Eastern and Southern Africa

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ABSTRACT

The countries included in this review are Angola, Botswana, Burundi, Djibouti, Eritrea, Ethiopia, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, Somalia, South Africa, Sudan, Swaziland, Tanzania, Uganda, Zambia, and Zimbabwe. Very little research has specifically addressed the important issue of the relationship between migration and HIV/AIDS in these regions of Africa. However there is a great deal of information about migration, and also about HIV/AIDS, in isolation from each other.

HIV/AIDS is widespread and prevalent throughout the two regions. Since HIV prevalence rates are now high in almost all African countries, the concern that migrants may bring the virus with them is no longer appropriate. Instead, the concern is that migrants may be vulnerable to acquiring the infection during migration, and that they may spread the infection when they return to their homes at the end of migration.

In the eastern African region there has been rapid growth of urban populations during the last ten years, mainly as a result of rural to urban migration. In addition, the conflict in Sudan and disputes in the Horn of Africa have created large numbers of internally displaced persons. Most recently, conflict in the Great Lakes region has also resulted in very large numbers of refugees crossing international borders. The UNHCR estimates that there were approximately 1.3 million refugees from and in eastern African countries in 1997, and an estimated 5 million internally displaced persons (4 million in Sudan alone).

In the southern Africa region there has been a rapid increase in rural-urban migration. In post-apartheid South Africa, many workers come to the cities for contract periods only, during which they are often housed in hostel accommodation, separated from their families. There are large internally displaced populations in Angola (up to 1.2 million persons) as a result of

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civil war in that country and large refugee populations in various countries as a result of conflict in Mozambique, South Africa and Angola.

Although it is often stated that migrants are at increased risk of HIV infection, direct data from eastern Africa are difficult to find. A study from the Horn of Africa region has shown HIV prevalence rates among Ethiopian sailors to be 9.6 per cent, and rates may be particularly high among long distance truck drivers. In southern Africa there is some direct prevalence data available for mineworkers, but an extensive search did not find any data for undocumented migrants. The most widely accepted risk factors for many migrant groups include high rate of partner change, unprotected sexual intercourse, non-use of condoms, prior STDs, injections, and a high prevalence of HIV in the community. There are also a number of recognized associations, such as age, gender, occupation, and mobility, which may be associated with confounding factors, or may play some causal role in their own right. Rural to urban migration in particular appears to result in a redefining of traditional "family" units. Women migrants are twice as likely to enter into "alliance" households (in which friends, family and lodgers make up the family unit) or be heads of households.

The state of medical services available to migrants varies from country to country, and between different migrant groups. In particular, the state of services for family planning, women's health, and the early detection and treatment of STDs may not always have been recognized as a priority in large camps for refugees and internally displaced persons. In South Africa, there are indications that the large undocumented migrant population may avoid the use of the public sector health services for fear of being reported to the authorities, and may not benefit from health promotional and preventive interventions offered there. This may be the case in a number of other countries in these two regions.

INTRODUCTION

This article reviews some of the current literature, published and unpublished, concerning migration and HIV/AIDS in the eastern and southern regions of Africa. The countries included are Djibouti, Eritrea, Somalia, Ethiopia, Kenya, Sudan, Uganda, Rwanda, Burundi, Tanzania, Zambia, Malawi, Zimbabwe, Mozambique, Swaziland, South Africa, Lesotho, Botswana, Namibia and Angola. The review indicates that very little research has specifically addressed the relationship between migration and HIV/AIDS. However, there is a great deal of information about migration, and also about HIV/AIDS, in isolation from each other, for the two regions.

HIV/AIDS is widespread and prevalent throughout the two regions which means that migrants of all types may be exposed unnecessarily to the risk of HIV

infection. Since HIV prevalence rates are high in almost all African countries, the concern is that migrants may be vulnerable to acquiring the infection during migration, and may spread it when they return to their homes.

The review covers material from 1987 to the present. The most important objective has been to collect information concerning the prevalence of HIV infection and of risk factors for HIV infection amongst migrant populations. This was not always possible to achieve, especially for cross-border (international) migrants. Organizations concerned with caring for migrant populations may, for ethical reasons, resist routine serum testing for the presence of HIV, as well as research which, if conducted outside a constructive and humane agenda, may result in harm to migrant communities (personal communication, Myriam Henkens, Brussels, 1997).

The types of migration referred to in this chapter and given special attention are:

- Rural-rural migration; common in parts of Africa where rates of urbanization are low and includes nomadic and pastoral persons in many parts of east Africa.

- Rural-urban migration; of increasing importance in Africa and may be estimated from changes in urbanization rates between censuses, and the growth of population in urban areas. The phenomenon is typical of the internal migrant labour system employed by the South African gold mines.

- Urban-urban migration; becoming more common as populations are urbanized.

- Urban-rural migration; manifest mainly through the return of rural-urban migrants to rural areas, for example during periods of unemployment or chronic illness. In some cases, refugees from urban areas flee to rural areas.

The United Nations High Commission for Refugees (UNHCR) differentiates between "internally displaced persons" and "refugees", the latter being persons who have "fled their country because of a well-founded fear of persecution for reasons of their race, religion, nationality, political opinion, or membership in a particular social group, and who cannot or do not want to return" (UNHCR, 1998a). This definition is based on the United Nations Convention Relating to the Status of Refugees. In Africa, it has been extended by the Organization of African Unity Convention Governing the Specific Aspects of Refugee Problems in Africa (Organization for African Unity, 1969) to include "…every person who, owing to external aggression, occupation, foreign domination, or events seriously disturbing public order in either part or the

whole of his country of origin or nationality, is compelled to leave his place of habitual residence in order to seek refuge in another place outside his country of origin or nationality."

This review has involved two distinct methodologies, one aimed at finding published (listed) sources; the other aimed at obtaining unpublished information.[1]

OVERVIEW OF MIGRATION IN THE TWO REGIONS

In the past, these regions have seen the migration of pastoral people and, in some cases, entire populations. Later, there were migrations from the north of Africa and the Middle East and, from the beginning of the twentieth century, large numbers of persons of European and Asian descent, first entering, and decades later leaving the regions or migrating between countries in the regions (Ade Ajayi and Crowder, 1985). Large numbers of African people were also forcibly removed from the continent during the slave trading era (Ade Ajayi and Crowder, 1985) and, in recent years, there has been a mass movement of persons internally in Tanzania as a result of the policy of Ujamaa (rural collectivization); and also Jews migrating from Ethiopia to Israel.

In South Africa, the policies of the previous Afrikaner Nationalist government, and governments that preceded them in power, were responsible for legal restrictions on the migration of Africans from overcrowded "reserves" to the major urban areas of the country. This continued until 1987, when the relevant laws were relaxed (Peberdy, c.1995; Gelderblom and Kok, 1994). The previous Nationalist government was also responsible for the forced migration of African people within South Africa. An estimated 3.5 million persons were moved forcibly between rural areas, from urban to rural areas, and from urban to peri-urban areas, during the almost 50 years of Nationalist government (Walker, 1985).

Eastern Africa

There has been rapid growth of urban populations in the eastern African region during the last ten years, mainly as a result of rural to urban migration (Mafeje and Radwan, 1995; Toure and Fadajami, 1992). In addition, the conflict in Sudan and the numerous disputes in the Horn of Africa region have resulted in large numbers of internally displaced persons. Conflicts in Great Lakes region have also resulted in large numbers of refugees crossing international borders (UNHCR, 1998c).

In their report, the State of the World's Refugees 1997-1998 (UNHCR, 1998c), the UNHCR estimates that in 1997 there were 22.7 million persons of concern

to that organization around the world; 13.2 million were refugees and almost 33 per cent of these were in Africa. Furthermore, of the 30 million internally displaced persons world-wide, 16 million were in Africa. The UNHCR also estimates that there were approximately 1.3 million refugees from and in eastern African countries in 1997, an estimated 5 million internally displaced persons (4 million in Sudan alone) and that 1.7 million refugees were repatriated within the region.

Southern Africa

In the southern Africa region, rapid increases in internal migration comprise mainly rural-urban migration (Mafeje and Radwan, 1995; Toure and Fadajami, 1992). In South Africa this is occurring after decades of apartheid, during which time "influx" of African people to urban areas was strictly controlled and even prohibited (Peberdy, 1995). It was always easier for young men to migrate to the cities with the result that men hugely outnumbered women in the cities (Gelderblom and Kok, 1994), and the men would return to their families in rural areas on a seasonal schedule (i.e. over Christmas). In addition, since migration of African persons to the urban areas was contrary to policy, housing and social amenities were not prepared in urban areas, with the result that the backlog of persons now moving to urban areas is met with inadequate infrastructure to provide for their needs, thus aggravating pressure on housing, health, welfare and social services.

Another issue in South Africa is the system of migrant labour, whereby workers are recruited in rural areas for work in cities for contract periods only, during which they are often housed in hostel accommodation. This system is most commonly, but not exclusively, encountered in the gold mines. In the Western Cape Province, for example, there are no gold mines, but there are substantial numbers of rural-urban migrants housed in hostels (Ramphele and Heap, 1991).

South African policy with regard to international migration, especially migration of refugees and undocumented migrants, has received considerable, and critical, attention as a result of the work carried out by the Southern African Migration Project. Concentrated on historical, ethical, political, and legal issues, as well as the practical problems facing migrants as a result of hostility (xenophobia) towards migrants in South Africa, their research has examined issues surrounding migrant or contract labour (internationally within the region rather than internally within South Africa) as well as undocumented migration to South Africa. The migrant labour system in South Africa also has implications for neighbouring countries (Mojapelo, 1996; Crush, 1997a). In fact, the foreign born component of South Africa's formal labour force has varied from 5 per cent to 10 per cent since the beginning of the century, in spite of legislation passed in 1913 aimed at excluding "non-whites" and further legislation in the 1930s aimed at excluding Jews (Peberdy, c.1995).

There are large internally displaced populations in Angola (up to 1.2 million persons) as a result of civil war in that country (UNHCR, 1998c) and, from time to time, smaller numbers of internally displaced persons in South Africa. South African victims are as a result of political strife in the Province of Kwazulu-Natal (ICRC, 1997a).

There have been large refugee populations in recent years in Malawi, Zambia and, to a lesser extent, South Africa, Botswana, Zimbabwe and Namibia, mainly as a result of conflict situations in Mozambique, South Africa and Angola. Most of these refugees have been able to return home, or are in the process of doing so (UNHCR, 1997), e.g., 1.7 million Mozambican refugees between 1992 and 1996, and almost 60,000 Angolans under their own auspices during 1997, although almost 300,000 Angolans continue to live as refugees in neighbouring countries.

In general, most of the countries in the region have been complimented for the willing way in which they have received refugees from neighbouring countries. The large numbers of refugees involved, however, coupled with the poor economic state of recipient countries, has made it necessary for international agencies to assist with the management of the problem.

OVERVIEW OF HIV/AIDS IN THE TWO REGIONS

HIV prevalence rates reported in countries in the regions may be based on antenatal clinic surveys, or on special studies of high risk persons such as STD clinic attendees, prostitutes, truck drivers, soldiers and hospitalized patients, especially those with tuberculosis. Prevalence rates based on antenatal clinic attendees may be biased in several ways. It may be argued, for example, that in the early stages of an epidemic figures may over-estimate the general prevalence rate. However, in the early stages of an epidemic there may also be factors (secondary infertility in women who have a history of pelvic inflammatory disease, for example) which may result in the figures being an under-estimate of the general prevalence rate. Recently, it has been argued that antenatal prevalences are probably a good reflection of the general prevalence, since many of the biases towards over-estimation are cancelled out by biases towards under-estimation. It has been suggested that antenatal prevalence rates are good indicators of overall prevalence in African countries, once the epidemic is established (Missen, 1998).

Most of the published studies from the two regions show lower prevalence rates in rural areas compared with urban areas (US Census Bureau, 1998). However, where major transport routes run through rural areas there are increased prevalence rates along these routes (Barongo et al., 1992). Furthermore, the

lower prevalence rates in rural areas may not reflect the ultimate risk for persons living in these areas (Quinn, 1994).

Prevalence rates vary considerably, mainly between rural and urban areas. While urban prevalence rates are much higher and similar in all countries of the region, the main problem for increased risks of infection among migrants is when they move from rural to urban areas, whether or not they cross borders in the process. Such movement increases the risk of acquiring STDs as well as risk of exposure to HIV, even if rates of partner change remain the same.

The additional risk is that these migrants take the infection back to their rural homes, infecting partners from whom they might have been separated during migration. UNAIDS, in its report on the global HIV/AIDS epidemic released in December 1997, estimates that 30.6 million persons were infected with the HIV at the end of 1997. Some 20.8 million of these persons live in Sub-Sahara Africa, where overall prevalence among those aged 14 to 49 is thought to be 7.4 per cent. Whereas the prevalence is declining in Uganda (including in the younger age groups, so that this is not merely an epidemiological artefact), in southern Africa the situation is extremely grave, with prevalence rates high and increasing, especially among the young.

Within countries, prevalence rates are quite variable with, as a rule, urban populations and those living close to traffic routes having higher rates. However, there are also situations of high prevalence in some rural areas, so rural populations are not always at a lower risk. Furthermore, reported rural prevalence rates are now approaching those reported from urban areas in many countries (AIDSCAP, 1996).

FINDINGS

THE MIGRANTS

In eastern Africa, current migration is overwhelmingly non-voluntary movement of persons within the borders of countries (leading to internal displacement), and across borders to result in refugee populations. The main areas affected in this region are the Horn of Africa and Great Lakes region.

Migrant populations tend to comprise mainly women, children and the elderly, and are heavily concentrated in temporary rural camps. Table 1 (page 546) shows the distribution of many of these refugees and provides some indication of countries of origin. Numbers fluctuate dramatically as large numbers of refugees cross borders at short notice and subsequently return to their countries of origin. This is particularly the case for refugees from Rwanda and Burundi.

An estimated 250,000 refugees from Rwanda are currently unaccounted for in the forests of the Democratic Republic of Congo, where some may be hiding; others may have been killed by the armed forces of that country (UNHCR, 1997). In addition, at mid-1997 this country was host to an estimated 40,000 refugees from Burundi, 20,000 Ugandans and 110,000 Sudanese (UNHCR, 1997).

The UNHCR also reports at the end of 1997 that there were a million internally displaced persons in Burundi and up to 4 million in Sudan (UNHCR, 1998a). There are also reports of smaller numbers of internally displaced persons in other countries in the region, for example in Uganda where the ICRC has been assisting up to 80,000 internally displaced persons in the south-west of the country (as of 13 November 1997) (ICRC, 1997). It is reported that 100,000 persons had to abandon their homes during fighting between government troops and the Allied Democratic Forces. At the end of 1997, flooding in eastern Ethiopia and southern Somalia resulted in temporary displacement of 16,000 persons, and outbreaks of cholera (ICRC, 1998).

In addition, there is a continuing voluntary movement of persons within countries of the region from rural to urban habitats. These migrations are characterized by backward and forward movement between urban and rural settings. Some persons may return to rural areas for recreation during periods of unemployment, in times of illness (including AIDS) (Quinn, 1994) and on retirement. Table 2 (page 546) indicates the extent of this urbanization process in each country in eastern Africa in recent times (UNICEF, 1998).

In southern Africa, the main situation concerns non-voluntary migration in Angola, economic migration to South Africa, and internal rural-urban migration in all countries. However, returning migrants and the post-war situation in Mozambique are also relevant. There are still an estimated 150,000 refugees from the Angolan conflict in the Democratic Republic of Congo (UNHCR, 1997), and smaller numbers in Zambia and Congo Brazzaville. While plans have been drawn up for their repatriation, the continuing situation within Angola, and a shortage of funds, have meant that the plans have yet to be implemented (UNHCR, 1997).

Within Angola, there are approximately 1.2 million internally displaced persons unable to return home in safety as a result of banditry and the presence of landmines (UNHCR, 1997; IOM, 1996c). Up to 1.7 million refugees from the internal conflict in Mozambique have now returned to their home country from neighbouring countries (UNHCR, 1997). Good progress is now being made with the re-establishment of the health and social infrastructure that had been destroyed during the war (IOM, 1996c).

In South Africa, there is a long history of cross-border economic migration. Since the beginning of the present century, the contribution of non-South Africans to the labour force has seldom been lower than 5 per cent (Peberdy, 1997). In addition, many migrants come to South Africa, mainly from neighbouring African countries, to take up tertiary education (Ramphele, 1997). Current estimates of the number of foreigners in the country are controversial. Flawed studies suggest that the number could be as high as 25 per cent of the population. Since foreigners are concentrated in certain areas, such as Gauteng Province, this would imply that well over 25 per cent of persons in these areas are foreign-born and mostly present illegally. A recent census and other opinion make it more likely that although the number of undocumented migrants in the country is not known, there are probably fewer than 1 million and possibly fewer than 500,000 (Crush, 1997b; Brink, 1996).

The few localized studies of undocumented migrants in South Africa indicate that foreigners stimulate the economy, create jobs for local persons, have a higher than average educational background and in general regard themselves as temporarily in South Africa (Reitzes, 1997b; Rogerson, 1997; Brink, 1996; Bam and Reitzes, 1996). In addition, migrants may be less likely than local citizens to make use of the public health services, partly because the migrants are younger and healthier, but possibly also because they fear detection and deportation (Reitzes, 1997b; Bam and Reitzes, 1996).

There is considerable opposition to and prejudice against migrants in South Africa (Madywabe, 1997; Cresswell, 1997; Southern Africa Migration Project – SAMP). Migrants have been forcibly and illegally evicted from their accommodation and had their personal possessions and trade wares destroyed by members of the public, sometimes in full view of the police, and, it is alleged, have been subjected to harassment from police and army, frequently having to pay bribes in order to be left in peace (Reitzes, 1997a; Bam and Reitzes, 1996). The South African Minister for Home Affairs appears to believe claims that large numbers of undocumented migrants are taking jobs from local persons and imposing a burden on the health and social services of the country, although the small amount of published evidence does not support such a conclusion (SAMP).

Reitzes has argued convincingly that the laws of South Africa, and the way in which the various government departments enforce these laws, have actually aggravated the problems experienced both by the migrants and South African citizens (Reitzes, 1997b). For example, when voluntary registration of farm workers was introduced, the high fee charged and the bureaucracy involved, discouraged farmers from doing so and led to opportunities for bribery. Furthermore, the repeated arrest and deportation of undocumented migrants encourages

large numbers of family members to migrate in order to be sure that some will be able to remain, earn some money, and return to their home country with consumer goods for re-sale. The "illegal" status of migrants makes them vulnerable to exploitation and low wages. This makes it more difficult for local workers to secure a fair wage. In this way, official policy actually contributes to the exploitation that is driving down wages in the agricultural and construction sectors. Another charge against migrants – that they are more likely to be engaged in criminal activities – is not supported by the little research that has been done. Neither is it corroborated by senior police officers (Reitzes, 1997b).

The post-war situation in Mozambique, where 1.7 million refugees have in recent years returned home from neighbouring countries, highlights the needs of refugees and non-voluntary migrants on their return. Some writers have suggested that many Mozambican refugees, repatriated to that country from South Africa, have subsequently returned to South Africa as undocumented migrants (Crush, 1997b).

As in eastern Africa, rural to urban migrants may also move backwards and forwards between the rural and urban settings, although the policies of the previous South African government have meant that the patterns have been somewhat different than in other countries.

Prior to 1987, rural to urban migration of African persons was severely restricted and, even when permitted, was usually on a temporary basis. Frequently, men were allowed to migrate but were required to leave their families behind in rural areas (Wilson and Ramphele, 1989). Restrictions were relaxed in 1987, but unrestricted migration between rural and urban areas has been possible only during the present decade. The extent of rural-urban migration in southern Africa is shown in Table 3 (page 547).

HIV PREVALENCE RATES AMONG MIGRANT POPULATIONS

Although it is often stated that migrants are at increased risk of HIV infection (Quinn, 1994; Djeddah, 1997), data from eastern Africa are difficult to find, perhaps because of political sensitivity relating to the testing of refugees and internally displaced persons for the presence of antibodies. Reported HIV and AIDS prevalence rates are extremely scarce for migrant communities in this region.

One source alludes to "sero-prevalence" studies among refugees from Burundi, but the data could not be located (IOM, 1996a). An extensive e-mail search for unpublished information produced only one report, namely the numbers of HIV sero-positive patients identified in a refugee community (IOM Geneva, personal

communication). These data indicate that approximately 2,500 tests for HIV antibodies were performed during a 12-month period in one medical programme. The number of positives is not given, and there is no accompanying information about the denominator, or exclusion and inclusion criteria, so interpretation is difficult.

On the other hand, the same centre performed nearly 2,500 serology tests for STDs on the same community during the same period from which only 13 positive RPR/VDRL tests were reported, suggesting that prevalence of syphilis is low in this community. Attempts to obtain data for applicants from refugee communities wishing to settle in North America were unsuccessful.

In the Democratic Republic of Congo it was possible to compare rural HIV sero-prevalence rates from 1976 (using sera collected during an outbreak of Ebola virus infection, which had been saved) with serum prevalence in the same community in 1986. The rates were unchanged at 0.8 per cent. Over the same period, urban sero-prevalence rates had increased from zero to 11 per cent among prostitutes in a nearby city. This gave rise to the view that rural-urban migration had introduced the virus to the urban community, and that sociological factors prevalent in the urban area had contributed to its spread thereafter, while rural rates remained low and unchanged (Quinn et al., 1986).

It has also been proposed that the infection, once established in the urban population, may spread along transport routes and, via returning rural-urban migrants, to rural communities previously unaffected by the disease. Thus, internal rural-urban migration may have contributed, at least in this instance, to the spread of the virus first to the cities and then to previously uninfected rural communities.

A study from the Horn of Africa region has shown HIV prevalence rates among Ethiopian sailors to be 9.6 per cent (Demisse et al., 1996) at a time when the general prevalence among adults in the same country was below 7.7 per cent (Demisse et al., 1996) and below 3 per cent in the Eritrean part of Ethiopia (US Census Bureau, 1998). Another study (Bwayo et al., 1994) suggested that HIV prevalence rates may be particularly high among long distance truck drivers, although the role (plausible that it may seem) of truck drivers in the spread of the epidemic has not been well analysed.

In southern Africa some direct prevalence data are available for mineworkers, but an extensive search has been unable to find any data for undocumented migrants. Table 4 (page 547) refers to prevalence rates among mine workers in South Africa (Jochelson et al., 1991). Though old, the data are the most recent available since routine testing of mineworker recruits has ceased. About 350,000 persons are currently employed on the gold mines in South Africa, approximately 95 per cent are migrants, either internal or international, and the

majority are housed in single sex hostels (Campbell, 1997). These prevalence rates relate to early stages of the southern African epidemic. Interestingly, the prevalence rate for mine workers recruited in South Africa is well below ante-natal rates reported from around the country for the same period (Doyle et al., 1991).

Data presented in Table 4 relate to mine workers who migrated mainly from rural to urban areas. A more recent study (Kravitz et al., 1995) reports prevalence rates among construction workers who moved into a rural hydroelectricity dam construction site in rural Lesotho. In this study, the HIV sero-prevalence rate among the workers was 5.3 per cent compared with 0.8 per cent among age- and sex-matched surrounding villagers. It was not indicated whether in-migrant workers came from rural or urban backgrounds.

RISK FACTORS AMONG MIGRANTS

"Risk factors" for the spread of HIV have been approached differently by different authors depending on whether they take a biological, medical, or sociological approach to explanation of the epidemic. For this article, both medical-biological and sociological risk factors have been examined on the assumption that each plays a role and provides insight that might inform successful interventions.

The most widely accepted risk factors include high rate of partner change, unprotected sexual intercourse, non-use of condoms, prior STDs, injections, and a high prevalence of HIV in the community. There are also a number of recognized associations, such as age, gender, occupation, and mobility, which may be associated with confounding factors, or may play some causal role in their own right.

These risk factors are an example of a predominantly medical model for the spread of the epidemic, and offer possible medical interventions such as treatment of STDs, distribution of good quality condoms, and the targeting of certain groups for educational and promotional activities. A sociological model to explain the epidemic and suggest interventions is also popular, and a number of sociological theories have been proposed (Quinn, 1994; Quinn et al., 1986; Hunt, 1996). For instance, Quinn proposes the following seven risk factors for the epidemic, based on a sociological model: population migration, social disruption, declining economy, STD epidemic, urbanization, poor medical services, and low social status of women (Quinn, 1994).

It has been argued that both biological and sociological theories require more good quality evidence before they can offer convincing explanations for the

differing scale of the epidemic in different places and concrete and reliable intervention possibilities (Hunt, 1996). Some of the quoted "risk factors" may be mere associations, linked to other factors which are the root causes. Ultimately, both the biological and sociological theories are relevant and may not be mutually exclusive. The following risk factors, both causal and associations, have been reported in migrant communities in the two regions (migration and urbanization are excluded as factors since these are assumed for the population in question).

High rate of sexual partner change

A number of references refer to the assertion that rates of partner change increase during times of war and social disruption, as well as during periods of travel. Some are reviewed by Mabey and Mayaud (1997). However, in the only report found for this region, it is stated that 37 per cent of male respondents in two large refugee camps in western Tanzania denied having experienced sexual intercourse during the previous three months. No other studies of rates of partner change were found for African refugees or internally displaced persons. A qualitative study among migrant mine workers in South Africa used a purposive sampling technique, so that the findings, while adding to our insight and understanding, may not be generalized (Jochelson et al., 1991). In their Zimbabwe study, Bassett et al. (1992) found that of (presumably non-migrant) STD patients and their partners, very few, if any, women admitted to sexual partnerships outside their marriages or regular relationships. In that study, only two instances were found where the female partner was positive for HIV antibodies and the male was negative. In both cases there was a plausible explanation (blood transfusions, an earlier marriage to a man who had died of an AIDS-like illness), making it unnecessary to assume multiple partner relationships.

Rate of partner change has not been reported for migrant communities from these two regions, and suppositions that women migrants might increase their number of sexual partners are not substantiated by any published evidence. In fact, the study of STD incidence carried out in east African refugees showed an unusually low rate of sexual intercourse among the men, and this is supported by the low incidence rates of STDs reported in that study for both men and women.

Among migrant workers in South Africa, however, there was a very high reported rate of STDs, and the fact that chancroid was reported as being especially high suggests that there is indeed a high rate of partner change in that group of migrants. It should also be pointed out that although rates of partner change remain the same before, during and after migration, if the background prevalence of HIV infection changes then so too will the risk of acquiring HIV infection.

Demography of migrants

If it is generally true in Africa that men are more likely to experience multiple sexual relationships, then the demographic composition of migrant communities is of some relevance. It also implies that men make extensive use of the services of prostitutes, or at least of a small core group of women who have multiple partners. Some writers have claimed that in Africa women too may indulge in unusually high rates of partner change. Reasons may include trying to become pregnant if they have failed to do so with their husbands, attempting to prove their fertility (Temmerman, 1994; Caldwell et al., 1989) and also to ensure the survival of their families (Sachs, 1997). While no published quantitative studies were found on the demographic composition of refugee and internally displaced persons, there are numerous qualitative reports from persons with field experience to the effect that these populations tend to be predominantly women and children (Sachs, 1997), or women, children and the aged (Adepoju, 1989), and that sometimes the populations may be 90 per cent women and their dependant children (UNHCR, 1995b).

Numerous reports indicate that, until recently, rural to urban migration has been a predominantly male phenomenon. As a result, population pyramids show a preponderance of young males in cities and a dearth of young males in rural areas (Director General, Department of Health, 1997). On this basis, Quinn (1994) suggested that sex ratios of HIV infected persons would favour males in the early, urban stage of an epidemic, but that as the epidemic spreads to rural areas, women would ultimately predominate.

That rural to urban migrants are more likely to be young men has been borne out by localized studies, for example in a rural area of South Africa (Fraser, 1993), as well as census data available for South Africa which show ratios of men to women in some mining towns as high as 5:1 (Jochelson et al., 1991). More recently, in South Africa, there is evidence from surveys that more women are moving to the cities than previously (Cooper et al., 1991; Pick and Makhlouf-Obermeyer, 1996). A study of women street vendors in an inner city area of Johannesburg, reported that 15 per cent were foreign-born and a further 59 per cent were born outside Johannesburg (Pick et al., 1998). If men are more likely than women to experience high rates of partner change, then urbanization and urban-to-urban migration pose migration situations of particular risk for the HIV epidemic.

High underlying HIV prevalence

While HIV prevalence rates have not been reported among refugees and internally displaced persons, it would appear that many of them move from rural communities to either densely aggregated quasi-urban situations or to urban situations as a result of their displacement. The evidence thus far suggests that,

in general, HIV prevalence rates are higher in urban populations, and have the greater potential to increase quite rapidly where persons are living in close proximity to one another.

In the first part of this article it was shown that rural prevalence rates are generally (but not always) lower than urban rates. Furthermore, urban rates are high in almost all countries. In some countries with better developed communication and transport networks, and in which urban-rural travel is common, such as Zimbabwe and Swaziland, there is little difference between rural and urban rates. Nevertheless, it would appear that, in general, migration from a rural area to an urban one, ceteris paribus, will result in an increased risk of contracting HIV infection.

HIV prevalence rates have not been described for migrant populations owing to the political sensitivity of testing and screening. However, a very large number of studies are available from civil communities for ante-natal prevalence, testing of blood donors and certain risk groups such as prostitutes, STD clinic attendees, truck drivers, the military and sailors. These data show that Burundi, Djibouti, Mozambique and the Sudan have relatively low prevalence rates in rural communities.

Low rate of use of condoms

A number of aid organizations have provided figures in their annual reports on the distribution of condoms among refugees and internally displaced persons. However, no reports were found of the use of condoms in refugee or migrant labour settings. Demographic and Health Surveys (DHS) in Africa give rates of condom usage among the general populations, and these data show that between 0.2 per cent (Rwanda 1992) and 2.3 per cent (Zimbabwe 1992) of married women interviewed are using condoms (DHS, 1997). No data were given for unmarried persons or, specifically, for migrants.

High STD prevalence

STD prevalence has been reported from a few migrant situations within the two regions. Mabey and Mayaud (1997) used a standardized rapid assessment technique to assess the STD situation in two large refugee camps in Western Tanzania and found that between 1 per cent and 2 per cent of the men in the camp had gonorrhoea and a further 3 per cent had urethritis. Three per cent of the women had gonorrhoea and 2 per cent had positive syphilis serology. These point prevalence rates were similar to those in the surrounding Tanzanian rural population. Jochelson et al. (1991) provided STD morbidity rates from the South African Anglo American Corporation mines where most of the workers may be regarded as rural-urban and cross border migrants. Covering the period

1978-1985, the rates varied between 50 cases per thousand employee years to 100 cases, and there had been an apparent increase over the years.

Exposure to non-sterile equipment and blood products

No specific quantitative reports of exposure to non-sterile equipment among migrant communities have been found. Other factors of relevance are razors used for shaving, traditional scarification, tattooing, hairdressing, and traditional birth attendants (TBAs). A UNHCR report quotes a refugee camp resident's concern about the sharing of razor blades which were in short supply in the camp (UNHCR, 1995a). Sachs (1997) reported that up to 25 per cent of refugee women may be pregnant at any given time. The UNHCR reports that, whereas prior to flight women knew where to find TBAs, in the refugee situation this is a problem and TBAs moved from shelter to shelter to announce their availability (Sachs, 1997; UNHCR, 1995a).

Non-sterile and unregulated deliveries could, under refugee camp conditions, lead to the spread of blood-borne diseases such as HIV infection and hepatitis B. It should also be noted that TBAs are also at increased risk of becoming infected with HIV (Mugerwa et al., 1996), although this aspect has not been specifically studied among refugee populations.

The association between exposure to injections and HIV has been noted in a study of Ethiopian sailors (Demisse et al., 1996), who reported exposure to injections were more likely to be HIV positive. This association may have had something to do with a greater incidence of (or fear of) having contracted an STD, since this may lead to requests for injections and therefore result in the HIV infection.

Also of concern is the exposure to infected blood. Many countries and regions where refugees congregate do not have well developed blood donor screening services (Emmanuel and Britten, 1990; Abdurahman, 1997) and, especially in a community with a high pregnancy rate, the need for blood transfusion may be high. Although the reliability of transfusion services may have improved in some areas (Mugerwa et al., 1996), under the conditions of massive population movement with populations concentrated in rural areas, current procedures may not be adequate to ensure safe blood for those who need it.

Social disruption

All migrant communities researched were likely to experience family disruption which may lead to increased sexual activity with strangers, either opportunistically, or in an attempt to replace children who are missing as a result of the disturbance. In addition, migrants may become separated from their usual

friends, family and community support systems, leading to alienation and a lack of resolve to exercise caution when approached by strangers for sexual favours.

Qualitative studies among migrant mine workers in South Africa have shown that many men, separated from their usual social supports, seek prostitutes to allay loneliness, and when asked about the risk of HIV, express a fatalistic attitude. This may be reinforced by their vulnerability in an industry that is perceived by them as being extremely dangerous. Other than the work by the Red Cross Society in seeking to reunite families, no reports were found of initiatives to try and preserve, restore or strengthen social support systems, although migrants may, themselves, attempt to do this through innovative family structures or ethnic clustering.

The fact that refugee populations and populations of internally displaced persons, as well as rural-urban migrant populations, are demographically skewed, would suggest that families do not keep together during migration (Quinn, 1994; Director General, Department of Health, 1997; Jochelson et al., 1991; Sachs, 1997; Fraser, 1993). A study carried out among undocumented migrants in Johannesburg showed that only 25 per cent of the group (almost all men) who were married, were accompanied by their spouses (Rogerson, 1997). Furthermore, large numbers of children become separated from their families, either during the migration process or later (Djeddah, 1997; Abdurahman, 1997). Migrant workers, where they are the caregivers, may have to leave their children with non family members during the day, making them more vulnerable (Brockerhoff, 1995).

Rural to urban migration in South Africa has been shown to result in a redefining of traditional "family" units. Women migrants are twice as likely to enter into "alliance" households (48.7 per cent compared with 25 per cent for non-migrants), and 15.5 per cent of the women live in households of which they are the heads (Pick and Makhlouf-Obermeyer, 1996; Pick et al., 1998). Alliance households are households where friends, family and lodgers make up the family unit.

Poor medical services

The state of medical services available to migrants may be quite variable. In particular, the state of services for family planning, women's health, and the early detection and treatment of STDs may not always have been recognized as a priority in large camps for refugees and internally displaced persons (Chinnock, 1996; Mabey and Mayaud, 1997), although numerous agencies such as CARE have been active in refugee and internally displaced person populations with educational, promotional, and condom distribution programmes (CARE, 1996).

The ICRC also supports a number of health initiatives in refugee camps, working with other agencies. In the Kivu area of the Democratic Republic of Congo, the ICRC supported clinic services for 270,000 Rwandese refugees (ICRC, 1997c). Their statistics indicate that refugees were making contact with the formal health services at the rate of 1-2 contacts per person per year. This is a very low figure, especially in view of the demographic structure of the refugee population, suggesting that there may be considerable unmet need for health care in this area.

The main focus of health services provision has been provision of clean water and aspects of camp hygiene (Chinnock, 1996; Mabey and Mayaud, 1997; ICRC, 1997a). However, a number of initiatives are now being evaluated for the provision of comprehensive reproductive health services, including education, the early detection and treatment of STDs and condom distribution, as well as clean delivery packs for TBAs (Sachs, 1997; UNHCR, 1995a). However, no reports were found of studies that attempt to measure the accessibility, acceptability and utilization of these services, perhaps because the initiatives are new.

The state of medical services in the home country, or at the end of internal displacement, may actually be worse than services in the camps, due to disruptions caused by the conflict or natural disaster which led to flight in the first place. This may deter persons from returning to their homes. This aspect has also received some attention, and in Mozambique there have been successful attempts to restore health services in general. However, the IOM report on re-integration suggests that reproductive health and HIV prevention are not a high priority (IOM, 1996a). Again, utilization and acceptability have not been reported.

In South Africa, the large undocumented migrant population may avoid the use of the public sector health services for fear of being reported to the authorities and, if they cannot afford private curative care, do without formal health care (Reitzes, 1997b; Bam and Reitzes, 1996). By avoiding the public sector services, they may not benefit from health promotional and preventive interventions offered there. In their study of street vendors (predominantly migrant women) in Johannesburg, however, Pick et al. (1998) found that the main reasons for not obtaining medical care were lack of money, no time, or because self-treatment was considered adequate. None of the respondents mentioned fear of being reported as a reason for not obtaining care even though 14.6 per cent were foreign-born and a large proportion of these may be assumed to be undocumented cross border migrants. The situation with regard to immunization and KAP studies has not been reported in the literature, and informal inquiry has not discovered any data for this group. In the South African mines, migrant labourers' access to health services has been good, but the high rate of STDs reported earlier (Jochelson et al., 1991) would suggest that promotional and preventive services should be improved.

Declining economic status

Refugees and internally displaced persons will usually experience a decline in their economic status, even if only temporarily (Chinnock, 1996; Caatecye, 1994). The return phase may also be a time of great economic hardship, a situation well documented for internally displaced persons living in a state of prolonged war, and also for those returning home across international borders (IOM, 1996a, b, c).

No reports were found detailing or analysing the extent of economic hardship experienced by refugees and internally displaced persons. However, one report based on the DHS data shows that children of migrants have worse survival prospects (Brockerhoff, 1995), and the situation of children of migrants living in hostels in South Africa (Western Cape area) shows that they have worse infant mortality rates and worse under 5 mortality rates than children of non-migrants (Ramphele and Heap, 1991). These findings may be used as surrogate measures of economic and social deprivation.

In the case of rural-to-urban voluntary migrants, there is published evidence that the migration process may benefit some migrants as well as the host country economically (Rogerson, 1997), as well as the rural communities from which they might originate (DHS Country Surveys). Their situation may be different from hostel dwellers or involuntary migrants in the Horn of Africa and the Great Lakes region.

In the case of undocumented migrants, lack of documentation may lead to abuse and economic exploitation. Undocumented farm labourers in South Africa are notoriously poorly paid, and many alleged incidents have been cited where their presence is reported to the police just before pay day and they are rounded up, arrested and deported without their wages. It has been alleged that there is complicity between the farmers, the police and Home Affairs Department officials. Ironically, such actions undermine wage levels for citizens. Yet the unemployed may have very little sympathy with the victims of this corrupt and unjust system, with the unemployed or underpaid citizens blaming the migrants for their low wages and clamouring for more and more Draconian action against the migrants.

Low social status of women

Women away from home and traditional support systems may be particularly vulnerable to exploitation (Tanne, 1992; Bassett and Mhloyi, 1991; Temmerman, 1994; MacDonald, 1996; Mhalu and Lyamuya, 1996). Demographic and Household Surveys show that, in general, a large proportion of women (up to 33.9 per cent in Tanzania, 38 per cent in Rwanda, 47.2 per cent in Malawi) (DHS Country Surveys) have never received any formal education.

There are exceptions, however, and in Zimbabwe the proportion is reported as 11.1 per cent and in Namibia 14 per cent (DHS Country Surveys). During refugee and internal displacement situations as currently experienced in Angola and in eastern Africa, the migrant populations are predominantly females with children (Sachs, 1997; Adepoju, 1989), and, as it is in these areas that women have received so little education, this has implications for their ability to cope.

In South Africa, where women are beginning to migrate to the cities, an increasing number are choosing to live in households not dominated by men. It has been argued that this is done partly to separate themselves from traditional power structures (Pick and Makhlouf-Obermeyer, 1996; Pick et al., 1998; Ramphele, 1986). It also has implications for the female children of undocumented migrants who may not attend school since their undocumented status may be reported to the authorities leading to their exclusion, and possibly the detention and deportation of their families. If the child is female, her chance of receiving an education may be even less.

Sexual violence against migrants

The poor economic, social, and power status of women and their children under circumstances of internal or cross border flight renders them vulnerable to sexual exploitation and abuse (UNHCR, 1995b), although aid agencies did not list this as a perceived priority in refugee and displaced persons camps (Chinnock, 1996).

Anecdotal reports have been made of sexual abuse in refugee settings. Mworozi (1993) claims that this kind of abuse exists but does not cite examples or data. Human Rights Watch (1996) are more specific. Their report on sexual abuse of women during the 1994 upheavals in Rwanda, cites "thousands" of rapes, gang rapes, instances of sexual slavery and gross indecent assault with, for example, sharpened sticks or gun barrels. It is also stated that there were between 2,000 and 5,000 rape-related pregnancies among refugees in the Great Lakes region of Africa during 1994. The perpetrators of these crimes were mainly military personnel, a group shown to have a very high prevalence of infection with HIV (Smallman-Raynor and Cliffe, 1990). In addition, some women may be forced into prostitution in order to obtain funds to feed themselves and their children, and clients may pressure them not to use condoms (Temmerman, 1994).

In South Africa, where undocumented migration is criminalized (Human Rights Watch/Africa, 1997), and where even "legal" women may be summarily detained, assaulted and then repatriated (Grosskurth et al., 1995), there are numerous anecdotes and allegations of corruption, including demand for sexual favour on the part of officials, the police, and the army (Reitzes, 1997b).

The commercial sexual exploitation of children is now receiving the attention of UNAIDS (UNAIDS, 1996). Factors that need to be considered include the tendency of migration to result in social disruption and separation of children from their families, and that this may increase the numbers of street children (Brockerhoff, 1995). In South Africa it has been suggested that children of undocumented migrants may take to the streets in an attempt to acquire a local identity (Reitzes, 1997b).

Knowledge of HIV among migrants

No reports were found which specifically examined knowledge among migrants. Such studies may have been carried out and not published, but requests to numerous aid agencies working among refugees in eastern Africa failed to uncover any such studies. A report from the UNHCR suggests that knowledge and awareness may be quite high, at least in Lumasi camp in Tanzania (UNHCR, 1995a). There is evidence, however, that in spite of having good knowledge and awareness, some persons may continue to become infected, so that knowledge and awareness are not, in isolation, good predictors of practice (Campbell, 1997).

Health seeking behaviour for STDs among migrants

A report from the UNHCR (1995b) indicates that refugees have requested that appropriate health services be made available since they had these services at home before fleeing to the camps and see the need for them. However, no reports were found reporting actual health seeking behaviour in the camps other than a mention that TBAs were popular and well organized, and presumably were sought by pregnant women (Sachs, 1997). Although studies of health seeking behaviour have been conducted among migrant communities in South Africa, and suggestions that undocumented migrants may avoid making use of the health services (Pick et al., 1998), these did not specifically address STDs.

SERVICES AND INTERVENTIONS FOR MIGRANTS

Although many international organizations work with refugees and internally displaced persons, they have not prioritized reproductive health and sexually transmitted diseases, although the situation is changing and a number of services and interventions are currently offered. A number of recent integrated intervention programmes have been shown to result in a reduction of age and sex specific incidence rates (Grosskurth et al., 1995) and prevalence rates (Mulder et al., 1995) of HIV infection in eastern African rural communities. These interventions were centred on educational programmes, early detection

and treatment of STDs (including partner tracing) and free distribution of condoms. Their success suggests that similar interventions should be evaluated in refugee settings and among communities of migrant workers and undocumented migrants. Africa Health conducted a survey of opinion among major agencies working in refugee communities in Africa during 1996, asking them to list the challenges facing them (Chinnock, 1996). Amongst other concerns, the agencies are reported to have mentioned that "HIV can spread rapidly in a time of war and in refugee camps", that there was a need for coordination of relief agency work, and a need for standards to be set for this work, and that the persons affected by disasters should participate actively in the relief operations.

This section examines some reported interventions relevant to the control of the HIV/AIDS epidemic in refugee camps. No examples of interventions were found for migrant workers and undocumented migrants, other than the routinely available health services offered in the South African mining sector for their employees.

A large number of agencies act in the various relief operations in refugee camps in Africa, and many, such as the CARE organization and ICRC, are also active in civil society in the affected countries (Sachs, 1997; UNHCR, 1996).

An example of how these agencies may work together to improve the service delivery is given by the convening by UNHCR, in 1995, of over 50 agencies to workshop an approach to maternal health (UNHCR, 1996). As a result of that workshop, two manuals were developed for use in refugee situations in Africa and inexpensive birthing packages, which could be used by women and TBAs, and which would help ensure safe deliveries. These packs contained a plastic sheet, piece of string, and razor blade. They can be made up easily on site. Also included were UNICEF midwife kits, post-coital contraception (essential for cases of rape for example) and condoms. The use of these manuals and packs is currently being evaluated in the Great Lakes area. Sachs (1997) has pointed out that, valuable as this initiative may be, it addresses only in part the needs of pregnant women, and has advocated a broader and more comprehensive response to the whole question of reproductive health and prevention of STDs and HIV/AIDS. Indeed, such an intervention has now been tried in Lumasi camp for Rwandese refugees in Tanzania (UNHCR, 1996).

This initiative was brokered by the UNHCR in response to expressed needs for such a service by refugees in the camp. ICRC was the implementation partner in this initiative, the first time that such an intervention has been introduced so early in the migration life cycle. The focus was family planning, STD early diagnosis and treatment, condom distribution, and HIV/AIDS education and prevention. The intervention consisted of AIDS community workers, recruited

from among the refugees and specially trained, and special clinics set up to focus on reproductive health. In addition, in cooperation with UNESCO and Norwegian People's Aid, school teachers from primary schools were especially trained using adapted and translated Tanzanian training manuals. A course on HIV was introduced into primary schools. The service has been well received and utilized.

The ICRC is also involved with the re-uniting of families (ICRC, 1997b), an important issue in the restoration of social supports and stability, as well as for rehabilitating street children and minimizing their abuse (Djeddah, 1997). Human Rights Watch recently reported that sexual violence resulted in between 2,000 and 5,000 rape-related pregnancies in the Great Lakes region in 1994 (Human Rights Watch, 1996). These pregnancies might have been prevented if the emergency post-coital pill had been more widely available, for example in reproductive health packs currently being evaluated (Sachs, 1997). Such violence may be discouraged if perpetrators are tried, found guilty, and punished. In the case mentioned above, this has not yet happened and the incidents have not even been investigated. However, the international tribunal has set up a committee to coordinate the investigation of gender violence (Human Rights Watch, 1996). No reports were found concerning the extension of safe blood initiatives to refugee camps. There is one report of a training programme in international military law for Rwandese military officers (ICRC, 1997d). The training was arranged by the ICRC and may help reduce abuses in the future.

Finally, attention must be paid to the re-integration phase of the refugee life cycle. Qualitative evidence from the UNHCR/ICRC initiative in Lumasi suggests that many refugees intend to return home and make continued good use of the knowledge and skills which they acquired during the intervention (UNHCR, 1995a). A description of the re-integration of the refugee community from Mozambique gives an idea of the scale of such operations as well as their current emphasis (UNHCR, 1997). In that operation, which lasted 4 years and resulted in the successful re-integration of 1.7 million persons at a cost of $100 million, attention was paid to provision of food for one season, seeds, tools and shelter materials, and the rehabilitation of infrastructure. This involved some 1,575 "quick impact" projects, such as refurbishment of clinics, hospitals and classrooms, sinking bore holes and shallow wells, and provision of roads. Sixty per cent of the projects were concerned with ensuring access to potable water. UNHCR coordinated this program, and worked with 55 implementation partners; an example of successful inter-agency and inter-sectoral collaboration.

All these activities are relevant to the prevention of STDs/HIV/AIDS since they promote the restoration of a supportive and stable social and economic

structure and infrastructure necessary for educational programs, and the early diagnosis and treatment of STDs.

RECOMMENDATIONS

Whereas, early in the HIV epidemic, some persons may have been concerned that migrants might spread the virus to native communities, the generally high prevalence rates which currently exist throughout most of the regions make this concern, whether or not it is justified, of little relevance. Of far greater concern is the fact that many non-voluntary migrants may move from areas of low prevalence to situations in camps where HIV can spread very rapidly, and then, on their return home, carry the virus back with them to previously low prevalence rural communities. In other words, the camps might act as "incubators" for the epidemic, speeding its spread. This argument supports the idea that management of migrant flows should take account of the threat of HIV and embrace measures designed to reduce or even eliminate this threat.

A number of studies show the effectiveness of comprehensive civil interventions centred around the early recognition, diagnosis and treatment of STDs, coupled with condom promotion, so that from a medical model point of view there are successful models for the prevention of HIV. These will have to be combined with interventions inspired by models that take into account the social, economic and political situation of migrants.

The very large numbers of migrants involved in recent non-voluntary movements within the regions has required numerous aid agencies to become involved to deal adequately with the problems encountered. As a result, there is a need for the organizations to be managed in a coordinated way. The success of a number of projects in which UNHCR played the important coordinating role shows that this coordination is possible and fruitful.

International aid agencies should continue to work closely with national governments in order to encourage and promote adherence to the various international conventions and agreements which are designed to protect the basic human rights of migrants, especially women and children. These agencies should also continue to play a leadership role among the numerous organizations working with migrant communities, developing protocols, consistent policies and educational messages and minimum standards of practice.

In addition, for this region, the following specific interventions might prove worthwhile. These should be designed, implemented and evaluated, using action research methodologies and involving all role players, especially the migrants themselves, at all stages:

- *High rate of sexual partner change and demography of migrants.* It is recommended that accurate demographic profiles be assembled for all migrant communities. These will enable authorities to plan appropriate services for voluntary migrants and improve their preparedness for non-voluntary migrants. In particular, it will enable the better planning of interventions aimed at reducing the spread of HIV.

- *High underlying HIV prevalence.* Knowledge about the underlying prevalence of HIV already exists for most countries in these two regions. Effective interventions to reduce prevalence should be extended and strengthened so that migrant communities may also benefit from them.

- *Low rate of use of condoms.* Data concerning the distribution and use of condoms within migrant settings should be made available, and KAP studies and qualitative research should be funded in an attempt to identify ways in which distribution and use may be improved in migrant populations.

- *High STD prevalence.* High quality comprehensive STD control programmes based on the syndromic approach should be made available in all migrant communities as a matter of urgency, and, in the case of massive population displacements, early on. These programmes may form part of reproductive health initiatives.

- *Exposure to non-sterile equipment and blood products.* Several recommendations can be made for camp settings. Male migrants in camp settings should be provided with personal razor blades for shaving and hair cutting and the risks of sharing razor blades should be explained. Adequate disposal facilities should be provided for used needles and razor blades, and this aspect of the HIV epidemic should form part of education programmes and the training of TBAs and all clinic staff. Finally, contingency plans should be drawn up for the ensuring of safe blood products under emergency circumstances.

  A general recommendation is that traditional healers should be identified early during population displacements, and they should be educated about the risk of spreading HIV through scarification practices. If necessary they should be provided with disposable instruments.

- *Social disruption.* Wherever possible, families should be kept together and mechanisms set in place early on to assist family members to find each other. In general, however, persons should be encouraged to discover and develop their own social support networks (they will anyway). In this regard it would be helpful if, for example, auxiliary community social

workers were to be recruited from among the migrants themselves and then trained and employed to work in the migrant community.

- *Poor medical services.* Good quality, accessible and acceptable primary health care services should be provided for migrants and should include maternal and child health, STD, and reproductive health components among others. Maximum participation of migrants in the design, operation and delivery of these services should be encouraged and promoted.

  Specially focused programmes, staffed wherever possible by culturally competent personnel, should be developed for migrants and implemented by ministries of health or, if this is politically not possible, by aid agencies. This recommendation applies equally to both documented and undocumented migrants.

- *Declining economy.* Wherever possible, services within migrant communities should be provided by paid members of the community so that a maximum of economic aid remains within the community. Proper analysis of the economic needs and potentials should be carried out in order to better inform this response.

- *The status of women.* Every effort should be made to ensure that young migrant girls have equal access to at least basic schooling during migration. This applies equally to non-voluntary and undocumented and other voluntary migrant workers. Self-esteem may be promoted through peer instruction initiatives such as the "circuses" run by the ICRC, and through self-awareness and counselling sessions aimed at young persons of both sexes.

- *Sexual violence against migrants.* Training programmes as run by the ICRC for the military in Rwanda should be promoted during peace time as well as during wars, and these programmes should include gender issues and sensitivity training.

  Tribunals must recognize the serious light in which the international community holds sexual violence and be seen to respond accordingly and appropriately.

  Adequate counselling, post-coital contraception and, in countries where this is acceptable to the local population and permitted by the laws of the country, abortion facilities should be available for women who have been raped. As well, facilities should be available where migrant women may report such violations without fear of victimization or repatriation.

- *Knowledge of HIV among migrants.* KAP studies need to be carried out among migrants to test their knowledge, attitudes and practices for appropriateness in their new environment. This will permit remedial educational activities and programme alterations being made early on if necessary.

- *Health seeking behaviour for STDs among migrants.* Health seeking behaviour should be studied and documented among migrants, using rapid epidemiological techniques, so that appropriate interventions, aimed at improving the early recognition, diagnosis and proper treatment of STDs, can be designed and implemented.

- *Services and interventions for migrants.* Although this review suggests that a large volume of basic research information is missing, wherever possible, future research priorities should be along the lines of intervention or action research, since each situation and each community may be different and have unique needs. The interventions that have already been reported provide encouraging examples.

NOTE

1. The majority of sources found in the formal (listed) search pertain to HIV/AIDS, whereas most of the information relevant to migration, and useful for this review, was obtained from the World Wide Web (WWW). The latter was relevant for background information rather than for answers to specific questions posed by the review. In some cases, such as policy and legal issues concerning migration in South Africa, or the political situation in the Horn of Africa, the amount of material was overwhelming in its technical detail.
   Selectivity may have introduced bias to the review, and the reader is asked to exercise caution. With regard to the specific questions addressed, all documentation found has been included. Where an article or a piece of information has been obtained through personal communication this has been indicated in the text, and not in the list of references. It has not always been possible to return to the source to examine the methodology used. Numerous requests for original articles remain unanswered. Where articles quoted have not been seen in their original forms, this has been indicated in the references list.
   The known considerable repositories of unpublished work in Uganda, Kenya, and Tanzania, have not been accessed. It is unlikely that no KAP studies, details of condom issues, and studies of health seeking behaviour have been undertaken in the many large refugee camps in eastern and (until a few years ago) southern Africa.

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TABLE 1

DISPOSITION OF EASTERN AFRICAN REFUGEES
(end of 1997)

Country	Total refugees	Country of origin (numbers if known)			
Uganda	265,000	Sudan			
Ethiopia	340,000	Somalia (285,000)	Sudan (35,000)	Kenya (8,600)	Djibouti (8,000,000)
Sudan	400,000	Eritrea			
Tanzania	n.a	Rwanda	Burundi		
Eritrea	+/- 3,000	Somalia (2,800)	(Sudan) (144)		

Source: UNHCR, various.

TABLE 2

URBANIZATION IN EASTERN AFRICA

Country	Annual population growth rate (per cent)		Annual urban population growth rate (per cent)	
	1965-1980	1980-1996	1965-1980	1980-1996
Burundi	1.7	2.6	6.2	6.3
Djibouti	5.4	4.9	8.4	5.5
Eritrea	2.6	2.0	4.8	3.6
Ethiopia	2.4	2.9	4.5	5.6
Kenya	3.6	3.2	7.7	7.0
Rwanda	3.2	0.3	6.8	1.9
Somalia	3.1	2.4	3.9	3.4
Sudan	2.8	2.4	5.5	5.4
Tanzania	3.0	3.2	9.9	8.5
Uganda	3.3	2.7	5.3	5.1

Note: Rates are averages and should not be compounded. Total population: 169 million (1991).

Source: UNICEF, 1998.

TABLE 3

URBANIZATION IN SOUTHERN AFRICA

Country	Annual population growth rate (per cent)		Annual urban population growth rate (per cent)	
	1965-1980	1980-1996	1965-1980	1980-1996
Angola	2.0	2.9	5.4	5.5
Botswana	3.3	3.1	12.5	12.0
Lesotho	2.3	2.5	7.3	6.5
Malawi	2.9	2.9	7.1	5.6
Mozambique	2.5	2.4	9.5	8.6
Namibia	2.6	2.7	4.6	5.7
South Africa	2.6	2.3	2.7	2.5
Swaziland	2.8	2.8	9.5	8.5
Zambia	3.1	2.3	6.6	2.8
Zimbabwe	3.1	3.0	6.0	5.3

Note: Rates are averages and should not be compounded. Total population: 77 million (1991).

Source: Source: UNICEF, 1998.

TABLE 4

HIV PREVALENCE AMONG SOUTH AFRICAN MINE WORKERS (1986-1987)

Country of Origin	General Population of Mine Workers (1986)		Mine Workers Attending STD Clinics (1987)	
	Number tested	HIV positive (per cent)	Number tested	HIV positive (per cent)
Malawi	3165	119 (3.76)	466	83 (17.8)
Botswana	2063	7 (0.34)	1269	7 (0.55)
Lesotho	2246	2 (0.09)	5230	5 (0.10)
Mozambique	2152	2 (0.09)	1298	7 (0.54)
Swaziland	1885	1 (0.05)	846	2 (0.24)
South Africa	18450	4 (0.02)	16784	14 (0.08)
Total	29961	135 (0.45)	25893	118 (0.46)

Source: Jochelson et al., 1991.

AFRIQUE AUSTRALE ET DE L'EST

Les pays faisant l'objet de cette étude sont l'Afrique du Sud, l'Angola, le Botswana, le Burundi, Djibouti, l'Erythrée, l'Ethiopie, le Kenya, le Lesotho, le Malawi, le Mozambique, la Namibie, l'Ouganda, le Rwanda, la Somalie, le Soudan, le Swaziland, la Tanzanie, la Zambie et le Zimbabwe. Très peu de recherches ont été spécifiquement consacrées à cette question importante du lien entre les migrations et la propagation du VIH/SIDA dans ces régions d'Afrique. Toutefois, il existe une importante somme d'informations sur les migrations et aussi sur le VIH/SIDA, mais sans relation les unes avec les autres.

Le VIH/SIDA est répandu et omniprésent dans l'ensemble des deux régions. Maintenant que le taux d'infection par le VIH a atteint un taux élevé dans presque tous les pays africains, les craintes que les immigrants soient porteurs du virus n'ont plus guère de justification. En revanche, il faut s'inquiéter de leur vulnérabilité face à l'infection durant leur migration et le risque qu'ils propagent l'infection à leur retour chez eux.

En Afrique de l'Est, les populations urbaines ont rapidement augmenté au cours des dix dernières années, principalement sous l'effet de l'exode rural. Par ailleurs, les conflits qui sévissent au Soudan et dans la Corne de l'Afrique ont occasionné de vastes déplacements internes. Plus récemment, le conflit qui a dévasté la région des Grands Lacs s'est traduit par une vague massive de réfugiés qui se sont déversés dans les pays voisins. Selon les estimations du HCR, les réfugiés en provenance et à l'intérieur des pays d'Afrique de l'Est auraient été au nombre d'environ 1,3 million en 1997, et les personnes déplacées à l'intérieur des frontières auraient atteint 5 millions (dont 4 au seul Soudan). En Afrique australe, on a pu constater une augmentation rapide de l'exode rural. Dans l'Afrique du Sud aujourd'hui sortie du régime de l'apartheid, nombreux sont les travailleurs qui se rendent dans les villes pour des durées déterminées seulement, pendant lesquelles ils sont fréquemment logés dans des foyers et restent éloignés de leurs familles. Il existe aussi d'importantes populations de déplacés de l'intérieur en Angola (jusqu'à 1,2 million de personnes) à la suite de la guerre civile qui a ravagé ce pays, et aussi de vastes populations de réfugiés dans différents pays, à la suite des conflits au Mozambique, en Afrique du Sud et en Angola.

Si l'on entend souvent dire que les migrants sont davantage exposés à un risque d'infection par le VIH, il est difficile d'obtenir des données qui confirment la chose en ce qui concerne l'Afrique de l'Est. Une étude portant sur la Corne de l'Afrique a révélé des taux d'infection par le VIH atteignant 9,6% chez les marins éthiopiens, et on suspecte un taux particulièrement élevé chez les chauffeurs de poids lourds effectuant des déplacements sur de longues distances. En Afrique australe, on dispose de données directes concernant les travailleurs saisonniers, mais des recherches approfondies n'ont pas permis de

mettre la main sur des données concernant les migrants sans papiers. Parmi les facteurs de risque les plus largement reconnus au sein de nombreux groupes de migrants, on peut citer la fréquence des changements de partenaire, les rapports sexuels non protégés, la non-utilisation de préservatifs, la préexistence de MST, les injections, et un taux élevé d'infection par le VIH au sein de la communauté. Il existe en outre un certain nombre d'associations reconnues, telles que l'âge, le sexe, le type d'activité et la mobilité, qui peuvent se combiner avec des facteurs interférents, ou jouer un rôle déterminant par eux-mêmes. L'exode rural en particulier semble entraîner une redéfinition de la cellule familiale traditionnelle. Les femmes migrantes sont doublement susceptibles de fonder des ménages « d'alliance » (dans lesquels les amis, la famille et les pensionnaires éventuels forment une unité familiale), ou d'être elles-mêmes chefs de ménage.

L'infrastructure médicale accessible aux migrants varie d'un pays à l'autre, et aussi entre les différents groupes de migrants. C'est ainsi que les services de planning familial et les soins gynécologiques, de même que la détection avancée et le traitement des MST, peuvent ne pas toujours constituer des priorités dans les grands camps de réfugiés et de déplacés internes. En Afrique du Sud, il semble qu'un grand nombre de migrants sans papiers préfèrent rester à l'écart des services de santé publique par crainte d'être dénoncés aux autorités, et qu'ils ne puissent donc pas profiter des campagnes de promotion de soins de santé et de prévention pouvant occasionnellement être mises sur pied. Cela s'applique sans doute aussi à un certain nombre d'autres pays de ces deux régions.

ÁFRICA ORIENTAL Y MERIDIONAL

Los países incluidos en este estudio son Angola, Botswana, Burundi, Djibouti, Eritrea, Etiopía, Kenya, Lesotho, Malawi, Mozambique, Namibia, Rwanda, Somalia, Sudáfrica, Sudán, Swazilandia, Tanzanía, Uganda, Zambia, y Zimbabwe. La investigación ha encarado específicamente la importante cuestión de la relación que existe entre la migración y el VIH/SIDA en estas regiones de África. No obstante hay gran cantidad de información sobre la migración y también sobre el VIH/SIDA pero lamentablemente separada una de otra. El VIH/SIDA es un fenómeno difundido y predominante en ambas regiones. Habida cuenta de que las tasas de prevalencia actuales son elevadas en casi todos los países africanos, la preocupación de que los migrantes aporten el virus consigo ya no es apropiada. Más bien, la preocupación es que los migrantes sean vulnerables y contraigan la infección durante su migración y puedan propagar la infección cuando retornen a sus hogares al final de su migración.

En África oriental se ha registrado un raudo crecimiento de poblaciones urbanas durante los últimos diez años, principalmente a raíz de la migración rural hacia las urbes. Por otra parte, el conflicto en el Sudán y las disputas en el cuerno de África han dado lugar a considerables cantidades de desplazados internos. Recientemente, el conflicto en la región de los Grandes Lagos produjo importantes números de refugiados que cruzaron fronteras internacionales. El ACNUR estimó que en 1997 había aproximadamente 1.300.000 refugiados de África oriental y en países de esa región, y alrededor de unos 5 millones de desplazados internos (4 millones únicamente en el Sudán).

En la región de África meridional, se ha registrado un raudo incremento de la migración rural urbana. Tras el apartheid en Sudáfrica, muchos trabajadores vienen a vivir a las ciudades con pequeños contratos, durante los cuales se alojan en albergues al estar lejos de sus familias. Angola cuenta con una importante población de desplazados internos (alrededor de 1.200.000 personas) como consecuencia de la guerra civil. También hay importantes poblaciones de refugiados en distintos países a raíz de los diversos conflictos ocurridos en Mozambique, Sudáfrica y Angola.

Aunque a menudo se afirma que los migrantes corren mayores riesgos de infectarse con el VIH, es difícil encontrar información directa de África oriental. Un estudio realizado en la región del cuerno de África ha demostrado que las tasas de prevalencia del VIH entre marinos etíopes es del 9,6 por ciento, y que esas tasas pueden ser particularmente elevadas en los conductores de camiones que recorren largas distancias. En África meridional hay datos sobre la prevalencia directa para mineros, pero no se ha encontrado ningún dato sobre una investigación exhaustiva relativa a los migrantes indocumentados. Los factores de riesgo más comúnmente aceptados para diversos grupos de mi-

grantes comprenden la gran diversidad de parejas sexuales, las relaciones sexuales sin protección, la no utilización de preservativos, enfermedades anteriores sexualmente transmisibles, inyecciones, y una prevalencia elevada del VIH en la comunidad. También hay una serie de asociaciones reconocidas como la edad, género, profesión y movilidad que pueden asociarse con factores de confusión o simplemente desempeñar una función casual por su propia función. La migración rural hacia las urbes parece ser responsable de una redefinición de las unidades "familiares" tradicionales. Las mujeres migrantes tienen el doble de posibilidades de ingresar en hogares de "alianzas" (en los cuales amigos, familiares, personas que ofrecen alojamiento constituyen la unidad familiar) o pueden ser cabezas de familia.

La situación de los servicios médicos a disposición de los migrantes varía de un país a otro y también según los distintos grupos de migrantes. Especialmente en importantes campamentos de refugiados y desplazados internos no se concede prioridad a los servicios de planificación familiar, de salud de la mujer, de detección temprana, o de tratamiento de enfermedades sexualmente transmisibles. Hay pruebas de que en Sudáfrica la importante población de migrantes indocumentados evita utilizar los servicios de salud del sector público por temor a ser delatados a las autoridades y no benefician de las intervenciones promocionales y preventivas de salud que allí se ofrecen. Este podría ser el caso de muchos otros países en estas dos regiones.