INTERNATIONAL ORGANIZATION FOR MIGRATION

HISTORICAL PERSPECTIVES OF MIGRATION HEALTH ASSESSMENTS

PUBLIC HEALTH BENEFIT

PRE-ARRIVAL (MIGRATION) HEALTH ASSESSMENTS (IOM)

SUMMATION AND QUESTIONS
Seven decades of growth

- UN related organization
- 172 Member States, 10 Observers
- Headquarters in Geneva
- More than 480 offices in 150 countries
- Over 10,000 employees
- Committed to the principle that humane and orderly migration benefits migrants and societies

The only agency with a global footprint dealing with all aspects of migration for 67 years
“Dignified, orderly, and safe migration for the benefit of all”

As the leading international organisation for migration, IOM acts with its partners in the international community to:

- Assist in meeting the growing operational challenges of migration management
- Advance understanding of migration issues
- Encourage social and economic development through migration
- Uphold the human dignity and well-being of migrants
## IOM - HOW WE GOT STARTED

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>1951</td>
<td>Founded as the Provisional Intergovernmental Committee for the Movement of Migrants from Europe (PICMME) following WWII</td>
</tr>
<tr>
<td>1952</td>
<td>PICMME becomes the Intergovernmental Committee for European Migration (ICEM)</td>
</tr>
<tr>
<td>1980</td>
<td>ICEM becomes the Intergovernmental Committee for Migration (ICM) during the Indochinese refugee crisis</td>
</tr>
<tr>
<td>1989</td>
<td>ICM becomes the International Organization for Migration (IOM)</td>
</tr>
</tbody>
</table>
IOM SERVICE AREAS

Facilitating Migration

Policy, Research & Forum Activities

Regulating Migration

Migration & Development

Resettlement, Movement, Emergency & Post-Crisis

Migration Health
For various categories of migrants, including resettling refugees, immigrants, temporary migrants, labour migrants, returnees and displaced persons, either before departure or upon arrival.

Promoting migrant sensitive health systems (focus labour, irregular migrants and host communities) advocating for migrant-inclusive health policies, delivering technical assistance and enhancing capacities.

Especially in natural disasters, IOM assists crisis-affected populations, governments and host communities to strengthen and re-establish primary health care systems.

Psychosocial support, including counselling, group building, conflict transformation and public information, become crucial elements of wellbeing, cultural diversity competency.
MHD within IOM

IOM Staff: 10,184 | 1,223 on Health Projects

One in eight IOM Staff
BUT FIRST SOME STATISTICS........

International Migrant (Regular or Irregular)

Migrant Worker

Migrant in an Irregular Situation

International Migration

Mixed Migration

Internally Displaced Persons (IDP)

Refugee

Internal Migrant

Victims of Human Trafficking (VoT)
GLOBAL MIGRATION SNAPSHOT

258 million: International > 740 million: Internal

**Trends**
- Urbanisation: 50% +
- ‘Irregular’: 15-20%
- Feminisation: 50%
- < 20 years of age: 14%

**Displacement**
- 40 million IDPs
- 23 million refugees

**Migration drivers**: Violence, war, organised crime, persecution, natural disasters, economic opportunity, education, family reunification, etc.

Sources: UNDP; ILO; UNHCR; UNDESA; UNHCR; US State Dep
GLOBAL MIGRATION SNAPSHOT

Students:

- 1 million in 1985
- 4.5 million 2015
- Est. 7 million 2030
- 13 million ‘cross-border students’

Sources: UNESCO institute for statistics 2015

WHERE DO THEY GO AND COME FROM?

International Migrants Stock Dataset in 2015

North America
54 million
4 million

Europe
76 million
62 million

Asia
75 million
104 million

Latin America and the Caribbean
9 million
37 million

Africa
21 million
34 million

Oceania
8 million
2 million

Notes:

- All numbers are millions of people.
- Unknowns and others were redistributed proportionally to the size of groups for which data on international migrants were available by origin.

48% are women
39 median age
15% are below 20 years old

Statistics in International Migrant Stock: The 2015 revision.
For more information visit: www.unmigration.org
MODERN MIGRATION PROCESS
MIGRANTS AND THE ECONOMY

- Migrants contribute to economies and development
- Migrants contribute more in taxes and social contributions than they receive in benefits

Most international migrants are of working age. In 2015, 177 million of them (72%) were between ages 20-64.

MIGRANTS AND THE ECONOMY

Remittances vs. other international financial flows

$Billion US

Data show international financial flows to developing countries.
TREATMENT OF LABOUR MIGRANTS

It is not always managed well......

- Unethical medical screenings for prospective migrant workers
- Pre-departure forced contraception; deportation of pregnant migrant workers
- Refusal of visa to dependents for temporary labour migrants
- Deportation of migrants with treatable infectious diseases (TB) and health conditions (pregnancy)
- Exploitation, poor living and working conditions
A SHORT HISTORY OF MIGRATION, AND DISEASE CONTROL

International Organization for Migration

History of migration and disease control: the quarantine

- The second pandemic of bubonic plague during the great expansion of European trade in the early 14th century
- In 1377, the Great Council of the City of Ragusa (modern Dubrovnik, Croatia) passed a law establishing a fourteen- or thirty-day isolation period for citizens or visitors from plague-endemic areas.

International Organization for Migration

- The Public Health Service Act of 1944 established the federal government’s quarantine authority with the responsibility for preventing the introduction, transmission, and spread of communicable diseases from foreign countries into the United States.

International Organization for Migration

- Cholera pandemic of the mid-nineteenth century
- Immigration health practices were legislated by several countries.

QUARANTINE CONTAGIOUS DISEASE

The label of “attired immigrant” we can not afford to admit.”

1883 The Buck: Drawing which shows members of the New York Board of Health wielding a bottle of carbolic acid, a disinfectant, in their attempts to keep cholera at bay.

Ships Docking at the Lazzaretto Vecchio, Venice 14th Century

the quarantine

US Quarantine Inspectors in Public Health Service uniforms, late 19th century

Immigrants are inspected in ‘the line’ at Ellis Island, circa 1904

(Photograph: US National Library of Medicine)
SCREENING STRATEGIES

1. Pre-entry/premigration
2. Port of arrival
3. Transit centre (e.g. asylum seekers)
4. Community post arrival screening
5. “Occasional” screening in community – e.g. outbreaks
6. Follow up screening (health undertaking)
“COMPULSORY” MEDICAL SCREENING

- Sometimes criticised as “human right” violation
- Complexity and diversity of migration
- Diseases may be ‘latent’*
- Real or perceived discrimination*
- Potential corruption (fear of rejection)*
- Manifestation of disease dependent on complex matrix based on the populations themselves and variety of social determinants

- Positives have been identified with highly infectious diseases posing immediate threats, as well as with adequate post-arrival services contribute to addressing health needs of migrants

*Carballo, M., TB screening of migrants and implications for Europe, ICMHD, June 2012
HOW DOES MIGRATION INFLUENCE HEALTH?

Common myths:
1. Migrants are carriers of diseases
2. Migrants are a burden on the health system

Reality:
• Most migrants are healthy – ‘Healthy migrant effect’
• Migrant populations are diverse and health profile of a migrant depends on the conditions surrounding the migration process at all stages
• Migrants often under-utilise services
• If no health insurance, some migrants must pay for services; delay seeking care
• Migrants contribute hugely to economic development in both sending and receiving countries
Factors affecting the well-being of migrants during the four phases of the process of migration.

**Pre-Migration Phase**
- Pre-migratory events and trauma (war, human rights violations, torture), especially for forced migration flows;
- Epidemiological profile and how it compares to the profile at destination;
- Linguistic, cultural and geographic proximity to destination.

**Movement Phase**
- Travel conditions and mode (perilous, lack of basic health necessities), especially for irregular migration flows;
- Duration of journey;
- Traumatic events, such as abuse;
- Single or mass movement.

**Return Phase**
- Level of home community services (possibly destroyed), especially after crisis situation;
- Remaining community ties;
- Duration of absence;
- Behavioural and health profile as acquired in host community.

**Arrival and Integration Phase**
- Separation from family/partner;
- Discrimination and social exclusion;
- Abuse and exploitation;
- Legal status;
- Language and cultural values;
- Duration of stay.

**Cross-Cutting Issues:**
- Gender; age; genetic factors; socioeconomic status, etc.
MIGRATION HEALTH SCREENING

- Economy
- Geopolitical situation
- Government policies and law
- Media and public interest groups
- The changing nature of “borders” from lineal to continuum

- Health as a threat……
WHY FOCUS ON MIGRANT HEALTH?

Health of migrants bridges human rights, public health, and development

1. Migrants are human beings, and have a right to health.

2. Migrant-inclusive health systems improves public and global health outcomes.

3. Healthy migrants contribute to positive sustainable development outcomes.

Better health, better integration, better migration!
The evaluation of the physical and mental status of migrants, made prior to departure or upon arrival, for the purpose of resettlement, international employment, enrolment in specific migrant assistance programmes, or for obtaining a temporary or permanent visa.

• IME = Immigration Medical Examination
MIGRATION HEALTH ASSESSMENTS

Reasons:

- Legal imperatives
- Reduce morbidity and mortality among immigrants
- Prevent the introduction, transmission, and spread of communicable diseases
- Promote and improve the health of migrating populations

Service to the receiving country:

- Avoided cases
- Avoided potential for transmission after migration
- Removes barriers to migrant presentation

Service to the country of origin

- Improved TB services: detection & treatment
- Migration seen not as a threat, but an opportunity
Examples of immigration policies and laws that govern health assessments

1. The Immigration and Nationality Act (INA) of the United States
2. The Migration Act of 1958 (Section 60) of Australia
3. The Immigration Act of 1971 (Section 4) and corresponding Immigration Rule 36 of the United Kingdom
4. The Immigration and Refugee Protection Act (Section 16.2b) and corresponding Immigration and Refugee Protection Regulations (Division 3) of Canada, and
5. The Immigration (Visa, Entry Permission, and Related Matters) Regulations of New Zealand (Section 5.3c)
6. By-laws Regulating Medical Examination for Expatriates coming for residence in the CC States (Rules & Regulations for Medical Examination of Expatriates Coming to GCC States for Residence)
WHAT TO TEST FOR? A ‘THRESHOLD FOR TESTING’

QUESTIONS

➢ Will the screening detect those with the condition?
➢ Will screening assist in achieving the desired public health objective?

1. Capacity to **effectively perform** the testing - sensitivity and specificity of the test
2. **Benefit of the test** (protect the host population from a migrant-associated health risk, improved quality of life for the migrant)
3. **Cost, acceptance/rejection, availability of treatment, prevalence of the condition in the population** (a risk-based approach – screen to treat!)
SCREENING STRATEGIES

International TB screening Comparisons*

• Countries selected on:
  – Top 20 immigrant countries OR
  – Migration screening results published in peer review journal AND
  – Low domestic TB Incidence (< 15/100 000)

• Compared USA, Germany, France, Canada, UK, Switzerland, Australia, UAE, Israel, NZ, Jordan, Netherlands, Norway, Sweden, & Japan, Spain, Italy (final three - no programme)

• No two countries had a common approach

• Temporary residents represent a significant TB source

• Screening programmes can be made more evidence-based

• Cooperation between countries on research would be an asset to improve screening algorithms and approaches

• Without programme to manage LTBI in new arrivals, immigration screening of active PTB will have limited impact

*Alvarez et al., Comparative analysis of TB immigration screening programs, BMC Inf Diseases, 2011
PURPOSE OF MIGRATION HEALTH ASSESSMENT

- Screening for the purpose of excluding
  - Detection of inadmissible conditions
    - Tuberculosis, infectious
    - STIs, untreated
    - Mental health conditions (associated with harmful behaviour)
    - HIV
  - Detection of conditions presenting excessive demand on health care systems

- Screening for the purpose of integrating
  (Exclusionary or integrationist approaches (particularly in cases of NCDs) often depend upon the characteristics of the health care system in the receiving country, i.e. public social security service, vs. private, insurance-based, etc.)
PUBLIC HEALTH BENEFIT

Screening for the purpose of *integrating*
Falzon D. et al. *Italian J Pub Health*. 2012;9(3)

“… can we turn around the perception embraced by many national public health authorities that migration is a threat into an opportunity…”

“… can we improve our grasp on the global TB epidemic by taking advantage of the motivation which drives one billion … individuals to seek a better future…”

**Regulatory Mission**
- Prevent the introduction, transmission, & interstate spread of communicable diseases by refugees & migrants versus

**Public Health Mission**
- Reduce morbidity & mortality among refugees, & migrants
- Prevent the introduction, transmission, & spread of communicable diseases through regulation, science, research, preparedness & response
PARADIGM SHIFT

Traditional approach:
- Exclusion
- Security
- Disease control
- National focus

Modern multi-dimensional approach:
- Inclusion
- Reduction of inequities
- Social protection in health
- Multi country & intersectoral policy development
From 2000 to 2017, IOM has performed over 3.5 million health assessments worldwide.

<table>
<thead>
<tr>
<th>Region</th>
<th>Immigrants</th>
<th>Refugees</th>
<th>Total</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>24%</td>
<td>79.2%</td>
<td>82,634</td>
<td>12.8%</td>
</tr>
<tr>
<td>MENA</td>
<td>29.3%</td>
<td>70.7%</td>
<td>44,049</td>
<td>12.8%</td>
</tr>
<tr>
<td>Americas</td>
<td>29.3%</td>
<td>70.7%</td>
<td>777</td>
<td>1.1%</td>
</tr>
<tr>
<td>Europe</td>
<td>18.7%</td>
<td>81.3%</td>
<td>64,551</td>
<td>18.7%</td>
</tr>
<tr>
<td>Asia</td>
<td>24%</td>
<td>76%</td>
<td>152,858</td>
<td>44%</td>
</tr>
</tbody>
</table>

**Programmes**
- Resettlement and Immigration to USA, UK, Canada, Australia, New Zealand, Malaysia, EU and other countries

**Assisted Population**
- 344,869 refugees and immigrants (30.6% refugees) worldwide, 2017

**Locations (coverage)**
- 93 countries worldwide

**Locations (presence)**
- 67 clinics across 48 countries
IOM HEALTH ASSESSMENTS WORLDWIDE, 2017

The chart shows the number of health assessments conducted by IOM worldwide from 2009 to 2017. The data is categorized by year and type of assessment: refugee health assessments (blue bars), immigrant health assessments (gray bars), and total health assessments (dark blue line).

From the chart, it can be observed that the number of total health assessments fluctuated over the years, peaking in 2016 and 2017. The number of refugee health assessments also varied, with a notable increase in 2016 and 2017. The immigrant health assessments remained relatively consistent throughout the period.
THE EVOLVING NATURE OF MHA’s

Core Health Assessment

Expanded Activities

Knowledge Management

Partnership and collaboration
Health assessments (HAs) may include some or all of the following:

- Review of medical history
- Detailed physical examination
- Mental health evaluation
- Clinical or laboratory investigations
- Pre- and post-test counselling
- Referral for consultation with a specialist
- Health education
- Pre-embarkation/fitness-to-travel checks (PECs)
- Pre-departure medical procedures (PDMPs)
- Vaccinations

- Provision of, or referral for treatment
- Documentation of findings and preparation of required immigration health documentation
- Confidential transfer of relevant information or documentation to appropriate receiving authorities
- Disease surveillance and outbreak response
- Provision of medical escorts and special arrangements for travel
THE EVOLVING NATURE OF MHA’s

- Core Health Assessment
- Expanded Activities
- Knowledge Management
- Partnership and collaboration
EXPANDED HA ACTIVITIES

- Digital Radiology
- New Laboratory Techniques
- Health Informatics

- Protocol Harmonisation
- TB reach projects
- DOTs centers
- Community Health Clinics

- Vaccination,
- Health Education
- Outbreak surveillance and response

- Nutritional Surveillance
- Mental Health
- Tuberculosis

- Laboratories
- TB clinics
THE EVOLVING NATURE OF MHA’s

Content

Core Health Assessment

Expanded Activities

Knowledge Management

Partnership and collaboration
Data collection and sharing
• Individual medical records (MiMOSA to EDN interface)
• HAP summaries
• Prevalence of conditions of interest
• Surveillance data

Resettlement population profiles include the following components for the major resettlement populations assisted by IOM:

• Demographics
• Analysis of classified medical conditions (DS forms)
• Analysis of resettlement needs (SMC forms)
• ICD coding of medical records
PUBLIC HEALTH FOCUS: VACCINATIONS

- > 1M doses administered
- 11 vaccine preventable diseases
- Provide individual protection
- Prevent outbreaks
- Cost-effective
- Facilitate integration

Number of countries with IOM vaccination programme

- Africa
- MENA
- Asia
- Europe and CA
- TOTAL

<table>
<thead>
<tr>
<th>Year</th>
<th>Africa</th>
<th>MENA</th>
<th>Asia</th>
<th>Europe and CA</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>2013</td>
<td>14</td>
<td>8</td>
<td>5</td>
<td>8</td>
<td>25</td>
</tr>
<tr>
<td>2014</td>
<td>20</td>
<td>9</td>
<td>8</td>
<td>10</td>
<td>47</td>
</tr>
<tr>
<td>2015</td>
<td>20</td>
<td>9</td>
<td>8</td>
<td>9</td>
<td>46</td>
</tr>
<tr>
<td>2016</td>
<td>23</td>
<td>12</td>
<td>12</td>
<td>12</td>
<td>59</td>
</tr>
</tbody>
</table>
PUBLIC HEALTH FOCUS: TUBERCULOSIS

Figure 11.2: Number of pulmonary TB cases diagnosed by pre-entry screening in the 101 programme countries and those identified within one year of UK entry*, 2006 to 2015**

* The number of pulmonary TB cases identified within one year of entry into the UK was from all 101 high incidence countries but the number of TB cases diagnosed by pre-entry screening were from an increasing number of countries as screening was rolled out: 6 pilot countries (2006), 15 pilot countries (2007 and 2012), 101 countries (by 2014).

** As of May 2016, 513 sputum samples are pending and the rate may increase when final results are available.
TB DETECTION BY REGION AND MIGRANT TYPE

TB DETECTION AMONG IMMIGRANTS, 2017

<table>
<thead>
<tr>
<th>Region</th>
<th>Detection (per 100,000 HA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>95</td>
</tr>
<tr>
<td>Middle East</td>
<td>14</td>
</tr>
<tr>
<td>Asia</td>
<td>266</td>
</tr>
<tr>
<td>Europe</td>
<td>34</td>
</tr>
</tbody>
</table>

TB DETECTION AMONG REFUGEES, 2017

<table>
<thead>
<tr>
<th>Region</th>
<th>Detection (per 100,000 HA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>172</td>
</tr>
<tr>
<td>Middle East</td>
<td>12</td>
</tr>
<tr>
<td>Asia</td>
<td>462</td>
</tr>
<tr>
<td>Europe</td>
<td>48</td>
</tr>
</tbody>
</table>
## Prevalence Data: Hepatitis (B and C) and HIV by Region & Migrant Type, 2017

<table>
<thead>
<tr>
<th>Region of HA, 2017</th>
<th>Hepatitis B Positive, % (No. of tested)</th>
<th>Hepatitis C Positive, % (No. of tested)</th>
<th>HIV Positive, % (No. of tested)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Immigrant</td>
<td>Refugee</td>
<td>Immigrant</td>
</tr>
<tr>
<td>Africa</td>
<td>3.28% 944</td>
<td>3.34% 17.386</td>
<td>0.43% 925</td>
</tr>
<tr>
<td>Asia</td>
<td>2.12% 11.706</td>
<td>2.39% 9.244</td>
<td>1.35% 9.289</td>
</tr>
<tr>
<td>Europe</td>
<td>2.86% 735</td>
<td>0.73% 3.269</td>
<td>2.20% 728</td>
</tr>
<tr>
<td>MENA</td>
<td>1.20% 251</td>
<td>1.28% 18.176</td>
<td>0.45 220</td>
</tr>
<tr>
<td>Total</td>
<td><strong>2.22% 13.636</strong></td>
<td><strong>2.20% 48.075</strong></td>
<td><strong>1.31% 11.162</strong></td>
</tr>
</tbody>
</table>
Pre-travel medical conditions of all escorted migrants, IOM, 2017

Total number of migrants with escort = 1,744

- Cardiovascular disorder
- Neurologic disorder
- Psychiatric disorder
- Pulmonary disorder (excluding TB)
- Musculoskeletal and connective tissue disorder
- Endocrine and metabolism disorder
- Old age and frailty
- Hematology and oncology disorder
- Eye Disorder
- Genitourinary disorder
- Gastrointestinal disorder
- Not Categorized
- Hepatic and biliary disorder
- Nutritional disorder

Male | Female
--- | ---
Cardiovascular disorder | 15.0%
Neurologic disorder | 10.0%
Psychiatric disorder | 10.0%
Pulmonary disorder (excluding TB) | 10.0%
Musculoskeletal and connective tissue disorder | 10.0%
Endocrine and metabolism disorder | 10.0%
Old age and frailty | 10.0%
Hematology and oncology disorder | 10.0%
Eye Disorder | 10.0%
Genitourinary disorder | 10.0%
Gastrointestinal disorder | 10.0%
Not Categorized | 10.0%
Hepatic and biliary disorder | 10.0%
Nutritional disorder | 10.0%

MIGRANTS ESCORTED, 2017
## Syrian Refugees in ME: Medical Conditions 2016

<table>
<thead>
<tr>
<th>Condition (number of examinations = 67,026)</th>
<th>Percentage of all conditions</th>
<th>Prevalence / 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diseases of the circulatory system</td>
<td>16.4</td>
<td>52.6</td>
</tr>
<tr>
<td>Endocrine, nutritional and metabolic diseases</td>
<td>12.2</td>
<td>39.2</td>
</tr>
<tr>
<td>Diseases of the musculoskeletal and connective tissue</td>
<td>7.8</td>
<td>25.1</td>
</tr>
<tr>
<td>Mental and behavioral disorders</td>
<td>5.4</td>
<td>17.4</td>
</tr>
<tr>
<td>Diseases of the eye and adnexa</td>
<td>5.0</td>
<td>16.0</td>
</tr>
<tr>
<td>Diseases of the digestive system</td>
<td>4.9</td>
<td>15.6</td>
</tr>
<tr>
<td>Diseases of the respiratory system</td>
<td>4.9</td>
<td>15.6</td>
</tr>
<tr>
<td>Diseases of the nervous system</td>
<td>4.3</td>
<td>1.7</td>
</tr>
<tr>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
<td>2.9</td>
<td>9.3</td>
</tr>
<tr>
<td>Other conditions</td>
<td>15.5</td>
<td>49.8</td>
</tr>
</tbody>
</table>
THE EVOLVING NATURE OF MHA's

Content

- Core Health Assessment
- Expanded Activities
- Knowledge Management
- Partnership and collaboration
MHA’s—PARTNERSHIP AND COLLABORATION

Overview over Best Practices in MHD / RC for South-Eastern Europe, Eastern Europe and Central Asia (including achievements 2016)

Intergovernmental collaboration for the health and wellbeing of refugees settling in Australia

Culturally and linguistically diverse communities Health services planning and management

Published 15 March 2018. https://doi.org/10.17403/jmp.201807


IOM’s involvement in addressing and responding to Mental Health issues amongst Defence Personnel – MISSIONMIND (Russia and Nagorno-Karabakh)

October 2014 – June 2017

Objective: Provision of a systematic response to mental health issues amongst the Armed Forces of Russia and Nagorno-Karabakh (ARMF)

- 6 workshops held by psychologists meeting more than 1,000 members of Armed Forces ARMF
- Presentations about mental health difficulties faced by military personnel in 20 sectors
- Development of a Standard Operating Procedure for MISSIONMIND psychological support

- Two study visits about the work of military psychologists organized with Ministry of Defence and BI psychosis

IOM Tajikistan’s engagement for the health of migrants

IOM has been cooperating with the government of the Republic of Tajikistan to develop a multi-sectoral approach for migrant’s health promotion through capacity building among the state migration service and by increasing their health interventions in the field.

- Informational campaigns and community mobilization, as well as peer education
- Strengthening the multi-sectoral approach for TB prevention and care (including migration service and on-site health services within IOM’s TB control project)
- Enhancement of cross-border cooperation for TB-related and care among migrants
- Providing psychological services including healthcare support to advance TB case detection and treatment adherence
- Capacity building of the migrants and health agencies as well as local NGOs for TB control and case detection

IOM-supported tuberculosis screening programmes: IOMFWS experiences

- Efforts towards initiating and continuing efforts to engage refugees and migrants in TB screening programmes, with a focus on promoting the use of screening services
- The IOM-supported TB screening programmes in Lebanon, Jordan, and Egypt have significantly contributed to detecting and treating active TB cases among refugees and migrants
- The programmes have also raised awareness among refugees and migrants about the importance of early detection and treatment of TB

CRediT authorship contribution statement

Clare-Ann Martin: Conceptualization, Methodology, Investigation, Writing – Original Draft, Software

Douglas P.: Conceptualization, Methodology, Investigation, Writing – Original Draft

IOM UN Migration
IOM HEALTH ASSESSMENT PROGRAMMES – VALUE ADDS

- Vaccines
- TB diagnostics
- TB management
- Health profiles and knowledge management
- Teleradiology
- Capacity building
CARING FOR THE MIGRANT BEFORE ARRIVAL

Benefits of IOM Health Assessments

- Early detection and treatment of conditions of individual and public health concern
- Safe travel; prevention of negative health events during travel or on arrival
- Protect the public health of both migrants and host communities
- Reduce expected demand on domestic health and/or social services
- Allow resettlement agencies to prepare adequately by providing important medical information prior to arrival
- Positively impact on the migrant’s capacity to integrate fully in the receiving society
- Coherent with the IOM’s goal of promoting “healthy migrants in healthy communities”
CARING FOR THE MIGRANT BEFORE ARRIVAL – KEY POINTS

- Migration is a process starting overseas (host community); through transit (“pipe-line” and travel) to the post-arrival domestic (Reception and Integration)
- Continuum of Care is essential through clear role definitions (avoiding “falling through the cracks”); ensuring exchange of information (electronic systems!); and better partnerships (for better use of resources)
- Health assessments should be considered within the overall framework of national and international public health measures.
  - information generated from health assessments should be used more widely by the health sector, not just the immigration authorities.
  - information on health conditions of various migrant groups should be disseminated to and integrated within health systems of receiving communities
  - detection and treatment of infectious diseases such as Tuberculosis should be closely linked with national and regional TB control programs.
  - screening programs need to be integrated with domestic disease control programs and linked to international partners to ensure quality standards and coordinated patient care across borders
- Technological advances in diagnostics and treatment should be applied for improved quality in migration health assessments
Migration is…. 

1. **Inevitable** – demographics & disasters  
2. **Necessary** – development  
3. **Desirable** – if well-governed

“Migration is not a problem to be solved, but a reality to be managed” 

*WL Swing*
MHA’s – a mountain of a task

Thank you and questions......