A RAPID ASSESSMENT OF ACCESS TO HEALTH CARE

AT SELECTED ONE STOP BORDER POSTS (OSBP) IN EAST AFRICA

IOM International Organization for Migration

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For copies or further information please contact:

International Organization for Migration (IOM)
Regional Office for East and Horn of Africa
Church road off Rhapta Road, Westlands,
PO Box 55040 - 00200 Nairobi, Kenya
Tel: +254 020 4221000, Fax: +254 2 4449577
E-mail: migrationhealthnairobi@iom.int
Web:http://nairobi.iom.int

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Acronyms

AIDS	Acquired Immunodeficiency Syndrome
BCC	Behaviour Change Communication
CSO	Civil Society Organizations
COMESA	Common Market for Eastern and Southern Africa
EAC	East African Community
FSW	Female Sex Worker
HIV	Human Immunodeficiency Virus
IGAD	Intergovernmental Authority on Development
IOM	International Organization for Migration
NGO	Non-Governmental Organization
OSBP	One Stop Border Post
SADC	Southern Africa Development Community
STI	Sexually Transmitted Infections
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

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Executive Summary

Migration is a central determinant of health, requiring appropriate policy and programme responses. Unprecedented levels of migratory patterns are leading to variability in demographic structures and associated social, economic and public health implications. Cross border populations in East Africa reflect poor health and epidemiological profiles characterized by a heavy disease burden associated with social and economic vulnerabilities. The health and social problems experienced by border communities are multi-faceted including not only infectious and non-infectious diseases but also poverty, poor housing settlements, shortage of safe water and unhygienic sanitary conditions. Additionally, malaria, diarrheal diseases, injuries due to accidents, HIV and other sexually transmitted infections remain a major public health problem in cross border communities. Globally and within some East African countries research on migration has demonstrated a positive association between HIV risk and migrants. Given that migration health concerns are not restricted to national or even regional borders, responses to migration health issues require coordinated regional and interstate frameworks and programmes.

Therefore migration health has started to be conceptualized within the context of political and socio-economic processes of regional integration. For example, the East African Community (EAC), Southern Africa Development Community (SADC), Intergovernmental Authority on Development (IGAD) and Common Market for Eastern and Southern Africa (COMESA) partner states are working towards harmonizing border control with the development of One Stop Border Posts (OSBP). These are intended to ease freedom of transport and movement of people, goods and services between states as both entry and exit procedures will occur at one site.

The implementation of the OSBP framework by member states in the region has implications for migration health. Whereas there has been progress on setting up OSBP in East Africa, there is yet to be corresponding investment and coordination on aspects that affect the health of migrants[1] at border posts. Although the EAC member states have prioritized the

1. At the international level, no universally accepted definition for international "migrant" exists. The United Nations defines migrant as an individual who has resided in a foreign country for more than one year irrespective of the causes, voluntary or involuntary, and the means, regular or irregular, used to migrate. Under such a definition, those travelling for shorter periods as tourists and businesspersons would not be considered migrants. However, common usage includes certain kinds of short-term migrants, such as seasonal farm-workers who travel for short periods to work planting or harvesting farm products (see Glossary on Migration, IOM, 2011). The majority of those migrating, although not all, are migrant workers and their family members. Migrant worker is a person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national (Article 2(1), International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families - ICRMW, 1990). Truck drivers, cross border traders, boda-boda, and migrant women sex workers are migrant workers.

development of an HIV policy and response for migrants, a regional and coordinated response by players in these spaces of vulnerability at OSBP is yet to be developed. Thus this study was commissioned by the International Organization for Migration (IOM) to provide evidence on the context of health services within OSBP and to assess the health vulnerabilities in select OSBP in East Africa. The objectives of the study included: exploring and documenting the health vulnerabilities; and assessing the acceptability, affordability (or in other words economic accessibility) and geographical accessibility of health services at OSBP.

Methods: This was a multi-site study utilising qualitative approaches of data collection. The study included three components: an institutional mapping/health facility assessment focusing on the available health services; in-depth interviews focusing on selected key informants including health service providers, immigration officials and local leaders at OSBP; and focus group discussions with men and women aged 18 years and older, representing different categories of migrants, inclusive of sex workers and truck drivers, as well as members of the host communities.

Study sites: The study was conducted in 6 sites/border posts namely: Uganda/Rwanda (Kagitumba-Mirama Hills); Rwanda/Uganda (Gatuna-Katuna); Tanzania/Mozambique (Mtambaswala-Negomano); Tanzania/Zambia (Tunduma/Nakonde); Burundi/Tanzania (Kober-Kabanga); South Sudan/Uganda (Nimule-Elegu).

Key findings: The study revealed that cross border populations in East Africa are experiencing health and epidemiological profiles characterized by a burden of disease and other social and economic vulnerabilities. The health and social problems at OSBP extend beyond the obvious infectious and non-infectious diseases. Shortage of safe water and unhygienic sanitary conditions as well as poor housing settlements, exacerbate the already precarious social economic status of communities at border points in East Africa. Cross border communities, including both migrants and host community members, have high risk of ill health and other health-related vulnerabilities. The most reported health conditions included: malaria, diarrhoeal diseases, HIV and other STI, injuries due to accidents and respiratory infections.

Most cross border communities surveyed in this study remain unable to access the much needed health services in spite of their poor health profile. This study has shown that migrants and other community members at OBSP have poor access to health care services. The barriers encountered while accessing health services include: long distances to health facilities and the inability to afford the cost of basic health care; in adequate medicines, health supplies and human resources at the existing health facilities, unavailability of health services at some border posts; stigma and fear to access health services particularly for female sex workers

and irregular migrants[2], limited knowledge regarding how to access health care, unfriendly attitudes from facility staff especially at public health facilities, and policy variations among countries affecting access to health, particularly regarding access to anti-retroviral therapy.

At all border posts, there was lack of adequate sanitation facilities and waste disposal facilities both at the border posts and the communities. Some border posts lacked public toilets yet cross border traders and other migrant workers, such as truck drivers and assistants, spend considerable time and sometimes days awaiting clearing of their goods. In quite a number of cases, pit latrines were located less than ten metres from the potable water source, thus risking contamination. Furthermore, there was limited access to safe water sources. A combination of poor sanitation, hygiene and limited access to safe water was reported to have resulted in high prevalence of diarrhoeal diseases. This study revealed that despite the thriving economic activity at OSBP, a large section of the communities were poor, characterized by low income women engaged in petty trade activities, considerably high numbers of unemployed and underemployed youth involved in casual labour activities, overcrowded settlements and lodging facilities with poor sanitary facilities.

Partly due to limited access to health facilities, border communities have resorted to alternative health seeking practices such as self-medication, in some cases use of traditional healers, and tend to use private facilities that were reported to be expensive.

On a positive note, there were a few cross-border arrangements in place especially in respect to joint disease surveillance and joint meetings in case of outbreaks of epidemics. This was particularly reported in Tunduma-Nakonde and Kabanga-Kobero border sites at the Tanzania-Zambia border and Tanzania-Burundi border respectively. There were also promising civil society interventions at different OSBP (such as Nakonde in Zambia) addressing prevention of HIV and other sexually transmitted infections (STI), empowerment of female sex workers and creation of awareness among truck drivers and construction workers, and an informal association of low income women and female sex workers at Kobero in Burundi.

2. Migrant workers and members of their families: (…) (b) (…) are considered as non-documented or in an irregular situation if they do not comply with the conditions provided for in subparagraph (a) of the present article (article 5 of ICRMW). This is the case for migrant women sex workers working in countries where sex work is illegal. More generally, a migrant in an irregular situation is a person who, owing to unauthorized entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or host country. The definition covers *inter alia* those persons who have entered a transit or host country lawfully but have stayed for a longer period than authorized or subsequently taken up unauthorized employment.

1.0. Introduction and Background

Migration is acknowledged to be a central determinant of health, requiring appropriate policy and programme responses (MacPherson and Gushulak 2001). Evidence shows that migrants' health as well as that of host populations presents a challenge to countries, but especially so in cross border regions (Ford and Chamratrithirong 2012; IOM, et al. 2012; WHO and IOM 2010). States therefore face particular and often overlapping concerns on the phenomenon of migration (both internal and international) and the health of their respective migrant and non-migrant populaces (IOM 2011).

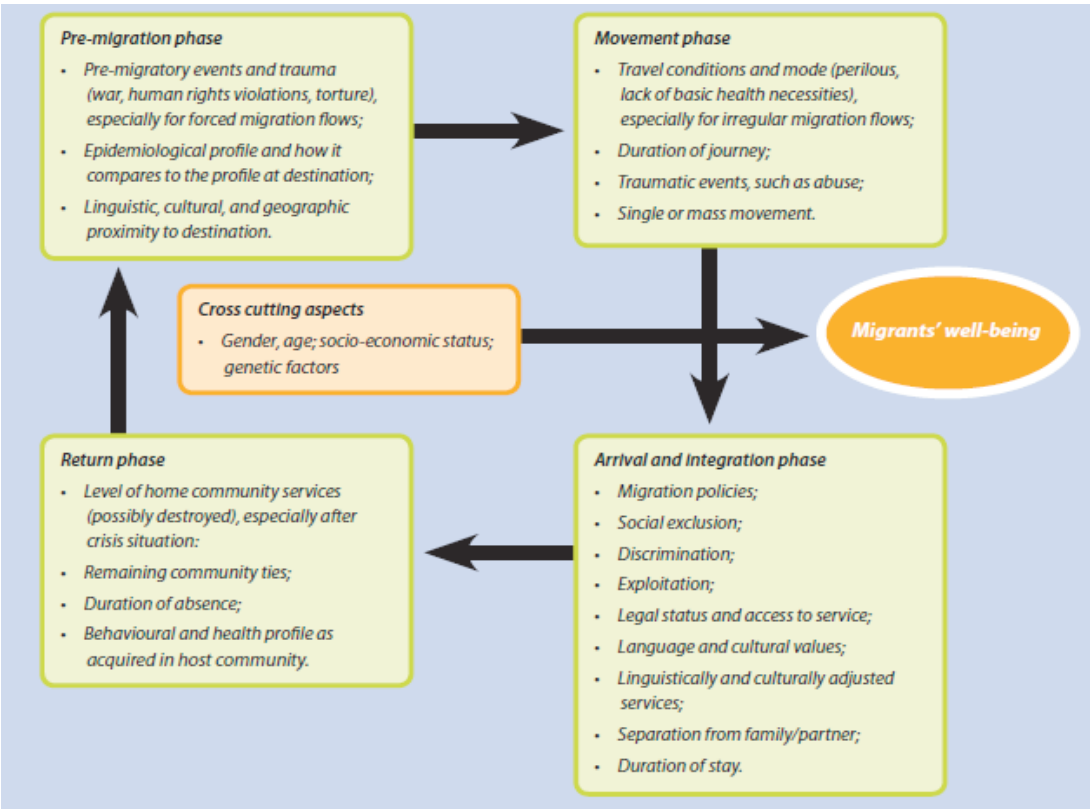
Recent reports and reviews have explored the factors associated with migration and migratory patterns (WHO and IOM 2010), and linkages between migration and health (IOM 2008a; IOM 2008b; IOM 2010b; IOM 2010c; IOM 2011; IOM, et al. 2012; Tansey, et al. 2010; WHO 2010). Migration is, in and of itself, not a risk to health. It has been shown that it is the conditions associated with the migration process that can contribute to the vulnerability of individuals to health risks (Banati 2007; IOM 2010c; IOM and UNAIDS 2003; Martin 2011; UNAIDS 2001). This notion formed the basis for the Resolution on the Health of Migrants which was endorsed by the sixty-first World Health Assembly in May 2008.

Generally, the migration process consists of four distinct phases: the pre-migration phase, the movement phase, the arrival and integration phase, and the eventual return phase (see Figure 1 below). The scheme presented in figure 1 demonstrates the complex linkages between migration and health, and how these linkages can shift and change. Determinants of migrants' health can therefore be identified at each migration phase (CSDH, 2008). Notably, in all the phases, inequalities in access to healthcare and associated inequalities in health outcomes are created by the interaction of three basic variables: the person, place and time (Vearey, et al. 2011). In particular, the contexts and circumstances in which migration takes place, socio-economic and individual factors such as gender, language, immigration status in the country of destination, and culture, all have a significant impact on health related vulnerabilities and access to services (IOM 2010a; IOM, et al. 2012; Ondimu 2010; Watters 2011)

Despite the theoretical and policy debates on migration health, especially those related to health hazards experienced by individual migrants (and their families) and the subsequent challenges they pose to health services (Zimmerman, et al. 2011), measures and approaches to manage the health consequences of migration especially in East and Southern Africa have not kept pace with these debates. In addition, there has not been commensurate

development of coordinated policy approaches to address the health implications associated with migration. There is still inadequate information regarding migrants health needs and as a result this may cause disparity in allocation of health facilities and services that serve migrants and local communities.

Figure 1: Factors affecting the well-being of migrants during the migration process



(IOM, 2010c)

- In the pre-departure stage, migrants' health status is influenced by the health determinants of their home country. When they move migrants generally carry with them the health status they have acquired in their country of origin.

- During the movement process, travel-related conditions may cause health risks, particularly in cases of human trafficking, irregular migration, or displacements brought about by human-made or natural disasters.

- At arrival in host countries, migrants might be exposed to other socio-economic health determinants they may not have encountered in their home country, such

as exclusion, discrimination, exploitation, language and cultural barriers, and limitations to access to healthcare.

- After eventual return, migrants' health is further determined by the availability of and accessibility to national health and social services, including services that facilitate reintegration in their country of origin.

Border areas as "spaces" of vulnerability

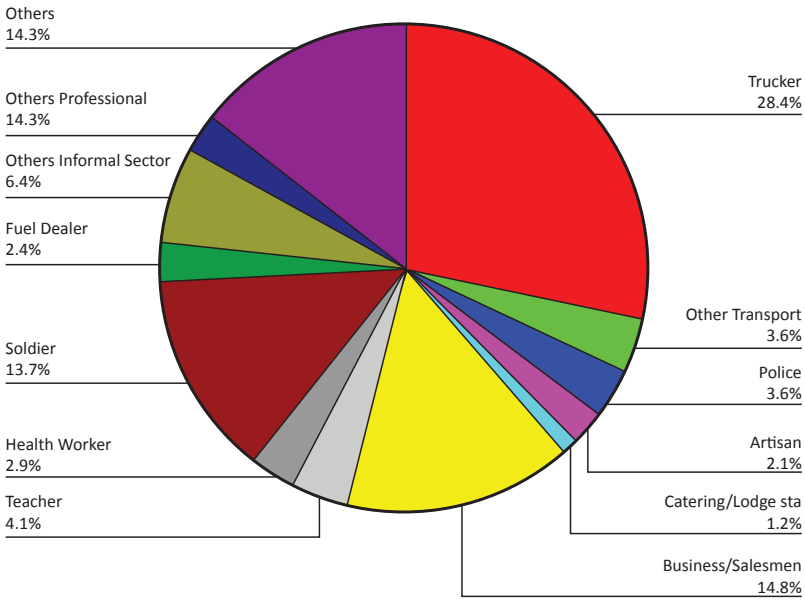
Border areas are spaces of vulnerability. First, borders can involve all four migration phases: (i) individuals may transit through the border space, (ii) move into the border space, (iii) leave the border, (iv) or they may return. Second, border areas are made up of diverse and heterogeneous population groups. For some, the "border space" is transitory. For others, it is home. A border area is therefore an 'interactive space" that involves both one-off and repeated encounters between different groups; each with potentially different health determinants, needs, and levels of vulnerabilities (Vearey, et al. 2011). The groups of people (for example, sedentary populations residing in the 'border spaces' and the different migrant categories) interact in various ways, including through sexual networks (Vearey, et al. 2011). Studies on international migration also indicate that affordable means for migrants to protect themselves are not always available e.g. insecticide treated mosquito nets (ITN) at rented accommodation for travellers and condoms for HIV prevention. While there have yet to be extensive studies done in Eastern Africa, preliminary rapid assessments by IOM in Kenya and Tanzania (IOM, et al. 2012), as well as studies conducted in Southeast Asia and Botswana, have indicated infectious diseases such as tuberculosis (TB), acquired immunodeficiency syndrome (AIDS) and malaria remain one of the most significant public health challenges along borders (Ford and Chamratrithirong 2012; Montague, et al. 2011; Moroka and Tshimanga 2009).

In addition, border regions lack adequate health care services, are characterized by high levels of economic insecurity and in some regions such as the Great Lakes in Eastern and Central Africa, have a recent history of conflict and a sustained common perception of violence. Where health services are available, they may not necessarily be tailored to meet the migrants' needs (WHO and IOM 2010). In addition, factors such as cost of access and language barriers inhibit access to health care services (IOM 2010a; IOM, et al. 2012; Moroka and Tshimanga 2009). Further, for countries shown to have repressive measures to control irregular migration, e.g. criminalizing it[3], such measures may reduce access to health services.

3. Decriminalization of irregular entry and stay, which should never be considered criminal offences, is vital, as, *inter alia*, the UN Working Group on Arbitrary Detention and the UN Special Rapporteur on the human rights of migrants have called for long time.

Studies on international migration also indicate that border crossings are characterized by a socio-cultural context of high risk HIV behaviours and profound mobility, as migrants such as truckers, traders, itinerant sex workers, and others move through these spaces (Crush et al 2005; Haour-Knipe, et al. 2013; IOM, et al. 2012; Oliveira 2012). It is not surprising, therefore, that high-risk groups along transport corridors such as sex workers and truck drivers remain substantial contributors of new infections and remain among the most at-risk populations not adequately covered by prevention efforts. A 2005 study, for example, estimated that along Mombasa-Kampala highways 3,200 to 4,148 new infections occur every year (Morris and Ferguson 2006).

Figure 2: Pie chart of sexual networks - clients of FSW



(IOM and UAC 2008)

The vulnerability to HIV along transport corridors is not restricted to truck drivers and sex workers. Research shows that female sex workers engage with diverse clients, of which only about 28-30 per cent are truckers (IOM and UAC 2008; Republic of Kenya 2005). Other clients of female sex workers come from a range of occupations, and include fuel dealers, businessmen, bar/lodge workers, uniformed personnel (immigration, soldiers and police men), and drivers of other types of vehicles. This shows the extent of sexual networking, thereby supporting the concept of programming within 'spaces of vulnerability'[4].

4. IOM Migration Health Working Definition: The spaces of vulnerability approach is based on an understanding that health vulnerability stems not only from individual but also a range of environmental factors specific to the unique conditions of a location, including the relationship dynamics among migrants and sedentary populations. These factors must be taken into

It has been suggested that in order to combat the negative health consequences of migration, especially in border communities, there needs to be commitment from States and proper coordination and collaboration of all actors, along with strategy and policy development combined with implementation frameworks and advocacy around inclusive and equitable services (Ford and Chamratrithirong 2012; WHO and IOM 2010). In addition, there is need for improved and standardized data collection methods to allow policy makers and practitioners to make informed decisions on how to adequately provide health services to migrants to help improve their health status; what interventions will be helpful in targeting migrants; and how resources should be allocated. This can also help answer questions like should mobile clinics be used; are health care workers adequately trained to identify some of the common health conditions that can affect migrants? Answering these questions could improve the health status of migrants and also greatly contribute to promotion of public health in cross border communities in regions that are already resource constrained and vulnerable.

Regional integration and health service delivery

The Regional Economic Communities (REC) of Sub-Saharan Africa have placed a renewed focus on regional integration in the pursuit of Africa's economic and social regeneration, and are implementing regional integration programmes in trade and economic development as well as regional infrastructure development programmes in transport corridors. This initiative now comprises a key part of the continent's development strategy.

The East African Community (EAC), Southern Africa Development Community (SADC), Intergovernmental Authority on Development (IGAD) and Common Market for Eastern and Southern Africa (COMESA) member states are working towards harmonizing border management with the development of One Stop Border Posts (OSBP). These will ease movement of people and goods between states as both entry and exit procedures will occur at one site. The cooperation of the REC will likely result in a free trade area and increase the free movement of people, goods and services (EAC 2010). All REC have prioritized the development of an HIV policy and response for populations at cross border areas. However, a regional and coordinated response by players in spaces of vulnerability at OSBP is yet to be developed and data on current health context and availability of services is lacking.

Thus to provide evidence on the context of health services within OSBP, the appeal of the current study was to assess the health vulnerabilities in select OSBP in East Africa. This regional study aims to inform larger activities which address all four action points of the

consideration when addressing migration health concerns and interventions must consider and target both migrants and the communities, with which they interact, including families in migrant-origin communities. Spaces of vulnerability are those areas where migrants live, work, pass-through or from which they originate. They may include the following; land border posts, ports, truck stops or hot spots along transport corridors, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant-origin sites, detention centres, and emergency settlements.

Madrid Consultation of 2010 co-organized by IOM, WHO and the Spanish Government, which aimed at operationalizing the aforementioned WHA Resolution on the Health of Migrants. The four actions points are as follows: (1) migrant sensitive health systems; (2) policy-legal frameworks; (3) monitoring migrant's health; and (4) partnership, networks and multi-country frameworks (WHO, 2010). These rapid assessments contribute to the following action points:

- Action point two – providing the evidence for a regional strategy for health, including HIV interventions along transport corridors.
- Action point four— the Regional IOM East Africa team is collaborating with multiple partners and donors including SADC, EAC, IGAD, national governments, local and international NGO and implementing partners working at OSBP and along the corridors. One of the aims of this project is to develop a coordinating mechanism which streamlines healthcare facilities, goods and services and utilizes research to programme effectively within spaces of vulnerability at OSBP.
- Rapid assessments will support the above two action points; in addition, they will contribute to the monitoring of migrants' health through the development of future research and health assessment objectives (Bhopal, 2007).

1.1. Objectives Of The Study

This study sought to assess and document the health vulnerabilities (including vulnerability to HIV) and access to health services of the different population groups (truck drivers, female sex workers, border officials among others) around OSBP. In addition, the study sought to map the existing health services at the different border posts. The study is expected to inform implementing partners and stakeholders who are developing OSBP in regards to evidence-based policies, service delivery and capacity building interventions to support improved health outcomes amongst migrant and local populations.

2.0. Methodology

2.1. Research design

This multi-site study utilized predominantly qualitative approaches. The qualitative approach was selected because it is suitable for exploratory studies where limited information is available. It also facilitates a comprehensive understanding of the context including the social, political and cultural dimensions of the various border posts and how these influence access to health services and perceived health needs of border populations. Limited research on migration health had been carried out in OSBP. This research is aimed at generating information with intent of providing data to contextualize and integrate health within the OSBP model. Given the differences in the social, economic and political context of each country, the study explored how policies and practices in some of the countries affect access to health at the border posts as spaces of vulnerability.

The rapid assessment included three components:

- An institutional mapping/health facility assessment component focusing on the available health services;
- In-depth interviews component focusing on selected key informants such as health service providers (pharmacy, public and private facilities), NGO staff providing services at the OSBP, bar/guest, house/lodge owners or managers, and selected community leaders;
- Focus group discussion component for men and women aged 18 years and above, representing different categories of populations in and around OSBP.

2.2. Study sites

These border posts were selected because of their unique socio-economic dynamics and strategic location. It should be noted that these border posts are at different stages in the process of becoming fully operational OSBP. Whereas some like Kabanga –Kobero are in advanced stages, others like Gatuna- Katuna are still in the process of becoming functional.

1. The study was conducted at six border posts listed below:
2. Rwanda/ Uganda (Kagitumba-Mirama Hills);
3. Rwanda /Uganda (Gatuna-Katuna);
4. Tanzania/Mozambique (Mtambaswala-Negomano);
5. South Sudan/Uganda (Nimule-Elegu)

6. Tanzania/Zambia (Tunduma-Nakonde);
7. Burundi/Tanzania (Kober-Kabanga);

2.3. Study population

The study focused on different population groups at the selected sites, including female sex workers (FSW), truck drivers, night club/bar and lodge owners/attendants, itinerant traders, business/salesmen, customs and immigration officials, uniformed personnel (such as security personnel), health service providers (pharmacy, public and private facilities), staff of NGO providing services at the OSBP, community leaders and others. Estimates were obtained and information on migrants from immigration officials, community leaders and service providers at each OSBP and consequently derived a sample to be interviewed.

2.4. Data collection

2.4.1. Institutional mapping

An institutional mapping exercise was undertaken to establish service providers within a radius of 5 kilometres (km) of the border post involved in the provision of health services in the adjacent communities on both sides of the border. However, because some of the facilities were beyond the radius of 5km, facilities nearest to the border posts under study were included. This assessment intended to ascertain the range of health services that are currently available, along with the location and capacities of the different health service providers to deepen understanding of the health needs and service delivery gaps in these 'spaces of vulnerability'. In total, twenty nine facilities serving different border communities were assessed.

Table 1: Number and type of health facilities assessed at OSBP

Border Post	Government Owned	Private Owned	Total
Kabanga (Tanzania)	2	1	3
Katuna (Uganda)	1	3	4
Gatuna (Rwanda)	2	0	2
Mutambaswala (Tanzania)	1	1	2
Elegu (Uganda)	1	1	1
Mirama Hills (Uganda)	1	5	6
Kagitumba (Rwanda)	2	0	2
Tunduma (Tanzania)	3	1	4
Kobero (Burundi)	1	1	2

Nakonde (Zambia)	1	2	3
Total	14	15	29

2.4.2. Focus group discussions (FGD)

Focus group discussions (FGD), each comprising 8-12 participants, were conducted with different population groups at the selected OSBP.[5] Effort was made to include participants from both sides of the border. All FGD were audio recorded with consent and transcribed into English thereafter. Discussions lasted approximately ninety minutes.

Table 2: Category of FGD conducted by study site

Study Site	FSW	Truck Drivers	Community Leaders	Male Community Members	Female Community Members	Health Workers	Immigration Officers
Tunduma	1	1	-	1	1	-	-
Nakonde	1	1	1	1	1	-	-
Mtambaswala	1	-	1	1	1	-	-
Negomano	-	-	-	1	1	-	-
Kabanga	-	1	-	1	1	-	-
Kobero	1	1	-	1	1	-	-
Mirama Hills	1	-	1	-	-	1	1
Kagitumba	1	-	-	-	-	-	-
Katuna	2	2	1	1	-	-	-
Gatuna	1	1	-	-	-	-	-
Tunduma	-	-	-	-	-	-	-
Nimule	-	-	-	-	-	-	-
Elegu	2	1	-	-	-	-	-

2.4.3. In-depth interviews (IDI)

In-depth interviews were conducted with selected informants at the six sites.[6] These included:

1. Health services providers (pharmacy, public and private facilities);
2. Immigration officials;
3. Staff of NGO providing services at the OSBP;
4. Bar/guest house/lodge owners or managers;
5. At least two community leaders at each site;
6. Selected members of cross border communities with unique circumstances such as sex workers, clients of sex workers, cross-border traders and casual workers.

5. Specific groups not mentioned were determined in consultation with gate keepers/community leaders for each site.
6. These categories changed depending on the context and dynamics of a particular border site.

In-depth interviews with selected informants were conducted to explore and deepen our understanding of issues relating to health vulnerabilities and access to services for vulnerable populations at OSBP.

Table 3: Category of IDI conducted by study site

Study Site	FSW	Community Leaders	Bar/ guesthouse/ lodge Managers	District Administrators	Health Workers	DMO	Immigration Officers / Border Guards	NGO Staff
Tunduma		2		2		1	2	2
Nakonde	1		1	1			1	2
Mtambaswala				1	1	1	1	
Negomano						1	1	
Kabanga				1	2	1	1	2
Kobero								
Mirama Hills		2	2		1		1	1
Kagitumba	1				1		3	
Katuna		1	1	1	1		1	1
Gatuna	1	1			2		1	
Nimule		1					3	
Elegu		1		1			2	

2.5. Data management and analysis

Focus group discussions and in-depth interviews were transcribed *verbatim* into Microsoft Word. No names were included in the transcription. Each speaker was identified by gender, a reference number provided by the moderators and a location based code. Either native speakers or native speaker facilitator/translators were recruited. When recorded, all transcriptions were translated into English and checked by the facilitator. Data were coded and analyzed using NVivo QSR, qualitative text analysis software. Deductive content analysis techniques were used to identify emerging categories linked to health vulnerability issues at OSBP. As a first step in analysis, the team read all transcripts and identified recurrent themes to develop a coding tree. Once all the transcripts were coded, memos and display matrices were developed to examine each code in detail for sub-themes, nuances, and patterns across interviews.

Deductive content analysis was then used to determine how respondents perceived health vulnerabilities and the challenges they faced in health care seeking at OSBP. Patterns in responses were compared to existing data from literature regarding the challenges faced in health service provision and health care seeking among migrants to identify convergent and other emerging issues. Relying on manifest analytical approach, converging issues were again

reviewed by the rest of the research team and where interpretation differed, consensus was achieved through revisiting the raw data and discussions. Where necessary, quotations that best represented emerging issues were edited slightly for flow, but the meaning of the text was preserved.

2.6. Ethical considerations

Informed consent was obtained from all respondents prior to the interviews. Study participants were informed about the purpose of the study and the scope of the issues in the in-depth interview guide. Confidentiality was ensured in data management, and only aggregate information without subject identifiers is reported. All data were secured in a safe location accessible only to the study team. Study approval was obtained from the following local country Institutional Review Boards:

1. The National Health Research Committee in Rwanda (Ref: NHRC/2013/PROT/0104);
2. The ERES Converge IRB in Zambia (Ref. No. 2013-June-001);
3. The Higher Degrees, Research and Ethics Committee at Makerere University School of Public Health (Protocol 221, IRB00011353);
4. The Uganda National Council for Science and Technology (SS 3096):
5. Permission was also sought from local government officials in Tanzania, Rwanda, Mozambique, South Sudan and Uganda prior to undertaking field activities.

2.7. Limitations of the study

This was a rapid assessment that followed a cross sectional design. Comparison of sites was made difficult because the populations were different and the level of businesses differed widely. For example some border posts had minimal business activity and could not attract key populations. This means that conclusions drawn from comparing across border posts may be more suggestive than indicative and thus call for further research to inform interventions tailored to the specific border contexts.

3.0 Results

3.1. Migrants at One Stop Border Posts (OSBP)

The selected OSBP examined in this study are home to a diverse and heterogeneous population. For some, the "border space" is transitory. For others, it is home. Migrants include temporary and longer term migrant workers, such as cross-border traders, truck drivers and their assistants and migrant FSW. These interact, in various ways, with other border population groups such as uniformed security personnel, local community leaders, and civil servants like customs and immigration officials. For example, truck drivers may have to wait for long periods of time as they await inspection and clearance from border authorities; thereby leaving them time to develop a variety of relationships with the surrounding communities (for example sex workers, low income women, health officials, patrons of bars and lodges).

3.2. Health vulnerability at OSBP

Our findings indicate that the health vulnerabilities of migrants at the different OSBP stem from a complex interaction of factors that relate to the migration process, long periods away from home, separation from family members, limited availability of social services, limited access to health care and education, unhygienic living conditions and a environment characterized by inadequate social protection. These factors are discussed in turn below:

Migration process and status

Our findings indicate conditions surrounding the migration process can increase vulnerability to ill health. The most common factors engendering specific health vulnerability among migrants at cross border communities were patterns and frequency of mobility, travel conditions and associated mode of travel, and duration of the journey. These factors were reported to pose serious health risks to migrants.

Mobility also affects access to and utilization of health services. Specifically it is associated with delays in seeking treatment, especially during transit consequently turning minor health problems into life threatening illnesses. For example, truck drivers interviewed reported that on several occasions they fail to seek healthcare services on time due to the perception that this will delay their travel schedules.

> *"….many times we have situations where you get an accident and a serious injury, where by medicine from the local shop is useless. Here when you are supposed to go to Gulu or*

Lacor hospital for care, you miss that because it takes more than 2 days yet you will be going ahead with the trip…you cannot use that option." (FGD with trucker drivers, Elegu)

Similarly, high mobility was reported to affect adherence to treatment. Adherence monitoring was also reported to be a challenge because they could not be tracked by health providers. Conditions requiring long-term treatment were reported to be difficult to monitor due to high mobility of those afflicted. In addition, the process of migration is sometimes so stressful and traumatic that often migrants appear to overlook their health and safety.

Risky sexual behaviours

Findings also reveal that migrants and border communities engage in risky sexual behaviours, which increases their vulnerability to HIV infection and other STI. Discussions with study participants revealed that migrants at OSBP such as trucker drivers tend to spend long periods away from home. Separated from their familiar social structures and from shared norms and values, language and social support, thus they are more likely to engage in risky sexual behaviour. The narratives we collated reveal that border spaces often lack strong community cohesiveness, and that the anonymity created by the fluid social environment at OSBP, as well as the diversity of migrants, affect adherence to social norms that regulate behaviour in stable communities. Moreover, lengthy delays at border crossings can turn those areas into hotspots for high-risk sexual activities.

"For me if I start from Mombasa to Sudan, it can take me about one full month on average. The same applies to other trips across East Africa… I am looking for a second wife because I take too long to go back to my family. I think I need to have another wife that I can spend time with when am away from home… Like I told you it takes me too long to get back to my family and I cannot control myself." (FGD with truck drivers, Katuna)

"Truck drivers and their assistants are susceptible to sexually transmitted infections, including HIV. Because of formalities at customs, they can stay here for about a week or more. This makes them stay away from their partners for long. They therefore may not be patient to wait to go back to their families." (Immigration Officer, Tunduma)

"Imagine. You are here. Don't you see vehicles parked? Does it mean that the offices are not working? They are open but we may spend the whole day here. As you can see we are sitting here waiting for services and they may delay for the whole day. If in the process of waiting I find one Maria (their code for woman) and she invites me to her home for sex, I cannot hesitate because I would have nothing else to occupy me. I go there, return and move like any other person here (laughter)." (FGD with truck drivers, Gatuna)

Transactional sex around OSBP

Border posts comprised a high proportion of young women and men from communities near and far, attracted by perceived economic opportunities at border posts. However, the shortage of employment and other income generating activities restricts many of the young women to sex work, as reflected in the statements below:

> *"Many young girls are unemployed and sex work is their only means of survival. So it is a risk to them because they can easily get sick with HIV and other STIs like Syphilis."* (FGD with FSW, Elegu)

> *"…because of a poor economy here in Kabanga, Female Sex Workers (FSW) disturb the truck drivers knocking on their window screens asking for money in exchange for sex."* (KII with Officer in-charge of a dispensary, Kabanga)

> *"There are sex workers. These FSW are many in bars and guest houses. Some come from Dar because they hear that Tunduma is busy. They have already decided that this benefit is their main source of getting money… some disguise as bar maids"* (Immigration Officer, Tunduma)

> *"Many come from their villages: they live here, rent houses but have no money to pay so these truck drivers offer them the means. Some of these ran away from a hard life in the villages so they look up to the peri-urban areas for better opportunities which at times do not really surface. When they come to town, they engage in sex work. They go to bars and hotels, seek for employment but aiming at getting clients…"* (FGD with female community members, Kabanga)

FSW represent a vulnerable population at OSBP. They are particularly at risk of infection with HIV/STI, violent victimization, and other health risks. Focus group discussions with FSW reveal a range of factors that places them and their clients at risk of HIV. FSW revealed that some of their clients plainly refuse to use condoms (citing the desire to feel "skin on skin") or offer more money for condom-less sex, which FSW can hardly turn down because of economic hardship. FSW also reported that negotiating for condom use was quite difficult especially in the presence of a language barrier or under the influence of alcohol. Some FSW also reported cases of condom breakage during intercourse with their clients. Situational factors, especially those associated with male clients' behaviours, were the most important predictors of breakage, including sexual roughness and violence.

" The issue is money. When a condom is used and it bursts the price rises because then this is considered 'live sex' [unprotected sex]. And because of the many needs, when a client asks for 'live sex' which means more money: for example 200,000 Zambian Kwacha (about $40+) instead of 50,000 Kwacha (about $10) for protected sex we normally go for live sex." (FGD with FSW, Nakonde)

"… when am with the truck driver we discuss to use condoms. If he refuses, and since am in need of money, I oblige and this is what most of us do. If the man uses a condom he pays less. If not, he pays more. Because I have nothing to eat, even if he gives 5000 or 10000 Burundi Francs (about $3 or $6), I take it." (FGD with FSW, Kobero)

It was also reported that women accept temporary marriages with migrants to avoid the stigma associated with being perceived as FSW. Study participants observed that women in such relationships are likely not to demand and insist on condom use.

FSW are also sometime subjected to violent victimization by their clients, placing them at an increased risk for infection.

*"There are times when a man goes to pick a FSW and suggests taking her to his home/ room. Getting there, find 5 other men, who all want to have sex with you. For instance, these bruises [participant shows off her bruises to the FGD moderator and note taker], are a result of this very experience. The men took my phone and all the money I had and they took off. The other experience was when I was coming from a bar, one motorcyclist stopped me and agreed with me to have sex so I jumped on the motorcycle, he drove me too far — towards the border hills of Tanzania and Zambia. While there, he called his friends and when I heard this, I got into a scuffle with him and he had a knife so he stabbed me. But I managed to run away from him, hid in the bush till morning." (*FGD with FSW, Nakonde) *"I had experiences where we agreed on a fee with my client but after being used [after sexual intercourse] he turned against me and beat me up. One time I was beaten with a bottle; so these are some of the risks we face."* (FGD with FSW, Nakonde)

Poor water quality, sanitation and hygiene

Good hygiene, sanitation and access to safe water contribute to physical, emotional and mental health. This study however indicates that most border areas are characterized by lack of safe and sanitary living spaces, with limited access to affordable safe food and water. The absence of washing and sanitary facilities places border communities at increased risk of waterborne diseases like cholera and diarrhoea. For example at Elegu-Nimule border site,

participants reported that they sometimes bathe and wash in the River Aswa. Similarly water shortage was observed to be a big challenge at Kabanga-Kobero and Tunduma-Nakonde border posts thus affecting the hygiene practices of host communities and migrants.

> *"Here we don't have good [safe] water. We get domestic water from downstream— it is a small stream called Kazanye and when it rains, we find the water so dirty. There is no piped water in the community. There is a built water spring but when it rains we don't use it because it is dirty."* (FGD with FSW, Kobero)

> *"The major problem here is water shortage. If you don't wake up early in the morning and go for it at 10am, it means that day you will not get water. So water comes first before we go for work…the other thing is poor sanitation. The environment is contaminated and this contaminates the well (the most used water point/source)... The distance to the water source takes between 30 minutes to an hour walking on foot."* (FGD with female community members, Tunduma)

Similarly, study participants at Tunduma mentioned the lack of toilet facilities and poor waste disposal practices as a major problem, and considered this to be the leading cause of outbreaks of diarrheal diseases.

> *"You go to the harbour at Dar es Salaam, you are staying there for 2 weeks but there is no specific parking for trucks and no toilets for truck drivers. So what about our health?"* (Interview with truck driver, Tunduma)

> *"There is a lot of garbage dumped, leftovers dumped and children go there to pick these foods contaminated by flies, leading to diseases like diarrhoea. People are building settlements close to these water sources, and latrines are side by side with water points. Yet ideally water points should be about 75m away from settlements but this is no longer the case nor is it realizable… there is no public toilet, no public bathroom and no water for the migrant workers and travellers."* (FGD with community members, Tunduma)

Furthermore, while at many OBSP some migrants are able to rent decent accommodation, many reported that they often lived in crowded and unsanitary lodgings. As such, most of the health problems that respondents faced were closely related to the poor living conditions. These included respiratory tract infections, musculoskeletal problems (often described as generalised body pain), and skin diseases.

Limited access to health care and services

Limited access to health care was also reported to contribute to vulnerability of migrants as well as their host communities. The transient nature of populations at the various border posts limits their access to health care services such as HIV prevention, care and treatment, TB diagnosis, treatment, screening and treatment of sexually transmitted infections (STI), as well as treatment for common ailments like malaria, diarrheal diseases and respiratory tract infections (RTI). In addition, they are more likely to delay health care-seeking, and miss out on opportunities for health education and behavioural change communication campaigns. They also face challenges adhering to treatment regimen. A detailed discussion of health seeking practices and barriers to health care access is provided in the preceding sections.

> *"The lack of access to proper treatment forces migrants to adopt some very unhealthy behaviour when falling ill. Upon falling ill, they would typically wait and see in the beginning, hoping the illness would go away. If the situation got worse, they would go to small pharmacies to buy medicines according to their own medical knowledge. Only when the illness becomes unendurable would they visit hospitals, by which time, the disease may have already become very serious."* (KII with senior health worker, Kabanga)

Violence and exploitation

Some members of the cross border communities reported experiencing physical and psychological trauma. During the migration process, many migrants experience conflict, violence, rape or other forms of sexual violence in their countries of origin or during their journeys (Nguyen Van, et al. 2010; Oliveira 2012). In this study, participants including truck drivers and cross border traders reported suffering physical violence at the hands of uniformed personnel or other administrative personnel in host communities. Such acts of violence from uniformed personnel were perceived to exacerbate feelings of psychological trauma as illustrated below:

> *"Here (South Sudan), there is a heavy military presence compared to the Ugandan side. We are here now, our trucks are in Sudan awaiting customs clearance, but we are here because it is rough across, not safe. They can shoot you anytime, any mistake you make, and they are rough…"* (FGD with truck drivers, Nimule)

3.3. Migrants' health care needs and access to health services

3.3.1. Common health problems

Study participants perceived the common health problems at border posts to include common ailments such as malaria, respiratory tract infections (RTI), diarrheal diseases, skin infections, and sexually transmitted infections (STI) including HIV and AIDS. Malaria and

diarrheal diseases were perceived to be among the most serious health problems. Notably, these diseases are associated with poor sanitation and hygiene practices evident at most OSBP.

3.3.2. The state of existing health services at OSBP

Availability and accessibility to health services

The availability of and access to health care services at the OSPB varies from one situation to another. Formal public health services were limited and in some areas almost non-existent. For instance, at Elegu border there is no public health facilities. At Elegu border post, there was only one dispensary (on the Uganda side) run by the police, while in South Sudan there was only a health centre run by an NGO but contracted by the South Sudan government to cater for cross border communities. Other facilities were available in Atiak and Gulu which are 40km and 70km away from Elegu respectively.

At several other border posts such as Mtambaswala (Tanzania), Tunduma (Tanzania) and Gatuna (Rwanda), the health facilities were located far from the border posts. For example at Mtambaswala, the dispensary was located 15km from the border while the hospital was located 40km away. At Tunduma the public health facility is located within several kilometres away from the border and receives a very large proportion of the population in the area. At Gatuna, truckers reported that the nearest accessible health facility for them is 40km away at Byumba although other respondents reported nearer but off-road and distant facilities at Gicumbi and Rubaya villages.

> Moderator: *"Are you sure that as we speak there is no health facility on the Rwandan side of this Gatuna border?"*
>
> Response: *"There is none on the Rwandan side. If we had a health facility here at Gatuna (Rwanda) the service would benefit more than 1000 people that use this border. It is as important as you see that restaurant. We do not know of any health facility on this side except the one at Byumba which is 40km from the border. Once you cross the border, the next health facility is at Byumba. At Byumba we also have Dr. Bugingo's clinic where all laboratory tests can be done."* (FGD with truck drivers, Gatuna)
>
> *"The main health facility we have is in Gicumbi, and we also have a dispensary in Rubaya, but sometimes you reach there and you find they cannot treat you and they refer you to that hospital in Gicumbi and the major challenge here is the ability to get there in terms of transport, and yet sometimes you do not have mutual health insurance and that becomes a problem."* (FGD with FSW, Gatuna)

"There is a man we are using. Actually he is I think a medical assistant. He has a clinic somewhere there. So when there are people who are sick among us including civilians, we just call and tell him to come and see the patients, prescribe and dispense drugs. We share with the community because they have the same healthcare problems like us although the drugs are not exactly enough to handle that big number." (FGD with uniformed personnel, Mirama Hill)

At most border posts, private for profit facilities are an important source of health care services. These facilities have different functional capacity and offer a varying degree of services. The distance of the facilities to the OSBP also varies. For example in Tunduma, three functional private health clinics were visited, located within a radius of 2km from the border post. Contrastingly, at Kabanga border post, a private dispensary was located within metres from the immigration department.

Table 4: Facilities at the different OSBP

Name of border post	Facilities Available			
	Government Facility	*Private Clinic*	*NGO Clinics*	*Pharmacy/ drug stores*
Kabanga (Tanzania)	2	1		
Katuna (Uganda)	1	3		
Gatuna (Rwanda)	2	0		
Mtambaswala (Tanzania)	1	1		
Elegu (Uganda)	1	1		1
Nimule (South Sudan)	1	1		
Mirama Hills (Uganda)	1	5		
Kagitumba (Rwanda)	1	0		
Tunduma (Tanzania)	3	1		
Kobero (Burundi))	1	1		
Nakonde (Zambia)	1	1	1	

Health services available at various OSBP

This study involved mapping of existing service providers at the different OSBP to ascertain the nature of services provided. In total 30 facilities were surveyed, with the majority of facilities being private-for profit facilities (15), while the rest were public health facilities. Most of the border posts have at least one facility providing treatment for common ailments like malaria, diarrheal diseases, upper respiratory tract infections, backache and fatigue (see Table 5). Table 6 provides an overview of the HIV and AIDS services provided by facilities.

Table 5: Number of facilities providing treatment for common ailments at OSBP

COMMON AILMENTS	Number of Facilities Providing Services											
	Nimule (n=1)	Kabanga (n=3)	Katuna (n=4)	Mutambaswala (n=2)	Elegu (n=1)	Mirama Hills (n=6)	Tunduma (n=4)	Kobero (n=2)	Nakonde (n=3)	Gatuna (n=2)	Kagitumba (n=2)	Total (n=30)
Malaria treatment	1	3	4	2	1	6	4	1	2	2	2	27
Treatment for diarrheal diseases	1	3	4	2	1	5	4	1	2	2	2	27
Treatment for upper respiratory tract infections	1	3	4	2	1	3	4	1	2	2	2	25
Treatment for backache	1	3	4	2	1	6	4	1	3	2	2	29
Treatment for fatigue	1	3	4	2	1	1	3	1	2	2	1	21
Treatment for skin infections	1	3	4	2	1	6	4	1	2	2	0	26
Treatment of occupation related injuries	1	3	3	2	1	4	4	1	2	0	2	23

Table 6: Facilities providing HIV and AIDS services (n=30) at OSBP

SERVICE	Number of Facilities Providing Services										
	Kabanga (n=3)	Katuna (n=4)	Mutamba swala (n=2)	Elegu (n=1)	Mirama Hills (n=6)	Tunduma (n=4)	Kobero (n=2)	Nakonde (n=3)	Gatuna (n=2)	Kagitumba (n=2)	Total (n=29)
HIV counselling and testing	3	3	2	1	3	4	1	4	2	2	25
Condom promotion and distribution	3	4	2	1	5	3	1	4	2	2	27
Behaviour Change Communication (on STI and HIV and AIDS)	2	4	1	1	4	4	1	4	2	2	25

ART	2	1	2	0	1	1	1	1	2	2	13
Treatment of OIs	2	4	2	1	2	3	1	1	2	2	20
Diagnosis and treatment STIs	3	3	2	1	4	4	1	4	2	2	26
Livelihood activities which reduce HIV and AIDS Vulnerability	0	1	0	0	2	1	0	1	1	2	8

3.3.3. Health care-seeking behaviours

Four major themes emerged from the narratives of the study participants on health care seeking behaviour of migrants at OSBP: (i) acceptable and unacceptable pain/discomfort, (ii) preference of private health care facilities, (iii) self-medication, (iv) transnational health seeking behaviour, (v) postponement of treatment in order to seek health care at 'home.'

'Pain' or 'discomfort' and health care-seeking decision

Our findings indicate that migrants' decision to seek and to continue to use health care services is influenced by the presence and magnitude of pain. Migrant narratives show that they do not seek professional health care until they experience a certain level of 'pain' or 'discomfort'. Minor pain is often ignored, and the absence of pain is considered an acceptable level of health. Thus, many of them often ignore and tolerate illness for a long period of time and do not seek professional health care until pain becomes unbearable. In addition, some reported that they did not continue treatment, pursue follow up care, or take medication once discomfort, pain, and other symptoms were alleviated.

Overall, study participants revealed that most migrants are disinclined towards seeking preventive health care (for example, regular check-up or screening) and do not see a 'doctor' as long as they do not have symptomatic pain.

> *"Screening or regular check-up is a 'foreign concept' for them. There is no concept of preventive care such as regular check-up or screening. In their perception, health or wellness means 'no pain' or 'not having discomfort'. Thus, most of the patients came to the clinics or hospitals at the very late stage of illness."* (Officer in charge, Masuguru dispensary)

This suggests that policy intervention and consistent health education from health care providers about the importance of primary and preventive health care may result in changes to Marshallese health care behaviours.

Preference for private facilities

Study participants were asked about their preferred choice of treatment facilities. Overall, majority of participants indicated preference for private health care facilities. Our findings illustrate that migrants, especially truck drivers and cross border traders/travellers, are more likely to use private health facilities, especially where they were perceived to provide faster and quality services compared to public health facilities. In addition, some reported using private facilities/clinics because they tended not to inquire about their immigration status as the quote below illustrates:

> *"…they don't ask migrants about their background".* (FGD with truckers, Elegu)

Common explanations for not seeking health services at government health facilities included; long distances, busy business schedules, high transport costs, long queues, corruption and the perennial absence of prescribed drugs. The situation at a typical government health facility was commonly described as below:

> *"You find that you are in the queue for a long time. Sometimes even children die while in that queue. So at times we end up preferring to stay at home painfully. At times to get timely treatment, you need to pay a bribe which money we don't always have. There is a shortage of health workers. At times you find only one or two to attend to a long queue. And when they attend to you, they tell you they don't have the needed drugs so they refer you to buy. An improvement of services at the facility only comes when they expect a Member of Parliament or minister to visit the facility. At times they attend to you at the public facility and prescribe for your panadol, coartem, amoxyl syrup etc. but the doctor ticks all those indicating that he has given them to you yet in actual sense he has only given you panadol. Where do the others go? The environment at the facility is bad during rain with pathetic toilets that are sometimes blocked."* (FGD with FSW, Nakonde)

Similarly during an FGD with women at Kobero, some study participants described how they had been told vaccines for under five are free and available at a public health facility. However, when they go to the public health facility on the vaccination days, the facility runs out of vaccines and they are consequently told to leave.

Alternative forms of health-seeking behaviour

In the absence of, or where access to formal biomedical health services is limited, cross border populations at the different OSBP employ a range of alternative strategies when seeking health services. These strategies include:

Self-medication

A common strategy among the respondents was self-diagnosis and self-medication. Self-treatment was especially common in the case of minor or mild, non-threatening illnesses. Self-medication involved mainly buying medicine without prescription at private-for-profit pharmacies and drug stores. The majority of FGD participants mentioned that they purchase medicine at pharmacies or local drug stores to treat themselves. This preference for pharmacies or local drugstores as the first stop for self-medication was primarily because of the reported convenience but also due to the perceived lower costs involved. In addition, at such facilities participants reported that they were able to negotiate for cheaper prices, and drug stores are easily accessible, which reduces the opportunity cost of time away from work and traveling longer distances to access care as illustrated below:

> *"The service from the pharmacy is not bad. It is near, fast, inexpensive and my illness was cured."* (FGD with FSW, Elegu)
>
> *"We are supposed by law, to move with a first aid kit in our vehicles. So you buy headaches, action, dichlophenac for treatment of muscle pulls, we treat ourselves. We have to find ways of treating ourselves on our own."* (FGD with truck drivers, Gatuna)

Transnational health-seeking strategies

Transnational health seeking also emerged as a strategy used by migrants. Study participants reported that some migrants choose to use services from either side of the border, depending on illness and perceived quality of services. It appears that within cross border communities some participants sought care from regions that they perceived to be accommodative and accepted non-nationals to access health care and other social services. For instance, in Tanzania, participants reported that some categories of migrants like truck drivers were allowed to access health care such as resupply of ARV. This is however not the case in Zambia and South Sudan. Participants perceived this restricted access in Zambia and Southern Sudan to budgetary reasons. They argued that perhaps the need to budget for nationals and avoid shortfalls in service delivery was a major influence in not allowing non-nationals to access health care services at the OSBP.

Postponement of treatment in order to seek health care at ''home''

This study also revealed that participants sometimes resorted to postponement of treatment seeking while on the move until they return to their countries of origin. As such, migrants would under use or delay accessing health services in order to seek care at "home". For example, during an FGD with truck drivers in Elegu it was noted that sometimes participants, mostly Kenyans, wait until they have reached Nairobi, which they considered 'their home' where they feel culturally free to seek care in spite of severe illness or injury from accidents

suffered while on the trip. Other reasons for postponement of treatment include mistrust in the health systems abroad and perceived discrimination.

3.3.4. Barriers to accessing health services

As noted earlier, migrants at OSBP are a diverse population with varying health needs. Thus, they will experience different barriers to accessing health care. These barriers influence service use and may explain patterns of ill-health (Hargreaves and Friedland 2012).
In this study, we sought to understand the barriers that are encountered by the different migrant groups at OSBP when attempting to use health services. These include language barriers, financial constraints, limited knowledge regarding how to access health care, unfriendly attitudes from facility staff, especially at hospitals, and confusion about eligibility for treatment. Some of these are extensively discussed in turn below:

Cultural beliefs and values

Cultural values and beliefs emerged as one of the barriers to seeking health care. For example in Kobero it was reported thus:

> *"...men regard themselves as strong so they don't easily accept to seek services. They are always drinking local beer while the women are designated to dig. The men perceive seeking health care as feminine."* (Interview with health worker, Kobero)

In Mtambaswala, the community leaders noted that malaria takes the lead in contributing to the burden of disease among children less than five years of age. However they noted that some people believe that convulsions usually caused by malaria cannot be treated using modern medicine and do not usually seek treatment from biomedical health providers for those symptoms, but rather through traditional means. These cultural barriers appeared to be common among local community members compared to migrants at OSBP.

Language barriers and cultural differences with 'host' communities

OSBP are comprised of people from various cultural backgrounds and national identities. Because of the differences in languages and cultural norms, participants reported experiencing difficulty in accessing health care and other social services relevant to health. Inability to communicate effectively hampered access to health and social services. Participants indicated that sometimes they were unable to communicate their health needs and concerns to health workers while others expressed inability to negotiate health financing options when having problems communicating to health care workers. Overall, such communication barriers reduced the quality of care they received. Language differences make communication difficult and can discourage people from obtaining health services.

Lack of knowledge about the health care system

In addition to inability to communicate in the local language, some study participants also reported unfamiliarity with availability of local health facilities. In some locations, this constraint is due to lack of local knowledge about available services, how to access them and what costs will be involved.

Distance from OSBP to health facilities

The distance from the border to the nearest health facility was cited by some study participants as a barrier to accessing health services. With the exception of Kabanga, Katuna, Nakonde and Tunduma, other border posts examined did not have accessible health facilities within 5km radius from the border points. For example, in Mtambaswala and Negomano, access to health services is difficult because of the distance—about 15 km—from the border to the nearest health facility. At Elegu, some truck drivers reported that when they needed care for injuries or other severe illnesses that required appropriate care, they often resorted to visiting Lacor Hospital in Gulu town, which is approximately a three hour drive from the border with South Sudan on rough surface. Frustration with long distances to health facilities could be felt in study participants' voices found below:

> *"Sometimes you may fall and you need someone to work on your leg, but there is no hospital to handle this. We need a government hospital to provide services to us when we are in such need. But now if one gets a problem he needs to be driven all the way to Lacor. How much is that? A lot of money! It is about 20,000 from here to Lacor and yet people do not have money."* (FGD with truck drivers, Elegu)

> *"The main health facility we have is in Gicumbi, and we also have a dispensary in Rubaya, but sometimes you reach there and you find they cannot treat you and they refer you to that hospital in Gicumbi and the major challenge here is the ability to get there, in terms of transport and yet sometimes you do not have mutual health insurance and that becomes a problem."* (FGD with FSW, Gatuna)

At Kobero, the health centre was about 6km from the border post but most referrals are made to Muyinga province hospital about 20km further because the nearby health facility is located in a hard to reach hilly rugged terrain and regularly suffers drug stock- out. At Negomano the accessible health facility was ill equipped. Local host community members and migrants have to trek long distances to access health services. Similarly, because of the long distance to Masuguru dispensary, there were reported segments of the population that hardly access healthcare services including the aged, the very poor, pregnant women and

widows. In addition, these three particular groups are unable to raise transport fares or to ride a bicycle or go on foot to seek services at Masuguru. The study established that long distance to the nearest facility discourages people at the border post from seeking healthcare and pushes them into more risky treatment options such as unregulated herbal medicine.

"…we go as far as Masuguru dispensary as the nearest service point and sometimes we bypass this up to Nanyumbo H/C which is an additional 45km. Transport is still the major problem. That is why sometimes people resort to traditional healers." (FGD with FSW, Mtambaswala)

The quotes below offer further testimony that distance was also reported to be a barrier to seeking health care in other border regions:

"…there are some pregnant mothers who want to deliver at this Masuguru dispensary but can't reach so there is a high rate of home deliveries. The distance is long from Mtambaswala to here. Some deliver on the road side while coming here...then the under 5 miss out on getting vaccination on time because as a facility we don't have transport of facilitate outreach from Masuguru to Mtambaswala and the community women cannot also afford transport to here. As a facility, we do one immunization outreach per month at Mtambaswala. But we just have the motorcycle from the neighbour. Then we buy fuel." (Officer in charge, Masuguru Dispensary)

"The Midwife can write a referral note but there is a challenge of distance and high cost of transport to the facilities where patients are referred." (KII Mawodea NGO, Masasi District Tanzania)

"We do not know what measures National Drug Authority is taking but we are not certain of the drugs. The distance to Bibia is far. However, if something happens at night, you know this is a border so around 7pm and 8pm there is completely no movement of vehicles in case of emergency to rush you to the hospital unless you have your personal car." (KII with woman community leader, Elegu)

"*…the community is suffering from a long distance to health facilities and even their income is a problem. Once you are sick, and have no money, the time you look for the money may be long and the patient may die or the sickness worsens. So if the government could consider constructing a health facility here at Mtambaswala, our access to health services will improve and we would be better.*" (FGD with community leaders, Mtambaswala)

"…access to health at the border post is not good. Distance from Mtambaswala to Masuguru dispensary is about 10km which according to our national target of access to health facility in a radius of 5km is far from being reached." (KII with district official, Mtambaswala)

High Mobility

The high level of mobility of some population groups at the different OSBP, such as truck drivers and their assistants results in poor continuity of care. This is because they are often unable to complete treatment regimens, keep track of medical records, and obtain routine or preventive care. Mobility is one of the larger barriers to continuity of care, and simultaneously increases the need for care.

Long waiting time, under staffing and unavailability of medicine

Other challenges mentioned relating to health services were the long waiting time and the lack of medicines at some facilities. The long waiting times in health facilities were particularly important for truck drivers and their assistants. They reported that in order to meet their tight business schedules related to clearing at the customs and immigration stations, they are inconvenienced by having to wait for a long time to be attended to at health facilities. Migrants at border posts were frustrated by the long queues at health facilities and often gave up treatment as illustrated by the following narrative:

"You find that you are in the queue for a long time, sometimes even children die while in a queue. So at times we end up preferring to stay at home." (FGD with FSW, Nakonde)
"The health service situation would have been fair but it is not easy to go to the health center sometimes because the care is not quick. They take long to respond to patients." (FGD with FSW, Kagitumba)

A combination of few staff in public health facilities and big catchment populations at these sites were prominent factors contributing to the long waiting times.

At all border posts, the catchment population is significant yet the human resource capacity is limited in number, the majority of whom are low level health personnel. The available health workers are thus overstretched because work shifts are too demanding on the health facility staff. The table below highlights the average working hours of health workers per border site.

Table 7: Average working hours for health facilities at different border posts

Name of Border Post	Opening Time	Closing Time	Working Hours
Kabanga (Tanzania)	8:00h	20:00h	12:00h
Katuna (Uganda)	8:00h	21:00h	13:00h
Gatuna (Rwanda)	7:00h	17:00h	09:00h
Mtambaswala (Tanzania)	8:00h	23:00h	15:00h
Elegu (Uganda)	8:00h	17:00h	09:00h
Mirama Hills (Uganda)	8:00h	18:00h	10:00h
Kagitumba (Rwanda)	00:00h	00:00h	24:00h
Tunduma (Tanzania)	7:00h	19:00h	12:00h
Kobero (Burundi)	7:00h	16:00h	09:00h
Nakonde (Zambia)	8:00h	16:00h	08:00h

Whereas the human resource concerns noted above remain a challenge, study participants noted that longer opening hours would improve access to health services because trucker drivers, their assistants, FSW, cross-border traders and people from the host communities who work at night would have more choices for times to visit health facilities outside working hours. Preferential treatment for these populations in the form of expedited services was also suggested.

Costs of accessing health care

Participants perceived the cost of accessing medical services to be prohibitively high. As such, costs of accessing health care discourage or obstruct some people at the OSBP from seeking health services as the quote below illustrates:

> *"When I go to Muyinga hospital and I have a health insurance card, I pay 30,000 when I spend 3 days and without it, I pay 70,000 and they again ask me to go and buy drugs from private service providers. They told us that with this insurance card, we would be paying only 800 but we in reality pay more. This card is given by government through facilities at 3000 Burundi Francs; we bring 2 passport photos, an identity card."* (FGD with female community members, Kobero)

"Even me what I can supplement, like those health problems we encounter, we don't have the ability to raise money for health mutual insurance, if you are one or two you fail to raise the six thousand for health insurance and even feeding is a problem here." (FGD with FSW, Gatuna)

Similarly, participants noted that most of the existing health facilities were not adequately financed and thus had poor quality service provision. This sentiment was also expressed by health care workers who decried what they perceived as the prohibiting cost of healthcare and were often frustrated by the inability to provide high quality service due to limited resources and facilitation.

Poor health workers' attitude

The study revealed that community members' negative perceptions about health workers had influenced healthcare seeking behaviour at border site settings. Some participants reported that they hesitated to go to health facilities because some health workers were perceived to be hostile or had poor attitudes towards work and their clientele.

"*Even when you are on drip and it is finished, you can't say anything because you can't tell what their reaction will be …sometimes the nurses don't know how to interact with us. They blame us, asking us why we got these diseases. At times one may even want to slap you.…*" (Female community member, Nakonde)

"…sometimes the health workers in the public dispensary are rude, not welcoming, with a bad attitude. For instance, I came here, found you talking, the session was going on but you accepted me. You did not ask me questions like where are you coming from? Why did you come late? But when you go to a public dispensary, they ask you many blaming questions, they don't give you an opportunity to explain yourself." (FGD with community, Kabanga)

"Although we go to health centres, majority go for herbs at traditional healers where there is no language barrier and no stigma." (FGD with FSW, Kagitumba)

Legal status and administrative barriers

Some study participants also cited unfavourable administrative regulations as a barrier to seeking health care. For example, at some facilities one of the prerequisites to access care was registration procedure that required proof of residence or legal status in the country. While this procedure was deemed necessary for accountability and monitoring of service delivery for reimbursement of costs incurred on behalf of the government, it often discouraged migrants from accessing health.

3.3.5. Gaps in health service delivery at OSBP

Overall, health facilities examined in the selected OSBP had deficiencies in service delivery mainly due to shortage of qualified health workers. Health facilities assessed at OSBP were largely operated by low cadre staff (Table 8).

Table 8: Profile of health personnel by qualification and site

	Kabanga		Katuna		Mutamba swala		Elegu		Mirama Hills		Tunduma		Kobero		Nakonde		Gatuna		Kagitumba		Total
	Government	Private	Government	Private	Government	Private	Government	Private	Government	Private	Government	Private	Government	Private	Government	Private	Government	Private	Government	Private	
Doctors	3	1	0	0	2	0	0	1	0	1	2	0	0	0	2	1	0	0	0	0	13
Clinical Officer	3	1	1	1	5	1	0	0	3	0	3	2	2	0	6	1	0	0	0	0	29
Registered Nurse	0	1	1	0	1	0	0	1	0	0	4	0	2	0	28	1	1	0	2	0	42
Enrolled Nurse	3	0	3	1	2	1	0	0	1	0	7	3	4	0	15	1	8	0	9	0	58
Midwife	0	0	2	0	0	0	0	0	3	0	7	0	0	0	9	1	0	0	0	0	22
HIV Counsellor	4	0	0	0	4	0	0	1	0	0	5	1	5	0	10	5	0	0	1	0	36
Social Worker	2	2	0	0	4	0	0	1	5	0	0	3	0	0	1	0	1	0	1	0	20
Laboratory Technicians	2	0	1	0	6	0	0	1	1	1	2	1	0	0	6	0	2	0	2	0	25
Drug Dispenser	0	0	0	0	1	0	0	1	0	0	1	1	1	0	5	1	0	0	0	0	11
Biostatistician	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	0	0	0	0	0	2

The table above shows that health workers with higher qualifications such as clinical officers and doctors work for public sector health facilities which most migrants as well as host community members seemed to shun. Private facilities were manned by enrolled nurses, while clinical officers were in-charge at government health centres and therefore carried out more administrative functions. In addition, nurses running health facilities had add-on tasks such as HIV/AIDS counselling, social work, drug dispensing, and providing antenatal care services.

Limited scope and coverage of health education services

Some of the OSBP almost had no public facilities and/or civil society organizations providing health awareness and behavioural change communication (BCC). For example Mtambaswala and Negomano border posts had no known health promotion agencies within a radius of 15km. Elegu border post at the border of Uganda and South Sudan had only a Police dispensary. At Kobero and Tunduma border posts there were informal groups of FSW providing peer education to their members and distributing condoms when available. They would also provide protection to their peers in case of abuse by travellers passing through the space. The inadequacy of health education and BCC is reflected in remarks of study participants below:

> *"Most people do not like condoms and therefore do not understand their importance. Others do not know how to use them and think that condoms may remain in the woman during sex. There are some groups of people who come to educate us about HIV/AIDS and how to control it. They are called "Abalemeshakiyago" It is a group of people which moves around educating people about HIV."* (FGD with FSW, Kobero)

Study participants acknowledged the inadequate access to health education and information and where to find health services, and recommended that health education at border posts needs to be scaled up.

> *"Regarding HIV, they (migrants) need health education to protect their health and health of others, they need to use condoms. There should be health education centres targeting these drivers and others migrants …all this information about globalization is good but has led our girls to join bad behaviours and unprotected sex hence having/getting STIs, AIDS etc. So those ladies working in bars, hotels should get health education."* (FGD with male community members, Tunduma)

Limitations in approach used to target migrant populations

A review of the approaches used by health facilities to reach out to the communities at OSBP revealed that most of them largely rely on static/facility based approaches providing health education to individuals who visit health facilities. These are not appropriate for most of the migrants like truck drivers, FSW, construction workers and cross border traders. Language and cultural differences were also found to affect health education at OSBP because some are multi-lingual for example Nimule and Elegu and Katuna border posts.

At Katuna, most truck drivers find it difficult to communicate with health workers and the local population because they speak Swahili which is not commonly used by health service providers particularly in Uganda. At Nimule and Elegu border posts, the communities on the South Sudan and Uganda side, respectively, are emerging from conflict and therefore most of the infrastructure and services including health promotion are just being established. Tribal tensions connected to previous conflicts are still evident in the way people relate to each other and especially to people across the border seeking health and other services.

4.0. Discussion, Conclusion and Recommendations

Evidence has found that some migrant categories at border posts in East Africa reflect poor health and epidemiological profiles characterized by a burden of disease and other social and economic vulnerabilities. The health and social problems at OSBP extend beyond the obvious infectious and non-infectious diseases. Poverty, poor housing, shortage of safe water and unhygienic sanitary conditions exacerbate the already precarious social economic status of communities at border points in East Africa. Additionally, malaria, diarrheal diseases, HIV and other STI, respiratory infections and injuries due to accidents, remain a major public health problem in cross border communities. Globally, research on migration has demonstrated a positive association between HIV risk and migration (Araujo, et al. 2010; Ford and Chamratrithirong 2012; Halberstein 2011; Haour-Knipe, et al. 2013; IOM 2004; IOM, et al. 2012; Moroka and Tshimanga 2009; Ondimu 2010). This study's results concur with such findings.

At all border posts, there was lack of adequate sanitation and waste disposal facilities both at the border posts and the communities. Some border posts lacked public toilets yet migrant workers spend considerable time and sometimes days awaiting clearing of their goods. In quite a number of cases, pit latrines were located in a distance of less than 10 metres from the water sources thus risking contamination. Furthermore, there was limited access to safe water sources. A combination of poor sanitation, hygiene and limited access to safe water was reported to have resulted into high prevalence of diarrheal diseases. This study revealed that despite the thriving economic activity at OSBP, a large section of the communities was poor characterized by low income women engaged in petty trade activities, considerably high numbers of unemployed and underemployed youth involved in casual labour activities, overcrowded settlements and lodging facilities with poor sanitary facilities.

Most cross border communities surveyed in this study remain unable to access the much needed health services. Factors hindering access to health services at border posts are varied and complex and include the following: long distances to health facilities, inability to afford the cost of basic health care; lack of adequate medicines, health supplies and human resources at the existing health facilities, non-availability of health services at some border posts; stigma and fear to access health services particularly for female sex workers and irregular migrants, limited knowledge regarding how to access health care, unfriendly attitudes from facility staff especially at public health facilities, and policy variations among countries affecting access to health of migrants particularly regarding access to anti-retroviral

therapy. Given that truck drivers and other migrant workers are not able predict the time away they will spend while travelling, especially due to delays in clearing goods at border posts and other unforeseen circumstances, the failure to refill ARV in transit makes it difficult for them to adhere to treatment regimens. This illustrates a gap in harmonization of universal access to health, which has also been reported previously in East Africa (IOM, et al. 2012).

Similarly, other studies have shown that both individual and structural factors influence risk and impede access to health services. For instance individual factors include: risky behaviours, fear of identification, detention and expulsion or cumbersome administrative procedures, stigma related to certain conditions or economic activities like sex work, loneliness arising from being away from families and close social networks for long periods, and alienation of newcomers by local communities (Ford and Chamratrithirong 2012; IOM, et al. 2012). Economic deprivation is a key structural factor contributing to poor health access at OSBP given that a number of service providers are private clinics charging relatively higher user fees. Some studies have shown that poverty, poor housing especially when coupled with low access to information and services breeds neighbourhoods with structural disadvantage (Parrado et al. 2010).

A major societal factor that influenced vulnerability among cross border communities was the limited mainstreaming of migrants in social and economic spaces. Perceptions of exclusion, discrimination, communication barriers, exploitation, and poor physical protection impeded access to health care services and thus exacerbated vulnerability. For instance in Elegu – the truckers from Uganda and Kenya felt that their physical security was at threat in particularly in South Sudan where the better quality health facility within a reasonable radius was located. Together these factors appeared to reduce social support necessary for appropriate health care seeking behaviour. Yet as scholarship in health care seeking behaviours has shown, limited or poor quality social networks often hinder access to appropriate health care even where it may be free or affordable (Berkman and Kawachi 2000; Berkman 2000; Hendrikson 2010; Nguyen Van, et al. 2010). Moreover, exclusion from mainstream health and other social services that affect health may exacerbate existing vulnerability by hindering the ability to cope with ill health and other forms of misfortune associated with the migration process.

Perceived poor quality, and in some cases non-existent public health service delivery systems at some OSBP make border communities resort to alternative health care seeking practices such as self-medication, in some cases use of traditional healers and use of private facilities that were reported to be expensive. On the other hand, particularly for serious health events like adverse injuries, that are common among truck drivers and cross border traders, care would be sought from the nearest health facility.

However, the study revealed that at many OSBP the closest health centres considered appropriate to handle such serious health events were at considerably long distances away. A case in point is in northern Uganda were some people at the border town of Elegu reportedly seek care as far as Lacor Hospital, the nearest hospital with what they regarded as appropriate care, approximately 100 km from the Uganda/South Sudan border. Similarly, at Mtambaswala and Negomano border posts, Nanyumbu Hospital is the nearest hospital and is over 40 km away. In other cases, the absence of public health facilities is often bridged by private not for profit facilities. However these were lacking at these border posts. Mitigating the above factors is constrained by limited public resources available to the respective local governments to provide the much needed health services.

On a positive note, there were a few cross-border arrangements in place especially in respect to joint disease surveillance and joint meetings in case of outbreaks of epidemics. This was particularly reported to be taking place in Tunduma-Nakonde and Kabanga-Kobero border sites at the Tanzania-Zambia border and Tanzania-Burundi border respectively.

Recommendations

a. There is need to integrate migration health into the OSBP strategy of the East African Community and build consensus on a framework of collaboration aimed at developing common access to health protocols, facilitation and coordination of cross border health activities and capacity building of Member States.

b. Strengthening inter-country coordination, surveillance and information sharing on several aspects including infectious diseases for example HIV/AIDS, malaria, tuberculosis and VHF e.g Ebola. There is also need to strengthen enforcement of international health regulations that underscore maximising health protection while minimizing interference with international travel.

c. There is need to improve capacity and functionality of existing health facilities through refurbishing, staffing, and provision of adequate essential medicines and other health supplies.

d. There is need to support provision of migrant-friendly health services with specific attention to truck drivers and female sex workers. Such services should pay specific attention to: waiting time, flexible working hours and availability of health workers and health supplies.

e. Access to safe water and sanitation was a major need at all border posts. There is therefore an urgent need to advocate for a comprehensive assessment and provision of universal access to safe water and sanitation facilities at all OSBP.

f. Some of the border posts lacked any form of formal health care facility within a radius of 5km. There is need to advocate for establishment of health facilities at these border posts.

g. There was a dearth of Civil Society Organizations (CSO) at some border posts, yet these cannot fill the gap in absence of public health care facilities. There is need to support CSO and government facilities to scale up migrant sensitive health services at border posts.

h. There is need to create awareness and lobby for effective implementation of the International Covenant on Economic, Social and Cultural Rights which recognise the right of migrants to health and their entitlement to preventive, curative and palliative

services on an equal basis with nationals and on the basis of medical needs regardless of their status. Towards this end governments and partners should make the necessary steps towards the implementation of the World Health Assembly Resolution on the Health of Migrants.

i. Further research is needed on health seeking behaviours and practices of migrants in East Africa.

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Annex – Associated Study on the Kenyan/ Tanzanian Border

SYNOPSIS OF PRELIMINARY REPORT OF A RAPID OPERATIONAL ASSESSMENT OF HIV PREVENTION IN SELECTED SITES ALONG THE KENYA – TANZANIA BORDER 2012

Background: Sub-Saharan Africa bears the brunt of HIV infections, whereas of 2011, more than 22.9 million adults and children were reported living with HIV. In East Africa, the HIV prevalence has shown a relative decline since the beginning of the epidemic and by the end of 2011, HIV prevalence among those aged 15 and 49 stood at 6.2 per cent. Factors which contribute to continued HIV transmission are similar in both Kenya and Tanzania. These include engagement in risky sexual behaviours, multiple concurrent partnerships, transactional and paid sex, low perception of risk, lack of knowledge on HIV status, low condom use, early sexual debut, circumcision status and lack of social and legal protection for vulnerable populations.

The goal of the rapid assessments focuses on providing evidence for developing HIV combination prevention interventions that offer both male and female friendly packages, targeting key populations in selected sites along the Kenya – Tanzania border.

The objectives of the assessments included:

- Assessment of female sex workers and their clients in regards to their attitude, behaviour and level of knowledge on matters of HIV prevention and care.
- Assessment of the attitudes of these population groups toward safe sex practices and the level of their engagement in risky sexual behaviour.
- Assessment of availability, acceptability, affordability and geographical accessibility of health care services that impact HIV prevention in cross border settings.

Approach: The mixed methods approach was used during the assessments involving both qualitative and quantitative data. Questionnaires were used to assess the quantitative information obtained from female sex workers, their clients and health facilities. Data was collected in the three border areas of Isebania/Sirari, Lunga Lunga/Horo Horo and Taveta/ Holili. A total of fifty eight female sex workers (FSW) and fifty seven clients were interviewed during the assessments, along with seventeen focus group discussions.

Findings: Findings indicated that HIV knowledge among both respondent groups was fairly high, but at the same time, several misconceptions regarding HIV transmission and prevention existed, such as witchcraft being the cause of HIV, and that the sharing of utensils could also lead to the contraction of the virus. Risky sexual behaviours were common and respondents engaged in multiple sexual partnerships usually with inconsistent use of condoms. Additionally, a combination of mobility, disposable income, alcohol and availability of sex increased the risks greatly. Prevention interventions by Community Based and Non-Governmental Organizations were found to be fragmented and lacked coordination. The majority of health services available were deemed substandard by the majority of the respondents owing to their low service delivery capacity as most are understaffed and inadequately equipped.

Conclusion: The data obtained during these assessments established the need for HIV combination prevention interventions in cross border areas along the Kenya – Tanzania border targeting key populations. The low levels of knowledge of migrants about HIV prevention and care, their susceptibility to risky sexual behaviour and the sub-standard levels of health service availability, acceptability, affordability and geographical accessibility, all render these populations at high risk of acquiring HIV. The assessments assisted in generating key information that will inform development of evidence based programming in cross border areas.

Recommendations:

Public Health Implications

The characteristics of migrants make them susceptible to health risks more than the general population. Factors such as language, religion or cultural practices, may act as a barrier to their integration into the host community, and the resulting isolation will hinder their access to health. In this context, migration is regarded as a social determinant of health, and needs to be recognized as such so that public health initiatives will integrate migrant health at all levels of programming.

Research needs to be carried out to determine the prevalence amongst all key population groups. Knowledge of prevalence can assist in determining the impact interventions are having on the HIV rates in these target sites.

Policy Implications

A policy needs to be developed that addresses health issues of key populations in cross border settings. This policy document should provide a framework for the coordination and harmonization of interventions among stakeholders and partners working in these areas.

Additionally, migrants should be included in national health strategies and migrant health issues should be addressed at senior policy levels. Advocacy for removal of discriminatory policies and practices which affect the health of key populations should be done, i.e. FSW.

Programmatic Implications

Numerous programmatic interventions should be undertaken and include: prevention and awareness raising campaigns, which include condom promotion and distribution, development and distribution of targeted IEC materials, outreach activities and moonlighting services. Also, health facilities need to be scaled up by increasing staffing, incorporating VCT and STI services in a manner that allows for provider-client confidentiality, prolonging working hours to meet the needs of key populations, and equipping the facilities with essential laboratory equipment and medical supplies.

Training activities should be undertaken for health care personnel, key populations and border officials. Health care providers need to be trained on health issues of key populations in order to become sensitized to their needs. They must be able identify these population groups and provide them with the special care they need. Key populations on the other hand need to be provided with life skills trainings and trainings for peer educators. Capacity building and income generating activities may provide an entry way into alternative means of livelihoods.

Resource mobilization activities must be undertaken so as to ensure long term sustainability of interventions. Funds can be sourced through government initiatives, as well as from international donors.

Structural Interventions

Wellness Centres should be established in cross border areas where health service delivery is substandard. These centres should be open 24 hours a day, seven days a week and offer male and female friendly service packages that are especially tailored to key populations.

International Organization for Migration (IOM)
Regional Office for East and Horn of Africa
Church road off Rhapta Road, Westlands,
PO Box 55040 - 00200 Nairobi, Kenya
Tel: +254 020 4221000, Fax: +254 2 4449577
E-mail: migrationhealthnairobi@iom.int
Web:http://nairobi.iom.int

IOM International Organization for Migration