IOM Briefing Note 2: Population Mobility and HIV in Southern Africa

This briefing note provides an overview of **the relationship between population mobility and HIV in the Southern African Development Community (SADC)**. Population mobility within the SADC region is growing, both inter and intra-regionally. The region is affected by a high prevalence of communicable diseases, in particular the human immunodeficiency virus (HIV), tuberculosis (TB) and malaria. **Population mobility is increasingly recognised as a central determinant of health,** affecting health outcomes in various ways.[1-6]

Population mobility impacts on the health vulnerability not just of the individual that moves but also on the communities that are left behind, lived in, passed through and returned to. An individual's health profile stems not just from his or her behaviour but also from a range of social, economic and structural factors specific to the unique conditions of a location, hence a "**spaces of vulnerability**" approach is promoted when addressing migration and health.

While underscoring the benefits of migration, it has also been linked to changes in health seeking behaviour of the migrant. Migration as a process tends to delay or prevent health seeking behaviour, and – as a result - can be associated with the transmission of undiagnosed and untreated communicable diseases. Therefore, effective disease control programmes must actively engage with the reality of diverse population movements and its impact on programming.

The Southern Africa region is urged to adopt a multi-sectoral and multi-level approach whereby stakeholders become active participants in design, implementation, and monitoring **communicable disease control programmes that address the health needs of migrants and communities affected by the migration process.**

Box 1: Spaces of Vulnerability

The spaces of vulnerability approach is based on the understanding that health vulnerability stems not only from individual but also a range of societal and economic factors specific to the unique conditions of a location, including the relationship dynamics among migrants and sedentary populations. These factors must be taken into consideration when addressing migration health concerns and interventions must consider and target both migrants and the communities with which they interact, including families in communities of origin. Spaces of vulnerability are those areas where migrants live, work, pass-through or from which they originate or return to. They may include: land and water border posts, and ports, truck stops or hot spots along transport corridors, construction sites, commercial farms, fishing communities, mines, informal settlements, migrant communities of origin, detention centres, and emergency settlements. [7]
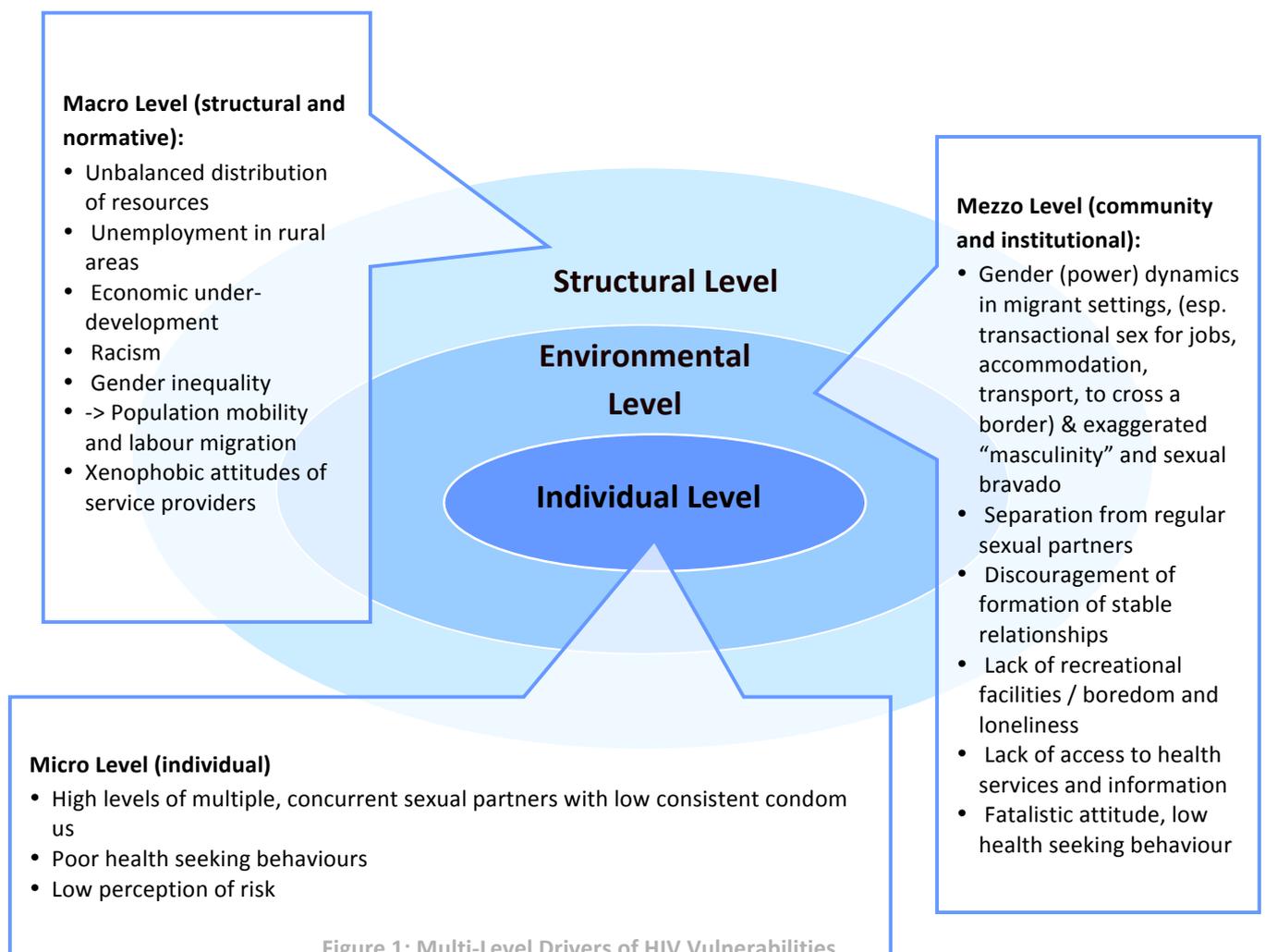

HIV and Population Mobility in Southern Africa

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

- Migrants are highly mobile and mobility can encourage high risk sexual behaviour;
- Mobility can make people more difficult to reach for HIV prevention, treatment, care.
- Currently, the SADC region lacks coordinated cross-border referral systems. This has negative effects for people who move across the borders, as well as for sedentary populations with whom they interact
- Migrants' multi-local social networks create opportunities for sexual networking; and

- There is a higher rate of HIV infection in "communities of the mobile", which often include socially, economically and politically marginalized people. [14] This is because mobile populations and migrants may work and reside in **spaces of vulnerability**, where physical, social and economic conditions may lead to increased risk of acquisition of HIV (see Box 1).

In addition, social, economic and political factors in both the country of origin and destination influence HIV risk for the migrants, the partners they left behind and new partners in their destination. Other factors that contribute to HIV risk amongst migrants include the HIV prevalence in the countries of origin, the gender disparities and unequal vulnerabilities amongst girls and young women to HIV, or among migrants in key populations such as sex workers, men having sex with men people who inject drugs.

Macro Level (structural and normative):
- Unbalanced distribution of resources
- Unemployment in rural areas
- Economic under-development
- Racism
- Gender inequality
- -> Population mobility and labour migration
- Xenophobic attitudes of service providers

Structural Level

Environmental Level

Individual Level

Mezzo Level (community and institutional):
- Gender (power) dynamics in migrant settings, (esp. transactional sex for jobs, accommodation, transport, to cross a border) & exaggerated "masculinity" and sexual bravado
- Separation from regular sexual partners
- Discouragement of formation of stable relationships
- Lack of recreational facilities / boredom and loneliness
- Lack of access to health services and information
- Fatalistic attitude, low health seeking behaviour

Micro Level (individual)
- High levels of multiple, concurrent sexual partners with low consistent condom us
- Poor health seeking behaviours
- Low perception of risk

Figure 1: Multi-Level Drivers of HIV Vulnerabilities

- **The southern African region is the most affected by HIV globally:** While home to just 10% of the world's population, it is home to 70% of all people living with HIV.[9]
- **The region is also associated with high levels of population mobility:** Despite this, responses to HIV that integrate migration and mobility within their responses are currently inadequate.
- **Migrants can face barriers accessing HIV prevention, treatment and care services:** [10] Delayed testing and/or treatment initiation has negative impacts for infected individuals and for the populations with which they interact.
- It is the **migration process and associated conditions that increase vulnerability to HIV/AIDS**, not migrants per se. The interventions should therefore seek to address factors as well as individual needs and circumstances of migrants.
- **Healthcare systems in the southern African region are not designed to ensure continuity of care for migrant and mobile populations**.[10]
- Successful prevention programs require a combination of evidence-based, mutually reinforcing biomedical, behavioural, and structural interventions[1] [17]

IOM's Approach to Addressing Population Mobility and HIV

The 61st World Health Assembly Resolution on the Health of Migrants (WHA 61.17), adopted in May 2008, calls upon governments to "promote migrant-sensitive health policies" and "to promote equitable access to health promotion and care for migrants". Guided by this resolution, IOM, WHO and the Government of Spain organised a Global Consultation on the Health of Migrants – The Way Forward in March 2010. The consultation developed a four pronged operational framework through which health issues could be viewed with migrants - including displaced and conflict populations - in mind.

Addressing Population Mobility and HIV	
Monitoring migrant health	*Policy and legal framework*
In order to ensure evidence based programming and policy development, IOM strengthens existing knowledge on the health of migrants via research and information dissemination.	**In order to create an enabling policy and legislative environment that facilitates the realisation of migrants' right to health, IOM works closely with government counterparts and UN partners to ensure that regional and national level policies and legal instruments, or national strategic plans, are developed, amended and finalised with migration health concerns incorporated.**
Within the context of HIV:	*Within the context of HIV*

---

[1] This definition of Combination prevention was expanded upon in the 2010 UNAIDS discussion Paper on Combination Prevention which can be accessed on the link
http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/20111110_JC2007_Combination_Prevention
_paper_en.pdf

• Analyse HIV epidemiological data to monitor the burden, contributing factors and treatment outcomes amongst migrant populations. • Advocate for appropriate cross-border and regional monitoring systems to collect and analyse data on new HIV infections. • Adapt the monitoring systems to the specific realities of migration and mobility.	• Raise awareness among policymakers and key stakeholders on the health rights of migrants and the importance of developing responses to HIV that engage with migration and mobility. • Promote universal and equitable access for all in National HIV control policies to prevention, treatment and care services, regardless of residential status, nationality or legal status. • Ensure that there is coordinated and coherent regional and national policies (e.g. national strategic plans or bilateral agreements) which expounds for shared solutions between health and non-health sectors such as immigration/border management and labour.
Migration sensitive health systems **Recognising that services, even if available, may not be sensitive to the needs and rights of migrants or to the vulnerabilities associated to the migration process, IOM takes a public health approach that supports strengthening community and other health systems to facilitate social and behaviour change and support improved utilization of health services**	***Partnerships, networks & multi-country frameworks*** **IOM focuses on establishing and strengthening multi-sectorial partnerships, information sharing/ communication, coordination and collaboration, with the ultimate aim of increasing sustainability of interventions that promote and support realisation of migrants' right to health.**
Within the context of HIV • Promote HIV prevention education, HIV testing and treatment for all migrants, including irregular migrants and migrants held in prisons and/or detention centres. • Ensure access to rapid screening and efforts to ensure continuity of care for people on the move. • Advocate for people living with HIV who plan to travel to receive sufficient medication for the duration of their trip. • Promote provision of referrals to treatment services in other areas of the country/region, and disseminate information on such services. • Promote the provision of patient-held records (health passports) that indicate medication regimens, clinical findings and drug sensitivities. • Ensure that migrant-adapted counselling is conducted for potential and actual migrants at each visit to discuss potential movement and the importance of planning for this. • Ensure quality of services are provided to migrants through such methods as short questionnaires with returning mobile and temporary migrants on their treatment behaviour whilst they were away. • Ensure that testing and treatment is delivered in a culturally and linguistically appropriate way.	***Within the context of HIV*** • Promote and facilitate (through establishment and maintenance of various coordination mechanisms) partnerships among various governmental sectors, private sectors (private healthcare providers, pharmaceutical companies, insurance sector, and employers), civil society (including migrant groups), and development partners. • Advocate for effective cross-border and intra-country referral systems. • Ensure bilateral or regional agreements on migration (e.g. labour migration and border management) include health issues especially, the management of communicable diseases like TB.

Box 2: The SADC Framework on Population Mobility and Communicable Diseases.[15]
The framework aims to improve harmonisation and coordination of responses; improve access to

healthcare services – including prevention programmes; to improve disease surveillance and epidemic preparedness; improve information, education and participation of mobile people; increase operations research and sharing of information; and, address legal and administrative barriers.[21][2] The Framework provides guidance on:

- The protection of the health of cross-border mobile people in the face of communicable diseases, including source, transit and destination communities; and
- The control of communicable diseases in the face of movement of people across borders in the region.

Box 3: 2014 UNAIDS GAP Report

The report [18] recognises that migration can place people in situations of heightened vulnerability to HIV, and that migration has been identified in certain regions as an independent risk factor for HIV. Moreover it highlights that undocumented migrants face complex obstacles, such as a lack of access to health-care services or social protection. The Report suggests that, to close the gap in reaching migrants, countries should make a difference by:

- Ensuring that all people on the move-citizens and non-citizens alike- have access to essential HIV services;
- Expanding access to HIV treatment and other health services to migrants, ensuring that services are delivered through a rights-based approach;
- Recognizing the increased vulnerability of migrants in national AIDS strategies and including programmes to reach mobile populations with effective HIV prevention, treatment, care and support services;
- Ensuring that resources are directed to those migrant populations and communities that are most vulnerable to HIV;
- Designing programmes that are responsive to migrants' different backgrounds and needs
- Designing HIV information in the languages that migrants feel most at ease with when making decisions about their health and personal behaviour;
- Implementing and coordinating cross-border initiatives for issues with an impact that transects borders, including HIV treatment;
- Mobilizing communities by engaging people from migrant populations in order to ensure that their needs are being met and that programmes are culturally appropriate;
- Protecting all people from sexual and labour exploitation
- Strengthening civil society leadership to counter stigma and social exclusion;
- Meaningfully including migrants, as well as members of their families in community health programmes at the local level;
- Ensure consultations on health and development frameworks and programmes at the national level;
- Implementing and coordinating cross-border initiatives for issues with an impact that transects borders, including HIV treatment.

---

[2] The 2009 Framework has not yet been adopted by SADC Member States. A costing exercise is underway to provide possibilities for a regional funding and implementation system.

References

1.   Gushulak, B., *Monitoring migrants' health*, in *Background paper for National Consultation on Migrants Health, Madrid, 3-5 March 2010*. 2010, WHO.

2.   MacPherson, D.W. and B.D. Gushulak, *Human Mobility and Population Health: new approaches in a globalizing world* Perspectives in Biology and Medicine, 2001. **44**(3): p. 390.

3.   Anarfi, J., *Reversing the spread of HIV/AIDS: What role has migration?*, in *International Migration and the Millenium Development Goals. Selected papers of the UNFPA Expert Group Meeting, Marrakech, Morocco, 11-12 May 2005*, UNFPA, Editor. 2005, UNFPA: New York.

4.   Gushulak, B. and D.W. MacPherson, *Population Mobility and Health: An Overview of the Relationships Between Movement and Population Health.* J Travel Med, 2004. **11**(3): p. 171-178.

5.   MacPherson, D.W., B. Gushulak, and L. Macdonald, *Health and foreign policy: influences of migration and population mobility.* Bulletin of the World Health Organization, 2007. **85**(3): p. 200-206.

6.   WHO, *Closing the gap in a generation. Health equity through action on the social determinants of health*. 2008, Commission on Social Determinants of Health,: Geneva.

7.   IOM, Regional Assessment on HIV Prevention Needs of Migrants and Mobile Populations in Southern Africa, 2010 International Organization for Migration: Pretoria.

8.   Desmond Tutu Foundation, *Key Populations Key Solutions. A Gap Analysis and Recommendations for Key Populations and HIV in South Africa. POLICY BRIEF*. 2011.

9.   UNAIDS, *Report on the global HIV/AIDS epidemic 2008*, in *UNAIDS/08.25E / JC1510E*. 2008.

10.   MSF, *Providing antiretroviral therapy for mobile populations: Lesson learned from a cross border ARV programme in Musina, South Africa*. 2012.

11.   WHO, *International Health Regulations. Second edition*. 2005, WHO: Geneva.

12.   Klopper, M., et al., *Emergence and spread of extensively and totally drug-resistant tuberculosis, South Africa.* Emerg Infect Dis, 2013. **http://dx.doi.org/10.3201/eid1903.120246**.

13.   Stuckler, D., et al., *Mining and Risk of Tuberculosis in Sub-Saharan Africa.* American Journal of Public Health, 2010. **doi:10.2105/AJPH.2009.175646**.

14.   IOM HIV/AIDS, Population mobility and migration in Southern Africa: Defining a research and policy agenda. 2005

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

16.   Southern African Development Community SADC *HIV and AIDS Strategic Frame Work 2010-2015* 2009 http://www.sadc.int/files/4213/5435/8109/SADCHIVandAIDSStrategyFramework2010-2015.pdf (accessed 09-10-2014)

17.   The U.S Presidents Emergency Plan for AIDS relief (PEPFAR) Five year Strategy 2009 http://www.aidstar-one.com/focus_areas/prevention/pkb/combination_approaches/overview_combination_prevention (accessed 30-10-2014)

18.   UNAIDS, *The GAP Report 2014*. 2014, UNAIDS Geneva. http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Gap_report_en.pdf