Continuation of Care across Borders: Providing Health Care for People on the Move in East Africa

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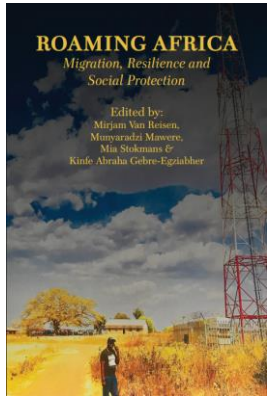

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Chapter 4

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Introduction

African borders are living places in which communities belong to, and often span, the border areas. People move, work and live across borders. However, essential services, such as health care, are nationally organised, which poses challenges in serving mobile communities across borders. Moreover, borders have traditionally been marginalised areas that are not highly prioritised in national policy implementation. This chapter investigates the challenges that emerge in the border areas, particularly when people move across borders, and the difficulties regarding the accessibility of health services. The main question addressed in this chapter is: *What are the challenges involved in providing health services in cross border areas?* The investigation on which this chapter is based was

People on the move may need to access health services in countries other than their own – and it is important that they can, as their mobility can increase the spread of communicable diseases. However, access to health care outside the home country can be complicated: people on the move often do not have time to wait for results and are not available for follow up. This study looks at cross-border communities in five East Africa Community countries to determine the challenges in providing health care to people moving across borders. It finds that health programmes are country specific and nationally administered, giving rise to a need to integrate health services and patient follow up to ensure the continuation of care across the region.

carried out as part of the Cross-Border Health Integrated Partnership Project[1] in East Africa.

Border towns are generally poorly served by national health programmes, in part due to the reluctance of governments on either side of the border to provide services to non-nationals. Although border populations report seeking services across national borders, there is a shortage of data on this transnational access due to a lack of harmonised health services in East African Community partner states. No formal cross-border coordination structures exist, and there is a lack of formal referral and patient monitoring mechanisms across borders. As a result, the health outcomes of cross-border populations are likely to be compromised due to missed appointments, poor treatment adherence, multiple registration in different facilities, and loss-to-follow-up, especially in HIV and tuberculosis (TB) care and treatment.

To investigate these issues further, this study was conducted among vulnerable populations at cross-border sites in five East African Community partner states: Burundi, Kenya, Rwanda, Tanzania and Uganda. The study looked at vulnerable women and girls, female sex workers, men who have sex with men, people who inject drugs, people living with HIV, long distance truck drivers and their assistants, clearing and forwarding agents, and fisherfolk. Health care workers and policymakers in facilities located within a 10 km radius of the cross-border sites were also included in the study.

Marginalised and underserved border areas, with weak health care systems, undermine global health security, because of their capacity to act as incubation sanctuaries for infectious diseases such as HIV and TB. Pockets of high-risk populations in cross-border areas are key bridges for HIV transmission to the general population. It is hoped that this chapter will prompt further research and

[1] The Cross-Border Health Integrated Partnership Project/FHI 360 is funded by United States Agency for International Development (USAID). The authors are engaged in the implementation of the research under the programme.

collaboration so that we can better respond to the challenges involved in providing health services for mobile communities living in cross-border areas in East Africa, as well as more broadly in other parts of Africa.

Health risks among mobile communities in East Africa

The road transport corridors in East Africa are economic lifelines that link Kenya, Uganda, Tanzania, Rwanda, Burundi, and South Sudan, which form the East African Community. However, this extensive road network, which links major cities and business hubs with border areas from one country to another, is also a major transmission route for HIV (East African Community, 2015). Surveys in the region have indicated that, compared to the general population, HIV prevalence is higher for some sub-populations concentrated along these routes, including female sex workers, men who have sex with men, people who inject drugs, long distance truck drivers, fisherfolk, and vulnerable women and girls. In Burundi, for example, data shows a HIV prevalence of 21.3% among female sex workers and 4.8% among men who have sex with men, compared to 1.1% in the general population (15–49 year olds) (UNAIDS, 2017a). In Kenya, HIV prevalence among men who have sex with men was estimated to be 18.2%, among female sex workers 29.3%, and among people who inject drugs 18.7%, compared to 4.9% among the general population (NASCOP, 2014). In Uganda, estimates put the prevalence of HIV among female sex workers at 34.2%, men who have sex with men at 13.2%, and people who inject drugs at 26.7%, compared to only 5.9% in the general population (UNAIDS, 2017b).

Wet border areas such as lake regions also report high levels of HIV and TB. For instance, populations in and around Lake Victoria (estimated at 1.7 million) often live in isolated, difficult to reach areas, which serve as incubation pockets for infectious diseases. These populations have a HIV prevalence 2–4 times national averages (NASCOP, 2014), report high levels of HIV/TB co-infection rates (40–60%), and lower HIV/TB treatment retention (up to 75% are lost to follow-up). A HIV prevalence of 15% and 21% was reported

among young women and girls and female fisherfolk, respectively, in Mbita and Rusinga Island, Kenya, where national prevalence is 4.9% (Measure Evaluation, 2017).

Several factors drive HIV transmission along land and wet border areas, including mobility, economic vulnerabilities pushing women into transactional sex, multiple concurrent sexual partnerships, substance abuse, gender-based violence, and poor access to quality health services including HIV services. For mobile workers, especially transport workers, extended periods away from home and family, delays at border crossings, boredom, and increased opportunities for sex with multiple partners have been found to contribute to an elevated risk of contracting HIV (World Bank, 2009). One study found that long-distance transport workers in East Africa had an annual average of 2.8 sexual partners (Morris & Ferguson, 2007). Contact with local communities and sub-groups such as sex workers also increases vulnerability to HIV for both the mobile transport workers and host communities (Measure Evaluation, 2017).

Health services in cross border areas

Research on cross-border populations in the region shows that the prevalence of HIV is high in cross-border and transport corridor sites. One study, which looked at female sex workers in 'hotspots' in Kenya and on the Kenya-Uganda and Tanzania-Uganda borders found HIV prevalence to be as high as 24% (Measure Evaluation, 2017). Several factors were found to contribute to the increased risk of HIV infection in the cross-border areas, including the phenomenon of 'mobile men with money', socioeconomic disparities and lack of alternative income-earning opportunities for vulnerable women and girls in the host communities, and vibrant entertainment venues, which all encourage risky sexual relationships for both men and women.

Because transport corridors and cross-border towns in East Africa are generally poorly served by national health programmes, some border posts have no health services at all (IOM, 2013). Where they

exist, many health facilities lack enough medicine and other supplies and have limited human resources. In addition, there are no systems to track the services provided to people across borders, increasing the risk of poor treatment adherence, multiple registration, and loss-to-follow-up of patients, especially in HIV and TB care and treatment.

One study found that along the transport corridors in the five East African Community partner states, the vast majority of health facilities reported providing HIV counselling and testing services, but less than half provided HIV treatment services and the majority did not have specific information and education materials for key populations (East African Community, 2015). Furthermore, less than a third of facilities offered TB treatment or rapid TB screening and testing. Also, while the majority of the facilities provided condoms and sexually transmitted infection (STI) screening and treatment, fewer than a quarter conducted screening and treatment for hepatitis B and C and cervical cancer. Another study concluded that, although by 2011 some donor-funded initiatives along the transport corridor targeted key and vulnerable populations, "the collective impact of the effort [was] minimal" (IOM, 2011a) and undermined by its limited geographical scope and focus (IOM, 2011b).

Subsequently, these groups report poor access to health services along the transport corridors. For instance, in Kenya, 70% of sex workers and truck drivers at five truck stops had never received information on HIV (IOM, 2011a). Some population groups also have better access to health services than others; for example, truck drivers and their assistants and female sex workers reported more frequent access to health services than people who inject drugs (East African Community, 2015). Measure Evaluation (2017) found that even where services exist, cross-border populations face other barriers in seeking care, including distance from the facility, inconvenient opening hours, cost/having to pay for services, and concerns about the attitudes of health care workers. Bogart *et al.* (2016) found that the cost of transport was the highest barrier for fisherfolk accessing care, as well as the scarcity of facilities in convenient locations such as landing sites.

Mobile populations also sometimes find that they cannot access any health services, or they must seek episodic care at health facilities, which are often not equipped to provide the scope and quality of services they need, leading to failure to complete prescribed treatment, incomplete and unreliable medical records, and disrupted preventive care (East African Community, 2015). For instance, among fisherfolk, it has been observed that their need to move to new areas seasonally to find the best source of fish impedes timely access to HIV care and their ability to get enough treatment to last for months at a time while they are traveling (Bogart *et al.*, 2016). Lack of time is also a barrier; Bogart *et al.* (2016) found that fishermen often decided not to seek care if they felt that they did not have enough time, and the need to earn money and keep their jobs often outweighed the need to get treatment for illness.

Mobility undermines treatment adherence monitoring, especially for TB and HIV, as patients cannot be tracked by health providers while on the move (IOM, 2013). Morris and Ferguson (2007) found that the majority of long-distance truck drivers preferred to seek care for STI treatment in private health facilities, some public facilities and pharmacies, with the largest proportion attending private facilities where they did not have to wait, but where adherence monitoring was not possible.

In summary, health services across East African Community partner states are not harmonised and there are no formal cross-border health coordination structures to address the needs of vulnerable and key populations along border areas. In addition, national differences in policies and legal frameworks related to health services undermine efforts to ensure the continuity of HIV and AIDS care across borders. All of these factors place the health of vulnerable mobile communities in cross-border areas at risk.

Research methodology

Between 2015 and 2017, research was conducted at cross-border sites in five East African Community states – Burundi, Kenya, Rwanda, Tanzania, and Uganda – to determine the availability and accessibility of health and HIV and AIDS services for key and vulnerable populations (Table 4.1). These were selected as strategic cross-border sites recognised as HIV transmission 'hotspots' along the transport corridors. The investigation looked at: the mobility and sexual behaviour of members of the target population (including engagement in transactional sex); the health-seeking behaviour of members of the target population; health services received across borders; and barriers and facilitators affecting access to health and HIV/AIDS services among members of target population.

Table 4.1. Assessment sites in Burundi, Kenya, Rwanda, Tanzania and Uganda

Border site	***Land border site***	***Wet border site***
Kenya-Uganda border	Busia and Malaba (Kenya and Uganda)	Sio Port and Port Victoria (Kenya) and Majanji (Uganda)
Kenya-Tanzania border	Taveta (Kenya), Holili (Tanzania)	Kirongwe and Muhuru Bay (Tanzania)
Rwanda-Uganda border	Gatuna (Rwanda), Katuna (Uganda)	Rubavu (Rwanda)
Burundi-Tanzania border	-	Kabonga (Burundi)

Integrated health surveys were conducted using a cross-sectional design to collect data from members of the target population and health care workers. In addition, key informant interviews were conducted with health care workers and managers and focus group discussions and in-depth interviews with members of target populations. Facility assessments were also conducted.

Combined, the integrated health surveys had a sample of 9,117 respondents comprising: 1,904 vulnerable women and girls; 2,155 female sex workers; 281 men who have sex with men; 350 people who inject drugs; 1,379 people living with HIV; 955 long distance truck drivers and their assistants; 461 clearing and forwarding agents; and 1,632 fisherfolk. The sample was distributed across the five countries, as illustrated in Figure 4.1. The study also included 275 health care workers spread across the five countries.

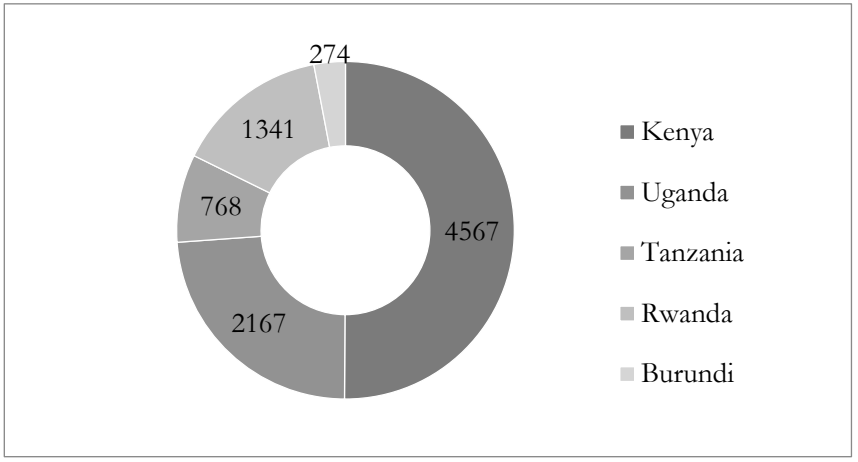

Figure 4.1. Key and vulnerable groups sample distribution by country (N=9,117)

The respondents were selected as follows:

- Female sex workers, men who have sex with men and people who inject drugs: Respondent-driven sampling was used.
- Vulnerable women and girls: Potential respondents were 15–24 year olds, assessed to be economically vulnerable. Simple random sampling was used to select households for the study, and a vulnerability checklist applied to select eligible women and girls. Vulnerability criteria included being out-of-school, married or pregnant/had children, or were the head of household.
- People living with HIVs: Identified and recruited through the clinics/centres where they were registered and receiving

antiretroviral therapy care and treatment services. Simple random sampling was used to identify potential respondents from the client registers.

- Long distance truck drivers and clearing and forwarding agents: Consecutive sampling was used to recruit respondents as they arrived at border points and work places until the complete sample was achieved.
- Fisherfolk: Time location cluster sampling was used with a two-stage sampling procedure to select respondents from this sub-group. Health care workers and facility in-charges were selected at health facilities located within a 10 km radius of the cross-border sites. These were recruited on site by research assistants and interviewed upon consent.

The data was collected using tablets pre-loaded with the study tools.[2] Once completed, the data was transferred electronically and stored in a central database for analysis and reporting. Data management and analysis was conducted using Stata software. The qualitative data was analysed using a thematic framework in NVivo10. Analysis was done separately for different countries and by population.

[2] The research tools used were: exit face-to-face structured interviews with people living with HIV; face-to-face and venue-based interviews, using a structured questionnaire with men who have sex with men, female sex workers, people who inject drugs, fisherfolk, long distance truck drivers, clearing and forwarding agents and vulnerable women and girls; individual face-to-face interviews using a structured questionnaire with facility in-charges and health care workers from family planning clinics, HIV clinics, outpatient departments, STI clinics, TB clinics and records departments; an inventory checklist administered to health facility managers and health care workers to catalogue equipment and supplies in all facilities in each site as part of functional quality assessment; and health records/document review using the District Health Information System (DHIS2) and other relevant records to assess the utilisation of health services at the facilities. No personal identifying information was collected. Aggregate data on people accessing HIV and AIDS services; maternal, newborn and child health; and STI, TB, family planning and reproductive health services were collated and disaggregated by gender, age and target population. Permission to review health records was sought from ministries of health at national and local levels in all sites.

Mobility and sexual behaviour

Among the vulnerable women and girls, mobility characteristics varied by country.[3] In Rwanda, over half of the girls (57%) had lived at the border site for more than six years and about 42% were born there. In Kenya, only 9% were born at the border sites and 43% had lived there for two years or less. In Tanzania and Uganda, nearly all were born at the study site – 88% in Tanzania and 85% in Uganda. In Uganda, about 28% reported having crossed the border into the neighbouring country more than 3 times in the 12 months prior to the survey.

Except in Ugandan sites where the majority were born in the cross-border site, most of the female sex workers in the other sites had come from elsewhere. The study found a lot of movement away from the usual place of residence (cross-border areas) among female sex workers. For instance, among female sex workers in Uganda, about three quarters (74%) reported that they planned to travel outside their usual county/district of residence within the next three months, with 84% planning to travel for sex work. The main reason for travelling elsewhere by female sex workers in Kenya was sex work.

Female sex workers also reported frequent cross-border travel in the study sites in four of the five countries,[4] mostly for sex work. In Uganda and Tanzania, 50% and 29%, respectively, of the female sex workers interviewed reported that they had travelled out of the country for sex work, while in Rwanda, 35% said that they crossed the border to the neighbouring country every week. In Burundi, while over half of the female sex workers said they had never crossed the border, 25% (6 out of 24) of those who said they had, did so at least every month.

There were equally high levels of mobility among men who have sex with men for reasons that included sex work and visiting sexual partners. In Uganda, a large proportion (93%) were planning to travel

[3] The Burundi sample did not include vulnerable women and girls.
[4] Respondents in Kenya were not asked about cross-border travel.

away from their usual district of residence within the next three months. In Kenya, 8% of those who planned to travel away from their district of residence in the next three months said they would be travelling for sex work.

Among fisherfolk, data on mobility was only available for Tanzania, Uganda, and Burundi, where results show that the majority of the fisherfolk interviewed often slept away from home, mostly on fishing business or visiting relatives. The proportion of those who reported often sleeping away from home was 54% in Tanzania, 79% in Uganda, and 82% in Burundi. The period away from home varied widely, from 1 week for 41% of the respondents in Tanzania, to 7–13 days for 16% of the Uganda respondents, and 3 months for 13% of Burundi respondents. The results also show that cross-border/transnational movement is frequent among the respondents in this group. In Tanzania, 60% of the respondents reported having crossed the border to the neighbouring country before, with 11% crossing every week. In Burundi, 40% reported that they cross the border to the neighbouring country every month, and 12% every week.

Among long distance truck drivers in Tanzania and Uganda,[5] when the same question was asked, 64% and 84%, respectively, said that they had been driving long distance trucks for over five years, but while the average duration of a single road trip in the entire Uganda sample was under four days, 23% of the Tanzania group were on the road for over eight days on any one trip. In addition, 95% of the Tanzanian respondents and 74% in Uganda often went to other towns not necessarily on the transport corridor, showing their high level of mobility.

In Tanzania, about half of the clearing and forwarding agents who took part in the research had lived at the border sites for over five years, and 52% travelled to other towns for work. In Rwanda, 32.7%

[5] The Kenyan long distance truck drivers were not asked about mobility and sexual behaviour.

of the clearing and forwarding agents interviewed had lived in the area for six or more years; of those who came from elsewhere, 56.3% returned home more than once a year.

Reported engagement in transactional sex

Among the people living with HIV, sex work was also one of the reasons some travelled out of their usual district of residence. In Rwanda, a third (31%) of the people living with HIV interviewed gave sex work as the reason they travelled out of their district. In Kenya and Uganda, the proportions traveling for sex work were 29% and 36% respectively. None of the people living with HIV in Tanzania and Burundi appear to be engaged in commercial sex – none reported travelling for sex work or receiving goods or cash in exchange for sex.

Although most vulnerable women and girls did not report engaging in commercial/transactional sex, in Uganda 18% said they had received goods or money in exchange for sex and 3.4% said that sex work was the main reason they had travelled outside the district in the previous three months. Transactional sex was also reported by a small proportion of fisherfolk: 17% in Tanzania, 12% in Uganda, and 11% in Burundi said they had received gifts/goods or money in exchange for sex in the three months before the survey. In Uganda, 56% of the people who inject drugs had more than one sexual partner and 38% had received or given money or goods in exchange for sex within the last three months.[6] Data regarding the sexual behaviour of long-distance truck drivers is not available, except in Tanzania, where 36% of the respondents said that they had exchanged goods or cash for sex in the three months prior to the survey. Among the clearing and forwarding agents, 9% in Tanzania and 14% in Uganda reported having received or given cash or goods for sex in the previous three months.

While the data shows that most vulnerable women and girls did not report engaging in commercial/transactional sex, in Uganda 18% said they had received goods or money in exchange for sex and 3.4% said

[6] This question was not asked of the Kenya group.

that sex work was the main reason they had travelled outside the district in the previous three months. In Tanzania, 42% of the vulnerable women and girls reported that they were engaged in cross-generational sexual relationships. Transactional sex was also reported by a small proportion of fisherfolk. Asked if they had received gifts/goods or money in exchange for sex in the three months before the survey, 17% of the fisherfolk respondents in Tanzania, 12% in Uganda, and 11% in Burundi said they had. In Uganda, 56% of the people who inject drugs had another sexual partner(s), and 38% had received or given money or goods in exchange for sex within the last three months.[7] Data regarding the sexual behaviour of long distance truck drivers is not available, except in Tanzania, where 36% of the respondents said that they had exchanged goods or cash for sex in the three months prior to the survey.

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Health seeking behaviour

To examine the health seeking behaviour of the study population, participants were asked what service they had sought the last time they went to a health facility and whether they had received it. The data shows that while treatment for common illnesses was the leading service sought during the last visit to a health facility by most vulnerable women and girls, there were also some remarkable variations. While more vulnerable women and girls in Tanzania

[7] This question was not asked of the Kenya group.

sought antenatal care and new-born services (55%), in Uganda more vulnerable women and girls sought STI treatment (61%) and in Kenya most sought HIV testing services (44%).

Most of the female sex workers who sought health care services across all the cross-border sites needed treatment for common illnesses and HIV testing services. The highest proportion of female sex workers seeking HIV testing services was in Tanzania (32%) and Kenya (26%), while in Kenya and Burundi, the proportions were about 18% and 17%, respectively, and 14% in Rwanda. Demand for STI services was relatively low and was highest among female sex workers in Uganda (15%), Tanzania (14%) and Rwanda (13%). The services that were least demanded by this group across all sites were pregnancy testing, services for post-abortion care, services for sexual and gender-based violence, TB drug refills, substance abuse counselling, nutrition counselling, and screening for non-communicable diseases. Overall, the majority of the female sex workers said that they received the services they sought at the facility during their previous visit.

While the majority of the men who have sex with men across the three countries[8] where data was available sought treatment for common illnesses, a large majority in Kenya (71%) and about a third in Uganda (29%) sought HIV testing services. Comparatively, only 10% of the respondents in Rwanda sought HIV testing services. The results also suggest that health facilities may not be a popular/common source of condoms for this group, as very few reported seeking this service: 12% in Uganda, 2% in Kenya and none in Rwanda. In addition, except for Uganda (28%), very few of the men who have sex with men went to a facility for lubricants (10% in Kenya and 7% in Rwanda). STI services were equally in very low demand among this group across the three countries: highest in Kenya at only 10%, compared to 5% and 7% in Uganda and Rwanda, respectively.

[8] Data on men who have sex with men in this study was only collected in Kenya, Uganda and Rwanda.

The results show that in three of the five countries, fisherfolk most frequently sought treatment for common illnesses (Tanzania 60%; Uganda 83%; Rwanda 80%). Demand for laboratory services by this group was high only in Burundi (40%) and Tanzania (37%) and negligible in the other countries. Demand for HIV testing services was highest in Kenya (54%),[9] followed by Tanzania (23%) and under 10% in the other countries. Only in Uganda did a notable proportion seek STI services (15%) – in other countries, the demand was negligible. Demand for condoms, antenatal care and family planning services was low across the five countries.

In Uganda, the most commonly sought service by people who inject drugs was for the treatment of common illnesses (79%), while in Kenya, it was HIV testing services (40%). About a third (33%) of the respondents in Kenya also sought treatment for common illness, while 16% and 9% in Uganda and Kenya, respectively, sought laboratory services (16%). Demand for other services was negligible among this group.

Over 60% of people living with HIV across the five countries studied needed antiretroviral refills at their last visit to a health facility. Treatment for common illnesses and laboratory services were also in moderate demand. In sharp contrast to the other countries, 57% of the people living with HIV in Kenya required antenatal care and newborn care services, and 42% in Uganda required STI services. For both services, demand was almost nil in other countries. Negligible proportions of respondents needed TB services, condoms, family planning and nutrition services. The majority of people living with HIV reported receiving the services they needed during their last visit to a health facility.

[9] Data is available for only one site in Kenya (Sio Port and Lake Victoria), where fisherfolk were sampled.

The results show that in Kenya, Rwanda, and Uganda, long distance truck drivers and their assistants[10] sought treatment for common illnesses more than any other service. The highest proportion seeking HIV testing services was in Kenya (30%). Demand for other services was low, under 10% in most cases.

A significant proportion of the clearing and forwarding agents[11] in Kenya (68%), Rwanda (58%) and Uganda (42%) sought treatment for common illness. More clearing and forwarding agents in Kenya (76%) needed HIV testing services than in any other country; in Uganda and Rwanda, only 25% and 9%, respectively, sought HIV testing services. In Uganda and Rwanda, 25% and 15%, respectively, sought laboratory services. Demand for antenatal care and newborn services, STI treatment, antiretroviral refills, and condom services was almost negligible among this group.

Health care services received across the border

Respondents were asked whether they had sought health care services from facilities located across the border in a neighbouring country in the six months before the survey. In Uganda, 44% of men who have sex with men and nearly a third of the people who inject drugs (29%) said they had sought services across the border in the last six months, as had 25% of long distance truck drivers, 16% of female sex workers and 17% of fisherfolk. The majority of these sought services for the treatment of common illnesses. In Uganda, men who have sex with men had also sought condoms (22%) and lubricants (42%) across the border. Vulnerable women and girls in Uganda were the only group who sought antenatal care and newborn care across the border (29%).

The results show that seeking health care services across the border is not common in the Burundi study site (Kabonga). Only 16% of

[10] The data from Tanzania was incomplete and was, therefore, not included in this analysis. No long distance truck drivers were included in the Burundi sample.

[11] No clearing and forwarding agents were sampled in Burundi. The Tanzania clearing and forwarding agents sample had only 23 respondents, of whom only 9 had sought services from a health facility. The sample was dropped from further analysis due to the small number of respondents.

fisherfolk, 8% of female sex workers and 5% of people living with HIV reported that they had ever sought health care services across the border. Of the fisherfolk who did, 15% sought laboratory services. In Rwanda, about a quarter of long-distance truck drivers had sought health services across the border, as well as 15% of female sex workers and 17% of vulnerable women and girls. Of those who did, more than 65% sought treatment and laboratory services. In Kenya, varying proportions of the different groups in the five sites sought health services in the neighbouring country from where they lived. The highest proportion of those who had accessed services across the border in the previous six months were female sex workers in Taveta (18%), vulnerable women and girls in Taveta (16%) and long-distance truck drivers in Busia (17%), mostly for the treatment of common illnesses. Lower cost, proximity and the better quality of services were cited as the main reasons for seeking services across the border.

Barriers and facilitators affecting access to health and HIV/AIDS services

The survey results, as well as the findings of the formative assessments conducted in the five countries, provide some insight into the factors that affect the ability of key and vulnerable populations in the region to fully benefit from available health care services. These factors are discussed here.

Lack of insurance cover and perceived high cost of care

In Rwanda, the formative assessment revealed that lack of money to subscribe to Community-Based Health Insurance (CBHI) was a key barrier in seeking care. Female sex workers, vulnerable women and girls, and people living with HIV on the Rwanda side of the border with Uganda reported that they sought services in Uganda and paid directly out of pocket because they were not members of the insurance programme. In Tanzania, qualitative interviews revealed that key populations prefer the Community Health Fund, which caters for people in the informal sector and rural areas and is seen as more affordable, than the national health insurance fund. In Burundi, the results also show that the majority of fisherfolk and female sex

workers paid for services directly, mostly out of pocket. In Kenya, over half of the respondents said they paid directly for services, even paying for drugs separately and out of pocket in most cases. The results also show that 'reasonable' cost was the key factor for most respondents in choosing facilities for care, including those who sought services across the border in neighbouring countries. For instance, in Holili, Tanzania it was reported that many patients from Kenya cross the border into Tanzania for cheaper health services, because services in Kenya were deemed very expensive:

> *The cost for services here is very fair and even the clients who come from Kenya find it easy to pay for the health services because the exchange rate is very friendly […] with KES [Kenyan shilling] 100 (USD 1), they are able to get a good amount of money.* (Key informant interview, health facility in-charge, Busia, Kenya)

Hence, differences in costs for health services may steer health-seeking behaviour across borders. As a result health services on one side of the border may be overextended.

Mobility and time taken waiting for services

Being on the move was noted to be a barrier to accessing health care services among long distance truck drivers and a major hazard in adherence to treatment:

> *For truck drivers who may be HIV positive, some of them may have challenges accessing HIV services because they are mobile. It might happen that the day when they should be going to the clinic, they have been assigned to travel outside the country. So, it becomes very difficult for the truck driver to access such services.* (Focus group discussion, long distance truck drivers, Malaba, Kenya)

Time taken waiting at the health facility for services was also of major concern, and the majority of respondents in the Kenya sample found the time taken to be too long. Nearly all the female sex workers and some of the long distance truck drivers found the time taken waiting for services too long. In Tanzania, delays and long waiting times in public health facilities were reported in the formative assessment as one of the reasons for not visiting health facilities.

Inadequate quality of services

The perceived low quality of services and lack of drugs was also seen as a barrier to accessing health care services in the study. For instance, in Rwanda, focus group discussants felt that the services provided were of low quality, the drug supply was inadequate and there were limited staff at the facilities. Some facilities were also seen as located in far off areas that took time to get to. In Kenya, it was reported that some of the facilities in the survey did not have drugs available – in one site (Busia), over 50% of the men who have sex with men and nearly half of the people who inject drugs did not get drugs at the facility. Two other sites (Taveta and Malaba) also had many respondents reporting not having received drugs during their last visit to a facility.

Perceived stigma and fear

Perceived stigma and fear due to the criminalisation of specific behaviours and practices, such as homosexuality, sex work and injecting drug use, was reported as another factor hindering people from seeking services. Some of the participants in focus group discussions reported that they felt discriminated against and stigmatised and this affected their willingness to seek health care services. In Uganda, for example, some sex workers, men who have sex with men and people living with HIV reported that they were regularly exposed to extremely negative, discriminatory and hostile reactions from health workers, which discouraged them from seeking care in public facilities: "They tell you to wait outside and that you want me to touch your rubbish and you are the ones destroying our marriages" (Focus group discussion, female sex workers, Busia, Uganda). Another respondent said:

> *As you know if we go to the main hospitals, most of us, we are likely not to share the problem, so at least if you go to a clinic you tell the nurse instead of the main hospital where you can be a story.* (Interview, men who have sex with men, Busia, Uganda)

On the other hand, factors that facilitate seeking health care were identified as friendly health care providers, good quality services, and

easily accessible facilities, as well as prompt services. For instance, in Tanzania, the perceived good quality of services was a key reason why respondents chose the facilities they did and was cited as a reason by nearly half (48%) of the female sex workers, 67% of fisherfolk and 27% of long-distance truck drivers. Easy physical access was also cited as a key reason for choosing a facility, by 61% of the female sex workers, 47% of fisherfolk and 74% of people living with HIV in Tanzania. In Kenya, most of the respondents chose a facility close to home (less than half an hour away). For long distance truck drivers, besides location, convenient opening hours was also a key factor in facility choice. 'Reasonable' cost and not having to pay directly for services was mentioned as important in choosing a point of care – most respondents were attracted to facilities that were perceived to charge reasonable or no fees for services.

Conclusion

Cross border mobility is a neglected area in research despite the substantial level of mobility in today's world. In particular, health care needs in cross border areas are significant and specific to different types of cross border communities. Mobility affects health through mobility-related life-patterns, and the utilisation of health care facilities by mobile populations affects treatment. Some of the problems with health care for cross border communities include incomplete patient records of users and lack of completion of prescribed treatment due to lack of follow up or unavailability of treatment. These problems, and others, are not sufficiently addressed by the current health programmes in the region, which are administered nationally. Accordingly, this chapter looked at the challenges involved in providing health services for mobile communities in cross borders areas. It examined the relationship between the cross border mobility of these groups and their sexual behaviour, as well as their access to health care (health seeking behaviour, health care services received across the border, and barriers and facilitators to access to health services).

The study was carried out among 9,117 individuals in 12 cross-border sites in the East African Community countries of Kenya, Uganda, Tanzania, Rwanda and Burundi. The participants in this survey were from the following groups: female sex workers; men who have sex with men; people who inject drugs; vulnerable young women and girls; people living with HIVs; long distance truck drivers and clearing and forwarding agents; fisherfolk; and health care workers. The study found that many members of these groups are engaging in transactional sex and traveling for sex work, which increases the spread of communicable diseases in cross border areas. Most of the respondents reported seeking health services for common illnesses, as well as HIV testing services and laboratory services, and to a lesser extent antenatal care and newborn services, STI treatment, antiretroviral refills, and condom services. Although there appears to be high levels of access to health care services, factors such as the quality of health care influence where individuals preferred to access services. In addition, the proportion of target groups seeking health care services across borders is considerable, suggesting the need to adopt and implement a standard package of health services, targeted at mobile and border communities across all the countries in the East African region. It is worth noting that in some of the sites, quality of care was not a major factor in respondents' choice of preferred health facility. A key barrier in seeking health care services in the region appears to be the cost of services and having to pay for services (lack of insurance), cited in both the survey and qualitative interviews. Other barriers include mobility and time waiting, quality of services, lack of drugs, and perceived stigma.

This study highlights the importance of understanding the health risks and needs of cross border mobile communities, which can vary for different groups and in different countries. It underlines the relevance of addressing these needs in order to ensure the quality of treatment and continuation of care across the region. Based on these findings, there is clearly a need for the increased integration of health services and patient follow up across borders to enable better care provision. There is also room for a health care financing product to remove direct payments for services across borders, which were reported as a barrier by the majority of those who paid for services. It is hoped

that this study will prompt governments of the region need to cooperate closely in order to develop joint approaches through which the health needs of cross border communities can be served.

References

Bogart, L. M., Naigino, R., Maistrellis, E., Wagner, G. J., Musoke, W., Mukasa, B., & Wanyenze, R. K. (2016). Barriers to linkage to HIV care in Ugandan fisherfolk communities: A qualitative analysis. *AIDS and Behavior, 20*(10), 2464–2476. Available from: http://doi.org/10.1007/s10461-016-1331-z (accessed 22 January 2018).

East African Community. (2015). *Mapping health services along major transport corridors in East Africa*. International Organization for Migration. Available from: http://kenya.iom.int/sites/default/files/Mapping_of_Health_Services_along_Major_Transport_Corridors_in_East_Africa%20(1).pdf (accessed 22 January 2018).

IOM. (2011a). *Scale-up of HIV prevention along transport corridors*. Brief, International Organization for Migration, Kenya. Available from: https://migrationhealthresearch.iom.int/scale-hiv-prevention-along-transport-corridors (accessed 24 May 2019).

IOM. (2011b). *Response analysis: Combination HIV prevention programming along the northern transport corridor in Kenya*. Nairobi, Kenya: International Organization for Migration. Available from: http://kenya.iom.int/sites/default/files/Response_Analysis_along_the_Transport_Corridors_in_Kenya.pdf (accessed 24 January 2018).

IOM. (2013). *A rapid assessment of access to health care at selected one stop border posts in East Africa*. Nairobi, Kenya: International Organization for Migration. Available from: https://www.iom.int/files/live/sites/iom/files/Country/docs/IOM-OSPB-Report-2013.pdf (accessed 24 January 2018).

Measure Evaluation. (2017). *East Africa cross-border integrated health study: Final report*. Chapel Hill, NC: University of North Carolina at Chapel Hill. Available from: https://www.measureevaluation.org/resources/publications/tr-17-188 (accessed 24 May 2019).

Morris, C. N., & Ferguson, A. G. (2007). Sexual and treatment-seeking behaviour for sexually transmitted infection in long-distance transport workers of East Africa. *Sexually Transmitted Infections, 83*(3), 242–245. http://doi.org/10.1136/sti.2006.024117

National AIDS and STIs Control Programme (NASCOP). (2014). *2010–2011 Integrated biological and behavioural surveillance survey among key*

populations in Nairobi and Kisumu, Kenya. Nairobi, Kenya: NASCOP, Ministry of Health.

UNAIDS. (2017a). *Country factsheet 2017 – Burundi*. United Nations Programme on HIV and AIDS. Available from: http://www.unaids.org/en/regionscountries/countries/burundi (accessed 28 January 2018).

UNAIDS. (2017b). *Country factsheet 2017 – Uganda*. United Nations Programme on HIV and AIDS. Available from: http://www.unaids.org/en/regionscountries/countries/uganda (accessed 28 January 2018).

World Bank. (2009). *Transport against HIV/AIDS: Synthesis of experience and best practice guidelines*. Washington, DC: World Bank.