Patterns of Migration, Settlement and Dynamics of HIV/AIDS in South Africa

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Chapter One

Background Paper: Patterns of Migration, Settlement and Dynamics of HIV/AIDS in South Africa

1. Introduction:

Most, if not all, discussions of migration in South Africa begin with an almost unavoidable reference to the nature and impact of the apartheid legacy of the migrant labour system. This linkage perhaps emphasizes the fact that the intractable impetus created by Apartheid driven social engineering is still visible in the existing migration patterns. Literature by authors such as Oosthuizen (1997) and Horner (1983) claims that in South and Southern Africa the "mobility transition" patterns as premised by Zelinsky (1971) were interrupted. One reason given for this is the failure of such hypotheses to account for the phenomenon of circular migration in developing countries that were previously under colonial rule (Ndegwa et al, 2004). There is much speculation in academic circles regarding the current extent of circular migration in South Africa. While some authors such as Cross et al (1998) and Bekker (2002) believe that circular migration is in decline, others such as Collinson et al (2003), Ndegwa et al, (2004) and Hosegood et al, (2005) believe that it is still highly prevalent.

Posel (2003) blames the lack of sound national level data for such conjectures. While earlier literature on migration in South Africa (1970s and 1980s) focused on its nature and impact, in the 1990s the focus shifted towards a concern with immigration, especially from other African countries, neighbouring and afar. Given the instability and conflict on the African continent in the 1990s, this preoccupation has not been misplaced but has, to some extent, come at the expense of research on other patterns of migration, such as rural-urban internal migration. Another reason for missing information in this field in the post apartheid years seems to have been an implicit belief that the abolition of influx control legislation would lead to a decrease in internal migration, especially circular migration. The assumption is that the only reason people were moving was due to

externally enforced oppressive apartheid laws, in the absence of which people would settle down close to their places of work (Posel, 2003).

This conviction has not only been proved naïve but it may very well explain why "the coverage of labour migration in national survey instruments in South Africa declined during the 1990s, and then ceased in 2000" (Posel, 2003:1). While there is some valuable information available from micro level survey sites such as Agincourt Health and Demographic Surveillance System (AHDSS), Halbisa etc., the problem of comparability across surveys remains significant in the absence of national level coverage of labour migrants in nationally representative household surveys and census data (Casale and Posel, 2002 a). It is only in the last couple of years that the study of the trends of temporary labour migration research has gained popularity leading to the grudging adoption of migration studies by demographers, albeit still subjecting it to second-class treatment.

Another understudied phenomenon in the migration conundrum has been its connection with the spread of the HIV/AIDS epidemic in South Africa. Much of the literature on migration trends and demographic changes has, until recently, failed to take into account the high prevalence of HIV/AIDS in South African society and its complex links with the conditions created by long-standing migratory patterns. However, it has of late unfortunately become something of a truism to connect the spread of HIV to the migration of human beings in spatial terms. Instead as Decosas and Adrien (1997) have pointed out, the association between migration and HIV is more likely to be a result of 'the conditions and structure of the migration process than the actual dissemination of the virus along the corridors of migration.'

Much of the research on Southern Africa's HIV/AIDS epidemic has neglected important socio-economic, legal, and cultural dynamics of migration that may be contributing to the spread of the virus. While migration is often posited as a significant vector in the disease's spread, there is very little understanding of the mechanisms in terms of which human movement contributes to new infections. Nor do we have a detailed understanding

of HIV fuelled migration in order to access better health care or, as the macabre phrase goes, "returning home to die". The need to explain these processes is now acute, and nowhere more so than in Southern Africa, where median HIV prevalence rates are among the highest in the world.

In this paper, I argue that although the existing literature and data on migration is inconclusive with regard to the national trends relating to circular migration in South Africa, we can still piece together trends from various studies, data from regional sites etc. that can point us to meaningful indicators of what kind of a demographic picture confronts South Africa. Such information can shed useful light on what implications migration will have for city planners and policy makers. After an analysis of migration trends, this paper will proceed to elucidate the relationship between migration and HIV/AIDS, the mechanisms operating within the migration process leading to new infections as well as the new forms of migration as a result of circumstances created by HIV/AIDS. It will demonstrate the need to mainstream migrants in planning for the public provision of services such as education, health, water, energy, housing etc. in order to accelerate the economic urban transition. The discussion will conclude by arguing for a need to develop strategies to address the needs and vulnerabilities this population in the HIV/AIDS prevention and treatment programs and presenting a framework to think about instituting such interventions. Failing to take into account migration patterns and the conditions created by them in South Africa could lead to misplaced development policy as well as hinder the achievement of the Millennium Development Goals to which South Africa is committed.

2. Defining Migration:

Defined in a very basic manner, migration simply means a movement of people from one place to another temporarily, seasonally or permanently, for a host of voluntary or involuntary reasons (Brummer, 2002). This definition includes refugees, asylum seekers, internally displaced persons, cross-border economic migrants as well as internal labour

migrants. For the sake of clarity, this paper has divided migrants within South Africa into three categories: internal (rural-urban, rural-rural) migrants (referred to simply as 'migrants'; 'cross border economic migrants'; and finally 'refugees and asylum seekers who are fleeing persecution and unrest, having lost the protection of their countries of origin.

While this basic definition of migration explains the physical aspect of movement, it does not capture the essence of the circumstances that go hand in hand with the dislocation, movement and relocation of an individual or a household. Often, especially in the case of internal migrants and cross border economic migrants, the process may not simply be linear in the form of a linear *gravity flow* (i.e. one way permanent move) to the urban destination. South Africa is especially peculiar in this case, as mentioned above, due to artificial patterns of movement created by apartheid policies, leading to *oscillatory migration* (i.e. going back and forth) patterns with the migrants maintaining strong urban and rural household ties. Migrants also evolve innovative coping strategies to establish themselves economically and socially in the destination sites. It is also important not to look at migration in isolation but in the context of the larger transformations taking place in the country on which it impacts. Hence, the discussion of migration here will begin by situating it in the framework of the broader demographic processes taking place in South Africa.

3. Population transitions in South Africa:

The discipline of demography identifies three kinds of transitions that any developing country undergoes before a successful population transition takes place in order for it to acquire the composition that characterizes most developed nations of today. These are: ***demographic, urban, and mobility transitions***. All three are complex phenomena and do not unfold independently of each other. For the purposes of this paper, the last two transitions are of chief importance. Without going into detail, one can describe ***'demographic transition'*** as the change in the size of a country's population as a consequence of modernization. This typically takes the form of the rising birth rate as the

death rate falls, which leads to a population boom until the birth rate also drops and a stable new level is achieved. While demographic transition is in progress in South Africa, its natural trajectory has been significantly affected by the HIV/AIDS epidemic (Rehle and Shisana, 2003).

'Urban transition', as the name suggests, is the shift in which a country's population moves from rural to becoming urban. As development takes hold, more people move to the cities in search of better economic prospects. At the same time there is a natural increase in the urban population from demographic transition forces. When this happens, the rural population should substantially decrease. South Africa is a special case in this regard as the "structure and functioning of the Apartheid System introduced a deliberate impermanence in the urbanisation process of the South African black population" (Collinson et al,, 2003). This was a result of the apartheid social structuring policy dispensed by means of the infamous Influx Control and Group Areas Acts (Giliomee and Schlemmer, 1985, Crush, et al, 1991).

African populations were forced live in ethnically homogeneous rural 'homelands' on the pretext of granting governing autonomy to the black population. However, this was in fact a way of keeping the black population out of the white populated cities, avoiding responsibility for the welfare of workers, reproducing the labour force and justifying low wages (Lurie, 2000). As a part of apartheid land planning legislation (especially, the 1913 Native Land Act) white power and property rights were entrenched in the countryside to stop the black farmers from working for themselves and to ensure that they could only work as cheap labour for white farmers owning big commercial farms. It was this coercive legislation became the central theme of Sol Plaatjies' vociferous campaigns.

The drastic shortage of land for black farmers due to such legislation forced a transition from an agrarian to a capital based rural economy (Gelderblom & Kok, 1994, Tollman et al, 1997 in Collinson et al, 2003). One of the outcomes of such land appropriation from the "natives" was overcrowded rural concentration of the black population and desperate

rural poverty. This, in turn, resulted in "massive migration of able-bodied males to mining, industrial, and urban centres" (Ndegwa et al, 2004) to be employed as the cheapest and most exploitative forms of labour, and thus, vast numbers of disunited families living in dense settlements with missing adult males. "From an urban perspective these laws resulted in a gross inadequacy of urban planning and a diversion of urban settlement into sprawling peri-urban areas, located in Bantustans, commuting distance from cities" (Giliomee and Schlemmer 1985, Graaff, 1987 in Collinson et al, 2003). Young black men were encouraged to return home a couple of times a year to visit rural families and remit their money home, hence creating patterns of oscillatory movement. Such ties were encouraged by the apartheid government who had an interest in these migrant males not losing their links with their rural families. The consequences of these processes were so strong that despite the end of apartheid, rural areas still remain overcrowded, as institutional and political processes do not allow African migration into commercial farming areas (Cross, 2000) and migration still powerfully influences contemporary livelihood strategies.

This brings us to the third kind of transition, viz. *'mobility or migration transition',* that was put forward by Zelinsky (1971) with later revisions by Todaro (1976). This transition is explained by a change in the migration patterns themselves as development progresses. As people begin to need things, they move out of rural areas in all sorts of ways (rural-urban as well as rural-rural), causing a simultaneous urban transition with growth in the urban population. According to this mobility transition hypothesis, "as populations move through different phases of demographic transition, migration patterns change in predictable ways" (Oosthuizen, 1997: 1 in Ndegwa et al, 2004). But South Africa represents an anomaly in the model of 'mobility transition' as it "failed to predict the patterns that would be peculiar to developing countries where lags in fertility implied continued higher rural population growth amidst declining labour absorption rates within existing employment sectors" (Ndegwa et al, 2004). With the end of apartheid, it was expected that circular or oscillatory migration would come to a halt and more permanent patterns of settlement (i.e. gravity flows) would emerge. However, the theorists

underestimated the imprint of apartheid policies and the decade of democracy has continued to see the prevalence of circular migration from rural to urban areas.

In further revisions to the mobility transition theory, Kelly and Williamson (1984) postulated that high levels of urbanization were predicted in developing countries, with the urban saturation of 85% population being reached in the year 2000 (Ndegwa et al, 2004). These trends have been also been defied by South Africa as the urban transition was delayed due to apartheid Influx Control laws and highly prevalent circular migration. Between 1996-2001 South Africa's population grew by 10.44% (or 2,01% / yr) and the nine cities belonging to the South African Cities Network (SACN)[1] grew by 14.82% (or 2,80% / yr) ('City Population trends', SACN Power Point Presentation 2004). This impression of fast growing cities must be understood carefully. While the growth is significant, it is still less than the growth in the 1960s and from 1991 to 1996. (See Table 1)

	9 CITIES	SA	SA - 9 CITIES
1946 pop	**2 894 710**	7 369 709	4 474 999
2001 pop	**16 581 772**	44 819 778	28 238 006
1946-2001	**3.22%**	3.34%	3.41%
1946-1960	**3.56%**	5.69%	6.83%
1960-1970	**3.31%**	3.14%	3.06%
1970-1980	**2.71%**	1.39%	0.77%
1980-1991	**2.13%**	1.96%	1.88%
Adjust 91-96	**(4.54%)**	(5.54%)	(5.96%)
1996-2001	**2.80%**	2.01%	1.55%

Table 1: Population Trends in South African Cites (borrowed from 'City Population trends' Power Point Presentation available on www.sacities.co.za)

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[1] Namely, Buffalo City, Cape Town, Ekurhuleni, eThekwini, Johannesburg, Mangaung, Masunduzi, Nelson Mandela Metropole and Tshwane.

However, not all SACN cities grew at the same or even at a similar rate, with three categories becoming clear. There were 3 fast growth cities (Ekurhuleni, Johannesburg Metro and Tshwane Metro), 2 stable growth cities (Cape Town Metro and eThekweni Metro) and 4 slow growth cities (Mangaung, Msunduzi, Nelson Mandela and Buffalo City). (See Figure 1)
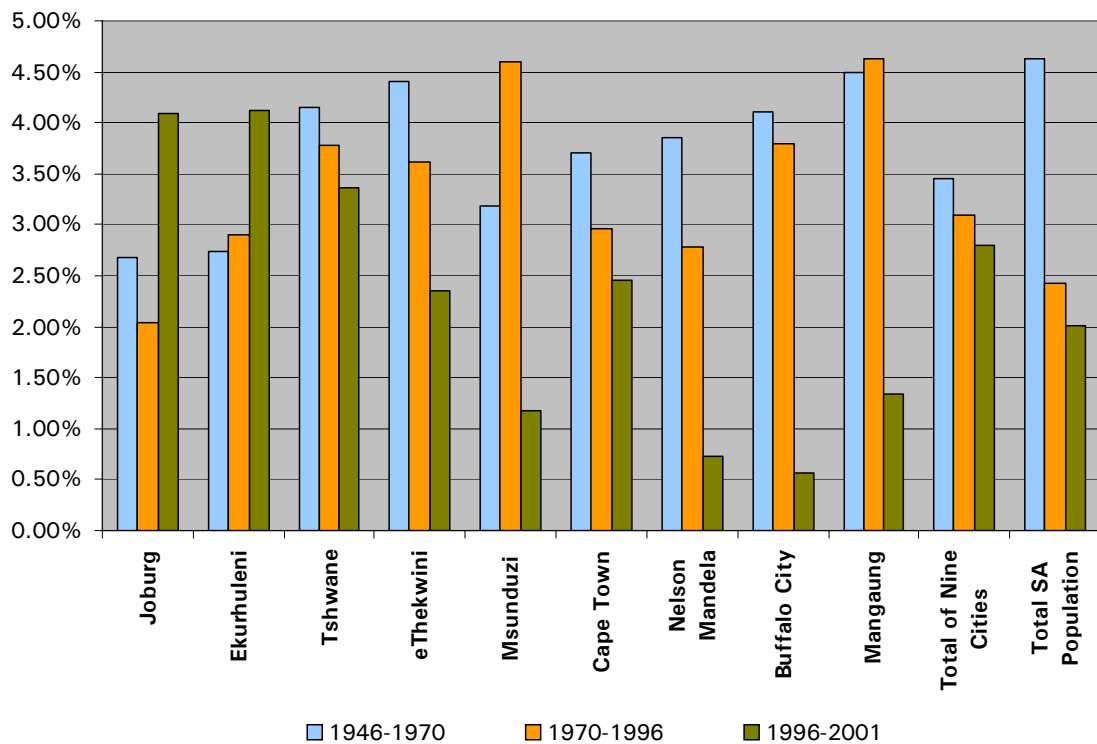

Figure 1: **Rate of Growth of the SACN cities over three time periods (borrowed from 'City Population trends' Power Point Presentation 2004)**

Moreover, some fast growth SACN cities are not growing nearly as quickly as some hyper-growth secondary cities.

Mogle C	Polokwne	Rustenbrg	uMhlathze	
223657	424976	311326	196183	
289724	508277	395540	289190	
29.54%	19.60%		47.41%	**28.25%**
5.31%	3.64%	4.90%	8.07%	**5.10%**
Joburg	**Ekurhulen**		**Cape Town**	
2639110		1682701	2563612	
3225812	2480276	1985983	2893247	
	22.37%	18.02%	12.86%	**18.77%**
4.10%	4.12%			**3.50%**

Table 2: **Comparative growth rates of four SACN cities and four secondary hyper-growth cities in South Africa (borrowed from 'City Population trends'. 2004. Power Point Presentation available on www.sacities.co.za)**

4. Patterns of Migration and Settlement

4.1 Internal migration

4.1.1 Urban moves and rural-urban ties

Considering that urban transition in South Africa is predominantly still a migration process rather than a process of natural increase (Cross, 2000), interesting conclusions can be drawn about the state of migration in South Africa. To begin with, it seems that the rural population is on the move to urban centres. Catherine Cross, in her address to students at a Graduate Workshop on Migration (2000) mentioned that according to her South Africa was about three quarters of the way up the urban transition slope. The discussion in the previous section confirms that we have not yet reached the peak of the slope although in some major cities we are perhaps quite close to the peak as the population in some metros is beginning to stabilise. But what does this say about the mobility or migration transition? Even if the rate of population growth in some major

cities is stabilising or somewhat declining, migratory movements are far from over. Further, the high rate of growth in secondary cities probably means that they are becoming popular migrant destinations.

What is hard to decipher from this data is whether the migrants counted in the census data in urban areas are engaging in permanent migration or are still circular migrants. The messages from regional surveys have been mixed and it is difficult to generalize about the whole nation. For example, Cross et al,, (1998) argue that KwaZulu Natal is experiencing a decrease in labour migration to metros as well as a decline in remittances being sent to rural areas, thus indicating less rural ties and therefore a decrease in circular migration. On the other hand, the data from the Agincourt Health and Demographic Surveillance System (AHDSS) site shows just the opposite i.e. high prevalence of circular migration. The most absent age group is the 35-54 year olds, whose absence remains high at around 60%. The data also showed significant levels of remittances to rural areas by migrants employed in work for payment. Among the most important destinations for employment from this site is Gauteng, the main industrial province, incorporating Johannesburg and Pretoria. 60% of employed temporary migrants surveyed at this site in 2001 preferred to move to Gauteng (Collinson et al, 2003).

Another study carried out in Mupmalanga Township near Durban lends support to the suggestion that circular migration and remittances in Durban are on the decline (Mosoetsa, 2004). This study maintained that although urban-rural linkages still persist and are significant in Mupmalanga Township, their nature seems to have changed due to high rates of unemployment and poverty. As noted earlier, rural-urban ties were encouraged in the apartheid era and the economic aspect of remittances became a focal point in strengthening these ties. Now with the decreased labour absorption of urban areas, economic resources of households mainly take the form of social grants and not remittances. All households included in Mpumalanga Township's study relied on state grants to a significant degree. While the rural ties remained strong, when people made visits to rural areas these were more "ceremonial" in nature (Mosoetsa, 2004).

However, the case of Mpumalanga Township should not be overstated in proving the thesis of the declining circularity of migration and the changing nature of rural-urban ties. The origins of this township date back to as early as the 1960s when it was created as a labour reserve to service industrial centres such as Pietermarizburg, Pinetown and Durban. It has had a vibrant history throughout the 1980s with a strong political culture in the years leading up to democracy and an unfortunately violent series of years in the 1990s that left it bereft of the vibrancy and dynamism it once used to have. Eventually, in 2000 this township was included as a part of the financially well-resourced eThekweni Municipality in a move to facilitate service delivery. The reason for giving this brief description of Mpumalanga's history is to bring out the contrast in the manner in which the more recent arrivals in the city become a part of it. It is not in the well-established townships that the rural-urban migrants find themselves, but rather in the informal settlements on the urban edge that technically fall within the physical boundaries of the city but are poorly serviced by municipalities.

For a migrant living in these informal settlements, making it into the city means a move to be able to live in a township (Cross, 2000) that has comparatively much better service provision. However, migration streams should not to be thought of in terms of single, once off moves, but rather as involving more than one move in the form of *step-wise migration* (Bekker, 2002). While a migrant may aim to move to a metro, he/she may do so by initially moving to other rural areas, smaller neighbouring towns, and eventually peri-urban settlements before making it into the metro itself. It is not necessary that every migratory move will follow this trajectory or even make it to the big metro, but this is just to highlight that movement to urban centres are not necessarily simplistic.

4.1.2 Rural to Rural Moves[2]

This brings us to another competing trend in South Africa's current migration patterns. The data from the regional sites and surveys indicate an increase in mobility to smaller towns, semi-urban areas, other rural areas and to peri-urban sites (Cross et al, 1998, Bekker, 2002, Collison and Wittenburg, 2001). This is especially the case around transport routes, as the findings of Collinson et al (2003) demonstrate. The N4 road is a major travel route between Johannesburg and the port city of Maputo in Mozambique, and passes through a number of smaller industrial and mining towns. Destinations along this road are particularly important for employed men, but also for employed women and for both sexes looking for work or staying with relatives. Migration to rural areas of Mpumalanga, which is the focus of farm and game farm employment, is as important a destination as Gauteng for people living in the Agincourt field site (Collinson et al, 2003). There is some national level data available that seems to support these findings. Using the October Household Survey data from 1995-1999 Casale and Posel (2002a) write that "in 1995, a significant proportion of the households to which people had migrated were located in rural (including semi-urban) areas" (Casale and Posel, 2002a). This is especially the case for female labour migrants.

One of the main reasons for this is that the labour absorption capacity of urban areas in South Africa remains low, but returns from agriculture also remain low enough to create a need to engage in diverse livelihood strategies or 'complex non-wage strategies' (Cross, 2000). In a situation where it is very difficult to find a job in cities, and even more difficult to do so in rural areas, people move to areas of high population concentration that are closer to the rural home for three main reasons. Firstly, the cost of migration as well as the cost of living in smaller towns or peri-urban areas is lower than that of living in the cities, and there is better access to government-supplied welfare, services and national transport. In addition, such a move allows some level access to natural resources (Cross, 2000, Posel, 2003). Secondly, more people mean more potential customers and hence, a higher success in informal trading that migrants resort to in the absence of jobs

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[2] All of the 'non-metro urban' moves, i.e. moves to smaller towns, semi-urban areas, rural areas and to peri-urban sites are classified as rural to rural moves.

in the formal sector. Thirdly, "this "small-step" migration may make it easier for migrants to retain links to home areas, providing insurance in the event of unemployment or illness" (Casale and Posel, 2002a: 8).

There is also the added factor of declining remittances as a source of household income (Cross et al, 1998), and an increased reliance on pension and welfare grants. Hence, being closer to the localities where pensions are paid out makes it much easier and cheaper in terms of transport, while ensuring that the grants are paid out in time (Cross, 2000). Baber's (1996:293) research in Limpopo Province showed that "alternative savings instruments, such as pension and other savings policies with the major financial institutions have become more familiar to migrants", and have thus led to a reduction in investment in livestock. This relates to the changing nature of investment in rural areas. Although it may be true that traditional forms of investment, such as investment in livestock, are declining, some research shows that they are being replaced by other forms of investment in rural areas, especially with respect to housing, perhaps for retirement purposes (James, 2001). Collinson et al's (2003) findings show that the longer a person is a migrant, the higher his/her remittances are likely to be. A person who has been a migrant for 5-10 years is 60% more likely to remit than one who has been a migrant for less than two years; a migrant of 11-20 years is 3 times more likely to remit; and a migrant of over 20 years is four times more likely to remit (See Table 3 below).

Variable	Categories	Odds Ratio (95% CI)	p
Duration of Temporary Migration	0-1 years	1	*
	2-4 years	1.17 (1.00-1.36)	***
	5-10 years	1.64 (1.40-1.92)	***
	11-20 years	2.95 (2.42-3.60)	***
	>20 years	4.04 (2.90-5.62)	***

Table 3: Logistic Regression of an employed temporary migrant (Replication of table in part from Collinson et al, 2003)

Posel (2001) found that "after controlling for the migrant's expected wage, migrant workers older than 50 years still remitted significantly more than other migrants" (Posel, 2001 in Casale and Posel, 2003:16). Part of the reason for this may be that much older migrants have stronger ties with rural homes following the pre-democracy established patterns, but the tendency of remittances growing steadily with age also seems to be in line with the need to invest in anticipation of retirement. A study carried out in five low income settlements of Durban showed that while there was an emergence of households that had no or weak rural ties, there was a significant percentage of the sample (48%) that had strong links with rural areas and considered rural areas as their "real home" that represented a safety net in times of economic hardship (Smit, 1998). Collinson et al's (2003) study also shows that employed men are 25% less likely than employed women to remit in the Agincourt area. With the increased feminisation of migration, this can also be taken as a good indicator of the continued maintenance of rural linkages. More analysis is needed of the purposes for which migrant women remit and the nature of the investments they make.

4.1.3 Peri-urban moves

One element of rural-rural migration requires further unpacking, namely, the move to the peripheries of the metro into peri-urban settlements. Why do individuals who have made a long distance move away from the rural home then decide to remain at a significant distance from the city centre? Part of the explanation for this lies in the deeply entrenched spatial logic of apartheid that was inherent in the creation of assigned African districts (Bantustans) administered by traditional authorities in places as far outside the city boundaries as possible, but still within commuting distance to facilitate employment in the city. The only way of sustaining this system of keeping the black population as far away as possible but utilizing their labour services was by means of a heavily subsidized transport system (Cross, 2000). The locational advantage of these settlements continues to be seen in the continuous densification of the population on the edges of townships, where the cost of living is relatively cheaper and transport and services are still

accessible. Peri-urbanization also offers the possibility of utilizing natural resources, such as medicinal plants, water from natural springs, firewood etc (however meagre or unsanitary they may be), for reducing the cost of living. Further, peri-urban areas are perceived by migrants to be safer than cities and as still preserving tradition.

The new Municipal Demarcation Act 27 of 1998 was directed at bringing these peri-urban areas into the metro urban administration. As a result of this, many urban municipalities have to deal with developmental processes related to both urban and rural settlements. While the stand is a commendable one, "a series of problems arise when that stance is used to reject the existence of rurality and urbanity" and to assume that by physically being in within the urban boundaries, all disadvantaged populations are "functionally urbanized" (Sadiki and Ramutsindela, 2002:80). Being pulled into the urban municipalities was meant to be an advantage for the disadvantaged black population but this assumption has proven to be naïve, as neither have services been effectively delivered, nor has the payment capacity of the people in these townships for the services provided been taken into account. Sadiki and Ramutsindela's (2002) research shows that, unfortunately, this municipal integration, with its requirement of payment for services that were previously heavily subsidised, is being seen by people in these peri-urban areas as having increased poverty, and has resulted in an ironic nostalgic cherishing of the 'good old days'.

4.1.4 Infrastructure and services as a reason for migration

We have seen that rising unemployment, the increasing informalisation of work, resource constraints in rural areas and declining social capital is affecting where people move to in order to search for work (Casale and Posel, 2002a). Economic factors have always dominated the migration choices of an individual or a household, but as developmental processes take a stronghold the reasons for migration become increasingly complex. To some extent, this can be seen in the growing association between access to infrastructural services and migration decisions.

Cloete (2002) describes the relationship between infrastructure and migration as being twofold: infrastructure and services as pull factors for migration ("migration attractors"), and infrastructure and services as reasons for moving again. While people may migrate for better infrastructure and services, this is not independent of economic and employment concerns. It became apparent in Cloete's (2002:7) research, looking at the influence of education and health facilities on migration into the Western Cape, that "a poor household may well up and leave their present dwelling if household members remain unemployed and hear about job opportunities elsewhere" and "that the promise of work opportunities is the main reason for migrating" (Cloete, 2002:6). However, on its own, this study found that more than three quarters of the African population included in the study were willing to move again to obtain better general services and this was the case for both urban and rural populations in the province. Housing was the only other need that came before the need for other general infrastructural services such as health, transport, schools and water. The table below has been taken from the abovementioned study and demonstrates the importance of infrastructural services as a potential for on-migration.

Percentage distribution, 'yes' replies only

Would you move again to obtain...?	Coloured Total reply 'yes'	Coloured Metro urban	Coloured Non metro rural	African Total reply 'yes'	African Metro urban	African Non-metro rural	White Total reply 'yes'	White Metro urban	White Non-metro rural
Better jobs	32	27	56	80	82	70	34	34	34
Housing	46	43	59	83	84	81	44	46	33
General services	39	36	54	79	81	77	32	36	28
Health	35	32	51	70	68	78	20	19	24
Transport	25	21	45	58	55	74	17	16	19
Schools	31	28	48	57	54	71	14	15	12
Water	12	7	34	44	39	71	9	10	8
Peace	42	43	38	68	66	76	25	29	18
N=	384	155	229	204	68	136	232	97	135

Source: 2001 PAWK migration survey (weighted)

Table 4: Infrastructural services in relation to potential on-migration, by population group and sub-region (borrowed from Cloete, 2002)

4.1.5 Increasing female migration

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This trend, also termed as 'feminisation of migration', warrants an independent analysis since it is a crucial element in South Africa's changing migration patterns. In recent years, there has been a tremendous rise in the female out-migration from rural areas resulting in a "significant gender reconfiguration of migration streams" (SAMP, 2004:1). One of the reasons given for this is that since the restrictions on movement have ended with the advent of democracy, there is an increased movement of women to join their spouses in urban areas. At the same time national survey data shows that the marital rate among South African women has fallen since independence and more women are being reported as heads of households. Casale and Posel (2002b: 16-17) summarise the changes in female marital patterns in South Africa in recent years as follows:

> "The percentage of household heads between the ages of 15 and 65 who are female increased from 28 percent in 1995 to 34 percent in 1999. The increase in female-headed households may reflect greater male desertion, but it is also possible that more women are choosing to remain unmarried. The proportion of the female population of working age who reported themselves as married decreased from 39.5% in 1995 to 35.2% in 1999, while the proportion of females either living with a partner, divorced or separated, or never married, increased over the same period." (Casale and Posel (2002b: 16-17))

Such changes could influence migration of women in two ways. Firstly, it could mean a loss of access to the traditional male income due to higher unemployment or HIV/AIDS and therefore a greater need to migrate in search of a livelihood (Casale and Posel, 2002b) Secondly, it also signifies a decrease of male domination on female decisions and hence greater freedom to make a range of economic choices. This has also been supported by the decrease in the traditional structures of patriarchal chieftain control that entrenched the notion that women's place is in the home, and increased levels of education for both men and women. The data from the Agincourt Health and Demographic Surveillance System (AHDSS) site provides enlightening insights into female migration patterns. After a period of constant trends in temporary migration, a striking change took place in 1997 in both age groups of women, 15-24 and 35-54 years. Women migrants in the age group 35-54 moved from 15% to almost 25% in the next three years (1997-200), and those in the age group 15-24 showed a three-fold increase from about 6% in 1997 to 18% in the year 2000 (Collinson et al, 2003). As noted in

section 4.1.2 earlier, the destinations of women migrants seem to be characterized by movements closer to homes, in local towns and farms, as compared to male migrants.
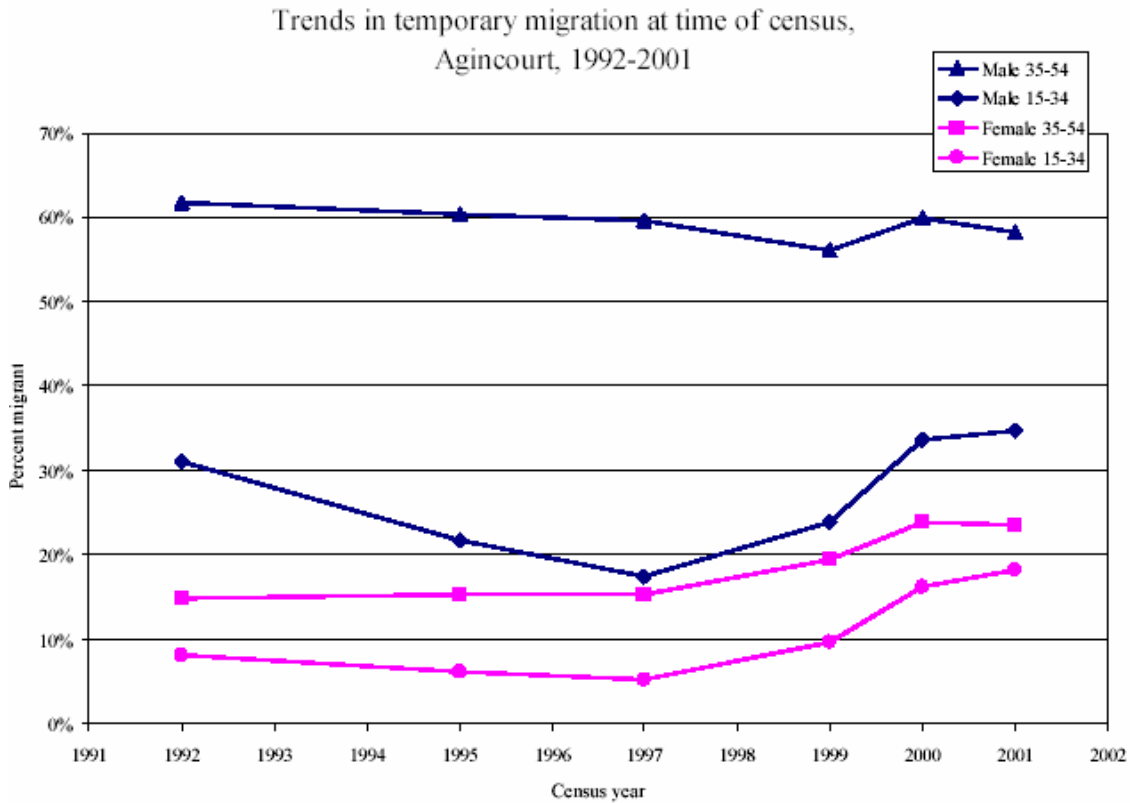

Figure 2: Trends in Temporary Migration from Agincourt Health and Demographic Surveillance System (AHDSS) field site (borrowed from Collinson et al, 2003)

In line with increased migration, South Africa has seen a simultaneous rise in the participation of women in the labour force. In 1995, 38 percent of all females between the ages of 15 and 65 were either working or actively looking for work in South Africa, and by 1999, this had increased to 47 percent (Casale and Posel, 2002b). However, at the same time, female unemployment has also grown. Hence the higher levels of female workforce participation relates mainly to the self-employment of women in the informal sector. We find that the continued feminisation of the labour force is associated

particularly with an increase in female unemployment, and where employment has grown, this has been mostly in self-employment in the informal sector (Casale and Posel, 2002b). Table 3, borrowed from by Lund and Skinner (2003) and originally drawn from the September 2001 Labour Force Survey (LFS) shows employment by sex within the formal and informal economy. It is interesting to note that while men dominate employment in both sectors, the female worker population is more significantly employed in the informal sector rather than the formal sector.

Gender	Formal	Informal
	economy %	economy %
Male	61.10	54.50
Female	38.90	45.50
Total	100.00	100.00

Original Source: StatsSA (2001) Labour Force Survey, September, Pretoria: StatsSA

Table 5: Proportion of South African workers in the formal and informal economy by sex, 2001 (borrowed from Lund and Skinner, 2003)

Such higher levels of female involvement in the labour force are a positive development for South Africa's growing economy. But the participation of women has mostly grown in the informal sector, which is also unfortunately associated with low earnings, little protection and insecure working conditions (Casale and Posel, 2002b). As a result, this has led to an increasing reliance of women migrants on survivalist activities such as engaging in transactional sex that increases the risk of contracting HIV. This has been explored in more detail later in section 6.3.

4.2 Cross border economic migrants

The next trend discussed here is that of cross border migrants, undertaking migration mainly for economic purposes. Foreign labour migration patterns go way back in the South African history. Amidst the fears of labour shortage from South African homelands, efforts to recruit labour from neighbouring countries as a source of cheap labour by the apartheid government. This was developed as a system of circular migration by the Chamber of Mines of South Africa and enforced with the help of neighbouring colonial administrations (Williams et al, 2002). The Employment Bureau of Africa (TEBA) was set up as the employment agency responsible for foreign recruitment in 1976. Since then, South African mines have always been dependent on foreign labour. The proportion of foreign workers on the mines has more or less stabilized at around 55 per cent since the 1990s (Crush et al, 2001).

Historically, foreign African contract labourers were subject to similar restrictions on employment and settlement in South African cities as the black African population and were not allowed to bring their spouses or children along. They were required by the South African labour policy to go back at least once every two years and had to be re-attested in order for them to re-enter, assuming that there was a need for their services (Posel, 2003). Understandably, this made permanent settlement practically impossible. Over a period of time these labour channels as well as cross-border movements of people became entrenched in the South African economic system. Currently, Mozambique, Malawi, Swaziland, and Botswana remain the main suppliers of foreign migrant labour to South African mines (Williams et al, 2002). A study carried out by Peberdy and Crush (1998) of cross-border informal traders found that most of the respondents had been travelling to South Africa to trade since at least 1990 and some even before.

As with the internal rural-urban migrants, the ending of apartheid influx control laws also brought opportunities for new cross border migrant patterns to emerge. At the same time, South Africa's reintegration into the regional economy and its enthusiastic support for 'New Partnership for African Development' (NEPAD) and for reformulating the

Organization of African Unity (OAU) as the African Union (AU) has placed it at the hub of the networks of trade, travel and industry. This has not only boosted South Africa's formal trade with its neighbours but has also given an impetus to informal sector cross border trade. Although migrancy on mines has been a much-studied phenomenon, there are other sectors that continue to employ migrants in high numbers, such as agriculture, manufacturing, construction work, and domestic services. It is mainly women migrants who are employed in the domestic service sector.

Cross border trading too is highly gendered with women from neighbouring countries involved in the buying and selling of goods across borders (Peberdy and Rogerson, 2000). This is concurrent to the phenomenon of the feminisation of migration that has been discussed in relation to South African internal migrant patterns. Women are becoming increasingly mobile and travelling more frequently for formal or informal work (Williams et al, 2002), and like their counterparts within South African migrant streams, they tend to move shorter distances than their male partners and return home more frequently (Lurie et al, 1997). A study in Lesotho showed that increased retrenchments of men on the gold mines have led to a rise in migration by women seeking work on South African farms (Ulicki and Crush, 2000). Belinda Dodson, (1998) in her analysis of migrants from Lesotho, Zimbabwe and Mozambique, writes that women are an increasingly significant part of the cross border migrant profile.

4.3 Refugees and asylum seekers

South Africa's freedom and prosperity since the first democratic elections in 1994, have facilitated its transformation into a central node in emerging networks of human mobility, especially from other parts of Africa. The beginning of 1996 saw South Africa finally become a formal signatory to all three major international instruments pertaining to international migration: the 1951 Refugee Convention, the 1967 UN Protocol and the 1969 OAU Convention. In the following year, the Green Paper on International Migration declared the Aliens Control Act (one of the last remainders of apartheid

legislation) unfit for refugee protection. Finally, based on the recommendations of the White Paper Task Team appointed in March 1998 by the Minister of Home Affairs, the Refugees Bill was passed by Parliament in November 1998 and came into force in April 2000 as the Refugee Act 130. Long-standing labour migration patterns now not only exist alongside new forms of urbanization, but also international migration. Refugees and asylum seekers represent a small, but significant part of those attracted by South Africa's commitments to human rights and the rule of law (see Table 6).

The Refugees Act 130 of 1998 is very progressive in its proclaimed commitment to refugee protection. Regulation 15(1)(C) of Section 27B of the Refugees Act guarantees asylum seekers and refugees access to basic human rights. Section 27B of the Act goes further by defining minimal levels of protection and outlines the state's responsibility for creating a more favourable environment for asylum seekers and refugees.

	2001	2002	2003	2004
Refugees	18 605	23 344	26 558	27 683
Asylum Seekers	4 860	52 451	84 085	115 224
Total	23 465	75 795	110 643	142 907

Table 6: Approximate Cumulative Numbers of Numbers of Refugees and Asylum Seekers[3]

The main reasons why non-nationals leave their home country include conflict, poverty, violence, and persecution (political, religious, gender-based). According to the Refugees Act 130 of 1998, a refugee can be defined as someone who:

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3 Statistics Presented at UNHCR Annual Planning Meeting, 14-15 February 2005 in Pretoria. Note: All figures here are based on statistics provided by the South African Department of Home Affairs (DHA). These are estimates and should not be cited unless confirmed with the DHA.

(a) Owing to a well-founded fear of being persecuted by reason of his or her race, tribe, religion, nationality, political opinion or membership of a particular social group, is outside the country of his or her nationality and is unable or unwilling to avail himself or herself of the protection of that country, or, not having a nationality and being outside the country of his or her former habitual residence is unable or, owing to such fear, unwilling to return to it; or

(b) Owing to external aggression, occupation, foreign domination or events seriously disturbing or disrupting public order in either a part or the whole of his or her country of origin or nationality, is compelled to leave his or her place of habitual residence in order to seek refuge elsewhere: or

(c) Is a dependant of a person contemplated in paragraph (a) or (b).

An asylum seeker, on the other hand, is any person who has applied for asylum in another country, South Africa in this instance, with the potential of being granted refugee status on the processing of his/her asylum application. Until an individual's application for refugee status is accepted or rejected, they are considered an asylum seeker and are also entitled to a set of rights, albeit one that is less extensive than those granted to legally recognized refugees.

The demographic profile of non-nationals living in South Africa is considerably different from the South Africans population, with most non-nationals belonging to a younger age group on average (Landau et al, 2004). In Belvedere *et al's* 2003 nationwide study of refugees and asylum seekers the average age of the sample was 31, with applicants from Rwanda, DRC and Somalia tending to be slightly older. Also, the number of male applicants in the country is higher than the females entering the country as refugees and asylum seekers. In a survey carried out by Wits University in 2002-2003, 70.6% of non-nationals were male compared to 46.9% of South Africans (Landau and Jacobsen, 2004, also see http://migration.wits.ac.za/FMNJ.html). However, this trend is changing with the

increasing feminisation of migration. With the unrest and social disruption in Zimbabwe becoming worse, South Africa is already noting increased refugee flows, including more women.

In a similar fashion to patterns everywhere else in the world, major urban centres remain the primary destination for migrants. In Gauteng province, home to South Africa's two major cities, Johannesburg and Pretoria, the foreign born population was estimated to have increased from 4.8% in 1996 to 5.4% in 2001. The census figures for Johannesburg indicate that the number of non-nationals in the city has gone up from 65,205 in 1996 to 102,326 by the next census in 2001. However, all these are conservative calculations that fail to capture the diversity of nationalities living in the inner city neighbourhoods (especially in Johannesburg) that have become most international migrants' primary homes.

Immigrants tend to be literate, usually multi-lingual, relatively highly educated, and overwhelmingly from urban origins as compared to South African internal migrants. Belvedere et al (2003) found in their national survey sample that two thirds of respondents had completed Matric (or the equivalent) or a higher level of education, and out of these, almost one third had completed some tertiary education (Belvedere, *et al,*, 2003:5). Despite this, the general perception in South Africa is of the country being inundated with illegal, illiterate non-nationals who are taking away their jobs. Research shows that in the face of rampant unemployment in South Africa, immigrants enter the informal sector and are self-employed, running small businesses. They have also been known to create jobs more quickly than South Africans[4] (Landau et al, 2004).

Unfortunately, the potential and skills of these people are being neglected due to the common attitudes of xenophobia amongst South Africans. There is well-documented media evidence of foreigners being subjected to discrimination, police harassment,

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[4] In the Wits survey, only 20% of South Africans reported having paid someone to do work for them in the past year. Despite the various obstacles the face, 34% of the migrants in the sample report that they had. Even more significantly, 67% of the people hired by the forced migrants were South Africans.

barriers to accessing services and anti-foreigner violence.[5] While the Constitution has given progressive rights to refugees and asylum seekers, this protection is effectively denied due to numerous hurdles in accessing Refugee Reception Offices,[6] delays in processing asylum applications, corruption networks etc (Mushwana, 2005, HSRC 2001, Segale, 2004). Overtly xenophobic political leadership has further exacerbated these patterns (Landau, 2005, Palmary, 2002).

Apart from immediate livelihood and human rights concerns, the conditions in which these people often live also raise the possibility of considerable health risks. Not only do new arrivals (both domestic and international) often live in over-crowded residential units, they also have little access to public health facilities even though they are constitutionally entitled to them. Data from the Agincourt field site shows that factors associated with being a settled former-refugee appear to produce an inequitable burden of child mortality due to lack of legal status and social and economic barriers, which have negative consequences, such as poor access to health and social services, as well as indirect negative consequences, such as social discrimination and marginalisation (Kahn et al, 2003). The violent circumstances of flight and difficulty in gaining entry into the borders of another country expose this population, especially women, to human rights violations, sexual violence, rape etc. In addition, the disintegration of social networks as well as the disorientation of being in an alien environment create opportunities for further human rights violations and lead to risky sexual behaviour. Women may be forced to engage in survival or transactional sex, or fall prey to trafficking networks (IOM, 2003).

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[5] See *Cape Times*. 2005: 'Preying on Desperate Refugees' (28th February 2005) and 'Home and Away' (3rd March 2005); *Mail and Gaurdian*,2004: 'Migrants Are Not Flooding South Africa' (3rd November 2004) and 'Get legal, Minister tells Foreigners' (4th November 2004); *Saturday Star*. 2004: 'Crippled in Zim - Humiliated here' (11th December 2004) and 'Bribe Scam Fleeces Refugees' (11th December 2004); *The Star*. 2004. 'Some Cops See Foreigners as ATMs' (4th November 2004).

[6] South Africa has five Refugee Reception Offices (RROs) located in Cape Town, Port Elizabeth, Pretoria, Durban, and Johannesburg that serve as the first port of call for refugees and asylum seekers. The Regulations to the Refugees Act (1998) require asylum seekers to report 'without delay' (Section 21[1]) to one of the country's Refugee Reception Offices to apply for an 'Asylum Seekers Permit' (Section 22 Permit).

While planning interventions, care should be taken not to bundle this group with the general category of migrants, as the nature of their problems may be unique. This does not mean that policy planners should think of this population as competing for resources with South African citizens. Rather they should be thought of as people within South African borders with constitutional rights, but with difficulties in accessing them, due to extraneous factors that can be addressed, such as xenophobia, administrative delays in the asylum application process, discrimination etc. Department of Home Affair's 'turn around strategy' is aimed at reforming the refugee admission and application procedures and is anticipated to bring about the much-needed changes in the system as well as enhance refugee protection.

5. Lagging Economic Urban Transition in the Cities

While we may be nearing the peak of urban transition, the socio-economic side of this transition is lagging far behind. The informal settlements mushrooming on the fringes of the cities are evidence of the failure of migrants to successfully make it across the economic urban transition. What this means in effect is that while these people physically make it to the city, they remain economically, socially and institutionally outside of it. For refugees and asylum seekers living in inner cores of major urban centres and in many cases having skills to offer, the situation of an 'inside outsider' is even more ironic. While the needs and conditions of this latter category may be very different, it still forms a part of the lag in the economic transformation of a city.

In recent years authors have claimed that the people living in informal settlements on the urban periphery see themselves as being a part of the rural sector (Spiegel, 1999 in Cross, 2000) because of the way they function. According to Cross (2000) informal settlements are seen by their inhabitants as places of social cooperation to get by on a daily basis and, as mentioned before, it is the township lifestyle that is seen as an urban benchmark to which to aspire. As Nedegwa et al (2004:6) note for the City of Cape Town: "poor people

from Eastern Cape are migrating to less poor areas in Western Cape but their end destination is already the poorest district in the city with informal settlements, low incomes and high unemployment rates." The ideal of productive, inclusive, sustainable, and well-governed cities cannot be effectively reached unless this population makes it across the socio-economic urban transition divide. This is even more crucial in the situation of South Africa's HIV pandemic that is known to thrive in conditions of vulnerability. The following sections of this chapter will explore the association between the HIV/AIDS and vulnerabilities of the migrant categories discussed here.

6. Migration and HIV

The following section will concern itself with unpacking the relationship between migration and the HIV/AIDS epidemic. The connection will be looked at from the dual standpoints of (i) migration resulting in an increased vulnerability to HIV infections, and (ii) the need to cope with illness due to HIV resulting in new forms of migration.

6.1 Overview

South Africa is recorded to have the largest number of persons living with HIV/AIDS in the world (Rehle and Shisana, 2003). In their 2004 annual report, the Red Cross has declared the epidemic of HIV/AIDS in southern Africa 'an unprecedented disaster that conventional intervention can no longer contain' (World Disasters Report, 2004). In the '*2004 Report on the Global HIV/AIDS Epidemic'*, ranking countries by prevalence, eight out of the top ten countries are in the southern African region with Botswana (37.3%), Swaziland (38.5%), Zimbabwe (24.6%), Lesotho (28.9.0%), South Africa (21.5%), Namibia (21.3%), Zambia (16.5%) and Mozambique (12.2%). Life expectancy by 2010 is expected to drop by 20 years (from 68 to 48 years), child mortality is expected to double and there may be an additional two million AIDS orphans (Taylor, 1998). These figures only touch the tip of what constitutes an iceberg of depressing statistics with reference to HIV/AIDS.

Most of the data available on the prevalence and incidence of the epidemic has been dependent on antenatal clinic sentinel data, in the absence of population based studies. However, this data is subject to selection biases, such as convenience sampling of the chosen sites, the extent of the usage and coverage of antenatal clinic services, differentials in risk behaviours and contraceptive use, and lower fertility rates among women with HIV-1 infection (Gray, Wawer, Serwadda, Swankambo, Li & Wabwire-Mangen, 1998 in Rehle and Shisana, 2003). Moreover, there may be other socio-demographic factors like the age distribution of those attending antenatal clinics, the level of education, socio-economic status, migration patterns, etc. that could affect the accuracy of generalizations made from this data, especially its authenticity over time (Rehle and Shisana, 2003). Sounding the figures against data generated from population-based surveys can help rectify these biases.

The Nelson Mandela/Human Science Research Council conducted such a population-based survey in South Africa in 2002. The survey was household based and unfortunately that meant the exclusion of homeless people, those living in institutionalised settings, such as university dorms, prisons, barracks or homeless people as well as migrants in overcrowded inner city settings or single sex hostels, which probably resulted in an underestimation, to some extent, of the prevalence of HIV. But even so, it has been hailed as the source of valuable data, especially in so far as it can serve to allow the necessary 'calibrations' of results obtained from pregnant women, as has been done by Rehle and Shisana (2003)[7]. The projections made for selected years up to 2020 reflect the devastating effect of AIDS on South Africa.

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[7]The Epidemic Projection Package (EPP) recently developed by the UNAIDS Reference Group on Estimates, Models and Projections and the Spectrum model program developed by the Futures Group were used to model the South African HIV epidemic, project future trends in HIV/AIDS and estimate the demographic impact of AIDS. The national HIV prevalence surveys among pregnant women from 1990–2001 and the first national, population-based HIV survey in 2002 served as the data sets used to calibrate the input HIV prevalence values for the model (Rhele and Shisana 2003).

Year	Cumulative no. of Deaths
By 2000	0.71 million
By 2003	1.69 million
By 2005	2.56 million
By 2010	4.96 million
By 2015	7.15 million
By 2020	9.31 million

Table 7: Estimations of Cumulative number of Deaths in South Africa by 2020 based on current data (borrowed from Rehle and Shisana, 2003)

Rehle and Shisana (2003) calculated the peak adult (15–49 years) HIV prevalence rate for South Africa to be 17.3% in the year 2001, with 2.34 million women and 1.71 million men living with HIV/AIDS in that year (female to male ratio 1.37). The prevalence is expected to fall slightly until 2010 (15.2%) and is projected to remain relatively stable at this level until the end of the modelled period (15.7% in 2020).
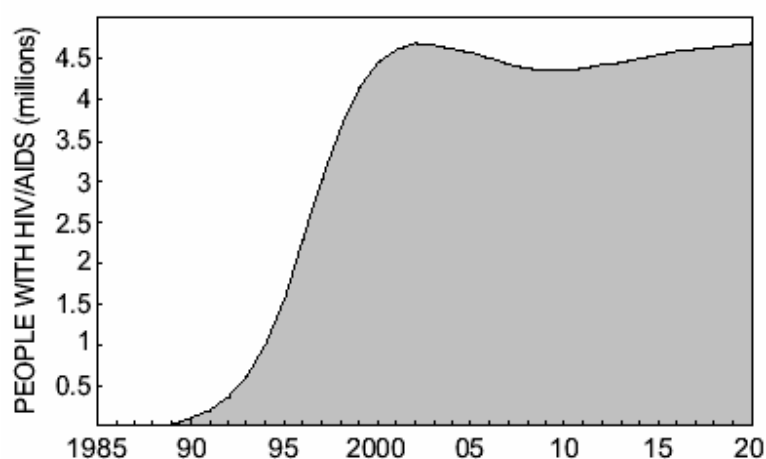

Figure 3: Estimated total number of persons living with HIV/AIDS (borrowed from Rehle and Shisana 2003)

The manifestations of these results in terms of the demographic impact is expected to look like this for South Africa:
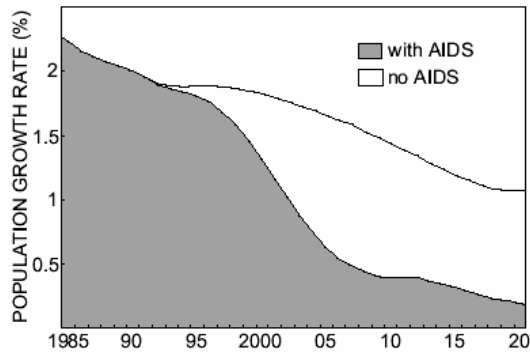

Figure 4: Estimated Annual Population Growth Rate in % (borrowed from Rehle and Shisana 2003)
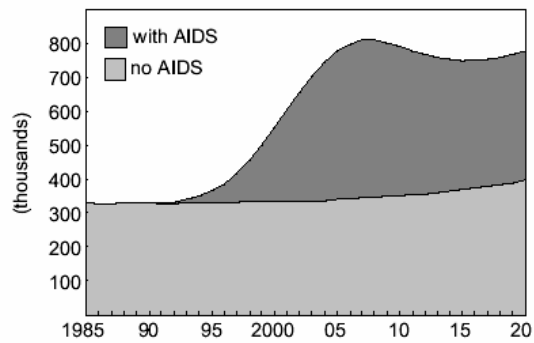
Figure 5: Projected Number of Deaths (borrowed from Rehle and Shisana 2003)

According to the *State of South Africa's Population Report: Population, Poverty and Vulnerability* (2000:61) "the HIV/AIDS pandemic is the single most important phenomenon that will shape future demographic and development trends in South Africa". The Nelson Mandela/HSRC Survey (2002) also shows that while the epidemic in South Africa is generalised throughout the population, hence affecting all persons regardless of race, sex, age, province and locality, there are significant differences within these variables. For example, the HIV prevalence was found to be highest in Africans (12.9%), followed by Whites (6.2%), Coloureds (6.1%) and Indians (1.6%). The prevalence in the female population was much higher (12.8%) than the male population (9.5%). HIV prevalence among adults aged 15–49 years was 15.6%, with 17.7% in the case of women and 12.8% in the case of men in this age group. Africans in this age group had the highest prevalence of 18.4%.

With regard to locality types, the highest prevalence was found in those living in urban informal settlements with an HIV prevalence of 21.3%, followed by formal urban areas (12.1%), tribal areas (8.7%) and farms (7.9%) (Nelson Mandela/HSRC Survey, 2002). The contributing factors for the higher rates of prevalence in informal settlements in

urban areas were postulated by this study to be related to labour migration, mobility and repeated relocation. According to Dr. Shisana, Executive Director of HSRC's Unit on Social Aspects of HIV/AIDS and Health and Principal Investigator on this study, "the mobility and transient nature of life in informal settlements, rather than socio-economic status, makes those living in these areas most vulnerable to HIV." (Press Briefing, 2002). 23.5% of men living in informal settlements reported more than one sexual partner in the past year, as compared to19.2% in tribal areas, 10.2% in urban formal areas and 8.2% in farms. Youth (15-24) in informal settlements had a significantly higher rate of sexual experience (74%) than those in rural areas (58.3%) and formal urban areas (53.2%) (Nelson Mandela/HSRC Survey, 2002).

6.2 Relationship between migration and spread of HIV

Many reasons have been given for southern Africa's high level of HIV prevalence. Among others, these include: overall high rates of disease (especially sexually transmitted disease and tuberculosis), high levels of poverty, social inequalities as a result of apartheid, xenophobic sentiments, gender power imbalances that make condom negotiation difficult, low levels of political will, lack of access to basic services including health, education, housing, water etc. However, perhaps the most neglected factor has been the prevalence of migration in the country as well as in the region.

On one hand, there is an obvious connection between the spread of an infectious disease and increased mobility. Since the early part of the 20th century, migration has been held responsible for facilitating the spread of infectious diseases in South Africa (Packard, 1989). More recently, we saw the world panic with the breakout of the Sudden Acute Respiratory Syndrome (SARS). Like all infectious diseases, it is thus no surprise that migration of populations facilitates the spread of the HIV virus. But unlike the measures taken by many countries to isolate SARS infected individuals, this is neither a practical nor an ethical option for responding to HIV (White, 2003). . However, it is clear that

migrants are more vulnerable to HIV infection than more settled populations. This has been well documented both in southern Africa (Abdool Karim, 1992; William et al, 2002, Decosas et al,, 1995; Lurie et al,, 2003) and in other African countries (Kane *et al,*., 1993; 1995; Pison *et al,*., 1993, Brockerhoff and Biddlecom, 1999)

While the vulnerability of migrants may be high, "it is not the origin, or the destination of migration, but the social disruption which characterizes certain types of migration, which determines vulnerability to HIV" (Decosas et al, 1995). It is the social economy of mobility that creates complex and interconnected circumstances, which may lead to migrants' heightened vulnerability to HIV infection. Some of these have been identified (especially for the southern African region) as poverty and marginalisation; high rates of sexually transmitted disease and other opportunistic infection; differing strains of HIV; the presence or absence of male circumcision (Williams et al, 2002); higher partner-change rates; and increasing contact with higher risk sex partners, such as commercial sex workers or clients (White, 2003). It is only once we have conceptually shifted our focus from the physical act of movement and its association with HIV that we can begin to understand the dynamics that are responsible for the spread of this disease.

South Africa's HIV epidemic is primarily a heterosexual one spread via sexual intercourse (UNAIDS, 2003). There is also substantial evidence that migrancy plays a key role in the spread of sexually transmitted diseases, HIV and other opportunistic infections (Williams et al, 2002, Abdool Karim et al, 1992). Migrant men are more likely than non-migrant men to have multiple sexual partners and to engage in high-risk sexual behaviour (Lurie et al, 2003). Evidence from India's HIV epidemic, where truck drivers and commercial sex workers, especially in towns on trucking routes, are among the groups with highest HIV prevalence, constitutes a good illustration of this reality (Singh and Malaviya, 1994). In South Africa it has historically been easy to causally connect the prevalence of sexually transmitted disease to patterns of circular or oscillatory migration from mineworkers to rural areas. Many authors, such as Jochelson (2001), Setel, Lewis and Lyons (1999), have written about how sexually transmitted infections, such as syphilis, found their way through the migratory routes to rural South Africa where they

were previously unknown. There is no easy way to discern such connections for the HIV epidemic primarily because it coincided with the major socio-political changes in South Africa that made migration patterns more complex than ever.

We have discussed the trends of migration patterns in the country that remain significant to date and that also established urban migrants as people who physically, institutionally, economically and socially remain outsiders to effective urban processes, and hence involuntarily non-participant residents of the city. However, it may be argued that in a matured epidemic with high levels of HIV prevalence as is the case in South Africa, it is futile to try to pinpoint a core population that can be held responsible for the spread of the epidemic. What might be the special reasons to focus on migrants? The following sections attempts to answer this question.

6.3 Reasoning for migrant-focussed interventions

Firstly, the HIV/AIDS epidemic is likely to affect those who are economically marginalized and politically disfranchised much more severely. This works as a two-way relationship of cause and effect. In most cases, people in socio-economically vulnerable conditions may be at a higher risk of HIV transmission. On the other hand, being ill with AIDS may create circumstances of impoverishment, hence making them and their families even more vulnerable and thus generating a vicious cycle of disease. Migrants in cities form a part of the poorest of the poor, who are physically in the city but socially, institutionally and economically outside of it, and hence in a much more vulnerable position than the local populations. This chapter has demonstrated that migrant population, hovering on the fringes of economic urban transition, falls outside of the structures delivering services such as health, water, sanitation, education etc. Needless to say, all this contributes to the existing vulnerabilities that make migrants a group of concern.

Secondly, interventions to deal with the HIV/AIDS epidemic must begin with an understanding of the context of exposure to the virus. High-risk conditions created due to

the migrants' unique circumstances make them especially vulnerable. Literature has historically focused on the particular risks for the population of migrant men working on mines with little recourse to any entertainment other than easy access to alcohol and sex workers (Campbell 2000). This, added to the fact of isolation from family networks and appalling living conditions, created a breeding ground for various sexually transmitted diseases including HIV/AIDS. Today, the typical migrant does not necessarily fit the image of a mineworker but still signifies the prototype of a challenge to the responses against HIV/AIDS as well as to the functioning of an effective democracy. Migrants are no longer only an able-bodied males engaging in oscillatory migration but is increasingly female with a unique set of imperatives and facing different sorts of risks.

Female migrants are particularly vulnerable due to increased sexual risk behaviour, such as using sexual networking as a survival strategy. Research carried out by the 'Mobility Project' (2001-2005)[8] found that "in northern Tanzania, HIV incidence in migrant women was higher than in non-migrant women due to an increase in risk behaviour during the migration period, rather than pre-existing higher-risk behaviour" (Voeten, 2005). Campbell (2000) talks about the thriving commercial sex industry close to the South African gold mines, with women from rural areas within South Africa and neighbouring countries living in informal settlement shacks close to the mines that are considered 'hotspots' of sex work. Zuma et al, (2003), in a study of risk factors for HIV infection among women in a township in Carletonville District of South Africa, found that migrant women were at a significantly higher risk of HIV infection than non-migrant women in the area. Migrant women from rural areas who are engaged in other informal livelihoods may also engage in transactional sex, but do not identify themselves as sex workers (Akileswaran, 2005).

Transactional sex is not seen in the same light as commercial sex work but is identified with 'sex for money', especially in the context of sub-Saharan Africa, and can take many

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[8] The "Mobility Project" was a collaboration between the Erasmus MC in Rotterdam, the London School of Hygiene and Tropical Medicine in the UK, the TANESA Project in Tanzania, and the Manicaland HIV Prevention Project in Zimbabwe. It was funded by the European Commission to carry out research on the role of mobility in the spread and control of sexual transmitted diseases (STD) and HIV in sub-Saharan Africa

different forms. "[S]ex can be exchanged for drinks, food, or a non-specific amount of money, and the sex-for-money relationship can be for one night or more long-lasting" Wojcicki (2002). The informal sector in which many of the migrant women participate is ridden with physical and economic insecurities. This could lead the migrant women to engage in transactional sex as a survival strategy. Further, gender inequalities prevail within the migration context and migrant women, especially cross border informal traders, may be sexually harassed or even raped by border officials, truckers or taxi drivers (IOM, 2003). It is very likely that refugee women have experienced sexual violence during flight. Needless to say, condom use is low or rare in such encounters and the likelihood of HIV transmission is high.

Thirdly, the relationship between migration and health is neither simple nor simply negative. Remittances from labour migration have been a key source of income. Data from Agincourt HDSS shows that temporary migration is positively associated with economic status. A member of a "High Economic status" household [ES(High)] is substantially more likely to be a temporary migrant: ES(High) is 30% higher than ES(Medium), and ES(Low) is 25% lower than ES(Medium) (Kahn et al, 2003, Collinson et al, 2003). This could be due to the fact that increased income due to migrancy results in a higher socioeconomic status for rural households with links to the city. As work in health equity shows, this could mean higher affordability of health services, better nutrition, better sanitation, better access to education etc. for those who stayed, despite the spatial division of the household.

The study of the relationships between migration, urbanisation and health may have theoretical implications to better understand the determinants of child health (Garenne 2003). For instance, according to Kahn (2003), the net effect of female migration on children can be positive where the absent mother can find social networks to cater for childcare. When such networks are lacking, it could mean neglect for the children of migrant mothers. A study of child survival in the Bushbuckridge area by showed that the temporary female migration status of the mother did not increase the children's mortality risk. "In fact there was a small protection effect afforded by a mother being a temporary

migrant (OR: 0.84; 95% CI: 0.69 -1.03)" (Collinson, MSc(Med) thesis in Kahn et al, 2003). While this study would seem to suggest that kinship ties are still strong in this rural region, Kahn et al, (2003) caution against assuming that this trend will continue as AIDS-related mortality amongst adults increases, social cohesion decreases and the households become increasingly strained with the emerging mortality in young income earning adults. In the meantime, positive spin-offs from migration of individuals could be utilized to develop rural areas, not with the intent of controlling migration but rather with the intent of generating developmental processes.

However, better health for the children of migrants may not necessarily translate into better health for migrants themselves. An argument could be made regarding better access to health services and other infrastructure in cities, and hence better health outcomes for migrants. Migrants may themselves perceive these services to be better in the cities but this may not be the case in the informal settlements, the sites of migrant communities, which only nominally remain a part of the city. Even if in some cases health services may be better than is the case in their rural homes, the added pressures of survival needs in the face of low labour absorption and hence, lack of employment may negatively affect the health of migrants. As Graenne (2003) suggests, when the colonial legacy of neglecting urban slums continues after independence (such as in Kenya), situations of excess urban mortality among the poor may persist or even get worse. A proper understanding of the needs of migrants may help reshape current health and social policies at national, provincial and local levels. Lack of basic information to target the groups most in need can hamper the efforts of the NGOs and international aid agencies engaged in facilitation of such policies on the ground.

Much remains to be studied about African migration, since we have only vague accounts of the magnitude of migration flows over the past 50 years to understand its links with child mortality, as well as adult mortality (Garenne 2003). Moreover, although the Bantustans no longer exist, the migrant population remains visible with a majority of migrants inhabiting clearly discernible informal settlements, and in a way re-imprinting the former apartheid boundaries onto the map of South Africa. The current visibility of

migrants can be used to the advantage of structural interventions in the prevention and treatment of HIV. This is not to say that only migrants should be targeted for specific interventions, but rather that the sites of such migrant settlements could become the focal point of interventions for the poorest and the most vulnerable in the city.

Moreover, rural areas in certain provinces, such as Limpopo, where migratory processes were historically delayed, still present a window of opportunity for preventing the incidence of f HIV/AIDS from reaching the levels of KwaZuluNatal or Gauteng by understanding the dynamics of migration (Kahn et al, 2003). Further, while rural-urban migration is an important cause of spread in the beginning of the HIV epidemic, it is rural-rural migration that is the key to the further spread in mature epidemics like South Africa (Voeten, 2005). With different forms of rural-rural migration becoming prevalent in South Africa and even rural-urban migration taking place in step-wise flows, migration streams and patterns become crucial in conceptualizing prevention and treatment efforts.

Indeed in the context of HIV/AIDS treatment and ARV roll outs, as in South Africa, it is premature to say whether migration to urban areas will result in worse off health outcomes or result in more migration in order to access life saving drugs. An answer to this requires an analysis of how the roll out is taking place, the urban-rural differential in accessing ARVs and whether or not it is economically and socially feasible for an individual or a household to make an urban-ward move to access AIDS treatment.

6.4 HIV induced migration

Three trends will be examined in this section. Firstly, the claim that people are returning home to die; secondly, the suggestion that people are moving to access health services; and thirdly, the migration of children in AIDS affected families. The literature on these trends is, at most, only indicative of the trends that may unfold in the future. Researchers have only recently begun to shift their attention to understanding these new forms of migration. It is beyond the scope of this paper to give an accurate answer to the extent of

the prevalence of these trends in South Africa. Instead, this section will attempt to set out the claims being made by the emerging literature and understand their significance. Once again, with no conclusive national data available, we can only rely on regional studies within South Africa or in the similar settings of other SADAC countries to gain an understanding of these trends.

6.4.1 "Returning Home to Die"

Although little research has been carried out in this field, there is a growing concern about urban migrants returning home to convalesce and, in many cases, to die. People who fall sick with AIDS require demanding care and this can lead to a need to change living arrangements at the critical stages of the illness. The debilitating effect of AIDS also results in the inability to work, and hence to pay for urban expenses. Coupled with this is stigmatization from the community. A less noticed aspect is the loss of dignity in the absence of services such as access to water and sanitation that make the management of AIDS-induced symptoms, such as diarrhoea, difficult to manage for the affected person. Even in the fairly immobile population of the United States, research found that 10% of the HIV positive people change their place of residence before they die, over half of them moving to another state (Crush et al, 2004).

A study in Thailand showed extensive return migration to parental homes by people living with AIDS, mostly in the final stages of their illness, and hence dying within a few months of their return. Research in Uganda and Zimbabwe showed the increasing role of older parents in taking care of their adult children affected with AIDS (Ntozi and Nakayiwa 1999, Williams and Tumwekwase, 1999). In the context of South Africa, where circular migration is prevalent, where links to rural homes are maintained by households who make permanent moves, and where the tradition of being buried in one's ancestral home is strong, this phenomenon is likely to be rife. The study carried out in the Mupmalanga Township near Durban, talks of rural areas "as a 'hide away' or final resting places for people dying of AIDS" (Mosoetsa, 2004). The following anecdote

taken form this study describes a mother speaking of migrating to her rural home with her critically ill daughter:

> *"Lindiwe has been living with the evil disease for the past four years. Her daughter passed away when she was only 6 months old. Her only sources of support are myself, the church, and an AIDS organisation she joined two years ago. It saddens me to see how the community is not being supportive of my family and many other families in the Mpumalanga. Even our neighbours are not talking to us anymore. All her friends have turned their back against her. At the end of the month, I am taking her home, where I was born- Eshowe. My aunt will nurse her where she might recover or will die peacefully and with dignity"*
> -(Mosoetsa, 2004, Interview 10, 29th November 2004)

While rural familial ties may be seen as sites of stability and refuge, the migration undertaken by a person living with AIDS also has economic consequences for the families where the person moves. More directly, it may involve moving with a sick spouse or moving to take care of sick relatives, especially parents. This will be explored in a little more detail in the section on children's migration. One must also be careful not to assume that the stigma in the rural communities where migrants move is necessarily less than that in the urban settlements where the migrant was previously living. While the AIDS-inflicted migrant may move to escape stigma in his or her urban community, s/he and his/her family might face similar stigmatization from the rural community. This could result in the further dislocation of the individual and hence in multiple moves involving other family members moving to perform care-giving roles.

The Agincourt HDSS site is one of the first to undertake careful study and documentation of this phenomenon in South Africa through verbal autopsies. The Agincourt sub-district, comprising 21 villages with a population of slightly under 70 000, is situated in the Bushbuckridge district of South Africa's rural north-east, adjacent to the country's border with Mozambique. More than a quarter of the population (29%) are of Mozambican origin (Collinson et al, 2003). Labour migration is the most predominant livelihood strategy as local employment opportunities are few. While 16% of the households in

2001 had at least one member who had made a permanent move outside of the site, 55% of the households contained at least one temporary migrant, signalling high levels of circular migration (Collinson et al, 2003, Kahn et al, 2003). During the past decade the site has seen a rise in AIDS-related mortality and in-migration. Calculations done by Clark et al (2005a) using discrete time event history analysis show that such in-migration has led to "excess" adult mortality in this rural site. "Excess in the sense that there is more death at less advanced ages than the risk factors and exposure in the rural area would produce on their own" (Clark et al, 2005b). The analysis of data in this field site showed that "the odds of dying for returning men between the ages of 20 and 60 are between 1.5 and 2 times greater than resident men in that age group, with greater differences in most recent years when HIV prevalence is highest; women experience similar but muted effects" (Clark et al, 2005a). The table below borrowed from Clark et al (2005a) describes the overall trend in the number of adult deaths as a result of HIV and TB. For both females and males the fraction of total deaths in the age groups 20-39 and 40-59 attributable to HIV and TB show marked increases. This is a critical piece of information for the policymakers while deciding the allocation of health care budgets to rural areas.

Age	1992-1997		1998-2002	
	Number of Deaths	Percent of Total Deaths in Age Group	Number of Deaths	Percent of Total Deaths in Age Group
Female				
20-39	29	22.83	203	52.86
40-59	10	9.26	73	27.44
Male				
20-39	34	17.62	161	42.59
40-59	48	19.83	130	36.41

Courtesy: Samuel J.Clark (Institute of Behavioral Science, University of Colorado at Boulder, USA and Agincourt Health and Population Unit, School of Public Health, University of the Witwatersrand, South Africa)

Table 8: Trends in Adult TB and HIV Deaths in Agincourt (de jure Population) (borrowed from Clark et al, 2005, publication forthcoming)

6.4.2 Migration for accessing health services

With the government's increasing emphasis on providing services to the poor and developing economic and social infrastructure, there is an increasing imperative to pay attention to "spatially informed push and pull factors affecting the migration decisions of the poor" (Western Cape Migration Study Project 2001). While the search for employment is without a doubt the most important reason, the qualitative difference in service delivery between urban and rural areas is increasingly influencing migration decisions.

Section 6.4.1 tried to unpack moves to rural areas to access social support by the migrants at a critical stage of the illness or to escape HIV-related stigma. But in order to understand post diagnosis migration, it is important to take into account the potential for moves to urban places and certain metropolitan areas in order to access better health services (Nedgwa et al, 2004). At the moment, a majority of HIV-infected individuals are ignorant of their status. The assumption that moves are made in search of better health services is only relevant when awareness of HIV status is assumed. "As self knowledge of infected status becomes more current (as will probably be the case in the South African HIV positive community during the next five years), the effect on migration decisions will increase, potentially dramatically" (Bekker, 2002).

We discussed the increasing feminisation of migration in South Africa as well as in the larger southern African region. Another interesting finding in this regard, but in relation to HIV/AIDS, comes from the Khayelitsha study by Ndegwa et al (2004) and one can refer to it as the 'feminisation of VCT'. Data from selected Cape Town city clinics showed that the attendees were primarily women and that they were mainly referred by medical doctors (Ndegwa et al, 2004).
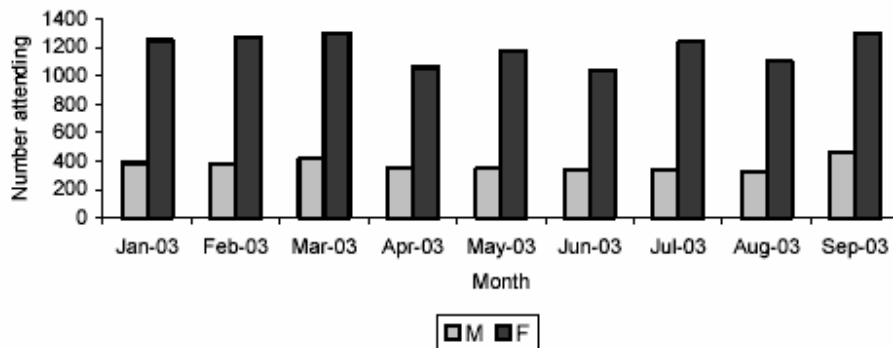
<u>Figure 6:</u> Males and females attending VCT at clinics in Khayelitsha January to September 2003 (borrowed from Ndegwa et al,, 2003)

Interestingly, a majority of them seemed to be seeking services other than MTCT and TB, with the demand for other services being substantially higher in February and March of the particular year.
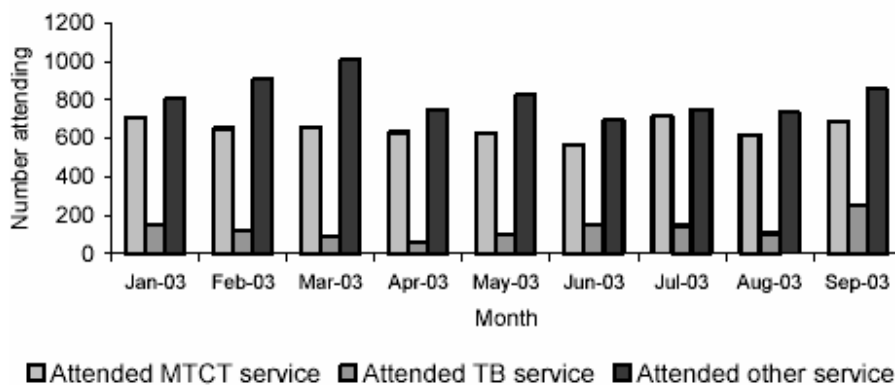

<u>Figure 7:</u> Those attending VCT by type of service attended (borrowed from Ndegwa, et al, 2003)

While increased female migration has led to speculation that the traditional male dominated labour migration is being overtaken by female dominated migration (Booysen, 2003), and has generated a hypothesis regarding the breakdown of tradition patriarchal control structures (Casale and Posel, 2002b), there may be something more that is being overlooked. If women are more likely to be amenable to finding out their HIV status, as

the data above indicates, they may also be more likely to undertake migration to access better health services.

In Table 4, we noted that the African population in the sample identified access to general services as a significant imperative for on-migration (although it was significant in other racial groupings as well). If we probe further, we find that within these general services, health tops the list (See Table 4). Health services were regarded as a potential reason to move on by 35% of all Coloured respondents, 20% of Whites, and 70% of Africans. This was highest amongst the African rural population at 78%. As noted in section 4.14, migration in search of better services is not independent of migration undertaken to seek better employment. On the other hand, if levels of migration are quite high, then the number of potential patients in the migration streams will also be high. Cloete (2002) summarises the question that we are asking quite well:

> "It is clear accordingly that demand for state health services will rise in the province as migrating households enter the province. The question remains whether patients are entering the province *specifically* to seek out better health services." (Coelete, 2002)

Qualitative work done as part of a Western Cape Study by Cloete (2002) shows a general dissatisfaction with the health facilities, especially in the rural areas, and led the author to conclude that this may have already been factored into the migration decisions. If it is already factoring into migration decisions, then it is reasonable to assume that it will probably become an important factor of its own as the knowledge of HIV status and access to ARVs increase, as travelling long distances simply to access health services is generally prohibitive for poor people. At the same time, this study also found that the clinics in the informal settlements of the Western Cape are overwhelmed and lack the infrastructure to cope with the loads they have. Despite this, coming to metros still has the relative advantage of obtaining access to facilities over and above what is available in rural areas. Understanding post-diagnosis migration will be important in allocating

appropriate response and care facilities and services at the destination areas (Booysen, 2003).

6.4.3 Children's migration

In the case of sickness due to AIDS, migration is not a coping strategy employed only by the sick individual. As a study in Free Stare by Booysen (2003) showed, households or families affected by AIDS often reallocate household labour for decreasing costs, generating income and performing care-giving roles. The results of this study showed that mortality in a household increased the probability of out-migration and affected households had a higher probability of out-migration from them as compared to those who were not affected. Such re-allocation of household labour amounts to the re-location of children in many instances.

Very little is known about the situation of children in HIV/AIDS affected households. Even less is known about their coping strategies. However, children are a key vulnerable group in many ways. Substantial numbers contract the disease from their mothers and die at a young age or even during birth. The table 9 below shows projected infant and under-five mortality rates for 2010 in the presence and in the absence of HIV/AIDS.

Projections for 2010 (Deaths per 1000 live births)	With AIDS	Without AIDS
Infant Mortality	48	35
Under-five Mortality	62.6	43

Table 9: Projected 2010 infant and under-five adult mortality rates for South Africa (data from Rehle and Shisana, 2003)

Older children, who grow up as maternal or paternal orphans (or both), have no support and guidance while growing up, may end up having sexual debuts at an early age and

may also be more likely to engage in risky sexual behaviour. Researchers are only beginning to understand the vulnerabilities of these children. The main coping strategy amounts to relocation of children and this takes three forms that will be discussed in this report: children's migration in response to low household resources due to sickness, children's migration to help sick relatives, and children's migration after the death of both parents. Ansell and Blerk (2004) identify three criteria that contribute to decisions made by family members concerning children's AIDS-related migration in all three cases:

- Who is responsible for the children;
- Whether a particular household can meet the children's needs;
- Whether a household might usefully employ the child's capacities.

However, the decisions are never completely rational and are "highly influenced by emotional attachment and a sense of moral obligation" (Ansell and Blerk, 2004). Although children are not actively involved in the initial decision making phases of where they will be sent, they may have influence and may engage in further migration on their own, if dissatisfied with their circumstances in the new household (Ansell and Young, 2004). Further migration would probably be most significant in the case of children whose parents have both died.

Adults with AIDS can face debilitating illnesses over months or years that reduce their capacity to generate income. Added to this is the cost of caring for the sick person and the household has to deal with this double squeeze of low income and higher expenses. Particularly relevant here is the diminished capacity of the household to care for children (Ansell and Blerk, 2004). In order to address these problems, migration of children is employed as a coping strategy for the household and the child is sent away to live with and help out a relative as this decreases the burden of the household that no longer has to spend its dwindling resources on one more child. Although the care-giving roles have traditionally been assigned to adults, with children only being used as a last resort (Robson and Ansell, 2000), the weight of AIDS may be shifting this balance. Children are increasingly being sent to help out sick relatives or households where an adult,

especially the woman, has passed away. Ansell and Blerk's (2004) research in Malawi and Lesotho shows that the work is often gendered. Boys are more in demand for outdoor labour (such as herding, agriculture, gardening) while girls are required for household work.

> *"When we were still at my father's village [after he'd died] my [maternal] uncle came to beg for one child to help reduce the number of children [that my mother was looking after], as ... my uncle's wife had passed away. I went with my uncle to Blantyre to help him. I wasn't really happy, but since it was the decision they made to reduce the number of children my mother had to care for I had to accept. ... I was ten years old when I came ... I have to cook for him, go to the maize mill and clean the place. He has five children but all are boys so they only help me cleaning the place."*
> *-Extract from Ansell and Blerk (2004: 24).*

However, migration related to caring is usually short term and, particularly in the case of AIDS-related illness, may terminate when the relative passes away (Ansell and Blerk, 2004). Ansell and Young (2004) point out that although girls are more likely to be carers, boys may also be involved, especially when the recipient is male. Results of the Khayamandi (2002) study carried out for selected households in nine South African provinces show that an overwhelming majority (73.6%) of respondents living with HIV/AIDS believe that if they pass away, their relatives will take care of the minors in the family (See Table 10 below)

	Province									SA (%)
	Eastern Cape	Western Cape	Northern Cape	Gauteng Province	KwaZulu Natal	Mpumalanga	Northern Province	North West	Free State	
COUNT	301	86	34	216	260	104	171	172	113	1457
No plans	5.3	17.4	0.0	12.0	13.1	5.8	19.3	46.5	6.2	14.9
Relatives will take care	84.7	70.9	73.5	80.1	67.7	82.7	73.7	46.5	80.5	73.6
Care center of orphanage	2.7	1.2	14.7	6.0	8.5	4.8	5.8	5.8	8.8	5.8
Charity organisations should take care	0.3	3.5	0.0	0.0	0.8	5.8	0.0	0.0	0.0	0.8

Welfare department of government must take care	6.6	2.3	8.8	1.9	8.8	1.0	1.2	1.2	4.4	4.3
Other	0.3	4.7	2.9	0.0	0.8	0.0	0.0	0.0	0.0	0.5
TOTAL	100	100	100	100	100	100	100	100	100	100

Table 10: Future plans undertaken by parents for care of minors if they should pass away (borrowed from Khayamandi 2002)

However, when both parents die, relatives may not always be willing or able to take care of the children, which may result in child-headed households (Khayamandi, 2002, Ansell and Blerk, 2004). The qualitative phase of the Khayamandi (2002) study certainly showed anxiety on the part of parents concerning this issue. These parents were uncertain about the future care, accommodation and education of their children, but, at the same time, they regarded the support of the family as crucial in the absence of other options. The study also found that 5% of the households in their sample were child-headed, 7.5% were headed by grandparents and a quarter of the households were headed by a single parent.

Ansel and Blerk (2004) also claim that many urban children in Southern Africa now live in nuclear family units, and when the household is dissolved upon the death of the parent (or grandparent), the children move to live with relatives, are occasionally joined by an adult at their place of residence, or form child-headed households. Children may also refuse to move in order to maintain the ownership of the dwelling but few manage to retain the ownership of their homes for long due to economic and social vulnerabilities and eventually have to move. As a consequence of a lack of supportive familial ties, difficulties in living with the adoptive family, or economic difficulties experienced by the adoptive family, the orphans may move to another family or, in some cases, move to the streets and engage in various forms of child labour. Children, especially girls, may be married off at an early age since that not only secures a permanent shelter for them, but also provides the families with some economic benefit in the form of 'lobola'.

Needless to say, much of the physical and psychological vulnerability is caused by these forms of migration (often involving multiple moves). The pressures of dealing with the immediate survival needs are so strong that psychological needs such as love, emotional support etc. are overlooked. The children whose parents have died of AIDS may also be stigmatized. Multiple moves undoubtedly disrupt children's access to education, as do early marriages. Child labour, whether undertaken by orphans as a survival strategy or by children to support an AIDS-affected family, can be demanding, exploitative or even dangerous. Children living on the streets or heading a household are probably most susceptible to economic and social insecurity, physical and sexual violence, malnutrition, risky sexual behaviour, and to becoming the targets of criminal syndicates (IOM 2003).

7. Responding to the challenges: a framework

This paper has tried to outline different migratory processes at work in South Africa and the challenges that they pose with regard to HIV/AIDS. As the developmental processes take hold in South Africa in the coming years, migration is likely to increase, although its composition and nature may change. It is important that "development or poverty reduction programmes do not aim to reduce migration for its own sake, or see reduction of migration as an indicator of success" (De Haan 2000:18). Rather, policies should be supportive of migrants.

In this section, I will suggest broad ways of thinking about the responses to migration and the challenges posed by it. The concern here is not only with 'mobile' persons but with those who have already made a move outside of their 'home' to come to an urban area and are still waiting to become full participants of the city. At the same time gaining an understanding of the implications on the larger community that the migrants interact with is also necessary. Migration is not only an economic process but also a social one. It not only affects a migrating individual's life but also changes the social structures at the place of origin as well as the destination by social interactions. This may mean the creation of new social capital but could also lead to re-enforcement of old identities (De Haan 2000).

This paper has also tried to explain the connection between migration and HIV/AIDS as one arising from the conditions and circumstances of the migration process, which is not simply related to the physicality of movement but to the whole process of leaving home to relocating in the destination area to making a living from thereon. In other words it is the underlying 'mobility systems' that constitute HIV vulnerabilities and transmission (Hsu 2004), and this will form the basis of my argument for thinking of effective responses to the challenge of migration and HIV.

'Mobility systems' can be defined as broader political, socio-economic exchanges, human interactions, interlinked environments, and developmental processes that impact on or are impacted upon by migrants and migration streams. For Hsu (2004), "mobility systems are very much response mechanisms to development factors, processes and interventions: differences in the level of development between geographical areas and development-associated activities, such as the construction of transport infrastructure etc., are all relevant to HIV vulnerabilities." But in another sense, the environments created by migrants as agents of social change or those that come up in response to their presence, such as mushrooming informal settlements on city boundaries, commercial sex work hotspots around mining sites, subsidized transport systems etc., also constitute mobility systems.

The conventional approach for HIV interventions has been to target the high-risk groups or even high-risk individuals. While interventions at individual levels are important, they stop short of addressing the systemic factors that create vulnerabilities. "Too often we have shied away from structural-level interventions for fear that the problems are so systemic that we cannot have an impact" (Lurie 2005). Perhaps one reason for this reluctance is that HIV is interlinked with so many societal and human conditions in developing countries that a holistic response seems unmanageable and almost impossible. 'Mobility systems' approach gives one such way of realistically conceptualizing a structural response, while still targeting a high-risk population. This is especially the case for South Africa, where migration has historically been a key process and continues to dominate the country's developmental processes.

The merits of this kind of an interventional strategy are threefold: one, it allows for thinking about the developmental processes related to mobility (such as informal settlements, labour rights of informal traders, making living arrangements of miners family friendly (Lurie 2005), addressing conditions in workplace etc.); two, it is able to target a broader range of people who may be vulnerable within the mobility system rather that focusing on a narrow group of just 'migrants' (such as, rural partners, partners of returnees to home countries, commercial sex workers around mines or trucking nodes etc.) ; and three, it is able to capture those populations that may otherwise may remain hidden (such as, refugees, foreign labour and even undocumented populations) without needing to expose their personal characteristics or confronting ethical dilemmas. An understanding of mobility systems will also allow us to see where interventions are more needed and in what form. For instance, findings of the Mobility Project (2001-1005) show that in the mature stage of the HIV/AIDS epidemic (like in South Africa), it is the rural-rural migration (including migration to smaller towns and secondary cities) that becomes more significant with respect to new transmissions.

The other important element for the success of 'mobility systems' approach is its potential to be advanced at multiple levels: local, provincial, national, and even regional. AIDS policies at national level need to be made in consultation with provinces, which in turn, seek inputs from local governments, as well as from other actors involved in the implementation process such as NGOs, faith based organizations etc. Using a 'mobility systems' approach in this context, could mean that micro as well as macro socio-economic processes can be taken into account while designing interventions. Further, South Africa has taken a leading role in the southern African region and is also itself a key regional mobility node. It is hence, well-placed within the South African Developmental Community (SADAC) to be at the forefront of developing an integrated regional HIV/AIDS response based on the 'mobility systems' approach. In this regard, it can learn valuable lessons from existing regional partnerships in South East Asia, such as South East Asia HIV and Development Programme (SEAHIV) that have created specific

methodologies to "capture the dynamic process of population movement and associated HIV vulnerability" (Hsu 2004) in the south east Asian region.

South Africa must not shirk from borrowing the lessons learnt in other countries in HIV/AIDS mitigation. At the same time, it has the potential of emerging as a leader in presenting other countries, especially those confronting the next wave of the epidemic, with successful strategies of dealing with the HIV/AIDS epidemic. Good governance will eventually be the key to resolving the challenge posed by the HIV/AIDS, along with an astute understanding of the contexts in which the epidemic unfolds. This paper has attempted to demonstrate the nature of one such context, i.e. the relationship between migration and HIV/AIDS, and has shown how the knowledge of this association could be used to design effective interventions.

Finally, true participatory approaches that create a sense of entitlement of the programmes within the citizenry; consideration of human rights while implementing interventions; transparency in the decision-making; and visible and vocal buy-in from the government will be most crucial in halting and reversing the HIV/AIDS epidemic.

Chapter Two

Research Findings

(1) Background:

This section is based on the findings of a qualitative study that took place during August 2005 following the commission of a background paper that forms Chapter 1 of this document. The study was carried out in five cities, namely Johannesburg, eThekwini, Cape Town, Mangaung and Msunduzi. Key findings are presented in this Chapter from 52 interviews with representatives from local and provincial governments involved in HIV/AIDS related policy making and implementation; non-governmental organizations (NGOs); faith based organizations (FBOs) and medical practitioners involved with HIV/AIDS related health services. The study serves to provide empirical support to the literature based claims made Chapter 1 and also begins to unpack the broader trends postulated in literature relating to migration and HIV/AIDS.

(2) Objectives:

The aims of this study were to:

a) Create a more qualitative understanding of the nature of migration in these cities and the reasons for it.
b) Understand the challenges posed by migration to HIV/AIDS related service provision
c) Gain a better understanding of the factors that make migrants more vulnerable to HIV/AIDS.
d) Uncover the impact of HIV/AIDS on migration, if any

e) Explore the nature of partnerships that exist between local government, civil society organisations and medical practitioners in their response to the challenge of HIV/AIDS.

In this chapter, research findings have been divided among sub-headings for a better conceptual understanding. Where possible, good practice examples as well as anecdotes from the interviews have been incorporated. Names of respondents have not been included to ensure confidentiality. Where names of specific organisations are used, permission was verbally sought from the respondents belonging to those institutions during the interview process.

(3) Methodology:

In depth interviews were carried out by the consultant in English, using a semi-structured interview guide with the help of two postgraduate students from Wits University's Forced Migration Studies Programme. Purposive sampling methods were used to select the respondents, i.e. the selection of individuals for interviews was deliberately non-random in order to ensure the collection of qualitative, detailed and relevant information pertaining to HIV/AIDS services and the effect of migration. Respondents were identified with the help of a few initial key informants (researchers, academics and government officials working in the field of HIV/AIDS) in Johannesburg as well as from leads given by those initially interviewed. Each respondent interviewed was contacted via email or telephone prior to the interview in order to set up a convenient time and place to carry out the interview process. All but two interviews (that were telephonic) were carried out face to face and lasted between 40 min to 1.5 hours. Data capturing was done through note taking.

(4) Key findings:

Key findings from the interviews are presented in the following pages and have been broken down into sections that also formed broad interview themes. While the migration information has been broken down with respect to each city municipality in the first two sub-sections, the rest of the findings are presented thematically with relevant examples and anecdotes from various cities in order to avoid repetition. Successes and failures have been highlighted, where possible.

4.1. Patterns of Migration:

4.1.1 Cape Town:

The study found significant trends of migration into Cape Town. The following categories of 'migrants' were noted to be prominent:

a) Migration from Eastern Cape is most prominent with a higher number of men than women. These migrants are mostly Xhosa speaking with low skill levels. According to the 2005 IDP hearing report for Cape Town, there is an annual in migration of about 40 000 to 50 000 people mainly from Eastern Cape.

b) Migrants also come from surrounding rural areas of Western Cape, especially to work on farms in Stellenbosch. Migration to farms can be both oscillatory as well as seasonal. Seasonal migrants to farms either go back once the work is finished or try to find other ad hoc labour jobs in the city.

c) Many of these migrants live in along the N2 freeway setting up informal settlements that are now the focus of the N2 Gateway Project aimed at upgrading these settlements, providing services such as water, sanitation and electricity, as well as aiming for economic growth that will lead to job creation.

d) Of all the cities studied, the migration for seeking health services seemed to be most noted in Cape Town, especially for people coming from Eastern Cape. This is especially the case for women who either move to join their husbands (many times when they are very sick) or come when they are pregnant.

e) Cape Town also has refugees and asylum seekers mainly from DRC (highest number among this group), Burundi, Rwanda, Angola, Somalia, Nigeria, Cameroon and Sierra Leone. These people are not concentrated in the inner city as is the case in Johannesburg and Durban but are scattered in nationality-based clusters all over Cape Town. For instance, many of them tend to live close to the train routes between Cape Town and Wyneberg (as in Observatory), Rwandese in Retreat, Somalians in Belleville, Angolese in Else River, Goodwood and Perow.

f) Another group of migrants that is usually less mentioned but is highly mobile is that of fishermen from Namibia and Angola at Cape Town's ports, especially around the Hout Bay area. Some have settled down in that area and others are attached with the boats and are required to travel at short notices for prolonged periods of time.

4.1.2 Johannesburg:

The study found evidence of high levels of migration into Johannesburg, both internal as well as foreign. This is not surprising since Johannesburg remains a node of trade and continues to be seen as a hub of economic opportunities. There have been long standing patterns of migration fuelled by mining industry in and around the city, which continue to attract migrants moving in search of work. It also remains attractive to foreign migrants due to its centrality, presence of the Refugee Reception Office (that is currently non-operational) and livelihood opportunities that the city affords. The following major migratory trends can be highlighted:

a) Migrants were reported to be coming from other provinces, especially, Mpumalanga, KZN (especially, Transkei and Kimberly) and Limpopo, Eastern Cape and few from Northern Cape. Most of these migrants live in informal settlements or backyard shacks in townships.

b) Most of South African migrants live in squatter camps and informal settlements and some in backyard shacks in the townships. A large number of informal settlements exist in regions 1, 2, 5, 6, 9, 10, 11. The biggest informal settlement in Johannesburg is Freedom Park (GS check) with approximately 100 000 people.

Migrants also live in hostels, especially those connected with the mines. Many hostels are still single sex, for instance, those in Region 8. Although these are meant to be single sex male hostels but currently men live with their partners.

c) Cross border migration is predominantly from Mozambique, Zimbabwe, Malawi and Lesotho. Many of these people come to work in mines, especially those from Malawi and Lesotho. It is difficult to infer from this research whether these migrants had been here for a long time or whether these were more recent arrivals, although more new arrivals seem to be taking place from Zimbabwe. Most of these migrants, other than those working at the mines, are engaged in informal sector employment.

d) Refugees and asylum seekers in Johannesburg are mainly from DRC, Somalia, Ethiopia, Burundi, Zimbabwe, Angola and tend to live in overcrowded units of the inner city.

4.1.3 eThekwini:

Qualitative interviews with a range of service providers suggest that patterns of migration in eThekwini are complex and dynamic. Migration is not only from outside of the municipality but also within the municipality. The following patterns were noted:

a) Majority of internal migrants in eThekwini come from Transkei and surrounding rural areas in Umthata, Stranga as well as rural areas further afar in KZN. There is also migration from Eastern Cape although not as significant as migration from other parts of KZN. The proof of migration can be seen in the ever-growing number of informal settlements.

b) Cato Manor has had a long history of migration from and into the area. The forced removals of people of colour in the 1950s led to an out-migration from the area. From 1994 onwards people began to move back again in an ad hoc, politically driven manner leading to population growth with a lack of spatial or service delivery planning. The skills training programmes initiated by the first democratic government were a major migration attractor. Although the initial influx is over, migration still continues into the area. People are moving from surrounding rural

areas but even more significantly from other parts of eThekwini, such as Kwamashu and Umlazi townships. The society in Cato Manor was reported to be quite fluid and the movement seems to be taking place around social networks. Migration is mostly of economically productive single young men and women aged between 20-30 years.

c) It seems that there is considerable political pressure to curb migration into this area and assertions were made that people are now not coming in anymore. But other evidence seems to point in the other direction. There is a move to encourage the setting up of light industries in the Cato Manor area that is definitely a migration attractor. Truck stops have attracted commercial sex workers. People also move into the squatter camps in the hope of housing upgrades.

d) There are a considerable number of single sex hostels in Durban for migrant men who still have families in rural areas. Wives and girlfriends of these men often move from rural areas to join their partners. But then men continue to live in the hostels while the women establish themselves in informal settlements around the hostels. There is a move to convert the hostels into family units but concerns were raised regarding this in the interviews, especially from health service providers. The feeling was that provisions for accommodation families were not adequate and that hostels were still no place for raising children.

e) eThekwini is also a home to a number of refugees and asylum seekers mainly from Great Lakes region (DRC, Burundi, Rwanda), Somalia, Ethiopia, Iraq and other Asian countries. These are mostly men aged between 18-40, but also a significant number of women. It was reported that it is not easy for foreigners to stay in Townships because of xenophobia. A number of xenophobic incidents were said to have taken place where foreigners had lost their lives, for instance, cases of violence surrounding soccer matches. These foreigners therefore prefer to stay in town especially around Point Road and St George St in the city centre, close to their respective national communities.

f) Migration around the ports also came up although it was reported that there were no mechanisms in place for monitoring port health.

4.1.4 Mangaung:

Significant and unique migration patterns were noted for the Mangaung Municipal area. Mangaung consists of the core city of Bloemfontein, Botshabelo and Thaba Nchu. Mangaung Municipality has considerable rural areas and the challenge of balancing urban and rural development is key for the municipality. Anecdotal evidence based on qualitative interviews with local government, NGOs, FBOs and other health service providers strongly suggest the existence of circular or oscillatory migration patterns.

Main migratory or movement patterns were noted as:
a) Migration between the various areas of Mangaung local municipality as well as from various areas of Motheo District Municipality, especially from the former trust areas of Thaba Nchu. This is mainly of two types:
b) Those seeking employment
c) Young adults wanting to stay separately from parents squatting where land is available, usually on city peripheries.
d) Migration from farm areas surrounding Mangaung, especially in cases of farmers becoming bankrupt.
e) Cross border migration from Lesotho.
f) Migration from other parts of Free State such as Welkom in the event of mine closures.
g) Movement of labour force into Mangaung, especially Botshabelo, with the establishment of factories. For example, when a textile factory relocated from Harrismith to Botshabelo, it brought along a number of women workers to settle close to the factory site.
h) Notable movement of non-South African migrant Asian population, especially the Bangladeshi community in the townships to establish small businesses such as tuck-shops.
i) Migration from Eastern Cape, although not as significant as other migration streams.

j) Mangaung is the home of many tertiary level education facilities and therefore has a significant number of students from within the province of Free State as well as from other provinces.

4.1.5 Msunduzi:

Unexpectedly high levels of migration were noted Msunduzi Municipality. Instead of being overshadowed by eThekwini, Msunduzi emerged as a significant migration node for internal migrants and one that was reported to have growing in popularity in the past five years. The following trends were noted:

a) Single young men aged between 20-30 years were moving from surrounding rural areas seeking employment. Interview with a pastor running a soup kitchen three days a week revealed that a majority (around 85%) of those coming to get bread and soup from this service were migrants from neighbouring rural areas. There were some young women in this group but the majority were reported to be men.

b) Migration patterns seem to begin with commuters who come on a daily basis to look for odd jobs. Interviews revealed that there are well known locations where these migrants stand and are picked up by anyone looking for a handy man or a worker. Since the jobs are not available everyday, the commuters' money eventually runs out and they migrate to the city while their families stay back in the rural home.

c) NGOs mentioned that these people end up sleeping on the streets or living together in overcrowded rooms and informal settlements with no proper sanitation, hence creating health hazards.

d) Interviews also showed migration of women from Eastern Cape and Lesotho looking to work as domestic workers. These are mostly young women aged 20-30 years and many of them are single mothers migrating with children.

4.2 Reasons for migration:

4.2.1 EThekwini, Johannesburg and Msunduzi:

Reasons for migration into eThekwini and Johannesburg seem to be very similar and range from economic to social to the need for accessing medical treatment. In the case of Johannesburg, economic factors are more predominant. The migrant profile is both male and female but differs with respect to the kind of employment activity engaged in. For example agricultural workers and miners tend to be mostly men, while women are engaged in more informal activities. Many women seem to be migrating to join their husbands or boyfriends. These women are in a particularly vulnerable situation and the reason for this is described in the next section as this is also a trend for migration in Cape Town and the vulnerabilities remain the same. People from rural areas were also reported to be moving to access tertiary health services. Of more interest to this study was migration to access Anti-Retro Viral (ARV) drugs, as noted by the service providers. In Johannesburg people have been noted to come from as far as Venda to access ARVs, especially at well-known hospitals like Johannesburg General Hospital and Chris Baragwanath. This is also the case for hospitals like King Edward in eThekwini whose reputation attracts people from areas further away. Women also move to access pregnancy related medical care and may have their HIV positive status detected during this time, hence getting enrolled in the PMTCT programmes, and eventually access ARV treatment.

As noted above, anecdotal evidence collected in the research period suggests that Msunduzi is facing a high level of in-migration that has a potential to increase in the coming years. It also happens to be one of the most important university towns of South Africa, housing a significant number of students from outside its boundaries. This research however, does not go into detail about student movement and focusses into other forms of migration such as that related to employment, for accessing better infrastructure and services etc. Initial findings show that the migration in Msunduzi (mostly internal from rural areas) is related to livelihood. But a more in-depth study is needed to decipher

how prominently other reasons for migration exist. Moreover, very little is known about the frequency of mobility as well as the health seeking behaviour of the migrants who come to live in the city but maintain families in rural areas. This could have important repercussions for HIV transmission as well as for designing prevention and treatment interventions. Interview with a medical professional working in a primary health clinic in a neighbouring rural site in Vulendela on a PEPFAR funded initiative to provide ARVs, revealed that their patients tend to be mostly women as the men are mostly working outside of the site. At the same time interviews with doctors involved with ARV roll out in Msunduzi also revealed that among migrants, they see more women than men. A significant gap in the knowledge about the health seeking behaviour of migrant men in this area was noted.

4.2.2 Cape Town:

As with everywhere else, search for economic opportunities remains a key factor in the movement of people into Cape Town. But Cape Town is unique in the sense that people, especially from Eastern Cape, also seem to be moving to access health services, especially HIV related services. Migration to access ARV treatment seems significant, although it would be false to claim that this exists as a stand-alone reason in the majority of cases. Migration for accessing health services seems to be more significant in the case of women than men. Health service professionals dealing with HIV related services (Voluntary Counselling and Testing or VCT; Prevention of Mother To Child Transmission or PMTCT, ARVs etc.) mentioned that they see many more people from rural areas or other provinces after Easter and Christmas as the returning migrants bring along sick family members when they return after holidays.

Women from rural areas move to join their husbands but many times find that the husband has married another woman in the city and are thus, left to fend for themselves. Given the high levels of unemployment and lack of education, many of these women have to find work in the informal sector that is ridden with insecurities. All service providers mentioned that poverty forces these women to have multiple sexual partners for survival, and even more so when they have children to look after. Many end up in

abusive relationships with no option but to carry on in order to keep a roof over her and her children's (if any) head. Disclosure of HIV status was also noted to be a reason for women being forced to leave families due to HIV related stigma and move to another part of the city.

The situation of the fishermen in ports is unique and understudied. These people are mostly men who are linked with boats and rely on them for livelihood. Their lives are perhaps more mobile that any other migrant category discussed in this report as they are expected to be prepared to leave at a short notice. Most of the ones reported in the interviews were Namibian and Angolan and many of them have families back home from whom they are separated from for long periods of time. Some of them have come and settled in South Africa but take trips with the boats for prolonged periods of time. The conditions on the boats make them prone to catching TB and in some cases multi drug resistant strains of TB. These fishermen also become the targets of police due to their ambiguous legal status when the boats land on South African ports. Medical professionals suggested that this is problematic as they have begun to see multi drug resistant strains of TB in prisoners that were previously unknown. There seems to be very little cooperation from the boat owners to do address the unsanitary conditions on the boats. At times, these fishermen have been known to bring their wives from their countries of origin to get VCT.

4.2.3 Mangaung:

The decision to migrate is an outcome of many complex factors and processes that influence a person's choices. Migration into Mangaung is mainly driven by economic opportunities or at least a perception of the existence of such prospects. Another reason for growing urban informal settlements seems to be for accessing housing based on the hope of eventual formalisation for informal settlements and provision of RDP housing. Both men and women were reported to be migrating into Bloemfontein city in search of informal sector employment, such as housework, and manual labour. Many of the single youth (both men and women) were reported to have moved out from their parental homes

at younger ages than what was previously seen as normal. The reasons given by the service providers interviewed ranged from a need for independence, breakdown of cultural norms as well as desire to access urban opportunities and acquire free housing.

Two reasons were given by community-based organisations for the migration of farm workers from surrounding rural areas outside of Mangaung. One, when workers are laid off work by farmers facing financial crisis and two, when workers are employed on a non-permanent contractual basis by farmers to avoid payment of benefits to them. In the latter case, when a worker's contract comes to an end, he is not necessarily re-employed, or at least not immediately. This has resulted in many workers moving to live in squatter camps around Bloemfontein from where they are picked up by the farmers in trucks on a daily basis. This seems to serve a twofold purpose of being able to access marginally better infrastructure and services than those available on the farms as well as the capacity to access 'piece work' (once off jobs such as daily labour on a construction site) in the event of the farmer laying off workers or during low agricultural season. While some of these workers move in with their families many are single men who maintain a household in the rural areas surrounding Mangaung and return home every so often. Another reason cited for migration from farm areas was serious drawbacks in the provision of education facilities.

Botshabelo and Thaba Nchu exist at significant distances from the city of Bloemfontein (approximately 55Kms and 65Kms respectively) but remain the home for a considerable number of people working in the city of Bloemfontein. Government subsidised system of buses that run to and fro between these areas sustain such daily commute. But despite subsidised transport, the cost of travel remains prohibitive for many people. The most common solution to this problem of unaffordable transport was reported by many organisations to be the decision for the main breadwinner of the family to move to the squatter camps closer to the city and see the family a few times every month. All this results in split households and oscillatory patterns of migration. Both Botshabelo and Thaba Nchu themselves serve as interesting nodes of movement, inward and outward in nature. Botshabello has an industrial area with light industries that have generated

employment and attracted migration from the surrounding region. According to the NGOs working in that area, people from surrounding rural areas of Botshabelo and Thaba Nchu with ethnic linkages with one or the other, find it easier to move into these townships rather than directly into the city. These migrants may either try to find employment in the limited opportunities available in these townships, especially Botshabelo, or commute to the city centre. At the same time there is a movement out of these townships as well as other rural areas of Mangaung with young men moving to gold fields in search for work on the mines. The municipality faces newer challenges of movements into the city as many factories in Botshabelo are now closing down and miners are being laid off. In addition to this, the unsold and abandoned factory buildings become sites of health and safety hazards as well as grounds for criminal activities.

All respondents spoke about a thriving Asian, mostly Bangladeshi, community that has recently made Mangaung's townships its home. This population is mostly male and usually engaged in small businesses like opening small tuck-shops, convenience stores etc. and doing relatively well. There were divergent views on the popularity of this group. Some felt that they were good for the economy, while others felt that they were taking away the jobs from South Africans. Others commented upon the tendency of this population to marry South African women, leading to integration as well as acquisition of permanent residency. Once again, there were divergent views about the nature of such marriages. While a few commented that these were simply marriages of convenience, others said that these men were generally known to be 'good' to their wives. Nothing conclusive can be said about these men having partners in their countries of origin or the ties they maintain. Many commented upon the diligence put in by this population to make a success of their businesses that also led to job creation for the unemployed residents of the community. But the concern raised was the inability of these men to pay taxes in the event of not being able to open bank accounts or deliberately avoiding taxation. More research needs to be conducted to understand how this community can be included to contribute to the productiveness of the city.

Migration from Lesotho was mentioned to be taking place by all respondents but no clarity could be achieved on whether these are migrants have been in South Africa for many years (since before democracy) but have never been naturalised here or gone back to Lesotho, or whether these are new arrivals. Nevertheless there is anecdotal evidence of border crossings by people from Lesotho coming in search of work or to access health services. This is more significant in the case of bordering towns like Ladybrand that is both a node of out migration of its residents in search for economic opportunities as well as in migration of people from Lesotho. Once again, the extent of this is cannot be pinned down. Also, the movement into Ladybrand for access clinics seems to be solely for this purpose and usually not for the purposes of settlement. Even in this case, it is hard to separate this from the pre-democracy well-established migration routes.

Finally, as indicated above, there seem to be emerging patterns of migration from Eastern Cape although they don't seem to be as significant as the other trends outlined here. Both men and women seem to be migrating from the Eastern Cape. Men from Eastern Cape seem to be moving to seek job opportunities. Women were reported to move into Bloemfontein city from Eastern Cape when they were pregnant or close to delivering a baby, in order to access health services, and mostly known to leave after giving birth.

4.3. Impact of HIV/AIDS on Migration:

Since an objective of the interviews was to find out the implications of migration on HIV/AIDS related health services, we tried to find out whether HIV/AIDS is instrumental in migration decisions. It would be naïve to say that health was the only motivator for migration but it came up as a significant reason given by service providers interacting with migrants. Although this information is based on the perception of service providers and the level of prioritisation cannot be measured, there was enough anecdotal evidence to suggest that accessing health, and more importantly accessing HIV/AIDS relation service provision was a motivator of migration. The following trends seem significant:

a) Migration taken by pregnant women to access PMTCT services. This can be temporary or longer term in nature depending upon whether or not the mother is found to be HIV positive. If found positive, the women either migrate temporarily to access ARVs when they fall sick (going back once they have been stabilised and then returning every three months) or become commuters to access ARVs. Uptake of VCT as well as ARV services seems to be higher in many clinics and hospitals, although this differs with respect to the location of the health facility. For instance, a clinic run by an organisation called Sino Sizo in eThekwini sees mostly migrant men working on farms while the King Edward hospital reported the balance being skewed in favour of women.

b) Migration undertaken in order to access ARV treatment by both men and women, especially if the waiting list in their area is too long, or due to the reputation of a particular hospital. The latter was pointed out to us by medical professionals at a few tertiary hospitals whom the patients gave this reason.

c) Forced migration of people who are thrown out of their families on disclosure of HIV positive status. This seems to be especially the case for women who are told to leave by their husbands or even their own families. Respondents also mentioned cases where the neighbours of a community were unwilling to let HIV positive individuals stay in the locality, especially in informal settlements and rural areas.

d) Although this phenomenon cannot be classified as migration, it certainly indicated conditions of increased mobility undertaken by individuals tested HIV positive. Firstly, people generally try to go to a clinic as far as possible for HIV testing rather than to a clinic closer to where they live or work. Secondly, if tested positive they move around from one VCT service to another in order to confirm and reconfirm their test result. Finally, they also try to access ARV treatment at far away as possible, where they can be sure that the chances of meeting someone they know will be very remote. But this last trend cannot be generalised as it also depends on the level of stigma existent in the person's community, level of awareness messages being spread, length of time ARVs have been available as well as the success of the programme being run in their community.

4.4."Returning home to die"

Another pattern of migration seems to be return to rural homes when the person is very sick. Many NGOs and FBOs expressed concern that there was an increasing trend of relatively younger migrants returning to their parental homes when they are terminally sick. Doctors reported that this is not always the case when a person is on treatment and hopes to recover. But for most of those terminally ill and having strong links with their rural home, there is a strong tendency to go back before they die, especially since the cost and trouble of transporting a dead body would be much more. Although this phenomenon is not unique to those sick with AIDS, the effects of the disease seem to be fuelling this sort of migration at younger ages. People do not simply move to die in rural communities but also to seek care since the effects of HIV/AIDS can be very devastating, including body wasting, diarrhoea, inability eat as well as mental isolation in urban settings due to a lack of social capital.

A stark example of this trend can be seen in Botshabelo, a township in Mangaung, approximately 55 Km from Bloemfontein city. While many factories are shutting down in Botshabelo, the funeral parlours were reported to be doing booming business and that there was literally a funeral every second Saturday, if not every Saturday. Respondents said that the cemetery had grown at a much more rapid rate than before in the past few years and parents were outliving their children. Many of those returning were workers from mines coming back when they were very sick. Respondents also indicated that no one would ascribe the cause of death to be AIDS but the symptoms and the high rates of fairly young people dying were a good indication that there was a high HIV/AIDS related mortality.

4.5. Migrant awareness and attitudes

Level of HIV awareness in migrants was reported to range from low to none, with a range of misconceptions. While myths about HIV/AIDS as well as negative attitudes towards people living with HIV/AIDS are not something unique to this population, two reasons make it important to include this as a separate section. Firstly, migrants bring with them their own notions and myths regarding HIV/AIDS that may differ from those held by the host communities. This has implications for intervention strategies that may not take into account certain misconceptions held by these communities. Secondly, in most cases migrants have a much diminished support base that makes them even more vulnerable to the negative consequences of stigma and discrimination. This is especially notable in the case of migrant women.

Interviews with service providers working with these communities at different levels revealed that many of them feel that HIV is their lot (especially women) and face high level of stigma in their community as well as from their partners and close family members. Others believe that HIV is a punishment from God and feel guilt and anger. As discussed earlier, such stigma forces many to migrate to another part of the city or to another city altogether. This was especially reported for the three metros studied. There is a lot of denial about being HIV positive as well as about being at-risk to the infection. Some organisations reported that they faced a lot of challenges in getting migrants in the communities in which they work to come and attend HIV/Aids workshops, join support groups or listen to health talks. Encouraging people to come for Voluntary Testing and Counselling has been an uphill task. Even when people do come forward, they generally tend not to go to a site close to their place of residence or work, as discussed before. Women stay at the receiving end of stigma and discrimination as they tend to get blamed for transmission of the virus and subject to domestic violence, especially on disclosure of their status.

Cape Town:
"There was a case recently where we were asked to provide support and intervene. One of our clients disclosed to her husband that she was HIV positive and suggested that he should get tested too. The man consequently put a knife through the woman's body. She survived and he was arrested but now she wants her husband to be released. When we tried to reason with her she said that if her husband was in jail who would feed her children?"

eThekwini:
"When I started working here I saw many cases of stigma towards women who were HIV positive. Once we went to a rural part of eThekwini in a mobile clinic and were told of this incident. One of the young girls found out that she was HIV positive and told her family of her status. Her father was furious with her and threw her out of the house. We intervened and finally the mother accepted her but the father never did. Then there was this other case when a woman had told her husband that she was HIV positive. He beat her up and threw her out of the house. When she went back to her family in rural area she was locked in a hut by them and would just push the food in the hut for her. We were asked to intervene in that case for the girl's sake."

Johannesburg:
"As a doctor, I see incidents of women being abused all the time when they disclose their status. To put people on ARVs we encourage (initially we used to insist) that they at least disclose it to someone close, preferably their partner so that they get support during the treatment as this increases the chances of adherence. But a lot of women were being driven out of their houses with children and this made them even more vulnerable. Many times these women would never come back and that was a big problem. Now we have stopped insisting on disclosure to their partners but this is very tricky."

NGOs working with refugees and asylum seekers commented that although their clients generally saw themselves at a low risk of HIV/AIDS as compared to the South Africans, but in the last 3-5 years the concern was increasing due to a higher number of deaths related to HIV/AIDS. But the level of awareness seems to be generally low. Denial and stigma are as prominent as in their South African counterparts and the uptake of VCT is very low. More recently, UNHCR has taken on the role of a facilitator to raise the level

of HIV awareness among refugees and asylum seekers as well as support refugees' access to ARVs.

Following are excerpts from conversation with a person working in an faith based organisation working with refugees, who also did some lay HIV counselling to encourage VCT:

"Refugees and asylum seekers who come here don't want to talk much about HIV. They say it's a killer disease but the concerns of rental and food take over any discussion. They don't take HIV as a concern because there are many other competing circumstances."

"Before I go for sex, I make sure that I drink lots of warm lemon seasoned water so that immediately after sex I will be able to urinate, and thus reduce the risk of being infected. I do it even when I have used a condom. Meanwhile the woman remains the receiver and it would be possible for her to do the same strategy I use".

A refugee service provider in eThekwini:

"Everybody is at high risk but refugees might be more exposed. Because of mobility, they end up with multiple sex partners and because of their living conditions in overcrowded units they also share partners. Women are particularly at a higher risk; single mothers and young girls engage in transactional sex to make a living and like other women in families are not in a position to negotiate safe sex with partners"

"I don't think we service providers are doing enough with respect to HIV services for refugees and asylum seekers. We could do more. They are not a big group of concern for local government. As far as AIDS deaths are concerned, it is not yet a big concern. But at the same time these people are at risk. Young people are away from their families, away from all the codes of conduct in their home countries and in the meantime sex is very easily available here. Also, when one feels isolated one tends to use more alcohol and engage in risky behaviours."

In all cities, it was a consistent finding that more women than men access HIV related services confirming the finding of the literature based review. While PMTCT is a directed at women, the uptake of VCTs as well as ARVs is higher for women than for men, except where the programmes are directed at male migrants. Many reasons were given for this:

(a) Reproductive health has historically had a women focussed approach and many women have the opportunity to get tested. Men seem to have been left out of

reproductive health programmes that afford an opportunity to get HIV awareness messages across.

(b) Women are also predominantly responsible for the health of their children and tend to come to the hospital more often, hence increasing the chances of becoming more aware HIV services and messages.

(c) Men seem to be getting missed in HIV awareness campaigns as many of them are during the day when men may be at work, with the exception of workplace awareness campaigns, which are not consistent, if they take place at all.

(d) Anecdotal evidence suggests a higher level of denial in men than in women.

(e) Men were also reported to be more likely to access curative health services rather than preventive. As a medical professional in Cape Town commented, *"Males feel intimidated when they come here and they hardly find other men. Moreover men prefer to go to private medical practitioners and traditional healers. They always want a quick-fix."*

(f) Finally, medical practitioners were of the view that men's health seeking behaviour differs from that of women in that they are likely to ignore ill health for as long as possible.

It is interesting to note that while we have had a decade of HIV awareness campaigns and preventive services, the level of awareness in migrant communities seems to be very low. This is discussed in more detail in the following section.

4.6. Failure of prevention:

Respondents were asked what they thought about the effectiveness of HIV/AIDS prevention messages, especially in the areas of large migrant populations in every city. Most respondents felt that the prevention programmes were not working with the exception of local government's in Mangaung. All government interviewees felt that a lot was being done at the government level to promote prevention programmes such as condom provision, awareness campaigns etc. but the concern was with the effectiveness

of these interventions. Civil society organisations also felt that while prevention campaigns were taking place, the extent to which they were successful was questionable. Medical practitioners involved in HIV related service provision, especially in ARV roll out were perhaps the most cynical about the efficacy of prevention programmes and almost all insisted that they did not see behaviour change taking place in their patients or in the migrant communities they are in contact with.

This study found that two kinds of dynamics are in play that have resulted in a failure of prevention: (a) that the prevention messages are not reaching certain communities in a consistent manner, especially the migrant communities and (b) that knowledge about HIV does not necessarily translate into perception of risk and/or behaviour change.

While the awareness campaigns and condom promotions are taking place in all the cities, they were reported to be on an ad hoc basis rather than in a more consistent and organised manner, especially in the squatter settlements where most migrants tend to stay as well as in refugee communities. One of the respondents working for a NGO in Mangaung herself lived in a squatter settlement that housed a lot of migrants and explained the situation (referring to her locality) as follows:

"The youth in our settlements, especially coming from rural areas, don't know anything about how you contract HIV. Some know about it but are in denial. Others accept that there is HIV but wont go to VCT or care about prevention because they say that you could get raped and get it anyway. Then there is 'muti' that people believe in. Men think that condoms are a waste of time. There are a lot of teenage pregnancies in such settlements. It is considered a woman's responsibility not to fall pregnant and so the men don't care about condoms. Prevention programs are not working. Many time these prevention campaigns are a once off or even an yearly thing. What is needed is regular messages as understand the risk as well as changing behaviours is a process. In these squatter camps you can get condoms at the clinics but clinics are too far. Sometimes they come to distribute condoms but not on a regular basis. I sometimes take a box myself and just go and give to my neighbours but that's not like a routine thing. I don't think there are free condoms in spaza shops and shabeens as there should be. And then even when condoms are distributed I find children playing with them in the street!"

Working with refugee and asylum seeker population is even more difficult since they tend to remain hidden and do not always participate in community-based programmes.

All organisations thought that prevention programmes were not bringing about the behaviour change that they were supposed to and more creative strategies needed to be employed. A few reasons were cited the failure to bring about behaviour change.

Firstly, an inability to adapt and translate concepts used in prevention campaigns to apply to different cultural contexts was also cited as a reason for the failure of prevention, especially that directed at behaviour change. While this is especially a problem while working with cross border migrants or refugees and asylum seekers, it was also noted to be a challenge with rural populations coming from different provinces, speaking ethnic languages that the providers may not be familiar with. Prevention material and messages often don't reach such people effectively and this becomes an accessibility problem.

Secondly, they were of the view that people were tired of hearing about HIV and condoms, especially when the risks were not internalised or as the effects of the infection were not visible for many years. They felt that the prevention campaigns needed to focus on other related things like STIs that people were familiar with, and once one had their attention, one could go ahead with HIV education. Most respondents said that HIV has become a 'stand alone problem' and not enough attention is being paid to reproductive health in South Africa. Exclusion of men from reproductive health programmes was identified to be a detriment to HIV prevention. Both NGOs and medical personnel identified the lack of education of men in taking care of their own sexual health needs, knowledge about those of their partner's or understanding their role in pregnancies contributed to the detriment of prevention activities. PPASA's 'Men as Partners' programme is designed to constructively involve men in sexual and reproductive health and could become a model for effective interventions in the future.

Thirdly, approaching HIV from a rights based perspective of empowering communities, especially women, was reported to be catching more listeners as compared to things such as condom promotions. But respondents also pointed out the creation of imbalances between genders by keeping the focus only on women in empowerment campaigns. They

felt that simply empowering women could not resolve issues like violence against women without incorporating men in the education process.

Finally, many service providers were of the view that the focus of HIV activities has been on those who are or may be already positive. While there is an obvious need for this, prevention strategies must not neglect those who are not HIV positive and encourage them to keep their status negative. Suggestions were made regarding a lower age of children targeted in sex education classes although there seemed to be a disagreement regarding how young one must begin.

Love Life Project: Example of a successful prevention initiative

'Catch them young' seems to be the motto of this project, particularly in the Botshabelo Township of Mangaung. The success of this project is enormous and unique. During the course of this study, it was perhaps the only example of successful prevention. The inherent logic of this project lies in creating a supportive environment for children of the township, providing accessible sex education and encouraging boys and girls to come forward to get tested for HIV. And once tested negative, they are instilled with the feeling of pride and responsibility to remain HIV free. Not only does starting the interventions at a young age give the prevention programme an edge, it also has the advantage of being able to target both boys and girls together in reproductive health interventions from a young age. Peer educators are trained from amongst the youth in the community to whom the others in that age group can relate and hence, the prevention messages become more accessible.

Love Life in Botshabelo is also in a strategic location of being close to the Botshabelo Hospital and has a cooperative relationship with the staff. While the success of this programme is obvious in this township, caution must be exercised while taking it to other surrounding areas where conditions may differ. One such criticism came up in the interviews conducted in Ladybrand where Love Life wants to start a programme using the staff in Bloemfontein and Botshabelo sites. The criticism was mostly with regard to the complexity of messages, handling of the subject and the language used during the initial promotions in Ladybrand. The service providers working with the population in Ladybrand felt that the messages of HIV prevention were not getting across to the youth of Ladybrand as they did not identify with the peer educators used in the campaigns due to differences in socio-economic backgrounds and level of education. But if such practical problems can be resolved, this model may become an ideal instrument of long term HIV prevention.

4.7. Transactional sex

Poverty and cultural factors result in women's disempowerment to negotiate condom use. A woman asking to use a condom with her regular partner is seen to be promiscuous and ends up being beaten by her partner. Transactional sex remains prominent among women in these settlements, especially those who migrate for economic reasons. Young girls as old as 16 were reported to be exchanging sexual favours for survival or for gifts they themselves cannot afford. For young school going girls it may be peer pressure that makes them engage in sexual networking. As one respondent pointed out:

"When a young girl goes to school and looks at her friend wearing new shoes, she also wants them. So she ends up making boyfriends who will buy her nice gifts. It's a 'Triple C Man' who is most desirable- a man with cellphone, car and cash!"

In most other instances of adult women who do not identify themselves as commercial sex workers, having multiple partners is a way of survival or making ends meet for themselves and their children. Needless to say, in such relationships the woman's control over condom use by her partner is minimal. One organisation reported that female condoms were also not used as they were not easy to use, were visible and were reported by their women clients to be making a too much noise while having sex. Similar trends were reported for Botshabelo that was a somewhat industrial node. The factory owners (reported by respondents in Botshabelo as 'mostly Chinese looking') were seen to be having multiple relationships with the women residing in Botshabelo, perhaps even working under them. Interviewees suggested that condom use in these relationships was probably quite low (and consequently risk of HIV transmission quite high) as there were many instances of mixed race babies of single mothers.

Commercial sex workers were seen to have increased over the last few years and were identified as a group at high risk. It could not be established with certainty where these women were coming from or whether they had always lived in Mangaung. Bloemfontein is centrally located with the N1 Bypass as well as the N6 and N8 corridors providing

opportunities but also placing it on major trucking routes. The commercial sex industry services the truck drivers as clients, hence creating a high potential for HIV transmission.

4.8. Child headed families

While the respondents reported the existence of child headed families in each of the cities visited, this phenomenon came up most starkly in the Mangaung municipality. It seemed that due to a decline in social capital and increased financial constraints on the kin, children were left to take care of their younger siblings when both parents died. Anecdotal evidence suggests that most of these deaths were probably due to HIV/AIDS since parents were dying at a very young age. The head of households in such cases could be as young as 14 years of age taking care of even younger siblings. The phenomenon seems significant enough for these children living alone, especially heading families, to have been given a specific name in Botshabello as 'Mpintshis' (meaning 'young people who are active'). Many of these families are assisted by social workers but the access to social grants is hindered due to the lack of ID documents or birth certificates. This was not only the case in Mangaung but also the adjoining town of Ladybrand from where many migrants into Mangaung originate. These children seem to be in particularly vulnerable circumstances with relatives wanting to become guardians in order to access the child welfare grants entitled to these children, resulting in a lack of care of the foster children. This results in the children either running away from home and/or engaging in risky practices like drug abuse, transactional sex (or girls as young as 13 or 14). Without doubt, these practices place the children at a higher risk to HIV.

4.9. HIV/AIDS, Tuberculosis (TB) and migrancy:

The connection between TB and HIV/AIDS is well known due to the high incidences of co-infection and co-morbidity. It was not an initial intention of this study to specifically explore this connection but it came up significantly enough to warrant a separate mention, especially with respect to the vulnerabilities of mobile populations. The

association of TB with migrant status especially came up in the interviews in the port cities of Cape Town and Durban. Doctors interviewed identified fishermen and sailors, who tend to be highly mobile, as a group of high risk to both TB and HIV/AIDS. In other instances, overcrowded residential units without proper ventilation and lacking proper sanitation, which are typical to many migrants, were also mentioned as risk factors for the incidence of TB.

People living with HIV/AIDS have already compromised immune systems and are more likely to contract TB as an opportunistic infection. Doctors in Cape Town commented that in Western Cape, TB and HIV co-infection rate was higher than 40% in the province and even higher (60-70%) in poorer settlements. Musty and unhygienic conditions in which the fishermen and sailors live on the boats are ideal for contracting TB. Multi drug resistant strains of TB are increasingly being seen in this population along with HIV/AIDS. This study did not find any evidence of effective steps being taken to address the conditions on boats.

Medical personnel interviewed in Cape Town, eThekwini and Johannesburg felt acute need to integrate TB and HIV/AIDS services, especially in clinics that see huge numbers of patients with HIV/AIDS and TB co-infection. But many respondents were apprehensive about stigmatisation of TB patients by the community if the two services came to be identified with each other. Concerns were also expressed about the feasibility of this integration, given that the success of national TB programme has not been very encouraging.

4.10. Impact of migration on HIV/AIDS service provision

The study found qualitative evidence to suggest that the planning being undertaken by the cities is being done for static population rather than taking into account the dynamism of migratory trends. This undoubtedly leads to misplaced planning. Also the rural areas of migratory origin are being neglected while trying to understand how ARV roll out should take place. Although the need for ARVs and other related service provision is felt more in

the cities, some respondents mentioned that this may be due to the bad service provision in rural areas that pushes people to access health services in the city, hence reflecting an inaccurate need. Indeed an ARV roll out programme started with Pepfar funding in Vulendela (a rural site close to Msudunzi) reported seeing the beginning of return migration or at least accelerated frequency of visits by migrant men to access ARVs, although they still form a relatively small proportion of their patients. Cities like Msunduzi and Mangaung need to take migration as well as rural surroundings into account even more significantly. They would also benefit by learning from the failures and successes of other municipalities. This is especially crucial for Mangaung as it is on the brink of accelerating its ARV roll out.

Another problem cited by most medical practitioners was the loss of patients on ARVs to follow up when they are migrant workers. Many reasons were cited for it, ranging from lack of knowledge about the importance of adherence, discontinuation when feeling better, inability to cope with hunger and lack of nutrition and not being able to afford transport to the medical facility in order to access drugs. For instance, in Johannesburg patients were reported to be coming from as far as Venda, doctors noted that if patients travel long distances to access ARVs, their chances of adherence are lower than those coming from nearby areas.

Interestingly, while this was noted as a challenge in most of the interviews with doctors in all five cities, it was denied to be a significant reason for defaulting treatment in Khayelitsha, Cape Town. One of the doctors mentioned that their patients living farther away in Eastern Cape happened to be much more dedicated than many others. The reason for this was given to be a clear understanding of the importance of adherence by the patients as well as the stabilized condition of patients that required them to come only periodically.

Adherence to treatment was reported to be even more of a challenge while working with highly mobile populations, for example 'piece workers' (looking for daily odd jobs), seasonal labour, fishermen at the ports etc. Although almost all hospitals involved in

ARV roll outs require that the patients come from an address in their identified catchment area, yet patients who are desperate to access treatment try to get on to the system by giving false address, hence making the tracing of a defaulting patient almost impossible. Even when the address is correct, a migrant may only be staying there temporarily. Doctors also mentioned that initially sick patients come regularly but once they start feeling better they may begin defaulting. On other occasions default by a migrant is purely circumstantial. For example, when there is simply no more money to pay for transport or when an economic opportunity requires moving to another part of the city or in a different city altogether. Hunger was also noted to be a big deterrent with adherence to treatment, although it is not unique to any one kind of population. One of the doctors interviewed in eThekwini reported that she often had patients telling her that they could no longer take the treatment as the drugs made them so hungry that they would end up consuming the food budget for the entire family for a whole month within two weeks.

Finally, language was identified as a barrier in prevention, treatment as well as care. We have already noted how language barriers hamper prevention initiatives. While prescribing treatment, doctors may not be able to do a proper determination of the patient's medical history. Hospices also struggle with language barriers and the terminally ill clients feel even more isolated being in an environment where they are not able to communicate.

Even when language is not an issue, lack of education becomes a barrier. Doctors and nurses explained that the jargon of HIV/AIDS prevention as well as treatment messages is difficult to grasp for people without formal education since the terms are at times too technical and they struggle to find equivalent concepts in other languages and cultures. For instance, the concept of adherence, especially life long adherence is very hard to conceptualise for someone who sees the role of medication as curing the symptoms.

There also seems to be a lot of confusion regarding the right of refugees to access ARVs. Interestingly, with the exception of Cape Town, all interviews with local government revealed that the officials did not think that recognised refugees were entitled to ARV

treatment. While this is true for asylum seekers whose claims have not yet been processed, it is not the case for recognised refugees. This group has the same entitlement as South African citizens to access ARVs. While UNHCR is trying the facilitate the access to health care for this group, its role should not be misinterpreted as the 'provider' of separate health services to refugees and asylum seekers. Their goal is promote the access of services to these people as stipulated by South African legislation. Moreover, effectively leaving out a vulnerable group, especially out of HIV related service provision would only set back the strategies being employed to deal with the epidemic.

4.11. Partnerships

This study wanted to begin understanding the nature of sort of partnerships; collaborations or productive overlaps that exist among the different kinds of actors involved in HIV related service provision. We tried to understand this with respect to NGOs, FBOs, medical personnel and local government. The partnerships this study was interested in were regarding the systems and structures of cooperation that exist at different levels of these agencies as well as amongst them. We found the examples of some extremely creative collaborative programs that exist in certain cities and also identified gaps where concerted efforts were strongly required.

Government Level: The most recurrent theme emerging from the different government actors was the lack of a clear understanding of roles and implementation strategies between local and provincial levels of the government. This was most prominent in the case of eThekwini and less so for other cities visited. In the case of eThekwini, this study identified a need for procreative action to bring about better engagement between these two spheres of the government. At present, the provincial and local governments are struggling to make sense of their working relationship in facilitating different spheres of HIV related service provision. It seems that the province of KZN has no provision for any service level agreements or memorandums of understanding that can be used to engage with the city municipalities. KZN could take away lessons regarding this from Western

Cape and Free State (with respect to Cape Town and Mangaung). This must be done with a view of tailoring the lessons learnt from other provinces to suit the needs of KZN.

In Cape Town the local government is very proactive with regard to HIV related service provision, especially in prevention and care related activities and this seems to be endorsed by NGOs. Local government also feels that it has had generally good relationships with the provincial HIV/AIDS team. For instance, the local government officials participated in the Global Fund discussions for the province and are involved with the implementation and facilitation of provincial funding. But concern was expressed with the recent move at the national level to take away primary health care from the local government's portfolio, leaving it with only environmental health. The purpose of such a move is to create an integrated health service system. But it might be more effective in cities of a much smaller scale or in rural areas where local municipalities are not as active as they are in metros like Cape Town. Given the involvement of local government in various aspects of HIV related service provision, and having the advantage of being closer to organisations at the grassroots level organisations, the argument made against such a move seems justifiable. It also seemed that although good relations exist, politics at the provincial level does get in the way of service delivery, thus creating hindrances in implementation. HIV/AIDS remains a highly politicised issue. Individual driven agendas, tendency of strict ownership of programmes, and personality clashes makes effective cooperation difficult among different levels of government.

Civil Society and Medical Practitioners: Once again, there is a dire need of facilitating dialogue between different actors in this field. There are many dedicated organisations and individuals working in different but related areas that could create useful synergies to make service provision more effective and accessible. What is lacking is communication and cooperation amongst these different actors. This study provides strong evidence that in places where such connections exist, the implementation of programmes, delivery of service and achievement of targets is much more successful. Four case studies have been

highlighted in this regard (a) Johannesburg's Esselen Clinic; (b) CAPRISA in eThekwini, (c) Cell Life project in Cape Town and (c) Love Life in Mangaung

(a) Esselen Street Clinic:

Located in Hillbrow, Region 8 of Johannesburg, this clinic has become a pioneer mainstreaming health care for refugees and asylum seekers within the existing structures of South African health system. It has also proved to be a leader in spreading HIV prevention messages in the numerous foreign nationalities, especially refugees and asylum seekers living in the neighbourhoods of Hillbrow and Yoville. Apart from the work of dedicated medical personnel, the success of this clinic also lies in its partnerships with NGOs such as CARE and Planned Parenthood Association of South Africa.

One of the services offered at this clinic is Voluntary Counselling and Testing. But the big challenge being faced was that of language barriers in working with non-nationals accessing the facilities of this clinic. This problem was resolved in an innovative manner by CARE. CARE began to train people from these communities as voluntary HIV/AIDS counsellors thus doing away with the need to have interpreters in the counselling sessions, which was ethically an uneasy situation before.

These counsellors have now begun to work in Esselen Street Clinic and are not only making effective VCT possible but also creating a confidence in communities that were previously hesitant to access these services. These counsellors also attend to the local South Africans when they are free, hence addressing the general perception of separation of services for non-nationals in South Africa. At the same time, utilising the language and skills of the people from within the refugee and asylum seeker population is likely to go a long way in creating a sense of belonging and ownership among these populations living in South Africa.

(b) CAPRISA

Centre for AIDS Policy and Research in South Africa (CAPRISA) is involved in piloting a research based clinical programme to put TB patients on ARVs in conjunction with Prince Cyril Zulu Communicable Diseases Clinic (formerly, the Durban Chest Clinic), which could form the basis for a large scale programme to integrate ARV treatment with TB care. The need for this programme arose from when it was found that there was at least 65% co-morbidity of TB and HIV/AIDS in the TB patients visiting this clinic.

This integrated approach has synergised TB and HIV service provision. While CAPRISA provides ARV roll out capacity to the Prince Cyril Zulu Communicable Diseases Clinic through its own doctors and arranges for the required drugs, the existing infrastructure of the TB Clinic has been utilised to incorporate AIDS treatment within the current system. This programme has also collaborated with an NGO called Open Door and a municipality based organisation doing VCT work called ATTIC to facilitate voluntary participation of patients in getting tested and counselled for HIV. These organisations talk to the patients queuing at the chest clinic to tell them about HIV/AIDS, explain about CAPRISA's research and ask for participants to get involved with the study.

Participation ensures the patients of receiving ongoing HIV care, which includes self-administered anti-retroviral therapy and counselling, if found HIV positive and in need of treatment. Ongoing counselling creates the required support systems for pre and post-test coping, adherence to medication and prevention of future transmission of infection. This collaborative approach has made sure that the treatment to patients is given in a way that facilitates a better management of existing resources and expertise, while making ARVs available to a high risk population without creating independent vertical structures.

(c) Cell Life Project:

Based in Cape Town, this innovative project has proved that partnerships to control and manage HIV/AIDS epidemic are not restricted to medical expertise or service providers directly involved in HIV service provision. Rather, technology can be creatively used to support and upscale HIV/AIDS service provision with relatively low costs.

Cell Life began with a pilot in Gugulethu Township of Cape Town in 2002 to collect information on patients' adherence to ARV treatment and also recording the information on prescriptions, changes to prescriptions, tracking visitation of patients by home based caregivers etc. Recognising that home-based care givers had a lot of interaction time with patients, the data collection was done by training them to use cell phones with a pre existing menu installed on them, which had various categories of information that were to be filled out on each visitation made by the caregiver. In return for this, the caregivers got to keep the cell phones. This information was then uploaded into a central database managed by the Cell Life Project using cell phone technology and refined for the use of the doctors and nurses. The success of this partnership has resulted in an initial buy-in for a future larger scale project by the City of Cape Town to use cell phone technology to connect more medical institutions involved with ARV roll outs in Cape Town to this central database.

Along with the success of this projects also came some lessons. First and foremost, the Cell Life project managers realised that for this collaboration to work, not only a buy-in from the hospital manager was important, but also from the home based caregivers who would be the actual implementers. Secondly, coming from outside the context of health services, Cell Life could give important insights about the difficulty in implementing HIV/AIDS treatment. Their view was that the barriers in smooth implementation could be attributed to a lack of clear information on and understanding of the health systems in place to provide treatment and care. In their opinion, the focus seems to be on care and while each actor is trying to do the best, there is no clarity about how that fits in with the larger scheme of things. Finally, using technology does not complicate things, but can be

used as an empowerment tool (in this case for the home based caregivers). Tools and systems being developed in other fields can come to the aid of in health services and help in scaling up the response to HIV/AIDS when the existing capacity is overwhelmed.

4.12. Role of Faith Based Organisations (FBOs):

FBOs emerged as strong actors in having leverage to promote HIV/AIDS service provision. In all the cities visited these organisations were very involved and ran some of the most successful programmes. They seemed to be very well placed to have a real grassroots level impact due to the nature of their work that gave them the ability to gain the confidence of people. But the role of FBOs was also criticised by many others actors for the following reasons.

One of the biggest problems seems to be with regard to the conflicting prevention messages being sent out by FBOs that other organisations saw as setting back the prevention programmes. This study also found that there were problems in talking about safe sex in church based HIV prevention campaigns as many church organisations preferred to focus on abstinence. When asked about condom availability in an FBO working directly in the filed of HIV prevention and care programmes the respondent indignantly replied, *"We don't preach condoms here, we preach abstinence. Why would we be promoting condoms?"* Other problem was identified around the propagation of a discourse of guilt with respect to sex being seen as sinful and divine punishment accorded to those who had erred. Medical practitioners and NGOs felt that this discouraged patients from coming forward to get tested or seek an early treatment.

Despite these issues, there are many instances of noteworthy programmes being run by FBOs, especially in facilitating ARV roll out as well as in taking care of those who are terminally ill. Many of these involved cooperation and partnership with other organisations and medical practitioners. An example of such a successful programme is one run by an eThekwini-based organisation called Sino Sizo. Churches in inner city

Johannesburg are also playing a key role in the life of foreign migrants by providing emotional, spiritual and at times material support. Many have now started HIV prevention campaigns and taken it upon themselves to combat the stigma of living with HIV/AIDS within refugee and asylum seeker communities. Congolese churches in Yoville have taken a particularly leading role in promoting prevention messages in conjunction with NGOs such as PPASA, Johannesburg.

The success of Sinosizo

Sinosizo is the home based care organization of the Archdiocese of Durban. Sinosizo started off as an Southern African Catholic Bishops Conference (SACBC) ART site in February this year, funded by Cordaid. It employed the services of a dedicated doctor with whom an interview was carried out, a professional nurse and a co-ordinator. Groutville was identified as the site where it would provide ARVs to those in need of treatment. Groutville is also an area where a lot of migrant labour come to work on the farms. Approximately 70% of its patients were reported to be migrant labourers.

Sinosizo has managed to get all its policies in place and formalise referral arrangements with the local hospital and presented itself as a model for all the other SACBC ART sites. It faces a formidable challenge, being the first roll out site that is only a home based care organisation, not linked to a clinic, hospice or hospital. But Sinosizo has managed to integrate its home based care programme into the treatment programme to facilitate adherence. Now, with the help of PEPFAR funding, Sinosizo is busy scaling up the treatment it provides.

Sinosizo was also mentioned by the refugee organisations interviewed as the most accessible organisation, where they could refer refugees and asylum seekers to without fear of xenophobia and discrimination.

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(5) Conclusion:

Key findings of this research have attempted to demonstrate the nature of migration into the five cities studied; the impact of migration on HIV/AIDS and vice versa. An effort

has also been made to explore the factors in the migration process that create vulnerabilities to HIV/AIDS for migrants, especially at destination sites. Strains on HIV/AIDS related health service provision due to migration have also been described. Finally, this study has demonstrated a need for effective inter-sectoral partnerships in order to successfully manage and reverse the HIV/AIDS pandemic. Recommendations arising from these findings as well as the theoretical discussion in the previous chapter have been discussed at length in the following chapter along with areas where further investigation is required.

Chapter 3

The Way Forward

1. Introduction

HIV/AIDS presents us with the dual challenge of responding to the epidemiological aspects of the disease as well as to begin thinking of improvements in health in the broader context of socio-cultural norms and sustainable economic development. The theoretical and empirical discussion in this document has demonstrated the nature of a much-neglected relationship between HIV/AIDS and migration. It is clear that this association is not merely physical or linear but rather one that is complex and embedded in the socio-economic conditions and structures of the migration process.

Movement of people into the cities is an important dynamic that affects urban development and impacts upon the efficiency of governmental planning processes in South Africa. South African Cities Network's analytical framework for a 'city development strategy' includes four characteristics that revolve around the residents of the city. These aspire for the cities to be productive, inclusive, sustainable and well-governed. Migration poses challenges for cities with respect to all of these conditions. On the other hand, migrants are additions to the city's population and should be taken into account when cities aim to fulfil these criteria. This will not only ensure that migrants become fully participating citizens, but also assist cities in achieving their vision of becoming well-developed and efficiently functioning cities.

Chapter One theoretically explained that in South Africa urban transition is still very much a migration driven process and that mobility transition is far from over. Findings of the qualitative research in Chapter Two established that there is enough anecdotal evidence to suggest that there are still high levels of migration into the three metros and two secondary cities, and especially in the secondary cities. It also revealed that although

local government officials identify migration as a concern, it has not yet been factored into the planning processes. More worrying were the indications that migration is seen as a problem at the government level that must be contained or reversed for a better functioning of the city.

While the crucial role of political leadership in responding to the challenges of HIV/AIDS has been well recognised and documented, the nature of partnerships needed to create a consolidated front in the fight against AIDS has been less explored and understood. Even with respect to ARV roll out, government's focus seems to be on numbers rather than the holistic management of the disease. This study also looked at the nature of existing partnerships among actors working at various levels of HIV/AIDS prevention, treatment and care. It made observations about successes and failures of current collaborative efforts and areas that are lacking effective partnerships. Integrated responses from civil society organisations, medical practitioners and government will go a long way in overcoming the epidemic. However, in addition to this the necessity of managing these responses also needs to be further explored. The role of local government in this regard seems to be the key as it is best placed to understand the local circumstances and has mechanisms in place for interacting with a wide rage of groups at grassroots level.

Five years from the pledges made for achieving Millennium Development Goals (MDG), South Africa is faced with significant challenges that must be resolved for realising the stipulated targets. While the 2005 Millennium Development Goals Country Report for South Africa claims that the country is well on its way to meet the targets, critics point to the highly skewed income distribution, jobless growth of the economy and high levels of poverty as significant obstacles to success. South Africa is the largest economy on the African continent with a GDP larger than that of all other SADAC nations combined. But the current socio-economic and political realities of South Africa have been deeply influenced and shaped by the policies during apartheid years that resulted in severe disparities in access, allocation and entitlement of resources. As a result of this extremely skewed income distribution pattern, it is ranked 111 in its Human Development Index

after countries such as Uzbekistan (101), which has a low per capita income of only US$450 (AFRODAD Report, 2005).

As explored in detail in Chapter One, one of the legacies of apartheid policies was the creation of a migrant labour system with circular patterns of migration (both internal and cross border) that continues to persist till date. Disparities in income distribution, high levels of unemployment and severe differentials in accessing basic services have only contributed to the continued migration dynamics in South Africa. The 2005 MDG Country Report for South Africa identifies migration as a continued phenomenon as well as a challenge to the achievement of its targets. Achievement of Millennium Development Goals is only beginning to be linked with the implications of migration. This is especially true of the South African case where the faster growth of households as compared to population growth can be attributed to migratory movements.

While the MDG for Health speaks clearly about the effect of mobility of health professionals and consideration of the needs of refugees, it does not outline explicit plans to give special consideration to the needs of internal migrants. The reason for this is perhaps the implicit understanding that interventions for the whole nation would include this group. But it fails to appreciate fully the socio-political conditions of migrants who may not necessarily be effective participants in the democratic structures or may fail to be captured in population censuses. Both positive and negative circumstances brought about by migration may not be understood or appreciated at national level although they impact not only on the MDG of health but also MDGs on income, education and environmental sustainability (Development Research Centre on Migration, 2005). This is especially crucial in the case of South Africa where migration is a significant factor in demographic changes.

A response to the challenge of HIV/AIDS requires a multi pronged approach involving inter-sectoral partnerships as well as recognition of the need to contextualise interventions within South Africa's socio-economic realities. Although structural interventions are undoubtedly difficult to design and implement, they may be one of the

few alternatives available that could to deal with South Africa's mature epidemic. By demonstrating the relationship between migration and HIV/AIDS, this study offers one way of instituting such an approach by taking into consideration the existing 'mobility systems' and their relationship with HIV/AIDS.

2. Recommendations

The recommendations arising out of the study described in Chapter Two have been divided into the following five sub-headings:

(i)   **Designing structural interventions based on mobility systems:**

Structural interventions based on mobility systems can be justified on two accounts. Firstly, because migrants are a high-risk group with respect to HIV transmission and pose a challenge to the successful implementation of HIV/AIDS related services. Secondly, migration is a livelihood strategy employed by a large number of socio-economically poor in South Africa. Hence, mobility systems can give us the opportunity to understand and take into account the dynamic socio-economic processes at play in the society that affect HIV vulnerability. It involves a recognition that 'migrants' may be a group with special circumstances such that pro-poor policies may need to be somewhat tailored to have a greater responsiveness to the welfare of this group. This does not mean giving special treatment to migrants over other poor people. Rather that they should not simply be "incidental beneficiaries or victims of other interventions" (DIFID Briefing, 2004) without an understanding of their needs.

(ii)   **Need to address the challenges posed by migration and migrant populations to HIV/AIDS prevention, treatment and care:**

(a) Addressing the disparities in health systems: The findings of this study show that migration is not being factored into the planning for HIV/AIDS related service provisions. Due to a lack of clear understanding of migration patterns, there seems to be skewed distribution of resources for HIV/AIDS service provision. Doctors were of the view that disparities in health systems between rural and urban areas as well as between provinces fuelled migration into bigger cities. This in turn led to an increased allocation of health budgets in these receiving areas based on need, thus furthering the disparities and resulting in continued movement of people to access health services.

(b) Prevention programmes tend to miss out populations living in poorest areas such as urban slums or at best, carry out prevention campaigns in a piecemeal manner, hence decreasing their efficacy. While all local government officials interviewed said that a lot was being done in the way of prevention education, condom drives etc., NGOs and medical practitioners felt that the manner of implementation is problematic. A more systematic and consistent approach, especially in areas of migrant concentration is much more likely to be effective than the current programmes that tend to be more ad hoc and occasional.

(c) Vulnerabilities of migrant women: Migrant women are more vulnerable than men and engage in transactional sex for survival, as described in section 4.7 of the previous chapter. The desperate circumstances of these women increase the chances of risky sexual behaviour with very little power to negotiate safe sex. Most of these women lack skills that would allow them to gain economically viable formal sector employment. Government's skill building programmes are thus essential. In addition to this civil society organisations as well as the government could adopt options such as, workable micro credit models to supplement skill-building activities.

(d) Introduction of patient cards: Currently, no system exists for medical practitioners to determine where a patient has sought treatment before or access

to his/her complete medical history. Efforts should be made to address this as it would enable doctors to make faster, more accurate decisions regarding diagnosis and treatment as well as avoid duplication of already over burdened diagnostic services. This would be especially important in the case of migrants. These cards could be designed to have the bare minimum information needed in order to generate the least amount of paperwork but at the same time be informative, taking into account the concerns of patient privacy and confidentiality. This could be resolved by using a standardised codes representing sensitive information like HIV status.

(e) Addressing adherence: The majority of doctors interviewed in this study were concerned about migrants' failure to adhere to treatment. The reasons for this include: eventual depletion of finances to get transport to medical facilities far away from informal settlements, hunger, lack of understanding about the importance of adherence and the stigma associated with carrying a bag of medicines during holiday visits back home to rural areas, hence defaulting the ARV treatment that requires 95% or more adherence. The following suggestions have been made to deal with this problem:

- Free transport can be made available on a weekly basis to settlements at a distance from hospitals or clinics.
- Nutrition and food security must be addressed not simply by giving food packages but thinking of long-term solutions such as individual or communal vegetable gardens.
- Adherence education should increase in momentum as roll out of the treatment intensifies in order to ensure higher success rates for AIDS treatment. There is thus an acute need to involve media partners in generating messages about the critical importance of adherence to ARVs.
- Many clinics and hospitals now require disclosure of HIV/AIDS status to at least one close friend or family member. This is done to ensure that patients are provided with support during the treatment process

and anecdotal evidence suggests it also decreases the possibility of default. Many patients are however hesitant to tell family members and friends about their status due to the fear of being stigmatised. Thus more widespread campaigns are needed to reduce stigma and this will require a greater involvement by government, NGO's and especially media. Addressing the discrimination faced by people living with HIV AIDS, will not only increase the rates of adherence, but also enhance prevention of further transmission by creating favourable circumstances for disclosure.

(f) Responding to the needs of refugees: Creative strategies for overcoming language barriers are needed. CARE's training of refugee peer counsellors for VCT services as described in Chapter 2 (section 4.11) is a good example on how this could be achieved. Addressing xenophobia is an ongoing process and could go a long way in promoting access to services for this group. This research noted that the root causes of xenophobia among the local government officials and medical staff (mostly nurses) was due to ignorance about the constitutional rights of refugees and asylum seekers as well as due to popular myths about the high numbers of refugees and asylum seekers in South Africa who are mistakenly blamed for taking away the jobs from South Africans.

(g) Need for supporting care programmes: As more people begin to die of AIDS, the need for carers will only increase. Hospices have already begun to feel the burden of AIDS related illness. In the case of migrants in cities, support systems for care in the event of sickness are severely lacking and the stigma of AIDS may at times prevent them from accessing family support in rural areas. Along with this, poor water and sanitation facilities in some informal settlements, inner city areas of Johannesburg and Durban or other areas of migrant settlement may make taking care of persons sick with AIDS very difficult.

(h) Facilities at migrant hostels that still exist should be upgraded to accommodate families and those that cannot be upgraded should be abolished. Although some of these facilities were being upgraded to create family accommodation, organisations interviewed were not very optimistic about these changes. Respondents insisted that these hostels were not suitable for bringing up children. Also, it was reported that the migrant men in many instances themselves did not wish to bring families to stay with them and were resisting this change. Change in hostel facilities needs to be monitored more carefully and the concerns and opinions of the residents taken into account for it to be successful.

(iii)   Addressing the failure of prevention:

The need to start using more creative prevention strategies was expressed by all respondents in the study. As explained in Chapter 2, although a variety of prevention programmes are underway and government officials are of the view that enough is being done, the impact of these programmes is not translating into success. Current prevention strategies are focussed on behaviour change that is difficult to achieve and even harder to measure. Even when condom uptake increases there is no way of determining how consistently condoms are being used. The respondents in this research reported that no significant behaviour change is being noted. Some recommendations are made below to address the failure of prevention, especially with respect to migrant populations:

(a) Strategies to reduce the stigma related to HIV/AIDS need to be intensified. To achieve this, greater involvement by the government and the media is necessary. This could translate into a higher rate of accessing VCT as well as disclosure that will go a long way in preventing new infections.

(b) Voluntary counselling training needs to be standardised and mechanisms need to be built into the system to ensure quality assurance. This study found

capabilities of counsellors (for instance their ability to influence people to get tested, treatment of patients, knowledge about prevention and services available for treatment etc.) varied significantly and such inconsistencies affected the effectiveness of HIV prevention and VCT initiatives.

(c) Intensifying treatment should be accompanied with the scaling up of practical strategies of prevention as discussed in the following section.

(d) The focus on reproductive health seems to be missing from South Africa's MDG achievement strategies and this is to the detriment of HIV/AIDS prevention and treatment.

(e) Reproductive health interventions have traditionally excluded the participation of men as partners. Involving men in reproductive health programmes will go a long way in creating responsible sexual behaviours.

(f) Men seem to be falling through the cracks in HIV prevention campaigns that usually take place during the day and seldom at workplaces, especially where unskilled labour is employed. VCT facilities are generally not 24-hour services and thus often miss out on those who are employed. Having prevention campaigns after work hours or at the workplace, on weekdays and holidays, as well as opening more night-time VCT centres can help address this problem.

(g) A greater partnership is needed from business sectors that employ migrant labour to facilitate prevention messages and encourage access to VCT.

(h) Prevention campaigns are usually not aimed at refugees and asylum seekers. Many government officials interviewed during the interview phase discussed in Chapter 2 expressed the opinion that their responsibility lay primarily towards South African citizens and not with asylum seekers and refugees. But this is

problematic since excluding certain populations from HIV prevention messages and AIDS treatment can only lead to setbacks in reversing the epidemic.

(i) The role of faith based organisations and traditional healers needs to be better understood and acknowledged in spreading prevention messages and supporting the roll out of treatment.

(j) Younger populations need to be targeted for sex education. They should be taught to take pride in responsible sexual behaviour and made to understand the importance of keeping oneself HIV negative.

(iv)   Strengthening of health systems:

While behaviour change is a process that cannot be expected to happen at will, strengthening of health systems could go a long way in both prevention of new transmissions and management of the current epidemic. As mentioned earlier in Chapter 1, the increased availability of treatment could help promote preventive measures as patients' interaction with medical practitioners increases. But this can only be achieved if the existing health services are boosted in capacity and resources. Better health systems would mean an improvement in the treatment of other infectious diseases, especially those that are associated with HIV/AIDS such as STIs and TB.

One of the prevention approached suggested here, is the creation of mechanisms supplementing behaviour change strategies. Prevention must also focus on practical measures using the resources available to us now, such as: prevention of mother to child transmission; increased and standardised counselling; management of opportunistic infections, and treatment and increased counselling of already patients sick with AIDS. For this to make a significant difference there

will be a need to combat what has been termed as 'HIV exceptionalism'. By this is meant the tendency to institute vertical interventions and create parallel systems to for HIV/AIDS treatment and care.

This does not mean that there is no need to build mechanisms to facilitate AIDS treatment or prevention, but that a greater interaction is needed between different health care activities to build on each other's strengths. For instance, Chapter Two cited examples of TB and HIV collaborations creating successful synergies. Unfortunately, such efforts to provide comprehensive care are far and few. In most of the hospital sites visited, HIV services, e.g. VCT and PMTCT, were usually located at quite a distance from family planning and reproductive health services as well as chest disease units. It is well known that South Africa is lagging behind in its national management of TB. Perhaps capitalising on the incidence of high rates of co-infection between TB and HIV could have positive effects on the success of TB management.

As mentioned before, disparities in health systems between urban and rural areas force people to move in order to access better facilities. This is even more likely to be the case as improvements in AIDS treatment take place and will depend on how the roll out is carried out. It seems that at the moment, focus is on numbers of people getting on to ARV treatment. Medical practitioners interviewed in this study said that they were struggling to maintain quality while boosting up the numbers. It seemed that there was a dire need for understanding how the various micro level implementations fitted into the macro picture. An understanding of mobility systems that have been postulated in this document could help give a handle to guide the implementation process.

Shortage of nursing staff and doctors trained to prescribe ARVs must be addressed urgently. Once again, 'migration' could be used creatively to address the immediate shortage of medical professionals. Interviews in Mangaung showed that nurses from Lesotho come looking for work in South Africa. In the absence

of structures to make formal employment possible for foreign migrants, they either cannot find relevant employment and end up being employed informally where their skills remain un-utilised; or they get employed privately as nurses but at very low wages and in exploitative labour conditions. Similarly, the Somali refugee community in South Africa is known to have qualified nurses who are not able to work in South Africa due to lack of certificates that may have been lost during flight or due to a non recognition of their qualifications. South Africa could address its nursing crisis by hiring such nurses from other nationalities on contract basis (as in the case of Lesotho) or channelling them into diplomas that can ascertain their qualifications and help upgrade their skills (as in the case of Somali nurses).

Finally, more attention should be paid to the technological developments that can be used to support HIV/AIDS activities. An example of this was given in Chapter Two as demonstrated by the success of Cell Life Project in Cape Town that has streamlined the maintenance of patient records as well as facilitated the monitoring of drug adherence, thus increasing the efficiency and capacity of the exiting health systems.

(v)   Addressing the issue of child headed households:

Orphaned children are more vulnerable to HIV/AIDS as well as more likely to undertake migration themselves in the face of depleted social support. Due to their lack of ID documentation in most cases, community based organisations find it difficult to access child support grants on the behalf of these children. Mechanisms need to be built to facilitate these children's access to child support grants. Interventions are also needed to ensure that they can be channelled into the education system and life skills programmes in the absence of parental guidance.

(vi)   Facilitation and management of partnerships between various actors in this field:

This study found that very little coordination exists between efforts of different actors (government, NGOs, medical personnel etc.) involved with various aspects of HIV/AIDS management, i.e. prevention, treatment and care. This is not only a case amongst different aspects of HIV/AIDS service provision but also with respect to different sectors involved in this work. On one hand, different aspects of HIV/AIDS management are not interlinked to create comprehensive front, and on the other, different actors are doing similar tasks without consultation, thus creating duplication and inefficiency. Programmes that are run as collaborations and partnerships were undoubtedly found to be more successful but in circumstances where each partner has a significant expertise to offer. Creation of consortiums simply to build the capacities of smaller organisations or for accessing funding sources was not found to be counter productive.

> Two kinds of tasks are required in creating effective synergies: one, the role of facilitation of the current and future partnerships, and two, proper management of the existing expertise at the local level. Local government seems to be well placed to dispense both these roles. Lack of clarity about the role of the local government, especially with regard to the issues that fall under provincial government, hampers its ability to do this efficiently. The relationship between provincial and local governments could gain from clearer policies on how the two spheres should relate to one another, how delegation of tasks should take place and what role the local authorities should play a key role in the implementation of policies made at the provincial levels. This should be done as a consultation process between the two levels of government for the best possible outcome.

> The recent move to put all areas of health, expect environmental health, under the jurisdiction of provincial governments could bring the much needed streamlining of health services (esp. in rural areas) but will also come at a risk of losing the

grassroots level expertise of the local authorities. This is especially a danger for metros such as Cape Town, where the local authorities are actively involved in delivery of health services, especially HIV/AIDS related services. Since the HIV/AIDS epidemic is deeply rooted in the socio-economic realities of the lives of people, taking away the capacity of local government rather than enhancing it could prove to be detrimental to the management of this epidemic.

Finally, there is a need for a body that can serve as platform for promoting better communication between different local authorities and other key organisations across provinces, in order to share the reasons for successes and failures. The South African Cities Network is well placed to take on such a function. The success of Local Level HIV/AIDS Forum in Johannesburg should be duplicated in other cities. This could serve as a step in the direction of bringing much needed coherence to the variety of efforts taking place to deal with the epidemic of HIV/AIDS.

3. Areas of further investigation

- Little is known about the nature of migration streams in secondary city municipalities and the challenge they pose for service delivery, especially to the existing health services.

- Mobile populations of sailors and fishermen in port cities are understudied. Investigation into the circumstances and conditions of these people is urgently needed to address their vulnerabilities, especially to TB and HIV/AIDS.

- There is a need to explore the possibilities of integrating TB and HIV/AIDS care and the implications it will have on dealing with both TB and HIV/AIDS.

- The roll out of AIDS treatment should not be at the detriment of prevention efforts and should be seen as an opportunity to promote prevention. More

research is needed to create workable models and strategies for prevention that are based on the increased interaction between AIDS patients and medical personnel.

- More behavioural research is needed to understand the failure of prevention with respect to behaviour change and models of prevention need to be developed that can be tested for efficiency.

- The role of social grants, especially child support grants, needs to be better understood in AIDS affected households, especially for orphaned children.

- Effective and creative use of technology to ease off the burden from HIV/AIDS services should be investigated further.

- Population based research that speaks directly to the migrants is needed to get a clear understanding of the reasons for migration as well as of the challenges faced by them in accessing health services.

- An exploration of the health seeking behaviour of refugees and asylum seekers, their perception of risk to HIV, obstacles preventing their access to health services and development of ways to intervene with such hidden populations is needed.

- Enhanced understanding how mobility systems approach can streamline the interventions and its usefullness in mapping the need for relevant HIV services is required.

- Comparative studies of South Africa with other developing countries in Africa and elsewhere should be commissioned in order to import experience-based knowledge and avoid reinvention of the wheel in dealing with the AIDS epidemic.

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