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MIGRATION HEALTH

MIGRATION MANAGEMENT

MIGRATION HEALTH DIVISION

Annual Review 2012

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

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DEPARTMENT OF MIGRATION MANAGEMENT

Migration Health Division

Annual Review 2012

MHD

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2012 by the numbers

IN TOTAL

88.5
MIL USD EXPENDITURE

PARTNERS

Governments
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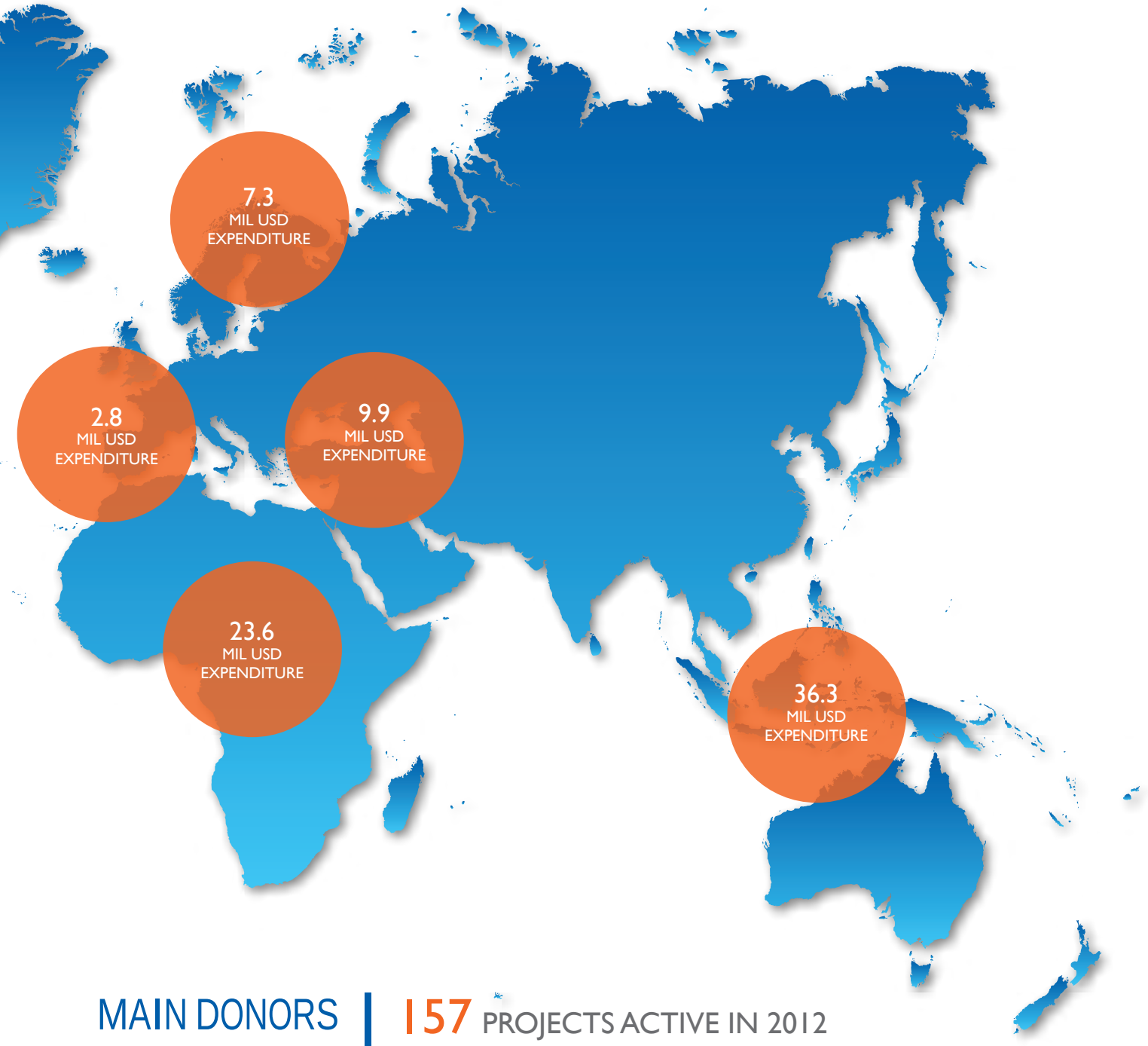

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157 PROJECTS ACTIVE IN 2012

- 26 Migration Health Assessments and Travel Health Assistance
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foreword

With this Report I am delighted to present a review of the activities of IOM's Migration Health Division (MHD) in 2012, recall the salient migration health highlights of 2012 and note key upcoming events in 2013.

The year 2012 marked the beginning of the UN-wide process of revising the post-2015 development goals – launched with the report entitled "Realizing the Future We Want for All." This report proposed an inspiring vision of a people-centered, equitable, inclusive and sustainable development. It flagged the need for change to transform globalization into "a positive force for all the worlds' people of present and future generations." In parallel, countries around the world recognized the relevance of migration and human mobility for all three pillars of sustainable development – namely, economic, social and environmental. In spite of these intentions, a lot remains to be done to reflect migration adequately within development frameworks and multisectoral policies at the national and regional levels.

Unfortunately, human migration remains a neglected issue on the global health agenda as well. The public perception of migrants and migration remain predominantly negative, not having kept pace with the reality and scale of human mobility. Often, migration, social and labour policies do not ensure adequate protection of migrants' human rights, nor fully uphold safer and more transparent systems for international mobility. Such migration-related factors determine migrants' vulnerability and ill health, and contribute to otherwise-avoidable economic and human costs of migration.

In 2012 IOM continued evidenced-based advocacy with its partners to ensure that migration is part of the health debate and that, in turn, health is part of the migration debate. Addressing the health of migrants is indispensable for reaping the benefits and reducing

the negative effects of international migration for all stakeholders – that is, migrants, as well as communities of origin, transit and destination – from a human rights, public health and development perspective.

This Annual Report includes an editorial on why and how the health of migrants should be included in the post-2015 UN development framework. It is encouraging to note that the April 2013 Global Thematic Consultation on Health in the post-2015 agenda recognized that "the most disadvantaged, marginalized, stigmatized, and hard-to-reach populations in all countries should be prioritized" – migrants often fall in this category. Although IOM supports Universal Health Coverage (UHC) as the overarching goal in the area of health in the post-2015 development framework, we caution that the UHC objectives for migrants may not be achieved without addressing the migration-specific social determinants of health. For this reason, specific indicators of migrant health should be monitored within future global health goals, whatever they may be.

In October 2013 the second High-level Dialogue on Migration and Development will be held at the UN General Assembly in New York. We hope that migrants' health issues will feature in this important debate alongside other migration themes. Often, the health sector is not represented in migration and development dialogues, especially given the perception that health should be addressed in public health forums. Yet, many of the solutions to improve migrants' health lie in other sectors, such as labour, social protection and immigration. Therefore, IOM will continue to work closely with its Member States, migrant beneficiaries, the United Nations, civil society and other stakeholders to ensure multisectoral collaboration for promoting the health of migrants.

2012 has been a busy year again for MHD, as evidenced by this Report. Total expenditure of the Division in 2012 amounted to USD 88.5 million, an increase of 21 per cent from 2011. This Report highlights selected examples of major IOM activities in the area of migration health assessments, health promotion and health assistance for migrants in crisis situations. Sincere gratitude and admiration go to all staff, colleagues, partners and Member States who promote migration health – a rapidly growing area of IOM work.

We hope you enjoy the read!

Davide Mosca
Director, Migration Health Division
Department of Migration Management

list of acronyms

AIDS	Acquired immunodeficiency syndrome
APMEN	Asia-Pacific Malaria Elimination Network
ARRA	Administration for Refugee and Returnee Affairs
ART	Antiretroviral therapy
ASEF	Asia-Europe Foundation
AVRR	Assisted voluntary return and reintegration
BHS	Basic health staff
CBO	Community-based organization
CCCM	Camp Coordination and Camp Management (IASC cluster)
CDC	Centers for Disease Control and Prevention
CHA	Community health agent
CHIPS	Combination HIV Prevention
CHV	Community health volunteer
CHW	Community health worker
CIC	Citizenship and Immigration Canada
DNA	Deoxyribonucleic acid
DOTS	Directly observed therapy – short course
DST	Drug susceptibility testing
ECDC	European Centre for Disease Prevention and Control
ECOWAS	Economic Community of West African States
EU	European Union
FINNSOM	Finnish–Somali
FSW(s)	Female sex worker(s)
GBV	Gender-based violence
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHC	Global Health Cluster
GMS	Greater Mekong Subregion
HAP	Health assessment programme
HIV	Human immunodeficiency virus
IASC	Inter-Agency Standing Committee
ICT	Information and communication technology
IDP	Internally displaced person
IEC	Information, education and communication
IIRHWG	Intergovernmental Immigrant and Refugee Health Working Group
ILO	International Labour Organization
IOM	International Organization for Migration

JICA	Japan International Cooperation Agency
LSHTM	London School of Hygiene and Tropical Medicine
LTBI	Latent tuberculosis infection
MDGs	Millennium Development Goals
MDR	Multidrug-resistant
MHA	Migration health assessment
MHD	Migration Health Division (of IOM)
MHI	Migration health informatics
MHPSS	Mental Health and Psychosocial Support
MIDA	Migration for Development in Africa
MoH	Ministry of Health
NCD(s)	Non-communicable disease(s)
NCDC	National Centre for Disease Control and Public Health
NDPHS	Northern Dimension Partnership in Public Health and Social Well-being
NGO	Non-governmental organization
NTP	National tuberculosis programme
OPD	Outpatient department
PDMS	Pre-departure medical screening
PEC	Pre-embarkation check
RHA	Rapid health assessment
SADC	Southern African Development Community
SGBV	Sexual and gender-based violence
SIDA	Swedish International Development Agency
SMC	Significant medical condition
STI	Sexually transmitted infection
TB	Tuberculosis
UHC	Universal Health Coverage
UKTBDP	United Kingdom Tuberculosis Detection Programme
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	Office of the United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNRISD	United Nations Research Institute for Social Development
VHC	Village health committee
WASH	Water, sanitation and hygiene
WHA	World Health Assembly
WHO	World Health Organization
WPRO	Western Pacific Regional Office

Part I: Emerging themes in migration and health

Mobilizing diaspora health professionals for health systems strengthening

Migration of health professionals

Many low- and middle-income countries experience a significant loss of skilled professionals who migrate to European, North American and other high-income countries. Human resource gaps are particularly felt in the medical education and specialized care sectors, due in part to the fact that it is often the most skilled and qualified individuals who emigrate. The 2006 World Health Organization (WHO) World Health Report estimated a global shortfall of almost 4.3 million health personnel, with 57 countries (mostly in Africa and Asia) facing severe shortages. Apart from migration, other factors causing this shortfall include limited investment in health sector education, which results in a shortage of young graduates who would take available health-care jobs; inappropriate skill mixes; and inequitable geographic distribution of health workers (WHO, 2006). Such shortages significantly hamper the realization of health and development goals in affected countries, which, according to WHO data, struggle with a very large burden of disease and health risk factors (WHO, 2008).

The migration of health professionals occurs due to various reasons, which include relatively low wages, poor working conditions and the lack of adequate professional development opportunities in regions and countries of origin, coupled with the growing demand for health professionals in developed countries resulting from accelerating demographic changes and inadequate domestic health workforce planning and investment. This outmigration of skilled health workers, often labeled "brain drain," has long been a major concern about national health systems, as well as a hindrance to the achievement of health-related Millennium Development Goals (MDGs). While the freedom to seek employment opportunities abroad needs to be recognized for all workers, including health professionals, high-income countries have to ensure that health worker recruitment policies do not oppose global development goals by depriving low- and medium-income countries of much-needed health personnel. In this regard it is important that countries implement the WHO Global Code of Practice on the International Recruitment of Health Personnel, which was adopted at the Sixty-third World Health Assembly in 2010 (WHA 63.16; WHO, 2010) This voluntary Code aims to "establish and promote voluntary principles and practices for the ethical international recruitment of health personnel" (Art. 1.1) and "discourages the active recruitment of health personnel from developing countries facing critical shortages of health workers" (Art. 5.1). It honours the right of any individual, including health professionals, to leave any country and migrate to another that wishes to admit and employ him or her (Art. 3.4). Although the Code is not legally binding, Member States are required to periodically report to the WHO Secretariat on their progress in its implementation. IOM has been identified as one of the organizations that will work with WHO, Member States and other stakeholders to facilitate the implementation and monitoring of the Code.

While there has been progress in reducing the disease burden in the African region in recent years, the situation remains alarming. According to the 2006 African Regional Health Report of WHO, 19 of the 20 countries with the highest maternal mortality ratios worldwide are in Africa. The region also faces a high burden of life-threatening communicable diseases, combined with increasing rates of non-communicable diseases such as hypertension and coronary heart disease. The workforce that has to deal with these enormous health challenges is relatively small compared to that of most countries with a lighter burden of disease. The density of health workers in most African countries is insufficient to meet the needs of the population, and one of the many factors that further deteriorates already weakened health systems is the outmigration of skilled health professionals from the region. For instance, the expatriation rate for doctors in Congo is 41.6 per cent; in Burundi, 26.2 per cent; in Ethiopia, 24.6 per cent; in Angola, 31.2 per cent; in Rwanda, 10.1 per cent; and in Somalia, 33.3 per cent, according to the Organisation for Economic Cooperation and Development (2007; figures for 2000).

Mobility of Health Professionals (MoHProf)

Mobility of Health Professionals (MoHProf), a three-year research project funded by the European Commission as a medium-scale collaborative project within the Seventh Framework Programme (FP7), Theme 1: Health, was completed in 2012. The general objective of the project was to research current trends in the mobility of health professionals to, from and within the European Union (EU). IOM was one of the main partners of the consortium which conducted the research in 25 countries; it also contributed to six African country reports (namely, Ghana, Kenya, Morocco, Angola, South Africa and Egypt). A final thematic analysis of the findings across the regions and countries, *Mobility of Health Professionals: Health Systems, Work Conditions, Patterns of Health Workers' Mobility and Implications for Policy Makers* (Tjadens et al., 2012), as well as a research paper discussing health worker migration from the perspective of the South-east European region, entitled *Health Workforce Mobility in the South-east European Health Network Region*, were published. IOM presented the country reports at national and regional events in Africa and disseminated them at international conferences in Europe and Africa.

Mobility of Health Professionals provides a comprehensive description and analysis of the mobility streams of health professionals, the motives and driving forces behind them and their impact on and the challenges for health systems.

Diaspora engagement: Mitigating the medical brain drain

The WHO Global Code of Practice on the International Recruitment of Health Personnel reflects the recognition that migration, including that of health professionals, is a fact of life, and that the retention of health workers cannot and should not be the sole or primary objective of efforts to mitigate the medical brain drain. Hence, it is critical as well for countries of origin and destination to work together and strive to harness the development potential of the health diaspora. In addition, the migration of health workers should not only be seen as causing a "brain drain" – migrants can also contribute to the development of their countries of origin in multiple ways, for instance, by sending financial remittances to their families and by sharing newly gained knowledge and expertise with friends and colleagues back home. Health professionals with a migration background, in particular, can act both as agents of development for their home countries and as mediators for migrant-friendly health services in countries of destination (Davies, Mosca and Frattini, 2010).

IOM's programme, named Migration for Development in Africa (MIDA) seeks to encourage and harness the positive impacts of migration by mobilizing members of the African diasporas in Europe and North America to contribute to the development of their countries of origin. Within the programme framework, IOM has started a number of capacity-building initiatives to assist African countries to benefit from the skills of their nationals abroad. Several MIDA projects specifically target health professionals. Since 2003, the MIDA Ghana Health Project, funded by the Dutch Government (through the Embassy of the Kingdom of the Netherlands in Accra), has supported Ghanaian health professionals living in the Netherlands, the United Kingdom, and Germany in strengthening the health system and human resources for health capacity in Ghana. The project focused on several medical subsectors, including mental health, emergency care, orthopedics, and information and communication technologies (ICT) for health. Based on the specific "expertise requests" of health training institutions and hospitals in Ghana, Ghanaian health professionals from the diaspora countries mentioned transferred specific knowledge, skills and experience through temporary,

one-time or repeated assignments in Ghana (lasting between three weeks and three months).

In Somalia, MIDA Finnish-Somali (FINNSOM) Health, a project funded by the Ministry for Foreign Affairs of Finland, seeks to enable the temporary return of qualified Somali health professionals from Finland to contribute to the rehabilitation and development of the health sector in two regions in northern Somalia. Similar health-related diaspora engagement projects have been implemented in Rwanda (funded by the IOM Development Fund), the Democratic Republic of the Congo (funded by the Belgian Development Cooperation), Ethiopia (funded by UNDP Ethiopia) and Burundi (funded by the Belgian Development Cooperation). In 2012, IOM launched a new project, in collaboration with WHO and other partners, which seeks to contribute to the implementation of Sierra Leone's National Health Sector Strategic Plan 2010–2015 (see report on Health Promotion and Assistance for Migrants on page 35). In particular, the project facilitates short-term placements of Sierra Leonean health professionals residing in the United Kingdom, the United States of America, Canada and Germany in selected health-care learning institutions in Sierra Leone.

Main principles of diaspora engagement projects

In 2012, IOM and the Migration Policy Institute jointly published a handbook for policymakers entitled Developing a Road Map for Engaging Diasporas in Development. As the handbook explains, diaspora engagement projects need to be demand-driven and based on priority needs identified in cooperation with local authorities and project partners if they are to successfully contribute to mitigating brain drain effects. In addition, linkages and partnerships established during the course of the project ideally must continue even after the project ends.

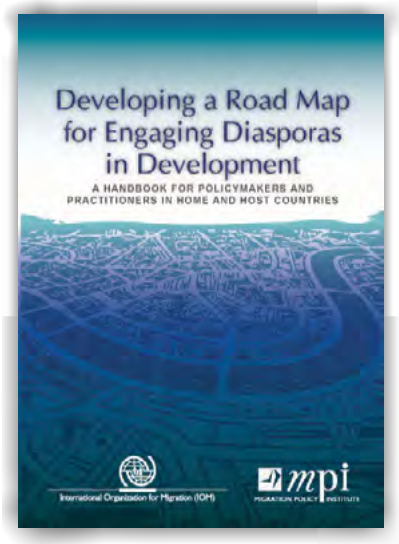
MIDA health projects generally put special emphasis on facilitating the transfer of knowledge, skills and experience from members of the diaspora to local staff in health institutions in countries of origin. Moreover, female health professionals in the diaspora are particularly targeted and gender-based gaps in the provision of health services are identified. A best practice in diaspora recruitment procedures is the non-payment of salaries per se to MIDA project participants, so they don't pose a threat to local employees. The participants, however, are assisted with all travel arrangements and provided with medical and evacuation insurance and in-country transportation. Furthermore, project participants receive a living allowance based on their proven qualifications, which is intended to cover basic living expenses and accommodation. A lesson learned from several of the projects is that technical capacity-building missions must include provision of basic medical devices and equipment. Support is also needed in maintaining technical medical devices, for example, in the form of training sessions for local maintenance officers conducted by experts from the diaspora.

Maximizing the positive impact of diaspora engagement projects on public health and health systems

Diaspora engagement projects are no panacea for the global shortfall and geographic maldistribution of health professionals. They can, however, serve as interim solutions to health worker shortages and the lack of specific skills in countries of origin, and, by offering training to local staff, support the development of local health systems. More importantly, perhaps, these programmes can raise the political visibility of the issues at stake and highlight especially the struggles of low- and middle-income countries' to build sustainable health systems. The key actors (and their corresponding roles) in diaspora engagement programmes are as follows:

1. **Migrant health professionals** participating in diaspora engagement projects can, in addition to transferring their knowledge and skills to colleagues in origin countries, act as bridges between health institutions and health policymakers in countries of origin and destination.
2. **Governments** should implement the WHO Code of Practice on the International Recruitment of Health Personnel and secure adequate financial resources to ensure sustainable solutions to the human resource crisis in the health sector.
3. **Health policymakers** in countries of origin and destination need to cooperate and jointly collect statistics on health worker mobility, develop strategies for forecasting health workforce needs and workforce planning, share good practices in health professional recruitment and implement ethical recruitment principles.

4. **Civil society** institutions and non-governmental organizations can play an active role in twinning or pairing individuals and institutions in countries of origin and destination for the development of health systems.
5. **International organizations** need to carefully monitor ongoing diaspora engagement projects and evaluate the impact of completed projects, to assess the (financial and non-financial) costs and benefits of these programmes and determine criteria for success.



Dr Clement Jafani Nabare, a Ghanaian health specialist residing in Germany, demonstrates the use of a trocar (a sharp-pointed instrument equipped with a cannula, used to puncture the wall of a body cavity and withdraw fluid) to Dr Afoko (resident) during a lecture for medical students in Tamale, Ghana on minimally invasive urology.

Developing a Road Map for Engaging Diasporas in Development is a handbook that provides governments with a strategic road map that can help them establish a clear sense of direction in building a constructive relationship with diasporas.

Participant testimonial: MIDA Ghana health expert Clement Jafani Nabare

Before coming to Germany, Clement Jafani Nabare worked as a "general duty" doctor (general medicine, surgery and administration) in Kintampo Hospital in the Brong-Ahafo Region. "We encountered all kinds of cases and had to deal with the fact that there were hardly any urologists in Ghana. When I received a scholarship, I went to Rotenburg to train in urology, general surgery and uro-gynaecology," the doctor explains.

The lack of skilled health staff is Nabare's main motivation to offer workshops for medical students, nurses and intermediate health-care professionals in the northern part of Ghana. Since 2009, he has used all his vacation time to do so. "We all have to be prepared to sacrifice time, energy and money to make a difference in the long run. Bringing about change is never easy."

In the workshops, he focuses on specialized urological care. "The nurses and other professionals are now able to deal with simple problems and can provide pre- and post-operative care. Some of them can also pass on their new skills to colleagues. […] they did not have a urology department; there was no nurse who knew how to take care of urology cases. But now this has definitely changed."

Clement Jafani Nabare is very clear about the importance of the MIDA Ghana Health Project: "The effect is huge; its impact cannot be just expressed in terms of money." For other professionals contemplating to share their knowledge with colleagues in their home country, he has a word of encouragement: "This whole project makes me very happy. You should see me in Ghana, working with a big smile on my face."

MIDA FINNSOM Health, northern Somalia (2008–2014)

The MIDA Finnish-Somali (FINNSOM) Health project was launched in 2008, building on IOM Finland's long-standing engagement with Somali diaspora initiatives in Finland in response to the interest voiced by Somali health-care institutions and authorities. The project seeks to enable the temporary return of qualified Somali health professionals from Finland to contribute to the rehabilitation and development of the health sectors in Somaliland and Puntland, two states in northern Somalia.

Working with a broad range of partners, MIDA FINNSOM Health aims to identify key human resource gaps in the health sector in Somaliland and Puntland that can be temporarily filled by professionals from the Somali diaspora in Finland or, to a limited extent, by Finnish specialists. In addition, the project seeks to facilitate sustainable partnerships between health institutions in the two countries. It envisions the facilitation of up to 72 temporary assignments for Finland-based Somali professionals to train, and work with, colleagues in Somaliland and Puntland. Selected professionals will work in the field for periods of 3 to 12 months, or as requested by the host institution.

Main achievements and challenges to date

Since 2009 IOM has conducted assessments of the Somaliland and Puntland health sectors, including a detailed description of their most prevalent needs, and arranged for 58 assignments for voluntary experts (from 3.5 weeks to 12 months) to some 20 host institutions in different regions of Somaliland and Puntland, thereby increasing the capacities of their staff in various fields of specialization. The presence of voluntary experts has made a considerable impact to these public health institutions. New wards, such as a hemodialysis unit and a dental unit, have been established by voluntary experts in the largest hospitals, and training of the local staff and interning medical students is ongoing. The project has also contributed to the creation of networks and partnerships between IOM, Somali health institutions and authorities, as well as members of the Finland-based Somali diaspora, laying the ground for extending and deepening the cooperation between these partners in the future.

The project faced some initial challenges. Security was particularly demanding: Terrorist attacks in northern Somalia forced IOM to suspend four assignments and delay others in 2008. Another challenge relates to sustainability: Because volunteer experts have become lead figures in the health facilities where they work, a consistent exit strategy needs to be developed in order to ensure that the tasks they currently carry out will be continued by local staff when the project is over. From this perspective, it is important that the assignments of the volunteer experts are long enough, since making a sustainable impact on the under-resourced health sector is a long-term effort. Third, although the lack of medical supplies in Somalia was a well-known problem beforehand and efforts had been increased to obtain donations in Finland so that quality material can be brought to Somalia by the project participants, donations turned out to be hard to obtain.

International organizations need to carefully monitor ongoing diaspora engagement projects and evaluate the impact of completed projects, to assess the (financial and non-financial) costs and benefits of these programmes and determine criteria for success.

A place for the health of migrants in the post-2015 development goals?

Integrating migrant health into the post-2015 thematic consultations

With the Millennium Development Goals expiring in 2015, the world is currently debating on a successor UN global development framework. Thematic and country consultations have been taking place all over the world – some of them online – since autumn 2012, involving a wide range of stakeholders. The Migration Health Division of IOM has been flagging the importance of addressing the health of migrants within this emerging development agenda.

In response to WHO's call for papers for the thematic consultation on health, MHD has submitted a position paper entitled "The importance of migrants' health for sustainable and equitable development." The paper calls for specific attention to the underlying determinants of health that relate to mobility and migration and why migrants' health is a cross-cutting development issue that should be addressed in the post-2015 development agenda. MHD also provided comments on other thematic consultations, such as the one on population dynamics (co-led by IOM, the United Nations Population Fund [UNFPA], the UN Department of Social and Economic Affairs [UN DESA] and the United Nations Human Settlements Programme [UN Habitat]) and the one on inequalities. The text box below presents the main arguments for why migrant health should be featured in the post-2015 development framework.

Insights from the global thematic consultation on health for the post-2015 development agenda

"**Health is central to sustainable development:** Health is a beneficiary of development, a contributor to development and a key indicator of what people-centred, rights-based, inclusive, and equitable development seeks to achieve. Health is important as an end in itself, and as an **integral part of 'human well-being'**, which includes interrelated and interdependent material, psychological, social, cultural, educational, work, environmental, political and security dimensions."

"The achievement of health goals requires policy coherence and shared solutions across multiple sectors: that is, a whole-of-government or 'health in all policies' approach."

"The guiding principles for the new development agenda should include human rights, equity, gender equality, accountability and sustainability. **The most disadvantaged, marginalized, stigmatized, and hard-to-reach populations in all countries should be prioritized**. Equity can be made explicit in all the goals by disaggregating indicators and targets, at all levels; the post-2015 health agenda should include specific health-related targets as part of other development sector goals."

"Examples of effective intersectoral action should be shared and widely disseminated so that others can learn from these experiences."

WHO, UNICEF, the Government of Sweden and the Government of Botswana, Health in the Post-2015 Agenda – Report of the Global Thematic Consultation on Health, April 2013 (emphasis added).

In line with the above, post-2015 health goals should include migrants regardless of their legal status: Specific indicators should be adopted to monitor migrants' access to health care and health outcomes. Social determinants of migrants' health need to be addressed using a "health in all policies" approach, that is, health of migrants needs to be included in relevant migration, population and development debates.

Background

There are approximately 215 million international migrants today. If current rates of international migration continue, the number could reach 405 million by 2050. Adding the approximately 740 million internal migrants to the picture, all in all there are about one billion people on the move today, a seventh of the world's current population of seven billion. With migration a megatrend in the twenty-first century, societies are more culturally and ethnically diverse than ever before and are experiencing an unprecedented diversity of health needs and profiles. This puts increasing pressure on health systems all over the world. Ensuring migrants' health means ensuring the health of a seventh of the world's population and carries positive multiplier effects through improved public health and development outcomes.

IOM supports the approach spearheaded by WHO that, with regard to health, the new development agenda should focus on achieving universal health coverage, that is, ensuring access for everyone to "the promotive, preventive, curative and rehabilitative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship" (WHO, 2012). However, IOM supports a wider interpretation of universal health coverage and suggests that the concept should include public health interventions and other measures that address the underlying determinants of health. IOM supports the explicit inclusion of indicators that measure universal health coverage for marginalized individuals and populations, such as migrants, regardless of legal status.

The world has changed since the adoption of the United Nations Millennium Declaration in 2000. With persistent and increasing inequalities within and among countries in the developed and the developing world, development is currently not only understood as improvements in living standards and the economy for the poorest countries, but as enhancing the fulfilment of individual potential and equal opportunities for people all over the world.

Evidence suggests that the MDGs have contributed to improvements in global health. Yet, a lot of work remains to be done. The new framework should build on the current one, but focus more strongly on equity and measure data disaggregated by gender, socioeconomic status, geographic location, migration status and other similar variables. Indicators should monitor progress in removing the underlying social factors that determine health outcomes, including in the migration context.

Migration as a social determinant of health for migrants

As is the case with many marginalized populations, the health of migrants is in large part determined by factors outside the health sector. The conditions in which migrants travel, live and work often carry exceptional risks for their physical, mental and social well-being; thus, the migration process can be regarded as a social determinant of health for migrants. The 2008 World Health Assembly (WHA) Resolution on the Health of Migrants (WHA 61.17, 2008) recognizes "that health outcomes can be influenced by the multiple dimensions of migration."

Risks to migrants' health vary according to their individual characteristics (for example, gender, age, educational attainment and disability, among others) and, more notably, their legal status. Irregular migrants especially face higher risks of exploitation and marginalization, including the lack of access to health services. In addition, even if migrants had access to health services, they generally choose to avoid them because of the fear of deportation and possible xenophobic and discriminatory attitudes of health-care staff, as well as linguistic, cultural and gender barriers.

In order to improve health equity for migrants, certain policies outside the health system (specifically, those pertaining to immigration, labour and housing) need to be adapted, and, as such, cross-sectoral action is crucial. This view is also recognized in the Rio Political Declaration on Social Determinants of Health (2011), which promotes a health-in-all-policies concept, recognizing that intersectoral cooperation and action are a promising approach towards health equity.

Kids of immigrants left out of health care

Findings of a recent study on low-income families in the US have shown that those with more precarious immigration statuses show the poorest health outcomes, and that families with non-citizen members face barriers, real or perceived, to using […] health-related programmes. (Ziol-Guest and Kalil, 2012)

Undocumented workers in Canada

Researchers found that undocumented migrant workers in the Greater Toronto Area in Canada constitute a flexible and cheap workforce for Canadian businesses, and that the conditions under which they live and work have severe consequences for their health. (Gastaldo, Carrasco and Magalhaes, 2012)

Efforts to enhance access to health services for migrants

A number of countries are using innovative approaches to address the health of migrants. For example, Sri Lanka and the Philippines have put in place insurance schemes for their overseas migrant workers. Thailand offers health services to certain categories of registered migrants and their families through a compulsory migrant health scheme. Brazil and Portugal are two countries that have adopted a policy of equal access to coverage for all migrants irrespective of legal status. Other initiatives are being led by trade unions and employees. For instance, in Argentina, employers contribute a percentage of workers' salaries towards a special fund that covers social benefits, including health insurance. Only a few cases of portable health-care benefits exist, such as the Moroccan-German agreement. Despite their limitations, these efforts recognize the important contribution of migrants to development and the need to ensure the health of migrants.

(Refer to Annex 1: "Examples of global migrant health responses," which accompanied the Roundtable 2.1 background paper on reducing the costs of migration and maximizing human development, presented at the fourth meeting of the Global Forum on Migration and Development, held in Mexico in 2010, available from www.gfmd.org/en/docs/mexico-2010.)

Three arguments for the inclusion of migrant health in the post-2015 development agenda

1. Migrants have a right to health.

The right to health is an all-inclusive human right that encompasses equal opportunities for everyone to enjoy the "highest attainable standard of physical and mental health" (WHO, 1946; ICESCR, 1966). The human right to health is closely interrelated and interdependent with other basic rights, such as housing, education and employment, among others. Yet, for migrants, the right to health is often not fully realized due to legal, social, economic, linguistic and cultural barriers which persist despite international and national legal commitments.

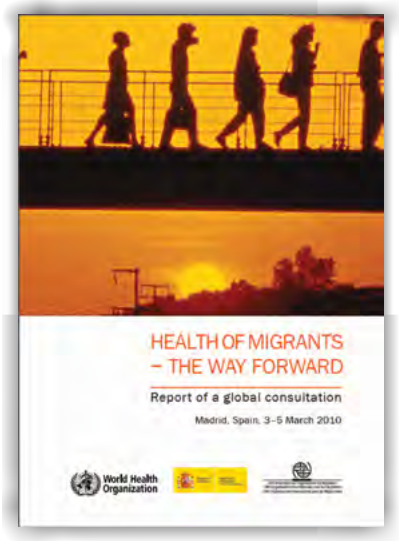
2. Including migrants in health systems improves public health outcomes.

The exclusion of migrants from public health systems is not just a violation of migrants' rights; it is also counterproductive from a public health perspective. Migrants are an increasingly large part of today's societies, and addressing their health needs is a vital component of any effective public health policy. Guaranteeing migrants equitable access to health promotion and care makes practical sense – it is cost-effective and improves public health outcomes. Promoting migrants' use of primary health care and early treatment, and including them in disease control programmes, reduces the need for costly emergency care. Addressing the health of migrants caught in crisis and post-conflict situations is especially relevant to public health, and continuous access to health care and treatment, including psychosocial support, needs to be ensured.

3. Healthy migrants contribute to positive development outcomes.

Health is a prerequisite for, as well as an outcome of, sustainable development (WHO, 2012). It is now widely acknowledged that migration carries a development potential due to migrants' intellectual, cultural, social and financial capital and their active participation in societies of origin and destination. Being and staying healthy is a precondition for migrants to be able to work, be productive and contribute to the social and economic development of their communities of origin and destination, for example, via remittances, shared knowledge and diaspora trade networks. Thus, "a substantial case can be made for the inclusion of migration as a cross-cutting issue" in the new development framework (IOM and

UNDESA, 2012). Universal health coverage, including for marginalized populations, can help leverage the positive development impacts of migration.



Health of Migrants – The Way Forward is a consultation report that offers a summary of the issues discussed at the Global Consultation on Migrant Health and presents an outline for an operational framework to guide action by key stakeholders.

WHA Resolution on the Health of Migrants and a Global Consultation

In 2008, the WHO World Health Assembly endorsed the Resolution on the Health of Migrants (WHA 61.17), which spelled out actions for governments to enhance the health of migrants and promote bilateral and multilateral collaboration. In response to the Resolution, WHO, IOM and the Ministry of Health and Social Policy of the Government of Spain, organized the Global Consultation on Migrant Health in Madrid, Spain in 2010.

Two years after the global consultation, the Resolution on the Health of Migrants is still far from being fully implemented. Addressing the health of migrants in the post-2015 development framework could help to refocus attention towards implementation of the resolution.

Recommendations

In discussions leading up to an agreed health goal, IOM advocates the explicit recognition of health coverage for marginalized individuals and populations, including migrants. This would contribute to ensuring that universal health coverage, as a potential overarching health goal, addresses the specific needs of these vulnerable and marginalized populations, recognizes the impact of migration-related social determinants of health and supports a human rights-based approach to health.

A major obstacle to effectively addressing migrant health needs is the universal lack of standardized data on the issue. Therefore, it is of utmost importance that the post-2015 UN development agenda encourage the collection and harmonization of data on health, disaggregated by, among others, migrants' legal status. With this in mind, IOM recommends that a combination of quantitative and qualitative indicators should measure progress in the four key priority areas of the WHA Resolution on the Health of Migrants, as shown in Figure 1.

Figure 1. WHA Resolution on Migrant Health (selected action points)

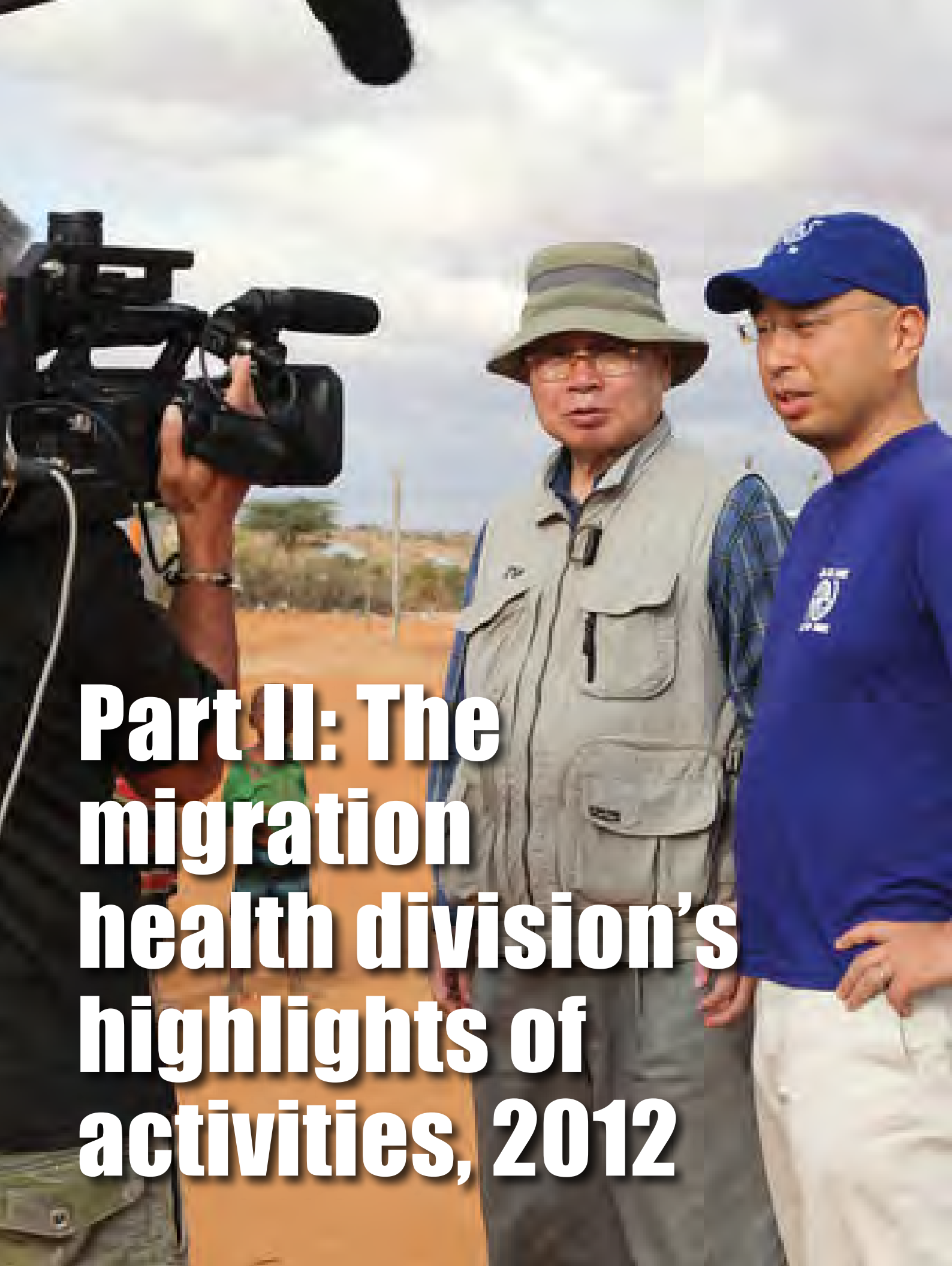
Monitoring migrant health
- Develop health information systems, collect and disseminate data
- Assess, analyse migrants' health
- Disaggregate information by relevant categories

Policy-legal frameworks
- Promote migrant sensitive health policies
- Include migrant health in regional/national strategies
- Consider impact of policies of other sectors

Migrant sensitive health systems
- Strengthen health systems; fill gaps in health service delivery
- Train health workforce on migrant health issues; raise cultural and gender sensitivities

Partnerships, networks and multi-country frameworks
- Promote dialogue and cooperation among Member States, agencies and regions
- Encourage a multisectoral technical network

To ensure the relevance and effectiveness of the post-2015 development framework, the voices of marginalized populations, such as migrants, should be heard in the country consultations and other relevant dialogues that will take place in the coming years. IOM supports the active participation of civil society organizations and emphasizes the need to include migrants' associations and other relevant actors in country and thematic consultations.



Part II: The migration health division's highlights of activities, 2012

Migration health assessments and travel health assistance

The Migration Health Assessments and Travel Health Assistance Unit (also referred to as the "Health Assessment Programme Unit") contributes to global migration health priorities through the provision of comprehensive health services for migrants, as well as through research and information on the determinants of the health of migrants. The Unit advocates for policy revisions, provides technical expertise to strengthen the capacity of local health systems, and promotes and strengthens inter-country dialogue and coordination.

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, international employment, enrolment in specific migrant assistance programmes, or the obtainment of temporary or permanent visas. Reflecting differences in immigration and public policies and practices, there is likewise a diverse range of health assessment requirements among countries. These requirements may be specific to certain diseases of public health concern, such as screening for tuberculosis, as in the case of the United Kingdom Tuberculosis Detection Programme (UKTBDP). Requirements may also be more general in nature, as is the case with other resettlement and immigration programmes. Despite differences in health assessment requirements among countries, one thing is constant: the need to ensure that the migration process does not endanger the health of migrants or host populations.

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

MHAs provide an opportunity to promote the health of migrants through the initiation of preventive and curative interventions for conditions that, if left untreated, could have a negative impact on migrants' health and/or the public health of their host community. 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/or 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. Migration health assessments are coherent with the IOM goal of "healthy migrants in healthy communities" and, as such, positively impact on migrants' capacity to integrate fully in receiving societies.

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

and epidemiological boundaries. Within health assessment programmes (HAPs), pre-embarkation checks (PECs) and pre-departure medical screenings (PDMS) are performed in order to assess migrants' fitness to travel and provide medical clearance. These measures also ensure that migrants are referred to appropriate medical services once they arrive at their destination countries. Migrants who need medical assistance and care during travel are escorted by health professionals to avoid complications during transit. Pre-departure treatment, vaccinations and other public health interventions are also tailored to meet the needs of migrants and immigration authorities.

A woman and her child at the IOM Migration Health Assessment Centre in Accra, Ghana. (Photo: Nyani Quarmyne)

The IOM approach to migration health assessments

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

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

Profile of IOM HAP beneficiaries, 2012

In 2012, IOM conducted around 270,000 health assessments among migrants, covering both immigrants (57%) and refugees (43%), in more than 60 countries. The majority of the assessments were conducted in Asia (57%), followed by Africa (19%) and the Middle East (14%) (see Table 3 in Annex 2). This represents a modest but steady growth in the number of global health assessment activities conducted

by IOM over the last five years. The number of refugees coming from Africa and the Middle East for resettlement to the United States increased notably since 2010, while that of immigrants decreased slightly since 2009, as the number of United Kingdom-bound immigrants, particularly from Asia, also decreased (see Figures 2, 3, 5 and 6 in Annex 2). In 2012, most migrants assisted by IOM were bound for the United States (52%) and the United Kingdom (23%). Slightly over half the migrants screened were male, and comparable sex distributions were observed regardless of the type of migrant (that is, refugee, student or immigrant). Overall, the population of migrants screened in 2012 was young, with an average age of 27.2 years and majority (66%) below the age of 30.[1]

There was a slight variation in age distribution between immigrants and refugees. Minor regional differences in age distribution were also observed within similar categories of migrants (see Figures 4a to 4d and 7a to 7d in Annex 2).

For quality control purposes, IOM also managed and supervised more than 7,600 health assessments conducted by non-IOM panel physicians, mostly at the request of the United States. In addition, IOM provided medical examinations to more than 100 migrants from Europe who were returning to their countries of origin, as part of the Organization's Assisted Voluntary Return and Reintegration (AVRR) programme for unsuccessful asylum-seekers, stranded persons and other migrants. More than 100 occupational health exams were also performed by IOM for staff members of international agencies in Europe.

Refugees for resettlement (urban and camp-based)

In 2012, major locations where refugees were assessed (that is, locations with over 3,000 people each) included Baghdad, Kuala Lumpur, Amman and Addis Ababa; the Sanischare and Beldangi camps in Nepal; and the Kakuma refugee camp in Kenya. More than 2,000 refugees were screened at the Mae La, Mae Ra Ma Luang and Mae La Oon camps in Thailand; the Mbarara and Kampala centres in Uganda; and the Nairobi and Dadaab camps in Kenya. Refugee health assessments were carried out at the request of multiple resettlement countries, with the top three being United States (88%), Canada (6%) and

IOM examines refugees at Mae La Camp in Thailand. (Photo: Siam Karnchanasai)

[1] Estimates for age and sex distribution were calculated based on data from 270,065 migrants.

Australia (5%), which were the top three countries of destination in 2012. Other countries of destination for refugees included New Zealand and several Scandinavian nations. The refugees examined by IOM resided in both camp (for example, Nepal) and urban settings (for example, Jordan).

Immigrants (various categories)

In 2012, major locations where immigrants were examined (that is, those with over 4,000 each) included Karachi, Lahore, Mirpur and Islamabad in Pakistan; Dhaka and Sylhet in Bangladesh; and Ho Chi Minh City, Nairobi, Kyiv, Bangkok, Moscow, Kathmandu and Accra. Other locations with at least 3,000 immigrants examined included Phnom Penh, Addis Ababa and Amman. Immigrant health assessments were carried out at the request of countries such as the Australia (15%), Canada (18%), United Kingdom (40%) and the United States (25%).

MIGRANT-SENSITIVE HEALTH SYSTEMS

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

- Review of medical and immunization history
- Detailed physical examination and mental health evaluation
- Clinical or laboratory investigations (for example, serological tests, radiological screening, chemical analysis of blood or urine)
- Referral for consultation with a specialist
- Pre- and post-test counselling
- Health education
- Pre-departure medical screenings
- Administration of vaccinations
- Provision of, or referral for, directly observed treatment for some conditions (for example, intestinal and other parasitic infestations, tuberculosis, malaria and sexually transmitted infections)
- 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 or PECs
- Public health surveillance and outbreak management in camps, transit centres and other temporary settlements
- Provision of medical escorts and special health accommodations for travel.

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

IOM tuberculosis services

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

In 2012, as a core component of health assessments, the majority of migrants examined by IOM underwent TB screening prior to their migration or resettlement. IOM MHAs took place in more than 60 countries worldwide, mostly in countries with a high prevalence of active TB (>40 per 100,000 population). Among migrants assessed, about 14,000 were referred for further laboratory investigations, resulting in the detection of 713 cases (or 264 per 100,000 migrants)[2] of microbiologically confirmed TB (sputum smear and/or culture-positive results). In addition, 203 migrants were diagnosed with pulmonary TB and referred for treatment based on advanced clinical findings.

The overall prevalence of active TB,[3] including all cases referred for TB treatment, in the migrant population assisted by IOM in 2012 was 339 per 100,000 migrants,

[2] The denominator used in this section is the total number of migrants who received TB screening from IOM in 2012 (n=270,065).

[3] Active TB includes cases referred for TB treatment, based on either microbiological confirmation (n=713) or clinical findings (n=203).

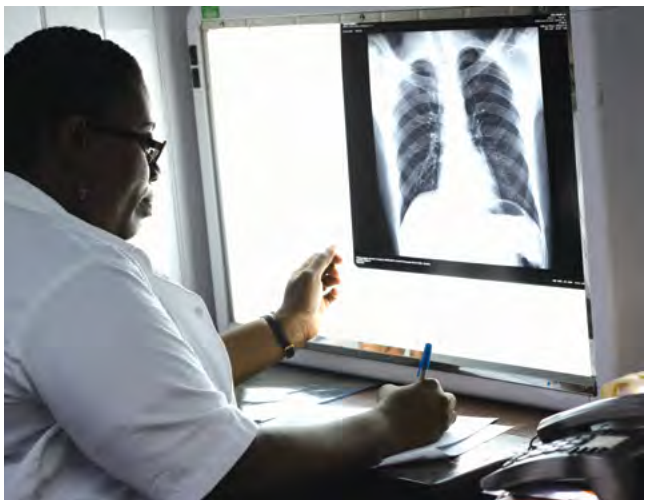
or 916 TB cases. The prevalence of active TB was higher among refugees, at 536 per 100,000 population, than among immigrants, at 191 per 100,000 population. Refugees were almost three times more likely (prevalence ratio = 2.81) to be detected with active TB than immigrants. Investigation into the causes of this difference is beyond the scope of this review; however, the difference is thought to be connected to poorer health and nutritional status and the living and socioeconomic conditions of refugees.

As Tables 4 and 5 show (see Annex 2), active TB case detection was highest in refugee populations in Asia, ranging from 820 per 100,000 in Thailand to 1,256 per 100,000 in Malaysia. The lowest figures were observed among migrants from the Middle East. It is important to note that the prevalence of latent TB infection was also high in several populations, particularly, refugees in Malaysia (24%) and Uganda (19%). Determining the prevalence of latent TB (in the form of inactive pulmonary TB lesions) is also essential for organizing proper follow-up in countries of destination.

Directly observed treatment supervised by an IOM nurse in Mae La Camp, Thailand. (Photo: Siam Karnchanasai)

Radiological services in tuberculosis diagnostics

Along with clinical signs and symptoms, radiological investigations are important in order to diagnose TB. More than 217,000 radiological investigations were performed by IOM in 2012, resulting in the identification of around 14,200 migrants (7%) with presumptive TB and referrals for these migrants to undergo further TB laboratory investigations. The prevalence of X-ray findings suggestive of TB varied in major IOM screening programmes, with the highest prevalence found among Bhutanese and Burmese refugees in Thailand and Nepal (16,615 and 19,338 per 100,000, respectively) and the lowest prevalence found among immigrant populations in the Middle East (154 and 247 per 100,000 in Jordan and Iraq, respectively).



An IOM National Medical Officer examining an X-ray image during a pre-departure medical screening examination at the IOM Office in Accra, Ghana. (Photo: Nyani Quarmyne)

Tele-radiology

In 2012, the IOM Radiological Interpretation and Quality Control Centre, based in Manila, Philippines, provided remote X-ray reading services to Nepal and Afghanistan. Through a network of IOM picture archiving and communication systems (PACS) and specially developed tele-radiology software, digital X-rays were sent from remote clinics to Manila, where highly qualified radiologists interpreted them in real time.

IOM's tele-radiology network is being expanded to include more missions where the availability of skilled radiologists remains a challenge. With more than 80 per cent of IOM screening locations now utilizing digital X-rays, connecting them to the network will eventually pave the way for the establishment of an X-ray quality control and monitoring system within MHD health assessment programmes.

Laboratory services in tuberculosis diagnostics

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

In 2012, around 14,000 individuals, including both refugees and immigrants, underwent laboratory diagnostics, specifically, either sputum smear microscopy and/or sputum culture examinations. Depending on receiving-country protocols and the venue of the IOM-administered health assessment examination, a total of 10,932 individuals underwent both smear and culture testing. Overall, 713 refugees and immigrants were diagnosed with infectious pulmonary TB, based on positive sputum microscopy and/or culture results from IOM or partner laboratory services. DST was conducted for 94 per cent of all cases with *Mycobacterium tuberculosis* growth (n=580) through TB cultures. Of this figure, 11.1 per cent of cases (n=61) were found to be resistant to one or more anti-TB drugs, and 2 per cent were found to be multidrug-resistant (MDR) (n=10). These findings helped clinics to better align their treatment protocols, improving the overall performance of TB treatment programmes (see Table 6 in Annex 2).

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

Tuberculosis treatment in IOM health assessment programmes

The final step in IOM health assessment services includes the provision of treatment to migrants, which is undertaken in close collaboration with NTPs and in accordance with international protocols. IOM runs several certified TB treatment centres in locations in Africa and Asia that offer directly observed treatment. In 2012, IOM centres started TB treatment for 610 (80%) of the active cases referred for treatment. In addition, IOM clinics also provided directly observed preventive therapy for cases with latent TB infection in selected locations. Drugs were procured in collaboration with NTPs in the respective countries.

For migrants on TB treatment, IOM performs routine monitoring of treatment outcomes in coordination with the United States Centers for Disease Control and Prevention (CDC), using a set of predefined TB laboratory and treatment performance indicators. Available data on treatment outcomes, mostly for US-bound migrants, are shown in detail on Tables 7a and 7b (see Annex 2).

United Kingdom Tuberculosis Detection Programme

One of the projects of IOM HAP with the highest number of assisted migrants is the pre-departure TB detection programme that the United Kingdom Government runs, with IOM as its implementing partner. The purpose of the programme is to screen visa applicants (those who apply to stay in the United Kingdom for six months or more) for infectious pulmonary TB. Directly observed treatment for positive cases is provided either by IOM, in partnership with NTPs, or through a referral system. From 2005 to 2012, IOM ran a pilot

version of the programme in eight countries, namely, Bangladesh, Cambodia, Ghana, Kenya, Pakistan, Sudan, Thailand and the United Republic of Tanzania. Upon successful completion of the pilot phase in mid-2012, the United Kingdom Government expanded the programme to a total of approximately 60 countries worldwide. IOM will start programme activities in many of these additional countries over the course of the next year, nearly tripling the current number of countries of implementation by mid-2013.

In 2012, IOM assessed over 62,000 United Kingdom visa applicants, who fell under visa categories such as "students" (46%) and "settlement and dependents" (47%). Radiological investigations yielded 718 cases of active (1.2%) and 1,884 cases of inactive TB (3%). Overall, 67 individuals (with a prevalence of 107 cases per 100,000) were found to have infectious TB, as confirmed by microbiological findings. Thirty-three confirmed cases of infectious TB (50%) involved those in the "student" visa category, while 28 (42%) were in the "settlement and dependent" visa category.

Table 1.

Prevalence of infectious TB cases by country, UK Tuberculosis Detection Programme, 2012

UKTBDP site	Number of migrants screened	Prevalence per 100,000 (95% CI)
Bangladesh	9,078	77 (20 - 134)
Cambodia	95	-
Ghana	3,920	-
Kenya	2,511	119 (0 - 255)
Pakistan	38,657	96 (65 - 127)
Sudan	912	-
Thailand	6,524	307 (172 - 441)
United Republic of Tanzania	662	-
Total	**62,359**	**107 (82 - 133)**

Pre-departure services and travel assistance

Pre-departure medical procedures comprise a range of services to ensure that people travelling under the auspices of IOM do so in a safe and dignified manner, are fit to travel, receive appropriate assistance when necessary, and do not pose health hazards to other travellers, personnel or receiving communities. Services in this category include PDMS, PECs or fitness-to-travel checks, medical escorts and travel health assistance, which includes special travel arrangements, such as the provision of wheelchairs, stretchers or oxygen supply. Other pre-departure activities include immunization campaigns and presumptive treatment of conditions such as malaria and parasites.

Pre-departure medical services are offered in addition to core MHAs, which often take place several months prior to departure. Not only do these pre-departure services complement MHAs by providing additional health measures (for example, immunizations for vaccine-preventable diseases), they also ensure that a migrant's health condition has not changed in the period between the initial health assessment and the actual departure, which often spans several months. PDMS and some immunization activities may take place up to several weeks prior to departure, while PECs generally take place one to three days prior to departure.

In 2012, IOM performed around 80,000 pre-departure medical procedures for the majority of departing refugees. In the event that a significant medical condition (SMC) was identified, a passenger could have been delayed or prevented from travelling until they were treated and their health condition improved. For instance, among refugees bound for Australia, an important component of PDMS was

malaria screening. In 2012, out of the approximately 4,900 refugees screened, 13 (or 0.26%) were found to have malaria. Accordingly, treatment was provided for confirmed cases, while for some other programmes, presumptive anti-malaria treatment was given for all refugees departing from malaria-endemic countries in Asia and Africa.

Refugees who need medical assistance and care during travel are escorted by health professionals to avoid complications during transit. In 2012, IOM provided group and individual medical escorts to more than 1,300 refugees with a variety of medical conditions, such as cardiovascular, neurologic, respiratory and psychiatric disorders (see Figure 8 in Annex 2).

Pre-departure immunizations

In close collaboration with CDC and the United States Bureau of Population, Refugees and Migration, IOM conducts a variety of pre-departure immunization activities. Within the context of several CDC–IOM cooperative agreements, IOM has been providing immunization services for US-bound refugees since 2007. These services include the development of a vaccination procurement and storage system, cold chain and shipment arrangements, education and awareness-raising, and immunization coverage. Under these Cooperative Agreements, in 2012, vaccination activities were implemented in Kenya, the United Republic of Tanzania and Ethiopia against measles-mumps-rubella (MMR), yellow fever, meningitis, polio, hepatitis A and B, pneumococcal disease, diphtheria-tetanus-pertussis (DTP), human papilloma virus (HPV) and varicella (chicken pox).

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

In addition to the immunization activities conducted in the context of the CDC–IOM cooperative agreements, IOM increasingly carries out immunization activities for both refugees and immigrants in a variety of other operations. For example, oral polio vaccines and MMR vaccines are included in the list of recommended vaccines for United States-bound refugees. In 2012 alone, more than 110,000 vaccinations were provided to migrants prior to departure for Australia, Canada, United States and other countries. Common vaccines given included MMR, DTP, hepatitis B and chicken pox.

Pre-departure treatment activities

During pre-departure medical screening, IOM provides resettling refugees with presumptive anti-parasitic and antimalarial treatment. In 2012, more than 26,000 refugees, mostly bound for the United States, received pre-departure medical treatment.

Significant medical conditions and follow-up needs

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

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

As a result of an assessment in 2012, IOM noted that approximately 15.4 per cent of refugees had significant medical conditions that required health-related follow-up or special assistance upon arrival in the United States. These conditions primarily involved vision (1.9%), mobility (1.7%) and hearing (1.7%). In addition to medical concerns, there was a need for special schooling and employment considerations upon resettlement due to the presence of moderate to severe mental conditions (1.1%) among refugees.[4]

DNA services

IOM provides DNA sampling and testing services for family reunification purposes, as required by certain immigration authorities. The Organization has established a system for the collection, storage

[4] Data from Jordan, Russian Federation (the) and Thailand do not include fourth-quarter exams with SMC.

and testing of DNA samples, as well as appropriate counselling for applicants. In 2012, the majority of tests were performed in Cambodia, Ethiopia, Pakistan and Viet Nam (see Figure 9 in Annex 2).

MONITORING MIGRANT HEALTH

Increasing the health knowledge of refugees and immigrants

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

ICD coding of refugee health profiles

In the past years, IOM launched a project to ensure that health information on several refugee groups it has assisted is readily available in literature. By coding data using the International Classification of Diseases, Tenth Revision (ICD-10), and using data from its own SMC forms and other relevant sociodemographic information, the Organization could analyse medical and public health information on existing and emerging refugee groups at key locations.

Most recently, such analyses were conducted for IOM-assisted Congolese refugees examined in Burundi, Kenya, Rwanda and Uganda from 2010–2012. The resulting profiles captured population descriptions, the prevalence of SMCs, the top ICD-10 disease groups and the top diseases in each of the prevalent groups. IOM placed special emphasis on children under five years of age, mental health and infectious diseases, and the assistance and medical follow-up needs of each group. As shown in Table 2, common causes of morbidity among Congolese refugees examined in selected locations in Central and East Africa from 2010 to 2012 were infectious and parasitic diseases such as TB, HIV and dermatophytosis (“ringworm”). Risk factors and conditions related to non-communicable were also present in this group, including obesity, hypertension, heart disease and malnutrition. Among Congolese refugees under five years of age, the leading disease conditions found were latent TB infection, HIV infection and dermatophytosis (ringworm). There were also cases of umbilical hernias, mental retardation and mild to severe malnutrition.

IOM conducts health assessment among Congolese refugees in Kenya.

Table 2.

Top ten disease conditions (ICD-10) among Congolese refugees (n=3,304) screened in Burundi, Kenya, Rwanda and Uganda, 2010–2012

ICD-10 disease condition	No. of people	Prevalence (%)
Latent TB Infection (LTBI)*	87	2.63
Respiratory tuberculosis, not confirmed bacteriologically or histologically**	79	2.39
Blindness and low vision	77	2.33
Asymptomatic human immunodeficiency virus [HIV] infection status	62	1.88
Essential (primary) hypertension	41	1.24
Complications and ill-defined descriptions of heart disease***	36	1.09
Protein-energy malnutrition	34	1.03
Obesity	29	0.88
Epilepsy	14	0.42
Other and unspecified syphilis****	13	0.39
Total	**472**	**14.28**

Notes:
* Latent TB infection (LTBI) refers to cases of positive reaction to tuberculin tests.
** Respiratory TB not confirmed bacteriologically or histologically is defined as inactive TB.
*** Complications and ill-defined descriptions of heart disease pertain to unspecified heart disease.
**** Other and unspecified syphilis pertains to latent infection (not specified as early or late), with positive serologic reaction, due to the causative agent *Treponema pallidum*, and acquired syphilis not otherwise specified.
(Data as of December 2012)

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

Nutrition surveillance profiles

IOM uses data from refugee health assessments to estimate childhood undernutrition and refer children to appropriate feeding programmes. The prevalence of undernutrition is usually expressed in terms of two indicators: (1) wasting (low weight for height) is indicative of recent and severe weight loss, while (2) stunting (low height for age) is the result of chronic suboptimal nutritional and health conditions.

A total of 7,439 refugee children aged 6 to 59 months assisted by IOM in Ethiopia, Iraq, Jordan, Kenya, Malaysia, Nepal and Thailand were included in the nutrition surveillance analysis in 2012, which revealed an overall prevalence of undernutrition in this age group. Specifically, there was a medium prevalence of wasting and a low prevalence of stunting, in accordance with the classification criteria for the population-level analysis of nutrition (WHO, 1997).

In terms of wasting, global acute malnutrition was found in 7.5 per cent of refugee children, with the level of severe acute malnutrition in this study population at 2.1 per cent (see Figures 10 and 11 in Annex 2). Stunting or chronic malnutrition was found in 19.4 per cent of the children, with 5.1 per cent suffering from severe chronic malnutrition. More specific findings included a high prevalence of wasting in urban locations in Iraq and Ethiopia and a medium prevalence of wasting in Malaysia and several camps in Kenya and Nepal. On the other hand, camps in Thailand that have hosted

displaced refugees for several decades showed a high prevalence of stunting. Medium prevalence levels of stunting were observed in Nepal and Ethiopia.

Outbreak surveillance and response

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

In 2012, refugee camps around Damak, Nepal experienced two rounds of varicella outbreaks, the first extending from November 2011 to August 2012 and the second beginning in November 2012. An outbreak of mumps was also detected, in April 2011, which continued until April 2012.

Immediately following notification of the outbreaks, daily surveillance measures were put in place in NGO-run refugee camp clinics. The resettlement process for cases identified by IOM's daily active surveillance and refugee camp clinics was put on hold to prevent possible transmission of the disease during processing and actual travel.

During the varicella outbreaks, a total of 206 cases were identified by camp clinics, MHD Damak and the Kathmandu Transit Centre. Of these cases, 75 (involving a total of 302 family members) were in the midst of the resettlement process. Flights were delayed for 12 of these cases (involving a total of 41 refugees). During the mumps outbreak, 107 cases were identified, out of which 36 cases (involving a total of 154 family members) were in the resettlement pipeline. Flights were delayed for five of those cases (involving 24 family members).

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

The Rapid Health Assessment Pilot Project

After several years of preparatory activities, in 2012, the Rapid Health Assessment (RHA) study was implemented among a group of Congolese refugees residing in Rwanda, in a joint effort by CDC and IOM teams from Kenya and Rwanda. The RHA aimed to identify highly prevalent and migration-relevant medical conditions in clustered refugee populations selected for resettlement to the United States. The RHA consisted of physical examinations, rapid tests (namely, hepatitis B, HIV, urinalysis and hemoglobin count), full blood counts, stool and urine microscopies, and counselling for HIV tests. Serum and stool samples were also collected and stored for shipment and further analysis in CDC laboratories in Atlanta. Over 400 participants were recruited for the study. Data entry, cleaning and analysis of the gathered data were carried out in 2012. Funds from the CDC–IOM cooperative agreements were used to facilitate part of the logistics for the survey, including travel expenses and purchase of laboratory supplies.

Managing and sharing data/ health informatics systems and data management

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

The main highlights of MHI in 2012 include the web roll-out of the Migrant Management Operational Systems Application (MiMOSA) and the update to the UK TB Global Software, covering operational, monitoring and reporting activities in HAPs for more than 80 per cent of assisted migrants. Additionally, more IOM missions started using the e-Health System for migrants bound for Australia, eliminating the need to process paper-based health examination reports and allowing HAP operations to record a visa applicant's health information, including digital chest X-rays, electronically.

MHI also enables the exchange of information between IOM and its partner agencies, improving their capacity to deliver cost-effective and timely services and ensuring the consistency and completeness of data. Such continuation of health-care provision through the electronic transmission of relevant data is currently being provided for CDC, with medical data for more than 223,000 refugees transmitted since the launch of the interface in 2008.

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

Other MHI initiatives in 2012, developed upon request of internal and donor communities, included a web-based compendium of IOM HAPs and the Global Incident Management System, which is capable of recording, tracking and aggregating incidents in health assessment activities.

POLICY AND LEGAL FRAMEWORKS

Third Global Health Assessment Programme Summit, September 2012

From 17 to 21 September 2012, the Global Health Assessment Programme of MHD held its third summit meeting in Negombo, Sri Lanka. Senior HAP colleagues from Africa and the Middle East, Asia, Europe and North America were joined for two days by government representatives from CDC, Citizenship and Immigration Canada, the Australian Department for Immigration and Citizenship, the UK Border Agency and Sri Lanka's Ministry of Health.

The HAP Summit, which was hosted by IOM Sri Lanka, served as a venue for focused communication between key staff at the global, regional and local levels. The five-day meeting was an opportunity for participants to learn from the experiences and expertise of their colleagues and partners in key areas of HAP work, exchange ideas and promote the continuous improvement of programme services. Participants reflected on the events, achievements and challenges since the Second HAP Summit in 2010 and set objectives for the coming year, such as the elaboration of a results-based management of HAP. Major themes discussed included quality assurance and quality control of HAP services, results-based management, performance indicators, client satisfaction, global incident reporting, medical escorting, and the management of tuberculosis and complex medical cases. The presence of government partners allowed for timely discussions of programme developments and donor expectations prior to the Intergovernmental Immigration and Refugee Health Working Group (IIRHWG) Meeting in London, which IOM attended in October 2012.

Intergovernmental Immigrant and Refugee Health Working Group

From 18 to 19 October 2012, IOM participated in the ninth annual IIRHWG Conference in London, United Kingdom. This working group is composed of the Five-Country Conference partners: Australia, Canada, New Zealand, the United Kingdom and the United States.

The main theme of the ninth annual conference was managing public health risks and deepening alignment among IIRHWG countries to meet international challenges. The themes of quality, partnership, coordination, harmonization of standards and procedures, and the value of pre-departure health assessments in the context of global health and migration goals were also discussed. Several additional agencies participated in the meeting for the first time: WHO, the United Kingdom Public Health Agency and the Public Health Agency of Canada.

As in previous years, the participation of IOM in the conference provided an opportunity for IIRHWG countries to learn about the achievements of, the challenges to and the trends in IOM activities in 2012. The conference also provided an opportunity for IOM to receive feedback from its partner countries and to engage in constructive discussions on issues of common interest.

Participants at the Third IOM Global HAP Summit in Negombo, Sri Lanka.

PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

Collaboration with national tuberculosis programmes

Pakistan

IOM Pakistan continued to strengthen its collaboration with the National TB Control Programme in 2012 through a joint capacity-building workshop for laboratory technicians from various districts of Pakistan. The workshop focused on training district laboratory technicians on culturing, molecular testing and DST for *Mycobacterium tuberculosis*. The training, which was organized by the IOM laboratory in Islamabad, provided a total of 26 participants with the latest diagnostic techniques for tuberculosis.

CDC–IOM cooperative agreements

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

The overall goals of the cooperative agreements are to prevent the disruption of resettlement activities (that is, movement delays or cancellations due to outbreaks), protect public health in the United States against the importation and spread of communicable diseases, reduce the financial burden on the US health system through improved diagnostics and prevention of communicable diseases, enable a rapid response to outbreaks and epidemics, and improve the transmission of health data from IOM to CDC. In fiscal year 2012, the cooperative agreements funded seven modules, of which six were in Africa and Asia and one was global, and had access to over USD 600,000.

Cooperation framework with Canada

In 2012, the Health Branch of Citizenship and Immigration Canada (CIC) and the Migration Health Division of IOM signed a new cooperation framework, which defines the scope of current areas of collaboration between them. It also aims to facilitate the development of future country- or region-specific initiatives and agreements between CIC and MHD in the provision of health assessment programmes.

e-Medical

In late 2012, within the context of the CIC–IOM Cooperation Framework signed several months prior, 14 IOM staff members attended a three-day training-

of-trainers' workshop in Paris on the use of the e-Medical system. e-Medical is a web-based system originally developed by the Australian Department for Immigration and Ditizenship (DIAC) to enable the electronic submission of immigration medical examinations. CIC had requested the assistance of IOM in the full implementation of the e-Medical system by mid-2013. The role of IOM in the initiative consists of organizing trainings for all IOM CIC panel physicians, as well as for some non-IOM panel physicians, predominantly in Eastern Europe, Central Asia, South and South-east Asia, as well as all regions of sub-Saharan Africa. Training will be delivered either face-to-face or through webinar sessions.

M-assessments for Canada

As a result of the strong partnership between IOM and CIC, in addition to the provision of MHAs for both immigrants and refugees bound for Canada, several IOM migration health processing sites have been entrusted with admissibility determinations (or "M-assessments"), a function normally reserved for CIC Regional Medical Officers. An M-assessment determines a migrant's admissibility, judged according to his or her potential impact on the public health or safety of the receiving community, and whether a health condition may create excessive demand for health or social services. In 2012, around 8,000 M-assessments were carried out in IOM Moscow, Kyiv and Bucharest.

Health promotion and assistance for migrants

In support of the IOM vision of "healthy migrants in healthy communities," regional and country-based activities were undertaken in 2012 in line with the Organization's strategic objectives on migration health. These activities contribute to strengthened governmental and non-governmental capacity to address migration-related health challenges. The following sections provide a summary of activities carried out by various IOM Offices in the programmatic area of health promotion and assistance for migrants.

MONITORING MIGRANT HEALTH

Timely research on pertinent migration health topics, dissemination of findings and strengthened information systems on migration and health ensures the development of evidence-informed policies and programmes. Research priorities at the national and regional levels are typically determined through situational analyses and consultations with government and other partners. This section highlights some of the activities of IOM in 2012 to strengthen the monitoring of migrant health.

Bangladesh

In partnership with UNAIDS, the IOM Office in Dhaka coordinated a study on the HIV vulnerability of female Bangladeshi migrant workers. The study, entitled "HIV and Bangladeshi Women Migrant Workers: An assessment of vulnerabilities and gaps in services," found that female migrant workers are at a high risk of contracting HIV, as they have inadequate and inappropriate access to HIV information and health-care services in both countries of origin and destination. The main findings included that female migrant workers' vulnerability is compounded by poor working conditions and that there is a lack of a regulatory framework and administrative and judicial measures to prevent and prosecute exploitation and abuse of migrants. In addition, it was found that pre-departure medical tests lack ethical standards and migrant workers are often not provided with adequate information to prepare them for safe migration.

Sri Lanka

IOM Sri Lanka, in collaboration with the Ministry of Health, completed four national research studies on the health and social impacts of migration on internal, outbound and inbound migrants and the families left behind by Sri Lanka's migrant workers. The findings of these studies led to an improved understanding of the current health and social status of migrants and their families, as well as the main migration-related health challenges. The research findings directly informed the formulation of Sri Lanka's migration health policy and the related national action plan (see Policy and Legal Frameworks). In addition to carrying out migrant health research IOM hosted four scientific symposiums and three policy forums in Sri Lanka in partnership with the Government. Representatives from 13 Government ministries and specialists in migration, law, health, economics, foreign affairs, child welfare and labour relations were involved in this intersectoral effort.

Cambodia

In 2012, the IOM Office in Cambodia completed the "Situational Assessment on the Health of Cambodian Irregular Migrants," which was about Cambodian migrants returning from Thailand, in collaboration with the Cambodian Ministry of Health. The objective of the assessment was to gain an in-depth understanding of the health issues faced by returning Cambodian irregular migrants and border communities in the provinces of Banteay Meanchey and Svay Rieng. The study found that the lack of legal documentation and rights in the country of destination (Thailand) left irregular migrants much more vulnerable to health risks and occupational hazards, as they lack social protection and access to health services. Migrants were more likely to seek out a pharmacy than a health clinic or doctor, mainly out of fear of arrest and deportation. The study has led to a better understanding of migrant health concerns, including barriers to accessing health services.

A cross-sectional, multi-site research project, entitled "Trafficking, Exploitation and Abuse in the Mekong

IOM staff probes a Cambodian fisherman for physical injuries. (Photo: Brett Dickson and Keo Korindeth)

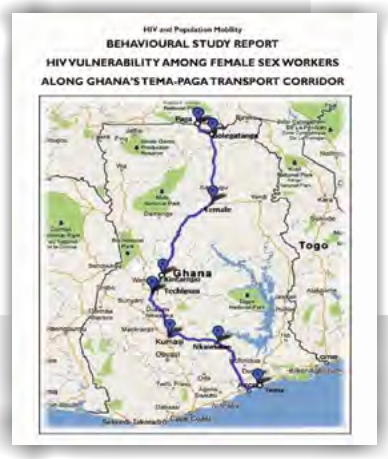
Subregion (STEAM)," is being carried out in Cambodia, Thailand and Viet Nam. The research aims to identify trafficked persons' physical and mental health consequences and associated health-care needs, and the results of the study will serve to inform the development of policies, strategies for health service provision and specific care of trafficked persons in the Greater Mekong Subregion (GMS). From the beginning of field work in October 2011 until the end of 2012, 797 trafficked persons were interviewed. In Cambodia, the majority of interviewees have been Cambodian males trafficked by Thai fishing vessels for an average of two years. In Thailand, the most common forms of exploitation among the interviewees have been in the sex industry, fishing industry and begging. Most of the trafficked Vietnamese interviewed were from the northern part of the country and were returned from China after being trafficked for agricultural work. One of the main challenges with doing field work so far has been tracking interviewees for follow-up interviews. The project will continue through 2013, when it will complete the field work, data analysis and report-writing.

Ghana

In partnership with UNAIDS, IOM Ghana conducted a study on HIV vulnerability among female sex workers (FSWs) along Ghana's Tema-Paga transport corridor, which runs from north to south. In Ghana, two types of FSWs are commonly described: (1) "roamers" and (2) "seaters." Roamers are sex workers who move around within or between cities and towns and actively seek clients in bars, night clubs, hotels, popular eating and drinking spots, recreational spaces and on the streets. Seaters are home- or brothel-based sex workers and may live and stay in a community for longer periods. The overall objective of the study was to generate data on HIV and mobility that will contribute to reducing the vulnerabilities of FSWs, who are considered a "most at risk population" in Ghana. The most important findings of the study were that mobile FSWs had significantly more non-paying partners than more sedentary FSWs (59.9% versus 34.29%, P<0.001) and also had a significantly higher frequency of sex with non-paying partners on a weekly basis (87.30% versus 74.47%; P=0.023). A large majority of participants (90.2%) reported consistent condom use with clients, but fewer reported consistent condom use with non-paying (non-transactional) partners (53.3%).

Kenya

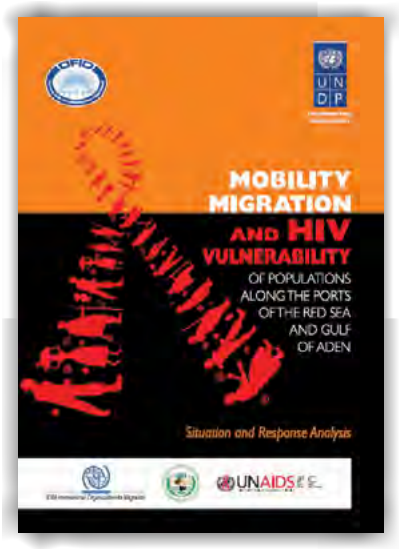
As a result of the technical assistance provided by IOM Kenya, the Kenya National AIDS Indicator Survey (KAIS) now has migration indicators migration included in its data collection tool. Questions about country of origin, nationality and migration status are included. KAIS is the most comprehensive national HIV and AIDS surveillance effort implemented by the Kenyan Government. The data collected plays a crucial role in building an evidence base to guide the design and evaluation of the Kenya National HIV and AIDS Strategic Plan, as well as other health planning mechanisms in the country.



Ports of the Red Sea and the Gulf of Aden

In collaboration with UNAIDS, UNDP and the Intergovernmental Authority on Development, IOM launched the publication, "Mobility, Migration and HIV Vulnerability of Populations along the Ports of the Red Sea and Gulf of Aden" on 1 December 2012, World AIDS Day, in Cairo, Somaliland, Puntland and South Central Somalia. The report included a comprehensive situational analysis, as well as describes achievements in and obstacles and remedial actions taken towards the attainment of universal access to HIV prevention, treatment, care and support for mobile populations along the Ports of the Red Sea and Gulf of Aden. The study recommended, inter alia, to mainstream issues related to gender inequality and gender-based violence in regional and national strategies addressing the HIV vulnerability of cross-border mobile populations and to initiate data collection on HIV prevalence

among key populations, especially truck drivers and their assistants, seafarers, pastoralists and refugees, in order to support the development of evidence-informed strategic guidelines at the regional, national and local levels.



Mobility Migration and HIV Vulnerability is a comprehensive update on the regional initiative addressing mobility, migration and HIV vulnerability of populations along the ports of the Red Sea and the Gulf of Aden.

Somalia

In Somalia, IOM conducted a study looking at the health vulnerabilities of mobile sex workers and other vulnerable populations in the coastal areas of Puntland to assess the availability and accessibility of basic health services, as well as the health vulnerabilities and health-seeking behaviours in these communities. Some of the key findings indicate that: most respondents (90.7%) do not know where to receive confidential counselling and support; many of the respondents (81%) have a low HIV risk perception (for example, they believe that they are not at risk because they "fear Allah"); and malnutrition and anemia were perceived to be the most common health problems. In addition, most respondents cited the lack of availability of health services and providers and the cost of services as the main barriers to health. A total of 113 men and 117 women between the ages of 15 and 50 were interviewed for this study. Of the women who were interviewed, 81.7 per cent have given birth at home with assistance from family and friends, and only 41.9 per cent of respondents felt that a pregnant woman could protect her baby from HIV by taking antiretroviral medication. The study was shared with the Puntland AIDS Commission as a reference document for its health policy and planning.

Jordan

In Jordan, IOM worked closely with the Ministry of Health to conduct an assessment entitled "Health Needs and Living Conditions of Migrants in Jordan." The assessment provides baseline information about the health needs and challenges that affect different migrant groups in Jordan, including Arab (predominantly Egyptians and Iraqis) and non-Arab Asian migrants (most commonly from Sri-Lanka, Indonesia, the Philippines, Pakistan, Bangladesh, China, India and Nepal). The study found that language is a key barrier to accessing health services, especially for non-Arab migrants, along with the high costs of health care and the lack of health insurance coverage. Most migrants included in the study reported satisfaction with their working and living conditions in Jordan, despite the fact that existing health policy in Jordan does not include a clear focus on migrants' health needs and specificities. All foreigners in Jordan, regardless of their legal status, however, have access to Jordan's public health-care system at rates subsidized by the Government (the Government covers 60 per cent of the total health cost). Moreover, the Ministry of Health provides free vaccination services to all children living in Jordan, including foreigners. As Jordan's national health surveys do not collect data on the migrant population living in the country, identifying the major health needs of such population is difficult. The health insurance coverage rate of the study population was 25 per cent, with the coverage rate among non-Arabs being nearly five times more than that among Arabs. Also, employed migrants were more likely to have health insurance than did the unemployed. The Jordanian Labour Law obligates all workers, whether Jordanian or non-Jordanian, in establishments to undergo periodic medical examinations (every six months), which include laboratory tests and X-ray, to be screened for occupational diseases. Moreover, Regulation No. 42/1998 of the Preventive and Therapeutic Medical Care for the Workers in Establishments obligates employers to appoint the required number of physicians and nurses or to establish a medical unit appropriate for the number of their workers. Some of the key recommendations of the study included: (1) establish formal and mandatory health insurance for all migrant workers at a reasonable cost; (2) develop strategies to regulate the right and access to health care; (3) to implement the strategic plan that has been proposed by the Ministry of Health regarding the need to conduct pre-arrival, entry and post-entry medical examinations for migrant workers; (4) to raise health awareness of citizens and migrants; (5) to develop a mechanism to overcome language

and cultural barriers that prevent access to services for migrants; (6) to conduct further, in-depth research on certain topics like health insurance, the living and health conditions of irregular migrants, awareness of migrants and their employers of migrants' rights, including their right to health. A national consultation was organized to review the study findings and discuss and agree on recommendations to ensure migrants' health in Jordan (see page 43).

Assessment of Health Needs and Living Conditions of Migrants in Jordan provides baseline information about the health needs and challenges that affect different migrant groups in Jordan, assisting the Government and the relevant parties in developing policies and strategies to manage migrants' health.

Georgia

IOM Georgia completed the country's Migrant Health Survey in 2012, in collaboration with the National Centre for Disease Control and Public Health (NCDC). This comprehensive survey, which was conducted in four regions of Georgia, determined the behavioural and biological risk factors to major non-communicable diseases (NCDs) among the diverse migrant populations residing in the country. The study assessed the psychosocial and cultural needs of migrants; defined the prevalence of psychosomatic conditions subsequent to migration; explored the issues pertaining to the access to and affordability of health and psychosocial services; and ascertained migrants' knowledge, attitude and practices on NCDs. The surveyed migrant groups consisted of internally displaced persons (IDPs), foreign migrant students, asylum-seekers, trafficked migrants, returned migrants (Georgian nationals), and migrant detainees. The survey findings showed that almost all migrants are exposed to one or more risk factors for NCDs and are significantly more vulnerable than the native population, whose NCD risk factors were surveyed in a nationwide STEPS Survey (WHO STEPwise approach to the Surveillance of NCDs) conducted by the NCDC in 2010. In addition, migrants' awareness concerning NCDs was considerably low. All of the surveyed persons reported certain psychosomatic vulnerabilities subsequent to migration and pointed to distinct mental health and psychosocial support needs. The preliminary findings were disseminated in June 2012 at a consultation facilitated by IOM Georgia, with the support of the NCDC, where the findings were discussed and the survey recommendations were fine-tuned. Subsequently, the report was endorsed by the Ministry of Labour, Health and Social Affairs of Georgia and launched at a ceremony at the NCDC office in December 2012.

IOM-NCDC Migrant Health Survey Publication Launch Ceremony, 14 December 2012 – on the photo, left to right: Mr Amiran Dateshidze (Head of Social Issues and Program Division, Ministry of Labour, Health and Social Affairs), Mr Zurab Utiashvili, Ms Ekaterine Kavtaradze [(former Director General, NCDC), Ms Dali Trapaidze (Chief Specialist, NCDC), Ms Ilyana Derilova, Ms Anna Kakushadze (Project Assistant, IOM Georgia), Ms Nino Chavchavadze (Deputy Minister, Ministry of Refugees and Accommodation), Mr Archil Talakvadze (Deputy Minister, Ministry of Corrections and Legal Assistance).

Costa Rica

In partnership with UNAIDS, IOM Costa Rica conducted a study on the health vulnerabilities of Panamanian indigenous populations which migrate temporarily to Costa Rica to harvest coffee. The study found that these populations are highly vulnerable to ill health, including HIV, due to limited access to information, testing and health services. The report is being used in both Costa Rica and Panama to strengthen local responses and specific actions with an intercultural approach. Another IOM study pertaining to the migration of indigenous populations is that on the health vulnerabilities of Ngöbe-Buglé populations that travel along the migration route between Panama and Costa Rica, in coordination with the ILO and the Latin American Faculty of Social Sciences. The research, which used both quantitative and qualitative methods, studied the governing legal and normative frameworks and determined local conditions for access to public services, as well as labour rights for indigenous populations throughout the migration route.

Regional Research Capacity-building Workshop, 5–7 December 2012

In order to strengthen research skills on migration and health, IOM staff from Nairobi, Pretoria and Manila organized a research capacity-building workshop for migration health staff from 20 countries in Africa and the Middle East. The aim of the workshop was to capacitate these country focal points to better manage the research they undertake, and for the research to support and strengthen migration and health policy and programme development through the improved collection, analysis and use of data. The workshop covered topics such as research conceptualization, the importance of strong terms of reference and the roles of partners and stakeholders in research implementation, advocacy and dissemination.

Participants during the Regional Research Capacity-Building Workshop held in Pretoria, South Africa.

POLICY AND LEGAL FRAMEWORKS

Advocacy is essential to influence policies and build sustained political and financial commitment to migration and health issues. The advocacy efforts of IOM are often combined with direct technical assistance to governmental and non-governmental stakeholders for the development of migrant-inclusive health policies and "healthy and safe" migration policies in other sectors, such as labour and immigration.

In 2012 IOM's advocacy efforts continued with key policymakers at the global, regional and national levels to ensure that migrants have equal rights to health with everyone else. Through these efforts of IOM and its partners some successes were booked.

International AIDS Conference 2012

During the nineteenth installment of the biennial International AIDS Conference held in July 2012 in Washington, D.C., IOM organized a number of sessions with different partners to raise awareness on the links between HIV and migration and to strengthen partnerships in order to ensure future action. Below are these sessions, each accompanied by a brief description:

IOM participated at the International AIDS Conference in July 2012.

Bridging session on migration and HIV. *HIV Responses in the Context of Migration–What Have We Learned?*
This session, which was developed and moderated by IOM, was part of the official programme of the Conference. It highlighted different responses to migration-related HIV challenges in sub-Saharan Africa, Asia, Eastern Europe as well as North America and Western Europe. IOM invited different partners (government agencies, civil society and others), who presented how they have addressed the specific HIV vulnerabilities of a variety of migrant types, including irregular cross-border migrants, temporary migrant workers, immigrants and victims of trafficking. The session identified key components that make responses successful and effective, for the benefit of migrants and host communities alike.

Special session. *Responses to HIV and Migration in Western Industrialized Countries: Current Challenges, Promising Practices, Future Directions*
Co-hosted by IOM, the Canadian Public Health Agency, CDC and the European Centre for Disease Control and Prevention (ECDC), this special session examined the challenges related to monitoring HIV among migrant populations and in providing migrant-sensitive HIV programmes and services in North America and Europe.[5]

Global Village. *Spaces of Vulnerability: HIV and Mobility in the Caribbean*
Organized in partnership with the African Black Diaspora Global Network, the event provided an overview of the response to HIV and population mobility in the Caribbean. The round table featured speakers from IOM, the Center for Integrated Training and Research (a well-recognized NGO in the region that provides educational and prevention services for HIV), and the Pan-Caribbean Partnership against HIV/AIDS regional project on HIV and migration.

Satellite session. *Digging for Solutions: Implementation of the Declaration on Tuberculosis and HIV in the Mining Sector in Southern Africa*
Organized by the IOM Regional Office for East and Southern Africa, in partnership with the Southern African Development Community (SADC) and the Stop TB Partnership of WHO, this event presented an overview of the challenges and opportunities brought about by the forthcoming Southern African Development Community Declaration on TB in the Mining Sector (signed in August 2012 by SADC Heads of State).

[5] The meeting report can be downloaded from www.ecdc.europa.eu/en/publications/publications/hiv-migration-meeting-report.pdf.

Somalia

In Somalia, a short documentary to promote the health of migrants and mobile populations was produced in Japanese as an advocacy tool for the Government of Japan. The film was shown to the Japanese audience, including officials from the Japanese Ministry of Foreign Affairs, at the *Global Festa Japan*, the biggest international cooperation event in Japan, in November. It was also uploaded to YouTube: www.youtube.com/watch?v=QwdxBDXB84c. Similarly, in December 2012, the Japanese company Nippon Poly-Glu Co., Ltd., and the TV Tokyo crew, accompanied by IOM Somalia, shot various activities in IOM's water provision site in the Kasapa IDP settlement in Dollow, Somalia, near the border with Ethiopia. The activity is part of the project "Improving Environmental Health Conditions of Internally Displaced Persons in Somalia: Public–Private Partnership for Human Security Using Innovative Japanese Water Treatment Technology, Poly-Glu," for which the Government of Japan provides financial support and Nippon Poly-Glu supplies the flocculants and provides technical assistance and know-how. The short documentary was aired during the weekly one-hour programme on TV Tokyo, *Gaia no Yoake*, one of the most popular TV programmes in Japan, with 7–12 million viewers every episode. The Japanese Ministry of Foreign Affairs is interested in using the documentary to showcase this unique public–private partnership project at the Tokyo International Conference on African Development in Japan in June 2013.

Comprehensive water quality analysis is regularly conducted across Somalia by Water, Sanitation and Hygiene (WASH) specialists. Mr Koji Kumamaru, IOM Somalia's WASH Specialist from the United Nations Volunteer (UNV) programme in Japan, carefully examines a water sample. (Photo: Ali Eide)

Sri Lanka

In Sri Lanka, IOM helped establish an interministerial coordination mechanism to implement the 2008 WHA Resolution on Migrant Health. After a series of consultations and stakeholder interviews and the analysis of empirical evidence over a period of three years, the Sri Lanka National Migration Health Policy was developed by the Inter-ministerial Task Force on Migration Health and endorsed by the National Steering Committee. The final draft of the document was presented for public debate by the Minister of Health on 28 November 2012. Following the compilation of public responses, the policy will be submitted for the approval of the Cabinet of Ministers in 2013 and will be adopted for implementation.

Sri Lanka's Director General of Health Services presents the draft policy to the Minister of Health. The Director General of the Economic Division of the Ministry of External Affairs and the Secretary of the Ministry of Health were also present.

Cambodia

IOM participated in the Eighth Technical Advisory Group Meeting for TB Control in the Western Pacific Region, held in Phnom Penh in October 2012 and organized by the WHO Western Pacific Region Office (WPRO), along with an estimated 70 participants from the national TB programmes of Cambodia, China, the Lao People's Democratic Republic, Mongolia, Papua New Guinea, the Philippines and Viet Nam, WHO WPRO and other partner agencies, who agreed on an action plan to manage drug-resistant TB in the region. During this meeting, WHO WPRO introduced the draft Regional Framework on TB and Migration in the Western Pacific, the first of its kind in the region that outlines the guiding principles and key actions that national TB programmes should take into consideration

in dealing with migration-related issues in their TB control efforts. The framework that was presented is in accordance with the four pillars of the Operational Framework for Migrant Health, which was identified during the Global Consultation on Migrant Health in Madrid (2010). The final framework will be circulated for discussion with other government sectors before it can be adopted in 2013.

Greater Mekong Subregion

IOM participated in the Consultation on Migrants' Access to Antiretroviral Therapy (ART) Along the Migration Continuum in Four Greater Mekong Subregion (GMS) Countries held in Bangkok in April 2012). Nearly one million people are infected with HIV in the Asia-Pacific region, with rates of ART coverage varying widely. The challenge is to harmonize and align health systems in the region to provide consistent health care to cross-border migrants, as health systems are still primarily nation-based and not designed for migrant and mobile populations, especially migrants that travel irregularly. This consultation provided an opportunity for representatives from four countries (Thailand, Lao People's Democratic Republic, Myanmar and Cambodia), as well as representatives from NGOs, UN agencies and donor agencies to review the situation of migrants' access to ART services and programmes along the migration continuum, share experiences, identify the challenges and brainstorm about key steps towards improving access. Some of the recommendations identified include improving migrants' awareness of their rights to health; setting up referral systems between health facilities across borders; and standardizing responses and treatment regimens across countries and across the region, to ensure continuous access to ART throughout the migration continuum.

Southern Africa

In Southern Africa, IOM assisted the Southern African Development Community Secretariat and SADC Member States with the development of the SADC Declaration on TB in the Mining Sector, signed by Heads of State in August 2012. As an invited member of the technical working group established by SADC, IOM provided input during the drafting of the Declaration, including facilitating consultations at the country level and supporting a regional consultation meeting in March 2012 on TB in the mining sector, at which the Director of the Migration Health Division of IOM, Davide Mosca, presented the paper entitled "Migrant Health: Challenges and Obligations." The meeting saw the participation of relevant government ministries, the private sector, workers' and former mine workers' representatives, regional and global experts and civil society organizations. Since then, IOM has been assisting the SADC Secretariat and SADC Member States with the implementation of the Declaration to reduce TB vulnerabilities of migrant workers and their families. IOM advocated that the Declaration take a broader public health approach rather than a purely occupation health focus, so as to include the families of mine workers and the communities in which mine workers live and work.

Dr Erick Ventura, Regional Migration Health Coordinator, addressing delegates of a satellite session hosted by IOM, in partnership with SADC and STOP TB Partnership, entitled "Digging for Solutions: Implementation of the Declaration on TB and HIV in the Mining Sector in Southern Africa" at the Eighteenth International AIDS Conference in Washington, D.C.

West Africa

In line with the memorandum of understanding between it and the West African Health Organization, IOM participated in the development of the Economic Community of West African States (ECOWAS) 2013–14 Multisectoral Strategic Plan on HIV and AIDS. The process was participated in by representatives from ECOWAS countries' health ministries and other regional partners, such as UNAIDS, WHO, UNDP and UNICEF. To strengthen interventions to reduce HIV vulnerability along the corridors in the ECOWAS region, the following activities were included in the strategic plan: (1) identifying and describing the HIV epidemiological situation along the corridors; (2) defining key populations most at risk of HIV infection; (3) developing a coordination framework for intercountry implementation of interventions along the corridors; and (4) supporting the countries in the implementation of their national strategic plans.

Kenya

In Kenya, IOM supported the development of a new strategy to scale up HIV prevention, care and support for mobile populations along transport corridors in Kenya. The technical assistance was requested by both the National AIDS Control Council and the National AIDS and STI Control Programme, in an effort to standardize the response to the HIV epidemic along transport corridors. The focus on transport corridors came about because several studies have shown existing gaps in health service delivery along transport corridors, including the uncoordinated and fragmented manner that multiple organizations have been working along these corridors. The aim of this strategy is to provide a national framework that will guide the delivery of HIV prevention, treatment, care and support services to mobile populations and communities along the transport corridors in Kenya through the HIV combination prevention approach.

Uganda

In Uganda, a new national strategy for migrant and mobile populations, Combination HIV Prevention (CHIPS), was developed. The CHIPS framework was launched and projects were supported within the CHIPS framework. IOM has supported the position of a full-time HIV focal person in the Ministry of Works and Transport. In the subsequent year, the Ministry absorbed this position in their payroll on a permanent basis, thus making this intervention sustainable. The secondment eased internal coordination of and follow-up on action. As a result, the HIV policy and prevention strategy for the sector were completed in 12 months. In addition, the seconded person mobilized key officials from the Ministry to support the functioning of an "HIV Team" at the Ministry which meets regularly to develop and implement an action plan based on the strategy.

Hon. John Byabagambi, Minister of State for Works, Ministry of Works and Transport, Uganda at the launch of the HIV Prevention Strategy for the Transport Sector, a project supported by IOM.

Uganda's Ministry of Works and Transport staff offering HIV counselling services during the sectoral workplace campaigns supported by IOM.

Jordan

In August 2012, the Jordanian Ministry of Health and IOM co-hosted the First National Consultation on the Health of Migrants in Amman, Jordan. It discussed the results of the research study that was concluded earlier in the year. During the consultation the Minister of Health expressed the commitment of the Government of Jordan to work actively with all partners and stakeholders towards promoting migrants' health and increasing migrants' access to sensitive, affordable and quality health care. Representatives from the Jordanian Government (from the Ministry of Health, Ministry of Labour and Ministry of Interior) interacted

with delegates from migrant worker-sending countries – including the Ministries of Health and Labour of Bangladesh and the Ministry of Health of Sri Lanka – IOM, WHO, the NGO network CARAM (Coordination of Action on AIDS and Mobility) Asia, and recruitment agencies in Jordan. Recommendations from this consultation were framed along the priorities of the 2008 WHA Resolution on the Health of Migrants and aim to further support the promotion of migrants' health and adequate policies in Jordan.

Dr Abdellatif Woreikat, former Minister of Health, during the First National Consultation on the Health of Migrants in Amman, Jordan.

Europe

In Europe, in 2012, IOM was invited by the ECDC to present at the experts' meeting on malaria and migration in Stockholm. In addition, IOM was asked to provide technical support to an EU policy report on haemoglobinopathies[6] and migration, funded by Novartis, as well as contributed to the Pan-European Conference on Haemoglobinopathies and Rare Anaemias, which was held in Limassol, Cyprus in October 2012 during Cyprus' EU Presidency and done within the framework of the European Network for Rare and Congenital Anaemias Project[7], a partnership of 48 partners in collaboration with Cyprus' Ministry of Health and the EU Presidency.

IOM supported the inclusion of migration and health in the Northern Dimension Partnership in Public Health and Social Well-being (NDPHS)[8] Workplan for 2012–13 as well as in the action plan on non-communicable diseases. NDPHS is a transnational cooperative effort of eleven governments, the European Commission and eight international organizations to tackle challenges regarding health and social well-being issues in the Northern Dimension area. Its mission is to promote sustainable development of the Northern Dimension area by improving people's health and social well-being. In addition to being part of the decision-making body of the Committee of Senior Representatives of the NDPHS, IOM is participating in the expert groups on primary health care, prison health and HIV.

[6] Haemoglobinopathies (thalassaemias and sickle-cell disorders) are rare blood disorders affecting 330,000 infants born annually (83% sickle cell and 17% thalassaemia) around the world. According to WHO, they present a growing health problem in 71 per cent of 229 countries that account for 89 per cent of all births worldwide.

[7] More information can be found at www.enerca.org/activities/training/3rd-pan-european-cyprus.html.

[8] More information can be found at www.ndphs.org/?about_ndphs. NDPHS is a transnational cooperative effort of 11 governments (Canada, Estonia, Finland, Germany, Iceland, Latvia, Lithuania, Norway, Poland, the Russian Federation and Sweden), the European Commission, and eight international organizations (Baltic Sea States Subregional Cooperation, Barents Euro-Arctic Council, Council of the Baltic Sea States, ILO, IOM, Nordic Council of Ministers, UNAIDS and WHO).

Tajikistan

IOM, working within the framework of the project "Improving Migrant Workers' Access to Health Services in Tajikistan," initiated a two-day workshop in collaboration with the Tajik Ministry of Health and Migration Service and with the technical support of the ILO. The workshop was designed to build the knowledge in occupational health and safety of employers who have foreign citizens working for them. The main goal of the workshop was to raise employers' awareness of migrants' right to health services and of the new occupational safety and health management system (namely, the ILO-OSH), which includes the prevention of infectious diseases, such as HIV and TB, in the workplace. The event was attended by representatives from various foreign and private companies, including specialists from the Ministry of Health, the Migration Service, the State Service for the Supervision of Labour, Employment and Social Protection, the Employers' Association, Health Care Union of Tajikistan and HIV service community organizations.

Jamaica

The Planning Institute of Jamaica, in partnership with IOM, convened a series of national consultations to develop the National Policy and Plan of Action on International Migration and Development for Jamaica in September 2012. IOM was asked to provide technical support with regard to the inclusion of the health of migrants' in the policy, in coordination with the Jamaican Ministry of Health.

MIGRANT-SENSITIVE HEALTH SYSTEMS

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

Tuberculosis

In a number of countries IOM implemented TB REACH projects, which were funded by the Stop TB Partnership, in 2012. TB REACH provides short-term and fast-track grants to improve early and increased TB case detection using innovative approaches in populations that are poor, vulnerable, hard to reach and with limited access to health care.

Cambodia

In Cambodia, with TB REACH funding IOM increased TB case detection among returned irregular Cambodian migrants from Thailand through systematic TB screening at the border district of Poipet in Banteay Meanchey Province. From January to December 2012, 6,000 irregular migrants were referred from the Immigration Centre to the local hospital, where they were screened for TB through X-ray. Of the migrants screened, 1,323 were tested for TB using the rapid diagnostic tool GeneXpert MTB/RIF. Ninety-one per cent of the 127 migrants detected with TB were treated through government services within or outside the Banteay Meanchey Province.

IOM staff providing introduction on TB screening using promotional flyer at Poipet Immigration Centre in Cambodia.

Lao People's Democratic Republic

In order to assist the Lao People's Democratic Republic national TB control centre in its efforts to control TB in hard-to-reach populations, IOM brought TB screening, with TB REACH funding to villages in Savannakhet and Champasak Provinces. IOM trained health centre staff, village health volunteers and laboratory technicians on how to conduct TB screening and diagnostic microscopy. The project, which was implemented in close collaboration with the National Tuberculosis Control Programme, identified 8,082 persons who were to be further evaluated for TB and detected positive TB infection among 176 persons, among which 175 started treatment during the 15-month period of project implementation.

Nepal

IOM aimed to increase case detection among hard-to-reach populations in 16 districts in the Eastern Development Region and two locations in the Central Development Region of Nepal using GeneXpert and by improving the referral system for TB testing through a targeted large-scale information campaign. In collaboration with the National TB Centre, IOM has installed nine GeneXpert diagnostic centres to improve TB case detection by increasing the sensitivity of the TB test. From January to December 2012 a total of 7,739 GeneXpert tests were performed in nine diagnostic centres, and a total of 1,484 TB cases were detected. Likewise, over 10,000 posters and leaflets were distributed; articles were published in newspapers; and radio messages were broadcast from seven local radio stations to raise awareness of TB. Additionally, over 500 health-care providers received orientation on TB and GeneXpert technology. The GeneXpert centres are running well and continue to detect hidden cases of TB.

IOM trained health centre staff, village health volunteers and laboratory technicians on how to conduct TB screening and diagnostic microscopy.

Living a new life

Sahadev Yadav, 35, was living a happy life with his wife and two children in Nepal. He was the breadwinner in his family. The bad days started when he fell ill with tuberculosis and spent almost all of his savings to visit hospitals, private practitioners and pharmacists to treat his illness. For the last six months he had had a cough, diarrhoea, chest and abdominal pain and fever.

Despite receiving treatment, Sahadev did not feel better. One private doctor even diagnosed him with lung cancer. He was very sad when he was informed of the diagnosis and lost all hope of getting better. One day, he heard from a local radio about tuberculosis and the availability of a new diagnostic tool called "GeneXpert," which was available at the Nepal Anti-tuberculosis Association clinic in Biratnagar.

Sahadev visited the clinic, where he underwent sputum microscopy test and chest X-ray . His sputum was also subjected to the GeneXpert test. He tested negative for TB through sputum microscopy, but was diagnosed with TB by the GeneXpert test. Sahadev was enrolled for TB treatment and referred to a directly observed therapy centre, where he continued his TB treatment. Sahadev has completed six months of treatment and is currently cured, all of his symptoms now gone. He is very happy and thankful to IOM Nepal and GeneXpert technology, which helped diagnose and treat his TB. He is living a new life.

Thailand

The northern and north-eastern border provinces of Thailand are home to some of the most vulnerable groups, which include migrants, elderly people with limited mobility and disadvantaged or poor people with limited resources who live in hard-to-reach areas. These groups are vulnerable to TB and face multiple barriers to accessing health care, including TB screening and treatment. Migrants, especially those whose legal status in Thailand is not secure, have to overcome huge barriers to receive health care. There has been some anecdotal evidence of sick migrants being refused health care because they lack identity cards and reports of migrants harassed by police when their status is revealed by hospital staff. Migrants quite often settle in remote areas, so bringing diagnostic services to them is a better alternative than waiting for them to come to health centres, which is often the case.

IOM, therefore, aims to increase TB case detection in high-TB-burden districts in seven provinces of northern and north-eastern Thailand using GeneXpert technology and community mobilization. From March to December 2012 a total of 7,716 individuals were screened using GeneXpert technology, with 580 testing positive. Of the 580 TB-positive individuals, 19 (3.28%) indicated resistance to the anti-tuberculosis drug rifampicin. All positive cases detected through the project were enrolled into the National TB Treatment Programme. The project is expected to result in an 85 per cent treatment success rate, and a network of 54 community health workers[9] and 162 community health volunteers[10] trained in TB case-finding, education and treatment monitoring.

Myanmar

In Myanmar, IOM reinforced TB control in remote river delta locations and semi-urban sites in the township of Bogalay in Ayeyarwady Region. The activities sensitized communities by engaging village health committees and trained existing community health workers (CHWs) as TB mobilizers, thus creating demand for services. Mobile TB screening units (fluorescent microscopy and mobile chest X-ray) were deployed to these communities, and referrals were facilitated to the National TB Programme for further diagnosis and treatment. Directly observed therapy–short course (DOTS) was provided by NTP through CHWs. A total of 2,140 persons with suspected TB were referred for screening; 312 confirmed cases were initiated on DOTS, and 104 additional case notifications were made compared to the previous year.

Nepal

In addition to Stop TB Partnership's TB REACH Project, several other donor agencies have also focused on TB detection and treatment for vulnerable migrant and refugee populations. For example, in December 2008 the United States Bureau of Population, Refugees and Migration and Citizenship and Immigration Canada started to support the initiative entitled "The Harmonization of Protocols for Tuberculosis Diagnosis and Treatment of the Bhutanese Refugees in Nepal" to ensure effective diagnosis and treatment of TB among Bhutanese refugees residing in seven camps in the south-eastern part of Nepal, through the extension of diagnostic and treatment services to refugees who were not due for resettlement. Before the start of this project, TB screening and the treatment protocol implemented in the refugee camps were different from the protocols observed by the resettlement countries. The purpose of this project is to ensure that both refugees in and outside of the resettlement programme receive the same effective TB diagnosis and treatment services. Importantly, through this project IOM has strengthened the capacity of local health professionals in TB detection and management, which will benefit the country beyond the project period. In 2012, 614 refugees were tested for TB by the IOM laboratory, with 76 cases of active TB detected, including 8 drug-resistant cases, applying TB diagnostic technologies, including digital radiology, sputum cultures and drug susceptibility testing.

Colombia

In Colombia, IOM, with financial support from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Colombian Government, seeks to strengthen the "Stop TB in 46 priority municipalities of Colombia" strategy as part of the strategic plan, "Colombia Free of TB 2010–2015." The project focuses on the country's Pacific Region, which hosts a large population of African-descent and indigenous communities, which account for 15 per cent of the

[9] Community health workers (CHWs) are usually recruited as field staff and are paid a small salary for a project. For this particular project, one CHW was assigned to each target district. Each CHW was assigned to a district hospital from where our specimens were sourced. These CHWs were responsible for ensuring that the samples were forwarded to the centralized testing centre.

[10] Community health volunteers are usually unpaid field staff working within the communities that they live in. They usually know the health statuses of individual community members and, thus, may identify possible TB cases. They can, therefore, encourage patients to attend the nearest health facility. These field staff do not get a regular salary from the project but do have their out-of-pocket expenses (fuel for transportation to visit patients or deliver patients to health posts) met.

total TB burden in the country and where 78 per cent of the population has unmet basic needs. During its first year, in 2012, the project strengthened the National TB Programme through four specific operational research studies on TB mortality, pediatric contacts, barriers to accessing TB-related health services, and public knowledge of TB. The project brings the activities of timely diagnosis and treatment through community DOTS, strengthening its quality and effectiveness with six local and one regional workshops and encouraging local response for TB control through advocacy and specific social communication strategies.

Jordan

IOM Jordan, in collaboration with the Jordanian Ministry of Health and the National TB Programme, started a project to strengthen the programme TB Management for Migrants in Jordan. Funded by the GFATM, this project seeks to increase migrants' awareness of TB, overcome language barriers between treatment recipients and health workers, improve the quality of DOTS and strengthen the capacity of health workers in the countries of migrants' origin and in Jordan to perform effective health screening to detect TB. In 2012 four training programmes on TB screening and treatment were conducted for health workers in Bangladesh and Egypt. Egypt was chosen because the majority of migrant workers in Jordan are from Egypt and pre-departure screening centres in Egypt do not exist. Health-care workers from different institutions attended the training, including staff from the Egyptian Ministry of Health, to learn how to better perform effective health screening to detect TB. The topics covered in the training included TB epidemiology; how to suspect, diagnose and treat TB cases, including cases of MDR TB; and how to carry out TB prevention and control. A TB hotline was set up in Jordan that employs a nurse who speaks Arabic, English and Filipino (the languages most commonly used by migrants in Jordan) and receives calls and provides information about TB.

Malaria

Sri Lanka

While Sri Lanka is progressing towards the MDG goal of malaria elimination, importation of malaria through mobile populations poses a major source of reintroduction. IOM worked with Sri Lanka's Anti-malaria Campaign to develop leaflets that inform inbound and outbound migrants on malaria prophylaxis, signs, symptoms and services available, with the ultimate goal of malaria prevention and treatment. In November 2012, IOM distributed 15,000 information leaflets in three languages (Sinhala, Tamil and English), for distribution to migrants travelling to malaria-endemic countries. The leaflets are distributed by government immigration and health authorities at ports of entry, in coordination with the National Malaria Control Programme. These agencies are actively engaged in malaria screening of inbound migrants arriving from malaria-endemic countries.

Leaflets for migrants travelling to malaria-endemic countries.

In line with the Anti-malaria Campaign, IOM assists the Ministry of Health with malaria screening of Sri Lankan migrants who have returned through the Organization's Assisted Voluntary Return (AVR) Programme. From January to December 2012, all irregular migrants returning from West African countries assisted by IOM were subjected to malaria screening upon arrival at the Bandaranayke International Airport in Sri Lanka, in partnership with the Anti-malaria Campaign. Screening was conducted on site using the rapid diagnostic test kit, and diagnosis was done at the National TB Reference Laboratory. This screening of returning irregular migrants led to the detection of 23 positive cases out of a total of 70 imported malaria cases in Sri Lanka in 2012.

Myanmar

Despite progressive initiatives over recent decades to control malaria, artemisinin resistance has emerged in remote areas of Myanmar. In line with the Government's Malaria Artemisinin Resistance Containment Strategic Framework, IOM established malaria control initiatives in 183 villages in four townships in Mon State in 2012 to prevent, or at least significantly delay, the spread of artemisinin-resistant malarial strains and reduce malaria mortality and morbidity using appropriate measures, such as the use of artemisinin-based combination therapy.

Sexually transmitted infections and HIV

In many countries migrants remain vulnerable to sexually transmitted infections (STIs), including HIV. Female migrant workers, in particular, often migrate under unsafe conditions that increase their vulnerability to STIs. In response to this, IOM works with several partners to reduce STI/HIV vulnerabilities related to the migration process. For example, in Bangladesh IOM implemented the project entitled "HIV Prevention Initiatives for Returning Migrants," from 2009 to 2012. The project promoted HIV prevention services to prospective and returnee migrants, as well as their spouses, in partnership with local community-based organizations, the government health and family planning department and the Bureau of Manpower, Employment and Training. The activities included capacity-building of relevant government officials on migration and HIV issues through a "training of trainers" programme (in all, 290 government staff working at 28 technical training centres were trained); development of training manuals and the distribution of these to the technical training centres involved in skills-building of potential migrants; community-based awareness-raising programmes through the distribution of picture-based education materials on HIV and STI prevention in selected migrant sending areas; and the distribution of information at the international airport in Dhaka on HIV prevention and available service points for counselling, testing and care to returnee migrant workers.

Pakistan

In Pakistan, IOM implemented the project "Strengthening the Capacity of the Government of Pakistan and Key Stakeholders in Addressing HIV Vulnerabilities of Pakistani Migrant Workers." Approximately 150,000 to 200,000 migrant workers travel from Pakistan to countries in the Gulf region and the Middle East every year. They undergo mandatory HIV screening prior to departure from Pakistan and usually again upon their arrival in the countries of destination; however, there are no systems for educating, counselling or providing treatment to migrants found to be HIV-positive. To bridge the gap, project activities included a mapping of HIV risks and vulnerabilities of Pakistani migrant workers. The findings were discussed in a multi-stakeholder consultation followed by the development of a training module. Subsequently, training was given to 250 staff members of the Bureau of Emigration and Overseas Employment, overseas employment promoters and other relevant stakeholders from Pakistan to better manage HIV risk and vulnerability of migrant workers. Trainings were held in Rawalpindi, Peshawar, Lahore and Multan in cooperation with UNAIDS and National and Provincial AIDS Control Programmes. Migrant-focused HIV prevention educational materials were developed after participatory research, targeting communicable diseases like HIV, hepatitis and TB. The Bureau of Emigration distributed 14,000 brochures to prospective migrants, in addition to materials sent to the Pakistani Embassy and Consulate in the United Arab Emirates for dissemination.

Tajikistan, Kyrgyzstan and Kazakhstan

In June 2012 IOM launched an eight-month regional project on HIV and TB prevention among migrant workers from two sending countries, Tajikistan (specifically, the cities of Qurghontepa and Kulob) and Kyrgyzstan (Bishkek), and a receiving country, Kazakhstan (Almaty). The project was implemented in close partnership with the health ministries of the three countries. Together with Population Services International, IOM developed information, education and communication materials and conducted training to prevent HIV and TB among migrant workers in countries of origin and destination. The main achievements to date include the improvement of migrants' health-seeking behaviour, strengthening of referral systems, improvement of treatment adherence support to migrants with TB, and strengthening of the capacity of NGO partners. In Tajikistan 1,157 migrant workers were covered by the outreach work between August and December 2012. Trained social workers from NGO partners ensured migrants' access to TB treatment and social support. The results of the project were presented during a regional TB symposium, "TB Care – A Patient-Centred Approach: Treating TB in Central Asia and Eastern Europe," organized by Médecins Sans Frontières in Bishkek in December 2012.[11]

[11] More information can be found at www.msf.org.

The USAID Dialogue on HIV and TB Project among migrants in Tajikistan, Kyrgyzstan, and Kazakhstan

When you get sick, it seems that the world is crumbling around and in such situations, people's and relative's support are very helpful.

- Beneficiary from Tajikistan

I was hospitalized in July 2012 and was under treatment for three months. … [The] three consecutive sputum [smears] and X-rays… did not identify any Mycobacterium tuberculosis, meaning that I am not at risk any longer. However, I still have to receive outpatient treatment to complete the entire course of treatment. My family was also [screened] for TB. Thanks to God, they are all healthy! Now, I am at home and follow all recommendations for TB treatment. You gave me hope for the future.

- Migrant worker from the Russian Federation

Thanks to the activities of the project, the migrant workers have an increased access to information, diagnosis and treatment of socially significant infections.

- Beneficiary from the Kyrgyz Republic

Before, [like] the majority of the Kazakhstan population, I had a perception that it was forbidden to approach HIV-positive people or even come less than two meters [of them], not even having any conversation with them. I thought that patients with AIDS look[ed] scary and people with tuberculosis should be avoided. But the outreach work has changed my view on these things. Everything that I have learned through training, I have conveyed to my friends and acquaintances with pleasure.

- Gaukhar, trainer and outreach worker on sexually transmitted infections and TB from Kazakhstan

Bosnia and Herzegovina

In Bosnia and Herzegovina IOM finalized the implementation of a two-year project in 2012 to strengthen the capacity of the Government and other partners to decrease the HIV vulnerability of mobile populations in the country. Key accomplishments of the project were the creation of a network of 22 NGOs, 7 electronic and print media organizations and 2 public health-care institutions and the improvement of their knowledge and expertise on the links between HIV and mobility using social communication. A total of 5,325 migrants and mobile populations were reached with information on access to prevention, counselling, testing and treatment services; and 404 truck drivers were anonymously tested for HIV and STIs as a result of a voluntary, confidential counselling and testing information campaign conducted at key border crossings in the country.

Training for NGOs and media on HIV and AIDS and social communication, held in Bosnia and Herzegovina in May 2012.

Lao People's Democratic Republic

In Lao People's Democratic Republic, with funding from the Asian Development Bank, IOM translated a previously developed training tool for HIV prevention and safe migration in road construction settings and affected communities into the local Lao language. The tool, entitled "For Life with Love," aims to reinforce positive health-seeking behaviour among migrants working in the construction sector in Lao People's Democratic Republic. It consists of a training manual in English and a DVD containing an animated film dubbed in five national languages of the Greater Mekong Subregion, namely, Cambodian, Lao, Myanmar, Thai and Vietnamese. The training manual was translated into Lao in order for the Centre of HIV/AIDS and STIs and other relevant stakeholders to implement HIV prevention activities in the construction sector in the country.

South Africa

In 2012 IOM South Africa began Phase 2 of its Ripfumelo project, which is aimed at scaling up access to HIV prevention and care services for migrants and migration-affected communities in South Africa. The project will continue to be implemented in Limpopo and Mpumalanga provinces, but will expand to Gauteng and KwaZulu-Natal provinces. The agricultural sector focus will remain but will be expanded to include other geographical spaces affected by migration such as mines, urban informal settlements, ports and transport corridors.

Health and counter-trafficking

In May 2012 IOM migration health officials were part of a team of trainers that trained senior officials from China's Ministries of Foreign Affairs, Public Security and Civil Affairs on strengthening mechanisms to protect and assist trafficked persons. This four-day workshop, which took place in Beijing, was part of the "Capacity-Building for Migration Management in China" project. Trainers from IOM, China's Ministry of Public Security, Frontex, Germany and Portugal shared Chinese and European best practices on how to identify and assist trafficked persons, including addressing their psychosocial and health needs.

In 2012 seven pilot trainings were undertaken to test and further develop a training package based on the handbook *Caring for Trafficked Persons*, which is now available in English, Arabic and Chinese. This initiative is part of a global programme on health and human trafficking that IOM and the London School of Hygiene and Tropical Medicine (LSHTM) have jointly been carrying out since 2010 to assist health practitioners in addressing a range of challenges related to diagnosing and treating trafficked persons. In total, 178 health providers participated in these pilot trainings in seven countries across three regions –El Salvador and Costa Rica (Central America); Belize, Guyana and Antigua (Caribbean); and Jordan and Egypt (Middle East) – and were held, respectively, in Spanish, English and Arabic. The trainings were conducted by specialists in health and human trafficking from IOM and LSHTM and were implemented in coordination with local health and counter trafficking partners. During these pilot trainings, IOM and LSHTM significantly improved and eventually finalized the training materials, which will be published in a facilitator's guide in 2013.

IOM Regional Migration Health Adviser for Asia, Dr Jaime Calderon, addressed Chinese immigration and law enforcement officials at the Capacity-Building for Migration Management in China held in Beijing in May 2012.

Strengthening the capacity of health services

Costa Rica

IOM Costa Rica finalized a training manual in 2012 on the basic concepts of migrant health in the Latin American region, which is being used to train and sensitize policymakers and health practitioners on migration health issues. The training modules are aimed at increasing the knowledge on migrants' health issues, addressing local myths and perceptions related to migration and health and increasing migrants' skills to reduce their health vulnerabilities. A total of 220 migration officers and health service providers were trained in 2012.

The facilitator's manual for *Migración Saludable en América Central* was designed to support and direct the implementation of workshops and training on health awareness and migration.

Sri Lanka

In order to address the medico-legal and mental health aspects of migrant workers in Sri Lanka, IOM organized a joint programme with the Foreign Employment and Promotion Board for staff working at Sahana Piyasa, a shelter for migrant workers who have been victims of abuse. The Chief Judicial Medical Officer and experts from the Sri Lanka College of Psychiatrists provided training for staff at the shelter on evidence-based practices in early detection, effective case management and referral. The capacity-building workshops covered early identification of victims of abuse, supporting returnees with psychological assistance, medical legal issues and referral mechanisms.

In addition to providing training to Sahana Piyasa staff members, IOM strengthened the capacity of Sri Lanka port medical officers through a joint IOM-Ministry of Health capacity-building workshop in November 2012 to enhance the management of border health issues, such as the identification of trafficked victims, the medico-legal aspects of the repatriation of the dead bodies of migrant workers, quarantine functions, the International Health Regulations and the identification of the psychological needs of returned migrants. The workshop was followed by a project, started in November 2012, to enhance the health information system of the Quarantine Unit of the Ministry of Health and especially the vaccination centre. Currently, IOM is working with the Ministry of Health by providing technical input on training modules for port health medical officers. Furthermore, IOM supported the drafting of new protocols for airport and seaport border health protection. This process is being finalized through a series of consultative meetings with the Department of Immigration, the Sri Lanka Port Health Authorities and other key stakeholders.

Tajikistan

In Tajikistan, IOM assists the Government in its efforts to implement the 2008 WHA Resolution on the Health of Migrants and develop migrant-sensitive health policies and services for foreign migrant workers in the country. A number of activities were carried out in 2012, including the implementation of research on foreign migrants' health status and access to health services in Tajikistan, as well as the development of information and educational materials, in seven foreign languages, on HIV, STI and TB prevention, which were approved by the Ministry of Health. As a result of these activities, nearly 2,000 foreign migrant workers received brochures in their native languages and improved their knowledge of STIs, HIV and TB prevention.

IOM Tajikistan developed information and educational materials, in seven foreign languages, on HIV, STI and TB prevention.

South Asia

Public health systems in some South Asian countries have not kept pace with the growing migration-related health challenges. Therefore, the main objective of a project that started in 2012 in Bangladesh, Nepal, and Pakistan is to strengthen the capacity of these countries' governments to address the health needs of inbound and outbound migrants using a multisectoral approach. Specifically, the project is assessing the health vulnerabilities of inbound and outbound migrants, including their access to health and other social services, mapping the governments' responses to address these vulnerabilities, organizing a regional consultation attended by the three target countries, as well as other relevant countries in the region, and coming up with recommendations for action for the same.

Thailand

IOM Thailand has been providing support to migrants in the Bangkok Immigration Detention Centre since 2002. The detention centre continues to house, on average, 1,000 migrants at a time from all over the world. The cells are often overcrowded and lack proper ventilation, and the migrants have poor access to regular exercise and recreation. Through a project, IOM has continued to contribute to the improvement of the living conditions and health of migrants, including mental and psychosocial health, specifically

of migrant children (ages 3 to 18) and women. In 2012 the project provided childcare services for detained children through a variety of educational and recreational activities at a day-care centre. One of the aims of the centre is to help improve hygiene, nutrition and psychosocial assistance. In 2012, for the first time, IOM was allowed to take the children from the detention centre to attend a psychological support programme conducted by professional psychologists and specifically designed for the children in detention.

Viet Nam

IOM Viet Nam, with support from the Asian Development Bank, is assisting the Government of Viet Nam to mitigate the possible negative health impacts of major infrastructure projects in the Mekong Delta. The "Strengthening the Capacity of Women along the Central Mekong Delta Connectivity Project" focuses on new infrastructure projects that stimulate economic growth, but which may also put some people at a higher risk of contracting HIV. Such risk groups include migrants, mobile communities, host communities and, in particular, women. The objective of this project, therefore, is to reduce women's vulnerability to ill health, including HIV, sexual exploitation and human trafficking. This will be achieved by enabling the socioeconomic empowerment of women and increasing awareness amongst women and men on issues pertaining to gender, HIV and AIDS and trafficking in women.

Tajikistan

In the context of the project "Improving Migrant Workers Access to Health Services in Tajikistan," a collaboration with the Ministry of Health of Tajikistan, the Government's Migration Service and NGO partners Apeiron and Targibot, IOM organized two public events to mark International Migrants Day with migrant communities in Tajikistan on 16 December 2012 and 04 January 2013. A public event was organized at the Huaxin Gaur Cement factory, which employs nearly 500 Chinese migrant workers, for its workers and another one in Korvon, the biggest market in Tajikistan. Free medical testing and consultation were arranged to improve Chinese migrants' access to STIs, HIV and TB prevention services at the workplace. In addition, an interactive information session was organized, wherein tribute was paid to the migrant workers, highlighting their contribution to the economic development of Tajikistan, and where health promotion messages were conveyed by specialists on infectious diseases, including TB, HIV and STIs. To increase the health-related knowledge of the migrant workers, health promotion materials in Mandarin Chinese, Farsi, Dari, Turkish and Uzbek were distributed. The event was followed by cultural and theatrical performances by artists, spreading the word on free HIV testing and reducing stigma and discrimination towards people living with and affected by the disease.

Somalia

In coordination and close partnership with UNICEF and other partners, IOM Somalia launched a series of mass hygiene promotion campaigns in IDP settlements in all three regions of Somalia on Global Handwashing Day held on 15 October 2012. In collaboration with Somali government authorities and local NGOs, children and families in targeted schools, communities and displacement settlements benefitted from hygiene awareness-raising activities, which included handwashing demonstrations and hygiene promotion messages. In total, IOM reached approximately 4,100 households, that is, over 20,500 persons, including over 1,000 children.

Zimbabwe

In 2012 IOM handed over two rural health centres in Manicaland Province, south-east of the Zimbabwean capital of Harare, to communities hosting large numbers of displaced farm workers. These health centres, which were set up by IOM with financial support from the European Commission and the Swedish International Development Agency (SIDA), were a priority undertaking for the benefit of about the approximately 160,000 farm workers who, since the early 2000s, have lost their jobs and became displaced when Zimbabwe's Government introduced a fast-track land reform programme.

Kenya

With support from SIDA and Norwegian Agency for Development Cooperation, over 1,000 migrants in Nairobi, Kenya were reached by TB and HIV services through the Eastleigh Wellness Centre. In partnership with the District Health Management Team, over 400 children under one year of age were immunized at Eastleigh. IOM supported measles immunization campaigns for children under five, which in total benefited 32,352. In addition, 34,131 children received vitamin A supplements.

Horn of Africa

Every year, a large number of irregular migrants from the Horn of Africa, particularly, Ethiopia (80%) and Somalia (20%), cross Djiboutian borders to transit to the Arabian Peninsula. Between 1 January and 30 November 2012 alone, a total of 99,620 migrants

who transited through Djibouti arrived in Yemen. The main point of departure from Djibouti is Obock, a small town about 250 km north of the capital city, Djibouti. Irregular migrants often arrive in Djibouti in dire condition and in need of humanitarian support, including for their health. Cognizant of the situation, national and local authorities, as well as community leaders, asked IOM for support. To address this issue, IOM Djibouti received funding from the Central Emergency Response Fund and the Tokyo International Conference on African Development in 2012 for two projects aimed at enhancing the response capacities of the Djiboutian Government to provide life-saving assistance and promote public health and prevention measures, all in order to reduce avoidable mortality and morbidity among migrants and host communities. The health components of these projects were implemented by an IOM mobile health team stationed in the districts of Obock and Tadjourah, where most migrants live. The team conducts health promotion activities to prevent cholera and improve health awareness. A total of 35,392 individuals, 12,753 of whom were migrants, benefited from health promotion, especially cholera prevention and general health awareness interventions. Migrants with health conditions were provided treatment and referred to health facilities, as needed. Information, education and communication (IEC) materials, soaps, Aquatabs, albendazole tablets, oral rehydration solution and Poly-Glu water treatment systems were distributed. In addition, eight traditional wells were rehabilitated. Although no detailed research was done on causal links, no cholera outbreak was reported in 2012 in these two districts that are known for annual cholera outbreaks.

Cholera prevention, health promotion and assistance in the districts of Obock and Tadjourah, Djibouti.

Egypt

Egypt, due to its geographic location, is considered a main transit country for several migratory routes. Traditionally, the primary passage for both regular and irregular migration from sub-Saharan African countries to Europe was through the Maghreb region. More recently, several major sub-routes have emerged: today, structural factors and, in some cases, conflict, compel people to leave their countries of origin (including Sudan, South Sudan, Ethiopia, Eritrea and Somalia) and migrate to Egypt, in many cases, travelling onward to Europe and/or neighbouring countries. In general, migrants in transit are more vulnerable to forced labour, sexual exploitation and torture. Others are injured while trying to cross international borders and/or apprehended by border authorities. IOM, in close support and coordination with the Egyptian Ministry of Health, thus strengthened health-care services for migrants near the borders. The support provided by IOM support focuses on strengthening referral mechanisms and health-care services for migrants stranded at the borders, by supporting the Ministry of Health in establishing a Migration Health Committee, which was activated in July 2012. The project also facilitated capacity-building projects for the staff employed at health facilities at the borders, provided emergency medical support for urgent medical cases and supported the Ministry of Health in providing health-care services for migrants stranded at the borders, in reception facilities and within communities. Notwithstanding the extreme challenges, the activities of this project have been accomplished through successful liaison and by lobbying with the relevant partners at the borders, as well as the ability to deploy immediate emergency medical assistance.

The year 2012 marked the signing of the first direct grant agreement between IOM and the European Commission Directorate General for Health and Consumers entitled “Fostering health provision for migrants, the Roma and other vulnerable groups (2013–2015).” With this grant agreement, IOM is acknowledged as an organization with “specific competence and [a] high degree of specialization in the areas covered by the direct grant and capacity in the field to act as a strategic long-term partner to the Commission.” Within the framework of this agreement, a number of activities have been planned, including mapping and analysis of EU policies and systems; capacity-building; providing evidence, evaluating and sharing good practices; and fostering research on health and migration issues of high concern in the EU region. The ultimate goal of this action is to

improve the access to and appropriateness of health-care services and health promotion and prevention programmes, to meet the needs of migrants, the Roma and other vulnerable ethnic minority groups, including irregular migrants.

Turkey

Since 2011, IOM Turkey has supported the Government of Turkey, specifically, the Ministry of Interior and the Ministry of Health, in its efforts to strengthen the response to migration-related health challenges. The project "Technical Assistance in Migration and Health: Enhancing National Public Health Standards in Migration Management" addresses public health concerns related to migration, the specific health needs and rights of migrants, as well as the occupational health issues of staff working in migrant detention centres. This project is particularly important, as it is the first initiative taken in the area of migration and health and focuses on Turkey's accession to the EU. Based on a preliminary assessment of conditions in migrant detention centres in Istanbul, a technical working group, composed of representatives from the Ministry of Health, the Ministry of Interior, IOM and well-known experts in the area of public health, drafted specific guidelines to improve the health conditions of irregular migrants staying at detention centres in Turkey. These guidelines will be finalized in 2013. In addition, in 2012 IOM did a desk review on the health profiles of irregular migrants and their access to health services as well as the public and occupational health issues related to migration and mobility in Turkey.

On 6 and 7 December, IOM Turkey, in collaboration with the UK Embassy in Ankara, organized a two-day induction training in psychosocial capacities for 26 police officers working in 15 transit centres for migrants, in which IOM implements its AVRR programmes. The training aimed at passing to the officers basic capacities in comprehending the psychosocial experiences of migrants, protecting their emotional well-being in the given administrative system, and using supportive communication skills.

In December 2012, IOM Turkey, in collaboration with the British Embassy in Turkey, organized a two-day training programme to strengthen the psychosocial capacities of 26 police officers working in 15 transit centres for migrants. The training, which was held in Istanbul, aimed to build the basic capacities of officers in understanding the psychosocial experience of migrants, protecting their emotional well-being in the given administrative system and using supportive communication skills.

Peru

In late 2012, IOM started a project in Peru, *Caravana de la Vida: La Salud en Marcha* (The Caravan of Life: the Road to Health), to increase access to health services in Madre de Dios, an Amazonian region in Peru which is home to indigenous populations and a favorite destination for internal migrants due to the growth of the local mining industry. IOM Peru aims to strengthen existing health services provided by the regional government of Madre de Dios by supporting a mobile clinic, manned by health workers and furnished with medical equipment, which travels throughout the region.

Ecuador

In 2012 IOM Ecuador and the Ecuadorian Ministry of Public Health worked together to improve the health conditions of migrant women in communities along the border with Colombia, in the provinces of Esmeraldas and Sucumbíos, through the National AIDS Programme and in collaboration with the respective provincial health directorates. In 2012 the activities focused on the diagnosis, treatment and prevention of STIs, including HIV, and featured laboratory testing, vaginal smears and cytology, colposcopy and biopsy (whenever necessary). A total of 773 women received these services, with 232 undergoing a colposcopy and 83 undergoing a biopsy. The project also provided primary health, dentistry, psychological and vaccination services. In addition, 17 sensitization workshops on reproductive health issues, participated by more than 1,250 beneficiaries, were implemented. Community health promoters, migrant women from Colombia and local women from Ecuador jointly received the trainings and were empowered by learning about their rights, health risks they might face and preventive measures that promote healthy lifestyles. A total of 120 women and men were trained to undertake awareness-raising activities in their communities that reached 810 women and men, including adolescents. In addition, 111 local health officers were trained in counselling and syndromic management of STIs, including the particular needs of

migrants in this respect, and are now able to better diagnose and treat patients with STIs.

PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

Effectively addressing migration-related health challenges requires governments and other stakeholders to seek collaboration beyond national borders and recognize that the challenges cannot be resolved by the health sector alone. Therefore, IOM supports intercountry collaboration and international partnerships that promote regional consultative and coordination mechanisms, in particular, between countries of origin and destination. IOM also facilitates partnerships between the health and immigration, foreign affairs and labour (including employers and social security agencies) sectors, as well as trade unions, community groups, academia, civil society groups and the media.

National Agency for the Roma

A memorandum of cooperation was signed between IOM Romania and the National Agency for the Roma (NAR) in the field of health on 29 November 2012. NAR and IOM Romania are committed to working together on migrant health, Roma health, the mobility of health workers and other topics of mutual interest in Romania. Activities include joint research, development of publications, joint participation in projects and technical assistance, through advisory and/or working groups, short-term missions and joint contribution to third parties' relevant projects.

UN Research Institute for Social Development

In 2012 IOM engaged in a new partnership with the UN Research Institute for Social Development (UNRISD) to implement the project "Migration and Health in China," in partnership with the China Medical Board in the United States, and in collaboration with the Sun Yat-sen Center for Migrant Health Policy, an academic centre in Guangzhou, China. This project aims to provide a comprehensive assessment of the health challenges associated with rural-to-urban migration in China, as well as international migration from and to China, through thematic papers, workshops and capacity-building activities. Under this partnership with UNRISD, IOM conducted a desk review of the health situation of international migrants to and from China (specifically, Chinese labour emigration to Africa and labour migration into China). In November 2012, along with other authors involved in the Migration and Health in China project, IOM Beijing presented initial research findings at the Second Global Symposium on Health Systems Research[12] in Beijing. The symposium brought together researchers, policymakers, donors, representatives from international organizations, civil society and other stakeholders to share new evidence, identify opportunities and gaps, build understanding across disciplinary boundaries and discuss the way forward to support health systems research and the use of evidence in decision-making in low- and middle-income countries.

IOM Beijing hosted a PhD scholar from the Sun Yat-sen Center for Migrant Health Policy based in Guangzhou in southern China. The scholar contributed to a review of Chinese-language literature relevant to the IOM paper on migrant health. Furthermore, the hosting and research collaboration between IOM and the Sun Yat-sen Center provided an opportunity for IOM to strengthen the partnership with a key academic actor in the area of migrant health in China. Recommendations from the Migration and Health in China Project were discussed during a workshop in July 2012 in Guangzhou, with the participation of academics, policymakers and international organizations.

Asia-Pacific Malaria Elimination Network

At the invitation of the Asia-Pacific Malaria Elimination Network (APMEN), IOM participated in the network's fourth annual meeting in Seoul, 7–10 May 2012, to present its work, especially in regard to malaria elimination, and its collaboration with various countries in Asia. A diverse network composed of 12 Asia-Pacific countries (namely, Bhutan, Cambodia, China, the Democratic People's Republic of Korea, Indonesia, Malaysia, the Philippines, Republic of Korea, Solomon Islands, Sri Lanka, Thailand and Vanuatu) as well as leaders and experts from key multilateral and academic agencies, APMEN collaboratively addresses the unique challenges of malaria elimination in the region through leadership, advocacy, capacity-building, knowledge exchange, and building of an evidence base. The network has identified cross-border movement and the risk of importing malaria as one of the emerging issues to prioritize.

Asia-Europe Foundation

In 2012 IOM strengthened its ongoing partnership with the Asia-Europe Foundation (ASEF) by participating in the ASEF Research Exchange Workshop entitled

[12] More information can be found at www.who.int/alliance-hpsr/hsr-symposium/en.

"Social Determinants of Migrants' Health Across Asia and Europe" in March 2012, in Barcelona, Spain. The workshop provided an overview of the migration trends and patterns in Asia and Europe, as well as the health challenges faced by migrants during the migration cycle. As a recommendation, it was underlined that, globally, more attention is needed to address internal migration and bring migrant-sending and migrant-receiving countries and communities to work together and, most importantly, address the health issues and challenges of Asian migrant workers in future EU-Asia Dialogues. IOM also played a key role in the two-day ASEF workshop, "Bringing the Migrant Health Discourse into Policy," held in November 2012 in Manila, Philippines, which gathered policymakers from Asia and Europe to inform them of the evidence generated by the ASEF Public Health Network's research initiative on health and migration. The workshop aimed at helping decision makers revise and develop policies to positively impact migrant health. IOM chaired the session on "Challenges and Opportunities of International Migration for Sending and Receiving Countries" and moderated the session on "Policy Options for Improving Social Inclusions of Migrants."

CARAM Asia

In 2012 IOM continued to strengthen its partnerships with civil society organisations. For example, IOM was invited to deliver a keynote speech at a Regional Consultation on Violence against Women Migrant Workforce in Kuala Lumpur in May, organized by CARAM Asia and sponsored by UN Women. The regional consultation saw the participation of a large number of NGOs and migrant workers' associations from Asia and the Middle East, as well as government representatives from Bangladesh, Sri Lanka, Cambodia, Nepal, Indonesia and Malaysia, plus representatives from ILO, UNHCR, UNFPA and the media. During the consultation, the debate focused on the implementation of ILO Convention 189 (Decent Work for Domestic Workers), adopted in 2011, and the risk of abuse and exploitation associated with the Kafala system, which is in force in the Gulf States. (The Kafala system requires all low-skilled workers to have an in-country sponsor, usually their employer, who is responsible for their visa and legal status.) The consultation allowed the sharing of country experiences and practices, and participants expressed the will to build closer partnerships between civil society organizations and governments of countries of origin and destination, whereby health could be seen as an effective entry point for dialogue. CARAM Asia is an open network of NGOs and CBOs involved in action research, advocacy, coalition- and capacity–building, with the aim of creating an enabling environment that empowers migrants and their communities to reduce all vulnerabilities, including HIV risk, and enhance their health rights globally. The network is in a "special consultative status" with the Economic and Social Council of the United Nations.

African and Black Diaspora Global Network on HIV/AIDS

During the 101st session of the IOM Council in November 2012, the African Black Diaspora Global Network on HIV and AIDS joined IOM as an Observer. Established in 2006, this Toronto-based "network of networks" aims to strengthen the response to existing and emerging HIV and AIDS epidemics and associated stigmas and discrimination among African, Black and Caribbean populations in the diaspora, including migrants and refugee populations.

Wangari Tharao, Co-Chair of the African Black Diaspora Global Network on HIV and AIDS at the 101st Session of the IOM Council in November 2012.

Southern Africa

In Southern Africa, IOM facilitated a one-day meeting between 14 regional civil society organizations providing health-related services to migrants, and those they interact with, to discuss improved coordination and collaboration. Following the meeting, a Migration and Health Regional Forum was established for regionally mandated organizations working in the Southern African region, supporting, promoting, facilitating or providing services that address the health vulnerabilities of migrants, mobile workers and the communities with which they interact. The purpose of the forum is to serve as a platform to support a coordinated response to migration and health in the region at all operational levels (regional,

national and local) and to stimulate collaboration to address migration-related health challenges. IOM was mandated to act as the forum's secretariat.

Eastern Africa

Collaboration in the academic sphere was formalized through the signing of cooperation agreement with two large universities: the University of Nairobi in Kenya and Makerere University in Uganda. This is the first step towards systematically promoting migration health as a research topic by the academic community in East Africa. By promoting migration and health as a topic of research, IOM aims to contribute to better data on migration and health, as well as achieve increased information-sharing, coordination and collaboration within the research community and partners in the region. The partnership includes several components, namely: (1) implementing a strategic and proactive internship programme that targets key academic institutions; (2) implementing a fellowship programme for masters and PhD students that supports their thesis and addresses relevant and agreed migration and health topics; (3) integrating migration and health within different academic curricula, such as demography, public health and medicine, among others; (4) guest-lecturing at universities and other academic institutions; (5) developing joint research projects and publications; and (6) involving academic research steering committees or developing a specific research advisory group to support the research activities of IOM.

Caribbean

IOM provided technical support to the pilot project "Improving Access to HIV Services for Mobile and Migrant Populations in the Caribbean," developed by the Pan-Caribbean Partnership against HIV/AIDS and supported by the German Agency for International Cooperation and EPOS Health Management. The project, piloted in five countries (namely, Antigua, Guyana, Trinidad and Tobago, Suriname and Sint Maarten), gathered important information about legislation and regulation frameworks, financing mechanisms, empowerment of organizations supporting migrants and the promotion of best practices in the provision of HIV services for mobile and migrant populations. IOM, as part of the Regional Advisory Group, supported the project, opening new opportunities for regional partnerships and specific actions for addressing the health of migrants in the Caribbean.

Health Worker Migration Policy Council

IOM is a member of the Health Worker Migration Policy Council, which is hosted by Aspen Global Health and Development and has for its members the Global Health Workforce Alliance and the WHO Health Systems Division, among others. At the Health Worker Migration Policy Council Innovation Award Reception in May 2012, the Innovation Award, for progress made by countries on the implementation of the WHO Global Code of Practice on the International Recruitment of Health Personnel, was awarded to the Norwegian Ministry of Health (as a country of destination) and the Ghanaian Ministry of Health (as a source country).

Migration health assistance for crisis-affected populations

The Migration Health Assistance for Crisis-affected Populations Unit responds to the health and psychosocial needs and vulnerabilities of populations affected by armed conflict, natural disasters and other crises that result in population movements. Framed within the November 2012 IOM 101st Council Resolution on the Migration Crisis Operational Framework, health support and psychosocial support are two sectors of assistance among the 15 identified core areas of the crisis response of IOM. As a core partner of the Global Health Cluster and a member of the WHO-led Country Health Cluster network of partners and the Mental Health and Psychosocial Support (MHPSS) Working Group, the Unit integrates health and psychosocial support responses to the overall IOM emergency response. Being also the Global Camp Coordination and Camp Management Cluster (CCCM) Lead in natural disasters, IOM must ensure that life-saving health and well-being services are accessible to displaced people, including migrants, in the aftermath of a disaster.

IOM assists governments and affected communities in increasing their emergency preparedness for vulnerable settings, as well as mitigation and response during the emergency phase. The Organization also engages in recovery and transitional or post-crisis efforts in both conflict and natural disaster situations. Health assistance for crisis-affected populations includes managing the health and psychosocial issues resulting from population displacement. The assistance may take the form of primary health care services through mobile clinics and/or support to permanent health centres; facilitation of health referral mechanisms and hospital discharge with assisted transportation; establishment of transitional or temporary health posts while permanent health structures are under repair or rehabilitation; and arrangements for international medical evacuations for individuals who cannot be cared for locally because health facilities are either overstretched or have been destroyed. IOM ensures that mechanisms are in place to address public health concerns and contributes to disease outbreak surveillance and early-warning mechanisms. In addition, the Organization ensures the provision of pre-embarkation health checks and fitness-to-travel assessments for migrants and displaced people, the continuity of patient care and the promotion of health and well-being in situations of displacement and emergency evacuations or assisted movements. Coordination for integrating health and psychosocial support activities into the CCCM programming include, among others, the public health aspects of WASH (water, sanitation and hygiene), environmental health, psychological first aid and training for humanitarian workers and partners on psychosocial support services. The profiles of assisted populations vary depending on the crisis situation; the beneficiaries may be internally displaced people, as in the aftermath of the Haiti earthquake in 2010 and the floods in Pakistan in 2010 and 2011; migrants and third-country nationals, during the Libya crisis in 2011; refugees, for example, Somalis during the drought in Ethiopia and Kenya and Syrians fleeing to Jordan because of the ongoing crisis in their country; or returnees, such as the Chadians who repatriated after the Libya crisis in 2011 and the South Sudanese who, to date, continue to come back from the North after South Sudan declared independence in 2011.

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

MIGRANT-SENSITIVE HEALTH SYSTEMS

In crisis and natural disaster contexts, strengthening or establishing health systems with population-specific human, infrastructure and financial resources is a critical component of the IOM response. Here are some salient examples of such initiatives undertaken in 2012.

Joint Initiative on Maternal, Neonatal and Child Health (JI-MNCH). Implemented through IOM in the townships of Bogalay and Mawlamyinegyun in Ayeyarwady Division, Myanmar, the JI-MNCH

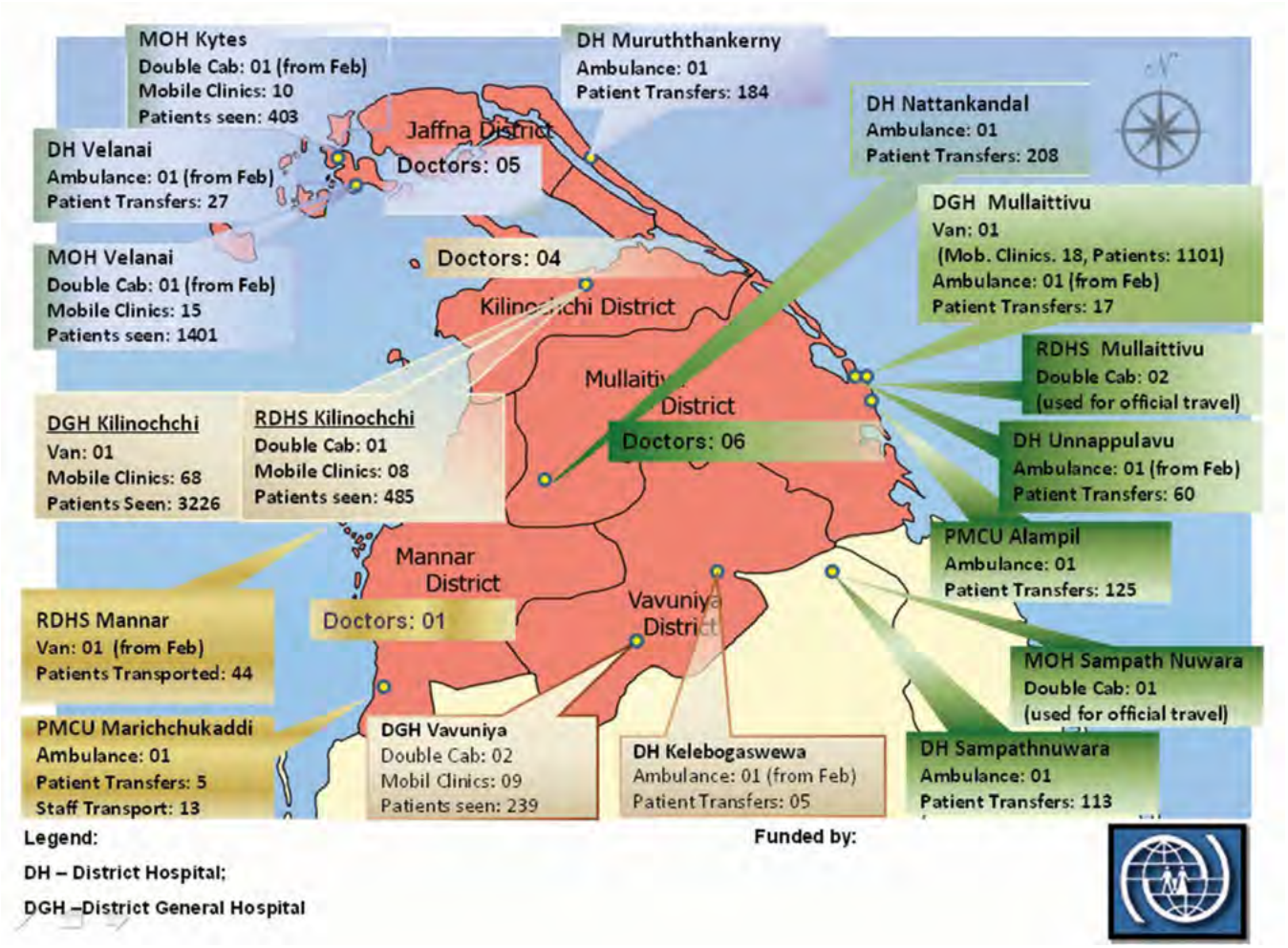
framework is a collaboration among the Ministry of Health (MoH), the donor community and international partners, including the United Kingdom, Australia, the European Union, Norway, Denmark, Sweden and the Netherlands. It was initially aimed at re-establishing the health system in the aftermath of Cyclone Nargis in May 2008. Presently, the initiative is an important and innovative model for health systems strengthening which development partners are implementing in other States and regions as well. In the two townships, IOM supported MoH counterparts and partner agencies in 2012 to successfully develop and implement coordinated health plans and to equip and capacitate the entire 180-strong MoH peripheral-level health cohort referred to as "basic health staff" (BHS). IOM achieved its goal in Mawlamyinegyun of assisting 20 communities to establish functioning village health committees (VHCs). Ninety-five per cent of nearly 600 communities have "functioning" VHCs per joint IOM and MoH criteria. VHCs collaborate with BHS in implementing outreach activities (including immunization campaigns) and enabling populations in these highly remote river delta communities to access available health services. JI-MNCH is supported through a multi-donor trust fund managed by the United Nations Office for Project Services.

Enhanced Emergency Health-care Services for Flood-affected Displaced Population of Sindh, Pakistan. Due to unprecedented monsoon torrential rains August 2011 onwards, many districts of lower Sindh in western Pakistan were affected by flooding and a significant loss of homes and lives. According to provincial authorities, sustained heavy rains affected an estimated 3.5 million people in southern Sindh and resulted in a notable number of deaths, injuries and displaced people. Many of these internally displaced persons had been living in poor conditions in roadside camps until, at the request of the Government, IOM Pakistan responded to this very challenging situation by intervening in the following areas in 2012:

- **Support for primary health-care services**. IOM health teams provided enhanced primary health-care services to more than 25,000 individuals, including women, men, boys, girls and the elderly, within the existing but overburdened outpatient departments (OPDs) of government health facilities in the towns of Tando Muhammad Khan and Tando Allah Yar. Some of the diagnostic aspects of the services included the provision of WHO malaria rapid diagnostic test kits for the 180 cases of suspected malaria and random blood sugar checks for 1,000 individuals suspected of being obese and/or having diabetes mellitus.
- **Support for health information management and coordination**. IOM assisted with health information management, in collaboration with WHO and the Director General for Health Services in Hyderabad, thereby supporting the dissemination of health cluster-related information to all humanitarian health cluster partners, government authorities and other stakeholders.
- **Support for health promotional activities**. IOM provided hygiene information to almost 5,000 individuals, as well as education on malaria and dengue protection. Individuals, including females and adolescents, were provided with health awareness-related brochures developed and provided by WHO. The distribution of IEC materials was carried out on a daily basis, with the participation of government health care workers. The materials raised awareness of proper dietary and nutritional habits; taught methods for improving hygiene and sanitation; and provided information on water treatment and the prevention of various communicable diseases and healthy lifestyles.
- **Mental health-oriented approach**. Mental health disorders were segregated at the OPDs of both the clinics in Tando Muhammad Khan and Tando Allah Yar and referred for further work-up to teaching hospitals in the vicinity. IOM doctors and paramedical staff were trained in the provision of psychological first aid services which benefitted more than 200 patients at the OPDs.

Enabling Health Protection in Northern Sri Lanka to Avert Irregular Flows. This project aims to strengthen the fragile, conflict-damaged health system in northern Sri Lanka by providing essential, life-saving medical services; deploying human resources for health mobilization; and rehabilitating basic facilities for health staff in the districts most affected by conflict, namely, Kilinochchi, Mullaitivu, Manar, Jafna and Vavuniya. The project helps address the lack of access to and adequate provision of basic primary health care services and referral care for resettling communities in formerly conflict-affected areas. Nine ambulances, eight double cabs and three vans, provided to the Northern Provincial Health authorities through the project, facilitate 24-hour emergency health services and specialized mobile and outreach clinics for the resettled and vulnerable populations in the Northern Province, with financial support from the Australian Government's Displaced Persons Program. In late 2012, more than 968 critically ill patients were transferred to tertiary care hospitals for life-saving treatments, and over 9,565 were provided primary and specialized health services through mobile and

outreach clinics facilitated by vans and double cabs. The project also supports field research on the social determinants of irregular migration to Australia and other countries, providing empirical evidence for resource allocation, programme planning and policy development.



Services provided by IOM in Sri Lanka from September 2012 to February 2013.

IOM Health and Assisted Voluntary Return and Reintegration (AVRR) units worked in partnership with the Ministry of Health's anti-malaria campaign and immigration officials at the Bandaranayke International Airport (BIA) to undertake malaria screening for all Sri Lankan irregular migrants returning from West Africa. Malaria screening was conducted on site using the rapid diagnostic test kit CareStart™ Malaria HRP2/ PLDH (AccessBio Inc., Monmouth, USA) , which has 98 per cent sensitivity to and 97.5 per cent specificity for *Plasmodium falciparum*, and through the microscopic examination of blood smears collected at the airport, performed at the National Malaria Reference Laboratory. Sri Lanka is heralded as a "success story" in malaria control in Asia, having succeeded in reducing malaria cases by 99.9 per cent since 1999 and aiming to eliminate the disease entirely by 2014.

IOM reported on a malaria importation flow that until recently, received little attention from health authorities. Imported cases contributed to 75 per cent (n=93) of the total malaria burden in Sri Lanka in 2012, overtaking indigenously acquired cases for the first time. Of the total number of 534 returnees screened at BIA from January to December 2012, 23 were positive for *P. falciparum*, and one for *Plasmodium vivax*. This number accounted for 31 per cent of the total number of 70 imported malaria cases in Sri Lanka in 2012.

Malaria incidence among returnees from endemic countries has proven to be a sensitive predictor of malaria risk, particularly where there is subnational transmission. The attack rate for malaria in this irregular migrant group is considerably high (43 cases per 1,000), compared to the risk of contracting malaria for travellers to West Africa (3 per 1,000). For the migrants themselves, their irregular status and the clandestine nature of their movement amplify health vulnerabilities, including the partial or total lack of access to health care in transit countries. Beyond human rights abuses and exploitative practices of people smugglers, irregular migration plays an important, but often forgotten, pathway for malaria reintroduction. IOM took a lead role in 2012 in working with Sri Lanka's Ministry of Health to ensure not only a safe and dignified process for screening, but that elimination goals are realized.

Health assistance to vulnerable flood-affected and displaced migrant populations in support of the Royal Thai Government's flood relief efforts. Funded by the Federal Republic of Germany, this project contributed to the Royal Thai Government's efforts to provide emergency health assistance to 25,000 flood-affected vulnerable persons. Through the funding, IOM procured 4,600 "dignity" kits (for women), 4,600 hygiene kits (for men), 1,000 vector kits, 7,200 medical kits, 1,000 infant kits, 50 water filters and 50 alcoholic soaps for distribution to flood-affected communities in five provinces, including greater Bangkok. The distributions were implemented in cooperation with Thai Red Cross, which managed the logistics, and Medicins Sans Frontieres, which provided information on some locations where migrant communities were sheltering. Beneficiaries included affected Thai, as well as migrant communities, with a special focus on vulnerable individuals, such as pregnant women, the elderly, children and the physically challenged.

Reducing the Vulnerabilities of Minority Groups from Myanmar through Community Outreach and Increasing Their Access to Social and Health Services (Phase III). Funded by Australia's Department of Immigration and Citizenship, the project began in September 2010 and is scheduled to end in November 2013. Phase I (September 2010 to January 2012) began in Tak Province with a rapid needs assessment to understand the main problems facing the target communities concerning access to health and social services. The phase was extended as a result of the 2011 flood crisis in Thailand. Phase II (December 2011 to November 2012) aimed to gather information about and increase the knowledge of minority group migrants regarding health and sanitation, as well as gender-based violence, in Tak Province. The establishment of three "drop-in corners" in migrant communities in Mae Sot provided a safe space for a number of minority group migrants to gain knowledge, prepare outreach and community activities, communicate about migrants' rights issues and receive trainings. The strategy was extremely successful, and in all, the project was able to carry out six focus group discussions on gender-based violence with minority group women; a training programme on domestic violence for minority group women, NGO and community-based organization (CBO) workers, teachers from migrant learning centres and Thai-Islamic schools; and a training programme on trafficking for minority group migrants and Thai students. During this phase as well, the project was expanded to include Ranong Province and largely concentrated on gathering assessments, conducting outreach and disseminating IEC materials and raising awareness by increasing the knowledge of minority group migrants. The main topics that were covered included: health and social services, garbage management, elimination of violence against women and children, capacity-building trainings and prevention of human trafficking. Significant accomplishments include the establishment of six health corners; the creation of three information centres and the execution of training programmes on counter-trafficking, capacity-building and prevention strategies for health risks; and the dissemination of products such as IEC materials, garbage management trainings and equipment, and direct-assistance provisions to minority groups in the population. To address some of the hardships for migrants occurring in the provinces of Tak and Ranong, Phase III (December 2012 to November 2013), now ongoing, aims to alleviate the acute vulnerabilities of displaced minority groups in Mae Sot District of Tak Province and Muang, Suksumran and Kapure Districts in the province of Ranong.

Refurbished health stations for return communities in Philippines. IOM started operations in Mindanao in 2008 and continues to respond to complex emergencies in the region. Through a project under the Humanitarian Action Plan of 2011 and funded by the United Nations Central Emergency Response Fund, IOM and its partners in the health cluster in the Autonomous Region in Muslim Mindanao repaired and

refurbished the stations in the villages of Nunangen, Tugal and Linamonan in Maguindanao province. The initiative has benefited thousands of families who had been displaced several times since 2008 by armed conflict, clan feuds locally known as "rido" and natural disasters. The health stations were equipped with medical kits, weighing scales, blood pressure meters, medicine cabinets, sterilizers and medical examination tables, among other items which were lost or damaged during the displacement and which were identified by medical personnel as necessities. Medical personnel for the health stations are being provided by the Philippine Department of Health, which led the project alongside the World Health Organization. Community leaders and representatives, as well as government officials and health cluster partners, attended the turnover ceremonies on 28 and 29 March 2012.

Provision of emergency primary health care and mobile laboratory services to the most vulnerable flood-affected communities in Bulacan and Pampanga. In response to the disaster brought by typhoons Nesat and Nalgae, which hit the Philippines in 2011, IOM rolled out two mobile clinics in the provinces of Bulacan and Pampanga in 2012. Each mobile clinic was manned by a team of four doctors and four nurses, who visited target communities to provide medical consultations. Mobile laboratory services provided by the medical team included X-ray, complete blood count (CBC), electrocardiogram (ECG), urinalysis and thyroid profile. Medicines were dispensed by the mobile pharmacy. A total of 17,768 patients received health-care services from the mobile clinics from November 2011 to May 2012. To help patients that required immediate and more serious medical care, IOM implemented a referral system to ensure appropriate medical attention. Referral cases were brought to the nearest health facilities, such as barangay health-care units and functioning hospitals. These were often patients who had hypertension or diabetes, pregnant women and those who required diagnostic, medical management, hospitalization or surgical intervention. A total of 4,713 patients were referred by IOM through the consultations and check-ups conducted in the affected communities from November 2011 to May 2012. In addition, IOM medical staff conducted follow-ups and monitoring of referrals to ensure that proper medical care and continuity of care were provided. Following this, IOM provided supplemental medicines and copies of the patients' files to the beneficiaries, with the assistance of the Barangay Health Units and Municipal Health Office.

In addition to deploying mobile clinics, IOM also conducted health education sessions and distributed health education materials in the communities. The topics covered by the sessions were based on the leading causes of morbidity in the communities, as revealed in the collation and analysis of patient consultation sheets. (The five leading causes of morbidity for the whole project were upper respiratory tract infection, hypertension, diabetes mellitus, urinary tract infection and arthritis.) Common disaster-associated diseases were also integrated in the session modules.

Mobile clinic in Bulacan, Philippines.

Mobile pharmacy in Bulacan, Philippines.

Migration Health in Emergencies: The Case of Dollo Ado Migration Health Activities in Ethiopia. The worst drought in decades struck the Horn of Africa in 2011, affecting millions of people in the region. Consequently, many refugees from Somalia fled to neighbouring Ethiopia and Kenya. Close to 150,000 Somali refugees, in particular, have been accommodated in five refugee camps in Dollo Ado in southern Ethiopia. IOM, together with other humanitarian partners, immediately responded to the crisis. The Organization's involvement was two-fold: (1) the provision of safe and dignified emergency transportation assistance to thousands of refugees from reception areas to transit centres, as well as from transit centres to camps; and (2) capacity-building of the Administration for Refugee and Returnee Affairs (ARRA) in the provision of primary health care in Melkadida and Bokolmanyo camps. The transportation assistance includes pre-departure medical assessments, movement assistance to vulnerable cases, escorts and referrals to migrants who need additional medical attention. IOM also builds the capacity of ARRA by deploying medical doctors and nurses, as well as by providing some emergency drugs to the camps' health centres.

In 2012, IOM continued its health operations to reduce preventable morbidity and mortality among Somali refugees in Bogolmayo and Melkadida camps. Pre-departure medical screenings and fitness-to-travel activities have been ongoing since July 2011, and, to date, IOM has provided 52,390 pre-departure screenings and 221 medical escorts, and has referred 652 refugees for further health care in the camps. Primary health care activities started in July 2011 and ended in mid-March 2012.

Capacity-building training for implementing partners and consultative meeting in Kampala, Uganda. IOM conducted a four-day training programme in Kampala, Uganda from 4–7 June 2012 for a total of 14 participants from 10 implementing partners in Somalia. The training focused on two areas: (1) WASH and (2) psychosocial support. The training was conducted to enhance the technical capacity of the implementing partners, as well as local authorities, and to implement more efficient and effective projects within the Migration Health Division. The training also aimed to create synergistic effects from implementing partners working on different subjects but on the same implementing sites. For instance, an implementing partner working on the WASH project should know the importance of the psychosocial support project, so they could sensitize their community hygiene promoters to raise awareness on sexual and gender-based violence (SGBV) and detect potential survivors of SGBV because key beneficiaries for WASH and psychosocial support are often the same vulnerable women. During the training, IOM also conducted a consultative meeting with implementing partners to finalize the detailed workplan and budget. The training programme, alongside the consultative meetings, enabled IOM to set a concrete implementation strategy and approach for the two projects, as well as finalize detailed workplans and budgets for implementing partners. It also deepened IOM's understanding of implementing partners, as well as their understanding of the projects, and strengthened the partnership between IOM and its implementing partners.

Psychosocial support within the reintegration programme in Chad. Following the Libya Crisis in 2011, IOM initiated the first phase of the psychosocial support programme for Chadian returnees at reception and transit centres. The second phase, funded by the Government of Germany and which ended in November 2012, focused on supporting returnee communities through assessments, counselling, referrals and recreational and socialization activities. The psychosocial activities in Chad have served a total of more than 4,600 returnees and vulnerable individuals and trained 700 health, social and educational professionals. Being a pilot, the project is the first time that IOM addresses psychosocial protection in the context of emergency repatriation upon return to the country of origin. The global lead for the MHPSS Working Group of MHD was in Chad to discuss with project staff the lessons they learned from this experience. At the same time, the global lead and the project staff brainstormed training ideas and provided materials for activities that may be beneficial for future initiatives in other countries and conceptualized a third phase of intervention that would focus on institutional capacity-building for health staff and social workers using innovative approaches such as mixing bio-psychological, socioeconomic and sociocultural elements. This third phase is due to start in 2013.

Psychosocial support in Ghana. IOM, in collaboration with the UN High Commissioner for Refugees (UNHCR), conducted a psychosocial assessment mission in 2012 to assess the psychosocial needs of Ivorian refugees in the Ampain and Egyeikrom refugee camps. Based on the findings, IOM identified two important psychosocial interventions: capacity-building of community-based health workers through training and the establishment of a communal

recreation centre in the Egyeikrom refugee camp. In April 2012, IOM conducted psychological first aid training which aimed to provide the 35 participants with a framework for psychosocial support through a humane and practical approach. In addition, IOM constructed and equipped a communal recreation centre in the Egyeikrom refugee camp, with support from the Australian Agency for International Development. The recreation centre was handed over to UNHCR and the refugee community in July 2012. This centre and the psychological support being provided accrue as cost-effective community services to reduce the psychosocial vulnerabilities of over 1,400 Ivorian refugees and asylum-seekers and enhance their coping abilities.

2012 State of returnee health: South Sudan

Continuing insecurity after two civil wars and escalating violence in 2012 left thousands of South Sudanese men, women and children displaced from their communities and stranded while trying to return home. In collaboration with the Government of South Sudan, the International Organization for Migration (IOM) worked to assist returnees and displaced persons with emergency health services and subsequently longer-term health reintegration support.

Figures from the Tracking and Monitoring Unit of IOM reveal that in the last five years, more than 1.8 million people have returned to South Sudan. While it was first anticipated that roads would remain open between Sudan and South Sudan, to allow for free and spontaneous return of South Sudanese, rising political tensions in May 2012 resulted in the closure of the border between the two countries. Renk, a small town along the border, became the only point of entry for thousands of returnees.

South Sudan has a maternal mortality ratio of 2,054/100,000 live births and an infant mortality rate of 102/1,000 live births. These rates can be partially attributed to the low percentage (46%) of pregnant women who make at least one antenatal care visit and the low national immunization coverage of children less than one year of age (13.8%). The major causes of morbidity and mortality are preventable illnesses such as malaria, pneumonia and diarrhoeal diseases. While prevention and treatment options for these illnesses are readily available, particular barriers exist in South Sudan that hinder the provision of basic primary health care. For instance, limited accessibility to areas such as Renk (due to the difficult terrain and the perennial rainy season) presents considerable supply chain management and logistics challenges. Thus, pre-positioning and adequate storage of sufficient quantities of medicines, particularly anti-malarial drugs, are essential. In 2012, IOM clinics provided close to 20,000 treatments for malaria among all ages in Renk.

IOM health activities in South Sudan clearly demonstrate migration as a social determinant of health, as the conditions of the migration process impact the health of migrants and their host communities. For the individuals in Sudan wishing to return home, their sheer number overwhelmed the available onward transportation options, so many of them spent long months stranded, with limited access to health or social services, thus increasing their vulnerability to ill health. For host communities, the massive influx of returnees placed significant additional stress on already limited health structures and scarce resources. Without humanitarian intervention, the high vulnerability of the returnees, combined with the weakened health system, could have led to further deterioration of the health of both populations.

IOM Nurse, Catherine Emelio Nyika, checks the health status of a South Sudanese infant whose mother was among the returnees arriving by barge at Juba Port in August 2012.

It is for this reason that IOM believes that providing life-saving health services in regions highly populated with vulnerable individuals is vital. Through support from the Common Humanitarian Fund, IOM operated three clinics in Renk in 2012, providing services to more than 94,380 beneficiaries. The semi-static clinics offered critically-needed basic primary care services, including curative consultations, antenatal care, vaccinations and health promotion activities. The number of consultations given varied from seasons to season, but the overall weekly average was more than 1,050 patients, including at least 355 children under five years old. In comparison, many government-run primary health care units registered less than 100 patients per week. In total, more than 54,628 consultations were conducted in Renk by IOM in 2012.

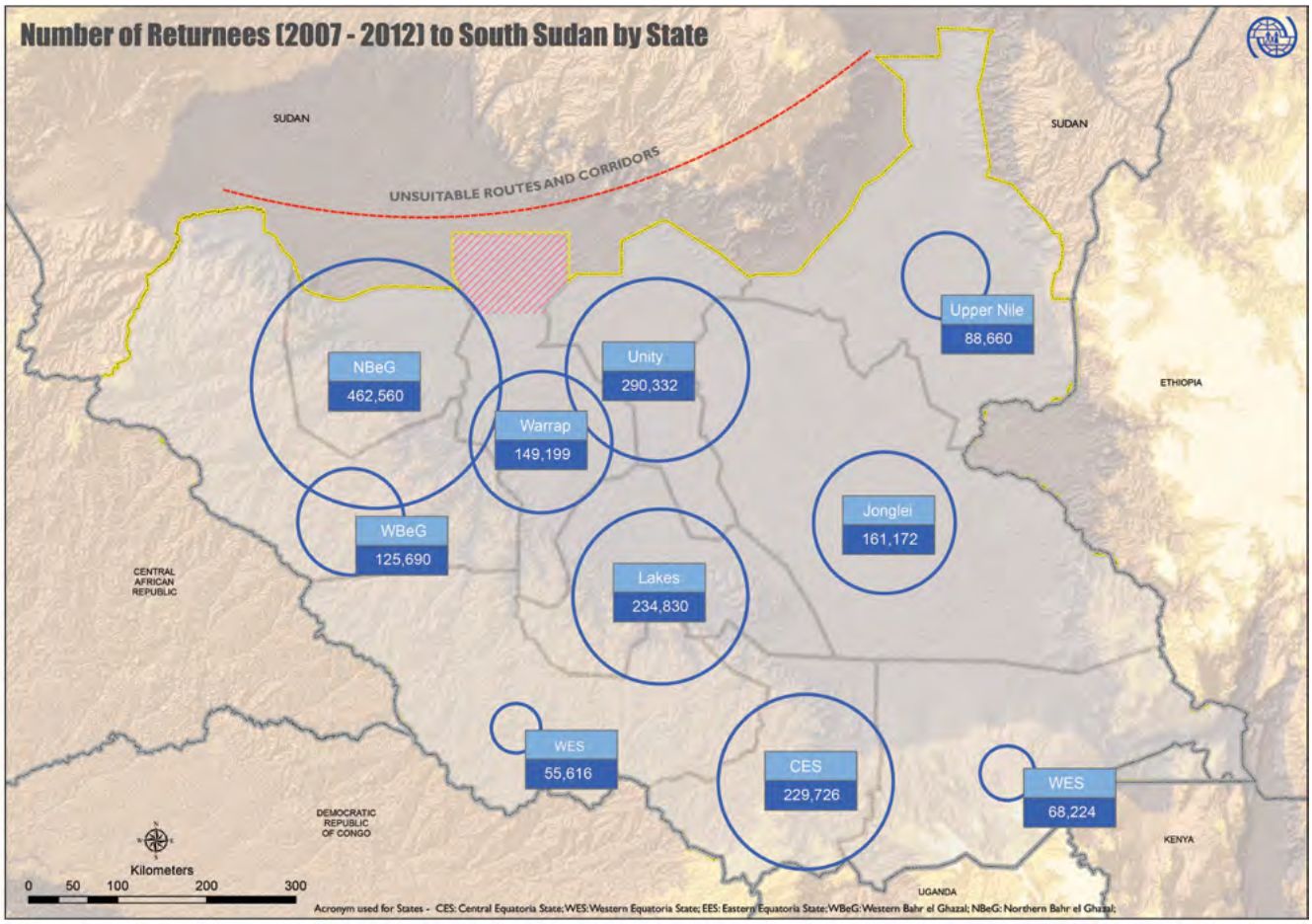
Patients queue outside of the IOM semi-static clinic in Payuer Returnee Site while waiting to receive health services.

South Sudan medical screening and escort

In 2012, IOM South Sudan transported 40,615 returnees by air, road and river to counties across all of the country's ten states. All returnees travelling on an IOM-organized convoy benefited from medical screening, either prior to or upon arrival. Pre-departure screening is a critical component of the assisted movement process and aims to ensure that the beneficiary is "fit to travel," that is, he or she does not pose any health risk to the other passengers or persons encountered during transit or after arrival at the final destination. Screening involves taking a brief medical history of each passenger, as well as administering basic curative treatments as needed. Preventative services, such as vaccinations for all children under five (per the WHO Expanded Programme on Immunizations) and outbreak prevention through the identification of communicable diseases. IOM also facilitates medical escorts during the movements, further ensuring that beneficiaries reach their final destination safely and in good health. All screenings and escorts are conducted by trained IOM medical staff.

Pre-embarkation screenings, however, are less rigorous than traditional medical examinations and are not meant to identify silent diseases or underlying conditions. This highlights the importance of providing proper reintegration services in places of final destination. IOM works with health actors on the ground to refer and link returnees to community-level primary and secondary care to ensure that they have access to health services.


IOM staff assist an extremely vulnerable man off the plane during an emergency airlift operation of returnees from Khartoum, Sudan to Juba, South Sudan.



Health-care services for Syrian refugees. In response to the ongoing Syrian crisis, IOM has been providing health-care services to Syrian refugees in Jordan at the request of the Ministry of Health and in close collaboration with UNHCR, WHO and other health partners. From March to September 2012, IOM provided primary health-care services in King Abdullah Park, one of the busiest transit centres for Syrian refugees close to the Syrian-Jordan border. IOM partnered with AmeriCares, an IOM health partner, to provide essential medicines and medical supplies.

From March 2012 to date, IOM health teams conducted active TB screening and prevention and awareness-raising activities for Syrian refugees, mainly in the Za'atri refugee camp, but also in locations where there are high numbers of refugees living in host communities. By the end of December 2012, 20 TB cases (16 of which were pulmonary and 4 were extra-pulmonary), including 4 which were multidrug-resistant, were confirmed based on chest X-ray findings, sign and symptom checks and medical history, out of 202 suspected cases from a screened pool of 60,222 refugees. Six of the cases successfully completed the treatment, with the rest now under treatment. In addition, IOM health staff have provided targeted TB awareness-raising sessions to close to 45,437 Syrians seeking refuge in Jordan.

As the security situation in the Syrian Arab Republic continues to deteriorate, escalating numbers of Syrians continue to cross into Jordan. In 2012, IOM provided transportation assistance to displaced Syrians from the border to Za'atri, as well as initial health screening for 76,386, conducted by doctors and nurses upon arrival of the refugees at the camp. A triage system is utilized to identify vulnerable individuals in need of medical attention and determine the urgency of medical interventions needed. Thus far, the most significant medical conditions detected upon arrival have been referred to health-care providers operating inside the camp, while individuals suffering from urgent, life-threatening health conditions are referred directly to nearby hospitals or other partners that provide primary health care.

Italian medical aid for stranded migrants in Haradh, Yemen. In May 2012 IOM in the town of Haradh on the Yemen-Saudi Arabia border received essential medicines and medical supplies donated by the Italian Government aid agency Cooperazione Italiana. The consignment was part of a 35-ton Italian donation of medicines, high-energy biscuits and blankets intended for conflict-displaced people and stranded migrants in Yemen. The donation also included three supplementary health kits – each designed to treat a population of 10,000 people for three months. IOM worked closely with Yemen's Ministry of Health and Executive Unit for Internally Displaced Persons to distribute part of the aid in Haradh, Abyan and Al-Jawf governorates. The Haradh delivery came at a critical time, when some 3,000 migrants, mainly from the Horn of Africa and stranded en route to Saudi Arabia, struggled with an outbreak of dengue hemorrhagic fever in Haradh from February to July 2012, spread by mosquitoes in the town and its surroundings. The IOM clinic in Haradh, along with partner hospitals, treated close to 80, five of whom subsequently died from dengue shock syndrome. IOM worked closely with the Ministry of Public Health and WHO and partners in Haradh to contain the outbreak.

Provision of emergency health-care services and follow-up care to Egyptians and migrants affected by violent unrest in Egypt. Traditionally, the primary route for both regular and irregular migration from sub-Saharan African countries to Europe was through the Maghreb region. Rather recently, however, several major sub-routes have emerged. Today, structural factors and, in some cases, conflict, compel people to leave their countries of origin (including Sudan, South Sudan, Ethiopia, Eritrea and Somalia) and migrate to Egypt and, in many cases, travel onwards, that is, to Europe or neighbouring countries. In general, migrants in transit are more vulnerable, and recent attention has focused on migrants who are victims of forced labour, sexual exploitation and torture. In addition, some migrants are injured while trying to cross the border and/or apprehended by border authorities.

IOM, in close support and coordination with the Egyptian Ministry of Health, is conducting programmes focused on the following objectives: strengthening the referral mechanism for migrants stranded at the country's borders, by supporting the MoH to establish a Migration Health Committee, which was activated in July 2012; building the capacity of MoH staff employed at facilities along the borders, which involved training 640 medical staff and renovating four training facilities at three border Egyptian governorates and providing emergency medical support for urgent secondary and tertiary medical cases and other forms of humanitarian assistance, including non-food items, to stranded migrants who are most in need (more than 8,400 were assisted).

IOM is providing health protection through a combination of direct medical and humanitarian assistance to stranded migrants, as well as through capacity-building efforts for the Egyptian Government and NGOs to provide migrant-friendly health-care services. Notwithstanding the extremely challenging security and operational issues ongoing at the borders, the activities of this project have been accomplished through successful liaison with and lobbying of the relevant partners at the borders, and the ability to deploy immediate emergency medical assistance.

In 2012, IOM established and maintained contact with over 30 government hospitals, NGOs and community-based health-care providers in Cairo, Alexandria, Suez, Mansura, Port Said, Menia and Ismailia to assess and respond to health providers' capacity-building and equipment needs, and to identify patients eligible for medical support. In line with the needs and priorities identified, IOM donated medical equipment and supplies, pharmaceuticals, and food and non-food items to six government and NGO health-care providers in Cairo and Ismailia. The project also trained 173 nurses, medical staff, medicine and pharmacy students and volunteers on basic life support and mass casualty management. Finally, a total of 375 beneficiaries received medical assistance. Among them, 106 were provided with direct support to access secondary and tertiary hospital care, thereby largely exceeding the initial target of IOM. An additional 12 Egyptians and 26 migrants received livelihood and socioeconomic assistance, which indirectly benefited 112 of their family members.

Mental health and psychosocial support in Libya. In 2012, IOM introduced the programme entitled Psychosocial Course in Libyan University to Aid War Victims. Thirty-five Libyan health, education and social experts completed a six-month IOM-administered psychosocial support course offered at the University of Tripoli. Participants of the Italian-funded diploma course, Psychological Intervention in War-Torn Societies, were taught how to devise emergency psychological programmes to tackle the long-term emotional and social effects of the Libyan crisis. The course, designed specifically for the Libyan context, is part of a wider IOM psychosocial response to the Libyan crisis, which started with the provision of psychosocial

assistance at transit centres for thousands of migrants fleeing Libya. It builds on a similar course organized by the IOM in 2007 in Lebanese universities in the aftermath of the war there. As in all major crises, the events in Libya have had a considerable psychosocial impact on the people. Those who witnessed atrocities have suffered emotional problems, including stress, depression and feelings of insecurity. Without psychosocial assistance, affected individuals may develop long-term complications, negatively impacting Libyan society. The Italian Government's donation of EUR 1.5 million has also enabled IOM, which is working in coordination with the Libyan Ministry of Social Affairs and other government bodies, to provide psychosocial counselling to families in Tripoli, Misurata and Bengazi, and to build three recreation centres in those cities. IOM is also implementing a number of other psychosocial programmes targeting people affected by the war, including the internally displaced.

In the context of the Libya Psychosocial Support Programme funded by the Italian Government, the Moltakana (or "our space") Centre for Recreational and Social Activities for children, youth and their families was inaugurated in the Abu Slim district of Tripoli in October 2012. The centre offers a combination of recreational, community mobilization and counselling activities in the poorest area of the Libyan capital, which also hosts the highest concentration of IDPs. The programme maintains two similar centres in Misrata and Benghazi, and offers a university diploma in psychosocial support at the University of Tripoli. The opening ceremony was attended by the Ambassador of Italy and Libya's Deputy Minister of Social Affairs. IOM provided training to the 30 psychosocial team members from IOM.

Mental health and psychosocial support in the Syrian Arab Republic. Amidst a rapidly fragile situation, as well as increasingly difficult working and living conditions, the psychosocial and mental well-being of affected Syrians is of growing concern. In response IOM initiated the following key activities: (1) provision of support for 52 IOM staff members through individual or group sessions on the subject of "emotional responses to complex crises," which focused on common emotional consequences of complex crises and on ways to limit the impact on individual, family and group well-being (meetings were conducted with Damascus-based psychotherapists to set up or strengthen existing referral mechanisms for the staff, given that currently available options are limited); (2) training and workshops were conducted in Damascus for: (i) five NGOs, including SOS Syria, the Syria Trust for Development, to introduce the emergency activities of IOM in the Syrian Arab Republic, as well as its psychosocial activities and model of work globally (NGOs identified their needs as emergency crisis management, collective centre management, registration, needs assessment and mapping, non-specialized psychosocial services, psychosocial and displacement paradigms, workshops for children and adults, capacity-building for specialized mental health care workers; (ii) training in the "use of creativity in emergency psychosocial responses" for 12 IOM and UNHCR staff, including selected members of their psychosocial, child protection and direct assistance teams; and (iii) induction in "psychosocial support and animation in collective centres, including elements of management" for 30 staff of nine agencies, including IOM, the Syria Trust for Development, SOS Syria, the Syrian Arab Red Crescent, the International Medical Corps and UNHCR, among others (this session presented general principles of psychosocial support in emergencies, the 2010 Collective Center Guidelines and the 2012 draft Inter-Agency Standing Committee [IASC] guidelines on MHPSS for camp managers).

Cholera prevention, response and mitigation in Haiti. Working within the transition and post-emergency context, IOM Haiti, with support from UN Central Emergency Response Fund, implemented a project entitled "Enhanced Provision of Life-saving Prevention, Rapid-response and Treatment for Cholera for the Most Vulnerable IDPs Remaining in Camps in Port-au-Prince Metropolitan Areas" from April to November 2012. While most humanitarian health agencies were down-phasing their presence in camps, there were increasing health needs amidst deteriorating camp conditions. The project aims to provide life-saving cholera prevention, treatment and response support to extremely vulnerable IDPs remaining in camps.

International Handwashing Day event in a camp in Port-au-Prince, Haiti.

An IOM Nurse demonstrating handwashing to children in the camp during the Global Handwashing Day event in Port-au-Prince, Haiti.

Additionally, IOM Haiti, with support from the UN Emergency Relief Response Fund, implemented the project "Life-saving Community-level Response to Cholera in the Upper Artibonite." The first phase ran from November 2011 to April 2012 and carried out activities in five communes (namely, Gonaïves, Anse-Rouge, Terre Neuve, Gros-Morne, Ennery and Marmelade). The second phase, which runs from June to November 2012, will cover three communes (L'Estère, Marchand and St Michel) and will include operations of the oral rehydration posts, case surveillance, training of brigadiers and community sensitization activities. A total of 608,141 people benefitted from oral rehydration posts and all kinds of sensitization activities (249,992 for the first phase and 358, 149 for the second phase).

Preventive public health information and education in Haiti. This project aims to contribute to collective efforts to improve access to preventative public health information and education and link health service providers with project beneficiaries in IDP camps and return/resettlement communities. By the end of 2012, the project has reached a total of 136,260 IDPs through community health education sessions and campaigns in 48 priority camps and trained 109 community health workers who provided health education sessions, conducted home visits, registered families and referred of cases. A total of 1,505 beneficiaries were referred to specialized facilities/hospitals and 1,435 pregnant women were registered and given antennal care. Community health education sessions and mass campaigns in 48 priority camps reached 136,260 IDPs. Health education featured topics in maternal and child health, gastroenteritis, cholera, malaria and dengue, TB and HIV and AIDS, sexually transmitted infections, nutrition and personal hygiene. Target groups consisted of children, adults, the elderly and women. A total of 386 suspected TB cases were referred, of which 172 (45%) were diagnosed and provided treatment. These cases were identified by community health agents (CHAs), and an initial assessment of the suspected cases was conducted by IOM nurses. These suspected cases were referred to the IOM mobile TB team to undergo screening, together with family members living in the same tent at the GHESKIO "tent city" (GHESKIO is the national centre for TB and HIV screening and treatment). Confirmed cases of TB were monitored by the CHAs to ensure that the treatment was followed as prescribed by the doctors. Health education on key messages for TB was provided to the patients and their families. A total of 331 suspected cases of cholera were detected and provided with first-line treatment from July 2011 to March 2012. The case management also included the evaluation of dehydration level, administration of oral rehydration solution if the patient was conscious and referral to the nearest health facilities. The decontamination of IDP tents and camp surroundings, as well as health education on key messages to prevent cholera and other infectious forms of gastroenteritis, was provided to the case patients and their families. In addition, 232 IDPs benefited from psychosocial support services, such as individual counselling, family visits and referral to Psychiatric hospital. As the CHAs were trained in identifying signs and symptoms of psychological distress, they were able to identify individuals and families with psychosocial needs. With the assistance of an IOM psychologist or social worker, those individuals and their families benefited from support groups, relaxation activities and, for psychiatric cases, from the Mars and Kline Psychiatric Center. Also, 109 community health workers were trained in the baselines of the training curriculum for community polyvalent agents, which have been validated by the Ministry of Health. The curriculum included the following topics: maternal and childhood health, vector-borne diseases, TB, sexually transmitted infections, including HIV, gastroenteritis and cholera, psychological distress signs and symptoms and case management, and ethics and confidentiality.

Addressing health and psychosocial barriers to the return and reintegration of IDPs in Haiti. After the devastating 2010 earthquake in Haiti, IDPs encountered multiple barriers to accessing health care, including a poorly functioning health system, physical immobility due to injury, physical barriers due to displacement, destroyed health clinics, lack of knowledge on where care is available and inability to pay for

transportation or fees for health services. Those who remain in IDP camps are often the most vulnerable, and the catastrophic health costs and incidents can be significant barriers to successful return and reintegration and can compound vulnerability upon return. As efforts by the Government of Haiti and the international community scale up to support return and reintegration initiatives, there was a critical need to address health and psychosocial barriers to return, in order to assist the most vulnerable and prevent the return process from having negative consequences.

The project was designed to complement IASC inter-cluster initiatives contributing to comprehensive return and reintegration assistance, which prioritized support for the most vulnerable sectors, which included the following: pregnant, post-partum and lactating women; children under the age of five; people living with disabilities; elderly persons; individuals who had suffered from SGBV; people with chronic illnesses, including TB and HIV and AIDS; and acutely ill patients, with a focus on IDP camps used in return and resettlement initiatives. The health team worked closely with the CCCM Cluster in the return and relocation initiative and has provided direct care or referral assistance to health facilities based on the needs identified through individual assessments. Services provided by the psychosocial team included counselling, recreational activities, family support and education in effective coping mechanisms, along with a needs assessment of the protective and risk factors impacting on individuals and families facing difficulties with returning to their home or shelter. Of the 11,194 persons relocated in the areas within the coverage of IOM activities, to date more than 3,264 vulnerable individuals were assessed for the medical needs by the health team before, during and after the return; 2,244 cases were referred to health facilities and other units (protection, psychosocial, among others); and 5,678 were provided with psychosocial assistance in IDP camps.

Health response in Somalia. With support from the Japan International Cooperation Agency (JICA) and the Japanese Government, IOM received funding to conduct WASH activities, namely, the provision of safe and clean water using an innovative Japanese water treatment technology called "Poly-Glu" to vulnerable IDPs and their host communities, as well as hygiene promotion activities, with the aim of reducing waterborne diseases, such as acute watery diarrhoea and cholera, which are prevalent. In 2012, through its WASH projects, IOM Somalia provided 50,000 IDPs and vulnerable host communities with 7.5 litres of clean and safe water per day per person (per the recommendation of the WASH Cluster in Somalia) in three districts in Mogadishu (namely, Hodan, Howlwadaag and Xamar Jajaab); Afgooye, in the Lower Shabelle region; and Dollow within the Gedo region (located along the border of Somalia and Ethiopia) in coordination with the IOM Dollo Adow sub-office. In addition, distributed 12,000 jerry cans, 19,275 bar soaps and 169,902 aqua tablets. Around 53,000 beneficiaries were targeted with social mobilization and awareness campaigns on hygiene promotion and on the cleaning of jerry cans to improve their knowledge to prevent cases of acute watery diarrhea within their communities. These activities were also conducted on the World Water Day and Global Handwashing Day in Somalia, with the participation of the local communities and target beneficiaries, as well as civil society organizations and other key stakeholders.

With support from the Government of Japan, IOM Somalia, together with implementing partners, established water treatment units where communities living within the IDP settlements can access clean water. The project is aimed at improving the environment and also promoting good health and water hygiene in Mogadishu. (Photo: Feisal Omar)

In addition to WASH, IOM also implemented activities that targeted sexual and gender-based violence in all three regions (specifically, in Burao, Somaliland; Garowe, Puntland; and Mogadishu, South Central Somalia) with the support of implementing partners. The activities included awareness-raising on domestic violence, rape, female genital mutilation, forced marriage and the provision of psychosocial support to victims. IOM and its partners strengthened the referral system to enable survivors to access and use required medical, transportation and other services, such as legal assistance, shelter and non-food items, among others. In Mogadishu, IOM provided dignity kits to 200 female–headed households and households that have women with disabilities.

IOM Somalia collaborated with Panasonic Corporation on the provision of 1,550 solar lanterns to reduce the vulnerability of women IDPs against sexual and gender-based violence when fetching water at night. The solar lanterns were distributed in Somaliland, Puntland and South Central Somalia and were provided to IDP women, including gender-based violence survivors, women at risk of gender-based violence and people living with HIV.

Through solar lantern distribution, community social mobilization and awareness-raising on gender-based violence, IOM is contributing to the protection of vulnerable women and girls from sexual and gender-based violence within IDP settlements as well as the host-community throughout Somalia, which has been a significant feature in the prolonged civil conflict. (Photo: Deeq Afrika)

POLICY AND LEGAL FRAMEWORKS

In the context of emergencies, policy and legal frameworks for migration health are required to address gaps in health care and social protection, as well as ensure compliance with international standards for the respect of health-related human rights.

Consultation on evaluating policies and strategies of tuberculosis in complex emergencies (12–14 March 2012, Sharm el-Sheikh, Egypt). The WHO Eastern Mediterranean Regional Office convened this consultation with the aim to review and discuss the most relevant experiences regarding TB control in complex emergencies, identify the methodology and indicators needed to evaluate TB activities in these settings and assess partners' coordination and implementation of TB control interventions, among others. National TB programme managers and WHO experts from its headquarters in Geneva and 11 countries, NGO partners, academia, as well as the UNHCR, the International Federation of Red Cross and Red Crescent Societies and IOM, actively engaged in identifying potential challenges and sharing lessons learned and experiences gained, as well as developed a workplan for the region. IOM highlighted its experiences in addressing the challenges of TB detection, case management and continuity of care during pre-departure health assistance and fitness-to-travel checks for the thousands of migrants waiting for evacuation and assisted transportation at the onset of the Libya Crisis in the border camps in Choucha,

Mental health and psychosocial support and Sant'Anna school of advanced studies partnership

In June 2012, IOM implemented the Summer School in Psychosocial Interventions in Emergency and Displacement, in coordination with the Sant'Anna School of Advanced Studies of the University of Pisa and the Center for Trauma, Asylum and Refugees of the University of Essex, and in collaboration with experts from King's College London, the Transcultural Psychosocial Organisation, the War Trauma Foundation, Sport2Build, the Lebanese Center for Policy Studies, Xenios USA, and the Chair of the IASC Reference Group on MHPSS. Thirteen IOM staff members from Iraq, Yemen, Kenya, Libya, Colombia, Georgia, Egypt, Italy, Belgium, South Africa and the Headquarters successfully completed the course, together with one official from the Government of Libya and colleagues from UNICEF and other governmental and non-governmental organizations from more than 20 countries.

Participants of the Pisa Summer School 2012.

Tunisia and in Salloum, Egypt in 2011. Since the end of March 2012, IOM Amman – at the request of the Jordanian Ministry of Health's National TB Program, which supported by UNHCR and WHO – continues to implement an active TB case detection, referral and awareness-raising and prevention project for Syrian refugees in Za'atari camp in Jordan.

PARTNERSHIPS, NETWORKS AND MULTI-COUNTRY FRAMEWORKS

The management of health in the context of emergencies requires close collaboration among various sectors and institutions, to ensure better access of displaced migrants to health services and maintain political will through regional and global platforms on this issue.

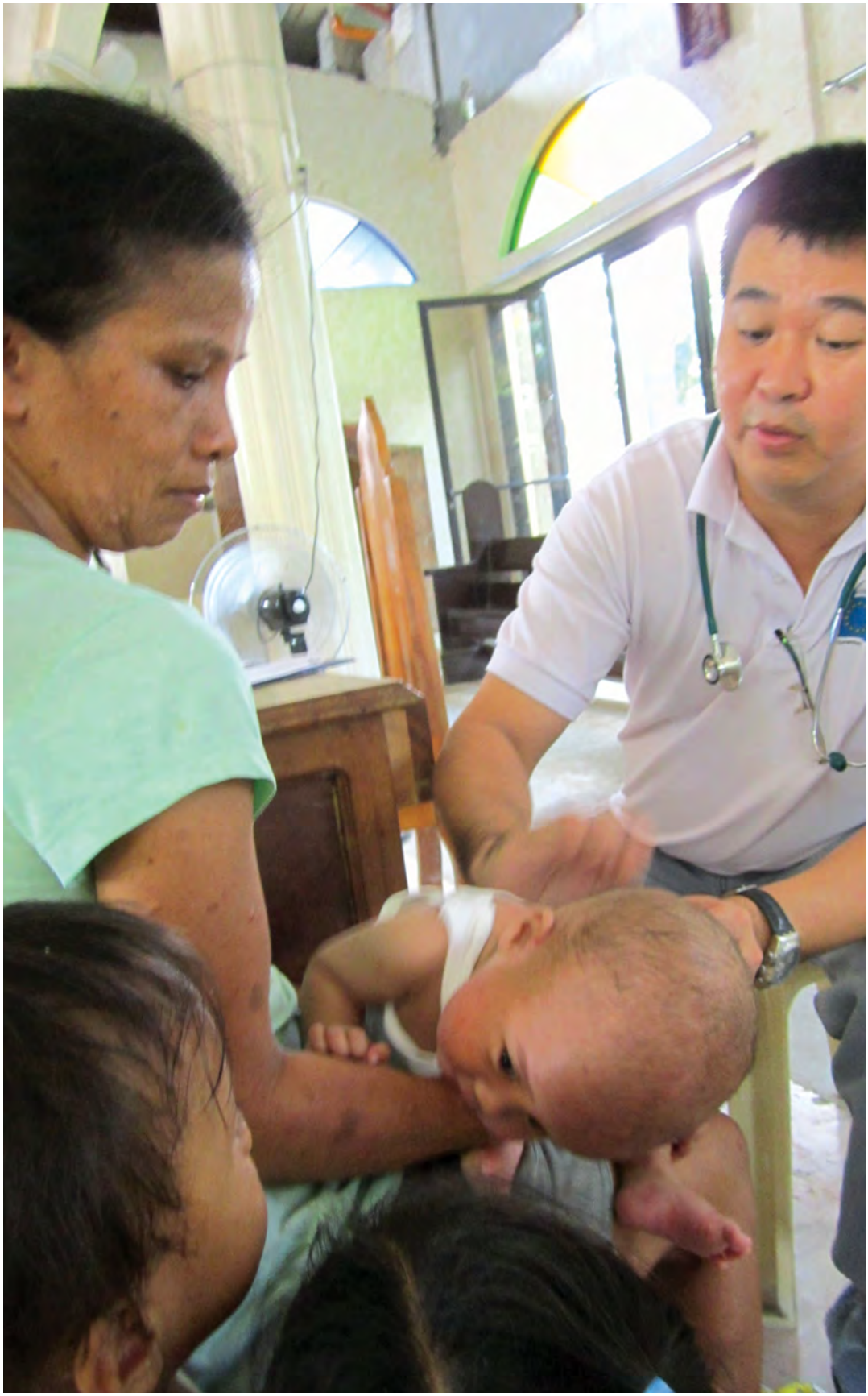
IOM strengthened its private sector partnership with its emergency health response activities in 2012. AmeriCares, an IOM health partner since the Asian tsunami response in 2005, has increasingly supported the activities of MHD in the last two years with in-kind donations of medicines and medical supplies and cash grants to support ongoing primary health-care services, health referrals and assisted transportation activities in Jordan, Egypt and South Sudan. In collaboration with Procter and Gamble and the United Parcel Service, AmeriCares also provided water purification sachets to support IOM in Mali, Niger and Cameroon, in response to the Sahel drought crisis and internal displacement. A specific IOM-AmeriCares grant agreement template has been finalized and a working draft for a global memorandum of understanding is in progress. IOM and AmeriCares held a meeting at the Americares headquarters in Connecticut in October 2012.

IOM Somalia has also engaged with Panasonic Corporation on the provision of solar lanterns, to reduce the vulnerability of women IDPs against sexual and gender-based violence when fetching water at night, and with JICA, to fund water and sanitation, safe water supply and hygiene promotion activities through the use of an innovative Japanese water treatment technology called "Poly-Glu."

IOM, as a core partner of the IASC Global Health Cluster (GHC), continues to participate in face-to-face meetings and/or scheduled teleconferences to discuss GHC workplans, policies and strategies to support country health clusters in areas such as surge capacity, information management and deployment mechanisms and joint support missions to selected countries in crisis among others.

IOM participated in the Regional Meeting on Disaster Risk Management in the Health Sector in June 2012 organized by the WHO Southeast Asia Regional Office in Bangkok. The meeting was especially timely for Asian countries, given the increasing number of natural and man-made disasters hitting the region in recent years. Ninety-nine participants came from 11 south-east Asian countries, NGOs, universities and UN and other international agencies involved in disaster risk management. Key themes focused on initiatives for enhanced inter-country cooperation, such as improving information management and research, methods of supporting community resilience in emergencies, facilitating various ways of integrating risk management in health systems in various ways, and the potential establishment of a structured network for information and expertise exchange, to improve this area of work between countries. IOM also advocated for the inclusion of migrants and mobile populations living in urban or hard-to-reach communities in national disaster preparedness and response planning and actions.

annexes



Annex 1: IOM publications, guidelines and tools on migration and health

1. IOM, *Behavioural study of female sex workers along Ghana's Tema-Paga transport corridor* (IOM, Accra), available from www.iom.int/files/live/sites/iom/files/pbn/docs/HIV-Vulnerability-among-FSWs-along-Tema_Paga-Transport-Corridor.pdf.
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3. IOM, *Determinants of HIV in key hotspots on the Southern transport corridor: Maputo to Swaziland* (IOM, Pretoria).
4. IOM, *Evaluation des vulnérabilités socio-économiques et en matière de santé des Rodriguais résidant à Maurice* (IOM, Pretoria).
5. IOM, *Healthy Migrants in Healthy Communities: IOM Health Promotion Strategy for East and Southern Africa, 2012–2017* (IOM, Pretoria).
6. IOM, *HIV and Bangladeshi women migrant workers: An assessment of vulnerabilities and gaps in services* (IOM, Dhaka), available from http://publications.iom.int/bookstore/index.php?main_page=product_info&cPath=41_7&products_id=812&zenid=72152eb9a19405b2ffd6ac4c5c457e69.
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13. IOM et al., *Key populations, key solutions: A gap analysis and recommendations for key populations and HIV in South Africa* (policy brief) (IOM, Pretoria).
14. IOM and the Jordanian Ministry of Health, *Assessment of health needs and living conditions of migrants in Jordan, 2011–2012* (IOM, Amman), available from http://publications.iom.int/bookstore/index.php?main_page=product_info&cPath=41_7&products_id=847.
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16. IOM and Migration Policy Institute (MPI), *IOM–MPI Issue in Brief No. 2 – Asian Labour Migrants and Health: Exploring Policy Routes* (IOM and MPI, Bangkok and Washington, D.C.), available from http://publications.iom.int/bookstore/index.php?main_page=product_info&cPath=35_36&products_id=798.
17. IOM Geneva and IOM Sri Lanka, "Strengthening Migration Health Management in Sri Lanka" (chapter 6, text box 3). In: *Global Migration Issues, Volume 1: Global Perspectives on Migration and Development* (GFMD Puerto Vallarta and Beyond) (IOM and Springer, New York), available from http://publications.iom.int/bookstore/index.php?main_page=product_info&cPath=36&products_id=802.
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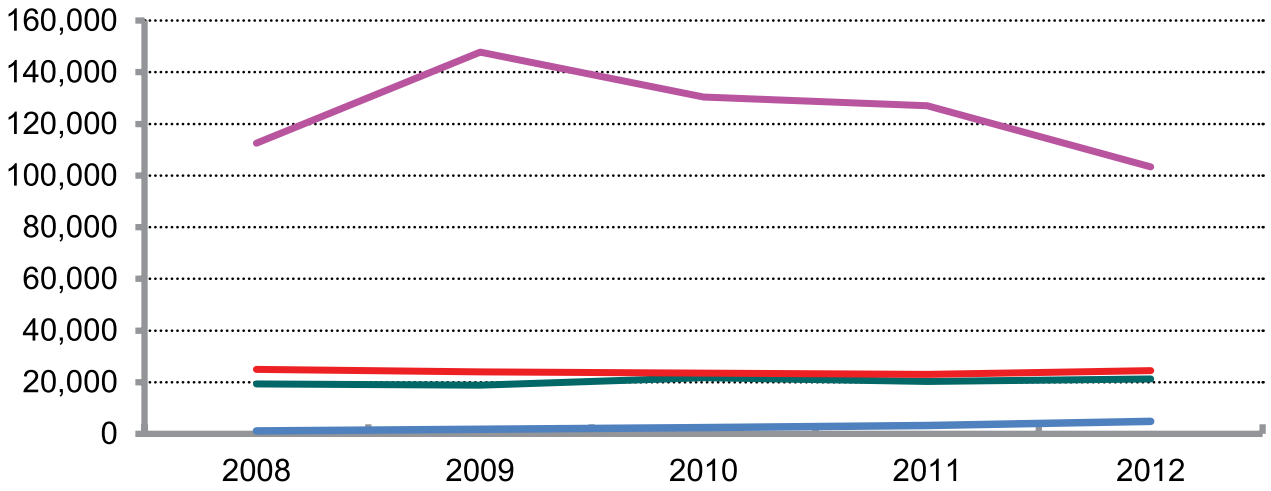
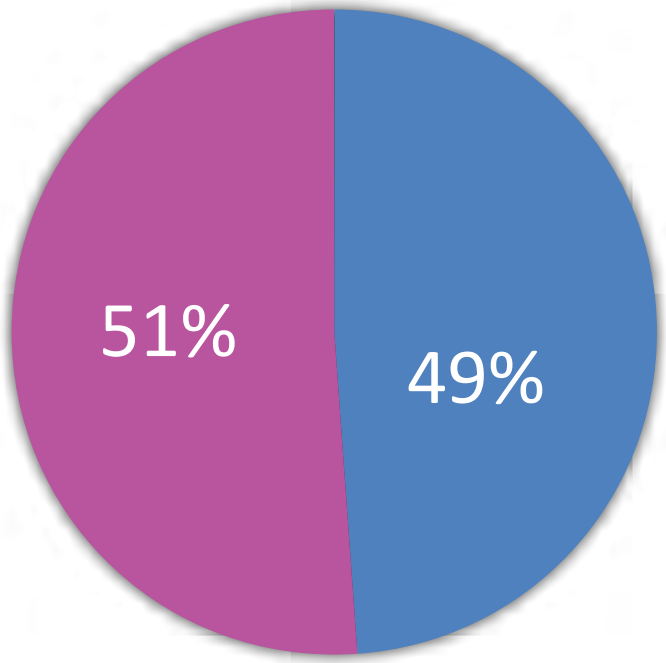
Annex 2: Service delivery in numbers, 2012

Figure 2.
IOM health assessments among immigrants by region of origin, 2008–2012

Immigrants



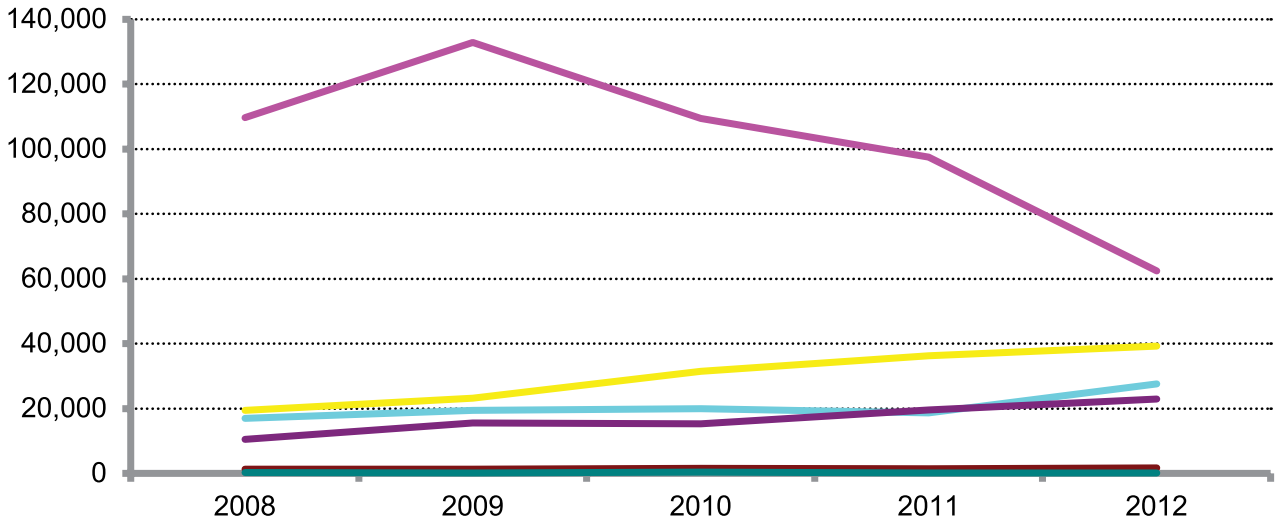
Distribution of immigrants by sex, IOM, 2012



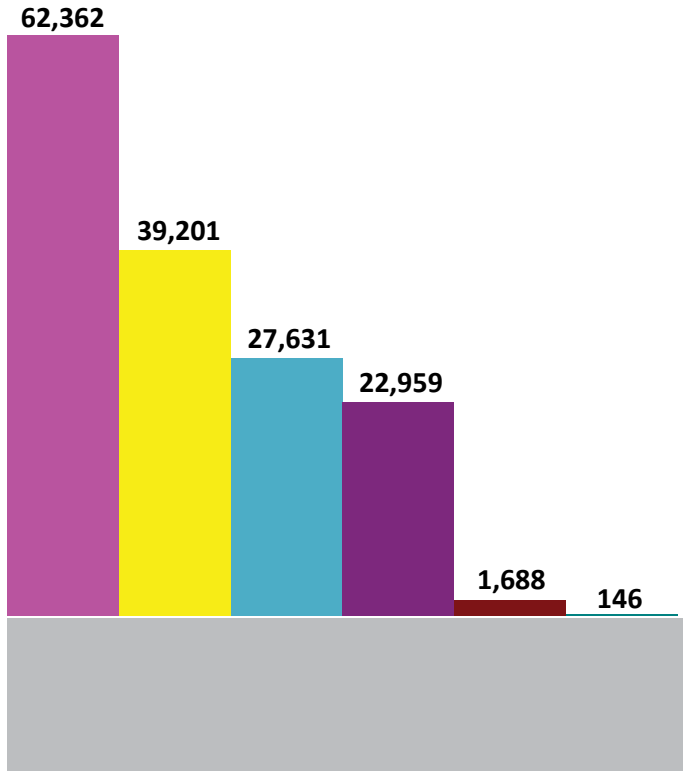
Total number of immigrants = 153,987

Figure 3.
Immigrants examined by country of destination, 2008–2012

Immigrants



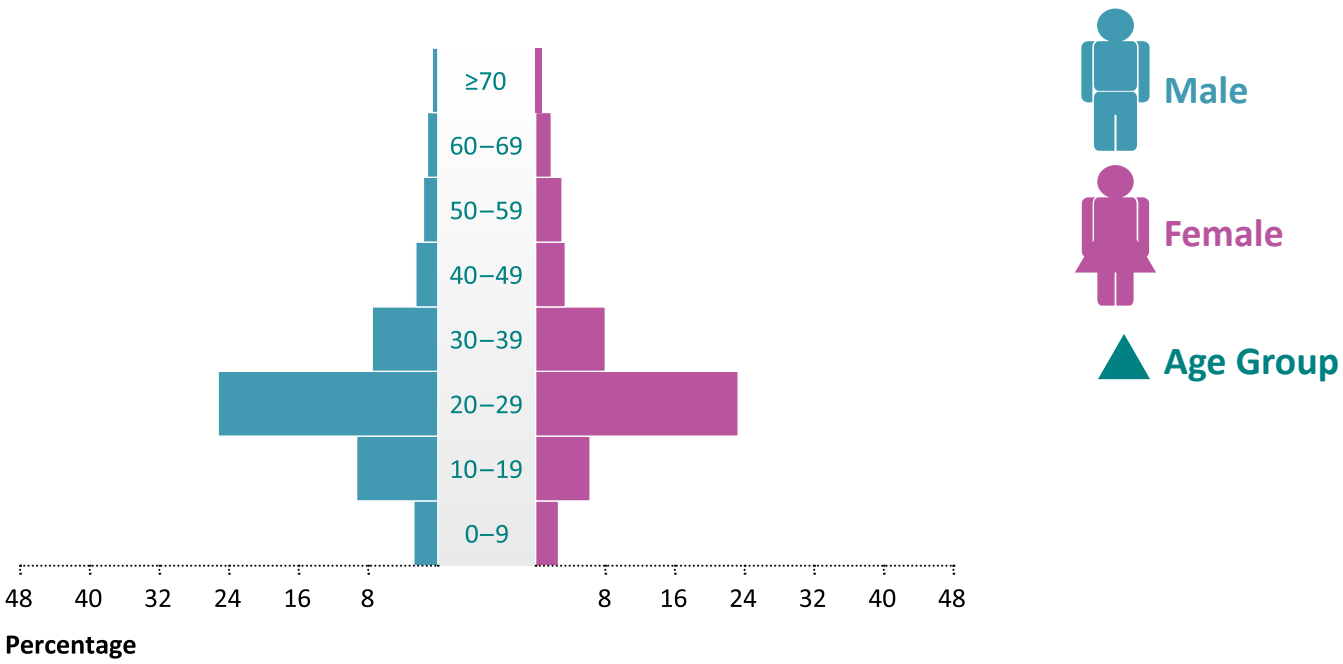
Distribution of immigrants by country of destination, IOM, 2012



United Kingdom
USA
Canada
Australia
New Zealand
Others

Figure 4a.

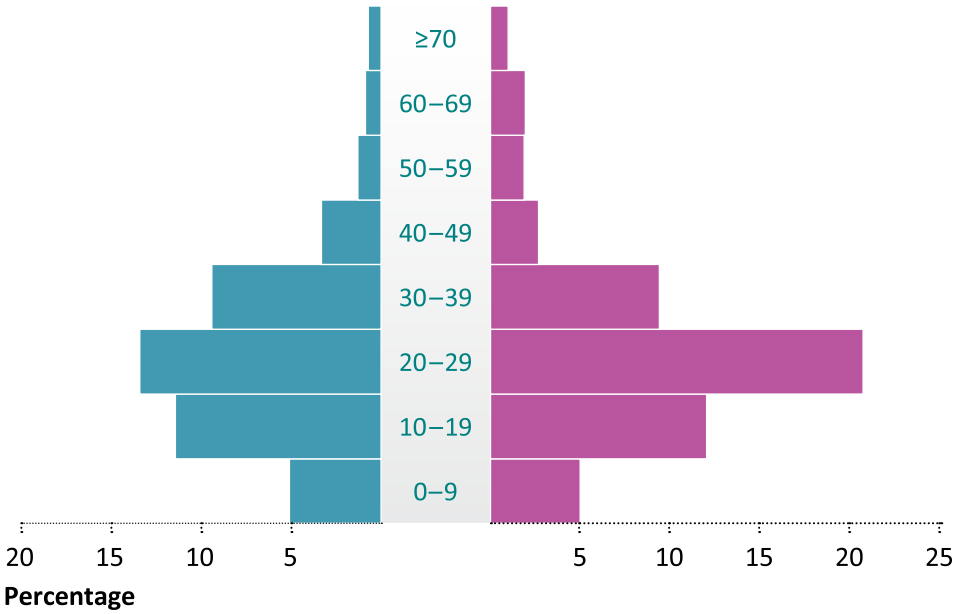
Distribution of immigrants from Asia and Oceania by sex and age, 2012



Total number of immigrants from Asia and Oceania = 103,369

Figure 4b.

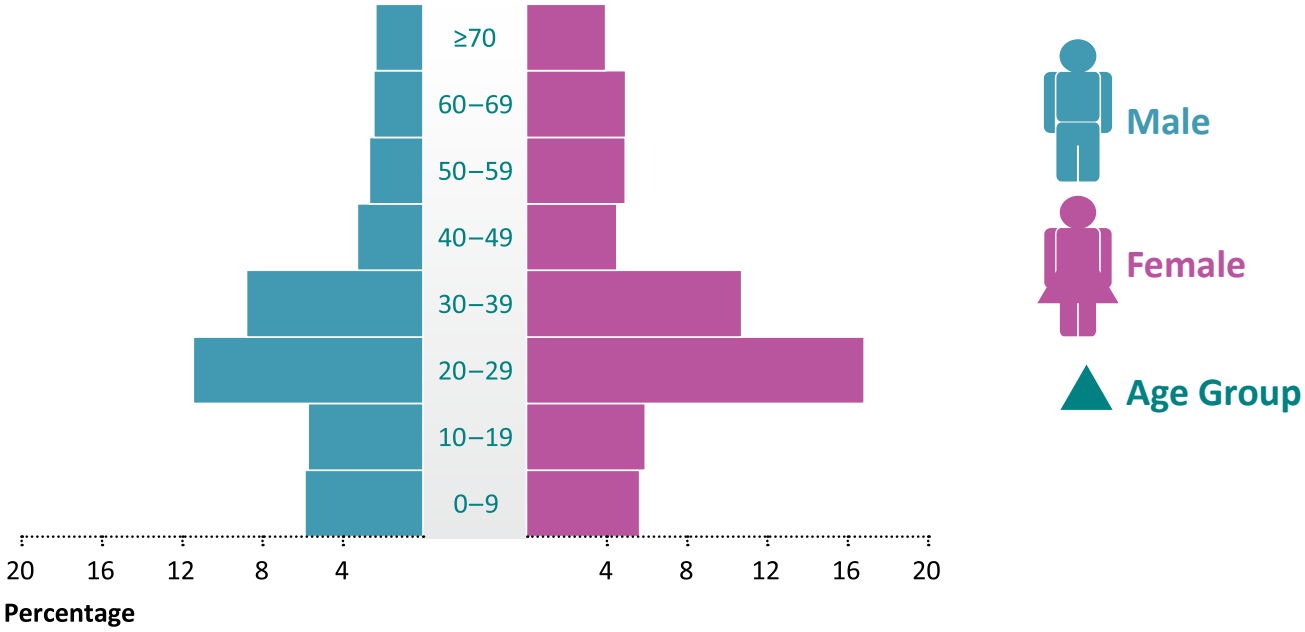
Distribution of immigrants from Africa by sex and age, 2012



Total number of immigrants from Africa = 21,184

Figure 4c.

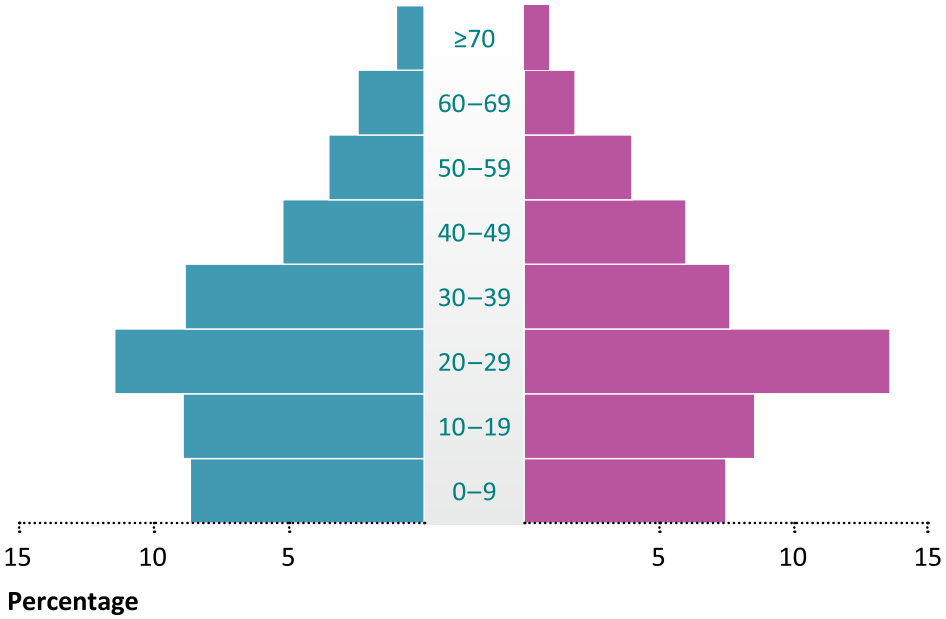
Distribution of immigrants from Europe and the Commonwealth of Independent States by sex and age, 2012



Total number of immigrants from Europe and the Commonwealth of Independent States = 24,535

Figure 4d.

Distribution of immigrants from the Middle East by sex and age, 2012

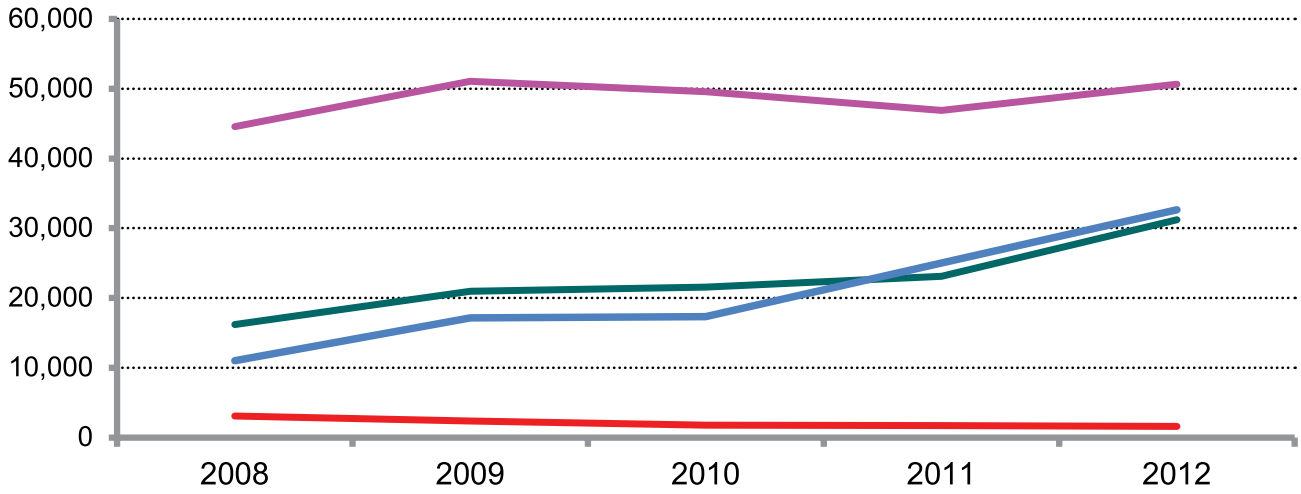


Total number of immigrants from the Middle East = 4,899

Figure 5.

IOM health assessments among refugees by region of origin, 2008–2012

Refugees



*Includes US humanitarian resettlement from Viet Nam

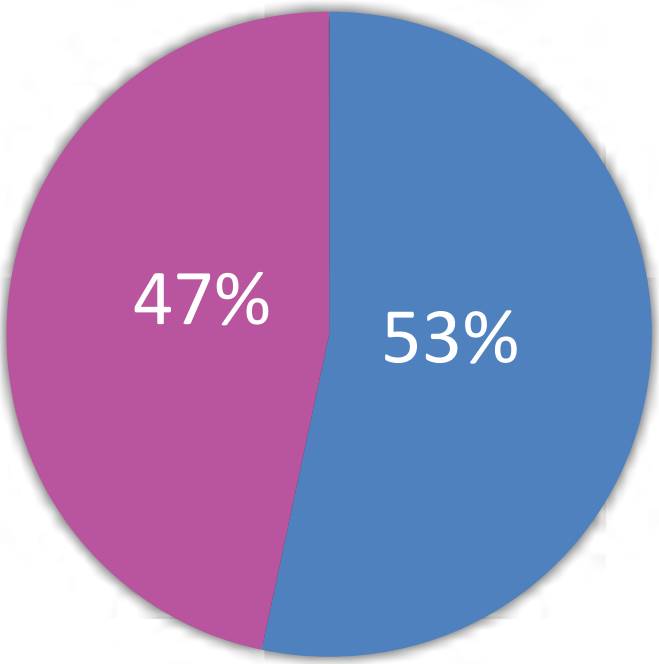
Asia and Oceania

Africa

Europe and the Commonwealth of Independent States

Middle East

Distribution of refugees by sex, IOM, 2012



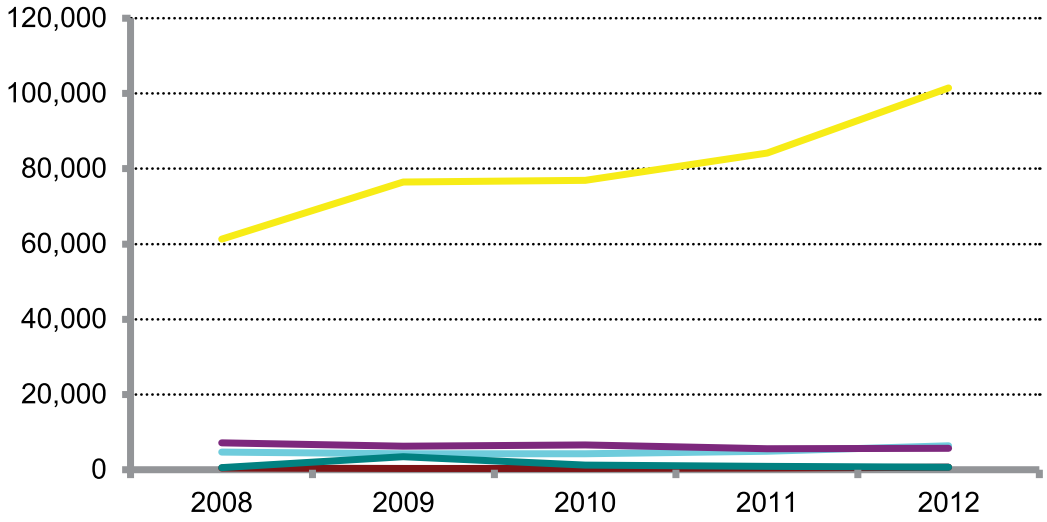
Male

Female

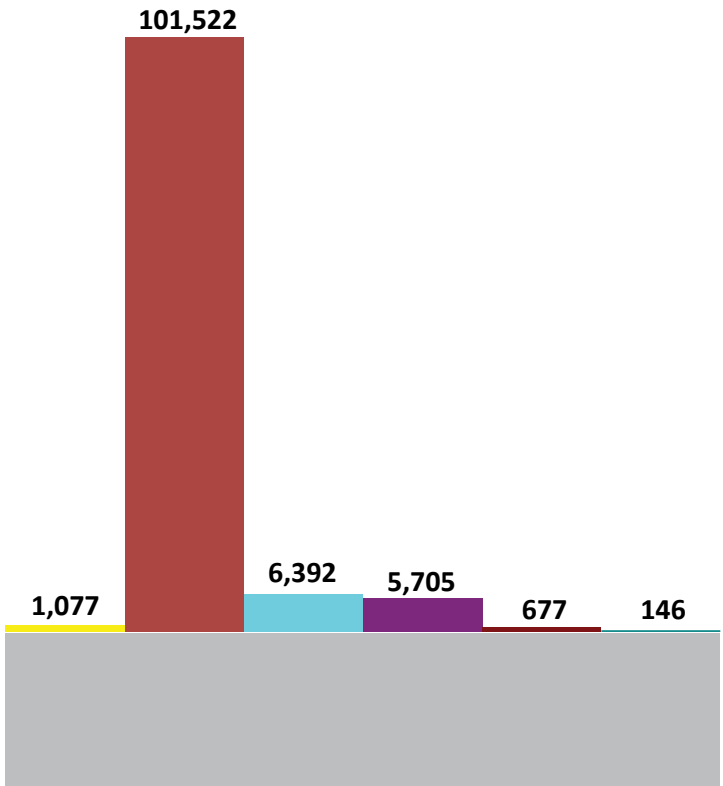
Total number of refugees = 116,078

Figure 6.
Refugees examined by country of destination, 2008–2012

Refugees



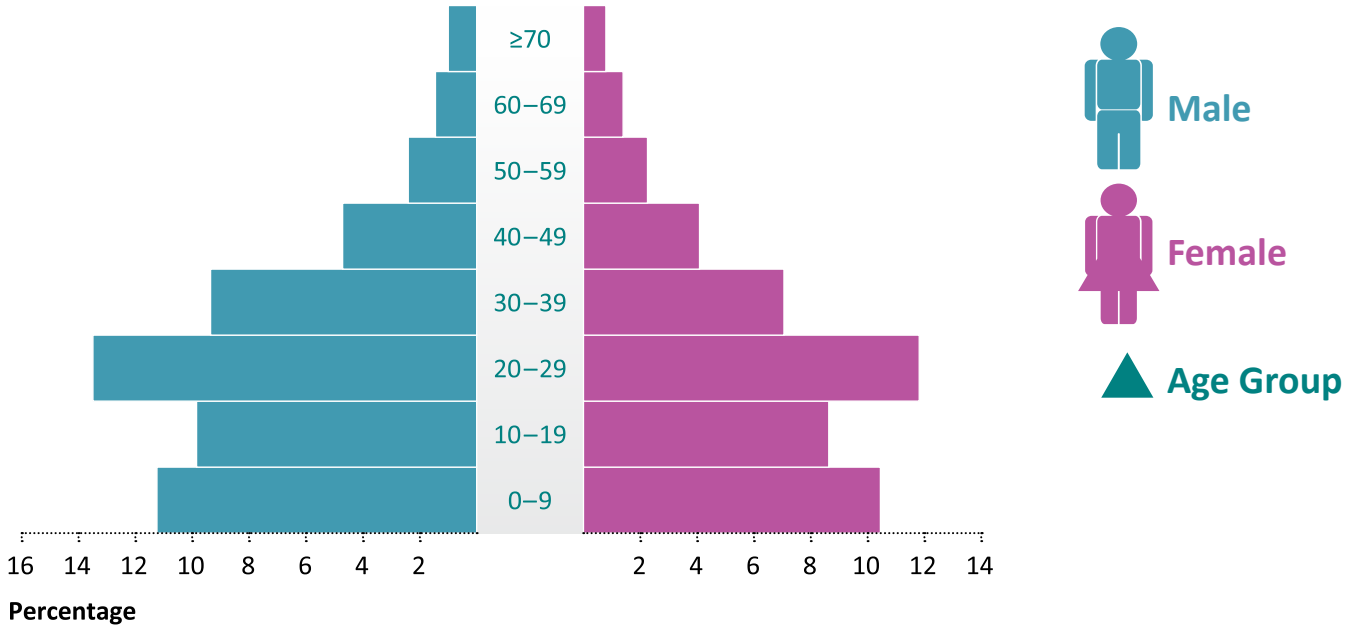
Distribution of refugees by country of destination, IOM, 2012



United Kingdom
USA
Canada
Australia
New Zealand
Others

Figure 7a.

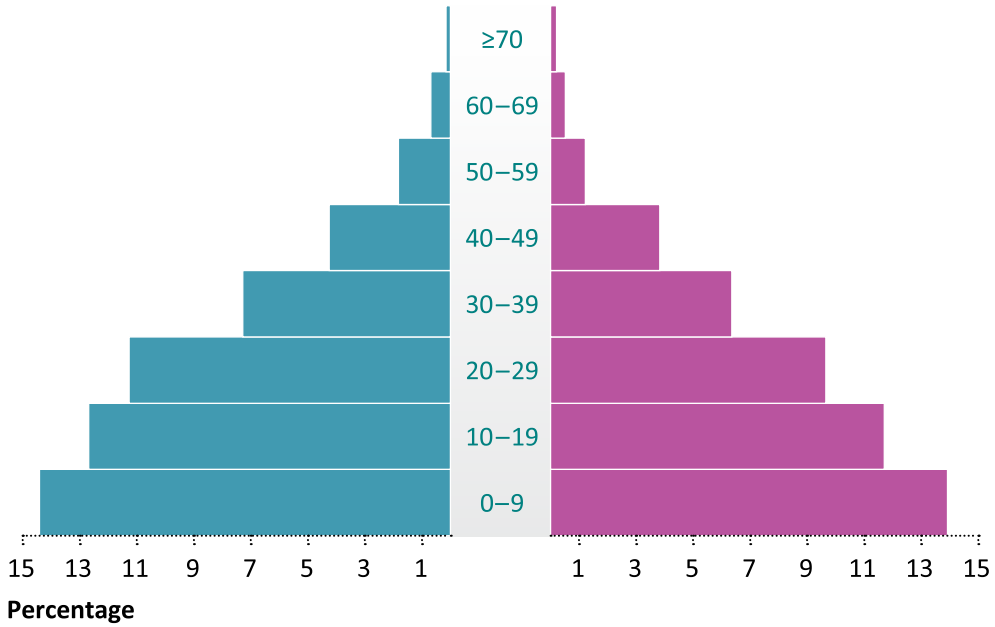
Distribution of refugees from Asia and Oceania by sex and age, 2012



Total number of refugees from Asia and Oceania = 50,658

Figure 7b.

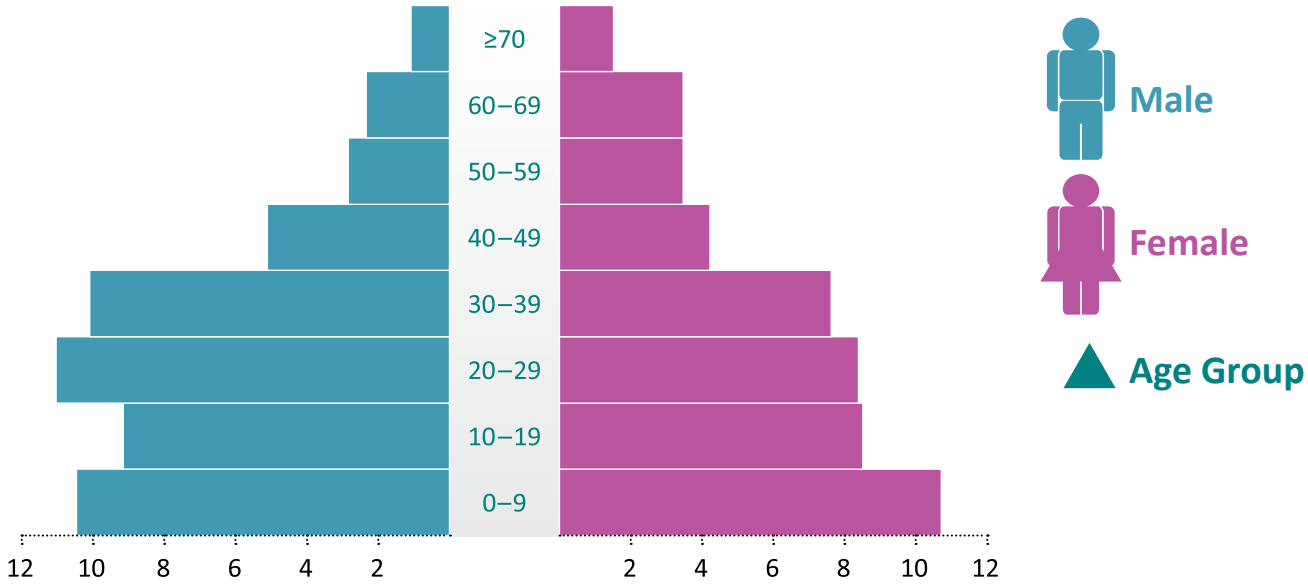
Distribution of refugees from Africa by sex and age, 2012



Total number of refugees from Africa = 31,205

Figure 7c.

Distribution of refugees from Europe and the Commonwealth of Independent States by sex and age, 2012

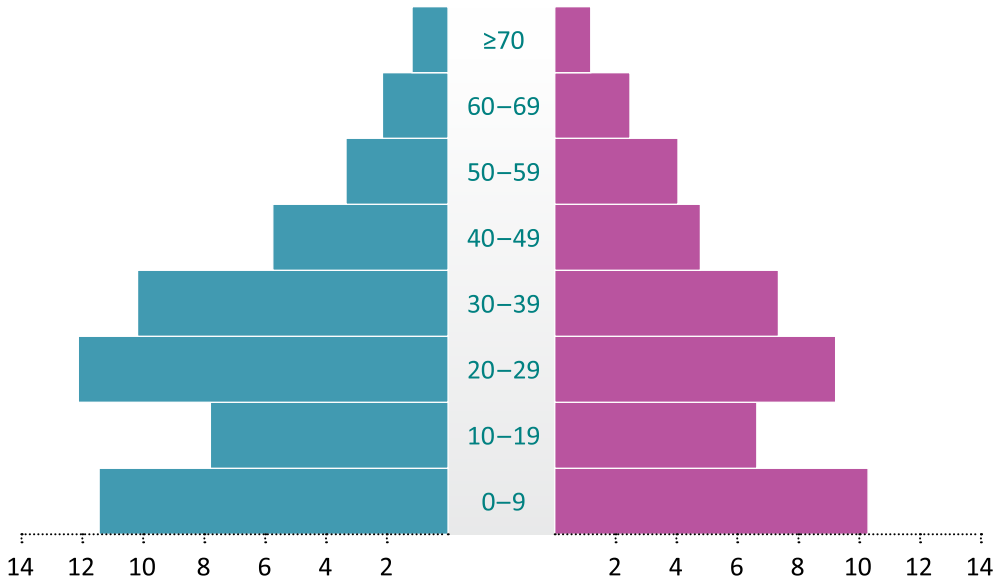


Percentage

Total number of refugees from Europe and the Commonwealth of Independent States = 1,586

Figure 7d.

Distribution of refugees from the Middle East by sex and age, 2012

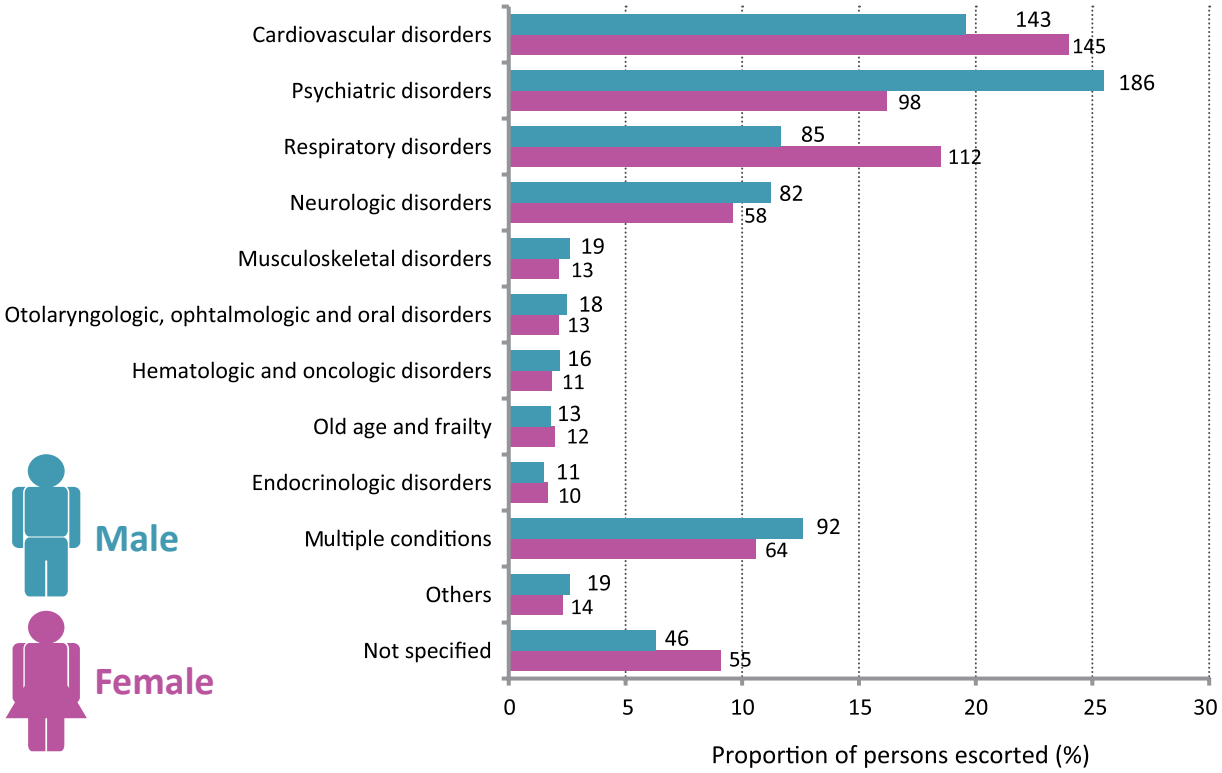


Percentage

Total number of refugees from the Middle East = 32,629

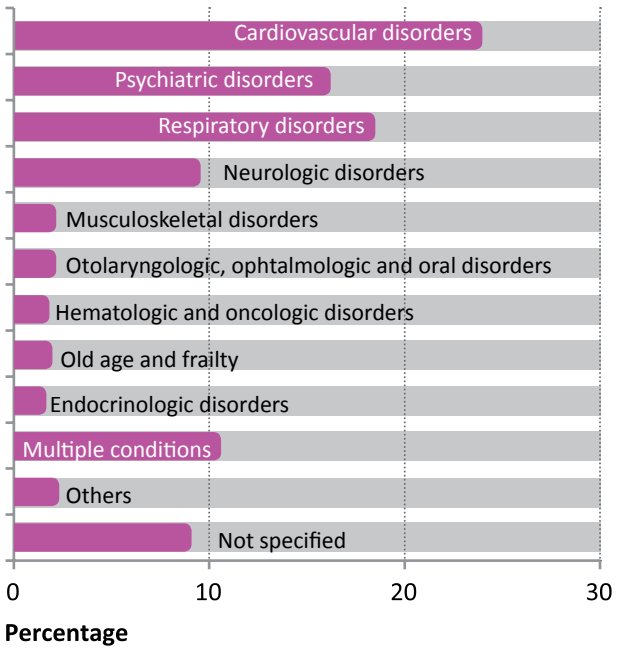
Figure 8.

Main conditions of migrants assisted by IOM medical escorts, 2012



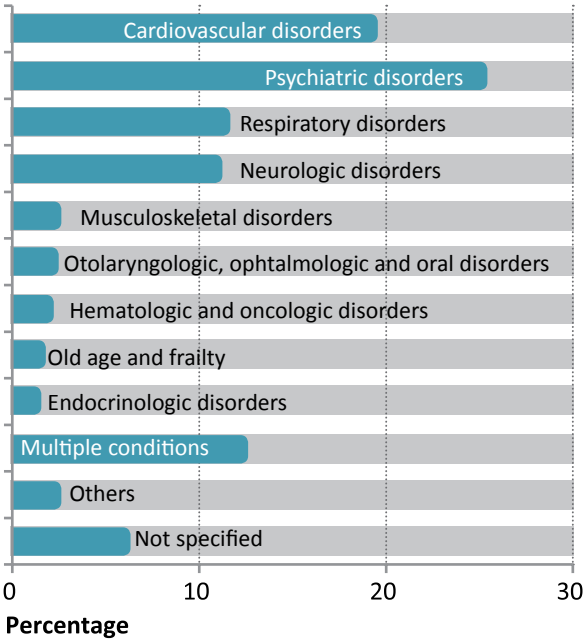
Total number of persons escorted = 1,335

Medical conditions of escorted female migrants, IOM, 2012



Total number of female migrants escorted = 605

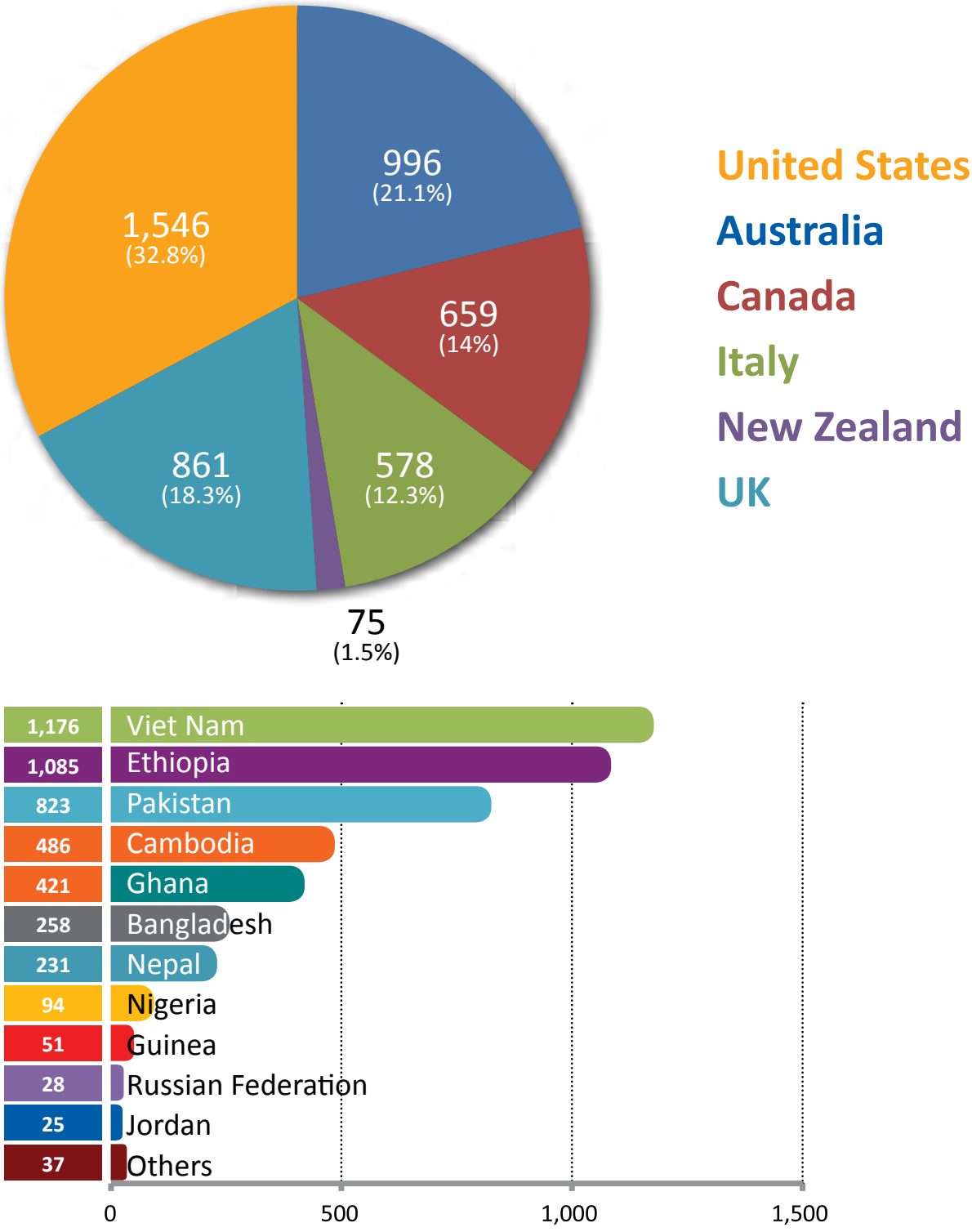
Medical conditions of escorted male migrants, IOM, 2012



Total number of male migrants escorted = 730

Figure 9.

IOM-assisted DNA services (sampling and tests) by country of destination and country of service, 2012



Total number of samples collected = 4,715

Figure 10.

Wasting among refugee children under age five in seven countries, 2012

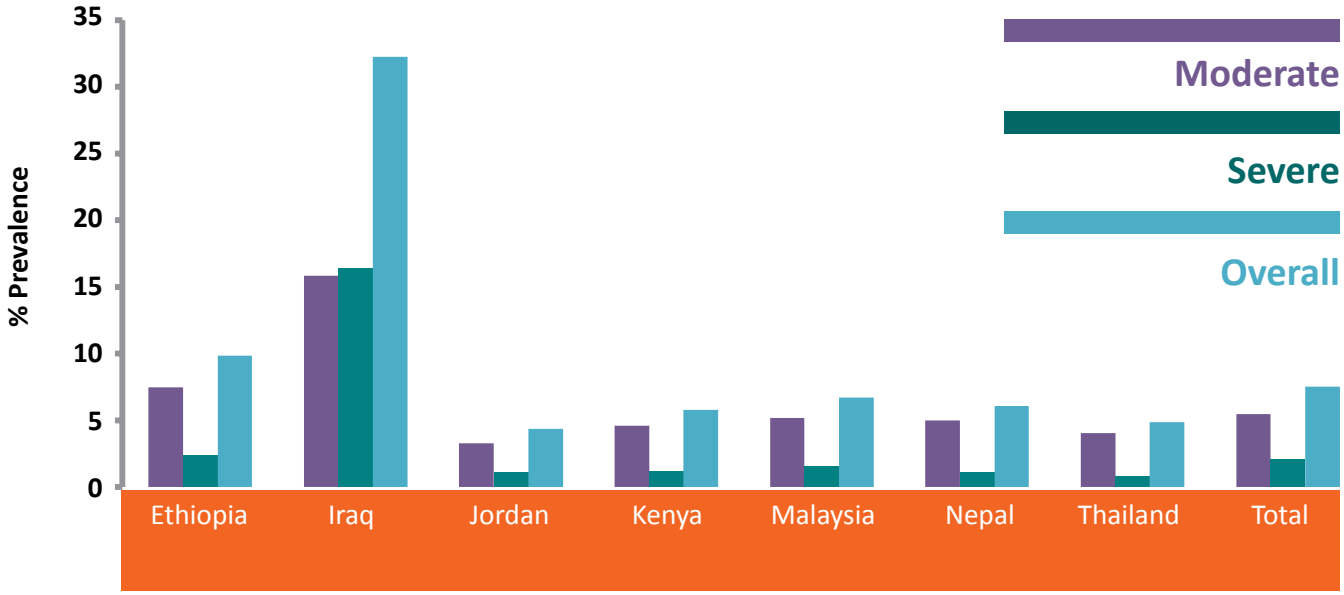


Figure 11.

Stunting among refugee children under age five in seven countries, 2012

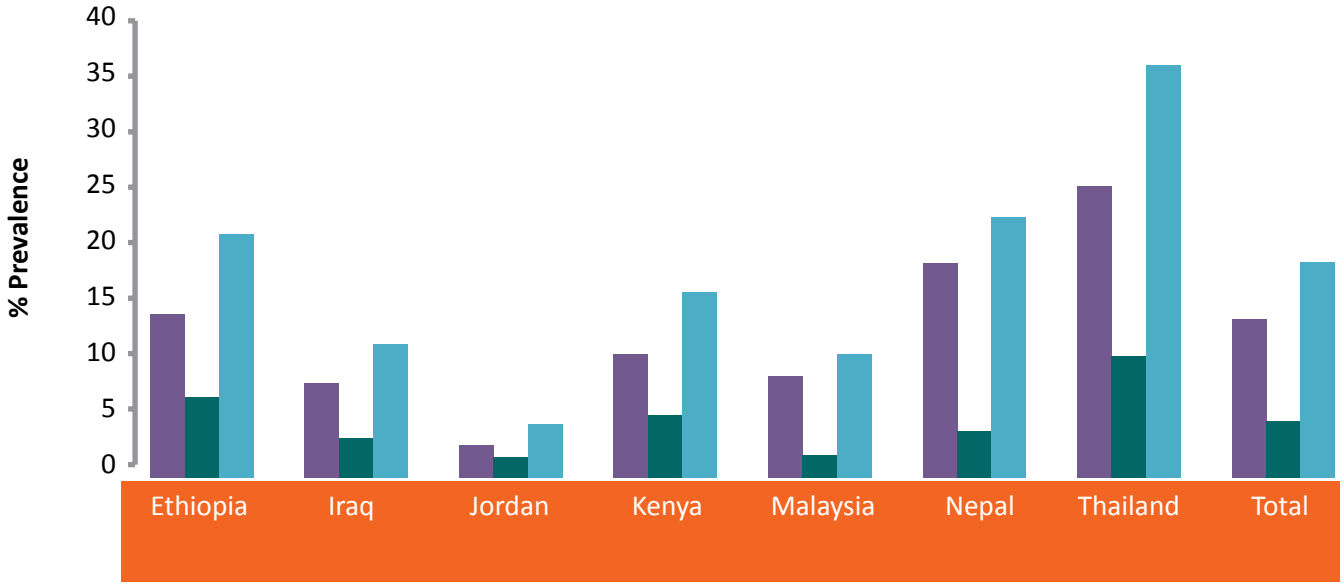


Table 3.

IOM health assessments by country of origin, country of destination and migrant category*, 2012

Country of IOM Health Assessment	Country of Destination					
	Australia		Canada		New Zealand	
	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees
Afghanistan	386	5	361	334	47	0
Bangladesh	1,325	0	411	0	0	0
Cambodia	1,811	0	606	14	574	0
Indonesia	0	0	0	0	0	57
Kazakhstan	264	1	578	18	61	0
Kyrgyzstan	0	4	0	0	0	0
Malaysia	0	1,726	0	128	0	267
Nepal	145	625	0	1,048	0	152
Pakistan	10,029	724	7,892	577	321	0
Thailand	0	285	0	94	0	129
Viet Nam**	3,043	0	3,100	0	135	0
Asia and Oceania	**17,003**	**3,370**	**12,948**	**2,213**	**1,138**	**605**
Algeria	0	0	0	0	0	0
Bahrain	0	0	0	0	0	0
Iraq	524	27	416	1	9	0
Jordan	252	149	174	58	6	1
Morocco	0	0	0	0	0	0
Oman	0	0	0	0	0	0
Saudi Arabia	0	0	0	0	0	0
Syrian Arab Republic	126	1,144	37	223	0	71
Tunisia	0	1	0	0	0	0
Middle East	**902**	**1,321**	**627**	**282**	**15**	**72**
Angola	0	0	4	3	0	0
Benin	0	4	0	38	0	0
Botswana	0	0	1	78	0	0
Burundi	0	0	18	140	0	0
Cameroon	0	0	1	0	0	0
Central African Republic	0	0	1	0	0	0
Chad	0	0	0	2	0	0
Democratic Republic of the Congo	0	0	14	15	0	0
Djibouti	0	1	7	106	0	0
Eritrea	51	50	9	210	0	0
Ethiopia	374	160	1,528	383	2	0
Gabon	0	0	0	0	0	0
Ghana	317	21	157	13	1	0
Guinea	21	80	156	0	0	0
Kenya	1,197	337	1,102	1,016	2	0
Liberia	14	0	0	0	0	0
Malawi	1	59	1	78	0	0
Mozambique	0	44	0	0	0	0
Namibia	0	0	1	96	0	0
Nigeria	4	0	0	0	0	0
Republic of the Congo	0	0	0	1	0	0
Rwanda	2	8	3	10	0	0
Somalia	0	0	4	0	0	0
South Africa	3	26	0	150	0	0
Sudan	0	0	0	1	0	0
Togo	0	0	3	0	0	0
Uganda	66	154	438	1,246	0	0
United Republic of Tanzania	20	8	0	11	0	0
Zambia	10	34	20	155	0	0
Zimbabwe	0	28	16	52	0	0
Africa	**2,080**	**1,014**	**3,484**	**3,804**	**5**	**0**
Azerbaijan	0	0	0	0	0	0
Belarus	122	0	338	0	20	0
Bosnia and Herzegovina	140	0	138	3	3	0
Bulgaria	0	0	441	0	0	0
Croatia	55	0	24	0	0	0
FYROM***	247	0	157	0	18	0
Malta	0	0	0	0	0	0
Republic of Moldova	82	0	1,450	0	12	0
Romania	90	0	1,889	0	24	0
Russian Federation****	1,267	0	1,813	79	319	0
Serbia	504	0	341	0	40	0
UNSC resolution 1244-administered Kosovo	37	0	225	0	0	0
Slovakia	0	0	0	0	0	0
Ukraine	430	0	3,756	11	94	0
Europe and the Commonwealth of Independent States	**2,974**	**0**	**10,572**	**93**	**530**	**0**
Worldwide	**22,959**	**5,706**	**27,629**	**6,392**	**1,690**	**677**
	28,665		**34,021**		**2,367**	

* Immigrants moved on a voluntary basis. Refugees were displaced on an involuntary basis and fall under the definition of the 1951 UN Convention.
** In addition, IOM Viet Nam conducted health assessment for 96 humanitarian resettlement cases bound to the US.
***Former Yugoslavia Republic of Macedonia.
****included US-bound refugees from Germany (5) and Italy (1).

Country of Destination								Grand Total
UK		USA		Other		Total		
Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees	Immigrants	Refugees	
0	0	0	0	0	0	794	339	1,133
9,078	0	0	0	0	0	10,814	0	10,814
95	0	1,851	3	0	0	4,937	17	4,954
0	0	0	0	0	0	0	57	57
0	0	0	24	1	0	904	43	947
0	0	0	128	0	0	0	132	132
0	0	0	13,583	0	300	0	16,004	16,004
0	188	5,176	17,442	0	158	5,321	19,613	24,934
38,657	0	0	0	0	0	56,899	1,301	58,200
6,524	0	0	12,503	0	45	6,524	13,056	19,580
0	0	10,898	0	0	0	17,176	0	17,176
54,354	**188**	**17,925**	**43,683**	**1**	**503**	**103,369**	**50,562**	**153,931**
0	0	0	30	0	0	0	30	30
0	0	0	96	0	0	0	96	96
0	288	670	18,967	0	5	1,619	19,288	20,907
0	0	2,685	10,063	0	0	3,117	10,271	13,388
0	0	0	25	0	0	0	25	25
0	0	0	7	0	0	0	7	7
0	0	0	33	0	0	0	33	33
0	44	0	0	0	0	163	1,482	1,645
0	0	0	1,396	0	0	0	1,397	1,397
0	**332**	**3,355**	**30,617**	**0**	**5**	**4,899**	**32,629**	**37,528**
0	0	1	0	0	0	5	3	8
0	0	0	0	0	0	0	42	42
0	0	0	75	0	0	1	153	154
0	0	0	66	0	0	18	206	224
0	0	0	0	0	0	1	0	1
0	0	0	0	0	0	1	0	1
0	0	0	321	0	0	0	323	323
0	0	0	86	0	0	14	101	115
0	0	6	1,072	0	0	13	1,179	1,192
0	0	0	0	0	0	60	260	320
3	0	1,245	8,496	0	171	3,152	9,210	12,362
0	0	0	60	0	0	0	60	60
3,920	0	17	167	0	0	4,412	201	4,613
0	0	0	55	0	0	177	135	312
2,511	234	6,310	7,552	0	26	11,122	9,165	20,287
0	0	0	0	0	0	14	0	14
0	0	0	209	0	0	2	346	348
0	0	0	353	0	0	0	397	397
0	0	0	35	0	0	1	131	132
0	0	0	0	0	0	4	0	4
0	0	0	23	0	0	0	24	24
0	0	4	777	0	0	9	795	804
0	0	3	0	0	0	7	0	7
0	0	1	1,497	0	0	4	1,673	1,677
912	0	3	123	0	0	915	124	1,039
0	0	0	0	0	0	3	0	3
0	0	12	3,540	0	0	516	4,940	5,456
662	323	5	569	0	0	687	911	1,598
0	0	0	243	0	0	30	432	462
0	0	0	314	0	0	16	394	410
8,008	**557**	**7,607**	**25,633**	**0**	**197**	**21,184**	**31,205**	**52,389**
0	0	0	2	0	0	0	2	2
0	0	816	67	0	0	1,296	67	1,363
0	0	0	0	0	0	281	3	284
0	0	0	0	0	0	441	0	441
0	0	0	0	0	0	79	0	79
0	0	0	0	0	0	422	0	422
0	0	0	130	0	0	0	130	130
0	0	887	174	0	0	2,431	174	2,605
0	0	0	37	0	0	2,003	37	2,040
0	0	3,033	587	9	0	6,441	666	7,107
0	0	174	0	136	0	1,195	0	1,195
0	0	559	0	0	0	821	0	821
0	0	0	191	0	0	0	191	191
0	0	4,845	305	0	0	9,125	316	9,441
0	**0**	**10,314**	**1,493**	**145**	**0**	**24,535**	**1,586**	**26,121**
62,362	**1,077**	**39,201**	**101,426**	**146**	**705**	**153,987**	**115,983**	**269,969**
63,439		**140,627**		**851**		**269,970**		**270,065**

Table 4.

TB detection among immigrants (rate per 100,000 population), IOM major operations*

Country	Total Number of Immigrants	Latent Tuberculosis Infection		Chest X-ray TB Screening		Active TB per 100,000		
		Number tested	Positive (%)	Number tested	Positive (per 100,000)	Lab-confirmed	Clinical	Total
Africa								
Ethiopia	3,152	384	25 (6.5)	2,392	86 (3,595)	95	-	95
Ghana	4,412	4	-	3,998	28 (700)	-	-	-
Kenya	11,122	1,304	171 (13.1)	9,459	525 (5,550)	171	90	261
Middle East								
Jordan	1,619	0	-	2,600	4 (154)	-	-	-
Iraq	3,117	0	-	1,215	3 (247)	-	-	-
Asia								
Bangladesh	10,814	0	-	9,640	915 (9,492)	74	-	74
Cambodia	4,937	158	17 (10.8)	4,572	156 (3,412)	263	20	284
Nepal	5,321	874	54 (6.2)	4,311	407 (9,441)	489	-	489
Pakistan	56,899	0	-	49,963	1,103 (2,208)	70	-	70
Thailand	6,524	0	-	5,641	608 (10,778)	399	-	399
Viet Nam	17,176	1,545	16 (1)	14,988	722 (4,817)	792	6	798
Europe								
Republic of Moldova	2,431	2	0 (0)	1,942	111 (5,716)	-	41	41
Romania	2,003	0	-	1,721	62 (3,603)	50	-	50
Ukraine	9,125	0	-	7,494	303 (4,043)	22	-	22
All Regions								
Other immigrants	15,335	11	-	13,523	871 (6,441)	20	26	46
Total	**153,987**	**4,282**	**284 (6.6)**	**133,459**	**5,904 (4,424)**	**180**	**11**	**191**

*An IOM major operation is defined as having more than 1,000 assisted immigrants or refugees.

TB Detection in Immigrants

Detection Rate per 100,000

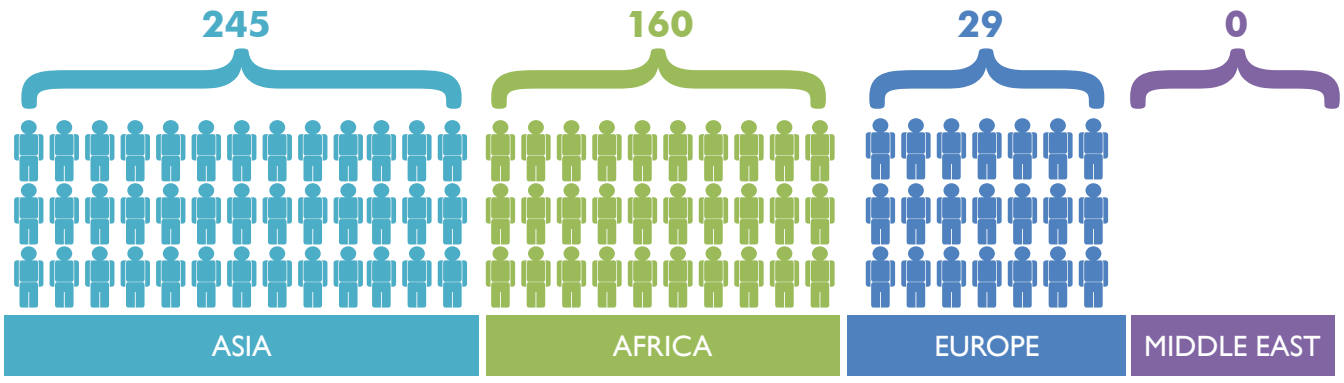


Table 5.

TB detection among refugees (rate per 100,000 population), IOM major operations*

Country	Total Number of Refugees	Latent Tuberculosis Infection		Chest X-ray TB Screening		Active TB per 100,000		
		Number Tested	Positive (%)	Number Tested	Positive (per 100,000)	Lab-confirmed	Clinical	Total
Africa								
Ethiopia	9,210	3,048	296 (9.7)	5,812	571 (9,825)	119	54	174
Kenya	9,165	2,775	303 (10.9)	5,992	659 (10,998)	218	371	589
Uganda	4,940	1,218	234 (19.2)	3,453	239 (6,922)	202	202	405
Middle East								
Jordan	10,271	-	-	8,050	44 (547)	-	-	-
Iraq	19,288	-	-	13,118	54 (412)	16	-	16
Syrian Arab Republic	1,482	-	-	1,102	-	-	-	-
Asia								
Malaysia	16,004	2,538	606 (23.9)	12,331	1,566 (12,700)	1,062	194	1,256
Nepal	19,613	3,772	532 (14.1)	15,296	2,958 (19,338)	851	41	892
Thailand	13,056	4,249	255 (6)	9,606	1,596 (16,615)	360	460	820
Europe								
Russian Federation	660	-	-	609	101 (16,585)	303	-	303
All regions								
Other refugees	12,390	1,233	118 (9.6)	8,200	580 (7,073)	48	307	355
Total	**116,079**	**18,833**	**2,344 (12.4)**	**83,599**	**8,368 (10,010)**	**376**	**160**	**536**

* An IOM major operation is defined as having more than 1,000 assisted immigrants or refugees.

TB Detection in Refugees

Detection Rate per 100,000

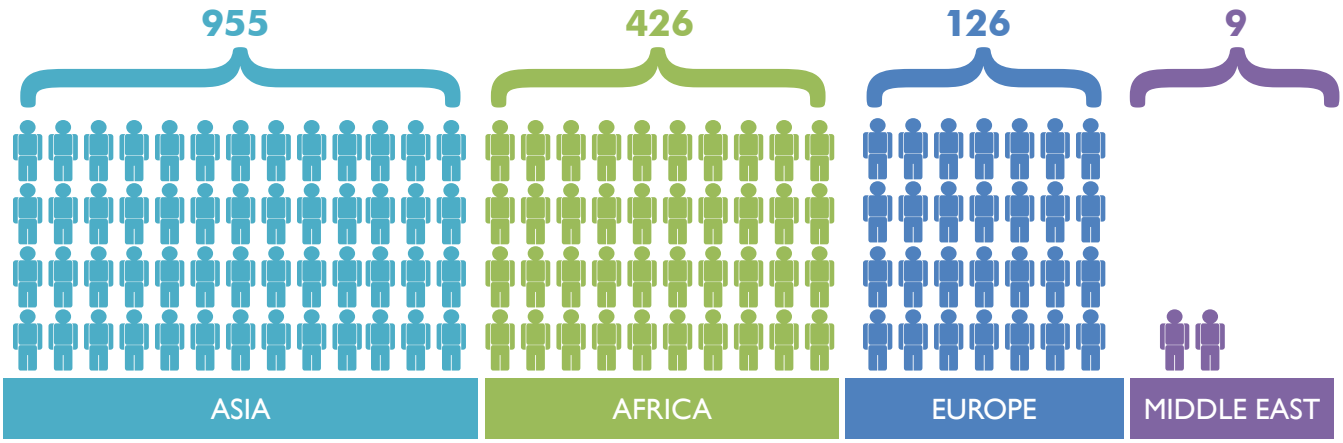


Table 6.

DST results among cases (n=548) with *Mycobacterium tuberculosis* (MTB) growth on culture, IOM, 2012

DST result	No.	%
Pansusceptible	429	78.4
Monoresistance	51	9.3
Polyresistance	10	1.8
MDR TB	10	1.8
Contaminated/Pending	48	8.6
Total	**548**	**100.0**

Table 7a.

TB treatment outcomes* among immigrants who started TB treatment in 2012

Country	All outcomes for treatment started in 2012, n (%)						
	Cure/ Completed	Default	Ongoing treatment	Change in diagnosis	Transferred out	Died	Others**
Cambodia (3)	2	0	1	0	0	0	0
Nepal (n=21)	13	0	8	0	0	0	0
Viet Nam (n=134)	19	4	94	3	12	2	0
Kenya (n=10)	0	0	9	0	1	0	0
Others*** (n=2)	0	0	1	0	0	0	1
Total (n=170)	**34 (20%)**	**4 (2.4%)**	**113 (66.5%)**	**3 (1.8%)**	**13 (7.6%)**	**2 (1.2%)**	**1 (0.6%)**

*Typical treatment outcomes recommended by WHO for TB reporting forms.
**Other outcomes include continuing treatment in country of destination.
***Other countries include Romania (1 case) and the Russian Federation (1).

Table 7b.

TB treatment outcomes* among refugees who started TB treatment in 2012

Country	All outcomes for treatment started in 2012, n (%)					
	"Cure/ Completed"	Default	Ongoing treatment	Change in diagnosis	Transferred out	Died
Malaysia (n=121)	14	0	107	0	0	0
Nepal (n=167)	87	0	80	0	0	0
Thailand (n=32)	4	0	28	0	0	0
Djibouti (n=5)	0	0	5	0	0	0
Ethiopia (n=14)	1	0	12	0	0	1
Kenya (n=10)	0	0	10	0	0	0
Uganda (n=6)	0	0	6	0	0	0
Others** (n=6)	1	0	5	0	0	0
Total (n=361)	**107 (29.7%)**	**0 (0%)**	**253 (70.3%)**	**0 (0%)**	**0 (0%)**	**1 (0.3%)**

*Typical treatment outcomes recommended by WHO for TB reporting forms.
**Other countries include Viet Nam (1 case), Russian Federation (2), United Republic of Tanzania (1), Zambia (1) and Zimbabwe (1) .

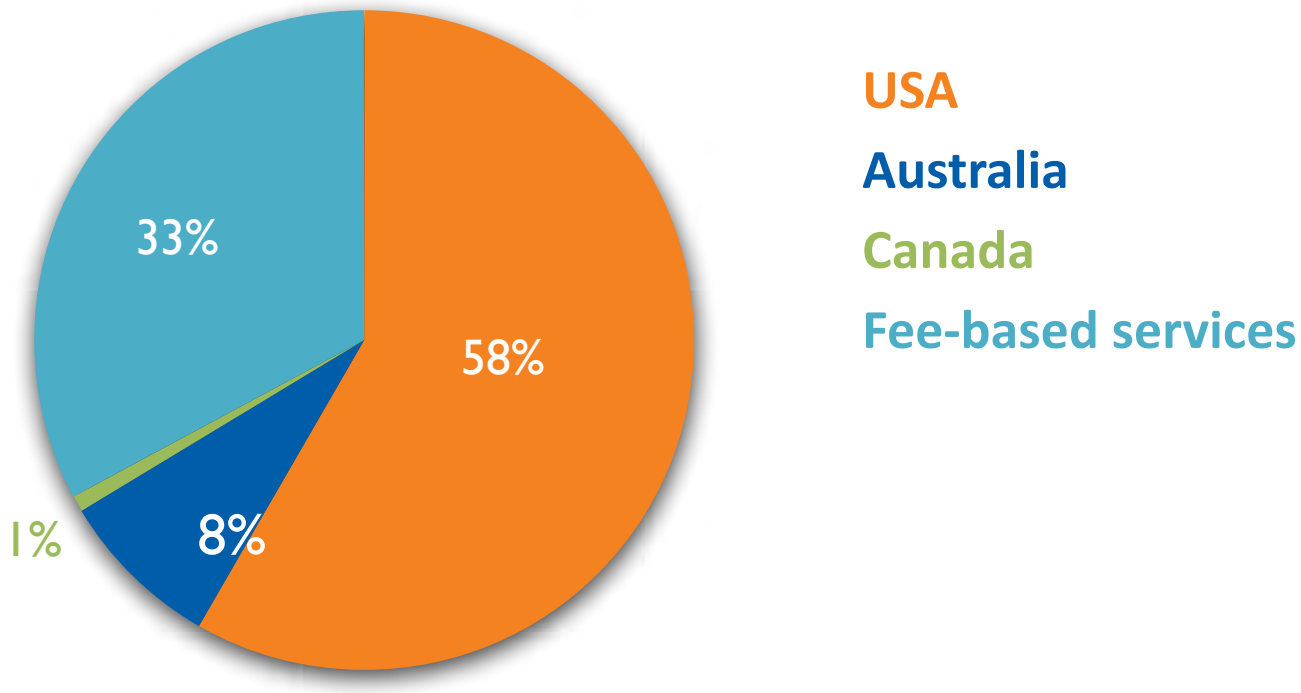
FINANCIAL REVIEW

Table 8.

MHD expenditure by donor, 2011-2012

A. Migration Health Assessments and Travel Health Assistance					
FUNDING SOURCE	2012 EXPENDITURE		2011 EXPENDITURE		Increase/(Decrease)
	(In USD)	%	(In USD)	%	
Governments	35,532,299	67%	30,596,840	65%	4,935,459
USA	30,874,665	87%	26,157,713	85%	4,716,952
Australia	4,240,953	12%	3,918,189	13%	322,764
Canada	416,681	1%	520,937	2%	(104,257)
Fee-based services	17,394,764	33%	16,581,574	35%	813,190
Migration Health Assessments and Travel Health Assistance	52,927,063	100%	47,178,414	100%	5,748,649

Funding sources for migration health assessments and travel assistance,* 2012

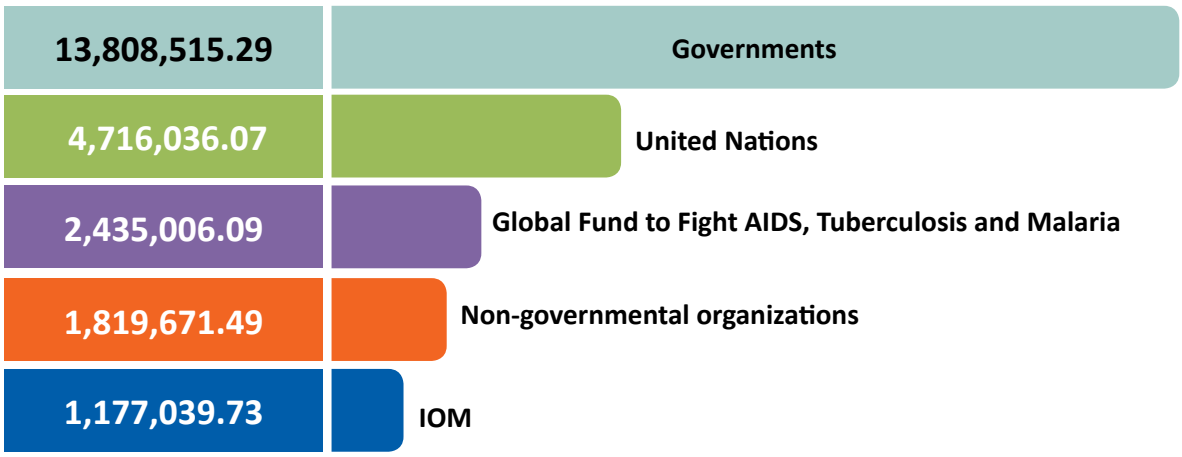


*This constitutes expenditure from government funding and fee-based services.

B. Health Promotion and Assistance for Migrants					
FUNDING SOURCE	2012 EXPENDITURE		2011 EXPENDITURE		Increase/(Decrease)
	(In USD)	%	(In USD)	%	
Governments	13,808,515	56	7,951,805	49	5,856,710
Colombia	5,351,440	39	3,414,088	43	1,937,351
Sweden	3,045,974	22	2,175,141	27	870,834
Thailand	1,555,724	11	-	0	1,555,724
United States of America	1,448,437	10	1,856,245	23	(407,808)
Japan	1,228,440	9	(148)	0	1,228,588
Finland	943,163	7	215,617	3	727,546
Switzerland	111,516	1	(817)	0	112,333
Italy	91,521	1	158,407	2	(66,887)
Jordan	37,300	0	-	0	37,300
Africa	2,633	0	151	0	2,482
United Kingdom	-	0	2,703	0	(2,703)
Germany	-	0	(631)	0	631
Kazakhstan	-	0	(26,534)	0	26,534
Portugal	-	0	(3,170)	0	3,170
Norway	-	0	131,009	2	(131,009)
Croatia	-	0	(2,599)	0	2,599
Poland	(738)	0	32,340	0	(33,078)
Belgium	(6,895)	0	-	0	(6,895)
Fee-based services	8,272	0	7,855	0	417
United Nations	4,716,036	19	4,736,749	29	(20,713)
United Nations Office for Project Services (UNOPS)	1,173,604	25	411,524	9	762,080
United Nations Development Programme (UNDP)	1,116,464	24	1,494,516	32	(378,052)
United Nations TB REACH	935,023	20	62,519	1	872,505
World Health Organization (WHO)	672,905	14	505,740	11	167,165
Joint United Nations Programme on HIV/AIDS (UNAIDS)	445,221	9	390,692	8	54,529
United Nations Trust Fund for Human Security (UNTFHS)	164,895	3	209,169	4	(44,274)
United Nations Children's Fund (UNICEF)	137,302	3	1,051,451	22	(914,149)
World Food Programme (WFP)	69,705	1	70,791	1	(1,085)
United Nations One Fund	4,232	0	314,475	7	(310,243)
United Nations High Commissioner for Refugees (UNCHR)	300	0	-	0	300
United Nations Development Fund for Women (UNIFEM)	-	0	5,785	0	(5,785)

FUNDING SOURCE	2012 EXPENDITURE		2011 EXPENDITURE		Increase/(Decrease)
	(In USD)	%	(In USD)	%	
Central Fund for Influenza Action (CFIA)	-	0	178,519	4	(178,519)
United Nations Population Fund (UNFPA)	(3,616)	0	41,569	1	(45,185)
Non-governmental organizations	1,819,671	7	1,229,945	8	589,726
Save the Children	1,355,738	75	952,561	77	403,177
TEBA Development	160,383	9	11,402	1	148,982
Consorzio Connecting People	92,745	5	48,242	4	44,504
Population Services International	86,929	5	-	0	86,929
ANESVAD Foundation	67,695	4	55,273	4	12,422
Family Health International	52,680	3	73,054	6	(20,375)
Ethno-Medizinisches Zentrum Verein (EMZ)	2,777	0	81,856	7	(79,078)
World Vision Australia	758	0	7,557	1	(6,800)
Chemonics International Inc.	(35)	0	-	0	(35)
IOM	1,177,040	5	1,094,190	7	82,850
European Commission	824,425	3	776,645	5	47,780
Global Fund to Fight AIDS, Tuberculosis and Malaria	2,435,006	10	540,993	2	1,894,013
Universities	-	0	38,921	0	(38,921)
The Regents of the University of San Francisco, California	-	0	38,921	100	(38,921)
Asian Development Bank	116,021	0	-	0	116,021
World Bank	-	0	-	0	-
Private Sector	-	0	4,939	0	(4,939)
Health Promotion and Assistance for Migrants	24,904,987	100	16,382,041	100	8,522,946

Top five funding sources for health promotion and assistance for migrants, 2012



C. Migration Health Assistance for Crisis-Affected Populations					
FUNDING SOURCE	2012 EXPENDITURE		2011 EXPENDITURE		Increase/ (Decrease)
	(In USD)	%	(In USD)	%	
Governments	2,891,568	27%	5,488,665	56%	(2,597,097)
Italy	605,794	21%	-	0%	605,794
United States of America	556,672	19%	3,299,996	60%	(2,743,324)
Japan	528,722	18%	-	0%	528,722
Canada	458,078	16%	734,479	13%	(276,401)
Sweden	237,839	8%	687,692	13%	(449,853)
Nigeria	231,621	8%	-	0%	231,621
Australia	138,463	5%	(2,480)	0%	140,943
Germany	134,380	5%	135,418	2%	(1,039)
Switzerland	-	0%	345,154	6%	(345,154)
United Kingdom	-	0%	172,212	3%	(172,212)
Denmark	-	0%	21,598	0%	(21,598)
Belgium	-	0%	(3,109)	0%	3,109
Colombia	-	0%	(7,647)	0%	7,647
Netherlands	-	0%	105,352	2%	(105,352)
United Nations	7,178,701	67%	3,456,404	35%	3,722,297
Central Emergency Response Fund (CERF)	2,980,111	42%	1,393,582	40%	1,586,528
United Nations Office for Project Services (UNOPS)	2,194,548	31%	1,045,457	30%	1,149,091
United Nations Office for the Coordination of Humanitarian Affairs (OCHA)	1,076,704	15%	583,692	17%	493,011
United Nations High Commissioner for Refugees (UNCHR)	549,199	8%	-	0%	549,199
Common Humanitarian Fund for Sudan (CHF)	278,221	4%	358,005	10%	(79,783)
World Health Organization (WHO)	49,997	1%	57,125	2%	(7,128)
Joint United Nations Programme on HIV/AIDS (UNAIDS)	49,922	1%	20,078	1%	29,844
United Nations Children's Fund (UNICEF)	-	0%	(1,337)	0%	1,337
United Nations Development Programme (UNDP)	-	0%	(198)	0%	198

FUNDING SOURCE	2012 EXPENDITURE		2011 EXPENDITURE		Increase/ (Decrease)
	(In USD)	%	(In USD)	%	
European Commission	26,353	0%	462,826	5%	(436,473)
Universities	434,359	4%	230,703	2%	203,656
University Hospital in Linkeoping	434,359	100%	230,703	100%	203,656
Non-governmental organizations	30,000	0%	62,768	1%	(32,768)
AmeriCares	30,000	100%	62,768	100%	(32,768)
Private Sector	149,525	2%	49,755	1%	99,771
Foundation D'Harcourt	115,337	77%	29,145	59%	86,191
United States Association for International Migration	34,189	23%	16,428	33%	17,761
CREADEL – Liban	-	0%	4,181	8%	(4,181)
IOM	-	0%	557	0%	(557)
Migration Health Assistance for Crisis-Affected Populations	10,710,506	100%	9,751,678	100%	958,828
Grand Total	**88,542,557**	**100%**	**73,312,133**	**100%**	**15,230,423**

Top five funding sources for migration health assistance for crisis-affected populations, 2012

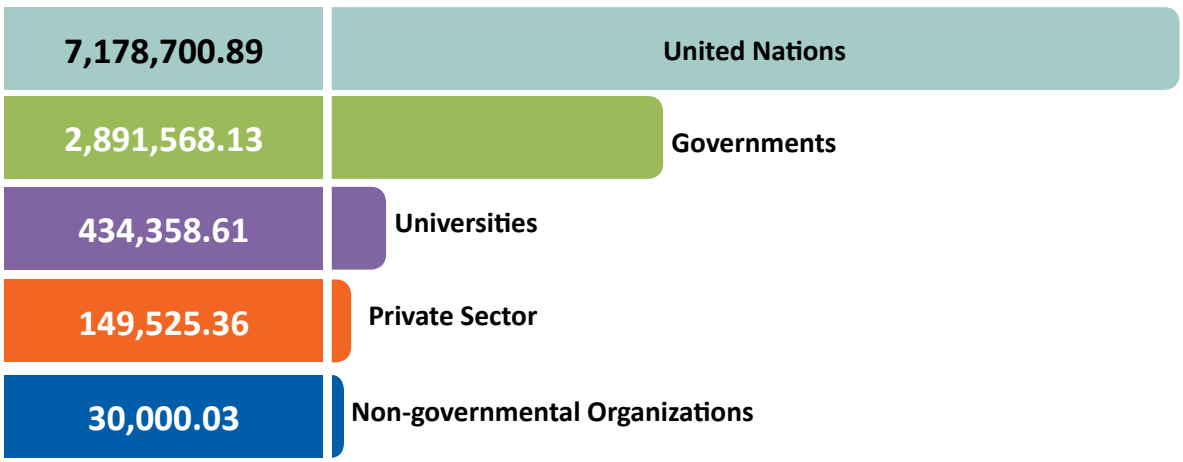
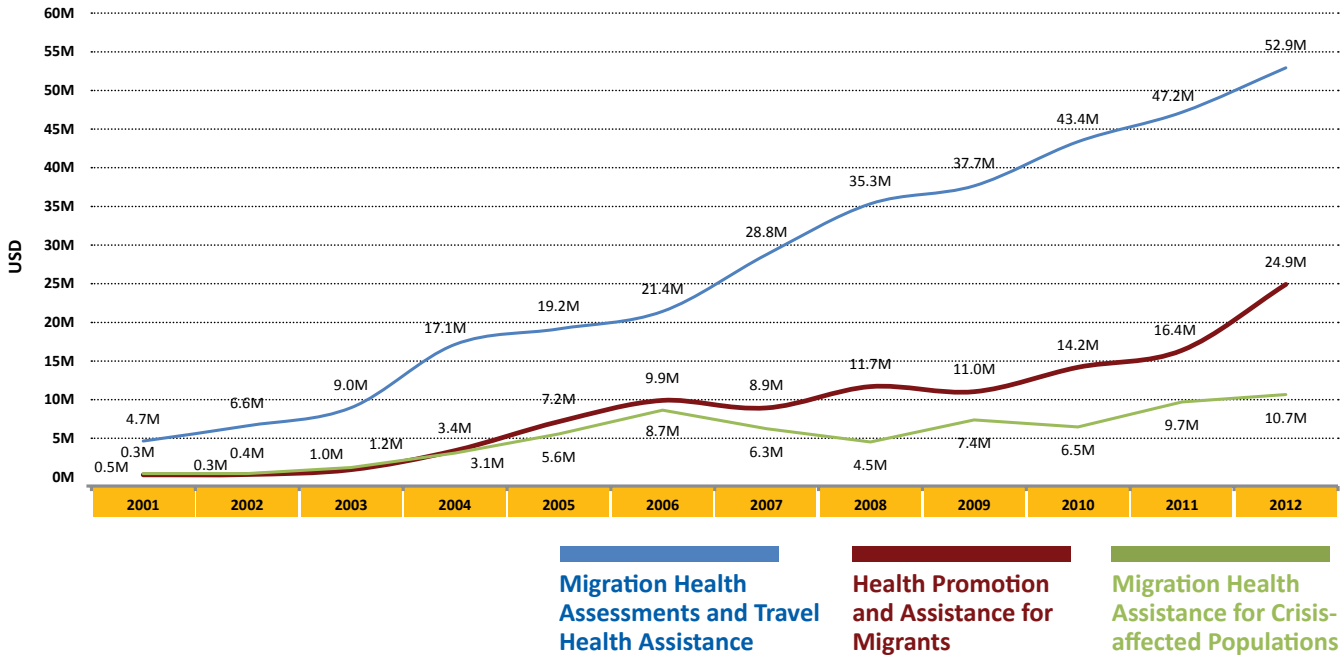


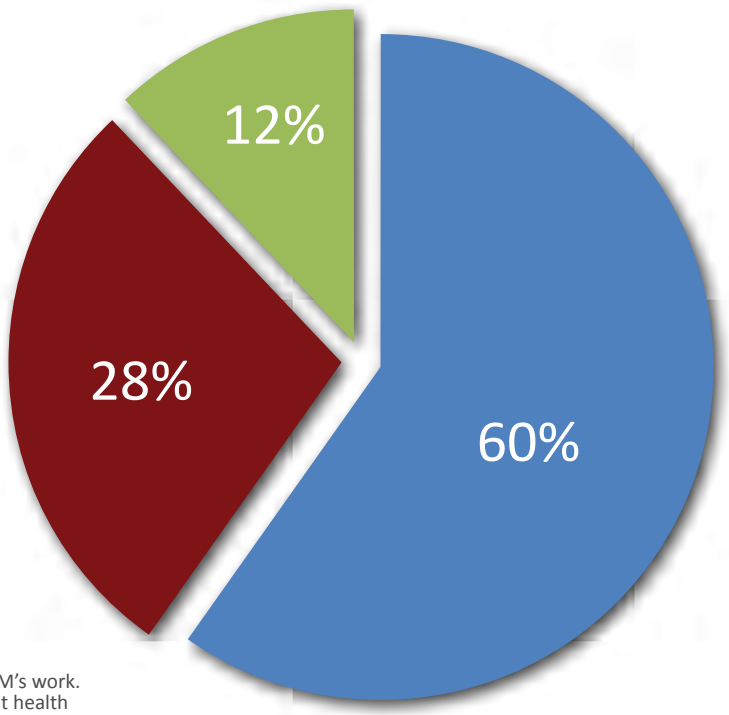
Figure 12.

MHD expenditure by programmatic area, 2001–2012



Total expenditure = USD 88.5 million

Distribution in 2012*



* Health issues cut across all areas of IOM's work. This figure reflects only specific migrant health activities and does not include health-related expenditure integrated into other services.

Figure 13.

MHD expenditure by region and programmatic area, 2009–2012

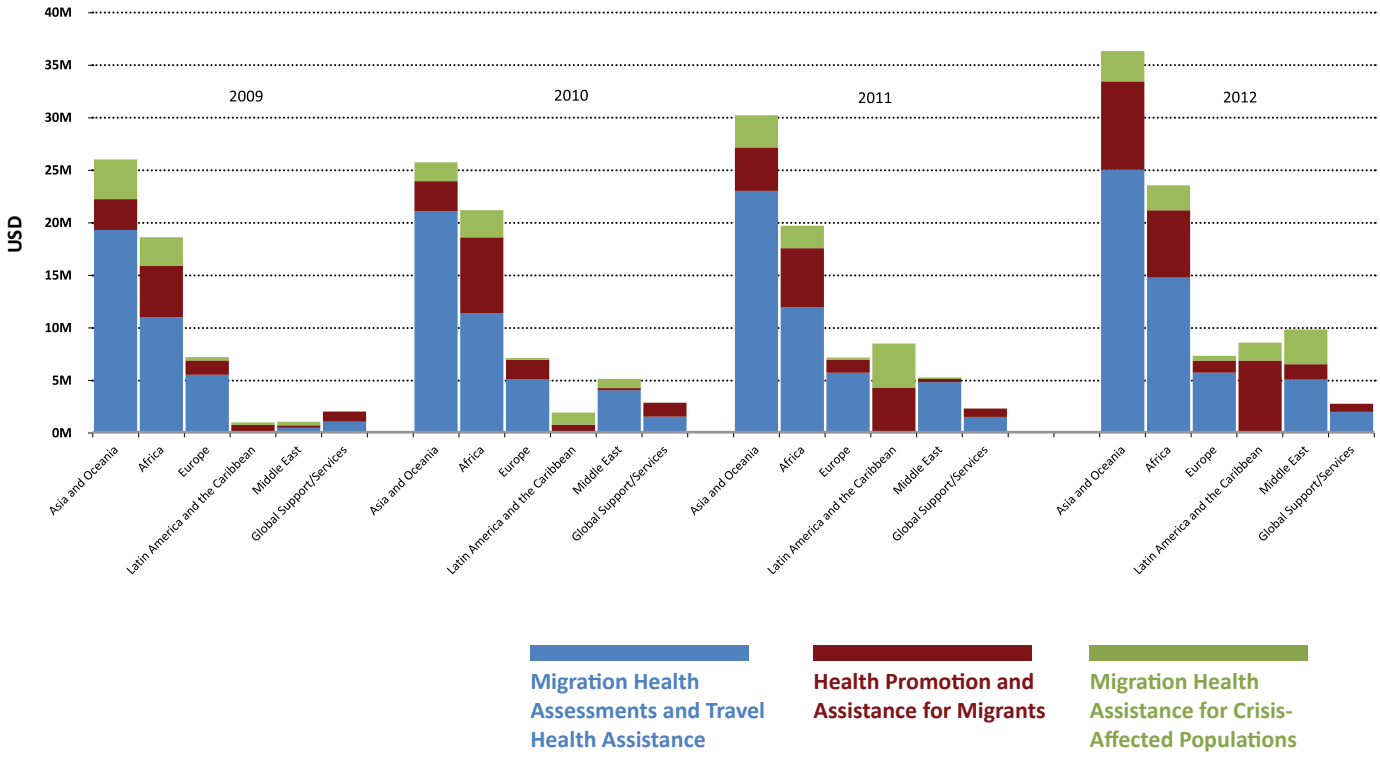
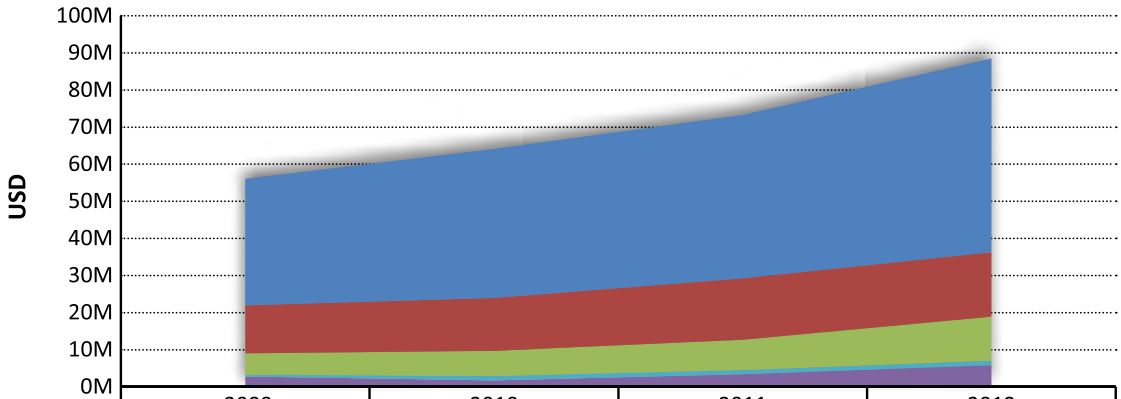


Figure 14.

MHD expenditure by funding source in USD, 2001–2012



	2009 EXPENDITURE (USD)	2010 EXPENDITURE (USD)	2011 EXPENDITURE (USD)	2012 EXPENDITURE (USD)
Governments	34.1M	40.2M	44.0M	52.2M
Fee-based services	12.9M	14.2M	16.6M	17.4M
United Nations	5.8M	6.8M	8.2M	11.9M
IOM	0.5M	1.2M	1.1M	1.2M
Other	2.8M	1.7M	3.4M	5.8M

BY IOM'S SIDE

Thanks to our 2012 major partners

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

IOM is dedicated to promoting humane and oderly 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 oderly and humane management of migration; to promote international cooperation on migration issues; to aid in the search for pratical solutions to migration problems; and to provide humanitarian assistance to migrants in need, be they refugees, displaced persons or other uprooted people. The IOM Constitution gives explicit recognition of the link between migration and economic, social and cultural development as well as respect for the right of freedom of movement of persons.

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

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

IOM • OIM

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