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HIV vulnerability in migrant populations in southern Africa: Sociological, cultural, health-related, and human-rights perspectives

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ABSTRACT

The International Organization for Migration has noted that migration is the strongest single predictor of HIV risk and prevalence in sub-Saharan Africa. Several major factors affect HIV vulnerability in migrant populations in southern Africa. This paper will address the issues of HIV disease in migrant populations from health-related, sociological, cultural and human-rights approaches. A review of the literature was conducted to examine the issues related to HIV and migration in southern Africa and the complex issues in the post-colonial period that place people at risk for acquiring HIV. The multi-faceted relationship between migration and HIV is a critical link to infection and the sexual networks that occur with migration are known to expand the spread of the disease, intersect with cultural and social mores, as well as human rights, and increase vulnerability for migrants, sex workers, and families at home. Migrants often seek work in new regions for economic, political and social reasons, but often are ill-informed about the dangers associated with migration. Structural, cultural, social, health-related, and human-rights dimensions that influence migration and the risk of HIV disease are explored. A model for understanding the factors associated with increased risk of HIV acquisition was developed.

1. Introduction

Migration in sub-Saharan Africa is a complex issue that influences the prevalence of HIV disease and intersects with human-rights issues. The literature suggests that migration is the strongest single predictor of HIV risk and prevalence in sub-Saharan Africa (International Organization for Migration [IOM], 2002). This paper will address the complex issues of migrant populations from health, sociological, cultural and human-rights perspectives. Several major factors affect HIV vulnerability in migrant populations in southern Africa. A critical link to HIV infection includes the sexual networks that occur with migration and that are known to expand the spread of the disease. In addition, the intersection with cultural and social mores, increased vulnerability for violence and abuse in migrant populations, the influence of sex work in migrants, and risks for families at home will be examined.

Migrants often seek work in new regions for economic, sociopolitical and human-rights reasons, but often are ill-informed about

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the dangers associated with migration. Structural and contextual dimensions including sociological, cultural, health-related, and human-rights issues may influence migration and the risk of HIV disease. Other structural dimensions include absence of infrastructure for the health departments and ministries and lack of funding for reaching key groups at risk for HIV. Post-apartheid in South Africa, large urban areas received funding whereas rural areas with a lack of infrastructure were neglected. Cultural issues include the large numbers of ethnic groups that exist within the countries of southern Africa. Social dimensions address the breakdown in community support when family members leave home for work and the isolation that many migrants experience. Health-related dimensions include the individual health factors as well as health system issues that may limit access to care to maintain health or treat chronic illnesses such as HIV.

The intersection of HIV, migration, and human rights is complex. As Oppenheimer, Bayer, and Cosgrove (2002) note:

> It is one of the remarkable and significant consequences of the AIDS epidemic that out of the context of enormous suffering and death there emerged a forceful set of ideas linking the domains of health and human rights. At first, the effort centered on the observation that protecting individuals from discrimination and unwarranted intrusions on liberty were, contrary to previous epidemics, crucial to protecting the public health and interrupting the spread of HIV. But in fairly short order, the scope of the health and human rights perspective expanded dramatically to focus on the ways in which the most fundamental social arrangements rendered individuals and communities vulnerable to HIV. Racial and ethnic minorities, those who were marginalized, and women were at risk because of their subordinate status (p. 522).

Migrant populations and those living in post-apartheid South Africa and southern Africa emerged as among the most vulnerable and at risk for HIV due to the complex fabric of social, cultural, and political issues that affected their human experiences. The purpose of this paper is to provide an overview of aspects of vulnerability to acquisition of HIV infection related to migration in southern Africa. The scope of the problem of HIV prevalence is explored with a lens on migration and its intersection with increased likelihood of becoming infected with HIV.

2. Review methods

This paper offers a scoping review of the literature undertaken to examine the extent, range, and nature of the literature related to HIV vulnerability in migrant populations in southern Africa. The purpose of this review was to explore the nature and to systematically review the literature on HIV vulnerability and migration. This approach offered a critical analysis of existing evidence and defined and developed the conceptual boundaries of HIV vulnerability and migration. A search strategy was developed with the assistance of a health sciences librarian at a health sciences education institute. Inclusion and exclusion criteria were determined a priori and iteratively reviewed throughout the search. Two reviewers analyzed the articles to determine inclusion or exclusion in this review process.

Using a Boolean combination of keywords and medical subject headings, we searched OVID Medline, PubMed, and CINHAL for studies published in English from 1949 through 2013. We selected 1949 since the search terms migration and risk emerged in the literature and used the following keywords and subject headings: migration, HIV/AIDS, HIV vulnerability, culture, human rights, HIV prevalence in southern Africa, and migration in southern Africa. In our scoping review process, we identified relevant research studies and other extant literature; selected appropriate studies and literature related to the topic of migration and HIV; charted the data and policy findings; and collated and summarized the findings; and developed a model related to risk of HIV acquisition in migrants in southern Africa. The search yielded 35 articles with the following inclusion criteria: infection in southern Africa, migration and HIV in southern Africa, risk for HIV or STI in southern Africa, migrant workers in southern Africa, and socioeconomic status and HIV infection. The review of these articles yielded 29 papers that explored the relationship between the increased risk of HIV acquisition and the sociological, cultural, human rights, and health-related problems in southern Africa.

2.1. Theoretical framework: HIV risk related to migration from a health-related, sociological, cultural and human-rights perspectives

The theoretical framework of the study was developed by the study authors and is based on the premise that HIV risk acquisition increases related to migration in southern Africa. This risk has its roots in global health inequalities, as well as sociological, cultural, and human-rights issues that arise with migration. With migration due to many factors including political, economic, and social issues, HIV risk is substantially greater as evidenced by its high prevalence in migrant populations. The existing structural and contextual reasons for migration, as well as human-rights issues will be explored related to HIV acquisition. Fig. 1 illustrates the issues related to sociological, cultural, human rights, and health-related challenges that increase the risk of HIV in migrant populations. Sociological issues in the model include the legacy of inequality that lingers post-apartheid, pervasive poverty, the breakdown in community related to migration, migrant hostels which increase risk of HIV acquisition due to sexual activity, and political instability in countries/communities. Cultural issues in the model include the specificity of culture in ethnic groups in southern Africa, the status of women, loss of parents to HIV thus limiting the fabric of family with grandmothers raising children, rural versus urban cultural life, and the path of HIV along commercial routes as a cultural and structural phenomenon. Key human rights issues in the model include the legacy of apartheid, stigma associated with HIV, gender issues and the status of women, the dynamics of inequality, and the lower status associated with migration. Health-related issues in the model include co-morbid health conditions (such as tuberculosis and chronic diseases, lack of access to medications including pre-exposure prophylaxis, sex work due to poverty and sex practices that are associated with greater risk of HIV acquisition, substance use and limited access to care.

The theoretical framework displayed in Fig. 1 illustrates human rights and health-related issues often impact HIV acquisition among migrant populations in southern Africa. Human rights challenges include the legacy of the apartheid; the stigma associated with HIV; the role of gender; the status of women; the dynamics of inequality; and the status of migrants in the receiving country. Human rights factors may lead to an increase in HIV acquisition due to legal and socioeconomic realities of migrants, migrant sex workers, and female migrants. Fig. 1 also shows that health-related factors that lead to an increased risk of vulnerability to HIV infection. Health-related factors include co-morbid health conditions and issues related to substance use; lack of access to pre-exposure prophylaxis; sex work due to poverty; sex practices that lead to greater risk of HIV; and lack of access to care. Health-related infrastructural barriers hinder access to the services needed to prevent HIV acquisition and transmission. Health-related factors also indicate that an individual's health and health behaviors often increase the risk of vulnerability to HIV infection. Human rights and health-related factors demonstrate areas of needed policy commitment and intervention.

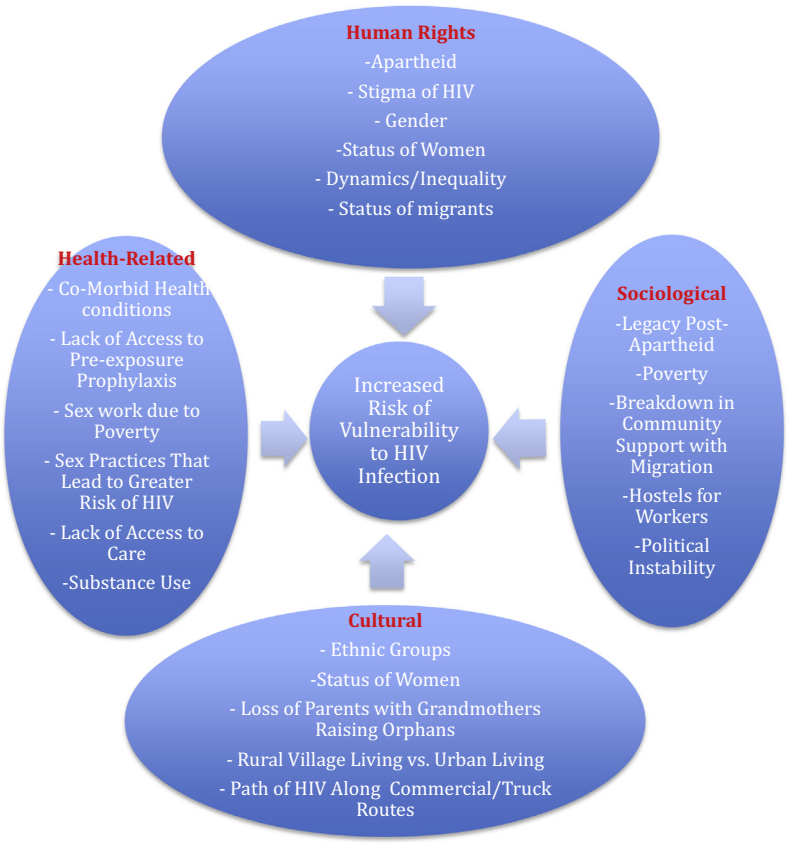

Fig. 1. Model of Increased Risk of HIV Acquisition: Structural and Contextual Dimensions Including Health-Related, Cultural, Sociological, and Human Rights Issues.

As Fig. 1 shows, cultural and sociological dynamics increase the vulnerabilities and risks of HIV infection among migrants in sub-Saharan Africa. Cultural factors encompass the different ethnic groups; the status of women; marital dynamics; the loss of parents and grandmother's raising orphans; differences between rural and urban areas; and the path of HIV along truck routes. Cultural aspects are magnified among those impacted by migration as racial and ethnic minorities are more likely to be marginalized and pressured to migrate given the political or economic situation. Cultural dynamics, such as the disempowerment of vulnerable groups, often leads to work in the informal sector and limited control over sexual activities. Sociological factors comprise the living conditions that may increase the risk of HIV acquisition. Sociological factors include the legacy of the post-apartheid era; poverty; marital concurrency; breakdown in community support with migration; hostels and living arrangements for workers; political instability; and employment options. Post-apartheid policies have produced inequalities impacting access to health services and employment opportunities. Poverty coupled with urbanization has increased vulnerabilities to HIV infection at the sociological and cultural levels.

3. Overview of migration in sub-Saharan Africa

Migration concerns the movement of peoples from one area to another and may or may not involve the crossing of international borders and settling in another country. In general, migration may be classified as voluntary, economic, and sociopolitical. While there may be elements of all three aspects in a move, the categorization is determined by the stimulus for the move. Voluntary migration is characterized by moves stimulated by a desire to be with family or to gain financial advantage or limit workforce challenges in resource-limited settings. And while such moves occur in all regions of the world, this section of the paper will consider migration in southern Africa—particularly South Africa—and stimulated by economic, human rights, and political safety concerns.

According to the International Labour Organization (ILO) (2009), over 20 million African men and women are migrant workers. The World Bank (2010) examined migration in sub-Saharan Africa and reported that remittances by Africans working in other countries account for significant amounts of the gross domestic product in several southern African countries. Often migrant workers experience discrimination and xenophobic violence that has been increasing in countries including South Africa. Both historically and more recently, human-rights organizations and the United Nations have responded in their efforts to achieve justice via the creation of specific international migrant worker rights conventions, including the Migration for Employment Convention (Revised) of 1949 (International Labour Organization, 1949); the Migrant Workers (Supplementary Provisions) Convention of 1975 (International Labour Organization, 1975); and the United Nations Convention on the Protection of the Rights of Migrant workers and their Families, adopted by the United Nations General Assembly (1990). Rutabanzibwa (2007) notes that these legal instruments created principles for the establishment of national laws and judicial and administrative procedures related to the human rights of migrant workers (such as equal treatment in employment, social security, non-discrimination, and anti-trafficking activities). In addition to other challenges and discrimination faced by migrant workers in Africa, the risk of HIV disease is coupled with the complex social, behavioral, psychological, and human-rights dynamics of migrancy, which lead to a constellation of risk factors that heightens vulnerability for contracting HIV/AIDS (Rutabanzibwa, 2007).

> As Jonathan Mann (1996) noted early in the HIV epidemic: Modern human rights, born in the aftermath of the second world war crystallised in the Universal Declaration of Human Rights of 1948, reflects a broader, societal approach to the complex problem of wellbeing. The implicit question behind the modern human rights movement is: "what are the societal (and particularly governmental) roles and responsibilities to help promote individual and collective wellbeing?" (p. 924).

As HIV/AIDS has evolved over many decades, the enormous societal and governmental roles and responsibilities have lagged well behind the needed approaches to achieving optimal health for those living with HIV/AIDS. Migrant populations are likely to retain fewer human rights and compounding their situation is the complexity that both acquiring HIV and the stigma of HIV confer while separated from family, friends, and villages.

Migrants in southern Africa—and particularly those who migrate to South Africa—are often motivated to seek work in other countries due to political instability or economic reasons, yet are often ill-informed about the dangers. As noted in *HIV and People on the Move* (Health and Development Networks and the International Organization for Migration Partnership on HIV/AIDS and Mobile Populations in Southern Africa, 2007):

> 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.

In this document, Lurie (Health and Development Networks and the International Organization for Migration Partnership on HIV/AIDS and Mobile Populations in Southern Africa, 2007) describes the complex issues of migration and the intersection with HIV disease within unfamiliar contexts and difficult living and working conditions. He notes:

> 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.

A recent United Nations (UN) initiative (UN, Gender, Migration, Remittances, and Development, 2006) focused on *Gender, Migration, Remittances and Development* and addressed the difficulties of migrants, particularly female migrants. Notable among the findings was that women who are victims of violence in their home settings may choose to migrate to another area or country within the scope of seeking employment, yet many women may subsequently encounter further risks of violence and HIV/AIDS acquisition during migration. The complex issues of gender, migration, and remittances to family account for additional risk for women who engage in sex work for those without other opportunities for employment.

Agadjainian (2008) emphasizes the importance of two regional organizations in facilitating migration between member countries in sub-Saharan Africa; namely the South African Development Community (SADC) created in 1992, and the Economic Community of West African States (ECOWAS) formed in 1975. The latter was especially concerned about reducing restrictions to migration in member countries. Consequently laborers flocked to those countries requiring a workforce, for example to countries of Africa like Nigeria for work in the oil fields. This is an example of both out-migration from neighboring countries and in-migration into Nigeria. Such in-migration may be temporary or circular or may become permanent. Out-migration has emanated from impoverished countries such as Burkina Faso, Niger, Chad and Mali. Economic migrants have moved to countries in need of laborers. An interesting example of the change in direction of such migration is given by Agadjainian (2008) who observes that Nigerian workers flowed into Ghana to work in cocoa production until the world prices in cocoa fell, at which time the migration was reversed and Ghanaian workers came to Nigeria to work in the oil fields.

Migrants are attracted by commercial opportunities but will leave if the political climate imperils their safety. The civil war in Cote d'Ivoire in 2002–2004 had an impact on the economy and increased anti-migrant feelings. A similar situation erupted in South Africa when some migrants were killed by the local populace in 2009. The migrants were perceived to be taking jobs from the local population. The deaths of these migrants were treated with outrage as evidenced by the many articles reminding South Africans of the hospitality they received in neighboring countries during the apartheid period.

Ease of entry for temporary or permanent residence is clearly influenced by the need for workers. When nationals do not want to engage in low-paying, tedious work requiring long hours of physical work, the stage is set for in-migration, legal and illegal. This flow is increased and the potential for conflict with local workers enhanced when migrants are willing to work for lower wages. This obviously describes the situation for persons with few marketable skills. Such is not the case for the highly educated whose loss to a country is considered brain drain.

Such a term ignores the reality of whether the infrastructure exists to employ highly educated persons in their country of origin. This lack of infrastructure in the home country as much as the opportunity to ply one's trade, as it were, with similarly educated colleagues in the country of destination leads to out-migration. Another factor leading to out-migration are the opportunities for advancement. This is clearly related to infrastructure and the emphasis on the skills of the migrants. Another factor leading to brain drain is compensation. Nurses leave their home countries for lack of opportunities where they reside, and the more lucrative salaries abroad. In addition the opportunity to work in countries where the nurse's position is accorded more respect adds to the desire to migrate but it is not the only factor. The desperate poverty of the family leads family members to migrate so as to send home remittances.

The migration of nurses and in particular female nurses is emblematic of the shifting gender dynamic of male underemployment necessitating female employment. In addition with female–headed households, there is an increasing need for these individuals to find compensated employment outside the home in order to provide for their families. Employment includes cross-border trading of goods as well as work in agriculture where women are preferred as employees by South African farmers who consider the women to be harder working and less of a problem than male migrants (Agadjainian, 2008). Female migrants are also at increased risk of acquisition of HIV—particularly in sex work or but also due to gender issues that limit condom negotiation and decision-making related to sexuality in most settings.

Changes in the political structure of a country influence both in and out migration. When apartheid existed in South Africa, Black South-Africans sought refuge in neighboring countries as was noted previously. With the fall of Apartheid, Africans from sub-Saharan Africa were attracted by the relative prosperity in South Africa as sector-limited as it is. The point here is that the political stability of the country and the safety of people from various ethnic groups to live and work are key to an environment attractive to migrants seeking employment. Where persecution of ethnic

minorities occurs such as the savage treatment of the Fur by the Arab inhabitants in Dafur makes Sudan a less than desirable site for in-migration for Black Africans.

Another factor to consider is the availability of services for migrants including health care, housing, and social services. No small matter is having familiar foods and contact with those of similar origin and language. These needs are the spur to the development of food stores, restaurants, and other services that cater to a given population. Housing in close proximity assures access to these services as well as providing a buffer to the inhospitality of the citizens of the host country. However, it also serves as a vector for HIV and other sexually transmitted infections with easy access to sex workers.

Finally, the issue of legal and illegal immigration becomes more significant in times of economic downturn when the question of just claim to host resources becomes more pronounced. The tension between the ideals of the host country and the philosophy of the health care professionals on the one hand, and the limits to resources on the other creates tensions between migrants and local citizens who both desire the skills of the migrant workers in particular and hold in disdain the claims for services in general. This also represents a complex human-rights issue.

As Adepoju (2000) observed there has been a change in the patterns of migration to an increase in undocumented migration. This can be attributed to poverty, the decline in social conditions, and the lack of employment opportunities in the home country. The lack of employment opportunity and the absence of stable sociopolitical environments singly and together contribute to migration. To the degree such conditions continue, individuals and families will seek conditions more conducive to survival regardless of international boundaries. Corno and De Walque (2012) note that mines, migration and HIV/AIDS are integrally linked due to the complex social structure that includes sexual behavior in areas where HIV prevalence is high.

4. Findings: themes that emerged in the literature

The scoping review provided a synthesis and analysis of the extant literature on the relationship of migration to risk of HIV acquisition. Conceptual clarity was gained from the literature and provides support for the theoretical framework and for health policy, education, practice, and research implications. The themes that emerged include: structural and contextual perspectives; influence of human-rights issues; forced migration; sociological and cultural perspectives; gender/feminization of migration; discrimination and the legacy of apartheid; and health-related perspectives.

4.1. Structural and contextual perspectives on migration and HIV risk: influence of human-rights issues

4.1.1. Forced migration and sub Saharan Africa

Globalization has increased the numbers of migrants worldwide. The increase in migration is directly related to people as social capital and with migration as a key component of globalization (International Organization for Migration, 2002). Migration may be viewed on a continuum of voluntary to involuntary with migrants not volunteering to leave their home country. As previously stated, people leave their homelands for many reasons—work, education, and the promise of financial reward. Migration in this sense is voluntary and consensual and is viewed as a human right. Yet there is a form of migration that exists that subjugates individuals into what has been termed modern day slavery. There are important similarities and differences in the circumstances of trafficked individuals and migrant sex workers. The 2000 UN Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, defines trafficking as the movement of individuals through various means, including threats, force or coercion, for the purpose of exploitation (UN, 2000; Vijeyarasa & Stein, 2010). Forced migration can take the form of displaced persons in conflict or natural disasters, refugees who fear persecution and cannot rely on the protection of their government (UN High Commission on Refugees), and persons trafficked for exploitation for profit exploitation (United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, 2000).

Human trafficking has become a complex problem and linked with the HIV/AIDS pandemic. As the International Labor Organization (ILO, 2005) notes in its report on *HIV/AIDS and Work in a Globalizing World:*

> Persons who move as a result of forced labour and human trafficking comprise a group at special risk of HIV/AIDS, because of the reliance of the sex industry on force labour and trafficking to supply human beings for exploitation. The ILO estimates that a minimum of 12.3 million persons were in a situation of force labour in mid 2005 and that 1.4 million (11 per cent) of cases were in forced commercial sexual exploitation. The region of sub-Saharan Africa where HIV/AIDS is particularly prevalent, has the third largest number of person in forced labour in relation to population size—1 per thousand—and 8 percent of them are in forced labour for commercial sexual exploitation. The vast majority of persons in this situation—98 percent—are women and girls. Although the proportion of girls is not known, the ILO estimates that in the case of forced labour, as many as 40–50 percent of persons exploited are children (p. 22).

Despite these documented efforts, most countries in sub-Saharan Africa continue to need focused attention on this social injustice. However, there continues to be a large network of women and children domestically who are recruited by traffickers from rural areas for prostitution, domestic servitude, forced labour, begging and drug and criminal activity (ILO, 2005). Subsequently, in several countries including South Africa, the government has attempted to pass a comprehensive anti-trafficking bill without success. The practice of *ukuthewala*—arranged marriage of older men to young girls—is still practiced in the eastern Cape and results in abuse and commercial sex work (Troung 2006). Other countries have taken the lead in working to create legislation to force government agencies to respond to reports of forced labour. In Zambia, gender-based violence victim support units in police stations have been established and the human trafficking bill has been introduced in parliament (ILO, 2009).

Gender inequality is a major barrier to seeking decent work which exacerbates the situation of human trafficking (Vijeyarasa et al. 2010). Globally, women comprise most victims with many being pushed out of developing countries to work in urban locations where there is little protection from abuse or enslavement (United Nations Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, 2000; Vijeyarasa et al. 2010). In fact, in the International Labour Organization's (2005) report on *HIV/AIDS and Work in a Globalizing World,* young women are noted to be at considerable risk of HIV infection. "In sub-Saharan Africa, 1 in 4 (12–13 million of 52 million) youngest women of working age (15–24 years) may be at risk of HIV because they are urban and poor and 1 in 7 (7–8 million) may be at great risk due to poverty" (p. xi–xii). It is also well known that male migrants frequently become HIV-infected, return to their rural homes, and subsequently their wives—whose only risk factor is being married—are also at greater risk of acquiring HIV.

4.1.2. Forced migration and the intersection with HIV/AIDS

Vijeyarasa et al. (2010) discuss the relationship between forced migration in the form of human trafficking and HIV/AIDS, and the need for further study in this area. Similarities in the circumstances common in HIV/AIDS including poverty, marginalization, and violence are also common in human trafficking. Furthermore, they note that a woman who is HIV positive before migration may be at higher risk for trafficking. They note that: "the interrelationship between HIV and human trafficking could in fact be bidirectional. While it is less likely that a woman who is ill would choose to migrate for work, the stigma associated with HIV/AIDS may force a woman to leave her community and risk unsafe migration" (p. 344).

Forced migration, regardless of root cause, is a problem throughout sub-Saharan Africa that warrants attention, intervention, and research. Victims of forced migration are at increased vulnerability for HIV/AIDS and the precarious situation of the trafficked person complicates access to HIV testing, treatment, and care. Furthermore, the forces of gender and poverty intersect with trafficking making it in some instances, the only viable opportunity for advancement in a depressed region of the world (Troung, 2006). Further evaluation is needed for this vulnerable population as it is difficult to quantify their vulnerability due to the illegal circumstances of their migration and the stigma attached to disclosing one's HIV status.

5. Sociological and cultural perspectives on migration and HIV risks

Sociological perspectives include the historical imbalance of power based on race and ethnicity in Sub Saharan Africa and the legacy of apartheid. In South Africa, AIDS is not viewed as associated with apartheid as such. Many South Africans blame themselves for being sexually irresponsible, for the decreasing incidence of marriage and high incidence of non-marital childbearing. Often men blame the women and the women blame the men. It can be viewed as a mode of social transition, in which women increasingly demonstrate their capacity to head households within a patriarchal system—particularly when men must migrate from rural areas to cities for employment.

Economic globalization is accompanied by global labour markets, in which people are looking and seeing beyond national boundaries for means of sustenance. Rural poverty is rampant in the developing regions, and constitutes a "push factor" for outmigration to urban areas, both nationally and across national boundaries. The global HIV/AIDS scenario emerged within a context of heightening movements of national and regional populations and to a lesser extent, across the global regional populations. For the African populations which are least urbanized compared to the developing regions in Asia and Latin America, the emergence of HIVAIDS coincided with a period when urbanization gained momentum, with the outcome of heightened rural-urban interactions. Regional conflicts have also generated migration streams, along with sexual and AIDS infection vulnerabilities of populations that occur in conflicts.

In addition, African population movement occurs affecting both the source country and the destination country. Most migrants are younger and either single or living far from family, thus their risks and vulnerability to HIV and other sexually-transmitted infections is greater. As Abdool Karim, Churchyard, Abdool Karim, and Lawn (2009) suggest there is a need to reverse conjugal instability and family separation created by the migrant labour situation. They propose three structural interventions that could help to achieve sustained reductions in HIV transmission: legalization and regulation of sex work; aggressive law enforcement on rape and violence against women in terms of current legislation; and tax incentives to companies who join public–private housing partnerships to reverse the instability of separated families. Gender inequity and migrant labour are key drivers in the South African HIV epidemic. There is also reduced social control associated with anonymity among migrants as noted in *HIV and People on the Move* (2007). As Africa's urban growth occurs, migrants increasingly move from rural to urban areas. With sex work common and HIV prevalence high, migrants become infected and return to rural areas thus increasing HIV infection rates in those areas. Comorbid STIs also increase the likelihood of contracting HIV and sharing the virus with partners at home (Coovadia, Jewkes, Barron, Sanders, & McIntytre, 2009).

> As Coovadia and Colleagues (2009) note:
> The migrant labour system further affected these sexual practices. Male migrants usually had sexual partners, either male (common in mining hostels) or female, in towns as well as in their rural home and many men established second families in urban areas. In rural areas, women often had another sexual partner too when men were away. These practices had substantial implications for the spread of sexually transmitted diseases (p. 822–823).

African sexual norms are shifting in the 21st century with sexually transmitted infections and secondary infertility also increasing in the population. In many countries of sub-Saharan Africa, male sexual abstinence in migrant populations is impractical and unlikely, particularly when male migrants are away from home for prolonged time periods. Further, in some cultures, condom use is perceived as foreign whether with a sex worker or married partner at home. Other complex issues including patriarchy, polygamy, widow inheritance and traditional belief systems also make women's rights more complex.

5.1. Migration and the legacy of apartheid

5.1.1. The legacy of apartheid and racial discrimination: the link with migration, human rights, and HIV risk

Between 1990 and 2005, HIV prevalence rates in South Africa rose from 1% to approximately 29% in part due to what Hunter (2007) describes as racialized structure entrenched by colonialism and apartheid which set the scene for the rapid unfolding of HIV disease. Hunter also notes that "the legacy of circular male migration from rural to urban areas led to the transmission of sexually transmitted infections prior to the emergence of HIV/AIDS. As HIV spread via migrants the virus was more efficiently transmitted by coexisting sexually transmitted infections". Recent changes in the political landscape and economy have further resulted in the linkage of male migration with human rights issues. Hunter views HIV within ethnographic, historical, and demographic approaches in her views on sexuality in the late-apartheid and early post-apartheid periods. These views suggest that three factors were responsible for the scale of the epidemic in South Africa: rising unemployment and social inequalities that leaves some groups particularly vulnerable—including poor women; reduced marital rates and one-person households; and rising levels of women's migration, especially circular migration from rural areas to informal settlements and urban areas.

Further explication of the intersection of migration, human rights, and HIV/AIDS requires analysis of the legacy of apartheid and racial discrimination throughout southern Africa. Changing economic conditions affected migrants more severely in terms of access to services or support, including health care. Increases in unemployment, changes in political agendas, and globalization are among the many forces that intersect. In South Africa, for

example, the post-apartheid years saw sweeping changes in economic policy and health services availability as the government sought to shrink its deficit spending while adopting a more neo-liberal economic policy to attract investors (Coovadia, Jewkes, Barron, Sanders, & McIntytre, 2009; Hunter, 2007). The government also encouraged privatization of healthcare and insurance, which benefited the wealthy, but left the poor vulnerable due to a lack of healthcare services. Also, the opening up of travel to every South African citizen created new forms of circular migration where the blacks were limited to travel within the Bantustans only during the apartheid era (Hunter, 2007). All of these conditions created a context for increased HIV vulnerability for migrants.

5.1.2. Feminization of migration and risk for HIV infection

Literature on migration and HIV risk largely focused on men until recently. Few studies have examined the situations faced by migrant women, and the different behavioral consequences and economic situations encountered (Camlin et al., 2010). Dworkin and Ehrhardt (2007) indicated a need to look beyond the "abstinence, be faithful, condom use" (ABC) approach to HIV prevention, and to begin to reflect on the realities faced by women in light of major gender inequalities, differing economic opportunities, and the role of female migration.

Condom use is often cited in the literature as simple and effective, though there are many underlying assumptions in this statement that need to be addressed in terms of the feminization of poverty and HIV in Africa (Dworkin & Ehrhardt, 2007). Camlin and Colleagues (2010) identified a small body of evidence that may suggest that migration patterns differ between men and women in that women have tended to migrate to informal, rural settlements. They often tend to only have access to informal sector work like market vending or beer brewing with reduced access to prevention or health programs. Because of the gender inequities faced by these women, they may be more easily coerced into sex work in exchange for housing, money, transport or other immediate needs.

This pattern of women engaging in sex work has been well documented in the literature. Desmond et al. (2005) discussed the differing levels of sex workers at a mining settlement in rural Tanzania. Women who held jobs in the local market, and whose sex practices were more discreet, were more respected than the poorer unemployed women who sold sex as their main or only source of income. This is a significant distinction to make because these perceptions will affect a woman's ability to even negotiate condom use with a male (Dworkin & Ehrhardt, 2007).

6. Health-related perspectives in migration and HIV risk

For migrants at risk of acquiring HIV, there are complex issues related to health care. Few migrants have access to health care facilities except for those who receive occupational health services in the mines or factories. Even for these migrants, health services may only be available when they have AIDS and become so ill that they seek care. As noted by IOM and reported in *HIV and People on the Move* (2007):

> 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.

It has also been noted that some companies are assuming leadership roles in addressing the problems of migrants being far from home. One company, London Platinum, has increased its family-centered housing in order to address the complex social and health-related issues that can arise when migrants live in single-sex hostels. These approaches foster a family- and society-centered approach aimed at equipping the next generation for the 21st century. However, greater sociopolitical pressure and a commitment from business leaders is needed to address the problems that migrants face.

7. Conclusions

Camlin and Colleagues (2010) note that high levels of mobility of both men and women are linked to the sustained high HIV prevalence in southern Africa. For those who migrate frequently between urban areas and their rural homes represent an important link to geographically spread sexual networks, and high female mobility also "enables greater inter-connectedness of sexual networks beyond those created by male migrants alone, potentially contributing to the region's exceptionally high and sustained HIV prevalence." As Morris and Kretzschmar (1997) noted earlier in the HIV epidemic and Camlin and Colleagues (2010) concur that the greater the inter-connectedness among sexual networks, the more quickly and broadly HIV will circulate.

Intervention programs are needed to target sexual behavior and enhance sexual education for migrants and rural communities. The South African Department of Health (2007) has identified five key areas of achievement in its *HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011*, which have relevance for sub-Saharan Africa. These include: increased distribution of male condoms and introduction of the female condom; expansion of tuberculosis control efforts; research contributions in HIV/AIDS and tuberculosis; scale-up of the free HIV/AIDS treatment program; and development of the strategic plans for South Africa. In addition, it is critical to increase access to voluntary counseling and testing and provide access to antiretroviral therapy for those living with HIV/AIDS. Addressing the complex human-rights issues that affect migrants must include governmental and international agencies that focus on advancing the health and human rights approaches for those living with or at risk of HIV/AIDS (Joint United Nations Programme on HIV/AIDS, International Labour Organization, International Organization for Migration [ILO/IOM/UNAIDS] 2008). In 2013, the South African Department of Health developed the Republic of South Africa Global AIDS Response Report with specific objectives to be achieved in reducing HIV infection, increasing access to antiretroviral medications, and reducing TB infection.

References

Abdool Karim, S. S., Churchyard, G. J., Abdool Karim, Q., & Lawn, S. D. (2009). HIV infection and tuberculosis in South Africa: An urgent need to escalate the public health response. *Lancet, 374*(9693), 921–933. http://dx.doi.org/10.1016/S0140-6736(09)60916-8.

Adepoju, A. (2000). Issues and recent trends in international migration in sub-saharan Africa. *International Social Science Journal, 52*(165), 383–394. http://dx.doi.org/10.1111/1468-2451.00267.

Agadjainian, V. (2008). Research on international migration within sub-saharan Africa: foci, approaches, and challenges. *The Sociological Quarterly, 49*(3), 407–421. http://dx.doi.org/10.1111/j.1533-8525.2008.00121.x.

Camlin, C. S., Hosegood, V., Newell, M. L., McGrath, N., Barnighausen, T., & Snow, R. C. (2010). Gender, Migration and HIV in Rural KwaZulu-Natal, South Africa. *PLoS ONE, 5*(7). http://dx.doi.org/10.1371/journal.pone.0011539.

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntytre, D. (2009). The health and health system of South Africa: Historical roots of current public health challenges. *Lancet, 374*(9692), 817–834.

Corno, L., De Walque, D. (2012). *Mines, migration and HIV/AIDS in Southern Africa.* doi: http://dx.doi.org/10.1596/1813-9450-5966 Accessed 19 February 2016.

Desmond, N., Allen, C. F., Clift, S., Justine, B., Mzugu, J., Plummer, M. L., Watson-Jones, D., & Ross, D. A. (2005). A typology of groups at risk of HIV/STI in a gold

mining town in north-western Tanzania. *Social Science and Medicine, 60*, 1739–1749. http://dx.doi.org/10.1016/j.socscimed.2004.08.027.

Dworkin, S. L., & Ehrhardt, A. A. (2007). Going beyond "ABC" to include "GEM": Critical reflections on progress in the HIV/AIDS epidemic. *American Journal of Public Health, 97*(1), 1–12. http://dx.doi.org/10.2105/AJPH.2005.074591.

Health and Development Networks (HDN) and the International Organization for Migration (IOM) Partnership on HIV/AIDS and Mobile Populations in Southern Africa (PHAMSA), (2007). *HIV and People On the Move: Risk and Vulnerabilities of Migrants and Mobile Populations in Southern Africa*. Available at http://www.sudafrica.cooperazione.esteri.it/utlSudafrica/IT/download/pdf/2007-01_IOM_HIVandPeopleOnTheMove.pdf.

Hunter, M. (2007). The changing political economy of sex in South Africa: The significance of unemployment and inequalities to the scale of the AIDS pandemic. *Social Science and Medicine, 64*(3), 689–700. http://dx.doi.org/10.1016/j.socscimed.2006.09.015.

International Labor Organization (2009). *HIV and international labour migration.* <http://data.unaids.org/pub/Manual/2008/jc1513a_policybrief_en.pdf> 19 February 2016.

International Labour Organization (1949). *Migration for Employment Convention (Revised), 1949.* <http://www.ilo.org/dyn/normlex/en/f?p=NORMLEXPUB:55:0::NO::P55_TYPE,P55_LANG,P55_DOCUMENT,P55_NODE:CON,en,C097,%2FDocument> Accessed 19 February 2016.

International Labour Organization (1975). *C143 Migrant Workers (Supplementary Provisions) Convention, 1975*. <http://www.ilo.org/ilolex/cgi-lex/convde.pl?C143>.

International Labour Organization (2005). *HIV/AIDS and work in a globalizing world*. <http://www.ilo.org/wcmsp5/groups/public/—ed_protect/—protrav/—ilo_aids/documents/publication/wcms_116185.pdf> Accessed 19 February 2016.

International Organization for Migration (2002). IOM Position Paper on HIV/AIDS and Migration 2002. Retrieved from: <http://www.iom.int/jahia/webdav/shared/shared/mainsite/about_iom/en/council/84/Mcinf252.pdf>.

Mann, J. M. (1996). Health and Human Rights. *British Medical Journal, 312*(7036), 924–925. http://dx.doi.org/10.1136/bmj.312.7036.924.

Morris, M., & Kretzschmar, M. (1997). Concurrent partnerships and the spread of HIV. *AIDS, 11*, 641–648. http://dx.doi.org/10.1097/00002030-199705000-00012.

Oppenheimer, G. M., Bayer, R., & Cosgrove, J. (2002). Health and human rights: New wine in old bottles. *Journal of Law and Medical Ethics, 30*, 522–532. http://dx.doi.org/10.1111/j.1748-720X.2002.tb00423.x. R.

Rutabanzibwa, A. (2007). Migration and HIV in Africa: Challenges and Recommendations. *Gay Mens' Health Crisis Newsletter of Experimental Treatments, 21*, 15–16. <http://www.thebody.com/content/art45455.html>.

South African Department of Health (2007). *HIV & AIDS and STI Strategic Plan for South Africa, 2007–2011*, (Pretoria: Department of Health, 2007). http://www.info.gov.za/otherdocs/2007/aidsplan2007/ Accessed 19 February 2016.

Troung, T. D. (2006). Governance and poverty in sub-Saharan Africa: Rethinking best governance and poverty in sub-Saharan Africa: Rethinking best practices in migration management. *International Social Science Journal, 58*(190), 697–714. http://dx.doi.org/10.1111/j.1468-2451.2008.00663.x.

UN (1990). *United Nations Convention on the Protection of the Rights of Migrant workers and their Families, adopted by the United Nations General Assembly in 1990*. <http://www.un.org/documents/ga/res/45/a45r158.htm> Accessed 19 February 2016.

UN (2000). *The protocol to prevent, suppress, and punish trafficking in persons, especially women and children, supplementing the UN Convention Against Transnational Organized Crime*. UN: New York, New York. <http://www.osce.org/odihr/19223> Accessed 19 February 2016.

UN (2006). *Gender, migration, remittances, and development*. <http://www.un.org/esa/population/meetings/fifthcoord2006/P02_INSTRAW.pdf> Accessed 19 February 2016.

UNAIDS, International Labour Organization, International Organization for Migration (ILO/IOM/UNAIDS) (2008). *HIV and international labour migration*. <http://www.unaids.org/en/Resources/PressCentre/Featurestories/2008/July/20080716NewUNAIDSpolicyHIVandintlabourmig/> Accessed 19 February 2016.

Vijeyarasa, R., & Stein, R. A. (2010). HIV and human trafficking-related stigma. *Journal of the American Medical Association, 304*(3), 344. http://dx.doi.org/10.1001/jama.2010.964.

World Bank (2010). *Leveraging Migration for Africa: Remittances, Skills and Investments*. <http://postfi.files.wordpress.com/2011/03/leveraging20migration-p4-rev-3-31-2011.pdf> Accessed 19 February 2016.