviour. He cites himself as one such person, and his mother who runs a support group. Even people who are not HIV positive have joined the group to learn more about HIV and gender relations. It is very likely that Ramalumane's positive and open attitude towards sex and HIV has been influenced by his mother, with whom he has a close relationship. Ramalumane's attitude and knowledge, according to TEBA outreach staff, is unusual among Basotho men, most of whom are still very traditional and shy away from talking about sex and HIV.

Mineworkers have a code for conducting themselves

Mphaka, in fact, fits much more into the patriarchal Basotho mould, and was not at all comfortable or open to discuss issues relating to sex and HIV. He conceded that there are temptations at the mine such as drinking and women, but said that he did "not like doing those things". This may be true for him, but when asked if his co-workers ever fell for these temptations he said that he had never seen his colleagues engaging in any such behaviour before. A TEBA employee explained his cagey answer

as follows: "Mineworkers have a code among themselves that they are not allowed to tell outsiders what they do at the mines. If you tell or reveal what is happening, you can even be beaten up."

Both young men were positive about the fact that their fathers were mineworkers and the kinds of opportunities this afforded their families. However, it is clear that their fathers suffered in various ways due to the nature of their living and working conditions. The stories illustrate how dangerous mine labour is for the health and physical well-being of migrant workers.

For more information, please visit: www.iom.org.za

Eyewitness

January – June 2011



Clients at the Eastleigh Community Wellness Centre, Nairobi, Kenya



Busia Trailer Park Wellness Centre opens on the Kenyan-Ugandan border



IOM staff ready to treat TB patients in Kenya



New IOM health assessment centre in Ghana



An urban migrant household in Majengo, Kenya



The Horn of Africa suffers the worst drought in 60 years



The Republic of Yemen plays host to hundreds of migrants and IDPs



IOM transports and provides health care for migrants on the Libyan/Egyptian border



Truck drivers in truck stops account for 30.2 per cent of a sex workers clientele



Mother & child on the Kenyan/Ugandan border



IOM strengthens the national response to HIV along transport corridors



As we go to print, IOM responds to the $\operatorname{\mathsf{Horn}}$ of $\operatorname{\mathsf{Africa}}$ famine crisis



Kenya holds first national consultation on migration health

"Migrants and mobile populations deserve to live healthy lives among us"

The Kenyan Ministry of Public Health and Sanitation, in partnership with the International Organization for Migration (IOM), the World Health Organization (WHO), and partners, hosted a National Consultation on Migration Health to reach a common consensus on a way forward for securing quality and equitable health services for migrants and mobile populations in Kenya.

Migrants and mobile populations face many obstacles in accessing essential health care due to a number of factors, these include irregular immigration status, language barriers, a lack of migrant-inclusive health policies, and geographical inaccessibility of services. Such disparities are impacting upon the well-being of migrants and host communities, and undermine the realization of Kenya's health goals, such as preventing HIV and containing tuberculosis.

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

Accountability

Dr. Davide Mosca, Director of Migration Health for IOM added: "There is need for a paradigm shift, strategies to address antimigration sentiments, and appreciation that migration is here to stay. Migrants are a part of the solution for achieving the Millennium Development Goals."

World Health Assembly

The National Consultation on Migration Health, held in Mombasa from 4-6 May 2011, also served as a platform to operationalize the World Health Assembly Resolution 61.17 Health of Migrants, a resolution that calls upon member states to ensure equitable access to health services.

Speaking at the consultation, Dr. Abdoulie Jack, WHO's Country Representative, called for multi-sectoral collaboration in addressing migration health issues. "The health of migrants is by no means just the business of the health sector, or an agency like the World Health Organization, indeed, the management of migration health requires close cooperation and collaboration among sectors, and related institutions involved in the migration process," he stated.

National forum

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

For more information on the Ministry of Public Health & Sanitation, please visit: www.publichealth.go.ke

Stranded migrants & trafficked persons receive emergency health care in the Republic of Yemen

The Republic of Yemen is a country in crisis, wrestling with many social, political and economic problems that result in extremely precarious living conditions for both the Yemeni population, and its marginalized migrants. The Republic of Yemen possesses a weak health workforce; for every 10,000 people, only two primary health care units, seven hospital beds, three physicians and seven paramedics are available. The International Organization for Migration (IOM) is working continuously to provide health care support and services for stranded migrants who are unable to access the care they need.

IOM sets up a clinic in Yemen providing emergency health care to stranded migrants

Haradh, a town on the Yemeni/Saudi Arabian border, is a hotspot for migrants trying to reach Saudi Arabia. The journey across the sea from the Horn of Africa, notably Ethiopia, and onward by foot to Haradh is perilous; many migrants reach Haradh severely dehydrated and malnourished, and often suffering from serious health conditions, such as renal failure. Since early 2011, 7,000 migrant men, women and children have been stranded in Haradh, unable to cross the border. High morbidity and mortality among migrants is compounded by Haradh's harsh climate where temperatures climb to over 45 degrees. Many migrants are found in a comatose state, often suffering from cerebral malaria or heatstroke. IOM and partners immediately responded by setting up a clinic in January 2011.

Two medical doctors and three nurses operate around the clock providing emergency medical care, treatment of common ailments, medical referrals, pre-departure health checks, vaccinations and environmental spraying against mosquito breeding sites. From January to June 2011, 5,384 migrants have been provided with health care.

The most common medical conditions diagnosed and treated so far are diarrhoeal diseases and respiratory tract infections. The incidence of falciparum malaria, measles and tuberculosis is also high among migrants. Additionally, IOM provided medical care to 121 injured migrants within two months, 64 of whom were surgical cases, notably caused by gunshot wounds. The unmet health needs of migrants remain immense and IOM is continuously seeking for additional support.



Provision of health and psychosocial care for trafficked persons

Yemenis and migrants residing in the Republic of Yemen are vulnerable to human trafficking due to poverty, gender discrimination and vast discrepancies in the distribution and possession of wealth and resources. Yemenis and migrants are trafficked within the country, and to the Republic of Yemen's wealthier neighbours. Responding to an urgent need to identify and protect trafficked persons in the Republic of Yemen, IOM has assisted over 310 trafficked persons since March 2011. This includes providing psychosocial support and medical care. Psychosocial care offered for trafficked persons and vulnerable migrants includes individual counselling, group counselling, psychological assessment, psychiatric referral, sports, recreational and educational activities. IOM also delivers treatment and prevention services for common communicable diseases, and offers referrals for reproductive health care and hospitalization.

For more information, please visit: www.egypt.iom.int

"I thought I would never be able to see my country again, but I am now getting ready to fly back to Nigeria tomorrow. It was a miracle when IOM found us in prison. Many of my friends and I had been detained for more than one year here in Yemen. I never understood why they put me in jail, I did not do anything bad, and I just wanted to go to Saudi Arabia. IOM helped us get out of prison, and we have since stayed in this nice place where we can also see a doctor and get medicine."

A Nigerian woman detained in a Yemeni prison. IOM assisted 18 imprisoned Nigerian women and children in Yemen 2011.





DR. Stanley Sonoiya, Principal Health Officer for the East African Community (EAC) talk to IOM

What are some of the EAC's regional health priorities?

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

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

Trans-border HIV programming needs to be scaled-up, with a common package of comprehensive services that prioritize prevention. We need to reach key populations in fishing communities, at one-stop border posts, and along regional transport corridors.

Why is trans-border collaboration and partnership so important among EAC partner states?

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

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

What is the biggest health challenge, or risk, among mobile populations and migrants in East Africa?

I would say HIV and tuberculosis (TB). Although epidemiological data is lacking, we believe that there may be higher HIV prevalence in 'risk zones' along regional transport corridors

stemming from transactional sex. The prevalence of HIV is particularly high among fishing communities and migrant plantation workers, partly as a result of the nature of their work which demands that they are away from home for long periods of time, and hence the likelihood of engaging in unprotected sex with multiple concurrent partners, which may in turn contribute to a significant number of new HIV infections.

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

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

EAC and IOM are currently implementing a memorandum of understanding that was jointly signed on 5th June 2006 which covers various areas of mutual interest including development of a regional migration policy, capacity building of immigration officers, and other health issues.

IOM is assisting in two main ways. Firstly, as a technical agency, IOM is facilitating the gathering of data, assisting with regional coordination, providing ongoing specialized technical advice, and working to develop a regional strategy aimed at preventing HIV along transport corridors.

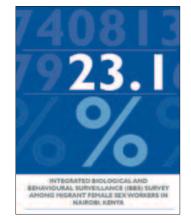
Secondly, governments have specifically requested assistance from IOM, as an implementing partner, to scale-up comprehensive HIV programming in border areas, including one-stop-border posts which fast-track the various clearance procedures of immigration, customs, and health at border sites.

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

Two important meetings and field visits took place from 26th to 30th June 2011 and were considerable milestones cementing EAC's relationship with IOM. The first meeting took place between the Republic of Rwanda and the United Republic of Tanzania at the proposed Rusumo one-stop-border post. The second meeting was between the United Republic of Tanzania and the Republic of Burundi at Kabanga and Kobero border post

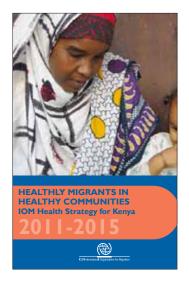
For more information, please visit: $\mathbf{www.eac.int}$

Publications



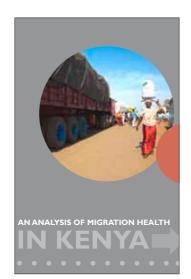
Editor's pick: Integrated biological and behavioural surveillance survey among migrant female sex workers in Nairobi, Kenya

Published in 2011, this 2010 study was the first of its kind among a migrant population in Kenya. The objective was to establish information that contributes towards developing an evidence-informed response to HIV/AIDS among migrant female sex workers, as migrants have not been targeted as a distinct category under the national response. As a direct result of this study, the target population is now accessing services. This study was undertaken in collaboration with Kenya's National AIDS and STI Control Programme, the National AIDS Control Council, the Joint UN Team on AIDS, and the Kenya AIDS Control Project. A pair of manuscripts has been drafted for publication in peer-reviewed journals.



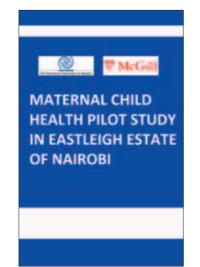
Healthy Migrants in Healthy Communities: The IOM Health Strategy for Kenya 2011-2015

The IOM Health Strategy for Kenya falls within the IOM Health Strategy for East and Southern Africa. Through its health programme, IOM promotes a comprehensive approach which is multisectoral in nature, adds value to national partnerships, and addresses the social determinants of health at an individual, community, and policy level.



An Analysis of Migration Health in Kenya

This report was undertaken by IOM in partnership with the Kenyan Ministry of Public Health and Sanitation. It provides a concise overview of migration health in Kenya, reinforcing the fact that migration is a social determinant of health. The analysis looks at specific health concerns in Kenya such as tuberculosis and migration, HIV and mobility, and reproductive health and migration.



Maternal Child Health Pilot Study in Eastleigh Estate of Nairobi

This study is the result of a partnership between IOM, the School of Nursing at the McGill University in Montreal, Canada and the Clinical Epidemiology Unit at the University of Nairobi, Kenya. Evidence suggests that migrant communities access and use health care services differently than host populations, and that migration status is associated with compromised access to health care and health outcomes.

For all reports email: migrationhealthnairobi@iom.int or call +254 20 444 4174

Additional IOM publications

Kenya

US Centers for Disease & Control & Prevention, Atlanta & International Organization for Migration

2011 Household survey to assess health care utilization in an urban neighbourhood in Kenya, Nairobi. IOM, Nairobi.

Somalia

International Organization for Migration

2010 Sexual and Gender-Based Violence (SGBV) and HIV Assessment Among Vulnerable and Displaced Women in Somaliland in Non-Camp Settings. IOM, Nairobi.

2008 HIV & Syphilis Integrated Biological and Behavioural Surveillance (IBBS) Survey Among Female Sex Workers in Hargeisa, Somaliland. IOM, Nairobi.

2008 Somali HIV Hot-Spot Mapping: Exploring HIV Vulnerability Among Populations at Increased Risk. IOM, Nairobi.

Kriitmaa, K. et al.

2010 HIV prevalence and Characteristics of Sex Work Among Female Sex Workers in Hargeisa, Somaliland. *AIDS* **24**: **S61–S67.**

South Sudan

International Organization for Migration

2011 Knowledge, Attitudes and Practices: A Review of IOM's Health Education Sessions in South Sudan. IOM, Juba.

Tanzania

International Organization for Migration

National Consultation Migration & HIV in Tanzania: Uniformed Personnel, Mobile Populations, and Border Communities 1-2 June 2010. IOM, Dar Es Salaam.

2010 Rapid Field Assessment of HIV Vulnerabilities and Service Delivery Gaps in Border Zones: Tanzania, January –May 2010. IOM, Dar Es Salaam.

Follow up Workshop to Stakeholders Meeting on Migration & HIV in Tanzania: Uniformed Personnel, Mobile Populations, and Border Communities: 10-11 August Ngara, Tanzania. IOM, Dar Es Salaam.

Uganda

International Organization for Migration

2010 Health Service Availability Mapping for Most-At-Risk Populations at HIV Hotspots along the Kampala – Juba Transport Route. IOM, Kampala.

2010 Project Report on HIV Service Delivery along the Kampala-Juba Highway. IOM, Kampala.

A Response Analysis of HIV/AIDS Programming along Transport Corridors in Uganda. IOM, Kampala.

2009 HIV Knowledge and Practices of Truckers and Female Sex Workers along Major Transport Corridors in Uganda. IOM, Kampala.

2008 HIV Hot-Spot Mapping and Situational Analysis along the Kampala-Juba Transport Route. IOM, Kampala.

Yemen

International Organization for Migration

Caring for Trafficked Persons, Guidance for Health Providers. IOM, Geneva/Yemen.



Meet the team

An interview with Hussein Hassan, IOM Somalia's Migration Health Officer

Hussein Hassan has been with the International Organization for Migration (IOM) for just over one year. A Somali national, but originally from the Republic of Yemen, Hussein is a specialist in primary health care and health system strengthening. He loves reading novels, and discovering new innovative plans for community development.

What is the current situation in Somalia with regards to health?

Health care in Somalia is largely owned by the private sector, as national health care systems have been destroyed by civil war. This is an issue for migrants who often cannot afford private health care services. The reconstruction of a national health care system is in progress, but it is still a huge challenge.

What is the biggest challenge, or risk, facing the health of migrants and mobile populations in Somalia?

In Somalia, we have an eclectic mix of migrants. Refugees and asylum seekers are mostly from Ethiopia, and other African countries including Tanzania, Rwanda and Zambia. We also have a variety of mobile populations including truck drivers who cross the border between Somalia and Ethiopia, and Kenya and Djibouti. Then there are port workers who arrive from India, Yemen, Pakistan, Kenya and Djibouti. Another significant group are internally displaced persons (IDP), mainly from South Central Somalia, where there is continuous conflict.

Migrants in Somalia rarely have social protection, and often feel discriminated against and, for this reason, are less likely to access vital health care services. IDPs, asylum seekers and refugees also need specialized attention as they often make long, arduous journeys into, and within Somalia, by foot. What are the types of populations you deem most susceptible to health vulnerabilities in Somalia?

Mothers and their children are particularly susceptible to health vulnerabilities in Somalia. IDPs and migrants is the second most susceptible group, as there is a lack of migrant-friendly or affordable health care services available to them.

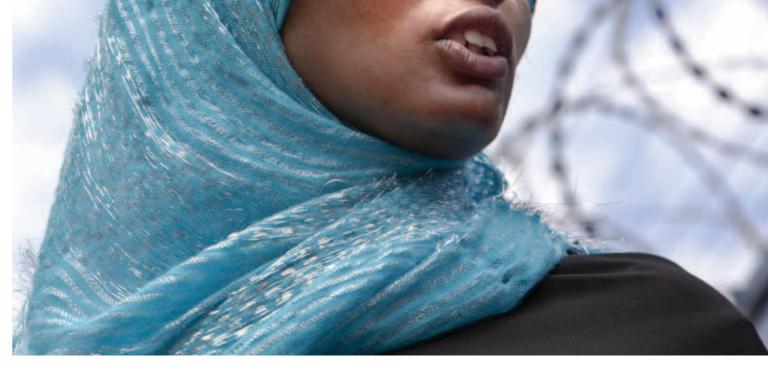
How have attitudes to health evolved over the last 10 years in Somalia?

Over the last 10 years, a considerable number of Somalis have returned from the diaspora. They have brought new ideas and plans to launch comprehensive private health facilities, but still, they remain too expensive for vulnerable populations.

How is IOM dealing with health care challenges in Somalia, what is our impact?

Currently we are managing two important HIV projects in Somalia. Both programmes target most-at-risk groups, including mobile populations such as truck drivers, migrants, IDPs, refugees and uniformed services. A key component are behavioural change communication (BCC) messages on HIV and sexually transmitted infections which will help erase stigma and prevent new infections. We also hope it will create awareness on what HIV testing and counselling services are on offer. We have already seen success with our BCC outreach campaign and saw many people after the campaign voluntarily go for a blood test to find out their status.

One immediate impact that IOM achieved during 2011 has been improving partnerships between each regions Ministry of



Health and National AIDS Commission. Only with partnership can we boost migrant-friendly packages and improve accessibility to HIV counselling and testing services.

Are there programmatic gaps, and if so, how would you address them with adequate funding?

There are programmatic gaps. Different partners with different visions are managing HIV prevention and treatment separately, and as a result, no combination HIV prevention strategy is in place. Communities affected by piracy are also extremely neglected as they reside in remote coastal areas and are far from health facilities.

During your time at IOM, what has been your foremost success?

My foremost success has been the management of two HIV programmes in Somalia. In a very short period of time we have partnered with over 21 organizations and doubled our donor targets.

We also launched the first ever youth survey focusing on health care in Somalia. I succeeded in coordinating the implementation of this survey, and provided technical assistance. The data is now in, and is currently being pulled together for analysis.

And, lastly, how do you see the relationship between mobility and health unfolding over the next 10 years in Somalia?

In Somalia, awareness on the relationship between mobility and health is lacking. Existing health services are only catering for the general population, and are not targeting mobile populations, or migrants, who face unique vulnerabilities. This is why the presence of IOM is needed: to work with governments to facilitate the creation of national strategies to ensure mobile populations have access to comprehensive, affordable and equitable health care.

Do you have any questions for Hussein? Email us at: migrationhealthnairobi@iom.int



