

An Assessment of Factors Associated with HIV infection among migrants within the SADC region.

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Introduction

Globally an estimated 37.6 million people are infected with Human Immunodeficiency Virus (HIV) (UNAIDS 2015). Migrants are generally considered a vulnerable group to HIV infection. The International Organisation for Migration estimates that at least 1 out of every 33 people is a migrant. Migrants are usually separated from their spouses and families for long periods. As such, they have little family and social support, this unfortunately also limits social pressure that governs sexual behavior. This paper seeks to highlight the factors that predispose migrants to the risk of HIV infection.

Migrants pose health risks to communities they travelled to, make demands to health care and change the demographic characteristics of the sending country and the receiving country. Compounding this is, are variations in the reporting data on migration in various countries.

Since the HIV was first reported, bold targets have been set and resolutions made. Social and economic gains made in preventing the spread of HIV continue to be threatened by increased population migration around the world. Achievement of the United Nations Goal 3 of the sustainable development goals, which is to ensure healthy lives and promote well-being for all at all ages will remain a dream unless innovative HIV programs are in place.

Different HIV Prevalence HIV Rates in Sending and Receiving Countries

Sub-Saharan Africa bears the brunt of the HIV epidemic with at least 66% of all people living with HIV residing in the region. Within Sub-Saharan Africa, the epicentre of the epidemic is Southern Africa. In the SADC region, South Africa is the main recipient of migrants (SADC Draft migration Policy 2013). Exacerbating the spread of HIV in the region and posing HIV programming and policy implementation issues is the different HIV prevalence and incidence rates in the region. With continued migration in the SADC region, the spread of HIV remains a great concern particularly from highly endemic countries. Empirical evidence suggests at least 50% of migrants know their HIV status. As a result of this, migrants who do not know their HIV status are most likely to infect

communities they travel to. This is further culminated by a long incubation period of HIV (about 15 years). Of particular importance is that the different HIV prevalence rates do not act in isolation to spread HIV, this in combination with other factors such as increased risky sexual behaviour among migrants exacerbates the spread of HIV.

Fig.1; HIV prevalence in Southern Africa 2014



Gender Imbalances in Sending and Receiving Communities

Migration alters the population demographics in sending and receiving areas. Johnson and Budlender 2002, in a study in HIV risk factors highlight that in areas where there is high migration there are unusually high or low male to female ratios (Johnson & Budlender 2002). In light of this, in communities where there is a high number of males and few women or vice versa, sexual networks and multiple partnering which fuel the spread of HIV are bound to occur. This is well illustrated in mining communities which attract a lot of male migrant labourers and few females, such communities are usually characterised by sexual networks and increased spread of HIV and sexually transmitted infections. In contrast, sending communities, which characteristically have a high female

to male ratio. This coupled with the spousal separation results in multiple sexual partnering spreading HIV incidences.

Increased sexual networking

Migration also poses an increased risk of sexual networking, fuelling the spread of HIV. Williams 2000 in a study in Carltonville in South Africa found that only 5.4% of migrant labourers reported having a regular sexual partner within Carltonville while more than half reported having at least one casual sexual partner in the last year. Nunn et al 1995 in a cohort study in rural Uganda analysed migration and HIV sero-prevalence in rural Uganda. The results showed that HIV prevalence among adults who had not changed their address was 5.5%, HIV prevalence among adults who had moved within the village was 8.2% and the highest HIV prevalence was among the adults who had moved out of the village -12.4% (Nunn et al 1995). Similarly in a cross-sectional study on the impact of migration on HIV-1 transmission in South Africa: A Study of migrant and non-migrant men and their partners study results showed that 25.9% of migrant men are HIV infected in comparison with 12.7% of non- migrant men Lurie et al 2003. Migrant workers are usually separated from their families and their communities; as such there is reduced pressure for them to adhere to prescribed sexual norms and values of communities they come from. In view of these, migrants engage in risky sexual behaviour such as casual sexual encounters, low condom usage and multiple partnering which increases their chances of being infected by HIV.

In addition, concurrent partnerships exponentially increase the spread of HIV especially during the initial phase of HIV infection (Morris & Kretzschmar; 1997). In this study, the authors utilised a stochastic simulation to represent population of sexual partnerships they form and dissolved over time and the spread of disease and compared this with sequential monogamy. Through this, the researchers illustrated that when half the partners are concurrent sexual partners after 5-10 years the size of the epidemic is ten times as large as under sequential monogamy.

Poor Health Seeking Behaviour

HIV prevention programs in most countries are ubiquitous and accessible. Poor health seeking behaviour among migrants remains a major obstacle in implementing prevention programs. In a study in the United States, Leclere, Jensen and Biddlecom; 1994 highlighted that recent immigrants

are less likely to seek health services in comparison to immigrants that have stayed longer than 10 years and native migrants. Similarly Dias et al 2010 in a study in Portugal that sought to describe HIV testing and related factors among migrants highlighted that 90% of the study respondents knew where to obtain HIV prevention and support services and only 9.2% had sought HIV information at the National Health Services (Dias et al ; 2010). Notably the authors suggest innovative approaches to HIV programme implementation in order to improve efficacy (Dias et al; 2010).

Conclusion

Mobility, migration and HIV have been discussed extensively in many studies in sub-Saharan Africa. Inputs from these have been utilised to inform policy and program in HIV prevention care and support. This paper sought to enable insight into the interaction of these factors as such forming basis for discussion, policy review and HIV program innovation. Factors discussed that influence spread of HIV among migrants include risky sexual behaviours like multiple partnering, inadequate condom use and poor health seeking behaviour. Such issues are not unique to migrants, however a combination of these factors including institutional and policy related factors such as inadequate health insurance and undocumented migrants exacerbate vulnerability to HIV of migrants.

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