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

INTERNATIONAL CONFERENCE ON AIDS AND STIs IN AFRICA (ICASA)

EAST AFRICA MEETS SOUTHERN AFRICA:

A Bi-regional perspective on HIV and Migration

SATELLITE SESSION

Monday 5 December, 17:30 – 19:00

Venue: A6 hall Simien

Speakers:

Doreen Sanje, Southern Africa Development Community (SADC)

SADC Business Plan and Framework on Communicable Diseases and Population Mobility

Southern Africa perspective

Sikhulile Ngqase, International Organization for Migration (IOM)

HIV Vulnerability of Migrants and Mobile Populations

Spaces of Vulnerability

Joseph Kwong-Leung Yu, International Director, L uke International Norway (LIN) & Superintendent, PingTung Christian Hospital (PTCH), Taiwan

An Introduction of Biometric Information in Patients' Identification and Tracking for People on Anti-retroviral Therapy (ART)

Philip Yi-Chun Lo, Medical officer, CDC, Taiwan

Cross-Border Management of People on Antiretroviral Therapy

Experiences and Challenges

Dr Osman and Dr Rahman, Intergovernmental Authority on Development (IGAD)

Regional HIV/AIDS Partnership Program (IRAPP)

East Africa Perspective

Discussion and networking will follow the session. Drinks and snacks will be available

Organised by: Luke International Norway (LIN), Intergovernmental Authority on Development (IGAD), International Organization for Migration (IOM) and Southern Africa Development Community (SADC).

Please note that this session will be in English only with no formal translations.

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SESSION DESCRIPTION

With increased population mobility either in search of better opportunities or safety, human mobility in East and Southern Africa impacts on the health of migrants and the public health of host communities and countries. Human mobility is a significant public health issue both in terms of epidemiological aspects of disease and physical access to health services[1]. Particular concerns are communicable diseases such as HIV and tuberculosis. Many studies in Southern Africa suggest that mobility has been a factor in the spread of HIV as well as related sexually transmitted infections and Tuberculosis. Health concerns of migrants have become especially acute in the era of HIV and AIDS.[2]

Migration is a critical factor in understanding the epidemiology of HIV and AIDS including the incidence and prevalence of the epidemic. There are at least three key ways in which mobility is tied to the spread of HIV:

- Mobility per se can encourage or make people vulnerable to high-risk sexual behaviour;
- Mobility makes people more difficult to reach, whether for prevention education, condom provision, HIV testing, or post-infection treatment and care; and
- Migrants' multi-local social networks create opportunities for sexual networking

EXPECTED OUTCOMES ARE:

1. Increased understanding of HIV vulnerability of migrants, mobile populations and communities they interact with, and the various regional responses to address HIV and population mobility in East and Southern Africa.
2. Sharing experiences and challenges of cross border management of people on anti-retroviral treatment
3. Facilitate networking among stakeholders working on HIV in East and Southern Africa and beyond

1 Weiss & Michael,2004

2 International Organization for Migration/South African Migration Project (IOM/SAMP) 2005. *HIV/AIDS, Population Mobility and Migration in Southern Africa*. Defining a Research and Policy Agenda. IOM, Pretoria

Cross-border Management of People on Antiretroviral Therapy

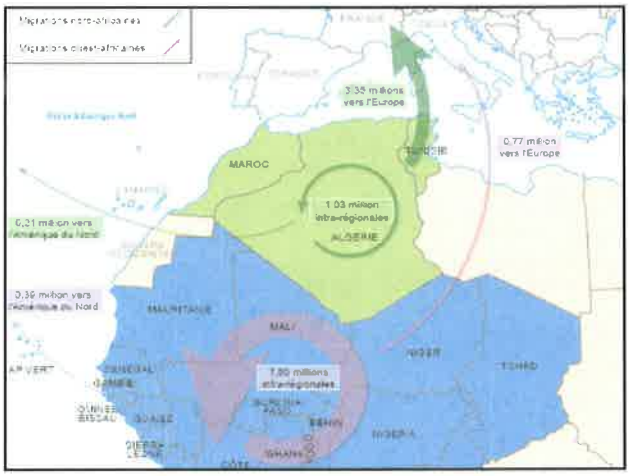
Experiences & Challenges

Philip Yi-Chun Lo, MD

Medical Officer, Taiwan Centers for Disease Control
Former US CDC Epidemic Intelligence Service Officer

Mobility in Africa – Facts

- 30 millions of Africans had changed their residence between 1960 and 1990
- In 1990's 2% of population in Africa were migrants – 0.5% for European Union



Mobility in Africa – Factors Involved

- Involves selective population
  - Mainly young men
  - Increasing number of women & fragile populations
- Facilitating factors
  - Same cultural context – language, religion
  - Strong cross-border family relationships
  - Infrastructure development – roads, bridge, airport, telecommunication

Mobility & HIV Care – Why Cross Border?

- Unbalanced quality & accessibility of ART services across the border
- Attraction of better services
- Communication facilities
- Family relationship
- Seeking for confidentiality

Mobility & HIV Care – Example (Senegal)

March 2010

- Bigona, Senegal – 6% of patients on ART are from Gambia
- Ziguinchor, Senegal – 11% of patients on ART are from Guinee Bissau

Mobility & HIV Care – Example (Malawi)

Mzuzu, Malawi, July 2010

- 799 patients surveyed
- 11 (1%) non-Malawians
  - 8 – Tanzania
  - 1 – Repub. of South Africa
  - 1 – Zambia
  - 1 – Zimbabwe
- Reasons to come to Malawi
  - 8 – for work
  - 3 – residents

Mobility & HIV Care – Example (Malawi)

- 100 (13%) Malawians on ART will go broad
  - Countries – Tanzania, RSA, Zambia, Zimbabwe, Mozambique
- Reasons to go broad
  - 62 – for work
  - 25 – for travel
  - 2 – for study
  - 9 – residents

Mobility & HIV Care – Example (Malawi)

- Of 100 Malawians on ART who will go aboard
  - 19 will go abroad without ART
  - 59 will stay abroad >3 months
  - 87 cannot get ARVs supply abroad
- Being migrants or going abroad associated with
  - Default
  - Suboptimal (<95%) drug adherence

Cross-border HIV Care – Challenges

- Underdevelopment of cross-border partnership
- No effective cross-border platform for mutual experience sharing / learning among communities & health professionals
- Lack of formal and systematic cross-border program or collaboration on ART
- Consequences
  - Default & suboptimal drug adherence
  - ↑ morbidity / mortality / transmission / resistance

Cross-border HIV Care – Barriers

- Differences exist
  - Health policies & health system for HIV care
  - HIV prevention and control program
  - ART regimens and treatment protocol
- Barriers to cross-border ART access
  - Higher user fees charged
  - Lack of information
  - Language barrier
  - Fear of deportation

ART Program 2009 – Comparisons*

Country	CD4 threshold to initiate ART	First-line ART
Botswana	250	TFE+3TC+EFV or NVP
Malawi	250	d4T+3TC+NVP
Mozambique	200 (non-TB) 350 (TB)	AZT+3TC+NVP d4T+3TC+EFV AZT+3TC+ABC
RSA	200	d4T+3TC+EFV
Swaziland	350	AZT+3TC+NVP or EFV
Tanzania	200	AZT+3TC+NVP or EFV d4T+3TC+NVP d4T+3TC+NVP or EFV
Zambia	350	TDF+FTC+NVP or EFV

*Data compiled in August 2009 and might be outdated

Conclusions

- A substantial proportions (6–13%) of patients on ART needs cross-border management
- Challenges & barriers exist in cross-border HIV care
- Gaps in cross-border ART provision might lead to default and suboptimal drug adherence
  - Reduce benefits of ART to patients & community

Recommendations

- Expand citizenship-based ART access to migrants
- Create migrant-friendly services and monitoring & evaluation mechanisms in the region

Cross-border issues need cross-border communication & collaboration

Acknowledgments

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Mzuzu Central Hospital
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