HEALTHLY MIGRANTS IN HEALTHY COMMUNITIES

IOM Health Strategy for Kenya

2011-2015

IOM International Organization for Migration

HEALTHY MIGRANTS IN HEALTHY COMMUNITIES

Regional Mission for East & Central Africa
Church Road – off Rhapta Road, Westlands
PO Box 55040-00200, Nairobi, Kenya

Tel: +254 20 444 4174
Email: migrationhealthnairobi@iom.int

www.nairobi.iom.int

COVER: Mother and child at a new border town Community Wellness Centre supported by IOM and catered for mobile populations © IOM 2011 (Photo: C Hibbert)

CONTENTS

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
CCMH	Coordinating Centre for Migration Health in Kenya
DHMT	District Health Management Team
DLTLD 2011-15	Division of Leprosy, Tuberculosis, and Lung Disease, Kenya: Strategic Plan 2011-2015
DOTS	Directly-Observed Treatment, Short-Course
DRA	Department of Refugee Affairs
EAC	East African Community
EHRP	Emergency Humanitarian Response Plan
FSW	Female Sex Worker
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
IAWG	Interagency Working Group on Emergencies, Gender Based Violence and HIV
IDMC	Internal Displacement Monitoring Centre
IDP	Internally Displaced Person
IGAD	Intergovernmental Authority on Development
IMO	International Maritime Organization
IOM	International Organization for Migration
IPCC	Intergovernmental Panel on Climate Change
JUNTA	Joint United Nations Team on HIV and AIDS in Kenya
JUPSA	Joint United Nations Programme of Support on HIV/AIDS in Kenya
KACP	Kenya AIDS Control Programme
KDHS	Kenya Demographic Health Survey
KNASP III	Third Kenya National HIV/AIDS Strategic Plan 2009/10-2012/13
MCH	Maternal and Child Health
MDR TB	Multi-Drug-Resistant Tuberculosis
MHAC	Migration Health Assessment Centre
MOSSP	Ministry of State for Special Programmes
MOU	Memorandum of Understanding
NACC	National AIDS Control Council
NASCOP	National AIDS and STI Control Programme
NHSSP II	Second National Health Sector Strategic Plan 2005-2010
NLTP	National Leprosy and Tuberculosis Control Programme
NOPE	National Organization for Peer Educators
PEPFAR	President's Emergency Programme for AIDS Relief
RSD	Refugee Status Determination
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually-Transmitted Infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/ AIDS
UNDAF	United Nations Development Assistance Framework for Kenya
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
UNICEF	United Nations Children's Fund
UNDESA	United Nations Department of Economic and Social Affairs
UNV	United Nations Volunteers
WHA61.17	61st World Health Assembly resolution on the health of migrants
WHO	World Health Organization

IOM Rapid Response Team in Chemoset Primary School - Uasin Gishu District in Rift Valley Province

1.0 THE INTERNATIONAL ORGANIZATION FOR MIGRATION'S APPROACH TO HEALTH

The International Organization for Migration (IOM) is an intergovernmental organization, with 132 member states, committed to the principle that humane and orderly migration benefits migrants and society. Kenya became the first African Member State of IOM on 24 May 1985.

The long-term goal of the IOM Health Strategy for Kenya 2011-2015 is to improve the management of migration health and decrease health vulnerability among populations affected by migration and mobility in Kenya, in line with the National Health Sector Strategic Plan (NHSSP) objective of reducing inequities in health for all persons in Kenya.

IOM aligns its health programme to Kenya's Second National Health Sector Strategic Plan 2005-2010 (NHSSP II), the Third Kenya National HIV/AIDS Strategic Plan 2009/10-2012/13 (KNASP III), the National TB Strategy 2011-2015, and related instruments.

The IOM Health Strategy for Kenya 2011-2015 falls within the bi-regional IOM Health Strategy for East and Southern Africa (IOM, 2011). Through its health programme, IOM promotes a comprehensive approach which is multisectoral in nature, adds value to national partnerships, and addresses social determinants of health at the individual, community / environmental, and policy / systemic level. IOM practices a human rights-based, public health, and participatory approach to facilitate access to promotive and curative health services for migrants, mobile populations, and the communities where they live.

IOM's health programme in East and Southern Africa works with partners and governments under five distinct yet inter-related components:

1) Service Delivery and Capacity Building: IOM facilitates, provides, and promotes equitable access for migrants and mobile populations to promotive and curative health services, with particular attention given to HIV/AIDS, TB, sexual and reproductive health and rights (SRHR), gender-based violence, and psychosocial well-being.

2) Advocacy for Policy Development: IOM undertakes awareness raising, capacity building interventions, engages media outlets, and works with national processes at all levels to create a supportive policy environment for responding to Migration Health concerns and public health needs of host communities.

3) Research and Information Dissemination: IOM undertakes primary and secondary research on Migration Health, as evidence-based

programming and strategic information are critical for addressing the "invisibility" and the "vulnerability" of migrants, and for effective health programming, policy, and dialogue.

4) Regional Coordination: IOM offers technical and coordination support to regional partners and government focal points responsible for regional programming, for enhanced information sharing and trans-border collaboration on Migration Health.

5) Governance and Control: IOM acts to ensure transparent, efficient and effective governance and control within its programme.

IOM targets three main groups of mobile and migrant populations in East and Southern Africa: 1) Labour Migrants and Mobile Workers in sectors characterized by high levels of mobility; 2) Forced Migrants including internally displaced persons, refugees, deportees/returnees, and all persons affected by conflict and natural disaster; 3) Irregular Migrants such as undocumented migrants, trafficked persons, urban migrants, smuggled migrants, stranded migrants, child migrants, migrants in detention, and deportees.

IOM's approach to Migration Health means that it targets these groups within the context and environment in which they live and work, thus including sex partners and families of migrants as well as the host communities with whom they interact. IOM follows a place-based approach, identifying "vulnerable spaces", within which appropriate responses to addressing health in a context of migration can be generated.

IOM addresses Migration Health through three global interlinking programmatic areas:

- Health Promotion and Assistance for Migrants: IOM provides health advice and services that meet the specific needs of migrants and their host communities, across a wide range of priority areas.

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

IOM, 2004

- Migration Health Assistance for Crisis-Affected Populations: IOM supports governments and affected populations during the acute phase and in the aftermath of emergencies, addressing the acute, individual life threatening conditions, psychosocial needs or infectious conditions with public health hazard related to the mass population displacement.

- Migration Health Assessments and Travel Assistance: IOM provides high quality migration health assessment services to migrants and refugees on behalf of destination governments, as well as medical assistance to population movements by air, land and sea, ensuring safe and dignified travel for migrants and populations of interest.

2.0 BACKGROUND AND JUSTIFICATION

2.1 Country Description

Kenya borders five countries namely Tanzania, Uganda, Sudan, Ethiopia, and Somalia, as well as bordering Lake Victoria and the Indian Ocean. Kenya's population stood at 38.6 million people in 2009, with a demographic structure of 0-14 (42.9%), 15-64 (53.6%), and > 65 (3.45%). The ratio of men and women was 1:1 (Republic of Kenya, 2010a). Kenya has a population growth rate of 2.6 per cent and life expectancy of 55 years at birth (WDI Website). 67.7 per cent of the population lives in rural areas (Republic of Kenya, 2010a), and more than 75 per cent of Kenya's population occupies only 10 per cent of the country's land which is arable (source not found). The rest of the population occupies either arid or semi-arid land. There are more than 40 ethnic groups with English and Swahili as the official languages. During the past decade, the 47 year old country has seen opening of political space with the introduction of multipartism, and this democracy culminated in the passing and promulgation of the ambitious new constitution in August 2010. The new constitution promises improved distribution of resources, justice, human rights, governance, and economic development.

2.2 Development, Health, and Migration in Kenya

2.2.1. Human development status

Kenya's economy is rebounding from the impact of post-election violence in 2008, and is expected to revert to the pre-election annual growth rate of 6-7 per cent by mid-2014 (Republic of Kenya, 2010b). The main drivers of Kenya's economy include agriculture, tourism, transport, and human expertise. Movement towards an East African Community common market strategy will further strengthen economic standing, while facilitating free movement of trade goods and workers. Kenya stands to benefit substantially from this cooperation, being

widely recognized as the regional economic hub for East Africa. The demand in Kenya for skilled and unskilled labour will increase, with neighbouring countries meeting much of this demand. The region will continue to rely heavily on the port of Mombasa and Kenya's developing road network infrastructure for commerce and movement of humanitarian relief supplies. This will be augmented by the expected independence of Southern Sudan, which if peaceful will rely heavily on Kenya's infrastructure for transport of goods and services, particularly as Africa's newest country looks towards East African Community (EAC) membership. Nevertheless, if violence eventually breaks out in Southern Sudan, this will result in significant refugee inflows with major challenges to existing systems for health and social services.

In 2007, the Kenya government unveiled "Vision 2030" which is an economic blueprint aiming to place the country in the same league as the Asian Economic Tigers. Currently 39.9 per cent of Kenya's population lives below the poverty line defined as two dollars per day in 2005 (WDI Website). Adult literacy stands at 87 per cent an increase of 10 per cent since 2000, but gender disparities persist as nearly two-thirds of illiterate adults are women (UNESCO, 2011).

2.2.2. An overview of health in Kenya

In achieving "Vision 2030", the Kenyan Government has recognized that the path to progress lies in the potential of the Kenyan people. Health and education have therefore received increased emphasis as national priorities. Nevertheless, the under-financing of the health sector means that access to basic healthcare still remains beyond the reach of the majority of Kenyans. In the 2010/2011 budget, health allocations received a moderate increase, but still comprise just 5.6 per cent of the government's budget, and this falls well short of the 15 per cent agreed by African nations in the Abuja Declaration (Republic of Kenya, 2010c). Thus, the provision of health care services in Kenya is heavily dependent on donor funding – particularly for HIV/AIDS. As health is not appropriately resourced, the system overly focuses on unsustainable curative services rather than prioritizing health promotion. In order to "reverse the trends", focus must be placed on health promotion and reducing inequities in access to services (Republic of Kenya, 2005a).

In 2009, 16 per cent of children under five year of age were moderately or severely underweight, with 35 per cent of children showing chronic effects of stunting (UNICEF, 2011). Kenya ranks 39th from the bottom in under-five mortality rate at 84 per 1,000. The infant mortality rate stood at 55 per 1,000 live births in 2009, and the maternal mortality rate was 530 / 100,000 in 2008. Just 43 per cent of deliveries take place in a health facility (UNICEF, 2011). In 2007, HIV prevalence in the general 15-49 age group was between 6 per cent (KDHS 6.3%) (Republic of Kenya 2010d) and 7 per cent (7.4% KAIS) (Republic of Kenya, 2008). The KAIS showed

significant differences between men and women (8.7% among women; 5.6% among men), with the majority of people living with HIV/ AIDS in the 30-34 age group. 37 per cent of Kenya's population does not have access to clean safe drinking water and just 22.6 per cent have access to an improved toilet (Republic of Kenya 2010d). Malaria still remains the leading cause of morbidity and mortality (Republic of Kenya 2010d). It is unlikely that the targets of any of the Millennium Development Goals on health will be achieved by the year 2015 (Republic of Kenya, 2005a).

2.2.3. Migration trends

Kenya has for several years seen high levels of both internal and international migration and population mobility. This is driven by factors within the country and among its neighbours, and includes the search for better job opportunities, international commerce, natural disasters, competition over land use in dryland and agricultural areas, and civil conflict. These trends have been significant and most are foreseen to increase substantially in the coming years.

Kenya is still faced with its long-term humanitarian challenges. Human security in Somalia continues to disintegrate, resulting in continued inflows of refugees and irregular migrants. A similar situation continues in parts of Eastern DRC, Northern Uganda, Southern Sudan, and Ethiopia. Southern Sudan may stabilize post-referendum in 2011, or conversely may destabilize resulting in significant new inflows to Northern Kenya.

Water transport is important for movement of persons and cargo in East Africa. Ports, such as Mombasa and communities on Lake Victoria are commercial centres hosting mobile populations and civil servants such as immigration and customs staff. Ports and their immediate surroundings are offloading zones where road and rail transport links with watergoing vessels.

Truck stops and border crossings exhibit similar environments as ports, wherein the social context (mobility, alcohol, separation from family, etc.) drives both men and women to engage in unprotected sex with multiple concurrent partners.

Kenya has a number of commercial farms, including sugar, tea, coffee, and the cut flower industry, attracting internal migrants – largely youth travelling alone or with friends vulnerable to HIV and other health hazards. The Lake Victoria and maritime fishing industry is highly mobile, with seasonal migration among fishermen who follow the movement of fish stocks. Fishermen frequently coerce women into engaging in sex in return for access to fish (for sale in market) or for jobs, for example, cooks in fishing camps (IOM, 2010). Some fishing communities in Kenya have been decimated by HIV/AIDS, and Nyanza Province, along the shores of Lake Victoria, has the highest prevalence of HIV in Kenya.

Within Kenya, land ownership issues may improve with Kenya's new constitution, together with hopes for more equitable distribution of Kenya's social assets, but the underlying inter-tribal conflicts that have driven internal displacement since the introduction of multiparty rule in 1991, and which caused major IDP movements after the 2007 general election, remain. The multifaceted complexity of injustice and inequity in Kenya is highlighted by numerous sources, including a report by the Internal Displacement Monitoring Centre in 2006 (IDMC, 2006).

Most of Kenya's land is semi-arid, and is largely occupied by nomadic or semi-nomadic pastoralists. Pastoral areas in Kenya transverse through four provinces, namely North Eastern, Rift Valley, Eastern and Coast Provinces of Kenya. These areas are subject to frequent severe droughts occurring every three to four years. The communities that practice pastoralism in Kenya include the Samburu, Turkana, Orma, Pokot, Borana, Somali, Maasai, Gabbro, Marakwet and the Kuria. Traditionally, pastoralists move from one area to another with their livestock in search of pasture and water. In pursuit of this, pastoralists sometimes travel hundreds of kilometres and across national borders to support their animal-based livelihood. However, as a result of frequent droughts, the resultant population movements, and border insecurity, as well as increased population growth and settlements, the delicate balance between the pastoralists' way of life and nature has come under increased stress.

Furthermore, it is foreseen that due to climate change, by 2020 crop yields fed by rainwater will drop by 50 per cent in parts of Africa, with water stress displacing up to 250 million (IPCC, 2007). The worst-case scenarios are that by 2050, 160 million could be displaced annually, increasing to over 420 million early in the 2100s. Drought, flooding, and related competition among nomadic, semi-nomadic, and sedentary populations over water resources is already a recurrent threat to human security in Kenya, leading to displacement and lost livelihoods. This is exacerbated by continued occurrence of violent raids on Kenyan livestock, including from relatively lawless areas in neighbouring countries.

Weak health systems in the very porous Kenya border areas remain a serious public health problem, as evidenced by outbreaks of cholera and vaccine-preventable diseases, including sporadic re-emergence of polio and almost permanent outbreaks of measles in the past few years.

Kenya, like many other developing countries, is experiencing a high rate of urbanization. It is expected that by 2050, 48 per cent of the population will be urban, up from 22 per cent in 2009 (UNDESA, 2009). This will result in increased urban disparities and expansion of urban slums. Moreover, untold hundreds of thousands of irregular migrants are residing in Nairobi and other cities. The inherent "invisibility" of

these populations results in social disempowerment and inequitable access to basic social and health services.

Most countries in Africa including Kenya continue to experience the loss of a sizeable number of highly skilled health professionals by their migration to developed countries. The total cost of educating a single medical doctor from primary school to university is US$ 65,997; and for every doctor who emigrates, a country loses about US$ 517,931 worth of returns from investment. The total cost of educating one nurse from primary school to college of health sciences is US$ 43,180; and for every nurse that emigrates, a country loses about US$ 338,868 worth of returns from investment (Kirigia, 2006).

Below are the estimates of mobile and migrant populations in Kenya (IOM & MOPHS, 2010):

• Long distance truck drivers	57,800
• Migrant/mobile sex workers	8,000
• Refugees	464,864*
• IDPs	310,000*
• Cross-border traders	910,000
• Pastoralists	5,800,000
• Irregular migrants	Assumed over 100,000
• Farm workers	Unknown

*OCHA, 2011

2.3 Health Vulnerabilities in the Context of Migration in Kenya

2.3.1. Health vulnerabilities in relation to irregular migration

Irregular migrants live under a veil of invisibility, which systematically excludes them from access to basic health services. This is a particularly important health prerogative in urban settings in Kenya and across the region. Even if social and health services are locally available and affordable, migrants in an irregular situation are often hesitant to use them due to language and cultural differences, poor provider attitude, lack of health literacy, gender disempowerment, and fear of being reported to immigration officials or deported (IOM & MOPHS, 2010; IOM & McGill, 2010; IOM & NASCOP, 2010).

IOM believes that immigration status is a particularly important determinant of health outcomes and access to services, as recognized refugees and citizens face less harassment and enjoy a higher degree of social inclusion. This social exclusion is also a driver of migrant women into transactional sex, which brings serious HIV risk. A recent IOM study

found an HIV prevalence of 23.1 per cent among migrant FSW (IOM & NASCOP, 2010). For irregular migrants, health seeking behaviour is therefore reduced to a function of affordability in the unregulated private sector of curative care. Due to lack of promotive service access, major challenges exist in terms of immunization, sexual and reproductive health and rights, and TB case detection. Though local authorities are keen for IOM's assistance, in Kenya irregular and undocumented migrants are overlooked by policy-makers and the international development partners who instead focus on sector-wide approach programmes that strengthen health services for general communities and offer protection (including health services) for recognized refugees.

2.3.2. Health vulnerabilities along transport corridors and near ports

Studies by IOM in Kenya and elsewhere in East and Southern Africa highlight diversity of key population groups and of social drivers of HIV risk behaviour in "vulnerable spaces", which comprise truck stops, ports, and border crossings with large service sectors largely active at night. The income disparities between "mobile men with money" and women (and men) of low economic status drives a market for transactional sex (IOM & GLIA, 2006; IOM Kampala, 2008; Republic of Kenya, 2005b; IOM & NACC, 2011). Similar to the epidemiological driver of the hyper epidemic in Southern Africa (Halperin & Epstein, 2007), IOM believes that in "vulnerable spaces" the phenomenon of both men and women engaging in unprotected sex with multiple long-term concurrent partners, combined with low levels of male circumcision, is a significant driver of new infections in Kenya.

A 2005 study estimated that on just the Mombasa – Kampala highway, 3,200 – 4,148 new HIV primary infections occur annually. Condom use with regular partners in Kenyan truck stops was just over 68 per cent, but half of sex acts were with regular clients. The authors estimated that increasing condom use in all FSW liaisons (casual and regular) from 78 per cent to 90 per cent will prevent two-thirds of new infections (Morris & Ferguson, 2006).

The social factors driving HIV risk behaviour in vulnerable spaces are well-documented globally, and include separation from families, peer pressure, alcohol use, desensitization to risk-taking behaviour, and poverty which drives sex workers to assertively seek clients. A recent study among workers in the Port of Mombasa had similar findings, and moreover indicated the challenges of language and culture in engaging international seagoing personnel in HIV prevention (IMO & PMAESA, 2008). A low risk-perception – particularly between regular partners, is cause for alarm, and in face, a number of studies show that in spite of the challenge of HIV/AIDS in these populations, the priority health conditions for truckers are malaria, respiratory infections and backaches (IOM & GLIA, 2006, Republic of Kenya, 2005b).

2.3.3. Health vulnerabilities in relation to fishing communities

Factors such as young age, unmarried status, multiple sex partners including transactional sex partners, duration of stay in the fishing camps, lack of condom use, and prevalence of sexual violence have been found to be associated with increased vulnerability of fishing communities to HIV infection. Fishing communities do also, to a large extent, represent a population that is hard to reach as they often reside in remote areas, sometimes only reachable by boat, and are mobile in accordance with the fishing seasons of different areas. The men and women who work in associated occupations such as fish trading and processing are also vulnerable, in part because they are often within the fishermen's sexual networks. Trading fish for sex is a common practice between the fishermen and the fish-vending women on the shore. Additionally smaller scale fishing communities are often severely poverty stricken, with transactional sex being the only available means for women to sustain themselves and their families.

Although there are no specific figures for the fishing community, Nyanza province which borders Lake Victoria has the highest HIV prevalence in Kenya of 15.3 per cent (Republic of Kenya, 2008).

2.3.4. Health vulnerabilities in relation to farm workers

Factors that may lead to HIV vulnerability among semi-skilled and non-skilled commercial farm workers include a lack of access to information on HIV, belief in HIV myths, very few interventions from government and non-governmental organizations targeting the farm workers, lack of incentive or facilities to test for HIV, lack of appropriate information, education and communication (IEC) materials, and lack of access to condoms. Other additional factors may also include poor living conditions and seasonal mobility - poor living and working conditions include a lack of adequate accommodation, lack of security of tenure and the increasing casualization of labour preclude workers from bringing their families to the farm sites. These circumstances may lead some workers to seek other multiple relationships. In general, there is a lack of health care and HIV and AIDS services in commercial farming areas. This is exacerbated by the few rights and legal protections accorded to agricultural workers. Boredom and loneliness due to limited availability of recreational activities such as sports or entertainment at or around farms may lead to high-risk sex. Also, workers are often distanced from traditional norms and support systems that regulate behaviour in stable communities, and coupled with feelings of boredom, loneliness, and isolation, this can result in a disregard for health. In addition, the proximity and availability of transactional and/or casual sex may fill the workers' (temporary) emotional and sexual needs.

2.3.5. Health vulnerabilities in the context of emergencies

Kenya faces repeated disasters related to environmental disaster and potentially climate change – these include floods and drought, and lead to loss of livelihoods, displacement, and conflict over resources. In addition, the political climate has in the past led to wide-spread violence and population displacement. The groups most frequently at risk in disasters are women, children, older people, disabled people and people living with HIV/AIDS. In certain contexts, people may also become vulnerable by reason of ethnic origin, religious or political affiliation, or displacement. Specific vulnerabilities influence people's ability to cope and survive in a disaster, and those most-at-risk should be identified in each context. Availability of health care is a critical determinant for survival in the initial stages of a disaster. Disasters almost always have significant impacts on the public health systems in the affected areas and consequently on the well-being of affected populations. The public health impacts may be described as direct (e.g. injury, psychological trauma, interrupted treatment) or indirect (e.g. increased rates of infectious diseases, outbreaks of water-born diseases, malnutrition, complications of chronic diseases, increased cases of rape and gender-based-violence, psycho-social effects on individuals due to loss of their usual livelihood, schooling, employment etc). These indirect health impacts are usually related to factors such as inadequate quantities or quality of water, breakdown in sanitation, interruption in food supplies, disruption of health services (including ART and TB-DOTS), overcrowding and population displacements.

In some cases, including a situation documented by IOM in Somalia (IOM & UNAIDS, 2008), agencies catering to the well-being of displaced populations can exacerbate vulnerability through rape or forcing women to engage in sex in exchange for assistance. This could likewise occur in Kenya.

2.3.6. Health vulnerabilities related to pastoralism

Pastoralists are faced with a myriad of challenges which range from insecurity to health. Health issues for the pastoral communities revolve largely around their mobility, insecurity, water and sanitation. Poor hygiene necessitated by lack of water and toilet facilities have led to water-borne diseases like diarrhoea in children, intestinal worms, and typhoid. Skin diseases and ear and eye infections are common. TB, malaria and HIV are also health challenges faced by pastoralist communities. Community members continue to be in denial as to the extent of HIV, whilst statistics continue to indicate rising cases of HIV prevalence among the pastoralist communities due to a combination of factors such as low levels of awareness among the community, polygamy, expensive customary procedures that bar young people from getting married hence indulge in loose sex outside marriage, rape, scanty HIV

Counselling and Testing (HCT) services, low condom uptake rates, high HIV-related stigma, increasing transactional sex as a way of livelihood, poverty and language barrier which reduces negotiating power. Health service provision is available in urban and periurban areas with partners supporting mobile units periodically. Staff shortages, lack of equipment and medicines continue to pose a challenge in pastoral areas. Pastoralists face health vulnerabilities which are attributed to their lifestyle, poverty and illiteracy.

2.3.7. Health vulnerabilities in relation to trans-border communities

IOM has been unable to identify data to show the health vulnerabilities in border communities in Kenya, however, it is assumed based on experiences in other countries that health systems are weaker in remote border areas, HIV risk behaviour higher in bustling trans-border communities, and generally high level of irregular migration.

3.0 EXISTING INITIATIVES ON MIGRATION HEALTH IN KENYA

3.1 Current policy and legislative framework of Kenya

National Commitments

The Constitution of Kenya promulgated in August 2010

The rights of migrants and mobile populations are protected by the Bill of Rights, which is an integral part of Kenya's democratic state, and dictates that by law, a fundamental duty of the State is to fulfil the rights of every person in Kenya, including the right to the highest attainable standard of health. In addition, the State is obliged to progressively achieve realization of the rights of vulnerable groups including minorities and marginalized communities.

The Second National Health Sector Strategic Plan of Kenya 2005-2010: "Reversing the Trends"

The NHSSP II commits to reducing inequities in health care for all households in Kenya, including for non-citizens. The strategy is intended to shift emphasis from "burden of disease" towards promoting individual and community health.

Kenya National AIDS Strategic Plan 2009/10-2012-13: "Delivering on Universal Access to Services"

In achieving "an AIDS-free society", the KNASP III emphasizes combination prevention and improved coordination of responses, and includes as a priority the importance of reaching mobile populations with services. The Kenya HIV Prevention Response Analysis and Modes of Transmission Analysis in 2009 specifically mentioned FSW and populations along transport corridors as key unmet gaps in the national response. In addition, the report agrees with nearly a decade of IOM data in specifically indicating that refugees are not a significant contributor of new infections in Kenya.

The Refugee Act of 2006

The Refugee Act established a Department for Refugee Affairs (DRA) within the Ministry of State for Immigration and Registration of Persons to implement the 1951 United Nations Convention Related to the Status of Refugees. Upon entry into the country, asylum seekers have up to 30 days to report to UNHCR reception centres set up by the DRA where they are issued with an Asylum Seekers Certificate which provides protection against arrest as an illegal migrant. According to the "encampment policy", the government expects refugees to stay in camps to facilitate their protection and assistance needs and to safeguard national security.

Ministry of State for Special Programmes

With recurrence of natural and man-made emergencies, both within Kenya and in neighbouring countries, MOSSP is responsible for a coordinated multisectoral response. A Steering Committee has been established by NACC to assist MOSSP and partners to mainstream HIV in emergency situations.

UN Development Assistance Framework in Kenya (UNDAF) 2008-2012

IOM is an active and equal partner in the UNDAF, which through joint programming provides a value-added to the Government of Kenya in achieving the Millennium Development Goals. Extending health services to reach marginalized populations, including migrants in urban settings, is a cornerstone of the National Health Sector Strategic Plan II and is emphasized in the UNDAF. The Joint UN Programme of Support on HIV/AIDS (JUPSA) comprises the UN System assistance in the HIV response.

International Strategies and Commitments

The United Nations General Assembly Special Session on HIV/AIDS (UNGASS, 2001), included a Declaration of Commitment on HIV/AIDS which recognizes the relationship between HIV/AIDS and migration.

Paragraph 50 of the Declaration of Commitment stipulates that Member States should: "develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services."

The African Union Abuja Declaration on HIV/AIDS, TB & Other Related Infectious Diseases, 2001 declared a state of AIDS emergency on the African continent, and accorded the fight against it the highest priority in national development plans. The declaration called on State parties to strengthen ongoing successful interventions and to develop new and more appropriate policies, practical strategies, effective implementation mechanisms, and concrete monitoring structures at regional, national, and continental levels.

The EAC Regional Integrated Multi-sectoral Strategic Plan for HIV & AIDS 2008–13 aims to reduce incidence of HIV infection in the East African region in order to secure sustained sub-regional socio-economic development. Specific objectives are to: 1) Enhance the institutional capacity of the EAC Secretariat and that of the EAC member states so as to secure effective implementation of regional and national responses to HIV and AIDS; 2) Mainstream HIV/AIDS through the EAC and its institutions and sectors; 3) Improve the effectiveness of interventions through the harmonization of EAC Member States' HIV/AIDS protocols, policies, plans, strategies, and legislation 4) Improve the design and management of national and regional responses to HIV and AIDS through the generation of, and easy access to, strategic information and knowledge on the epidemic; 5) Scale-up regional and national responses to HIV and AIDS through the strengthening of political leadership and commitment towards addressing the epidemic; and 6) Consolidate effective partnerships among strategic partners within and outside the EAC region in its response.

The Resolution on Health of Migrants (WHA 61.17) was adopted during the 61st World Health Assembly in May 2008, and calls upon Member States, including Kenya, to:

- To promote equitable access to health promotion and care for migrants
- To establish health information systems in order to assess and analyse trends in migrants' health
- To devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery
- To gather, document, and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination
- To raise health service providers' and professionals' cultural and

gender sensitivity to migrants' health issues; and
- To train health professionals to deal with the health issues associated with population movements.

3. 2 Current Interventions in the Context of Migration Health in Kenya

3.2.1. Through the project "Technical Cooperation on Migration Health in Kenya", which commenced in March 2009, IOM has endeavoured to strengthen the capacity of the Government of Kenya to promote the health of migrants by supporting stakeholder meetings for action planning and information sharing, completing situational assessments, and establishing and supporting the Coordinating Centre on Migration Health (CCMH), located within the Department of Health Promotion of the MOPHS. The project has facilitated a South - South study visit of MOPHS officials to Thailand, where IOM and the Ministry of Public Health in Thailand are collaborating on the programme "Healthy Migrant – Healthy Thailand". Through the same project, IOM and WHO co-hosted a sub-plenary on implementation of WHA 61.17 resolution during the 7th Global Conference on Health Promotion, that was held in Nairobi in 2009. Through the conference resolution and action plan, participating governments committed themselves to mainstream health promotion both in policy and practice, including that of migrants.

3.2.2. 25 years ago, the world became aware of a HIV epidemic among key population groups engaging in risk behaviours along transport corridors in East Africa, including Kenya. Today, a multitude of organizations are engaged in a metaphorical tug-of-war, pulling in different directions. Despite meaning well, the national response remains fragmented, not targeted, and lacks both intensity and scale.

"Sometimes you find that those who are not HIV positive are given support, and you who is positive do not benefit. This is why if her husband tries to seduce me I will not refuse because they benefit from the support which I am supposed to get and I will say, 'to Hell let them die with me."

HIV-Positive Female Sex Worker working in Busia truckstop

While some important strategic information exists to guide programming, the most recent seroprevalence data among sex workers and clients along transport corridors in East Africa dates to the mid-1990s. Solid data on knowledge, behaviours, health-seeking practices, and state of the response are also missing. This lack of strategic information means that currently partners are unable to measure the collective impact of programming, including the capture of UNGASS indicators (UNGASS, 2007). This also hinders advocacy and planning as computer modelling of the epidemic, as in the number of new infections occuring along the corridor each year, is based on outdated data inputs.

In 2010, IOM collaborated with NACC on a combination prevention response analysis, which aimed to identify the extent to which high-quality and targeted combination prevention programming was taking place in five major stops. The results were strongly indicative of a need for improved coordination. There was no commonality of messaging, and in fact, just a quarter of IEC materials were targeted to the main messaging required for the target population, for example, "know your status", use condoms consistently. A month of fieldwork resulted in failure to identify any instances of implementing agencies collaborating and found no instance of behavioural interventions being implemented, such as peer education, in spite of nearly 30 agencies reporting to provide such services. Of over 600 truck driver and female sex workers interviewed, 70 per cent had never received any information on HIV/AIDS. In some cases, HIV programming was available in the surrounding community, but overlooking populations that are key to effective HIV prevention and in most need of assistance (IOM & NACC, 2011).

As the national response along transport corridors requires strong focus and cohesion, IOM is partnering with NACC and major stakeholders in a six-month process of elaborating the national combination prevention package – including both male-friendly and female-friendly clinical services that integrate maternal and child health. This process should hopefully result in a major scale-up in the response, so that meaningful impact can be collaboratively achieved among partner agencies in preventing HIV.

3.2.3. Irregular migrants in urban settings are particularly vulnerable as they lack recognition by the government and thus are marginalized from access to health services. In collaboration with the DHMT IOM has offered TB-DOTS to migrants in Eastleigh since 2002 through the IOM Eastleigh Community Wellness Centre, which reaches both migrants in the resettlement process and the general community. Activities such as TB counselling, laboratory testing, and treatment have been extended to all migrants and host community members, free of charge. IOM currently assists an average of 200 walk-in clients per month for HIV Testing and Counselling (HTC), and provides antiretroviral treatment (ART), TB diagnostics, TB DOTS, and facilitates weekly immunization

/child health promotion campaigns with the DHMT and other local health authorities. In partnership with the Kamukunji DHMT, IOM has regularly participated in Malezi Bora (Good Nurturing) campaigns organized twice yearly. This is a national initiative launched in 2008 offering a comprehensive service package to promote children's and mothers' health – the DHMT has requested IOM support in offering the package on a daily basis.

3.2.4. In Nairobi, as across East Africa, many irregular migrant women are surviving through engaging in transactional sex. To identify the needs of this population group, IOM in partnership with the NACC, NASCOP, KACP, University of Nairobi, and the JUNTA in Kenya completed an HIV and STI integrated biological and behavioural surveillance (IBBS) survey among migrant female sex workers (FSW) in Nairobi in 2010 (IOM & NASCOP, 2010). The study utilized respondent-driven sampling to reach over 600 respondents in capturing the UNGASS indicators for most-at-risk populations with specific information collected on migration. The study identified an HIV prevalence of 24.3 per cent, and showed that these women are marginalized from health services including HIV and STI testing, treatment, care and support. Health seeking behaviour is low, knowledge of HIV and STI is minimal with many misconceptions common place, and evidence of sexual and gender based violence is present. These vulnerable women expressed the desire for free, non-judgmental comprehensive reproductive and sexual health services and livelihood and social support. As a direct result of the study, IOM has been able to mobilize some small resources to initiate pilot combination prevention programming among this population group, in collaboration with the National Association of Peer Educators and a local community clinic.

3.2.5. Some other studies conducted by IOM and partners to inform the government and other stakeholders on HIV/AIDS among mobile populations in Kenya include a national situational assessment of migration health (IOM & MOPHS, 2010), a national situational assessment of pastoralism and HIV in 2009 (IGAD & IOM, 2009), and an assessment of service needs among truck drivers in 2006 (IOM & GLIA, 2006). The findings of these studies have been helpful in shaping the policy framework on HIV and mobility in Kenya.

3.2.6. IOM has been implementing several cholera emergency response programmes in Rift Valley Province, and in Northern and Western Turkana during 2009 and 2010, in close collaboration with various government agencies including: Department of Health Promotion, Ministry of Public Health and Sanitation, Division of Disease Surveillance & Response, District Health Management Teams (DHMT), World Health Organization,

community leaders, youth leaders, church leaders, community health workers and counsellors . Cholera outbreak has been on-going in the country, requiring a proactive multi-sectoral and collaborative approach between government agencies, health service providers, local authorities and affected communities. To-date, due to funding limitations, IOM's role has been limited to conducting awareness activities in schools, churches, and community settings; development and distribution of IEC materials such as posters and pamphlets in the -Turkana language, Kiswahili and English; health promotion and education sessions, and re-stocking of government facilities with supplies for cholera prevention and treatment. Since May 2009, IOM has reached 124,243 individuals (44,622 households) through outreach sessions.

3.2.7. Through the established Migration Health Assessment Centres in Nairobi, Kakuma and Dadaab, IOM has been involved in evaluation of the physical and mental health status of migrants, prior to their departure from Kenya, either for the purpose of refugee resettlement, enrolment in humanitarian migrant assistance programmes, international employment, family reunification, or studies abroad. The main driver of the set of health assessment requirements is the need to ensure migration process per se is not going to endanger the health of migrants or the host communities. Therefore, the main purpose of the migration health assessments is identification and addressing of conditions of public health importance, to include communicable diseases, diseases with potential threat to the public safety, and diseases presenting with high impact and burden on the health and social services. Besides the offered treatment and stabilization options for migrants, for example, tuberculosis, STIs, other acute infectious diseases, hypertension, epilepsy and psychotic conditions etc, they benefit from awareness of their personal health conditions, from the detailed information sharing that addresses their health needs, and better facilitating their integration in the new host communities. In the context of health assessments and assistance to travel, IOM provides a full range of immunization activities for migrants in Kenya, as well as medical travel assistance and medical escort provision where needed.

4.0 COUNTRY STRATEGY ON MIGRATION HEALTH

4.1 Comparative advantages of IOM in the context of Migration Health in Kenya

IOM's comparative advantages are rooted in its mandate as an intergovernmental organization that assists governments to manage the health aspects of migration. All East African Community countries are IOM Member States and IOM MHD has full-time technical experts

working with government counterparts in Kenya, all its neighbours, and the regional economic communities (REC) Further benefit to addressing the health of migrants on a regional level is that the IOM Migration Health Teams in East Africa work together across countries – often in close partnership with governmental focal points responsible for regional programmes. As a result, IOM is uniquely positioned to support cohesive country-level and trans-border health initiatives under government leadership.

IOM in Kenya is working as a strong technical leader within the domain of migration health, including irregular migration and HIV and People on the Move. IOM is the lead agency in the UN Joint Team on AIDS (JUNTA) related to population mobility, including issues related to HIV and populations of humanitarian concern. IOM implements some of these activities as a member of the Joint UN Programme of Support on HIV/AIDS in Kenya (JUPSA). IOM is leading a national taskforce, together with NASCOP and NACC, which is leveraging partnerships towards rapid scale-up HIV combination prevention along transport corridors. IOM is a reliable and active participant in the national technical working groups on HIV surveillance, HIV research, and HIV among most-at-risk populations, as well as the national tuberculosis and health promotion working groups. IOM is a convenor in the JUNTA on HIV & Emergencies in Kenya, and through this role is supporting NACC to strengthen national capacity and preparedness planning to address HIV in emergency response across sectors.

As an implementing partner IOM is capable of handling large grants in a cohesive manner so that partners together achieve meaningful impact on fulfilling national health and HIV objectives. IOM's Migration Health Team in Nairobi is currently managing a multi-year portfolio for Kenya, Somalia, and regional activities of about US$ 6 million, excluding the migration health assessments programme, which amounts to approximately the same figure per annum. Within IOM's bi-regional health programme, IOM has received successive grants as a Prime Partner in the President's Emergency Programme for HIV/AIDS Relief (PEPFAR) to address HIV on commercial farms in South Africa, and in Nairobi, IOM is managing two grants as a major sub-recipient of the Somalia Round 8 HIV programme under the Global Fund to Fight HIV, TB, and Malaria. The Somalia Round 8 proposal was based upon data provided through IOM's research team in Nairobi, and IOM provided substantial technical support to developing the proposal and national strategy upon which it is based. IOM Kenya's overall donor-funded budget for the year 2009 was over US$ 40 million (>90% absorbed), and in 2010 this grew to US$ 50 million. The flexibility and efficiency that IOM offers as a non-UN agency provides a solid technical, administrative and financial platform for rapid and meaningful scale-up of migration health programming in Kenya.

Migrants, particularly those with irregular immigration status, have come to know and trust IOM, which facilitates increased health equity for the overall benefit of communities, and a number of pilot activities are underway among these population groups, in collaboration with and through the appropriate governmental channels.

Rather than separate out migrants with a protection mandate which would reach just a small subset of the overall population and potentially lead to conflict with host communities, IOM takes a public health approach that supports the capacity of government in strengthening health systems to effectively reach migrants and their host communities. This is a unique niche and key comparative advantage that is highly appreciated by health and HIV authorities in Kenya, but still goes largely unnoticed by international development partners.

IOM is keenly aware of the importance of assisting governments to implement international conventions and resolutions, including WHA61.17, and further has existing Memoranda of Understanding (MoU) both globally and locally with UN Agencies including WHO, UNICEF, UNAIDS, UNV, UNFPA, UNDP, and UNIFEM, among others. IOM has strong cordial working partnership with various Ministries in the Government, including the Ministry of Public Health and Sanitation (MOPHS) and most of its departments, National AIDS Control Council (NACC), the Ministry of Immigration and Registration of Persons (MOIP), and the Ministry of State for Special Programmes (MOSSP). MOUs with the University of Nairobi, Kenya Red Cross Society, and Ministry of Public Health and Sanitation are presently being negotiated, and district-level MOUs already exist in key sites.

IOM has operational field presence in various parts of the country including Eastleigh estate in Nairobi, Lokichoggio, Kakuma, Eldoret, and Dadaab – offering a platform upon which to expand programming together with national and local governmental entities and their implementing partners.

In the realm of the fight against TB, IOM has developed significant global capacities and has developed excellent relations with the Division of Leprosy, Tuberculosis and Lung Diseases, within the MOPHS in Kenya, that has recognized IOM as a key partner in providing TB management to vulnerable populations. IOM has developed expertise and capacities in dealing with the issues of advanced diagnostics, including radiology and an advanced tuberculosis laboratory. This expertise is gained through IOM offering high quality TB diagnostics and treatment to refugees and migrants undergoing migration health assessments for resettlement or migration to third countries. Besides the permanent presence of skilled international staff in Kenya, several of IOM's Kenyan medical staff have benefited from trainings and specialization in TB management in the USA. IOM's TB laboratory diagnostic capacities in Kenya complement

the national system, and work in close cooperation. Overall capacities of IOM laboratories in Kenya are in a range of 10,000 sputum samples cultured and processed on liquid media, and 20,000 samples processed on solid media. Both first and second line anti TB drug susceptibility testing (DST) is available at IOM, making IOM the only laboratory in the country and region capable of processing second line DST for TB.

IOM's TB clinic in Eastleigh received the Koch's award for second best managed TB Clinic in Kenya by the DLTLD in 2007, and best in Pumwani district of Nairobi.

Through the UK TB Detection Programme, IOM also provides services to prospective migrants to the UK while operating a clinic at Nairobi Hospital. Full range of TB related services are also provided at the Migration Health Assessment Centre (MHAC) in Nairobi, and to a smaller scale in the remote location MHACs in Dadaab and Kakuma. IOM MHD in Nairobi addresses TB screening and treatment in numerous locations of interest around the continent via mobile teams who travel to remote or difficult to access sites (Somali, Eritrea, and Burundi, to name a few). IOM Nairobi is the regional technical and logistical hub for migration health assessments across the Middle-East and all of Africa.

4.2 Overall Objective

To contribute to the improvement in the standards of physical, mental and social well-being of migrants and their families, sending, transit and receiving communities, by responding to health needs throughout all phases of the migration process.

4.3 Long-Term goal

To improve the management of migration health and decrease health vulnerability among populations effected by migration and mobility in Kenya, in line with the NHSSP objective of reducing inequities in health for all persons in Kenya.

4.4 Specific Objectives

The objectives for Service Delivery and Capacity Building include:

- To facilitate, provide and promote access to sensitive services for migrants and communities affected by migration
- To develop and strengthen networks and strategic partnerships to promote the health of migrants and affected communities
- To deliver high quality migration health assessments which are gender, age religion and culturally sensitive, aiming at

identification, reporting, information sharing, and sensitively addressing health conditions of interest prior to, during, and after travel.

The objectives for Advocacy and Policy Development include:

- To advocate for national and sectoral policies and programming that address Migration Health concerns
- To facilitate and strengthen national coordination on Migration Health concerns

The objectives for Research and Information Dissemination include:

- To increase the understanding of migration health through research
- To ensure that IOM and non-IOM research is quoted and/or reflected in policies and programmes
- To build strategic partnerships with academic and research institutions at national level

The objectives for Regional Coordination include:

- To complement and strengthen mutual outputs of PHAMESA, regional partners and donors and make efficient use of available resources through partnerships, strengthened networks, coordination and collaboration.

4.5 Key Migration Health Priorities for IOM in Kenya

4.5.1 Urban Migrant Health Programme

With serious obstacles to accessing health services among irregular migrants in Eastleigh (and other urban settings in Kenya), issues such as SRHR / MCH, tuberculosis (incl. MDR TB), and transactional sex are major health challenges.

IOM's approach is to strengthen health systems for the entire community affected by irregular migration. Systematically including irregular migrants within health programming such as TB and immunization programmes ought to be seen as a public health imperative, not only for the host community, but for the other transit and destination countries to which migrants travel through regular and illegal means. Drug-resistant tuberculosis, polio, measles and other communicable health conditions do not discriminate on immigration status, so why should the health sector do so?

IOM's envisioned programme in Eastleigh (and other urban settings) aims to "contribute to the reduction of health inequalities", in line with the

overall objective of the Kenya National Health Sector Strategic Plan. The envisioned programme meets priority health needs of the community – including irregular migrants – by utilizing evidence collected by IOM and others, and using existing pilot activities implanted through a partnership between IOM, Kamukunji District Health Management Team, and NGOs.

Components of the programme include upstream collaboration at central level in the MOPHS, including Department of Health Promotion, NASCOP, and National Leprosy and TB Control Programme (NLTP), so that disaggregated health data and lessons learned flow to the higher levels and raise awareness of the multiplicity of typologies and their health disparities – including differentiating between registered refugees (a small minority of the population that enjoys access to health services) and irregular migrants (the majority of the community who remain invisible and marginalized). Upstream components also include government-led coordination at the local and national level and completion of research that "unpacks the box" in terms of social determinants of health and health outcomes faced by different migrant typologies. Best practices should be documented, disseminated, and duplicated in other urban settings in Kenya and abroad.

In downstream activities, IOM aims to build upon achievements by IOM and government partners in Kenya and other countries, by involving the migrant community in government-led service delivery through deploying health volunteers and offering migrant-sensitive services. IOM and the DHMT would like to build upon pilot activities to offer integrated health services through the Eastleigh Community Wellness Centre, government clinics, private sector, mobile outreach, and/or other mechanisms.

The pilot programme which IOM is working to bring to scale involves the following components:

- SRHR – ensuring that Family Planning and the Malezi Bora package are adapted for and available to migrant communities;
- Communicable disease community surveillance and primary care clinic;
- TB and HIV package – prevention, case detection / HCT, and treatment;
- Targeted HIV Combination Prevention Programme reaching "vulnerable women" and their clients.

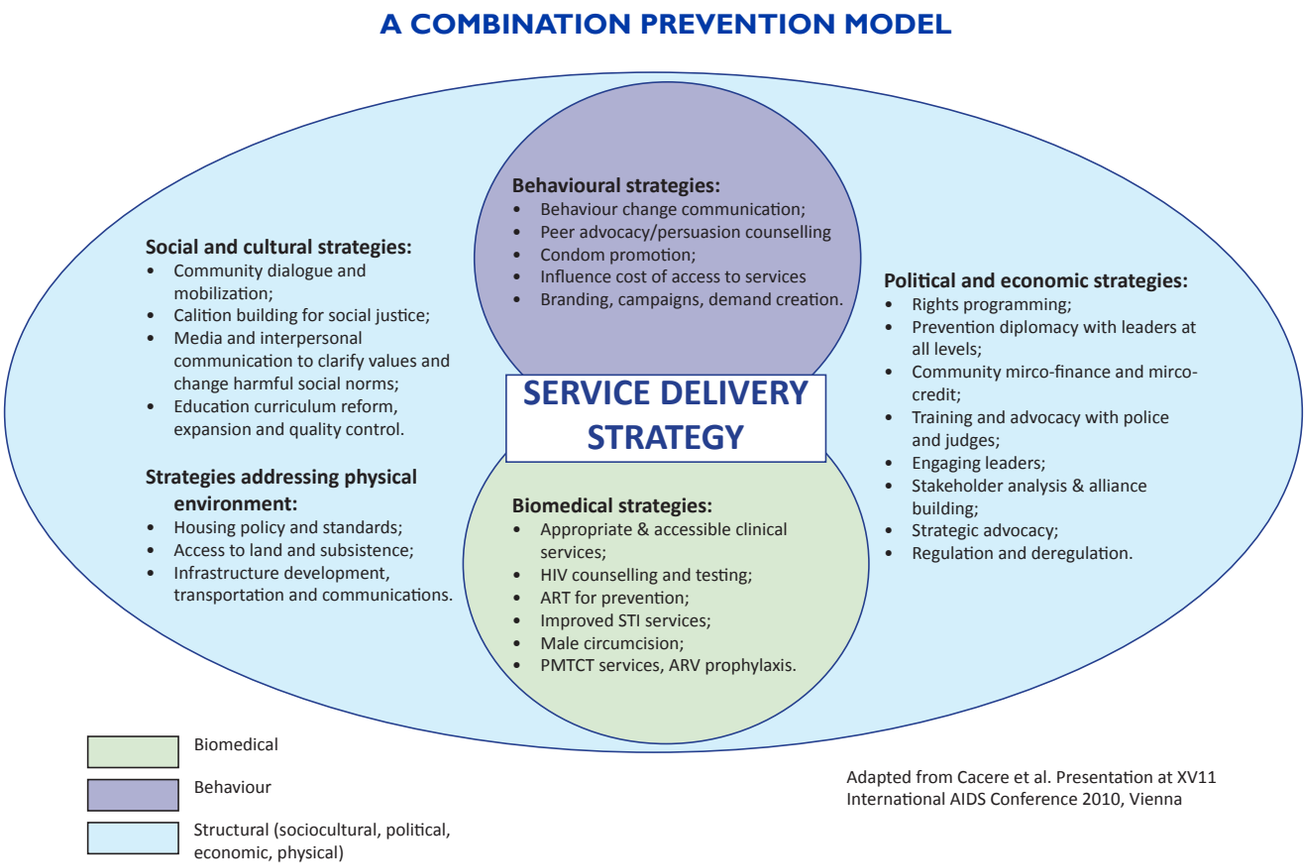
4.5.2 Scale-up of a Cohesive HIV Combination Prevention Programme along Transport Corridors

A targeted combination prevention package reaching vulnerable populations in truck stops, ports, and border crossings has yet to exist in Kenya or elsewhere in East and Southern Africa, in spite of numerous agencies offering HIV services. Data collected by IOM in Kenya indicates a response that is seriously lacking in targeting, service availability, capacity of implementers, intensity, and scale (IOM, 2010d). Instead of working together towards common corridor-wide objectives and messaging, agencies are working in opposite directions, contributing towards a stagnated response. As a corridor, it is impossible to measure collective outputs, quality, and impact. Integrated biological and behavioural surveillance has yet to be undertaken anywhere in East Africa among FSW and clients along corridors and is required for improved modelling, advocacy and planning, and evaluation.

IOM's approach is to support a national consensus-building process with NACC and NASCOP wherein stakeholders will all agree upon a concise national strategy (expected by mid-2011), which includes just a few key objectives that are measurable (e.g. 100% knowledge of serostatus). Thereafter, a common menu of male-friendly and female-friendly services will be elaborated as part of a combination prevention package that includes condom promotion, a communication strategy with key messages, key activities aimed at addressing structural determinants of behaviour, then mapping existing pockets of funding, and mobilizing the additional resources required to bring the programme to scale. The envisioned programme will focus on key population groups who engage in risk behaviour inside hot-stops, directly addressing the proximal drivers of infection (i.e. making sex safer, reducing viral loads, male circumcision), and rely upon government structures as much as feasible for clinical service delivery.

The programme would prioritize the biomedical and behavioural package with the structural strategies that address underlying determinants used sparingly and strategically, once the priority package is already in place (See Figure 1). M&E would capture collective outputs as a corridor, not per individual agencies, with repeat IBBS surveys capturing impact. A quality assurance component using methods such as "secret shoppers" and a system of accreditation should be utilized so that a common menu of services is indeed available and branded to be recognizable to the target groups. Men and women require different approaches for behavioural and clinical interventions.

Figure 1: A Generic HIV Combination HIV Prevention Model



4.5.3. Tuberculosis Prevention, Case Detection, and Treatment, incl. MDR-TB

Migrants and mobile populations are particularly susceptible to pulmonary TB due to poor living conditions and the relative lack of access to specialized services for early case detection and initiation of TB-DOTS. Due to the tendency of migrants to access health care in the largely unregulated private sector (e.g. pharmacies) or to wait until it is too late to access services, they are at increased risk of contracting or developing drug resistant TB infection. Multiple-drug resistant (MDR) TB presents a special public health threat for Kenya, and beyond, to where migrants travel, due to the complexity of creating and implementing policies for management of MDR TB patients and their contacts.

IOM is aiming to improve TB awareness and access to services in a number of locations and population groups in Kenya, including refugee camps, urban settings, along highway corridors, and where pastoralists congregate. In addition, with its existing MDR TB laboratory capacity,

IOM is working to develop programming that will determine the efficacy of treatment regimens using culture and sensitivity testing. IOM is in process of constructing and commissioning a second bio-safety level 3 laboratory in Kenya, with capacity to perform both solid and liquid culturing of biological samples to at least Mycobacterium Tuberculosis complex level, and drug susceptibility tests (DSTs). IOM will offer its services to humanitarian cases in the area, host communities, and pastoralist communities in the Eastern Province.

IOM also aims to expand existing TB-HIV programming in Eastleigh and beyond. It is foreseen that IOM will embark on using the latest molecular TB testing methods, implementing the first "point of care" TB test that gives results within hours (and not months) in its TB clinic in Eastleigh. Evaluation and results of this testing will contribute towards the data used in creating countrywide policies for TB testing in Kenya.

IOM is actively contributing to wards the National TB Programme and approach to the issues of TB in vulnerable groups, as well as towards the National MDR TB strategy.

4.5.4. Migration Health Assistance for Crisis-affected Populations

Population displacement brought on by recurrent natural disasters, conflict, political crises, and slow-onset environmental emergencies related to climate change continuously pose challenges to Kenya.

IOM has major Emergency and Post-Crisis programming underway in Kenya and in neighbouring countries. Activities include water and sanitation, rebuilding and skills building of health infrastructure, shelter (IOM is global cluster lead on shelter), peace-building, transport assistance, rapid assessments, livelihoods, and other activities. In Southern Sudan, IOM runs a key programme on Geographic Information System mapping of displacement, population needs, and relief programming.

The Migration Health Division in Nairobi has managed cholera and hygiene promotion activities funded through the Central Emergency Relief Fund in Rift Valley and Western provinces in 2009 and 2010, as well as psychosocial programming in the aftermath of the post election crisis. IOM was very efficient in implementing these projects, in close collaboration with government counterparts and partner agencies, including UNICEF and WHO.

IOM's MHD approach in emergencies is guided by the principle that humanitarian health actions in emergencies shall rapidly assess and address the urgent health needs and identified gaps in provision of health services, while aiming towards the early recovery and health systems strengthening. IOM fills in the gaps whereby the health

system infrastructure is unable to meet the demand posed by the displaced population and their host communities; or where the health infrastructure is non-existent. Concepts of temporary and transitional health posts are considered, as well as use of mobile health clinics for conducting outreach activities. These activities are always in support of the existing health infrastructure and are accountable to the host country government and its local and central health authorities. IOM's assistance to crisis affected populations is an integrated part of a global IOM response to the same population and concerned Government. IOM also supports capacity-building and coordination efforts.

In Kenya, opportunities lie in implementation of the mobile medical unit concept, awareness raising on health issues using the same concept, addressing water and sanitation issues, and psychosocial well-being. Mainstreaming health into non-health specific activities of IOM is the way forward, as well as post-crisis programming with the aim of supporting the Government to rebuild the central and community health systems.

4.5.4.1. Leadership and Capacity-building on HIV & Populations of Humanitarian Concern

As co-convenor in the UN system on HIV in Emergencies, IOM will continue to support NACC and partners to mainstream HIV into the different sectoral response plans. Much remains to be done. In the 2011 Emergency Humanitarian Response Plan, HIV was not mentioned, not even in the health sectoral plan. Since 2010, IOM has initiated a process with NACC, NASCOP, MOSSP, and UN Partners to raise awareness within the sector groups, to develop a plan of action for addressing HIV in emergency settings, to build capacity of stakeholders and implementing partners, and to support NACC's coordination capacity in the event of emergencies. Important partners in the process include NGOs, faith-based organizations, Kenya Red Cross Society, district officials, community leaders, among others. IOM is also a member (and the previous convenor of) the East Africa Interagency Working Group (IAWG) on Emergencies, GBV, and HIV.

4.5.5. National Advocacy on Migration Health

IOM MHD will continue to advocate in Kenya for increased awareness of the issue of migration health and inclusion of migrants and mobile populations in strategies, action plans, and service delivery. IOM has worked to increase internal staffing capacities in order to assist governments in addressing the challenges of migrants' health, to expand its participation in related government processes, and to actively promote provision of evidence, and further translation of evidence into strategies and programming. Partnerships are considered key in facilitating high quality research and ethical reviews, so that

findings can be published in peer-reviewed journals and further utilized for evidence-based health programming. IOM has greatly increased communications activities through partnership with media and use of multimedia to disseminate messages. IOM will continue to support the Coordinating Centre on Migration Health (CCMH) in the DHP to address migration health within governmental systems, and forge MOUs with academia and key implementing partners for research, internships, and co-implementation of activities. Additional advocacy activities include consultations on migration health, facilitation of knowledge-sharing between countries, facilitating coordination meetings, and expanded donor liaison.

4.5.6. Strengthening Health Service Delivery for Pastoralists, including SRHR/MCH, TB, and Targeted HIV Combination Prevention 2

As health literacy and service access for pastoralist communities lag significantly behind national averages, IOM will build upon its existing data and activities to increase health service delivery to pastoralists. Specifically, the areas of focus will involve SRHR, MCH, tuberculosis control, and targeted combination prevention focusing on the key behavioural drivers. Time and location are particularly important aspects of reaching pastoralists with services. For HIV prevention, the focus involves following the mobility patterns – grazing, water and market cycles – to reach those engaging in alcohol use and transactional sex after selling livestock. Similarly, innovative and targeted programming is needed to address other health concerns.

4.5.7. Continue with leadership on, provision of, and promotion of high quality Migration Health Assessments

Through established Migration Health Assessment Centres in Nairobi, Dadaab and Kakuma, IOM will further endeavour to elevate the quality of health assessments for migrants and refugees travelling to third countries. Strengthened flow of information with the Kenyan government, destination country, and migrant clients will support improved quality and continuity of care. Data will also be utilized to improve service delivery and referral in camps and urban settings among IOM, NGOs, and government facilities, particularly on the issues of HIV, sexually transmitted infections, and HIV/AIDS. IOM will continue to approach Migration Health Assessments as a key tool facilitating effective integration of migrants into the receiving communities, and promoting the health of both migrants and host communities.

REFERENCES

Halperin D.T. and Epstein H.

2007 Why is HIV Prevalence so Severe in Southern Africa? The role of multiple concurrent partnerships and lack of male circumcision: Implications for AIDS prevention. The Southern African Journal of HIV Medicine, March 2007, pages 19-25.

Intergovernmental Panel on Climate Change

2007 Climate Change 2007: Impacts, Adaptation and Vulnerability. Contribution of Working Group II to the Fourth Assessment Report of the Intergovernmental Panel on Climate Change, M.L. Parry, O.F. Canziani, J.P. Palutikof, P.J. van der Linden and C.E. Hanson, Eds., Cambridge University Press, Cambridge, UK, p. 13.

Internal Displacement Monitoring Centre

2006 'I am a refugee in my own country': Conflict-Induced Internal Displacement in Kenya (Special Country Report). IDMC, Nairobi.

Intergovernmental Authority on Development (IGAD), NACC, International Organization for Migration

2009 Pastoralism and HIV/AIDS in IGAD Countries: Programme mapping, data synthesis, and recommendations for policy and further research – KENYA REPORT, IOM, Nairobi.

International Maritime Organization (IMO) and Ports Management Authority of East & Southern Africa (PMAESA)

2008 Impact Assessment Study of HIV/AIDS in PMAESA Port of Mombasa, Kenya, IMO, Nairobi.

International Organization for Migration

2011 Journey to Health: IOM Migration Health Strategy for East and Southern Africa 2011-2015, IOM Pretoria & Nairobi.

2010 Dar Es Salaam, Tanzania. IOM, Dar es Salaam.

2010a National Consultation Migration & HIV in Tanzania: Uniformed Personnel, Mobile Populations, and Border Communities, 1-2 June

2004 International Migration Law No. 10, Glossary on Migration. IOM, Geneva.

International Organization for Migration and Great Lakes Initiative on AIDS (GLIA)

2006 Long-distance Truck Drivers' Perceptions and Behaviors Towards STI/HIV/TB and Existing Health Services in Selected Truck Stops of the Great Lakes Region: a Situational Assessment. IOM, Nairobi.

International Organization for Migration, McGill University, and University of Nairobi

2010 Access to Maternal & Early Childhood Health Care for Urban Migrants in Eastleigh, Nairobi, Kenya: A Pilot Study (in press). IOM, Nairobi.

International Organization for Migration and Ministry of Public Health and Sanitation

2010 Situational Analysis on the Health of Migrants and Other Mobile Populations in Kenya (in press). Njeru E.K., IOM, Nairobi.

International Organization for Migration and NACC

2011 Response Analysis of Combination HIV Prevention along the Northern Transport Corridor in Kenya (in press). IOM, Nairobi.

International Organization for Migration, NASCOP, University of Manitoba, NACC, and UNFPA

2010 Integrated Biological and Behavioural Surveillance (IBBS) Survey among Migrant Female Sex Workers (FSW) in Nairobi, Kenya (in press). IOM, Nairobi.

International Organization for Migration, UNAIDS, UNDP, Somaliland National AIDS Commission, Puntland AIDS Commission, South-Central AIDS Commission

2008 Somali HIV Hot-spot Mapping: Exploring HIV Vulnerably among Populations at increased risk. Testa A. et al. IOM, Nairobi.

International Organization for Migration, UNAIDS, UNFPA, and Ugandan AIDS Commission

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

Kirigia J .S. et al

2006 The cost of health professional brain drain in Kenya. BioMedical Central (BMC) Health Services Research.

Morris C.N. and Ferguson A.G.

2006 Estimation of the sexual transmission of HIV in Kenya and Uganda on the Trans-Africa Highway: the continuing role for prevention in high risk groups, Sex. Transm. Inf., July 2006, doi:10.1136/sti.2006.020933.

Republic of Kenya

2010a Kenya 2009 Population and Housing Census Highlights, Kenya National Bureau of Statistics, Nairobi.

2010b Budget Policy Statement, March 2010, Ministry of Finance.

2010c The MP's Budget Watch, Budget Digest Vol. 3, June 2010, Parliamentary Service Commission, Nairobi.

2010d Kenya Demographic and Health Survey 2008-09. Kenya National Bureau of Statistics (KNBS) and ICF Macro, Calverton, Maryland, USA.
2010e Division of Leprosy, Tuberculosis, and Lung Disease, Kenya: Strategic Plan 2011-2015, Ministry of Public Health and Sanitation, Nairobi.
2010f The Constitution of Kenya, Revised Edition 2010, National Council for Law Reporting, Nairobi.
2009a Kenya HIV Prevention Response and Modes of Transmission Analysis – Final Report, March 2009. NACC, Nairobi.
2009b Kenya National AIDS Strategic Plan 2009/10 – 2012/13: Delivering on Universal Access to Services (KNASP III). National AIDS Control Council, Nairobi.
2008 Kenya AIDS Indicator Survey 2007: Preliminary Report, National AIDS/STD Control Programme and Ministry of Health, Nairobi.
2005a Reversing the Trends: The Second National Health Sector Strategic Plan of Kenya 2005 – 2010 (NHSSP II). Ministry of Health, Nairobi.
2005b Hot Spot Mapping of the Northern Corridor Transport Route: Mombasa – Kampala, Final report, Ministry of Transport, Nairobi.

United Nations Children's Fund (UNICEF)
2011 The State of the World's Children 2011: Adolescence – An Age of Opportunity, UNICEF, New York.

United Nations Department of Economic and Social Affairs (UNDESA)
2009 World Population Prospects: The 2008 Revision and World Urbanization Prospects: The 2009 Revision. UNDESA Population Division, New York.

United Nations Development Assistance Framework
2008 United Nations Development Assistance Framework (UNDAF) Kenya (2009-2013).

United Nations Educational, Scientific and Cultural Organisation
2011 Education for All Global Monitoring Report 2011 – The hidden crisis: Armed conflict and education, UNESCO, Paris.

United Nations General Assembly Special Session on HIV/AIDS
2001 Declaration of Commitment on HIV/AIDS: "Global Crisis - Global Action", Resolution adopted (27 June 2001) by the General Assembly, A/RES/S-26/2, United Nations, 2 August 2001, New York.
2007 Monitoring the Declaration of Commitment on HIV/AIDS: Guidelines on Construction of Core Indicators, 2008 Reporting. UNAIDS, Geneva.

United Nations Joint Programme on HIV/AIDS and International Organization for Migration

2001 Migrants' Right to Health: UNAIDS Best Practice Collection – Key Material. UNAIDS, Geneva.

United Nations Office for the Coordination of Humanitarian Affairs

2011 Eastern Africa: Displaced Populations Report, Issue 9, OCHA, Nairobi.

United Nations Population Fund

2010 The state of World Population 2010 - From conflict and crisis to renewal: generations of change, UNFPA, New York.

World Bank

2010 World Development Indicators, http://data.worldbank.org/.

World Health Organization

2008 Health of migrants: Resolution of the Sixty-first World Health Assembly (WHA61.17), World Health Organization, Geneva.

Nairobi North District Health Team performs growth monitoring during child health and immunization campaign at Eastleigh Community Wellness Centre in Nairobi © IOM 2009 (Photo: A. Corio)

HEALTHY MIGRANTS IN HEALTHY COMMUNITIES

International Organization for Migration
Regional Mission for East & Central Africa
Church Road – off Rhapta Road, Westlands
PO Box 55040-00200, Nairobi, Kenya

Tel: +254 20 444 4174
Email: migrationhealthnairobi@iom.int

www.nairobi.iom.int

IOM International Organization for Migration