



IOM International Organization for Migration  
OIM Organisation Internationale pur les Migrations  
OIM Organización Internacional para las Migraciones



## MIGRATION DIALOGUE FOR SOUTHERN AFRICA (MIDSA)

“Promoting health and development: Migration health in southern Africa”

DAR ES SALAAM, TANZANIA  
10 – 12 JUNE 2009



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# 1 Foreword

The International Organization for Migration (IOM) in partnership with the Southern Africa Migration Project (SAMP) and in special collaboration with the World Health Organization (WHO) organised a Migration Dialogue for Southern Africa (MIDSA) on Promoting Health and Development: Migration Health in Southern Africa from 10 to 12 June 2009 in Dar es Salaam, Tanzania. The MIDSA was hosted by the Government of Tanzania with the main objective being to work towards the implementation of the WHA 61.17 resolution 'Health of Migrants' within the SADC region.

The specific objectives of the MIDSA were outlined as follows:

## *Specific Objectives*

- To raise awareness and increase understanding among Southern Africa Development Community (SADC) Government officials on migrant health issues globally and in the SADC region in particular;
- To share good practices of governmental and non-governmental responses to improve migrant health from the SADC region as well as from other regions;
- To identify and agree on the main needs, gaps and challenges with regard to policies and programmes in the SADC region;
- To facilitate networking and increased coordination among SADC Ministries of Health, Home Affairs and other relevant sectors on the issue of migrant health; and
- To identify priority areas and recommendations for the implementation of the WHA resolution on Migrant Health in the different SADC countries.

The MIDSA brought together representatives of the governments of Angola, Union of Comoros, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe. The Southern Africa Development Community (SADC) HIV Unit, Swedish International Development Cooperation Agency (SIDA), International Centre for AIDS Care and Treatment Programs (ICAP), Intergovernmental Authority on Development (IGAD), Comprehensive HIV/AIDS Management Programme (CHAMP), Medical Research Council of South Africa, Department of Public Health-Portugal, Ministry of Public Health-Thailand, SADC Parliamentary Forum, University of Witwatersrand-Forced Migration Project, and the UNAIDS Regional Support Team for East & Southern Africa were represented as observers or presenters. The dialogue culminated in a set of conclusions and recommendations that, if implemented, would contribute towards improving migrants' access to health.

Hans-Petter Boe - IOM Regional Office for southern Africa

Vincent Williams - Southern Africa Migration Project

Dr. Habib Somanje - World Health Organisation Regional Office for Africa

*To raise awareness and increase understanding among Southern Africa Development Community (SADC) Government officials on migrant health issues globally and in the SADC region in particular;*



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## 2 *Acronyms*

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<b>ACHPR</b>	African Charter on Human and People's Rights
<b>AIDS</b>	Acquired Immuno Deficiency Syndrome
<b>ART</b>	Anti Retroviral Treatment
<b>ARV</b>	Anti retroviral
<b>CHAMP</b>	Comprehensive HIV/AIDS Management Programme
<b>CSO</b>	Civil Society Organisations
<b>DRC</b>	Democratic Republic of Congo
<b>EU</b>	European Union
<b>ESA</b>	East and Southern Africa
<b>HIV</b>	Human Immuno Virus
<b>HSS</b>	Health Systems Strengthening
<b>IBBS</b>	Integrated Biological and Behavioral Survey
<b>ICAP</b>	International Centre for AIDS Care and Treatment Programs
<b>ICESCR</b>	International Covenant on Economic, Social and Cultural Rights
<b>IDP</b>	Internally Displaced Persons
<b>IGAD</b>	Intergovernmental Authority on Development
<b>IOM</b>	International Organization for Migration
<b>IRAPP</b>	Intergovernmental Regional HIV and AIDS Partnership Programme
<b>LSDI</b>	Lubombo Spatial Development Initiative
<b>PHAMSA</b>	Partnership on HIV and Mobility in southern Africa
<b>PHC</b>	Public Health Care
<b>PMTCT</b>	Prevention of Mother to Child Transmission
<b>M &amp; E</b>	Monitoring and Evaluation
<b>MIDSA</b>	Migration Dialogue for Southern Africa
<b>MOPH</b>	Ministry of Public Health
<b>NAC</b>	National AIDS Council
<b>OIs</b>	Opportunistic Infections
<b>SAMP</b>	Southern Africa Migration Project
<b>SIDA</b>	Swedish International Development Cooperation Agency
<b>STI</b>	Sexually Transmitted Infections
<b>TB</b>	Tuberculosis
<b>UNAIDS</b>	United Nations Joint team on AIDS
<b>UNFPA</b>	United Nations Population Fund
<b>UNICEF</b>	United Nations Children's Fund
<b>VCT</b>	Voluntary Counseling and Testing
<b>WHA</b>	World Health Assembly
<b>WHO</b>	World Health Organization



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## 3 *Background*

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The Migration Dialogue for Southern Africa (MIDSA) on Promoting Health and Development: Migration Health in Southern Africa was held from 10 to 12 June 2009 in Dar es Salaam, Tanzania. The MIDSA was hosted by the Government of Tanzania and co-organised by the International Organization for Migration (IOM) and the Southern Africa Migration Project (SAMP), in special collaboration with the World Health Organization (WHO).

### *Countries, Presenters and Observers*

The governments of Angola, Union of Comoros, Democratic Republic of Congo, Lesotho, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe participated. The Southern Africa Development Community (SADC) HIV Unit, Swedish International Development Cooperation Agency (SIDA), International Centre for AIDS Care and Treatment Programs (ICAP), Intergovernmental Authority on Development (IGAD), Comprehensive HIV/AIDS Management Programme (CHAMP), Medical Research Council of South Africa, Department of Public Health-Portugal, Ministry of Public Health-Thailand, SADC Parliamentary Forum, University of Witwatersrand-Forced Migration Project, and the UNAIDS Regional Support Team for East & Southern Africa were represented as observers or presenters.



## 4 Summary of Proceedings

### 4.1 The Opening Session

The MIDSA was opened by the co-organisers, with a keynote address from Mr Gilbert Mliga, Director of Human Resources, Ministry of Health and Social Welfare, who spoke on behalf of the Minister of Health and Social Welfare. Mr Mliga spoke about the need to respect migrants' rights.

**Mr. Hans-Petter Boe, IOM Regional Representative for Southern Africa,** welcomed all the delegates, experts, presenters and observers, to the 16<sup>th</sup> MIDSA Workshop and thanked the Government of Tanzania, WHO and SAMP for co hosting this important workshop on Promoting Health and Development: Migration Health in Southern Africa. Migration involves a diverse group of people such as regular and irregular migrants, victims of trafficking and smuggling, migrant workers and internal migrants. Most of these migrants and mobile populations encounter difficulties in accessing health care and services as they move to meet social and economic challenges. Research indicates that communities living around border areas show high HIV prevalence. The World Health Assembly (WHA) Resolution 61.17 on 'Health of Migrants', which will be the focus of discussions at this dialogue, is a positive step in addressing migrants' access to health. It is acknowledged that such challenges have also caused huge burdens on the capacity of health systems in southern Africa. The workshop will culminate in a set of recommendations that hopefully Member States will put on the agenda as part of implementing the resolution and improving migrants' health.

**Dr. Jean-Baptiste Tapko, WHO Representative for Tanzania,** presented remarks on behalf of the WHO Regional Director for Africa, Dr Luis Gomes Sambo. The WHA Resolution 61.17 calls upon Member States to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and policies without discrimination on the basis of gender, nationality or race. The Ouagadougou Declaration on Primary Health Care and Health Systems in Africa that took place in 2008 also reaffirms the need for policy reform and calls for strong collaboration among states to address issues regarding transformation and renewal of the health sector to improve poor service delivery and health infrastructure. Dr. Tapko encouraged Governments to play a leadership role in facilitating the process of improving services for migrants.

The keynote address was delivered by **Mr Gilbert Mliga, Director of Human Resources, Ministry of Health and Social Welfare, Government of Tanzania,** on behalf of the Minister of Health and Social Welfare. The health needs of migrants can only be fully met when migrants' rights are respected and protected. There are different types of migrants; on the one hand there are migrants who move involuntarily, forced by natural or man-made disasters and human violations; and on the other hand there are migrants who migrate voluntarily to seek employment or other opportunities. Some are documented and others are not; however it is important that the discussions revolve around how the health needs of ALL migrants could be met.

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The need to address migrants' rights has recently been acknowledged by the Member States of the WHO, who gathered in Geneva for the 61<sup>st</sup> WHA in May 2008, through the adoption of the Resolution WHA 61.17 '*Health of Migrants*'. Furthermore, the 61<sup>st</sup> WHA also requested the Director General of WHO to submit to the 63<sup>rd</sup> WHA in 2010 a report on the implementation of this resolution. Mr Mliga urged Member States to support the resolution. Participants should discuss and reach consensus on how partnerships between various governments and organisations may be strengthened to take action in support of the resolution.

***Ms. Reiko Matsuyama, Regional Project Manager, from the IOM Regional Office for southern Africa*** gave a brief background to the MIDSA highlighting that it started in 1999 as a Regional Consultative Process for the southern African region to foster regional dialogue and cooperation on migration-related issues.

The overall and specific objectives of the MIDSA were outlined as follows:

- **Overall Objective:** To work towards the implementation of the WHA 61.17 resolution 'Health of Migrants'
- **Specific Objectives:** 1) To raise awareness and increase understanding among SADC Government officials on migrant health issues globally and in the SADC region in particular 2) To share good practices of governmental and non-governmental responses to improve migrant health from the SADC region as well as from other regions; 3) To identify and agree on the main needs, gaps and challenges with regard to policies and programmes in the SADC region; 4) To facilitate networking and increased coordination among SADC Ministries of Health, Home Affairs and other relevant sectors on the issue of migrant health; and 5) To identify priority areas and recommendations for the implementation of the WHA resolution on Migrant Health in the different SADC countries.

The issue of the migration of health personnel will not specifically be addressed at this workshop for two reasons: First, it was deemed to be a very broad issue that impacts upon health systems and human resources for health in general, and thus the MIDSA workshop as outlined here would not be able to do it justice. Second, there are various other regional and global forums that address human resources for health (eg. Global Health Workforce Alliance) which would be better suited to take on the issue.

## 4.2 ***Plenary: Setting the Scene – Migration Health in Southern Africa***

This plenary session aimed to set the scene for subsequent discussions by giving an overview of: Migration and mobility trends; Impact of migration and population mobility on health of migrants and societies; and Health system responses and need for changed multi-sectoral approaches.

***Mr. Vincent Williams, SAMP*** started by setting the scene on migration and mobility trends in the southern African region. Since 1990 there have been significant changes in intra-regional migration patterns between countries in the region; in particular labour

migration has become more voluminous, dynamic, and complex. In order to understand the exact nature of these migration challenges it is important to have a good grasp of current migration characteristics and trends. However, unfortunately there is inadequate reliable and comprehensive data on migration in southern Africa.

Statistics obtained from South Africa showed that the total number of entries into South Africa increased from 1 million in 1990 to 5.1 million in 1996 and 7.5 million in 2005. Looking at the origins of these flows, the total number from the rest of Africa rose from less than a million in 1990 to 3.8 million in 1996 and 5.4 million in 2005.

The growth in irregular labour migration to and within many SADC countries has been accompanied by growing numbers of labour migrants employed in the informal sector. Linked to irregular migration are problems of smuggling and human trafficking. Another migration phenomenon was the growing feminisation of labour migration.

**Dr. Davide Mosca, Migration Health Department, IOM Geneva**, presented on the impact of migration and population mobility on the health of migrants and society. In a context of high economic and environmental uncertainty, as well as political instability in some areas, to seek income opportunities is a sound risk-management strategy; hence for many, livelihood is increasingly based on mobility. The disruption of social support networks increases the vulnerability of migrants to ill health; at departure, during travel, at host community or upon return to place of origin.

Health is a key determinant of economic growth and poverty reduction. When migrants are healthy they are able to work and contribute to economic growth in the host country and also improve livelihoods of their families through sending remittances. In this sense, migration plays a critical role in bridging disparities between poverty and wealth.

A challenge that most countries experience in providing access to health is the high disease burden, decline in the number of health care workers and inadequate health care spending in low income countries. According to WHO, there is a direct relationship between the ratio of health care workers to population survival. As the number of health care workers decline, the vulnerability to disease increases resulting in a decrease of the population.

In addition, challenges such as anti migrant sentiments, the food and fuel crisis which is pushing people deeper into poverty and the financial crisis resulting in less employment opportunities and less remittances have increased the focus on migration. Furthermore, people have been displaced due to floods and conflict related to land and climate change is increasingly becoming a factor for displacements as well. The health challenges associated with these trends require a multi sectoral approach for both policy and programme responses because the health sector alone may be unable to address these problems.

**Dr. Habib Somanje, WHO Regional Office for Africa** addressed the health system responses and the need to improve the health of migrants. There is global recognition that weak health systems contribute to health inequities, inadequate coverage of essential health services and failure to achieve the health Millennium Development Goals (MDGs). The WHA through its resolution 61.17 has already determined what action should be taken so that migrants may enjoy their full right to

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health. These actions involve improved health policies, access of health services, health information, sharing of best practices in service delivery, reducing the global deficit of health workforce and many more.

The latest comprehensive documents on health systems strengthening and Primary Health Care (PHC) reforms are the WHO framework for health systems strengthening, "Everybody's business", and the World Health Report 2008. In the African Region, renewed commitment towards health systems strengthening using PHC approach is guided by the adoption of the "Ouagadougou Declaration on Primary Health Care and Health Systems in Africa: Achieving Better Health for Africa in the New Millennium" and its implementation framework. "Everybody's business" describes six health system building blocks which, if strengthened, simultaneously lead to overall improved health. These building blocks are: service delivery; health workforce; information; medical products; vaccines and technologies; and financing and leadership.

### 4.3 *Plenary: Multi-Sectoral Responses to Migrant Health in the SADC Region: Identifying Good Practices*

In order to identify good practices in multi-sectoral responses to Migrant Health in the SADC region, four panels were held, each with several presentations and subsequent discussions. The four panels were categorised as follows:

- **Panel 1:** Emergency and Crisis-Induced Migration and Associated Health Concerns;
- **Panel 2:** Labour Migration and Access to Health;
- **Panel 3:** Regional Cooperation in Southern Africa; and
- **Panel 4:** Experiences in Migration and Health from other Regions.

#### *Panel 1: Emergency and Crisis-Induced Migration and Associated Health Concerns*

This section presents challenges and responses to health concerns associated with migration that has been induced by emergency and crisis situations (natural or man made)

**Dr. Olushayo Olu, WHO Inter-country Support Team, Eastern and Southern Africa,** presented an overview of the Health Impact of Emergency and Crisis Induced Migration in Eastern and Southern Africa (ESA). He pointed out that emergencies, both natural and complex, have become a common phenomenon globally, but Africa is particularly affected: Africa is second to Asia in terms of occurrence of natural disasters with ESA particularly prone to emergencies, such as floods, drought, civil and political conflicts, and epidemic outbreaks.

The extent of the impact of emergencies on the public health sector depends on many factors such as socio economic status of the area prior to disaster, population displacement, the type of disaster and many other factors. In addition, the insecurity that prevails during conflicts results in people living in poor living conditions in displacement camps,

destruction of health infrastructure, diversion of health and social services budget to other expenditures such as defence and security.

Some important strategies to address the health concerns include establishment of community based health initiatives and surveillance systems; the deployment of mobile clinics and conducting outreach programmes to improve access to health.

**Ms. Mumtaz Osman, UNAIDS** addressed the topic of HIV in Emergency Settings. She highlighted three different perspectives to conceptualize HIV and emergencies. First, HIV is a key consideration in emergencies, especially complex emergencies characterised by armed conflict and violence. In such cases, HIV can worsen the severity of the emergency and undermine prospects for recovery, and emergency conditions can worsen or exacerbate HIV risk factors. Second, HIV itself constitutes a global emergency, whose consequences may last for many decades as a long-term development crisis. Third, the most complex emergency context is where emergency conditions occur concurrently with high levels of HIV – or HIV as emergency in emergency. The recent famine in parts of southern Africa illustrates the difficulties in managing a food insecurity emergency when one of the main drivers of the crisis is HIV itself.

It is important to address HIV in humanitarian action in order to deal with issues such as negative coping mechanisms, sexual and gender based violence, disruption of social networks and inaccessibility of HIV prevention commodities. Efforts to integrate communities affected by emergency should be included in the national strategic plans. However, some of the challenges in providing HIV services in humanitarian situations pertain to deciding whether funding should come from HIV and AIDS funds or humanitarian funds.

Since HIV is an important issue to address in humanitarian emergencies, a global task team on HIV has developed guidelines on how to address HIV during emergency situations. These guidelines are available on [www.aidsandemergencies.org](http://www.aidsandemergencies.org)

**Ms. Annie Lane, IOM Zambia**, addressed the topic of Cross-Border HIV/AIDS Prevention and Vulnerability Reduction for Angolan Returnees in Zambia and Angola. Key factors on the issue of conflict and mobility include the exposure to violence including rape, and limited opportunities for income generation. Social norms are affected, families split and there is high risk sexual behaviour, either as a survival strategy, or through forced sex. One of the positive health effects of conflict, as was the case with Angola, was the lack of population mobility during the country's civil war which may have served to restrict the spread of HIV.

IOM implemented a comprehensive Cross-border HIV Prevention Project in Zambia and Angola which targeted Angolan refugees in Zambia and subsequent returnees in their communities of absorption in Angola. In late 2007, IOM conducted an assessment in the Angolan provinces of Moxico and Huambo where many refugees and Internally Displaced Persons (IDPs) returned to, and it was found that knowledge on HIV was strongest among returnees, compared to those who have never moved.

Since refugees are vulnerable to forced and transactional sex, there should be targeted, integrated prevention programmes for mobile and conflict affected populations at all stages of the migration process. Furthermore, opportunities for income generation need to be explored.

*... HIV itself constitutes a global emergency, whose consequences may last for many decades as a long-term development crisis.*



**Mr. Raymond Yekeye, Zimbabwe National AIDS Council**, introduced the case of Zimbabwe in the context of Health and HIV in Emergency Settings. Since 2003, Zimbabwe has been reporting a decline in the estimated national HIV prevalence, from 24.6% in 2003, 20.1% in 2005 to 15.6% in 2007 among the 15-49 age groups. However, areas bordering Botswana, Zambia and Mozambique recorded high HIV prevalence. The main driver for the spread of HIV was deemed to be Multiple Concurrent Partnership (MCP) combined with factors such as low condom use in long term relationships, gender imbalances and mobility.

Zimbabwe has experienced difficulties in addressing HIV due to socio economic challenges, unemployment, migration of skilled health workers and the decline in basic social service delivery.

The Zimbabwe National AIDS Council (NAC) works closely with UNAIDS and is part of the humanitarian coordination mechanism, and also participates in the newly established Early Recovery cluster. Work is under way to develop a strategy for NAC to address emergency preparedness and management within their structures. In addition, a draft HIV and AIDS strategy for Mobile and Migrant populations has been produced.

One of the lessons learnt from the Zimbabwe experience is that interventions should not just target specific population groups but include the surrounding communities with which they interact. Gender equity and equality is pivotal to the successful implementation of national responses to HIV and AIDS. Some of the groups such as sex workers and illegal miners engage in activities that are deemed illegal by the authorities and hence offering services to such groups can at times present enormous challenges.

**Ms. Amal Ataya, IOM Lebanon**, addressed the topic of Mental Health and Psychosocial Response in Emergency Settings. In Kenya, Tanzania and the Democratic Republic of Congo (DRC) IOM conducted capacity building of professionals in the field of psychosocial assistance and provided direct psychosocial assistance to individuals in Kenya. Findings from a psychosocial assessment in the DRC indicated that the displaced populations suffered many challenges, such as losing family, losing primary social and economic structures, and difficulty in accessing mental health services. Thus, in response to this assessment, IOM has started to implement a mental health and psycho-social capacity building project in the DRC with the overall objective of strengthening its efforts in improving integrated health care services targeting war-affected families and communities.

## ***Panel 2: Labour Migration and Access to Health***

The presentations in this section provide an overview of different types of labour migration and challenges faced by migrants in accessing health services as well as research findings on migrants' access to health.

**Ms. Barbara Rijks, IOM Regional Office for southern Africa** presented on the different types of labour migrants: documented and undocumented; permanent and temporary; circular and seasonal and skilled and unskilled migrants. Sectors that are characterised by high levels of migration and mobility include: construction, transport, mining,

commercial agriculture, domestic work, maritime and cross border trade. Factors that contribute to health vulnerabilities in migrant settings include lack of legal immigration status, gender based violence, and poverty. Separation from regular partners creates opportunities for sexual networking.

Furthermore, some sectors, such as construction and mining, have high levels of morbidity and mortality due to occupational health and safety hazards such as silicosis, TB, and accidents. Meanwhile other sectors are characterised by seasonal/temporary contract workers who are often not included in company wellness programmes. There is also a tendency, especially in construction and farming sectors to sub-contract, which makes it difficult to assess who is ultimately responsible for the wellness of the sub-contracted workers.

Ms Rijks shared evidence from different studies:

- An Integrated Biological and Behavioral Survey (IBBS)<sup>1</sup> conducted in 2008 on ten farms in the Limpopo Province in South Africa, where most workers are internal migrants, found that permanent and seasonal farm employees were highly vulnerable to HIV: Of the 1500 employees who voluntarily participated, 28.5% were living with HIV; HIV prevalence was found to be significantly higher among females living away from the workplace than males living 'away' (32% vs. 17.9%); and mobility appeared to increase women's vulnerability to HIV with those travelling more than an hour to work more vulnerable than males (33.3% vs. 24.3%).
- Research in the port of Walvis Bay in Namibia found that fishermen engaged in varying types of relationships with sex workers:<sup>2</sup> short term relationships; medium term relationships (also regarded as temporary girlfriends); and long term relationships where some international fishermen brought sex workers from their original countries for a period of up to 3 months. Factors that contributed to the health vulnerability of fishermen include lack of access to health promotion prior to arrival or during stay in Walvis Bay; likely to have low levels of awareness and knowledge on STI/HIV prevention; frequent unprotected sex with commercial sex workers (especially Chinese fishermen); high risk sexual practices; and inability to communicate in local languages.
- Research that was conducted on transactional sex on Northern Corridor highway (Kenya/Uganda)<sup>3</sup> found that only 30.2% of sex workers' clients were truck drivers, the majority of clients coming from other groups such as health workers, businessmen, artisans and others. This shows the importance of focusing health promotion programmes not just on truck drivers but on local vulnerable sites along corridors of mobility in which all people at risk are captured. 89.9% of the sex workers reported using condoms with a casual partner and 64.5% with regular partners. The lower condom use with a regular partner raises concerns of higher HIV risk between the regular partner and the sex worker.

*... some sectors, such as construction and mining, have high levels of morbidity and mortality due to occupational health and safety hazards such as silicosis, TB, and accidents.*

1 IOM, 2009 HIV Integrated Biological and Behavioural Study: [http://iom.org.za/site/index.php?option=com\\_docman&task=doc\\_download&gid=111&Itemid=50](http://iom.org.za/site/index.php?option=com_docman&task=doc_download&gid=111&Itemid=50)

2 IOM, 2006. Ships, Trucks and Clubs: They Dynamics of HIV Risk Behaviour in Walvis Bay Namibia: [http://iom.org.za/site/index.php?option=com\\_docman&task=doc\\_download&gid=52](http://iom.org.za/site/index.php?option=com_docman&task=doc_download&gid=52), [http://www.biomedexperts.com/Abstract.bme/16815730/Mapping\\_transactional\\_sex\\_on\\_the\\_Northern\\_Corridor\\_highway\\_in\\_Kenya](http://www.biomedexperts.com/Abstract.bme/16815730/Mapping_transactional_sex_on_the_Northern_Corridor_highway_in_Kenya)

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- An IOM study that was conducted on health vulnerabilities among irregular Zimbabwean migrants in Livingstone and Chirundu, in Zambia, found that most of the interviewed migrants (42%) stated that the most important basic need that they found difficult to obtain was food. Also health care was cited as important and said to be difficult to access.

In sum, migration and mobility increases health vulnerabilities for migrants as well as for host populations living and working in migrant sites. There was furthermore a lack of effective policies and wellness workplace programmes to guide access to health services for migrants.

**Ms. Joanna Vearey, Wits University Forced Migration Project** presented the key findings of various research studies on migrants' access to health in South Africa. Ms. Vearey listed relevant South African policies, directives and legislation with regard to non-nationals' access to public health services, including antiretroviral treatment (ART) in South Africa: 1) the South African constitution; 2) Refugee Act (1998); 3) HIV & AIDS Strategic Plan for South Africa 2007 – 2011; 4) National Department of Health (NDoH) memo 2006; 5) NDoH Directive September 2007; and 6) Gauteng Department of Health letter (April 2006).

The often-voiced assumptions and fears about migrants' access to health include fears that the host community will carry an additional burden on health care services, that migrants travel in order to seek healthcare and that migrants are unlikely to adhere to ART regimens.

However, findings of research conducted by the Forced Migration Studies Programme challenge some of these assumptions. Of 1,403 respondents interviewed at Non Governmental service providers and Refugee Reception offices in Gauteng, less than half reported ever needing health care since arriving in South Africa. Of the respondents who accessed health services in South Africa, 30% reported having experienced problems in accessing health care, especially those who are undocumented. Also, the survey findings highlighted that migrants travel mostly for economic reasons rather than to seek healthcare and are more likely to adhere to anti retroviral treatment compared to citizens

Policies are not uniformly applied in the South African public health system, resulting in a dual health care system where some migrants are referred by public hospital and clinics to Non Governmental health services to access ART while other Government health institutions do provide ART to migrants.

**Mr. Musa Temba, IOM Zambia** presented findings of a social impact assessment that was conducted by IOM in Chirundu and Livingstone, Zambia. The objectives of the assessment were to assess the magnitude and social impact of irregular migration in these border towns, to ascertain gaps in humanitarian assistance, and to make recommendations about the feasibility of a migrant support centre. The findings of the assessment showed that migrants have a lack of accommodation, were vulnerable to exploitation and sexual abuse and lacked knowledge of their rights. They also lacked access to water and sanitation facilities. Data on migration in general was found to be lacking as well. IOM responded to some of these challenges through the establishment of a migrant support centre in Chirundu in August 2008, which is providing services such as water



and sanitation, mosquito nets, condoms, and raising awareness to migrants and host communities on migrants' rights. IOM also assisted in improving the registration system at the border. The centre is a result of collaboration between the Ministry of Health, law enforcement units and IOM, and more than 5000 migrants have accessed services at the centre to date.

**Ms. Rosanna Price-Nyendwa, Comprehensive HIV/AIDS Management Programme (CHAMP)** explained that CHAMP is a Public Private Partnership (PPP) of the Government of Zambia, the United States Agency for International Development (USAID) and large private sector agribusiness and mining organisations. CHAMP provides HIV prevention programmes including condom distribution, HIV testing, care and treatment for employees of the companies under the partnership.

CHAMP established a partnership with IOM. The main purpose of the IOM/CHAMP project is to reduce HIV incidence and impact of AIDS among migrants, mobile populations, their families and those they interact with through on-the-ground interventions and enhanced programme capacity in different target sites in Zambia. This project specifically targets the mining sector in Kansanshi Mine, North Western Province, and commercial agricultural sector in Katete Ginney, Eastern Province, both in Zambia.

### ***Panel 3: Regional Cooperation in Southern Africa***

**Mr. Innocent Modisaotsile, HIV unit, SADC Secretariat** presented the Draft Policy Framework on Population Mobility and Communicable Diseases. The region is faced with three main communicable diseases, namely HIV, TB and malaria which are the major causes of morbidity and mortality in the region. In responding to these epidemics, Member States have developed national strategic plans, policies and programmes for each of these diseases and there is also the SADC Health Protocol. However, gaps exist in providing cross border migrants with access to health care and services. These include inadequate disease surveillance and epidemic preparedness, legal and administrative barriers and inadequate harmonisation and coordination. The Draft Policy Framework on Population Mobility and Communicable Diseases has been developed to provide guidance to the SADC governments on the protection of the health of cross border mobile populations with regard to communicable diseases and to provide guidance on the control of communicable diseases as people move across borders. A proposed SADC HIV Trust fund may be considered as an option to finance the operationalisation of the framework. The framework will be coordinated by SADC Secretariat with input from Member States.

**Dr. Andre Laas, Medical Research Council** shared the experiences from the inter country collaboration between Swaziland, South Africa and Mozambique towards malaria control in the Lubombo Spatial Development Initiative (LSDI) region. He explained that the LSDI implements malaria control across the borders of the three countries. The programme is managed by the Regional Malaria Control Commission which comprises a core group of experts who are Programme Managers, Public Health Specialists and Scientists from the three countries. The malaria programme was developed out of a realisation that malaria needs to be controlled at regional level due to cross border movements of both parasites and vectors. Resources and expertise is shared to ensure that there is a common

***The main purpose of the IOM/CHAMP project is to reduce HIV incidence and impact of AIDS among migrants, mobile populations, their families and those they interact with through on-the-ground interventions and enhanced programme capacity in different target sites in Zambia.***



approach to malaria control. Funding for the programme is mainly from the Global Fund to Fight AIDS, Tuberculosis and Malaria and partners include Ministries of Health from Swaziland and Mozambique, the Department of Health in South Africa, Medical Research Council of South Africa and the University of Cape Town. The main lesson learnt from the LSDI programme is that the decrease in the incidence and prevalence of malaria is a result of implementing a standardized regional approach to malaria control. As a recommendation, there should be an organization that has the responsibility of ensuring technical, logistical and financial management of the LSDI programme.

#### ***Panel 4: Experiences in Migration and Health from other Regions***

**Mr. Sutat Kongkhuntod, Ministry of Public Health (MOPH), Government of Thailand** presented on challenges and lessons learnt from the MOPH-IOM Migrant Health Programme in Thailand. Cross border migrants in Thailand come from countries such as Burma, Laos and many migrants work as sex workers, construction workers, seafarers in Thailand. The challenges faced by Thailand with regards to providing migrants with access to health and services include lack of Government policy on migrants' access to health; limited financial resources; ineffective collaboration among stakeholders to deal with communicable diseases such as malaria, TB, HIV and cholera; and other health problems such as abortion.

The MOPH established a partnership with IOM with the aim of improving health and well-being of migrants and host communities through the provision of comprehensive, participatory, sustainable and cost effective health service. In implementing migrant health services there is collaboration among different partners such as WHO, United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), IOM and other partners. Activities for improving migrant health include information, education and communication sessions, providing treatment, water & sanitation, home visits to migrants and reproductive health services. The main lesson learnt is that the existing government services alone are not adequate for all migrants and that more partners should be involved from policy makers to local implementers.

**Ms. Ana Alexandre Fernandes, Department of Public Health, Government of Portugal** shared with participants the conclusions and recommendations from the European Union (EU) Conference on Health and Migration that was held in Lisbon on 27-28 September 2007. The conference titled "Health and Migration in the EU: better health for all in an inclusive society" set out to provide the scientific basis and political vision needed to introduce this important theme into the EU health agenda. The basis of this principle is that the EU needs migrants and migrants need Europe: Thus, together they can contribute towards creating a better future, in a win-win situation, where health plays a major role. In sum, health and migration are two global phenomena that call for urgent global responses.

**Dr. Ahmed Hassan Ahmed, Intergovernmental Authority on Development (IGAD) Regional HIV and AIDS Partnership Program (IRAPP)**

Dr. Ahmed Hassan Ahmed presented on the Intergovernmental Authority on Development (IGAD) Regional HIV/AIDS Partnership Programme (IRAPP). The IGAD region covers Sudan, Kenya, Eritrea, Somalia, Djibouti, Uganda and Ethiopia and has a

population of 160 million. The region has one of the most complex political, social and economic environments on the continent. Migration and mobility are important factors that contribute to the HIV prevalence. There are refugee camps in all IGAD countries (except Somalia, where there are mostly IDP camps), and these populations often fall outside of the national HIV/AIDS programmes, and remain a very vulnerable population to HIV epidemic.

One of the goals of IRAPP is to contribute to the reduction of HIV infections amongst cross border and mobile populations and to mitigate the socio-economic impact of the epidemic in the IGAD region. Furthermore, IRAPP aims to establish a common and sustainable regional approach to supporting these populations in the IGAD Member States with regard to HIV. Major achievements for the IRAPP to date include the harmonisation of protocols and standardisation of referral system and research conducted in mobile population settings.

*One of the goals of IRAPP is to contribute to the reduction of HIV infections amongst cross border and mobile populations and to mitigate the socio-economic impact of the epidemic in the IGAD region.*



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## 5 Discussion

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### 5.1 *Migration Data and Free Movement of Persons*

In response to a question about the accessibility of migration data in Namibia, Mr Williams explained that in Namibia, some information is available only if applied for, from the Ministry of Home Affairs yet in South Africa and Botswana it is published and available for the public. In most countries there is a problem of public access to information on migration.

Another participant asked for Mr. Williams' view on SADC authorities working towards removing borders between countries and the implications for registering the numbers of people moving in and out of countries. Mr. Williams clarified that the movement of persons has been formally on the agenda since 1993 and the **SADC Protocol on the Facilitation of Movement of Persons** was now adopted. However, it does not intend to abolish borders, but it rather implies the strengthening of borders, appropriate procedures and personnel. It is further designed to facilitate the movement of 'desirable persons'.

### 5.2 *Migration and Employment*

Regarding refugees' right to employment Mr Williams highlighted that refugees' employment in the host country would benefit the state through the reduction of costs for health and other services since refugees would be able to pay for their basic needs.

### 5.3 *Migration Management*

One participant raised the concern that migrants sometimes cause problems for host countries, for instance when they are moving through the country with their cattle and thereby causing degradation of the environment. This was for example the case in Congo. Dr. Mosca highlighted that migration, if not controlled, may result in situations that are not favourable to migrants and surrounding communities. Migration management should provide for rules that will guide the migration process and enforce their implementation, and at the same time ensure migrants' rights, such as the right to access health care.

Responding to a question on whether SADC may develop a common policy on migrants' access to health, Mr Williams stated that in order to provide adequate health care and services Member States need to determine where migrants are in the country. Eg farms, mines etc. also there is a need to determine the type of services required and to what extent the State is able to provide those services.

## 5.4 *Multi-Sectoral Approach*

A participant made a comment on inter-sectoral collaboration and suggested that it should not be the health sector alone that is involved in migrants' health but other stakeholders such as parliament should also participate. Dr. Mosca also emphasised the need to look into the different typologies of migrants to see who is really at risk and what the determinants for these risks are. Migrant-friendly services were mentioned as a means of improving migrants' access. However, migrants may hesitate to access these services due to their irregular status. Looking at lessons learnt in other parts of the world, some systems have incorporated former migrants into the response to understand and incorporate better their experience and perspectives. Political will is another crucial factor in addressing migrants' health and to ensure the necessary structure and budget for the required services. The collaboration between receiving and sending countries, as well as the cooperation on a regional level should also be encouraged.

## 5.5 *PHC Reform and Provision of Health Service*

One participant suggested that the proposals made by WHO on PHC reform could be part of existing programmes but maybe the proposals on the four interdependent blocks should have focused on services beyond facility level, to community level in order to reach migrants. Dr. Somanje agreed with the suggestion and emphasised that one proposal is to relocate health reform from hospitals to communities, where the people are. One gap is that states are unsure of the extent to which services should be provided. It is important to understand persons affected by the disease and provide services such as preventive, curative, rehabilitative services closer to where the people are. The intention is to understand the communities more, and taking into account the underlying factors associated with disease, e.g. issues of unemployment, communication etc. through a continuous process of service delivery.

## 5.6 *HIV in Emergency Setting*

The high HIV prevalence in Swaziland was acknowledged as an emergency, and a suggestion was made to provide sex workers access to services in a friendly environment. A response to a question on how to deal with an emergency within an emergency was that countries should ensure that there are no legal barriers for migrants to access health services so they can be included in the response to an emergency.

***Political will is another crucial factor in addressing migrants' health and to ensure the necessary structure and budget for the required services.***



### 5.7 *Case of Zimbabwe*

A participant raised a question on how the health system in Zimbabwe may be strengthened not just for migrants but for the general population. The complexity of the situation in Zimbabwe requires a high level of intervention and the creation of partnerships is critical. However, the situation is slowly improving with assistance from the Global Fund.

### 5.8 *Emergency Preparedness*

One lesson learnt during the floods in Namibia was to develop an emergency preparedness plan so that people continue to access health care even during an emergency.

### 5.9 *Conflict and HIV*

A participant raised a question on whether there is a correlation between HIV and conflict. Ms. Osman stated that although there is no hard data on the correlation between HIV and conflict, there is evidence of the vulnerability of people in conflict situations which cannot be ignored. However, this doesn't mean that HIV prevalence rates are automatically higher in these populations; it depends on the circumstances of each emergency.

### 5.10 *Burden on Health Care System*

A concern was raised that providing health care to migrants places a burden on already inadequate health care systems which are unable to cater for their own citizens. Ms B. Rijks stated that a forum like this migration dialogue aims to present more information on health seeking behaviour of migrants which shows that, in general, migrants, especially undocumented migrants will try to avoid public health facilities and rather attend non-governmental health services or private health care facilities if they have the resources to do so. In addition, the costs of providing primary health care services to migrants are lower than if migrants are left untreated and come to public hospitals for emergency care. Ms Weekers also pointed out that migrants make a significant contribution to the economic development of many countries and granting them access to basic health care services benefits the migrant and the host country alike. A recommendation was made to invite the Ministries of Finance/Treasury to such dialogues in the future.

### 5.11 *Condom Distribution*

Dr. Tawanda suggested to CHAMP to consider informal traders as effective condom distributors since their business involves a lot of movement including across borders.

### **5.12 *Lubombo Spatial Development Initiative***

Responding to a question seeking clarity on the malaria programme, Dr. Laas stated that the programme involves conducting epidemiological surveys, monitoring and treatment of malaria. The plan is to move towards using safer insecticides to spray mosquitoes. Ms J. Weekers suggested exploring whether the Global Fund may support regional programmes for malaria.

### **5.13 *The SADC Policy Framework on Population Mobility and Communicable Diseases***

Dr. Mosca commended the draft framework and encouraged Member States to finalise it. Mr. Modisaotsile mentioned that the finance aspect is also hampering the process and the HIV trust fund may be what is required.

### **5.14 *The Thailand Response to Migrants' Access to Health***

A question was raised on the sustainability of the Thailand comprehensive programme on migrants' access to health. Currently the Thai Government, donor community and technical support from IOM support the programme.

*The complexity of the situation in Zimbabwe requires a high level of intervention and the creation of partnerships is critical.*





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## 6 Country Updates

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Each participating country delegation appointed one representative to provide a country update to the Plenary, focusing on one or two key migration health issues relevant to the country. The following is a summary of each update.

### 6.1 *Union of Comoros*

The population of about 652,202,000 is mostly a young population with a life expectancy of 70 years. The Union of Comoros has a large diaspora, with almost the same number of people living in the diaspora as the population on the island.

The country has had a number of disasters such as cyclones, floods, volcanoes, tsunamis, earthquakes, forest fires, and ship sinking, not all of which necessarily result in the displacement of people. Awareness-raising on HIV and other emergency services such as humanitarian assistance for populations affected by disasters have been conducted.

The HIV prevalence is less than 0.1%, but there are also other epidemics such as chicken pox and cholera. The Government of Comoros has a national plan on HIV, and provides VCT and condoms.

### 6.2 *Democratic Republic of Congo (DRC)*

The DRC is in the process of consolidating a peace process after the war. There have been massive migration flows out of the country and the health infrastructure had collapsed. However, the health system has been restructured and is up and running. The donor community and the state are channelling funds towards the restructuring process. There are adequate human resources, as there are many universities. Migrants in the DRC are now returning to their countries, e.g. Sudan, Angola, Burundi etc., and IOM will also be starting a project to return qualified Congolese nationals in the immediate future.

In terms of health care, the DRC provides services to all people in the country and does not discriminate against non nationals. However, the challenge is the provision of anti retroviral treatment – health centres offer a minimum package for HIV, but it is not available to all who need it. The current HIV prevalence is relatively low at 4% but with more Congolese nationals returning, it is expected to increase. To respond to this likely increase in HIV prevalence, HIV awareness programmes are provided at the four points of entry into the country, and returnees who are on treatment are provided with continued treatment upon their return. However, the DRC is concerned about the sustainability of these interventions.

### 6.3 *Lesotho*

Lesotho mainly has two types of migration: internal, where people migrate from rural to urban areas in search of employment, and external, such as the migrants who go to work

in the mines in South Africa. The population is about 1.89 million with an HIV prevalence of 23.2%. The main driver of the HIV pandemic is multiple concurrent partnerships. The HIV response in the country includes a pre-departure programme for mineworkers, a programme for returning mine workers, a prevention programme targeting transit areas at the main borders, and a cross border initiative between Lesotho and South Africa targeting mobile populations and border communities to provide free TB and anti retroviral treatment. The issue of undocumented migrants makes it difficult to provide adequate access to health to migrants because the numbers are unknown. Another challenge is the limited institutional capacity and partnerships among stakeholders. To improve migrants' access to health, one recommendation is to not discriminate against migrants, and to provide similar services both in sending and receiving countries.

## 6.4 *Malawi*

Malawi shares borders with Mozambique, Zambia, Zimbabwe and Tanzania with no access to the sea. The population is 14 million people with an HIV prevalence of 12%, and GDP of \$350 per capita. The pattern of migration is mostly internal migration from rural to semi-urban and urban areas in search of jobs. Malawi is also a transit country for migrants from the East to southern Africa. There are also many truck drivers who spend a lot of time away from their families, and there is an increasing number of women in search of jobs, going to trade informally in South Africa. In the past, Malawians used to work in the mines in South Africa and some returned after the xenophobic attacks. Clinic services and outreach programmes are provided for nationals and non nationals for free.

## 6.5 *Mauritius*

Mauritius has a population of 1.2 million. It is a multi-ethnic and multi-racial community with a long history of migration. It has a mono-crop economy depending mainly on sugarcane plantations and exportation of sugar. Since independence Mauritians have been migrating to Australia and England in search of jobs. Temporary documented migrants in Mauritius are around 40 000, with the construction and manufacturing sectors employing mostly foreign workers. Migration is regulated in the sense that people need permits to work and the Non Citizens Employment Act prohibits migrants to work without permits. The law does not allow refugees and asylum seekers into the country.

Non nationals have free access to medical facilities available in government institutions, but the challenge is that health facilities have become over burdened. A recommendation is to provide social workers that will visit hostels to ensure the well being of non nationals.

## 6.6 *Namibia*

Migration patterns in Namibia are mostly internal, and labour migration is a common phenomenon in the mining sector. Since spouses of mine workers are not allowed into the mines, living arrangements result in workers engaging in commercial sex.

The Government needs to provide a clear policy direction on services that should be provided to migrants since migrants fear deportation, arrest and do not access services.

*To improve migrants' access to health, one recommendation is to not discriminate against migrants, and to provide similar services both in sending and receiving countries.*



## 6.7 *Seychelles*

Seychelles has a population of 84,600. The health care system provides free services at Government health institutions for all persons including migrants. The construction sector employs most migrants. Approval to employ non nationals is granted if posts cannot be filled by nationals and pre immigration medical screenings need to be conducted at the country of origin.

A major problem with regards to HIV is that anti retroviral treatment is not accessible to migrant workers unless the employer can pay for it. Challenges faced by migrants in accessing health, include language barriers between health care providers and migrants. Migrants also fear to take sick leave due to possible wage loss and deportation.

## 6.8 *South Africa*

The borders of South Africa opened significantly after 1994 to migrant labourers and tourists. Since then, the country is experiencing a huge influx of migrants, especially from Zimbabwe, and border controls are often inadequate. Some of the challenges the country is facing are related to the situations in other countries e.g. the cholera outbreak in Zimbabwe. The brain drain from other countries has resulted in qualified migrants from neighbouring countries working in low level jobs in South Africa, e.g. teachers working as petrol attendants.

South Africa provides free public health care service for all children under the age of five. However, there is a need to focus on the plight of children at border posts. NGOs working at border posts provide services to children who have been left by their parents to work in South Africa. Forums like MIDSA should be instrumental in facilitating the respect of migrants' rights by Governments in southern Africa.

## 6.9 *Swaziland*

Swaziland has realized that one of the major milestones towards the care of vulnerable groups is their inclusion in the country's national Multi Sectoral Strategic Framework on HIV&AIDS (2009-2014). The Government of Swaziland has noted that one of the factors that contribute to the spread of the HIV epidemic is conditions in relation to migration such as the long distances travelled by truck drivers. Migrant workers may also be clients to commercial sex workers due to separation from partners for long periods of time. Achievements made in addressing health of migrant workers are: 1) Implementing partners identified; 2) Peer educators for migrant workers trained; 3) Community dialogues, health education with long distance truck drivers and transport workers conducted; 4) Linkage of transport workers to health facilities at flexible hours convenient to them; 5) and Distribution of condoms at major outlets e.g. border- posts, airport, bus ranks, shops, hotels, and bars for easier access.

Challenges in providing migrants' access to health include the lack of data on migration for programming and targeted interventions; and stigma and discrimination towards STIs, HIV and AIDS bringing about fear to access health services.

## 6.10 Tanzania

Tanzania has had problems with refugee camps and some have been closed down. There is a health policy for refugees and protocols which contribute to managing migrants' health.

Governments' response in providing access to health of migrants was to link the services provided in refugee camps with national health services. In emergency services migrants are cared for through a partnership between the Government and UNHCR. There is also a programme for Kenya, Uganda, Rwanda and Tanzania to provide services to truck drivers. Challenges in providing health care and services to migrants include labour abuse, shelter, security, language among others.

## 6.11 Zambia

Zambia has a population of 11.6 million and an HIV prevalence of 14.3%. It is a landlocked country with various migration flows internally and externally. The country has experienced brain drain from health and education sector to Namibia, Botswana and South Africa. Zambia has also been a host country to migrants due to political and social instability from other countries.

Challenges include sex work, which is illegal, the difficulty to interview migrants due to language barriers, an overburdened health care system, and migrant unfriendly services.

Responses to challenges regarding migrants' access have been provided by NGOs, IOM, CHAMP and UNHCR.

## 6.12 Zimbabwe

In Zimbabwe, levels of inflation have been higher than anywhere in the world, with over 80% of the population struggling to survive. More than half of the Zimbabwean skilled population has left to seek employment in other countries. Cross border trade has increased and also high concentrations of sex work at border areas. The temporary permits for Zimbabweans entering South Africa have resulted in drastic reduction on the number of deportees, but there is inadequate reliable data on migration to give a picture of the magnitude and pattern of migration in Zimbabwe.

There is internal migration as well due to illegal mining and it also attracts lots of foreigners who buy the diamonds.

Some of the concerns in the country are with regards to diagnosis of diseases and initiating treatment and follow up among migrants. Designing programmes for migrants is also a challenge due to lack of collaboration among member states and not implementing guidelines and protocols developed by SADC.

The country needs to strengthen referral systems between institutions and countries. ARVs should be part of the national HIV programme with no discrimination against migrants and other marginalized groups.

*In Zimbabwe, levels of inflation have been higher than anywhere in the world, with over 80% of the population struggling to survive.*



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## **7 *Break-Out Groups: Implementing the World Health Assembly Resolution on Migrants Health***

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Each group was asked to identify and propose five top challenges in implementing the WHA resolution, as they relate to the southern African context, and come up with corresponding recommendations which will be included in the final communiqué of the MIDSA workshop recommendations.

GROUP 1: Multi-Sectoral Policy Coherence

GROUP 2: Health Systems Strengthening

GROUP 3: Regional Coordination

The draft conclusions and recommendations from each group were presented to the Plenary.

## 8 Concluding Session

The conclusions and recommendations from the three break-out groups were compiled by the Secretariat and presented and finalised by consensus at plenary as shown below:

Participants of the MIDSA workshop on “Promoting Health and Development: Migration Health in Southern Africa” concluded that:

- *Health is a basic human right and that addressing the health needs of migrants benefits migrants and host communities alike, facilitates integration and contributes to social and economic development and security in the region;*
- *The 61<sup>st</sup> World Health Assembly Resolution 61.17 on “Health of Migrants” recommendations are relevant and applicable within the SADC context;*
- *The development of the Draft SADC Policy Framework on Population Mobility and Communicable Diseases should be commended and sustained; and*
- *SADC Member States need to take steps to implement the above noted Resolution.*

Further, there was consensus with regard to the following recommendations:

- SADC Member States should explicitly state migrants’ access to health in national health policies and implementation plans;
- Ministries responsible for immigration should undertake a policy review to ensure that immigration policies explicitly reflect the rights of migrants to access health care and services;
- SADC Member States should promote the inclusion of migrant health into primary health care reform principles and ongoing health systems strengthening efforts;
- SADC Member States should implement existing SADC policies and protocols as well as bilateral agreements that facilitate migrants’ access to health;
- SADC Member States should adopt the Draft Policy Framework on Population Mobility and Communicable Diseases and then implement it to ensure policy coherence in the Region;
- SADC Member States under the initial leadership of the Ministries of Health should designate focal points responsible for establishing mechanisms to facilitate multi-sectoral dialogue and promote partnerships on migration and health, including public-private collaborations to provide and contribute to health services for migrant populations;

***Health is a basic human right and that addressing the health needs of migrants benefits migrants and host communities alike, facilitates integration and contributes to social and economic development and security in the region;***



- SADC Member States should recommend the inclusion of the topic of migrant health into the agenda of the WHO Africa Regional Committee Meeting and other appropriate fora, in order to strengthen the commitment of Member States to address the needs of migrants and their host or home communities in the Region;
- SADC Member States should partner with expert organisations and academic institutions to conduct research and strengthen health information systems, to better inform policies, foster policy coherence, and strengthen service delivery to all including migrants;
- The African Union should facilitate and the SADC Secretariat should engage in dialogue among African Regional Economic Communities. SADC Member States should advocate for migrant health issues to be more prominent at multilateral fora such as the Global Forum for Migration and Development;
- SADC Member States and SADC Secretariat, in collaboration with partners should address the financial constraints of migrant host, transit and source communities through adequate allocation to national health budgets, pre-payment systems, public-private partnerships, and resource mobilisation from regional and international funding mechanisms;
- SADC Secretariat, in collaboration with the MIDSA organisers and other partners, should take the lead in establishing and maintaining a forum to review and discuss the implementation of the above recommendations, and share information and knowledge on good practices.



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## 9 Closing Session

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Vincent Williams, in his closing remarks spoke of the value of taking migration seriously in that it benefits society as a whole. The discussions showed that governments in the SADC region are committed to taking action on migration issues and migrants' rights.

Dr. Somanje spoke on behalf of the WHO Representative and stated that WHO attaches significance to the meeting. He thanked all the partners for co hosting the meeting and expressed his hope that the collaboration that had been started among Member States will continue and be even stronger. All should strive to ensure that migrants' right to health is respected and create a conducive environment for migrants to enjoy their rights. Future action on migration health should be guided by the recommendations that have been developed at this workshop.

Closing remarks were made by Dr. Gilbert Mliga on behalf of the Government of Tanzania, who thanked all participants for a very productive meeting. The recommendations agreed upon should be implemented in collaboration with other organisations. He officially closed the workshop.

***SADC Secretariat, in collaboration with the MIDSA organisers and other partners, should take the lead in establishing and maintaining a forum to review and discuss the implementation of the above recommendations, and share information and knowledge on good practices.***



# Annex 1

Opening Sessions		
08:30	Welcome – IOM & WHO <ul style="list-style-type: none"><li>- Mr. Hans-Petter Boe (Regional Representative for Southern Africa, IOM)<ul style="list-style-type: none"><li>– on behalf of IOM and SAMP</li></ul></li><li>- Dr. Jean-Baptiste Tapko (Representative, WHO Tanzania)</li></ul>	
09:00	Opening of the workshop Representative from the Government of Tanzania (TBC)	
09:30	Introduction / Objectives of the Workshop <ul style="list-style-type: none"><li>- Reiko Matsuyama (IOM MRF Pretoria) (Workshop objectives, MIDSA programme overview, administrative matters)</li></ul>	
10:00-10:30	Tea Break & Group Photograph	
Plenary: Setting the Scene - Migration Health in Southern Africa		
10:30	<b>Presentation: Migration and mobility trends</b> Mr. Vincent Williams, SAMP Content: Overview of migration and population mobility flows and trends in Southern Africa; various types of migrant populations; and how migration and population mobility impacts on the social and economic context in the region.	
10:50	<b>Presentation: Impact of migration and population mobility on health of migrants and societies</b> Dr. Davide Mosca, IOM Migration Health Department, Geneva Content: What is migration health; how does migration affect public health; and what are the vulnerabilities associated with the migration process?	
11:10	<b>Presentation: Health system responses and need for changed multi-sectoral approaches</b> Dr. Habib Somanje, WHO AFRO Content: The health needs of migrants and public health consequences of migration calls for a paradigm shift, changed health systems and closer collaboration among various sectors involved in migration; the need for a WHA resolution on Migrant Health	
11:30	Q&A (30 minutes)	
12:00-13:00	Lunch	
Plenary: Multi-Sectoral Responses to Migrant Health in the SADC Region: Identifying Good Practices		
13:00 – 15:30	Panel 1: Emergency and crisis induced migration and associated health concerns	
	Content: Presentations on challenges and successful responses to a range of health concerns associated with emergency/crisis (natural or man made) induced migration; the special vulnerabilities of certain groups; and how non health sector responses affect health.  5 presentations, 20 minutes each plus 50 minutes for discussions	
	<b>Presentation 1.1: Overview of Health Impact of Emergency &amp; Crises Induced Migration in Eastern &amp; Southern Africa (ESA)</b>	Dr. Olushayo Olu, WHO Intercountry Support Team, Eastern and Southern Africa

	<b>Presentation 1.2: HIV in Emergency Settings</b>	Ms. Mumtaz Osman, UNAIDS
	<b>Presentation 1.3: Cross-Border HIV/AIDS Prevention and Vulnerability Reduction for Angolan Returnees in Zambia and Angola</b>	Ms. Annie Lane, IOM Zambia
	<b>Presentation 1.4: Addressing Health and HIV in Emergency Settings – Case of Zimbabwe</b>	Mr. Raymond Yekeye, Zimbabwe National Aids Council
	<b>Presentation 1.5: Mental Health and Psychosocial Response in Emergency Settings: Provinces of North Kivu in the DRC</b>	Ms. Amal Ataya, IOM Lebanon
15:30 – 16:00	Tea Break	

16:00 – 18:00	<b>Panel 2: Labour Migration and Access to Health</b>	
	<p><b>Content:</b> Much of the migration flows in the region involve people searching for work and companies and countries attracting workers. The health of the workers as well as the public health of hosting and home communities are to be considered, with special attention given to health concerns of undocumented workers and those in an irregular situation.</p> <p>4 presentations, 20 minutes each plus 40 minutes for discussions</p>	
	<b>Presentation 2.1: Overview of the different types of labour migration &amp; corresponding health concerns</b>	Ms. Barbara Rijks, IOM Regional Office for Southern Africa
	<b>Presentation 2.2: Key findings of research studies on migrants' access to health in South Africa: challenging common assumptions</b>	Ms. Joanna Vearey, Wits University Forced Migration Project
	<b>Presentation 2.3: Migrant Support Centre at the Zambia-Zimbabwe border town of Chirundu</b>	Musa Temba, IOM Chirundu
	<b>Presentation 2.4: Access to Health for Seasonal Workers in the Mining and Agriculture Sector in Zambia</b>	Rosanna Price-Nyendwa, Comprehensive HIV/AIDS Management Programme
18:00	Closing and Wrap-up of Day One	
19:00	Reception Hosted by the World Health Organization (WHO)	



MIDSA Programme DAY 2		
Facilitator: Mr. HP Boe (IOM Pretoria)		
08:00	Recap of Previous Day	
Plenary: Country Presentations		
08:30 –11:00	Country Feedbacks: Country updates on key migration health issues (challenges, responses) 15 feedbacks, 10 minutes each	
11:00 – 11:30	Tea Break	
Plenary: Multi-sectoral Responses to Migrant Health in the SADC Region: Identifying Good Practices – Continued from Day 1		
11:30 – 12:10	Panel 3: Regional Cooperation in Southern Africa	
	Content: This session will highlight good practices in regional cooperation from the SADC region 2 presentations, 20 minutes each	
	Presentation 3.1: Draft Policy Framework on Population Mobility and Communicable Diseases	Mr. Innocent Modisaotsile, SADC Secretariat
	Presentation 3.2: Inter country collaboration towards malaria control in the Lubombo Spatial Development Initiative (LSDI) region	Dr. André Laas, Medical Research Council
12:10 – 13:10	PANEL 4: Experiences in Migration and Health from other Regions	
	Content: This session will consist of presentations from other regions on challenges and good practices on migrant health. Lessons learned in other regions which can include migrant -receiving or -source countries, can be helpful for the management of migrant health related challenges of SADC. 3 presentations, 20 minutes each	
	Presentation 4.1: Intergovernmental Authority on Development (IGAD) Regional HIV and AIDS Partnership Program (IRAPP)	Dr. Ahmed Hassan, IGAD
	Presentation 4.2: Migrant Health Strategy: Challenges and Good Practices on Migrant Health - MOPH-IOM Migrant Health Program in Thailand	Mr. Sutat Kongkhuntod, Ministry of Public Health, Government of Thailand
	Presentation 4.3: Migration Health – Experiences from Portugal and EU	Ms. Ana Alexandre Fernandes, Dept of Public Health, Govt of Portugal
13:10 – 13:30	20 minutes discussions for Panels 3 and 4	
13:30-14:30	Lunch	

## **MIDSA Programme DAY 2**

**Facilitator: Mr. HP Boe (IOM Pretoria)**

### **Break Out Groups: Implementing the World Health Assembly Resolution on Migrants Health**

14:30	<p>Content: Each group will identify and propose 5 top challenges in implementing the WHA resolution, as they relate to the southern African context, and come up with corresponding recommendations/action points. These recommendations/action points will form the basis for the finalisation of the MIDSA workshop recommendations for the region to consider for appropriate follow up, including for the report to the 63rd WHA on mentioned Resolution. (see separate sheet for specific instructions)</p> <p>GROUP 1: Multi-Sectoral Policy Coherence (Plenary room)            GROUP 2: Health Systems Strengthening (Breakaway room 1)            GROUP 3: Regional Coordination (Breakaway room 2)</p>
16:30 – 17:00	Tea Break (to be taken during breakaway group sessions)
17:00 - 18:30	<p>Report back from the breakaway groups and discussions</p> <p>20 minute presentations by each group plus 30 minute discussions</p>
18:30	Closing and Wrap-up of Day Two
19:00	Dinner

## **MIDSA Programme DAY 3**

**Facilitator: Mr. Davide Mosca (IOM Geneva)**

### **Plenary: Concluding Session**

08:30	Recap of Previous Day IOM
09:00	Presentation and Finalisation of the Draft Conclusions and Recommendations Vincent Williams, SAMP
10:30 - 11:00	Tea Break

### **Closing Ceremony**

11:00	<p>Closing Address</p> <p>IOM, SAMP, WHO and Government of Tanzania</p>
12:00	Lunch
	Departure of delegates – afternoon or next day (depending on flight)



## Annex 2

### **Migration Dialogue for Southern Africa (MIDSA): Promoting Health and Development - Migration Health in Southern Africa 10-12 June 2009, Dar es Salaam, Tanzania**

#### **Participants List**

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**10-12 June 2009, Dar es Salaam, Tanzania**

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**10-12 June 2009, Dar es Salaam, Tanzania**

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