Migrant Health Assessment in South Sudan 2013
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IOM is committed to the principle that humane and orderly migration benefits migrants and society. As an intergovernmental organization, IOM acts with its partners in the international community to: assist in meeting the operational challenges of migration; advance understanding of migration issues; encourage social and economic development through migration; and uphold the human dignity and well-being of migrants.

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With the signing of the Cooperative Peace Agreement in 2005 and independence in 2011, millions of South Sudanese returned home in the hope that peace and economic prosperity would flourish in South Sudan. Conversely, the last two years have seen rising insecurity along the border with Sudan leading to a 14 month shutdown of oil production and consequently a period of government austerity.

South Sudan currently faces a fragile humanitarian context as continuing tensions with Sudan and in-fighting among tribes in South Sudan have triggered substantial population movements of returnees and internally displaced persons to and within the country. Moreover, while austerity measures remain and limit the possibilities for large scale economic growth, porous borders with neighbouring states (excluding Sudan) have allowed a significant influx of migrant workers in search of jobs from the Democratic Republic of the Congo, Ethiopia, Kenya and Uganda. Yet, despite these large population movements, there is little to no consolidated data on migration health available in the country.

The International Organization for Migration (IOM) in South Sudan through funding from the Partnership on Health and Mobility in East and Southern Africa (PHAMESA) commissioned this report on the state of migrants’ health in South Sudan in order to address the lack of reliable data on the particular health challenges encountered by migrants, including those faced by the recent returnees.

IOM recognises that migration is a key social determinant of health for migrants. For instance, while migrants often start their journey healthy, the conditions of the migration process may make a migrant more vulnerable to ill health. These conditions include biological, environmental and structural drivers of health vulnerabilities, such as poverty, stigma, discrimination, social exclusion, language and cultural differences, separation from family and socio-cultural norms, administrative hurdles and legal status.

As the lead technical and implementing organisation mandated to assist governments in managing the health aspects of migration, IOM is uniquely positioned to support governments and the United Nations organisations at national, regional and global levels to implement the World Health Assembly resolution on the health of migrants (WHA 61.17). Adopted in May 2008, this resolution calls on Governments to promote the health of migrants through policies and programmes.

The results of this assessment provide the necessary evidence to support the development of specific policies and programmes in line with the WHA resolution on the health of migrants. The report outlines 21 recommendations for partners and key stakeholders including the Government of the Republic of South Sudan and the United Nations organisations, structured using IOM’s fourpillared approach to migration health: Research and Information Dissemination; Advocacy for Policy Development; Health Service Delivery and Capacity Building; and Strengthening Inter-Country Coordination and Partnership.

This report is the first of its kind in South Sudan and will be useful in highlighting the key health vulnerabilities and needs faced by migrants in South Sudan as well as providing reliable evidence for future collaboration between the Government of the Republic of South Sudan, the United Nations organisations and IOM as together we strive to promote equitable access to health services.

David Derthick
Chief of Mission a.i.
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# Acronyms

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<th>Acronyms</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ARC</td>
<td>American Refugee Committee</td>
</tr>
<tr>
<td>ART</td>
<td>Antiretroviral Therapy</td>
</tr>
<tr>
<td>CAR</td>
<td>Central African Republic</td>
</tr>
<tr>
<td>CEDAW</td>
<td>Convention to Eliminate All Forms of Discrimination against Women</td>
</tr>
<tr>
<td>CERD</td>
<td>Committee on the Elimination of Racial Discrimination</td>
</tr>
<tr>
<td>CMMB</td>
<td>Catholic Medical Mission Board</td>
</tr>
<tr>
<td>DNPI</td>
<td>Directorate for Nationality, Passports and Immigration</td>
</tr>
<tr>
<td>DRC</td>
<td>Democratic Republic of the Congo</td>
</tr>
<tr>
<td>FGD</td>
<td>Focus Group Discussion</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender Based Violence</td>
</tr>
<tr>
<td>GRS</td>
<td>Government of the Republic of South Sudan</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>ICCPR</td>
<td>International Covenant on Civil and Political Rights</td>
</tr>
<tr>
<td>ICESCR</td>
<td>International Covenant on Economic, Social and Cultural Rights</td>
</tr>
<tr>
<td>ICRMW</td>
<td>International Convention on the Protection of the Rights of Migrant Workers</td>
</tr>
<tr>
<td>IDI</td>
<td>In-Depth Interview</td>
</tr>
<tr>
<td>IDP</td>
<td>Internally Displaced Persons</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organization for Migration</td>
</tr>
<tr>
<td>LRA</td>
<td>Lord’s Resistance Army</td>
</tr>
<tr>
<td>MSF</td>
<td>Médecins Sans Frontières</td>
</tr>
<tr>
<td>NFI</td>
<td>Non-Food Items</td>
</tr>
<tr>
<td>OHCHR</td>
<td>Office of the High Commissioner for Human Rights</td>
</tr>
<tr>
<td>PHAMESA</td>
<td>Partnership on Health and Mobility in East and Southern Africa</td>
</tr>
<tr>
<td>PHCU</td>
<td>Primary Health Care Unit</td>
</tr>
<tr>
<td>PSI</td>
<td>Population Services International</td>
</tr>
<tr>
<td>RRC</td>
<td>Relief and Rehabilitation Commission</td>
</tr>
<tr>
<td>SIDA</td>
<td>Swedish International Development Agency</td>
</tr>
<tr>
<td>SPLA</td>
<td>Sudan People’s Liberation Army</td>
</tr>
<tr>
<td>SSAC</td>
<td>South Sudan AIDS Commission</td>
</tr>
<tr>
<td>SSP</td>
<td>South Sudanese Pound</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
</tr>
<tr>
<td>UNDAF</td>
<td>United Nations Development Assistance Framework</td>
</tr>
<tr>
<td>UNHCR</td>
<td>United Nations High Commissioner for Refugees</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, Sanitation and Hygiene</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
### Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Boda-Boda</strong></td>
<td>Motorcycle taxis</td>
</tr>
<tr>
<td><strong>Change agents</strong></td>
<td>Members of the target community who have committed themselves to driving the change process and who are capacitated with skills to enable them to engage with their peers in a structured manner</td>
</tr>
<tr>
<td><strong>Dobbi</strong></td>
<td>Term for clothes washing services</td>
</tr>
<tr>
<td><strong>Internally Displaced Person (IDP)</strong></td>
<td>Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognised State border (African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa, 23 October 2009)</td>
</tr>
<tr>
<td><strong>Internal Migrant</strong></td>
<td>A person who moves but has not crossed an internationally recognised State border, including migrant workers, victims of trafficking, IDPs, children who migrate on their own or with their families and guardians</td>
</tr>
<tr>
<td><strong>International Migrant</strong></td>
<td>A person who crosses an international border to stay for either short or long periods of time in the host country, and who may be either in a regular or irregular situation. Within this category are migrant workers and their families, victims of trafficking, children who migrate on their own or with their families and guardians, asylum-seekers, refugees, other displaced persons, migrants who have been smuggled, or returnees</td>
</tr>
<tr>
<td><strong>Irregular Migrant</strong></td>
<td>A person who, owing to unauthorized entry, breach of a condition of entry, or the expiry of his or her visa, lacks legal status in a transit or host country</td>
</tr>
<tr>
<td><strong>Migrant</strong></td>
<td>Persons moving to another country or region to better their material or social conditions and improve the prospects for themselves or their family</td>
</tr>
<tr>
<td><strong>Migrant Worker</strong></td>
<td>A person who is to be engaged, is engaged or has been engaged in a remunerated activity in a State of which he or she is not a national (article 2(1), ICRMW, 1990)</td>
</tr>
<tr>
<td><strong>Mummies</strong></td>
<td>Term for female traffickers who encourage girls to leave their homes to engage in sex work</td>
</tr>
<tr>
<td><strong>Neem leaves</strong></td>
<td>Leaves from the Neem tree (Azadirachta Indica) used as traditional medicine</td>
</tr>
<tr>
<td><strong>Returnee</strong></td>
<td>A returnee is a South Sudanese who has returned to his or her home country</td>
</tr>
<tr>
<td><strong>Side Dishes</strong></td>
<td>Slang term used by truck drivers to refer to the girls and sex workers they interact with while en route</td>
</tr>
<tr>
<td><strong>Transport Corridor</strong></td>
<td>Highways, waterways, and border points that come together in the transport of people and goods</td>
</tr>
<tr>
<td><strong>Tukul</strong></td>
<td>Traditional, permanent conical mud living structure with thatched roof</td>
</tr>
<tr>
<td><strong>Turn boy</strong></td>
<td>Truck drivers’ assistant who acts as secondary driver and general helper</td>
</tr>
<tr>
<td><strong>Voltage</strong></td>
<td>Slang term used by truck drivers in reference to alcohol percentage</td>
</tr>
<tr>
<td><strong>Waraga</strong></td>
<td>Slang term for immigration documents derived from the Arabic word for paper (warqa)</td>
</tr>
</tbody>
</table>
South Sudan is a country largely characterised by migration. Not only is South Sudan still in the process of receiving thousands of returnees from neighbouring countries, but the nation’s emerging economic opportunities are attracting increasing numbers of regional migrant workers. Meanwhile, domestic conflicts are causing the internal displacement of hundreds of thousands of people. IOM South Sudan commissioned this situational assessment on the health of migrants to better understand the health vulnerabilities and mobility patterns of migrants within the country, in order to inform future health programming and interventions.

Spaces of vulnerability were identified along transport corridors, transit sites, and urban settings, and qualitative field research was carried out in five locations within Central Equatoria, Eastern Equatoria, Western Bahr el Ghazal, and Upper Nile States. A total of 118 in-depth interviews, focus group discussions, and key informant discussions were carried out with migrant workers and migrant female sex workers as well as truck drivers and their mechanics, Internally Displaced Persons (IDPs), and returnees. Information was gathered on these populations’ self-reported health concerns and the barriers and enabling factors they face in accessing health care, from which general trends were noted and assessed.

The findings suggest that along transport corridors, that run predominantly south-north from Kenya and Uganda to Juba and beyond, individual and environmental determinants such as risky behaviour in hotspots and frequent interaction with violent or armed members of the host population, make truck drivers and migrant female sex workers particularly vulnerable to HIV, sexually transmitted infections (STIs), and (gender based) violence (GBV).

Returnees and IDPs in way stations or transit sites were found to be highly vulnerable to poor nutrition and infectious diseases, while returnees and IDPs in urban settings face high levels of discrimination and difficulty in reintegration.

Migrant workers from neighbouring countries such as Kenya, Uganda, the Democratic Republic of the Congo (DRC), Eritrea, and Sudan were found predominantly in market places of urban spaces and exhibited some health advantages over other migrants and the host population due to their ability to access a wider range of health service options and their more advanced HIV and hygiene knowledge relative to the host communities. These advantages were generally the result of improved financial situations, the option of accessing health facilities in their home countries, and the fact that HIV sensitisation and awareness programmes have long been in place in countries such as Kenya and Uganda.

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1 Although truck drivers were accompanied by turn-boys (driver’s assistant and sometimes secondary driver), interviews were not conducted with them firstly because the emphasis of research was placed on truck drivers only, and secondly because the turn-boys were often over-shadowed by the drivers.
Universally cited barriers to health care were cost, whereby ‘free’ public health services still generate hidden out of pocket costs and private clinics are unaffordable for many, as well as distance and lack of transport to free health care services. Low recognition and uptake of HIV Voluntary Counselling and Testing (VCT) services were found amongst all target and host populations and indicate the need for significant behavioural change interventions. Change is also needed in challenging gender norms that leave women and girls highly vulnerable to gender based violence and HIV infection.

Some priority recommendations to emerge from the findings are presented below, based around the four action points of the 2008 World Health Assembly (WHA) Resolution (61.17) on the health of migrants, which were further elaborated on during the Global Consultation on the Health of Migrants in Madrid (2010).

Monitoring Migrant Health Systems through research and information dissemination

- Work with the Ministry of Health and the WHO to develop standard migrant health indicators (on access, quality and cost) in order to improve national monitoring systems, and advocate for sharing migration health data among sectors and countries for the purpose of enhancing migrants’ health;
- Conduct further research with the UN Joint Team on HIV and AIDS and the South Sudan AIDS Commission - focusing on key populations within select spaces of vulnerability to target the relationship dynamics between migrants, female sex workers, and truck drivers as well as the knowledge, attitudes, and practice of South Sudanese host communities toward HIV;

Migrant sensitive health systems through promoting health service delivery and capacity building

- Work with the Ministry of Health to provide visible, accessible, affordable, and culturally accepted migrant friendly health services along major trucking routes, as well as a harmonised primary health care package of services taking into account specific needs and preferences of female sex workers and truck drivers;
- Collaborate with the Ministry of Health to provide cultural sensitivity trainings in order to promote migrant sensitive service delivery and build health providers’ capacity in responding to the health concerns and vulnerabilities of migrants;

Policy-legal frameworks using advocacy for migrant sensitive policy development

- Advocate for the Government of the Republic of South Sudan to uphold its responsibility to respect, protect, and fulfil the human rights of migrants regardless of their legal status through the addition and implementation of migrant-inclusive health policies to national multi-sectoral public health responses;
- Advocate with UN partners for South Sudan’s ratification of international human rights conventions, in particular the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) which stipulates migrant workers’ rights to social and health services;

Partnerships, networks and multi-country frameworks - strengthening intercountry coordination and partnership

- Look to regional cross-border best practices such as the Trans-Zambezi Malaria Initiative to reduce malaria among migrant populations by improving knowledge and action for the prevention, diagnosis and treatment of the disease;
- Contextualise and apply good practices demonstrated in HIV service delivery along the Kampala-Juba transport corridor by the IOM mission in Uganda, and extend them within the South Sudanese context in coordination with the Ministry of Health, the South Sudanese Transport Union, and foreign truck company employers.
Rationale and Objective

This situational assessment of migrant health in South Sudan has been conducted for the International Organization for Migration (IOM) with the support of the Partnership on Health and Mobility in East and Southern Africa (PHAMESA) and sponsored by Sida and Norad. It aims to address the lack of consolidated data on the particular health challenges faced by migrants, notably returnees, IDPs, migrant female sex workers, truck drivers, and migrant workers in South Sudan.

The overarching goal of the South Sudanese Health Sector Development Plan 2012-2016 is to increase the utilisation and quality of health services, scale up health promotion and protection interventions, and strengthen institutional effectiveness, efficiency and equity (Republic of South Sudan, 2012). In turn, the Migration Health Division within IOM aims to improve the overall standards of physical, mental, and social well-being of migrants by responding to their health needs throughout all phases of the migration process, while also responding to the public health needs of host communities within a human rights based approach to health. This assessment therefore seeks to understand the current health situation of specific migrant populations in South Sudan in order to contribute strategic information to the Ministry of Health for improved mainstreaming of migration health concerns into government policies and practice.

Specific objectives of this assessment are to identify some of the prominent spaces of vulnerability for migrants in South Sudan and outline the mobility patterns of populations associated with such spaces. It also seeks to identify the main health concerns in the key vulnerability spaces and to understand broadly the experiences of migrants in accessing health services in South Sudan, including specific challenges or enabling factors.
Background

In keeping with global trends, migration is a significant livelihood strategy and coping response to the ongoing economic and security pressures within South Sudan and its neighbouring countries. Independence, expanding trade, and tentatively more stable political conditions within regions of South Sudan are creating increasingly positive incentives and opportunities for labour migration as well as the return of thousands of South Sudanese from their countries of refuge. Many are returning voluntarily but some are doing so against their will, ‘returning’ to a country that they have never even been to and to which they have few, if any, links.

While there is no universally agreed definition for the term ‘migrant’, for the purposes of this report ‘migrants’ will refer to both international and internal migrants. International migrants may be in either a regular or irregular situation, but all have crossed an international border with the intention to stay for either short or long periods of time in South Sudan. The majority of international migrants are migrant workers and their families. While other categories can be victims of trafficking, children who migrate on their own or with their families and guardians, asylum-seekers, refugees, other displaced persons, migrants who have been smuggled, or returnees, within this study only migrant workers, migrant female sex workers, returnees, and truck drivers are addressed. Internal migrants may include migrant workers, victims of trafficking, IDPs, and children who migrate on their own or with their families and guardians. Within this study, IDPs are the only category of internal migrant addressed.

“A migrant worker is a person who is to be engaged, is engaged, or has been engaged in a remunerated activity in a State of which he or she is not a national” (article 2(1), ICRMW, 1990).
Irregular status refers to persons who, owing to unauthorized entry, breach of a condition of entry, or the expiry of his or her visa, lack legal status in a transit or host country (IOM, 2011). This status often prevents migrants without documentation from seeking public health care because of fear of deportation or harassment. In spite of high overall levels of undocumented migrants in South Sudan, irregular status here is a less direct hindrance to migrant health than in some other nations, given the open door health policies in place. Having said this, irregular status is still significant in negatively influencing the nature and conditions of migrant employment and therefore affecting migrant health indirectly.

IDPs are persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human made disasters, and who have not crossed an internationally recognized State border.


Figure 1: Factors that Affect the Well-Being of Migrants during the Migration Process

Source: Migration and Health: IOM’s Programmes and Perspectives SCPF/12, 2008)
Health is defined by the 1946 constitution of the World Health Organization (WHO) as a, “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”. In the migration context, this state of well-being extends to migrants, their families, and communities affected by migration. Furthermore, the WHO Constitution underlines the centrality of health as a human right stating that, “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.”

The act of migration itself is not inherently a risk to an individual’s health but the conditions surrounding the process at all stages of pre-departure, during movement, at arrival, and upon return as well as the individual characteristics of the migrant will influence the degree of their vulnerability (see Figure 1).

Understanding migration as a social determinant of health in this manner allows us to unpack the health risks faced by migrants, as well as the challenges they may experience in accessing and seeking health care. This approach, also referred to as a spaces of vulnerability approach, understands that migrants are influenced by the unique environmental and structural conditions of a specific location, and explores the relationship between migrant and host populations within specific ‘spaces’. IOM defines spaces of vulnerability as areas where migrants live, work, pass through, or from which they originate (IOM, 2010; UNDP, 2008). Figure 2 below highlights the different levels of vulnerability that migrants may be exposed to, sometimes in isolation but due to their multi-directional nature, often in combination with each other.

**Figure 2: IOM Multi-Level Approach in Regard to Determinants of Health**

<table>
<thead>
<tr>
<th>Structural Vulnerability Factors:</th>
<th>Environmental Vulnerability Factors:</th>
</tr>
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<tbody>
<tr>
<td>Socio economic situation and unemployment in rural areas</td>
<td>Epidemiological profile and how it compares to the profile at destination</td>
</tr>
<tr>
<td>Mobility is primary livelihood strategy</td>
<td>Lack of access to health services, including HIV and AIDS prevention and care programmes</td>
</tr>
<tr>
<td>High percentage of women in rural areas</td>
<td>Lack of targeted and appropriate health information</td>
</tr>
<tr>
<td>High levels of gender inequality</td>
<td>Challenging working and living conditions</td>
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<tr>
<td>Lack of migrant health policies and guidelines</td>
<td>Gender norms</td>
</tr>
<tr>
<td>High population mobility</td>
<td>Linguistic, cultural, and geographic proximity to destination</td>
</tr>
<tr>
<td>Cultural factors</td>
<td>Accepted high levels of transactional and intergenerational sex</td>
</tr>
<tr>
<td>Individual Risk Factors:</td>
<td>Gender and sexual based violence</td>
</tr>
<tr>
<td>Low level of knowledge on health and low health seeking behaviour</td>
<td></td>
</tr>
<tr>
<td>High health vulnerability during migration process (travel conditions/mode of transport) including HIV vulnerability and traumatic events such as abuse</td>
<td></td>
</tr>
<tr>
<td>Precarious legal status and limited access to services</td>
<td></td>
</tr>
<tr>
<td>Behavioural and health profile as acquired in host community</td>
<td></td>
</tr>
<tr>
<td>Pre-migratory events and trauma</td>
<td></td>
</tr>
<tr>
<td>Social exclusion and discrimination related to gender, age, and social status</td>
<td></td>
</tr>
<tr>
<td>Language and cultural differences</td>
<td></td>
</tr>
<tr>
<td>High level of multiple concurrent sexual partners, and separation from family/regular partners</td>
<td></td>
</tr>
<tr>
<td>Peer pressure and sub-cultures that promote risk taking behaviour</td>
<td></td>
</tr>
</tbody>
</table>

(Source: An Analysis of Migration Health in Kenya. IOM, 2011)
Characteristics of the Spaces of Vulnerability

This report will focus on three primary spaces of vulnerability and the interactions between migrants and host community members within those spaces.

Transport Corridors

Numerous studies have highlighted transport corridors, defined by the IOM as highways, waterways, and border points that come together in the transport of people and goods (IOM, 2013), as areas of high vulnerability especially for the transmission of HIV by truck drivers (Bwayo et al., 1991; Kulis, 2004; Ferguson and Morris, 2007; World Bank, 2008). Truck drivers, who are often young, sexually active men, spend prolonged periods of time away from their families and social support networks. The long distances, stress due to the nature of their employment, and influence of peers have been noted as individual risk factors that can lead to high levels of risky sexual behaviour, which in turn affect the rise of corollary industries such as the sex industry and service sector businesses that attract migrant female sex workers and migrant workers (IOM, 2008; UNDP, 2011). Hotspots (understood as particular sites of vulnerability within a particular space that facilitate risky behaviour, often most notable along transport routes or in urban settings [IOM, 2010]), such as bars, truck stops, and lodges along transport routes and at border towns typically enable close interaction between host populations, sex workers, truck drivers, and other migrants. Each serve as potential bridges for infectious diseases to others; but the mobility of truck drivers in particular has long been recognised for its role in facilitating the spread of HIV (Ferguson and Morris, 2007; Halperin and Epstein, 2007).

“Transport corridors are highways, waterways, and border points that come together in the transport of people and goods.”

(IOM, 2013)

Transit Sites

Transit sites, such as returnee or IDP settlements, are created as emergency and temporary residences for migrants during their journey or after displacement. They are often situated in locations separate from host communities and thus levels of interaction between IDPs, returnees, and host populations in these spaces are usually low. Yet interaction may occur to some degree as host communities use transit site health facilities and conversely, IDPs and returnees may enter the urban space for use of the market or recreational facilities. Because of the intended temporary nature of transit sites, populations there are likely to be unemployed and unable to engage in formal income generating activities, as well as prone to living in crowded environments. The structural and environmental conditions of transit sites may make IDPs and returnees vulnerable to high levels of food aid dependence and high rates of infectious disease.

Urban Settings

Urban settings provide multiple spaces for interaction between populations, and market places are one of the few spaces that enable high levels of interaction between host populations and migrant workers, truck drivers, IDPs, returnees, and migrant female sex workers combined.

IDPs or returnees may be settled in urban areas beyond the confines of a defined transit site; however, in reality they may be segregated from host communities by geographical or social boundaries that serve to marginalise IDPs and returnees and affect the frequency and nature of their interactions with host populations. These structural and environmental risk factors significantly influence the levels of vulnerability for these migrant populations within urban setting spaces, especially as unfavourable land allocations mean that populations in such spaces may experience disproportionately higher challenges in forming livelihoods and accessing health services than host populations.
South Sudan is not yet party to core international human rights instruments including the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR), the Committee on the Elimination of Racial Discrimination (CERD), the International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (ICRMW), and the Convention to Eliminate All Forms of Discrimination against Women (CEDAW). Neither is it party to any of the main regional human rights instruments such as the African Charter on Human and People’s Rights. Advocating for the ratification of these conventions is a top priority for the Office of the High Commissioner for Human Rights (OHCHR) in South Sudan and it is anticipated that South Sudan will soon ratify the 2010 African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa, also known as the Kampala Convention (UNHCR, 2013). South Sudan has though, adopted the UN Security Council Resolution 1983 calling for greater efforts to support access to HIV and AIDS services in post conflict situations, including for vulnerable populations such as sex workers and truck drivers.

On a national level, a defined government migration policy does not exist and national strategies toward migrants are not yet fully developed. However, the South Sudan National Strategic Plan for HIV and AIDS 2013-2017, designed to address the epidemic over the next five years, does identify key populations that should be prioritised for HIV prevention and as such, targets female sex workers and their clients as well as international migrants, specifically including truck drivers and other migrant workers.

In addition to the aforementioned categories, the National Strategic Plan for HIV and AIDS also addresses populations of humanitarian concern, including IDPs and returnees, in recognition of the fact that these migrant populations have not yet been effectively mainstreamed into humanitarian programmes or national strategies.

Furthermore, the National Strategic Plan for HIV and AIDS has identified Eastern, Western, and Central Equatorias as particular areas of vulnerability as they are the regions of South Sudan with the highest HIV prevalence rates and highest number of hotspots (including transport corridors, border points, and trading centres), especially for migrants. In targeting these populations and spaces, the Government of the Republic of South Sudan (GRSS) aims to achieve its objective of reducing new HIV infections by 50 per cent by 2017. However, to date most of the policies and strategies outlined are yet to be implemented or even fully endorsed.
In terms of migrant health policy and migrants’ right to health, the current primary health care system integrates migrants within its service with a non-discriminatory, open door policy meaning that migrants – regular or irregular – are able to access public health services. The South Sudan Health Sector Development Plan (2012) emphasises the provision of free primary health care at point of service and key informant interviews with State Ministry of Health officials suggest that this policy, with respect to migrants, is unlikely to change in the near future. There appears to be some recognition of the public health benefit of integration of migrants into the public health system, and aspects of the current system bear similarity to a migrant sensitive health system in terms of the free and non-discriminatory provision of health care. However, a fully migrant sensitive health system aims to systematically and consciously incorporate the needs of migrants into all aspects of health services (Global Consultation on Migrant Health, 2010:3) and it is unclear how intentional South Sudan’s open-door health policies have been and how much they are the result of an as yet under-developed overall health policy.

In many ways the open access to health care is equitable for migrants only in so far as placing them at the same disadvantaged position as the majority of the national population. That the level of public health care for the majority of South Sudanese nationals, let alone international migrants, is basic is undisputed. Less than 40 per cent of the population has access to any form of health care (UNDAF, 2012) and pharmaceutical shortages pose huge challenges to the population at large (Health Sector Development Plan, 2012). The current means for dealing with such shortages is to rely on development partners and the UN system (Health Sector Development Plan, 2012), thereby lessening the advantage of open access to migrants to a significant degree.

Similar gaps in health provision and policy exist for mental, and sexual and reproductive health care, the former point being particularly important for returnees and IDPs. After four decades of civil war, vast proportions of the population have been displaced and exposed to conflict and violence, yet national strategies to address the resultant psychosocial and mental health issues remain undeveloped and there is no mention of general or targeted mental health care provision within the Health Sector Development Plan (2012). This is worrying given the likelihood of internal migrants and returnees suffering from such issues, and that more than half of female respondents in the South Sudan Household Survey (2010) stated that they had suffered a form of sexual or gender based violence (GBV) and one in five had suffered sexual abuse. Furthermore, a post-conflict study from Juba found that 36 per cent of the sampled population (n=1,242) met criteria for post-traumatic stress disorder and 50 per cent for depression (Roberts et al., 2009).

In terms of immigration policy, all international migrants to South Sudan are obliged to pay for a visa to enter the country and also to register with the Directorate of Nationality, Passports, and Immigration (DNPI) within three days of entering the country. The cost of a visa for nationals from African Regional Countries that border South Sudan is 150 South Sudanese Pounds (SSP)² and for other African nationals is SSP 300. All such visas are valid for one month while registration costs SSP 170 and is valid for six months. There is a fine of SSP 10 for each day over-stayed. However, results from in-depth interviews with migrants suggest that they are paying fines of SSP 20 per day for overstay. Human error and misunderstanding of the immigration system are partly to blame, but such practices could be indicative of exploitation and corrupt practices on the part of the police (as reported by migrants). Migrants also reported that police officers explicitly target and search for undocumented migrants, specifically identifying ‘non-South Sudanese’ sounding or looking people in the market-space and fining or arresting them.

Migrants interviewed were largely well aware of the visa requirements for non-South Sudanese and of the immigration registration process for those staying in the country for longer than three months, but there were notable differences in their responses to prices and length of validity, as well as some confusion regarding the meaning of registration. Truck drivers are required to obtain a visa and road license (from the traffic police) but often their mechanics stay behind in the country for long periods of time and therefore are required to register with the DNPI. Confusion regarding the registration process appears to be widespread, in terms of which authority is in charge of the process and what registration actually means; one Ugandan mechanic understood immigration registration to mean he had purchased citizenship rights and was therefore angered at having to ‘renew his citizenship’ every six months.

² As of July 2013, the approximate official exchange rate was USD 1 = SSP 3 although black market rates ranged from USD1=SSP 4-5.
Methodology

A combination of methodologies were employed to achieve the objectives of the assessment including a desk review, qualitative focus group discussions, in-depth interviews, and key informant interviews. A small quantitative component was included to capture demographic data as well as trends on key migrant health concerns and top barriers to health care. However it must be stressed that as this was intended as a primarily qualitative survey, the sample sizes are too small to be representative of migrant categories or spaces of vulnerability. Three field researchers visited five field sites in five different states, identified by the IOM as informative spaces of vulnerability, to conduct the qualitative fieldwork. These sites were: Juba in Central Equatoria, Yambio in Western Equatoria, Wau in Western Bahr el Ghazal, Renk in Upper Nile, and Nimule in Eastern Equatoria.

Covered within the assessment were regular and irregular migrants, including migrant workers, migrant female sex workers, truck drivers, returnees, and IDPs. Pastoralists, asylum seekers, and refugees were not included.

Ethical considerations were addressed by seeking approval from the County Commissioner in each field site, and by explaining the purpose of the assessment to all participants, assuring them that they were under no obligation to respond to questions that caused them discomfort and that the results would be presented anonymously. Efforts were made to ensure equal gender distribution of respondents, range of nationalities, and where possible, a mixture of regular and irregular migrants. Methods used to secure interviews varied but going through community leaders of migrant communities by nationality proved an effective means of securing in-depth and focus group participants and gaining trust amongst those communities.

Dependent on location and migrant nationality, interviews were carried out in English, Arabic, Zande, and French using locally hired translators or local staff. Questionnaire and discussion-guide toolsets were discussed with translators before conducting interviews to check each question and ensure correct comprehension of the survey aims.
In-depth interviews:
A standardised toolset was created to capture data on the mobility patterns, health concerns, health barriers, and enabling or preventative factors of migrant health for all migrant categories. The term ‘health worry’ was originally used in the toolset but results from the pre-testing stage showed that this was not well understood, hence the change in terminology to health concern. In each location, researchers aimed to conduct three in-depth interviews with each of the five migrant categories. However in some cases it proved problematic to find the requisite individuals meaning that in total, 66 interviews were carried out (see Table 1 below for more details).

Focus group discussions (FGD):
Unique FGD toolsets were drawn up for each migrant category and each researcher aimed to conduct one discussion with each category plus one extra with whatever was determined to be the most dominant migrant category in their location. In this manner, a total of 26 FGDs were conducted (see Table 1). In general, researchers held discussions with between three to 11 participants. Standard FGD qualitative format was used to capture individual voices on most questions including quantitative demographic data. However for quantitative purposes, semi-structured questions regarding self interpretations of health (top health concerns and top health barriers) required participants to come to a collective consensus on a hierarchy of responses. This meant that for these responses the FGD itself was counted as a single unit of response rather than the individual voices within the group. In this manner n-values for these responses are lower than the n-values for demographic responses, which include individual voices.

Key informant interviews:
In order to triangulate the information gleaned from interview participants, 26 key informant interviews were carried out with relevant actors in each location, as identified by IOM or researchers (see Table 1 and Annex II for further details). Examples of key informants include officials from the State Ministries of Health, private clinics and pharmacies, UN organisations, partners of IOM such as Intersos, health focused NGOs, and members of the Relief and Rehabilitation Commission (RRC) who are the main governmental counterpart in managing the relief, rehabilitation, and reintegration of IDPs and returnees.

Table 1: Overview of number of focus group discussions, in-depth interviews, and key informant interviews carried out in Juba, Nimule, Renk, Wau, and Yambio, June 2013

<table>
<thead>
<tr>
<th></th>
<th>Truck drivers</th>
<th>Migrant female sex workers</th>
<th>Returnees</th>
<th>Migrant Workers</th>
<th>IDPs</th>
<th>Total</th>
</tr>
</thead>
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<tr>
<td>FGD</td>
<td>5</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>3</td>
<td>26</td>
</tr>
<tr>
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<td>Key Informant Interviews</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>26</td>
</tr>
<tr>
<td>Total Interviews</td>
<td>14</td>
<td>13</td>
<td>32</td>
<td>24</td>
<td>9</td>
<td>118</td>
</tr>
</tbody>
</table>
Challenges and Limitations

Every effort was made to gather data that was equally weighted between categories; however, inevitably, each location was characterised by different compositions making it impossible to meet sample requirements in every case. For example, IDPs in Renk and Nimule were unwilling to identify themselves as IDPs as they were accustomed to receiving benefits meant for returnees; they were therefore unwilling to participate in FGDs organised by the field researcher in order not to lose the benefits awarded to them as alleged ‘returnees’. In such cases, numbers were made up with FGDs with other migrant categories.

In Renk and Yambio in particular, researchers faced challenges gaining access to migrant female sex workers. Conservative attitudes in Renk proved a strong constraint in acknowledging or openly discussing the sex industry and even after explaining the health purposes of the interview, prospective participants were unwilling to continue. Transactional sex trends showed that organised sex work operating from a centralised location such as brothel or lodge are not universal and that many sex workers – both migrant and host community – operate on a highly individualistic basis whilst also engaging in other jobs. These factors proved prohibitive as it was difficult to locate such women during the day, and even efforts to engage with them at night proved challenging, meaning that FGDs were not held with migrant female sex workers in Yambio or Renk.

Ascertaining the legal status of migrants was a sensitive issue. At the beginning of each interview and focus group discussion, the health rationale of the assessment was stressed and it was emphasised that it was in no way associated with immigration officials. The delicate nature of this question meant that direct questions regarding status were not always appropriate and therefore indicative proxy means were used such as asking about migrants’ knowledge of immigration processes, the consequences of not having the correct documents, and the experiences of ‘others’ who may not have documentation. Some migrants, especially truck drivers, were very confident and open about their status meaning that more direct questions could be asked; but others, in particular female migrant sex workers, showed signs of unease during interviews, and therefore extra sensitivity was employed in discussing issues related to status, as outlined above. This proved an effective means of ascertaining an idea of legal status but cannot be considered wholly accurate, as interpretations are likely to have varied between researchers and even migrants in an irregular situation could produce ‘regular’ knowledge.

Methodological Challenges

This assessment was initially designed as a qualitative study; the stipulation of quantitative data added after the main toolsets were designed posed some challenges in adjusting the tools and communicating the changes to field researchers comprehensively. The resulting quantitative data is therefore of two parts - the first (demographic) whereby n-values should reflect the actual number of respondents and the second (self interpretations of health) whereby n-values are lower as they consider each FGD as a single response. In the latter case, multiple answers were allowed meaning that the data is presented by frequency. The sample sizes are not significant enough to be representative of either space or category and therefore should be viewed as indicative rather than absolute trends.

While efforts were made to limit the sizes of FGD to around 10 participants, in some cases the presence of a researcher willing to talk about health concerns attracted large crowds of over 25. In the few cases where large numbers of FGD participants were involved, quantifying their responses meant distorting the data with disproportionate numbers and answers that were not necessarily wholly representative.
South Sudan has an extremely diverse cultural and tribal mix with over 60 major ethnic groups (Embassy of the Republic of South Sudan in Washington DC, 2013), not including many more ethnic subdivisions, spread across its ten states. These tribes are largely divided into three dominant ethnic groups – the Nilotic, Sudanese Nilotic, and Sudanese. The Nilotic group includes the two largest tribes in South Sudan – the Dinka and Nuer – as well as the Shilluk, who are predominantly pastoralists and traditionally situated in the country’s northern regions. Sudanese Nilotic tribes include the Bari, who have traditionally been the dominant tribe in Juba, as well as the Mundari and Taposa. The Sudanese group includes the Zande and other agriculturalist tribes living west of the Nile and near South Sudan’s southern and south-western borders (Gurtong, 2013; Joshua Project, 2013).

**Juba**

Juba is the capital and largest city in South Sudan. It is also the capital of Central Equatoria State, positioned along the banks of the White Nile. While Juba is situated on the land of the Bari tribe, as the country’s prime urban centre it has naturally attracted the full array of South Sudan’s tribes. It is the first stop for most international migrants, particularly those coming from Uganda and Kenya, and is also where many people not traditionally from the area have moved to upon being displaced or upon returning to South Sudan. This mixed group of people creates an atmosphere more sexually liberal than the northern parts of the country; however, in Juba, a woman still generally lives in her father’s house until she gets married.
Nimule

Nimule is situated north of the Ugandan border in Eastern Equatoria State. It lies approximately 190km southeast of Juba and is a linchpin for most road traffic into South Sudan. As a border location with heavy traffic flows from Uganda and Kenya, Nimule is a bustling and fast-growing town, attracting many migrants with its burgeoning economic opportunities. Nimule sits on land owned by the Acholi tribe whose traditional territory straddles the border between South Sudan and Uganda. Early marriage and extra-marital sex are widely practiced and accepted in Nimule. There are high levels of sex worker activity due to it being both a border town and truck stop hotspot, and NGOs like Merlin and the American Refugee Committee (ARC) carry out various awareness campaigns in the community areas, markets, and in the hospital to educate the population on HIV and AIDS. Nimule Hospital has been managed by Merlin, a British-based health charity, since 2004.

Renk

Renk is located in Upper Nile State, in the northeastern section of the country, close to the international border with the Republic of Sudan and approximately 970km north of Juba. Renk is host to all the major tribes of South Sudan, although the Dinka are most dominant. Subsistence agriculture and nomadic animal husbandry are key livelihood activities. Due to its proximity to Sudan, the majority of the population is Muslim, and while Christianity is gaining steady influence, conservative Islamic culture has had a strong influence on dress codes and sexual permissiveness. Due to this cultural influence, the efforts of NGOs and the Catholic Church to carry out HIV awareness campaigns to educate the community at large have not been massively influential and use of condoms is still low. Returnees from Khartoum, Sudan are the dominant migrant category in Renk, the majority of whom live in transit sites waiting to move to other parts of South Sudan. Other groups of returnees are integrated within the host communities as they are either planning to settle or waiting until there is security at their place of origin.

Map 1: South Sudan by State and field research sites
Wau

Wau is a city located approximately 650km northwest of Juba on the western side of the Jur River and is the capital of Western Bahr el Ghazal State. It is the second largest city after the country’s capital, Juba, populated largely with people from the Dinka, Fertit, and Luo tribes. Most of the preferred and more cost-friendly hospitals in Wau are connected with the Catholic or Protestant churches. Unfortunately, HIV prevention initiatives by the government are currently underfunded in the area as in many parts of the country. Attitudes regarding sex are considerably stricter in comparison to Juba, and although polygamy remains common, condom use is stigmatised.

Yambio

Yambio is the state capital of Western Equatoria and situated around 30km north of the border with the Democratic Republic of the Congo (DRC) and south-east of the border with Central African Republic (CAR). The Azande are agriculturalists and the dominant tribe in this state, well known amongst South Sudanese and neighboring countries for their tolerance and peacefulness. Christianity is very strong here and the Catholic Church highly influential. HIV prevalence rates are high and indeed Western Equatoria has the highest HIV prevalence rates in the country; at 6.8 per cent it is significantly above the national average of 2.6 per cent (South Sudan AIDS Commission cited in the National Strategic Plan for HIV and AIDS, 2013). Condom use is broadly mistrusted and has not yet gained widespread cultural acceptance. Intergenerational and extra-marital sex is widely practiced and accepted, and polygamy and multiple concurrent partnerships amongst men and women are common. Gender norms strongly disfavour women, and the combination of weak female agency with the above mentioned sexual practices results in high levels of early marriage, early pregnancies, and gender based violence.
Migration Push and Pull Factors

A commonly accepted theory for why people migrate frames mobility within a push and pull framework, acknowledging factors that compel people from their areas of origin and draw them to a specific destination. Qualitative interviews with migrants across the five states present some distinct mobility trends in the context of South Sudan and its neighbours.

The Comprehensive Peace Agreement (CPA) signed in 2005 and South Sudan’s subsequent independence from Sudan in 2011 have been decisive factors in shaping migration trends to and within the country. Moderately improved security levels combined with a growing demand for goods and services, and an absence of local industry or a skilled national workforce have become pull factors for entrepreneurial migrants from neighbouring countries, who are being drawn to the growing number of economic opportunities available in South Sudan.

Migrant workers attracted by substantiated rumours of high profits have left behind saturated job markets with no new employment opportunities in Kenya, Uganda, Ethiopia, Eritrea, Somalia, the DRC, and Sudan’s Darfur region to do business in South Sudan. For example, for Eritreans who do not complete military service, finding gainful formal employment in Eritrea is almost impossible, hence the motivation to seek opportunities abroad; this motivation was cited multiple times in interviews. In a classic example of Ravenstein’s early “step migration” theory, migrant workers often arrive first in Juba whereupon high costs of living and competition push them to towns such as Yambio and Wau where business opportunities and profits are more easily pursued and at a lower cost.

Traffic along transport corridors, predominantly from Mombassa, Nairobi, and Kampala through Nimule to Juba and beyond, has increased significantly and been accompanied to varying degrees by an increased sex industry. Migrant female sex workers are often found to combine petty trade or service sector jobs with sex work, or indeed to have abandoned their initial, low paying jobs for more profitable sex work. Diffusion of information from relatives and social networks plays a key role in drawing women to South Sudan, and they have often left behind young families in order to act as sole breadwinners, sending remittances home regularly. This is in keeping with the growing feminisation of migration whereby more women are migrating independently to support their households; as such there should be a greater focus on the associated vulnerabilities to health for women in spaces along the migration route.
Independence and ensuing peace has also meant the return of hundreds of thousands of South Sudanese living in Sudan, predominantly in Khartoum, back to the South. Most southerners living in Sudan lost their citizenship after South Sudan’s secession on 9 July 2011, irrespective of the strength or weakness of their connections to either State or their desire to remain in Sudan or return south. A deadline of 8 April 2012 was set for southerners in Sudan to regularise their status, i.e. obtain South Sudanese citizenship, but hundreds of thousands of people failed to do so meaning they had no recognised legal status in Sudan (Open Society Initiative for Eastern Africa, 2012). Interviews with returnees indicate that the subsequent increase in discrimination against non-Muslim southerners and repressive policies regarding their access to public services and freedom of expression in Sudan served as compelling push factors to return to South Sudan. Despite numbers of southerners having lived in Khartoum for several decades, some speaking only Arabic, many were thrilled at the prospect of returning ‘home’ to cast their vote. For example, when the governor of Western Equatoria offered to fly Zande communities living in Khartoum back to the state prior to elections, hundreds grasped the opportunity and returned to Western Equatoria armed with a single suitcase and hopes for a brighter future.

Despite overall improvements in peace and stability, pockets of violent conflict and localised natural disasters have acted as strong push factors and resulted in the internal displacement of large numbers of South Sudanese. Particular examples being the forced displacement of border communities in Western Equatoria due to the cross-border movements and atrocities committed by the Lord’s Resistance Army (LRA) that peaked in 2008. Internal violence continues to displace communities, and the 2011 oil conflict in Abyei, when Sudan Armed Forces took control of Abyei town, resulted in the displacement of a reported 150,000 people who fled to Western and Northern Bahr el Ghazal states (Episcopal Church of the Sudan Diocese of Wau, 2013). According to interviews with urban-periphery residents, tensions in Juba have reportedly risen due to the mass displacement of communities whose homes are being destroyed and land grabbed by returning populations as well as by dominant tribes-people in order to clear the land for further building and development.

### Transport Corridors

Notable transport routes are those running north from Mombassa and Nairobi to Kampala and then either through Gulu (north-central Uganda) to Nimule border point and on to Juba, or through Arua (western Uganda) to the Kaya border point and on to Western Equatoria. Occasionally the routes disperse from Juba to Wau, Bentiu, or Malakal.

Other routes run from Kampala and then west to Yei, Yambio and Wau bypassing Juba altogether. The southern route from Khartoum into South Sudan passing through Renk has been closed and there is little legal traffic along this corridor. Goods to Renk usually travel by river, and ports along this route may be a focus for further study. Drivers in the northern states tend to travel internally between Renk, Malakal, and Bentiu.

The characteristics of urban truck parks, spaces where truck drivers congregate to park their trucks during rest stops and which may or may not be officially sanctioned, varied. In Juba, the Nessito truck park is an established zone with many snack shops and recreational facilities and is located out of town. Yambio’s truck park is also located about 3km out of town but has no amenities or recreational spaces attached to it and truck drivers must drive into town to access bars, restaurants, and hotels. Wau’s truck park is located within the town and therefore is within close reach of bars and lodges. In the latter cases, hotspots are well integrated within the town and not contained to truck parks, indicating high levels of interaction between migrant and host communities. Aside from established truck parks, the vast distances between towns and the low levels of development or settlement in such areas means that drivers often make informal stops along uninhabited roadsides, sleeping ‘in the bush’ with no sanitation amenities and heightened vulnerability to armed groups, insect bites, and related skin infections.

Lodges frequented by truck drivers are well established in Nimule, Juba, and Wau, whereby sex workers, truck drivers, and other migrant and host populations come into interaction; in Nimule, interaction between IDPs and sex workers was particularly highlighted in interviews with UNHCR personnel. In Yambio however, lodges and a centralised sex industry were less well established and according to in-depth interviews with sex workers and key informants, transactional sex often takes place in private spaces like the home.
**Truck Drivers**

Most truck drivers interviewed in Nimule, Juba, and Yambio (n=25) were Kenyan (60.0%, n=15) or Ugandan (24.0%, n=6), whereas in Wau and Renk (n=14) there were noticeably fewer East African truck drivers and more South Sudanese (35.7%, n=5) and Sudanese (35.7%, n=5) drivers. Employment acts as a social determinant of health for truck drivers as differences in contract type between South Sudanese and foreign drivers result in differing levels of well-being and health outcomes. Foreign drivers tend to be contracted by large trucking companies that provide relatively stable working conditions and care for drivers including formal contracts; stipends for accommodation, food, and health expenses; and some reimbursement for fines incurred along the journey. In contrast, South Sudanese drivers tend to be hired on an ad hoc basis by private individuals who do not provide any kind of commensurate expenses, leaving these drivers more financially vulnerable and risk prone than their foreign counterparts. Further differences in religion, HIV awareness, and language distinguish national and international drivers from each other and serve to influence their health outcomes and health seeking behaviour. The overwhelming majority of those who provided information on their marital status (n=30) were married (93.3%, n=28) while the other two (6.7%, n=2) were engaged.

**Map 2: Key truck routes into and within South Sudan, also showing journey starting points**

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4 A total of 39 truck drivers were interviewed. A total of 14 interviews were conducted with truck drivers, including 5 x FGD and 9 x in-depth interviews. The total n-value for health concerns, health seeking behaviour, and health needs is therefore n=14.
Health Concerns
Out of the 5 FGDs and 9 in-depth interviews carried out with truck drivers, malaria was the most frequently cited health concern (71.4%, n=10) followed equally by insecurity and violence (42.8%, n=6) and back or chest pains (42.8%, n=6) and then HIV (35.7%, n=5). HIV was rarely given as the topmost serious health concern and sometimes was only included after some probing. This may be indicative of safe sex practices, but researchers felt that in many cases truck drivers were very sensitive to assumptions of risky behaviour and associations to HIV and deliberately sought to avoid emphasising HIV or being defined by it. Insecurity was mentioned only six times, but it is clear that it is an important underlying determinant of truck driver health as it is linked to stress and risky behaviour as well as negative sleeping habits.

For truck drivers, mobility and poor environmental features, such as insecurity along roads and at truck parks, are strongly linked to malaria as a large proportion of truck drivers (of all nationalities) and their ‘turn boys’ are compelled to sleep in or underneath their trucks along roadsides rather than in lodges to protect their vehicles. Use of mosquito nets varies, but most sleep with open windows thus increasing their risk of being bitten by mosquitoes carrying malaria.

Intimidation at gunpoint and physical violence such as slapping and caning from armed civilians and soldiers causes stress and psychological trauma to drivers. Checkpoints are numerous (one driver claimed the presence of 67 stops between Renk and Malakal, a distance of 282km) and bribery rife. Volatile behaviour of South Sudanese officials and civilians, especially under the influence of alcohol at checkpoints and hotspots, was cited multiple times as cause for high stress levels. Non-South Sudanese truck drivers feel that they have ‘no rights’ within South Sudan and fear that the slightest retaliation to South Sudanese provocation will lead to assault, arrest, or both. The strain caused by poor roads combined with the fear of assault and insecurity, due to perceptions of South Sudanese authorities’ disregard for their rights, was explicitly linked by one truck driver to his ‘need’ for interaction with sex workers en route. Given such responses, it is striking that STIs did not feature within truckers’ top five health concerns. This is suggestive of shame or stigma concerning their sexual behaviours, which is likely to have influenced their reticence in disclosing such concerns.

Barriers and Enabling Factors in Accessing Health Care
A barrier, as understood in this paper, is a factor that restricts the use of health services due to a lack of transport or money, an absence of services available, or limited communication with health personnel due to the inability to speak the local languages. Other factors that prevent migrants from using health services may be endogenous feelings of unease caused by perceptions of stigma directed at them, fear of the modes of transport available to them, or poor health knowledge that reduces their sense of urgency in seeking treatment. Enabling factors are those that allow migrants to make greater use of health services and may be due to sufficient availability and provision of services, good personal knowledge and understanding of when and where to access services, and the financial means to do so.

Self-reported condom use with sex workers at hotspots appeared to be high, backed by a study of the Kampala-Juba transport route in 2008 which suggested that 75 per cent of Ugandan truck drivers ‘always’ used condoms with female sex workers; however, consistent use of condoms with all non-spousal partners was only 46 per cent (IOM, 2008). This suggests that truck drivers with
regular ‘girlfriends’ en route may well use condoms less frequently and simultaneously transmit and be vulnerable to sexually transmitted infections – this was not a consistently asked question in interviews and a further study focusing on HIV related behaviour would be beneficial to identify specific programming needs. Truck drivers also confirmed the prevalence of individual risk factors such as fatalistic “I don’t care” attitudes, whereby those already infected care little about protecting others and purposefully neglect to use condoms.

Multiple preventative environmental vulnerability factors were self-reported by respondents, including the cost and scarcity of condoms, delayed journeys due to breakdowns from poor roads or lengthy clearance procedures, and mistrust of the health system in South Sudan. The latter point includes strong perceptions that local health systems in South Sudan have poor quality medical staff and medicine (i.e. medicine that is expired, in addition to being insufficient in quantity) and notes the lack of health services in between towns. The majority of drivers were not aware of VCT services within South Sudan – those in Renk claimed they were unnecessary and East African drivers claimed to use services in their home countries exclusively.

East African drivers were all contracted by trucking companies and all appeared to have regular immigration status and all appeared to have regular immigration status; given the number of checkpoints along the routes it would be impossible to travel without a valid visa or road license. Strong enabling factors for them were the widespread provision of first aid kits (often but not always accompanied by first aid training provided by their employers) to trucks as well as budgets for accommodation and health care en route.

A structural barrier to truck drivers’ health is the length of time they must spend waiting at borders. This is dependent on clearance times which average 2-3 days, but which can sometimes take over a week – supposedly due to clients in Juba delaying the flow of goods into the city in order to raise public demand, and therefore price, of goods. In-depth interviews with truck drivers in Nimule indicated that during these waits, drivers often socialise together drinking locally brewed alcohol such as Rambo or Orange Bomb with ‘voltages’ (alcohol content percentages) of up to 13.8%. This indicates a high level of alcohol consumption which has been noted as a link to increased risk-taking behaviours, such as unprotected sex (Fisher et al., 2007).

Discussions with foreign truck drivers highlighted several positive individual characteristics such as high levels of knowledge, fear, and openness concerning HIV compared to South Sudanese drivers. Strong understanding of multiple means of transmission and methods of protection were demonstrated, which is almost definitely the result of long term and widespread public awareness campaigns and education in their home countries. However, over-confidence and over-estimation of actual knowledge levels and safe-practice should be taken into consideration. A few interviewees were extremely open about their ‘side dishes’, a term for sex workers they visit along their trucking routes, but a large number were adamant that they did not engage in sexual activities while working because of fatigue, fear of HIV contraction, and faithfulness to their wives – the latter point being relevant as the majority were married. As a Kenyan participant in Nimule stated, “I hate that people all think we have sex with prostitutes. There are drivers who do it, but it is unfair to generalise for all of us”.

A truck transporting teak logs from Western Equatoria State to Uganda stops over in Yambio truck park.
Health Seeking Behaviour

Many non-South Sudanese truck drivers own their own first aid kits containing a basic cache of painkillers, antiseptics, bandages and sometimes malaria testing kits, and 35.7 per cent (n=5) would turn to these kits as their first choice of health care. This response is indicative of the lack of health services along sparsely populated routes in between towns. Returning to their home country was cited by 21.4 per cent (n=3) as their first choice and by 14.2 per cent (n=2) as their second choice of health care. No participant cited that they would seek treatment in a government hospital, preferring rather to use private clinics or pharmacies (21.4%, n=3; 14.2%, n=2 respectively) instead. Unwillingness to use government facilities was explained by factors of mistrust of the quality of South Sudanese health staff as well as lack of knowledge of where such sites were located. Given the often long-haul journeys, the reluctance to use South Sudanese services may result in the delayed diagnosis and treatment of illnesses and the increased probability of serious long-term complications.

Health Needs

When asked what they most needed in order to improve their health along transport corridors, the most frequent responses, shared by all nationalities, were for more health centres and VCT services along the road (50.0%, n=7) and a combination of improved security/reduced road blocks and better roads (42.8%, n=6). South Sudanese truck drivers specifically wanted more first aid training (21.4%, n=3) while non-South Sudanese wanted more information on existing health facilities along transport routes (28.5%, n=4).

Migrant Female Sex Workers

Along the transport corridors assessed, migrant female sex workers were found in lodges, bars, and restaurants frequented by truck drivers, host communities, and IDPs in Nimule, Juba, and Wau. In Yambio they had to be identified through private contacts, although such hotspots do exist. The majority (62.5%, n=15) of sex workers interviewed were from Uganda and all were adults, although anecdotal evidence from Yambio suggests that there is a growing trend of under-18 Congolese girls getting involved in the sex industry. Most women were encouraged to enter South Sudan by friends or relatives to undertake jobs in the service sector, which they have either willingly abandoned or chosen to supplement with sex work. There was no evidence among the women interviewed of trafficking for sexual exploitation; however, a State Ministry of Health official conceded that while trafficking in persons is not commonly heard of, it is possible that ‘mummies’ who lure girls into the country are operating below the radar.

5 A total of 24 female migrant sex workers were interviewed, from 4 FGDs and 9 in-depth interviews. For data relating to health concerns, health barriers, and health needs the total n-value=13

6 ‘Mummies’ is a term used to reference female traffickers who encourage girls to leave their homes to engage in sex work
Health Concerns

The most frequently expressed health concern by migrant sex workers was sexual and gender based violence (SGBV) from clients, including rape, violent use of weapons, refusal to wear condoms or pay for services, and physical assault (61.5%, n=8). Some interviewees expressed a direct link between GBV practices and the ignorance of the host population (especially men) regarding HIV and means of protection (46.1%, n=6). Malaria was the next most common concern (46.1%, n=6) followed by HIV and AIDS (38.4%, n=5).

Rose, a sex worker originally from Arua (Uganda), told the following story:

“After my husband died, my friend encouraged me to go out to clubs in Uganda to look for men. When I arrived in Yambio I did dobbi work and I started going to some bars and discos like I did at home. It was sometimes dangerous to move at night so I carried out my business in my house. One night I was with my friend at a disco and two South Sudanese men came to talk to us. One of them got very drunk and didn’t want to pay; he threatened me with a machete and pushed the blade into my back. After that I was so scared to go back to the discos; even now when I pass that place I feel nervous. I didn’t go to the police because I didn’t renew my waraga.”

Barriers and Enabling Factors in Accessing Health Care

A large proportion of the migrant female sex workers were exposed to individual risk factors as it appeared common for them to have irregular immigration status, which meant they were subsequently worried about encountering the police or immigration officials. Even though the health care system does not discriminate by legal status, several women stated that one of the reasons they prefer to use private clinics instead of free government services is because of concerns over their status. GBV cases go unreported, partly due to misunderstanding and fear of legal processes thought to be attached to post-GBV medical care. Survivors of GBV are only required to fill out the Form 8 police document if they wish to seek justice for the crime committed against them; however, this does not appear to be widely known amongst health practitioners, police officers, and host or migrant communities, leading many people to believe that GBV survivors need this form to receive medical treatment. Evidence from speaking with migrant female sex workers suggests that rumours of the necessity of filing a police report may be negatively impacting migrant GBV survivors’ willingness to seek medical help, particularly for those with irregular status.

At both environmental and individual levels, a combination of absent counselling services and exceptionally weak knowledge of existing ones prevents women from accessing psychosocial care. Women therefore rely on each other to talk about their experiences and support each other. The general absence of pimps in organised brothels leaves women unprotected, and particularly vulnerable are those who conduct business in their own homes.

Ugandan and Kenyan interviewees were well aware of the dangers of HIV and other STIs; while some stated that they turn down men who refuse to use condoms, others reported that they are intimidated by slapping and the threat of guns into acquiescing. Language too is a barrier in negotiating condom use; one woman in Wau explained that when there is a problem, men will often stop speaking Arabic (which many of the migrant workers speak) and switch to Dinka, which they cannot understand.

A repeated vulnerability factor raised by sex workers was the high-risk host environment whereby low knowledge of and concern for HIV is shown by the host population men and women. From the four FGDs and nine in-depth interviews carried out with migrant sex workers, the most recurrent vulnerability themes were the lack of testing among host populations, the lack of accessible or free condoms (combined n=10, 76.9%) and the complacency toward HIV (specifically directed at men, 46.1%, n=5). The lack of testing amongst

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7 This is not her real name
8 Clothes washing service
9 From the Arabic ‘Waraga’ literally meaning papers, and a common reference to visas and entry permits
males in towns along transport routes was raised by local and migrant sex workers and verified by Merlin and CMMB representatives in Nimule and Yambio respectively, who confirmed that their VCT programmes see far more women than men. This indicates underlying attitudinal problems among the male population that make female sex workers and their clients particularly vulnerable to HIV and strongly suggests that targeted attitudinal change interventions are needed for men. Migrant female sex workers in multiple locations felt that their superior health knowledge was an enabling factor and put them at an advantage to host populations; but underlying conditions of host population ignorance that facilitate the spread of HIV, and the use of violence that forces sex workers into unsafe practices, means that this knowledge does not sufficiently protect them from infection.

Misconceptions regarding condom use among host populations were found to be a strong driver of migrant vulnerability. When a Ugandan sex worker in Yambio heard that local boys were afraid of using condoms because they fear paralysis of their penises, she burst out laughing in disbelief and said that no Ugandan man would be so ignorant. Yet such reasons for not using condoms were common and local girls reported how boys had even tried to convince them that condoms would cause their (the boys’) death.

The reluctance of South Sudanese to use condoms presents a deep environmental challenge and health risk for migrant sex workers as this unwillingness is widespread and not contained to men: women appear to worry that by suggesting condom use their partner will suspect that they are living with HIV, so prefer to go ‘live’ to convince them of the opposite. Young men claimed that in some cases girls convince them not to use condoms in order to get pregnant and ‘trap’ them into marriage.

The implications of such sexual norms put all communities within transport route spaces at risk as sexual interactions in this space are notoriously high and in the case of South Sudan, as noted previously, are exacerbated by a volatile security environment that compels truck drivers to engage in transactional sex from security-related high stress levels. The cyclical interactions between the host population and migrants mean that clients who refuse to use condoms with their spouses or with sex workers pose severe health risks to migrant female sex workers, who in turn perpetuate the risk of transmission to clients. Such interactions and bridges between all population categories exemplify how the transport corridor space exposes a broad network of populations to HIV and STI vulnerabilities.

Health Seeking Behaviour
Out of the 13 FGDs and in-depth interviews, seeking treatment from a private clinic was the first choice for 84.6 per cent (n=11) of the interviewees, with government hospitals and returning to their home countries as joint second choices (38.4%, n=5 each). A common interval period between going home was cited as being around three months although it was often longer, meaning that treatment for those seeking health care in their home countries may be significantly delayed, allowing illnesses or diseases to develop for longer and to a more serious degree. Ugandan sex workers living in Nimule were far more likely to cross the border to seek services in Uganda and almost all prefer to get tested when they return home even though a third of all respondents (38.4%, n=5) were able to name VCT services provided by ARC, Merlin, and CMMB in their locations. Some women worried that they would face discrimination at government hospitals for being sex workers and therefore if unable to return home or if suffering from ‘minor’ symptoms such as headaches, they stated that they would prefer to seek treatment at private clinics in South Sudan, despite the cost.

Health Needs
In terms of self-reported needs, better awareness and education on HIV (in terms of means of transmission and protection) for the host population, including more testing and condom use, was the most frequent comment (46.1%, n=6), followed by equal demands for better quantity and quality of drugs (i.e. that are not expired) and condoms (38.4%, n=5 each), and counselling and psychosocial services for sex workers (23.1%, n=3). Of course, it should be recognised that the demand for better quality drugs is not limited to this particular migrant category, nor to migrants alone, but rather is a universal concern shared by host populations too.
Millions of people started returning south in the lead up to South Sudan’s independence, and have continued to do so since 2011. However, tens of thousands still remain in semi-permanent transit sites, organised and serviced by NGOs, UNHCR, and the IOM for humanitarian purposes (primarily in Renk, Upper Nile State). Despite the government’s guarantee of land for all returnees, a series of interlinked factors has prevented many from settling on this land, meaning the prolonged occupation of way stations intended for transits of only three to four days. Such transit sites, that are either in requisitioned buildings or that have been purposefully constructed for humanitarian purposes, are immediately distinguishable from permanent and well-serviced urban settings. They are often overcrowded and have insufficient provision of sanitation facilities, potable water, or access to health services.

**IDPs and Returnees**

Some IDPs who fled violence and sought shelter in IDP camps still remain in these transit stations despite the return of many of their fellow countrymen and women to their places of origin. The lengthy periods of time that IDPs are spending in transit locations, of up to three years in some instances, have inevitably led to relatively permanent settlements and lifestyles; these temporal considerations then raise problematic questions regarding IDP status and accordingly, when they should cease to receive targeted aid.

As of July 2013 there were 12,000 returnees stranded in Renk (IOM, 2013), although as the situation is far from static – as people arrive, are relocated, or integrate into the host community on a regular basis – accurate numbers are hard to come by. Efforts have been made to provide latrines and address WASH (Water, Sanitation and Hygiene) issues, but conditions remain challenging and shelters range from semi-permanent grass-walled to temporary tarpaulin structures. Despite these challenges, some returnees, especially men, have been stranded here for up to two years due to financial restrictions on their onward transportation. Ongoing conflicts, as in Jonglei State, mean that it is unsafe for many returnees to reach their final destinations and the transit site facilities are viewed as an enticing environment in which to remain. Renk transit sites are notable for the high proportions of unaccompanied men, whose wives and families have continued to their end destination leaving the men to guard the furniture and valuables they
brought from the Sudan, but have insufficient funds to transport them further. This separation serves to increase individual-level health vulnerabilities for each of the separated parties in their respective transit spaces, as spousal absences can lead to heightened financial and physical insecurity for single women as well as reduce inhibitions toward risky behaviour among both parties. Prolonged separation was noted to have caused severe distress amongst the single returnee women in transit sites and overall poor emotional and social well-being.

The returnee way station on the edge of Yambio town is a classic example of prolonged settlement in a temporary transit site. Around 90 returnees are living in cramped conditions with insufficient access to clean water. Allocated land is waiting for them, but most of the returnees here are elderly or single mothers whose husbands are stranded in Renk. This is in line with national trends where 50 per cent of returnees are in female headed households (International Rescue Committee, 2013). The allocated land is bush, isolated from town with no easily accessible health or education facilities. For women who have spent the past three decades in the urban environs of Khartoum, they have little farming knowledge and without any physically able men around, they are hesitant to settle with their children in such isolated and unprotected areas.

**Health Concerns**

In line with the health concern trends of four of the five targeted populations, malaria ranks highest amongst populations in transit sites at 83.3 per cent (n=15). A standout trend in this space of vulnerability is the self-reported concern of malnutrition and related weakness among adults and children, with a frequency response of 72.2 per cent (n=13). WASH concerns relating to dirty water and poor sanitation were raised by 55.5 per cent (n=10) of returnees and IDPs in these spaces.

**Barriers and Enabling Factors in Accessing Health Care**

Insufficient amounts of nutritious food are affecting inhabitants of transit site spaces. This is due to short-term rationing intended only for three months from distributors such as the World Food Programme (WFP), as well as high prices and limited supply of food in the markets. Interviews with members of the RRC in Renk confirmed the challenges returnees face in sourcing food and a Ministry of Health official in Yambio noted that malnutrition amongst returnee children was a severe challenge given the difficulties of securing a job with sufficient income to buy food; this is especially problematic for single mothers who seek work and are sometimes forced to leave their children unattended during the day, with no food.

Multidirectional factors at all structural, environmental, and individual levels make finding employment extremely challenging for populations in this space, and was spoken of by several interviewees as one of the greatest challenges to their overall well-being. Employment opportunities are scarce even for those with skills and qualifications from Khartoum, and the mobility and isolation factors of those still in transit en route or in semi-permanent transit sites at destination mean that their levels of social capital are typically extremely low. Without someone to secure them a position, it is ‘impossible’ to get work. The lack of livelihood opportunities are strongly linked to health vulnerabilities and there is a vast array of academic literature to support the causal relationship between income deprivation and poor diet, low standards of housing, and insufficient access to health care (Kawachi et al., 1999; Ostlin et al., 2004). Moreover, a lack of formal jobs increases the likelihood of turning to informal income generating activities, and unaccompanied female returnees are especially vulnerable to turning to transactional sex work and therefore susceptible to the corresponding health vulnerabilities. While this was not mentioned by female returnees during in-depth interviews, it was raised independently by both the County Commissioner and Deputy Director General of the Ministry of Health in Yambio.

The relative levels of security, the presence of on-site IOM clinics, and supply of water are strong enabling factors that encourage returnees to remain in the Renk transit sites. Free health care provided by IOM before and during onward travel assistance movements and at some transit sites means that some of the vulnerabilities associated with mobility such as unavailability or ignorance of services are being mitigated. At a transit site in Wau for displaced persons from Abyei, an IOM mobile clinic visited twice weekly and was well utilised. However, high demand for health services means that many pay out of pocket for private clinic treatment or resort to traditional medicine in between visits, strongly indicating high levels of unmet health needs. Those in the Yambio way station do not receive any outreach services and can barely afford the SSP 2 registration fee at the general hospital. Cost was cited as the top barrier to health care by 66.6 per

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10 Returnees were initially guaranteed the transport of their possessions to their final destinations by the government, but austerity measures have halted this

11 Data includes Akol Chol IDP camp in Wau, Yambio way station, and transit sites in Renk. FGD = 5 and in-depth interviews = 13; total = 18)
cent \((n=12)\) of respondents in transit sites. For those without on-site IOM clinics, distance and the lack of transport to health services are the second most commonly cited barrier \((38.8\%, n=7)\).

Interaction between host populations and migrant populations in segregated transit sites varies and discrimination as an environmental vulnerability factor was less noticeable among interviewees in Renk, who tended to say that integration was easy and that they faced few problems with host communities. Conversely, IDPs and returnees in Yambio and Wau described much higher levels of discrimination. One man in Wau describes how returnees from Sudan were treated upon their arrival.

"When they came people said they were Arabs - not sons of South Sudan. People said, “When we were fighting where were you? You were lying down and drinking under the fence while we were defending this country.”"

However, in spite of perceptions that are clearly upsetting and hurtful to returnees, none claimed that this discrimination was sufficient to prevent them from seeking health care when needed.

Joseph\(^\text{12}\), returned from Khartoum in December 2010 because of the coming Independence – he wanted to vote in the referendum. He was happy to return to his home country and be part of building a new nation. Now he lives in Abayok Transit Site with his mother, wife, and six children.

"I expected to settle down and live in peace. But it is like a lost dream. Nothing has been achieved. I have become weak due to poverty and often we eat only one meal a day. Sometimes I get small jobs like digging boreholes or latrines in the camp, but it makes me weak and sick from working under the sun with no food."

Health Seeking Behaviour

The IDPs and returnees interviewed in Renk and Wau camps all have the option of accessing free IOM clinics and all such respondents \((72.2\%, n=13\) of the total respondents in this space) reported the IOM clinic as their first choice of health care, bar one respondent in Renk who preferred to use traditional medicine \((i.e.\ neem leaves)\) before seeking any external help. For the returnees in the transit site in Yambio, no free IOM or NGO services were available and all respondents \((22.2\%, n=4\) of the total respondents in this space) reported that they would choose free government hospital services or alternatively the limited, but free services provided by the military hospital in Yambio. A minority \((16.7\%, n=3)\) would seek care at a private clinic as their second choice. It is clear that free services are highly preferred for IDPs and returnees within this space; however it should be noted that the returnees in Yambio’s way station are less privileged than those in other organised transit sites as there is a total absence of targeted and free services available to them.

Health Needs

Satisfaction with government hospital services is low at all locations, and the most frequently cited need was for more doctors and trained “professional” staff such as midwives \((66.6\%, n=12)\). Interviewees reported high levels of mistrust of the diagnoses and the veracity of the qualifications of health personnel in government hospitals. Linked to their desire for better trained staff was the cited need for more lab equipment, accurate testing, and diagnoses \((33.3\%, n=6\) combined). This was primarily cited as needed in government-run facilities, although the desire for more lab equipment in humanitarian-run facilities was raised too. The creation of more clinics or more accessible clinics was also a commonly cited need, along with increased availability of free drugs, especially for malaria \((33.3\%, n=5\) in both cases).

\(^{12}\) This is not his real name
Market Places

As every town’s focal trading point, market places are an obvious hub for migrant workers. Within these spaces, migrants engage in a range of economic activities as roaming hawkers of religious posters, clothes sellers with individual patches on the market floor, wholesale drinks traders, and electric goods shop owners, amongst others. Markets are one of the few spaces of vulnerability in South Sudan where all migrant categories and host communities can interact freely with each other, besides restaurants and bars, making it an important site to note the dynamics between populations. Although interviews conducted in the market place were primarily carried out with migrant workers, owing in part to the change in methodology after fieldwork was completed, it is recognised that all migrant categories use this space too, and a small number of female migrant sex workers were also interviewed in market places in Juba. However, these numbers were insignificant compared to those of the migrant workers, with whom the focus of this section lies.

Migrant Workers

A total of 50 migrant workers were interviewed within a total of 24 interviews. The majority were found trading in the market place (66.6%, n=16), whereas the rest were found working in hotels and restaurants (33.3%, n=8). The composition of nationalities is shown in Figure 3, and the predominance of Ugandan and Kenyan migrants is clear. While Ethiopian migrant workers are also present in South Sudan, they were not captured in the field research.

An overwhelming trend found amongst these migrant workers was the propensity for both men and women to travel to South Sudan without their families (i.e. spouse and children). Of the 39 interviewees that provided information on this subject, 82.1 per cent (n=32) were unaccompanied by their spouse or children, although in some cases they had travelled with a sibling, and only 17.9 per cent (n=7) were currently living with their spouse. Kenyan and Ugandan migrant workers reported fairly regular return trips home, on average every three to six months, whereas Eritreans and Sudanese were less likely to return; due to the large proportion of Darfuri interviewed, this is unsurprising. Congolese migrants, especially those in Western Equatoria, tend to return often given their proximity to the border, but the porous nature of the border means that they often cross over in an irregular fashion, without documentation, by foot or by bus. The distinction between Congolese migrant workers and refugees in this context is somewhat unclear as it is understood that a number of refugees are shuttling between refugee camps in South Sudan and DRC, whilst also leaving the camps to engage in businesses on the side; they are often unwilling to admit either activity for fear of losing their camp privileges.

The vast majority of migrant workers interviewed were involved in some form of trade, either selling goods formally and operating out of permanent shop structures or rented market plots, or informally through roving hawking. Other common types of migrant worker employment were in the service sector, primarily working in restaurants, bars, or hotels; but some also worked as beauticians (a number of Ugandan males were working as hairdressers or manicurists) or carpenters.

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13 Broken down, this translates to 5 x FGD and 19 x in-depth interviews
14 Key informant interviews with Intersos personnel based in Yambio and Bunia, June 2013. In-depth interview with Congolese migrant in Yambio, June 2013
There were signs of step migration taking place as many of the migrants in Wau, Renk, and Yambio had initially started trading in Juba, but due to high costs of living and competition had moved outwards to different towns such as Yei or Malakal before settling in their current location. Similarly, traders new to Nimule stated their ambition to move to Juba eventually. The role of social networks in promoting this diffusion is important and contributes to the relatively high level of migrant worker mobility. Although unconfirmed by interviews, it is possible that such mobility is negatively linked to health vulnerabilities as the multiple moves necessitate fresh acquisition of local knowledge and trust at each site, which are key factors at the individual level in promoting physical, mental, and social well-being.

**Health Concerns**

The stated top health concerns of migrant workers were largely similar to those of other target populations, with the most frequently named being malaria (50.0%, n=12) and typhoid (45.8%, n=11). WASH related health concerns and stress followed, with a frequency of 20.8 per cent (n=5) and 16.6 per cent (n=4) respectively.

**Barriers and Enabling Factors in Accessing Health Care**

In general, migrant workers reported much fewer barriers to health care than other populations, and the most frequent complaints of this nature were to do with cost (20.8%, n=5), disappointment with medicine i.e. not enough, poor quality, or expired (20.8%, n=5), and long queues at government hospitals (20.8%, n=5). Language barriers were also mentioned, although a significant number of migrant responses suggest that they choose to frequent clinics staffed by people of their own nationality, enabling them to communicate freely and ask detailed questions about their illness and medicine regime.

Stated preventative factors showed that the environmental conditions in South Sudan were prime areas of concern. The lack of WASH facilities and dirty restaurants within the host environments were the most commonly cited causes for concern (combined: 33.3%, n=8). Responses highlighted that the lack of toilets and running water and crowded living conditions were negatively affecting all communities within.
the market place. Migrant workers often reported living together with other migrants of the same nationality, mostly renting rooms or houses, which they shared with up to seven other people. The size of these shared spaces was not well detailed, but participants did not raise complaints concerning overcrowdedness. While running water was uncommon (as for the host population too), most participants stated that their accommodation had a latrine – one however, said that there was no latrine at her rented house so she and her boyfriend had to pay to use public facilities.

Migrant market sellers and roving vendors complained that the nature of their jobs kept them in the sun for long hours leading to fatigue and general weakness especially when unable to eat lunch, which was often the case for the roving vendors. However, one benefit of such self-employed jobs was that migrant workers were in charge of their own activities and were not poorly treated by employers. Poor treatment was more commonly cited by migrants working in the hotel business, whereby they were sometimes made to work long hours and subjected to rude treatment by customers, thus increasing their vulnerability to stress and fatigue. In isolated cases, poor treatment from customers was felt to be linked to discrimination based on their nationality (Ugandan), but the majority of interviewees did not identify a specific reason for rude behaviour.

Environmental level concern regarding the lack of HIV knowledge or good hygienic practice amongst the South Sudanese was raised equally frequently (33.3%, n=8) and it was noted by one female migrant worker in Wau that, “Most of the people who use condoms are foreigners. The South Sudanese are still tied with their culture.” When probed further for why foreigners were more likely to use condoms she responded, “These foreigners are aware; they left their families in their countries so they must protect themselves.” This response underlines the general trend of better HIV knowledge and safer sex practice among foreigners, but also indicates that unaccompanied migrants are sexually active while away from their spouses.

This interaction between migrant and host populations is particularly significant given the proven high proportions of unaccompanied migrants and has potential health implications for their families and communities at home. Despite the insistence among certain interviewees of their enabling advantage of having better knowledge of safe sex, this does not guarantee the consistency with which migrant workers put this knowledge into practice.

While interacting with people of their own nationality clearly defines migrants’ social lives, many cited integration to their host communities as enabling factors for their lives in South Sudan, especially through church groups. Almost a third (29.2%, n=7) specifically stated that they did not feel discriminated against at health services, although this may be due to their primary use of private clinics owned by fellow nationalities. Eritreans appeared to be the most integrated to host population communities whereas Ugandans and Congolese were most likely to mention discrimination.

**Health Seeking Behaviour**

Due to their income generating activities, migrant workers often had a slight health advantage over the host communities and other migrant populations, which enabled them to access private health care with slightly more freedom. This is reflected in the number of interviewees who choose to use private clinics as their first choice of health facility (62.5%, n=15) rather than the government hospital, whereby only 8.3 per cent (n=2) stated this as their first choice of health care. Satisfaction with government services was again found to be low, such that migrants stated they would rather borrow money from their neighbours to go directly to a private clinic. In one extravagant case, a Darfuri community leader stated that he would fly straight to Cairo for any kind of serious checkup.

**Health Needs**

The most commonly stated needs within this category were for more information and awareness on HIV and good hygiene (linked to behaviour change) to be provided for the host population (29.2%, n=7), followed by increased availability of drugs for malaria (20.8%, n=5) and more qualified doctors (20.8%, n=5). Secondary health care for issues such as diabetes and eye problems were also mentioned. Few respondents expressed the need for preventative measures such as mosquito nets even though they were all aware of the benefits of using nets. Remedial treatment was far more in demand indicating a need for attitudinal change favouring preventative measures for malaria as well as infectious diseases in general.
Non-transit Site
Returnees and IDPs

Not all returnees or IDPs remain in the transit sites mentioned previously, and many have managed to settle in urban settings, either interspersed among the local population or congregated in specific settlements on land allocated to them by the government. The allocation of land continues to be a source of grievances for many returnees who returned to their home places only to find their land occupied (International Rescue Committee, 2013). In some cases, as in the Dudoma settlement in Yambio, IDPs have also been allocated land by the government, and like that of returnee land, it is in marginalised, undeveloped areas on the periphery of the town with no easily accessible health or education services. Sanitation facilities are often absent and housing may range from permanent tukuls to fragile tarpaulin structures.

A total of 19 interviews were held with returnees and IDPs in urban settings.

Health Concerns

Malaria was cited as the most common health concern of IDPs and returnees in urban settings (73.6%, n=14) followed by typhoid at 57.8 per cent (n=11). Sexually transmitted infections were a concern for 63.1 per cent (n=12) of interviewees; disaggregation shows HIV and AIDS as the dominant concern at 42.1 per cent (n=8) with other STIs mentioned specifically four times (21.0%).

Barriers and Enabling Factors in Accessing Health Care

In theory, returnees and IDPs in urban settings should have better access to jobs than those in temporary transit settlements as their closer contact with the urban space means they are not so distinctly segregated as those in transit sites. However, responses from interviewees suggested that the majority of returnees and IDPs in this space are unemployed (57.8%, n=11) and of the eight (41.8%) that were employed only three were employed in the formal sector as business people or traders. Over half of unemployed interviewees...
were engaged in subsistence agriculture in small plots of land around their homes, or on the edge of the urban space. The lack of income meant that health care costs were the most significant barrier for migrants in non-transit site spaces.

After cost, distance and lack of transport to public health services were the most commonly cited barriers. This was a special concern for pregnant IDP women, some of whom spend up to four hours walking to and from the hospital on a weekly basis for their antenatal check ups. The distance between the locations where returnees were given land and health services, as well as the overall lack of income, means that use of traditional medicine is relatively high among these communities. Satisfaction with NGO services, especially Merlin and MSF, and their early child care and maternal health programmes were particularly mentioned as enabling factors. Interviewees appreciate the respectful and dignified service they receive from these practitioners, in contrast to the lack of migrant sensitive treatment from government staff, who are reported to provide rude and cursory services. The absence of migrant-friendly services and the lack of empathy or psychosocial consideration toward migrants exhibited by government health staff was frequently raised as a reason why returnees and IDPs in urban settings were unsatisfied with government run health facilities.

An enabling factor that was not well acknowledged by interviewees, possibly in order to emphasise challenges and elicit further relief, was the fact that packages of non-food items containing mosquito nets were distributed to all organised returnees on arrival at destination and to IDPs by cluster humanitarian agencies. However, spontaneous returnees who were not assisted by IOM in their return did not receive such packages. The expense of new mosquito nets, cited as being up to SSP 30 in some cases, was raised as a barrier to good health and provides one explanation for the predominance of malaria as a concern amongst returnee populations in integrated urban spaces.

Not only do these populations have too few income generating opportunities to be able to afford nets, but individual risk factors are pronounced for those returning from malaria-free Khartoum where preventative behaviour was not necessary, leaving returnees with insufficient malaria prevention knowledge. While this suggests that host populations would have acquired relevant knowledge on malaria protection, this was proven false on at least one occasion whereby a female returnee residing with her in-laws in Yambio was jeered at by neighbours for trying to maintain her children’s net by darning the holes. This disregard for preventative measures and over-reliance on remedial treatment suggests a pervasive environmental level challenge. This notion is reinforced by the fact that while the difficulty in procuring mosquito nets was often raised as a concern in the course of interviews, it was rarely referred to as a top priority, nor did it feature in any of the top five health barriers.

Health Seeking Behaviour
Lack of income amongst non-transit site returnees and IDPs strongly influences their health seeking behaviour, and is reflected in the high use of government health facilities (73.6%, n=14) despite strong feelings of dissatisfaction with their services. Even at the so-called free Primary Health Care Units (PHCU) and government hospitals, the lack of medicines often means that out of pocket costs are necessary. Private clinics are only used in emergencies when they need fast service and if they have enough money. A female returnee in Nimule referred to the clinics as ‘witch doctors’ because of their high prices and this combination of individual level financial constraints and structurally poor quality of facilities serves to exacerbate health risks and poor well-being within this space.

Health Needs
The most frequently stated health needs by populations in this space were for more drugs (36.8%, n=7), reflecting the poor overall state of pharmaceutical access in South Sudan. The next most frequently cited needs were for better treatment from health staff, including the specific desire for more respect and less careless handling of their children (31.5%, n=6). Equally frequently cited was the need for closer health facilities, pertinent to these non-transit site populations who are often settled on urban peripheries, far from central services. Similarly 31.5 per cent (n=6) of responses cited the need for behaviour change amongst their own and host populations regarding increased uptake of VCT.
Interpreting the overall data of the targeted migrant categories highlights several points for concern regarding the health and vulnerability of these categories. To some degree, select migrants have a health advantage over the host population in terms of superior HIV and hygiene knowledge and more health service options such as on-site clinics at transit sites and the availability of health services in their country of origin for those able to return easily and often. Non-discriminatory, free public health care and free VCT services offered by NGOs are equally enabling factors for migrant and host populations alike. Some of the key findings are summarised below.

**Key barriers and health concerns by category and space**

In terms of specifically cited health concerns, malaria and typhoid were consistently at the top of self-reported concerns across all target populations in all spaces of vulnerability.

- Lack of mosquito nets and the expense of new ones were cited as barriers to good health, although rarely referred to as a top concern. It was noted as more of a disadvantage;

- For truck drivers, vulnerability to ill health is increased by environmental and occupational factors such as the lack of accommodation in between towns, break downs in the bush due to poor roads, and insecurity meaning that they often sleep underneath or in their trucks with the windows down, with no mosquito nets;

- Environmental vulnerabilities such as lack of access to latrines and potable water at truck parks, transit sites, and urban settings, as well as poor host population hygiene habits are likely determinants of typhoid prevalence;
Within transport corridors and urban settings, HIV was not often raised immediately by interviewees, nor even featured in their top three concerns. However, it was inevitably mentioned after some probing and proved a consistent if warily expressed concern.

- It was most often reported as a concern in **hotspots, border towns, and truck parks** where high levels of transactional sex take place between local and migrant female sex workers, truck drivers and other migrants;

- HIV was mentioned **less frequently in transit sites and urban settings**, but the prevalence of unaccompanied individuals in these spaces is a strong risk factor. Although this was not an explicit link, the strong presence of unaccompanied returnee women with few income generating options makes it probable that they are engaging in transactional sex as an economic survival response;

- Religious constraints upon sex and alcohol meant that HIV was viewed with less concern by Muslim interviewees who said that they did not engage in behaviour that would put them at risk of infection. Yet conflicting responses from Muslim interviewees concerning condom use and behaviour of ‘others’ suggests that some answers may have been given to conform to religious expectations;

- Preventative factors are numerous and multidirectional but include the underlying behaviour of host populations who are negatively influenced by cultural and religious intolerance of condoms, ignorance and fear of testing, and the acceptance of multiple concurrent partnerships in certain areas;

- Preventative occupational characteristics of migrants mean that individuals are often unaccompanied by a spouse and spend long periods of time away from families. This separation from family, accompanied by stressful working conditions and boredom from long waiting periods, may facilitate risky sexual behaviour and high alcohol consumption.

In a similar vein to reticence concerning HIV discussion, STIs were not mentioned very frequently, but conversations with pharmacists suggested that antibiotics for STIs were one of the most overall demanded drugs, after malaria and typhoid medicine. It is likely that this demand is shared by migrant customers and this therefore suggests that migrants were embarrassed to admit the effects of sexual activity. Such attitudes could impact related HIV prevention efforts.

As a health concern for targeted populations, malnutrition ranked highly amongst IDP and returnee populations in transit sites, and to a lesser degree in urban settings.

- Food rations for populations still considered ‘in transit’ are alone insufficient for a balanced diet, but are nonetheless welcomed for the substance they provide. However, for returnees who have reached their destinations and IDPs in semi-permanent and semi-settled situations, there is little in the way of targeted food rations. Lack of income prohibits buying food from the market, where prices are high;

- Humanitarian partners supply a short term package of support (including non-food items) once returnees arrive at their self-determined final destination. However, a lack of broader reintegration interventions aimed at supporting income generating activities, cultivation, WASH and health facilities, as well as social interaction opportunities with the host communities leave these returnees, IDPs, and their children especially vulnerable to poor health outcomes, specifically malnutrition;

- The lack of food was linked to overall weakness and fatigue, which affected the ability of returnees and IDPs in transit sites to undertake physical activities, especially in conditions of extreme heat;

- Lack of tools and agricultural know-how, feelings of insecurity among female-headed households and elderly persons, and absence of health or education facilities are discouraging returnees from settling on their government-allocated land, thereby reducing the possibility of supplementing their diet through cultivation.
Violence and insecurity are highly prevalent along transport corridors whereby truck drivers and migrant female sex workers suffer disproportionately.

- Armed civilians and soldiers threaten and harass drivers and sex workers with apparent impunity on a regular basis. Migrants feel vulnerable and unprotected by what they perceive to be a prejudiced system of law;

- There was little evidence of migrant workers or migrant female sex workers entering South Sudan as a result of human trafficking or smuggling; however, highly porous borders (especially with the DRC) mean that migrants may enter South Sudan irregularly by foot or bus without documentation. They thus avoid the environmental vulnerabilities and insecurity associated with human smuggling but increase their individual vulnerability in terms of illegal status and harassment from the authorities;

- Sex workers, especially those operating independently without pimps, are exceptionally vulnerable to gender based violence including rape, assault, and clients’ refusal to wear condoms. They are poorly informed of counselling services and psychosocial support, which in any case are lacking, and some are being negatively influenced in seeking post-GBV medical treatment due to misconceptions of legal processes thought to be attached to such services;

- When probed on stress and possible health seeking behaviour, some said they might see a doctor, but the majority stated that they would do nothing as it was simply the result of, “too much thinking”, which in itself is suggestive of repressed anxiety. The church and peers are important sources of support;

- A large proportion of the host population was exposed to violence over the 40 years of civil war and the absence of widespread psychosocial care for civilians and ex-combatants manifests itself in high levels of violence, including gender based violence, toward migrants as well as host populations.
Health Seeking Behaviour

- For those with money, private clinics are the preferred first choice of health care. The absence of queues and fast service suits truck drivers on schedules and, migrants felt comfortable using clinics staffed by their own nationalities. However, the cost of private clinics is prohibitive for those without incomes. Environmental constraints are such that opening hours do not reflect the needs of the target populations and prevent access at night, when it is convenient for truck drivers and sex workers and when it is needed by other migrants (and the host population) for emergencies in general. Private clinics and pharmacies are also largely unregulated, operating as businesses and hiring untrained staff that are unable to provide adequate or accurate advice to patients and may sell expired medicine;

- The majority of returnees, IDPs, and other economically vulnerable populations rely on the free services provided by public hospitals or PHCUs while those in temporary settlements and transit sites rely on NGOs and actors such as the IOM to provide on-site or mobile clinics. There is strong dissatisfaction with government health services, which acts as a strong deterrent in seeking treatment. Notable points of dissatisfaction being the lack of migrant sensitive services, due mostly to staff indifference; long queues, sometimes linked to discrimination based on personal contacts or nationality; limited opening hours; general shortages of drugs; and mistrust of the qualifications and diagnoses of doctors. ‘Free’ hospital service can also be misleading as hidden costs such as registration fees and insufficient supplies of drugs, necessitating their purchase at pharmacies, result in out of pocket costs;

- Aside from cost, distance and lack of transport are the next most significant barriers to accessing health care. This is especially true for IDPs and returnees in marginalised areas of urban settings without access to mobile clinics and without incomes to afford boda-bodas\(^{18}\) to the nearest hospital. While pregnant women suffer disproportionately from lack of transport, for truck drivers distance is less of a barrier, being superseded rather by a lack of awareness of the locations of existing facilities;

- There is low overall uptake of VCT services among migrants. This is due to lack of migrant friendly services in terms of visibility, opening hours, or sufficient availability of services in strategic places along transport corridors. Concomitantly, poor health seeking behaviour amongst host populations (most pronounced amongst males) stems from either end of the spectrum of concern (i.e. complacency regarding HIV status against fear of testing positive). These factors are preventing South Sudanese from getting tested and therefore posing a serious vulnerability to the health of migrant populations, especially migrant female sex workers with whom they interact in multiple spaces;

- Interviewees were not aware of targeted HIV interventions and indeed only Population Services International (PSI) is carrying out interventions aimed specifically at sex workers. The absence of operational and targeted HIV interventions highlights the overall lack of migrant friendly services as a significant barrier to migrant populations.

Health Needs

- A reliable supply and stock of medicines, at least for the most common malaria, typhoid, cough, and STI needs;

- More doctors and trained health professionals and improved quality of care amongst hospital staff – more empathy, more training, and more counselling to advise migrants of treatment regimens and diseases;

- Improved equipment such as x-ray machines for injuries and more laboratories for more accurate testing.

\(^{18}\) The most common form of public transportation, boda-bodas are motorcycle taxis.
Monitoring Migrant Health Systems through research and information dissemination

1. Work with the Ministry of Health and the WHO to develop standard migrant health indicators (access, quality, and cost) as well as disaggregated data, in order to improve national monitoring systems, and advocate for sharing migration health data among sectors and countries for the purpose of enhancing migrants’ health;

2. Advocate with the Ministry of Health and the National Bureau of Statistics for the inclusion of migration health data in national health surveillance surveys such as the AIDS Indicator Survey in order to monitor migration as a social determinant of health for migrants and migration affected communities;

3. Advocate for the establishment of a focal point within the Ministry of Health for IOM and partners concerning the health of migrants;

4. Conduct further research on the health behaviour, utilisation of services, barriers to access, and occupational safety, throughout the migration process of hard-to-reach migrant populations, including irregular migrants, through targeted surveys in order to identify effective health interventions;

5. Conduct further research with the UN Joint Team on HIV and AIDS and the South Sudan AIDS Commission focusing on key populations within key spaces of vulnerability including major ports along the Nile, Sobat, and Kiir Rivers, targeting the relationship dynamics between migrants, female sex workers, port workers, and truck drivers as well as the knowledge, attitudes, and practice of South Sudanese host communities toward HIV. Data captured will contribute towards core UNDASS Indicators;

Recommendations

The following recommendations are in line with the four action points identified in the Global Consultation on the Health of Migrants in Madrid (2010).
Migrant sensitive health systems through promoting health service delivery and capacity building

6. Work with the Ministry of Health to provide visible, accessible, affordable, and culturally accepted migrant friendly health services along major trucking routes, with special emphasis on accessible condom distribution and VCT services, anti-migrant stigma education for health providers, convenient locations and operating hours, access to hygiene and sanitation facilities, and a harmonised primary health care (preventative and curative) package of services taking into account specific needs and preferences of female sex workers and truck drivers;

7. Collaborate with the Ministry of Health to provide cultural sensitivity trainings in order to promote migrant sensitive service delivery and build health providers’ capacity in responding to the health concerns and vulnerabilities of migrants with culturally and linguistically appropriate services;

8. Work with the National Malaria Control Programme and key health partners to recognise the relationship between malaria and migration and improve returnee and migrants’ knowledge of and access to preventative vector control programming and services (i.e. long lasting insecticidal nets, repellents, and indoor residual spray), culturally acceptable and language-appropriate prevention, and reliable and early access to malaria diagnosis and treatment;

9. Promote use of change agents at hotspots along transport corridors, and market places in border towns and urban settings to encourage behavioural change regarding the prevention of key migrant health concerns such as malaria and diarrhoeal diseases like typhoid. Use change agents to encourage best practices for sanitation and hygiene, and stress the importance of early health seeking behaviour and referral to available facilities for treatment;

10. Identify and train change agents with technical support from UNAIDS, SSAC, and the WHO in targeted hotspots along transport corridors, and market places in border towns and urban settings as HIV and AIDS Peer Educators and Counsellors in order to strengthen HIV prevention and responsiveness as well as ensuring condom availability, providing negotiation and usage training, promoting VCT capacity of health providers at local levels, and referrals for antiretroviral therapy (ART) services to ensure continuity of care for migrants living with HIV;

11. Work with the Ministry of Health and GBV partners to develop and pilot a training curriculum for health providers in targeted spaces of vulnerability to scale up service delivery interventions including sensitisation of gender based violence among returnees, and female sex workers and their clients, as well as the delivery of counselling and psychosocial support and timely administration of HIV Post Exposure Prophylaxis for survivors of GBV including sexual violence such as rape;

Policy-legal frameworks using advocacy for migrant sensitive policy development

12. Advocate for the Government of the Republic of South Sudan to uphold its responsibility to respect, protect, and fulfil the human rights of migrants regardless of legal status through the addition and implementation of migrant-inclusive health policies in national multi-sectoral public health responses such as the Health Sector Development Plans and through the implementation of recommendations in the National HIV and AIDS Strategic Plan (2013 – 2017);

13. Advocate with UN partners for South Sudan’s ratification of international human rights conventions, in particular the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICRMW) which stipulates migrant workers’ rights to social and health services;
14. In collaboration with IOM Immigration and Border Management Unit, the Ministry of Interior, and the Ministry of Health, conduct capacity building trainings with public service officials in direct contact with migrants (such as police and immigration and border officials) to sensitise them regarding migrants’ right to health, migrant health issues, cross-border outbreak preparedness and response, cultural and gender sensitivities, referral networks, and the responsibility to abide by national and international rights standards;

15. Organise information campaigns targeting female returnees and IDPs, migrant female sex workers, health workers, and police in targeted spaces of vulnerability to raise awareness of the appropriate uses of Form 8 and facilitate GBV survivors’ rapid access to psychosocial counselling and medical services to ensure provision of prevention and care for HIV and other STIs;

16. Develop and implement with the South Sudan Relief and Rehabilitation Commission and the Reintegration Theme Group a comprehensive reintegration strategy for returnees providing durable solutions through access to livelihood options as well as health and social services such as education and WASH. Such solutions should take into account gender considerations for returnee female headed households;

17. Advocate for the Government of the Republic of South Sudan to approve and fund the implementation of the South Sudan National HIV and AIDS Strategic Plan (2013 – 2017);

18. Look to regional cross-border best practices such as the Trans-Zambezi Malaria Initiative to reduce malaria among migrant populations by improving knowledge and action for the prevention, diagnosis, and treatment of the disease;

19. Contextualise and apply good practices demonstrated in HIV service delivery along the Kampala-Juba transport corridor by the IOM mission in Uganda, and extend them within South Sudan in coordination with the Ministry of Health, the South Sudanese Transport Union, and foreign truck company employers. This may include developing behavioural change communication toolkits for health partners along transport corridors and addressing environmental and structural factors such as reducing waiting times for trucks at loading / unloading and custom clearing sites;

20. Work with the Government of the Republic of South Sudan to strengthen border cooperation for disease prevention, counselling, and treatment and engage in regional dialogue to develop a strategy to address malaria and HIV and AIDS programming and other health concerns that may affect migrant populations and host communities affected by migration;

21. Strengthen cooperation with the Government of the Republic of South Sudan, NGOs and faith-based organisations, and IOM offices in Uganda, Kenya, Ethiopia, the Central African Republic, the Democratic Republic of the Congo, and Sudan in order to coordinate and harmonise migrant health interventions that require cross-border management and monitoring.
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Bwayo, J.J., et al. 

CESVI 
2013 CAP Project Sheet

Embassy of the Republic of South Sudan in Washington DC 

Episcopal Church of the Sudan Diocese of Wau 

Ferguson, A.G. and C.N. Morris 

Fisher, J.C., H. Bang, and S.H. Kapiga 

Government of the Republic of South Sudan (GRSS) 
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Morris, C.N. and A.G. Ferguson


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2013 Available from www.unhcr.org/pages/4e43cb466.html; accessed on 27/06/13

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1946 Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference. New York, 19-22 June
Standard FGD qualitative format was used to capture individual voices on most questions including quantitative demographic data. However for quantitative purposes, semi-structured questions regarding self interpretations of health (top health concerns and top health barriers) required participants to come to a collective consensus on a hierarchy of responses. This means that for these responses the FGD itself is counted as a single unit of response rather than the individual voices within the group. In this manner n-values for these responses are lower than the n-values for demographic responses, which include individual voices. Certain questions were not well answered, especially regarding level of education. Levels of education are presented by Primary levels (P1-P7) and Secondary levels (S1-S7), undergraduate and postgraduate university levels, vocational training and other.

Please note that graphs have been divided by colour to distinguish between the different methodologies and sample sizes used. Blue graphs include total numbers of individuals. Red graphs include number of interviews (FGD and IDIs) and are measured as frequencies. This is explained further in the methodology section of the main report.

**Truck Drivers**

**Figure 4: Age distribution of truck drivers**

![Age distribution of truck drivers graph]

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>16-20</th>
<th>21-25</th>
<th>26-30</th>
<th>31-35</th>
<th>36-40</th>
<th>41-45</th>
<th>46-49</th>
<th>50+</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td>2</td>
<td>5</td>
<td>11</td>
<td>4</td>
<td>7</td>
<td>1</td>
<td>9</td>
<td></td>
</tr>
</tbody>
</table>
Figure 5: Level of truck driver education

Education

<table>
<thead>
<tr>
<th>None</th>
<th>P1-P3</th>
<th>P4-P7</th>
<th>S1-S3</th>
<th>S4-S7</th>
<th>Undergraduate</th>
<th>Post graduate</th>
<th>Vocational Training</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

Figure 6: Truck driver places of origin

Place of Origin

<table>
<thead>
<tr>
<th>Place of Origin</th>
<th>Kenya</th>
<th>Uganda</th>
<th>Sudan</th>
<th>Yei (South Sudan)</th>
<th>Renk (South Sudan)</th>
<th>Nimule (South Sudan)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>17</td>
<td>11</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Figure 7: Languages spoken by truck drivers, by frequency

Language

<table>
<thead>
<tr>
<th>Language</th>
<th>Freq (N=39)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
<td>23.1%</td>
</tr>
<tr>
<td>Swahili</td>
<td>17.9%</td>
</tr>
<tr>
<td>English</td>
<td>15.4%</td>
</tr>
<tr>
<td>Luganda</td>
<td>12.8%</td>
</tr>
<tr>
<td>Other (Madi, Nukosa, Kamba, Mantora)</td>
<td>10.3%</td>
</tr>
<tr>
<td>Kikuyu</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

*Other includes: Madi, Nukosa, Kamba, and Mantora (each concern under ‘other’ equals a response of n=1)
Figure 8: Most frequently cited health barriers as reported by truck drivers

- No Facilities in the Bush: 28.6%
- Language: 21.4%
- Cost of Private Clinics: 14.3%
- Poor Government Services: 7.1%

Aggregate Barriers

Figure 9: Most frequently cited health concerns as reported by truck drivers

- Malaria: 71.4%
- Security/Safety: 42.9%
- Back/chest pains: 35.7%
- HIV: 28.6%
- Typhoid: 28.6%
- Diarrhoea: 21.4%
- Cholera: 14.3%
- WASH: 14.3%
- Insects: 14.3%
- Headaches: 7.1%
- Fatigue: 7.1%
- Poor diet: 7.1%
- STI: 7.1%
Migrant Female Sex Workers

Figure 10: Age distribution of migrant female sex workers

![Age distribution of migrant female sex workers](image)

Figure 11: Level of education of migrant female sex workers

![Level of education of migrant female sex workers](image)

Figure 12: Distribution of migrant female sex workers’ place of origin

![Distribution of migrant female sex workers’ place of origin](image)
Figure 13: Languages spoken by migrant female sex workers, by frequency

<table>
<thead>
<tr>
<th>Language</th>
<th>Frequency (N=24)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luganda</td>
<td>54.2%</td>
</tr>
<tr>
<td>Lua</td>
<td>12.5%</td>
</tr>
<tr>
<td>Lughawa</td>
<td>8.3%</td>
</tr>
<tr>
<td>Swahili</td>
<td>8.3%</td>
</tr>
<tr>
<td>Arabic</td>
<td>8.3%</td>
</tr>
<tr>
<td>English</td>
<td>8.3%</td>
</tr>
<tr>
<td>Kinyarwanda</td>
<td>4.2%</td>
</tr>
<tr>
<td>Kikuyu</td>
<td>4.2%</td>
</tr>
</tbody>
</table>

Figure 14: Most frequently cited health concerns as reported by migrant female sex workers

<table>
<thead>
<tr>
<th>Aggregate Health Concerns</th>
<th>Frequency (N=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal Safety/Violence</td>
<td>61.5%</td>
</tr>
<tr>
<td>Attitude of SS Men (no condom/violence)</td>
<td>46.2%</td>
</tr>
<tr>
<td>Malaria</td>
<td>46.2%</td>
</tr>
<tr>
<td>HIV</td>
<td>38.5%</td>
</tr>
<tr>
<td>Typhoid</td>
<td>30.8%</td>
</tr>
<tr>
<td>Stress</td>
<td>23.1%</td>
</tr>
<tr>
<td>STIs</td>
<td>15.4%</td>
</tr>
<tr>
<td>WASH</td>
<td>7.7%</td>
</tr>
</tbody>
</table>

*Attitudes of South Sudanese Men include lack of condom use and violence.

Figure 15: Most frequently cited health barriers as reported by migrant female sex workers

<table>
<thead>
<tr>
<th>Aggregate Barriers</th>
<th>Frequency (N=13)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>38.5%</td>
</tr>
<tr>
<td>Discrimination</td>
<td>23.1%</td>
</tr>
<tr>
<td>Language</td>
<td>15.4%</td>
</tr>
<tr>
<td>No HIV medicine at clinic</td>
<td>7.7%</td>
</tr>
<tr>
<td>Favoritism/contacts</td>
<td>7.7%</td>
</tr>
<tr>
<td>Irregular Status</td>
<td>7.7%</td>
</tr>
</tbody>
</table>
Migrant Workers

Figure 16: Age distribution of migrant workers

![Bar chart showing age distribution of migrant workers.]

Figure 17: Sex distribution of migrant workers

![Bar chart showing sex distribution of migrant workers.]

Figure 18: Level of education of migrant workers

![Bar chart showing level of education of migrant workers.]

Age in Years

- 16-20: 20
- 21-25: 17
- 26-30: 15
- 31-35: 5
- 36-40: 1
- 41-45: 0
- 46-49: 0
- 50+: 0

Education

- None: 0
- P1-P3: 5
- P4-P7: 10
- S1-S3: 2
- S4-S7: 12
- Undergraduate: 2
- Post graduate: 0
- Vocational Training: 1
- Other: 0

SITUATIONAL MIGRANT HEALTH ASSESSMENT
Figure 19: Migrant workers’ places of origin

<table>
<thead>
<tr>
<th>Place of Origin</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uganda</td>
<td>27</td>
</tr>
<tr>
<td>Kenya</td>
<td>17</td>
</tr>
<tr>
<td>Sudan (majority from Darfur)</td>
<td>9</td>
</tr>
<tr>
<td>Eritrea</td>
<td>8</td>
</tr>
<tr>
<td>DRC</td>
<td>6</td>
</tr>
</tbody>
</table>

Figure 20: Languages spoken by migrant workers, by frequency

<table>
<thead>
<tr>
<th>Language</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luganda</td>
<td>20.9%</td>
</tr>
<tr>
<td>Other</td>
<td>17.9%</td>
</tr>
<tr>
<td>Tigrinya</td>
<td>11.9%</td>
</tr>
<tr>
<td>Kikuyu</td>
<td>11.9%</td>
</tr>
<tr>
<td>Arabic</td>
<td>11.9%</td>
</tr>
<tr>
<td>English</td>
<td>11.9%</td>
</tr>
<tr>
<td>Swahili</td>
<td>7.5%</td>
</tr>
<tr>
<td>French</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

*Other includes: Zagaura, Duro, Zarkawi, Lingala, Nyakola, & Acholi (each concern under ‘other’ equals a response of n=1)

Figure 21: Composition of migrant worker nationalities in market places

<table>
<thead>
<tr>
<th>Nationality</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenyan</td>
<td>26%</td>
</tr>
<tr>
<td>Congolese</td>
<td>12%</td>
</tr>
<tr>
<td>Ugandan</td>
<td>30%</td>
</tr>
<tr>
<td>Sudanese</td>
<td>18%</td>
</tr>
<tr>
<td>Eritrean</td>
<td>14%</td>
</tr>
</tbody>
</table>

These figures are specifically for migrant workers in market places only (i.e. n=16 out of N=24)
Questions to returnees were not well answered resulting in non-uniform n-values for each question. This is likely due to the fact that some returnee interviews attracted very large crowds, whose numbers distorted responses and had to be discounted.

---

**Returnees**

**Figure 24: Age distribution of returnees**

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>Returnees</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-20</td>
<td>1</td>
</tr>
<tr>
<td>21-25</td>
<td>9</td>
</tr>
<tr>
<td>26-30</td>
<td>11</td>
</tr>
<tr>
<td>31-35</td>
<td>12</td>
</tr>
<tr>
<td>36-40</td>
<td>8</td>
</tr>
<tr>
<td>41-45</td>
<td>10</td>
</tr>
<tr>
<td>46-49</td>
<td>4</td>
</tr>
<tr>
<td>50+</td>
<td>8</td>
</tr>
</tbody>
</table>

---
Figure 25: Sex distribution of returnees

- Male: 36
- Female: 35

Figure 26: Level of education among returnees

- None: 9
- P1-P3: 5
- P4-P7: 5
- S1-S3: 3
- Undergraduate: 1
- Postgraduate: 1
- Vocational Training: 0
- Other: 2

Figure 27: Towns and Countries from which returnees have returned

- Khartoum, Sudan: 38
- Port Sudan, Sudan: 2
- El Gadarif, Sudan: 1
Figure 28: Most commonly spoken languages among returnees

<table>
<thead>
<tr>
<th>Language</th>
<th>Freq (N=71)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nuer</td>
<td>16.9%</td>
</tr>
<tr>
<td>Dinka</td>
<td>8.5%</td>
</tr>
<tr>
<td>Shilluk</td>
<td>8.5%</td>
</tr>
<tr>
<td>Zande</td>
<td>7.0%</td>
</tr>
<tr>
<td>Maadi</td>
<td>7.0%</td>
</tr>
<tr>
<td>Arabic</td>
<td>5.6%</td>
</tr>
<tr>
<td>Other (Kuku, Bari, and Karish)</td>
<td>4.2%</td>
</tr>
<tr>
<td>Balanda</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

*Each language under ‘Other’ equals a response of N=1

Figure 29: Most frequently cited health concerns as reported by returnees

<table>
<thead>
<tr>
<th>Aggregate Health Concerns</th>
<th>Freq (N=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malaria</td>
<td>66.7%</td>
</tr>
<tr>
<td>Typhoid</td>
<td>37.5%</td>
</tr>
<tr>
<td>Poor Diet</td>
<td>37.5%</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>29.2%</td>
</tr>
<tr>
<td>Back/Chest Pain</td>
<td>25.0%</td>
</tr>
<tr>
<td>HIV</td>
<td>25.0%</td>
</tr>
<tr>
<td>Stress</td>
<td>20.8%</td>
</tr>
<tr>
<td>Cough</td>
<td>20.8%</td>
</tr>
<tr>
<td>Other (ulcers, kidney, pain, rash, violence, infections (non-sexually transmitted), STI)</td>
<td>16.7%</td>
</tr>
<tr>
<td></td>
<td>8.3%</td>
</tr>
</tbody>
</table>

Each concern under ‘Other’ equals a response of n=1

Figure 30: Most frequently cited health barriers as reported by returnees

<table>
<thead>
<tr>
<th>Aggregate Barriers</th>
<th>Freq (N=23)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost</td>
<td>52.0%</td>
</tr>
<tr>
<td>Distance</td>
<td>36.0%</td>
</tr>
<tr>
<td>Poor Quality of Service</td>
<td>24.0%</td>
</tr>
<tr>
<td>Not Enough Medicine</td>
<td>24.0%</td>
</tr>
<tr>
<td>Discrimination</td>
<td>20.0%</td>
</tr>
<tr>
<td>Overcrowded</td>
<td>16.0%</td>
</tr>
<tr>
<td>Mistreatment of Diagnosis</td>
<td>12.0%</td>
</tr>
<tr>
<td>Opening Hours</td>
<td>12.0%</td>
</tr>
<tr>
<td>Not Enough Services</td>
<td>12.0%</td>
</tr>
<tr>
<td>Not Aware of Services</td>
<td>4.0%</td>
</tr>
<tr>
<td>Lack of Female Empowerment</td>
<td>4.0%</td>
</tr>
</tbody>
</table>

*Each language under ‘Other’ equals a response of N=1
Internally Displaced Persons

Figure 31: Age distribution of IDPs

![Age distribution of IDPs graph]

Figure 32: Sex distribution of IDPs

![Sex distribution of IDPs graph]

Figure 33: Level of education among IDPs

![Level of education among IDPs graph]

---

21 Low n-values for this question are likely due firstly to difficulties in accessing IDPs in certain locations such as Renk, and secondly may also be due to inconsistencies when asking this question to interviewees, resulting in the question being poorly answered or recorded.
Although there were a total of 9 interviews carried out with IDPs, responses from two interviews had to be discounted meaning that n=7 in total.
Figure 37: Most frequently cited health barriers as reported by IDPs

*Other includes: not enough medicine, mistrust of health personnel competence, quality of care, low female empowerment, inaccessible condoms. (Each concern under ‘other’ equals a response of n= 1)
## ANNEX II – List of Key Informants

<table>
<thead>
<tr>
<th>Location</th>
<th>Organisation</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Juba</td>
<td>UNHCR</td>
<td>Associate Reintegration &amp; Livelihoods Officer</td>
</tr>
<tr>
<td></td>
<td>Directorate for Nationality, Passports and Immigration (DNPI)</td>
<td>Director General</td>
</tr>
<tr>
<td></td>
<td>PSI</td>
<td>HIV Programme Manager</td>
</tr>
<tr>
<td>Nimule</td>
<td>UNHCR</td>
<td>Head of Field Office</td>
</tr>
<tr>
<td></td>
<td>Nimule Hospital (Merlin)</td>
<td>Medical Director</td>
</tr>
<tr>
<td></td>
<td>Payam Administration</td>
<td>Health Officer, Health Inspector</td>
</tr>
<tr>
<td>Renk</td>
<td>Military Hospital</td>
<td>Director</td>
</tr>
<tr>
<td></td>
<td>Red Cross</td>
<td>Head of Action Team/Finance</td>
</tr>
<tr>
<td></td>
<td>RRC</td>
<td>Coordinator</td>
</tr>
<tr>
<td></td>
<td>Transport Union</td>
<td>Deputy Director</td>
</tr>
<tr>
<td></td>
<td>Private Clinic</td>
<td>Clinician</td>
</tr>
<tr>
<td></td>
<td>Medair</td>
<td>Project Officer</td>
</tr>
<tr>
<td></td>
<td>Renk Civil Hospital</td>
<td>Acting Director</td>
</tr>
<tr>
<td></td>
<td>Abayok Transit Site</td>
<td>Transit Site Manager</td>
</tr>
<tr>
<td>Wau</td>
<td>El Sabreen Association</td>
<td>VCT Coordinator</td>
</tr>
<tr>
<td></td>
<td>Wau AIDS Commission</td>
<td>Director for Western Bahr el Ghazal</td>
</tr>
<tr>
<td></td>
<td>UNHCR</td>
<td>Programme Associate</td>
</tr>
<tr>
<td></td>
<td>WFP</td>
<td>Field Monitor Assistant</td>
</tr>
<tr>
<td>Yambio</td>
<td>CMMB</td>
<td>Project Manager Social Health</td>
</tr>
<tr>
<td></td>
<td>RRC</td>
<td>Secretary General</td>
</tr>
<tr>
<td></td>
<td>Yambio Modern Pharmacy</td>
<td>Pharmacist</td>
</tr>
<tr>
<td></td>
<td>Kangoyesi Pharmacy</td>
<td>Pharmacist</td>
</tr>
<tr>
<td></td>
<td>State Ministry of Health</td>
<td>Director General</td>
</tr>
<tr>
<td></td>
<td>Intersos</td>
<td>Project Manager</td>
</tr>
<tr>
<td></td>
<td>County Commissioner’s Office</td>
<td>County Commissioner</td>
</tr>
<tr>
<td></td>
<td>UNHCR</td>
<td>Community Services Officer</td>
</tr>
</tbody>
</table>