International Organization for Migration (IOM)

The UN Migration Agency

Regional Strategy for Migration and Health 2016 - 2018:

Priorities among the Southwestern Islands of the Indian Ocean

COMMISSION DE L'OCÉAN INDIEN

Norad

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PREFACE

The *Regional Strategy for Migration and Health 2016 - 2018: Priorities among the Southwestern Islands of the Indian Ocean* was made possible with the support of the Swedish International Development Corporation Agency (SIDA) and the Norwegian Agency for Development Cooperation (NORAD) to the International Organisation for Migration (IOM) within the context of the second phase of the Partnership on Health and Mobility in East and Southern Africa programme (PHAMESA 2) (2014-2017).

This strategy builds on progress and lessons learned from the first phase of the PHAMESA programme (2010-13) and presents a holistic view of health and mobility so that national and regional plans among Indian Ocean states may respond to migrants' needs and ensure their well-being. This strategy is aligned with migration and health goals in the *2030 Agenda on Sustainable Development* that recognises migrants' contributions and the importance of migration to support development. Addressing the health needs of migrants through specific targets and evidence-based programmes is a good public health practice that reduces long-term health and social care costs, facilitates integration and enables equitable development.

Building on this strategy, deliberate efforts are needed to strengthen health service delivery to migrants and migration-affected communities to achieve universal health coverage. Implementing the strategic actions requires a strong partnership guided by the principles outlined in the World Health Assembly Resolution on the health of migrants (2008) and through the ongoing process of reaching a Global Compact for safe, orderly and regular migration, which offers new opportunities to identify structural trends and facilitate the achievement of the sustainable development goals.

I wish to express my appreciation to all of you who worked tirelessly to develop this strategy on behalf of the Indian Ocean states. I call upon all Governments, UN Agencies, development partners, civil society and the private sector to accelerate the implementation of this strategy to achieve our migration and health goals.

Regional Director,
IOM Pretoria, South Africa.

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ACRONYMS

ACP	African, Caribbean and Pacific
AIRIS	Support project for the Regional Initiative for STD/HIV/AIDS Prevention
CHU	University Hospital
FENAMUSAC	National Federation of Health Insurance Providers of the Comoros
GFTM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
INSTAT	National Institute of Statistics of Madagascar
IOC	Indian Ocean Commission
IOM	International Organisation for Migration
MDGs	Millennium Development Goals
MP	Migration Profile
NACC	National Aids Control Committee
NGO	Non-Governmental Organisation
NTWG	National Technical Working Group
ODEROI	Indian Ocean Child Rights Observatory
ORS	Regional Health Observatory
PHAMESA	Partnership on Health and Mobility in East and Southern Africa
PLHIV	People living with HIV/AIDS
RWGM	Regional Working Group on Migration
SIDA	Swedish International Development Cooperation Agency
STI	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
WHA	World Health Assembly
WHO	World Health Organisation

ACKNOWLEDGEMENTS

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Finally, we wish to express our gratitude to the team in IOM's Country Office in Mauritius as well as that in IOM's Regional Office in Pretoria and in particular Dr Erick VENTURA, PHAMESA project manager and Mr Theogene NSHIMIYIMANA, PHAMESA project officer, who both travelled to facilitate two regional workshops and to share their experiences on issues relating to migrants' health.

FOREWORD

Migration and Health = Security and Solidarity

Message from S.E.M. Hamada Madi

Secretary General of the Indian Ocean Commission

Countries in the Indian Ocean have built themselves upon successive migratory waves. Our forebears arrived from Africa, the Middle-East, India, China and Europe. In a way, mobility is inscribed in our peoples' DNA. In this age of globalisation, South to North, South to South, and North to South migration flows are intensifying, and inter-regional migration even more so. There are many causes: economic and political, social and cultural, ecological and climatic. Understanding migration flows, studying their potential impacts, deciphering the stakes involved and their outcomes seem essential to ensure they become a source of growth, of strengthened exchange and innovation, rather than a cause for economic, social and health-related tensions.

Let us not be overcome with optimism: truthfully, managing migration flows poses many challenges relating to integration, assimilation, and oversight; in brief, concerning the welcome we provide. Whether it be among Madagascar's cities that are growing with rural populations arriving in search of a better future, or Comorians settling in Réunion, European territory of the Indian Ocean, varying levels of development are fuelling many migration dynamics.

Studies undertaken by the International Organisation for Migration (IOM) have highlighted health vulnerabilities experienced by migrants. The links between migration and health raise issues of prevention, monitoring and treatment at both national and regional levels.

It is based on this work that the Indian Ocean Commission (IOC) and the IOM have chosen to focus our common efforts on the links between migration and health. This means broaching the health conditions of migrants themselves. It also means reducing epidemic risks in our countries, particularly fragile to health crises. In one word, this is about security.

The Regional Strategy for Migration and Health fits within the virtuous dynamic of securing the Indian Ocean over the long-term. It is essential for our Member States to meaningfully engage in this strategy's implementation, together with the IOM and further partners, as it touches upon the sovereignty of our Member States, just as it does health: a global public good that we aim to improve collectively.

We now have an adequate tool, based on well-researched migratory profiles, to respond as best we can to all issues linked to migrants' health. Several of our countries have signed agreements concerning health cooperation. I think of Mauritius, which opens its health facilities to Comorians. This represents solidarity, which is the foundation of our regional cooperation.

I would like to commend all stakeholders here and particularly the IOM for its remarkable and ground-breaking work towards identifying our region's priorities within the framework of this regional migration and health strategy that, I hope, will provide an impulse for national and regional policymakers' involvement in this field. For this, we may rely on much-appreciated support from the European Union to implement priority actions flowing from the Regional Action Plan on Migration, using resources available from the 11th European Fund for Development's trans-regional allocation.

Forthcoming activities led by the IOC in favour of migration and health will no doubt demonstrate our regional organisation's constant concern with the security needs of our Members States and populations. The evidence is clear: this strategy places people at the heart of its priorities. This is the very essence of our regional cooperation.

EXECUTIVE SUMMARY

The ***Regional Strategy for Migration and Health 2016 - 2018*** establishes priorities to improve the management of migrants' health and to reduce migration-related vulnerabilities over the next three years. In doing so, it will contribute to strengthening national authorities' capacity to promote a coherent approach to pioneering policymaking on migration and health.

Addressing issues of migration and health in their broadest sense, among the southwestern islands of the Indian Ocean, lies beyond the scope of this document. Nevertheless, the topic of migration and health is a starting point and can certainly serve as a framework to consider further public health issues. This strategy focuses on people rather than diseases. It aims to gather key evidence on the means to promote health equity and to provide the impetus required to act.

The strategy includes four areas of intervention based on four objectives that address barriers to accessing health services experienced by migrants and that propose changes to remove these, considering current and future challenges.

This strategy is human rights-based and analyses migration and health issues faced by states, focusing on social determinants of health to enable them to overcome migration and health-related challenges. Rather than an end unto itself, this strategy should inform multi-dimensional and multi-sectoral policymaking concerning migration.

It has been developed using an inclusive approach that has aimed to foster partnerships with institutions and organisations working in the migration and health fields. It builds on existing strategic documents and considers the specificities of each state and internal, regional and international migration flows.

Data was first collected through a review of existing literature on each country's migratory flows and health systems, focusing on how accessible health services are to migrants (within reach, affordable, non-discriminatory, informative). This review was complemented by key informant interviews and group discussions with migrants, service providers, and representatives from NGOs, UN agencies and workers' unions.

The ***Regional Strategy for Migration and Health 2016 – 2018*** was validated by the Indian Ocean Commission and its Member States on 27 February 2015 during a regional workshop held in Antananarivo, Madagascar.

I). INTRODUCTION

Migration is a phenomenon that contributes positively to the socio-economic development of both the destination country and the country of origin, although conditions at each stage of migration (pre-departure, in movement, arrival-integration, return) can heighten health vulnerabilities among migrants and their host communities. Some migrants are more vulnerable than others. Poverty and a lack of education, language or professional skills can be a source of greater morbidity. Similarly, children, the elderly, single-parent families and irregular migrants are more likely to develop physical or mental health conditions due to poor living conditions, labour exploitation and/or barriers to accessing health services.[1]

Health systems alone cannot eliminate inequities in health and unequal access to quality care faced by migrants. Social determinants of health affect several sectors (education, employment, housing, social services) and all have an impact on the health of migrants. The right to health is thus tied to the realisation of many other human rights.

Varying levels of economic development among the islands of the sub-region constitute one of the factors influencing migration, often inter-island, for those seeking to improve their living conditions. Furthermore, the emigration of skilled health personnel can affect development and health services in migrants' countries of origin. In effect, the increasing lack of (para)medical staff in higher income countries is increasing the mobility of human resources for health, which affects health care delivery in countries of origin. As such, several migration flows relate to health.

Intensifying global trade has created more migrant workers than ever before. Unemployment and poverty have prompted many workers from developing countries to seek work elsewhere. The migration of populations in the southwestern islands of the Indian Ocean has increased significantly and reflects multiple motivations, including the search for a (better) job and for a change of environment (social or political). Indeed, the region has not avoided the effects of globalisation, which have contributed to increased mobility among the workforce in all sectors of development due to the growing efficiency of transport and communication networks. Other factors favouring labour migration include disparities in pay and working conditions between states with varying income levels.

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1. See IOM, 2013: *Health Promotion Strategy for East and Southern Africa 2012 – 2017*, pp.7-8. Available online: https://southafrica.iom.int/publications/health-promotion-strategy-east-and-southern-africa-2012-%E2%80%93-2017.

A) Migratory Specificities

Until recently, the characteristics of mobility to, from and among the southwestern islands of the Indian Ocean were largely unknown. Understanding the nature and context of migratory flows is essential for policymakers to establish development strategies that enable their states to fully benefit from migration while mitigating against negative consequences. In 2013, IOM led an analysis of the migratory situation in the sub-region to produce national migratory profiles.[2] These have enabled a better understanding of the national and sub-regional migration context.

1. Internal Migration

Statistics on internal migration (rural – rural, or rural - urban) are non-existent and there is a dearth of data on the prevalence, motives and effects of migratory flows. In **Madagascar,** among traditional internal migration flows, one mainly finds seasonal migration related to rice cultivation and zebu herding. Some are compelled to migrate to less populated land, mines, cities or even foreign countries to find employment in a sector other than agriculture. Other reasons forcing people from a region to migrate include natural disasters (floods, droughts and cyclones), insecurity due to zebu thieves, and further include cases where people are dispossessed of their land by investors. Land-use planning policy leads to better-managed migration to arable areas. Young girls and women may also migrate to big cities such as Antananarivo for domestic work. Moreover, mention should be made of internal migration by students to urban centres as well as officials to various regions.[3]

Cities attract rural populations as they provide economic opportunities other than a quasi-exclusive dependency on agriculture in rural areas. Income-generating opportunities, predominantly in the informal sector, are varied: street trading, hospitality services, domestic or casual work, and begging and sex work. For many, crises of poverty are displaced from rural to urban areas.[4] The poverty rate remains high in urban areas where inequalities are glaring and there exists a real risk of

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2. Poulain, M., Herm, A., Mohamed, O.R., 2014: *Profil Migratoire : Union des Comores.* Available online: http://www.inseed.km/index.php/themes/statistiques-demographiques/migration?download=101:document-profil-migratoire-comores;IOM, 2014 : *Migration à Madagascar : Profil National 2013.* Available online: https://publications.iom.int/fr/books/migration-madagascar-profil-national-2013; IOM, 2014: *Migration in Mauritius: A Country Profile 2013*. Available online: https://publications.iom.int/fr/books/migration-mauritius-country-profile-2013; IOM, 2014: *Migration in Seychelles: A Country Profile 2013*. Available online: https://publications.iom.int/books/migration-seychelles-country-profile-2013.

3. Raised during interviews with key informants.

4. ATD Quart Monde, 2012 : « Le Défi urbain à Madagascar » *Dossiers et documents de la revue Quart Monde No.18.* Available online: https://www.atd-quartmonde.fr/produit/le-defi-urbain-a-madagascar/.

destitution.[5] A UN study conducted with households in Tulear in 2010 shows that 87% of households reported having experienced financial difficulties and/or lack of food.[6] The social support network on which households rely in times of difficulty mainly consists of groups of people close-by. Quite often, traditional mechanisms of social solidarity tend to disappear in cities, precipitating marginalisation and exclusion for some.

Migrants who do not have land or a fixed abode settle in city slums and suburbs due to lower rents. "It is very difficult to identify households in extreme poverty to the extent that they are in areas deemed uninhabitable, particularly in shelters that do not resemble housing and where door-to-door censuses must be done even where there are no doors." [7] In addition to precarious housing, they are confronted by a lack of infrastructure, clean water, waste management and transportation.

Migrant workers in the public or private sectors who are temporary migrants (of a few months to a few years) may also face the problems mentioned above. They are swiftly identified by residents and are often unwelcome. They also suffer unfairness in terms of market prices, as well as in most shops and are not always well received when accessing public services. Voluntarily or independently of their will, they are perceived as competitors or rivals in host communities, whereas external migrants are viewed as promoters of development. An unhealthy climate is then created in these areas, with migrants unable to adapt to their host communities and ill-suited public services (including basic health care).

A new migration phenomenon resulting from illegal mining is the growth of "boom towns" around Moramanga, Tamatave, Fort Dauphin and Tulear. This phenomenon is caused by an influx of migrants fleeing poverty in search of better economic opportunities. Ilakaka is cited as a town where the discovery of sapphire deposits has caused a sudden influx of migrants, catching authorities off-guard. These migrants often settle in unplanned housing without a supply of drinking water, waste management, or access to roads and transportation.

Illegal rosewood logging inside the Marojejy and Masoala national parks in the

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5. Republic of Madagascar, National Institute for Statistics, 2005; 2010: Periodical household surveys. Available online: http://www.ilo.org/surveydata/index.php/catalog/1001/study-description (2005); http://catalog.ihsn.org/index.php/catalog/5127/study-description (2010).

6. United Nations System in Madagascar, 2010: *Situation socioéconomique des ménages de la commune urbaine de Toliara et impact de la crise sociopolitique au niveau des ménages en juin 2010, Madagascar*, p.6. United Nations Multi-cluster Rapid Assessment Mechanism (McRAM IV) in Antananarivo, July 2010, 116 pages. Available online: http://reliefweb.int/sites/reliefweb.int/files/resources/1199BF88DBFF2AA0852577B600779209-Rapport_complet.pdf.

7. ATD Quart-Monde, 2012, op. cit.

Sava region has also caused forestry workers to migrate. Intensive logging practices have a negative impact on the lives of migrants and villages.[8] Studies report further population movements to remote areas in forest reserves, in search of arable land.[9]

In **Mauritius,** the movement of people from **the island of Rodrigues** may also be highlighted. A small island of 104 km^2 located 570 km east of Mauritius, Rodrigues is part of the Republic of Mauritius but received autonomous status in 2002. The tenth district of the Republic of Mauritius, Rodrigues' development lags behind Mauritius. Many Rodriguans, mainly youth, migrate to Mauritius in search of better employment opportunities. According to the 2011 Census, 1,116 Rodriguans[10] migrated from Rodrigues to Mauritius between 2006 and 2011, and around 13 700 Rodriguans (6 300 men et 7 400 women) live in Mauritius.[11]

2. Other Forms of Migration

Many migration movements take place within the **Comoros, particularly between Anjouan and Mayotte** by sea on board "kwassas kwassas" (small motorised canoes). Conditions during the crossings are often poor and risks are high, leading to many casualties at sea. Health reasons are the third most cited motivation for **emigration to Mayotte**: "In total, 11% of the migrant population born abroad migrated and/or moved for health reasons and/or to treat a known chronic disease. The majority of the foreign population has migrated for economic (50%) and family reasons (26%)."[12]

Migration in the sub-region is marked by diverse flows which raise significant challenges, including a lack of data on migration, weak management and border controls, lack of harmonized migration management plans, the recurring need for

8. Global Witness and Environmental Investigation Agency, Inc. (Etats-Unis), 2009: *Enquête sur l'exploitation, le transport et l'exportation illicite de bois précieux dans la région Sava Madagascar*. Available online: https://www.globalwitness.org/documents/14427/madag_report_revised_finalfr.pdf See also: https://www.globalwitness.org/en/archive/7669/

9. Rabemananjara, Z. H., 2014: "Migration causing forest degradation in Madagascar: prevention or adaptation to the effects?" *Pinnacle Natural Resources & Conservation,* Vol.1, No.1. Available online: http://pjpub.org/Abstract/abstract_pnrc_130.htm

10. A Rodriguan referring here to someone born in Rodrigues.

11. Statistics Mauritius, 2014: "Analysis Report," *2011 Housing and Population Census*, Vol. IV – Migration, p.3. Available online: http://statsmauritius.govmu.org/English/Documents/census%20report/Migration%20Report2014.pdf; Statistics Mauritius, 2015: "Analysis Report," *2011 Housing and Population Census*, Vol. V – The situation of Rodriguans living in the Island of Mauritius, p.3. Available online: http://statsmauritius.govmu.org/English/Documents/Census%20and%20Population%202011/VolV-RodriguansinMu2011.pdf

12. Florence, S., Lebas, J., Parizot, I., Sissoko, D., Querre, M., Paquet, C., Lesiuer, S., and Chauvin, P., 2010: "Migration, health and access to care in Mayotte Island in 2007: Lessons learned from a representative survey," p.9. *Revue d'épidémiologie et de santé publique,* Vol.58, No.4, pp.237-44. Available online: https://www.researchgate.net/profile/Daouda_Sissoko/publication/45199585_Migration_health_and_access_to_care_in_Mayotte_Island_in_2007_Lessons_learned_from_a_representative_survey/links/09e41507d8e2378559000000/Migration-health-and-access-to-care-in-Mayotte-Island-in-2007-Lessons-learned-from-a-representative-survey.pdf

humanitarian assistance of displaced persons, irregular migration, trafficking in persons and an overall increase in migrants' vulnerability.[13]

3. Migrant categories

The literature used to produce migration profiles[14] and further situation analyses have helped to identify the following categories of migrants among the southwestern islands of the Indian Ocean:

- Migrant workers;
- Internal migrants;
- Students;
- Investors;
- Migrants that are victims of trafficking or exploitation;[15]
- Pensioners choosing to retire in the countries of this sub-region.

The types of migrants listed above reflect the dynamism of migration in this sub-region.

B) Health Situation: Country Contexts

Before situating issues of migration health in a regional context, it is important to first provide an overview of the health situation in each country. Several factors point to the need to mitigate the impact of migration on health in the region, including the levels of inter-island and internal migration, weak health systems and policy frameworks, the relative lack of mechanisms for border cooperation in terms of migration and health, and the lack of data on mobility and health.

1. Union of the Comoros

In the **Comoros**, access to health care remains a real challenge. Factors limiting access to services include the poor quality of road infrastructure, a lack of highly qualified and stable personnel in public health facilities, low staff productivity linked to an uneven organisation of public and private services and distribution of human resources for health, who are concentrated in urban centres.

Information relating to social security for immigrants in the Comoros is non-existent. There is a *Social Insurance Fund* for private sector workers and a *Comoros Pension Fund* for public sector workers. Several health insurance schemes have been

13. Raised during interviews with key informants.
14. See footnote 2.
15. Very specific cases were reported by key informants in Mauritius, Madagascar and the Seychelles.

established since 1999 and a federation of health insurance schemes, FENAMUSAC has also been set up. However, social security coverage for workers in the Comoros is minimal since most Comorians and Malagasy migrants are involved in informal labour sectors. Information on the living and working conditions of Malagasy migrants in the Comoros is also scarce. Some newspaper articles refer to a rural exodus and internal migration flows that contribute to grow shantytowns on the outskirts of Moroni. Within these poorer urban areas, there is a lack of infrastructure for health care, transportation, education and sanitation that puts the health of migrants at risk.[16] However, this situation is not well documented and further information may be obtained from the Comorian authorities.

2. Republic of Madagascar

In **Madagascar**, fewer than 65% of the population live within 5km of a health facility. Poor health service coverage is most acute in rural areas where 35% of the population lives further than 10 km away from a health care centre. Although basic health care is free, uptake remains low, with only 31.2% of the population accessing services.[17] According to the WHO, the public health system faces many challenges: lack of quality health infrastructure, understaffing, unmotivated staff, insufficient materials and equipment, and a lack of essential medicines and supplies. Case management is also an issue due to misdiagnosis and inefficient referral and monitoring systems.[18]

Many local and international NGOs contribute to promoting health and disease prevention in Madagascar, especially in rural areas by, *inter alia*, offering immunisation services, antenatal care, deliveries and family planning. However, there is a lack of synergy between these structures and the public sector that could be improved for more expansive and sustainable health coverage.

During the recent socio-political crisis (2009 - 2013), external funding for health and corresponding programmes were frozen, plunging the country into unprecedented economic and social stagnation. The volume of official development assistance declined significantly between 2008 and 2013, from USD 700 million to USD 478.3 million in 2013. In these circumstances, the prospects for effectively addressing the social determinants of health were very limited.

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16. http://www.casm.fr/pour-ladoption-du-statut-particulier-de-moroni/
17. WHO Regional Office for Africa, 2009: Stratégie de coopération de l'OMS avec les pays, 2008-2013 Madagascar. Available online: http://apps.who.int/iris/bitstream/10665/137178/1/ccs_mdg.pdf. See also Barmania, S., 2015 : « Madagascar's health challenges », *The Lancet,* Vol. 386, No. 9995, pp.729-730. Available online: http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)61526-4/fulltext?rss%3Dyes.
18. Sharpe, M. and Kruse, I., 2011 : « Health, Nutrition and Population in Madagascar 2000-2009 » *World Bank Working Paper* No. 216, pp.Xix, 73-74. Available online: http://documents.worldbank.org/curated/en/684481468271245643/Health-nutrition-and-population-in-Madagascar-2000-09 .

Internal migration in **Madagascar** has generated poorly managed urban growth and a concentration of acute poverty, together with high unemployment rates. These have resulted in insecurity, precarious housing, and limited access to water, sanitation and hygiene in poorer urban areas.

3. Republic of Mauritius

In **Mauritius,** health care goods and services are free in the public sector, including for tertiary care such as open-heart surgery.

The risk of introducing communicable diseases to Mauritius is a major public health concern. Cross-border health checks are carried out through a form to be completed by all passengers arriving in Mauritius. Health inspectors undertake follow up checks with travellers from countries where transmissible diseases are endemic at their place of stay.

On the other hand, no specific health services are provided for Mauritians preparing to emigrate. However, those wishing to emigrate and having met all administrative requirements may access health services to receive medical consultations and tests required by destination countries. To this end, a vaccination centre with doctors and other paramedical staff is open to people who aim to travel abroad.

In 2012, the IOM commissioned an assessment of socio-economic vulnerabilities, including those relating to health among Rodriguans living in Mauritius. The study targeted low-income and middle-income Rodriguans. Several of the study's findings highlight the vulnerabilities mentioned above. Firstly, findings show that the location where Rodriguan migrants settle affects their integration into the host community. Those who settle in poorer areas where alcohol, drug use and sex work are prevalent face higher risks. Where they do find work, it is precarious and fails to offer job security. Nearly half of the men of the lower-income group disclosed their use of intravenous drugs. Although they access and take up reproductive, maternal, neonatal and child health care services, 21% of women in this group reported the death of an infant, while 23% of the same group experienced a miscarriage/abortion/stillbirth within 3 months of pregnancy, on average.[19]

A ministerial committee chaired by the Deputy Prime Minister, Minister of Tourism and External Communications was set up to examine how Rodriguans' living

19. IOM, 2012: *L'évaluation des vulnérabilités socio-économiques en matière de santé des Rodriguais résidant à Maurice*, p.11. Available online: https://www.iom.int/sites/default/files/country/docs/mauritius/Mauritius_Report_v5.pdf.

conditions in Mauritius could be improved. During its first meeting, the committee requested support from *Caritas Île Maurice* and *Solidarité Rodrigues* to establish the profiles of Rodriguan families listed on Mauritius' social register.[20]

4. Réunion (France)

In **Réunion,** the strength of health systems means the island has supported others within the sub-region to tackle health issues and to meet the Millennium Development Goals (MDGs). Among the priorities of Réunion's *Regional Cooperation Programme on Health in the Southwestern Zone of the Indian Ocean for 2012-16*[21] are MDGs that relate to maternal and child health, and ensuring that qualified and motivated staff are available in sufficient numbers to ensure efficient and sustainable health systems, to deliver quality care, and to manage the health impacts of demographic change and migration.

5. Republic of Seychelles

In **Seychelles** as in other countries, migrants have sometimes been associated with unhealthy lifestyles, drug use, sex work, violence and the risk of contracting disease. Overall, the management of migration is crucial to Seychellois society's sustained development and well-being.

The risk of introducing communicable diseases to Seychelles is a major public health concern. Cross-border health checks are carried out through a form to be completed by all passengers arriving in Seychelles.

On the other hand, no specific health services are provided for Seychellois preparing to emigrate. However, those wishing to emigrate and having met all administrative requirements may access health services to receive medical consultations and tests required by destination countries.

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20. The UN and the Global Innovation Exchange, 2017: "The Social Register of Mauritius is a computer-based application to register and identify the poor and their socio-economic profile so as to inform policy-makers on the effective demand for pro-poor policies. It uses a Proxy Means Test (PMT) to determine eligibility below a given threshold. Its main aim is to improve the targeting efficiency of social programs so that limited program resources primarily reach those who deserve them most." See: http://stisolutions4sdgs.globalinnovationexchange.org/innovations/social-register-mauritius.

21. Agence de Santé Océan Indien (ARS), 2011 : *Programme de coopération régionale en santé dans la zone sud-ouest de l'Océan Indien 2012-2016, Document d'orientation stratégique*. Available online: https://www.ocean-indien.ars.sante.fr/sites/default/files/2016-12/PRS_pro_coop_24_07.pdf

C) HIV in the Indian Ocean

All countries and territories of the southwestern Indian Ocean are affected by HIV, where one of the most common modes of transmission is drug use with non-sterile injecting equipment.

Table 1: HIV Prevalence and PLHIV size estimates among IOC member states and territories[1]

	Madagascar 2016	Comoros 2016	Seychelles 2016	Mauritius 2015	Réunion 2015
HIV Prevalence among adults 15-49	0.4%	0.025%	0.87%	0.92%	0.2%
PLHIV size estimates	48,000	304	823	8,251	927

In the **Comoros**, the HIV/AIDS epidemic is not well-documented and likely underestimated as key populations such as sex workers and men who have sex with men are left out of statistics. Nevertheless, the epidemic is marked by infection at a younger age among adolescent girls and young women, a high frequency of multiple concurrent sexual partners, and low condom use.[22]

In **Madagascar**, the HIV/AIDS epidemic mainly affects people who use drugs, men who have sex with men and sex workers.[23] In 2006, Madagascar enacted a law organising the fight against HIV/AIDS that includes provisions to protect the rights of PLHIV,[24] including protecting PLHIV from all forms of stigma and discrimination. On the other hand, this law also criminalises HIV transmission through clumsiness, imprudence,

22. Union of the Comoros, 2010 : *Plan Stratégique National de Lutte contre le VIH/SIDA 2010-2015*, p.10. Available online : http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_233010.pdf

23. République de Madagascar, 2015: *Rapport sur la réponse face au VIH et au SIDA à Madagascar en 2014,* p.6. available online: http://www.unaids.org/sites/default/files/country/documents/MDG_narrative_report_2015.pdf

24. Republic of Madagascar : *Loi N°2005-040 du 20 Février 2006 sur la lutte contre le VIH/SIDA et la protection des droits des personnes vivant avec le VIH/SIDA* et *décret d'application N°2006-902 du 19 Décembre 2006*. Both available online: http://hivhealthclearinghouse.unesco.org/library/documents/loi-ndeg2005-040-du-20-fevrier-2006-sur-la-lutte-contre-le-vihsida-et-la

inattention, or neglect.[25] The NACC fears this might discourage voluntary testing.[26]

In **Mauritius,** the HIV/AIDS epidemic primarily affects people who use drugs, men who have sex with men, sex workers, transgender people, youth and prisoners.[27] In 2014, with funding from the Global Fund against HIV/AIDS, TB and malaria, the NGO *Prévention, Intervention, Lutte contre le SIDA* (PILS) trained 5 Rodriguans living in Mauritius to become peer educators for HIV prevention activities. 3 of these were active and helped the organisation reach 2,107 Rodriguans. Several sessions about HIV prevention were carried out among migrant workers in their workplace, namely at *Princess Tuna, Ferney Spinning Mill* and *Floréal Knitwear.* Migrant workers came from Bangladesh, India and Madagascar. 1,328 people were reached this way.[28]

In **Réunion**, as at 1st January 2015, the active patient list had 902 patients of which approximately 30% were women and 70% men. The number of new infections peaked in 1993 has been stable since the 2000s, with between 23 and 45 new cases each year. Whereas 55% of the active list consists of heterosexuals, with just over 35% men who have sex with men, the majority of newly diagnosed PLHIV are mainly, half heterosexual foreigners or people infected abroad and half French men who have sex with men. Prognosis has been revolutionized by the introduction of combination highly active anti-retroviral therapies and the number of deaths is constantly decreasing: 97% of patients receive treatment, 94% have an undetectable viral load and 72% have a CD4> 500.[29]

In **Seychelles,** the *National Strategic Framework 2012 – 2016 for HIV and AIDS and STIs* prioritises key and vulnerable populations, including migrants. A survey among migrants has been proposed to better understand their needs. The framework also recommends peer-to-peer education programmes for each specific target group, outreach programmes, targeted communication and harm reduction measures.[30]

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25. Ibid, Article 67. Available online: http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/iiep_madagascar_loi_lutte_contre_sida_2006_eng.pdf
26. Republic of Madagascar, 2012 : *Plan stratégique national de réponse aux infections sexuellement transmissibles et au SIDA à Madagascar 2013-2017*, p.39. Available online: http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_334929.pdf
27. Republic of Mauritius, 2015: *UNGASS Country Progress Report 2015*, pp. 30-33. Available online: http://www.unaids.org/sites/default/files/country/documents/MUS_narrative_report_2015.pdf
28. Prévention, Intervention, Lutte contre le SIDA (PILS), 2015 : *Rapport d'activités 2014*, pp.12, 37. Available online: https://plateforme-elsa.org/wp-content/uploads/2015/09/rapport-dactivits-2014-pils.pdf
29. ARS Océan Indien - Cire Océan Indien, 2014 : « Situation du VIH, Sida et des IST, à la Réunion et à Mayotte, données actualisées au 31/12/2014 », *Bulletin de veille sanitaire océan Indien*, No.29, p.8. Available online: http://invs.santepubliquefrance.fr//Publications-et-outils/Bulletin-de-veille-sanitaire/Tous-les-numeros/Ocean-indien-Reunion-Mayotte/Bulletin-de-veille-sanitaire-ocean-Indien.-N-29-Decembre-2015
30. Republic of Seychelles, 2011: *National Strategic Framework 2012 – 2016 for HIV and AIDS and STIs*, pp.17-18. Available online: http://www.ilo.org/wcmsp5/groups/public/---ed_protect/---protrav/---ilo_aids/documents/legaldocument/wcms_222619.pdf

II). KEY FINDINGS AND CHALLENGES

The key findings and challenges are based on country-level situation analyses conducted to develop this strategy. These analyses covered four countries: The Union of the Comoros, the Republic of Madagascar, the Republic of Mauritius and the Republic of Seychelles.

A) Migration and Health Data

The four countries are faced with a lack of reliable and comparable health data concerning migrants and migration-affected communities.

In **Mauritius,** data is scarce and aggregated. For instance, information on foreign women accessing family planning does not specify their immigration status, and they may be foreign workers or permanent residents and/or women married to Mauritians. In **Seychelles,** migrant workers consult private clinics or medical services provided by their employers. Thus, access to medical records can be difficult. However, in Mauritius and Seychelles, there is statistical data on HIV and TB testing among migrants.

In **Madagascar,** public health databases do not disaggregate migrants from locals. However, companies and private clinics are required by law to publish annual reports that must include information on, *inter alia*, countries of origin of migrants receiving treatment, the epidemiological profile of their countries of origin, and their job positions. As such, data concerning legal migrant workers are available and INSTAT has begun collecting and inputting these into their statistical databases. Yet INSTAT has expressed that regulation providing for this disclosure of data must be better enforced to achieve more coherent databases. Collecting data on the health of internal and irregular migrants is a pressing challenge.

Data on the health of migrants and migration-affected communities in the **Comoros** are unavailable. However, two statistical structures - SIS, which performs monitoring and evaluation of the objectives of the national health strategy and the National Directorate of Statistics - could collect migration health data.

B) National Migration Policies and International Health Commitments

Although they may not have a national policy on migration per se, the four states have laws that control the entry of foreigners, define the categorisation of immigrants and regulate the duration of their stay, and these are well enforced. Each country's labour laws are also applicable to migrant workers. These regulate the safety, health

and well-being of employees in the workplace. They also provide for a healthy and hygienic work environment and occupational health services.

In **Mauritius** and **Seychelles,** occupational health and safety regulations apply equally to migrants and citizens.[31] These strengthen and extend the scope of legislation on safety, health and well-being of employees at work. They also make it possible to oversee employees' living conditions and to regularly check that accommodation provided by employers complies with set standards.

In the **Comoros**, a law which came into force in June 2014, explicitly protects the free movement of people living with HIV and prohibits any restriction on entry, stay or residence based on HIV status. Among other provisions, the law guarantees that HIV treatment is available to nationals and non-nationals living with HIV. It also ensures that people in prisons and other closed settings have access to HIV prevention and treatment services. Mandatory HIV testing as a condition of employment and termination of employment because of a person's HIV status are prohibited.[32]

In **Mauritius,** the Immigration Act provides for measures that prevent foreign PLHIV from living or working in the country and a health assessment including results from a HIV test is required to receive work and residence permits.[33]

In **Madagascar,** the Labour Code, adopted in 2004, applies to migrant workers as well as citizens.[34] The Labour Code regulates the safety, health and well-being of employees at work ensuring that their working environment is safe and hygienic. It contains regulations concerning occupational health services whose mission it is to prevent any deterioration in workers' health due to their work, and to monitor health and safety within the workplace. The law also guarantees that workers access clean water and nutritional food in canteens and adequate equipment to protect themselves individually and collectively against all risks in the workplace, particularly against HIV/AIDS. The Labour Code also tasks labour inspectors with enforcing these laws and regulations.

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31. See Ministry of Labour, Industrial Relations, Employment and Training (Mauritius), n.d.: "OSHA 2005 and Regulations," *Legislations.* Available online: http://labour.govmu.org/English/Legislations/Pages/OSHA-2005-and-Regulations.aspx ; See also NATLEX, n.d.: "Occupational safety and health," *Seychelles*. Available online: http://www.ilo.org/dyn/natlex/natlex4.listResults?p_lang=en&p_country=SYC&p_classification=14

32. UNAIDS, 2014: "New law in the Comoros strengthens protection for people living with HIV." Available online: http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2014/july/20140724prcomoros

33. Republic of Mauritius, 1973: *Immigration Act,* Article 8. Disponible en-ligne : http://www.ilo.org/dyn/natlex/docs/ELECTRONIC/68664/110139/F943544104/MUS68664.pdf. Voir aussi, République de Maurice, 2007 : *HIV and AIDS Act.* Disponible en-ligne : https://www.hsph.harvard.edu/population/aids/mauritius.aids.07.htm.

34. Republic of Madagacar, 2003: *Loi N°2003-044 Portant Code du Travail [sic].* Available online: http://www.droit-afrique.com/upload/doc/madagascar/Madagascar-Code-2003-du-travail.pdf

There is no law in Madagascar specific to migration and health. Yet, according to information gathered from the Ministry of Interior, and following a recommendation made in IOM's Migration Profile for Madagascar, a migration policy is currently being developed. A multi-ministerial consultation is expected to finalise the policy, which will include 11 sections relating to health, the environment and the economy. A new law against trafficking and exploitation is also being drafted, that will in turn serve to regularise migration.

The four states have laws to protect migrant workers against discrimination and HIV-related stigma in the workplace. The four countries have ratified international conventions on the wellbeing of migrants, such as ILO's *Migration for Employment Convention*[35] and/or the *International Convention for the Protection of All Migrant Workers Rights and Members of their Families*.[36] All have adopted the World Health Assembly's (WHA) Resolution 61.17.[37] Following the recommendations made in respective Migration Profiles, Mauritius is currently developing a migration policy that will also consider migrants' health. However, laws focusing on migration and health or the health of migrants have not been enacted in any of these countries.

C) Access to Health Services

The degree to which migrants can access health services varies across each country of the sub-region.

In **Seychelles,** employers are responsible for providing foreign workers with personal health insurance under their employment contracts. Companies employing a large number of foreign staff often have their own clinics that provide primary healthcare services. Foreign workers in the Seychelles also benefit from unlimited access to public health care. They must carry their identity card certifying their legal migrant status and any costs incurred are charged to their employer.

According to employment contracts in **Mauritius,** employers are responsible for transferring foreign employees who are ill or injured from their workplace to a health centre. However, the lines are blurred concerning who is responsible for healthcare costs. There is no policy regarding free public health services for foreigners. However,

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35. ILO, 1949: *C097 - Migration for Employment Convention (Revised), 1949 (No. 97).* Available online: http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:12100:0::NO::P12100_INSTRUMENT_ID:312242
36. UNGA, 1990: *International Convention for the Protection of All Migrant Workers Rights and Members of their Families.* Available online: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CMW.aspx ; or: https://treaties.un.org/Pages/ViewDetails.aspx?src=IND&mtdsg_no=IV-13&chapter=4&lang=en .
37. World Health Assembly (WHA), 2008: *WHA 61.17: Health of migrants*. Available online: http://apps.who.int/iris/bitstream/10665/23533/1/A61_R17-en.pdf . See also WHA, 2016: *Promoting the health of migrants, Report by the Secretariat.* Available online: http://apps.who.int/gb/ebwha/pdf_files/WHA69/A69_27-en.pdf

health care providers and migrant workers have confirmed that they may receive primary healthcare services free of charge. It is unclear whether all healthcare is free for migrants, and which measures are taken to overcome language barriers for some.

Regarding sexual and reproductive health, migrants in Seychelles and Mauritius participate in STI and HIV prevention sessions led by staff from the Ministry of Health and NGOs. They also have access to free condoms. Concerning reproductive health, companies provide single accommodation only and foreign workers are at risk of repatriation if pregnant. In Seychelles, foreign workers must take a 'sabbatical' leave from the fourth month of pregnancy to return to their country of origin to give birth.

Access to health services for migrants in **Madagascar** and the **Comoros** is more complex as the access and uptake of public health services is generally low. The two countries face a shortage of qualified personnel. Moreover, social security and health insurance coverage is minimal for locals and migrants. Since the majority of migrants work in the informal sector, they are often excluded from insurance schemes and must pay out of pocket for health services, despite their precarious financial situation.

In Madagascar, the vulnerabilities of internal and foreign migrants who are in an irregular situation remain a major challenge. The movement of Malagasy to urban areas places great pressure on housing, sanitation, waste management and the labour market, which are all social determinants of health. There is also direct pressure on public health services. In addition, internal migrants who settle in the slums of Antananarivo find themselves far removed from health services.

Furthermore, health conditions among illegal mining and rosewood logging sites in Madagascar are worrying. New informal settlements that develop spontaneously lack adequate facilities, including road access and health services, and are at risk of shortages of drinking water and food. Moreover, such migrants are exposed to difficult working conditions, harmful waste, and long working hours.

D) Partnerships and Cooperation on Migration

Since 2007, IOM's country office in Mauritius has developed positive working relationships with various regional partners. It forms part of the United Nations' country teams for the Union of the Comoros, Madagascar, Mauritius and Seychelles.

It is important to strengthen and sustain the National Technical Working Groups (NTWGs) established in the IOC member States that have been the technical, consultative and deliberative support body for the development of national Migration Profiles, the bases for future projects concerning migration. Adequate migration

management is a priority as it enables countries to take advantage of migration flows and to improve their populations' social, environmental and economic conditions. It also helps to reaffirm bilateral and multilateral bonds at regional and international levels and to promote cooperation in all its forms.

Building on the Cooperation Agreement signed between the IOM and the IOC in November 2013 to strengthen migration management capacities in IOC countries and territories and to continue expanding and consolidating this cooperation, it is important that a Regional Working Group on Migration (RWGM) be definitively established for consultation and dialogue on migration and to oversee regional initiatives relating to migration and development.

In Madagascar, as elsewhere, partnerships with NGOs will be key, and their work on to the socioeconomic, cultural and environmental conditions of internal migrants should be commended.[38]

The annual HIV/Indian Ocean Regional Symposium enables the exchange of medical, social and epidemiological information, updates on the knowledge base covering medical and social care for PLHIV and people living with hepatitis, as well as the implementation of workshops and further exchanges. Regional cooperation in this field is essential to reduce the burden of disease and address gaps in health care coverage, including by promoting inter-island care and solidarity vis-à-vis sharing essential medicines and services and structuring patient associations within a regional network.

The concept of migration and health is innovative in the sub-region. It is necessary to strengthen cooperation at a regional level to reduce migration-related health vulnerabilities.

38. Among others, the Malagasy Red Cross: http://www.croixrougemalagasy.org/en/ and ENDA Madagascar Océan Indien : http://www.enda-madagascar.org/

E) The Island of Réunion's Health Cooperation Priorities

As for **Réunion,** it has set up a regional cooperation programme for health which aims to promote healthcare service delivery for patients in the region, with support and technical advice from French healthcare providers such as the University Hospital Centre (CHU) of Réunion or the Hospital Centre of Mayotte, especially as it concerns health personnel training. This programme was developed to run for five years, from 2012 to 2016 with the following priorities: [2]

Health Priority 1: Manage health risks shared by countries in the region;

Health Priority 2: Confront the threat of non-communicable diseases (cardiovascular diseases, cancers, diabetes, mental health and addictions, respiratory diseases);

Health Priority 3: Achieve the MDGs relative to maternal and child health;

Health Priority 4: Fight against infections associated with poor health care and improve the safety of health care delivery for patients.

III). FOUR AREAS OF INTERVENTION

A) Objectives, Activities and Expected Outcomes

Building on progress achieved and overcoming the challenges cited above requires a strategy that benefits from a broad political consensus. A holistic view of the strategy is also necessary, considering forward-looking objectives and measures that enable us to reach these objectives.

Migrant populations and their well-being lay at the heart of this strategy. Health systems should be strengthened around migrants and their needs.

The Strategy's goal is to: Improve health management for migrants and their host communities in the southwestern islands of the Indian Ocean and reduce migration-related health vulnerabilities.

The Strategy's objectives are to:

1. Strengthen the capacity of Member States to collect reliable and comparable data on issues related to migration and health to develop activities based on this evidence;
2. Promote and make accessible health services that are responsive to migrants'

needs and tailored to their cultural sensitivities;
3. Facilitate and enhance multisector coordination and partnerships on migration and health;
4. Advocate for appropriate national and regional policies and programmes on migration and health.

Expected outcomes were raised during a regional IOC-IOM workshop held in February 2015 in Antananarivo, Madagascar. The findings and recommendations were validated by representatives of IOC Member States after two and a half days of work.

Outcome 1.	**Data quality and knowledge relative to health monitoring among migrants and their host communities are improved to help policymakers develop appropriate responses.**
Activity. 1.1 Incorporate indicators on migration in National Statistical Information Systems (SNIS). ***Activity 1.2.*** Train staff in charge of collecting and analysing data on these indicators. ***Activity 1.3.*** Share collected data and reports available from each country at the regional level to assist with policy formulation and programme development. ***Activity 1.4.*** Develop an integrated regional health monitoring system, which will be charged with collecting, analysing and sharing comparable and reliable data.	

A key objective of IOM's activities in the field of migration data is to build the capacity of governments to collect reliable and comprehensive data and statistics on migration, and to promote understanding of migration issues more broadly.

Migration statistics concerning the sub-region are scarce and issues of comparability are likely. The dearth of existing data, including administrative data, increases the potential for surveys to fill these gaps. Given the need to improve the quality of data on migration in the region, household surveys have great potential for collecting accurate and timely data. The inclusion of questions on migration in multipurpose household surveys, the primary objective of which is to gather other information, for instance, on health or labour, should be encouraged. Questions can be added individually or as part of a separate module on migration.

At a national level, different institutions collect a variety of data on aspects such as seeking advice on sexual and reproductive health and prenatal check-ups. It would be important to use this data to monitor the reproductive health of migrants and

their host communities. For this, coordination efforts are needed to harmonise concepts, develop quality control tools of administrative data and, eventually, to collect additional information relating to migratory routes. Secondary analyses of existing data may also provide important information about the health of migrants and mobile persons in this region.

Effective data sharing is often as important as data collection itself. However, one of the fundamental challenges in sharing and managing migration data is that, where available, statistics are either held by various institutions within the country or are not comparable with the statistics of other countries. This is mainly explained by the fact that governments often do not have the resources and trained personnel required to establish an effective data management system. IOM will work closely with the governments of IOC Member States on strengthening their capacities to address this situation at various levels

Outcome 2.	**Policies and laws based on international, regional and national commitments and considering the health needs and rights of migrants and migration-affected communities are adopted/ amended and implemented.**
Activity 2.1. Promote regional dialogue on developing policies aimed at reducing migration-related health vulnerabilities. ***Activity 2.2.*** Strengthen government-level advocacy efforts for migrants' rights to health with local and national decision makers. ***Activity 2.3.*** Develop, enact and implement national laws and policies on migration that include health considerations.	

Health is a human right and the right to health is essential to realise other human rights, as it is closely linked and subject to guaranteeing, among others, the right to housing, food, social security, work and family life. The right to health is also indivisible from the fundamental principle of non-discrimination.

As a result, states are duty-bound to protect and promote the rights of migrants without discrimination. They are also responsible for eliminating all forms of discrimination in their country. The principles of non-discrimination and equal treatment for all, including migrants, apply to various components of the right to health. Thus, countries must ensure the availability, accessibility, acceptability and quality of health goods and services. These obligations are incumbent on all countries.

Migrants bring major social and economic contributions to their countries of origin and destination. Nevertheless, many of them, especially irregular migrants, have little

or no access to health and social services although they are vulnerable to specific risks related to exploitation, hazardous work or poor living conditions.

Denying migrants their right to health leads to their marginalisation, increases morbidity and exacerbates inequities faced by migrants and their host communities. In the absence of legal or financial guarantees should they access health services, migrants tend not to consult a physician until they are seriously ill, which may require costly life-saving treatment.

It is important that countries include health needs and migration-related health vulnerabilities in their policies and strategic plans. It is also important that they address health inequities, barriers to accessing health services, and target further factors that affect health among migrants and their host communities. A good practice is to make primary health care the main point of access for most health services for migrants and their host communities.

Outcome 3.	**Migrants and migration-affected communities have access to sexual and reproductive health services that are affordable and responsive to their needs.**
Activity 3.1. Develop and apply communication/outreach tools to raise awareness among migrants concerning available health services.	
Activity 3.2. Strengthen capacities and awareness among health care providers concerning migration-related health vulnerabilities.	
Activity 3.3. Adapt health care service delivery to migrants' needs.	
Activity 3.4. Establish an equity fund through insurance recovery.	
Activity 3.5. Mobilise financial resources for vulnerable persons.	

It is important to respond proactively to the vulnerabilities and health issues that specifically or disproportionately affect migrants. This means that appropriate interventions be implemented to reduce health risks for migrants and that programmes and services be responsive to their needs, considering migrants' cultural, religious, linguistic and social backgrounds and providing tailored advice on how to navigate systems for health in their new country. This could include training health care providers, health policymakers, public health managers and health educators on how to address mobile populations' health-related vulnerabilities and sub-regional disparities in health service coverage and access.

The aim is to promote social and financial protection mechanisms to prevent excessive health costs among populations that are already economically vulnerable. The establishment of viable health insurance schemes between countries of origin or return, transit or destination should be considered. Companies employing migrants rarely offer occupational health services and few migrants receive compensation or access physical re-education programmes under national social security systems in case of workplace injuries. To prevent workplace injuries or illness, it may be necessary to completely reorganise working conditions in high-risk areas and to introduce training in occupational health and safety that consider various cultural sensitivities. The workplace could also serve as a point of access to health services and targeted health communication for migrant workers and their families.

Outcome 4.	**Strengthened partnerships, multi-country and multi-sector networks and frameworks maintain sustained responses to migration and health**
Activity 4.1. Strengthen cooperation between partners and civil society operating at national and regional levels. ***Activity 4.2.*** Strengthen capacities within countries and civil society through training and technical support. ***Activity 4.3.*** Develop regional projects that can be proposed to donors and implemented. ***Activity 4.4.*** Raise awareness for the importance of migrants' health among policymakers at all levels (community, national, regional). ***Activity 4.5.*** Strengthen networking and collaboration among member states, civil society organisations, and development agencies on the topic of migration health. ***Activity 4.6.*** Develop a resource mobilisation strategy to promote migrants' health.	

Governments, international organisations, the private sector, civil society organisations and migrant associations can all make a sizable and complementary contribution to migrants' integration. Partnerships are essential to address the complex aspects of migrants' integration holistically, which not only requires meaningful engagement by policymakers within a whole-of-government approach, but also the involvement of entire societies.

Effective coordination and cooperation among governments can help to guarantee that policy decisions on integration take due account of all aspects of integration. They can enhance cooperation, coordination and technical harmonisation to prevent duplication and enable more efficient use of resources, especially in decentralised systems. Moreover, migrants' access to health and social services can be facilitated if these various services are well coordinated. Effective partnerships are therefore beneficial for governments and migrants alike, and strengthen a country's overall capacity to integrate migrants.

Similarly, intergovernmental partnerships are crucial to ensure policy coherence within the sub-region. Intergovernmental partnerships often take the form of bilateral agreements between countries of origin and destination to manage regular and orderly migration and to facilitate migrants' integration.

Inter- or multi-sector partnerships can yield positive results relative to integration and are particularly important for migrants' economic integration. The private sector is an ideal partner for governments, in that it is well-positioned to assess existing skills gaps in national labour markets and to effect recruitment decisions. Substantial incentives exist for the private sector, insofar as companies have everything to gain from well-organized migration and well-integrated migrants.

IOM's country office in Mauritius can draw on its experience of collaboration and coordination with the United Nations country teams of the Union of Comoros, Madagascar, Mauritius and Seychelles to best participate in the formulation and development of strategies and programmes to reduce the health vulnerabilities of migrants and their host communities.

It is essential to strengthen regional cooperation for health to pool human and material resources, exchange information, expertise and best practices and thus significantly reduce the health risks to which residents of countries in this sub-region are exposed.

Partnerships with civil society on integration issues can be extremely effective at local, national and international levels. NGOs can be important mediators between migrants and society, and between migrants and policy makers.

B) Risks to Operationalising the Strategy

The absence of national policies on migration and/or migration and health may hinder the operationalisation of this sub-regional strategy. The theme of migration and health is not very well anchored into national development programmes among

countries in the sub-region. Therefore, existing literature for the sub-region on the topic, and information that may be provided through partner interviews are likely to be limited. The IOM's advocacy efforts must be strengthened by first raising awareness among the countries and territories of the sub-region for IOM's *Health Promotion Strategy for East and Southern Africa 2012 – 2017.*[39] Moreover, turning this strategy into a success will require the active participation of bilateral and multilateral partners (donors) in support of priority activities in each IOC member state.

39. IOM, 2013: *Health Promotion Strategy for East and Southern Africa 2012 – 2017.* Available online: https://southafrica.iom.int/publications/health-promotion-strategy-east-and-southern-africa-2012-%E2%80%93-2017.

International Organization for Migration (IOM)

The UN Migration Agency