Migration and Health in South Africa:

A review of the current situation and recommendations for achieving the World Health Assembly Resolution on the Health of Migrants

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Contents

List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
CoRMSA	Consortium for Refugees and Migrants in South Africa
DHA	Department of Home Affairs
DPLG	Department of Provincial and Local Government (current Department of Cooperative Governance and Traditional Affairs)
FIFA	International Federation of Association Football
FMSP	Forced Migration Studies Programme, University of Witwatersrand
HIV	Human Immunodeficiency Virus
HSRC	Human Sciences Research Council
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDP	Integrated Development Plan
IOM	International Organization for Migration
MDG	Millennium Development Goals
MIDSA	Migration Dialogue for Southern Africa
MRMP	Migrant Rights Monitoring Project
NDOH	National Department of Health
NGO	Non-governmental Organization
NSP	National Strategic Plan
ODA	Official Development Assistance
PEP	Post-exposure prophylaxis
PHAMSA	Partnership on HIV and Mobility in Southern Africa
PHC	Primary healthcare

SADC	Southern African Development Community
SALGA	South African Local Government Association
SAMP	Southern African Migration Project
SANAC	South African National AIDS Council
SDH	Social determinants of health
STI	Sexually transmitted infection
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Program
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
WHA	World Health Assembly
WHO	World Health Organization
Wits	University of the Witwatersrand

Glossary of terms

Asylum seeker	A person seeking to be admitted into a country as a refugee and awaiting a decision on their application for refugee status under relevant international and national instruments. In case of a negative decision, the person must leave the country and may be expelled, as may any alien in an irregular situation, unless permission to stay is provided on humanitarian or other related grounds (IOM Glossary on Migration, International Migration Law, 2004).
Cholera	Cholera is an acute infectious disease characterized by watery diarrhoea that is caused by the bacterium Vibrio cholerae (WHO Online, 2009).
Cross-border migrant	An individual who has crossed a border during the migration process and is now present within a country other than his/her place of birth (IOM Glossary on Migration, International Migration Law, 2004).
Determinants of migration	The political, social and economic factors that lead to a person deciding to migrate (IOM Glossary on Migration, International Migration Law, 2004).
Development	The process of improving the quality of life of all people (WHO Online, 2010).
Documented migrant	A migrant who has the required documentation which allows him/her to enter and remain in a country legally (IOM Glossary on Migration, International Migration Law, 2004).
Health	A state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living. It is a positive concept emphasizing social and personal resources as well as physical capabilities (WHO Online, 2010)
Healthy migration	A process of migration that ensures access to positive social determinants of health – including access to healthcare – throughout the migration cycle for both those that move and those that remain in the household of origin (FMSP, 2010).
Host community	The community of destination. The community which has accepted or received migrants and mobile workers (IOM Glossary on Migration, International Migration Law, 2004).
Informal settlement	The term "informal settlement" is used to describe unplanned settlements; this definition does not include other forms of informal housing – such as backyard shacks on the property of formal houses (Huchzermeyer, 2004: 148).
Internal migration	A movement of people from one area of a country to another for the purpose or with the effect of establishing a new residence. This migration may be temporary or permanent. Internal migrants move but remain within their country of origin (e.g. rural to urban) while cross-border migrants move across an international border (IOM, 2004).
Migrant	At the international level, no universally accepted definition of a migrant exists. The term migrant is usually understood to cover all cases where a decision to migrate is taken freely by the individual concerned for reasons of "personal convenience" and without the intervention of an external compelling factor. The term therefore applies to persons, and family members, moving to another country or region to better material or social conditions and improve the prospect for themselves and their families (IOM Glossary on Migration, International Migration Law, 2004).

Migrant 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 (Art. 2.1, International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families, 1990).
Migration	The process of moving, either across an international border or within a state. It encompasses any kind of movement of people, whatever its length, composition and causes; it includes migration of refugees, displaced persons, uprooted people and economic migrants (IOM Glossary on Migration, International Migration Law, 2004).
Mixed migration	Complex population movements including refugees, asylum seekers, economic migrants and other migrants (IOM Glossary on Migration, International Migration Law, 2004).
Mobile worker	A worker who is forced by the nature of his/her job to move. Sectors that employ such persons include: transport (e.g. truck drivers), fisheries, informal cross-borders traders and state officials, including military personnel and immigration officials (IOM Glossary on Migration, International Migration Law, 2004).
Palermo Protocol	Supplementary protocols to the Convention against Transnational Organized Crime (2000): Protocol Against the Smuggling of Migrants by Land, Sea and Air; Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children; and Protocol against the Manufacturing of and Trafficking in Illicit Firearms, Ammunition and Related Materials (IOM Glossary on Migration, International Migration Law, 2004).
Place-based approach	An approach based on an understanding of the local context where diverse migrant groups are situated. Through such an approach, spaces of vulnerability are identified, from which appropriate responses to addressing health in a context of migration can be generated (FMSP, 2010).
Place of origin	The place that is a source of migratory flows (legal or illegal) (IOM Glossary on Migration, International Migration Law, 2004).
Public health	Public health refers to all organized measures (whether public or private) to prevent disease, promote health and prolong life among the population as a whole. Its activities aim to provide conditions in which people can be healthy and it focuses on entire populations, not on individual patients or diseases (WHO Online, 2010).
Refugee	A refugee is a person who "owing to a well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion is outside their country of nationality and is unable to or, owing to such fear, is unwilling to avail themselves of the protection of that country" (UNHCR Convention and Protocol relating to the status of refugees, 1951).
Sex work	The exchange of money or goods for sexual services, either regularly or occasionally, involving female, male and transgender adults, young people and children, where the sex worker may or may not consciously define such activity as income-generating (UNAIDS Inter-Agency Task Team on Gender and HIV/AIDS, 2001).
Sex worker	Female, male and transgender adults and young people who receive money or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income generating (UNFPA, 2002).

Social determinants of health	The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices (Commission on the Social Determinants of Health, 2007).
Spaces of vulnerability approach	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 as well as the communities they interact with, including families in sending communities. Spaces of vulnerability are those areas where migrants and mobile populations live, work, pass-through or originate from and 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 centers, and emergency settlements. (IOM, 2010)
Trafficking	The recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation (Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention Against Transnational Organized Crime, 2000).
Undocumented migrant	Someone who, owing to illegal or the expiry of his or her visa, lacks the legal status in a transit or host country. The term applies to migrants who infringe a country's admission rules and any other person not authorized to remain in the host country (IOM Glossary on Migration, International Migration Law, 2004).
Urbanization	"Urbanization is the process of becoming urban, and it reflects aggregate population growth in cities, be it through natural population increase or migration" (Galea & Vlahov, 2005: 353)*.
Vulnerable (vulnerability)	Conditions determined by physical, social, economic and environmental factors or processes, which increase the susceptibility of a community to the impact of something harmful. For instance, HIV vulnerability results from a range of factors that reduce the ability of individuals and communities to avoid HIV infection. These may include (i) personal factors such as the lack of knowledge and skills required to protect oneself; (ii) factors pertaining to the quality and coverage of services, such as inaccessibility of services due to distance, cost and other factors; (iii) societal factors such as social and cultural norms practices, beliefs and laws that stigmatize and disempowers certain populations.
Xenophobia	An intense fear or dislike of foreign people, their customs and culture, or foreign things (IOM, 2009).

* It is acknowledged that there is no universal definition for the terms "urban" and "urbanisation" (WHO, 2008a)

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Executive Summary

Migration: a key driver of human development

The migration of people, both within a country (internal migration) and across borders (cross-border migration), is a global phenomenon. The 2009 Human Development Report clearly positions migration as a key driver of human development (UNDP, 2009a). The message is clear: the movement of people can – and should be – good for development. The movement of skilled and semi-skilled labour, and the ability of migrants to provide a range of resources to their linked households, contributes to social and economic development. However, for the development-associated benefits of migration to be realized, migration itself must be managed in a healthy way; population mobility must be recognized as a central public health imperative (Gushulak, Weekers, & MacPherson, 2009). It is therefore clear that, with 740 million people today estimated to have moved within their countries of birth, and 214 million people (3.1% of the global population) estimated to have crossed borders (UNDP, 2009a), regional, national and local governance structures must find ways to manage migration within a public health framework.

Southern Africa represents a region of diverse migration patterns – historical and contemporary – including the movement of people within countries, across borders and between different continents. A range of socio-political and economic drivers lead to the movement of people within the region: some are escaping political crises, others are forced to move in order to flee conflict or persecution, whilst the majority move in order to seek improved livelihood opportunities. Regionally, a combination of temporary, circular, transit and permanent migration patterns exist; within all these forms of migration one element stands out as common: most migrants remain connected to their households "back home" through the sending of remittances (money, food and goods), and through the reciprocal provision of care in times of sickness (Clark, Collinson, Kahn, Drullinger, & Tollman, 2007; Landau & Wa Kabwe-Segatti, 2009; Vearey, Palmary, Nunez et al., 2010).

This paper focuses on South Africa, and explores the linkages between health and the diverse movements of people within the county and across its borders. South Africa is historically associated with internal, circular labour migration and, increasingly, cross-border migration (Landau & Wa Kabwe-Segatti, 2009; Lurie, 2006). Whilst common estimates of the numbers of cross-border migrants within South Africa vary greatly (and there is a lack of good national migration statistics), analysis of national census and community survey data suggests that – in line with global trends – just over 3 per cent of the total population of South Africa are cross-border migrants, equating to around 2 million people (Landau & Wa Kabwe-Segatti, 2009; UNOCHA & FMSP, 2009). Within Gauteng, the most migrant-dense – and economically active – province of South Africa, between 5 and 6 per cent (around 58,000 people) of the population are estimated to be cross-border migrants (Landau & Wa Kabwe-Segatti, 2009; UNOCHA & FMSP, 2009). In comparison, almost 3.9 million South Africans living in Gauteng have migrated from another province within the county (UNOCHA & FMSP, 2009).

Current health-system planning within South Africa does not adequately engage with the health of migrants when they are in urban and peri-urban areas, resulting in the movement of migrants "back home" to their rural areas of origin should they become too sick to work. Planning should include addressing the needs of those who return home to die once they are too sick to work, increasingly from tuberculosis (TB) and human immunodeficiency virus (HIV) (Clark, Collinson, Kahn et al., 2007; Collinson, 2010; Collinson, Wolff, Tollman, & Kahn, 2006).

Migration, development and health

There are "distinct spatial dynamics" to both cross-border and internal migration in South Africa (Landau & Wa Kabwe-Segatti, 2009: 12). In this paper, we emphasize the importance of engaging with a "place-based" approach to address the health of those affected by the migration process in South Africa, including those who move and those who remain "back home". This involves understanding the specific contexts in which diverse migrant groups are situated, from whence they originate, the migration decisions made, the journeys undertaken, and their households that remain "back home". Through such an approach, "spaces of vulnerability" are identified, from which appropriate responses to addressing health in a context of migration can be generated.

A place-based approach to migration and health

There are "distinct spatial dynamics" to both cross-border and internal migration in South Africa (Landau & Wa Kabwe-Segatti, 2009: 12). In this paper, we emphasize the importance of engaging with a "place-based" approach to address the health of those affected by the migration process in South Africa, including those who move and those who remain "back home". This involves understanding the specific contexts in which diverse migrant groups are situated, from whence they originate, the migration decisions made, the journeys undertaken, and their households that remain "back home". Through such an approach, "spaces of vulnerability" are identified, from which appropriate responses to addressing health in a context of migration can be generated.

Cross-border migration and health

Within South Africa (and globally) negative assumptions prevail

which unfairly associate cross-border migration with the spread of infectious diseases and healthcare-seeking (made worse in a context of high HIV prevalence), position cross-border migrants as presenting a burden on the healthcare systems of destination countries, and assume that cross-border migrants cannot adhere to treatment – including antiretroviral therapy (ART) (Amon & Todrys, 2008; Harper & Raman, 2008; Southern African HIV Clinicians Society & UNHCR, 2007). Through recent empirical studies, this paper explores the gap between government legislation, which ensures the right to healthcare, and practice. It also challenges assumptions that negatively associate cross-border migration with healthcare seeking in South Africa. Empirical data clearly shows that: cross-border migrants do not initially move into South Africa in order to access healthcare; they are likely to "return home" should they become too sick to work; and (despite challenges faced in accessing treatment) cross-border migrants experience better clinical outcomes on ART than South Africans (McCarthy, Chersich, Vearey, Meyer-Rath, Jaffer, Simpwalo et al., 2009; Vearey, 2008a; Vearey, Palmary, Nunez, & Drime, 2010b). Even though the National Department of Health (NDOH) has taken steps to clarify that cross-border migrants have the right to access basic healthcare, including ART, those born outside of South Africa continue to face challenges in accessing care (CoRMSA, 2009; Vearey, 2008a).

A regional response to migration and health

South Africa is part of the Southern African Development Community (SADC) – a region associated with the highest HIV prevalence globally, and historically high levels of internal and intra-regional migration (with the majority of individuals moving in search of improved livelihood opportunities). In recognition of the important development-enhancing role that "healthy migration" can play within the region (Landau & Wa Kabwe-Segatti, 2009; UNDP, 2009a), SADC has drafted a policy framework for population mobility and communicable diseases; this 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 (SADC Directorate for Social and Human Development and Special Programs, 2009).

The health of migrants: an international concern

Whilst the 2008 report of the World Health Organization (WHO) Commission on the Social Determinants of Health did not specifically mention population mobility (WHO, 2008b), both internal and cross-border migration are increasingly recognized as central determinants of health (for example, see Gushulak, Weekers, & MacPherson, 2009; MacPherson & Gushulak, 2001). In response to this, the 61st annual World Health Assembly (WHA) adopted Resolution 61.17 on the Health of Migrants, which calls on member states (including South Africa) to promote equitable access to health promotion, disease prevention and care for migrants (World Health Assembly, 2008). Member states met in May 2010 at the 63rd WHA, to report on the progress made towards achieving Resolution 61.17. In preparation for this meeting, the WHO, the International Organization for Migration (IOM) and the Ministry of Health and Social Policy of Spain recently co-convened a Global Consultation on Migrant Health in Madrid, Spain. This Consultation brought together international migration and health actors, including the UN family, non-governmental organizations (NGOs), academia, policy makers and programmers.

The way forward

As a country of (predominantly circular) internal and cross-border migration, within a region of high population mobility, it is essential that South Africa develops, implements and monitors an evidence-based, coordinated, multilevel national response to migration and health. This includes acknowledging the developmental benefits of migration, ensuring "healthy migration" and engaging with a "place-based" approach to addressing the diverse health needs and health impacts of the multiple migrant groups present within South Africa.

An effective response requires a localized response to migration and health, with local government engaging in such a response in order to achieve its "developmental mandate". In addition, South Africa is encouraged to work towards developing a coordinated regional response to migration and health. South Africa is encouraged to take a lead, to ensure that "healthy migration" is facilitated for developmental benefits, and to work with the SADC secretariat to finalize, ratify and support the implementation of a regional framework for communicable diseases and population mobility.

To address migration and health in South Africa, and the recommendations from the Global Consultation, the Southern Africa office of the IOM (in partnership with the Forced Migration Studies Programme [FMSP] of the University of the Witwatersrand [Wits], the National Department of Health, UNAIDS and WHO) hosted a two-day National Consultation on Migration Health "Realising migrants' right to health in South Africa", 22–23 April 2010 to develop recommendations specific to South Africa.

More than 70 people actively participated from government departments (Health, Home Affairs, Education, Labour, Transport, Provincial level); academia; migrant groups; civil society; donors, UN family and health-facility representatives. The final product of the consultation, found in the final chapter of this report, is a series of actionable recommendations outlining a national response to the WHA 61.17 Resolution. The recommendations were structured around the four priority areas identified during the Madrid consultation: (1) Monitoring migrant health, (2) Partnerships and networks, (3) Migrant-sensitive health systems and (4) Policy and legal frameworks affecting migrants' health. Key lessons have been mainstreamed into the recommendations, and include ensuring that migrants and migrant communities are involved in health and migration responses, and the need to recognize the various types of migration: circular, linear, internal and cross-border.

The strength of the recommendations will only be as good as the resulting actions. The final framework provides a degree of accountability for stakeholders and demonstrates the commitment of organizations in South Africa towards improving healthcare for all, including migrants.

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Lerato Maduna – IOMMMPW Photography project 2006

Introduction

It is widely acknowledged that migrant groups – particularly cross-border migrants – experience challenges in accessing public healthcare within South Africa (Amon & Todrys, 2009; CoRMSA, 2009; Human Rights Watch, 2009a, 2009b; IOM, 2008; Landau, 2006b; Moyo, 2010; MSF, 2009; Pursell, 2004; Vearey, 2008a). In order to inform responses to improve access to public healthcare for all migrants in South Africa, this paper provides a synthesis of current knowledge, including empirical data, relating to migration and health within South Africa.

This paper is anchored in two key concepts. Firstly, it is essential that the South African government engages with migration as a key driver of development. This involves acknowledging that for South Africa to gain the full developmental potential associated with migration within and into the country, multiple levels of government must act to ensure that migration is a "healthy" process; the premise being that "healthy migration" is positive for development as migrants are needed for development (Landau & Wa Kabwe-Segatti, 2009). Secondly, that it is essential to acknowledge and engage with the need for localized responses to the health of migrants; this – it is argued – requires a "place-based approach" to addressing the health of migrants and includes consideration that places may become spaces of vulnerability. Through engaging with various empirical studies on migration and health, a framework has been developed that aims to assist multiple levels of government, within multiple – and diverse – geographic spaces, to address the interlinked features of migration and health. This framework has emerged through the synthesis of a range of studies[1] that clearly highlight the importance of "place" in explaining the profile of migrants and their associated health needs and vulnerabilities, as well as the need to engage in responses. The four "places" that have been identified are: border areas, rural commercial farming areas, urban centres and urban informal settlements.

The paper begins with a global overview of the linkages between migration, development and health, emphasizing that "healthy migration" is positive for development. This is followed by an overview of current migration patterns within South Africa, which emphasize the importance of urbanization. The paper then turns to synthesizing current knowledge and empirical data relating to health and migration within South Africa, and challenging common assumptions that negatively associate migration with health seeking. A place-based framework for exploring health and migration is presented, and examples are cited of the diverse health needs of migrants that are associated with diverse geographic places. The linkages between migration and HIV are explored, enabling lessons that are applicable to other communicable diseases to be discussed. The paper concludes with a range of recommendations that call on the multiple levels of South African government, non-governmental actors and academia to engage with – and address – the interlinked features of migration and health.

> "The challenge for South Africa is to formulate policy that takes advantage of the positive aspects of globalization, including the unprecedented movement of people with skills, expertise, resources, entrepreneurship and capital, which will support that country's efforts at reconstruction, development and nation-building."
>
> (Republic of South Africa,
> White Paper on International Migration, 1999)

1 These studies have been conducted by the Forced Migration Studies Programme, Wits.

3

Mpho Seleka – IOM/MPW Photography Project 2008

Migration, development and health in South Africa

"…migration is not a random individual choice. People who migrate are highly organised and travel well-worn paths."
(Harcourt, 2007: 3).

Multiple forms of migration: internal and cross-border migration are global realities

It is today estimated that 740 million people across the world are internal migrants (individuals who have moved within their countries of birth), and that 214 million people – roughly 3.1 per cent of the world's population – are cross-border migrants (those who have crossed borders) (UNDP, 2009a).

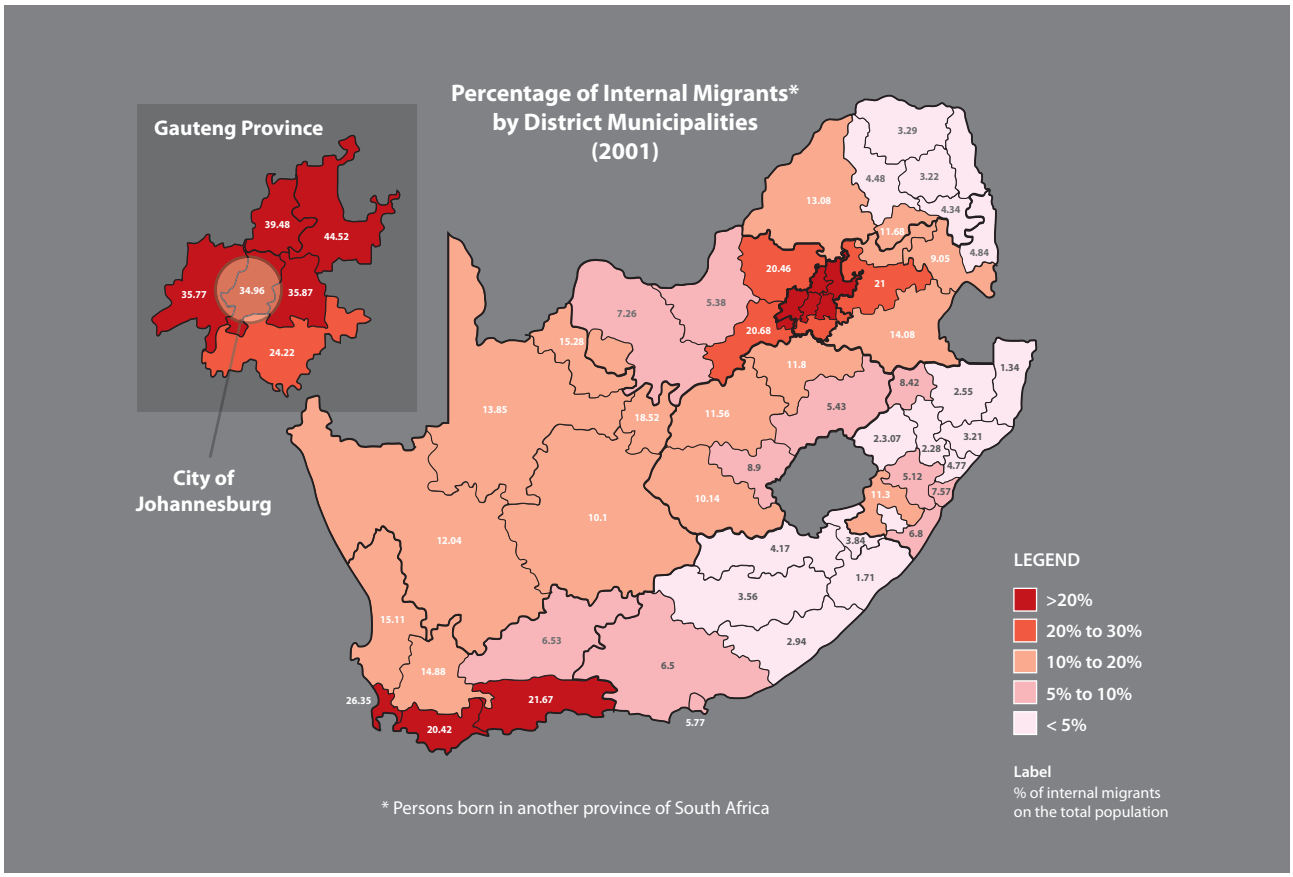
The African continent is typified by diverse migration configurations, including internal and cross-border movements. In 2005, it was estimated that there are 17 million cross-border migrants across Africa (18 per cent of whom are estimated to be refugees), accounting for less than 2 per cent of the total African population (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, 2005). Southern Africa is home to 9 per cent of the world's cross-border migrant population (Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat, 2005; Zlotnick, 2006). South Africa has a long history of migration and has become a primary destination for people from across the African continent and beyond. There are "distinct spatial dynamics" to cross-border and internal migration in South Africa (Landau & Wa Kabwe-Segatti, 2009: 12); the following section will present these dynamics.

Internal migration within South Africa

Map 1 below shows the distribution of internal migrants within urban areas across South Africa, highlighting their concentration within Gauteng province. The city of Johannesburg represents a "city of migrants" (Crush, 2005: 113); a cosmopolitan centre that is home to a heterogeneous population of migrants, many of whom come from within South Africa (internal migrants) (Beavon, 2004). Certain internal migrant groups are found to reside within "hidden spaces" – "inner-city areas that are broadly disconnected from the local government initiatives" within the city centre, requiring appropriate responses to address their particular health and development needs (Vearey, 2010: 37). The 2007 Community Survey indicates that 18 per cent of Gauteng's inhabitants moved into the Province since 2001 (Landau & Wa Kabwe-Segatti, 2009). A 2002 survey highlighted the internal movements of South African citizens: 68 per cent of inner-city residents (three-quarters of whom were South African) had moved to their household in the last five years (in Landau, 2006a). It is estimated that almost 35 per cent of Johannesburg's residents were born in a province outside Gauteng (UNOCHA & FMSP, 2009).

The movement of individuals within South Africa (internal migration) is of central importance to understanding the linkages between health and migration, and the responses that are required to address the health needs of migrant groups.

Map 1: Percentage of internal migrants living in urban settlements by district municipalities



(UNOCHA & FMSP, 2009)[2]

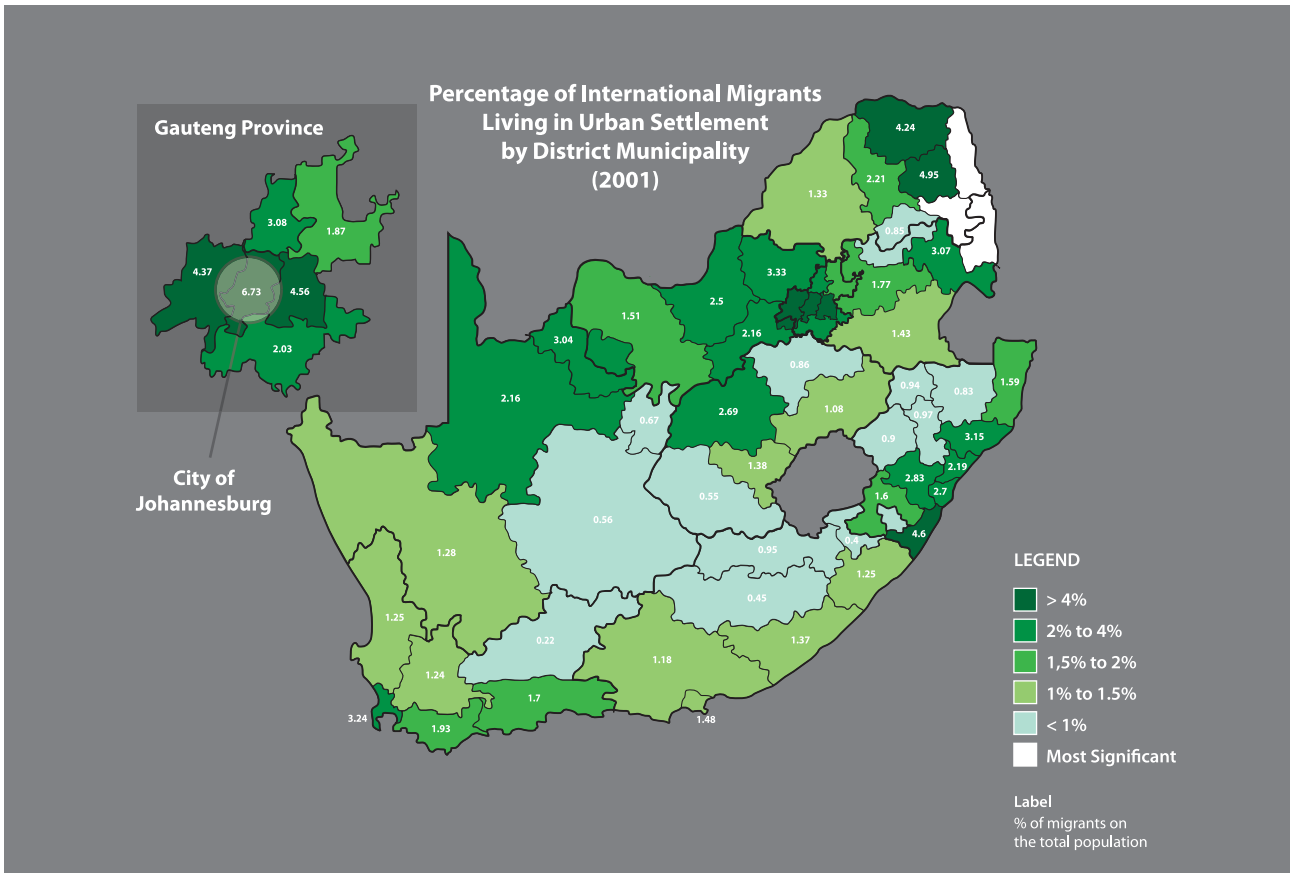
2 Thematic data source: Stats SA, 2001 Population Census. Geographic data source: Municipality Demarcation Board of South Africa, 2001. NOTES: (1) Stats SA only provides a 10% sample of the Census, but the data have been weighted according to their recommendations; (2) Since the data relate to the Census 2001, Province and District Municipality boundaries reflect the 2001 administrative sub-division of the country. For this reason, some of the District Municipalities have cross-boundaries in two different provinces.

Cross-border migration into South Africa

Whilst popular estimates of the cross-border migrant population within South Africa vary considerably, analysis of national census and community survey data suggest that there are approximately 1.6 million cross-border migrants in South Africa, which equates to 3.4 per cent of the total South African population (CoRMSA, 2009). There are different categories of cross-border migrants present in South Africa – as in other countries around the world – with many possessing a range of temporary visitor permits including work and study permits (Landau & Wa Kabwe-Segatti, 2009). A small, but important number, are refugees and asylum seekers. South Africa has been long associated with the movement of people; historically, most cross-border migration was related to labour migration within the agricultural and mining sectors. Migration into South Africa has consistently increased since the end of apartheid (see Figure 1 below) (Landau & Wa Kabwe-Segatti, 2009) and previously "forbidden cities" (Landau, 2005b: 1115) such as Johannesburg have become a destination for people from across the country, the continent and beyond.[3] As a result, cross-border migrants in South Africa tend to be concentrated in urban areas, as highlighted in Map 2 below.

3 During apartheid, cities were "off-limits" to most black South Africans, who required special permission and permits in order to enter the city.

The city of Johannesburg, located in Gauteng province, has a population of 3.9 million (City of Johannesburg, 2008). Despite being the city with the most international migrants in South Africa, it is estimated that just under 7 per cent of its total population are international migrants (UNOCHA & FMSP, 2009). While rigorous data on such "hidden" migrant populations is scarce (Banati, 2007; Jacobsen & Landau, 2003; Vigneswaran, 2007), particularly within urban areas (Jacobsen, 2006), a 2002 survey found that almost a quarter of Johannesburg's inner-city residents were born outside South Africa (Leggett, 2003). More recent survey data suggests that in certain inner-city neighbourhoods, over half of the residents are cross-border migrants (Landau, 2006a; Vearey, Palmary, Nunez et al., 2010). Cross-border migrants are concentrated in particular spaces in the city; place impacts the urban experiences of different migrant groups, depending on where they enter and settle in the city (Vearey, Palmary, Nunez et al., 2010).

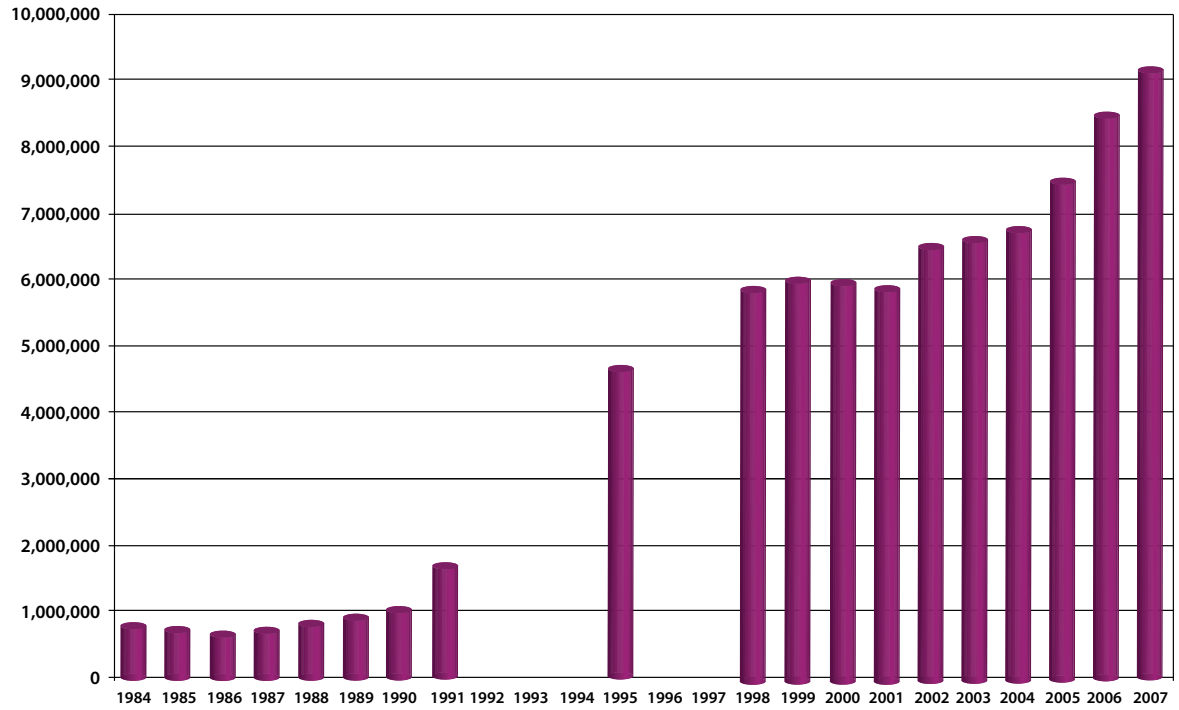


Map 2: Map showing percentage of cross-border migrants living in urban settlements by district municipalities

(UNOCHA & FMSP, 2009)[4]

4 Thematic data source: Stats SA, 2001 Population Census. Geographic data source: Municipality Demarcation Board of South Africa, 2001. NOTES: (1) Stats SA only provides a 10% sample of the Census, but the data have been weighted according to their recommendations; (2) Since the data relate to the Census 2001, Province and District Municipality boundaries reflect the 2001 administrative sub-division of the country. For this reason, some of the District Municipalities have cross-boundaries in two different provinces.

Figure 1: Numbers of Arrivals of Temporary Residents between 1990 and 2007 [5]



Source: Statistics South Africa, Tourism and Migration, 1984–2007. (Statistics unavailable for 1992–1994 and 1996–1997.)

(Figure taken from Landau & Wa Kabwe-Segatti, 2009: 7)

In addition to those cross-border migrants holding temporary residence permits, there are a small – but important – number of refugees and asylum seekers within South Africa; individuals who have been forced to flee their own countries and are seeking safety in South Africa.[6] Table 1 (below) illustrates the cumulative numbers of refugees and asylum seekers currently present within South Africa.

5 Temporary residents include entries for reasons of work, study, business, holiday, contract, border traffic, transit and other unspecifi ed categories.

6 There are no refugee camps in South Africa, and the majority of refugees and asylum seekers find themselves in cities. In 2008, 207,206 applications for asylum were made; with 7,049 (10%) approved (CoRMSA, 2009)

Table 1: Cumulative numbers of refugees and asylum seekers in South Africa[7]

	2001	2002	2003	2004	2005	2006	2007
Refugees	18,605	23,344	26,558	27,683	29,714	35,086	36,736
Asylum seekers	4,860	52,451	84,085	115,224	140,095	131,107	170,865
Total	23,465	75,795	110,643	142,907	169,809	167,193	207,601

(Table taken from Landau & Wa Kabwe-Segatti, 2009: 8)

Undocumented migrants

It is acknowledged that there are challenges with measuring cross-border populations within South Africa, including undocumented migrants (Landau & Wa Kabwe-Segatti, 2009). As a result, it is not possible to provide a realistic estimation of the numbers of undocumented migrants present within South Africa. However, claims that there are 8–10 million undocumented migrants in the country are overstated (FMSP & Musina Legal Advice Office, 2007; Landau & Wa Kabwe-Segatti, 2009). It is recognized that those without documentation are most likely to face challenges in accessing basic services (Human Rights Watch, 2009b; Landau, 2004; Vearey, 2008a).

Mixed migration

As highlighted in this section, South Africa is home to diverse patterns of migration; internal migration is taking place at higher levels than cross-border migration, and particular migrant groups are found to be located within particular geographic spaces. Landau and Wa Kabwe-Segatti remind us that "with South Africa's patterns of mixed migration, there is a need to develop bureaucratic and planning mechanisms to address human mobility more broadly" (2009: 3). In order to address this need, the following section provides an introduction to the importance of migration for development; for South Africa to achieve its development targets, it is essential that the government engages with the multiple migration patterns – and associated impacts – effectively.

7 Before the 2001 implementation of the Refugees Act (passed in 1998), there were officially no refugees or asylum seekers in South Africa.

Migration and development

> "Unlike the early 1990s where there was the blithe assumption that national economic and social policy could respond to citizen's needs, in today's world, migration and development are intertwined in a far more complex set of transnational realities."
>
> *(Harcourt, 2007: 2)*

Migration is increasingly recognized as a central factor of global development, requiring that national development policies engage with the movement of people – both within a country and across borders (Harcourt, 2007; Landau & Wa Kabwe-Segatti, 2009). This is particularly true within sub-Saharan Africa, where multiple factors (including widespread inequalities and poverty) are contributing to the migration of large numbers of people who – through remittances – support their communities back home (Harcourt, 2007). A range of economic and political realities have resulted in the movement of people from sub-Saharan Africa in order to establish livelihood strategies that aim to support both themselves and their communities back home; this migration is mostly within the region but also includes movement to Europe (Harcourt, 2007).

> "As the May 2008 violence against foreigners so starkly illustrates, domestic and international mobility are not without significant risks to human security and the country's developmental trajectory. However, the country will not meet its short and long-term development targets without significant migration of skilled and semi-skilled labour."
>
> *(Landau & Wa Kabwe-Segatti, 2009: 1)*

This section has introduced the importance of internal and cross-border migration for achieving development goals, highlighting that "development needs to catch up with the reality of transnational migration" and – importantly – emphasizing that it is essential for governments to recognize that "the implications of migration need to be much sharper in development policy discussions" (Harcourt, 2007: 2). The South African government is urged to engage with migration in a way that effectively addressed the drivers and impacts of migration.

> "The impact of migration is far from insignificant in relation to development goals and aims and yet decisions about where people are going, what jobs they take up and where the money they send back home is spent are outside the sphere of formal development institutions."
>
> *(Harcourt, 2007: 2)*

The paper now turns to discussing a central feature of development in South Africa that is associated with both internal and cross-border migration patterns: urbanization.

Engaging with urbanization

Urbanization is taking place rapidly across Africa, with 50 per cent of the continent expected to be residing in urban areas by 2030 (UNFPA, 2007). This process is associated with a high frequency of migration to urban hubs: this includes rural-to-urban migration, circular labour migration and movement across borders by those seeking asylum (Garenne, 2006). Bocquier explains that urbanization is important for economic development:

> "No developed country is poorly urbanised; no developing country can expect to improve its economic position without urbanisation. We should stop thinking of urbanisation as external to development: urbanisation ***is*** development" (2008: iii).

However, whilst the benefits of urbanization to economic development have been observed at the macro level, recent studies have challenged the notion of an urban advantage to development at the micro level (Bocquier, 2008). Within the global north, rapid urban growth has been associated with overall reductions in mortality, fertility and poverty, and with major economic progress and improvements in living conditions in urban areas. In contrast, urbanization in developing countries has been more recent, more rapid and has not been accompanied by the same levels of economic growth. As a result, within the context of developing countries, it is anticipated that the developmental gains of urbanization will come more slowly. Bocquier (2008) suggests two key reasons for this: (1) the proportion of informal settlement residents may increase; and (2) the total proportion of the population that becomes urban may be lower than anticipated. Whilst this may have benefits (such as reducing the growth of urban informal settlements), fewer individuals will have the opportunity to experience the benefits associated with urban life (Bocquier, 2008). Bocquier concludes by warning that "urbanisation trends will not solve the current inequality dilemma, and the world might actually end up more unequal twenty years down the road" (2008: v). It is important to consider that present urbanization, and current economic development in the global South, does not necessarily result in a developmental benefit to urban poor groups, and efforts to address the inequalities typical of developing country cities will need to be increased. Urbanization is recognized as a determinant of health (WHO, 2008a); urban change affects the health of populations. It is essential to acknowledge that the process of urbanization "promotes inequities through the expansion of deprived settlements and the inability of municipal authorities to respond to the growing demands of an increasing population for basic social and environmental amenities" (Konteh, 2009: 70 - 71).

South Africa has experienced a faster rate of urbanization compared to neighbouring countries, with almost 60 per cent of the population estimated to be urban (Kok & Collinson, 2006). For example, in just over 120 years, the city of Johannesburg has grown into what is now the economic hub of sub-Saharan Africa. Home to an estimated 3.9 million residents, the City[8] predicts that the population will reach 4.2 million by 2010, increasing by a further 1 million people by 2015 (City of Johannesburg, 2008). This translates to an average growth rate of 4.16 per cent per year, higher than other urban areas in the country (City of Johannesburg, 2008). This process of urban growth is a result of natural population growth, accompanied by migration into urban areas from within the country and across borders.

Different migrant groups are found to enter and settle in the city in different ways – with cross-border migrants concentrated in the central-city – resulting in different urbanization experiences (Vearey, Palmary, Nunez et al., 2010). Urban informal settlements are recognized as being important for many migrant communities (Banati, 2007); these informal areas are found to act as entry

8 "City" refers to the City of Johannesburg Municipality.

points for many internal, rural migrants seeking employment opportunities within the city (Vearey, Palmary, Nunez et al., 2010).

Policy responses to migration in South Africa

As discussed, there are different categories of cross-border migrants present in South Africa, with many possessing a range of temporary visitor permits including work and study permits. A small number are refugees and asylum seekers. In accordance with the South African Constitution's commitment to human rights and dignity, South Africa has a refugee policy that facilitates individuals' freedom and protection through enabling the temporary integration of refugees into local communities (Landau, 2006b). Unlike other countries in the region, no refugee camps exist in South Africa and many refugees and asylum seekers find themselves in complex urban environments such as Johannesburg. These individuals are assured the right to access existing welfare services, such as healthcare. Refugees and asylum seekers within South African cities are expected to become self-sufficient by earning a living and temporarily integrating within the host community (Landau, 2006b).

South Africa's immigration policy (The Republic of South Africa, 2002, 2004) makes it difficult for low and moderately skilled labour migrants to legalize their stay in South Africa, sometimes encouraging such individuals to make use of the asylum process as a "backdoor" to legalizing their stay in South Africa (Crush & Dodson, 2007; Landau, 2005a). It is possible for highly skilled workers to apply for permanent residence but others (those that are less skilled) are excluded, struggle to access documentation and – as a result – are often criminalized, struggle to access social services, and risk detention and deportation (Landau, 2005a). The result is a large population of undocumented cross-border migrants, who are exposed to the risk of arrest, detention and deportation (Vigneswaran, 2008) and – being undocumented – struggle to access basic services, including healthcare (for example, see CoRMSA, 2009).

Whilst various acts[9] exist to afford many rights to cross-border migrants, implementation remains challenging (Bailey, 2004; Landau, 2006b). Despite protective policies, cross-border migrants in South Africa regularly experience limited access to required documentation, health and social services, and economic, social and physical opportunities (Bailey, 2004; CoRMSA, 2009; Crush, 2005; IOM, 2008; Jacobsen, 2006; Landau, 2006b, 2006a; Landau, 2007; Moyo, 2010; MSF, 2009; Pursell, 2006; Vearey, 2008a).

A small number of cross-border migrants are asylum seekers and refugees, protected by the Refugee Act (The Republic of South Africa, 1998b). The majority of cross-border migrants are governed by the Immigration Act (The Republic of South Africa, 2002, 2004), experience challenges in legalizing their stay, and as a result are undocumented (Landau, 2006b; Vigneswaran, 2008). As will be described, it is this undocumented cross-border migrant population that experience the most challenges in accessing public healthcare services in South Africa (CoRMSA, 2009).

The following section turns to the main focus of the paper. It provides an introductory overview of the linkages between migration and health and emphasizes why the South African government must urgently address health and migration.

9 The Constitution of the Republic of South Africa (The Republic of South Africa, 1996), The Refugees Act (The Republic of South Africa, 1998b), The HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011 (Department of Health, 2007a), the National Department of Health's memo (Department of Health, 2006) and revenue directive (Department of Health, 2007b).

4

Tsvangirayi Mukwazhi - IOM/MPW Photography Project 2006

Migration and health in South Africa

Migration is recognized as a central determinant of health, requiring appropriate policy and programme responses (Anarfi, 2005; MacPherson & Gushulak, 2001). Recently, migration and health have received renewed attention through the 2008 World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants (Ghent, 2008; World Health Assembly, 2008) (see Box 1). 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; gather, document and share 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).

BOX 1

The WHA Resolution on the Health of Migrants

SIXTY-FIRST WORLD HEALTH ASSEMBLY WHA61.17

Agenda item 11.9 24 May 2008

Health of migrants

The Sixty-first World Health Assembly,

Having considered the report on health of migrants;

Recalling the United Nations General Assembly resolution 58/208 underlining the need for a high-level dialogue on the multidimensional aspects of international migration and development (New York, 23 December 2003);

Recalling the first plenary session of the United Nations General Assembly on migration issues and the conclusions of the High-level Dialogue on Migration and Development (New York, 14–15 September 2006) with their focus on ways to maximize the development benefits of migration and to minimize its negative impacts;

Recognizing that the revised International Health Regulations (2005) include provisions relating to international passenger transport;

Recalling resolutions WHA57.19 and WHA58.17 on international migration of health personnel: a challenge for health systems in developing countries, calling for support to the strengthening of health systems, in particular human resources for health;

Recognizing the need for WHO to consider the health needs of migrants in the framework of the broader agenda on migration and development;

Recognizing that health outcomes can be influenced by the multiple dimensions of migration;

Noting that some groups of migrants experience increased health risks;

Recognizing the need for additional data on migrants' health and their access to healthcare in order to substantiate evidence-based policies;

Taking into account the determinants of migrants' health in developing intersectoral policies to protect their health;

Mindful of the role of health in promoting social inclusion;

Acknowledging that the health of migrants is an important public health matter for both Member States and the work of the Secretariat;

Noting that Member States have a need to formulate and implement strategies for improving the health of migrants;

Noting that policies addressing migrants' health should be sensitive to the specific health needs of women, men and children;

Recognizing that health policies can contribute to development and to achievement of the Millennium Development Goals,

BOX 1

Continued

1. CALLS UPON Member States:

(1) to promote migrant-sensitive health policies;

(2) to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race;

(3) to establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;

(4) to devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;

(5) to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination;

(6) to raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;

(7) to train health professionals to deal with the health issues associated with population movements;

(8) to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process;

(9) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium Development Goals;

REQUESTS the Director-General:

((1) to promote migrants' health on the international health agenda in collaboration with other relevant international organizations;

(2) to explore policy options and approaches for improving the health of migrants;

(3) to analyse the major challenges to health associated with migration;

(4) to support the development of regional and national assessments of migrants' health status and access to healthcare;

(5) to promote the inclusion of migrants' health in the development of regional and national health strategies where appropriate;

(6) to help to collect and disseminate data and information on migrants' health;

(7) to promote dialogue and cooperation on migrants' health among all Member States involved in the migratory process, within the framework of the implementation of their health strategies, with particular attention to strengthening of health systems in developing countries;

(8) to promote interagency, interregional and international cooperation on migrants' health with an emphasis on developing partnerships with other organizations and considering the impact of other policies;

(9) to encourage the exchange of information through a technical network of collaborating centres, academic institutions, civil society and other key partners in order to further research into migrants' health and to enhance capacity for technical cooperation;

(10) to promote exchange of information on migrants' health, nationally, regionally, and internationally, making use of modern information technology;

(11) to submit to the Sixty-third World Health Assembly, through the Executive Board, a report on the implementation of this resolution.

Eighth plenary meeting, 24 May 2008,

A61/VR/8

Whilst recognizing that this high-level policy commitment was made only recently, multiple challenges to ensuring the health of international migrant populations persist (AIDS & Rights Alliance for Southern Africa, 2008; Amon & Todrys, 2009; CoRMSA, 2009; Forced Migration Studies Programme, 2009; Harper & Raman, 2008; Human Rights Watch, 2009a, 2009b) (See Box 2 for further details.) A range of assumptions persist within the southern African region that negatively associate the movement of people with poor health; and, present international migrants as placing an additional burden on the public health systems of destination countries (Southern African HIV Clinicians Society & UNHCR, 2007). Historically, cross-border migration has been associated with the spread of disease, and the prevailing assumptions of today reflect this (Harper & Raman, 2008). Globally (and within the SADC region), "foreigners" are often blamed by governments for introducing and spreading disease (Amon & Todrys, 2008; Harper & Raman, 2008). The resultant marginalization of non-citizen groups has led to health becoming conflated "with the politics of citizenship" – in many cases leading to the denial of healthcare to non-citizens (Grove & Zwi, 2006; Harper & 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 & Zwi, 2006; Harper & Raman, 2008; Worth, 2006). 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 (Amon & Todrys, 2008; Worth, 2006).

BOX 2

Challenges migrants face in accessing public healthcare in South Africa

Almost one third (30%; n = 396) of those who report ever needing healthcare in the Migrant Rights Monitoring Project (MRMP) survey experienced challenges when attempting to access public healthcare services. The most common challenges experienced were: being treated badly by a nurse; language problems; being denied treatment because of documentation problems and being denied treatment for "being foreign". Undocumented migrants were the most likely to report encountering problems, followed by asylum seekers and international migrants with other documentation (such as study and work permits). Refugees were the group least likely to encounter challenges when attempting to access public healthcare services in urban South Africa.

Facility-level policy decisions

A central challenge is that some public health facilities have been found to generate their own guidelines and policies that counter national legislation; and continue to demand South African identity documents and deny access to international migrants (CoRMSA, 2009; Vearey, 2008a). An additional problem is the inability of many lower-skilled international labour migrants to obtain the necessary documentation to be in South Africa legally, due to (1) a restrictive immigration policy and (2) poor implementation of this policy (Landau, 2004; Vearey, 2008a). In addition, access to documentation through the Department of Home Affairs is problematic for all international migrants, including refugees and asylum seekers (CoRMSA, 2009; Landau, 2006b).

Language

There are problems in terms of language. Some cross-border migrants do not speak South African languages; communication is therefore difficult. Furthermore, as healthcare providers assert, some cross-border migrants present themselves as South Africans and they do not speak any of the local languages. Language is therefore often used as a marker of belonging – an indicator of who does and does not belong. From the first interaction migrants are positioned as not belonging.

Forged documents and fake identities

In spite of the fact that the legislation does not state as a precondition the possession of documentation to provide care, documentation continues to be required by front line personnel in order to identify the patient (CoRMSA, 2009; Vearey, 2008a). Undocumented migrants, in turn, unaware of the legislation, may make use of fake identity papers (Moyo, 2010). This creates multiple problems; the interaction between healthcare providers and cross-border migrants is then framed in disbelief and fear (Moyo, 2010). Healthcare providers perceive cross-border migrants as trying to cheat the system, whilst undocumented migrants are reportedly fearful of arrest, detention and deportation via the healthcare system. It is important to engage with issues relating to the challenges that South African citizens encounter in obtaining documentation, and how this negatively impacts their health.

BOX 2

Continued

Difficult to follow up?

Whilst many healthcare providers state that the "mobility of migrants" and their "lack of a fixed address" represent difficulties in the provision of care – especially when the patient needs further treatment and follow up – evidence exists to challenge these perceptions (McCarthy, Chersich, Vearey et al., 2009; Vearey, 2008a). Healthcare providers report feeling frustrated that cross-border migrants "move on" – it is important to recognize that, if probed, healthcare providers will concede that this is also a problem for South African citizens. However, some efforts are made to secure continuity of treatment, to locate migrants within their communities, and to refer patients to other institutions in locations to which they may ultimately migrate. These challenges link with previous points: if undocumented migrants (both South African and cross-border) feel threatened, they may not be truthful about their future movements/travel plans, which ultimately will prevent effective planning to ensure continuity of care/treatment.

Attitude

The negative attitude of healthcare providers towards cross-border migrants is at times reinforced by the overburdening of the staff, and the lack of material and human resources (also see Moyo, 2010). There is the perception that within a limited resource setting, the "local" population should be given priority. In addition, in some healthcare institutions in Johannesburg, clinicians and high-ranking healthcare providers/managers openly express their criticism towards migrants. This may be openly, in front of migrant clients, and also when interviewed about their work with migrant clients. This sets an unfortunate precedent to the whole health system; it sends a message that "It is OK to mistreat cross-border migrants". It has also been reported that frontline healthcare providers (including receptionists and clerks) take decisions regarding whether the cross-border migrant deserves (or not) to be provided with healthcare; this is done based on their own appraisal of the seriousness of the health problem (for example, see Moyo, 2010).

Cross-border migrants in South Africa: health seeking?

A central challenge that cross-border migrants face in accessing public health in South Africa relates to prevailing discourse – particularly within the healthcare system – that negatively associates migration with healthcare seeking. As a result, healthcare providers feel justified in "rationing" healthcare through denying access to cross-border migrants. Cross-border migrants are "blamed" for presenting an additional burden to an over-stretched public healthcare system. However, there is little understanding of how healthcare systems are currently planned and financed, mostly being based on outdated 2001 census data, for example. Not only does this exclude in-migration to an area (including both internal and cross-border migration) but this also excludes natural population growth. As a result, budgets and services have been unable to meet the demands of changing (and often growing) populations.

In Johannesburg, frontline healthcare providers describe their workload as too great, and perceive cross-border migrants as the reason (Moyo, 2010). As a result, they will "choose" whether or not to facilitate access to healthcare (Moyo, 2010). The goal to improve the quality of healthcare for migrants poses questions regarding the need to develop a more comprehensive strategy to facilitate structural changes within the healthcare system itself. It is essential to recognize that one of the reasons cross-border migrants experience challenges in accessing public healthcare services is that of a public healthcare system that is under-resourced – both in terms of staff and budget.

BOX 3

Less than half of all cross-border migrants report "ever needing healthcare" in South Africa

Between 2007 and 2008, the national MRMP National Public Service Access Survey (coordinated by FMSP) completed surveys with more than 3,000 cross-border migrants in five South African cities (Cape Town, Durban, Johannesburg, Pretoria and Port Elizabeth). These interviews were conducted with international migrants seeking assistance at Refugee Reception Offices and NGOs that provide support to international migrants. Under half of all respondents (45%; n = 1,403) report "ever needing healthcare" in South Africa. This is associated with length of stay; recent arrivals do not report needing healthcare. The longer an individual has been in the country, the greater the likelihood of reporting ever needing healthcare.

The Forced Migration Studies Programme (FMSP) at Wits University (Johannesburg) has conducted a range of surveys over the last four years, reaching over 6,000 respondents in South Africa (for further information on the survey methodologies see CoRMSA, 2009; Landau, 2004, 2006a; Vearey, Nunez, & Palmary, 2009). The findings from these studies clearly show that international migrants report moving to South Africa for economic reasons, or to escape persecution; these individuals do not report moving in order to access healthcare services (CoRMSA, 2009). See Boxes 3 and 4 for further information.

BOX 4

Migrants indicate that they will "return home" should they become too sick to work

Findings from a cross-sectional household survey conducted in Johannesburg in 2008 show that cross-border migrants report that they will "return home" should they become too sick to work (Vearey, Nunez, & Palmary, 2009). In addition, results from the same survey show that less than 5 per cent of cross-border migrants report "ever bringing a sick relative to join them" in the country, indicating that they would either send money home or themselves return home to provide care (Vearey, Nunez, & Palmary, 2009). These findings challenge the assumptions that international migrants move in order to access healthcare services.

Challenges associated with access to public healthcare in South Africa[10]

Despite the development of protective policy guidelines and frameworks, and albeit that they have been developed relatively recently, international migrants continue to experience many challenges when they attempt to access public-health services in South Africa, as protective policy has not been effectively transformed into protective practices (Amon & Todrys, 2009; CoRMSA, 2009; Human Rights Watch, 2009a, 2009b; Landau, 2006b; Pursell, 2004; Vearey, 2008a). "One must also recognise the limited influence of public policy on practice. With poor implementation capacity and endemic corruption within the police and border officials, state policy of any kind is unlikely to achieve its desired effects, whatever those may be" (Landau & Wa Kabwe-Segatti, 2009: 2).

Public health reasoning that supports the provision of healthcare to international migrant groups is often overlooked in favour of concerns surrounding citizenship, legitimacy, entitlement and a resource-constrained healthcare system (Amon & Todrys, 2008; Grove & Zwi, 2006; Harper & Raman, 2008; McNeill, 2003; Worth, 2006). South Africa has a public healthcare system that includes free primary healthcare (PHC) at the point of use; however, many constraints relating to the definition of geographic boundaries and governance responsibilities have affected the equitable delivery of PHC services (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009). The South African public healthcare system is currently struggling to ensure adequate access to services – including ART – for all. However, as will be presented below, the numbers of cross-border migrants requiring basic healthcare – including ART – are small. The denial of services – including ART – to international migrants raises serious concerns; through actively denying healthcare to international migrants, the resultant

10 In addition to previously published reports, this section also draws on recent (unpublished) fieldwork conducted by the authors in Johannesburg, Musina and Hoedspruit (October–February 2010).

inability to access appropriate and timely care – including emergency care – may ultimately place the host population at risk, therefore placing an even greater burden upon the health system that destination countries were trying to avoid (Amon & Todrys, 2008; Grove & Zwi, 2006). It is important to acknowledge that South Africa is home to plural healthcare systems, including public, private and traditional medicine (Coovadia, Jewkes, Barron et al., 2009).

Boxes 5, 6 and 7 present an overview of the health needs of migrant sex workers, discusses the health implications of trafficking, and reflects on the psychosocial needs of refugees and migrants.

BOX 5

Sex work and migration: implications for health*

Research on sex work in South Africa and the region is limited (Richter, 2008). Partly because sex work in South Africa is illegal and highly stigmatized, little information or research exists on the number of sex workers in South Africa, where they come from and what their migrancy patterns are (Richter, 2008) The research that is available mostly focuses on two urban centres: Johannesburg and Cape Town. Systematic research conducted in Cape Town in 2008 found that 5 per cent of indoor sex workers were "foreign" (Gould & Fick, 2008). Research from Hillbrow in 1998 showed that a relatively small percentage of sex workers in Hillbrow were from other countries – only 11 per cent (Reproductive Health Research Unit, Sociology of Work Unit University of the Witwatersrand, & Vrije University Amsterdam, 2002). Recent evidence points to a much larger proportion of Hillbrow sex workers originating from countries outside of South Africa (Nyangairi, 2010).[11] The Hillbrow study found that 64.9 per cent of sex workers in Hillbrow migrated there from other provinces. The link between sex work and migrancy has been well established in the literature (Agustin, 2007; Bujra, 1975; Busza, 2004; Karnataka Health Promotion Trust and Population Council, 2008; Various authors, 2002)

Sex workers' health is compromised by violence (perpetrated by clients as well as the police), stigma, the nature and danger of their work, economic difficulties, and the lack of access to services and support. All of these factors are made worse by a legal system that criminalizes the industry. Public health and human rights approaches to sex work highlight the following consequences of the on-going criminalization of sex work:

1. Increasing sex worker vulnerability to violence from clients, partners and police;
2. Creating and sustaining unsafe and oppressive working conditions;
3. Increasing the stigmatization of sex workers;
4. Restricting access to health, social, police, legal and financial services;
5. A negative impact on safer sex practices; and
6. Impacting on the ability to find other employment.[12]

11 Sisonke – a small community-based organization run by sex workers that takes up sex worker issues – has a membership of between 150 and 200 members, half of whom come from other countries (mostly Zimbabwe). Healthcare workers at the Reproductive Health & HIV Research Unit's Sex Worker Project noted that the number of foreign migrant sex workers they attend to have increased over the last couple of years and now make half their patients.

12 This is a summary of the arguments that were advanced in the Constitutional Court in Sex Worker Education & Advocacy Taskforce (SWEAT), the Centre for Applied Legal Studies (CALS) and the Reproductive Health & HIV Research Unit (RHRU) (2002) Amicus curiae submission in the case Jordan v State. Johannesburg.

* Marlise Richter is thanked for contributing this "Box".

BOX 6

Trafficking and health

The Palermo Protocol provided by UN to prevent, suppress and punish trafficking of persons has been ratified by 135 countries of which 11 are SADC countries (UN, 2000). The SADC gender protocol has its own definition of trafficking:

> *The recruitment, transportation, harbouring or receipt of persons, by means of threat, abuse of power, position of vulnerability, force or other forms of coercion, abduction, fraud or deception to achieve the consent of a person having control over another person for the purpose of, amongst other things, sexual and financial exploitation.*

The Palermo Protocol and the SADC gender protocol cover trafficking within a country or across borders. While concern on the problem of trafficking has been put forward by the government, international and local NGOs, the hidden nature of the crime makes it impossible to know the extent of the problem.[13] While there is awareness of the problem in the SADC region, there is also a lack of comprehensive data on the prevalence of trafficking, the routes taken, the methods used to recruit women and the type of exploitation they enter into.

An additional complication is the connection between migration, smuggling and trafficking. The differentiation between the nature of these movements is a not so obvious matter. It can be said that smuggling and human trafficking are both forms of irregular migration which involve organized, illegal movement of people within and across borders. However, while smuggling tends to be defined as voluntary, with people arranging to be smuggled, trafficking is seen as involuntary. Migrant smuggling in turn is often a component of trafficking, and smuggling can shift into trafficking. Accounts of migrant women in shelters in the border city of Musina, subjected to exploitative relationships with their smugglers, abound (Human Rights Watch, 2009b; MSF, 2009). A recently released IOM report explores the evidence of trafficking in Musina, based on reported cases of women and girls retained against their will and sexually abused while smuggled into South Africa (IOM, 2010). The study highlights the difficulties in identifying a case of trafficking. Two aspects of the reviewed cases are in disagreement with the definition of trafficking: (1) the consent to be transported and (2) the opportunistic nature of these crimes. However, some of the circumstances in which these migrants found themselves (being transported, deceived/coerced and subjected to abuse of power and sexual exploitation) lead the author to argue that they constitute trafficking (IOM, 2010: 32).

Concerns have been raised in connection with the high degree of exploitation of migrant labour in South Africa and its similarity to the conditions in which trafficked people find themselves – aspects also discussed by the IOM report (2010). This parallel leads to the question "What differentiates these circumstances?", which in turn brings into question the utility of the term "trafficking".

The aspects above reflect the complexity of tackling the problem of trafficking in the region. In view of this, a central concern amongst migrant groups is to ensure the scope of trafficking is properly defined so that limited national resources "to address abuses against non-nationals are used to optimal effects" (CoRMSA, 2009: 75).

While controversy around the definition of trafficking is likely to continue, consensus exists on the health consequences of trafficking (Busza, Castle, & Diarra, 2004) or suspected trafficked persons (IOM, 2010). They are vulnerable to a variety of health exposures such as "sexual and reproductive health problems, sexually transmitted infections (STIs) including HIV, physical trauma, negative psycho-social reactions, malnutrition" (IOM, 2010: iv). In addition, reported health consequences are unwanted pregnancies, and psychosocial trauma, depression and anxiety. Considering the limited access to adequate healthcare, language barriers and isolation which migrants often confront, it is likely that most of these problems remain untreated.

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13 IOM provides direct assistance to trafficked people in six SADC countries through its Southern Africa Counter Trafficking Assistance Programme (SACTP). It has assisted 306 cases since 2004, and almost 30% of these cases (n=91) were SADC nationals.

BOX 7

The psychological effects of political and gender violence on cross-border migrants, including refugees: exploring existing socio-psychological interventions

There has been a proliferation of trauma interventions with refugees. Increasingly and regularly these kinds of services are being included in humanitarian interventions (Bracken, 1998). In the absence of a camp-based response to refugees, trauma interventions in South Africa have addressed migrants' needs for socio-psychological support either in specific situations or as integrated into broader interventions that are directed at the local population. A brief reference to the various emphases that trauma interventions have had in South Africa is presented next.

The initial phase: trauma services in a post-conflict context

Trauma services in South Africa became relevant in the post apartheid period. NGOs began to render services to ex political prisoners, returned exiles, ex combatants and survivors of human rights violations (Bracken, 1998). Gradually as refugees and asylum seekers fleeing from war and political violence arrived in South Africa, trauma interventions extended their focus to serve the need of a population which, besides their past experiences of violence, often confronted additional challenges in the host society including barriers to access services. These programs have conceptualized trauma as linked to the effects of political violence and human-rights violations. Initially – although not exclusively – men were seen as the main victims.

The gender dimension of political conflict and war

NGOs began to incorporate a gender approach to counselling in order to address the particularities of the violence experienced by women in armed conflict situations. As became clear, refugee women are often being subjected to sexual and gender-based violence in their own countries. Too often rape has being used as a war weapon in political and ethnic conflicts in the most varied contexts. Furthermore, patriarchal structures to which women are exposed in their own societies are deeply embedded in notions of "pure ethnicity" and national identity that often lie at the heart of armed conflicts and civil war (Palmary, 2005). The gender scope demonstrated how in armed conflicts the private and the public spheres are very closely linked. It also demonstrating the need for a broadening of the scope of trauma interventions to provide 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).

Gender violence in the private sphere

Gender-based trauma interventions also involved examining the pervasive effects of gender violence as it often manifests in the private sphere. A gender approach to violence (which has a profound psychological effect on women) has unveiled how often migrant and refugee women are subjected to new forms of violence in the host society, as their own partners become perpetrators. Existing studies have highlighted how migrants introduce new dynamics to these relations, and how migrant women face additional barriers to access to services and support in the host country (Kiwanuka, 2009). The scope of trauma interventions has been broadened to incorporate private forms of violence embedded in gender relations. NGOs that focus on gender and are involved in rendering services to South Africans,[14] are also offering migrant and refugee women counselling and support in sexual and gender-based violence, HIV/AIDS, marriage and family issues.

Violence against migrants while in transit

It has been reported that migrants often experience violence while fleeing their country of origin (MSF, 2009; Shaeffer, 2009). Migrants fall prey to gangs and criminals who offer to assist them to reach the destination country, but take their few possessions and subject them to violence. Women are particularly vulnerable to being raped and men to being beaten. Trauma services in the border city of Musina have been offered by NGOs, public institutions and churches, together with a comprehensive range of interventions including counselling, shelter, HIV/AIDS-related services, assisting the victims of sexual and gender-based violence to access medical care as well as (although less successfully) gain access to the justice system (Shaeffer, 2009).

Unaccompanied migrant children

In recent years, the number of unaccompanied migrant children has increased (CoRMSA, 2009). Some of them are orphans who have

14 Some NGOs are Powa (People opposing women abuse), Sonke Gender Justice Network and Famsa (Family South Africa).

BOX 7

Continued

fled their homes in order to survive; others have witnessed extreme forms of violence. Given the need to provide assistance to migrant children, a number of alternative trauma interventions have[15] engaged with unaccompanied migrant children in creative ways in order to provide psychological support and to stimulate their strength and resilience.

Xenophobic violence

Violent forms of xenophobia have being growing in South Africa, a country where violence is deeply rooted in historical racial divisions. The end of apartheid (1994) did not erase or eliminate the divisions between racial groups; such divisions were reorganized and redirected to a new form of "the other" – foreign migrants. The xenophobic violence which has exploded in the country can be traced back to early 2000, where diverse experiences of violence were recorded (particularly in the Western Cape). Violence was directed towards specific groups of foreigners, mostly Somalis. The growing trend erupted in May 2008 with widespread violence in the main cities of the country; thousands of foreigners were displaced as a result. A number of NGOs and faith-based organizations began to offer psychological support to foreigners and victims of the xenophobic attacks. Socio-psychological interventions are being conducted in areas affected by violence as part of interventions that include conflict resolution components as well as initiatives oriented to reintegrate foreigners into the communities from where they were expelled.[16]

The number of NGOs and faith-based organizations that offer socio-psychological support and trauma services to migrants has grown considerably over the last few years. In addition there is a greater diversity of types of violence being addressed. Each of these initiatives, with their own emphasis, is addressing the broader spectrum of forms of violence affecting migrants, refugees and asylum seekers. In general the challenges faced by these initiatives in addressing the needs of migrants and refugees have not been properly documented, nor their innovation in doing so. In order to close this gap and as part of an ongoing research project involving masters students and other researchers, FMSP is documenting the diversity of strategies and alternative trauma services offered to migrants and refugees in South Africa. The research is examining the types of psychosocial problems that migrants and refugee populations develop in host societies and the approaches being used in host communities to assist this population. Importantly, this initiative seeks to investigate to what extent worldviews, socio-cultural and political realities, as well as traditional forms of confronting conflict and practices of recovering from trauma are being incorporated into the models adopted for psychosocial assistance (Palmary and Nunez, 2009). The current areas of research include religious and political participation, memorialization, traditional healing and alternative strategies of trauma care for unaccompanied children (Palmary and Nunez, 2009).

15 To mention a few, initiatives such as "Hero Book Project" and the Suitcase Project.

16 Among others, institutions offering socio-psychological services to local populations as well as foreigners in various cites in South Africa are: Community Healing Network, Islamic Careline, Johannesburg Child Welfare (CoRMSA Guide to Services for refugees and migrants in South Africa, 2009. www cormsa.org.za).

The healthcare system as a central determinant of the health of migrant groups

The healthcare system itself is recognized as a central determinant of health. 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, Jewkes, Barron et al., 2009). Such challenges create obstacles in the provision of care; not only to cross-border migrants, but also to South Africans. 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.

BOX 8

A case study: healthcare provider frustrations at Musina Hospital, Vhembe District, Limpopo

Musina Hospital has now appointed three clinicians (up from just one in 2009) to work in a hospital responsible for a population of 700,000 (according to 2001 census data; this population is undoubtedly substantially larger in 2010). Due to its proximity to the South African border with Zimbabwe, the collapse in the health system in Zimbabwe has had repercussion on the amount and kinds of healthcare demands (cross-border) migrants present to Musina Hospital. The crisis in the neighbouring country has also created a new type of "migrant patient" – that of a "medical tourist" – that comes solely to access healthcare, especially for childbirth and HIV treatment (ART). After they receive care, they return to Zimbabwe. However, it is clear that there are misunderstandings at multiple levels relating to existing national legislation and – importantly – more localized healthcare plans and agreements. In the Musina area, for example, an agreement was established between Beitbridge and Musina relating to the provision of healthcare at Musina Hospital (including emergency care) to Zimbabweans residing in the Beitbridge area. Although this agreement may exist on paper, however, supporting human and material resources are lacking.

In Musina Hospital, healthcare providers feel that they are unable to provide an adequate response in cases where cross-border migrants are terminally ill; they need to provide room for other patients and therefore have to discharge terminal migrants who have no place to go. This is connected to the multiple challenges associated with the unclaimed bodies of cross-border migrants and there is a reported increase in the number of dead bodies that require a pauper burial. This was described as both an administrative and financial burden to the Hospital and municipality.

Healthcare provider perceptions

The lack of human resources results in an increased workload on the current staff at Musina Hospital. The lack of staff becomes easily conflated with an increase in "foreign" migrants. Healthcare providers should be provided with training which takes both sides into consideration: the migrants' side and the healthcare provider side. There is a need for an understandings' of both realities. For example, there is a large group of migrants (mostly cross-border but including South African migrants) that remains unattended, namely seasonal labourers working on farms in the border area. The district does not have sufficient staff to operate mobile clinics to visit all the farms in the area (despite there being three mobile clinics available).

Information based on interviews conducted by the researchers at Musina Hospital, November 2009

Engaging with a "place-based approach" to health

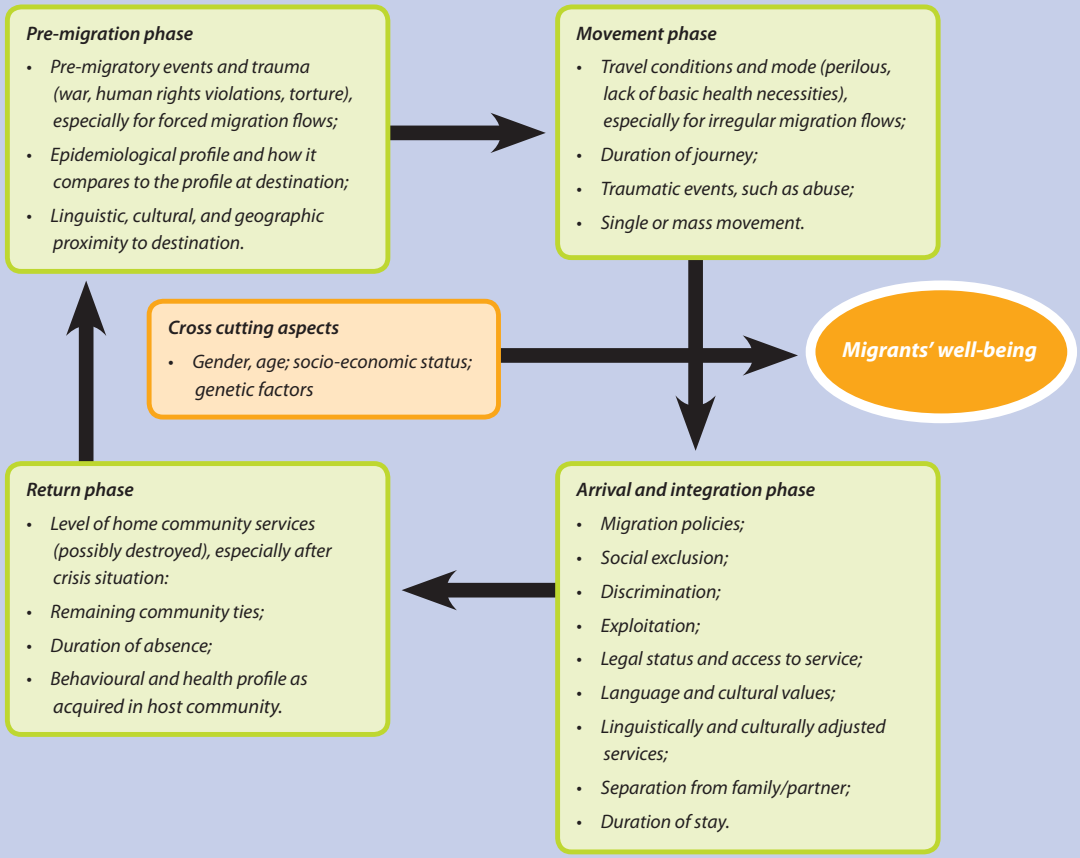
It is necessary to explore the dynamics of the multiple forms of migration in order to understand the range of health impacts and health needs associated with different stages of varied migration pathways. This includes investigating health benefits, as well as health risks and vulnerabilities that are found to be associated with different stages of the migration process for different migrant groups: from the place of origin, during the journey, within the destination, and upon return. In this paper, migration is viewed as a process that connects an individual with their place of origin.

BOX 9

Migration and the determinants of health: places in the journey

Health encompasses generic biological factors as well as wider environmental determinants of health such as water and sanitation, health behaviour, occupational environments, education, socio-economic status, food security, fear of arrest or harassment, cultural differences, language barriers, negative provider attitudes and legal status. As with host populations, inequalities in access to healthcare, and associated inequities in health outcomes are created by the interaction of three basic variables: the person, place and time. The migration process consists of four phases: the "pre-migration phase"; the "movement phase"; the "arrival and integration phase"; and the "return phase". Determinants of migrants' health can be identified at each stage – see Figure 2 (Commission on Social Determinants of Health, 2008).

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



In the pre-departure stage, migrants' health status is influenced by the health determinants of their home country. When they move migrants generally carry with them the health status they have acquired in their country of origin. During the movement process, travel-related conditions may cause health risks, particularly in cases of irregular migration, human smuggling and mass movements or displacements brought about by human-made or natural disasters.

In host countries, at arrival, migrants are exposed to other health determinants they may not have encountered in their home country. The disparities between these health determinants in countries of origin and host countries create gaps that have consequences for the well-being of a migrant. For example, a migrant's health-seeking behaviour may be different to that of the host community. Morbidity and mortality rates may remain relatively unchanged due to genetic factors or due to the carrying over of certain lifestyle habits (i.e. diet, smoking, alcohol, family size) from the native home. In cases where these habits are positive, they may benefit from a particular "protective effect" which persists even after migration. On the other hand, a change in mortality and convergence to the rates of the host population may occur due to the migrants' adoption of certain characteristics of the host community. In addition, the effect of duration of residence and the influence of selective migration must be considered (McKay, 2003).

After return, migrants' health is further determined by the availability, accessibility and affordability of national health and social services, including services that facilitate integration with the host community (Grondin, 2004; Carballo, 2007; IOM, 2007b; Commission on Social Determinants of Health, 2008).

Within the following section, in order to highlight the heterogeneity of migrant groups within South Africa, the importance of "place" within a framework for exploring – and responding to – migration and health is introduced.

Using a "place-based" approach to explore migration and health in South Africa

The research presented within this paper has identified the importance of engaging with a "place-based" approach to address – and improve – access to healthcare for those directly affected by the migration process in South Africa. This involves understanding the local context in which diverse migrant groups are situated. Through such an approach, "spaces of vulnerability" will be identified, from which appropriate responses to addressing health in a context of migration can be generated. This requires assessing the different spaces within South Africa where different migrant groups are located. Table 2 highlights four key "places" that have been identified as presenting specific health-related challenges which require appropriate, contextualized responses. The four "places" were identified through fieldwork and programmatic experience. The framework outlined presents a tool to assist government officials – at local, provincial and national levels – in responding to migration and health in South Africa.

Table 2: Towards a "place-based" approach for addressing migration and health in South Africa

"Place"	Profile of migrants	Key health-related challenges
Border (e.g. Musina)	Mostly cross-border; internal migration relating to employment (including military personnel and immigration officials).	Rape and violence; service access – including access to emergency care, post-exposure prophylaxis (PEP), counselling services; the process of crossing the border; communicable disease surveillance (e.g. cholera).
Urban centre (e.g. Johannesburg inner-city)	A mixture of cross-border and internal migrants.	Access to healthcare services; "othering" of cross-border migrant groups; food security; access to the social determinants of health.
Urban informal settlement (e.g. Sol Plaatjies, Johannesburg)	Mostly internal migrants. Increasingly cross-border migrants.	Access to healthcare services; "othering" of cross-border migrant groups; food security; access to the social determinants of health.
Rural, commercial farming areas (e.g. Hoedspruit)	A mixture of cross-border and internal seasonal labour migrants.	Farm worker access to emergency healthcare for occupational hazards (such as accidents with machinery); access to healthcare services and chronic medication (including for TB and HIV); access to the social determinants of health (including shelter).

BOX 10

The border: learning from the cholera outbreak in 2008

The 2008 cholera outbreak revealed the political, social and economic factors that lay at the heart of the deteriorating health of the population in the region and in particular the collapse of the healthcare system in Zimbabwe. The experience also provides a stark reminder of how infectious diseases cross borders and require coordinated emergency responses. A brief synopsis of the cholera outbreak in the southern African region is presented here in order to draw out lessons for improving migrant access to healthcare in South Africa, with a particular focus on border spaces.

The cholera outbreak began in August 2008, with Zimbabwe as its epicentre. It soon spread to all ten provinces in Zimbabwe as well as to nine other countries in the region (Angola, Botswana, Malawi, Mozambique, Namibia, South Africa, Swaziland and Zambia). The disproportionate impact of the cholera outbreak in Zimbabwe in particular was a symptom of a collapsed health system and the failure of the Mugabe regime to maintain water purification measures and manage sewerage systems (Vearey, 2008b). Political reasons have been advanced to explain why the epidemic went out of control. Reportedly, the cholera outbreak was only officially acknowledged by the Zimbabwean Government in December 2008, three months after the onset of the epidemic, and after it had already claimed a significant numbers of lives (Rights, 2009). According to PHFHR's report, Mugabe "intentionally suppressed initial reports of the cholera epidemic [and] underplayed the gravity of the epidemic with fatal consequences" (ibid.: 8).

However, the primary cause of the epidemic in the region was not the high levels of infections in Zimbabwe, as became clear in a regional meeting that was held on 19–20 February 2009, convened by WHO, UNICEF and OCHA.17 Two primary causes for all the affected countries were identified in this meeting: (1) the decline of basic social service provision and (2) particularly in South Africa, the "lack of preparedness and prevention measures" (UNDP, 2009b). In the same meeting migration was identified among several other factors which exacerbated the severity of the epidemic.18 The cholera outbreak brought to light critical aspects relating to the health of migrants, including the rights of migrants to access healthcare, and questions relating to linkages between healthcare-seeking behaviour and migration.

The evidence gathered revealed gaps in the responses of countries to the outbreak, and highlighted the need for SADC countries to develop a coordinated response to communicable diseases that extends across borders. As the regional meeting held in February 2009 clearly stated, the root causes identified in the outbreak require cooperation on cross-border issues among bordering countries, including: policies oriented to improve livelihoods, food security, and to address the difficulties cross-border migrants face in accessing public healthcare. The meeting led to resolutions to improve the preparedness of countries to respond and contain future outbreaks.19 From a South African perspective, the situation raises questions about what is hampering more efficient prevention, provision of care and treatment of those areas affected. There is a need to develop a more comprehensive approach to border health.

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17 The meeting was oriented to provide a regional response to the growing dimensions of the cholera epidemic and was aimed at strengthening the response in southern Africa with key UN, NGO and Red Cross movements from both the regional and national levels of the nine affected countries and Lesotho.

18 Factors identified are: lack of access to safe drinking water and adequate sanitation, economic reasons, climate change, migration, food insecurity and HIV/AIDS.

19 On 15 May 2009, WHO, UNICEF, OXFAM and OCHA convened a one-day meeting to follow up on the outcomes of the Regional Cholera Workshop held from 19 to 20 February 2009, and to discuss further modalities to support countries in the region in their medium to long-term response to cholera. A framework for a joint regional action plan was discussed. The framework focuses on capacity building, proactive resource mobilization and improving sanitation with development actors. The last cholera update OCHA bulletin of the 1 of July 2009 confirmed that: "Despite the overall reduction in cases, the underlying causes of cholera still remain unresolved. Inadequate safe water, break down of sewage systems and poor sanitation conditions prevail and continue to sustain outbreaks where cholera cases have been reported. As a result, communities remain vulnerable to future outbreaks" (UNDP, 2009b:1).

Health and cross-border migration in South Africa: a protective policy framework?

From an international human rights law perspective, migrants and mobile populations have a right to health regardless of their immigration status. Article 16 of the African Charter on Human and People's Rights (ACHPR, 1986) and Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR, 1990) grant every individual the right to enjoy the best attainable state of physical and mental health, regardless of the documentation they do (not) hold.

The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (GA, 1990) stipulates that all migrant workers and their families have the right to emergency medical care for the preservation of their life or the avoidance of irreparable harm to their health (article 28). Such care should be provided regardless of any irregularity in their stay or employment. The Convention further protects migrant workers in the workplace and stipulates that they shall enjoy treatment not less favourable than that which applies to nationals of the state of employment in terms of work, safety and health. South Africa has not ratified this convention and is urged to do so.

In South Africa, different categories of cross-border migrants are granted differential rights to access free public healthcare services. Legislation indicates that refugees and asylum seekers should be treated as South African citizens in terms of access to free public healthcare (The Republic of South Africa, 1998b). Other non-citizen groups (such as those with work or study permits) should be charged a "foreign fee" at the point of use. However, the multiple pieces of legislation and guidelines can prove confusing. Section 27 of the South African Constitution (1994) guarantees "access to health care for all" (The Republic of South Africa, 1996). The National Health Act (2003) and the Constitution assure everyone in the country – regardless of immigration status – access to life-saving care (The Republic of South Africa, 1996, 2003). The Refugees Act (1998) provides particular rights to legally recognized refugees (The Republic of South Africa, 1998b). It is therefore frustrating that ambiguity relating to the rights of non-citizen groups to accessing public health services, including antiretroviral therapy (ART), has prevailed (UNHCR & AIDS & Human Rights Research Unit University of Pretoria, 2006; Vearey, 2008a). The different documents that non-citizens may hold (e.g. refugee, asylum seeker, and the range of temporary residence permits) present challenges to service providers who may not be familiar with different documentation. In addition, national guiding documents, such as the 2007–2011 National Strategic Plan (NSP) for HIV & AIDS and STIs, use the terms "asylum seeker", "refugee" and "foreign migrant" interchangeably, which is an additional source of confusion for practitioners (NDOH, 2007a).

5

Mpho Seleka – IOM/MPW Photography Project 2008

Exploring migration and HIV in southern Africa: lessons for South Africa

Typified by historical and continuing migration patterns, southern Africa is the region most affected by HIV globally. Home to just 10 per cent of the world's population, it has almost 70 per cent of all people living with HIV (UNAIDS, 2008). Linkages between migration and the spread of HIV have been demonstrated (Anarfi, 2005; Banati, 2007; Lurie, 2000). Migration has been shown to increase vulnerability to HIV – both for migrants and their partners who remain behind (Anarfi, 2005; IOM & UNAIDS, 2003; Lurie, Williams, Zuma, Mkaya-Mwamburi, Garnett, Sturm et al., 2003; UNAIDS, 2001). 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 (Banati, 2007; IOM & UNAIDS, 2003; UNAIDS, 2001).

However, it is important to emphasize the bi-directionality of migration and HIV infection. It is not only migrants who experience an increased vulnerability to HIV as a result of the migration process (Lurie, 2006; Lurie, Williams, Zuma et al., 2003). 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" that was infected with HIV (Lurie, 2006; Lurie, Williams, Zuma et al., 2003). Whilst this study focussed on processes associated with internal labour-seeking migration, 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 migrants who cross-borders is driven by similar factors to 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 – is no longer thought to contribute to the spread of HIV (Coffee, Lurie, & Garnett, 2007; Mundandi, Vissers, Voeten, Habbema, & Gregson, 2006). 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.

For some migrants, the process of moving may affect their vulnerability to HIV. For example, women involved in sex work (see Box 5).

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 increased HIV infections have been challenged (Spiegel, 2004; Spiegel, Bennedsen, Claass, Bruns, Patterson, Yiweza 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, Bennedsen, Claass et al., 2007).

Policy and guidelines

South Africa began to roll out a free national ART programme in the public health sector in April 2004. Attempts to clarify ambiguity relating to the rights of international migrants to access ART have been made. For example, the latest NSP (2007–2011) specifically includes non-citizen groups (NDOH, 2007a). A key guiding principle to the successful implementation of the 2007–2011 Plan is towards "ensuring equality and non-discrimination against marginalised groups"; refugees, asylum seekers and foreign migrants are specifically mentioned as having "a right to equal access to interventions for HIV prevention, treatment and support" (NDOH, 2007a: 56). Importantly, Priority area 4 of the Plan encompasses human rights and access to justice, with goal 16 being to ensure "public knowledge of and adherence to the legal and policy provision" (NDOH, 2007a: 119). Furthermore, prior to the 2007 national plan, in early 2006 the National Department of Health (NDOH) issued a statement clarifying that patients do not need to be in possession of a South African identity booklet in order to access ART (NDOH, 2006). This has implications not only for international migrants but also for undocumented South Africans. Additional guidelines have been developed through collaborations between the Southern African HIV Clinicians Society and the United Nations High Commissioner for Refugees (UNHCR), supplementing the NDOH ART guidelines, to guide ART provision for international migrants, asylum seekers and refugees (Southern African HIV Clinicians Society & UNHCR, 2007). As a result of the lobbying of civil society groups, and the UNHCR, a more recent (September 2007) Financial Directive from the NDOH confirms that refugees and asylum seekers – with or without a permit – have the same right as South Africans to access free basic healthcare and ART in the public sector (NDOH, 2007b). However, legislation remains ambiguous for undocumented migrants (Moyo, 2010).

Cross-border migrants experience challenges in accessing Antiretroviral Therapy in South Africa

Despite the development of these guidelines, a 2007 cross-sectional survey conducted by the FMSP with international migrant and citizen ART clients (n = 449) accessing ART at two government and two non-governmental (NGO) ART sites in

inner-city Johannesburg, clearly shows that international migrant clients encounter many more challenges when attempting to access ART in the public sector, compared to South African citizens (for further details on the study methodology see Vearey, 2008a). The survey collected information on the ART access history of each client: international migrants were frequently referred out of the public sector (often at the time of testing) and into the NGO sector, and were unable to access ART in the public sector due to the demand for South African identity booklets (Vearey, 2008a). More than three-quarters of the international migrant clients interviewed access ART in the non-governmental sector (Vearey, 2008a). The demand for South African identity booklets goes against national legislation. The resultant "dual healthcare system" (government and NGO) that provides ART through separate routes to different population groups presents a range of logistical issues to healthcare providers and makes migrants reliant on a less sustainable form of ART access (Vearey, 2008a).

Adherence to Antiretroviral Therapy

In countries, such as South Africa, where public sector ART is available free of charge, unfounded assumptions prevail within the public health sector relating to international migrant groups being "unable to adhere to ART". There is a perception that the inclusion of migrant groups in ART programmes will result in a "flood of migrants" travelling to access treatment (Southern African HIV Clinicians Society & UNHCR, 2007). The 2007 ART access study challenges the assumption that international migrants living with HIV travel across borders in order to access ART. The study found that the majority of cross-border migrant clients first tested for HIV in South Africa (76%), and most (80%) discovered their HIV positive status while living in South Africa (Vearey, 2008a).

A recent clinical study conducted in Johannesburg clearly shows that, compared with South African citizens, international migrants receiving ART had: fewer hospital admissions; less missed appointments for ART initiation; faster median time to ART initiation; better retention in care and lower mortality (for further information on study methodology see McCarthy, Chersich, Vearey et al., 2009). Overall, international migrants were less likely to fail ART than citizens (McCarthy, Chersich, Vearey et al., 2009). This study provides strong evidence for good responses to ART amongst international migrants, and supports the recommendation of UNHCR that ART should not be withheld from migrant populations. These findings are supported by the FMSP ART access study, which found no significant difference between the numbers of international migrant and citizen clients that reported they sometimes failed to collect treatment or did not adhere to treatment (Vearey, 2008a).

In summary, cross-border migrants residing in South Africa require appropriate health responses – particularly in a context of high HIV prevalence where timely access to HIV treatment is critical; both from the perspective of the individual and for population health. Whilst it is acknowledged that much of the national policy and legislation changes have occurred in recent years, and that the data included in this paper may reflect a lag in the implementation of new directives, it is nevertheless essential to ensure that existing protective legislation is applied uniformly across all public health facilities, and that the objectives outlined within the NSP are implemented. This includes ensuring that the right to access ART is upheld. Enabling people living with HIV (regardless of immigration status) to access treatment early will ultimately reduce the burden on the public health sector, and on communities and households caring for the sick (Vearey, 2008a). The NDOH must urgently develop ways to monitor the implementation of protective policy and hold to account those facilities that flaunt national directives. Upholding the right to access healthcare services for all within South Africa is likely to have a population-level benefit.

Governance of health and migration

The three spheres of government – national, provincial and local – have different roles to play in facilitating "healthy migration". The national and provincial levels have important responsibilities – and opportunities – in developing and implementing "healthy migration" policies. Importantly, the National Treasury should engage with the population dynamics associated with migration in order to ensure that funds are appropriately – and equitably – distributed across different spaces where migrant groups are located. However, a key intervention that is required relates to understanding how migration and health vary across places, requiring local government to engage and respond at the local level – to develop a place-based approach to migration and health.

The critical role of developmental local government in responding to health and migration

The paper will now move to emphasize the critical role of local government in responding to migration and health, for two key reasons. Firstly, local governments experience the impact and

effects of migration and problematic access to healthcare as "it is local governments and service providers who must channel resources to those in need, and translate broad objectives into contextualised and socially embedded initiatives" (Landau & Singh, 2008: 177). It is essential that local government is able to respond to migration and health in an integrated way.

> "Although each sphere of government has jurisdiction over the specific powers and functions assigned to it by legislation, these must be performed in a cooperative, collaborative and co-ordinated manner. Local Governments are the point of integration and co-ordination, vertically and horizontally. Integrated Development Plans (IDPs) are intended to be the planning instrument to promote this integration and co-ordination between the spheres and sectors of government."
>
> *(dplg, 2007: 21)*

Secondly, South African local government has a "developmental mandate" – a "local government committed to working with citizens and groups within the community to find sustainable ways to meet their social, economic and material needs and improve the quality of their lives" (The Republic of South Africa, 1998a: 23). It is essential to understand that "the centrepiece of developmental local government is the Integrated Development Plan (IDP)" (Pillay, Tomlinson, & du Toit, 2006: 15). "The IDP is prepared by local, district and metropolitan municipalities for a five-year period which coincides with the term of the elected council. It is primarily a plan concerned with directing and coordination the activities of an elected municipal authority" (Harrison, 2006: 186). The IDP is a participatory process that provides a "long-term vision for a municipality"[20] and is designed to assist local government in promoting economic and social development (Pillay, Tomlinson, & du Toit, 2006: 15). Through the IDP process, the developmental mandate requires local government to inter alia address the interlinked challenges of urban growth, migration and access to healthcare (Bocquier, 2008; dplg, 2007; Landau & Singh, 2008; Landau, 2007; MRC, INCA, & dplg, 2007). Importantly, a "developmental mandate" highlights the need to establish partnerships across local government departments. Achieving this means thinking beyond the narrow confines of a set of delinked service sectors. The White Paper explicitly recognises that South African municipalities, like counterparts in other parts of the world, are responsible for managing space occupied by people: the challenge was no longer only how to provide a set of services, but how to transform and manage settlements that are amongst the most distorted, diverse, and dynamic in the world. (Landau & Singh, 2008: 169)

However, major challenges in implementing the developmental mandate of local government have been reported, in part due to the complexity of the mandate and in part due to a lack of skills, capacity and funding within local government (Harrison, 2006; Landau & Singh, 2008; Nel & John, 2006). A key challenge is that local government may lack the tools and information required to respond appropriately (Landau & Singh, 2008). For example, when attempting to plan appropriate responses to migration, local government requires guidance on what this means, and data on migration to plan appropriate responses (Landau & Singh, 2008; Tomlinson, Beauregard, Bremner, & Mangcu, 2003).

> In addition to a lack of information about population dynamics, local governments are impeded in developing effective responses by lack of coordination – and competition – among government entities and poor performance on the part of the Department of Home Affairs, the Department that issues visas and identity documents to foreigners and South Africans. The problems of information, co-ordination, and institutional capacity become most visible at the intersection between HIV/AIDS and human mobility.
>
> *(Landau & Singh, 2008: 183)*

20 "IDPs provide a long-term vision for a municipality; detail the priorities of an elected council; link and coordinate sectoral plans and strategies; align financial and human resources with implementation needs; strengthen the focus on environmental sustainability; and provide the basis for annual and medium-term budgeting" (Pillay, Tomlinson, & du Toit, 2006: 15). For a useful critique of the IDP Process, see Harrison (2006).

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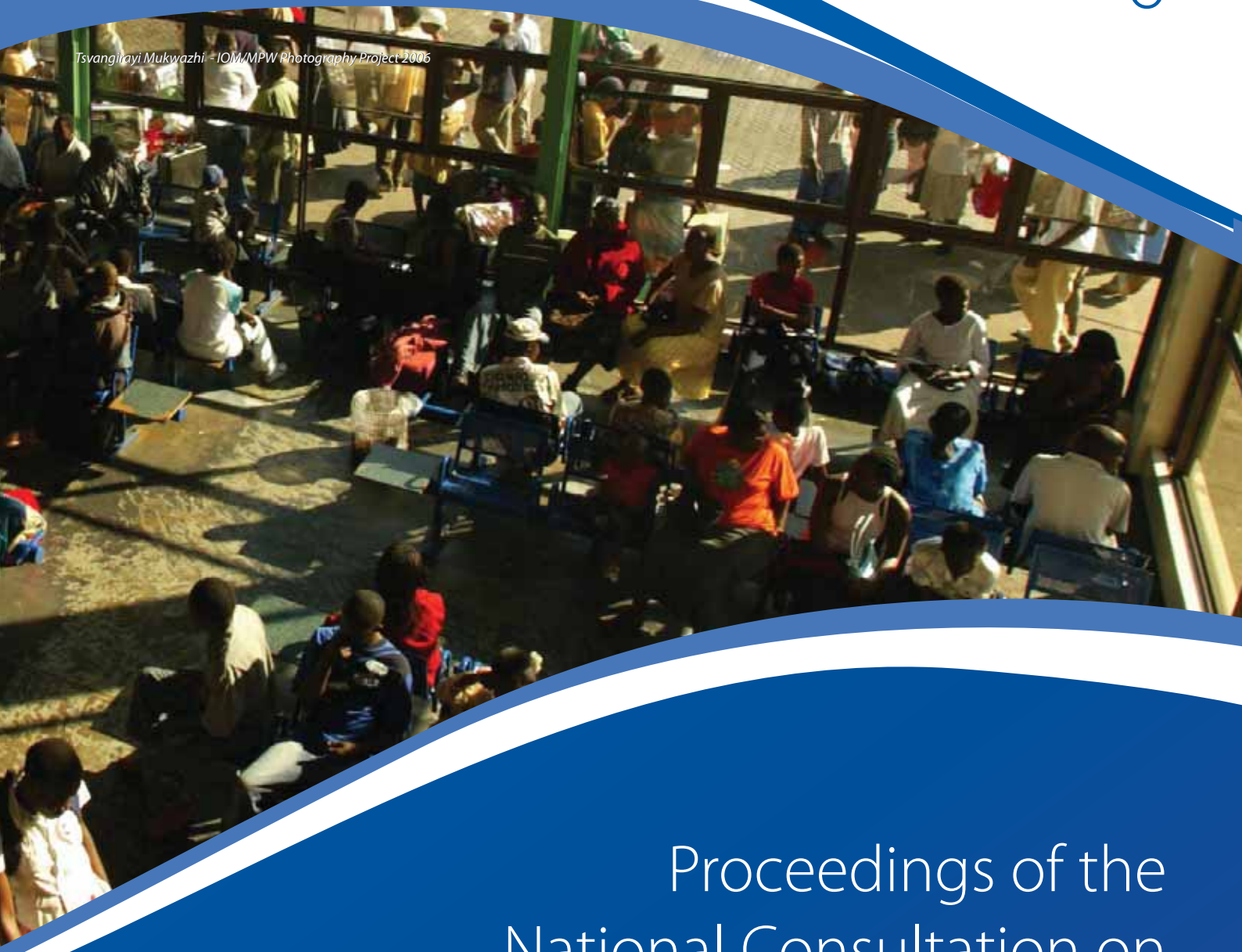
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Proceedings of the National Consultation on Migration Health in South Africa

In collaboration with the South African National Department of Health, Forced Migration Studies Programme (FMSP) – University of Witwatersrand; and the Joint United Nations Programme on AIDS (UNAIDS), the International Organization for Migration (IOM) Pretoria organized a National Consultation on migration health: "Realizing Migrants' Right to Health in South Africa", in Centurion, South Africa on 22–23 April 2010.

The consultation followed the Global Consultation on the Health of Migrants held in Madrid on 3–5 March 2010. The World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants guided and inspired the consultations' proceedings.

BOX 11

Global Consultation on Migrant Health, Madrid, 3-5 March 2010

The Global consultation on Migrant Health was organized by WHO, IOM and the Government of Spain. The meeting was a great success as consensus was reached on the following four main priority areas and strategies to improve the health of migrants:

It was agreed to improve the monitoring of migrants´ health through standardized data. The Consultation recognized the need to monitor migrants´ health seeking behaviours, access to health services, health care utilization and outcomes.

It was recognized that policies and legal frameworks affecting migrants´ health should adhere to international standards on protection of migrants and respect for rights to health in national law and practice. This entails promoting policy inclusiveness and policy coherence among the different sectors that may affect migrants´ ability to access health services.

It highlighted the importance of delivering health services in a culturally and linguistically appropriate manner, and enforcing laws and regulations that promote inclusiveness and stem discrimination. Overall, health systems need to enhance the quality of care received by migrants and become more migrant sensitive.

The importance of broadening and strengthening partnerships, networks and regional coordination was agreed upon.

More than 70 people actively participated from government departments (Health, Home Affairs, Education, Labour, Transport, as well as Provincial representatives); academia; migrant groups; civil society; donors, UN family and health-facility representatives. The final product of the consultation is a series of actionable recommendations outlining a national response to addressing migration health challenges, in line with the WHA 61.17 Resolution.

Opening the consultation

The consultation opened with welcoming remarks from ***Mr Ramphelane Morewane, Acting Deputy Director General: Special Programmes and Health Entities Management, National Department of Health***. He began by acknowledging the presence of colleagues from different sectors, including government, academia, migrant organizations, civil society organizations and others. He applauded their demonstrated commitment in advancing the rights of migrants in South Africa. Morewane stressed that the discussions initiated during the consultation should continue beyond the two days of proceedings and translate into actions.

People migrate to South Africa under various circumstances including socio-economic and political reasons. The migration process is associated with a number of health risks, especially communicable diseases, with women and children being the most vulnerable. Morewane underlined that diseases have no borders and pointed to the 2008 cholera outbreak as an example. The public health implications associated with neglecting to address migrants' health issues head-on can have a negative impact on the overall health and well-being of the entire population.

Morewane considered the challenge of effective resource allocation in the absence of accurate data. For example, the official head count in Musina, a border community in Limpopo province, indicates a relatively low population compared to what the real

situation is. Effectively planning to address the healthcare needs of Musina's population is extremely challenging in the absence of accurate data, especially when a relatively large percentage of the population is in transit on any given day.

For the most part, migrants do not come to South Africa in search of expensive healthcare. Morewane emphasized the need to revitalize primary healthcare in South Africa, explaining that it is most cost-effective to deal with health issues at primary level when they first manifest. Failure to do so indicates an ailing health system.

The South African Constitution guarantees access to primary healthcare for all people who are in the country. Morewane pointed out that no healthcare professional is trained only to help the people of his country. While identifying a patient is necessary, this should not deter undocumented individuals from seeking healthcare or in any way taint the quality of care that they receive. Improving the quality of care in South Africa cannot be selective; it must apply to everyone, nationals and non-nationals. This is a major challenge in South Africa.

Finally, Morewane encouraged the participants to point out the system's weaknesses and raise critical issues in the course of the consultation. He also urged participants to commit to finding solutions.

Objectives of the consultation

Dabea Gaboutloeloe, the IOM Migration Health Coordinator for South Africa, presented the objectives of the consultation. She emphasized that above all the consultation should be action oriented. The main objective of the consultation was to agree on a way forward in addressing migration health and to develop a framework for action to achieve the 61.17 WHA Resolution on the Health of Migrants in South Africa. This would include identifying the health and wellness challenges of migrants in terms of the social determinants of health, access to healthcare and realizing their right to health in South Africa.

Specific objectives were:

1. To raise awareness and increase understanding among different stakeholders on issues relating to migration, development and health;

2. To share good practices of government, academia and non-governmental organizations that seek to understand and effectively respond to migrants' health needs;

3. To identify and agree on the main needs, gaps and challenges and priority area's with regard to future research, policies and programmes on migration health;

4. To facilitate networking and increased coordination among stakeholders at local, district and provincial levels;

5. To formulate recommendations and develop an operational framework for the implementation of the WHA Resolution 61.17 on the Health of Migrants in South Africa.

Expected outcomes were:

1 Recommendations for actions for change at policy, strategic and implementation level at national, provincial and district level agreed upon;

2 Strengthening of partnerships on Migration Health in South Africa.

Consultation presentation

Through presentations and question/answer sessions important lessons learned were identified before formulating the recommendations. To set the scene, seven presentations were made by various stakeholders. These provided a broad perspective of migration and health in South Africa. In addition, two Masters' students from the University of Witwatersrand presented their research on migration and health in South Africa.

Global, regional and South African migration trends

Globally, there are an estimated 214 million international migrants, representing 3.1% of the global population. While vulnerability levels vary greatly amongst migrants, the collective health needs and implications of such a sizeable population group are considerable. As indicated by the 2009 UNDP report, southern Africa is unique in that it has a self-contained migration system; migration tends to be interregional throughout the rest of the world. Domestic or internal migration is therefore a particularly important issue in the southern African region.

In her presentation, ***Migration Health Officer from IOM, Reiko Matsuyama*** explained migrants' potential vulnerability to ill health and how IOM is responding to these vulnerabilities. She explained the various factors that affect the well-being of migrants throughout the migration process and how the

broader determinants of health such as legal status, customs and immigration systems, housing, education, nutrition and food security, environmental conditions and water and sanitation, as well as access to healthcare, may impact migrants at the various stages of the migration process. Due to the cross-cutting nature of migration, Matsuyama highlighted the importance of multi-sectoral partnerships and described the various relationships that IOM facilitates at both the regional and national levels.

Evidence from the field and conceptual challenges

Erin Tansey, IOM Migration Health Research Coordinator, described the results of a regional assessment conducted in 2009 that reviewed migrants' vulnerability to HIV and their access to prevention services during different stages of the migration process. The assessment considered various sectors in which many migrants are employed, focusing in South Africa on construction, domestic work, fisheries and informal cross-border trade. The findings indicated that under normal circumstances, migration is not a risk to health, but that conditions surrounding the migration process, particularly lack of legal status, can increase the vulnerability to ill health. Despite many workplace programmes migrant workers often have limited access to social benefits and health services due to legal, economic, language and cultural factors. The often dangerous working conditions inherent to the sectors in which migrants work, the lack of opportunity and general poverty foster a sense of fatalism. Migrant workers are therefore often preoccupied with day-to-day survival and may not be in a position to be looking after their long-term health.

Findings from the fieldwork suggested three levels of vulnerability: individual, environmental and structural. To a large extent the factors contributing to vulnerability cannot be controlled by the individual, for example type of accommodation, lack of healthcare facilities, impoverished social environment, but could be influenced by employers. ***Celicia Serenata, from the South African National AIDS Council (SANAC)***, echoed this point in her presentation by stressing that it is the conditions that propagate "unhealthy" migration that must be addressed, the labour market being a primary concern. The discourse that places blame on the individual, instead of looking to structural barriers, reproduces ideas of the migrant as the risky "*other*" and implies the use of exclusionary controls such as immigration and border controls. Serenata argued that stakeholders who accept this conceptualization of the "risky migrant" are not equipped to put the Resolution into action because in order for migrants to feel comfortable accessing healthcare, the service must be disconnected from exclusionary controls. Tansey underlined that a public health and human rights based approach to healthcare provision is inclusive of migrants and mobile populations and should therefore be prioritized.

The approach to migration as a problem was also challenged in a presentation made by ***Dr Landau from the FMSP***. He delved into the national policy responses of southern African countries to migration based on country-level statistics over a period of 20 years. Despite major changes in political and socio-economic conditions and unprecedented complications in migration situations in southern Africa, he explained that immigration policies have remained the same to a large extent and that bilateral, rather than regional, approaches to migration continue to predominate. South Africa, Namibia and Zambia are the only countries in the region with some degree of policy mainstreaming in migration. In South Africa specifically, implementation of these policies still needs to be strengthened. Landau suggested that the numerous conceptual challenges surrounding responses to migration might explain the stasis. For example, the general approach to migration as a security issue rather than a developmental issue practiced by SADC puts the focus on prevention, border control and the fight against illegal migration, rather than on the positive and effective management of migration. The anxiety over a perceived fiscal burden of providing treatment to "healthcare-seeking" migrants is another impediment to mainstreaming migration into healthcare according to Landau. This fear is based on the false presumption that migrants come to South Africa specifically for healthcare. As discussed in Morewane's opening remarks, most migrants are in fact livelihood seeking and do not require expensive healthcare interventions.

Effectively engaging with population dynamics

Urbanization was an important issue raised both in Landau's presentation and again in ***Dr Philippe Bocquier's, of the University of Witwatersrand***, who presented his research with Marc A. Collinson and focused on the impact of migration on health. Landau emphasized that increasing urbanization rates should be understood in the context of national population dynamics and that urban growth is in fact largely due to natural increase. Competition over resources in urban settings, for example, is high and informally regulated to a large degree. Bocquier elaborated on the historical and socio-political context of rural–urban labour migration in South Africa, putting special emphasis on apartheid's lasting impact on migration patterns and the ongoing context of rural poverty. He emphasized the important contribution of remittances to the improved socio-economic status of households left behind. For the poorest of the poor, female temporary migration is key. The linkage between

urban and rural dynamics is therefore an important relationship to engage with. Both presenters stressed the importance of being informed in terms of context-specific population dynamics in health-systems planning and budgeting.

Bocquier and Collinson's analysis of data collected through the Agincourt Health and Demographic Surveillance System highlighted the need for a "migration typology" that distinguishes between circular and permanent migration as well as the point of origin and destination, village-to-village migration, migration to nearby towns, to secondary urban areas, to primary metropolis and to other destinations. Central to Bocquier and Collinson's typology is the inherent recognition of the importance of internal migration patterns in South Africa. Feedback during the question-and-answer period emphasized the importance of defining migrant categories. The question was raised, for example, of how long a migrant has to be away from home to be considered temporary.

Bocquier and Collinson's findings shed light on the complexity of the relationship between migration and health, challenging assumed causal links. The presentation focused on four key relationships: migration and sexual behaviour, adult mortality and migration, child mortality and temporary migration of their parents and child mortality and refugee status. Contrary to popular thinking that migrants engage in riskier behaviour than a local population, multivariate analysis showed that male migrants that visit home more frequently may be less exposed to multiple partnerships than men who return three times or less in a year. The more permanent population was therefore at a higher risk than those that moved more frequently. With regard to adult mortality, HIV and AIDS-related TB was the overwhelming cause of death for migrants. As a single category, HIV and AIDS TB-stricken migrants returning home accounted for a double in deaths in less than 10 years. So, while migrants visiting home more frequently were less exposed to high-risk behaviour they were disproportionately affected by TB which is associated with HIV and AIDS. The study therefore concluded that migration is associated with HIV and TB but not in straightforward ways. In terms of child mortality, the children of households with temporary migrant mothers were less likely to survive than the children of households with no mother present. The highest child mortality was found among children of Mozambican parents residing in long-term refugee settlements.

Bocquier emphasized that the readily available census data and surveys that inform governmental planning are insufficient and often misleading, creating simplified ideas and misconceptions about migration and migrants. In order to understand poverty and inequalities in both migrant-sending and receiving communities, he underlined that proper information and analysis of data on details such as type of migration and length of stay are crucial.

Regional and Global responses

Victor Dintle, of the SADC Parliamentary Forum, briefed participants on some of the regional instruments and international guidelines relevant to the implementation of WHA Resolution 61.17 such as the SADC Declaration on HIV and AIDS (Maseru Declaration 2003), the SADC HIV and AIDS Strategic Framework 2010–2015 and the SADC Protocol on Health. Dintle also mentioned the draft SADC Policy Framework on Population Mobility and Communicable Diseases, whose goal will be to provide guidance on the protection of the health of the cross-border mobile population with regard to communicable disease and on the control of communicable disease given the movement of people within the region.

In October 2009, SADC Members of Parliament met to discuss strategies for ensuring the equitable access of migrants to public health services. Of particular concern was strengthening and promoting the health of migrants in order to achieve the Millennium Develop Goals. The positive contribution of migration and migrants to economic, social and cultural development is recognized by SADC in both countries of origin and host countries, as are the obstacles and barriers faced by some migrants such as discrimination, exploitation and xenophobia. Despite this recognition, other development issues tend to be prioritized before migration due to which the issue suffers a lack of political commitment. The short terms of office for Parliamentarians and Cabinet Members mean that those who are concerned about addressing regional migration health issues do not have adequate time to make an impact. Dintle encouraged ongoing dialogue about migrant health and supported the idea of health passports as a tool for improved care for migrants. During the question-and-answer session, the current effort to harmonize clinical treatment protocols across the region was mentioned as a positive step forward for SADC.

Dr Harry Opata, from the World Health Organization (WHO), briefed participants on the Global Consultation that took place in Madrid. He outlined the four key priorities; (1) Monitoring migrant health, (2) Partnerships and networks, (3) Migrant-sensitive health systems and (4) Policy and legal frameworks affecting migrants' health. These areas also served as the basis for the group work during the consultation. In addition, he described some of the gaps and concerns discussed with regard to the Resolution which are particularly relevant to South Africa. The discrepancy between migration-friendly policy, coherence with

other policies and of course actual implementation is evident in South Africa. Routine data collection of separate migrant health data – another recommendation from the Global consultation – while ideal was discussed as being a major challenge in South Africa where capacity is lacking. Finally, the scope of migration health in South Africa is usually narrowly focused on HIV and AIDS and does not encompass other important issues such as mental health and reproductive health.

Despite the gaps, Dr Opata underlined that the WHA Resolution 61.17 is an excellent tool for achieving real change in terms of realizing migrants' right to health in South Africa. By making use of the WHA platform, the Resolution creates a space for initiating positive action.

Group Work

Following the presentations, group discussions focused on formulating recommendations in response to the Resolution at various levels that would contribute towards broader development goals and avoid exceptionalizing migrant groups. The participants were divided into four groups, according to the Madrid Global Consultation's four areas of concentration:[21]

1 Monitoring migrant health
2 Partnerships and networks
3 Migrant-sensitive health systems
4 Policy and legal frameworks

Following the discussion sessions, each of the four rapporteurs made a report-back presentation for the plenary.

Recommendations

Keeping in mind the key lessons learned, Jo Vearey's summary presentation on the plenary reports revealed a great deal of overlap in terms of priorities to address, key actions and lead actors. This overlap highlighted the reality that achieving good health for all is a cross-cutting issue. The conceptual approach to migrant health is important: public health and human rights approaches should be prioritized.

Efforts will have to be made outside the traditional areas of focus, for example hospitals, clinics and the Department of Health, in order to make progress. Migrants should not be exceptionalized. The general consensus was that the biggest challenge to improving the access of migrants to healthcare in South Africa was not in the development of new legislation or policies but in the correct and consistent implementation of the policies and platforms already in place. Partnerships, platforms and migrant-sensitive policy exist in South Africa but there is room for improvement, particularly on implementation of these policies. A localized response is critical.

Vearey emphasized that increasing communication across disciplines, governmental levels and countries within the region, in addition to bringing in new stakeholders would therefore be fundamental to the advancement of the recommendations set forth by participants. She stressed that future actions respond to the voice of migrants, both internal and cross-border migrants, and actively engage with the situation on the ground. Vearey emphasized that migration patterns vary and so internal, cross-border, circular and linear migrants might need different approaches. Two other points which were stressed were that migrants often remain connected to the household/community "back home" and that migrants' health issues extend beyond communicable diseases. Lack of data and misconceptions around migration and migrants exist and therefore research and strong data should inform planning.

The following table summarizes the recommendations from the consultation:

21 WHO, Health of migrants: the way forward - report of a global consultation, Madrid, Spain, 3–5 March 2010.

(1) Monitoring Migrant Health: Strengthen migrant-sensitive data collection

Priorities to address		Ensure the standardization and comparability of data on migrant health; support the appropriate aggregation and assembling of migrant-health information; map good practices in monitoring and delivery of migrant health
Key actions	1.1	Strengthen national health information data systems in order to improve continuum of care for patients on the move and the consistency of data comparability for governmental planning purposes at all levels
	1.2	Establish a set of standardized data collection tools to ensure the comparability of data collected on migration and health across sectors (i.e. Government, NGO, academia, etc.)
	1.3	Involve migration and health experts in planning for national surveys in order to collect specific data on migration and health and to address the challenges associated with collecting data from undocumented populations
	1.4	Key research needs to: 1.4.1 Analyse how population movement could be prognosed 1.4.2 Map migrant population concentrations to direct services better 1.4.3 Map out existing resources/structures addressing or supporting migrants' health 1.4.4 Develop monitoring tools for implementation of the WHA Resolution on the Health of Migrants 61.17 1.4.5 Report annually on progress made towards resolutions
	1.5	Document key good practices on: health passports; continuum of care; health promotion service delivery; ARV treatment protocols; mental health; sexual and gender-based violence; migrants in detention 1.5.1 Include best practices on migration health in the CoRMSA report for June 2010 1.5.2 Disseminate documented best practices in existing fora/meetings/seminars, journals, newsletters; 1.5.3 Use multi-sectoral platforms such as SANAC to share good practices, (e.g. inclusion of Migration Health in SANAC position paper)
	1.6	Pilot, review and document capacity-building activities and link to good practices

(2) Partnerships and networks: Strengthen existing partnerships and encourage new ones

Priorities to address		Establish and support migration health dialogues and cooperation across sectors and among stakeholders
Key actions	2.1	Facilitate/strengthen coordination platforms at various levels and stakeholders 2.1.1 At national level: Inter-departmental working group on migration 2.1.2 At provincial level: Lead actor; provincial Official Development Assistance (ODA) 2.1.3 At local level: Lead actor; municipalities
	2.2	Compile e-mail ListServe of people/organizations involved in migration and health in order to share information more easily
	2.3	Increase public awareness around migration and health issues and rights 2.3.1 Encourage migrants to join community committees/boards, etc. 2.3.2 Raise awareness amongst companies and individuals who employ migrants of migrants' rights

(3) Migrant-sensitive Health Systems: Strengthen capacity building and service delivery

Priorities to address		Ensure that health systems are delivered to migrants in a culturally and linguistically appropriate way; enhance the capacity of health and related non-health workforce to address the health issues associated with migration; deliver migrant-inclusive services in a comprehensive, coordinated and financially sustainable fashion
Key actions	3.1	Sensitize (health) service providers around patients' rights, migration and health in general through: 3.1.1 Specialized training sessions 3.1.2 Materials about rights to accessing the healthcare system
	3.2	Display procedures on how the health system works at facilities
	3.3	Address language barriers: 3.3.1 Translate the "Patient Charter" and other public health into migrant languages 3.3.2 Strengthen/develop where necessary translation services available in the hospital and clinic setting 3.3.3 Post welcome signs at hospitals and clinics in South African and foreign languages
	3.4	Care for the carers – Acknowledge that healthcare workers have a high work load and recognize that this can affect the quality of service provided 3.4.1 Establish debrief procedures for front-line hospital staff 3.4.2 Encourage recognition of the work done by hospital staff and particularly of those who stand in solidarity with migrants
	3.5	Reduce burden of care on hospitals by sending mobile services to where they are most required
	3.6	Strengthen capacity to use data in the hospital/clinic setting by training hospital staff on how to use and collect, analyse and disseminate data
	3.7	Strengthen health infrastructure and capacity of district health systems in order to provide services to everyone
	3.8	Establish a neutral body/entity for patients to report to on quality of services and care

(4) Policy and legal frameworks affecting migrants' health: Mainstream migration and migrants into health systems

Priorities to address		Ensure implementation of national health policies that promote equal access to health services for migrants; extend social justice protection in health and improve social security for all migrants
Key actions	4.1	Strengthen adherence to policy: 4.1.1 Intensify the distribution of various directives that address health access 4.1.2 Disseminate information to the general population including migrants, workers, etc. on how to access the healthcare system (i.e. healthcare provision; ID numbers; patients charter) in relevant languages 4.1.3 Make national policy on health access rights understandable to the lay person 4.1.4 Inform public and (healthcare) service providers on uniform billing system 4.1.5 Verify a means to ensure patient are not charged if eligible for free treatment
	4.2	Clarify protocol on medical referrals upon arrival at DHA
	4.3	Improve national budget monitoring/budget development through use of current local data
	4.4	Encourage consideration of migration in all relevant policies
	4.5	Ensure all role-players are aware of the health rights of migrants (including but not limited to South African Police Services, correctional services, private sector)
	4.6	Advocate to soften regulations around foreign healthcare workers working in South Africa

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Mpho Seleka – IOM/MPW Photography Project 2008

Recommendations for improving migrant access to healthcare

Engaging with the recommendations from the Global consultation on Migrant Health in Madrid, Spain and the National Consultation on Migration Health in South Africa.

During the Global Consultation on Migrant Health in Madrid, held in March 2010, participants spent two and a half days discussing progress made towards achieving the WHA Resolution on the Health of Migrants. Recommendations for future action to ensure the health of migrants were generated. Key recommendations included a call for: (1) recognizing "healthy migration" as a key driver of development; (2) improved collection, analysis and use of migration and health-related data to inform policies and programmes; (3) moving from a health-systems focus to addressing the wide-ranging social determinants of migrant health; (4) improved policy coherence across sectors; and (5) follow-up Consultations to be held at national levels for localized frameworks for action to be developed. The South African National consultation was in response to the Madrid recommendation number 5. The South African government is urged to engage with these recommendations that aim to assist in implementing the WHA Resolution on the Health of Migrants.

Responding to migration, development and health: the role of government in developing a coordinated national response

> While recognising national government's important role, there is a need to enhance the role of local governments and regional bodies in evaluation, designing and implementing an approach to human mobility. Migration and development vary across both space and time. Any policy approach that fails to disaggregate migration according to these variables is unlikely to fully realise its objectives.
>
> *(Landau & Wa Kabwe-Segatti, 2009: 3)*

The South African National government should engage with the recommendations to develop – and implement – migration and development frameworks that are based on the specificities of any given country (including South Africa) as called for by the European Commission and the World Bank (see Landau & Wa Kabwe-Segatti, 2009 for further details). Current approaches to the governance of migration remain "dominated by security concerns ill adapted to development challenges" (Landau & Wa Kabwe-Segatti, 2009: 3). Linked to this, local, provincial and national government structures must engage with the realities of migration, development and health. This includes targeted training to ensure that government officials are aware of – and understand – the relationship between migration, development and health. Through this process, the South African government is urged to develop a national, coordinated response at national, provincial and local level, to migration, development and health.

The need for a coordinated regional response to migration and health

This paper has drawn on data relating to migration and health in South Africa, and it is hoped that the analysis presented will assist in generating future research that will further explore the multiple issues involved in cross-border migration, health and healthcare within South Africa. It is essential to view South Africa as part of a region of high population mobility; in order to generate an effective – and sustainable – response to migration and health within southern Africa, an appropriate coordinated regional response is urgently required. Such a response will assist South Africa in achieving its "long-term regional development outcomes" (Landau & Wa Kabwe-Segatti, 2009: 2).

To this end, South Africa should urge all member states to adopt and implement the SADC Policy Framework for Population Mobility and Communicable Diseases in the SADC region (SADC Directorate for Social and Human Development and Special Programs, 2009). This policy framework outlines the measures needed to address regional gaps related to the control and management of communicable diseases. These gaps include: inadequate harmonization and coordination of disease management guidelines across different SADC countries; lack of cross-border referral mechanisms; barriers faced by mobile populations in accessing curative and preventive health services, as well as health information; and inadequate disease surveillance and epidemic preparedness (SADC Directorate for Social and Human Development and Special Programs, 2009). The policy framework outlines the measures needed to address these gaps; including those specific to HIV and AIDS, TB and malaria, three major health challenges facing the region. Importantly, the framework makes reference to the principles

endorsed in the founding charter of SADC under article 6, 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; and Resolution 61.17 of the 61st WHA (held in 2008) which calls on member states to promote equitable access to health promotion, disease prevention and care for migrants. It is essential that migration and health are considered within the linked agenda of migration and development

In order to engage with migration health in the southern African region, the IOM and Southern African Migration Project (SAMP) convened a Migration Dialogue for Southern Africa (MIDSA) under the theme "Promoting Health and Development: Migration Health in Southern Africa" (Dar es Salaam, June 2009). This meeting brought together representatives from SADC to discuss the WHA resolution on migrant health, and implications for regional responses to migration and health. This forum provided a welcome opportunity to engage with prevailing assumptions linking migration and health, and with the challenges international migrants experience when attempting to realize their right to health. Resulting from the meeting, a range of recommendations were generated for presentation to SADC leaders, urging the adoption and implementation of both the SADC Policy Framework for Population Mobility and Communicable Diseases in the SADC region, and implementation of the WHA Resolution 61.17 on the Health of Migrants. It is essential that migration and health are considered within the linked agenda of migration and development; that the social determinants of migrant health are addressed; and that the availability of data to inform intersectoral, evidence-based, regional policies is strengthened (CoRMSA, 2009).

Finally, a regional response to migration and health will require monitoring to ensure that it is implemented appropriately. This includes the need to monitor the correct implementation of current protective legislation (where it currently exists) that has been designed to ensure that international migrants are able to access healthcare.

The way forward

Future research is required in order to inform ongoing and sustainable regional responses to migration and health in southern Africa. There is an urgent need to conduct research within different countries in the southern Africa region; at present, existing data on health and migration focuses on South Africa. Such research includes the need to determine the costs involved in providing (and the costs of not providing) basic healthcare – including ART – to international migrant populations. This will assist in working with national governments to ensure that appropriate responses to health and migration are budgeted and planned for. As presented in this paper, research on migration and health in South Africa highlights the "othering" of international migrants, which is amplified in a context of HIV. An effective response to migration and health must find ways to address this. To this end, it is argued that for action on migration and health to be effective, and to realize the potential population-level health benefits, there is an urgent need to return to the advocacy roots of a public health approach to address the health of international migrant populations. Such an approach calls on regional bodies, governments, civil society, public health professionals and researchers to advocate for and ensure that the right to access healthcare for all migrant groups is upheld (McNeill, 2003). Targeted trainings that engage with the multiple levels of healthcare provision are urgently required to ensure that access to healthcare is facilitated for all cross-border – and internal – migrants within South Africa. This will require engaging with national, provincial, district/local and facility levels. Engagement will require the provision of appropriate and targeted information, particularly around client-provider interactions and how the decisions made by frontline healthcare providers directly impact health outcomes. Importantly, the public health system requires strengthening, particularly in terms of human resources, service provision and an effective health information system.

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Tsvangirayi Mukwazhi – IOM/MPW Photography Project 2006

Annexes

Annex 1: Constitutional provisions

South African Constitution of 1996

Article 27: Health care, food, water and social security

1. Everyone has the right to have access to

   (a) health care services, including reproductive health care;

   (b) sufficient food and water; and

   (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. No one may be refused emergency medical treatment.

3. No one may be refused emergency medical treatment.

Article 39: Interpretation of Bill of Rights

1. When interpreting the Bill of Rights, a court, tribunal or forum

   (a) must promote the values that underlie an open and democratic society based on human dignity, equality and freedom;

   (b) must consider international law; and may consider foreign law.

2. When interpreting any legislation, and when developing the common law or customary law, every court, tribunal or forum must promote the spirit, purport and objects of the Bill of Rights.

3. The Bill of Rights does not deny the existence of any other rights or freedoms that are recognized or conferred by common law, customary law or legislation, to the extent that they are consistent with the Bill.

Article 231: International agreements

1. The negotiating and signing of all international agreements is the responsibility of the national executive.

2. An international agreement binds the Republic only after it has been approved by resolution in both the National Assembly and the National Council of Provinces, unless it is an agreement referred to in subsection (3).

3. An international agreement of a technical, administrative or executive nature, or an agreement which does not require either ratification or accession, entered into by the national executive, binds the Republic without approval by the National Assembly and the National Council of Provinces, but must be tabled in the Assembly and the Council within a reasonable time.

4. Any international agreement becomes law in the Republic when it is enacted into law by national legislation; but a self-executing provision of an agreement that has been approved by Parliament is law in the Republic unless it is inconsistent with the Constitution or an Act of Parliament.

5. The Republic is bound by international agreements which were binding on the Republic when this Constitution took effect.

[Article 231 of the South African Constitution therefore allows the process of international treaties to acquire the force of law in South Africa]

Annex 2: Legislation

African Charter on Human and Peoples' Rights (Ratified on 09/071996)

Article 16

1. Every individual shall have the right to enjoy the best attainable state of physical and mental health.

2. States parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

Article 24

1. States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services:

    (f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

Article 12

1. 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning

Article 11

1. 1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of employment in order to ensure, on a basis of equality of men and women, the same rights, in particular:

    (f) The right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.

International Covenant on Economic, Social and Cultural Rights (Signed on 10/12/1998)

Article 12

2. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

3. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

    (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

    (b) The improvement of all aspects of environmental and industrial hygiene;

    (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

    (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (not yet ratified by the Republic of South Africa)

Article 25

4. Migrant workers shall enjoy treatment not less favourable than that which applies to nationals of the State of employment in respect of remuneration and:

    (a) Other conditions of work, that is to say, overtime, hours of work, weekly rest, holidays with pay, safety, health, termination of the employment relationship and any other conditions of work which, according to national law and practice, are covered by these terms;

(b) Other terms of employment, that is to say, minimum age of employment, restriction on work and any other matters which, according to national law and practice, are considered a term of employment.

Article 28

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. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.

National Health Act National Health Act, 2003 (Act No. 61 of 2003)

Chapter 1 - Objects of the Act, Responsibility for Health and Eligibility for free health services

Article 2

The objects of this Act are to regulate national health and to provide uniformity in respect of health services across the nation by-

(a) establishing a national health system which-

(i) encompasses public and private providers of health services; and

(ii) provides in an equitable manner the population of the Republic with the best possible health services that available resources can afford;

(b) setting out the rights and duties of health care providers, health workers, health establishments and users; and

(c) protecting. respecting, promoting and fulfilling the rights of-

(i) the people of South Africa to the progressive realisation of the constitutional right of access to health care services, including reproductive health care;

(ii) the people of South Africa to an environment that is not harmful to their

(iii) children to basic nutrition and basic health care services contemplated in section 28(l)(c) of the Constitution; and

(iv) vulnerable groups such as women, children, older persons and persons with disabilities.

Chapter 2 - Rights and Duties of Users and Health Care Personnel

5. Emergency treatment

A health care provider, health worker or health establishment may not refuse a person emergency medical treatment.

South African Refugee Act (Act No. 130 of 1998)

Chapter 5 - Rights and Obligations of Refugees

Protection and general rights of refugees

27. *A refugee-*

(b) enjoys full legal protection, which includes the rights set out in Chapter 2 of the Constitution and the right to remain in the Republic in accordance with the provisions of this Act;

(g) is entitled to the same basic health services and basic primary education which the inhabitants of the republic receive from time to time

South African Immigration Act (Act No. 13 of 2002)

Exclusions and Exemptions

Prohibited persons

29. (1) The following *foreigners* do not qualify for a temporary or a permanent residence permit:

(a) those infected with infectious diseases as prescribed from time to time;

Exemptions

31. (1) The following persons or categories of persons are not *illegal foreigners*:

(2) Upon ***application***, the *Minister*, as he or she deems fit, after consultation with the *Board*, may under terms and conditions determined by him or her—

(b) grant a *foreigner* or a category of *foreigners* the rights of permanent residence for a specified or unspecified period when special circumstances exist which justify such a decision; provided that the *Minister* may—

(i) exclude one or more identified *foreigners* from such categories; and

(ii) for good cause, withdraw such right from a *foreigner* or a category of *foreigners*;

"On 3 April 2009, the Minister of Home Affairs announced that the DHA would issue 'special dispensation permits', under Section 31(2)(b) of the Immigration Act, affording temporary status to Zimbabweans on economic and humanitarian grounds. The temporary permit would entitle Zimbabweans to stay and work in South Africa and would be valid for one year. Depending on circumstances, it would be renewed or extended at the Minister's discretion. The national elections and the selection of a new minister have delayed the implementation of these measures. At the time of writing, the new Minister of Home Affairs had referred the matter to Cabinet for further deliberation.

While the Cabinet decides what documents to issue Zimbabwean migrants in South Africa, many Zimbabweans remain undocumented and continue to be subject to arrest and detention. That said, a general moratorium on deportations of Zimbabweans has been implemented since May and the government has instituted a free visa for Zimbabweans. This brings visa policy towards Zimbabweans in line with other neighbouring countries where free visa regimes already exist. While the new visa does not affect the Zimbabweans already in the country, those arriving at a port of entry receive a 90-day temporary residence visa free of charge, which also entitles them to work. The visa is renewable once inside the country for a fee of R450 and there is no limit to the number of times an individual may receive a new visa by exiting and re-entering the country.

The free visa is a very welcome measure, but people are likely to continue crossing the border illegally due to difficulties in obtaining the three forms of identification recognised by South Africa: a Zimbabwean passport, an emergency travel document, or a border pass. Zimbabwean passports are estimated to cost in the region of US$670, an emergency travel document costs in the region of US$40, and a border pass is only valid for travel for a radius of 20 kilometres around the border. The Departments of Home Affairs and of International Relations and Cooperation are reportedly engaging with their Zimbabwean counterparts on the fast provision of affordable Zimbabwean passports."

-CoRMSA "Protecting Non-Citizens in South Africa 2009 p. 36

Occupation Health and Safety Act (Act No. 85 of 1993)

The Occupational Health and Safety Act demands that employers provide for the health and safety of persons at work and that they ensure protection from any hazards in the workplace (Occupational Health and Safety Act 85 of 1993)

HIV & AIDS and STI Strategic Plan for South Africa, 2007-2011

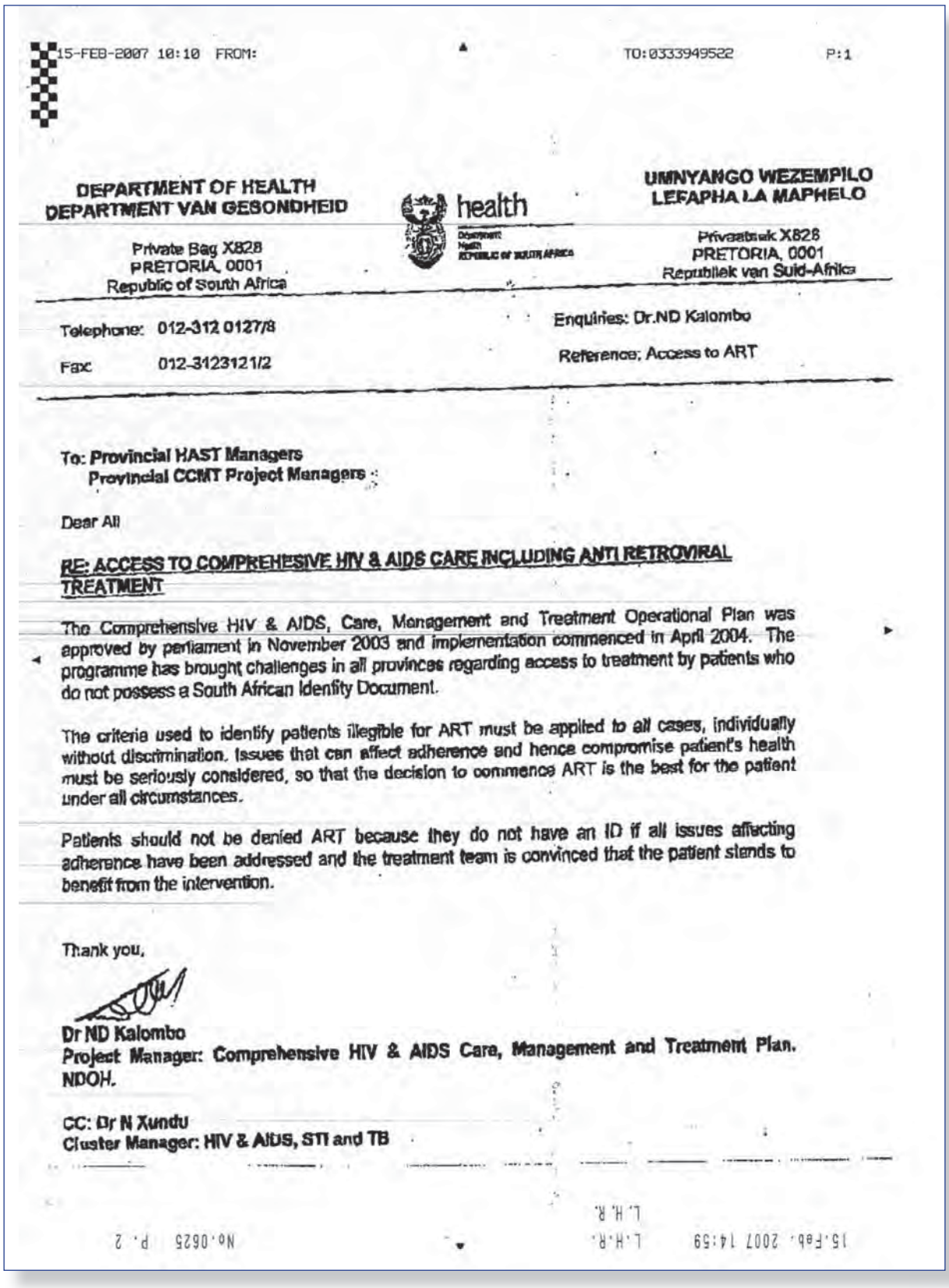
The guiding principles of the HIV & AIDS and STI Strategic Plan for South Africa confirm those articulated by the Constitution, the NACOSA Plan, the Department of Health *White Paper for the Transformation of the Health System in South Africa, 1997*, the Comprehensive Plan, and Batho Pele. These principles include, among others:

Tackling Inequality and poverty: the NSP affirms government's constitutional duty to take reasonable legislative and other measures to ensure progressive realisation of rights to education, health care services and social security to all people of South Africa. HIV and AIDS interventions will be implemented in a way that complements and strengthens other developmental programmes.

Ensuring Equality and non-discrimination: The NSP is committed to challenging discrimination against groups of people who are marginalised, including people with disabilities, orphans, refugees, asylum seekers, foreign migrants, sex workers, men-who-have-sex-with-men, intravenous drug users, and older persons. All these groups have a right to equal access to interventions for HIV prevention, treatment and support.

Annex 3: Memorandums and Letters

National Department of Health Memo, 2006



15-FEB-2007 10:10 FROM: TO:0333949522 P:1

DEPARTMENT OF HEALTH
DEPARTMENT VAN GESONDHEID

Private Bag X828
PRETORIA, 0001
Republic of South Africa

health

UMNYANGO WEZEMPILO
LEFAPHA LA MAPHELO

Privaatsak X828
PRETORIA, 0001
Republiek van Suid-Afrika

Telephone: 012-312 0127/8
Fax: 012-3123121/2

Enquiries: Dr.ND Kalombo
Reference: Access to ART

To: Provincial HAST Managers
Provincial CCMT Project Managers

Dear All

RE: ACCESS TO COMPREHENSIVE HIV & AIDS CARE INCLUDING ANTI RETROVIRAL TREATMENT

The Comprehensive HIV & AIDS, Care, Management and Treatment Operational Plan was approved by parliament in November 2003 and implementation commenced in April 2004. The programme has brought challenges in all provinces regarding access to treatment by patients who do not possess a South African Identity Document.

The criteria used to identify patients illegible for ART must be applied to all cases, individually without discrimination. Issues that can affect adherence and hence compromise patient's health must be seriously considered, so that the decision to commence ART is the best for the patient under all circumstances.

Patients should not be denied ART because they do not have an ID if all issues affecting adherence have been addressed and the treatment team is convinced that the patient stands to benefit from the intervention.

Thank you,

Dr ND Kalombo
Project Manager: Comprehensive HIV & AIDS Care, Management and Treatment Plan.
NDOH.

CC: Dr N Xundu
Cluster Manager: HIV & AIDS, STI and TB

National Department of Health Memo. BI 4/29 REFUG/ASYL 8 2007, 19 September 2007

DEPARTMENT OF HEALTH
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Republic of South Africa

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Faks/Fax : (012) 312-0759
Telefoon/Telephone : (012) 312-0550
Navrae/Enquiry : Ms. U Le Roux/ x0550
Verw/Reference : BI 4/29 REFUG/ASYL 8 2007

REVENUE DIRECTIVE- REFUGEES/ ASYLUM SEEKERS WITH OR WITHOUT A PERMIT

To: PROVINCIAL HEALTH REVENUE MANAGERS
HIV/AIDS DIRECTORATES

19TH SEPTEMBER 2007

Dear All

HOSPITAL FEES: ASSESSMENT OF REFUGEE / ASYLUM-SEEKERS (with or without a permit)

Preamble

REFUGEE ACT, Act No. 130 of 1998 (Chapter 5; Section27, (g))

RIGHTS AND OBLIGATIONS OF REFUGEES (Protection and general rights of refugees)
27. A refugee-
(g) Is entitled to the same basic health services and basic primary education which the inhabitants of the Republic receive from time to time.

To avoid contravening patients rights, as precepts to the Constitution (section 27 (3)) and the Refugee Act: **Act No. 130 of 1998 (Chapter 5; Section27, (g))**

1. **Where refugee status have been determined or asylum seekers with or without a permit:**

1.1. Basic Health Care:

1.1.1 Refugees / asylum seekers **with or without a** permit that do access public health care shall be assessed according to the current MEANS test. (as specified in the Annexure H).

1

Join the Partnership Against AIDS – Our Actions Count

1.2. Anti-retroviral treatment (ART)

1.2.1 Refugees / asylum seekers **with or without a** permit that do access public health care, shall be exempted from paying for ART services irrespective of the site or level of institution where these services are rendered. ***(Please refer to the ART directive: BI/429/ART dated the 20th April 2007).***

2. Full paying patients:

2.1 The following full-paying patients **are excluded** from free services (basic Health Care and ART) irrespective of the level of care where the service is being rendered:

2.1.1. Refugees / asylum seekers whose income **exceeds** the prevailing means test shall be levied at the full paying UPFS.

2.1.2. Externally funded patients, including members of medical schemes registered in terms of the Medical Schemes Act, 1998 (ACT No. 131 of 1998).

2.1.3. Externally funded patients whose medical schemes **are not recognised** within the RSA scheme pool shall be charged as full paying patients (Self Funded), unless prior arrangements have been made.

2.1.4. Patients treated on account of other state departments, e.g. Compensation Commissioner (COID), SA Police Services, Department of Correctional Services.

2.1.5. Patients treated in state facilities by their **private medical practitioner.**

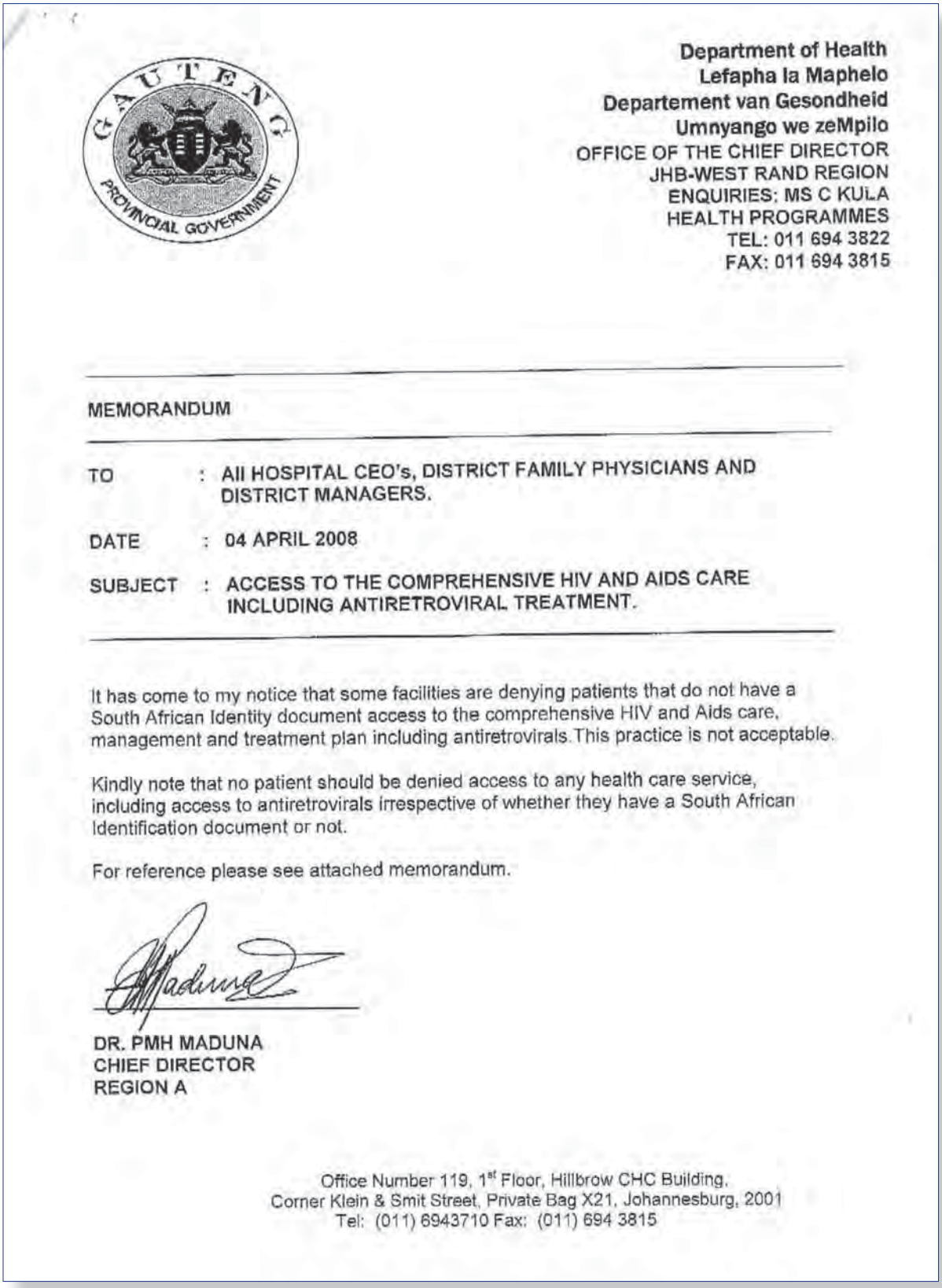
NB: The execution of this directive is with immediate effect.

Your co-operation would be appreciated.

MR. FG MULLER

CHIEF FINANCIAL OFFICER (CFO) (NDOH)

Gauteng Department of Health Letter, 04 April 2008



Department of Health
Lefapha la Maphelo
Departement van Gesondheid
Umnyango we zeMpilo
OFFICE OF THE CHIEF DIRECTOR
JHB-WEST RAND REGION
ENQUIRIES: MS C KULA
HEALTH PROGRAMMES
TEL: 011 694 3822
FAX: 011 694 3815

MEMORANDUM

TO : All HOSPITAL CEO's, DISTRICT FAMILY PHYSICIANS AND DISTRICT MANAGERS.

DATE : 04 APRIL 2008

SUBJECT : ACCESS TO THE COMPREHENSIVE HIV AND AIDS CARE INCLUDING ANTIRETROVIRAL TREATMENT.

It has come to my notice that some facilities are denying patients that do not have a South African Identity document access to the comprehensive HIV and Aids care, management and treatment plan including antiretrovirals.This practice is not acceptable.

Kindly note that no patient should be denied access to any health care service, including access to antiretrovirals irrespective of whether they have a South African Identification document or not.

For reference please see attached memorandum.

DR. PMH MADUNA
CHIEF DIRECTOR
REGION A

Office Number 119, 1st Floor, Hillbrow CHC Building,
Corner Klein & Smit Street, Private Bag X21, Johannesburg, 2001
Tel: (011) 6943710 Fax: (011) 694 3815

9

Mpho Seleka – IOM/MPW Photography Project 2008

References

Agustin, L.M. (2007). *Sex at the Margins: Migration, Labour Markets and the Rescue Industry*. London: Zed Books.

AIDS & Rights Alliance for Southern Africa (2008). The Mining Sector, Tuberculosis and Migrant Labour in Southern Africa: Policy and Programmatic Interventions for the Cross-border Control of Tuberculosis between Lesotho and South Africa, Focusing on Miners, Ex-Miners and Their Families, *http://www.arasa.info/files/pub_ARASA_Mines_TB_and_Southern_Africa.pdf:* ARASA.

Amon, J.J., & Todrys, K.W. (2008). Fear of Foreigners: HIV-related Restrictions on Entry, Stay, and Residence. *Journal of the International AIDS Society,* 11(8).

Amon, J.J., & Todrys, K.W. (2009). Access to Antiretroviral Treatment for Migrant Populations in the Global South. *Sur - International Journal on Human Rights*, 10.

Anarfi, J. (2005). Reversing the Spread of HIV/AIDS: What Role Has Migration? In UNFPA (Ed.), *International Migration and the Millennium Development Goals. Selected Papers of the UNFPA Expert Group Meeting, Marrakech, Morocco, 11–12 May 2005*. New York: UNFPA.

Bailey, S. (2004). Is Legal Status Enough? Legal Status and Livelihood Obstacles for Urban Refugees, *The Fletcher School.* Massachusetts: Tufts, p. 52.

Banati, P. (2007). Risk Amplification: HIV in Migrant Communities. *Development Southern Africa,* 24(1), 205–223.

Beavon, K. (2004). *Johannesburg: The Making and Shaping of the City.* Pretoria: University of South Africa Press.

Bocquier, P. (2008). Urbanisation in Developing Countries: Is the "Cities Without Slums" Target Attainable? *International Development Planning Review,* 30(1).

Bracken, P.J. (1998). Hidden Agendas: Deconstructing Post Traumatic Stress Disorder. In P.J. Bracken and C. Petty (Ed.), *Rethinking the Trauma of War.* London/New York: Save the Children/Free Association Books, pp. 38–59.

Bujra, J.M. (1975). Women "Entrepreneurs" of Early Nairobi. *Canadian Journal of African Studies,* 9(2), 213–234.

Busza, J. (2004). Sex Work and Migration: The Dangers of Oversimplification – A Case Study of Vietnamese Women in Cambodia. *Health & Human Rights,* 7(2), 231–249.

Busza, J., Castle, S., & Diarra, A. (2004). Trafficking and Health. *BMJ*, 328.

City of Johannesburg (2008). Draft Integrated Development Plan Review**.** Johannesburg.

Clark, S.J., Collinson, M.A., Kahn, K., Drullinger, K., & Tollman, S.M. (2007). Returning Home to Die: Circular Labour Migration and Mortality in South Africa. *Scandinavian Journal of Public Health*, 35(3 supp. 69), 35–44.

Coffee, M.P., Lurie, M., & Garnett, G. (2007). Modelling the Impact of Migration on the HIV Epidemic in South Africa. *Aids*, 21(3), 343–350.

Collinson, M.A., Wolff, B., Tollman, S.M., & Kahn, K. (2006). Trends in Internal Labour Migration from Rural Limpopo Province, Male Risk Behaviour, and Implications for the Spread of HIV/AIDS in Rural South Africa. *Journal of Ethnic & Migration Studies*, 32(4), 633–648.

Collinson, M.A. (2010). Striving against Adversity: The Dynamics of Migration, Health and Poverty in Rural South Africa. *Global Health Action*, DOI: 10.3402/gha.v3i0.5080.

Commission on the Social Determinants of Health (2007). A Conceptual Framework for Action on the Social Determinants of Health: Discussion Paper for the Commission on Social Determinants of Health DRAFT**.** Geneva: Commission on the Social Determinants of Health.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The Health and Health System of South Africa: Historical Roots of Current Public Health Challenges. *The Lancet*, 374(9692), 817–834.

CoRMSA (2009). Protecting Refugees, Asylum Seekers and Immigrants in South Africa**.** Johannesburg: CoRMSA.

Crush, J. (2005). Johannesburg, South Africa. Breaking with Isolation. In M. Balbo (Ed.), *International Migrants and the City.* Venice: UN-HABITAT and dipartmento di Pianificazione.

Crush, J., & Dodson, B. (2007). Another Lost Decade: The Failures of South Africa's Post-apartheid Migration Policy. *Tijdschrift Voor Economische En Sociale Geografie*, 98(4), 436–454.

Department of Health (DOH) (2006). Memo – Access to Comprehensive HIV and AIDS Care Including Antiretroviral Treatment. Pretoria: Department of Health.

Department of Health (DOH) (2007a). HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011. Pretoria: Department of Health.

Department of Health (DOH) (2007b). Revenue Directive – Refugees/ Asylum Seekers with or without a permit. In Department of Health (Ed.), *BI 4/29 REFUG/ASYL 8 2007***.** Pretoria.

dplg (2007). Framework for an Integrated Local Government Response to HIV and AIDS**.** Pretoria: dplg.

FMSP, & Musina Legal Advice Office (2007). ***S****pecial Report: Fact or Fiction? Examining Zimbabwean Cross-border Migration into South Africa.* Johannesburg: FMSP.

Forced Migration Studies Programme (2009). *Zimbabwean Migration into Southern Africa: New Trends and Responses.* University of the Witwatersrand.

Galea, S., & Vlahov, D. (2005). Urban Health: Evidence, Challenges, and Directions. *Annual Review of Public Health,* 26, 341–365.

Garenne, M. (2006). Migration, Urbanisation and Child Health: An African Perspective. In M. Tienda, S. Findley, S. Tollman, & E. Preston-Whyte (Eds.), *Africa on The Move: African Migration and Urbanisation in*

Comparative Perspective. Johannesburg: Wits University Press.

Ghent, A. (2008). Overcoming Migrants' Barriers to Health. *Bulletin of the World Health Organization,* 86(8), 583–584.

Gould, C., & Fick, N. (2008). *Selling Sex in Cape Town: Sex Work and Human Trafficking in a South African City.* Pretoria/Tswane: Institute for Security Studies.

Grove, N.J., & Zwi, A.B. (2006). Our Health and Theirs: Forced Migration, Othering and Public Health. *Social Science & Medicine,* 62: 1931–1942.

Gushulak, B., Weekers, J., & MacPherson, D.W. (2009). Migrants in a Globalized World – Health Threats, Risks and Challenges: An Evidence-based Framework. *Emerging Health Threats Journal,* 2:e10 doi: 10.3134/ehtj.09.010.

Harcourt, W. (2007). Editorial: Beyond Us and Them: Migration and Global Economic Development. *Development*, 50(4), 1–5.

Harper, I., & Raman, P. (2008). Less than Human? Diaspora, Disease and the Question of Citizenship. *International Migration,* 46(5), 3–26.

Harrison, P. (2006). Integrated Development Plans and Third Way Politics. In U. Pillay, R. Tomlinson, & J. du Toit (Eds.), *Democracy and Delivery. Urban Policy in South Africa.* Cape Town: HSRC Press.

Huchzermeyer, M. (2004). *Unlawful Occupation: Informal Settlements and Urban Policy in South Africa and Brazil.* Trenton: Africa World Press.

Human Rights Watch (2009a). Discrimination, Denial and Deportation: Human Rights Abuses Affecting Migrants Living with HIV, *1-56432-490-7.* New York: Human Rights Watch.

Human Rights Watch (2009b). No Healing Here: Violence, Discrimination and Barriers to Health for Migrants in South Africa, *1-56432-579-2.* New York: Human Rights Watch.

IOM, & UNAIDS (2003). Mobile Populations and HIV/AIDS in the Southern African Region. Recommendations for Action. *Desk Review and Bibliography on HIV/AIDS and Mobile Populations.* Geneva: IOM.

IOM (2008). *Migrants' Needs and Vulnerabilities in the Limpopo Province, Republic of South Africa, A Report by the International Organization for Migration.* Pretoria: IOM.

IOM (2010). Wolves in Sheep's Skin: A Rapid Assessment of Human Trafficking in Musina, Limpopo Province of South Africa. Prepared for IOM by Zosa De Sas Kropiwnicki. Pretoria: IOM.

Jacobsen, K., & Landau, L.B. (2003). The Dual Imperative in Refugee Research: Some Methodological and Ethical Considerations in Social Science Research on Forced Migration. *Disasters,* 27(3), 185.

Jacobsen, K. (2006). Refugees and Asylum Seekers in Urban Areas: A Livelihoods Perspective. *Journal of Refugee Studies,* 19(3), 273.

Karnataka Health Promotion Trust and Population Council. (2008). *Patterns of Migration/Mobility and HIV Risk among Female Sex Workers: Karnataka.* Bangalore: Karnataka Health Promotion Trust.

Kiwanuka, M. (2009). The Effect of Migration on Urban Migrant Women's Perceptions of Domestic Violence. *Forced Migration Studies Programme.* Johannesburg: University of the Witwatersrand.

Kok, P., & Collinson, M. (2006). *Migration and Urbanization in South Africa.* Pretoria: Statistics South Africa.

Konteh, F.H. (2009). Urban Sanitation and Health in the Developing World: Reminiscing the Nineteenth Century Industrial Nations. *Health and Place,* 15, 69–78.

Landau, L. (2004). *Forced Migrants in the New Johannesburg: Towards a Local Government Response.* Johannesburg: Forced Migration Studies Programme.

Landau, L. (2005a). Migration Trends, Management and Governance Challenges, *Testimony prepared for the ad hoc committee on Democracy and Good Political Governance.* Forced Migration Studies Programme.

Landau, L. (2005b). Urbanisation, Nativism, and the Rule of Law in South Africa's "Forbidden" Cities. *Third World Quarterly,* 26(7), 1115–1134.

Landau, L. (2006a). Transplants and Transients: Idioms of Belonging and Dislocation in Inner-City Johannesburg. *African Studies Review,* 49(2), 125–145.

Landau, L. (2006b). Protection and Dignity in Johannesburg: Shortcomings of South Africa's Urban Refugee Policy. *Journal of Refugee Studies*, 19(3), 308.

Landau, L., & Singh, G. (2008). Decentralisation, Migration and Development in South Africa's Primary Cities. In A. Wa Kabwe-Segatti, & L. Landau (Eds.), *Migration in post-apartheid South Africa. Challenges and Questions to Policy Makers. Notes and documents 38*: Agence Francaise de Developpment.

Landau, L., & Wa Kabwe-Segatti, A. (2009). Human Development Impacts of Migration: South Africa Case Study, *Human Development Research Paper 2009/5*: UNDP.

Landau, L.B. (2007). Discrimination and Development? Immigration, Urbanisation and Sustainable Livelihoods in Johannesburg. *Development Southern Africa,* 24(1), 61–76.

Lurie, M. (2000). Migration and AIDS in Southern Africa: A Review. *South African Journal of Science,* 96(6), 343–369.

Lurie, M.N., Williams, B.G., Zuma, K., Mkaya-Mwamburi, D., Garnett, G., Sturm, A.W., Sweat, M.D., Gittelsohn, J., & Abdool Karim, S.S. (2003). *The Impact of Migration on HIV-1 Transmission in South Africa: A Study of Migrant and Non-migrant Men and Their Partners. Sexually Transmitted Diseases,* 30(2), 149–156.

Lurie, M.N. (2006). The Epidemiology of Migration and HIV/AIDS in South Africa. *Journal of Ethnic & Migration Studies,* 32(4), 649–666.

MacPherson, D.W., & Gushulak, B.D. (2001). Human Mobility and Population Health: New Approaches in a Globalizing World. *Perspectives in Biology and Medicine,* 44(3), 390.

McCarthy, K., Chersich, M., Vearey, J., Meyer-Rath, G., Jaffer, A., Simpwalo, S., & Venter, W. (2009). Good Treatment Outcomes among Foreigners Receiving Antiretroviral Therapy in Johannesburg, South Africa. *International Journal of STD & AIDS,* 20(12), 858–862.

McNeill, P.M. (2003). Public Health Ethics: Asylum Seekers and the Case for Political Action. *Bioethics*, 17(5–6), 487–502.

Moyo, K. (2010). Street Level Bureaucracy: The Interface between Health Personnel and Migrant Patients at Hillbrow Community Health Centre, *Unpublished MA Thesis.* Forced Migration Studies Programme: University of the Witwatersrand.

MRC, INCA, & dplg (2007). *Handbook for Facilitating Development and Governance Responses to HIV/AIDS.*

MSF (2009). *No Refuge, Access Denied: Medical and Humanitarian Needs of Zimbabweans in South Africa.* Johannesburg: Medecins Sans Frontiers.

Mundandi, C., Vissers, D., Voeten, H., Habbema, D., & Gregson, S. (2006). No Difference in HIV Incidence and Sexual Behaviour between Out-migrants and Residents in Rural Manicaland, Zimbabwe. *Tropical Medicine and International Health,* 11(5), 705–711.

NDOH (2006). Memo – Access to Comprehensive HIV and AIDS Care Including Antiretroviral Treatment. Pretoria: Department of Health.

NDOH (2007a). HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011. Pretoria: Department of Health.

NDOH (2007b). Revenue Directive – Refugees/Asylum Seekers with or without a Permit. In Department of Health (Ed.), *BI 4/29 REFUG/ASYL 8 2007*. Pretoria.

Nel, E., & John, L. (2006). The Evolution of Local Economic Development in South Africa. In U. Pillay, R. Tomlinson, & J. Du Toit (Eds.), *Democracy and Delivery: Urban Policy in South Africa.* Cape Town: HSRC Press.

Palmary, I. (2005). Engendering the Trauma of War**.** Johannesburg: Centre for the Study of Violence and Reconciliation.

Palmary, I. and Nunez, L. (2009). Sanpad Research Project Forced Migration Studies Programme, SANPAD.

Pillay, U., Tomlinson, R., & du Toit, J. (2006). Introduction. In U. Pillay, R. Tomlinson, & J. du Toit (Eds.), *Democracy and Delivery: Urban Policy in South Africa.* Cape Town: HSRC Press.

Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat (2005). Trends in Total Migrant Stock: The 2005 Revision *Dataset http://esa.un.org/migration* (accessed 5 July 2009). New York: United Nations.

Pursell, R. (2004). Accessing Health Services at Johannesburg's Clinics and Hospitals. In L. Landau (Ed.), *Forced Migrants in the New Johannesburg: Towards a Local Government Response.* Johannesburg: The Foundation for Human Rights.

Pursell, R. (2006). Accessing Health Services at Johannesburg's Clinics and Hospitals. In L. Landau (Ed.), *Forced Migrants in the New Johannesburg: Towards a Local Government Response.* Johannesburg: The Foundation for Human Rights.

Reproductive Health Research Unit, Sociology of Work Unit University of the Witwatersrand, & Vrije University Amsterdam. (2002). *Women at Risk: A Study of Sex Work in Hillbrow.*

Richter, M. (2008). Sex Work, Reform Initiatives and HIV/AIDS in Inner-city Johannesburg. *African Journal of AIDS Research,* 7(3), 323–333.

Rights, Physicians for Human (2009). Health in Ruins; A Man-made Disaster in Zimbabwe. Executive Summary Emergency Report. Physicians for Human Rights.

SADC Directorate for Social and Human Development and Special Programs (2009). SADC Policy Framework for Population Mobility and Communicable Diseases in the SADC Region: Final Draft April 2009, *http://www.arasa.info/files/pub_SADC%20Policy_Framework_FINAL.pdf.* Gaborone: SADC Secretariat.

Shaeffer, R. (2009). *No Healing Here: Violence, Discrimination and Barriers to Health for Migrants in South Africa***.** Johannesburg: Human Rights Watch Report.

Southern African HIV Clinicians Society, & UNHCR (2007). Clinical Guidelines on Antiretroviral Therapy Management for Displaced Populations. South Africa.

Spiegel, P. (2004). HIV/AIDS among Conflict-affected and Displaced Populations: Dispelling Myths and Taking Action. ***Disasters***, 28(3), 322–339.

Spiegel, P., Bennedsen, A., Claass, J., Bruns, L., Patterson, N., Yiweza, D., & Shilperoord, M. (2007). Prevalence of HIV Infection in Conflict-affected and Displaced People in Seven sub-Saharan African Countries: A Systematic Review. *The Lancet,* 369(9580), 2187–2195.

The Republic of South Africa (1996). The Constitution of the Republic of South Africa – No. 108 of 1996: Pretoria.

The Republic of South Africa (1998a). The White Paper on Local Government: The Department of Constitutional Development: Pretoria.

The Republic of South Africa (1998b). Refugee Act - Act No. 130: Pretoria.

The Republic of South Africa (2002). Immigration Act - Act No. 13 of 2002: Cape Town.

The Republic of South Africa (2003). National Health Act - Act No. 61: Pretoria.

The Republic of South Africa (2004). Immigration Amendment Act - Act No. 19 of 2004: Cape Town.

Tomlinson, R., Beauregard, R., Bremner, L., & Mangcu, X. (2003). The Post-apartheid Struggle for an Integrated Johannesburg. In R. Tomlinson, R. Beauregard, L. Bremner, & X. Mangcu (Eds.), *Emerging Johannesburg: Perspectives on the Postaparthied City.* London and New York: Routledge.

UN (2000). United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Conventions against Transnational Organized Crime. New York: United Nations.

UNAIDS (2001). Population Mobility and AIDS, *Technical Update.* Geneva: UNAIDS.

UNAIDS (2008). Report on the Global HIV/AIDS Epidemic 2008, *UNAIDS/08.25E / JC1510E.*

UNDP (2009a). Human Development Report 2009. Overcoming Barriers: Human Mobility and Development. New York: United Nations Development Programme.

UNDP (2009b). Strengthening Cholera Preparedness and Response in South Africa. Narrative Report, *Regional Workshop to Strengthen Cholera Response.* Johannesburg, South Africa.

UNFPA (2007). State of the World Population 2007. *Unleashing the Potential of Urban Growth. New York: United Nations Population Fund.*

UNHCR, & AIDS & Human Rights Research Unit University of Pretoria (2006). *Asylum Seekers in South Africa and Their Rights to ARVs.*

UNOCHA, & FMSP (2009). *Distribution of Migrants in South Africa by District Municipality from 2001 to 2007.* Pretoria: UNOCHA.

Various authors (2002). Health, HIV and Sex Work: The Influence of Migration and Mobility. *Research for Sex Work,* 5.

Vearey, J. (2008a). Migration, Access to ART and Survivalist Livelihood Strategies in Johannesburg. *African Journal of AIDS Research,* 7(3), 361–374.

Vearey, J. (2008b). Health: A Focus on Cholera, TB and HIV. In T. Polzer (Ed.), *Zimbabwe–South Africa Futures Conference,* December 2008.

Vearey, J., Nunez, L., & Palmary, I. (2009). HIV, Migration and Urban Food Security: Exploring the Linkages, *RENEWAL – Regional Network on AIDS, Livelihoods and Food Security. South Africa Report.* http://www.ifpri.org/renewal/pdf/JohannesburgFinal.pdf: RENEWAL and Forced Migration Studies Programme, University of the Witwatersrand.

Vearey, J. (2010). Hidden Spaces and Urban Health: Exploring the Tactics of Rural Migrants Navigating the City of Gold. *Urban Forum,* 10.1007/s12132-010-9079-4 (published online, 9 February 2010).

Vearey, J., Palmary, I., Nunez, L., & Drime, S. (2010). Urban Health in Johannesburg: The Importance of Place in Understanding Intra-urban Inequalities in a Context of Migration and HIV. *Health and Place,* in press.

Vigneswaran, D. (2007). Lost in Space: Residential Sampling and Johannesburg's Forced Migrants, *Migration Methods and Field Notes #4:* Forced Migration Studies Programme, University of the Witwatersrand.

Vigneswaran, D. (2008). Undocumented Migration: Risks and Myths (1998–2005). In A. Wa Kabwe-Segatti, & L. Landau (Eds.), *Migration in Post-apartheid South Africa: Challenges and Questions to Policy-makers. Notes and Documents Number 38:* Agence Francaise de Development.

WHO (2008a). *Our Cities, Our Health, Our Future: Acting on Social Determinants for Health Equity in Urban Settings.* Geneva: Commission on the Social Determinants of Health.

WHO (2008b). *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health.* Geneva: Commission on Social Determinants of Health.

World Health Assembly (2008). Resolution 61.17 "Health of Migrants" *A61/VR/8 Sixty-first World Health Assembly.* Geneva: WHA.

Worth, H. (2006). Unconditional Hospitality: HIV, Ethics and the Refugee "Problem". *Bioethics,* 20(5), 223–232.

Zlotnick, H. (2006). The Dimensions of Migration in Africa. In M. Tienda, S. Findley, S. Tollman, & E. Preston-Whyte (Eds.), *Africa on the Move.* Johannesburg: Wits University Press, pp. 15–37.

Boxes, Figures and Tables

Boxes

Figures

Tables

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