



POLICY BRIEF

Availability, Access and Gaps in Health and HIV and AIDS Services among Key and Vulnerable Populations along East African Community (EAC) Transport Corridors

Even though mobility remains a facet of life and societies in the EAC region are increasingly diverse, public policies remain insufficiently integrated with the health needs of key and vulnerable populations living and working along transport corridors.

Globally, key and vulnerable populations living and working along major transport corridors are exposed to numerous health risks and vulnerabilities, stemming from a complex interaction of factors. Some of the main risk factors identified in current research include risky sexual behaviors, low risk perception, high levels of mobility, the nature and condition of work, repetitive work activities, unsanitary accommodation, separation and isolation and inadequate access to health and social services.ⁱ These factors combine in a complex web of interaction at individual, environmental and structural levels to raise the vulnerability of these populations to emerging and re-emerging infections, making them key link populations for transmission of sexually transmitted infections including HIV. Female sex workers (FSWs) and truck drivers are particularly at risk: FSWs mainly because they engage with diverse and multiple sexual partners,ⁱⁱ and truck drivers mainly because they spend long durations of time away from their families and support structures and often have multiple and concurrent sexual partners.

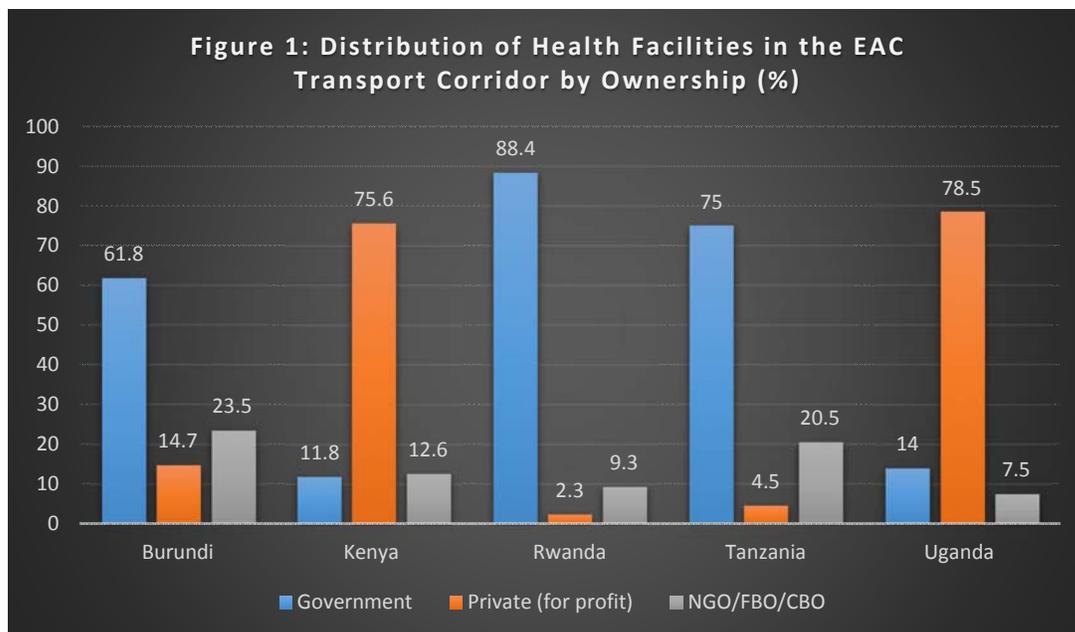
In the EAC region, the challenges facing the populations identified above are further compounded by the limited access to appropriate health care. Like many underserved populations, people living and working along major EAC transport corridors struggle to access health care, are forced to search for new care options, and sometimes completely lack care. These challenges have a number of health-related implications such as poor continuity of care

and lack of adherence, which in turn exposes the general public and more so the key and vulnerable populations to health risks.ⁱⁱⁱ Thus, there is a compelling need for comprehensive health programming targeting key and vulnerable populations/ communities along transport corridors, including migrant populations.

This Policy Brief highlights results of a mapping exercise conducted to gather up-to-date information on available health services along major transport corridors in the EAC and identify gaps. The information is critical for informing effective integrated programming for health and HIV and AIDS along the corridors.^{iv}

1. Most health facilities along EAC transport corridors are privately owned and charge user fees

Regionally, the majority of the 341 facilities surveyed along transport corridors are privately owned, for-profit (51.9%), whereas about a third are government owned (35.2%, n=120). Nongovernmental Organizations (NGOs), Faith-Based Organizations (FBOs) and Community-Based Organizations (CBOs) operated the least number of mapped facilities (12.9%, n=44). Figure 1 disaggregates this data per Partner State and reveals that public ownership is highest in Rwanda (88.4%), followed by Tanzania (75%), then Burundi (61.8%). Private ownership is dominant in Uganda (78.5%) and Kenya (75.6%).

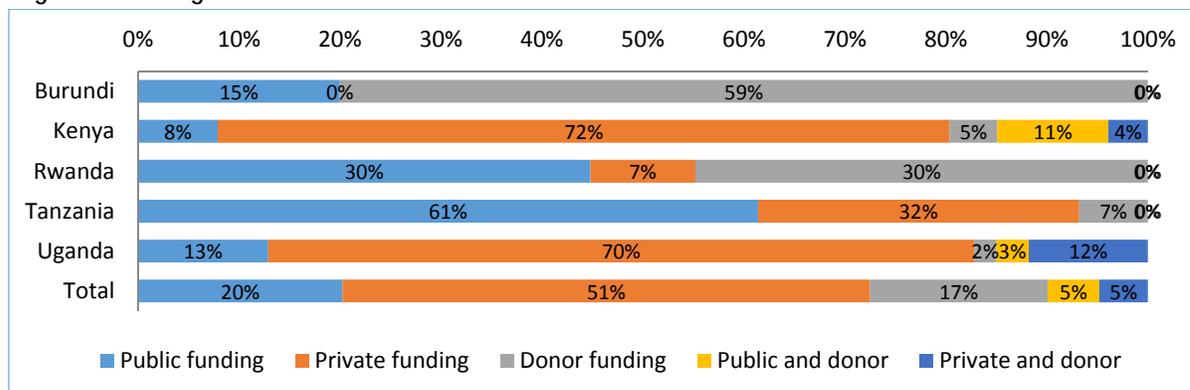


Source: Mapping Survey, 2014

Privately owned facilities are the most common facilities (44.9%, n=153), followed by health centers (26.7%, n=91), with hospitals comprising only 12 percent (n=41). There were marked differences across the countries. For instance, in Uganda, clinics represented the most common type of health facility along the transport corridors (65.6%, n=61), followed by health centers (22.6%, n=21), while in Rwanda,

health centers comprised 74.4 percent of facilities, followed by both hospitals and dispensaries (11.6% each). Private funding reflects ownership, over half of the survey facilities were privately funded and were charging user fees. Kenya, Uganda and Tanzania had the highest proportion of privately funded facilities—at 72.4, 69.9 and 31.8 percent, respectively. Figure 2 summarizes this information.

Figure 2: Funding Sources for Selected Facilities



Source: Mapping Survey, 2014

2. Partnering to deliver health services

Partnership for improved delivery of health services is now a common practice internationally, perhaps due to the realization that clients stand to benefit if key stakeholders providing health services leverage

scarce resources to deliver services. The most common partnership areas for facilities along the EAC transport corridors are in provision of medicines and essential supplies (e.g., laboratory equipment),

delivery of care (e.g., family planning and vaccination), and in administrative costs (e.g., construction of infrastructure). Partnership between facilities was most common in Rwanda and less so in Uganda, with 79.1% and 46.2% of facilities in those countries, respectively, reporting to have been involved in some partnership with NGOs/CBOs/FBOs to provide services. This is an

encouraging trend in collaborative health care delivery including referral, which needs to be harnessed to improve the current state of health care delivery along major transport corridors in the region. Partnership also provides opportunities for addressing the structural drivers of ill-health including vulnerability to HIV infection along the transport corridors and at cross-border points.

3. Distribution of transport corridor clients by gender

Results show that facilities along the transport corridors play an important role in service delivery. The facilities serve a large number of clients per month—a total of 342,843 adults and children, a majority (about 70%) being adults. Results also show that the facilities serve a higher proportion of female

clients for both adults and children. Table 1 below shows that overall, facilities in Tanzania recorded higher proportion of adults (about 78%) compared to the other Partner States, while Burundi recorded the highest caseload among children (about 54%).

Table 1: Monthly Health Facility Caseload by Country

Number of clients per month	Countries					TOTAL
	Burundi	Kenya	Rwanda	Tanzania	Uganda	
Adults						
Female	18,357	33,089	36,968	36,216	16,230	140,860
Male	11,611	20,940	22,775	29,540	12,425	97,291
Overall	29,968	54,029	59,743	65,756	28,655	238,151
Children						
Female	20,213	3,835	13,253	9,546	9,645	56,492
Male	14,566	1,831	10,428	9,083	12,292	48,200
Overall	34,779	5,666	23,681	18,629	21,937	104,692

4. Majority of facilities reported serving mainly truck drivers and FSWs among the key, mobile/migrant and other vulnerable populations

Client needs

Key and vulnerable populations along the EAC transport corridors include FSW, truck drivers and their assistants, trafficked persons, uniformed personnel, lesbian, gay, bisexual, transgender and intersex people (LGBTI), fisher-folk and other at risk groups. Majority of facilities that reported serving key and vulnerable populations reported truck drivers and their assistants, and FSWs as their main clients among these populations. People who inject drugs (PWID) and trafficked persons were the least served key and vulnerable populations. On average, the monthly proportion of clients from key and vulnerable population groups attended to comprised 16% or 38,349 of the total facility caseload.

13.6% of facilities in Tanzania reported to have provided services to LGBTI populations while 9.1% provided services specifically to men who have sex with men (MSM).

There were similarities in patterns of services needed by populations along transport corridors in all the EAC Partner States. Generally, the three main sought facility services were: treatment of common ailments such as malaria and cough; STI screening and testing; and HIV testing and counseling. Other services sought included treatment for accident-related injuries and provision of condoms. The type

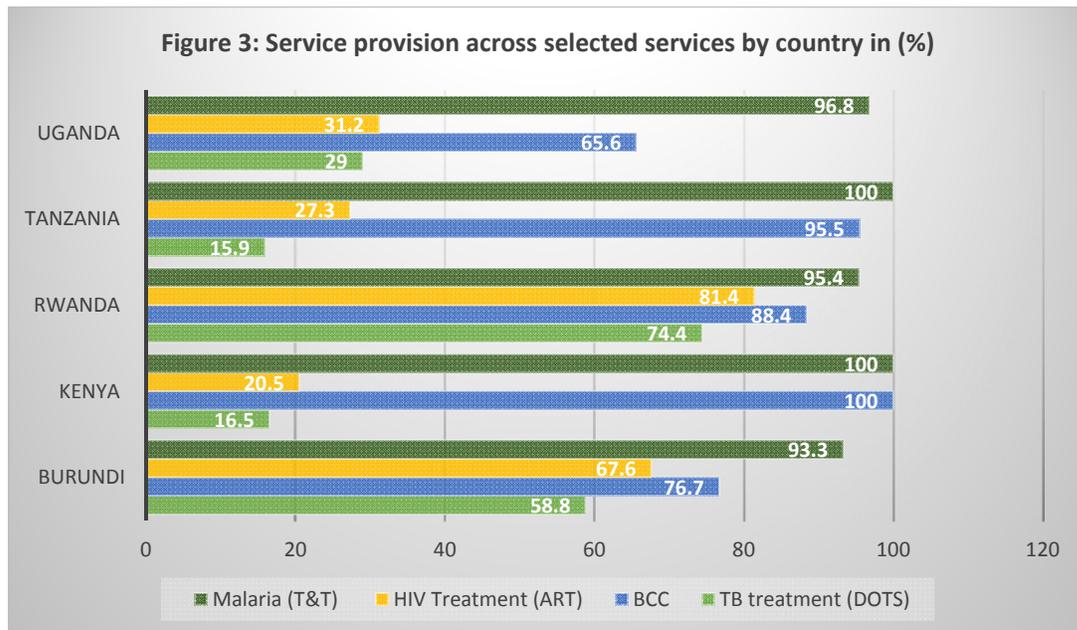
of services sought, however, differed by population group.

The three main sought facility services: treatment of common ailments such as malaria and cough; STI screening and testing; and HTC.

Services offered

Results show that even though most facilities (92.1%) reported providing both HTC services, only over a third (36.7%) offered HIV treatment services. Similarly, while about 89.1 per cent (n=304) of facilities provided TB counseling services, only 31.4 percent (n=107) offered TB treatment. Also less covered were Hepatitis B and C screening and treatment, and cervical cancer screening and treatment (less than 25% of facilities offered these services), highlighting a major gap between

diagnosis and treatment across these critical services. Malaria diagnosis and treatment was the most widely available service, recording close to 100% provision in all facilities followed by behavior change communication (BCC) at over 65% (see Figure 3). This is encouraging given the importance of social and behavior change communication (SBCC) in generating awareness and uptake of health services.



5. Not all facilities disaggregate Health Management Information System (HMIS) data by key populations

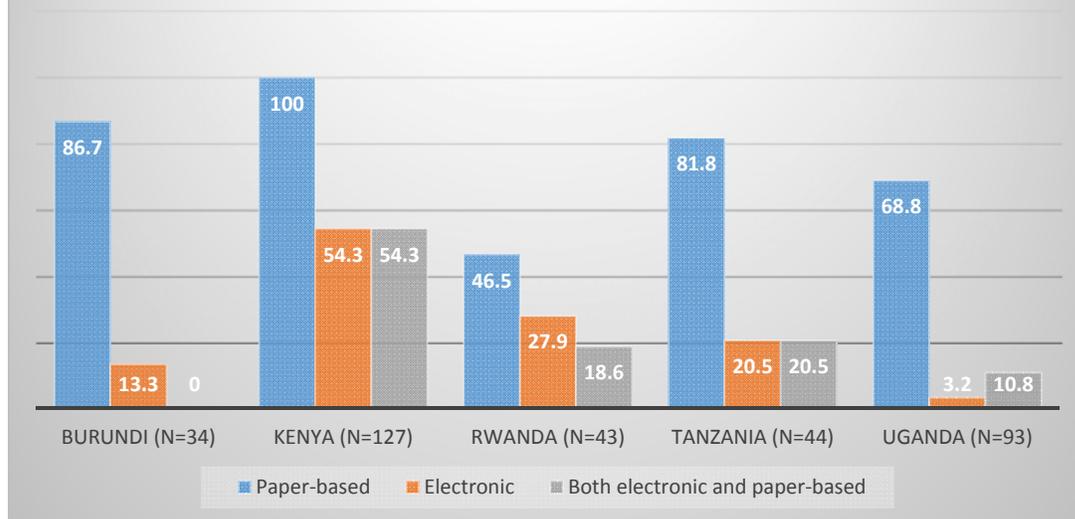
Even though majority of facilities (ranging from 83.9% in Uganda to 100% in Burundi and Kenya) utilize HMIS for data management, only a small proportion (ranging from 30% in Burundi to 78% in

Kenya) collect data on key populations, highlighting a need for these facilities to be supported to disaggregate data for these populations for targeted service delivery.

Most facilities still depend on paper based HMIS

Figure 4 below highlights the fact that most facilities depend on paper-based HMIS for data collection on clients.

Figure 4: Proportion of facilities using a given type of system for collecting data per partner state (%)



Majority of clients seeking health care along transport corridors are not served by doctors

Majority of doctors were found in hospitals, suggesting that the majority of clients seeking health care along transport corridors are not served by physicians.

medical doctors comprising only 6.6% of professional staff. Majority of medical doctors were found in hospitals, suggesting that the majority of transport corridors facilities' clients are not served by physicians.

Results revealed that most facilities are served by nurses and nursing aides (comprising 66.5%), with

Conclusion

The EAC transport corridors, together with the populations associated with these corridors, whether migrant or resident, key or vulnerable, play an important role in the regional integration and development process. Limited access to appropriate health care for these populations, especially the key populations, arising from the inability of current facilities to provide the services, or prohibitive costs in the case of private facilities, have the potential to negatively impact regional public health. It also

potentially infringes on the rights to health of these populations. It is therefore imperative that the health services limitations be addressed for key and vulnerable populations to reach their development potential and to concurrently contribute to sustainable development, while reducing the health costs of mobility for both migrants and communities where they originate and are hosted.

Policy actions to strengthen service delivery for key populations along EAC transport corridors

The EAC transport corridors, together with the populations, whether resident or migrant, key or vulnerable, play an important role in the regional integration

and development process.

1. Strengthen the capacity of health care facilities

- Enhance private facilities' capacity to provide a minimum package of service that addresses basic primary care, STI screening and treatment, malaria prevention and treatment, as well as provision of integrated TB and HIV responses for key and vulnerable populations.
 - Closely monitor and support private health facilities to ensure adherence to national and international guidelines and quality of services provided.
 - Support private providers through measures to ensure they collect and share with the government disaggregated HMIS data on key populations.
2. **Strengthen TB and HIV and AIDS responses along transport corridors**
- Scale up the provision of HIV and TB treatment services, especially by the private health care facilities in the areas where they are most prevalent.
 - Develop referral systems between private and government facilities to ensure that key populations are linked to services. This can be done through:
 - i. Mapping and supporting development of direct referrals between facilities within and between hotspots; and
 - ii. Supporting innovative ways of developing capacity to capture client data in terms of location, for example, by using a health passport or smartcard.
3. **Enhance key population and migrant-friendly health service provision**
- Avail more client-friendly, migrant-sensitive services that will attract key populations by:
 - i. Training health workers to provide client- and migrant-friendly services, addressing both the clinical and social aspects.
 - ii. Developing and disseminating guidelines on providing services to key and vulnerable population including migrant-friendly services to ensure health services at the different hotspots are uniquely suited to address the needs of these populations.
 - iii. Establishing a sustainable, cost effective and cost-friendly financing mechanisms for health services along major border points.
4. **Support the establishment of integrated health clinics or wellness centers in priority sites**
- Provide a minimum service package to key and vulnerable populations including migrants along transport corridors, particularly truckers, cross-border traders and FSWs.
 - Strengthen and expand health facilities to ease the heavy burden on existing services and improve access to quality care for the people who live, work and travel along the EAC transport corridors.

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ⁱ **Morris, C. N. and A.G. Ferguson (2006)** Estimation of the Sexual Transmission of HIV in Kenya and Uganda on the Trans-Africa Highway: The Continuing Role for Prevention in High Risk Groups. *Sexually Transmitted Infections*, 82(5): 368-371; **WHO and IOM (2010) Health of Migrants: The Way Forward.** Report of a WHO-IOM Global Consultation, Madrid, Spain, 3–5 March 2010. WHO, Geneva

ⁱⁱ **IOM and the Uganda AIDS Commission (2008)** HIV Hot-spot Mapping and Situational Analysis

along Kampala-Juba Transport Route. IOM and UAC, Kampala.

ⁱⁱⁱ **IOM (2013) Rapid Assessment of Access to Health Care at Selected One Stop Border Posts (OSBP) in East Africa.** IOM, Nairobi

^{iv} The study was led by the Regional Task Force on Integrated Health and HIV and AIDS Programming along Transport Corridors, established under the coordination of the EAC in 2013