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HIV/AIDS, Population Mobility and Migration in Southern Africa

Defining a Research and Policy Agenda

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LIST OF ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrom
ART	Anti-Retroviral Therapy
CIDA	Canadian International Development Agency
CSW	Commercial Sex Worker
DFID	The United Kingdom Department for International Development
GAP	Governance and AIDS Programme
HIV	Human Immunodeficiency Virus
Idasa	Institute for Democracy in South Africa
IDPs	Internally Displaced Persons
IOM	International Organization for Migration
KAP	Knowledge Attitudes and behavioural Practices
PLWHA	People living with HIV/AIDS
SADC	Southern African Development Community
SAMP	Southern African Migration Project
SANDF	South African National Defence Force
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UNAIDS	United Nations Programme on HIV/AIDS
UNHCR	The United Nations High Commission for Refugees

FOREWORD

As part of their overall collaboration on research under IOM's regional Partnership on HIV/AIDS and Mobile Populations (PHAMSA),¹ the International Organization for Migration (IOM) Regional Office for Southern Africa and the Southern African Migration Project (SAMP)² organized a regional workshop to bring together researchers and other stakeholders to brainstorm about research focused on the linkages between HIV/AIDS, population mobility and migration in Southern Africa. The workshop entitled "Research priority setting on HIV/AIDS, population mobility and migration in Southern Africa" was held on 22 and 23 November 2004 in Cape Town, South Africa.

Forty participants including researchers in the fields of migration and HIV/AIDS attended from all over the world. Also present were a trade union representative, and representatives from IOM, SAMP and the Netherlands' Embassy (see annex A).

This workshop was funded by the Regional HIV/AIDS Programme for Southern Africa of the Netherlands' Embassy in Pretoria. The Canadian International Development Agency (CIDA) and the UK Department for International Development (DFID), through their support to the Southern African Migration Project, sponsored the participation of the seven participants from SAMP.

The aims of the workshop were as follows:

1. To review past research:

- To define gaps in research on HIV/AIDS, population mobility and migration in Southern Africa;
- To critically review past approaches and methodologies in this research;
- To make an inventory of how research has resulted in policy recommendations and has been linked to existing programmes and policies.

2. To define future strategies:

- To set priorities in research on HIV/AIDS, population mobility and migration in Southern Africa;

¹ For more information on PHAMSA please visit www.iom.org.za/PHAMSA.html

² For more information on SAMP please visit www.queensu.ca/samp

- o To develop strategies to strengthen linkages between the research community and policy makers in order to better operationalize research outcomes into policies and programmes.

3. To improve communication:

- o To provide a discussion and networking platform for key stakeholders involved in research on HIV/AIDS, population mobility and migration in Southern Africa during the workshop and through an email network after the workshop.

The discussions during the workshop were divided into the following three themes, which guided the plenary presentations and breakaway group discussions that took place during both days:

- I: Review of research on HIV/AIDS, population mobility and migration in Southern Africa
- II: Review of methodologies used in research on the link between HIV/AIDS, Population Mobility and Migration
- III: Review the link between research and policy development

In preparation for the workshop, and to facilitate the discussions during the workshop, a background paper was produced. The purpose of this background paper was to:

- Examine major changes in mobility and migration (cross-border and internal) within and to Southern Africa;
- Review the state of knowledge of reciprocal connections between population mobility and HIV/AIDS;
- Assess the different research methodologies used to address population mobility and HIV linkages; and
- Examine the extent to which population mobility has been configured into policy thinking, dialogue and plans for HIV/AIDS.

This report “HIV/AIDS, Population Mobility and Migration in Southern Africa, Defining a Research and Policy Agenda” combines the background paper with the recommendations that came out of the workshop. We hope that this report will encourage stronger operational responses in terms of research, policy development and programmes to reduce the vulnerability of migrant and mobile populations to HIV infection.

In commending this publication to a wider readership, we would like to thank the Regional HIV/AIDS Programme for Southern Africa of the Netherlands' Embassy in Pretoria for its generous financial support for the development and printing of this paper.



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INTRODUCTION

The severity of the HIV epidemic in Southern Africa cannot be overstated. Globally, there are an estimated 43 million people infected with HIV. Some 25 million people infected with HIV, 66 per cent of the global burden, live in sub-Saharan Africa.³ Within sub-Saharan Africa, the countries of Southern Africa are the worst affected. The reason why the epidemic is particularly virulent in Southern Africa is still unclear. A number of different factors have been advanced to explain the general picture of HIV and AIDS in Southern Africa including its rapid spread, high HIV prevalence and uneven distribution.⁴ They include poverty and economic marginalization; differing strains of HIV; high rates of sexually transmitted infections (STIs) and other opportunistic infections; sexual networking and patterns of sexual contact, including high levels of concurrent sexual partners; the absence of male circumcision; and the role of core-groups such as commercial sex workers. But perhaps the key neglected factor in explaining the rapid spread of HIV over the last decade is population mobility. The social economy of mobility comprises a set of complex and interconnected factors that help to explain the high burden of HIV and AIDS faced by Southern African countries.⁵

Although both mobility and HIV have been exhaustively and separately examined in Southern Africa, we are still far from understanding just how mobility and HIV interact. Part of the reason is that studies of migration and disease tend to concentrate on the urban or "receiving" areas with much less attention being paid to people living in the rural or "sending" areas, or people "on the move" between the two. Furthermore, there have been few well-designed epidemiological studies documenting the relationship between migration and infectious diseases. Even more important, at this late stage in the Southern African HIV epidemic, there have been few intervention programmes, even on a small scale, which specifically

³ UNAIDS, 2004 Report on the global AIDS epidemic.

⁴ Macdonald, D.S., 'Notes on the Socio-economic and Cultural Factors Influencing the Transmission of HIV in Botswana', *Social Science and Medicine*, 42(9) (1996): 1325-33; Williams, B. and C. Campbell, 'Understanding the Epidemic of HIV in South Africa: Analysis of the Antenatal Clinic Survey Data', *South African Medical Journal*, 88(3) (1998): 247-51; Barnett, T. and A. Whiteside, *AIDS in the Twenty- First Century* (New York: Palgrave, 2002); Kalipeni, E., et al., (eds.), *HIV and AIDS in Africa* (Oxford: Blackwell, 2004).

⁵ Crush, J., et al., 'Spaces of Vulnerability: Migration and HIV/AIDS in South Africa', *Development Southern Africa* (in press).

attempt to reduce transmission among migrants and their rural or urban partners.⁶

From a research perspective, the connections between population mobility and HIV are more difficult to unravel because the disease arrived in the region at a time when population mobility and systems of migration were undergoing rapid transformation.⁷ Population mobility is, by its very nature, highly dynamic and has changed dramatically in scope, scale and diversity over the last two decades. Recent migration trends in Southern Africa will be discussed in Section 1.

Today it is certainly much more difficult to map the connections between disease and mobility than it was in the past. The vulnerability to HIV infection of people (migrant and non-migrant, mobile and relatively immobile) associated with Southern Africa's changing regime of mobility is poorly understood. The evidence seems to suggest that migrants and migrant households are particularly at risk.⁸ So too are the residents of non-migrant communities with whom migrants interact on a daily basis.⁹ The linkages between HIV and population mobility and a review of research done on this link will be discussed in Section 2.

The links between HIV and mobility have their roots in social and economic structures – to thoroughly understand these connections, we must explore the unique structural forces at play in Southern Africa's major migrant-employing industries and the movement regimes of non employment-related migration. Population movement in the Southern African region now takes many and increasingly complex forms. Indeed there are many different “types” of migration and each may carry different levels of risk for HIV and

⁶ Campbell, C. and B. Williams, 'Riding the Tiger: Contextualising HIV Prevention in South Africa', *African Affairs*, 100 (2001): 135-40; Campbell, C. and Y. Mzaidume, 'How can HIV be Prevented in South Africa? A Social Perspective', *British Medical Journal*, 324 (2002): 229-32.

⁷ McDonald, D. (ed.), *On Borders: Perspectives on the International Migration in Southern Africa* (New York and Cape Town: St Martin's Press and SAMP, 2000).

⁸ Lurie, M., *Migration and the Spread of HIV in South Africa*, (Baltimore, MD: Ph.D thesis, Johns Hopkins University School of Hygiene and Public Health, 2001).

⁹ Auvert, B., et al., 'HIV Infection Among Youth in a South African Mining Town is Associated with Herpes Simplex Virus-2 Sero-positivity and Sexual Behaviour', *AIDS*, 15 (2000):885-96; Williams, B., et al., *The Natural History of AIDS in South Africa: A Biomedical and Social Survey in Carletonville* (Johannesburg: CSIR, 2000); Campbell, C. and C. MacPhail, 'Peer Education, Gender and the Development of Critical Consciousness: Participatory HIV Prevention by South African Youth', *Social Science and Medicine*, 55(2) (2002):331-45; Eaton, L., et al., 'Unsafe Sexual Behaviour in South African Youth', *Social Science and Medicine*, 56(1) (2003):149-65.

other STIs. Section 3 presents an overview of the different groups of migrants and how each group is at increased risk of HIV infection. Some of these groups, like mine workers and transport workers, have been researched extensively in the region, while other groups like agricultural workers, construction workers, domestic workers, informal traders, commercial sex workers, members of military, and refugees have not been the subject of much HIV related research.

Section 4 describes the, often, missing link between research and policy development. Research findings should ideally feed into the development of new policies and programmes. This section looks at the different types of policies in the region and at what levels policy development takes place.

During the workshop "Research priority setting on HIV/AIDS, population mobility and migration in Southern Africa" that was held on 22 and 23 November 2004 a number of research gaps and recommendations for future research on the link between HIV and Migration were identified. These include recommendations on research methodologies and how to close the gap between the research community and the policymakers.

SECTION 1: MIGRATION TRENDS IN SOUTHERN AFRICA

Across Southern Africa (and the African continent more generally), people are engaged in a multiplicity of forms of movement. Forms of mobility vary in terms of their spatial, temporal and social characteristics as well as their motive and purpose. In a context of high economic and environmental uncertainty, as well as political instability in some countries, to seek income opportunities in multiple locations and different economic sectors is a sound risk-management strategy. For many, livelihoods are based increasingly on mobility. Informal traders, for example, are found practically throughout the continent, and trading networks are increasingly international and long-distance.¹⁰

Truck drivers, almost all of them men, transport goods over long distances, often across international borders. Seasonal migrant workers are common, especially in the agricultural sector, and many people move seasonally between a rural and an urban base.¹¹ Such migration can be either internal or international (and if the latter, either legal or irregular). There are also systems of formalized migrant labour in Southern Africa, where men from countries such as Lesotho and Mozambique, as well as from rural South Africa, leave their families for employment on the South African mines. In addition to the above forms of “structural” migration, there are also “contingent” migrants, which include refugees and internally displaced persons (IDPs) forced from their homes by war, natural disaster or both.

Such high levels of mobility across the socio-economic spectrum create spatially fluid households and families “stretched” across space in both rural and urban areas, or even living in different countries. Multi-local households, with considerable to-and-fro movement between them, are the norm rather than an aberration. This gives rise to various forms of circular and return migration; for example, as household members move between rural and urban bases to exchange goods, labour, money and other means of mutual support.

¹⁰ Peberdy, S., 'Mobile Entrepreneurship: Informal Sector Cross-border Trade and Street Trade in South Africa', *Development Southern Africa*, 17(2) (2000): 201-19.

¹¹ Crush J., et al., *Borderline Farming: Migrants in South African Commercial Agriculture* (SAMP, Migration Policy Series No. 16, 1999).

Given this complexity, it is difficult to point to clear trends in African migration. General migration trends can, nevertheless, be identified for the past two or three decades as the following:

- Rapid urbanization. In 1970, Africa's urban population was around 82 million people, or 23 per cent of the continent's population; by 2000, 295 million Africans, or 37 per cent of the population, lived in urban areas;
- Feminization of migration. More and more women are migrating independently. This is true of both internal and international migration;¹²
- Changing geography of migration. To long-established sources, routes and destinations, new ones have been added. For example South Africa has seen a significant increase in international migration since the end of Apartheid, with people coming into the country from all over the African continent;¹³
- Increased access to transportation, for example through expanded road networks and the burgeoning minibus taxi industry, has improved personal mobility and enabled movement across longer distances and to a wider range of destinations.
- Political instability and environmental catastrophes. At different times in different countries, political turmoil has led to internal as well as international displacement of people. Environmental catastrophes and famines have also led to major episodic human migrations;
- Migration of skilled workers. Through the brain drain, Africa faces a significant loss of its skills base as skilled professionals take advantage of opportunities arising from globalization and immigration policies of industrial countries. The brain drain is depleting the skills base of SADC countries.¹⁴ The impact is particularly acute in the public health sector where migration is

¹² Dodson, B., 'Porous Borders: Gender and Migration in Southern Africa', *South African Geographical Journal*, 82 (2000): 40-6.

¹³ McDonald, *On Borders*.

¹⁴ McDonald, D. and J. Crush, eds., *Destinations Unknown: Perspectives on the Brain Drain in Southern Africa* (Pretoria: Africa Institute, 2002).

undermining the ability of health systems to cope with the burden of HIV/AIDS.¹⁵

- International migration. Some movements of people take place within national borders, but there is also significant and increasing international migration, both across borders within Africa and from Africa to countries outside the continent, especially in Europe;

Future trends are difficult to predict, but high levels of mobility are already well established and are likely to further increase. More people are likely to go more often to more places. Countries that see positive social, political and economic change will see increased migration into their countries, as people pursue socio-economic opportunities. Countries that see negative social, political and economic developments will see increased migration for a different set of reasons, as people escape poverty or danger. HIV and AIDS itself will also impel people to migrate which will be discussed in Section 2.5.¹⁶

Within Southern Africa, patterns of internal and cross-border mobility have changed considerably over the last three decades and are likely to continue to do so in the future. With regard, first, to contract labour migration, there have been major shifts since the 1970s. Mining and commercial agriculture tend to employ contract workers, although many undocumented migrants also work in commercial agriculture. The South African gold mining industry employs migrant mine workers from South Africa, Botswana, Mozambique, Lesotho and Swaziland. The mining sector has seen changes of the last couple of years, with increased number of retrenchments and a growth in sub-contracting. Miners working for sub-contractors have experienced a marked decline in wages, working conditions and job security.

¹⁵ Gaidzanwa, R., *Voting with Their Feet: Migrant Zimbabwean Nurses and Doctors in the Era of Structural Adjustment* (Uppsala: Nordiska Afrikainstitute, 1999); Chikanda, A. 'Skilled Health Professionals' Migration and Its Impact on Health Delivery in Zimbabwe' In R. Cohen, ed., *Migration and Health in Southern Africa* (Cape Town: Van Schaik, 2003): 114-25; OECD, 'The International Mobility of Health Professionals: An Evaluation and Analysis Based on the Case of South Africa' Trends in International Migration 2003 Edition (OECD, 2004); Chikanda, A. *Medical Leave: The Exodus of Health Professionals from Zimbabwe* (SAMP, Migration Policy Series No. 34, 2005).

¹⁶ Young L. and N. Ansell, 'Fluid Households, Complex Families: The Impacts of Children's Migration as a Response to HIV/AIDS in Southern Africa', *Professional Geographer*, 55(4) (2003): 464-79

In households affected by retrenchment, other family members have often left in search of employment (including female family members).¹⁷

Although most attention is paid to the gold mines, the majority of migrant workers are employed in other sectors. Migrants work in manufacturing, agriculture, construction and services and, in the case of women, domestic service.¹⁸ Indeed, while single-sex hostels are discussed almost exclusively in relation to gold mines, they are common outside of the mining industry as well. Developments in the transportation industry and the removal of barriers such as influx controls have also had a significant impact on the patterns of migrants, making them much more mobile than in the past. While Mozambican migrants still follow the old pattern and tend to return home once a year, other migrants have effectively become long-distance commuters.¹⁹ For example, 60 per cent of the Basotho migrant miners now return home at least once a month.²⁰ On the one hand, this could lessen the pressures for migrants and their spouses to engage in extra-marital relationships. On the other, it means that the rural areas are far less "insulated" from HIV than before.

The collapse of Apartheid in South Africa brought new opportunities and reasons for migration across borders within the region. Migrants from neighbouring countries and further a field see South Africa as a place to trade, shop, seek essential services, be educated, work and seek asylum. The number of people crossing South Africa's borders in both directions has increased significantly since 1990. The African continent is now South Africa's major source of tourists who, on average, spend more money in the country than their western counterparts.²¹ Dramatically increased cross-border movement is not confined to South Africa and its neighbours. Throughout the region, border posts are experiencing increased flows. Not only does the

¹⁷ Crush, J. and W. James, eds., *Crossing Boundaries: Mine Migrancy in a Democratic South Africa* (Cape Town: IDASA, 1995); Crush, J. et al., 'Undermining Labour: The Rise of Sub-Contracting in South African Gold Mines' *Journal of Southern African Studies* 27 (2001): 5-32.

¹⁸ Crush, J. 'The Discourse and Dimensions of Irregularity in Post-Apartheid South Africa', *International Migration*, 37 (1999): 125-51.

¹⁹ de Vletter, F., 'Labour Migration to South Africa: The Lifeblood for Southern Mozambique' in D. McDonald, (ed.), *On Borders: Perspectives on the International Migration in Southern Africa* (New York and Cape Town: St Martin's Press and SAMP, 2000).

²⁰ Gay, J., 'Riding the Tiger: Lesotho Miners and Permanent Residence in South Africa', SAMP, Migration Policy Series No. 2, 1997.

²¹ Rogerson, C. 'The Rise of African Tourism to South Africa', SAMP, Migration Policy Briefs No. 13, (2004)

greater volume of movement have implications for the spread of disease, border-crossings have in itself become HIV “hotspots”. At border crossings, shack settlements and truck-stops spring up, traders and truckers sometimes have to wait for long periods of time before being allowed to cross which might attract commercial sex workers, and in some cases, border and customs officials demand sexual favours from border-crossers in exchange for rapid and/or duty-free transit.²²

One of the main reasons for increased commercial border traffic is the growth in cross-border formal and informal trade across Southern Africa.²³ Formal trade within the sub-continent has grown exponentially since 1994, with goods carried mainly by long-distance truckers. Informal cross-border trading has also expanded dramatically. Trading is highly gendered, with women playing a major role in the buying and selling of goods across international boundaries throughout the region.

1.1 Feminization of migration

Ordinary women are becoming considerably more mobile in Southern Africa, migrating for formal and informal work in ever-growing numbers and travelling more frequently for a variety of reasons. The structural mechanisms and social milieu of female migration is highly dependent on the line of work being pursued.²⁴ While women move in order to escape economic deprivation, lack of education often restricts them to unskilled jobs such as commercial sex work, informal trading, agricultural labour, or domestic work. A recent cross-sectional survey carried out in a rural area of KwaZulu-Natal Province, South Africa, found that about one-third of adult women were migrants at the time of the survey but unlike their male counterparts, female migrants tended to stay closer to home, and were therefore able to return home more frequently.²⁵ Studies in Lesotho have shown how increasing retrenchments on the gold mines

²² Wilson, D., 'Prevention of HIV Infection through Peer Education and Condom Promotion Among Truck Drivers and their Sexual Partners in Tanzania, 1990-93', *AIDS Care*, 12 (2000): 27-40; Wilson, D. et al., 'Corridors of Hope in Southern Africa: HIV Prevention Needs and Opportunities in Four Border Towns', *Family Health International* (2000).

²³ Peberdy, S., 'Mobile Entrepreneurship.'

²⁴ Dodson, B., 'Women on the Move: Gender and Cross-Border Migration to South Africa from Lesotho, Mozambique and Zimbabwe' In D. McDonald, (ed.), *On Borders: Perspectives on the International Migration in Southern Africa*, St Martin's Press and SAMP, 2000).

in particular have led to an increase in migration by Basotho women seeking work on South African farms.²⁶ There has also been a marked increase of impoverished rural women moving to towns across the region. Common income-earning strategies include beer brewing and commercial sex-work, often in combination.

1.2 Irregular Migration

Irregular migration has increased in virtually every country in Southern Africa over the last decade. Irregular migration is generally economically motivated and short-term in nature.²⁷ Most irregular migrants are from within Southern Africa but since 1990 migrants from other parts of Africa have started to move to the southern part of the continent as well. Many irregular migrants work in the informal sector and tend to cluster in commercial agriculture, construction and services. Most of the countries in the Southern African Development Community (SADC) deport irregular migrants. These deportations have ensured a large and continuous return of people to their home countries. From South Africa, for example, over 1 million migrants have been deported since 1994, mostly to Mozambique and Zimbabwe.²⁸ The established wisdom is, however, that a significant number of those deported find a way back into the country creating a form of involuntary-voluntary circulation of people.

Trafficking of women and children

The irregular migration of women and children in the region takes the form of trafficking and smuggling, sometimes as a result of political instability or conflict. The majority of women caught in a trafficking scheme become indentured to the sex industry and are forced to pay

²⁵ Lurie, M., et al., 'Circular Migration and Sexual Networking in Rural KwaZulu-Natal: Implications for the Spread of HIV and Other Sexually Transmitted Diseases', *Health Transition Review* 7 (supplement 3) (1997): 17-27; Lurie, M., et al., '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) (2003): 149-56; Lurie, M., et al., 'Who Infects Whom? HIV-1 Concordance and Discordance Among Migrant and Non-Migrant Couples in South Africa', *AIDS*, 17 (2003): 2245-52.

²⁶ Crush, J. and T. Ullicki, 'Gender, Farmwork and Women's Migration from Lesotho', in J. Crush and D. McDonald, (eds.), *Transnationalism and New African Immigration to South Africa* (Toronto: CAAS, 2001); I. Kimane et al, 'How Can You Tell the Sun Not to Shine? Knowledge, Attitudes and Practices of Basotho Migrants in Relation to HIV/AIDS and Sexually Transmitted Infections', Maseru: Sechaba Consultants, (2004).

²⁷ Crush, J., 'Discourse and Dimensions of Irregularity.'

²⁸ Ibid.

off an inordinate debt. Research done by IOM in 2003 found that the human trafficking routes in Southern Africa occur between neighbouring countries, within countries themselves, and from countries in this region to other areas of the world.²⁹ Furthermore, South Africa was found to be a frequent destination for victims of trafficking because of its relative wealth and therefore, market for sex workers. For example, an estimated 1,000 Mozambican women are trafficked into the Johannesburg sex industry every year.

Promises of work and educational opportunities in South Africa lure impoverished women not only from countries in Southern Africa but also from other countries such as China, Thailand, and Eastern Europe. In all of these arrangements, the women are coerced into debts that must be paid off through sex work. The IOM study also reported that there have been cases where male refugees in Cape Town, South Africa, have recruited female family members (girlfriends, nieces, cousins) by deception (false offers of employment) from their home countries (Burundi, DRC, Angola, Rwanda and Ethiopia) to be sexually exploited in South Africa.³⁰ Desperation makes women from refugee-producing countries highly vulnerable to the deceptive recruitment tactics of traffickers, particularly male family relations. The sexual exploitation of these women compromises their health and makes them highly vulnerable to sexually transmitted infection, including HIV.

²⁹ Martens, J. et al, *Seduction, Sale and Slavery: Trafficking of Women and Children for Sexual Exploitation in Southern Africa* (Pretoria: IOM, 2003).

³⁰ Ibid

SECTION 2: CONNECTING POPULATION MOBILITY AND HIV

The social, economic and demographic impact of AIDS has already started to be felt throughout Southern Africa. By the year 2010, life expectancy is projected to fall in most SADC countries. While countries in this region experience similarly devastating levels of HIV prevalence, they vary significantly in terms of development, wealth, and political stability. Countries with the highest incidence of HIV are not necessarily the poorest. Botswana, with an adult HIV prevalence rate of 37.3 per cent at the end of 2003,³¹ has had a stable, democratic government and a relatively strong economy since its independence in 1966. Also, South Africa presents a striking case, with an HIV adult prevalence rate of 21.5 per cent³² in 2003, despite its role as the economic powerhouse of the region.

2.1 Social perspectives on the link between population mobility and HIV

The inter-connectedness of mobility and disease has long been recognized, and there is no a priori reason why HIV should be any different.³³ Migration in Southern Africa in its modern form dates back to the mid-nineteenth century and was institutionalized and closely regulated by governments for much of the twentieth century. Labour migration to the South African gold mines from some other countries in the region³⁴ was halted for several decades because pneumonia on the mines was decimating workers from warmer climates.³⁵ Other scholars have detailed the way in which the migration of men between urban and rural areas led to the spread of tuberculosis in South Africa during the early part of the 20th century.³⁶

³¹ UNAIDS, 2004 Report on the global AIDS epidemic.

³² *Ibid*

³³ Callahan, B.T. and V. Bond, 'The Social, Cultural and Epidemiological History of Sexually Transmitted Diseases in Zambia', In P. Setel, M. Lewis and M. Lyons (eds.), *Histories of Sexually Transmitted Diseases and HIV/AIDS in Sub-Saharan Africa* (Westport, Connecticut: Greenwood Press, 1999); Jeeves, A. (ed.), *Histories of Reproductive Health and the Control of Sexually Transmitted Disease in Southern Africa*. Special Issue of the *Southern African Historical Journal* 45 (2001).

³⁴ Countries situated north of 20 degrees

³⁵ Jeeves, A., *Migrant Labour in South Africa's Mining Economy* (Montreal and Kingston: McGill-Queens Press, 1985).

³⁶ Packard, R., *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa* (Berkeley: UC Press, 1987).

Francis Wilson has argued more broadly that the system of housing male migrants in hostels away from their wives and families led to social and health dysfunctional behaviour including “family break-ups, bigamy, prostitution, alcoholism, violence, corruption, venereal disease, tuberculosis and malnutrition.”³⁷ With regard to STIs, as long ago as 1949, Kark suggested that the widespread prevalence of gonorrhoea and syphilis in both urban and rural areas of South Africa was a consequence of the migrant labour system.³⁸ Jochelson confirmed this argument, suggesting that the migrant labour system “facilitated the transmission of venereal and endemic syphilis to new regions, and into communities without previous exposure to disease”.³⁹

Several attempts have been made to link human migration to the continental spread and prevalence of HIV.⁴⁰ In the main, this literature tracks the diffusion of HIV in relation to major transport arteries and migration routes. Others have sought to explain spatial variation in HIV prevalence within and between countries and rural and urban areas.

There are at least four key ways in which mobility is tied to the spread of HIV:⁴¹

1. Mobility per se can encourage or make people vulnerable to high-risk sexual behaviour;
2. Mobility makes people more difficult to reach, whether for prevention education, condom provision, HIV testing, or post-infection treatment and care;
3. Migrants' multi-local social networks create opportunities for sexual networking; and

³⁷ Wilson, F., *Migrant Labour in South Africa* (Johannesburg, 1972).

³⁸ Kark, S., 'The Social Pathology of Syphilis in Africans', *South African Medical Journal* 23 (1947): 77-84.

³⁹ Jochelson, K., *The Colour of Disease: Syphilis and Racism in South Africa, 1880-1950* (London: Palgrave, 2001).

⁴⁰ Hunt C., 'Migrant Labour and Sexually Transmitted Disease: AIDS In Africa', *Journal of Health and Social Behaviour*, 30 (1989): 353-73; Haour-Knipe M. and R. Rector (eds.) *Crossing Borders: Migration, Ethnicity and AIDS* (London: Taylor and Francis, 1996); Auvert, B., et al., 'Sexual Behaviour, Heterosexual Transmission, and the Spread of HIV in Sub-Saharan Africa: A Simulation Study', *Computers and Biomedical Research*, 33 (2000): 84-96; Kalipeni, E., et al., 'Mapping the AIDS Epidemic in Eastern and Southern Africa: A Critical Overview', in E. Kalipeni, et al., *HIV and AIDS in Africa* (Oxford: Blackwell, 2004): 58-69; M. Lyons, 'Mobile Populations and HIV/AIDS in East Africa' in E. Kalipeni, et al., *HIV and AIDS in Africa*: 175-90.

⁴¹ Dodson, B. and J. Crush, 'Mobile 'Deathlihoods': Migration and HIV/AIDS in Africa', Paper for the UNAIDS Project 'AIDS in Africa; Scenarios for the Future', 2003.

⁴² Zuma, K., et al., 'Risk Factors for HIV Infection Among Women in Carletonville, South Africa: Migration, Demography and Sexually Transmitted Diseases', *International Journal of STD and AIDS*, 14 (2003): 814-17.

4. There is a higher rate of HIV infection in “communities of the mobile”, which often include socially, economically and politically marginalized people.⁴²

There is growing empirical evidence of the link between HIV and population mobility. In East Africa, the incidence of HIV is higher near roads, and amongst people who either had a personal migration experience or have sexual partners who are migrants.⁴³ In Southern and West Africa, migrant workers (and their sexual partners) have higher levels of infection than the general population.⁴⁴ For example, itinerant traders and long-distance truck drivers have shown to be at increased risk to contract HIV infection.⁴⁵ Border towns have high rates of HIV prevalence, being places where transient populations such as truck drivers encounter a more stable local population, and which are often not reached by national HIV and AIDS intervention programmes.⁴⁶

In a study of male factory workers in Zimbabwe, HIV positive men were more likely to live apart from their wives and have multiple sexual partners than HIV negative men.⁴⁷ In South Africa, high rates of STIs have been found among mine workers on the gold mines.⁴⁸ In a study of HIV prevalence in a rural KwaZulu-Natal community,

⁴³ Brockerhoff, M. and A. Biddlecom, 'Migration, Sexual Behaviour and the Risk of HIV in Kenya' *International Migration Review* 33 (1999): 833-56.

⁴⁴ Anarfi, J., 'Sexuality, Migration and AIDS in Ghana: A Socio-Behavioural Study' *Health Transition Review* 3 (1993): 45-67; Pison, G., et al., 'Seasonal Migration: A Risk Factor for HIV in Rural Senegal' *Journal of Acquired Immune Deficiency Syndromes* 6 (1993): 196-200; Nunn, A. et al., 'Migration and HIV-1 Seroprevalence in a Rural Ugandan Population', *AIDS* 9 (1995): 503-6.

⁴⁵ Wilson, D. et al., *Corridors of Hope in Southern Africa: HIV Prevention Needs and Opportunities in Four Border Towns* (Arlington, Virginia: Family Health International, 2000).

⁴⁶ Carswell, J. et al., 'Prevalence of HIV-1 in East African Lorry Drivers' *AIDS* 3 (1989): 503-6; Wilson, D., et al., 'Ethnographic and Quantitative Research to Design a Community Intervention Among Long-Distance Truck Drivers in Zimbabwe', In *Focusing Interventions Among Vulnerable Groups for HIV Infection: Experiences from Eastern and Southern Africa* (Nairobi: NARESA, 1994); Nunn, A., et al., 'HIV-1 Infection in a Ugandan Town on the Trans-African Highway: Prevalence and Risk Factors', *International Journal of STI's and AIDS* 7 (1996): 123-30; Wilson, D., 'Prevention of HIV Infection through Peer Education and Condom Promotion Among Truck Drivers and their Sexual Partners in Tanzania, 1990-93', *AIDS Care*, 12 (2000):27-40; Wilson, D. et al., *Lesotho and Swaziland: HIV/AIDS Risk Assessment at Cross-border and Migrant Sites in Southern Africa* (Arlington, Virginia: Family Health International, 2001).

⁴⁷ Mbizvo M.T., et al., 'HIV Sero incidence and Correlates of Seroconversion in a Cohort of Male Factory Workers in Harare, Zimbabwe', *AIDS*, 10 (1996):895-901.

⁴⁸ Day, J.H., et al., 'Integrated HIV Prevention and Care: Experience from the South African Mining Industry', *AIDS Bulletin*, 9(4) (2000).

⁴⁹ Lurie, M., et al., 'Circular Migration and Sexual Networking in Rural KwaZulu-Natal: Implications for the Spread of HIV and Other Sexually Transmitted Diseases', *Health Transition Review* 7 (supplement 3)(1997): 17-27.

people who had recently changed their place of residence were three times as likely to be HIV infected than those who had not.⁴⁹

The current geography of the HIV epidemic is also the clue to its link with mobility. The highest incidence is not in Africa's poorest countries, but in Southern African countries such as South Africa and Botswana which have a good transport infrastructure, relatively high levels of economic development, and considerable internal and cross-border migration.

2.2 The impact of HIV and AIDS on migrant sending areas

A central assumption in much of the research on migration and infectious disease is the uni-directionality of transmission.⁵⁰ It has long been assumed that the primary way in which migration contributed to the spread of HIV into rural areas was through migrant men, who had become infected while working in the urban areas, and return to the rural areas where they would infect their partners. It is very likely that this pattern was particularly true in the early stages of the HIV epidemic, where urban areas, and particularly migratory destinations were the areas of high HIV transmission. However, the precise way in which migration contributes to the spread of HIV and other STIs in rural areas is far more complex and not well understood. This is partly because few studies have considered both ends of the migration process, to focus on migrants who leave home as well as their families who remain behind.

One study in KwaZulu-Natal set out to measure whether migrants were at higher risk for HIV than non-migrants, and to quantify the extent to which infections by migrants have been a factor in increasing HIV prevalence in rural areas.⁵¹ The study found migrant men to be 2.4 times more likely to be HIV infected than non-migrant men, 25.9 per cent compared to 12.7 per cent respectively. In the multivariate analysis, the main risk factors for being HIV infected

⁵⁰ Lurie, M., et al., 'Migrancy and HIV/STDs in South Africa A Rural Perspective', *South African Medical Journal*, 87(7) (1997): 908-9.

⁵¹ Lurie, M., et al., 'Circular Migration and Sexual Networking in Rural KwaZulu-Natal: Implications for the Spread of HIV and Other Sexually Transmitted Diseases', *Health Transition Review* 7 (supplement 3) (1997): 17-27; Lurie, M., et al., 'Who Infects Whom? HIV-1 Concordance and Discordance Among Migrant and Non-Migrant Couples in South Africa', *AIDS*, 17 (2003): 2245-52.

among men were being a migrant, ever having used a condom, and having lived in four or more places during the course of his lifetime.

These findings are particularly interesting given the mature stage of the HIV epidemic in Southern African. The fact that, even against the background of extremely high HIV prevalence, migration was an independent risk factor for men highlights the importance of migration as an explanation for the spread of the HIV epidemic in Southern Africa.

The study also found very high rates of HIV among women. Overall 17.5 per cent of the women were HIV-infected, but women whose partners were migrants were as likely to be HIV infected as women whose partners were not migrants.

The study further examined patterns of HIV concordance and discordance⁵² among migrant and non-migrant couples. These patterns shed light on the issue of directionality of HIV infection. The study found that migrant couples were more than twice as likely than non-migrant couples to have one or both partners infected and to be HIV discordant

Among the discordant couples in this study, the female was the infected partner in 29 per cent of the case, which did not differ by migration status. Clearly a woman, who is HIV positive and whose primary partner is HIV negative, could not have been infected by her partner. The study therefore raises questions about the sexual networks of rural women, and challenges the common assumption of uni-directionality of HIV transmission in the context of population mobility. This finding highlights the importance of understanding the rural, as well as the urban dynamics of the HIV epidemic, and implies that prevention efforts should concentrate not only on the urban "migrant-receiving" areas but also on the rural "migrant-sending" areas.

⁵² An HIV discordant couple is one in which one partner is HIV infected and the other is not

2.3 Epidemiological perspectives on population mobility and HIV

In drawing connections between human mobility and the epidemiology of HIV, it is important to note that different forms of migration lead to different social and geographical forms of "mobile community". Where labour migration is regularized and formalized as in the South African mines, migrant communities and distinctive migrant cultures have developed.⁵³ Sex and sexuality are integral components of such cultures, which includes commercial, "transactional" sex and homosexual relations, in addition to sex with a partner at "home". Other forms of mobility disrupt or prevent the formation of a stable community. People who have multiple "homes", or who spend a lot of time away from or between homes, lead lives of contingent encounters and short-term relationships, whether economic, social or sexual.⁵⁴ This encourages high-risk sexual behaviour. While "on the road", women especially are vulnerable to exploitation and harassment, which can include sexual assault. The gender dynamics of migration therefore leads to differences in risk of exposure to HIV between men and women.⁵⁵

⁵³ Campbell, C., 'Migrancy, Masculine Identities and AIDS: the Psychological Context of HIV Transmission on the South African Gold Mines', *Social Science and Medicine*, 45(2) (1997): 273-81; Campbell, C., 'Representations of Gender, Respectability and Commercial Sex in the Shadow of AIDS: A South African Case Study', *Social Science Information*, 37(4) (1998): 687-707; Campbell, C., 'Going Underground and Going after Women: Masculinity and HIV Transmission on the Gold Mines', In R. Morrell (ed.), *Changing Masculinities in a Changing Society: Men and Gender in Southern Africa* (London: Zed Books, 2001).

⁵⁴ Chijere-Chirwa, W., 'Migrants Labour, Sexual Networking and Multi-Partnered Sex in Malawi', *Health Transition Review*, 7 (supplement 3) (1997): 4-15; Colvin, M. and B. Sharpe, 'Sexually Transmitted Infections and HIV in a Rural Community in the Lesotho Highlands', *Sexually Transmitted Infections*, 76 (2000): 39-42; Hope, K.R., 'Population Mobility and Multi-Partner Sex in Botswana: Implications for the Spread of HIV/AIDS', *African Journal of Reproductive Health*, 5(3) (2001): 73-83.

⁵⁵ Bassett, M.T. and M. Mhloyi, 'Women and AIDS in Zimbabwe: The Making of an Epidemic', *International Journal of Health Services*, 2(1) (1991): 143-56; Romero-Daza, N., 'Multiple Sexual Partners, Migrant Labor, and the Makings for an Epidemic: Knowledge and Beliefs about AIDS Among Women in Highland Lesotho', *Human Organization*, 53(2) (1994): 192-205; Bond, V. and P. Dover, 'Men, Women and the Trouble with Condoms: Problems Associated with Condom Use by Migrant Workers in Rural Zambia', *Health Transition Review* 7, (supplement 1), (1997): 377-91; Abdool-Karim, Q. and J. Frohlich, 'Women Try to Protect Themselves from HIV/AIDS in KwaZulu-Natal, South Africa'. In M. Turshen ed., *African Women's Health*. (Trenton, New Jersey: Africa World Press, 2000); Sussler, I. and Z. Stein, 'Culture, Sexuality, and Women's Agency in the Prevention of HIV/AIDS in Southern Africa', *American Journal of Public Health*, 90(7) (2000): 1042-48.

⁵⁶ Anderson, R. and G. Garnett, 'Mathematical Models of the Transmission and Control of Sexually Transmitted Diseases', *Sexually Transmitted Diseases* 27 (2000): 636-43; Williams, B. and E. Gouws, 'The

Since HIV was first described more than 20 years ago, mathematical models have been widely used to further our understanding of the dynamics of the epidemic, the impact that it will have on different groups and in different places, the likely future course of the epidemic, and the impact, cost and effectiveness of various control measures.⁵⁶ But perhaps the most striking aspect of the worldwide HIV pandemic is the variation in infection rates among and within countries. The prevalence of HIV among women attending ante-natal clinics in the northern states of India (excluding Manipur) is between 0.1 per cent and 0.4 per cent, in the four large states in the south of India (excluding Kerala) it is between 1 per cent and 3 per cent, ten times as high. The prevalence of infection in Brazil is less than 1 per cent, in West Africa the median prevalence is 3 per cent, in East Africa it is 5 per cent and in Southern Africa it is 21 per cent. Yet, there has still not really been an explanation for this extraordinarily variable pattern of HIV prevalence. If we cannot explain the overall patterns of infection, the chances of managing the epidemic effectively are small.

As outlined in the introduction, there are a number of co-factors that enhance or reduce the likelihood of HIV infection. These include, amongst many others, the number of (concurrent) sexual partners, condom use, other STIs, gender inequality, male circumcision, and poverty. Each of these has been shown to be significant at an individual level, but none have been used to explain the overall patterns of HIV infection noted above.⁵⁷ The role of mobility in both spreading and sustaining the HIV epidemic has been seriously neglected.

Brian Williams⁵⁸ argues that based on chances of HIV transmission, HIV should spread outwards from an initial infectious source at a rate of not more than 10 km per year and it should take 100 years or so to cover South Africa. The only way in which HIV could have spread from its initial focus (presumed to be somewhere in Central or East Africa) to Cape Town in less than ten years is if people carried the infection over very large distances in a short period of time creating new foci of HIV infection in many different places. Without very substantial movement of people, the epidemic of HIV infection could not spread.

⁵⁷ Carael, M. and Holmes, K. 'Dynamics of HIV Epidemics in Sub-Saharan Africa: Introduction' *AIDS* 15 Suppl 4 (2001): S1-4; Carael, M., et al., 'The Making of HIV Epidemics: What Are the Driving Forces?' *AIDS* 11 Suppl B (2001): S23-31.

⁵⁸ Epidemiologist, World Health Organization

⁵⁹ Packard, *White Plague, Black Labor*.

Furthermore, the people that spread the infection must be sexually active and engaging in high-risk sex acts. It would seem to be inevitable that mobility, but in particular migration in which men are separated from their wives, and vice versa, is one of the most important determinants of the spread of HIV infection.

Migrant labour has almost certainly been one of the key factors driving the HIV epidemic in Southern Africa, and has also played a key role in the development of other diseases.⁵⁹ For example, up to one-third of the men who have worked on the gold mines in South Africa suffer from varying degrees of silicosis and this increases their risk of developing tuberculosis by about three times.⁶⁰ While these men are entitled to substantial compensation under the law, very little effort has been made to compensate them and few steps have been taken to reduce the levels of silica dust exposure in the mines.⁶¹ In addition, the migrant labour system is a most efficient way of spreading tuberculosis throughout the region. HIV increases the risk of Tuberculosis (TB) by about five to ten times so that HIV is one of the strongest co-factors for TB.⁶²

While mathematical models have been developed to investigate the temporal trends of both HIV and TB and statistical models have been used to explore the associations between each of these and a myriad of risk factors, only a few models have been developed to explore the dynamics of the association between HIV and TB and none have explored the dynamics of the spatial spread of TB or HIV over time in detail. The role of migration in the spread of both diseases requires much more attention.

⁶⁰ Trapido, A., 'Prevalence of Occupational Lung Disease in a Random Sample of Former Mineworkers', *Journal of Industrial Medicine* 34 (1998): 305-13.

⁶¹ Churchyard, G., et al., 'Silicosis Prevalence and Exposure-Response Relations in South African Gold Miners', *Occupational and Environmental Medicine* 61 (2004): 811-6.

⁶² Corbett, E., et al., 'Risk Factors for Pulmonary Mycobacterial Disease in South African Gold Miners: A Case-Control Study', *American Journal of Respiratory and Critical Care Medicine*, 159 (1999): 94-9; Corbett, E., et al., 'Stable Incidence Rates of Tuberculosis (TB) Among Human Immunodeficiency Virus (HIV) Negative South African Gold Miners During a Decade of Epidemic HIV-Associated TB', *Journal of Infectious Diseases* 188 (2003): 1156-63; Corbett, E. et al., 'Human Immunodeficiency Virus and the Prevalence of Undiagnosed Tuberculosis in African Gold Miners', *American Journal of Respiratory and Critical Care Medicine* 170 (2004): 673-79.

2.4 Forced Migration: Refugees and Internally Displaced Persons (IDPs)

Armed conflicts and socio-economic stability in the Southern African region have produced streams of refugees and IDPs from and within countries like Angola, the Democratic Republic of Congo (DRC) and Zimbabwe. Many Angolans, Congolese and Zimbabweans have sought refuge and asylum in neighbouring countries in the region.

Refugees and IDPs may face several forces that make them vulnerable to HIV infection. The circumstances of their forced migration amidst violent conflict or human rights violations, including sexual violence and rape, can make refugee populations, particularly women and children, more vulnerable to HIV infection. The disintegration of infrastructure, social networks and stable relationships could also create risks of HIV infection for refugees.

Because refugees are vulnerable from a socio-economic standpoint, it has long been assumed they face a greater risk of HIV exposure than their host communities. However, recent evidence suggests that in many prolonged conflict situations refugees may not develop higher HIV infection levels. Between 2001 and 2003, the UNHCR and its partners measured HIV prevalence among pregnant women in more than 20 camps housing some 800,000 refugees in Kenya, Rwanda, Sudan and Tanzania. The results showed that refugee populations in three of the four countries had significantly lower HIV prevalence than the surrounding host communities. For example, in Kenya, 5 per cent of refugees were HIV positive, compared with an 18 per cent HIV prevalence in the surrounding host community population. In the fourth country, Sudan, the refugee camps and host community had comparable infection rates.⁶³

Several explanations may underlie discrepancies in HIV prevalence between refugee and host-country populations. Historically, the countries of origin of most refugees in Africa have typically had lower HIV prevalence than countries hosting the refugees. Refugees often live in camps in remote rural areas with limited freedom of

⁶³ Lubbers, R. 'HIV and refugees, Misconceptions and new approaches' (2003), UNHCR Press Statement.

⁶⁴ UNAIDS, Report on the Global AIDS Epidemic, (2004), 179-180.

⁶⁵ Dodson, B., 'Porous Borders: Gender and Migration in Southern Africa', *South African Geographical Journal*, 82 (2000): 40-6.

⁶⁶ *Ibid.*

movement, which may limit their exposure to the host country's population, especially in high HIV prevalence rural areas.⁶⁴

2.5 Female migration and HIV risk

Mobility as a driving force in HIV transmission has traditionally been studied as a male phenomenon. Nowadays, women are increasingly participating in both voluntary and involuntary migration in Southern Africa. The increasing mobility of women as traders, labourers, sex-workers, refugees, and victims of trafficking has been referred to as the "gendering" or "feminization" of migration. A number of reasons explain the gendering of migration,⁶⁵ which include political and economic shifts, poverty, and changing social traditions.⁶⁶

Research to date has focused primarily on the prevention and transmission of disease among male migrants in Southern Africa. Based on the examination of male migrants' socio-economic contexts, sexual networks, knowledge, and sexual behaviours, this diverse population demonstrates an increased risk to HIV.⁶⁷ In order to highlight a similar risk among female migrants, one needs to break down the behaviours, circumstances, and gender-specific issues that affect women during the migration process.

Research demonstrates that men experience health risks and contribute to the spread of HIV in Southern Africa as a result of their movement. Migrant women undoubtedly experience health risks as well, both similar and different from men. Thus far, epidemiological studies have neglected to focus on migrant women. In addition to the multiple partnerships that both male and female migrants are likely to engage in, what has yet to be fully examined are the gender-specific issues that confer additional risks upon migrant women and their partners.

⁶⁷ Williams, B., et al., 'A Model of HIV Transmission on South Africa Mines: Implications for Control', *South African Journal of Epidemiology and Infection*, 11(2) (1996): 51-5; Campbell, C. and B. Williams, 'Managing Disease on the Gold Mines: 'Work-Related' and 'Non-Work-Related' Diseases', *South African Journal of Public Health*, 88(6) (1998): 789-95; Williams, B. and C. Campbell, 'Creating Alliances for Disease Management in Industrial Settings: A Case Study of HIV/AIDS in Workers in South African Gold Mines', *International Journal of Occupations and Environmental Health*, 4(4) (1998):251-64; Campbell, C. and B. Williams, 'Beyond the Biomedical and Behavioural: Towards an Integrated Approach to HIV Prevention in the South African Mining Industry', *Social Science and Medicine*, 48 (1999):1625-39; Campbell, C. and B. Williams, 'Riding the Tiger: Contextualising HIV Prevention in South Africa', *African Affairs*, 100 (2001): 135-40.

One of the most important factors that must be considered is women's economic dependence on men. This often influences migrant women's line of work, their experiences during transit, working conditions, and risks for HIV and other STIs. As women can expect to be compensated for sex outside their primary relationships, they are more likely to engage in transactional sex and sex work. The socio-economic context of transactional sex or sex work leaves little room for a woman to negotiate condom use, and not using a condom often elicits more payment. These partnerships clearly increase migrant women's risks for acquiring HIV.

Economic disempowerment of women restricts them to unskilled jobs, such as sex work, agricultural labour, informal trade and domestic work. It also makes them more likely to becoming victims of trafficking into the sex industry. These jobs subject women to poor working conditions, including abuse or harassment. Some evidence suggests that migrant women who work as traders or agricultural labourers supplement their incomes with transactional sex.⁶⁸ It is important to note that migrant women who engage in transactional sex to supplement their incomes, do not necessarily identify themselves as sex workers.⁶⁹

A study conducted in Carletonville, South Africa, of self-identified, migrant and non-migrant women who did not consider themselves sex workers found that migrant women are older, more likely to be married, to have had sexual contact with someone other than their regular partner in the last year, and are less likely to use condoms

⁶⁸ Care International and IOM, 'Mobility and HIV/AIDS in Southern Africa: A Field Study in South Africa, Zimbabwe and Mozambique', (2003); IOM/JICA, 'HIV/AIDS Vulnerability among Migrant Farm Workers on the South African-Mozambican Border' (2004).

⁶⁹ Preston-Whyte, E., 'Survival Sex or the Culture of Sex Work in South Africa', *AIDS Bulletin*, 5(1) (1996).

⁷⁰ Campbell, C., 'Letting the Die': Why HIV/AIDS Intervention Programmes Fail (Oxford: James Currey, 2003).

⁷¹ Jewkes R. and N. Abrahams, 'The Epidemiology of Rape and Sexual Coercion in South Africa: An Overview', *Social Science and Medicine*, 55(2002): 1231-44.

⁷² Campbell, C., Y. et al., 'Gender as an Obstacle to Condom Use: Implications for HIV Prevention Amongst Commercial Sex Workers in a Mining Community', *Agenda*, 39 (1998): 50-57; Morar, N.S. and S.S. Abdool-Karim, 'Vaginal Insertion and Douching Practices Among Sex Workers at Truck Stops in KwaZulu-Natal', *Southern African Medical Journal*, 88(4) (1998): 470; Campbell, C., 'Selling Sex in the Time of AIDS: the Psychosocial Context of Condom Use by Sex Workers on a South African Mine', *Social Science and Medicine*, 50(4) (2000): 479-94; Outwater, A., et al., 'Patterns of Partnership and Condom Use in Two Communities of Female Sex Workers in Tanzania', *J Assoc Nurses AIDS Care* 11(4) (2000): 46-54; Marselle, E., et al., 'Cost-Effectiveness of the Female Condom in Preventing HIV and STDs in Commercial Sex Workers in Rural South Africa', *Social Science and Medicine*, 52(1) (2001): 135-48.

than non-migrant women.⁷⁰ Moreover, migrant women were more likely to have two or more lifetime partners, which in and of itself increases their risk of HIV infection. Migration was also found to be an independent risk factor for HIV, with female migrants 1.6 times more likely to be infected with HIV than non-migrants.

Migrant women are vulnerable to sexual harassment, coercion, and violence.⁷¹ Informal traders, for example, have been exposed to sexual harassment and rape by officials when crossing borders, and by truckers or taxi drivers while travelling to and from markets and other sales sites. In fact, migrant women regularly use sex as a tool to obtain food, transport, or leniency. Suffice to say, condom use is rare within these sexual encounters.⁷²

It would be inappropriate to apply male-focused theories on females since their social contexts are so different. Therefore, both ethnographic and epidemiological studies are necessary to determine women's migratory cycles, motivations for movement, and experiences as migrants.

In addition to research that fully examines the factors that propel women into migration, more studies should be done on migrant women's sexual networks and their dependence on sex to survive. Finally, it is imperative to explore inequalities at the structural level, including lack of economic opportunity, political and legal inequities, and injustices suffered by women. Research that examines structural, social, and community issues is vital to addressing the health of women and migrants in general.

2.6 AIDS-induced Migration

HIV and AIDS is increasingly becoming a factor influencing migration and mobility in Africa. Some factors that induce movement include the following:

- People with AIDS commonly return to live with family members to obtain care. This might entail moving from an urban area back to a rural area or from one country to another (e.g. from South Africa

⁷³Young L. and N. Ansell, 'Fluid Households, Complex Families: The Impacts of Children's Migration as a Response to HIV/AIDS in Southern Africa', *Professional Geographer*, 55(4) (2003): 464-79.

to Lesotho). Others migrate in order to provide care to family members living elsewhere;⁷³

- Loss of a household's income through mortality and morbidity of the breadwinner(s) encourages migration by other household members to seek income-earning opportunities;
- People diagnosed with HIV or displaying physical evidence of disease may migrate to avoid stigmatization by their community;
- People with AIDS-related opportunistic infections may migrate to obtain treatment (including ART) and quality healthcare elsewhere, if it is not available in their own communities. This could involve cross-border movements to a country perceived to have better health care facilities;
- AIDS related mortality disproportionately affects the most economically productive strata of Southern African societies. As a result, skills gaps and shortages could lead to "poaching" and migration of skilled workers in other African countries (this trend is generally referred to as the brain drain);
- Children that are orphaned by AIDS may migrate to live with relatives or to seek their own income-earning opportunities; and
- Widows or widowers may migrate upon the death of their partner. The tradition of "wife inheritance" in some African societies means that a widow becomes the wife of her late husband's brother, which may require relocation. Other women or men choose to move after the death of a spouse, perhaps to join biological family elsewhere. The death of a husband can lead to wife losing access to land and thus livelihood, forcing her to move elsewhere to seek a living.

HIV and AIDS may also impede certain forms of migration. For example, the fact that many parents are dying today means that there will be no grandparents for the next generation of children, and

grandparents have traditionally been important in caring for children while parents migrated in search of employment.

The migration of people living with HIV and AIDS (PLWHAs) and their family members may have considerable policy implications, which makes research in this area urgent. Whether or not people migrate specifically to access healthcare, migration of PLWHAs has implications in relation to health service provision. The migration of children infected and affected by HIV and AIDS needs to be considered in relation to the provisions of education (e.g. education systems need to be more amenable to children transferring schools) and healthcare facilities. If AIDS is generating significant patterns of migration of, for instance, sick people to rural communities, this could have severe implications to the coping mechanisms of households and community structures.

⁷⁴ International Organization for Migration, *Mobile Populations and HIV/AIDS in the Southern African Region* (Geneva: IOM, 2003).

⁷⁵ Crush, J. et al., *South Africa's Labor Empire: A History of Black Migrancy to the Gold Mines* (Boulder: Westview, 1992).

⁷⁶ Crush, J. et al., 'Spaces of Vulnerability'.

⁷⁷ Jochelson, K., et al., 'HIV and Migrant Labour in South Africa', *International Journal of Health Services*, 21(1) (1991):157-73; Macheke, C. and C. Campbell, 'Perceptions of HIV/AIDS on a Johannesburg Gold Mine', *South African Journal of Psychology*, 28(3) (1998): 146-53.

SECTION 3: POPULATION MOBILITY AND RISK: A SECTORAL OVERVIEW

Many of the factors that increase migrants' vulnerability to HIV are cross-sectoral: dislocated social support structures, limited legal rights, poor access to health care services, sexual coercion, exploitation, violence, and complex sexual networks that connect disparate communities.⁷⁴ However, there are also sector-specific risks and vulnerabilities that need to be investigated.

3.1 Mine Workers

Much of the published research on migrant labour in Southern Africa has focused on the South African gold mines, which have drawn large numbers of workers from all over the sub-continent.⁷⁵ Because most of these migrant men live almost exclusively in single-sex hostels, without their wives or families, they are seen as being at high risk of contracting STIs, including HIV.⁷⁶ Foreign workers on the mines (from e.g. Lesotho and Mozambique) generally return home less frequently than their South African counterparts, and their partners are less likely to be able to visit them on the mines. The prevalence of commercial sex and alcohol-related business supported by miners create conditions that render other groups in the surrounding communities more susceptible to infection as well.⁷⁷

⁷⁴ Williams, B., et al., 'A Model of HIV Transmission on South Africa Mines: Implications for Control', *South African Journal of Epidemiology and Infection*, 11(2) (1996): 51-5; Campbell, C. and B. Williams, 'Managing Disease on the Gold Mines: 'Work-Related' and 'Non-Work-Related' Diseases', *South African Journal of Public Health*, 88(6) (1998): 789-95; Williams, B., et al., 'The Carletonville-Mothusimpilo Project: Limiting Transmission of HIV through Community-Based Interventions', *South African Journal of Science*, 96(6) (2000): 351-9; Campbell, C., 'Selling Sex in the Time of AIDS: the Psychosocial Context of Condom Use by Sex Workers on a South African Mine', *Social Science and Medicine*, 50(4) (2000): 479-94; Williams, B., et al., *The Natural History of AIDS in South Africa: A Biomedical and Social Survey in Carletonville* (Johannesburg: CSIR, 2000).

⁷⁵ Steen, R., et al., 'Evidence of Declining STD Prevalence in a South African Mining Community Following a Core-Group Intervention', *Sexually Transmitted Diseases*, 27(1): 1-8.

⁷⁶ Romero-Daza, N. and D. Himmelgreen, 'More than Money for your Labor: Migration and the Political Economy of AIDS in Lesotho', in M. Singer (ed.), *The Political Economy of AIDS* (Amityville, New York: Baywood Publishers, 1998).

⁷⁷ Crush J., et al., *Borderline Farming: Migrants in South African Commercial Agriculture* (SAMP, Migration Policy Series No. 16, 1999).

⁷⁸ IOM, *HIV/AIDS Vulnerability among Migrant Farm Workers on the South African-Mozambican Border* (Pretoria: IOM, JICA 2004).

Despite changes to the volume and geography of migration, important aspects of mine migration have persisted: over 90 per cent of the industry's black employees are migrants. More than 90 per cent of mine workers live in single-sex hostels, with easy access to commercial sex workers. Some mining companies have begun to develop family-friendly housing, but this has not yet been implemented on a wider scale.

Studies on temporary and permanent residents in the mining town of Carletonville, South Africa, the largest gold mining complex in the world, reveal the conditions that render miners and the communities around them susceptible to HIV infection.⁷⁸ The high prevalence of HIV among men and women in the surrounding community demonstrates the high risk faced by all members of a mining community, not just the miners themselves.⁷⁹

As the majority of miners are migrants from distant rural areas, they will leave the mines and return to their rural homes when they become too sick to continue working or the mines will repatriate the seriously ill men.⁸⁰ Unfortunately, there is no data on the levels of infection among miners who have been retrenched or repatriated.

3.2 Commercial Farm Workers

Commercial farms in Southern Africa employ significant number of migrant workers, including from other Southern African countries. A large percentage of the former commercial farm labour force in Zimbabwe came from Zambia, Mozambique, and Malawi. South African commercial farms, particularly in Mpumalanga, Limpopo and Free State provinces, employ significant numbers of migrant workers from other Southern African countries, mainly from Mozambique, Zimbabwe and Lesotho.⁸¹

In 2004 IOM conducted a survey on HIV vulnerability among migrant farm workers in two farming districts in the Mpumalanga and Limpopo Provinces.⁸² The study identified three different categories of migrants: permanent, seasonal and temporary workers. Within these broad categories there are farm workers that live and work on the farm and have security of tenure; those that live on the farm but do not have security of tenure and commute home on a monthly

⁸³ Siziya, S., et al., 'Risk Awareness of HIV/AIDS Among Commercial Farm Workers in Zimbabwe', *Central African Journal of Medicine*, 45 (12) (1999): 316-20.

basis; the daily commuter, that travels between the farms and close by villages; and the foreign cross border migrant workers who retain a close connection with their home country. A picture of the workers' vulnerability to HIV emerges when one considers the combined impact of negative social, economic and labour conditions, which exist on the farms. Workers are confronted with difficult basic conditions: not only poor pay together with often exploitative working conditions, but also overcrowded accommodations, poor sanitation, long absences away from home, boredom, limited recreational opportunities, and a meager hand-to-mouth existence with little hope for the future. Within this context, HIV is seen as a distant threat.

The study also revealed a lack of access to information, high levels of misconceptions about HIV and AIDS and high levels of reported risky sexual behaviour. A significant number of workers reported having two or more concurrent sexual partners, and there were indications that during the harvesting season, transactional sex increases dramatically at the farm compounds. In addition, the study showed that, next to poor knowledge and misconceptions about the disease, there is widespread belief among workers that there is a cure for HIV and AIDS.

Lastly, the study showed that female workers were especially vulnerable to HIV infection. A large proportion of female farm workers reported poor knowledge and attitudes on HIV and AIDS and they reported much higher levels of unsafe sexual practices than male workers.

Foreign migrants were also found to be particularly vulnerable to HIV infection. Because of their insecure legal status, high mobility and

⁸⁴ Sechaba Consultants, 'How Can You Tell the Sun Not to Shine'?

⁸⁵ Wilson, D., et al., 'Ethnographic and Quantitative Research to Design a Community Intervention Among Long-Distance Truck Drivers in Zimbabwe', In *Focusing Interventions Among Vulnerable Groups for HIV Infection: Experiences from Eastern and Southern Africa* (Nairobi: NARESA, 1994); Ramjee, G. and E. Gouws, 'Targeting HIV-Prevention Efforts on Truck Drivers and Sex Workers: Implications for a Decline in the Spread of HIV in Southern Africa', Policy Brief No.3, Pretoria: Medical Research Council, 2000; Wilson, D., 'Prevention of HIV Infection through Peer Education and Condom Promotion Among Truck Drivers and their Sexual Partners in Tanzania, 1990-93', *AIDS Care*, 12 (2000): 27-40.

⁸⁶ Laukamm-Josten, U., et al., 'Preventing HIV Infection through Peer Education and Condom Promotion among Truck Drivers and their Sexual Partners in Tanzania, 1990-1993', *AIDS Care*, 12 (1) (2000): 27-40.

⁸⁷ Marcus, T., *AIDS: Interpreting the Risks- a Case Study of Long Distance Truck Drivers* (Pietermaritzburg: University of Natal, 1996).

short stays on farms, they are rarely able to access health services or be reached by the infrequent HIV/AIDS information campaigns targeted at farm workers.

Other than the studies described above, there is little substantive information on HIV vulnerability of farm workers on commercial farms in Southern Africa.⁸³ There is not much data available about the number of migrant farm labourers, their movements, employment patterns, recruiting strategies, working conditions, and health profiles. Further research is needed to design effective policies addressing issues of migrant farm workers and their risks of HIV infection.

3.3 Transport Workers

The road freight industry within Southern Africa has grown exponentially in the last decade and has played a significant role in the spread of HIV in Southern Africa. In Mozambique, for example, provinces with major transportation arteries have higher HIV prevalence rates than those that do not. Several studies have tracked the spread of HIV along major trucking routes, highlighting the role of truck drivers in introducing HIV into new areas. In Mozambique, a study in Tete and Maputo provinces studied 8,000 truck drivers and found that two-thirds of the drivers spent between eight and 30 days per month away from home with the vast majority sleeping in their trucks.⁸⁴

⁸³ Mwizaruba, B.K., et al., 'HIV/AIDS Education and Condom Promotion for Truck Drivers, their Assistants and Sex Partners in Tanzania', In *Focusing Interventions Among Vulnerable Groups for HIV Infection: Experiences from Eastern and Southern Africa* (Nairobi: NARESA, 1994); Mukodzani, L., et al., 'All Roads Lead to Harare: The Response of the Zimbabwe Transport Industry to HIV/AIDS', In I.O. Orubuloye, J.C. Caldwell and J.P.M. Ntozi (eds.), *The Continuing HIV/AIDS Epidemic in Africa: Responses and Coping Strategies* (Canberra: Australian National University, 1999); Mupembo, K., 'The Zimbabwe HIV Prevention Program for Truck Drivers and Commercial Sex Workers: A Behaviour Change Intervention', In J.C. Caldwell, P. Caldwell, J. Anarfi et al., (eds.), *Resistances to Behavioural Change to Reduce HIV/AIDS Infection in Predominantly Heterosexual Epidemics in Third World Countries* (Canberra: Australian National University, 1999).

⁸⁴ Ramjee, G., et al., 'Sexually Transmitted Infections Among Sex-Workers in KwaZulu-Natal, South Africa', *Sexually Transmitted Diseases*, 25 (1998): 346-9; Ramjee, G. and E. Gouws, 'Targeting HIV-Prevention Efforts on Truck Drivers and Sex Workers: Implications for a Decline in the Spread of HIV in Southern Africa', Policy Brief No.3, Pretoria: Medical Research Council, 2000; Ramjee, G. and E. Gouws, 'Prevalence of HIV Among Truck Drivers Visiting Sex Workers in KwaZulu-Natal, South Africa', *Sexually Transmitted Diseases*, 29(1) (2002): 44-9.

⁹⁰ Basic construction skills are relatively easy to learn and are generally acquired on the job. This affords an entry point to the formal economy for many young unskilled workers.

More important than the movement itself is the opportunity to find sexual partners along major transportation corridors. Sexual networks of truck drivers often include wives, girlfriends, sex workers, adolescent girls, assistants, and casual acquaintances.⁸⁵ Truck drivers frequently have partners at stops along their route which provide a social network for them, and which they help to support financially.^{86, 87} The wives that are left behind by the truck drivers may also have sex with other partners in their husbands' absence. In this way, the transport sector binds together many disparate communities, rural homes of truck drivers, stopover towns along major routes, and cross border communities. HIV programmes in the transport sector must therefore address the broad structures that put people at risk in each of these communities.⁸⁸

Ramjee et al studied sex workers and their truck driver customers along a South African trucking route and found that about 56 per cent of both the truck drivers and sex workers were infected with HIV.⁸⁹ Some 66 per cent of the truck drivers reported having an STI in the past six months. As with the miners in Carletonville, HIV prevalence among male truck drivers did not decrease with age as it does generally among South African men. This can probably be explained by the fact that truck drivers who are visiting sex workers, like miners discussed above, continue to be exposed to the same risk factors even as they get older. Truck drivers in this study did not report consistent use of condoms: 29 per cent had never used condoms, while 47 per cent always used condoms with sex workers, and only 13 per cent used condoms with steady girlfriends or wives.

3.4 Construction Workers

Construction is one of the sectors in Southern Africa that employs a significant numbers of migrants, both cross-border and internal. The construction industry is labour intensive, with a large number of semi-skilled and unskilled, young, and transient workers.⁹⁰ The industry usually employs people between the ages of 18 to 35 years, and the majority of the semi-skilled and unskilled workers are single and male.

Most construction projects are "one-off" projects, which wind up once the work is completed and then the labour is moved to a new project

site or laid off. Hence, there is an inherent migratory nature to construction, which means that the movement of labour, in terms of time and space, is relatively high compared to other industries. It creates a process of “circular migration” whereby migrant workers return home once their job is completed, returning to job-sites only when new work is available.

Construction workers face many of the same structures and circumstances that place migrants in other sectors at increased risk of HIV infection. The nature of construction work, and the “on-style” lifestyle exacerbates the HIV vulnerabilities of construction workers. Construction workers lead a nomadic “on-site” lifestyle in remote areas living away from families and support systems in temporary accommodations with few recreational facilities for long stretches of time. Thus, the workers are separated from traditional norms, culture and support systems that regulate behaviour in stable communities, which make them more likely to engage in high-risk sexual behaviour. Further, construction workers face difficult and dangerous working conditions, with risk of physical injury, and thus are likely to regard HIV infection as a distant risk, as they are preoccupied by immediate challenges of physical survival and financial need.

In addition, construction development sites are often located in remote, under-developed areas, surrounded by impoverished local communities. In such environments, local community dwellers are keen to interact with construction workers who have disposable income and are in a position to purchase sex. Further, isolated working and living environments often create a sense of anonymity among workers, that allows for more sexual freedom.

Lastly, in general, there is a lack of healthcare facilities and services available in the remote areas where construction sites are often located. Even in areas where healthcare facilities exist, workers may

⁹¹ World Bank. 1994. Considering HIV/AIDS in Development Assistance: A Toolkit. Chapter 3: A Sectoral Checklist, (a) infrastructure (transport). <http://www.worldbank.org/aids-econ/toolkit/infra.htm>

⁹² Colvin M., et al., 'Health and Safety in the Lesotho Highlands Dam and Tunnel Construction Programme', *International Journal of Occupational and Environmental Health*, 4(4) (1998): 231-5.

⁹³ Deputy Minister of Public Works Rev KM Zondi, 20 March 2003, speech at the launch of the HIV/AIDS Awareness campaign in Gugulethu, South Africa. See www.publicworks.gov.za/speeches/depmin/2003/20march2003.htm.

be reluctant to seek these services for fear of dismissal, or - in the case of foreign undocumented migrants - harassment or deportation.

Although there have not been many studies specifically looking at HIV in the construction sector, elevated HIV prevalence rates have been reported among construction workers. In Malawi, road construction has been linked to the spread of HIV,⁹¹ while in Lesotho, the Highland Water Project (Katse Dam) has led to an increase in STIs in the remote mountain areas.⁹² Other research indicated that the construction industry in South Africa has the third highest HIV incidence of the economic sectors in the country.⁹³

3.5 Domestic Workers

Domestic workers represent a vulnerable group because they often work in social isolation, have low levels of education, and are exposed to poor working conditions, which include lack of privacy and low wages. Domestic work includes cleaning, cooking, and caring for the young and elderly. Domestic work is generally considered an undervalued activity and therefore mostly done by people from disadvantaged social groups. Few domestic workers have any kind of written contract, paid leave, benefits or medical aid.

A significant proportion of domestic workers are migrant workers. Their vulnerability also lies in their social isolation and vulnerability in the workplace. Employers often place restrictions on domestic workers having visitors, and prevent husbands, partners and children from living with them. Even those who "live out" often live in very poor conditions and may be unable to live with their partners or children.

Domestic workers are likely to be at increased risk of HIV infection because of a number of factors including gender inequality, social isolation, poverty, low levels of education, lack of access to health care services and medical aid. The living conditions of domestic workers and their status as migrants could have a serious affect on

⁹⁴ Peberdy, S. and N. Dinat, 'Worlds of Work and Health: Domestic Workers in Johannesburg' SAMP Draft Report, 2005.

⁹⁵ Ibid.

⁹⁶ Ibid.

their health, in particular their reproductive and sexual health.

A recent SAMP survey that focused on the reproductive health of domestic workers in Johannesburg had three main objectives:⁹⁴ (a) to explore and describe the lives of domestic workers and how their lives affect aspects of their health status, vulnerability to HIV and access to health care; (b) to examine their patterns of mobility; and (c) to examine the impact of mobility on their health status, vulnerability to HIV and access to health care. The health aspects considered in the study included reproductive and sexual health, risk of HIV and the impact of HIV and AIDS on their lives. Gender-based violence and substance abuse were also looked at as important indicators of HIV risk.

The study found that the overwhelming majority of interviewees were migrant workers, and had been for some time. Some 86 per cent of respondents said they had a home outside Johannesburg. Of these women who had left their other homes to work in Johannesburg, 93.8 per cent came from elsewhere in South Africa and only 6.2 per cent from other countries (all SADC). The majority showed strong ties to their other homes.⁹⁵

Although the women interviewed worked long hours for little pay (the majority receiving between SAR500-1000 per month), they did not appear to have significant problems accessing health services. However, despite regularly using health services and having relatively significant personal experiences with HIV and AIDS, the workers interviewed showed low levels of knowledge around HIV and AIDS issues and extremely low levels of reported condom use. The low use of condoms is of concern as only about 25 per cent of the women in permanent relationships actually lived with their partner. Overall, the study indicates that domestic workers are likely to be vulnerable, which could be related to their, or their partner's migrant status. On the other hand, the socially isolated lives of many domestic workers may reduce their potential vulnerability.⁹⁶

⁹⁷ Peberdy, S., 'Mobile Entrepreneurship: Informal Sector Cross-border Trade and Street Trade in South Africa', *Development Southern Africa*, 17(2) (2000): 201-19.

⁹⁸ Nduru (2004) in Academy for Educational Development, 'Women who Engage in Transactional Sex and Mobile Populations in Southern Africa, Literature Review', AED, October 26, 2004.

⁹⁹ Peberdy, S., 'Hurdles to trade? South Africa's immigration policy and informal sector cross-border traders in the SADC', Paper presented at SAMP/LHR/HSRC Workshop on Regional Integration, Poverty and South Africa's Proposed Migration Policy, Pretoria, 23 April 2002.

¹⁰⁰ Ibid.

3.6 Informal Traders

Informal trade has grown significantly since the end of Apartheid in South Africa, both within South Africa and between South Africa and other countries in the region.^{97, 98} This form of trade provides an income earning opportunity for entrepreneurs around Southern Africa, and appears to comprise a significant proportion of intra-regional trade. Traders include people who travel for short periods to buy goods to take back to their home country; people who are involved in two-way trade; people who only sell in another country; and people who buy and sell across more than two countries. Existing research indicates that the types, value and volumes of goods carried by cross-border traders vary significantly. So, too, do spatial and temporal patterns of trade.

There are particularly strong trade networks between Zimbabwe on the one hand and South Africa, Botswana, Zambia, and Mozambique on the other. Also, studies of informal traders in Mozambique revealed extensive connections of Mozambican traders with Swaziland, Tanzania, South Africa, and Zimbabwe.

Informal cross border traders are better described as small entrepreneurs who carry goods across one or more of the borders in the region. They are called informal because generally, they travel with their goods, operate on a relatively small scale, do not access preferential tariff agreements, often buy and/or sell in informal sector markets, do not always pass through formal import and export channels and may be involved in smuggling. Most goods traded include fruit, vegetables, mattresses, stereos, household goods, fish, shellfish, handicrafts, curios, wire, crochet work, and coal.⁹⁹

Informal traders vary from being survivalist, to the other end of the spectrum where they are relatively well-off. In general there are four categories of informal sector cross-border traders:¹⁰⁰

1. Traders who cross borders for short periods (1-4 days) to buy goods for re-sale to formal retail outlets, individuals or markets in their home country;

¹⁰¹ Ibid.

¹⁰² Trade and Development Studies Centre - Trust, 'Informal Cross-border Trade: Salient Features and Impact on Welfare'.

¹⁰³ Peberdy, S.

¹⁰⁴ Trade and Development Studies Centre Trust.

2. Traders who cross borders for longer periods (1week to 2 months) and carry goods for sale in informal and retail markets in the recipient country. They use the proceeds from such sales to buy goods for resale in informal or formal markets in their home country;
3. Traders who cross borders, sell their goods and take money from the proceeds back to their home country;
4. Traders who travel across countries and buy and sell goods as they go.

Although cross border traders are informal, they are not necessarily illegal. Most migrant traders cross borders legally, even at great expense to themselves.¹⁰¹ Typically, informal traders are not immigrants. Despite stereotypes to the contrary, most informal cross border traders have no interest in staying in the recipient country, but will return home to continue conducting business. It is a myth that all are desperately poor; many are small entrepreneurs who, with start-up capital could expand their businesses.

In general the majority of informal cross border traders are female, relatively young and single. One study indicated that 80 per cent of traders going to South Africa from Zimbabwe were women,¹⁰² while another found that over 70 per cent of traders between Mozambique and South Africa were women.¹⁰³ The same study found that of the women respondents, 36 per cent were married, 42 per cent were single parents, and 22 per cent widowed.¹⁰⁴

Participation in informal trade provides opportunities for women's economic empowerment. However, legislative and regulatory frameworks may intentionally or inadvertently create conditions that favour male over female traders. For example, in Botswana, married women cannot open a bank account or obtain credit without their husband's support. Concerns for personal safety and their goods may lead to different patterns of travel and forms of transport for male and female traders. Women may also be particularly vulnerable to sexual assault and extortion, including demands for sexual favours

¹⁰⁵ Family Health International, 2000 in Academy for Educational Development, "Women who Engage in Transactional Sex and Mobile Populations in Southern Africa", Literature Review, October 26, 2004.

¹⁰⁶ The truckers either smuggle the goods across the border, or use their customs rebate to clear the goods.

¹⁰⁷ IOM, "Mission Report on HIV/AIDS among Informal Cross-border Traders in Botswana, Zambia and Zimbabwe", Pretoria, April 2005.

from officials at border crossings or truck drivers. A study conducted in towns along the Namibia/Angola border revealed that immigration and custom officials sometimes demanded sex from informal traders in exchange for not having their goods seized or being charged high fees to import their goods.¹⁰⁵

In order to avoid paying customs duties, some informal cross border traders negotiate with truckers to cross with their goods, and wait for all the trucks to cross the border before they can continue with their journey.¹⁰⁶ If one of the trucks is delayed, the trader may have to stay at the border post until the truck is cleared. In some cases traders are turned back by immigration officials because of insufficient foreign currency, which leads some traders to spend up to two weeks at the border post trying to raise the required money. As a result, some female traders may engage in transactional sex with money-changers, uniformed personnel, truck drivers or other local men in order to raise the required foreign currency and secure decent overnight accommodation for the duration of their stay.¹⁰⁷ In addition, as highly mobile people, informal cross border traders may find it difficult to access HIV/AIDS education and prevention programmes, or to act on information received.

Male informal traders face many of the same circumstances that render truck drivers vulnerable to HIV infection, including long periods away from home, lack of access to health care, and extended waits at border crossings, where the only affordable accommodation is often in the homes of sex workers.

Even as their significance in the Southern African economy appears to grow, informal trade networks remain largely undocumented, unregulated, and poorly understood. Their independence, mobility, and lack of legal rights make informal traders difficult to reach. Though several factors have been identified that put informal traders at risk, little is known about the dynamics of HIV infection among

¹⁰⁸ Academy for Educational Development (AED), 'Women who Engage in Transactional Sex and Mobile Populations in Southern Africa, a literature review', 2004, Pretoria, South Africa.

¹⁰⁹ Family Health International (FHI). Draft, amended June 2004, *An AIDS Assessment in the Oshana Region of Namibia*.

¹¹⁰ Family Health International (FHI). September 2003. Report on the Formative Assessment for the Zambia Cross Border Initiative. Funded by the USAID; The Synergy Project. no date. "Putting on the Brakes; Preventing HIV Transmission along Truck Routes", Part II. University of Washington, Centre for Healthy Education and Research. www.synergyaids.com.

¹¹¹ UNAIDS, Report on the Global AIDS Epidemic, (2004), 176-177.

informal traders in Southern Africa.

3.7 Commercial Sex Workers

Commercial Sex Workers (CSWs) have one of the highest rates of HIV infection when compared to the general population and other high-risk populations. A highly mobile group, CSWs frequently migrate to find work and also to avoid the social stigma from family and community members that is attached to sex work.¹⁰⁸ Migration patterns often mirror that of other mobile populations and may involve both movement within a country and into neighbouring countries. Studies have shown that clients of CSWs tend to prefer “fresh faces”, another factor resulting in frequent movement.¹⁰⁹

CSWs can work in a variety of settings; brothels, bars/hotels, on the streets, or within the community. They can engage in sex work full time or part time, as a primary occupation or as a secondary occupation. They can migrate within regions and countries or across borders or remain relatively stationary. Their clients can be truckers and other mobile populations or settled non-migratory men in their community. Death of a spouse or parents, divorce, unemployment, and poverty are common reasons that women give for becoming CSWs.¹¹⁰

3.8 Military Personnel

Most armed forces personnel are young men and women in their 20s and 30s and, as such, they represent one of the professional groups most affected by HIV and AIDS. Uniformed services personnel generally have an ethos of risk taking that can place them at higher risk of HIV infection. Often soldiers and peacekeepers are posted away from their families and communities for long periods of time, removing them from the social discipline that would normally prevail in their home communities. During conflict, both consensual and non-consensual sexual encounters tend to increase, and adherence to prevention measures declines.¹¹¹

¹¹² Ibid.

In general, estimates suggest that STIs among uniformed services could be at least twice as high as in the general population. In some countries where HIV has been present for more than 10 years, armed forces report infection rates of 50-60 per cent. In Botswana, for example, one in three members of the military tested HIV positive.¹¹²

¹¹³ Campbell, C., 'Letting them Die': *Why HIV/AIDS Intervention Programmes Fail* (Oxford: James Currey, 2003).

SECTION 4: POLICY AND RESEARCH: THE MISSING LINK

In Southern Africa the linkages between HIV/AIDS related research and policy development can roughly be divided into three categories: (a) research intended to develop a general understanding of the factors that drive the epidemic and that indirectly influences policy; (b) policy-oriented research; and (c) general discussions on the policy implications of an HIV-related issue, like population mobility, which may or may not make connections to research findings.

The first kind of research has been motivated primarily by the need to understand and explain the different dynamics of the HIV epidemic. There is an implicit argument in this literature that better knowledge will inform policy and produce more effective policy interventions. However, this outcome is not explicitly addressed in much of the literature. Often, the call is for more research before viable policy outcomes can be articulated.

The second category, "policy-oriented research" is research that is explicitly motivated by policy concerns and is designed to address the efficacy of existing policies or to develop new policies. While not altogether absent, this kind of endeavour has not been that common to date, except in certain sectors.

The third endeavour is exemplified by the UNAIDS/IOM South African National Consultation on Migration and HIV/AIDS which took place in 1999 and the more recent workshop on "Migration, Human Mobility, HIV and AIDS: The Policy Challenge", co-hosted by IDASA (GAP) and SAMP in Maputo in 2002. These two workshops brought together stakeholders from governments, NGOs and research institutions from southern Africa to discuss the policy implications of the relationship between HIV and population mobility.

One should also distinguish the different levels of government where policy is made in Southern Africa. Policy is made at the regional level (SADC); at the national level; provincial, and district/municipal level. Obviously, these different "jurisdictions" are nested within one another and decisions and policies taken at one level will impact those at another.

In addition, policy should not be viewed as the exclusive preserve of governments and regional organizations. In particular, employers and unions in sectors that employ migrants and mobile workers should respond to the challenges of HIV and AIDS and formulate policies that reduce HIV vulnerability of these workers. Hence, a distinction should be made between official (government) and non-governmental policy responses. Research may relate to both these policy environments in very different ways. However, these two environments should not be mutually exclusive. For example, employers developing sectoral policy responses operate within national and local governmental policy frameworks that may directly influence, or constrain responses by the private sector and organized labour.

Furthermore, the point needs to be made that research can play an important role in evaluating policies and programmes that have been developed to reduce HIV vulnerability of migrants and mobile populations in Southern Africa. Research could play a key role in helping us to understand why mobile populations are vulnerable, why existing policies do not work and what kinds of policy interventions would be more effective. Clearly, for a disease such as HIV, evaluations must include social, behavioural, biomedical and cultural determinants of disease. Unfortunately, at least in Southern Africa, few effective interventions have been put in place and few effective evaluations have been carried out.¹¹³

Finally, policy is not made in a vacuum. It is important to understand the institutional character, political environment, ideological drivers and competing interests involved in policy formulation and development. This is a particularly difficult task at the best of times. In general, there is a strong sense in the literature that policy responses to HIV and AIDS in southern Africa have been tardy, ineffective and compromised by extraneous political and other considerations. This observation has been made both with regard to government and employer responses.

¹¹⁴ Macdonald, D.S., 'Notes on the Socio-economic and Cultural Factors Influencing the Transmission of HIV in Botswana', *Social Science and Medicine*, 42(9) (1996): 1325-33 Chijere-Chirwa, W., 'Migrants Labour, Sexual Networking and Multi-Partnered Sex in Malawi', *Health Transition Review*, 7 (supplement 3) (1997): 4-15; Morris, M. and Kretzscmar, M., 'Concurrent Partnerships and the Spread of HIV' *AIDS* 11 (1997): Suppl A: S209-16; Mabey D. and P. Mayaud, 'Sexually Transmitted Diseases in Mobile Populations', *Genitourinary Medicine*, 73 (1997): 18-22; Setel, P., et al., (eds.), 'Sexual Networking, Knowledge and Risk: Contextual Social Research for Confronting AIDS and STDs in Eastern and Southern Africa', *Health Transition Review* 7 (Supplement 3) (1997).

SECTION 5: GAPS IN RESEARCH ON POPULATION MOBILITY AND HIV

This Section will summarize the recommendations that were put forward by the participants of the workshop “Research priority setting on HIV/AIDS, population mobility and migration in Southern Africa”, which was held on 22 and 23 November 2004 in Cape Town, South Africa. The participants of this workshop (see Annex A) were asked to identify gaps and recommendations on the following three themes:

1. Research on HIV/AIDS, population mobility and migration in Southern Africa
2. Methodologies used in research on the link between HIV/AIDS, Population Mobility and Migration
3. Link between research and policy development

5.1: Recommendations for research on HIV/AIDS, population mobility and migration in Southern Africa

In general, there was agreement that there needs to be further steps taken in order to better integrate the two research fields of “Migration” and “HIV/AIDS”. This can be done by building understanding in both research fields, and by creating new knowledge by exploring the interface between the two types of research. Also, the need for high quality national, regional, and international research collaboration around these themes was highlighted.

The recommendations that transpired from the workshop highlighted the importance of focusing on the following areas for research in the field of population mobility and HIV/AIDS: 1) Impact of migration on rural migrant communities and sexual networking; 2) The role of culture; 3) Evaluation of HIV interventions in the context of migration; 4) Different levels of causation of HIV transmission; 5) Role of population mobility in HIV epidemiology; 5) Health worker migration; and 6) Migration induced by HIV and AIDS.

¹¹⁵ Epprecht, M. *Hungochani: The History of a Dissident Sexuality in Southern Africa* (Montreal and Kingston: McGill-Queen's Press, 2004).

5.1.1 Impact of migration on rural migrant communities and sexual networking

A focus on migrants themselves as a high-risk group has led researchers to largely ignore the numerous groups who are not migrants themselves, but are nonetheless directly made vulnerable by the migration process. To reveal the rural impacts of migration, research must approach migration as a social and economic phenomenon with complex impacts on many different parties, rather than as a characteristic of an individual that places that person within a high-risk group. Because HIV in Southern Africa is spread almost exclusively by sexual contact, addressing the connections between HIV and population mobility requires a more thorough understanding of the sexual networks of migrants, their spouses, and their communities. Various studies have begun to document the vast, diverse, and complex sexual networks of migrants.¹¹⁴ These networks extend deep into the rural communities, the communities that host them at borders, stops along the way, and the communities of mining towns, farms, and other migrant destinations.

Migrants maintain strong and long-term economic, social and sexual relationships with rural communities, and often return to these communities when they get older or become too sick to work. Migration also transforms the role of wives who remain in rural settings without their husbands, facing a new set of economic and social needs. On a communal level, the exodus of a large proportion of the labour population changes the demographics of villages, the social structures of communities, and the dynamics within families. In this way, the impact of migration on rural communities is multi-faceted and extensive. Thus to design effective interventions that address the relationships between migration and HIV, it will be critical to study rural settings where migration has much of its long-term impact.

In particular, the specific circumstances in which rural women take on additional relationships need further investigation, as well as the ways in which these relationships increase their risk of HIV infection. Research is needed to better understand the complex social and sexual lives of women living in rural areas, especially in relation to the migration status of their partners. Understanding these dynamics could help to promote the development of new approaches for HIV

prevention among rural women.

To better understand the root connections between migration and HIV in rural settings, researchers must overcome several challenges. For instance, to examine the extent and impact of retrenched migrant workers with terminal illness, including AIDS, on their home communities it is necessary to receive data from the different industries (especially mining) on the health of the workers whom they retrench and send home to rural areas. However, migrant industries do not routinely collect this data. Another challenge is the fact that wives and partners of migrants in rural settings are often reluctant to discuss or report sexual activity outside of their permanent relationship. To understand how rural wives are becoming infected, researchers will first need to find creative ways to break through these barriers. Because the focus of much of the current research concerns migrants themselves, as an easily identifiable high-risk group, new research projects on rural impacts must include rural wives, families, and communities of migrants.

Tracking the sexual networks surrounding movement routes poses formidable challenges. The vast number, diversity, and geographic dispersion of rural departure points, destinations of migrant work, and stops on travel routes poses considerable logistical challenges to tracking the sexual networks surrounding migration. For some types of migration, such as informal trading, destinations, routes, and departure points are so varied, and the traders themselves operate with such independence, that studying their sexual networks as a group becomes extremely difficult. Stigma may also obscure important sexual networks surrounding migration. Men who have sex with men in single-sex environments such as migrant hostels may play a role in HIV transmission, but because of the taboo on homosexuality, this may not be discussed.¹¹⁵

In all, when the sexual networks surrounding all those affected by migration are better understood and mapped out, then the social and economic forces that create the links in these networks can be brought to the surface and targeted by more comprehensive and effective interventions. Following from this, some of the key research questions recommended are as follows:

¹¹⁶ Campbell, C. and B. Williams, 'Riding the Tiger: Contextualising HIV Prevention in South Africa', *African Affairs*, 100 (2001): 135-40; Campbell, C., *'Letting the Die': Why HIV/AIDS Intervention Programmes Fail* (Oxford: James Currey, 2003).

Impact of migration and HIV on rural migrant communities:

- How do the needs of rural residents with HIV reshape the social and economic structures of the rural communities?
- How do rural migrant-sending communities bear the burden of caring for relatives with AIDS, and in what ways does this burden increase the risk and vulnerability of other household members?

Sexual networking of migrants and their spouses:

- What influences the choices people make regarding sexual networking during the migration process? The choices might differ by gender, age, geographical area etc.;
- What is the reality of, and what are the reasons behind the practice of women reportedly having additional partners to assist households financially in the absence of a migrant spouse?
- What are the notions of "partner" or "relationship" in migrant families?
- Are there practices of men having sex with men in migrant sites and how does that affect HIV vulnerability?
- Women usually under-report sexual partners, and men usually over-report: What would be the most effective methodologies to produce data on sexual networks of migrant women?
- What interventions could help migrant's spouses to negotiate safe sex with their husbands without compromising the trust and intimacy of their marriage?

5.1.2 Role of Culture in the context of Migration, HIV and AIDS:

Culture may play a significant role in the context of migration and HIV/AIDS, as it often strongly influences the choices people make.

However, since culture is not fixed, but flexible, we must be cognisant of how varying cultural influences determine individual behaviours, particularly as people move and are exposed to, or expose others to, differing cultures, beliefs, norms, and traditions. The following research questions were recommended for clarifying these issues:

- How do migration and mobility affect cultural relationships and the culture in migrant receiving and migrant sending areas?
- What is the role of culture that puts some migrants at greater risk to HIV than others?
- What are some of the cultural practices, brought by migrants to new areas that exacerbate or reduce the transmission of HIV infection?
- What are the social, demographic, cultural, and economic factors that make the difference between infection and non-infection? Research should investigate why some migrants remain HIV negative despite living and working in high-risk environments;

5.1.3 Evaluate HIV interventions in the context of migration.

Research should be an integral part of HIV/AIDS projects targeting migrants. Since generic HIV/AIDS interventions seem to be having little impact in migrant settings and situations of high mobility,¹¹⁶ there is a need for policies and programmes that are sensitive to the circumstances of mobile people. Therefore, we need to know what HIV interventions work, especially in migrant sending areas and migrant receiving areas.

For example, with the availability of ART, field trials should be done with treatment for migrant workers. ART programmes in companies employing mobile workers need to be examined and evaluated for effectiveness.

In evaluating HIV interventions in the context of migration, key research questions may include:

- How does mobility impact on migrant workers that are on ARV treatment?

- How can treatment of mobile workers be maintained, and resistance to drugs be avoided?
- What are some examples of different models of care for migrants and their divided households?

5.1.4 Different levels of causation of HIV transmission

While each person has the freedom to make personal choices in terms of sexual behaviour, her/his choices are to a large extent shaped by what is going on around her/him, in other words the environment. It is during transit and/or at the point of destination that migrants are often faced with an environment that renders them vulnerable to social ills, including HIV infection. Environmental factors include socio-economic - living and working - conditions of migrants which are often characterized by social pressures, lack of recreational facilities, and lack of access to resources, opportunities and services.

Therefore, next to trying to change the individual sexual behaviour, attention needs to be paid to factors at the environmental level, such as the conditions at single sex hostels, access to commercial sex workers and alcohol.

Researchers should ask questions such as:

- Why do people migrate? Reasons could be economic, social, family reunifications, as a result of AIDS etc.
- How do housing conditions and other living conditions impact on migrants' vulnerability to HIV? What lessons could be learned for urban planners?
- What are the linkages between HIV/AIDS and the different migration flows; short/long distance, rural/urban, rural/rural, urban/urban?
- How is migrants' vulnerability to HIV affected by their access to health services, treatment and education? Do xenophobia and legal status influence health-seeking behaviour?
- What interventions successfully address the structural factors related to migration that place migrants, their partners, and

their communities at risk? What are the social, demographic, cultural, and economic factors that make the difference between infection and non-infection? Research should investigate why some migrants remain HIV negative in spite of living and working in high-risk environments.

5.1.5 Role of population mobility in HIV epidemiology

Although recent studies have indicated the positive correlation between population mobility and HIV, further research is certainly necessary to determine whether or not population mobility and migration are indeed key factors in the spread of HIV in Southern Africa. In investigating the role of population mobility in HIV epidemiology, researchers also need to look at countries and regions where the HIV epidemic has not spread and isolate mobility and migration as key determining factors.

There is a further need for research to test current theoretical assumptions on sexual networking, epidemiology, vulnerability and risk, and to produce evidence on the link between migration and HIV. Lastly, there is also a need to make distinctions between different types of migration, such as short/long distance, rural/urban, varying periods of circular migration, etc.

5.1.6 Health worker migration

As previously mentioned, an increasing and devastating phenomenon is the migration of skilled workers, particularly in the health sector, which is undermining the ability of health systems to cope with the burden of HIV and AIDS. Although various organizations, including WHO/World Bank, Equinet and SAMP, have established a research agenda on health worker migration for Southern Africa, there is still limited understanding on how migration of health workers affect the health sector in general and the response to HIV and AIDS in particular.

5.1.7 Migration induced by HIV and AIDS

AIDS affects migration both directly and indirectly. Examples of direct migration as a result of AIDS include children's migration and returning-to-die migration. Examples of indirect migration as a result of AIDS include migration to access health care (e.g. to access ARV treatment etc.) and migration of health care professionals.

There needs to be recognition that HIV and AIDS impact on mobility in various ways whether this be in the form of new patterns of movement (e.g. orphans or return migration of people living with AIDS), intensification of existing movements (e.g. rural-urban migration as rural production declines) or reconfiguration of particular industries (e.g. industries changing their recruiting patterns and labour demands).

Questions such as the following should be asked:

- What are the migration patterns of households affected by HIV and AIDS? Who is moving - PLWHAs, relatives of PLWHAs, men, women, children, labour migrants? When are they moving - e.g. in the early or late stages of the disease or immediately following the death of a relative?
- How does HIV and AIDS affect the migration of health workers from rural to urban areas, from public to private sector, and international migration to third countries?
- Where are people moving to as a result of AIDS? To urban areas with better health facilities, across provincial/national borders to secure (free) treatment, or back to rural families?
- Why are people moving as a result of AIDS? Are the reasons economic, e.g. inability to pay rent, or cultural, e.g. to be buried at home?

5.2 Recommendations for research methodologies used in research on the link between HIV/AIDS, Population Mobility and Migration

Beyond the recommendations made above in regards to areas for research, recommendations were also put forth on particular methodologies of research to attain the most effective data in an efficient and ethical manner. First, the need for interdisciplinary research on the link between migration and HIV/AIDS was stressed. Second, research related ethical and sensitive issues were highlighted. Also, the need to look at surrounding communities was pointed out. Further, specific research methodologies were recommended in the context of AIDS-induced migration. Lastly, alternative types of research methodology were explored.

5.2.1 Need for interdisciplinary research on the link between migration and HIV

Bio-medical research (including HIV testing) should be combined more frequently with social science research in order to come up with more conclusive outcomes and quality results. Social science questions, including on migration and mortality, should be inserted in regular epidemiological surveys (like the annual ANC survey). For instance, questions like, "how many deaths have there been in the last five years in the extended family in the 15-49 age group?" or "How many members of your household live elsewhere?" could be included.

5.2.2 Ethical and sensitive issues in research

Ethical questions related to stigmatization, confidentiality, access of researched groups to research information and findings should always be addressed when conducting research on HIV/AIDS. It is particularly important to respect privacy and dignity when conducting research on migrant populations, as they are already marginalized and vulnerable.

¹¹⁷ Young L and N. Ansell, 'Young AIDS Migrants in Southern Africa: Policy Implications for Empowering Children', *AIDS Care*, 15(3) (2003): 337-45.

For example, because of HIV-related stigma/taboo on sex, it is important to consider using proxy indicators to HIV and AIDS, such as chronic sickness and death, TB, medical reports, sexual behaviours etc.

Lastly, it is important for the researchers to return to the researched communities, give feedback on the findings and discuss policy implications of the findings. This is important not only from an ethical and transparency point of view, but also in terms of ensuring community ownership and subsequent effective interventions.

5.2.3 Community context

As migrants do not live and work in isolation, researchers need to be in touch with the “community context” in migrant sending and migrant receiving areas, when conducting research.

Research needs to take into consideration not only existing relationships migrants may have in their places of origin, but also relationships migrants may develop with those they come in contact with during transit (for example, customs officials, truck drivers, etc.) and at the places of destinations (for example local dwellers of surrounding communities, colleagues at work from local areas, etc.).

5.2.4 Research methodologies relevant for AIDS-induced migration

One area of research, which has limited data currently available is AIDS-induced migration. Census data is unlikely to provide the level of detail needed, and is likely to miss migrations that are of a temporary nature or occur only shortly before the migrant's death. There is little possibility that census records of migration can allow inferences to be made in relation to the role of HIV and AIDS. The questions outlined above are, to a certain degree, amenable to investigation through household level surveys. Even here, establishing causal relationships is likely to be problematic, given that HIV and AIDS may be only an indirect trigger of migration. For instance, where people move due to their inability to pay rent, this may in turn be the outcome of illness or death in the household, but

only a carefully designed and in-depth survey is likely to detect such a relationship. Household level surveys could be used to identify both those who have left and those who have entered households over a given timeframe.

While a quantitative approach might help to identify patterns of AIDS-related migration, surveys, and in particular multivariate studies, are problematic. In order to simplify analysis, these studies tend to treat migrants as individuals, thereby losing the connections between individuals and their households/communities that shape the experiences of migration. In Africa, migration is commonly undertaken as a livelihood strategy in response to household needs. However, relatively little research has been conducted in relation to the role of the household. Recent studies have given some emphasis to the decision-making processes within families and the ways in which power relations within a household are central to understanding both decision-making and the consequences of migration. Such processes are arguably best addressed using a case study approach, which relates individual decision-making to households, communities and to wider political-economic contexts. Nonetheless, given that many of those undertaking AIDS-related migration are sick and may die soon after moving, it is important to avoid over-reliance on the accounts of family members, and to ensure that the voices of migrants themselves are heard.

To examine the wider significance and meaning of AIDS-induced migration for individuals, families, and communities, ethnographic studies are required. Critical ethnography can be used to identify how migrants' experiences are socially constructed and situated in both political-economic and cultural contexts. Depending on the context, return migration to rural communities may, for instance, be experienced as failure. Beyond studying the conditions that produce migration, it is useful to recognize "migrants as interpretive subjects of their own mobility" whose identities are constructed in part through their experiences.

Given the involvement of children in AIDS-induced migration, both accompanied and unaccompanied, the use of children-centred methods is appropriate. Such methods acknowledge and attempt to minimize age-related power relations, by placing children in an active role and deflecting attention from adults. An example is the use of

storyboards, which allow children to select and depict a sequence of migration related events in pictures, and provide a useful prompt for discussion of their experiences. Children are also able to take on a more active, participatory role in migration research, identifying issues and taking a lead role in research design and execution.¹¹⁷

5.2.5 Alternative research methodologies

Suggestions were made for the utilisation of alternative research methodologies, and the pros and cons of various methodologies were discussed.

Longitudinal studies: In longitudinal studies, surveillance is done on population groups, like migrants, for a longer period of time and different (bio)data is collected. This could explain why some migrants stay negative even though they might be exposed to risk factors of HIV. However, following migrants for a longer period of time is complicated and expensive and the findings could be non-representative.

Modelling studies: Models could look at many factors, including migration and the link to HIV. Modelling is not used much in this area, although insurance companies and some researchers have developed sophisticated predictive models on the course of the epidemic. Obviously, the models are only as good as the data that is put into the model thus the availability of high quality data is crucial.

Comparative studies: In comparative studies, certain contributing factors to HIV transmission (like migration) can be isolated by comparing different groups such as: migrant/non-migrants;

- women with and without migrant spouses;
- internal/cross border migration; and
- between different geographical areas or regions (West Africa/Southern Africa).

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5.3: Recommendations to improve the link between research on migration, population mobility and HIV/AIDS and policy development

The participants at the workshop indicated that research findings are usually not communicated to policy makers. Most researchers found that policy makers are often not easily approachable. The participants recommended that more advocacy should be done with policy makers to convince them of the need for research on the link between migration and HIV. It was also agreed that there is a need for an independent facilitator that could communicate policy implications of research to policy makers. Such facilitation could be taken up by an independent international organization such as IOM with ready access to government partners.

All research needs a careful plan for engagement with policy makers. Dialogue between researchers and policy makers is crucial during the whole research process. Researchers need to understand and acknowledge the challenges of policy development, and the constraints for translating research into policy. Research should try to fit within the existing policy agenda but can - at the same time - be innovative.

CONCLUSION

Researchers have increasingly recognized the reciprocal connections between population mobility and HIV. However, the fact that migrants and mobile populations are more vulnerable to HIV infection than people who do not move has not been sufficiently realized by policy makers in Southern Africa. For instance, only a few countries in the region have included population mobility and migration in their national multi-sectoral strategic plans on HIV and AIDS, which shows that policy makers have not sufficiently understood the policy implications of the connections between HIV and population mobility.

These national strategic plans on HIV and AIDS should therefore be revisited and be aligned with the SADC HIV and AIDS Business Plan, which is based on three SADC instruments: the RISDP (Regional Indicative Strategic Development Plan), the HIV and AIDS Strategic Framework and Programme of Action, and the Maseru Declaration on HIV and AIDS. The SADC HIV and AIDS Business Plan includes five key intervention areas in which migrants and mobile populations are identified as vulnerable groups for which policies and programmes should be developed regionally.

In order to mainstream population mobility and migration adequately in the response to HIV and AIDS in the region, researchers should follow up the recommendations that were identified in Section 5 of this report. They also should involve policy makers in the design and implementation of the research and communicate their research findings to policy makers on a regular basis. That way, research reports will not be gathering dust on shelves but will feed actively into policy and programme development to reduce HIV vulnerability of migrants and mobile populations in Southern Africa.

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