



IOM International Organization for Migration



Migration and health in SADC

A review of the literature



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1. EXECUTIVE SUMMARY

This review presents a synthesis of published literature relating to migration and health in the Southern African Development Community (SADC). To support this review, a set of key informant interviews with representatives of academic institutions and international organizations working on migration and health in SADC have been undertaken to supplement the findings from the literature. From the synthesis of available literature, and findings from the key informant interviews, **eight key findings** have emerged.

- 1) **SADC is a region of historical and continuing, varied migratory flows.** Involving both internal and cross-border migration, SADC experiences a range of population movements that include: forced migration, labour migration, livelihood-seeking migration, temporary migration, and permanent migration. Importantly, those that migrate within these different categories are themselves varied: men and women, young and old.
- 2) **Linkages between urban and rural areas through circular migration processes have been identified as critical to the comprehension of health concerns within SADC.** Urban–rural linkages – mediated through circular migration both within countries and across border – present a range of urban and rural health implications to SADC member states. The literature identifies that appropriate responses from structures responsible for providing health services, social support, food security and development in both urban and rural areas, are required. This includes addressing urban and peri-urban informal settlements, identified as home to many recent internal and cross-border migrants, as well as developing appropriate health-system responses in rural areas, where migrants tend to return when sick, and to die.
- 3) **Cross-border migrants face challenges in accessing public-health services despite the presence of protective legislation.** Where research exists, this is shown to be the case in all SADC member states. A range of challenges are identified in the literature, including: health systems responses; the role of healthcare providers; healthcare-seeking behaviour of cross-border migrants; prevailing, negative assumptions linking migration with poor health and healthcare seeking; and problematic access to regularization/documentation for migrants.
- 4) **There is a strong bias present, with most published research focussing on migration within and into South Africa.** Given that South Africa is the SADC member state with the highest rates of internal and cross-border migration, this should come as no surprise. However, there is an urgent need for research exploring the relationship between migration and health in other member states to be conducted and published. Lessons from literature originating in South Africa should be applied to other SADC member states.
- 5) **The relationship between HIV and migration has emerged as the most researched and published.** The SADC region is home to one of the largest populations of people living with HIV, and the complex linkages between migration and HIV are well documented. It is essential that the lessons learnt from exploring migration and HIV are applied to other key health issues found in SADC, particularly communicable diseases such as tuberculosis and malaria.
- 6) **There is a lack of published research that (1) documents and (2) evaluates interventions addressing migration and health in SADC.** In reviewing “grey” literature from international and non-governmental agencies (NGOs), it is clear that much has been documented. However, the linkages between researchers and practitioners need to be strengthened so that interventions can be rigorously designed and evaluated. It is clear from the (limited) literature that there is a need to move to develop health interventions that engage with migration through addressing “spaces of vulnerability” rather than with “vulnerable populations”. This is applicable to both humanitarian and developmental responses to migration and health.

7) **Whilst this review has focussed on exploring migration and health in SADC, it is clear that migration is a central developmental issue for the SADC region.** More recent literature is beginning to engage with the need to ensure that a process of “healthy migration” is facilitated in order to ensure that the developmental potential of migration within SADC can be achieved. This will assist member states, and the region, in achieving both internationally ratified and nationally established developmental targets (such as the Millennium Development Goals, MDGs).

8) **Despite the international recognition of the importance of good governance in managing both migration and health, there is very little literature available that considers the governance of health and migration within the SADC region.** It is essential that research in the region on governance is linked with research exploring health systems, and that traditionally separate academic/research disciplines start engaging within the newer, multidisciplinary field of migration studies. Multidisciplinary studies are required in order to inform action to address and manage migration and health in SADC. This will involve engaging with academic institutions and training providers to ensure that researchers, practitioners and policymakers have the skills to work in multidisciplinary ways.

The **recommendations** presented at the end of this review emphasize the importance of a public-health approach to research, intervention design and evaluation, and policymaking in relation to migration and health in SADC. These recommendations have emerged from (1) the review of the literature and (2) findings from interviews with key informants working on migration and health in the region. Box 1 below highlights the key recommendations that have emerged from this review.

Importantly, the recommendations focus on the need to train a new generation of researchers and practitioners who can design and implement interdisciplinary research and programmatic responses to migration and health within SADC. This requires the support of graduate-training institutions in the SADC region and to continuing professional development for policymakers and implementers. Governance responses to migration and health are currently fragmented and there is an urgent need for improved interdisciplinary responses. This requires developing inter-ministry/inter-departmental responses at regional, national and local government levels. It is anticipated that improved governance responses at regional, national and local levels will assist the SADC region in implementing and achieving the World Health Assembly resolution on the Health of Migrants (World Health Assembly, 2008).

Specific recommendations (presented at the end of this review) are directed to different actors involved in migration and health within SADC, namely:

- Researchers based within academic and non-academic institutions;
- Different spheres of government at regional, national and local levels;
- SADC;
- International organizations, including the UN Family;
- Non-governmental organizations and civil-society organizations active within the SADC region;
- Training institutions; and
- Funding agencies active within the SADC region.

BOX 1: Key recommendations

1. There is a need to conduct comparative and collaborative research across SADC member states that explore the linkages between migration and health within – and across – state borders.
2. Partnerships between researchers and regional and national governance structures need to be established and/or strengthened so as to ensure that research findings inform policy and programmatic responses and will assist in developing appropriate responses required to implement and achieve the World Health Assembly Resolution on the Health of Migrants (World Health Assembly, 2008).
3. Research should support the development and implementation of effective regional, inter-state responses to migration and health and thereby support SADC to implement the draft framework for Population Mobility and Communicable Diseases.
4. In order to strengthen programming and policy development, researchers should work with national, regional and international non-governmental organizations (NGOs) to evaluate and document lessons learned and good practices in programmes that work with migrants, and publish this information so that it can be shared with the wider community.
5. International organizations should mainstream migration and health into their programmes and work with SADC and the governments of member states to strengthen evidence-informed responses to migration and health.
6. Training on migration and health should be integrated in graduate, post-graduate and continuing professional development health and social science training, and new transdisciplinary responses to migration and health research in the SADC region should be developed.
7. Resources to support regional, comparative, interdisciplinary research projects and training programmes to improve the generation and application of evidence to inform responses to migration and health in SADC should be made available from national, regional and international funding.

2. STRUCTURE OF THE REVIEW AND OVERVIEW OF METHODOLOGY

The Executive Summary provides an overview of this review's findings and recommendations, followed by a section on the structure of and methodology employed in writing the report. The Introduction presents an overview of the SADC region, offering a rationale for studying the linkages between migration and health, and introducing particular concerns and limitations of research in the region. Section 4 delivers an overview of regional migration trends and their implications for health, followed by a section discussing the determinants of migration and health in the SADC region. Section 6 focuses on HIV/AIDS and migration in SADC, beginning with a discussion of the breakaway focus on this health topic, presenting a literature-based description of HIV and migration linkages, and noting vulnerabilities relating to migration and HIV/AIDS in SADC. The final section of the review presents a set of recommendations. The bibliography represents those documents that are specifically referred to in the body of this Review. A more extensive list of publications on migration and health can be found in Appendix 4.

This review draws information from papers that consider issues relating to migration and health in SADC countries. The selection of literature included in this review was published within the last 10 years (not prior to 2000), with the exception of selected resolutions and declarations. All articles that were utilized in this review were written in either English or French.

The Netherlands Royal Tropical Institute conducted an initial search on the selected criteria. The following general inclusion criteria were used: articles were of primary empirical and peer-review status, focused on migrant health issues for those migrants in movement, and included opinion pieces

and review articles. Six databases were consulted (KIT Library Catalogue, PubMed, African Journals Online, AnthroSource, Cochrane Library and Embase) and the search terms used were: migrants, migration, health, HIV and AIDS, mobile populations, mobile workers, trafficked women, sex workers, internally displaced persons, seasonal workers, truck drivers, farm workers, fishermen, fisheries, mining sector and conflict-induced migration. The geographical focus was narrowed to southern Africa. The references uncovered by each database were scrutinized by a researcher, the abstract of each paper was retrieved, and the articles read.

Following this initial search, IOM Pretoria conducted an internet search using Google Scholar and Scirus, and including the content within the IOM, UNAIDS, WHO, AIDS and mobility and NAM websites. The following search terms were used: migrant health, migration and health, population mobility/movement and health, HIV and AIDS and mobility, tuberculosis and mobility, trafficking and health, child migration and health. Additional sources emerged from this search.

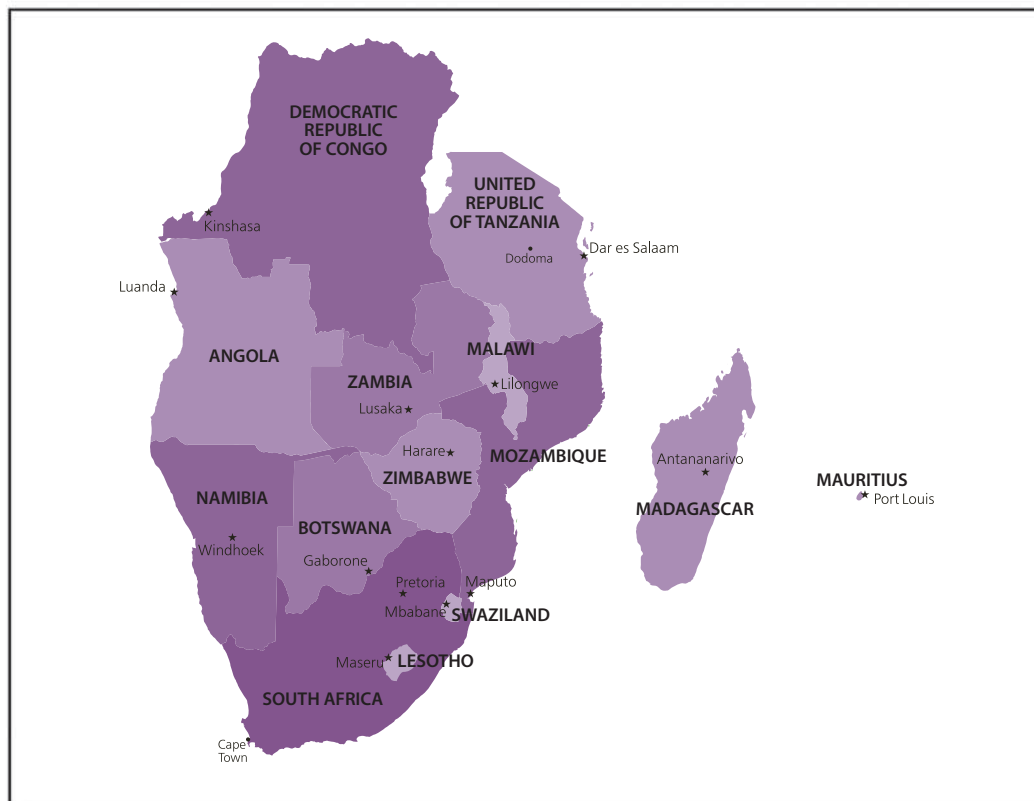
The Forced Migration Studies Programme at the University of the Witwatersrand conducted the final stage of this review, which included the addition of further, current literature and a revision of the format and focus points concerning migration and health. In addition, a set of key informant interviews were conducted with individuals representing academic institutions and international organizations working on migration and health in the SADC region. (See Appendix 2 for the list of interviewees.)

3. INTRODUCTION

The SADC, or Southern African Development Community, is currently (December 2010) composed of fifteen member states: Angola, Botswana, Democratic Republic of Congo, Lesotho,

Madagascar, Malawi, Mauritius, Mozambique, Namibia, the Republic of Seychelles, South Africa, Swaziland, United Republic of Tanzania, Zambia and Zimbabwe.

Figure 1: SADC countries



Each of these southern African states face particular and often overlapping concerns centring on the phenomenon of migration (both internal and cross-border) and the health of their respective migrant and non-migrant populaces. This review of current literature will present general findings on health-migration linkages as they affect the SADC region and identify gaps and areas for future research, as well as note recommendations for health interventions that take migration into account.

3.1 Why focus on health and migration in SADC?

Connections between health and migration can be found at different levels of debate in contemporary society today (for a recent review, see WHO, 2010). This review focuses on SADC, a region associated with **four key factors** that highlight the need to review current knowledge about the relationship between migration and health in SADC:

- 1) **High levels of historical and contemporary migration** (for example, see Crush et al., 2005; Agadjanian, 2008; Olivier, 2009);
- 2) **A high prevalence of communicable diseases**, including HIV, tuberculosis (TB) and malaria (for example, see Balfour, 2002; UNAIDS, 2008);
- 3) **A struggling public healthcare system** (for example, see Coovadia et al., 2009; Gilson and Erasmus, 2005); and
- 4) An increasing recognition that **“healthy migration” is required to achieve development targets in the region** (for example, see Landau and Wa Kabwe Segatti, 2009; IOM, 2010b; Vearey, 2010).

Considering both internal migration (the movement of people *within* a country), and cross-border migration (the movement of people *across international borders*), the review draws on global discourse in order to frame the linkages between migration and health in SADC, and then focuses on the literature on health and migration that is generated *in* or *about* the region.¹

As an initial point of reference, The World Health Assembly (WHA) has made clear that, with an increase in global mobility, the health of migrants has become a key global public health concern (MacPherson and Gushulak, 2001; Ghent, 2008; World Health Assembly, 2008; WHO, 2010). The Resolution calls upon member states to ensure the health of migrant populations, through a range of actions including: promoting migrant-sensitive health policies; promoting equitable access to health promotion, disease prevention and care for migrants; establishing health information systems in order to assess and analyse trends in migrants’ health; gathering, documenting and sharing information and best practices for

meeting migrants’ health needs in countries of origin or return, transit and destination; and promoting bilateral and multilateral cooperation on migrants’ health among countries involved in the whole migratory process (World Health Assembly, 2008).

Historically, cross-border migration has been associated with the spread of disease—reflected in the prevailing assumptions of today (Harper and Raman, 2008). Globally, “foreigners” are often blamed by governments for introducing and spreading disease (Amon, 2008; Harper and Raman, 2008). The resultant marginalization of non-citizen groups has led to health becoming fused “with the politics of citizenship” – in many cases leading to the denial of healthcare to non-citizens (Grove and Zwi, 2006; Harper and Raman, 2008:18). Cross-border migrants continue to be portrayed as “disease carriers” and viewed as placing an unnecessary burden upon the public-health systems of destination countries (Grove and Zwi, 2006; Worth, 2006; Harper and Raman, 2008). This has become ever more pronounced in the context of HIV, with destination countries increasingly concerned that cross-border migrants bring with them HIV, believing that this will threaten the public health of host populations (Worth, 2006; Amon, 2008). The denial of healthcare services to cross-border migrants raises serious concerns: through actively denying healthcare to cross-border migrants, their resultant inability to access appropriate and timely care may ultimately place the host population at risk, thereby placing an even greater burden upon the health system that destination countries were trying to avoid (Grove and Zwi, 2006; Amon, 2008).

Contemporary literature focused on the SADC region confirms many complex migration and health linkages, but there is an increasing need for a close assessment of this relationship in order for such associations to be understood and utilized in a meaningful way (for example, see Roux and van Tonder, 2005; IOM, 2009,

1 It is important to clarify that this review **will not** consider the migration of healthcare workers. This critical topic is being considered in a separate review funded by the EU Mobility of Health Professionals research project, which will be published in 2011.

2010b; WHO, 2010). Among other findings, myths surrounding healthcare-seeking and disease-introducing migrants have proven false in some contexts (Vearey, 2008, 2010); crucial connections between migrants and non-migrants have begun to be articulated and incorporated into health interventions and policy (IOM and UNAIDS, 2003); and, as highlighted in Box 1, evidence that healthy migrants are an asset to achieving wider national and regional development targets has illustrated a rationale for a public-health and development approach to managing migration in a healthy way within SADC (Landau and Wa Kabwe Segatti, 2009; IOM, 2010b; Vearey, 2010).

In response to the recognition of the importance of migration and health in the region (for discussion, see Vearey, 2010), SADC has drafted a policy framework for population mobility and communicable diseases. This policy framework outlines the measures needed to address regional gaps in the control and management of communicable diseases (with a focus on TB, HIV and malaria) (SADC Directorate for Social and Human Development and Special Programs, 2009). The framework makes reference to the principles endorsed in the founding charter of SADC, which emphasizes non-discrimination; the African Charter on Human and Peoples' Rights, which stresses the right to health; and the principles of equality and inalienability of rights (ibid.).

Box 2: Migration and development in SADC: The need to engage with a process of “healthy migration”

As highlighted in the 2009 Human Development Report, migration can – and should – contribute to social and economic development (UNDP, 2009). It seems clear that without the migration of skilled and semi-skilled labour, the SADC region will not meet its long-term development targets (Landau and Wa Kabwe Segatti, 2009). We argue that attaining development targets – including targets set by the national governments, as well as the internationally ratified Millennium Development Goals (MDGs) – requires (among other measures) a focus on the health of internal and cross-border migrant populations. In order to ensure that the developmental benefits of migration are realized, a process of “healthy migration” needs to be facilitated. In order to achieve this, a public-health approach to migration is required. The authors of the report suggest that in order to facilitate a process of “healthy migration”, all levels of government need to mainstream internal and cross-border movement into policies and programmes. This will ensure that *all* migrant populations are able to access positive social determinants of health (SDH) – including access to public healthcare systems. The SDH encompass “the full set of social conditions in which people live and work” (Commission on the Social Determinants of Health, 2007). This includes understanding the movements of internal circular migrants, particularly in relation to their healthcare-seeking and care-seeking migration decisions in times of sickness (Clark et al., 2007; Vearey et al., 2010).

(Adapted from IOM, 2010b)

3.2 An overview of migration and health in SADC

There is a great heterogeneity and history to migration in SADC, including, but not limited to, forced migrants fleeing conflict, individuals

moving in search of improved livelihood opportunities, asylum seekers and refugees, traders and seasonal workers, displaced within their own countries or moving cross-border; some have legal documents, others are without (Crush et al., 2005; Agadjanian, 2008; Olivier,

2009). Each provides a particular lens with which to consider the relationship between migration and health, whether migration is spurred by political instability (and the search for stability in countries such as post-Apartheid South Africa), environmental catastrophe, increased access to personal mobility, changes in gender dynamics or economic opportunity unavailable at home for skilled or unskilled workers (IOM, 2005:14).

Despite this variety in mobility, movement primarily flows within and between SADC nations, and member states are sometimes categorized into *sending* (Mozambique, Malawi, Lesotho) and *receiving* nations (South Africa, Namibia), though some states fall into both categories (Crush et al., 2005; Olivier, 2009). To some degree, this explains why countries like South Africa have been the focus of steady research or have experienced unfortunate and sizeable problems with xenophobia, including issues surrounding health access for cross-border migrants. This, however, is also a simplification, especially when we consider new evidence in observable migration patterns in southern Africa, which suggest “movement across areas that are increasingly economically integrated, involving the exchange of both goods and people, and not simply the mono-directional migration of labour” (Preston-Whyte, 2006:331).

It is indisputable that the SADC region has particular health and migration concerns (for example, see IOM, 2009; IOM, 2010b; Vearey, 2010). Notable among them are the scale of cross-border and internal migration found in the region and the HIV epidemic (and other communicable diseases), especially within certain countries of the SADC region. Home to just 10 per cent of the world’s population, the southern African region has almost 70 per cent of all people living with HIV (UNAIDS, 2008). In addition, the continuing impact of political, economic, social and historical realities, such as the opening of South Africa after apartheid or the migratory legacy of well-worn southern African migration patterns (Crush, 2002; Landau, 2005; Agadjanian, 2008; Landau and

Wa Kabwe Segatti, 2009; Olivier, 2009; Oucho and Ama, 2009; Landau, 2007), play a role in both the *types* of migration occurring and therefore the way in which specific health issues arise.

It should be noted from the outset that the research and publications available and drawn upon in this review cannot be said to have equal distribution within the SADC region. As Agadjanian summarizes:

Reflecting the geopolitical and economic marginalization of sub-Saharan Africa, the literature on international migration within the subcontinent remains relatively scarce and patchy. A perusal of the studies published ... suggests, in fact, that the amount of empirical research on this topic has diminished in recent years, while migration – arguably – has intensified. The sole and notable exception to this trend is southern Africa and specifically South Africa-bound migration flows ... Given the political and economic preeminence of South Africa, the disproportionate attention to South Africa-bound migration is understandable, but it also underscores the glaring imbalances in the distribution of scholarly coverage ... (2008:416)

Whilst we acknowledge the limitation of this bias to published literature from within South Africa, much of this research considers the migration of individuals from other SADC member states into South Africa. Indirectly, therefore, a range of South African focussed literature considers migrant groups from elsewhere. The review provides an opportunity to draw from South African literature and findings that are relevant to other SADC member states. To this end, it may sometimes be necessary to look *beyond* SADC in order to comprehend the health-migration question *within* SADC (for instance, in terms of interventions that might be applied). These limitations should be considered when reading this review.

4. MIGRATION AND HEALTH TRENDS IN SADC

4.1 Types of migrants/migration found in SADC

The International Organization for Migration's Standing Committee on Programmes and Finances defines migration today as involving "a diverse group of people, including regular and irregular migrants, victims of trafficking, asylum seekers, refugees, displaced persons, returnees, migrant workers and internal migrants" (IOM,

2008:1). Each situation may create and respond to its own set of health concerns, dependent in part upon where migrants work and live, the duration and conditions of their stay, and whether and when they return home (Preston-Whyte, 2006:331). The situation that different migrant groups experience in the destination place will affect their health. Table 1 identifies and defines some of the predominant general categories of migrants within the SADC region.

Table 1: Migrants in SADC

Migrant/mobile worker	According to International Migration Law, 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 (IOM, 2007b). However, within southern Africa, internal and cross-border migrants have similar vulnerabilities and within the scope of the IOM's southern Africa migration health programmes, no distinction is made between cross-border and internal migrants.
Regular migrant/ documented migrant	Refers to people who migrate through recognized, legal channels.
Irregular migrant/ undocumented migrant	Someone who, owing to illegal entry or the expiry of his or her visa, lacks the legal status in a transit or host country (IOM, 2007a).
Asylum seeker	Persons seeking to be admitted into a country as refugees and awaiting decision on their application for refugee status under relevant international and national instruments.
Refugee	A person who, "owing to well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country" (Convention relating to the Status of Refugees, Art. 1A(2), 1951, as modified by the 1967 Protocol).
Internally displaced migrant	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. (Guiding Principles on Internal Displacement, UNDoc E/CN.4/1998/53/Add.2.).
Economic migrant	A person leaving his/her habitual place of residence to settle outside his/her country of origin in order to improve his/her quality of life. It also applies to persons settling outside their country of origin for the duration of an agricultural season.
Trafficked person	A person who has been moved by deception, coercion, the threat or use of force and/or other forms of exploitation.

Seasonal migrant worker	A migrant worker whose work by its character is dependent on seasonal conditions and is performed only during part of the year (Art. 2(2)(b), International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990).
Cross-border traders	Cross-border migrants who move across an international border for the purpose of trade.
Labour migrant	A person who moves from their home country to another, or within their own country of residence, for the purpose of employment.
Internal migrant	A person who moves from one area to another within the same country. This movement may be temporary or permanent.

(Adapted from IOM, 2007a, 2007b, 2010a)

4.2 Regular and irregular migration

“identity documents cannot prevent discrimination or ensure social inclusion”

(Landau, 2007:65)

Irregular migration, or migration that does not have a legal status associated with it, is a long-standing phenomenon within SADC, and there are suggestions that the numbers of irregular – or undocumented – migrants are increasing within the SADC region (see Olivier, 2009:17).

IOM reports that irregular migration usually consists of those working in the informal sector on a temporary and economically motivated basis (IOM, 2005). A reason for the increase that should be considered, in the case of South Africa, a main migrant destination, is that the system currently has little recourse for those who are not seeking asylum, leaving few channels for legal migration (Amit, 2010). In South Africa, there is “a systematic failure of asylum systems, leaving labour migrants undocumented and unprotected” resulting in some cases in health access issues or general exposure to bad health through lack of shelter and poor access to basic services, including adequate water and sanitation (Human Rights Watch, 2009a).

Irregular or undocumented migrants may encounter special health vulnerabilities (for example, see Ghent, 2008; Vearey, 2008; Amon, 2009), whether it is in fear of deportation if they

show themselves at health facilities for care (most SADC countries deport irregular migrants (IOM, 2005), paying more for their medical care than citizens, or facing discrimination from health service providers, who also may not speak their language or understand their health history (IOM, 2010a). In South Africa – where most research on cross-border migrant access to healthcare has taken place – despite free emergency care and basic health care (including antiretroviral therapy) being available by law to citizens, undocumented refugees and asylum seekers, many undocumented migrants face challenges in accessing basic healthcare, including antiretroviral therapy (ART) (AIDS and Rights Alliance for Southern Africa, 2008; Amon, 2008; Harper, 2008; Vearey, 2008; CoRMSA, 2009; Forced Migration Studies Programme, 2009; Human Rights Watch, 2009a, 2009b; Moyo, 2010).

4.3 Migrants and non-migrants

The study of migration may centre more upon migrants themselves, but non-migrants are often as affected by the conditions underlying migration, whether physically or mentally (Horwitz, 2001; Alconada, 2006; Marchetti-Mercer, 2009). Non-migrants may be family or community members remaining in the home country or region (Horwitz, 2001; Alconada, 2006), or they may be the host community or larger populace into which a migrant settles. What may be overlooked is the deep connection between the well-being and health

of these two groups, which is primarily found within two areas: (1) the disparities of access and treatment of health problems between the two, and (2) the shared health conditions that interaction may bring about. Importantly, the conditions of migration affect the migrant as well as those who remain at home. As

highlighted in Box 3, the literature highlights an urgent need to understand the nature of the bi-directional relationship between migration and health when forming appropriate, place-based programming and policy to address health situations, rather than focus on single-risk groups (IOM, 2005, 2010b).

Box 3: Migrants and non-migrants: Why considering those who don't move is essential in engaging with migration and health

Outside of the host and in-migrant paradigm, migrants and non-migrants are often linked to one another through *circular migration*, “the dominant form of migration in most African countries” (Crush, 2006:3) This phenomenon of frequent or infrequent returns home of a migrant has proven critically important for comprehending the health of both groups, which may well become connected through this oscillating or circular contact (Rees, 2010). Between the migrant who leaves and the non-migrant who stays, health connections may come in the form of remittances sent home – which have a significant impact upon the economic viability of a household (Collinson, 2010b) or larger area and contribute to its well-being – or even food remittances sent from a rural home to an urban migrant, where costs may make a healthful existence difficult (Nunez, 2010). A migrant who has become ill may also directly impact the health of his/her community when he/she returns home to convalesce or die, thereby placing a burden upon the rural health system and community or familial resources; this is especially true in the context of HIV-related sickness, to which migrants may be particularly susceptible (Bärnighausen et al., 2007; Clark et al., 2007; Welaga, 2009; Collinson, 2010b; Nunez, 2010).

Perhaps most directly, the non-migrant may inherit communicable diseases which a migrant worker has contracted in his/her absence, some in a frequent “long-distance commuters” fashion (IOM, 2005; Basu, 2009), and the linkage has often been examined in the context of HIV. Alternatively, returning home can mean less likelihood of extra-partner sexual relationships and thereby of the spread of diseases such as HIV, or that “the rural areas are far less ‘insulated’ from HIV than before” (IOM, 2005:16). Likewise, some studies have shown qualified disparities between the prevalence of HIV in migrants (Bärnighausen et al., 2007; Clark et al., 2007; Collinson, 2010b) and some have shown, for instance, that a rural woman in South Africa with a male migrant partner does not create additional risk of HIV (Lurie, 2003). Yet, other studies exploring serodiscordance amongst couples show that the non-migrant spouses of migrants have an increased HIV prevalence, suggesting that non-migrants are contracting HIV without the help of their migrant partners (Lurie, 2006). This highlights the importance of exploring rural patterns of behaviour in a context of migration – including multiple partners – that need to be examined further (Lurie, 2006).

Migrants and their host communities also have a health relationship. Migrants such as refugees may be better informed and better connected to a viable health system, by nature of their legal status as such, or may react positively to receiving treatment, as McCarthy and Cherisch document with ART treatment of foreigners in Johannesburg (McCarthy, 2009). Such measures may create a positive impact when migrants disseminate knowledge into a larger context, but may also lead to hostility and negative impacts when migrant-focused health services are too far disparate from opportunities offered to local persons, often competing for already scarce resources. While migrants encounter many opportunities and vulnerabilities that may encourage risky sexual behaviour and inhibit health, and some studies confirm this heightened HIV risk (Barnighausen and Bloom, 2009), the belief that migrants may bring sickness with them, such as after a conflict, has been contested by Spiegel's research in seven conflict-prone southern African regions, where HIV prevalence was generally lower among migrants than that of the host population (Spiegel et al., 2007). This will be discussed further in Section 6.2 of this document.

4.4 Internal and cross-border migration

Internal and cross-border migration may result in differing migration patterns, or the types of migration may resemble each other due to the fact that:

international migration, especially relatively short-distance moves across a border, is much akin to internal migration. Not only the motivations and destinations of internal and international migrants may be similar but so also may be their labour market (e.g. Zuberi & Sibanda, 2004) and other outcomes, such as HIV risks (e.g. Crush, Williams, & Perbedy, 2005; Lurie, 2006). (Agadjanian, 2008:418)

Posel goes as far as to report that in South Africa, "Recent studies of cross-border migration

suggest that what is frequently presented as immigration may simply be continuing, or increasing, circular (cross-border) migration" (Posel, 2006:228). Differences may include situations such as those found in South Africa, where "internal migrants are significantly more likely to reside in the urban informal settlement and cross-border migrants are significantly more likely to reside in the inner city" (Vearey et al., 2010:698), wherein different health obstacles will be faced, especially concerning access.

4.5 Urbanization and migration: Implications for health

As highlighted in Box 4, urbanization within SADC has led to the towns and cities being identified in the literature as a critical *space* to consider when thinking through the relationship between migration and health. However, "urbanization remains understudied in Africa in general" (Garenne, 2006:274) and the literature highlights that linkages between migration, health and urbanization in SADC require further exploration. The connections between health outcomes and contributing urban or rural determinants of health within SADC are found in the literature (for example, Unwin et al., 2010). The literature highlights that an often presumed "urban health gain" is not found in many complex urban environments within the SADC region (Vearey et al., 2010), where "the nature of urban economic development in sub-Saharan Africa can lead to expanding and persisting pockets of extreme poverty" wherein an "urban health penalty" may be more likely (Africa on the Move, conclusions). For example, a recent study in Johannesburg shows that internal migrants located in peripheral urban informal settlements are shown to be worse off than cross-border migrants residing in the inner city, especially for reasons of access to basic services such as water, sanitation, refuse collection, food security and cramped conditions of informal houses, holding, on average, larger families struggling with insecure livelihoods (Vearey et al., 2010).

Box 4: Urban health: A critical focus for migration and health in SADC

Understanding how to ensure and sustain the public health of urban populations is of increasing importance as more than half of the world's population is now urban (UNFPA, 2007; Harpham, 2009). This is of particular importance to the SADC region as the urban population in Africa is set to double between 2000 and 2030 (UNFPA, 2007). It is widely recognized that ensuring good health presents many challenges within the complex urban contexts of developing countries (for example, Harpham and Tanner, 1995; see Harpham and Molyneux, 2001; Waelkens and Greindl, 2001; Galea and Vlahov, 2005; Thomas, 2006; Harpham, 2009). Central challenges include: rapid, unplanned urban growth; the migration of people to cities – from both within a country and across borders; inadequate tenure and housing opportunities, resulting in increases in urban informal settlements; the context of urban poverty, with expanding numbers of recently urbanized migrant residents adding to the urban poor; higher urban HIV prevalence than in rural areas; and increasing intra-urban inequalities in the social determinants of urban health (SDUH) – including access to healthcare services. These challenges all contribute to disparities in the health of developing country urban populations (Dyson, 1993; Harpham and Molyneux, 2001; UN-HABITAT, 2003; Freudenberg et al., 2005; Garcia-Calleja et al., 2006; UNFPA, 2007; WHO, 2008a, 2008b; Montgomery, 2009). These disparities in health outcomes are experienced by urban poor groups – in particular, recent migrants to the city, who tend to be concentrated into unhealthy spaces in the city (see, for example, Hardoy et al., 2001; Mitlin and Satterthwaite, 2004; Vlahov et al., 2004; WHO, 2005, 2008a, 2008b). For action to improve the health of poor urban migrant populations to be successful, urban policymakers and programmers need to understand the complexity of the urban context: this requires a focus on exploring the connections between migration and health in cities.

(Adapted from Vearey et al., 2010)

- Migration often results in reduced access to good quality health and social services, especially for undocumented migrants, who may fear presenting to the public-health system.
- There is a need to stop criminalizing undocumented migrants and address the stigma faced by cross-border migrants when accessing public healthcare. This is especially relevant to Zimbabwean migrants within South Africa and other SADC states.

(Taken from key informant interviews, Oct–Nov 2010)

4.6 Urban–rural linkages, migration and HIV

“What has not been acknowledged to date is the role of local, rural transmission in this complex epidemic” (Lurie, 2006:661). It is essential to engage with the bi-directionality involved when considering HIV in the context of migration. As highlighted in Box 5, health systems responses and interventions need to engage with both those who migrate and those who “remain at home”. To date, there

have been few well-designed epidemiological studies documenting the relationship between migration and infectious diseases. Even more important, at this late stage in the southern African HIV epidemic, there have been few intervention programmes, even on a small scale, which specifically attempt to reduce transmission among migrants and their rural or urban partners (IOM, 2005).

Box 5: Circular migration and HIV: Implications for rural health in SADC

A recent paper challenges the current view of cities as discrete urban spaces,² and calls for the recognition of an urban–rural continuum (Collinson et al., 2010). Whilst focussing on South Africa, the implications are relevant to all SADC member states. In South Africa, urban populations are growing but the countryside is not getting emptier. Between 2003 and 2006 the population of the Agincourt sub-district (a rural administrative area) was virtually stable, with a total growth rate of -0.2 per cent, comprising a net-migration rate of -1.2 per cent and a natural increase of 1 per cent (Bocquier et al., 2010). Households are diversifying their use of space to include urban and rural livelihoods with a rural sub-population retained. The links between urban and rural areas have hidden implications if the national census is used for planning (Landau and Wa Kabwe Segatti, 2009). Urban planners need to address the risks for internal migrants in cities. Informal settlements provide an urban entry point for many in search of livelihoods to support themselves and their households (Vearey et al., 2010). It is estimated that just over 1 million of the 2.4 million households in South Africa (16 per cent) residing in informal settlements are located in the nine major cities of South Africa (Del Mistro and Hensher, 2009).

The rural population lacks livelihoods and is therefore dependent on labour migration, which mostly brings economic returns for rural households through remittances (Collinson, 2010a). This has resulted in a major HIV epidemic (Coovadia et al., 2009). There is an influx of sick and dying migrants moving back to the rural communities from whence they migrated. This results in a loss of income for the household, increased health costs and the opportunity cost of caring for a severely ill household member.

South Africa has an expanding public-health system and, since 2009, renewed political will to combat HIV/AIDS, including an expanding ART programme. This paper argues that for the system to have an impact, the reality of migration needs to be accounted for. This includes providing greater support and resources for rural hospitals, which are providing care for large numbers of the most critically ill patients who return home when too sick to work; an effective referral system to support ART adherence for patients who move between urban and rural areas; improved prevention and treatment programmes in urban informal settlements; ensuring drug efficacy by initiating programmes to improve nutrition security, for example by establishing food markets within informal settlements; and by keeping transport systems effective to facilitate safer and cheaper movement of people between South African cities and rural areas.

A particular dimension is the challenge for health information systems. Referral mechanisms must traverse long distances and span different settlement types to maintain continuity for the health care of returning migrants. Some form of confidential patient-retained card may be the most effective means of conveying the vital information on healthcare treatments the person is or was taking. (Adapted from Collinson et al., 2010)

2 When designing research and interventions, urban areas are often considered as “discrete spaces”. However, there is increasing recognition of the way in which rural and urban spaces remain connected and linked, through the circular migration of internal and cross-border migrants between urban and rural areas. As a result, there is a need to consider an urban-rural continuum when planning responses to migration and health.

4.7 Gender, migration and health

As highlighted in Box 6, some research supports that migration within SADC is following the global trend of becoming feminized, particularly when considering the increasing numbers of women found to be employed within the

informal sector, and within informal cross-border trade (Agadjanian, 2008; Olivier, 2009). Working within the informal sector has a range of health implications, particularly for women (Olivier, 2009; IOM, 2010a).

Box 6: Women and migration in southern Africa: The need to address violence against migrant women

The growing importance in female migration observed globally is confirmed in the southern African region (Perbady and Dinat, 2005; Lefko-Everett, 2007). Some of the characteristics that distinguish women from men's migration in the region include their motivations to migrate as well as their productive and reproductive engagements in the destination places. According to (Oucho, 2006:55) some clear gender differentials in migration in southern Africa are:

- immigration is still dominated by males;
- males migrate primarily in search of employment while female migrants are motivated by a variety of social and reproductive factors, although women also migrate because of economic incentives;
- men tend to participate in the formal economy while women gravitate towards the informal sector and retail trade;
- males migrate to geographic areas where there are employment opportunities (e.g. mines); females migrate towards towns and cities where informal-sector trade flourishes due to better access to goods and services;
- while women migrants tend to observe the law, men are more likely to be illegal immigrants.

Violence against migrant and refugee women

South Africa has been home to an increasing number of refugees from African countries. A small but significant number of refugees and asylum seekers have come to South Africa. Approximately half of them are women who have fled their countries seeking safety. The particularities of the violence experienced by women in armed conflict situations require a gender-based approach to assist refugee women in host communities. As it has become clear, refugee women are often subjected to sexual and gender-based violence in their own countries. Too often rape has been used as a weapon of war in political and ethnic conflicts in the most varied context. Furthermore, patriarchal structures to which women are subjected in their own societies are deeply embedded in notions of "pure ethnicity" and national identity that often lie at the heart of armed conflict and civil war (Palmary, 2005). The gender scope to war and armed political conflict demonstrates how, in these contexts, the private and the public spheres are very closely linked. >>

Box 6: Women and migration in southern Africa: The need to address violence against migrant women (Continued)

A gender analysis also demonstrates the need for a broadening of the scope of support and interventions for refugee women so as to provide a more comprehensive understanding of how gender, as a social position, has the capacity to shape the experience of violence and the expression of trauma (Palmary, 2005).

Migrant and refugee women are shown to be vulnerable to domestic violence, particularly violence within relationships. Existing studies have highlighted how migration introduces new dynamics to gender power relations and how migrant women face additional barriers in access to services and support in the host countries (Kiwunika, 2009). Violence against migrant women is pervasive while in transit. It has been reported that migrant women often experience violence as they attempt to enter South Africa from neighbouring countries (Human Rights Watch, 2009b; MSF, 2009). Women are particularly vulnerable to being raped and beaten while in transit as they would have to “pay” to be assisted to enter South Africa. NGOs and churches have been pivotal in offering trauma services and HIV/AIDS counselling, as well as shelter to women migrants who have fallen victim to violence at the border city of Musina. They have also been assisting victims to access medical services and, less successfully, to gain access to the justice system (Human Rights Watch, 2009b). In most cases perpetrators of violence against women remain unpunished and women migrants as victims of violence find themselves facing even more obstacles to access services, the justice system and to claim their rights. (Adapted from Nunez, 2010)

Literature highlights differences in the reasons and ways in which women migrate compared to men, with men mostly reporting moving for work and women for family visits (for example see Agadjanian, 2008; Nunez, Vearey, and Drimie, 2010). Whilst there appears to be a tendency for women to follow their male partners (whilst men tend to move alone), there is increasing evidence showing that women are moving without their partners, and heading households in their new locations (for example see Agadjanian, 2008; Nunez et al., 2010). Drawing on the research of Muzvidziwa (2001), Agadjanian (2008:411) highlights that:

women’s increased participation in this labor and migratory niche is driven by two interrelated processes: economic structural adjustment policies that

undermine traditional, male-centered forms of livelihood, on the one hand, and a rise in female-headed households, on the other.

Posel (2006:227–228) points out that:

The increase in female labour migration may be consistent with the maximizing decisions of households in which women are less likely to be married and to be living with men (particularly employed men ...). On the one hand, these changes may have created greater income insecurity in rural households, pushing women into paid employment.

It is also suggested that the migration of women for employment has “afforded women

greater freedom and more incentives to leave rural households” (Posel, 2006:228). Despite increased female migration – mostly associated with an increase in their livelihood activities/productive roles in urban areas – the literature highlights that the caring roles/reproductive

roles of female migrants persist: decisions to move “back home” are associated with the reproductive and caring responsibilities of female migrants who will move in order to care for sick family members (Nunez et al., 2010). This is highlighted in Box 7 below.

Box 7: Urban–rural linkages, migration and the gendered provision of care

Southern Africa experiences high levels of migration, most of which is associated with the move to urban and peri-urban areas in search of improved livelihood opportunities (Vearey et al., 2010). Within southern Africa, HIV is increasingly associated with urban areas and urban informal areas in particular (Kyobutungi et al., 2008). This means that many urban migrants reside within areas of high HIV prevalence when they first enter the city through peripheral informal areas (Vearey et al., 2010). Although the linkages between migration and HIV are complicated, studies have shown that migrants may be at an increased risk of acquiring HIV (Lurie, 2000; Anarfi, 2005; Banati, 2007; Barnighausen et al., 2007). Whilst we know that migrants often return home when sick, little is known about how migrants and their households respond to the shocks and stresses of HIV-related sickness, and how this sickness affects migration decisions and – in turn – livelihood systems. Internal and cross-border migrants in the city are found to remain linked to their household “back home”, which is mostly located within a rural area (Vearey et al., 2010). These linkages are found to be mediated through the provision of remittances (money, food, goods) and the reciprocal provision of care in times of sickness. The authors argue that an understanding of these reciprocal networks of care, which span urban and rural households, can shed light on the livelihood strategies of urban migrants, in times of sickness, and on migration decisions associated with HIV-related sickness.

Reciprocal networks of care characterize an interlinked livelihood system that connects urban migrants with households “back home”, in predominantly rural areas. The availability of care drives migration patterns; migrants would mostly return “back home” if sick. Similarly, women report more than men that they would return home in order to provide care. These networks highlight the reproductive role of women and the importance of gender in decision making related to migration and the provision of care. Given the increasing number of female migrants who are assuming the role as head of their urban household – and engaging with both productive and reproductive livelihood roles – the double burden of care on women is emphasized. The centrality of women in the provision of care calls for an understanding of care as a woman’s commodity. In a region of high HIV prevalence, it is important to understand the double burden on female migrants who have a traditionally reproductive role and now an increasingly productive role in the city. They are most likely to be responsible to provide care to other household members when they are sick as care is a function of their reproductive role.

(Text adapted from Nunez et al., 2010)

5. DETERMINANTS OF MIGRATION AND HEALTH IN SADC

5.1 Health systems in SADC

The healthcare system itself is recognized as a central determinant of health (WHO, 2008a). The SADC region is associated with plural healthcare systems, including public, private and a range of traditional medical systems. Whilst this review does not focus on health systems, it is important to consider wider literature that acknowledges the challenges that public-health systems in the region face; many are struggling and under-resourced. As an example, South Africa has a public healthcare system that includes free primary healthcare (PHC) at the point of use. However, many constraints have affected the equitable delivery of PHC services and the evolution of an effective health information system (for further discussion see Coovadia et al., 2009). Structural challenges within the public healthcare system present as a range of obstacles in accessing care; not only to cross-border migrants, but also to host populations. Key challenges relate to the perceptions of healthcare staff relating to the health-seeking behaviour of cross-border migrants, as well as human resource challenges (IOM, 2010b). Appendix 1 contains a table that summarizes current issues relating to health systems and migration for each SADC member state.

5.1.1. *Health workers, migration and health*

It should be noted that the migration of health professionals came up as a recurring issue in most of the key informant interviews conducted for this review, when asked about what the most important issues are relating to migration and health within the SADC region. Certainly it is a pressing topic that needs serious attention from governments throughout the region.

However, this study did not look into the issue in any detail, as new research is currently being conducted and will be available in mid-2011.

In 2007 the IOM conducted an assessment to identify and map relevant institutions and associations in the Netherlands, United Kingdom and the United States, to gauge the interest and availability of foreign healthcare professionals to work in the public-health sector in South Africa. Furthermore, the assessment made recommendations on future activities that aim to strengthen the capacity of the public-health sector services in South Africa by facilitating the recruitment and placement of foreign healthcare professionals, as well as South African healthcare workers currently residing in the Diaspora, in the three selected countries (IOM, 2007b). In conjunction with this assessment, the IOM published a literature review on health-worker migration in South Africa and southern Africa (IOM, 2007a).

Currently, the IOM is a partner on the EU-funded Mobility of Health Professionals (MoHProf) research project. The general objective of the project is to research current trends in the mobility of health professionals to, from and within the EU. Research is being conducted in 25 countries, six of which are in Africa (Angola, Egypt, Ghana, Kenya, Morocco and South Africa). The findings from Africa will shed light on the nature of migration flows of African health professionals to the EU. The final results of the project will be available in late 2011.³

³ <http://www.mohprof.eu/>

5.2 Behaviour, vulnerability and access to public-health initiatives

Various interrelated factors account for migrant health, including behaviour and health-seeking behaviour and care-seeking decisions. Some behaviours are born of vulnerability, such as risky sex to procure food security, and some vulnerabilities are born of discrimination. Furthermore, health is not solely a physical

condition that should be attained or maintained, but one that also incorporates mental health, which can be damaged through trauma, torture or depression, and ultimately cause as much detriment to well-being and the ability to adapt to a new environment (IOM and UNAIDS, 2003).

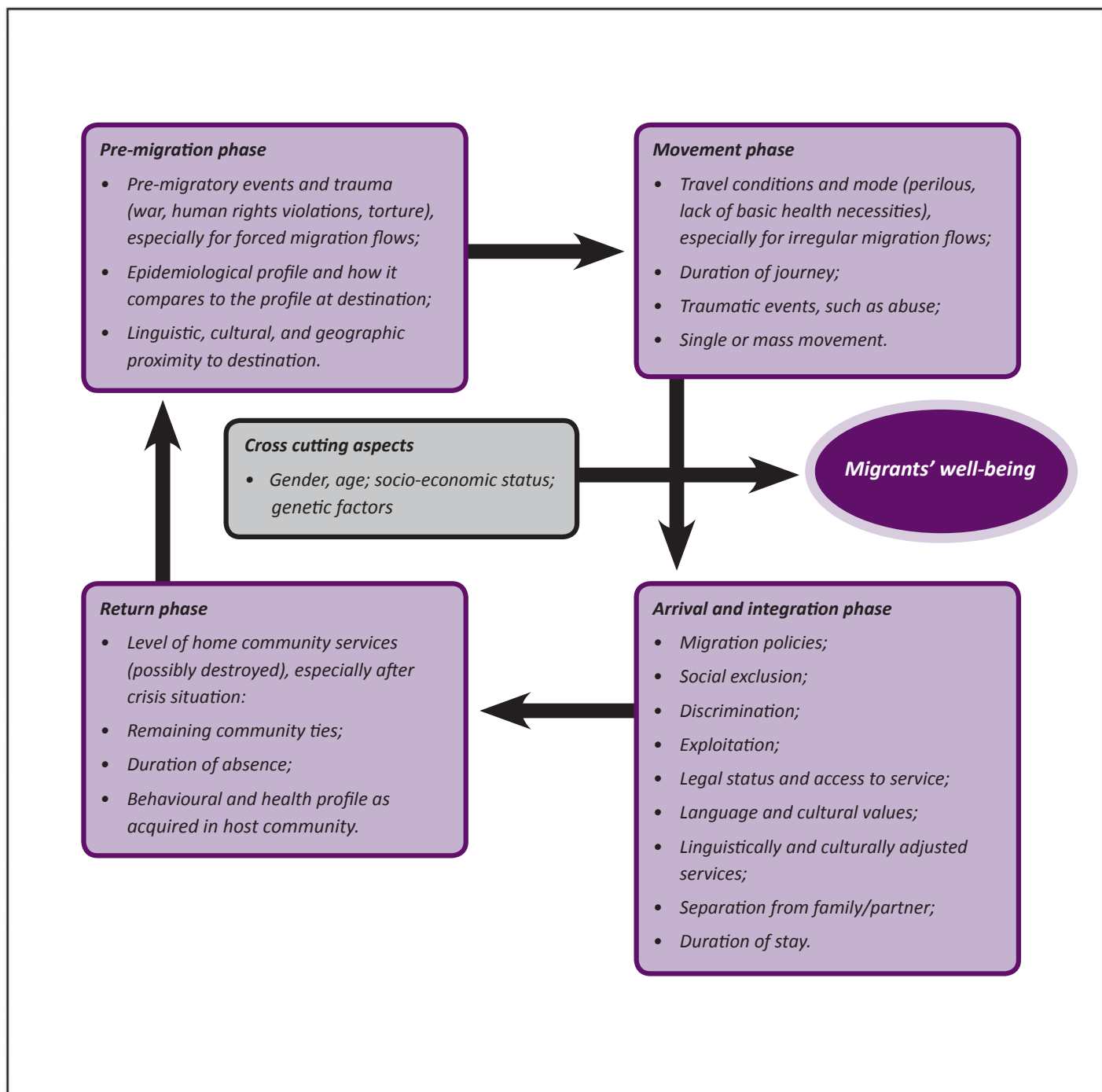
“We need to ensure that the voices of migrant groups are included in research and programme design. This involves exploring and understanding how and why decisions to migrate are made, and how migrant groups make decisions relating to their healthcare needs; what role do alternative and traditional medical systems play? How do different conceptualizations and understanding of “health” affect how migrants and programmers respond to migration and health in the SADC region?” (key informant interview, November 2010).

5.2.1 Stages of migration

Though it would be unwise to ascribe particular behaviours and vulnerabilities to particular points in time unilaterally, it is worthwhile to assess the ways in which differing parts of migrants’ journeys, settling and possible return home will impact their health. A chart published by IOM allows speculation upon how these frames of time may be divided, although cross-cutting aspects could perhaps include more features, depending upon the migrant. The chart does, however, highlight useful health

issues concerning temporary and protracted barriers to health, cultural and societal effects upon the well-being of migrants, and the impact of trauma or conflict. Rather than using this model as a guide to important behaviours and vulnerabilities migrants may enact or experience, the contents of the following section will allude to the times at which these behaviours and vulnerabilities may occur, where possible highlighting important cross-cutting aspects.

Figure 2: Factors that can affect the well-being of migrants during the migration process (IOM, 2008)



6. HIV/AIDS AND MIGRATION IN SADC

6.1 HIV/AIDS and migration: A model for other communicable diseases in SADC?

Towards SADC harmonization in responding to migration and health as interlinked regional priorities for development

- There is an urgent need to harmonize health policies across SADC, especially in relation to communicable diseases (TB, HIV, cholera, measles).
- We need to align healthcare protocols across member states.
- A health passport is needed that will be recognized within all SADC states and enable easy referral and continuity of treatment for chronic conditions (including HIV) across borders.
- We need to find ways to retain healthcare workers within SADC.
- Trans-border referral systems must be strengthened. This is especially important for referrals between neighbouring health districts that are separated by a national border.
- A platform/forum for discussion of migration and health should be established within SADC.

(Taken from key informant interviews, October-November 2010)

It is clear that HIV/AIDS is a topic of wide concern, both in SADC and globally. It is both a numerically significant public-health concern in SADC and one whose prevention and treatment may be problematic, in part due to its relationship (or perceived relationship) with numerous existing forms of migration. HIV/AIDS has even generated *new* forms of migration in the region, including the need to migrate when the breadwinner for the family falls ill or dies, to seek healthcare as a result of HIV/AIDS, child migration upon the death of a caregiver,

healthcare, and returning home to convalesce or die (Dodson and Crush, 2003; IOM, 2005; Clark et al., 2007). The global burden of HIV resides in sub-Saharan Africa, where HIV prevalence is higher than 23 per cent in some southern African countries (IOM, 2010a), and high levels of population movement in the region have today created a context in which migration must be considered in order to understand a disease that neither obeys borders nor makes distinction between interacting migrants and “host” populations (IOM 2010a).

Box 8: Migration and HIV in South Africa

Linkages between migration and the spread of HIV have been demonstrated (Lurie, 2000; Anarfi, 2005; Banati, 2007). However, the relationship between migration and HIV is complex. Migration has been shown to increase vulnerability to HIV – both for migrants and their partners who remain behind (Anarfi, 2005; IOM and UNAIDS, 2003; Lurie et al., 2003; UNAIDS, 2001) and different migratory processes are associated with different vulnerabilities to HIV acquisition. It has been shown that it is the conditions associated with the migration process that affect the vulnerability of individuals to HIV, rather than *being* a migrant per se (UNAIDS, 2001; IOM and UNAIDS, 2003; Banati, 2007). Linked to this, it is important to emphasize the bi-directionality of migration and HIV infection; it is not only those who migrate who experience an increased vulnerability to HIV as a result of the migration process (Lurie et al., 2003; Lurie, 2006). A prospective study conducted with internal migrants in rural South Africa showed that in almost one third of discordant couples, it was the female partner who “remained at home” who was infected with HIV (Lurie et al., 2003; Lurie, 2006). Whilst this study focussed on processes associated with internal labour-seeking migration – which involves the positive selection of a healthy, young population – it is argued that this finding is applicable to regional labour-seeking migration patterns that are prevalent within southern Africa; regional labour-seeking migration involving border-crossing migrants are driven by similar factors as internal labour-seeking migration within South Africa.

In mature epidemics, such as found in countries within southern Africa, the process of circular migration between rural and urban areas – both within and across borders – are no longer thought to contribute to the spread of HIV (Mundandi et al., 2006; Coffee et al., 2007); this emphasizes the need to explore the complex relationship between mobility and HIV. These findings challenge the prevailing assumption that HIV is spread only by male labour migrants who “become infected” in urban centres (within a country or across borders) and then return home and infect their partners in the rural areas. It is also important to consider the relationship between mobility and HIV associated with the forced migration of refugees and asylum seekers. In emergency and conflict situations, common assumptions that the vulnerability of forced migrant groups leads to increases in HIV infections have been challenged (Spiegel, 2004; Spiegel et al., 2007). It has been shown that there is insufficient data to support claims that conflict and displacement increase HIV incidence or that forced migrants contribute to the spread of HIV (Spiegel et al., 2007).

(Taken from Vearey, 2010)

There is a question, however, of whether and why HIV and AIDS is often emphasized and considered apart from other communicable or non-communicable diseases affecting migrants. Literature generally focuses upon communicable diseases that are deemed to be of public health significance (Lurie, 2000; Gushulak et al., 2010), leaving non-communicable diseases, which may also be the direct or indirect result of poor conditions in which migrants live and

work, under-researched. For this reason, while a justification of a focus on HIV and AIDS is currently necessitated by both the magnitude of prevalence in SADC and the amount of literature that focuses on it, the way in which HIV and AIDS is studied and reported in SADC might be used as a model for the consideration of advancing studies of other health concerns affecting migrant lives.

“[T]here is too much focus on migration and HIV at the detriment of other important public-health issues such as cholera, poliomyelitis, tuberculosis and even mental health” (key informant interview, October 2010).

6.2 HIV/AIDS and migration: Myths and assumptions

A number of myths and assumptions concerning the relationship between HIV, AIDS and migration exist and deserve attention and analysis.

Despite the foregrounding of HIV/AIDS in research and publication, it remains important to acknowledge that for migrants, HIV may be only one of many threatening health factors or concerns they regularly encounter. Physical abuse, mental health problems, illegal detention in poor conditions, hopelessness in the context of dangerous work, as well as other infectious diseases like tuberculosis, may all seem more pressing than an eventually fatal (if untreated) disease.

Countries with the highest prevalence – democratic Botswana and economically powerful South Africa – are neither the poorest nor least stable countries (IOM, 2005). Conflict areas, despite the well-documented vulnerabilities that exist in such spaces for contracting HIV, do not necessitate an increased HIV prevalence, for the reason that “the isolated and decreased mobility associated with conflict-affected areas can actually hinder the spread of HIV ... refugee camps may enjoy better access to HIV prevention programmes and messages that can help them avoid risk behaviours” (IFRC, 2008), referring to Spiegel et

al., 2007). In addition, some note that refugees and persons in such conflict situations are then prepared to act as potential emissaries of good health when they leave these situations (references). Importantly, “most refugees and asylum seekers are currently coming from countries with lower HIV prevalence, such as the Democratic Republic of the Congo (DRC), and moving to countries with higher HIV prevalence, such as South Africa. Their vulnerability to HIV infection, therefore, increases upon arrival” (UNHCR and Southern African HIV Clinicians Society, 2007), rather than these migrants filling the role of carrier of disease, as Spiegel also notes in his report on seven context-specific areas in southern Africa (Spiegel et al., 2007). Assumptions have also been made in the arena of treating HIV, regarding the insurmountable difficulty of treating mobile populations. Organizations like *Medicins Sans Frontiers*, however, have countered this with evidence of continuing care in places such as Bukavu, DRC in 2004. They note the use of emergency stocks, patient comprehension and an Emergency Plan as making the crisis both workable and a model for other groups working in conflict areas. However, there is a need to better understand the challenges and opportunities for working with more mobile groups, including cross-border traders and individuals engaged in the transport sector (IOM, 2010a).

An overview of several HIV-migration myths are addressed in Box 9.

Box 9: Myth busters

“Conflict always increases HIV”

On the contrary, despite the sexual violence, trauma and breakdown of family and community structures, evidence suggests that there are “protective” factors in a refugee setting that may offset these risks. Furthermore, displaced persons often come from countries of origin with lower HIV prevalence and move to countries of asylum with higher HIV prevalence. Thus, these populations often have lower HIV prevalence than their surrounding host communities, particularly in southern Africa.

“Displaced persons engage in high-risk behaviour”

While displaced persons are vulnerable to exploitation and abuse, they have often benefited from the assistance of international organizations. For example, dedicated HIV-awareness programmes and training in many refugee camps have resulted in a high level of skills and knowledge with less risky behaviour. Displaced people can use this knowledge in their country of asylum as well as upon return to their home country.

“High mobility among displaced persons prohibits good adherence”

Displaced persons are often denied access to care for fear that they are too mobile. However, by the end of 2003, refugee populations remained on average in their host country for 17 years. Even within a country, they are far less mobile than many assume and may move around less than local clients who work far from home.

“Providing care will bring on a flood across the border”

As HIV and AIDS related care is made increasingly available in the region and as more people can access such services, the more they tend to stay where they are. In countries that have provided free ART to refugees, there has not been an increase in movement across borders.

“Displaced persons never have support structures”

There are often tight and extensive support networks of similarly affected people within the host community; these may, however, not involve family, friends or more traditional support networks. Often innovative ways of ensuring adherence to ART, such as using clinical staff, counsellors and support groups, have proven effective.

“Conflict is limited to a short period”

Unfortunately, most conflict lasts for years and decades, resulting in conditions that force displaced people to remain in their host countries for extended periods.

(UNHCR, 2007)

6.3 Spaces of vulnerability

The recent IOM regional assessment on HIV prevention for migrant populations within southern Africa states that:

the most effective intervention that will ultimately reduce the HIV vulnerability of migrant workers and mobile populations is to develop projects and programs that target “places of vulnerability” as opposed to “persons of vulnerability”. (IOM, 2010a:11)

Box 10: Spaces (or places) of vulnerability

The spaces of vulnerability approach is based on an understanding that health vulnerability stems not only from individual but also a range of environmental factors specific to the unique conditions of a location, including the relationship dynamics among mobile and sedentary populations. These factors must be taken into consideration when addressing migration health concerns, and interventions must consider and target both migrants/mobile populations and the communities with which they interact, including families in migrant-sending communities. Spaces of vulnerability are those areas where migrants and mobile populations live, work, pass through or from which they originate. They may include the following: land border posts, ports, truck stops or hot spots along transport corridors, construction sites, commercial farms, fishing communities, mines, migrant communities and urban informal settlements, migrant-sending sites, detention centres, and emergency settlements.

(IOM, 2010b)

In recent years, there has been a shift in emphasis away from viewing migrants as “vectors” of disease and towards viewing the entire impacted community – migrants and non-migrants, those who are mobile and those who are not – as vulnerable. Williams et al. (2002) coined the phrase “spaces of vulnerability” in their article on migration and HIV/AIDS in South Africa to highlight the need to view the situation more holistically. It is the migrants *and* their host communities who are impacted upon by the migration process. As a result, it is important to engage with “places of vulnerability” to develop appropriate responses to HIV and migration, as opposed to focusing on “persons of vulnerability” (IOM, 2010a).

Lopman et al. (2008) have noted that whereas earlier in the epidemic mobility was thought to be an important driver of the spread of HIV into rural areas, more recently, in rural Manicaland in Zimbabwe, the prevalence of HIV among

migrants was no higher than among fellow members in the community. The authors go on to state that in a mature, generalized epidemic such as this, “there is little difference in readily identifiable individual characteristics between those who acquire infection and those who do not” (Lopman et al., 2008:89). In other words, when the epidemic is generalized throughout the community, the risk of acquiring HIV is not confined to sub-groups but is more evenly spread.

Table 2, which draws on a recent regional assessment of HIV prevention for migrant groups in southern Africa, highlights the key HIV-related vulnerabilities facing the range of migrant groups found in the SADC region (IOM, 2010a). It is essential that these groups are considered in the *spaces* in which they work, so that appropriate responses that consider “spaces of vulnerability” are developed (Williams et al., 2002).

Table 2: HIV vulnerabilities by migrant work group

Work sector	Researched locations	Noted vulnerabilities
Domestic	Malawi, Mozambique, South Africa	Poor living and working conditions, work contracts and unlawful labour practices, duration of time away from home, sexual and gender-based violence, limited access to health services and low HIV knowledge, low health-seeking behaviour
Commercial agriculture	Lesotho, Malawi, South Africa, Swaziland, Zambia	Poor living and working conditions, seasonal mobility/ duration of time away from home, lack of health services, poor education and HIV knowledge, boredom and loneliness, lack of labour recruitment and structures, low/inconsistent condom use, availability of sex workers, gender imbalances and farm hierarchy, illegal farm labour, economic power
Informal cross-border trade	Lesotho–South Africa border; Malawi–Zambia border; Swaziland–South Africa border; Zambia–Zimbabwe border; Cape Town, South Africa	Extended periods of time spent in high HIV-transmission areas, duration away from home, access to health services, lack of HIV-prevention services, gender inequalities, exploitation and abuse, frequency of movement, economic power
Transport	Angola, Namibia	Poor living conditions, long delays at border posts and ports, time spent in “hot spots”, dangerous working conditions, long periods of time spent away from home, boredom and loneliness, limited access to health services, low and inconsistent condom use, availability of sex workers, alcohol abuse, lack of workplace policies, inter-generational sex
Mining	Mine-sending Lesotho, Namibia, South Africa, Zambia, mine-sending Swaziland	Dangerous working conditions, time spent away from families, boredom, loneliness and social exclusion, masculine and gender inequality, limited access to healthcare, availability of sex and alcohol, partners of mineworkers, poor education and HIV knowledge, low/inconsistent condom use
Construction	Angola, Mozambique, South Africa	Nomadic lifestyle, dangerous working conditions, availability of sex, limited access to healthcare services, casual contracts and sub-contracting practices, gender inequality, low and inconsistent condom use
Fisheries (ports/ maritime)	Namibia’s port of Walvis Bay, South Africa’s port of Durban	Dangerous and stressful working conditions, casual contracts, distrust of management, time spent in “hot spots”, lack of knowledge among foreign seafarers, limited access to health services, low and inconsistent condom use, lack of workplace policies and programmes

(Taken from IOM, 2010a)

6.4 Vulnerabilities to HIV: Cross-cutting themes

A range of cross-cutting themes have been identified from the literature that relate to the vulnerabilities experienced by migrant groups

in relation to HIV. These themes are presented in Table 3. It is important that future research and programmes engage with these themes in an integrated and multi-level fashion.

Table 3: Cross-cutting themes identified in relation to migration and HIV within SADC

Cross-cutting theme	Description
Legal and political discrimination	<p>“Concerning refugees and asylum seekers, many countries in southern Africa, such as Namibia, South Africa and Zambia, have specific policies that include these groups in their public sector ART programmes. Others, such as Mozambique, Malawi and Zimbabwe do not specifically exclude refugees or asylum seekers from public sector ART. As at March 2007, Botswana is the only country with a policy that specifically excludes non-nationals from the ART programme. However, UNHCR and other organizations are advocating the government to lift this restriction.” (UNHCR, 2007:15)</p> <p>“Although governments have committed in the 2001 Declaration of Commitment on HIV/AIDS to enact appropriate legislation to eliminate all forms of discrimination against persons living with HIV (PLHIV), as of August 2008, 67 of the 184 countries in the world for which data were available placed special entry, stay, or residence restrictions on PLHIV. These discriminatory restrictions are not justified by public-health rationales and indeed have been criticized for their negative effect on public health, both on society as a whole and on individuals, including labour migrants, asylum candidates, and short-term travellers.” (Amon and Todrys, 2008)</p>
Gender imbalances	<p>It has been suggested that women may have a different relationship with their HIV status due to the fact that some women will receive medical care during their pregnancies, therefore being more likely to be tested. Women may also be more likely to engage in risky sex in order to procure safety or food security in insecure spaces (see below) (Vearey et al., 2010).</p>
Knowledge and access	<p>Access issues can stem from various situations, including discrimination, physical isolation from resources and lack of knowledge dissemination. In some cases, migrants do have legal rights to HIV treatment, but are either unaware of this right or, as mentioned previously, are discriminated against and therefore do not seek out care.</p>
Sexual behaviour	<p>While increased or risky sexual behaviour (inter-generational, transactional, etc.) undoubtedly changes the likelihood of contracting or spreading HIV, the reasons for this behaviour must be contextualized beyond aligning migration and dangerous sexual behaviour. Vulnerabilities encountered (such as food insecurity) may directly affect sexual behaviour, where sex may be used as a transaction ensuring safety or food security.</p> <p>Likewise, migrant workers separated from permanent partners are more likely to engage in relationships with other partners, putting them at heightened risk (Lurie et al., 2003). Changes in sexual behaviour may also pose a risk factor to non-mobile persons, such as the partners of migrants who remain at home (Kishamawe et al., 2006). Certain environments, such as construction sites reliant on migrant work, may position migrant workers to be more likely to pursue commercial sex with those engaging in selling sex from local, impoverished and under-developed areas (IOM, 2007a).</p>
Urban–rural issues	<p>Certain vulnerabilities exist in a rural context, such as among non-migrants who interact with returning migrant workers who have been living in high-risk areas. Within an urban context, which is ever-increasing within southern Africa, certain issues are more likely to be faced by those in cities with limited resources, and physical or financial access to treatment.</p>

7. RECOMMENDATIONS

A range of recommendations emerge from (1) a review of available literature and (2) interviews with key informants working on migration and health in SADC. Targeted to specific actors within SADC, these emphasize the importance of a public-health approach to research, intervention design and evaluation, and policymaking in relation to migration and health in SADC. Importantly, the recommendations are centred on the need to increase the amount and quality of research exploring migration and health that is undertaken within SADC, and to develop effective ways of ensuring that policies and programmes are evidence-informed.

To researchers based within academic and non-academic institutions:

- There is a need to conduct comparative and collaborative research across SADC member states that explore the linkages between migration and health within – and across – state borders. Currently, there is a bias to literature on South Africa.
- Many opportunities exist for conducting research with non-governmental and international agencies that are providing programmatic responses: there is a need for these interventions to be rigorously evaluated.
- Researchers should work across traditional disciplinary boundaries in order to design and implement research that engages with the many aspects of migration and health.
- Partnerships between researchers and regional and national governance structures need to be established and/or strengthened so as to ensure that research findings inform policy and programmatic responses and will assist in developing appropriate responses required to implement and achieve the World Health Assembly Resolution on the Health of Migrants (World Health Assembly, 2008).

To the various levels of government within SADC member states

- National governments should assess and possibly increase the amount of migration health data that is captured in its statistical plans/policies in order to ensure that relevant data is generated and available.
- National and local government departments should facilitate and promote partnerships with researchers in order to generate evidence to inform appropriate policy and programmatic responses on migration and health within SADC.
- There is an urgent need for research-informed multi-sectoral responses that engage both ministries responsible for health-system responses and those responsible for managing migration.
- The development of responses to the impacts of migration and health at a local level need to be multi-sectoral and to incorporate findings from localized research projects. This will ensure contextualized and appropriate responses to health and migration.

To SADC:

- SADC should collaborate with researchers in the region to develop effective regional, inter-state research-informed responses to migration and health and so support the implementation of the draft framework for Population Mobility and Communicable Diseases.
- SADC is encouraged to take an active role in working with member states to implement and achieve the World Health Assembly Resolution on the Health of Migrants (World Health Assembly, 2008). This includes working to ensure that research findings are used to inform the development of policies and programmes that contribute to implementing the WHA resolution.

- To non-governmental organizations, civil-society organizations and international agencies (including the UN) active within the SADC region:
- In order to strengthen programming and policy development, researchers should work with national, regional and international NGOs to evaluate and document lessons learned and good practices in programmes that work with migrants, and publish this information so that it can be shared with the wider community.
- Strategies and capacity should be developed to enable civil-society organizations to utilize research findings in order to advocate for strengthened regional and national responses to migration and health, that will support member states in implementing and achieving the World Health Assembly Resolution on the Health of Migrants (World Health Assembly, 2008).
- International organizations should mainstream migration and health into their programmes and work with SADC and the governments of member states to strengthen evidence-informed responses to migration and health.

To training institutions:

- Training on migration and health should be integrated in graduate, post-graduate and continuing professional development in the health and social sciences.
- There is a need for a new cadre of researchers and practitioners who are trained in multi/trans-disciplinary research and programme design.

To funding agencies active within the SADC region:

- Resources to support regional, comparative, interdisciplinary research projects and training programmes to improve the generation and application of evidence to inform responses to migration and health in SADC should be made available from national, regional and international funding.
- Funding agencies need to dedicate funds to the strengthening of the governance of migration and health in SADC. This requires funding for technical support to local, national and regional governance structures, and linking researchers with governance structures.



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 2008b Our cities, our health, our future: Acting on social determinants for health equity in urban settings. Commission on the Social Determinants of Health, Geneva.
 2010 Health of migrants: The way forward. Report of a global consultation, Madrid, Spain, 3–5 March 2010. WHO, Geneva.
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 2006 Unconditional hospitality: HIV, ethics and the refugee “problem”. *Bioethics*, 20(5):223–232.
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9. APPENDICES

9.1 Appendix 1

Table 4: An overview of migration and health concerns in SADC member states

(Adapted from IOM, 2009, except where noted)

The following table details the national migration and health concerns of the fifteen SADC member states, also considering their general national migration trends (both internal and cross-border), health and migrant-related legislation, and noted governmental or non-governmental interventions and/or recommendations. The information is primarily drawn from the 2009 Migration Dialogue for Southern Africa (MIDSA) report, with some incorporation of interviews with health experts interviewed for this literature review. The table illustrates that much of the existing legislation offers theoretical protection via the provision of a right to health or other human rights such as non-discrimination, but may be subject to the national differences and regional difficulties that either make such policies non-justiciable or have been noted to have failed various categories of migrants. This table should not be taken as a systematic summary of relevant health and migration issues in the SADC region, but rather a way of highlighting both national law and practitioner opinion on the way in which health and migration issues have been – and should be – addressed.

SADC country	The state of migration	Health and national legislation	Issues of concern	Noted interventions and recommendations
Angola		<p>Article 47 of the Constitution of the Republic of Angola provides for the right to health but its application is limited to citizens. Application of the non-discrimination clause is equally limited to Angolan citizens.</p> <p>In conformity with those standards which guarantee the right to access health services for all, especially in emergency situations, Angola's legal framework recognizes the right of migrants to access health services.</p> <p>Refugees in Angola are entitled to health assistance in accordance with legislation, which does not exclude the provision of health services to those with HIV/AIDS or mental disabilities.</p>	<p>There is little knowledge of the health status of refugees in places with high urban caseloads as opposed to refugee camps, like South Africa and Angola.[‡]</p>	<p>The urbanisation trend should be addressed by UNHCR and governments together in order to offer the provision of healthcare appropriately in urban contexts.[‡]</p>

SADC country	The state of migration	Health and national legislation	Issues of concern	Noted interventions and recommendations
Botswana	<p>Most cross-border migration into Botswana is born of established migrant networks that may facilitate the opportunity of work. These networks concurrently recognise the difficulty of migrancy in Botswana, but also the opportunities in a less competitive state/city. Zimbabweans workers are often favoured for piece jobs and may do well as tradesmen, in mines or as mechanics, and constitute a significant number in the city of Francistown. Zimbabweans have been entering Botswana since the early 1990s and, further, the historical boundary between the two countries runs through the Kalanga people. Botswana does not have an established path to citizenship, and the granting of permanent residence is rare.[¶]</p>	<p>The Constitution does not expressly provide for the right to health. The language of the Botswana Bill of Rights does not discriminate or differentiate between citizens and any other person in Botswana in the enjoyment of the rights enshrined in the Constitution. Although Botswana's Public Health Act "does not expressly provide for the right of access to healthcare", it places an obligation on the Ministry responsible for health to "carry out activities that could contribute to the realisation of the right to health".</p> <p>There are no statistics kept on migration, nor on health and HIV prevalence among citizens or migrants.[¶]</p> <p>Migrants must generally use a private medical aid scheme paid for themselves or use government hospitals and pay for their services, as there is no provision – including for ARVs – for foreigners.[¶]</p>	<p>Language barriers are a problem for migrant patients, who may be served by foreign doctors.[¶]</p> <p>Doctors may ignore expensive yet necessary tests for migrants based upon the assumption that migrants could not afford them. Doctors face general difficulties with operable technology and lack of drugs in hospitals, which the government is not improving. Further, doctors may find that even if they are able to test migrants for HIV, they are unable to do necessary follow-up tests. There is also a problem preventing mother-to-child transmission of HIV.[¶]</p> <p>Some hospitals have a reputation for contacting the police for deportation, affecting access issues for migrants.[¶]</p> <p>Migrants, such as those from Zimbabwe, may find a discrepancy between access to ARVs at home and in Botswana. They may return home for ARV treatment, affecting the continuity of service.[¶]</p>	<p>Persons in Dukwi Refugee Camp had no access to HIV treatment prior to September 2010, but the camp is now being supplied through BOTUSA via UNHCR.</p> <p>"The government of Botswana should improve the availability of reproductive health services to immigrants and refugees and expunge those laws and practices that make it difficult for immigrants and refugees to access available reproductive health services" (Oucho and Ama, 2009[¶]).</p>

SADC country	The state of migration	Health and national legislation	Issues of concern	Noted interventions and recommendations
Botswana (continued)	Dukwi Refugee Camp currently holds more than 3,000 persons, including Zimbabweans, Somalis and Namibians.*		In Botswana's Dukwi Refugee Camp, there is presently no clear structure on how to provide treatment for those outside the camp. Treatment provided by BOTUSA through UNHCR has taken the pressure off the government to provide treatment, and these ARVs are sent through a private clinic, rather than being processed along with the citizens of Botswana's ARVs.*	
Lesotho	Lesotho mainly has two types of migration: internal, where people migrate from rural to urban area in search of employment, and external, such as the migrants who go to work in the mines in South Africa. Lesotho does not discriminate against entry of migrants suspected of or living with HIV/AIDS.	<p>The right to health is non-justiciable in Lesotho. Principles of state policy and its application are limited to citizens. However, the right to life, freedom from discrimination and the right to equality before the law and equal protection are all enforceable in a court of law and apply to every person in Lesotho.</p> <p>Lesotho has an HIV prevalence of 23.2 per cent. The main driver of the HIV pandemic is multiple and concurrent partnerships.</p>	Unknown numbers of undocumented workers make it difficult to provide adequate access to health for migrants. There is also a noted limited institutional capacity and partnering between stakeholders. Lesotho has not, at present, enacted any HIV/AIDS specific legislation.	The HIV response in the country includes a pre-departure programme for mine workers, a programme for returning mine workers, and a cross border initiative between Lesotho and South Africa targeting mobile populations and border communities to provide free TB and anti retroviral treatment.
Madagascar		Article 19 of the Constitution of Madagascar provides for the right to health. The language of that provision does not limit the enjoyment of that right to citizens and as such would equally apply to migrants. Such an interpretation can be inferred from the fact that certain rights, especially political rights, are expressly limited to citizens, which is not the case for the right to health.	Although Madagascar has signed the OAU Refugee Convention, it is yet to ratify that Convention.	Madagascar has enacted a law that addresses issues of stigmatisation and discrimination against people living with HIV.

SADC country	The state of migration	Health and national legislation	Issues of concern	Noted interventions and recommendations
Malawi	The pattern of migration is mostly internal, from rural to semi-urban and urban areas in search of jobs. Malawi is also a transit country for migrants from East or southern Africa.	<p>Provision of adequate healthcare, commensurate with the health needs of Malawian society and international standards on healthcare is not a justiciable right but a principle of state policy.</p> <p>The constitutional equality provisions in Malawi expressly lists nationality as one of the prohibited grounds for discrimination, though the Immigration Act prohibits entry into Malawi of certain categories of persons, including persons afflicted with or suffering from a prescribed disease such as TB, gonorrhoea and syphilis (but which does not expressly include HIV/AIDS). In addition, this act provides that an immigrant may be deported in the interests of, among others, public health.</p> <p>Malawi has an HIV prevalence rate of 12 per cent. Malawi courts of law have declared that discrimination on the basis of one's HIV status is a violation of one's human rights and inconsistent with the Constitution's values and norms.</p>	The exclusion from Malawi of certain migrants on health status may impact upon access to health services of resident migrants, who may avoid services so as not to be detected and declared prohibited migrants.	Clinic services and outreach programmes are provided for nationals and non-nationals for free.

SADC country	The state of migration	Health and national legislation	Issues of concern	Noted interventions and recommendations
Mauritius	<p>Mauritius is a multi-ethnic and multi-racial community with a long history of migration. Temporary documented migrants in Mauritius are around 40,000 with the construction and manufacturing sectors employing mostly foreign workers. Migration is regulated in the sense that the Non Citizens Employment Act prohibits migrants to work without permits. The law does not allow refugees and asylum seekers into the country.</p>	<p>Non-nationals have free access to medical facilities available in government institutions.</p> <p>The Constitution of Mauritius does not expressly provide for the right to health. However, it does provide for the right to life, albeit formulated as a negative obligation – protection from intentional deprivation of life. Although section 16 of the Constitution prohibits against discrimination, it legitimizes enactment of a law that may discriminate against non-citizens (the Immigration Act exempts certain prohibited persons from entering Mauritius and accessing public services.</p> <p>Mauritius’ HIV and AIDS Act of 2006 does not discriminate against any person living with HIV who may seek voluntary counselling or testing. Although the Act does not expressly provide for treatment and access to essential medicines, it makes provision for testing and counselling, which is available for all.</p>	<p>Health facilities have become over burdened.</p>	<p>A recommendation has been made to provide social workers who will visit hostels to ensure the well-being of non-nationals.</p>

SADC country	The state of migration	Health and national legislation	Issues of concern	Noted interventions and recommendations
Mozambique		<p>Mozambique’s Bill of Rights provides for the right to health but limits its application to citizens. The right to life is equally limited to citizens, as is the non-discrimination clause.</p> <p>Mozambique’s immigration laws, however, do not place prohibitions of entry to migrants living with or affected by HIV/AIDS. According to information supplied by government officials in Mozambique, migrants –like citizens – have rights to access public-health services.</p> <p>Mozambique is a monist state, which means that the treaties it has ratified are part of its domestic law.</p>		
Namibia	<p>Migration patterns in Namibia are mostly internal, and labour migration is a common phenomenon in the mining sector.</p>	<p>The right to health, in Namibia’s Constitution, is not a justiciable right but rather a principle of state policy.</p> <p>Section 39(2) of the Immigration Control Act of Namibia prohibits entry into Namibia of, among others, “persons who are infected or afflicted with a contagious disease or are a carrier of such a virus or disease”. However, in practice migrants are not required to provide test results of their affliction to these diseases, including HIV/AIDS, and there has not been a reported incidence of migrants being barred from entering Namibia on the basis of their health status.</p>	<p>Spouses of mine workers are not allowed into the mines; such living arrangements may result in workers engaging in commercial sex.</p>	<p>There is a need for clear government policy direction on providing healthcare to migrants, in order to reduce migrants’ fear of arrest and deportation, resulting in their not accessing health services.</p>

SADC country	The state of migration	Health and national legislation	Issues of concern	Noted interventions and recommendations
The Republic of Seychelles	The Union of Comoros, with the Seychelles, has a large Diaspora, with almost the same number of people living in the Diaspora as the population on the island.	<p>Section 29 of the Constitution of Seychelles guarantees the right to healthcare but limits its application to citizens. However, the right to life is accorded to everyone, as is the right to equal protection under the law.</p> <p>Seychelles is the only SADC member state that is party to the Convention on the Rights of Migrant Workers and the members of their families. Article 28 of that Convention provides that “migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned.”</p> <p>The HIV prevalence is less than 0.1 per cent but there are also other epidemics such as chicken pox and cholera (Union of Comoros).</p>		Awareness-raising on HIV and other emergency services – such as humanitarian assistance for populations affected by disasters – have been conducted. The government has a national plan on HIV, and provides VCT and condoms (Union of Comoros).

SADC country	The state of migration	Health and national legislation	Issues of concern	Noted interventions and recommendations
South Africa	<p>The borders of South Africa opened significantly after 1994 to migrant labourers and tourists. Since then, the country is experiencing a huge influx of migrants, especially from Zimbabwe, and border controls are inadequate.</p> <p>The South African Immigration Act bars entry, grant of temporary and permanent residence permits to prohibited persons.</p>	<p>The South African Constitution guarantees everyone “access to healthcare services”. It further categorically states that “no one may be refused emergency medical treatment”. The National Department of Health (NDoH) has clarified that “refugees and asylum seekers – with or without a permit – should be assessed according to the current means test as applied to South African citizens when accessing public healthcare”. This should include equal access to antiretroviral treatment at all public-health providers.</p> <p>South Africa provides free public healthcare service for all children under the age of five.</p>	<p>In practice, “ambiguity persists within the public system on refugees’ and asylum seekers’ rights to access healthcare in general and anti-retroviral treatment (ART) in particular”. Public clinics and hospitals in South Africa are not implementing the Department of Health directive to provide ART to non-citizens, but are referring non-citizen patients to NGO health providers, thereby creating a dual healthcare system. Refugees and asylum seekers report being unable to access ART because they do not have green, barcoded ID documents.</p> <p>Persons living with HIV are not expressly mentioned as prohibited persons barred from temporary and permanent residence permits to the country. However, the fear of denial of a residence permit based on infectious diseases may prompt certain migrants to continue living as undocumented migrants with attendant consequences of serious limitation to access services from public service providers unaware/ignorant of the right of all to access health services.</p>	<p>NGOs working at border posts provide services to children who have been left by their parents to work in South Africa.</p> <p>A National Department of Health directive has enabled refugees/migrants to have access to basic healthcare and ARVS.[‡]</p> <p>The urbanisation trend should be addressed by UNHCR and governments together in order to offer the provision of healthcare appropriately in urban contexts.[‡]</p> <p>The South African Department of Health should keep non-discriminatory disaggregated information showing accurate data on how many non-nationals are accessing healthcare.[‡]</p>

SADC country	The state of migration	Health and national legislation	Issues of concern	Noted interventions and recommendations
South Africa (continued)			<p>There is little knowledge of the health status of refugees in places with high urban caseloads as opposed to refugee camps, like South Africa and Angola.[‡]</p> <p>Some of the challenges the country is facing are related to the situations other countries, such as the Zimbabwe cholera outbreak (¶; IOM 2009a/b?) or bi-directionally between Botswana and South Africa.[§]</p>	
Swaziland		<p>The government of Swaziland has noted that one of the factors that contribute to the spread of HIV epidemic is conditions of migration, such as the long distances travelled by truck drivers. Swaziland has also realised that one of the major milestones towards the care of vulnerable groups is their inclusion in the country's national Multi-sectoral Strategic Framework on HIV and AIDS (2009–2014).</p> <p>The right to health under the Constitution of Swaziland is not a justiciable right but a principle of state policy. The state is obliged to “take all practical measures to ensure the provision of basic health care services to the population”. In theory, a progressive interpretation of the right to life and non-discrimination would accord migrants in Swaziland a right to access health services, especially in emergency medical situations.</p>	<p>Migrant workers may be clients to commercial sex workers due to separation from partners for long periods of time.</p> <p>Challenges in providing migrants with access to health include the lack of data on migration for programming and targeted interventions, stigma and discrimination towards STIs. HIV/AIDS bring about fear among migrants of accessing health services.</p>	<p>Achievements made in addressing health of migrant workers include: (1) implementing partners identified (2) peer educators for migrant workers trained (3) community dialogues, health education with long distance truck drivers and transport workers conducted (4) linkage of transport workers to health facilities at flexible hours convenient to them (5) distribution of condoms at major outlets e.g. border-posts, airports, bus ranks, shops, hotels, and bars for easier access.</p>

SADC country	The state of migration	Health and national legislation	Issues of concern	Noted interventions and recommendations
Swaziland (continued)		Section 13 (b) of the Refugees Control Order of Swaziland empowers the Deputy Prime Minister to make rules that, among others, provide for the “reception, treatment, health and well-being of refugees”.		
United Republic of Tanzania	Tanzania has had problems with refugee camps and some have been closed down.	<p>Although a strict reading of the Constitution does not expressly mention health, it does call on the state to provide for social welfare in the event of infirmity and to ensure persons earn a livelihood, which should apply to all residents of Tanzania without discrimination.</p> <p>The Tanzania Refugee Act empowers the Minister to make rules that regulate “the reception, transfer, residence, settlements, treatment, health and well-being of [an] asylum seeker or refugee”.</p>	The challenges in providing healthcare and services to migrants include exploitation, shelter, security and language, among others issues.	<p>In emergency services, migrants are cared for through a partnership between the government and UNHCR. There is also a programme aimed at providing health services to truck drivers—also available in Kenya, Uganda and Rwanda.</p> <p>The governments’ response to the need to provide access to healthcare for migrants was to link the services provided in refugee camps with national health services.</p>
Zambia	Zambia is a landlocked country with various migration flows internally and externally. The country has experienced a brain drain from health and education sector to Namibia, Botswana and South Africa. Zambia has also been a host country to migrants due to political and social instability from other countries.	Article 112(d) of the Zambian Constitution entrenches directive principles of state policy, which include a non-justiciable right to “adequate medical and health facilities” for all. A limitation of personal liberties by the Constitution that could affect migrants’ access to health services in Zambia is the provision that personal liberty can legitimately be deprived “for the purpose of preventing the spread of an infectious or contagious disease”.	<p>According to Research from the Aids and Human Rights Research Unit, University of Pretoria, there have been cases whereby refugees and migrants are restricted from accessing public-health services.</p> <p>Challenges include sex work, which is illegal, the difficulty to interview migrants due to language barriers, an overburdened healthcare system, and migrant-unfriendly services.</p>	<p>Responses to challenges regarding migrants’ access have been provided by NGOs, IOM, CHAMP and UNHCR.</p> <p>The Zambia Public Health Act provides for the realization of the right to health for all, but may be complicated by the aforementioned legal restrictions.</p>

SADC country	The state of migration	Health and national legislation	Issues of concern	Noted interventions and recommendations
Zambia (continued)		<p>Zambia is a dualist SADC member state, meaning their standards are not legally enforceable in courts of law, but they may have persuasive value in interpreting the Bill of Rights.</p> <p>Zambia has an HIV prevalence of 14.3 per cent.</p>		
Zimbabwe	<p>Migration in Zimbabwe is both internal (illegal mining) and external, with more than half of the skilled population seeking employment in other countries, such as health workers, leaving the health system in Zimbabwe weakened.[±] This has also increased cross-border trade and strengthened concentrations of sex work at the border. Temporary permits for Zimbabweans entering South Africa have resulted in drastic reduction on the number of deportees, but there is inadequate reliable data on migration to give a picture of the magnitude and pattern of migration in Zimbabwe.</p>	<p>The right to health is not enshrined in Zimbabwe's Constitution. The Zimbabwe Public Health Act classifies certain diseases as infectious. The right to liberty of persons suffering from such diseases may be constrained. However, the Prevention of Discrimination Act expressly prohibits against discrimination to anyone on the basis of their nationality.</p>	<p>There are concerns regarding the diagnosis of diseases and initiating treatment and follow-up among migrants. Further, designing programmes for migrants is a challenge due to lack of collaboration among member states and the lack of implementation of protocols developed by SADC.</p>	<p>The country needs to strengthen referral systems between institutions and countries.</p> <p>ARVs should be a part of the national HIV programme, with no discrimination against migrants and other marginalized groups.</p>

± Key informant interview, October 2010

≠ Key informant interview, October 2010

‡ Key informant interview, October 2010

§ Key informant interview, October 2010

9.2 Appendix 2

Table 5: List of interviewees

Person	Position and Organization
Treasa Galvin	Lecturer, University of Botswana
Gloria Puertas	UNHCR, Pretoria
Dr Olushayo Olu	Health Cluster Coordinator, Zimbabwe, Emergency and Humanitarian Action Focal Point, WHO Inter-country Support Team, Eastern and southern Africa
Pierre Brouard	Deputy Director, Centre for the Study of AIDS, Pretoria
Mumtaz Mia	UNAIDS
Lorena Núñez	Senior Researcher, Health and Migration initiative, FMSP
Sharon Ekambaram and Bridget Steffen	MSF/Doctors Without Borders
Erin Tansey and Julia Hill-Mlati	IOM, Pretoria
Alvaro Alconada	Spanish researcher working in Mozambique

9.3 Appendix 3

Questionnaire Used for Key Informant Interviews

On behalf of the **International Organization for Migration (IOM)**, the **Forced Migration Studies Programme (FMSP) of Wits University** is undertaking a review of the literature relating to migration and health in the Southern African Development Community (SADC). **This review focuses on the SADC region and explores the linkages between health and the diverse movements of people within member states and across their borders.**

Whilst this review is focussing on an analysis of available literature, we are supplementing this process with **a set of interviews with specialists who are active in the field of migration and health in SADC.** Therefore, we would like to **ask for your input to this review process through the following five questions.** We would appreciate your responses, either as written responses provided through email, or we are happy to arrange a telephone interview. An analysis of these interviews and responses will be included in the final report. We will keep responses anonymous but would like to list the names and affiliations of respondents within the report.

- 1) Drawing on your experience and current work/research, please provide a brief overview of what you perceive to be **the most important issues relating to migration and health within the SADC region.**
- 2) Have there been any **key developments** relating to research and/or legislation in the field of migration of health within the last 10 years?

- 3) The review of literature on migration and health within SADC clearly highlights a focus on published literature exploring the relationship between HIV and migration. **What do you think of this?**
- 4) Are there any **key gaps in knowledge or evidence relating to migration and health** within SADC that you think should be addressed?
- 5) Do you have any **key recommendations for future work on migration and health within SADC?** These recommendations can be targeted to the research community, to policy makers, international organisations, non-governmental organisations and funders.



9.4 Appendix 4

Other Relevant Publications on Migration Health in Southern Africa

A

Ansell, N. and L. van Blerk

2004

HIV/AIDS and children's migration in southern Africa. Southern African Migration Project, Migration Policy Series No. 33, Cape Town.

Austin, J., S. Guy, L. Lee-Jones, T. McGinn and J. Schlecht

2008

Reproductive health: A right for refugees and internally displaced persons. *Reproductive Health Matters*, 16(31):10–21.

B

Busza, J., S. Castle and A. Diarra

2004

Trafficking and health. *BMJ*, 328:1369–1371.

<http://bmj.bmjournals.com/cgi/reprint/328/7452/1369>

C

Caldwell, J.C. et al.

1997

Mobility migration, STDs and AIDS: An essay on sub Saharan Africa. In: *Sexual cultures and migration in the case of AIDS* (G. Herdt, ed.). Oxford, Clarendon.

Campbell, C.

2003

Letting them die: Why HIV/AIDS prevention policies fail. James Currey, Oxford.

2004

Migrancy, masculine identities, and AIDS: The psychosocial context of HIV transmission on the South African gold mines. In: *HIV and AIDs in Africa: Beyond epidemiology* (E. Kalipeni, S. Craddock, J. Oppong and J. Gosh, eds). Blackwell, Oxford, pp. 144–154.

Campbell, C. and Z. Mzaidume

2001

Grassroots participation, peer education, and HIV prevention by sex workers in South Africa. *American Journal of Public Health*, 91(12):1978–1986.

Campbell, C. and B. Williams

1999

Beyond the biomedical and behavioural: Towards an integrated approach to HIV prevention in the South African mining industry. *Social Science and Medicine*, 48:1625–1639.

Carael, E.

2005

HIV and mobile workers: A review of risks and programmes among truckers in West Africa. IOM, Geneva.

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2007
The challenge of migration and health. International Centre for Migration and Health (ICMH), Geneva.
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Patterns of movement and risk of HIV infection in Rural Zimbabwe. *Journal of Infectious Diseases*, 191:159–167.
- 2007
Modelling the impact of migration on the HIV epidemic in South Africa. *AIDS*, 21(3):343–350.
- Collinson, M.A.
2002
Reflecting on social transition: A study of female temporary migration and the impact on child mortality in rural South Africa. AHPU Working Paper Series. University of the Witwatersrand, Johannesburg.
- Collinson, M.A., M. Lurie, K. Kahn, A. Johnson and S. Tollman
2006
Health consequences of migration: Evidence from South Africa's rural north-east (Agincourt). In: *Africa on the move. African migration and urbanisation in comparative perspective* (M. Tienda, S. Findley, S. Tollman and E. Preston-Whyte, eds). Wits University Press, Johannesburg, pp. 308–328.
- Collinson, M.A., S.M. Tollman and K. Kahn
2007
Migration, settlement change and health in post-apartheid South Africa: Triangulating health and demographic surveillance with national census data, *Scandinavian Journal of Public Health Supplement*, 69:77–84.
- Connor, A., L. Rainer et al.
2007
Increasing the delivery of health care services to migrant farm worker families through a community partnership model. *Public Health Nursing*. 24(4):355–360.
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2002
HIV/AIDS prevention and care programmes for mobile populations in Africa: An inventory survey of African organizations working on HIV/AIDS with mobile populations. IOM, Geneva. www.old.iom.int/documents/publicaitons/en/hivaidns_report_web.pdf.

Crush, J., V. Williams and S. Peberdy

1999

Borderline farming: Migrants in South African commercial agriculture. Southern African Migration Project, Migration Policy Series No. 16.

2005a

Migration in southern Africa. A paper prepared for the Policy analysis and Research Programme of the Global commission on International Migration. Global Commission on International Migration (GCIM), Geneva.

2005b

Spaces of vulnerability: Migration and HIV/AIDS in South Africa. *Development Southern Africa*, 22(3).

D

Datta, K.

1998

Gender, labour markets and female migration in and from Botswana. In: *South Africa in Southern Africa* (D. Simon, ed.). James Currey, Oxford, pp. 206–221

Davidson, J. and C. Farrow

2007

Child migration and the construction of vulnerability. Save the Children, Sweden.

Development Research Center on Migration, Globalisation and Poverty

2005

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Dladla, A.N., C.A. Hiner, E. Qwana and M. Lurie

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2000a

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2000b

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Dodson, B. and J. Crush

2003

Mobile deathlihoods: Migration and HIV/AIDS in Africa. Paper for the UNAIDS Project: AIDS in Africa, Scenarios for the Future.

F

Fatiha, R. and H. Hakima

2008

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2007

Mapping transactional sex on the northern corridor highway in Kenya. *Health and Place*, 13(2):504–519.

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2006

Using diaries to measure parameters of transactional sex: An example from the trans-Africa highway in Kenya. *Culture, Health and Sexuality*, 8(2):175–185.

Forced Migration Review

2004

Reproductive Health for displaced people: Investing in the future. *Forced Migration Review*, 19. www.fmreview.org/FMRpdfs/FMR19/FMR19full.pdf.

G

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