

HIV and people on the move

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Risk and vulnerabilities of migrants and mobile populations in Southern Africa



HIV and people on the move

Risk and vulnerabilities of migrants and mobile
populations in Southern Africa

Summary report of the structured discussion on
AF-AIDS eForum

April–August 2005

This is a joint publication of Health and Development Networks (HDN) and the International Organization for Migration (IOM) Partnership on HIV/AIDS and Mobile Populations in Southern Africa (PHAMSA)



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- Nicola Ansell, Department of Geography and Earth Sciences, Brunel University
- Lorraine van Blerk, Department of Geography and Earth Sciences, Brunel University
- Daan Brummer, Researcher
- Izeduwa Derex-Briggs, ActionAid International Africa
- Dela Dovlo, Consultant
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- Peter Wiessner, Social Scientist
- Brian Williams, Consultant

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The full text of the discussions, information on joining AF-AIDS and an electronic version of this document can be found online at:

www.healthdev.org/eforums/af-aids

Foreword

HIV is a major challenge facing Southern Africa today. According to the Joint United Nations Programme on HIV and AIDS (UNAIDS), every country in the Southern African region¹ has a national HIV prevalence of at least 10%, and approximately 11 million people are living with HIV in the region.

The multi-faceted relationship between migration and HIV is of particular significance in this region as the wide-ranging movement of people has been taking place for decades, beginning well before the arrival of the HIV epidemic in the 1980s.

This relationship was also recognised by the United Nations during the General Assembly Special Session on HIV/AIDS in June 2001. Paragraph 50 of the Declaration of Commitment stipulates that Member States should “[b]y 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services”².

The overall aim of this project was to share experiences and raise awareness about the issues of HIV, population mobility and migration in the Southern African region. Working together, Health and Development Networks (HDN) and the International Organization for Migration (IOM) developed and implemented a moderated and structured, time-limited e-mail discussion on the links between population mobility, migration and HIV in Southern Africa. The discussion took place on the AF-AIDS eForum, the regional eForum on HIV in Africa, from April

1 In this project, Southern Africa includes the following ten countries: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.

2 United Nations General Assembly, Declaration of Commitment on HIV/AIDS, June 2001

to August 2005. AF-AIDS has over 2500 members from various sectors and different countries in Africa and elsewhere. The discussion focused on three main topics:

- 1 How does migration and population mobility lead to increased HIV vulnerability in Southern Africa?
- 2 How does HIV affect migration and population mobility patterns?
- 3 The brain drain of healthcare professionals from Southern Africa.

Key Resource People were identified and asked to submit a short introduction on each of these three topics, based on research and/or project experiences in the relevant field. Thereafter members of the forum were invited to comment on the introduction pieces and participate in the discussion.

This document summarises the main contributions made by both the Key Resource People and the members of the eForum. It is our hope that the eForum discussion and this publication will increase understanding of the important and complex dynamics related to population mobility, migration and HIV.



Nadine France

Director, HDN



Hans-Petter Boe

IOM Regional Representative for Southern Africa

Summary of topic 1 discussions:



Migration and HIV

This section summarises the discussions that followed as a result of the following key question:

How does migration and population mobility lead to increased HIV vulnerability in Southern Africa?

The following three sub-questions were posed when this topic was introduced to guide the discussion:

- Question 1:** In your view, what are the major factors that affect the HIV vulnerability of mobile populations in this region?
- Question 2:** What are the other key factors increasing the HIV vulnerability of families and communities in migrant-sending areas?
- Question 3:** Based on your experience, what methods or interventions have been or could be used to reduce the vulnerabilities of migrants and mobile populations?

The background documents prepared for the structured discussion reminded readers that in Southern Africa today, the main direction of migration is, as it has been for many years, southwards, with South Africa, Namibia and Botswana being the main migrant-receiving countries. Historically, apartheid in South Africa necessitated labour migration since black people were forced to live in poor, often rural areas with few job opportunities. Key Resource Person (KRP) Mark Lurie, whose research in South Africa credits this system of segregation and migration with the rapid spread of HIV in the region, states that:

[Apartheid] prohibited workers from settling permanently in 'whites only' areas, and forbade them from bringing their families to live with them. Indeed, the aim of the system was to provide cheap black labour to the country's agriculture, industry and commercial sectors. Further, by sending workers who were old and sick back to rural 'homelands' the system absolved companies of the responsibility of caring for their own personnel. Migrant labour and apartheid were therefore almost inextricably linked and it is unclear what forms labour migration will take in the new, democratic South Africa.

With the end of apartheid in South Africa, cross-border labour migration has increased significantly. The number of people crossing South Africa's borders in both directions has increased dramatically since 1990, as has South Africa's formal trade with other countries in the sub-region.

Different studies on migration and HIV have found that analysing migration patterns provides some insight into the distribution of HIV infection in Southern Africa and the disparities in HIV prevalence between Africa and other regions of the world. KRP Helene Voeten, of the Mobility Project³, writes in her contribution to the discussion:

Migration is the strongest single predictor of HIV prevalence in sub-Saharan Africa; other potential socio-economic confounders cannot account for this effect.

In northern Tanzania, migration makes an independent contribution to HIV incidence, also after adjusting for its association with risky sexual behaviour.

3 The Mobility Project (2001-2005) is managed by the Department of Public Health of the Erasmus Medical Centre in Rotterdam, the Netherlands. The research project focuses on the role of population mobility in the spread and control of sexual transmitted diseases in sub-Saharan Africa.

Because HIV is a sexually transmitted infection, sexual networks are an important factor in understanding the spread and prevalence of the disease, and are critical to targeting prevention programmes. Many contributors to this discussion examined the intersection of migration and spatial networks. KRP Brian Williams' examination of HIV prevalence data from Southern Africa and across the world leads him to conclude that:

The rate of increase and the steady state of prevalence of HIV depend critically on the patterns of sexual networking that arise in response to migration of the kind that is most apparent in Southern Africa.

Migrants in Southern Africa are motivated to seek work in new regions largely for economic reasons, but are often ill-informed about the potential perils of labour migration. Frequently the only jobs available to migrants are those least desired by local residents, including mining, agricultural work, transport and informal trading, sex work, and domestic employment.

The unfamiliar context and frequently harsh, dangerous and lonely working conditions, as well as limited access to adequate and affordable health care, pose particular hazards for the health of migrants – including increased vulnerability to HIV.

The factors aggravating the HIV vulnerability of migrant workers that were brought up during the discussion are highlighted in this section.

The structural context

As many contributors to the eForum indicated, the conditions in which migrants work and live impact on their vulnerability to HIV. They often live in overcrowded, single sex accommodation that offers limited social support or access to recreation, and few opportunities for intimacy. In conditions of loneliness and isolation, far from home and family, sexual intimacy – often with sex workers – represents a form of emotional intimacy that may be lacking in other areas of their lives. As KRP Mark Lurie says:

It is not hard to see how migrant labour plays a major role in the spread of the HIV/STI epidemic in Southern Africa: take millions of young men, remove them from their rural homes, house them in single-sex hostels, give them easy access to sex workers

and alcohol and little or no access to condoms, and pretty soon you will have a major HIV/STI epidemic.

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The mining industry in South Africa has attracted migrants from all over Africa. KRP Brian Williams points out that mines have employed hundreds of thousands of workers from all over the region for many decades, but unfortunately the conditions in which miners live has not changed significantly over time. These workers are often away from their place of origin for eleven months of the year, sometimes for most of their adult lives.

KRP Daan Brummer concludes that:

Housing mineworkers in single-sex hostels is likely to exacerbate some of the negative social effects of the migrant labour system in Southern Africa.

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There has been some recognition of the need to change. A few companies are replacing crowded, all-male hostels with low-cost, family housing, often working with local governments to build houses and convert old hostels. Lonmin Platinum in South Africa is one of the leaders in these efforts (Itano, 2002).

Many migrant workers, whether employed in the formal or informal employment sectors, work in very harsh environments. They are often exploited and expected to work in difficult and dangerous environments. A report by IOM's Regional Office for Southern Africa found that among migrant farm workers on the border between South Africa and Mozambique, stressful work with a high risk of physical injury may induce a feeling of hopelessness in which the dangers of contracting HIV are outweighed by other pressing concerns and needs.

When one's daily life is a struggle in so many respects, HIV and AIDS appears as a distant threat, only one of many, faced daily by workers. Interviews with workers give a sense that many feel disempowered, leading them to believe that they have few choices and little possibility to improve, or alter the course, of their lives. They lament that there is little hope for the future, which suggests that workers may have little incentive to act in a manner which will safeguard their health in the long term, or seek help when their health and well being is threatened. (JICA/IOM, 2004).

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The cultural context

The move to a different cultural context in search of work can also mean isolation from protective social rules, which can increase vulnerability to HIV. KRPs Mary Haour-Knipe and Danielle Grondin of IOM point out that:

Although migrant and mobile people, as do any individuals, have a responsibility to take care of their own health, behaviour is often different when people are away from home, and away from the social norms that guide and control behaviour in stable communities. People who move from a conservative society to one perceived to be more liberal may be ill-equipped to deal with sexual freedom: they may not understand the norms or the limits in the new society, and how to protect themselves.

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In his research, KRP Daan Brummer reviewed migrants' construction of vulnerability in Lesotho using in-depth interviews with mineworkers. His findings highlight the importance of the socio-cultural context of migrant life.

Migration stands for change: change of physical environment, of cultural traditions, of social norms, of power structures etc. Migrant mineworkers move between their home country, where they are located within familiar local structures and practices, and the mines, where they live in a new environment, often devoid of traditional social norms... Separation from home, sharing crowded rooms in large hostels, loneliness, and the harsh working conditions seem to add up to a feeling of helplessness. Some mineworkers clearly express a fatalistic attitude towards their lives in general.

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Barriers to accessing care and support

The health of migrants is also jeopardised by the lack of access to health care and social services, including voluntary counseling, testing and treatment of sexually transmitted infections (STI). Research presented at the XV International AIDS Conference in Bangkok in 2004 suggests that in the Eastern Cape Province in South Africa, areas with poorer measures of infectious disease outcomes are correlated with larger migrant populations and lower socio-economic status:

Many migrant jobs, even formal or contracted positions, do not provide for doctor's visits or medication. Some migrant work is in rural areas far removed from clinics and health-care providers, or may not pay enough to access appropriate care. (Banati & Williams, 2004)

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Migrants may also delay accessing care when other concerns and needs are more pressing. KRPs Mary Haour-Knipe and Danielle Grondin emphasise the variety of migrant experiences and the motives for delaying or avoiding care:

People travelling, fleeing danger, or pursuing a dream by migrating are understandably reluctant to deal with the possibility of an illness that would slow them down, and may delay thinking about a symptom until a problem has become impossible to ignore: An immigrant girl may thus come for a first consultation when she is in an advanced stage of pregnancy; a trucker may present at a clinic only when a STI is very painful, and a would-be migrant in transit may find out about his HIV positive status only when he has advanced AIDS.

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Reaching mobile populations

KRP Helene Voeten reported that an important part of the Mobility Project's findings was that migration reduces the positive impacts of population-wide HIV programmes, such as promoting condom use. The project also found that interventions focused on mobile groups are 'promising additions' to the current HIV control options and that such interventions can reduce new infections.

The Mobility Project also studied the potential benefits of having spouses and families move with the migrant worker to their places of destination. This was however shown to be less effective than other means of preventing new infections.

Exploitation and the lack of rights and legal protection

Labour migrants who travel and work undocumented in Southern Africa face many challenges and often do not enjoy the same legal protection as residents and therefore cannot access health services, including voluntary counselling and testing (VCT) and treatment for STIs.

Undocumented workers, especially, fear contact with government or other officials. KRP Izeduwa Derex-Briggs sums up the particular risks for the health of workers without official status.

Undocumented migrant workers represent one of the most vulnerable groups to HIV infection. Because of their fear of deportation they avoid contact with official government agencies and have little access to health and welfare information and services.

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The lack of rights has been repeatedly recorded as one of the key factors increasing HIV vulnerability for migrants and mobile populations. Migrants' rights, including the right to work, to move within the country, to education or to access health care, are often directly related to the legal status of individuals. Foreign workers are generally not represented by unions, and often have weak negotiating and bargaining powers vis-à-vis their employers.

Gender dimensions of HIV and migration

Approximately half of the migrants in the world today are women (Global Commission on International Migration, 2005). In recent years women are increasingly leaving home for work, both in formal and informal sectors. Informal cross-border trading has expanded dramatically, with women playing a major role in the buying and selling of goods across borders. This reflects another significant trend – the feminisation of migration. Women are increasingly leaving their region of origin for work opportunities elsewhere. However, lack of education often restricts women to unskilled jobs such as informal trading, agricultural labour, or domestic work.

KRP Chitra Akileswaran, while emphasising the diversity of experiences among migrant women, points out their common experiences of increased vulnerability to exploitation and discrimination:

Migrant women represent a diverse group of motivations, routes, conditions, and livelihoods. The search for economic opportunity drives much of the female migration in Southern Africa. Based on the lack of formal employment available for many women, some migrate with the intention of pursuing inherently risky livelihoods such as commercial sex work. Others migrate autonomously to look for work in the informal sector, as domestic workers, or agricultural labourers.

In Southern Africa, as well as other areas of the world, the increasing mobility of women as labourers, sex workers, refugees, and trafficking victims has been referred to as the 'gendering' or 'feminisation' of migration by a number of scholars. (Williams, 2002; The Synergy Project). All sources of information indicate that while migrant women are quite heterogeneous in nature, poverty and gender inequalities heighten their risks for HIV and AIDS.

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Several contributors expressed concern at the dearth of knowledge and research about women migrants in particular, and their vulnerability to HIV.

Although women have composed part of the migrant labour force in Southern Africa since the turn of the century, there is little research that highlights the mechanics and socio-economic context of female mobility. (Chitra Akileswaran)

Women however are often invisible as major actors in the migration processes and statistics usually don't include them. (Izeduwa Derex-Briggs)

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Transactional sex

The vulnerability of female migrants to HIV can arise from a variety of factors that also affect the spread of HIV, including social isolation, poverty, low levels of education and lack of access to health care services such as testing and treatment for STIs. Women who migrate for work are also more at risk of violence and risk-associated sexual behaviour, such as transactional sex. KRP Chitra Akileswaran argues;

Female migrants who engage in transactional sex often do not identify themselves as sex workers. Thus, it is important to note that many of the risks faced by sex workers apply to them as well.

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Women are particularly vulnerable in these circumstances, and even programmes targeting either migrants or sex workers may not reach them. The Mobility Project found that:

Migrant women had higher incidence of HIV compared to non-migrant women and that migration often resulted in increased sexual risk behaviour. The research also found that although men reported equal numbers of sexual partners whether they migrated for work

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or remained in their place of origin, women who migrated for work had more sexual partners than resident women.

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Violence and exploitation

Violence and rape are also potential HIV risk factors for mobile women, whether they are migrating for work, fleeing war or engaging in cross-border trade. Several forum contributors expressed concern at the dangers faced by migrant women and the potential negative consequences of migration for their sexual and reproductive health. KRP Chitra Akileswaran describes the particular vulnerabilities faced by migrant women:

A study of farms in the Free State province [South Africa] revealed that 15% of female migrant workers had been raped, and a similar trend occurred with Zimbabwean farm workers in the Limpopo province. Female migrants experience a heightened risk of HIV infection in transit as well; female informal traders meet 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, sex is regularly used as a tool of exchange for food, transport, or leniency in the workplace. Suffice to say, condom use is rare within these sexual encounters.

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Non-migrating women

Women also appear to be at risk of HIV infection as the stay-at-home spouse of a migrant. This may be due to several factors, including having unprotected sex with an infected spouse or with other sexual partners in the absence of the spouse. Women may be unable to negotiate condom use with a spouse when he returns home, or with other partners. Several contributors to the discussion highlighted the fact that women left behind with insufficient resources may be forced to engage in transactional sex in order to support their families.

Research undertaken by Mark Lurie in the KwaZulu Natal province of South Africa compared 'migrant couples', in which one of the partners migrates for work, with 'non-migrant couples'.

Migrant couples were more likely than non-migrant couples to have one or both partners infected with HIV (35% versus 19%) and to be HIV discordant (27% versus 15%) – meaning that one partner is infected and the other is not. Among the HIV discordant migrant couples, 30% of the time it is the woman who is HIV-positive and her migrant partner who is negative. Clearly, someone else must have infected an HIV-positive woman whose migrant husband is not infected.

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These findings highlight the importance of working not only with migrants at their place of work, but with their rural partners who stay home as well.

The Mobility Project, of the Department of Public Health, managed by the Erasmus Medical Centre in Rotterdam, the Netherlands, also found increased vulnerability for spouses who remain at home, and that there may be other cultural factors, such as polygamy, which, in combination with migration, place non-migrating women at risk.

Men and masculinity

In the same way that gender inequality increases migrant women’s vulnerability to HIV, gender also impacts on the vulnerability of male migrants. For men, migration often means long periods of time away from partners and families, working long hours, living in bleak conditions and performing dangerous jobs. Isolation, loneliness, access to alcohol (and other drugs) and access to sex workers set the stage for sexual risk behaviours which ultimately may endanger the worker himself, his partner and his family.

KRP Daan Brummer’s research among Basotho⁴ mineworkers raised the issue of masculine identity as an important factor in understanding men’s vulnerability to HIV. Perceptions of their own ‘masculinity’ affected the behaviour of mineworkers with regard to their sexual choices. These Basotho men, who work in the mines in South Africa, described faithfulness and responsibility to wives and families at home as an important part of being a ‘real man’. They contrast their own traditional Basotho values with the ‘loose moral standards’ of South Africa.

4 Basotho are people from Lesotho

Yet, while they are in South Africa, mineworkers may feel freed from social restrictions and 'traditional' Basotho notions of masculinity. Moreover, when 'traditional' notions of masculinity are – literally – rather distant, mineworkers may be more likely to reinterpret and reconstruct these notions of masculinity.

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Brummer suggests that this construction of masculinity may be a barrier to using condoms with regular partners, since this conflicts with their image of 'real men' as faithful to their spouse and responsible to family.

Forum member Alan Beesey suggests that the Mekong region of South-east Asia and its highly mobile migrant communities may provide instructive lessons for Southern Africa.

Responses in South-east Asia have generally viewed male attitudes and behaviour as 'the problem'. And they are problematic, especially as women and girls are generally the 'victims' (in needing money; in being coerced, etc.). We may be talking about aberrant behaviours but they have become normal in many respects, thus, moral programmes and prohibitions may not be effective. This is not to say that social and cultural 'norms' cannot be confronted, but this is why it is imperative to work with the target group in seeking solutions to determine when and how, and when not to, confront such norms.

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Also from South-east Asia is eForum member Jacques du Guerny who suggests that countries from Southern Africa could follow the example of six countries in South-east Asia. Cambodia, China, Lao PDR, Myanmar, Thailand and Viet Nam signed a Memorandum of Understanding for Joint Action to Reduce HIV Vulnerability Related to Population Movement. This MOU (2004-2009) supports joint actions to reduce mobility related HIV vulnerability through development cooperation.⁵

5 <http://www.hiv-development.org/publications/MOU11.htm>

Summary of topic **2** discussions:



HIV-motivated mobility

This section discusses a number of areas related to the question: How does HIV affect migration and population mobility patterns?

Two sub-questions were posed to guide the discussion:

Question 1: In your view, how does HIV affect migrants and mobile populations in this region?

Question 2: Based on your experience, what methods or interventions have been/ could be used to reduce the impact of the HIV epidemic on migrants and mobile populations?

It is clear that particularly in Africa, poverty is one of the key factors influencing the spread of the virus and the continued movement of individuals and groups. HIV and migration are closely linked in this context as both are fuelled by poverty and are affected by many of the same forces and inequities.

HIV changes migration and mobility patterns in a variety of ways. Stigma is still an important issue in Africa, and people diagnosed with HIV or displaying physical evidence of disease may migrate, to avoid discrimination or stigmatisation by their community, in search of more tolerant surroundings.

Secondly, people living with HIV commonly return to live with their families to receive care. This might entail moving from an urban area back to a rural area or from one country to another.

Others migrate in order to provide care to family members living elsewhere. When a household loses its primary breadwinner due to HIV, the remaining family members may migrate to seek income-earning opportunities.

People with AIDS-related opportunistic infections may migrate to obtain antiretroviral (ARV) treatment and quality health care 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.

The impact of HIV-related migration is also being felt among non-government organisations (NGO) and other health research projects, as staff and participants are motivated to move due to HIV. eForum member Daniela Gennrich of Pietermaritzburg Agency for Christian Social Awareness (PACSA) in South Africa commented on the effects of losing participants in research on gender, poverty and HIV who were compelled to move because of stigma and other HIV-related reasons. She also explains how HIV-related migration has affected the service and care provided by her NGO:

Apart from the obvious implications for national decision makers with regard to social and economic planning, most if not all of the impacts of HIV on migration need to be taken into account as possible impacts on our projects in different areas. This is because, in our experience, we may lose development workers or community-based trainers, not only because of the obvious factor of their sickness and possible death, but because of the ways HIV affects them. One example is that one of three trained community home-based carers in a rural village near Pietermaritzburg had to move back to her mother's house in order to nurse her. This leaves a number of clients of the community based organisation in this area without adequate care, as it is hard for the other two to cover all the patients adequately.

We have also found that, although women tend to be the most committed and reliable community volunteers in different aspects of community development and training, they are also least predictable, because of family pressures on them.

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Child migration

HIV affects the lives of children in Africa profoundly. Approximately 90% of all HIV-infected children in the world, nearly 2 million children, live in Africa. (UNICEF, 2006). There are an estimated 12.1 million children in sub-Saharan Africa who have lost one or both parents to AIDS. (UNICEF, 2003). The issues associated with HIV for children are well documented: stigma, loss of caregivers and educational opportunities, extreme poverty, child labour and early death. But as KRPs Lorraine van Blerk and Nicola Ansell of Brunel University have found in their research, in the case of children “the increased vulnerabilities associated with migration are less well documented.” They studied 226 young people between 10 and 17 years old in urban and rural communities in Malawi and Lesotho. Their findings highlight the special nature and lack of attention paid to child migration associated with HIV.

Children engage in migration for many reasons, as orphans and even before they become orphans, if their parents or other members of their extended families are affected by the pandemic. However, policy rarely considers children as migrants and instead seeks to support children affected by AIDS as static members of their communities. Children who move between communities are faced with the additional problems of placelessness and lack of identity that can magnify some of the negative impacts of AIDS.

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Ansell and van Blerk suggest four situations that should be addressed in policies: children who move to live with relatives; children who move as young carers; homeless children; and children in institutions. They further warn that if these issues are not addressed in programmes and policies, there will be a generation of children in Africa living with stigma, homelessness, the burden of caring for terminally ill adults, and dealing with the loss of schooling opportunities.

Summary of topic **3** discussions:



The dynamics and impact of health worker migration

This section focuses on the third, and final, discussion topic: The migration of health care professionals from Southern Africa.

Three sub-questions were posed to guide the discussion:

- Question 1:** What are the factors that contribute to the emigration of skilled health-care workers from Southern Africa to more developed regions of the world?
- Question 2:** What impact does the increased migration of these health-care workers have on both the countries of origin and the receiving countries?
- Question 3:** What strategies/responses can you suggest for governments and other decision-makers in both sending and receiving countries to counter the negative effects of brain drain?

Worldwide, the migration of skilled health care workers from less developed countries to places with better opportunities – the so-called ‘brain drain’ – is having a catastrophic effect, particularly in public health service delivery. A number of countries, especially in Southern Africa, have reached the point where the public health sector cannot cope with the growing burden of HIV.

In a posting from Management Sciences for Health to the e-Forum some examples are given of the magnitude of the shortage of health professionals:

Shortages of trained health staff are a crisis of epidemic proportions in the developing world. Many health systems are near collapse due to a large population of HIV patients and a shrinking workforce. According to some figures, 66 percent of graduating doctors in developing countries eventually emigrate. In the last three years, Malawi ‘exported’ 20 more nurses than it graduated. In South Africa, the number of registered pharmacists has reportedly dropped from over 11,000 at its peak a few years ago, to less than 9,000 (Management Sciences for Health, 2005).

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The lack of qualified doctors, pharmacists, nurses and other health care workers has created a vicious cycle in the health sector in Africa.

A contribution that summarised a Lancet article by Katharina Kober and Wim van Damme (Mobile populations: Scaling up access to ARV treatment: who will do the job?) from early 2004, describes the situation in Malawi:

...Health workers are caught in a vicious cycle, a cycle in which they themselves are victims of the epidemic in several ways. Five- to six-fold increases in health worker illness and death rates have been reported for Malawi, and the number of deaths in nurses represents 40% of the average annual output of nurses from training (Huddart & Picazo, 2003).

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The deteriorating conditions force health care personnel to leave their home countries, and as a result, there are not enough trained staff to manage the ‘scale up’ of antiretroviral (ARVs) drug provision and other interventions needed to treat people with AIDS. Without improvement of this situation it is difficult to imagine how Africa, with 25% of the world’s disease burden and 66% of AIDS cases, will manage with only 1.3% of the world’s health-care workforce (UN-AIDS, 2004; Physicians for Human Rights, 2005).

The paucity of skilled health care workers in many Southern African countries is partly due to the fact that nurses and doctors are leaving to work in more wealthy, developed countries – especially the United Kingdom, a popular destination for African health care workers.

KRPs Gilles Dussault and Dela Dovlo's contribution gives an idea of the magnitude of the emigration of health workers from Southern Africa:

Data on migration are not collected systematically and it is difficult to estimate the full size of migratory flows. There is, however, enough information to alert policy-makers to a phenomenon which potentially has dramatic consequences for a region which already has an insufficient supply of health personnel.

One way of estimating emigration is to look at verification records; requests for verification of credentials are a good indicator of the intention to migrate. They show that there are migratory flows within the region, but in general, migration to countries of the North is stronger. Zambia's verification records show that 70% of enrolled and registered nurse requests were intended for South Africa (32.7%), Botswana (32.2%), Namibia (2.9%) and Zimbabwe (2%) (Munjanja et al., 2005). Malawi differed, as only 6.5% of nurses sought verification for other SSA countries compared with 82% (203) for the UK. In Ghana only 0.8% (24 nurses) verified their qualifications for work in South Africa compared with 80% for the United Kingdom (Buchan, Dovlo 2004).

Mobility of nurses from source countries has risen sharply especially between 1998 and 2002. Verifications by Malawian nurses rose to about 100 per year between 2001 and 2003 and in Zambia 1297 nurses sought verification in the 5 years between 1997 and 2002.

Shortages of health personnel in developed countries, like the United Kingdom, are caused by various factors including an ageing population, an ageing health-care workforce and complicated medical interventions. This scarcity, in turn, leads to increased demand for health care professionals, and has resulted in an increased dependence on overseas personnel to fill the gap.

John FK Mutikani of the University of Colorado School of Nursing points out:

Generally in the world, there is shortage of health manpower. In most of the developed nations, their workforces are ageing and the pace of training cannot fill the gaps. Another trend is that health workers, especially nurses are not paid well according to standards of

those countries hence younger people are not attracted to these professions. The next best thing for these nations is to recruit from the poorer nations.

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Subsequently, health personnel from developing countries fill the gap in the developed countries, resulting in gross inequities between developed and developing countries. In Malawi, for example, there is currently just one doctor for every 100,000 people, and in Mozambique the ratio is one to 30,000 (Kober & van Damme, 2004). In contrast, France has one doctor per 330 people (Kervasdou, 2002).

The movement of health-care personnel towards more wealthy regions is not a new phenomenon, however the current situation is more problematic than in the past because the HIV epidemic in developing countries is rapidly depleting workforces and increasing the overall workload.

The migration of health-care workers hampers the scale-up of treatment, effectively reducing the number of workers available to care for people with HIV and other illnesses.

The discussion on the migration of health workers highlighted the need to consider the varied and combined push/pull factors of migration, as well as the need to consider responses that go beyond just preventing health-care workers from emigrating.

Types of health worker migration

When analysing the migration of health care workers, different types of migration can be distinguished. KRP Reiko Matsuyama (IOM) highlighted the following categories: international, regional and internal migration.

International migration usually takes place from less or medium developed countries to developed countries (such as from South Africa to the United Kingdom). During 2002-2003, for example, 13,000 foreign nurses were registered to work in the United Kingdom. Among them were 3,472 nurses from developing countries already identified as having dangerously low numbers of nurses, and from where recruitment is therefore discouraged, including Zambia (Eastwood, 2005).

Regional migration occurs mainly from less developed to nearby medium developed countries (e.g. from Malawi to South Africa).

Internal migration happens from the public to the private sector, and from rural to urban areas. Even if personnel do not actually leave the country, there may be a shift away from public health care services. A senior Malawian doctor writing to the Lancet in 2004 commented that health care staff are leaving government hospitals to work for programmes sponsored by universities and NGOs (Kushner, 2004).

Factors of migration of health workers

Factors that may cause the migration of health workers and contribute to the ‘brain drain’, are generally understood to be ‘push’ factors – elements in the home country motivating nurses and doctors to leave, and ‘pull’ factors – the attractions of working in another country.

Push factors

Push factors are mainly related to the general environment in which staff in Southern Africa work. They include inadequate medical education and training, poor working conditions, and weak human resource management. Perhaps one of the most underrated reasons is job stress, especially in countries affected by HIV. Given that workloads throughout Southern Africa are increasing, pay is low and health care workers have inadequate access to universal precautions – fueling fear of HIV infection, it is easy to see why personnel are motivated to leave if the opportunity presents itself.

As KRPs Gilles Dussault and Dela Dovlo point out:

Most reasons [for migrating] are negative. These are a mix of reasons relating to working conditions (poor compensation, declining health services, heavy workloads, lack of promotion, poor management) and to the broader environment (economic decline, violence and crime) (Awases et al., 2004). All these relate to differentials between what health professionals get in their country of origin, and what they expect to have in a country of destination. As is often said, they look for greener pastures. The greater the differentials, the higher the temptation to migrate will become.

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The Environment

Health expenditure in most Southern African countries is low, and structural adjustment programmes implemented in many African countries in recent years, in response to heavy debt, have led governments to cut health care costs. This has been accomplished in part by down-sizing its workforce and cutting spending across the board. In Kenya, one third of qualified nurses are unemployed (Volqvartz, 2005).

The poor funding for health services has also resulted in a shortage of proper equipment, including supplies such as gloves needed to prevent occupational exposure to HIV and other diseases. One report on care and hospitals in Malawi described the situation as ‘medieval’ (Fraser, 2005). Health professionals in many Southern African countries, particularly in the rural areas, often feel constrained in fulfilling their tasks due to lack of medicines and equipment, resulting in ineffective and inadequate care for patients and high levels of stress for medical personnel.

In countries where HIV prevalence is high the health workforce has been profoundly affected. Stigma and fear cause even health care workers to hide their status, avoid treatment or move elsewhere. Kober and van Damme report that:

MSF [Médecins sans Frontières] staff from project sites in several countries shared stories of health workers who would rather die than disclose their HIV status to a colleague. As a consequence of this high attrition, staff has to cope with ever-higher workloads, and the remaining health workers’ fear of infection with HIV in unsafe care situations contributes to growing emotional and physical stress and job dissatisfaction. (Kober & van Damme, 2004)

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The general social milieu also affects health care professionals’ desire to leave their home countries. Violence, poverty, crime and political instability affect their daily life, family and work environment. eForum member John FK Mutikani, now at the University of Colorado School of Nursing, shared his own personal experiences in Zimbabwe. He was employed by the Ministry of Health and Child Welfare before leaving to work for an NGO which was better able to implement programmes and provide services. He describes the political dangers for health-care workers in Zimbabwe that forced them to leave.

There was a call for personnel development and a large number of nurses were sent, mostly to the USA, for further education in preparation for leadership positions in the new era. [Upon return], some of the nurses found themselves as 'undesirables' under the political system because they had gone to study abroad and quite a number had to seek political asylum in foreign countries.

Medical education and training

KRP Reiko Matsuyama (IOM) also pointed out that in general, health-care training institutions in Southern Africa do not adequately prepare graduates for the conditions in the rural or under-funded environments in which most of them will eventually practice. Hence, students are not properly prepared for the range of issues and diseases that they deal with, leading to burnout and dissatisfaction in their work. Insufficient funding for the training of medical, nursing, and related professions, as well as lack of specialisation courses, often result in low numbers of graduates.

There are also limited opportunities for health care workers to continue training and education once they are employed. It is often both difficult and expensive to attain study leave, and due to the shortage of health workers, there is little time or funding for health workers to attend conferences and professional meetings in order to exchange information and skills. This leads to a lack of upward mobility and growth in their careers, and, subsequently, potential frustrations among professionals.

Human resources management

In many Southern African countries, inadequate human resource planning and coordination has led to the mal-distribution and wastage of health care personnel capacity. This, combined with a lack of resources to recruit, train and support them, creates a frustrating working environment for most health care workers, which may push them to migrate.

Imbalances in the distribution of health human resources within Southern Africa occur in different ways and affect different population groups. The most obvious form of mal-distribution is the urban-rural divide. Health care institutions are often concentrated in urban areas, creating access problems for rural

populations. Inadequate distribution also occurs in terms of skills and specialisation. A poor skills mix means, for example, that highly trained health professionals undertake tasks that could be done by lesser educated/trained professionals, such as paramedics or community health workers.

The scarcity of personnel is acknowledged to be the greatest barrier to implementing strategies to combat HIV. Comprehensive human resource plans are often lacking and where management systems do exist, they are often inefficient and involve several ministries and departments (Management Sciences for Health, 2004). This may result in slow changes and inefficient use of time and resources.

Pull factors

Several of the above mentioned push factors in the sending countries are directly related to the pull factors in the recruiting countries. In receiving countries there is often a more stable and safer socio-political environment; the work environment is more conducive to training and skills development; and staff have access to state of the art equipment and facilities, which make advanced practices and procedures possible.

Government spending on research and development in Africa is very low and as a result there are more African-born scientists working in the United States than there are in Africa (Commission for Africa, 2005). Other factors that make migration attractive include good employment policies and recognition for good performance. In many recruiting countries health care workers enjoy benefits not available in their own countries and earn much higher wages. Recruitment agencies play an active role in pulling professionals from Southern Africa, making it easy for workers to leave.

Pay and benefits

The difference between the salaries and benefits that nurses, doctors and other health staff receive in their country of origin as opposed to what they can earn in wealthier countries is large. KRPs Gilles Dussault and Dela Dovlo analysed health sector shortages and found that poor compensation and benefits were a key reason why professionals sought opportunities elsewhere.

Many contributors to the discussion said that the inability of medical staff to earn a reasonable wage to support their families is a major motivator for migration. For example, John FK Mutikani says:

Patriotism is an honourable societal obligation, but nobody can feed on patriotism. Health workers, like any other workers, need to feed, clothe and educate their children as well as take care of their extended families. They also need to feel safe in their own land. If these basic needs are not met, it is difficult for any normal human being to be productive.

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He goes on to say that salaries are only part of the equation and that it is instructive to examine the case of Zimbabwe and its outflow of health workers.

In the mid to late 1980s, salaries and conditions of services were being improved as the health care services were being upgraded. It may not have been the salaries that the health care workers were worried about. For example the doctors went on strike for better incentives. They were asking for access to commodities such as housing and car loans. I believe their colleagues in Botswana were afforded easy access to loans for purchase of houses and cars whereas the loans in Zimbabwe were a pittance and one had to work for a very long time before qualifying for the little amount of loan.

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Enabling factors

In addition to push and pull factors, there are also ‘enabling’ factors that often influence the nature and direction of the migration flows. These may include: the use of western educational materials in Southern Africa, international trade agreements that facilitate trade in health services, international recruitment agencies, and transnational communities.

Use of western educational materials in Southern Africa

Many of the medical institutions in Southern Africa prepare students to work with diseases and facilities that are found in western medical settings, often using western medical texts written in English. Chilimba Hamavhwa of the Chainama College of Health Sciences in Lusaka notes:

...the training (curricula) of these professionals from Southern Africa countries is/are highly favoured by the receiving western countries.

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Many medical school degrees from Southern Africa, particularly those from English-speaking countries, have standards similar to western degrees, enabling students to practice abroad, and in that way, indirectly encouraging them to do so (Hicks, 2004).

International trade agreements

A major enabling factor for the migration of health workers is the existence of an international trade agreement that facilitates trade in health services. The General Agreement on Trade in Services (GATS) is a World Trade Organization (WTO) agreement that came into force in January 1995. It comprises of a set of multilateral, legally enforceable rules covering trade in services designed to encourage liberalisation of markets. Specifically relevant for the migration of health workers is the fact that under the GATS, health services may be ‘traded’ through the temporary presence of health workers in other countries. Further, since the GATS only defines the term ‘temporary’ as excluding permanent migration, individuals are perceived as service providers and thus not long-term entrants to the labour market (Bach, 2003). Therefore, this agreement in effect creates an enabling environment, which facilitates the migration of health workers.

International recruitment agencies

Another enabling factor is the active recruitment by some receiving countries, due to domestic shortages of health personnel. Recruitment agencies often make travel arrangements, and organise accommodation for health workers from developing countries. As eForum member John FK Mutikani writes, based on his own experience:

This is business and there are no ethical considerations for the effects on the countries where the workers come from.

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The United States government has made the immigration process easy for registered nurses and physical therapists. These professionals can take advantage of expedited processing for residence status and may eventually become citizens based on their qualifications. Many recruitment agencies assist in this process.

eForum member Hamavhwa Chilimba from Zambia argued that the combination of severe poverty in sending nations and neo-colonialist attitudes on the part of receiving countries ensures the continued flow of health care workers from Africa. A news article from the Herald newspaper in the UK (Fraser D, 2005) posted to the eForum discussion describes health-care worker ‘poaching’ in the following way:

The staffing crisis reflects the old colonial approach – except that instead of mining for gold and diamonds, Europeans are now going to Africa to ‘mine for nurses’.

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Although the continuing recruitment of professionals facilitates the flow of personnel, Meleis (2005) considers that one of the key elements contributing to the migration of nursing staff is the downgrading in status of formal and informal care giving. In order to retain staff in their home countries, Meleis recommends governments enhance the status of care giving itself. Otherwise personnel, especially nursing staff, will always be drawn to countries offering better status and characterised by technical and medical innovation.

Transnational communities

Lastly, existing networks of relatives and acquaintances in the country of destination (‘transnational communities’) facilitate migration and direct migration flows by providing the necessary information, contacts to find work, and a welcoming, supportive social environment. These networks of social and emotional ties reduce the costs and risks associated with migration, as people from the local immigrant communities, often from the same ethnic or social group, may help and take care of the new migrants.

Strategies and Responses

The contribution by Katharina Kober and Wim van Damme that summarises a Lancet article (Mobile populations: Scaling up access to ARV treatment: who will do the job?), outlines some existing initiatives by national policy makers to tackle the human resources for health challenges:

In Mozambique the Ministry of Health is planning to substantially increase the output of medical schools and training institutions for paramedical staff. However, as Avertino Bar-

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reto, Deputy Director of Health in Maputo points out, "this is a long-term measure and in the short term we will have to resort to intermediate solutions such as importing medical doctors from Cuba".

In Malawi, where most nursing schools are running well below capacity and many missionary nursing schools have completely closed, measures have been taken to raise the standards of secondary schools in order to produce more entrants for medical and nursing programmes. ... Reactivation and short-course training to return former community-health workers to the workforce is also being considered.

In South Africa, many call for a change in the type and orientation of training to increase its relevance to health needs in the country instead of focusing mainly on European style tertiary hospital skills. ... To make better use of the skills mix of existing staff, South Africa's plan for scaling up antiretroviral treatment relies mainly on nurses instead of doctors.

Von Wissel in Swaziland, says that "with this epidemic we have to keep our minds open for new ideas and keep looking for innovative ways of dealing with it". One such way is the Swazi strategy of including both public and private health sector medical doctors in the national AIDS plan.

In all four countries people tell us not only about measures to increase the production of health workers but also about retention measures to keep them in rural areas, in the public sector or in the country. In Mozambique and South Africa, for example, medical graduates are obliged to do a period of community service before being allowed to register in an urban centre. The South African government is experimenting with a variety of incentive schemes, distance learning possibilities, and support for spouses and families in rural areas.



John FK Mutikani of the University of Colorado, School of Nursing also points out that:

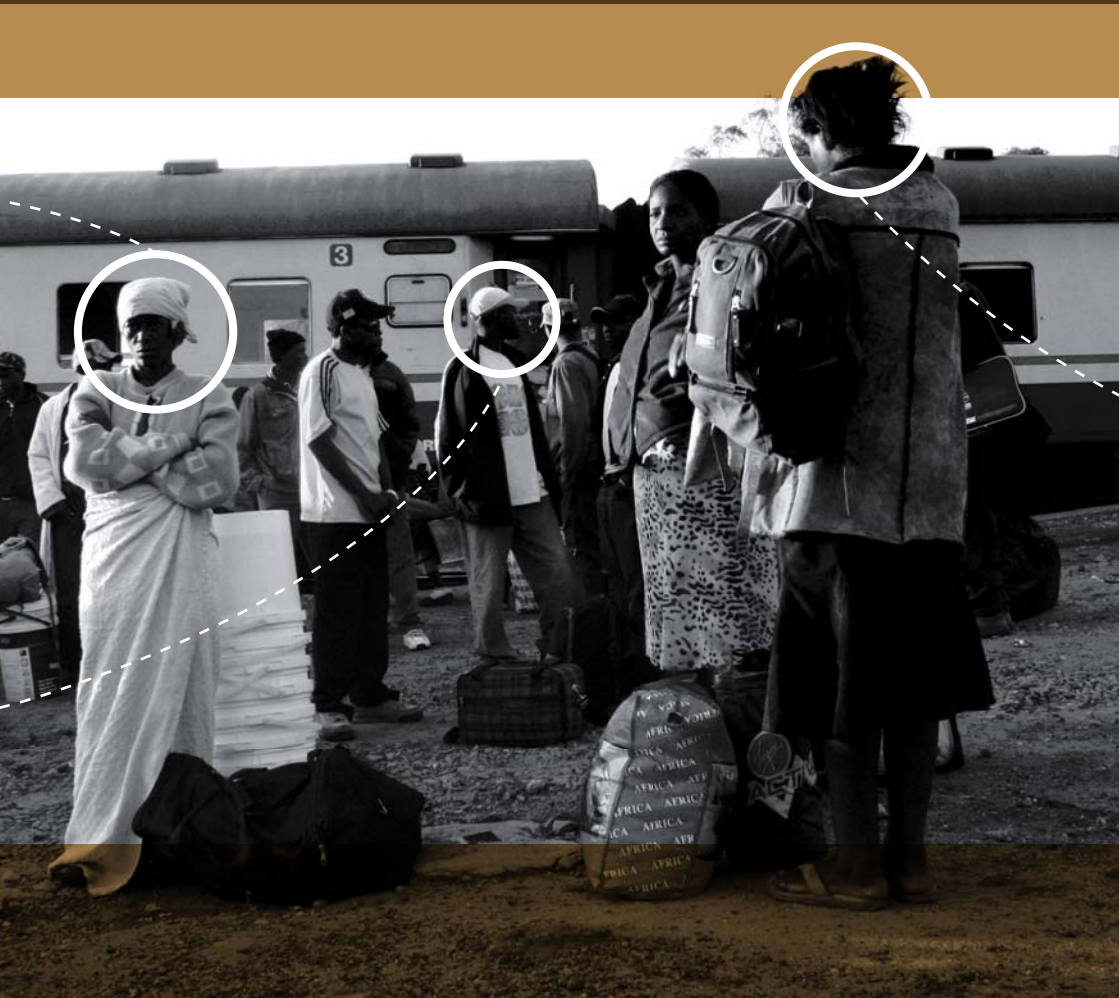
Enforcing laws that prevent workers from freedom of movement will not solve the problem because this equates to forced labour with no consideration for human freedom and survival. It is imperative for governments to consider providing decent salaries, incentives and good conditions of service including respect for the workers. Governments should also form coalitions with private industries who are benefactors of the product of government

trained health workers. Industries should provide funding for the enhancement of training of health personnel to benefit both the private and public health sectors. Developing countries can and should solicit assistance from richer nations to boost their workforce and enable them to provide for the satisfaction of the workers.

KRPs Gilles Dussault and Dela Dovlo make the following suggestions on the way forward:

There are no templates or generic prescriptions for countries to follow in their attempts to address the migration issue. Every country needs to start a process of developing and implementing comprehensive and effective health workforce strategies. These take time to produce results, which means that actions must be very immediate. Providers, such as health extension workers in Ethiopia and community health nurses in Ghana, are examples of ways of rapidly increasing access to health workers. Reviewing working conditions, including remuneration, career structures, management of posting, transfers and promotions, occupational safety, is urgent. African pastures must become greener, if the region wants to avoid losing the investments it makes in training health personnel, and above everything, if it wants to respond to its enormous health needs. International financial agencies and bilateral donors need to mobilise to support those actions.

There is also a moral case for rich countries to review their recruitment practices. While it is reasonable to argue that individuals are free to migrate, it is not acceptable to rely on immigration from countries with low supply to bridge demand for health personnel gaps. Rich countries need to address their shortages by improving working conditions of health staff, and by using their capacity to produce more of them. They should remain open to collaboration and exchanges with poorer countries, but this should be mutually beneficial.



Conclusions

In the long history of internal and cross-border migration and mobility in the Southern African region, HIV constitutes a relatively recent phenomenon and set of risk factors. Understanding and raising awareness of the importance of the links between population mobility, migration, and HIV is a key strategy in ensuring appropriate policies and interventions in the Southern African region.

The open and participatory discussion on AF-AIDS eForum captured many perspectives from the ground, providing a rich and insightful view of issues related to mobility, migration and HIV. It also provided a virtual learning forum for the members to share experiences and lessons learned.

One of the main agreements emerging from this structured discussion is that HIV coupled with the movement of people will remain a major challenge for Southern Africa in the years to come. Member contributions, and recommendations relating to the three main topic areas indicate that continued focus on the relationship between HIV and mobility, coupled with a practical, approach that acknowledges the multi-faceted nature of this relationship, is essential if solutions are to be found.

The first topic, ‘Migration and HIV: How does migration and population mobility lead to increased HIV vulnerability in Southern Africa?’ examined the various contexts affecting how migration impacts upon the spread of HIV. Structural factors surrounding migrants such as poor living and working

conditions, socio-cultural context, exploitation, and lack of legal rights and protection, were recognised as major factors exacerbating the HIV vulnerability of migrants. It was also noted that migrants often have limited access to health care and social services, and that due to pragmatic difficulties, interventions often do not target migrants.

Specific issues on the gender dimensions of HIV and migration (transactional sex, violence and exploitation, vulnerabilities of non-migrating women, and construction of masculinity) were also highlighted during the course of the discussions.

The discussions around the second topic, 'HIV-motivated migration: How does HIV affect migration and population mobility patterns?' particularly focused on the migration of children affected by HIV: children who are forced into a situation of giving care to sick relatives may need to move, and those who are orphaned may move to live with relatives, become homeless and live on streets, or move into institutions. The discussions also noted that mobility might occur due to HIV-related stigma and care giving.

Lastly, the discussion surrounding the third topic, 'The dynamics and impact of the migration of health workers,' focused on the widening gap in health care demand and supply caused by the 'brain drain' or the outward migration of skilled health care workers from the region, outlining the various push, pull and enabling factors of health worker migration. The emigration of skilled professionals to more developed countries is proving particularly detrimental, with health-care conditions – especially with regard to HIV and related opportunistic infections like TB and malaria – deteriorating dramatically in sending countries.

There is currently only a limited understanding of the importance of more consistently incorporating the issue of migration and mobility into HIV programme work (and vice versa), and the complexity of the relationship is still often misunderstood or underestimated when it comes to implementation. The wide gap between what we know and what is being done reflect the urgent need for effective and sustainable responses that take a long term approach.

Furthermore, interventions and policies must take into consideration the complexities of population mobility in Southern Africa, and recognise the

different groups of migrants and mobile populations, which include a range of labour migrants such as miners, truck drivers, commercial sex workers, informal traders and agricultural workers. Also, in Southern Africa, women and children are increasingly on the move.

Overall, the open and participatory nature of the discussions provided a broad range of insightful views on the issues related to HIV, population mobility and migration in Southern Africa. It is hoped that by increasing understanding and raising awareness of these issues the eForum played a role in influencing appropriate future interventions and policies in the Southern African region.



Appendix A: Terminology, definitions and acronyms

Most countries distinguish between a number of categories in their migration policies and statistics. The variations between countries indicate that there is no objective or universally agreed definition of migration. Nevertheless, for the purposes of this discussion, we have agreed upon the following definitions.

Migrants and mobile populations

The term ‘migrants and mobile populations’ refers broadly to people who move from one place to another temporarily, seasonally or permanently for a host of voluntary and/or involuntary reasons.

In this discussion, we restrict the term ‘migrant’ to those who move for voluntary reasons to a country or region in which he or she does not originate from. Thus, for the purposes of the discussion, the term ‘migrant’ will not include refugees, displaced persons or others forced/compelled to leave their homes.

Examples of voluntary migration include movement for professional reasons such as that of truck drivers, seafarers, agricultural workers, employees of large industries (e.g. mining, oil), members of the military, students and teachers, sex workers and traders. Examples also include people moving to join family members, as well as labour migrants, both regular and irregular.

Migrant workers

Migrant workers are those who are to be engaged, are engaged, or have been engaged in a remunerated activity in a state of which he or she is not a

national (Art. 2(1), International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families, 1990).

Different groups of migrant workers:

In much of the literature on HIV and population mobility, migrants or migrant workers are described and treated as one, homogenous group. However, different categories of migrant workers are vulnerable to HIV in different respects, and for policy and programmatic purposes it is important to distinguish them.

The different groups to be distinguished are:

- Military personnel (national and international uniformed services, including peace keepers, peace observers, national/civil defence forces etc.)
- Transport workers (truck drivers, fishermen, bus drivers, railway workers, taxi drivers, etc.)
- Mine workers
- Workers in the construction sector and other major industries (characterised by relatively short-term work on a variety of sites to construct roads, plants etc.)
- Agricultural workers (permanent, temporary and/or seasonal workers)
- Informal traders (often self-employed)
- Domestic workers

Irregular migrants

Irregular migrants are those who, owing to illegal entry or the expiry of his or her visa, lack legal status in a transit or host country. The term applies to migrants who infringe a country's admission rules and any other person not authorised to remain in the host country (also called clandestine/ illegal/undocumented migrant or migrant in an irregular situation).

Returnees, returning migrants

Returnees or returning migrants are those who return to their countries/place of origin after a period of time spent in another place or country, be it voluntarily or involuntarily.

Forced or involuntary migration

Forced or involuntary migration is a general term used to describe a migratory movement in which an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes (e.g. movements of refugees and internally displaced persons as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects). This includes for example, trafficked women (e.g. migrant sex workers, often undocumented, held hostage, subject to sexual harassment and abuse and constantly changing addresses).

Refugees

A refugee is a person who, owing to well-founded fears of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his/her nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country.

Asylum seekers

Asylum seekers are people seeking to be admitted into a country as refugees and awaiting decision on their application for refugee status under relevant international and national instruments. In case of a negative decision, they must leave the country and may be expelled, as may any alien in an irregular situation, unless permission to stay is provided on humanitarian or other related grounds.

Internally displaced persons (IDPs)

Internally displaced persons (IDPs) are people or groups of people who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalised violence, violations of human rights or natural or man-made disasters, and who have not crossed an internationally recognised state border.

Appendix B: References

The following list includes the publications referred to in this summary. All discussion contributions quoted in this summary, along with their own bibliographies, are available on line at: www.healthdev.org/eforums/af-aids

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Appendix C: Relevant websites

AF-AIDS eForum

www.healthdev.org/eforums/af-aids

Health and Development Networks (HDN)

www.hdnet.org

Health Systems Trust (HST)

www.hst.org.za

International AIDS Conference 2004

www.aids2004.org

International Organization for Migration (IOM)

www.iom.int

International Organization for Migration (IOM) Regional Office for Southern Africa

www.iom.org.za

Management Sciences for Health (MSH)

www.msh.org

Partnership on HIV/AIDS and Mobile Populations in Southern Africa (PHAMSA)

www.iom.org.za/PHAMSA.html

Physicians for Human Rights

www.phrusa.org

The Regional Network on Equity in Health in Southern Africa (EQUINET)

www.equinetafrica.org

Save the Children

www.savethechildren.org

United Nations Joint Programme on HIV/AIDS (UNAIDS)

www.unaids.org

UNDP HIV and Development Programme, South East Asia

www.hivdevelopment.org

United National High Commissioner for Refugees (UNHCR)

www.unhcr.org

World Health Organization (WHO)

www.who.int

World Trade Organization (WTO)

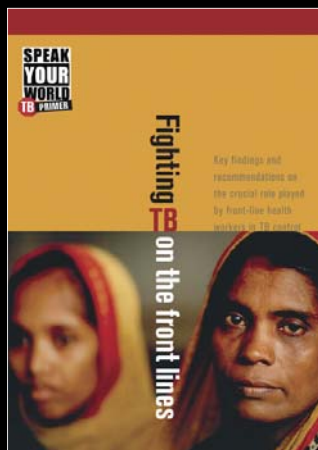
www.wto.org

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The logo consists of the words 'SPEAK YOUR WORLD' stacked vertically in a bold, black, sans-serif font, each word within its own white rectangular box. Below this stack, the word 'PRIMER' is written in a white, sans-serif font on a dark red rectangular background. A red ribbon is draped over the bottom right corner of the logo.

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