

GENDER, MIGRATION, AND HEALTH IN SADC:

A FOCUS ON WOMEN AND GIRLS

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVS	Antiretroviral
AU	African Union
CFTA	Continental Free Trade Area
CORMSA	Consortium for Refugees and Migrants South Africa
CSO	Civil Society Organisation
EC	European Commission
EDF	European Development Fund
EU	European Union
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HoA	Horn of Africa
IDP	Internally Displaced Persons
ILO	International Labour Organisation
IOM	International Organisation for Migration
INGO	International Non-Governmental Organisation
IPV	Intimate Partner Violence
LGBTIQ+	Lesbian, Gay, Bisexual, Transgender, Intersex and Queer
MIDSA	Migration Dialogue for Southern Africa
MPFA	Migration Policy Framework for Africa
MS	Member States
NGO	Non-Governmental Organisation
NSP	National Strategic Plan
OAU	Organisation of African Unity
ODI	Overseas Development Institute

PEP	Post-Exposure Prophylaxis
POA	Programme of Action
RAB	Refugee Appeal Board
REC	Regional Economic Community
RISDP	Regional Indicative Strategic Development Plan
RMPF	Regional Migration Policy Framework
RRO	Refugee Reception Office
SADC	Southern African Development Community
SCRA	Standing Committee for Refugee Affairs
SDG	Sustainable Development Goal
SAHRC	South Africa Human Rights Commission
SALRC	South Africa Law Reform Commission
SRHR	Sexual and Reproductive Health and Rights
TB	Tuberculosis
TasP	Treatment as Prevention
TiP	Trafficking in Persons
UHC	Universal Health Coverage
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNODC	United Nations Office on Drugs and Crime
UTT	Universal Test and Treat
VAWC	Violence Against Women and Children
WHA	World Health Assembly
WHO	World Health Organisation

1. EXECUTIVE SUMMARY

'While health has long been considered an essential component of human and economic development, the health of migrants has remained in the shadows of key global health, migration, and development dialogues and processes, and many migrants still lack access to affordable health services.' (IOM, 2017: 4)

This report explores policy responses to migration, health and gender – with a focus on women and girls – in the Southern African Development Community (SADC). As a region associated with high levels of population mobility, a high communicable and non-communicable disease burden, poor maternal and child health outcomes, pervasive gender inequity, and struggling public healthcare systems, SADC poses a number of challenges – and opportunities – to policy makers and those working with policy.

Based on a brief review of the existing literature; the identification and analysis of relevant policy frameworks at the national, regional, continental and global levels; and interviews with key stakeholders and policy-makers, this report explores if, and if so how, responses to migration and health engage with gender, particularly the needs of women and girls in SADC. The regional policy terrain was mapped in light of current global health priorities, including the increasingly recognised need to develop health responses that engage with migration and population mobility. Using South Africa and Zambia as case studies, the report highlights gaps in the development and implementation of responses to migration and health. Where responses do exist, the gendered dimensions of migration and health, including for women and girls, are lacking.

The review shows that the integration of a gender perspective into health and migration policies is, at best, patchy. Where gender is included, it tends to be translated to only mean 'women and girls' and often fails to translate into practice, or gender is addressed in superficial ways that fail to engage with the complexity of the experiences of female migrants. In some cases, policy and practice directly contradict one another. Interviews with policy-makers and key stakeholders involved in the delivery of services confirm the findings from the desk review: whilst gendered vulnerabilities and key gender issues in relation to migration and health may be recognised, guiding policies and frameworks to operationalise a gendered response are limited. Interviews suggest that current knowledge of key actors appears to be informed by the content of existing policies, rather than evidence.

FIVE KEY THEMES WERE IDENTIFIED IN RELATION TO THE RESPONSE TO MIGRATION AND HEALTH FOR WOMEN AND GIRLS IN SADC:

KEY THEMES:

- 1. Insufficient policy engagement with migration and health. Where responses do exist, the gendered dimensions are lacking.** Existing responses are also driven by non-governmental and international organisations.
- 2. Political agendas and popular perceptions are driving policy-making processes,** including the scapegoating of migrants for the poor performance of public healthcare systems. Insufficient use of existing evidence in the development of policy responses to migration and health.
- 3. Poor understanding of gender** which is often equated as referring to 'women and girls' with no consideration of the needs of male and LGBTIQ+ migrants. Engagement with sexuality is notably absent. Heteronormative assumptions about gender, sexuality and family structures persist, including the framing of migrant 'women and girls' as vulnerable, lacking agency and therefore in need of 'protection'.
- 4. Increasingly restrictive and securitised approaches to international migration** may negatively affect the health and wellbeing of people on the move, including women and girls.
- 5. Limited regional coordination, cooperation, and policy coherence** in the development of responses to migration and health, including for women and girls.

Whilst the Sustainable Development Goals (SDGs) and the associated 2030 Agenda call for action to ‘leave no one behind’, it is clear that much needs to be done to address the health needs of women and girls in a context of high mobility and migration. Without doing so, progress towards the SDG of Universal Health Coverage (UHC) will be limited. Where responses do exist, they tend to focus on sexual and reproductive health (SRH) – specifically HIV – and presume that populations are static. Where responses engage with migration, these tend to be through the lens of viewing migrant women and girls as vulnerable to multiple risks, including trafficking for sexual exploitation.

The findings presented in this report highlight the need for improved migration and health governance in order to address the needs of women and girls. This requires effective engagement across different sectors – including state, civil society, academia, international organisations, and the private sector – at multiple levels, from local to global. While SADC struggles to effectively design, coordinate and implement evidence-informed regional-level responses, member states need to drive their own responses, and engage in bilateral arrangements with neighbouring states in order to ensure the mainstreaming of migration into all health responses.

A key concern is how the increasing efforts to restrict international migration and securitise national borders has heightened health risks for women and girls on the move. This not only undermines approaches to address the gendered vulnerabilities that women and girls on the move face, but requires interventions that reflect complex realities and needs of female migrants.

Overall, the report highlights the disconnect between evidence, policy development, and practice. In doing so it outlines the challenges faced in terms of broadening knowledge and the need for a more complex understanding of the gendered dimensions of migration and health. Key recommendations are based on a set of guiding principles that call on the key actors responsible for developing and implementing response to migration, health and gender to:

- Recognise that **migration is a global reality and a key determinant of health**.
- Acknowledge that **migration, health and gender are politically and socially sensitive issues** – they are unpopular, associated with moral panics and negative assumptions.
- Partner with relevant organisations to implement a **targeted awareness campaign** aimed at key decision-makers demonstrating that a migration-aware approach is required to achieve the SDGs, with a focus on UHC.
- Identify a **national focal point** to coordinate **alliance building** in order to support the development of a national migration and health plan that mainstreams gender.
- Implement a ‘**Migration and Health in All Health policies (MHiAP)**¹ **approach** across government departments.
- Identify and use **strategic opportunities** for action, including in the development of National Strategic Plans (NSP) for HIV and a National Strategic Plan on Gender-Based Violence (NSP GBV), gender programmes, immigration management.
- Generate **quality evidence and strengthen evidence-informed policy processes**, including the development of a national migration and health score card that includes a gender component.
- Learn from **good practice examples** on the continent and beyond.
- Support **postgraduate training, continued professional development and capacity-building** amongst key actors: providers, policy-makers, politicians.
- Develop a **community of practice**, leading to the creation of a SADC region migration, health and gender network drawing on the **Migration Health and Development Research Initiative (MHADRI)**.

¹ Vearey (forthcoming)

2. INTRODUCTION

Throughout Southern Africa, women are on the move, engaging in cross-border and internal (within their country of birth) migration. Research shows that while there are still more men moving than women, the proportion of the latter is rising (O'Neil et al., 2016). Findings from the UNDP show that as a percentage of international migrants, female migrants in Southern Africa have increased from 40.9 percent in 2000 to 44.5 percent in 2017.² There are many reasons why women move and many different ways in which they do so. In line with global trends, women are mostly moving for economic reasons including searching for better education and work opportunities. Across the African continent, political instability in countries such as the Democratic Republic of Congo (DRC), Zimbabwe, Rwanda, Somalia, Nigeria and Burundi, combined with high levels of poverty and unemployment, have also led many women to seek safety and protection in other countries, particularly South Africa (Dodson, 1998).

In response to these trends, a growing body of work explores the experiences of women who move, and in particular focuses on the vulnerabilities and risks they face. A recent report by the World Health Organisation (Mbiyozo, 2018) exploring African women's health throughout the migration process, highlighted both the opportunities and benefits migration can bring, as well as the health issues and key challenges encountered. These issues have also been explored within a broader context of gender and migration. For a long time, female migrants have been migration studies' blind spot, where women were considered almost entirely in their relation to migrating men, rather than as migrants in their own right. Today, there is a small but growing body of work that documents the experiences of women who move. However, this remains limited and the majority of the focus is still on the risks and vulnerabilities women may face as the migrate, thus sidelining the positive experiences of migration for women (Mbiyozo, 2018; Hondageneu-Sotelo, 2000: 115).

This shift in research attention to the 'feminisation of migration' has brought to the fore not only the significant number of women migrating but also how migration shapes gender roles as more female migrants participate as wage earners and heads of households rather than simply as 'dependents' (Nolin, 2006: 5). Scholars and, to a limited degree, policy-makers have highlighted how gender intersects with race, class and other identities and pushed to make gender a more central category of analysis. This is reflected for example in the 2030 SDGs, in which gender is a central issue.

With the aspiration to 'leave no one behind', the SDGs recognise gender, migration and health as central to the social, economic and environmental dimensions of sustainable development. Throughout the targets and indicators of the 17 goals aimed to collectively improve national, regional, continental, and global development, the importance of gender, migration and health is implicit. However, the intersectional relationship is not fully explored. For example, gender and migration focuses almost exclusively on women and girls, excluding other genders and lesbian, gay, bisexual, transgender and queer (LGBTIQ+) persons. Furthermore, women and girls are commonly framed as victims of forced migration including trafficking rather than active agents when on the move.

² <https://www.un.org/development/desa/publications/international-migration-report-2017.html>

SDG 5, for example, deals with the promotion of Gender Equality and Empowerment of all Women and Girls and sets nine targets to be met by the global community by 2030. These include ending all forms of discrimination against women and girls; elimination of all forms of violence against women and girls in the public and private spheres, including trafficking and sexual exploitation; elimination of all harmful practices, such as child, early and forced marriage, and female genital mutilation; and ensuring the full and effective participation of women and equal opportunities for leadership at all levels of decision-making in political, economic and public life. Other SDG Goal 5 targets include universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development (ICPD) (1994)³ and the Beijing Platform for Action (1995).⁴ Child marriages are regarded as one of the factors contributing to the slow progress in the reduction of maternal mortality, but the definition of a child by age remains controversial.

SDG 3 aims to 'ensure healthy lives and promote well-being for all at all ages', including that of migrants, while a number of other SDGs incorporate elements relating to health outcomes and migration.

While the implementation of the SDGs presents major and complex challenges in the Southern African region, not least due to the high disease burden and increasing levels of inequality, there are fundamental policy gaps in addressing the health needs of migrants and, where they do exist, gender is inadequately considered. A better understanding of how and where gender, migration, and health intersect and why they should be considered together is therefore vital to develop successful national and regional approaches to these issues.

As such, the objective of this study was to assess the extent of understanding of gender and migration issues and policies in South Africa and across the Southern African Development Community (SADC) and African Union (AU). The report forms part of a broader project to better understand the relationship of migration and health through a gendered lens including, but not limited to, issues of gender-based violence (GBV) and the vulnerabilities that migrant and refugee women and girls face.

Whilst recognising the broader gendered context associated with migration and health, this report focuses specifically on the experiences of women and girls on the move and the ways that key actors understand these experiences. This is done as a first step in exploring if policy approaches to migration and health consider gender. Gender is a fluid, and socially constructed, concept and we recognise that it is more than the binaries of female and male. Currently, however, approaches considering gender fail to engage beyond 'women and girls', with the needs of other groups – particularly transgendered persons – ignored in the development of responses to migration and health.

The report considers the gender dimensions of migration and health across Southern Africa by looking at the ways in which policy and practice has shaped and, in turn been influenced by, migration issues and priorities nationally in South Africa, Zambia, SADC and the AU. The aim of the report is twofold: i) to highlight existing knowledge and identify gaps on gender, migration and health issues through a desktop review of current policy briefs, research reports and literature on gender, migration and health, and ii) to present the findings of primary research on current knowledge of gender, migration and health in SADC through fieldwork in South Africa and Zambia. The findings of the report will lay the groundwork for a regional symposium to be held in July 2019, resulting in a joint plan of action for improving gendered responses to migration and health in SADC.

³ At the ICPD, 117 countries adopted a forward-looking 20 year programme of action (extended in 2010) that continues to provide a comprehensive guide to people-centred development progress: <https://www.unfpa.org/publications/international-conference-population-and-development-programme-action>

⁴ <https://www.un.org/womenwatch/daw/beijing/platform/>

The main focus of the report is South Africa, a country regarded as the 'economic hub' of Southern Africa, to which a significant number of migrants head in search of improved livelihoods and opportunities. Unlike other refugee receiving countries on the continent, South Africa does not house refugees within camps, but rather encourages them to self-settle and integrate into local communities (Gordon, 2016; Rugunanan & Smit, 2011; Landau et al., 2005). As such, refugees and asylum seekers tend to settle mainly in South Africa's urban areas (Landau et al., 2005; Amisi & Ballard, 2005) for a variety of reasons including greater employment opportunities, access to resources, support networks and importantly, the need to access Refugee Reception Offices, which are found in the country's major cities and where refugees and asylum seekers must process their identity documents. Where there has been a lot of scholarly and developmental interest in both the country's engagement with migration, as well as the impact of migration on state resources, a number of key vulnerabilities facing migrants have also been identified. These include xenophobia, abuse and discrimination, and challenges accessing documentation and basic services including healthcare and education.

Zambia, was selected as a second SADC country to focus on due to its diverse and long-standing record of dealing with migration and recent shifts in its policy approach. As a land-locked country with many borders, Zambia has received high numbers of refugees from surrounding countries facing political instability, conflict and poverty including the DRC, Rwanda, Burundi and Angola. As a SADC member state, Zambia is also involved in a number of intra-regional migration and health programmes with South Africa and other countries. As an English-speaking country and within close proximity to South Africa, Zambia was also an accessible country to conduct fieldwork.

In SADC, there are fundamental policy gaps in addressing the needs of migrants in general and the specific needs of migrating women. Drawing from the review of literature, policy frameworks and empirical research with policy-makers and key stakeholders, the central finding of this report is that gendered perspectives on migration and health are rare, with even less consideration of how all three policy fields intersect. There are a number of critical gaps in policy, in practice, and in the nexus of policy and practice. Where policy does consider gender in relation to migration and health, this often fails to translate into practice, or is done in superficial ways that on the one hand fail to engage with the complexity of female migrants' experiences and, on the other completely exclude an understanding of gender beyond women and girls. In some cases, policy and practice directly contradict one another.

In terms of health, despite the fact that migration functions as a key social determinant of health (Castaneda et al., 2015), the bidirectional relationship between migration and health remains poorly understood in Southern Africa. There is a widespread assumption that migrants pose a threat both to the delivery of health services and to public health itself. This largely overshadows recognition of the positive effects of migration on development, including in the health sector. It also disregards empirical research documenting that migrants who have settled long-term tend to have similar health needs to the wider host population or that more recent arrivals tend to be in better health than their hosts because only the healthiest individuals tend to migrate (Thomas & Thomas, 2004).

Instead, the focus is more towards restriction the movement of people, rather than protecting people on the move. The developmental potential of migration is undermined by the continued failure of legal frameworks and public health systems to engage adequately with mobility in a region that has both high levels of migration and a high burden of communicable disease (Vearey, 2018: 93). This exacerbates the distinctive vulnerabilities to poor health that migrants face while simultaneously failing to harness the socioeconomic development opportunities inherent to healthy migration (Vearey, 2018: 95).

As we can observe in other areas of policy, a proactive approach to mobility is strongest at the continental level, reduces at regional level and finally resonates the least at the national level. This means that however progressive

and comprehensive policies developed at Regional Economic Communities (REC) or AU level may be, they typically result in little implementation on the ground. For example, there are existing and draft frameworks and guidelines which indicate efforts to negotiate regional coordination and the harmonisation of migration governance including the Revised SADC Protocol on Gender and Development (2015) adopted in June 2016, the SADC Labour Migration Policy Framework (2015); the African Union's "African Common Position on Migration and Development (African Common Position)" (2006), the "Migration Policy Framework for Africa" adopted by the Executive Council of the AU in 2006 and the "SADC Draft Policy Framework on Population Mobility and Communicable Diseases" (2009). Although these guidelines and frameworks show how policy can address the intersections of migration, health and gender, many remain as rhetoric rather than finalised and implemented policies. Thus there are two key challenges. Firstly, responses to migration and health are lacking. Secondly, where responses do exist, there is a failure to mainstream gender into everyday practice around migration and health.

Following global trends, the governance of migration in Africa is increasingly geared towards preventing mobility rather than enabling migration and protecting those who move. Despite efforts by the AU and SADC to promote free movement across the continent, perceptions of migration as a threat continue to dominate in rhetoric, legislation and policies on immigration across SADC member states. This is especially prominent in countries such as South Africa, which receive significant numbers of migrants due to the relative strength of their economies (Whitaker, 2017: 2; Lefko-Everett, 2007). While SADC, tasked with harmonising policies to achieve economic development, peace and security, has committed to harmonising migration policy and facilitating intra-regional migration, it can be argued that, 'state and public attitudes towards migration are at best ambivalent and at worst strongly hostile, including serious violations of migrants' rights' (Dodson & Crush, 2015).

These violations include denying migrants the right to access documentation and forcing them into a position of irregularity, which in turn renders them more vulnerable to abuse, discrimination and the threat of arrest and deportation (Polzer, 2007; Landau et al., 2005). The South African Government has been accused of actively putting in place measures that make the refugee and asylum process as difficult as possible to deter new applicants and force applicants to return to their country, in contravention of the UN Convention on Refugees (Heinrich Boll Stiftung, 2018). This includes the closure of a number of Refugee Reception Offices (RROs), where asylum seekers must report directly on arrival in the country and thereafter every 3 to 6 months to renew their temporary asylum seeker permits (Landau, 2006). The Department of Home Affairs (DHA) reported that, in 2015, of the 62,000 applications for refugee status received that year, only 2,499 were approved. The rest (59,501) were rejected, 14,093 of which were appealed, and a further 12,361 remained open (presumably on review at the Standing Committee for Refugee Affairs (SCRA)).⁵

While the gendered impact of the closure of RROs in South Africa is discussed further in section 5.2, it is important to recognise how, due to state-implemented immigration restrictions, migrants can be forced into an irregular status. Simultaneously, States argue that the links between migrants and criminality (including being undocumented) poses a security threat (Goodey, 2009) and this justifies further restrictions on entry. Meanwhile, migrants who are unable to access documentation are unable to access their rights – thus making an already vulnerable group even more vulnerable. It is therefore evident that increasing efforts to restrict migration and securitise borders has heightened risks for women and girls as well as other gender groups on the move and therefore targeted interventions are required in tune with the complex realities and needs.

⁵ Department of Home Affairs, "2015 Asylum Statistics: Analysis and Trends for the Period January to December": <http://pmg-assets.s3-website-eu-west-1.amazonaws.com/160308Asylum.pdf>.

2.1 THE IMPACT OF MORAL PANICS AND THE SECURITISATION OF IMMIGRATION ON HEALTH

'.....we find ourselves in a world increasingly concerned with securitising national borders and restricting the movement of people between nation states. Much of this focus on security is driven by moral panics - public anxiety about issues thought to threaten the moral standards of society - associated with migration, including human trafficking and the independent movement of women (Women in Migration Network, 2017), and the so-called 'Migration Crisis' in Europe (Castelli Gattinara, 2017; Crawley and Skleparis, 2018; Heaven and Franck, 2017).

Internationally, discussions on migration tend to ignore long-established population movements within Global South contexts where forced migration and movement in search of improved livelihood opportunities are commonplace and outnumber similar movements in the Global North; the Southern African region is no exception (United Nations, n.d.). The current global discourses surrounding population mobility - that are fuelling morally-panicked policy discussions - have negative impacts both for those who move, and for the development of improved responses to migration and health. Centrally, this includes the implementation of increasingly restrictive immigration policies, including further securitisation of the borders of nation states.

In relation to health and wellbeing, historical perceptions of the migrant as the 'diseased body'; as a carrier and transmitter of infectious diseases, particularly HIV; and, consequently, as a burden on the welfare state of receiving countries, are re-emerging (Farmer, 2004; for example, see Grove and Zwi, 2006; Quesada, 2012; Sargent, 2012). We need to remain vigilant and ensure that the re-emergence of this discourse is not used to support securitisation agendas as health status may (once again) be used to mediate the ability to legally cross national borders. Particularly worrying is that this may include an unwelcome return to a focus on the HIV status of people crossing borders.'

(Vearey, 2018)

2.2 OUTLINE OF THE REPORT

To assess how well gender is integrated into migration and health policies, the report is structured in two principal parts.

The first part documents existing knowledge and identifies gaps regarding the intersection of gender, migration and health in policy and practice. This assessment is based on a review of policy briefs, research reports and grey literature on gender, migration and health internationally, continentally across the AU, regionally across the SADC and nationally in South Africa and Zambia.

At each level, policies, protocols, guidelines and frameworks dealing with gender, migration and health are reviewed. Rather than providing an in-depth analysis of each singular policy reviewed here, this section aims to give overviews and identify broader, discernable trends in the policy landscapes at continental, regional and national levels. It is important here to note that this review is not exhaustive but based on a selection of those policies most relevant to the objectives of this report.

The second part of the report presents the findings of primary research on current knowledge of gender, migration and health in SADC informed by fieldwork in South Africa and Zambia. This primary research consists of semi-structured interviews with key stakeholders such as policy-makers; UN organisations, international non-governmental organisations (INGOs) and NGOs in South Africa and Zambia and working at the SADC level. There are five key themes that emerged in the data:

THERE ARE FIVE KEY THEMES THAT EMERGED IN THE DATA:

1. **Insufficient policy engagement with migration and health. Where responses do exist, the gendered dimensions are lacking.** Existing responses are also driven by non-governmental and international organisations.
2. **Political agendas and popular perceptions are driving policy making processes**, including the scapegoating of migrants for the poor performance of public healthcare systems. Insufficient use of existing evidence in the development of policy responses to migration and health.
3. **Poor understanding of gender** which is often equated as referring to 'women and girls' with no consideration of the needs of male and LGBTIQ+ migrants. Engagement with sexuality is notably absent. Heteronormative assumptions about gender, sexuality and family structures persist, including the framing of migrant 'women and girls' as vulnerable, lacking agency and therefore in need of 'protection'.
4. **Increasingly restrictive and securitised approaches to international migration** may negatively affect the health and wellbeing of people on the move, including women and girls.
5. **Limited regional coordination, cooperation, and policy coherence** in the development of responses to migration and health, including for women and girls.

These five themes frame the discussion and analysis and lead into a conclusion followed by recommendations.

3.METHODOLOGY

THE PROJECT INVOLVED:

- A desktop review of existing literature and grey literature on migration, health and gender in SADC,
- The identification and analysis of key policy documents,
- A policy review, which involved a systematic search for policies, protocols, frameworks and guidelines pertaining to migration, health and gender at a national, regional, continental and international level. From a list, key policies were selected and reviewed using search terms such as 'migration'; 'migrant'; 'mobility'; 'gender'; 'women'; 'female'; 'health'; 'health systems'; 'wellbeing'; 'healthcare'. In this way it was possible to assess the extent to which the selected policies were mobility/migration, gender/women and health aware.

3.1 INTERVIEWS WITH POLICY-MAKERS

- Three groups of participants were initially targeted: 1) key informants in South Africa including policy-makers and individuals working with policy; 2) key informants in Zambia including policy-makers and individuals working with policy; and 3) key informants working for SADC.
- Access to potential participants was done through using a snowballing method, as well as drawing on contacts established through ACMS's long history of work in the migration and health sector. Therefore, once ethical clearance had been obtained from the University of the Witwatersrand (protocol number: H18/10/32), the researcher contacted a wide range of possible respondents via an initial introductory email and phone calls. For South Africa the researcher also applied for permission to conduct interviews with The Department of Health

as well as the Department of Home Affairs via their official channels.

- Limitations included challenges faced in accessing policy-makers due to a low-response rate⁶, permission not being received and respondents not committing to interviews. The majority of respondents accessed were from organisations working with and responding to policy, rather than policy-makers.
- Interviews were carried out in-person in Cape Town, Johannesburg and Pretoria, as well as on a three day field trip to Lusaka, Zambia. In total 20 interviews were carried out: 10 in South Africa, 6 in Zambia and 3 with SADC representatives in Botswana. Please see Appendix A for a list of key informants.
- All interviews were recorded and transcribed and findings and subsequent themes were identified through thematic analysis.
- Respondents were offered the opportunity to remain anonymous. Based on responses, all respondents have been anonymised in order to protect the identities of those who chose not to be identified.

3.2 ANALYSIS

- A rigorous and systematic reading and coding of the transcripts allowed major themes to emerge.
- Once the key themes were identified segments of text from the interview transcripts were then coded on each particular theme allowing the identification of relationships or disconnects between themes and participant responses. Similarities and difference across sub-groups (e.g. respondents working in South Africa vs respondents in Zambia, and respondents working to develop policy vs respondents working with policy) were also explored.
- The presentation of the key themes in the findings section is supported by quotes from the respondents.



4. MIGRATION AND HEALTH IN SOUTHERN AFRICA

'Being a migrant is not in itself a risk to health: it is the conditions associated with migration that may increase vulnerability to poor health.'

Owing to the ways in which people move and the spaces they traverse or at which they arrive, migrants may reside in - or pass through - 'spaces of vulnerability' - key spaces associated with potentially negative health outcomes- including along transport corridors, urban slums, construction sites, commercial farms, fishing communities, mines, and detention centres.

Such spaces may contain a combination of social, economic and physical conditions that may increase the likelihood of exposure to violence and abuse and/or acquisition of communicable or non-communicable disease. The daily stressors that may be experienced in these spaces are increasingly acknowledged to affect emotional wellbeing and mental health.'

(Wickramage et al., 2018: 5)

⁶ As noted there were considerable challenges faced in accessing policy-makers. In South Africa requests for research permission were submitted to the Department of Health, Home Affairs and various ministers. However, no response was received from either. Personal contacts were also used, but this also proved to be largely fruitless. Where respondents were accessed, this was at a lower level but still with those who inform policy and work closely with ministers. In Zambia a similar situation was faced and despite many emails and calls to ministers and policy-makers no response or permission to interview was received. A number of respondents also cancelled interviews at the last minute once the researcher was in Lusaka. This is not unusual in South Africa as the red tape surrounding high-level officials and ministers is well known. The time of year that the research was conducted, was also an influential factor. November and December are well-known busy times in Southern Africa as organisations rush to complete work before the long summer/Christmas break. Given that many individuals only responded to emails towards the end of November it was then difficult to find a time when they were free to be interviewed and many also failed to confirm interviews or be available on the agreed time despite prior arrangements.

The health of migrant populations, and the ways in which the process of migration mediates health, are receiving increasing attention at the global level. One reason for this is acknowledging the right to health for all and the need to engage with migration in order to achieve international health targets. Secondly, there is increasing recognition that migration, health, and development are interlinked factors that can, if managed appropriately, positively reinforce each other and ensure that the developmental benefits of migration are realised. A third reason, however, is more sinister: an increasingly xenophobic and racist world has led to further stigmatisation of those who cross international borders and the generation of ‘moral panics’, with non-nationals often positioned by political leaders and the public as ‘disease carriers’ and as a burden on public healthcare systems in the destination country. This rhetoric is used to support efforts by (many) nation states to reduce international migration, with the health and migration agenda being increasingly – and incorrectly – co-opted to support arguments for further restricting movement across international borders. In spite of a lack of evidence to support these assumptions, it is this public and political rhetoric – rather than quality data – that are being used to drive policy-making processes in the realm of international migration management.

Whilst the right to health is recognised globally, those who migrate across national borders often struggle to access positive determinants of health, including the documentation required to be in a country legally, employment, housing, and education. This has negative implications not only for migrant populations but also for the wider public: an effective public health response is dependent on all members of a population being afforded the same opportunities to attain and maintain good health. Should some people struggle to access preventative or curative care, there will not only be financial costs to public healthcare systems (for example, it is more expensive to treat people who access healthcare when they are already very sick), but also health costs to the public, as a result of reduced vaccination coverage or communicable disease control, for example. To this end, developing appropriate public health responses that engage with the movement of people is an urgent global priority.

4.1 MIGRATION, HEALTH AND THE SDGs

KEY POINTS

- Migration is both a driver of development and a determinant of health at micro and macro levels.
- The Universal Healthcare Coverage (UHC) agenda is of critical importance as migrant groups often struggle to access good health as a result of multiple, intersecting challenges.
- Effective and evidence-informed governance responses will support efforts towards ensuring ‘healthy migration’ for all.

‘Migration is a social determinant of health that can impact the health and wellbeing of individuals and communities. Migration can improve the health status of migrants and their families by escaping from persecution and violence, by improving socioeconomic status, by offering better education opportunities, and by increasing purchasing power for ‘left behind’ family members thanks to remittances.’

(IOM, 2017a: 1)

(1) Good health is a critical concern – and opportunity – for supporting and strengthening the social and economic development opportunities associated with migration; (2) economic and social development can, in turn, lead to improved health outcomes, including of those who move; and (3) improved health outcomes can further drive development including through the positive selection of healthy migrants who can then access and contribute

to activities that support development at micro and macro levels. Social and economic development can provide opportunities to strengthen social wellbeing which will, ultimately, support good health. Consequently, social and economic security can have positive impacts on both mental and physical health, ultimately resulting in further socioeconomic gains at both the micro and macro levels.

In recognition of this important relationship between health and development, health is firmly embedded within the SDGs – including through the goal of achieving UHC that aims to ‘leave no one behind’ in ensuring access to quality healthcare for all. Ultimately, if governed effectively, healthy migration can support social and economic development, which will, in turn lead to improvements in health and wellbeing that can then further drive development. Health can – and should – be integrated into responses to govern migration and development in order to improve health for all and maximise the developmental benefits associated with all forms of migration. Any response to migration and health must engage with the needs of all migrant groups and be informed by a rights-based, ethical response. There is a need for quality, evidence-informed interventions that can positively reinforce the relationship between migration and health. Importantly, for the developmental benefits of migration to be realised, ‘healthy migration’ must be prioritised at global, regional, national, and local levels.

Migration is both a driver of development and a determinant of health at micro and macro levels. Critically, migration is now recognised as a global public health priority and should, therefore, be mainstreamed within all approaches aimed at improving health for all that are, intrinsically, tied to social and economic development. ‘Healthy migration’ governance approaches are required at global, regional, national, and local levels to harness the developmental benefits of migration. This requires working to ensure that the good health and wellbeing of migrants – both domestic and international, including asylum seekers and refugees – is embedded as a critical component of any response or governance approach to migration and development. It is essential, however, to recognise that good health is more than a driver of development: good health is a key human right for all and a global imperative. The 2030 Sustainable Development Agenda recognises the importance of the relationship between migration and health for economic and social development.

The Universal Healthcare Coverage (UHC) agenda is of critical importance as migrant groups often struggle to access good health as a result of multiple, intersecting challenges. For example, a lack of valid documentation can present challenges in accessing positive determinants of health, including housing, a secure livelihood, and healthcare. Non-nationals are more prone to abuse by employers, and more likely to be involved in dangerous and sometimes criminalised livelihood strategies, including working on construction sites, in the agriculture or domestic work sectors, or in sex work (Kihato, 2013). Anti-foreigner and xenophobic sentiments present additional barriers, as do fear of arrest, detention and deportation. These barriers to good health must be addressed as a key priority for realising the developmental benefits of migration.

The increasing recognition of the multiple associations between health and wellbeing, social and economic development, and diverse population movements, highlights the urgency of developing improved governance and programmatic responses to migration, development and health. Effective and evidence-informed governance responses will support efforts towards ensuring ‘healthy migration’ for all which will, in turn, have positive impacts for the multiple sectors reliant on migration for development. In particular, key opportunities exist for improving the health and wellbeing of individuals who participate in organised labour migration systems, and in the more informal movements associated with the search for improved livelihood opportunities.



5. WOMEN, GIRLS, HEALTH AND MIGRATION IN SOUTHERN AFRICA

KEY POINTS

- Women and girls are increasingly engaged in cross-border and internal migration across Southern Africa.
- Women's migration pathways and experiences are diverse and can involve exposure to greater vulnerabilities and risks.
- Certain categories of women and girls are more visible than others.
- Complex realities are often simplified into women as victims.
- Key vulnerabilities, including GBV and access to healthcare, are heightened by a lack of documentation and discrimination against non-nationals.
- LGBTIQ+ persons face increased vulnerabilities through their visibility.

Policies are not created in a vacuum: they reflect and are shaped by pressing political agendas and priorities. It is important therefore, to situate how and why gender matters (or not) in relation to migration and health. This includes exploring if migration results in adverse health outcomes for female migrants at national, regional and continental levels. The following review briefly explores what is known about women on the move and gendered migration patterns in southern Africa. It highlights the key issues arising in relation to the migration experience of women and girls in Southern Africa.

5.1 WOMEN AND GIRLS ON THE MOVE IN SADC

Throughout Southern Africa, women are on the move, engaged in cross-border and internal migration. Research shows that while there are still more men moving than women, the proportion of the latter is rising as across Africa women are engaged in both cross-border and internal (mostly urban-rural circular migration) (Hiralal, 2018: 3). Findings from the UNDP (2017) show that as a percentage of international migrants, female migrants in Southern Africa have increased from 40.9 percent in 2000 to 44.5 percent in 2017. Meanwhile in South Africa in 2010, female migrants constituted 42.7 percent of the total migration stock compared to 37.3 percent in 1990 (United Nations, 2015a).

Where migration is increasingly acknowledged as 'profoundly gendered' (Kanaiaupuni, 2000) it is also recognised as heterogeneous and complex. While the characteristics of women on the move have changed – so have the frames through which they have been viewed. Historically migrating women have been seen in relation to marriage, the family and households, and as burdened by 'normative gender expectations' (Nawyn, 2010: 755; O'Neil et al., 2016: 5). Therefore, while women have featured as migrant mothers leaving children behind and as wives joining their husbands, far less has been said about young women who travel independently for educational and work opportunities (Isike & Isike, 2012).

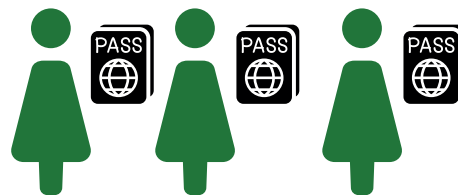
Women and men migrate for many of the same reasons – to get an education, to find work, to get married, or to flee war and violence (Stapleton et al., 2017). Yet women's migration pathways and experiences are also distinctive from those of men. Gender norms and expectations, power relations and unequal rights shape the migration of women and girls and also involve greater exposure to vulnerabilities and risks (Mbiyozo, 2018: 3). That said, not all women face the same experiences and thus diverse geographical and regional migration shaped by different motivations and needs provide differentiated and nuanced migration experiences.

Some of these experiences have been better documented than others. There are also particular ‘key frames’ for example, which appear in literature and policy. These include women as victims of forced migration and human trafficking, exploitation and women who face key reproductive and sexual health issues. Women as trafficking victims and of sexual exploitation in particular dominates much of the literature on women crossing borders despite their experiences often being far more complex (Walker & Galvin 2018; Palmary, 2010; Agustin, 2007).

Other experiences – especially those that do not easily fit into categories or frames – remain less visible and often hidden. This can be seen for example in the experiences of women who migrate and enter the sex work industry. While they may face multiple vulnerabilities on their journeys and once in their destination countries they are not necessarily victims of trafficking or of sexual exploitation.⁷ Therefore a focus only on women as victims of trafficking and forced migration can sometimes obscure an understanding of the full complexity and nuance of migration experiences for women, which remain less visible both in research, policy and practice.

Women who migrate and live independently to their husbands and male relatives are often cast as either vulnerable or as morally corrupted (Hertrich et al., 2012: 72; Palmary et al., 2018: 15). To restore order assumed to be disrupted by the migration of women, patriarchal discourses thus police and discipline women’s behaviour and sexuality. One way of doing this is by recoding activities that women themselves perceive largely as expressions of their agency as ‘exploitation’. A clear example here is sex work. Although sex work is a risky business given that it is criminalised across all of Southern Africa, it is also recognised as a viable form of income-generation and offers many migrant women the opportunity to earn money and support dependants without needing documentation, qualifications and with flexible hours (Richter et al., 2014). Yet despite many sex workers (as distinct from women forced into sexual exploitation) being clear that sex work is a choice, it is largely regarded as a form of violence against women. Migrant women who sell sex subsequently face a ‘double vulnerability’ through participating in a criminalised industry and through being non-nationals (often undocumented) (Walker et al., 2016).

5.2 IRREGULAR MIGRATION, ACCESS TO DOCUMENTATION AND INFORMAL LIVELIHOOD ACTIVITIES



While there are diverse patterns to women and girls’ migration across Southern Africa, there are also key vulnerabilities that they can face. Many women travel without documentation or face challenges accessing the documentation needed to legally enter another country, which then renders them “irregular migrants”. As noted in the introduction, this is often due to highly restrictive border control measures as well as corruption and poor service at Home Affairs, meaning that documentation cannot be accessed or finalised. Women are often forced to enter “illegally”, travelling along more hidden and dangerous routes increasing the risks of exploitation and violence on the journey. Reliance on “third parties” to assist with migration such as smugglers and traffickers is also increasingly common.

Women and girls also face increased risks once they reach their host country as a lack of documentation creates challenges accessing healthcare, schooling for children, securing employment, and renders women more vulnerable to harassment and exploitation (Mbiyozo, 2018). A lack of documentation means that women tend to engage in mostly unskilled and informal occupations which include domestic work and also informal trading and sex work (Kihato, 2013; Walker & Oliveira, 2015). While this can become an important means of livelihood for many migrants it can also lead to specific vulnerabilities and, through its hidden nature (Vearey, 2010), make them less visible – to researchers, to

⁷ A body of work in Southern Africa and globally explores the trafficking discourse – as a discourse that does not always reflect the realities of women on the move – and which is a part of a broader migration and securitisation agenda. Where there is a need for more understanding about the nature and scope of trafficked women there is also a need to ensure that trafficking is not conflated with other forms of irregular movement or with sex work (Walker & Galvin, 2018; Walker & Oliveira, 2015; Palmary et al., 2010; Richter & Vearey, 2016; Gould, 2011)

support services and, to the state (Palmary, 2009: 21; Dodson, 1998: 3; Camlin et al., 2014;). For example, research from South Africa shows that women face greater challenges entering the country – including the threat of and experiences of abuse, exploitation and violence on route, when crossing borders and on arrival (Mbiyozo, 2018).

A recent Institute for Security Studies (ISS) Report indicates that the majority of women enter South Africa without using the asylum system, resulting in a high number of women staying in the country without documentation (Mbiyozo, 2018: 28). The report shows, for example that in 2017 44.4% of total migrants in South Africa were women, but that in 2015 67% of asylum claims were men and 33% women (ibid: 8). While this point challenges claims by South Africa's Home Affairs, that migrants are increasingly abusing the asylum system (thus arguing that the system should be further restricted), it also underlines the fact that women face greater risks, because to be undocumented in South Africa is to face risk and discrimination on many levels and within many systems such as healthcare and education (Walker et al., 2016; Kihato, 2013; Mbiyozo, 2018). Thus 'efforts to restrict access to potential abusers are blocking vulnerable people with genuine needs' (Mbiyozo, 2018: 28).

Many migrants, including women and children, are also rendered "irregular" or "undocumented" by the very fact that they cannot access the legal processes through which they can process or renew their identity documents and become regularised. In South Africa, a clear example of this is found in the closure of a number of Refugee Reception Offices (RROs) which has led to an increased number of migrants being forced into illegality as they cannot, through no fault of their own, access documentation.⁸ A recent research report commissioned by Sonke Gender Justice shows how the decisions made by the DHA as well as the refusal to comply with various court orders to reopen RROs have had a disproportionate impact on women, children and sexual and gender minorities within the asylum seekers population in South Africa (Gandar, forthcoming).

The RROs themselves are notoriously under-served, cannot accommodate the numbers attending, and are plagued by corruption from those working there including clerks, interpreters and security guards (Landau et al., 2005). Asylum seekers can stand in queues for long hours, sometimes having to pay a bribe just to be let inside the gate, only to be told that they have missed their chance or to come back another day (Segale, 2004). Their gendered vulnerabilities here are clear. For women supporting families and who have dependents, this can mean that they lose their employment if they have to keep taking time off, they may have to take children out of school and travel with them, and sleep and wait in unsafe spaces outside RROs as they wait for the offices to open – leading to a number of risks. Pregnant women and women with children face many challenges both travelling and waiting in long queues outside the RROs, often spending a whole day in line only to be told that they have missed their chance and must return the next day. Women and LGBTIQ+ persons reported safety concerns outside and within the RROs with officers and staff accused of being xenophobic and discriminatory. Therefore, as Gandar argues in the Sonke report,

⁸ In South Africa when applying for refugee status, asylum seeker temporary permits and renewing of permits, asylum seekers must report directly to the Department of Home Affairs, through one of the Refugee Reception Offices (RROs) located in the five major cities namely Johannesburg, Pretoria, Durban, Port Elizabeth and Cape Town (Landau, 2006). These Refugee Reception Offices offer various administrative functions and serve as the main contact point between asylum seekers and the state (Carciotto et al., 2018). In 2011 the RROs in Johannesburg and Port Elizabeth closed down, and in 2012 the Cape Town office stopped accepting any new applications for asylum.



"Decisions made by the Department of Home Affairs to close urban RROs, such as the CTRRO, has rendered an already vulnerable portion of the population even more vulnerable. Women, children, and sexual or gender minorities, are in an exponentially more vulnerable place, as not only are they part of a vulnerable group of asylum seekers, but they are subjected to further oppression and vulnerability as a result of the intersection between class, race, gender, and identity – they thus face triple (or quadruple) discrimination" (Gandar, forthcoming).

The consequences of not having documentation and being rendered "illegal" are also ongoing for migrants. Without documents many have to work in the informal sector and in jobs that they are often over-qualified for or which are precarious and sometimes dangerous (Kihato, 2011). While working, even in the informal economy can of course create opportunities and increased forms of independence for migrant women, this rarely occurs in isolation from the broader structural conditions of patriarchy and gender norms which continue to reinforce women's oppression and lead to heightened risks (Kihato & Bule, 2017). Therefore, although the feminisation of migration can in many ways challenge and disrupt widespread gender and patriarchal norms (see for example, Palmay et al., 2010; Piper 2008; O'Neil et al., 2016: 5), at the same time they continue to be restrained by them, particularly in terms of limited options and a precarious financial position. Thus 'the power imbalances inherent in any male and female relationships are exaggerated in situations where women are more vulnerable' (Sigsworth et al., 2008: 19).

5.3 WOMEN AND GIRLS ON THE MOVE: A VULNERABLE GROUP?

'The feminisation of cross-border movement, with women and girls now crossing borders on par with men. This has grave implications for the health of migrants, as mobility process makes women more vulnerable to communicable diseases. They are more likely to suffer gender-based harassment and violence (including sexual). Also women are also more likely to move with their young children who will also be susceptible to communicable diseases.'

(SADC, 2009: 6).

While mobility may increase opportunities in finding work and other means of income-generation, it also puts significant limitations on ensuring continuity of care and access to health services. In addition, moving undocumented – as many women do – not only exposes them to heightened risk of gender-based violence (GBV) including sexual violence during risky migration journeys and while engaged in informal work, but also limits their access to healthcare at their destinations. These vulnerabilities often compound one another meaning that an understanding of the lives of migrant women must be intersectional and complex (Kihato & Bule, 2017).

GBV cuts across social, cultural and religious groups and can include sexual violence and exposure to HIV/AIDS; a lack of documentation and resources for example can lead to disempowerment in relationships thus diminishing women's capacity to negotiate condom use, and engagement in transactional sex and informal work (IOM, 2010: 8). Where the region of Southern Africa has a high communicable disease burden (Vearey, 2018: 93), migrant women also face risks in terms of access to healthcare services and treatment. There is 'substantial evidence indicating that younger HIV-positive women are often at increased risk for poor treatment outcomes' (Phillips et al., 2018: 89). In addition, women often carry the extra burden of supporting and providing for children and other dependents. Where civil society organisations have recorded high levels of GBV among refugee and asylum seeker communities they also show that the majority of these cases go unreported (Kihato, 2011; Lefko-Everett, 2007). A lack of reporting can be due to fear of being deported (especially if undocumented), a lack of trust in the policing system, abuse from the police as well as not knowing whom to turn to (Sigsworth et al., 2008). Further, in South

Africa some of the GBV services available do not provide services to refugee and asylum seeking individuals (ibid; Consortium for Refugees and Migrants in South Africa (CoRMSA), 2009).

The World Health Organisation (WHO) states,

(T)here is a gap in the literature on patterns of access to health care for the various categories of African female migrants – whether during transit or at their final destination- and how the governments of origin and host countries cater to the health needs of this highly heterogeneous group. The available data especially from Southern Africa on African migrants who have moved to other continents such as Australia, Europe and the Americas, point to underutilisation of health services by African female migrants in general, due to individual or systematic barriers

(Mbiyozo, 2018: 13–14)

While there is some data on the health vulnerabilities and the health needs of migrant women in Southern Africa this is an area that as the WHO (Mbiyozo, 2018) state, needs to be better understood and explored. In particular, as the above shows – the connection between GBV and health and wellbeing experiences and the continuum on which violence for women on the move is experienced – necessitates an exploration of gender within the intersection of migration and health. This also then allows for a better understanding of how the intersection of these three key issues has or has not been incorporated into policy responses across South Africa, Zambia and at a regional and continental level.

5.4 LGBTIQ+ MIGRANTS, VISIBILITY AND VULNERABILITY

Largely missing from much of the literature on gender, migration and health are the experiences of LGBTIQ+ persons. As a highly mobile population, LGBTIQ+ persons are often invisible in terms of scholarly attention and at a policy level. At the same time, their presence and position as they cross boundaries and move across and within spaces renders them highly visible – unable to hide from those who view them as violating gender norms – and as a result facing heightened vulnerabilities and risks. These are vulnerabilities when on the move and also vulnerabilities once they have reached their destination including abuse, discrimination, violence, marginalisation and threats to their lives (South African Human Rights Commission (SAHRC), 2017: 6). While these are also vulnerabilities faced by other migrants including women and girls, being visibly read as transgender or gay compounds these vulnerabilities and adds extra layers of risk (PASSOP, 2019)

For “gender refugees”⁹ (Camminga, 2018: 89) forced to flee their homes and countries due to persecution and discrimination based on their sexual orientation and gender identity, South Africa is often seen as a “safe haven” due to being the only country on the continent that has outlawed discrimination based on sexual orientation and gender identity and constitutionally protects transgender individuals. Across Southern Africa, same sex relationships are criminalised with the exceptions only of South Africa and Mozambique and life for sexual minority groups remain legally and socially difficult, if not extremely dangerous.¹⁰ However, even in South Africa, the experiences of LGBTIQ+ groups on the ground is very different to what the law proscribes and what those, fleeing persecution in their own countries hope for. As Camminga argues, rather than being able to access their rights, gender refugees from Africa and living in South Africa continue to experience significant hindrances to their survival “comparable with the persecution experienced in countries of origin” (2018: 89). Camminga continues,

⁹ Camminga (2018), adopts the term “gender refugees” to refer to individuals whose gender identity and birth assigned sex are experienced and perceived as incongruent. It is this incongruence, that often poses a threat to their lives and forces them to flee and seek refuge elsewhere. Although Mozambique recently removed the colonial-era laws that criminalise homosexuality, the country is still far from accepting same-sex relationships and LGBTIQ rights.

¹⁰ Although Mozambique recently removed the colonial-era laws that criminalise homosexuality, the country is still far from accepting same-sex relationships and LGBTIQ rights.

"Rather than being protected gender refugee, because they are read as violating the rules of normative gender, they find themselves paradoxically with rights, but unable to access them."

(Cammaing, 2018: 89)

A report by PASSOP states that only about 4% of LGBTIQ+ asylum-seeking persons in South Africa have been recognised as refugees, while the remaining number are either on temporary asylum permits, are undocumented or have received final rejections (2019: 2).¹¹ Being undocumented means there are immediate obstacles to accessing basic services such as healthcare and other means of support. Alongside women and children, LGBTIQ+ persons thus compose a vulnerable group in terms of migrants – and the latter face additional challenges due to the stigma, discrimination and violence directed at those seen to violate gender norms.

Women, girls and LGBTIQ+ migrants can be seen through the lens of “hidden” migrant populations (Vearey, 2010). “Hidden” here refers both to the invisibility rendered by being a non-national, often lacking documentation and living and working in less recognised space, as well as the tactics employed to survive and navigate spaces of risk. While literature highlights some of the experiences of vulnerability and draws attention to particular frames and narratives, such groups remain largely invisible – especially in policy – in terms of their complex, experiences and subsequent needs. This is illustrated in the policy review below.



6. WOMEN, GIRLS, MIGRATION AND HEALTH IN SOUTHERN AFRICA: A POLICY REVIEW

The previous section identified some of the key themes arising from the literature on women on the move and gendered vulnerabilities. In particular, it showed that where more women are migrating and in ways that are distinct from men, they are also facing increased vulnerabilities such as GBV, specific health risks and challenges in accessing services and support.

This section now reviews key policies relating to migration, health and gender in order to assess to which extent these three issues are considered as intersectional and taken account of in policies at the national level in two SADC countries (Zambia and South Africa), at the regional level of SADC and at the continental level of the African Union.

At each level, policies, protocols, guidelines and frameworks dealing with gender, migration and health are reviewed. Rather than providing an in-depth analysis of each singular policy reviewed here, this section aims to identify broader, discernable trends in the policy landscapes at national, regional and continental levels. It is important here to note that this review is not exhaustive but based on a selection of those policies most relevant to the objectives of this report.

¹¹ www.passop.co.za/wp-content/uploads/2019/05/My-Home-My-Body-and-My-Dreams-Reflections-by-African-LGBTQI-Refugees-in-South-Africa.pdf



Above each policy is a review box which indicates whether the policy is **1) mobility aware, 2) gender aware, and 3) mobility and gender aware**. For each of these three categories:

- 1) Mobility aware** refers to engaging with and addressing the impact of mobility, and challenges for mobile populations. Here we have looked for ‘mobility’ aware rather than ‘migration’ aware on the basis that mobility refers to a more complex understanding of movement and mitigates some of the negative connotations associated with the term migration, including the links made with criminal activity and the assumption that those on the move are in some way a risk/threat to local contexts. Although ‘migration’ itself has increasingly been recognised as a process – often continuous, with short movement (not always across a border) and often, no clear end – it still does not seem to capture the dynamic nature of human mobility.
- 2) Gender aware** refers to the extent to which the policy addresses gender as a specific issues that shapes migration experiences and where specific vulnerabilities are faced. This includes recognising that gender does not only mean female migrants and should include other genders and LGBTIQ+ populations.
- 3) Mobility and gender aware** refers to the intersectional nature of mobility and gender – where different gender categories on the move face increased vulnerabilities due to their gender and due to being migrants.

The intention here is to give a snapshot of the extent to which the policy engages with migration and mobility and gender before going into a more descriptive review. This also applies to table 2 on page 52, which gives an overview of all of the reviewed policies in relation to how mobility, gender, and mobility and gender aware they are.

6.1 RELEVANT INTERNATIONAL POLICIES AND FRAMEWORKS

We start the review with a table which provides an overview of the key global and regional migration and health policies and frameworks, and the year in which they were developed. Consulted alongside the policy review, this helps to situate the continental, regional and national policies in a global context and to understand the key issues being addressed and at what time.

TABLE 1: AN OVERVIEW OF KEY GLOBAL AND REGIONAL MIGRATION AND HEALTH POLICY PROCESSES (EXPANDED ON FROM IOM, 2017B: 23; VEAREY, 2018; VEAREY ET AL., 2017)

YEAR	PROCESS
2003	WHO publishes International Migration, Health and Human Rights (WHO, 2003)
	IOM Position Paper on Psychosocial and Mental Well-Being of Migrants (IOM, 2003)
2004	Migrant health for the benefit of all MC/INF/275 (IOM, 2004)
2006	African Union Executive Council. 2006. African Common Position on Migration and Development (African Union, 2006a)
	African Union Executive Council. 2006. The Migration Policy Framework for Africa. (African Union, 2006b)

YEAR	PROCESS
2008	WHA Resolution 61.17 on the Health of Migrants (World Health Assembly, 2008)
2009	Draft 2009 declaration on population mobility and communicable diseases and associated financing model (SADC) (Oxford Policy Management, 2015a, 2015b; SADC Directorate for Social and Human Development and Special Programs, 2009)
2010	2010 1st Global Consultation: The Health of Migrants – the Way Forward Madrid, Spain, 3–5 March 2010 (WHO, 2010)
	SADC HIV Cross Border Initiative (SADC, 2012)
2012	TB in the Mines (TIMS) (“Tims > Who we are > About TIMS,” n.d.) and SADC TB in the mines (SADC Directorate for Social and Human Development and Special Programs, 2012)
2015	IOM 106th Council Session: 26th Nov 2015, Geneva, Switzerland – Advancing The Unfinished Agenda Of Migrant Health For The Benefit Of All – C/106/INF/15 (IOM, 2015a) – High-level Panel Discussion on Migration, human mobility and global health: a matter for diplomacy and intersectional partnership (IOM, 2015b)
2016	UN GENERAL ASSEMBLY: 9th May 2016 – High-level Meeting on Addressing Large Movements of Refugees and Migrants – Report of the Secretary-General: In Safety and Dignity: Addressing Large Movements of Refugees and Migrants (United Nations, 2016a)
	69th World Health Assembly: 27th May 2016 – Technical Briefing on Migration and Health (WHO, 2016a) – Promoting the Health of Migrants. Report from the Secretariat (WHO, 2016b)
	UN General Assembly High-level Meeting to Address Large Movements of Refugees and Migrants: 22nd Sept 2016 – Side Event Report – Health In the Context of Migration and Forced Displacement (WHO, 2016c)
	3rd October 2016: New York Declaration for Refugees and Migrants Resolution adopted by the General Assembly on 19 September 2016 (United Nations, 2016b)
	Leaving no one behind: the imperative of inclusive development Report on the World Social Situation 2016 (United Nations, 2016c)

YEAR	PROCESS
2017	January 2017 – 140th Session of the WHO Executive Board of the World Health - Noted the WHO Secretariat report on 'Promoting the health of migrants (WHO, 2016b) - Adopted Decision EB140(9) – Promoting the health of refugees and migrants (WHO, 2017a)
	February 2017: 2nd Global Consultation – Health of Migrants: Resetting the Agenda (IOM, 2017b)
	17th May 2017: - WHO Input to the 70th World Health Assembly – Draft framework of priorities and guiding principles. A70/24 (WHO, 2017b)
	70th World Health Assembly – 30th May 2017 - Adoption of WHA Resolution 70.15 Promoting the Health of Refugees and Migrants (World Health Assembly, 2017)
	Global Compact Process - IOM Thematic Paper: The Health Of Migrants: A Core Cross-Cutting Theme (2017)
	IOM Migration Health Division – Thematic Paper Series - MIGRATION HEALTH IN THE SUSTAINABLE DEVELOPMENT GOALS: 'Leave No One Behind' in an increasingly mobile society (IOM, 2017a)
2018	142nd WHO Executive Board Meeting 71st World Health Assembly 109th IOM Council Global - Compact on Refugees - Global Compact on Safe, Regular and Orderly Migration IOM Proposed Health Component for the Global Compact (IOM, 2017c)
2019	World Migration Report: Chapter on Migration and Health 144th WHO Executive Board session 72nd World health Assembly - WHO Draft Global Action Plan on the Health of Refugees and Migrants to be submitted for consideration (2019–2023)
2030	UN 2030 Agenda for Sustainable Development (United Nations, 2015b)

6.2 KEY CONTINENTAL POLICIES AND FRAMEWORKS

OVERVIEW

At continental level, in comparison to regional and national, we find the most migration-aware and progressive policies. Across the policies there is evidence of engagement with gender and migration realities and the key challenges that exist. However, at the same time, at this level the policies and frameworks have little impact, they signal intent and set out commitment in terms of indicators and monitoring, but the ability to effect change is very weak.

A review of policies at the continental level must also consider two key intersecting issues. The first is the influence of broader context of global politics and especially the role of the European Union (EU) as focusing on stopping movement, rather than enabling it. The second is that, in relation to the first where migration is mainstreamed into government planning: where the primary goal is to stop migration, policies will not aim at enabling and making movement safer.

6.2.1 AU Revised Migration Policy Framework for Africa and Plan of Action (2018 – 2027)

Mobility aware: Yes

Gender aware: Yes

Mobility and Gender aware: Yes

The AU Revised Migration Policy Framework for Africa and Plan of Africa (2018–2027) provides a revised strategic framework that builds on the 2016 evaluation of the 2006 Migration Policy Framework (MPF) and the recommended updates and 10-year action plan for its implementation. The original 2006 MPF, adopted in Banjul, The Gambia in 2008, provided comprehensive and integrated policy guidelines to AU member states and RECs, which they were encouraged to consider in their endeavors to promote migration and development. These policy guidelines addressed nine thematic areas including: labour migration; border management; irregular migration; forced displacement; and the human rights of migrants. In addition, other social impacts of migration including migration and health, environment, gender and conflict were addressed – although not in-depth.

The revised plan takes a similar approach and offers a comprehensive exploration of the key issues and challenges regarding migration across the continent. The intention, as with the 2006 MPF is to guide member states and RECs in migration management. The revised plan provides an intersectional understanding through which the gender dimensions of migration and health are clearly shown and recognises that alongside an increasing number of women on the move ‘there is a lack of gendered research, analysis and understanding of women and men’s diverse experiences as migrants’. The framework calls for research that can aid ‘gender-responsive migration policy and programme development’ and that can offer,

...a deeper understanding of the gender dynamics of migration, which would enable both policy makers and practitioners to address the special needs of women and men migrants thereby enhancing: (a) the benefits that can accrue to women and men, as a result of their involvement in migration; (b) the contribution of women and men migrants to the up-liftment of their families and the socio-economic development of their host/sending countries, and the continent at large. It would also prompt policy makers and practitioners to address issues that impact negatively on migrants due to gender.

(African Union, 2018: 47–49).

6.2.2 AU Maputo Plan of Action (MPoA) 2016–2030 for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health and Rights (Draft) (2016–2030)

Mobility aware: No

Gender aware: Limited

Mobility and Gender aware: Limited

The MPoA (2016–2030) is a result of over 10 years' policy action to ensure universal access to comprehensive and sexual reproductive health services in Africa. In 2005, African ministers of Health approved the continental policy framework on SRHR. Replacing the first MPoA (2007–2015), the 2016–2030 MPoA is aligned to the UN 2030 Agenda for Sustainable Development and SDGs as well as the AU Agenda 2063. Where there are areas of improvement in this latest framework including reference to safe abortions, reduction of child marriage and adolescent and youth health there are also a number of key omissions. These include any mention of sexual rights for sexual minorities, lesbian, gay, bisexual and transgender (LGBT) persons as well as no engagement with migration and a recognition of the heightened risks faced by migrant women. Migration in fact is mentioned only briefly in reference to how the plan 'responds to vulnerability in all its forms, from gender inequality, to rural living and the youth, to specific vulnerable groups such as displaced persons, migrants and refugees' (2016: 9).

While the MPoA as a plan of action can only suggest a way forward in terms of the framework, it does include a set of indicators as a way of monitoring progress through set targets. In comparison, the African Union Agenda (below) while proving a more comprehensive framework for gender equality and the empowerment of women lacks an implementation framework which means that it exists more as a guide for ideas than using specific targets than can be measured.

6.2.3 African Union Agenda 2063 (2015)

Mobility aware: No

Gender aware: Yes

Mobility and Gender aware: No

The African Union finalised a framework in April 2015 which proposes a rights-based approach to development that is mirrored at a national and sub-regional level. The Agenda 2063 framework sets goals and targets for the continent's development including reducing gender inequality. The African Union further declared 2015 as a year of women's empowerment. In Aspiration Number Six, Agenda 2063 calls for people-driven, inclusive development through:

- Including women through decision making regardless of gender, political affiliation, religion, ethnic affiliation, locality, age or other factors.
- Fully empowering women in all spheres, with equal social, political and economic rights, including the rights to own and inherit property, sign contracts, register and manage businesses.
- Enabling rural women to have access to productive assets: land, credit, inputs and financial services.
- Eliminating gender-based violence and discrimination (social, economic, political) against women and girls.
- Attain full gender parity, with women occupying at least 50% of elected public offices at all levels and half of managerial positions in the public and the private sectors.

However, without indicators it is unclear how this framework will ensure that the goals and targets are being met. There is no mention of migration, mobility or migrant women despite the recognition of the range of vulnerabilities women face. The target of abolishing visa requirements for all African citizens in all African countries by 2018 was not met.

6.2.4 Common African Position (CAP) on the Global Compact for Safe, Orderly and Regular Migration (GCM) 2018

Mobility aware: No

Gender aware: Yes

Mobility and Gender aware: Limited

The Global Migration Compact was adopted in December 2018 as an international, non-binding agreement that ‘aims to make an important contribution to enhanced cooperation on international migration in all its dimensions’ (Ardittis, 2018). It represents the first time that all UN Member States have come together to negotiate an agreement on migration in a comprehensive manner – in recognition of the fact that an international co-operative framework is needed to address an international issue. The compact contains 23 objectives including inter alia: collecting adequate data; ensuring all migrants have legal proof of identity; strengthening the transnational response to smuggling and trafficking; managing borders in an integrated manner and giving migrants access to basic services. It also includes follow-up and review mechanisms.

The Common African Position (CAP) on the global compact serves as a guiding document for AU states involved in the GCM negotiations and like the GCM is non-binding, meaning there is no legal obligation for those who engage with it. The intention is to ensure a common voice in the negotiations but since the AU is a collective and not directly involved in the GCM negotiations it is not really comparable.

Like the GCM, the CAP focuses on the better management of migration with a particular security focus and prioritising issues such as human trafficking. However, whereas the GCM heavily emphasises the need for border management and national sovereignty, the CAP claims that too much emphasis on security and border control actually creates irregular migration. It states that more intra-regional migration would stimulate growth of integrated societies and economies. Where the GCM calls for the end to child detention it falls short of including all detention. Meanwhile the CAP states that any form of detention centres even if labeled as ‘holding camps’ or ‘processing centres’ are a serious violation of human rights.

Gender features in the CAP in terms of the recognition of ‘vulnerable groups including women, the elderly and those living with disabilities’ and suggests that assistance should be ‘gender- and age- specific’. There is recognition of the need for capacity building on migration governance including ‘gender-responsive, protection-sensitive, and human rights based practices, in accordance with international legal obligations and national laws.’

It should also be noted that the GCM has a glaring omission in terms of failing to make any reference to SRHRs and safe maternity care including neo-natal and adolescent health, despite claiming to have a gender-sensitive approach. This is also not addressed in the CAP.

6.3 KEY REGIONAL POLICIES AND FRAMEWORKS

It is important to note that in SADC the process of approval of a regional legal instrument first requires signing, and then ratification, which is a process that differs from country to country. A protocol ‘enters into force’ following ratification by two-thirds of SADC member states. This advances the regional law from being a stated intention to actual application, which then apply to all member states that have ratified. Those member states that join the protocol after a protocol has entered into force are said to “accede” to the protocol, meaning that the state signifies its agreement and is legally bound by the terms of the protocol.¹²

¹² Ascension requires agreement from other parties, usually based on whether the acceding member state (MS) is up to standard.

Of significance here is also the fact that the role of international (under which falls regional) law in national jurisdictions hangs on whether the state has a monist (one system in which international law supersedes national law) or dualist (international law is separate to national law and international law will only be taken into account if transcribed into national law) system. Generally civil law countries are monist and common law are dualist, but with exceptions. Of concern in this report Zambia follows a dualist system, South Africa uses a combination of the dualist and monist systems. For South Africa this means that there is no need for domestic legislation for international law to take effect.

While Protocols are legally binding documents, Frameworks are policy documents, usually outlining the agenda for cooperation on or implementation of a particular provision of a Protocol or the Strategic Indicative Plan for the Organ (SIPO). There is no fixed procedure for developing a Framework (they are not mentioned in the SADC Treaty), but the Secretariat or an Organ will usually give it legitimacy by submitting it for formal adoption at a Ministerial meeting or the Summit.

OVERVIEW

The SADC policies and frameworks show that regional integration is being pursued as an overarching continental development strategy by member states of the African Union. There is a clear trend in terms of engaging with some of the more complex realities of migration and gender and the key vulnerabilities this creates, and a number of regional initiatives have been shaped to directly respond to these. This is indicated in a number of key progressive SADC protocols including the ‘SADC Draft Policy Framework on Population Mobility and Communicable Diseases’ (2009), and the Revised SADC Protocol on Gender and Development (2015) adopted in June 2016 (see below). Also, where there is a level of engagement with migration and gender there is rarely engagement with the two as intersecting issues. In health policy this can be seen to an extent – but through specific frames of women as victims of trafficking and the sexual and reproductive vulnerabilities they can face.

MIGRATION AND HEALTH

6.3.1 SADC Protocol for Facilitation of Movement of Persons (2005)

Mobility aware: Yes

Gender aware: No

Mobility and Gender aware: No

The SADC Protocol on Facilitation of Movement in Persons seeks to fulfil the objective of the SADC Treaty to promote policies that eliminate obstacles to the free movement of persons in the region. This is also in line with efforts of the AU to encourage the free movement of persons in African Regional Economic Communities (RECs). A draft protocol on the free movement of persons was introduced in 1996, but was replaced by the more restrictive protocol on the Facilitation of Movement of Persons in 1997, which responded to concerns by member states concerning income disparities. The 2005 Protocol offers further revisions, which include granting visa-free entry, with lawful purpose, to citizens from other member states for a maximum of 90 days. While the overall purpose of the Protocol seemed to be to provide a regional instrument to help with the facilitation of movement in a context where there are high levels of movement for trade and labour the overwhelming focus has been on visas.

The Protocol has been adopted but is not operational due to inadequate ratifications by member states. Only Botswana, Mozambique, South Africa and Swaziland have signed and ratified the protocol. Although not operational, member states can conclude bilateral agreements for visa exemptions. Most states have exempted each other from visa requirements. The Protocol does not engage with gender in any way.

6.3.2 Policy Framework for Population Mobility and Communicable Diseases in the SADC Region (2009)

Mobility aware: Yes

Gender aware: Yes

Mobility and Gender aware: Yes

As the most progressive regional document, this proposed policy has remained in draft form since 2009. This is for a number of reasons including issues around the financing of proposed regional programmes. As Vearey writes, ‘the associated exercise to explore financing mechanisms – at the request of member states – was eventually completed by SADC in 2015, but remains unpublished (Oxford Policy Management, unpublished work)’ (Vearey, 2018: 93).

The framework draws on The Sixty-First World Health Assembly (WHA) of May 2008, stating that through the adoption of the Resolution on Health of Migrants, the WHA ‘recognised that some categories of migrants experience increased health risks and called for the development of intersectoral policies to protect their health’ (SADC, 2009: 5). However, despite strong engagement with cross-border migration (SADC, 2009: 5) there is no mention of internal mobility beyond the definitions upfront.

Having said that, the framework is important because it acknowledges different types of mobility stating, ‘Mobility may be voluntary – e.g. for work, study or exploration purposes—or it may be involuntary; as a result of coercion, trafficking, or poverty (this includes most refugees)’ (SADC, 2009: 4). It also considers how mobility links to communicable diseases, ‘When mobile people return home (source) with new infections, their source community may experience the impacts of the disease.’ (SADC, 2009: 4) and ‘[t]his Framework acknowledges that one of the risks mobile people encounter is communicable diseases.’ (SADC, 2009: 5).

The feminisation of cross-border movement, with women and girls now crossing borders on par with men. This has grave implications for the health of migrants, as mobility process makes women more vulnerable to communicable diseases. They are more likely to suffer gender-based harassment and violence (including sexual). Also women are also more likely to move with their young children who will also be susceptible to communicable diseases.

(SADC, 2009: 6)

Gender, is considered in detail as shown in the above quote and with a recognition that there has been, ‘inadequate attention to the gender dimensions of cross-border mobility.’ (SADC, 2009: 8). Within this, trafficking and forced movement is also considered: ‘Increased cross-border trafficking and involuntary movement. Although documented evidence is difficult to come by due to clandestine nature of such movements, it is said to be on the increase, particularly of adolescent children for illegal labour and sexual exploitation. Girls are particularly vulnerable in this process.’ (SADC, 2009: 6).

Awareness of the complexities of migration including the circular movement, are addressed in terms of communicable diseases, ‘This impact on movement of communicable diseases between source, transit and destination communities and the resultant need for more coordinated control action.’ (SADC, 2009: 6). The document also recognises the impact of undocumented migration in leading to difficulties in access to health services for communicable diseases. Inter-regional mobility is also taken account, thus ‘highlighting the need for intra-regional cross-border programming particularly for communicable diseases which do not recognise borders.’ (SADC, 2009: 6).

6.3.3. SADC Protocol on Health 2004

Mobility aware: No

Gender aware: No

Mobility and Gender aware: No

The SADC Protocol on Health was approved by SADC Heads of State in August 1999 and entered into force in August 2004. The protocol promotes cooperation among member states on key health issues. Although there is recognition of the need for ‘mechanisms to co-ordinate regional health promotion and education’ (SADC, 2004: 9) and for the need for regional advocacy efforts and the standardisation of surveillance systems regarding HIV/AIDS/STDs (ibid: 10) there is no mention of migration or mobility. There is also no mention of gender.

6.3.4 SADC HIV and AIDS Cross Border Initiative (2010)

Mobility aware: Yes

Gender aware: Yes

Mobility and Gender aware: Limited



In line with recognition of communicable diseases knowing no borders SADC ‘was awarded funding from the Global Fund to establish a regional cross-border HIV programme involving the establishment of 32 clinics (at least two in each of the mainland member states) offering HIV testing and treatment, alongside primary care, in border areas and along transit routes to serve migrant and mobile populations, and local migration-affected communities...’ (Vearey, 2018: 95). Although 12 mainland member states (Angola, Botswana, DRC, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe) signed Memorandums of Understanding (MoUs), and agreed to participate, progress has remained extremely slow. Phase 1 involved just 12 clinics being opened, and the second phase—with a further 20 clinics due to open—was initiated at the end of 2017, with the anticipation that all 32 clinics will be handed over to member states in the first half of 2018. ‘The slow process and challenges associated with this give a good indication of the challenges faced—both political and logistical—in developing and implementing cross-border, migration-aware HIV interventions at a regional level’ (Vearey, 2018: 95).

The initiative was funded by the Global Fund and involves multiple stakeholders. The reasons for the slow implementation and challenges encountered are likely both political and logistical. In addition, the funds ran out in the end of 2017 meaning that member state governments are responsible for running the initiatives. While claimed to make them more ‘sustainable’ there is a chance that this may have the opposite effect especially if there is not enough resources from the member states to maintain the clinics and to ensure effective implementation of systems etc.¹³

6.3.5 SADC Declaration on Tuberculosis in the Mines (2012)

Mobility aware: Limited

Gender aware: Limited

Mobility and Gender aware: Limited

Signed by the SADC Ministers of Health in 2012 this declaration and code of conduct demonstrates a close recognition between mining and TB in Sub-Saharan Africa the Declaration is the only regional health and migration policy process that has been implemented. Vearey, notes that ‘ratification of this Declaration happened quickly, and appears to be the result of any associated financial burden being the responsibility of the private sector, and not member states who are unwilling to commit to regional responses associated with migration and health’ (Vearey, 2018: 95)

As part of the Declaration, SADC countries have pledged to establish independent mining ombudsmen to handle health complaints and to classify TB and Silicosis among miners as occupational diseases. Countries also committed

¹³ <http://apanews.net/index.php/en/news/32-wellness-clinics-earmarked-for-12-sadc-members>.

to aligning their HIV, TB and Silicosis treatment regimes to facilitate treatment for miners who are working across neighbouring borders. However, the creation of regional databases and tracking systems are ambitious especially given the aforementioned lack of regional responses.

While the Declaration is gender and migration aware in terms of recognising the specific vulnerabilities faced by migrant men working on the mines there is no reference to the impact on families and, especially women. This is significant given that women largely carry the burden of unpaid care while men are away working on mines and this burden can increase when husbands, fathers, brothers and sons return home sick (Chen, 2008; Budlender, 2004). The Declaration does however call for the 'encouragement of standardized reporting of gender or disaggregated data on HIV across the SADC member states' (2012: 6).

6.3.6 SADC Health Policy Framework (2015)

Mobility aware: Limited

Gender aware: Limited

Mobility and Gender aware: Limited

This framework defines roles, responsibilities, and management mechanisms to improve the quality and reach of current prevention and health services for HIV and other important health conditions, including tuberculosis, sexually transmitted infections, malaria, hypertension, diabetes, and sexual and reproductive health services including family planning. It draws on the SADC Regional Standards for HIV Care along road transport corridors, developed in November 2015 and recognises the need to address the HIV prevalence rates of key populations and communities living in the region.

MIGRATION AND GENDER

6.3.7 SADC Protocol on Gender and Development (2008) and later revisions.

Mobility aware: No

Gender aware: Yes

Mobility and Gender aware: Limited

As a key policy regarding gender the SADC Protocol on Gender and Development entered into force in 2013 following the ratification of the instrument by the requisite two-thirds of member states. It was then revised in 2016 and the revised protocol has been signed by all member states, apart from Mauritius.

The SADC Gender Protocol encompasses ten thematic areas which include Constitutional and Legal Rights; Governance (Representation and Participation); Education and Training; Productive Resources and Employment, Economic Empowerment; Gender Based Violence; Health; HIV and AIDS; Peace Building and Conflict Resolution; Media, Information and Communication; and Implementation with the over-arching objective of 50/50 parity by 2015.

The Revised SADC Protocol on Gender and Development provides for the empowerment of women, elimination of discrimination and the promotion of gender equality and equity through gender-responsive legislation, policies, programmes and projects. The protocol was revised in 2016 so that its objectives are aligned to various global targets and emerging issues. Some of these global targets are contained in the post-2015 UN Sustainable Development Goals (SDGs), the African Union Agenda 2063, and the Beijing Declaration and Platform for Action (1995).

SDG Goal 5, for example, deals with the Promotion of Gender Equality and Empowerment of all Women and Girls, and sets nine targets to be met by the global community by 2030 including: ending all forms of discrimination against women and girls; elimination of all forms of violence against women and girls in the public and private spheres, including trafficking and sexual exploitation; elimination of all harmful practices, such as child, early and forced marriage,

and female genital mutilation; and ensuring the full and effective participation of women and equal opportunities for leadership at all levels of decision-making in political, economic and public life.

Other SDG Goal 5 targets include universal access to sexual and reproductive health and reproductive rights in accordance with the Programme of Action of the International Conference on Population and Development (1994) and the Beijing Platform for Action (1995). In addition, the revised Protocol captures emerging issues such as climate change and child marriages.

Despite its broad reach, the Protocol and its revised version is not migration or mobility aware. In fact, the only engagement with mobility is in terms of human trafficking, which is recognised as a serious issue affecting mostly women and children. The need for regional cooperation regarding anti-trafficking measures and the importance of collecting harmonised data collection mechanisms as well as effective programming and monitoring.

In line with the SADC Protocol on Gender and Development, the SADC Gender and Development Monitor as a Tracking Progress on Implementation of the SADC Protocol on Gender and Development (2016) checks the progress made towards the implementation of regional commitments to achieve gender equality and equity. Within this there is very little on migration and gender or on migration and health. The language is directed at 'citizens' of member states.

A reference is made to migrant women by way of recognising that the 'majority of trade programmes, policies and frameworks are blind to women traders, especially those in the informal sector. Trade norms and policies undermine the livelihoods and wellbeing of women and leave women vulnerable and unprotected.' Although migration is not explicit here, women traders are highly mobile and often migrants. There is also a call to strengthen the health sector in line with women's needs and especially the mainstreaming of SRHRs in primary care.

6.3.8 Strategy for Sexual and Reproductive Health and Rights in The SADC Region 2019 – 2030

Mobility aware: Yes

Gender aware: Yes

Mobility and Gender aware: Limited

The Strategy for Sexual and Reproductive Health and Rights in the SADC Regions (2019–2030) provides a framework for member states to focus on measures to ensure and strengthen the sexual and reproductive health rights of all people in the region. This strategy '...sets out to benchmark and harmonize the provision of integrated SRH and HIV interventions and services among SADC Member States, with a view to accelerating the effective delivery of quality and comprehensive health and related social services for all people, irrespective of age, sexual orientation, marital state and gender' (SADC, 2018: 43). Overall the initiative aims to actively promote SRHR as key for the realisation of SDG targets, the protection of all those living in SADC,

This strategy is intended to meet the SRHR needs of all people in the SADC region including: Adolescent girls and Young Women, Women of a reproductive age, Men and Boys, Key populations including sex workers, people who inject and use drugs, prisoners, MSM and LGBTQI, Migrants, Refugees, Mobile Populations, People living with Disabilities and victims of sexual exploitation

(SADC, 2018: 27)

Member states are also encouraged to take action to address the range of 'social, economic, cultural and systemic challenges' that prevent all key population groups from attaining their SRHR across their life cycle (SADC, 2018: 32).

Central to this initiative is the regional ‘score card’ which has been developed along with the strategy as a high-level strategic tool to track progress at a political level across the SADC region in the implementation of the strategy (SADC, 2018: 25)

The strategy is comprehensive and recognises migrants and mobile workers as vulnerable populations alongside refugees and sex workers. It also responds to the specific vulnerabilities of women as well as the specific needs of men and boys (SADC, 2018: 14). While the strategy does not specifically address vulnerable populations it notes the specific vulnerabilities of key population, ‘infection in certain situations or contexts, such as adolescents (particularly adolescent girls in sub-Saharan Africa), orphans, street children, people with disabilities and migrant and mobile workers. These populations are not affected by HIV uniformly across all countries and epidemics’ (SADC, 2018: 10). In doing so it ‘[e]mphasizes the need for strong political commitment and adequate human and financial resources, so that all people, in particular adolescent girls and young people, women, men and boys, key populations, migrants, refugees, mobile’ (SADC, 2018, 26).

There is also recognition of male–health seeking behaviours and the role played by men and boys as partners, which does not feature in other initiatives (SADC, 2018: 33). The strategy is also shaped by a broader recognition of gender equality and empowerment to ‘develop targeted messages to address social and cultural barriers to the realization of SRHR, particularly as it relates to the sexual and reproductive autonomy of women and girls and gender equality more broadly’ (SADC, 2018: 37).

6.3.9 SADC Regional Migration Policy Framework (RMPF) 2018–2030

Mobility aware: Yes

Gender aware: Yes

Mobility and Gender aware: Yes

The RMPF for the SADC region is currently in draft form. It was developed as a response to recommendations by SADC Ministers that there is a need for a broader Regional Migration Policy Framework that draws on the SADC Protocol on the Facilitation of the Movement of Persons and aims to ensure effective coordination and coherence in migration management. This framework would also be aligned with the aims of the AU Migration Policy Framework.

The draft version of the framework offers a comprehensive review of SADC policies and engages with much of the key literature on migration, health and gender. It devotes a significant amount of time to gender and migration, noting key trends in the feminisation of migration and key vulnerabilities. The vulnerabilities are framed mostly in terms of exploitation and trafficking with a failure to acknowledge any of the literature that challenges the conflation of trafficking and sex work as well as numbers, ‘Migrant women and girls’ vulnerabilities to exploitation are highlighted by the frequently abusive conditions under which they work, especially in the context of domestic service and sex industries, in which human trafficking is reported to be rampant’ (2018: 53). Recommendations are concise and include the need for gender-responsive research and enhanced data collection to address realities. There is also a call for women’s voices in the policy process. See Text box 5 for key recommendations given in this draft.

6.4 KEY NATIONAL POLICIES AND FRAMEWORKS: SOUTH AFRICA AND ZAMBIA

SOUTH AFRICA

OVERVIEW

At a national level the trend of policies in South Africa indicates increasing shifts towards the restriction of migration and keeping migrants out – both physically and in terms of accessing basic services such as healthcare and education. South Africa has one of the most progressive legal frameworks in the world, built to signal a clear departure from the divisions and oppressions of the apartheid system and bringing new commitments to human rights, international

cooperation, equal opportunity and democracy. However, increasing hostility towards non-nationals, who are regarded as a burden on the resources in the country and also blamed for crime and other social ills, are reflected in amendments to the Immigration Act and Refugee Amendment Act, as well as proposals for the National Health Insurance (NHI).

This can also be seen in policies regarding gender. While there is comprehensive and progressive legislation alongside a number of policies and programmes to promote gender equality and address GBV, South Africa also continues to have some of the highest rates of GBV and violence against women in the world (Meyiwa et al., 2017). Furthermore, in the policies that exist there is no reference to migration or to the specific vulnerabilities and needs of migrant women despite the fact that as the literature review showed, migrant women face heightened vulnerabilities due to their precarious positions as women and as non-nationals in South Africa.

TEXT BOX 1: THE LEGAL OBLIGATION TO PROVIDE HEALTHCARE TO ALL

The law on migrant access to health care services is quite clear. Denial of access to health care services to anyone, including migrants, is unlawful. Section 27(1)(a) of the Constitution states that “everyone” has the right to have access to healthcare services. Subsection 3 further states that “no one” may be refused emergency medical treatment.

The **National Health Act** 61 of 2003 in section 4(3)(b) states that subject to any condition prescribed by the Minister, the State and clinics and community health centres funded by the State must provide all persons, except members of medical aid schemes and their dependents and persons receiving compensation for compensable occupational diseases, with free primary health care services. In addition, all pregnant or lactating women and children under the age of 6 are entitled to free healthcare services (at any level)

The **Refugees Act** 130 of 1998 provides for access to basic health services by refugees (and by implication asylum-seekers)

The **Uniform Patient Fee Schedule** exempts certain categories of non-South Africans from being full paying patients. These exempted categories are immigrants permanently resident in South Africa but have not attained citizenship, non-South Africa citizens with temporary residence or work permits, and persons from SADC states who do not have the documentation required to be in the country legally. The exemption of these categories of non-South Africans from paying full amounts for accessing healthcare services clearly implies that all health facilities, including clinics, should be providing health care services even to foreign nationals.

The **South African law and policy** on this issue is in line with the SADC Protocol on Health in terms of which SADC states agreed to treat citizens of other SADC states like citizens of their own country.

Notices posted in hospitals requiring “foreign nationals” to pay for healthcare services are contrary to the policies explained above and are unlawful. The only time that a refugee, asylum seeker, or undocumented migrant from a SADC state should have to pay for health care services is when he or she does not qualify for free health services in terms of a means test. In that case, like for South Africans, there are sums of money that the patient can be asked to pay depending on the care required and the type of health facility.

While the law is clear, as noted above, it is often not implemented. In recent years an increase in challenges faced by non-nationals are being reported; these are outlined in Text Box 2. These challenges may be linked to difficulties in communicating due to the different languages spoken but can also be the result of the way that they are treated by frontline healthcare staff. Evidence suggests that there are increasingly xenophobic and anti-foreigner sentiments being displayed by healthcare staff, which results in non-nationals facing multiple hurdles when trying to access the care to which they are legally entitled. A key concern relates to issues of documentation. It seems that the frontline staff requesting this information may fail to clearly communicate what they need and how it can be provided. Instead they sometimes ask for a South African Identity Booklet (ID), or an asylum-seekers or refugee permit and if the patient is unable to provide that document they are turned away. These patients are not told that they can provide other forms of ID (such as a foreign passport or affidavit). Should an individual be without identification, they can

make an affidavit at a police station.¹⁴ Additionally, there are problems at the declaration of income stage where some people are not given an opportunity to declare their income – they just get classified as the least subsidised, full fee-paying patient.¹⁵

TEXT BOX 2: KEY CHALLENGES IN THE IMPLEMENTATION OF LAW AND POLICY¹⁶

- A demand for the up-front payment of fees by non-nationals in need of maternal healthcare, including at time of delivery, with reports suggesting that the babies of non-national mothers are not released to the mother until full fees are paid.
- A demand for up-front payment of fees before emergency treatment will be provided.
- The misclassification of non-nationals when calculating co-payments, including documented refugees and asylum seekers being incorrectly categorised as full fee-paying patients
- Miscommunication when demanding proof of ID and proof of income.

IMMIGRATION LAWS AND POLICIES

6.4.1 The Refugee Act (1998) and Immigration Act (2002)

Mobility aware: Yes

Gender aware: No

Mobility and Gender aware: Yes



As signatories to a number of international conventions, South Africa implemented the South African Refugees Act (1998) as a key piece of legislation in protecting of refugees and asylum seekers. This Act provides particular rights to legally recognised refugees and asylum seekers (The Republic of South Africa, 1998a) including the freedom to move, work and access social services such as health and education. Significantly, the Refugee Act also offers the possibility of asylum on the basis of persecution due to sexual orientation or gender identity. This, along with the Constitutional Bill of Rights which outlaws discrimination based on sex, gender and sexual orientation, means that South Africa is the only country on the African continent to not only recognise but also constitutionally protect transgender individuals and people who identify as gay, lesbian, bisexual and intersex. Furthermore, the fact that South Africa currently does not practice a system of encampment for asylum seekers means that it offers a distinctive asylum regime. The Act is also underpinned by two global conventions: the 1951 UN Convention Relating to the Status of Refugees and its accompanying protocol¹⁷; and the 1969 Convention governing the Specific Aspects of Refugee Problems in Africa.¹⁸

The Refugee Act therefore marked a significant and progressive change in South Africa's migration policy. However, The South African Immigration Act 2002 (amended in 2004) takes a more 'protectionist' and 'nationalistic' approach, emphasising border control over migration facilitation (Segatti, 2011: 46). Although, as a replacement to the outdated Aliens Control Act of 1991, the Act takes a more rights-based approach including commitment to combat xenophobia and recognise the positive aspects of migration, it is limited in many ways. Opportunities for legal labour for example are restricted and the numerous types of temporary permits decrease flexibility in

¹⁴ The Migrant Health Forum, a consortium of civil society organisations that assists migrants in accessing health care services, has produced a pamphlet laying out the rights of migrants to access health care services. See: <http://section27.org.za/2017/06/public-announcement-access-to-health-care-for-migrants/>

¹⁵ Johannesburg Migrant Health Forum, 2015; Vearey, 2014; Vearey et al., 2017)

¹⁶ Johannesburg Migrant Health Forum, 2015; Vearey et al., 2017)

¹⁷ UN General Assembly, Convention Relating to the Status of Refugees, opened for signature 28 July 1951, United Nations, Treaty Series, 189 UNTS 137 (entered into force 22 April 1955 and UN General Assembly, Protocol Relating to the Status of Refugees, 31 January 1967, 606 UNTS 267, available from <http://www.refworld.org/docid/3ae6b3ae4.html>.

¹⁸ Organisation of African Unity (OAU), Convention Governing the Specific Aspects of Refugee Problems in Africa ("OAU Convention"), 10 September 1969, 1001 UNTS 45, available from <http://www.refworld.org/docid/3ae6b36018.html>.

the job market and work against many of the realities of migration, including the increasing number of women migrating to South Africa. Looking from a particular gender perspective Dodson and Crush (2004) argue that the Act ‘entrenches a system of male-dominated regional labour migration’ in which the male bias in the work permits and other-employment based categories along with the limits to family reunification for those entering work are likely to discriminate against women over men.

perspective Dodson and Crush (2004) argue that the Act ‘entrenches a system of male-dominated regional labour migration’ in which the male bias in the work permits and other-employment based categories along with the limits to family reunification for those entering work are likely to discriminate against women over men.

Further amendments to the Act were made in 2004, 2007 and 2011. The 2004 amendments to the Immigration Act addressed South Africa’s need to attract scarce skills and facilitate rather than control migration. However, the Amendment increased a number of migration challenges in particular those faced by asylum seekers to stay in the country allowing them only 14 days to access Refugee Reception Offices (RROs) before the ‘asylum transit permit’ (Section 23) expired. Further amendments were tabled under the Refugee Amendment Act, signed into law in December 2017. However, the draft regulations have not yet been finalised and therefore it is currently unclear as to when and if the Amendment Act will be implemented. If implemented, the Act would mean fundamental changes for asylum seekers and refugees in South Africa including the following: the removal of the automatic right to work and study for asylum seekers; the reduction of the 14 days to access RROs to 5 days; the expansion of reasons to exclude asylum seekers from refugee status and the abandonment of asylum claims should an asylum seeker not attend an RRO in the month after the expiry of their asylum permit. Given the challenges outlined in the earlier section regarding accessing RROs, these measures would make an asylum seeker even more vulnerable to arrest and deportation if not able to meet with the new laws.

The Amendments would also mean that the Director-General of Home Affairs would be able to establish, and disestablish, as many RROs as he/she regards as necessary – ‘notwithstanding the provisions of any law’ (The Republic of South Africa, 2017a). This means that the Director General could direct any category of asylum seekers to report to any ‘place specially designated’ when lodging an application for asylum. While ‘place specially designated’ is not elaborated on – this could mean de facto refugee camps or detention centres for certain categories of asylum seekers.¹⁹

These amendments conflict with South Africa’s commitment to SADC’s Protocol on the Facilitation of Movement of Persons (2005) and the AU’s Common Position on Migration and Development (2006), which both call for the protection of migrant’s rights while recognising migration as a tool for development and greater regional cooperation.

6.4.2 The White Paper on Immigration (2017)

Mobility aware: Limited

Gender aware: No

Mobility and Gender aware: No

National migration policies continue to be founded on controlling and limiting irregular and “illegal” migration, while national responses focus less on migrants’ rights and protection and more on the legal status of migrants. Of greatest concern in the Department of Home Affairs’ White Paper on Immigration (2017), is that it seeks to further amend the Immigration Act and reverse the policy of self-settlement for asylum seekers and refugees. Currently self-settlement allows asylum seekers and refugees to integrate and co-exist within South African communities, rather than residing in camps as is the case in other SADC and African countries, including Zambia. However, the White Paper specifies that ‘in order to admit asylum seekers in the refugee regime in a humane, secure and effective

¹⁹ The following resource from the Scalabrini Centre, Cape Town outlines the proposed changes and impact in the Refugee Amendment Act: <https://scalabrini.org.za/news/teach-yourself-the-refugees-amendment-act-explained/>

manner, South Africa will establish Asylum Seeker Processing centres.’ (The Republic of South Africa, 2017b: 61). These facilities will ‘profile’ and ‘accommodate’ asylum seekers while their status is determined and will involve multiple stakeholders including the cooperation of the Department of Home Affairs (DHA), Refugee Appeal Board (RAB), the Department of Social Development, and the United National High Commissioner for Refugees (UNHCR) (ibid). It should be noted that the White Paper does not specifically mention migrant children and it is unclear what should happen to both children travelling with family members or other adults and unaccompanied migrant children. However, the detention of children is contrary to national and international law, and is only permitted in a matter of last resort.

When considered in terms of engagement with health issues as central to the management of migration, the amendments are extremely limited. Although the Department of Health is repeatedly listed as a key stakeholder in decision-making processes and consultations regarding immigration, this is as far as health engagement goes. The White Paper states that ‘during this process special services will be given to applicants in need of care and vulnerable groups’ (The Republic of South Africa, 2017b: 61), yet key issues regarding not only the provision of healthcare (beyond emergency care) but also continuity of care for those on treatment plans and the heightened gender vulnerabilities are not considered.

The White Paper also sets out a number of other key changes which will impact migrants and some of these are positive. For example, referencing the AU’s aim to abolish visa requirements for all African Citizens, the White Paper aims to allow African citizens entry for 90 days upon arrival in South Africa, subject to return agreements and security checks. In addition, the White Paper echoes SADC’s stance on the need for greater mobility across the region by planning to implement more ‘Special Dispensation Permits’ for certain SADC nationals as well as new SADC visas, for cross-border traders and those with small businesses.

However, there is also almost no engagement with gender in the amendments, other than to state, [T]he state may not unfairly discriminate directly or indirectly against anyone on one or more grounds, including race, gender, sex, pregnancy, marital status, ethnic or social origin, colour, sexual orientation, age, disability, religion, conscience, belief, culture, language and birth’

(The Republic of South Africa, 2017b: 3).

What is clear is that these changes reflect an increasing focus on the securitisation and restriction of migration and within a context where human rights abuses continue, often without recourse, and thus increase the risks that migrants and especially migrant women face (Vigneswaran, 2011).

The language of the policy is directed at the ‘risks’ of migration, namely ‘countries that effectively manage risks have in addition put in place the people, systems and awareness needed to monitor and assess risks...’ (The Republic of South Africa, 2017b: 10).

MIGRATION AND HEALTH

6.4.3 The National Health Act (2003)

Mobility aware: No

Gender aware: No

Mobility and Gender aware: No

This notion of risk is also reflected in the shifts in health policy in South Africa. As a member state to The World Health Assembly (WHA), South Africa is constitutionally mandated to ensure access to healthcare for internal and cross-border migrant populations in line with the 2008 WHA resolution (Walls et al., 2016). As previously mentioned, the inclusion of a Bill of Rights in the South African Constitution (1996) means that all individuals have a right to equality, freedom from discrimination, and access to essential services. Of these legally enforceable rights, access to healthcare as

interpreted within the National Health Act (The Republic of South Africa, 2003), guarantees rights to access healthcare for everyone in South Africa and also provides for the right to dispute resolution (Human Rights Watch (HRW), 2011; Makandwa, 2014).

Although multiple pieces of legislation and guidelines often cause confusion (IOM, 2010: 34), the law regarding healthcare in South Africa is clear as stated in Text Box 1.

Yet ‘...ambiguity relating to the rights of non-citizen groups to accessing public health services, including antiretroviral therapy (ART), has prevailed’. (Vearey, 2008a; IOM, 2010: 34), as outlined in Text Box 2. IOM argue, ‘The different documents that non-citizens may hold (e.g. refugee, asylum seeker, and the range of temporary residence permits) present challenges to service providers who may not be familiar with different documentation. In addition, national guiding documents, such as the 2007–2011 National Strategic Plan (NSP) for HIV & AIDS and STIs, use the terms “asylum seeker”, “refugee” and “foreign migrant” interchangeably, which is an additional source of confusion for practitioners’ (IOM, 2010: 34). In addition the variation in how this legislation is interpreted both regionally and locally within specific facilities not only creates space for discrimination, but also places healthcare practitioners and facility staff at the frontline as gate keepers and critical mediators of policy implementation (Walls et al., 2016).

6.4.4 The National Strategic Plan (NSP) for HIV, TB and STIs (2017–2022)

Mobility aware: Yes

Gender aware: Yes

Mobility and Gender aware: Limited

More recently The National Strategic Plan for HIV, TB and STIs (NSP) (2017–2022), which builds on the previous plans (2012–2016; 2007–2011 and 2000–2006) as well as addresses the identified gaps, does not specifically mention asylum seekers and refugees. Aligned to the Medium Term Strategic Framework and embedded in the National Development Plan, the NSP engages with mobility and migration through its recognition of ‘key and vulnerable populations’ of which ‘adolescent girls and young women’ as well as ‘Mobile populations, migrants and undocumented foreigners’ are highlighted (South African National AIDS Council, 2017: xv). Under Goal 3 to ‘Reach all key and vulnerable populations with customised and targeted interventions’ it is stated, ‘to ensure that no one is left behind, efforts to maximise access to high-quality services for key populations will be enhanced.’ (South African National AIDS Council, 2017: xvi).

Gender is central to the NSP and is considered in terms of the vulnerabilities faced by women such as GBV, adolescent and young women as a key vulnerable population and transgender people also as a key population for HIV and STIs. Challenging harmful gender norms and violence against women is recognised as central to protecting and prompting human rights and increasing the legal, social and economic empowerment of women (South African National AIDS Council, 2017: 33). Missing here and in the section on migrant communities is the recognition of the heightened vulnerabilities faced by migrant women and especially those who are undocumented – and looked at alongside the proposed changes in the white paper it can be assumed these vulnerabilities will increase as more migrants are forced to enter South Africa through risky, hidden routes to avoid the processing centres.

6.4.5 The National Health Insurance (NHI) (2017)

Mobility aware: Limited

Gender aware: No

Mobility and Gender aware: No

The NSP (reviewed above), while aiming to work with key populations and the realities of mobility, also faces clear challenges given the current confusion over laws related to public healthcare and in particular, the proposed National Health Insurance (NHI), which may further restrict access for migrants and particularly undocumented migrants. The NHI aims to ensure universal access to healthcare for all in South Africa, which in a country with high levels of

inequality and a two tier health system can be seen as a progressive development, building on and extending previous policies on health care. However, as Vearey, notes, there are currently a number of concerns around the NHI including that 'current iterations of the NHI present a possible regression in the rights of non-nationals to access healthcare, including [antiretroviral therapy] ART' (Vearey, 2018: 96). In fact, although the NHI appears mobility aware there is very little mention of migrants and migration. Continuity of care for example is only talked about in terms of internal migrants: 'to ensure continuity of care, access to healthcare services covered will be portable. This will ensure that internal migrant populations visiting a different part of the country where they were not initially registered, can still access NHI healthcare services. Migrant populations must provide notice to the NHI Fund prior to embarking on the journey' (The Republic of South Africa, 2017c: 25).

Where cross-border migrants are considered, the current document states, 'Migrants are not a homogenous group and consist of refugees, asylum seekers and irregular migrants and will receive basic health care services in line with the Refugees Act and international conventions that South Africa is a signatory to' (ibid: 21). Irregular migrants are defined in the following way, 'Irregular migrants (or undocumented / illegal migrants): People who enter a country, usually in search of income-generating activities, without the necessary documents and permits.' (The Republic of South Africa 2017c: v). However, as with the Refugee Act, 'basic healthcare services' remains undefined while as noted in this report, research shows, access to healthcare for cross-border migrants despite policy is often difficult and at times, refused. Overall it is clear that the focus is on healthcare for South Africans rather than 'access to health care for all' as stipulated in the Constitution (The Republic of South Africa, 1996). Gender is not well engaged with in the NHI. Reference is made to women only in the following terms: 'vulnerable groups such as children, women, people with disability and the elderly' (Republic of South Africa, 2017: 60) and 'Vulnerable groups, such as women, children, older persons and people with disabilities, orphans, adolescents and rural populations will be prioritised.' (ibid: 62).

6.4.6 The National Development Plan 2030 (2012)

Mobility aware: Yes

Gender aware: Limited

Mobility and Gender aware: No

The National Development Plan 2030 (2012), which sets out the country's long-term development plan including key societal challenges and development priorities engages with migration quite effectively. Where the diversity of migration and its potential benefits for development are recognised there is also acknowledgment of the need for 'a much more progressive migration policy in relation to skilled as well as unskilled migrants' alongside better planning for 'rapid urbanisation' (The Republic of South Africa, 2012: 97). Importantly the NDP engages with the risks faced by migrants when migration is not properly engaged with:

However, if poorly managed, however, the skills and potentials of migrants will be neglected. Migration will remain a source of conflict and tension, and migrants will be increasingly vulnerable, subject to continued abuse, exploitation and discrimination (105).

Internal migration is recognised as more significant than 'international migration' in terms of impacting on local planning (ibid: 104). Subsequently the NDP calls for better data on migration without and across borders (ibid). Emphasis is also placed on 'how to address the additional burden(s)' that migration places on national resources' (ibid: 256), while attention is drawn to the increase in communicable diseases as migration increases, as well as the increased potential for 'improved sharing of knowledge and information, which will help countries in the region deal with their health issues...' (ibid). While Chapter 10 deals with 'Promoting Healthcare' and considers the key challenges facing the healthcare system, as well as outlining the plans for the NHI, there is no engagement with migration as a key social determinant of health and key to the planning and provision of health services (ibid: 329 – 351).

Gender appears mostly in the context of violence against women in which the high levels of GBV are addressed. Strategies for combatting GBV are considered, however there is limited engagement with the experiences of women and the forms of heightened vulnerabilities faced.

Overall a key concern here is how the NDP and national policies will be aligned with South Africa's adoption of the UNs 2030 Agenda and its SDGs. In particular, the emphasis within the SDGs on 'measuring, monitoring and communication progress' pushes governments to consider and scale-up regional and national programmes and partnerships as well encapsulate SDG goals within national development plans and visions. However, the NDP along with the aforementioned key policies and frameworks not only suggest little engagement with the intersections of gender, migration and health, but significantly suggest that increasingly restrictive policies, of which some directly contradict international and regional frameworks, will severely impact South Africa's progress towards achieving the SDGs.

MIGRATION AND GENDER

The Domestic Violence Act (1998) and The Promotion of Equality and Prevention of Unfair Discrimination Act (the Equality Act), (2000), were developed to address the problems of GBV and gender equality in South Africa. They build on the Constitutional Bill of Rights, which sets out the founding tenants of equality and prohibits unfair discrimination on several grounds and, South Africa's commitment to the Convention for the Elimination of All forms of Discrimination Against Women (CEDAW), signed in 1993 and ratified in 1995.

6.4.7 The Domestic Violence Act (116 of 1998)

Mobility aware: No

Gender aware: Yes

Mobility and Gender aware: No

Building on the South African Constitution and its Bill of Rights, which prohibits discrimination on several grounds including gender, sex, and sexual orientation, the Domestic Violence Act (116 of 1998), can be seen as a progressive Act. This is particularly in comparison to the earlier, Prevention of Family Violence Act (1993), which although provided the first legal mechanism for women experiencing Intimate Partner Violence (IPV)²⁰ was still shaped by patriarchal ideology and aimed to protect the family unit rather than women in their own right.

In contrast the Domestic Violence Act, provides a broader definition of the intimate relationships in which IPV can occur, with specific mention of same-sex partnerships. For example, the Act defines a "domestic relationship" as a "relationship between a complainant and a respondent" (The Republic of South Africa, 1998b: 2) in a number of ways which significantly rejects the heteronormative language of the earlier Prevention of Family Violence Act (1993) and instead accounts for the different relationship configurations in which IPV can occur (Vetten, 2014). By positioning violence against women within a rights framework, the Domestic Violence Act also shifts the State response from a focus on protecting the family (as found in the earlier Prevention of Family Violence Act, 1993) to recognising women as requiring protection in their own right (Lynch & Sanger, 2016: 29; Vetten, 2014).

²⁰ Vetten (2014) argues that previously, violence against women by their intimate partners was considered a "private" matter and reduced to an individualised response with little consideration of the gendered and socio-political factors fuelling such violence.

The Act also recognises that men can experience IPV and also grants queer women experiencing partner abuse the same rights and protections as heterosexual women, such as having the abusive partner arrested or for the abused partner to obtain a protection order against her abusive partner. However, it should be noted that in accordance with the challenges that LGBTIQ+ populations experience in terms of discrimination and stigma – both from their communities and from service providers and government officials – the Act does not provide any measures to address these barriers. In addition, there is no reference to migration or to migrant, asylum seeker, refugee or non-national women. Thus those often facing heightened levels of vulnerability to domestic violence (especially when undocumented and unable to report to the police) are not considered.

Despite the progress made through the expansion of the legal definition of intimate partner violence to include violence between same-sex partners, violence occurring in non-marital relationships, and intimate partner violence experienced by men in the Domestic Violence Act, South African policy has largely failed to keep on this progressive trajectory. In fact, as Lynch and Sanger (2016) note, since the Act, South African policy development has returned to the pre-1994 emphasis on “preserving the family” (31). For example, the Integrated Social Crime Prevention Strategy (2011)²¹ developed by the Department of Social Development (DSD) names “dysfunctional families” as a key factor in perpetuating a cycle of crime and violence and states as one of its six strategic objectives the improvement of “social fabric and cohesion within families” (ibid: 9). A similar emphasis on the family as the site of moral regeneration is reflected in the development of a Green Paper on Families²² (2011) drafted by DSD.

6.4.8 The Promotion of Equality and Prevention of Unfair Discrimination Act (2000)

Mobility aware: No

Gender aware: Yes

Mobility and Gender aware: No

The Promotion of Equality and Prevention of Unfair Discrimination Act 4 of 2000 (the Equality Act) prohibits unfair discrimination, hate speech and harassment on a large number of grounds, including religion, conscience, belief and culture. However, although gender is addressed, as with the Domestic Violence Act, there is no reference to migration or to migrant, asylum-seeker, refugee or non-national women. Thus those facing heightened levels of vulnerability to violence and discrimination are not considered.

6.4.9 The Criminal Law (Sexual Offences and Related Matters) Amendment Act (2007)

Mobility aware: No

Gender aware: Limited

Mobility and Gender aware: No

The Criminal Law (Sexual Offences and Related Matters) Amendment Act of 2007, also referred to as the Sexual Offences Act, replaces some common law provisions on sexual offences and some sections of the old law, the Sexual Offences Act of 1957. The overall aim of the Amendment was to provide a uniform and coordinated approach to the implementation of laws relating to sexual offences, on the basis that previous law did not adequately or effectively address many aspects of the commission and adjudication of sexual offences. In this way better protection to the can be provided to victims of sexual offences.

The Amendment Act incorporates all sexual crimes into one law. It also expands the definition of rape and equalises the age of consent for both male and females to 16 years of age. The Act provides for various services to the victims of sexual offenses including free post-exposure prophylaxis (PEP) for HIV, and the ability to obtain a court order to compel HIV testing of the alleged offender. Significantly, here the Act also expands the criminalisation of sex work (from the earlier Sexual Offences Act 23 of 1957) to include the clients who pay for sex. Therefore,

²¹ https://www.saferspaces.org.za/uploads/files/Integrated_SCP_Strategy_0.pdf

²² https://www.gov.za/sites/default/files/gcis_document/201409/34692gen756a0.pdf

while aspects of the Sexual Offences Amendment Act demonstrate efforts to address gendered vulnerabilities and protect victims, who in South Africa are mostly women, the increased sanctions for the buyers of sex do the opposite and place women who sell sex at greater risk. Furthermore, while criminalised, women selling sex are often unable to report rape and access health services including HIV treatment (Scourgie et al., 2011; Shackleton et al., 2019)

6.4.10 The Women Empowerment and Gender Equality Bill (WEGE) 2013.

Mobility aware: No

Gender aware: Limited

Mobility and Gender aware: No

Building on previous legislation, The Women Empowerment and Gender Equality Bill (WEGE) (2013) gives effect to section 9 of the Constitution of South Africa (1996) in as far as the empowerment of women and gender equality. Establishing a legislative framework, the Bill aimed to align all aspects of law and implementation of laws relating to women empowerment and establishing mechanisms and procedures that will advance the South African Government towards gender equality. Although the Bill was adopted by Parliament, it has not been passed into law and is still subject to consultation.

The Bill calls for the progressive realisation of at least 50% representation of women in decision-making structures, aims to improve access to education, training and skills development, focuses on women's reproductive health and seeks to eliminate discrimination and harmful practices, including GBV. However, the Bill has been criticised for simply duplicating previous acts on gender equality, including the Commission on Gender Equality Act (1996), the Skills Development Act (1998), the Employment Equity Act (1998) and the Promotions of Equality and Prevention of Unfair Discrimination Act (2000). This means that while the WEGE Bill ambitiously bids to promote gender equality it also confuses the current system and also does nothing to address structural issues such as patriarchy. It has also been noted that the Bill lacks appropriate implementation processes and mechanisms and an understanding of the complex realities of women on the ground. In particular, there is no recognition of the intersecting vulnerabilities and forms of discrimination that women face based on race, class and sexual orientation. Therefore, while the Bill reiterates existing rights and protections to some women, it also simultaneously neglects the equality rights of other groups of women including sex workers, widows, rural women (in relation to land rights) and disabled persons as well as the right of LGBTIQ+ persons (Vetten, 2014).

Like the previously mentioned gender policies, the WEGE also fails to engage with migration in any way. Given that migrant women cross borders to trade, learn skills and earn remittances to send home and engage in the informal work sector their absence from these gender policies is concerning.

6.4.11 The Integrated Programme of Action Addressing Violence Against Women and Children 2014-2018

Mobility aware: No

Gender aware: Yes

Mobility and Gender aware: Limited

In 2010 the Inter-Ministerial Committee (IMC)²³ on Violence was established in response to the extremely high levels of GBV against women and children in South Africa and in recognition of the need to address the underlying issues and to ensure that women and children can realise their human rights. Without adequate consultation with key stakeholders in the sector, the Integrated Programme of Action Addressing Violence Against Women and Children (POA) was developed and brought out (Department of Social Development, 2014).

²³ This included the Ministers of Social Development; Justice and Constitutional Development; Women, Children and People with Disabilities; Health; Home Affairs; Police, Communications and Basic Education to look into the root causes of VAWC. In addition, Cabinet announced the establishment of a National Council Against Gender-Based Violence (NCGBV).

The POA outlines actions designed to prevent violence against women and children (VAWC), to improve the implementation of existing laws and services aimed at victims of violence and to provide adequate support services. The proposed interventions and programmes in the POA outline a range of existing and new measures aimed at complementing existing initiatives such as the Thuthuzela Care Centres, Sexual Offences Courts and other victim empowerment initiatives.²⁴

Drawing on evidence and research findings, stakeholder consultations and relevant reports from government departments, the proposed POA provides a framework for a comprehensive and systematic approach to address VAWC, which includes a set of expected outcomes to be achieved through the realisation of the main objectives and a set of key indicators.

The POA recognises that particular groups of women and children face heightened vulnerabilities, including women with disabilities, older women, lesbian, bisexual and transgender women, women with HIV and AIDs and also migrant and refugee children. However, there is little substance in terms of unpacking why such vulnerabilities exist and how they intersect. There is no other mention of migration for example, and no engagement with women and girls who are on the move and the vulnerabilities created by a lack of access to documentation, xenophobia and subsequent discrimination and violence. There is also no engagement with the needs of LGBTIQ+ persons, whom we know also face high levels of vulnerability to GBV.

The POA is currently undergoing a revision with the inclusion of civil society and participation of provincial governments. The scope of the review process includes identifying gaps in the current POA, as well as identifying evidence-based programmes that work.

THE NATIONAL STRATEGIC PLAN SHADOW FRAMEWORK REPORT

In response to a lack of movement with the POA, as well as claims that there was very little consultation before the POA was developed, over the period of 2014–2017 civil society developed the National Strategic Plan (NSP) Shadow Framework, under the Stop Gender Violence Campaign (Stop Gender Violence Campaign, 2017). The Campaign calls for the involvement of local communities and civil society to put pressure on the government to act and make sure that the voices of those affected by GBV are taken into account.

THE NSP SHADOW FRAMEWORK OUTLINES FIVE PRIORITIES:

1. Expand the definition of gender-based violence (to include all groups of marginalised individuals affected by GBV and not only violence against women and children)
2. Fill the gaps in implementing existing laws and policies
3. Improve and expand psycho-social services for survivors
4. Significantly increase investment in prevention, intervention, research and documentation
5. Establish robust accountability mechanisms and sufficient resources

In the call to expand the definition of GBV the shadow framework not only recognises GBV as an intersectional issue that transcends culture, race and gender (thus addressing the limitation of the WEGE Bill) but also demands more understanding of how different groups are impacted and in what ways. As stated,

²⁴ The Thuthuzela Care Centers are one-stop facilities that have been introduced as a critical part of South Africa's anti-rape strategy, aiming to reduce secondary victimisation, improve conviction rates and reduce the cycle time for finalisation of cases. Led by the NPA's Sexual Offences and Community Affairs Unit (SOCA), in partnership with various departments and donors, they are a response to the urgent need for an integrated strategy for prevention, response and support for rape victims (see: https://www.unicef.org/southafrica/protection_998.html)

In recent years, progressive steps have been achieved in developing laws and policies to address GBV and broadening the concept to be inclusive of a wider spectrum of victims and acts of victimisation. 'Gender based violence' has become an umbrella term, including all forms of physical, verbal, emotional, economic and sexual harm perpetrated against women, girls, men, boys, LGBTI persons and other vulnerable groups (such as sex workers, refugees, prisoners, and HIV-positive people).

(Stop Gender Violence Campaign, 2017)

In the call for a development of a National Strategic Plan (NSP) to end GBV – the aim is to align the country around a set of clear strategic priorities and create an accountability mechanism for the performance of government, the private sector and civil society organisations in addressing GBV. The Shadow Framework addresses the weaknesses and gaps in the Integrated Programme of Action and make recommendations accordingly.

ZAMBIA

IMMIGRATION LAWS AND POLICIES

Similar to South Africa, Zambia's early approach through laws and policies to immigration has been shaped by notions of control and restriction. This is shown by the fact that up until 2017, the reception of refugees was governed by the 1971 Refugee Control Act – with the very language of the act signaling the focus within Zambian law on the regulation of migration. As signatory to the 1951 Refugee Convention, Zambia did not adopt a number of its refugee-rights provisions into law (Maple, 2018) including elements of the refugee definition. As previously noted (see page 31) Zambia follows a dualist system through which international law provisions can only be enforced when formally incorporated into national/domestic law.

Zambian law is also based on restricting refugees to settlements or camps, rather than allowing free movement, as is the case in South Africa. That said, the frequent movement of people across borders found in Zambia and neighbouring countries means that there has also been a level of 'de facto integration' in border towns and urban areas. As a source, transit and destination country for migration, Zambia shares eight international borders thus facilitating frequent forms of migration. While migration for trade and employment is frequent amongst both men and women, Zambia's close proximity to unstable countries facing conflict, political tensions and violence and poverty mean that there is also high levels of asylum seekers and refugees crossing into Zambia in search of safety and protection. Therefore, Zambia is used by both regular and irregular migrants.

6.4.12 The Immigration and Deportation Act No. 18 of 2010 and The Refugee Act No. 1 of 2017

Mobility aware: Limited

Gender aware: No

Mobility and Gender aware: No

In contrast to South Africa, trends in Zambia indicate that there has been a shift in approach from one of restriction to more openness to and accommodation of the realities of migration and cross-border movements. The Immigration and Deportation Act no. 18 of 2010 is the principle act for regulating entry, exit and stay of foreign nationals in Zambia and is based on a human rights approach to migration issues (The Republic of Zambia, 2010). More significant here is The Refugee Act No.1 of 2017, which replaced The Refugee Control Act and which provides for the recognition, protection and control of refugees alongside the need to make provisions for the rights and responsibilities of refugees in Zambia (The Republic of Zambia, 2017a). The Act also domesticates the UN Convention relating to the status of Refugees 1951 and its Protocol of 1967, as well as the Organisation of African Unity (OAU) Convention Governing the Specific Aspects of Refugee Problems in Africa, 1969.

The Refugee Act, alongside a public commitment by the President to relax restrictions on the freedom of movement of refugees in the two main refugee settlements signals a recent shift in Zambia's approach to migration. Furthermore, the Strategic Framework for Local Integration of Former Refugees in Zambia (SFLI) (2014) indicates a significant shift in Zambia's approach to migration. The SFLI aimed to regularise the status of 10,000 former Angolan refugees and 4,000 former Rwandan refugees amidst pressure from the UN to repatriate them (Maple, 2018). However, the Act also retains restrictions from the earlier Act including the encampment policy, which poses one of the main protection challenges faced by refugees in Zambia.

Zambia has voluntarily signed up to the Comprehensive Refugee Response Framework (CRRF) – a centerpiece of the UN's current reform plans for the refugee system and as the operational pillar of the new UN Global Compact on Refugees. Zambia was the first country in Southern Africa to sign up.

MIGRATION AND HEALTH

6.4.13 National Health Strategic Plan (2017–2021)

Mobility aware: No

Gender aware: No

Mobility and Gender aware: No



Despite the discernable shift in Zambia's migration policy approaches, a review of policies and plans regarding health suggests that engagement with migration and gender is limited. In its National Health Strategic Plan (2017–2021) for example, as the most current plan regarding healthcare services, migration is not mentioned. There is only reference to 'vulnerable' and 'at risk' populations generally (The Republic of Zambia, 2016: 33) and in relation to TB (ibid: 35), but it does not include migrants specifically. Regarding gender, there is only a general reference, 'women and children are especially vulnerable' (The Republic of Zambia, 2016, p. 24). Meanwhile Zambia's National Health Policy (NHP) 'A Nation of Healthy and Productive People' (2012) also fails to include migrants or mobile populations in its groups of 'vulnerable and most at risk populations'. The exception is one reference to 'the main drivers' of the HIV epidemic, including 'multiple concurrent sexual partners, low and inconsistent use of condoms, low rates of male circumcision in some provinces, mobility and labour migration, vulnerability and marginalised groups and vertical mother to child transmission' (The Republic of Zambia, 2012: 7). One other reference mentions that 'the spread of disease, the importation of consumer goods and the migration of health professionals cannot be adequately controlled by states in isolation, but depend on international cooperation and assistance' (The Republic of Zambia, 2012: 7)

Without discussing migration, the document mentions global interdependence and that health approaches need to be adapted:

Globalisation, which has led to increased economic, political and social interdependence and global integration that occurs as capital, traded goods, people, concepts, images, ideas and values diffuse across national boundaries and is changing the way that states must protect and promote health in response to the growing number of health hazards that increasingly cross national boundaries. No country, acting alone, can adequately protect the health of its citizens or significantly ameliorate the deep problems of poor health.

(The Republic of Zambia, 2012: 7)

This omission of migration from key health policies is significant given Zambia's position as the designated 'Southern Africa Development Community Regional Collaborating Centre (RCC)' (The Republic of Zambia, 2016: 38). In this role Zambia is expected to coordinate the southern region of Africa under the Africa Centre for Disease Control

established by the Heads of State and Government during the 24th Ordinary (ibid) and to ‘ensure that the core capacities in surveillance, laboratory systems and networks, information systems, emergency preparedness and response, and public health research are implemented and strengthened’ (The Republic of Zambia, 2016: 39).’

6.4.14 National Health Policy (NHP) 2012, National Community Health Strategy 2017–2021 and National E-Strategy 2017–2021

Mobility aware: No

Gender aware: Yes

Mobility and Gender aware: No

The NHP however, does engage with gender. It states, “To ensure equitable access to healthcare for all the people of Zambia, regardless of their geographical location, gender, age, race, social, economic, cultural or political status.” (The Republic of Zambia, 2012: 25). It acknowledges that gender affects ‘the source of ill health and healthcare seeking behaviours’ (The Republic of Zambia, 2012: 4) including vulnerability to HIV: ‘according to ZDHS 2007... Females (16.1%) are more likely to be HIV positive than males (12.3%) due to biological, economic and social factors.’ (Republic of Zambia, 2012: 7). In addition, ‘there are some social, cultural and religious beliefs and practices, not the least gender related, that negatively affect health e.g. early marriages’ (The Republic of Zambia, 2012: 4).

The policy thus commits to ensuring ‘...gender sensitivity in the management and delivery of health services at all levels in accordance with the national gender policy’ (The Republic of Zambia, 2012: 26), to ‘facilitate the creation of a one stop centre in health facilities for gender based violence’ (The Republic of Zambia, 2012: 34), and to ‘ensure that infrastructure is user friendly, gender sensitive and accessible to differently abled people, appropriateness and designs of infrastructure’ (The Republic of Zambia, 2012: 41). This can be seen in some of the regional initiatives on public health that Zambia has been involved in.

Zambia’s National Community Health Strategy 2017–2012 also notes the centrality of gender in the NHP while also outlining key ways in which Zambia can address the key determinants of health – including gender – that affect the well-being of key populations including, ‘vulnerable groups: young children, adolescents, women in the reproductive age, and HIV/AIDS infected, and those affected by non-communicable diseases like diabetes, hypertension, coronary heart diseases and cancer.’ (The Republic of Zambia, 2017b: 16). It notes,

Gender is yet another major determinant of health since it influences access to health care and vulnerability. Just a quarter of households are led by women rather than men, while almost half of the houses are owned by women. The role of women is also diverse in terms of decision-making; a good quarter of women cannot participate in own health care decision making. Own decisions cannot be made by many women with regards to departure from house, sexual intercourse or own opinion. Gender Based Violence, also as a consequence of own decision making, is accepted by almost half of the women. The ways of decision making differs from province to province... (The Republic of Zambia, 2017b: 43)

There is recognition of the need for ‘gender sensitive interventions’ (The Republic of Zambia, 2017b: 62), which include working with the realities of socio-economic constraints, GBV and addressing a lack of gender awareness in communities and among health-practitioners. (The Republic of Zambia, 2017b: 62–80). However, the National Community Health Strategy does not consider of gender beyond women and men and thus a neglect of the rights and needs of LGBTIQ+ persons and there no mention migration or mobility at all.

Finally, Zambia’s National E-Strategy 2017–2021 intends to strengthen health systems by making them “...more efficient and responsive to dynamic needs globally.” through the use of information and communication technology (Republic of Zambia, 2017c: 5). The development of an electronic computer systems aims to ‘...improve health

service delivery by tracking HIV diagnostic services, managing patient data, providing telehealth infrastructure and eLearning platforms, and building the capacity of the Ministry to provide strong leadership and governance to ensure effective management in the application of health services' (The Republic of Zambia, 2017c: 5).

This strategy could be key in terms of shaping Zambia's approach to health and specifically the vulnerabilities experienced by migrants and migrant women, particularly given the recognised challenges in working with mobile communities. However, the strategy does not mention migration, mobility or gender.

MIGRATION AND GENDER

6.4.15 Anti-GBV Act no. 1 2011 and The Gender Equity and Equality Act 2015

Mobility aware: Yes

Gender aware: Yes

Mobility and Gender aware: No

Zambia has undertaken a domestication process whereby the international commitments and ratifications have been enacted into domestic laws and provides for a legal framework that seeks to end GBV and promote gender equality and equity.

Zambia is one of the only countries in the SADC region to have a specific anti-GBV law. The Anti-GBV Act (The Republic of Zambia, 2011), which is in line with international legal frameworks and draws experience from best global practices, provides a comprehensive and progressive framework for protection of GBV offences and guidance on adequate recourses. The aim is to create a 'holistic approach' to countering GBV, drawing on legal and non-legal support, as well as establishing a Gender Committee and Provincial and District Gender Task Force. The implementation of the Act has not been fully successful due to a lack of resources available including shelters for GBV victims and other structures of support. The Act is also without any indicators and therefore is difficult to monitor and measure in terms of impact.

The Gender Equity and Equality Act (GEEA) 2015 similarly is a progressive piece of legislation that seems to domesticate some of the women's rights and gender provisions in regional, continental and international instruments to which Zambia is party (The Republic of Zambia, 2015). However, the Act has not been operationalised.

While both Acts deal comprehensively with gender-based violence, this is based on an understanding of gender meaning women. There is no reference in either Act to those who are non-gender conforming and the LGBTIQ+ populations. There is also no mention of migration, mobility or the heightened risks of GBV faced by migrant and refugee women.

6.5 HUMAN TRAFFICKING LEGISLATION: SOUTH AFRICA AND ZAMBIA

The Prevention and Combatting of Trafficking in Persons Act No 7 of 2013 (South Africa) The Anti-Human Trafficking Act No 11 of 2008 (Zambia)

Mobility aware: No

Gender aware: Limited

Mobility and Gender aware: Limited

Finally, here it is important to note that at a national level both South Africa and Zambia, like other member states in the SADC region have (over the past decade), demonstrated their commitment to the United Nations (UN) Convention against Transnational and Organised Crime (UN Palermo Convention, 2000) and its supplementary protocols, The Protocol to Prevent, Suppress and Punish Trafficking in Persons (UN Palermo Protocol, 2000) and The Protocol Against the Smuggling of Migrants by Land, Sea and Air (UN Palermo Protocol, Smuggling, 2000) through legislative and policy measures. The enactment of national legislation has been justified as a necessary response to the crime of human trafficking and associated human rights violations, which is said to be widespread and increasing across the region.²⁵

South Africa signed the Palermo Protocol in 2000 and ratified it in 2004. Subsequently the Prevention and Combatting of Trafficking in Persons (TiP) Act was passed in 2013 and implemented in 2015 (The Republic of South Africa, 2013b). It is built on a similar definition to trafficking found in the Palermo Protocol with trafficking based on a three-part burden – recruitment, movement and control. Where the TiP Act differs is that the definition is extended to include some forms of illegal adoption of a child and forced marriage. The Act, like the Protocol addresses the trafficking of persons for labour, the removal of organs, and sexual exploitation. However, the focus at a global, regional and national level has been on trafficking for the purposes of sexual exploitation.

The TiP Act is a strong piece of legislation, however, this Act must be reviewed in a broader context of global international pressure on SADC states by the EU and the United States of America (USA) to externalise border control and to essentially prevent movement. Therefore, while on the one hand the Act offers a contrasting ‘protective orientation’ (Palmary & de Gruchy, 2016: 41) to the other migration-related policies in South Africa which are shaped by securitisation, on the other it is also a part of a larger agenda, which can be seen shaping AU and SADC approaches to migration.

Furthermore, the Act has a specific gender lens through which women are seen as victims, particularly in terms of sex trafficking and sexual exploitation – suggesting that women who migrate or enter sex work cannot do so of their own accord but are forced into it (Palmary & de Gruchy, 2016: 6). These two points are discussed further in the findings and discussion section (see pages 56).

Zambia meanwhile was among the first countries in the SADC to adopt an extensive domestic legislation on human trafficking: The Zambian Anti Human Trafficking Bill (The Republic of Zambia, 2008), which is also closely modelled upon the Palermo Protocol. It goes beyond the Protocol’s distinct focus on border controls and also includes comprehensive standards for victim protection and care that can be categorised in the domain of human rights.

²⁵ Over the past decade, 12 of the 15 SADC member states have implemented specific legislation to deal with human trafficking while the remaining three countries deal with the issue through their national legal frameworks. Through ratifying the Protocol countries are expected to develop counter-trafficking legislation as well as carry out other counter trafficking activities. Countries are subsequently assessed and ranked in the U.S. Department of State’s annual publication of the TiP report and those that do not appear to be complying with international norms and the minimal standards of the Trafficking Victims Protection Act (TVPA) are placed in a Watch List and face pressure to develop counter-trafficking legislation and implement anti-trafficking measures.



TABLE 2: AN OVERVIEW OF KEY POLICIES AND FRAMEWORKS: MOBILITY AND GENDER AWARE

POLICIES/ FRAMEWORKS	MOBILITY AWARE	GENDER AWARE	MOBILITY AND GENDER AWARE	CURRENT STATUS
CONTINENTAL – AU				
African Union Agenda 2063 (2015)	NO	YES	NO	FRAMEWORK – NO INDICATORS
AU Revised Migration Policy Framework for Africa and Plan of Action (2018-2027)	YES	YES	YES	FRAMEWORK AND PLAN OF ACTION
AU Maputo Plan of Action (MPoA) 2016-2030 for the Operationalisation of the Continental Policy Framework for Sexual and Reproductive Health Rights (draft) 2016	NO	LIMITED	LIMITED	DRAFT PLAN OF ACTION
AU The Continental Policy Framework for Sexual and Reproductive Health and Rights (2005)	YES	NO	NO	APPROVED
Common African Position (CAP) on the Global Compact for safe, orderly and regular migration	YES	NO	LIMITED	GUIDING DOCUMENT (NON-BINDING)
REGIONAL – SADC				
SADC Protocol on the Facilitation of Movement (2005)	YES	NO	NO	ADOPTED BUT NOT OPERATIONAL
Policy Framework for Population Mobility and Communicable Diseases in the SADC Region (2009)	YES	YES	YES	IN PROCESS – NOT YET FINALISED
SADC HIV and AIDS Cross Border Initiative (2010)	YES	YES	LIMITED	IMPLEMENTED BUT NOT COMPLETE

POLICIES/ FRAMEWORKS	MOBILITY AWARE	GENDER AWARE	MOBILITY AND GENDER AWARE	CURRENT STATUS
SADC Declaration on Tuberculosis in the Mines (2012)	LIMITED	LIMITED	LIMITED	RATIFIED 2012
SADC Protocol On Gender And Development (2008) Revised 2016	NO	YES	LIMITED	IMPLEMENTED
Revised SADC Regional Indicative Strategic Development Plan (RISDP) 2005-2020	NO	YES	NO	ADOPTED
SADC Gender and Development Monitor. Tracking Progress on Implementation of the SADC Protocol on Gender and Development (2016)	NO	YES	NO	IN PLACE
Sexual And Reproductive Health Strategy For The SADC Region 2006-2015	YES	YES	LIMITED	IN PLACE
SADC HIV And AIDS Strategic Framework (2010-2015)	YES	YES	LIMITED	IN PLACE
Strategy For Sexual And Reproductive Health And Rights In The SADC Region 2019 – 2030	YES	YES	LIMITED	IN PLACE
SADC Protocol on Health 2004	NO	NO	NO	ADOPTED
SADC Regional Migration Policy Framework (RMPF) 2018-2030	YES	YES	YES	DRAFT

POLICIES/ FRAMEWORKS	MOBILITY AWARE	GENDER AWARE	MOBILITY AND GENDER AWARE	CURRENT STATUS
SOUTH AFRICA				
The National Health Act 2003	NO	NO	NO	PASSED INTO LAW (ACT)
The Refugee Act (1998) and the Immigration Act 2002 (amended 2004)	YES	NO	NO	PASSED INTO LAW (ACT)
The National Strategic Plan (NSP) for HIV, TB and STIs (2012–2022)	YES	YES	LIMITED	STRATEGIC PLAN
The National Health Insurance (NHI) 2017	LIMITED	LIMITED	NO	DRAFT
The National Development Plan 2030 (2012)	YES	LIMITED	NO	IN PLACE
The White Paper on Immigration 2017	LIMITED	NO	NO	DRAFT
Prevention and Combatting of Trafficking in Persons Act 7 of 2013	NO	LIMITED	LIMITED	PASSED INTO LAW (ACT)
The Domestic Violence Act (1998),	NO	YES	NO	PASSED INTO LAW (ACT)
Equality and Prevention of Unfair Discrimination Act (2000)	NO	LIMITED	NO	PASSED INTO LAW (ACT)
The Sexual Offences Amendment Act (2007)	NO	LIMITED	NO	PASSED INTO LAW (ACT)

POLICIES/ FRAMEWORKS	MOBILITY AWARE	GENDER AWARE	MOBILITY AND GENDER AWARE	CURRENT STATUS
The Women Empowerment and Gender Equality Bill (WEGE) 2013.	NO	YES	NO	UNDER CONSULTATION (BILL)
The Integrated Programme of Action Addressing Violence Against Women and Children 2014-2018.	NO	YES	LIMITED	IN PLACE
ZAMBIA				
The Immigration and Deportation Act No 18 of 2010	LIMITED	NO	NO	PASSED INTO LAW (ACT)
The Refugee Act No. 1 of 2017	YES	NO	NO	PASSED INTO LAW (ACT)
National Health Strategic Plan 2017-2021	NO	NO	NO	IN PLACE
National Health Policy (NHP) 2012	NO	YES	NO	IN PLACE
National Community Strategy 2017-2021	NO	YES	NO	IN PLACE
The Gender Equality and Equity Act (GEEA) 2015	NO	YES	NO	NOT OPERATIONALISED
The Anti-GBV Act 2011	NO	YES	NO	ENACTED BUT CHALLENGES IN IMPLEMENTING
The Anti-Human Trafficking Act 2008	NO	LIMITED	LIMITED	PASSED INTO LAW (ACT)

6.7 CONCLUSION

The policy review identifies the extent to which the existing policies and frameworks across the AU, SADC, South Africa and Zambia engage with gender, migration and health. Overall, we found that while both the AU and SADC have produced a range of comprehensive policy frameworks, which address many of the identified gendered vulnerabilities and key issues in the literature, these are rarely fully implemented and tend to get watered down at the national level. Critically, many fail to contain indicators to monitor nor means to enforce these policy frameworks. A number of policies that have been implemented do not effectively engage with gender and migration. The few policies that do so remain in draft form.

The review also shows that at a national level in South Africa there are clear trends in terms of an increasingly restrictive approach to migration and health. This contradicts many of the regional protocols, frameworks and initiatives that South Africa is party to and which address the intersections of mobility and gender and particularly gendered vulnerabilities. Zambia's policies meanwhile suggest a shift towards a more open approach to migration despite an encampment policy still being in place. Zambia's and South Africa's gender policies indicate comprehensive and progressive policies but with little implementation.

Therefore, there is a lot to be done in order to translate commitments into action. Many of these policies are undermined by restrictive measures arising from inadequate implementation (often due to a lack of funding) of the adopted protocols and policy frameworks at national levels, thus hindering progress on regional integration and recognition of gender, migration and health realities in SADC.



7. DISCUSSION

An overview of the policy review revealed a cascading effect of engagement with gender and migration, down from continental to national level, that manifests in a change in focus: from responding to the realities of migration and advancing and more progressive and protection-orientated types of migration policies, to an almost singular focus on securitisation and restriction of mobility.

Accordingly, it is also important to note that the mere existence of (good or bad) policies and legislation does not necessarily mean change and as Dodson and Crush argue, '...the existence of protection on paper often does not equal protection in reality' (Dodson & Crush, 2015: 11). While in many instances laws are circumvented or simply flouted as highlighted in relation to corruption within the asylum system in South Africa (Amit, 2015), in many cases migrants find themselves facing greater risks as a direct result of the policies that shape their experiences.

Therefore, while the literature on gender dimensions of migration and health can point out key issues and concerns and a review of policy can show if and how policies are responsive to these key issues and concerns, it is critical to explore how those who are actually in charge of designing and/or implementing policy engage with gender and migration. In this section we report on the findings of the empirical research with policy makers and individuals working with policy at a SADC level and nationally, in South Africa and Zambia. In doing so, we consider the extent to which the issues of gender, migration and health are understood and engaged with, what challenges exist, and what is regarded as impacting on policy and practice at the different levels.

As the methodology described, the interviews took place with individuals who are influencing policy and working with policy on the ground. From 20 interviews a broad range of perspectives, concerns and challenges were explored.

FROM AN ANALYSIS OF THE INTERVIEW DATA, WE IDENTIFIED FIVE KEY THEMES. THESE ARE:

- 1. Insufficient policy engagement with migration and health. Where responses do exist, the gendered dimensions are lacking.** Existing responses are also driven by non-governmental and international organisations.
- 2. Political agendas and popular perceptions are driving policy making processes,** including the scapegoating of migrants for the poor performance of public healthcare systems. Insufficient use of existing evidence in the development of policy responses to migration and health.
- 3. Poor understanding of gender** which is often equated as referring to 'women and girls' with no consideration of the needs of male and LGBTIQ+ migrants. Engagement with sexuality is notably absent. Heteronormative assumptions about gender, sexuality and family structures persist, including the framing of migrant 'women and girls' as vulnerable, lacking agency and therefore in need of 'protection'.
- 4. Increasingly restrictive and securitised approaches to international migration** may negatively affect the health and wellbeing of people on the move, including women and girls.
- 5. Limited regional coordination, cooperation, and policy coherence** in the development of responses to migration and health, including for women and girls.

Each of these five themes are discussed in relation to the research findings and existing literature below.

7.1 INSUFFICIENT POLICY ENGAGEMENT WITH MIGRATION, HEALTH. WHERE RESPONSES DO EXIST, THE GENDERED DIMENSIONS ARE LACKING. Existing responses are also driven by non-governmental and international organisations

The policy review showed that although continental and regional policies engage to an extent with gender and migration and migration and health, that at a national level, where the impact is felt, the intersecting issues are largely ignored. In fact, the South African policies on immigration, health and on gender show no recognition of where these issues intersect to create heightened vulnerabilities for migrants and especially women on the move. This was also recognised by a number of the respondents in South Africa and SADC who noted that while the laws and frameworks in place in South Africa were "gender progressive" (as also shown in the review), a lack of implementation reflected a failure to prioritise a "gender lens". For example, David (not his real name) an advisor working for the Government Department in South Africa noted,

"...restrictions on access to healthcare in various countries would impact on the achievement of the SDGs...If there are still restrictions...then how do we move forward? There are repercussions in terms of impact levels – so how do we move forward with all populations concerned?" (Mpho, SADC).²⁶

"We have gender progressive laws and regulations but they are not implemented... The gender lens is not a priority" (David, Government Department SA)

This observation is also supported by the literature, through which the vulnerabilities faced by women on the move and especially in border spaces have been highlighted. Frida, a Legal and Advocacy Officer for a South African NGO also supported this claim in arguing that specific gender-based policies are absent at the borders and Home Affairs and this results in women and other vulnerable groups facing greater risks when on the move. As she stated,

²⁶ All names have been changed in order to protect the anonymity of the respondents who chose not to be identified. In addition, specific places of work/affiliations have been altered and are deliberately vague to protect identities.

"I would like to talk about the absence, more than the presence, of policies: there are no specific gender-based policies at the border and at Home Affairs" (Frida, Legal and Advocacy Officer, SA)

This was also confirmed by Dhana, working for a Government Department in South Africa who described what she had observed in terms of how gender, migration and health are approached in policy,

"Home Affairs has no specific gender programmes other than equity with the staff – they do not consider gender vulnerabilities with applicants etc... all I know is that in Cape Town [Home Affairs] they allow women with kids to go first..." (Dhana, Government Department, SA)

Dhana went on to explain that in the last seven years there has been no specific gender-related programmes in immigration and services at Home Affairs and, while initiatives around gender could be found at an international, continental and regional level, these did not filter down,

"What could potentially happen and this happened last year, is that international, continental and regional initiatives around migration and gender that are there – come up in national policy and development plans... gender is taken as gender mainstreaming but health – it's not really there" (Dhana, Government Department, SA)

"Gender stuff is definitely there in the big plans – development goals in the AU... global compact for migration... AU free movement – this all came out of meetings. But then doesn't really filter down" (Dhana, Government Department, SA)

Where policy responses therefore fail to engage with gender, migration and health it is clear that in order to fill the gap – where complex realities and gendered vulnerabilities are found – UN organisations, international agencies and local NGOs are often working on regional and national initiatives with member states. Respondents from a UN organisation working in both South Africa and Zambia on a collaborative HIV/AIDS programme described the key issues that shaped their work and the challenges faced. As Margaret, based in Lusaka described,

"there are a lot of challenges we face...the women crossing are very vulnerable as they do not have the papers...they often move together in groups but they are still at risk... There are many health issues they face and sometimes they are pregnant or they have been abused by those who they meet when crossing...the challenge is that they can't always access the healthcare and it is becoming so hard to cross...so we need to look at all of these issues..." (Margaret, International Organisation, Zambia)

Similarly, Leigh Ann, working for a UN agency in a border region of Zambia also noted that,

"Policy is not always going to help you here...it doesn't always match what we are seeing on the ground and what is coming up as the key issues."
(Leigh Ann, UN Agency, Zambia)

When asked how they worked with this disconnect between policy and practice, Atti responded,

"It's what we have always done...on the ground these are the real things happening... some of the policies we have to know what we can do where...but much of the time we have to make a plan to make this work" (Leigh Ann, UN Agency, Zambia)

Local NGOs in South Africa also spoke of their work and the cases they dealt with in terms of the gendered vulnerabilities faced by migrants. Abigail, from an HIV/AIDS organisation spoke of the advocacy work they were involved in to highlight the risks faced by migrants in need of HIV care and treatment. Frida also described the lack of documentation as the key issue faced by migrants and especially women who need to be able to access the clinics, to get healthcare and education for their children. As she states, “A denial of documentation is a denial of many basic rights” (Frida, Legal and Advocacy Officer, SA).

Documentation was identified by many of the respondents as a key issue, shaping the experiences and, vulnerabilities of migrant women. Many wanted to point out that those without documents were not without papers by choice but because the system made it so difficult. As Frida noted,

“Without papers you can’t move, you can’t get the services you need. But to get documents officially is very hard...and it is being made harder for many reasons...” (Frida, Legal and Advocacy Officer, SA)

Frida went on to describe these “many reasons” as including the long wait at Home Affairs, the high level of rejection of asylum claims and a lack of transparency and support.

7.2 POLITICAL AGENDAS AND POPULAR PERCEPTIONS ARE DRIVING POLICY-MAKING PROCESSES, including the scapegoating of migrants for the poor performance of public healthcare systems. Insufficient use of existing evidence in the development of policy responses to migration and health.

Key to the discussions around migration and gender policies was the recognition that beyond the limitations of policy, there was another agenda at play. Responses to questions about gendered vulnerabilities and migration showed an awareness that the arguments being used at a policy level and to drive policy shifts were part of a broader political agenda to shift blame onto migrants and away from state-failure. Dhana, working for a Government Department in South Africa for example claimed,

“This is a national thing – not only securitisation of migration and securitisation in general but also pre-election rhetoric – voting against migrants”
(Dhana, Government Department, SA)

Furthermore, what came out clearly in discussions around gender, migration and securitisation was that seeing migrants as a burden on state resources, in particular on healthcare played was central to how policies were shaped and politics was played. As David, from another Government Department in South Africa noted,

“Policy is directed by immigration rather than health systems”
(David, Government Department, SA)

This is reflected in Vearey’s argument that ‘attempts to develop interventions on migration and health – at all levels – may be undermined by the global migration policy terrain’ (Vearey, 2018: 92). Vearey (2018a) further argues that the emphasis on securitisation alongside the restriction of movement, also means that on the one-hand health-related issues are being ‘side-lined’ in current global discussions and on the other, they are also being ‘co-opted’ (93) to support a specific agenda: ‘vigilance is required to ensure that migration-aware public health programming is not co-opted to support securitisation agendas that place the health and wellbeing of people on the move at risk’ (Vearey, 2018: 96).

The findings indicate that in South Africa this level of co-option is happening. This can be seen in the proposed changes to the South African Immigration Act, White Paper on International Migration, and the National Health Insurance (NHI), as outlined in the policy review. Naledi, working for a Social Justice NGO in South Africa, described the NHI as a “constitutional violation and a retrogression”. She explained,

“Plans for the NHI are getting worse...it is taking away access to any kind of healthcare other than specific things...and it takes away for the undocumented completely...that is constitutionally not allowed...we have made this comment on every reiteration and it [the NHI document] keeps coming back worse...so you see you have all these great policies and for what? People are left with no access.” (Naledi, NGO, SA)

However, a number of respondents also echoed common perceptions and fears in South Africa and globally, that migrants pose a threat to state resources and that travel is often driven by a search for free healthcare. This is often applied particularly to migrant women who are pregnant. For example, Dhana noted,

“Its an unwritten policy i.e. if you give too many pregnant migrant women healthcare – becomes a drawing card for this hospital ” (Dhana, Government Department, SA).

Meanwhile Gerard, working for another Government Department in South Africa noted,

“[M]igration only appears in relation to health in terms of hospitals complaining about burden.” (Gerard, Government Department, SA).

However, when questioned about the numbers of migrant women accessing maternal health and what the data said about the level of “burden” on the South African healthcare system, was unable to give any figures and argued, “that is something we don’t have data on.” David, also from a Government Department in South Africa, was similarly vague about figures, but was still adamant that undocumented migrants were a central problem for the healthcare system,

“Our problem is with the undocumented migrants...if we don’t know how many are here then how can we plan and ensure that resources are there...in any clinic we know that the numbers of foreign women looking for maternal care are high...we see that.” (David, Government Department, SA).

This blame and burden approach, is not new and as Vearey notes, it is also shaped by historical perceptions of the migrant as a ‘diseased body’ (Vearey, 2018: 93). Through this, attempts at further securitising the border are justified by the view that migrants are ‘a carrier and transmitter of infectious diseases, particularly HIV; and, consequently, as a burden on the welfare state of receiving countries’ (ibid).

At a SADC level however, perspectives reflected a more sophisticated understanding of what is known about migration trends and what research has identified in relation to the apparent burden of migration on the healthcare system. Pierre, for example, was clear that the attempts to blame migrants for burdening the healthcare systems and claims that migrants travel specifically to access healthcare were unfounded,

“The major reason people cross borders is because they are doing business. In most SADC countries people can get the services they want. So I have never heard about people moving from one place to another to get services – health services is something that comes after they have crossed for a different objective.” (Pierre, SADC)

Pierre went on to note that the challenges of accessing healthcare for migrants is not just an issue faced in South Africa but in many SADC countries. Of ARVs for example he noted,

“they (SADC member states) don’t provide ARVs because they want to treat citizens first...it’s a political issue...it needs to be addressed at a higher level.” (Pierre, SADC)

Again this brings us back to questions about the real agenda here and how certain progressive policies and initiatives particularly regarding health at a regional level are being undermined by moves at a national level.

For example, when asked about how she felt the National Health Insurance (NHI) in South Africa might work with the challenges of access being faced by migrant women in South Africa, Mpho of SADC stated that “progressively – we will have to wait and see how this is going to happen”. She went on,

“The central government defines some of these policies and they say it is about numbers i.e. the population. That is, how much to citizens and how much to non-citizens but we also need to work with the realities and make sure public health is a key issue.” (Mpho, SADC)

Meanwhile, David, when asked about South Africa’s proposed changes in immigration and health policy and how this might impact women commented “We can’t mop the floor forever”. By this he meant that South Africa has always dealt with the health issues of migrants from across SADC and that there is a limit on what the country can offer. However, he also conceded that the main problems were not the number of migrants arriving from across SADC but actually internal migrants posed greater challenges because less was known about them.

“[T]he biggest problem is internal migrants...but we don’t know who is where.” (David, Government Department, SA).

A number of informers working for NGOs and civil society in South Africa, however, offered a very different perspective to that of the parliamentary researchers and government officials. For them, the problem did not lie with overwhelming numbers of migrants or even not knowing who was in what spaces but rather with the systems through which migrants were excluded and faced high levels of discrimination and abuse. Frida, a legal and advocacy officer for an NGO in South Africa for example noted,

“this has never been about the numbers. South Africa could manage if it wanted to but there is no will – no will to address the discrimination or to make things easier.”
(Frida, Legal and Advocacy Officer, SA)

Naledi also commented that much of their time was spent challenging violations of the law by health workers and officials. “All this blame on migrants” she argued, “and they are only trying to access what they are legally entitled to!” (Naledi, NGO, SA)

What is clear here however, is that popular perceptions, which reflect what is said on a daily basis in South Africa amongst communities, in clinics and hospitals and at a government level, are not shaped by empirical data. Nor are they informed by the work of civil society organisations and the research on gender, migration and health. In fact, empirical data and research does not seem to matter where there is a larger agenda – of migration management and securitisation – at stake. We return to this point in theme four.

7.3 POOR UNDERSTANDING OF GENDER, which is often equated as referring to ‘women and girls’ with no consideration of the needs of male, transgender, LGBTIQ+ migrants. Engagement with sexuality is notably absent. Heteronormative assumptions about gender, sexuality and family structures persist, including the framing of migrant ‘women and girls’ as vulnerable and in need of ‘protection’ with no agency.

Responses to questions about gender in relation to migration and health and particularly the gendered vulnerabilities experienced by migrants revealed a limited engagement with gender in policy but also in the perspectives of some of the policy-makers and those working on the ground. Many of the respondents when asked about gender framed their responses only in terms of women and girls. For example, Bryan from the City of Johannesburg (CoJ) noted,

“[W]hen we talk about gender and migration we know that women face many vulnerabilities...women get trafficked all the time.” (Bryan, CoJ, SA)

Similarly, Timo from the SADC Secretariat responded,

“[G]ender...we have standards, we make sure there is non-discrimination across all circumstances – race, gender etc....in the context of migration management we have measures to provide for the special needs of women, children and youth...this is not strong...but in a general sense rather than rules we apply...these are the vulnerabilities like sexual exploitation of women, smuggling and trafficking.” (Timo, SADC)



David from a Government Department in South Africa also noted,

“[W]omen can be at the greatest risk...gender is an issue and it is there in our policies.” (David, Government Department, SA)

However, a number of respondents also identified the limited understanding of gender in their own organisations as well as in the policies and programmes that they worked with. Naledi, for example, described the key issues that her organisation dealt with which included the lack of access to terminations for women as well as sexual violence in schools in South Africa. She noted,

“[G]ender is mostly seen in the context of SRHR – like everyone doing a lot of work on SRHR at the moment. Some legal work and some training and advocacy work...but again we have these policies, frameworks...we have a gender summit and there is some good protests and things but the outcomes are a bit ‘samey’...it doesn’t change.” (Naledi, NGO, SA)

Similarly, Mpho from the SADC Secretariat spoke about some of the regional initiatives that have a gender focus and commented, “Sexual and reproductive health rights are right at the centre here” (Mpho, SADC). Timo from SADC also spoke of gendered vulnerabilities in terms of the risks of HIV/AIDS for young women and girls noting,

“[I]n the context of poverty...sometimes for them to negotiate safe sex is difficult...when migrating they don’t have resources to sustain selves...so they engage in unsafe sex...most of the funding is about SRHR issues.” (Timo, SADC)

Only one of the respondents from a UN agency on Zambia spoke of gender in terms of men. Leigh Ann, working in a border region of Zambia noted the increasing difficulties that migrant men were facing crossing the border from neighbouring countries into Zambia,

"[T]hose who move regularly – those who are seasonal face a lot of challenges. They are coming for work and trading but now they cannot present an ID and come through a formal post. So they come informally. Even if they get a permit it is only for two weeks so they prefer to be hidden" (Leigh Ann, UN Agency, Zambia)

7.3.1 Visibility and Invisibility

In South Africa while there was little discussion of male migrants in relation to gender, there was recognition of the vulnerabilities faced by LGBTIQ+ communities and that these, largely remained absent in policy and in practice.

Both Frida and Abigail from local South African NGOs were quick to highlight the risks and vulnerabilities faced by sexual minority groups in terms of visibility and invisibility – those who are the most visible when crossing borders but the most invisible in terms of support and recognition of their needs (as also indicated in the background literature on page 23). Frida for example stated,

"The LGBTI community is discriminated against not only at the Refugee Reception Offices - where the gender-based persecution claims are not believed and therefore rejected - but also by the migrant communities, who ostracise these members." (Frida, Legal and Advocacy Officer, SA)

While Abigail also noted,

"There are very negative attitudes to migrants, being gay or trans compounds this." (Abigail, HIV/AIDS NGO, SA)

Abigail went on to describe the issues they identified and addressed in her organisation,

"Trans women face huge issues, and struggle because they are very seldom able to make any money aside perhaps in sex work. The fact that they had to travel to Musina or Pretoria to renew papers (impossibly expensive and dangerous), can't afford lawyers, they are visible to police (who often search them for drugs, take their stuff if they are homeless, and target them pretty much relentlessly). It's also hard to find a place to stay, because they are migrants, and trans." (Abigail, HIV/AIDS NGO, SA)

None of the policies that were reviewed engaged with the risks faced by LGBTIQ+ migrants beyond acknowledging them as a key population. As we showed in the review there was little to no recognition in the policies and very little amongst the respondents beyond local the South African NGOs that the visibility of this group of migrants meant they faced increased vulnerabilities. Furthermore, it is clear that specific moves by the South African Government, such as closing a number of RROs (as discussed on page 20) increases the risks for LGBTIQ+ individuals by, as Abigail states, forcing them to travel further distances to renew papers.

In fact, where engagement with sexuality and difference was notably absent, clear heteronormative assumptions about gender, sexuality and family structures persisted. This including the framing of migrant 'women and girls' as vulnerable and in need of 'protection' with no agency – as shown in the overwhelming focus amongst policy makers and stakeholders on the trafficking of women and children across the Southern African region.

In South Africa and Zambia many of the responses to questions about women and migration as well as gendered vulnerabilities were framed in terms of trafficking. One international agency working with migrants in particular located the trafficking of women as the key issue shaping gendered vulnerabilities and argued that not enough was

being done across the region and by member states to address the trafficking issue. In Zambia, Nina, working for a International organisation, began a discussion of the work that her organisation is involved in across the region in terms of the challenges of trafficking and the need to increase awareness and advocacy efforts. Elena of the same organisation in South Africa also commented that while there should be “hats off” to South Africa for the work done on trafficking especially in comparison to Zimbabwe and Malawi, “there is so much more we can do better” (Elena, International Organisation SA). Elena blamed many of the issues around dealing with trafficking on corruption amongst the police and other authorities and argued “this is what makes women less safe”.

This view was also supported by Bryan and Andrew from the City of Johannesburg (CoJ), who began their interviews by talking about the trafficking of women into and out of South Africa.

“[W]e are seeing more and more victims but we don’t always know how to help them...this is the most pressing issue we are seeing in our work.” (Andrew, CoJ)

When asked about the data on trafficking and dearth of evidence-based research to support claims that trafficking was widespread and increasing, both Andrew and Bryan claimed that they did not know the figures on trafficking but that there were many cases. In Zambia, Thomas of a legal organisation noted, “Trafficking is not a big issue but it is an issue, people are being trafficked”.

Nina, however did acknowledge that trafficking is not always well defined and often conflated with other forms of irregular movement,

“[T]rafficking is often very misunderstood and often loosely used to capture anything as trafficking which can lead to the system being suddenly overwhelmed and a panic.” (Nina, International Organisation, Zambia)

A growing body of research in South Africa and globally has documented the development and dominance of the trafficking discourse, despite the lack of substantial data. While we do not go into this debate here, it is important to note that in South Africa a number of scholars have argued that trafficking claims have been used to justify the increasingly restrictive migration measures in South Africa and serve a political agenda, influenced by the US and EU to stop migration across and out of Africa (Walker & Galvin, 2018; Walker & Oliveira, 2015). Furthermore the trafficking of women and girls for sexual exploitation has almost silenced discussions around the trafficking of men for exploitative labour and the many other kinds of risks that are faced through irregular migration – thus shaping a specific focus on women as victims and in need of protection and rescue.

Mpho, from SADC however, offered a view that suggested a recognition of these issues and that an over-emphasis on trafficking could eclipse some of the other risks women faced including other kinds of exploitation and being prevented from moving,

“[T]ake South Africa for example, there are important measures including security measures like the Trafficking Act but some of these restrictions also make women less safe and turn people away.” (Mpho, SADC)

Joan also noted,

*“...its politics – some of countries with a relatively good status [on trafficking] who have done some hard work – don’t deserve to be listed on the watch list. They are doing a lot of work...but it doesn’t make a difference.”
(Joan, International Organisation, SA).*

These last few quotes capture what is the key issue here – that certain categories of migrants and of women – such as trafficked women and girls – are more visible and recognised than others. Meanwhile, others such as male, transgender and intersex migrants remain invisible, despite often facing some of the greatest vulnerabilities, and in a policy shadow. However, this is not just an accidental omission but like the overriding political agenda that has been outlined here and as Joan identified, it is a political issue. A focus on women as victims and on trafficking plays a part in terms of meeting global, and in turn regional concerns which are not necessarily evidence-driven and based on what is happening but respond to broader agendas that seek to restrict migration and ultimately, prevent women from moving.

7.4 INCREASINGLY RESTRICTIVE AND SECURITISED APPROACHES TO INTERNATIONAL MIGRATION may negatively affect the health and wellbeing of people on the move, including women and girls.

“they [the Government of South Africa] make migration really difficult – the goal seems to be to stop migration rather than enable and make it safer.”

(Abigail, HIV/AIDS Advocacy Organisation, SA)

“The selling point for the government is that it is seen to protect the vulnerable because there are no longer women wandering around in rape-prone South Africa.”

(Dhana, Government Department, SA)

“Are you safer in a camp or are you safer on the street?”

(Elena, International Organisation, SA)



The policy review shows that across the African continent, there is an increasing trend that hardens from continental down to national level in which migration is predominantly considered a symptom of crisis and as a problem to be solved. The emphasis on migration management, border controls and securitisation is integral to and impacts on policies and practices on gender, migration and health. This is despite the fact that a number of continental and regional policies are progressive in terms of acknowledging and aiming to work with the complex realities of migration and mobility as well as gendered vulnerabilities. As the review also shows however, these policies often are not accompanied by progressive implementation or are unable to enforce change.

The interview findings also reflect these trends and concerns. As the previous theme shows, policy-makers at the SADC level and some at a national level, were keen to discuss the merits of the various regional initiatives and frameworks on migration and health and, while aware of the complex realities and challenges, also saw the initiatives as effective means to direct change. However, they also were clear that migration had become a contentious issue and that a move towards ‘migration management’ impacted on policies and practices. Mpho working for SADC argued,

“SADC places a lot of importance on migration. As people move around around – we are alive to the needs of policies that are pro-migration – but with a critical eye.”

(Mpho, SADC)

Pierre, from SADC, also spoke about the mandates for regional integration in SADC and argued that the free movement of people and goods needed to be further recognised,

“When people are moving freely we need to think how do we address some of the negative impacts emanating from policy or the goals of a region.” (Pierre, SADC)

Mpho suggested that,

“there are lots of key players on the ground who do not understand the national laws concerning migration.” (Mpho, SADC)

She argued that this meant that often they had to deal with a lack of co-ordination and with “players” who did not understand migration laws all in the same way – thus leading to competing interests and contradictory actions.

Meanwhile Frida, a legal and advocacy officer at an NGO in Johannesburg argued,

“there is no intention to assist migrants...it’s like...if we make it really hard then somehow they won’t come anymore.” (Frida, Legal and Advocacy Officer, SA)

This was echoed by Bryan, working for a department with the City of Johannesburg (CoJ) who noted that, “reality is more advanced than policy” (Bryan, CoJ, SA) and described the challenges the city faced when trying to assist migrants in accessing documentation. This included, Home Affairs refusing to recognise letters from the Migrant Help Desk, the long queues and also that migrant’s themselves often did not know their rights and how to access the correct documents. Bryan argued that as a result of these challenges “migrants give up and just get on with things but without the papers” (ibid).

Similarly, Joan noted that there is a tangible shift in the South African government from working with migrants in order to facilitate migration, to working against them and pushing for restrictions,



“Over...years frustration and friction has built – migrants coming in and the response has been more and more tense – this has increasingly led to a push by government to change the policy. We have seen friction the past years...seen a phobia. This has led to government pushing more, developing more policy that keeps migrants out.” (Joan, International Organisation, SA)



She further explained,

“From the government there has been a lot of resistance against migration...this has been visible because the government doesn’t want to be seen to welcome the flow of migrants into the country... to a certain extent there has been cooperation with government on facilitating migration but its very specific – i.e. on migrants with certain education and skills...but the government focuses first and foremost on trying to limit the inflow of migrants.” (Joan, International Organisation, SA)

Timo from SADC had a slightly different view arguing that,

“South Africa from the outside may seem to be a country averse to migrants but South Africa recognises that it is a country that is growing and needs to accommodate this...there is understanding and appreciation of labour migrants.” (Timo, SADC).

However, he went on to describe the challenges SADC had faced in pushing forward certain policies including the Protocol on Employment and Labour, which adopted in 2014 has not yet been enforced. This he said was due not least to,

"points of discomfort around the provision of labour migration and greater competition between nationals and locals..... [This] can lead to stricter migration laws...based on security and fears." (Timo, SADC)

The shift towards more restrictive and securitised migration described by the various key informers above reflects what is outlined in the policy review with particular reference to the proposed changes in the White Paper on International Migration in South Africa (see page 39). The comments by Joan and Frida for example, illustrate the assumed logic, that deterrent measures including stricter border controls can reduce the numbers of irregular migrants entering the country, or reduce the lengths of their stay. However, as we outlined in the introduction and as some of the comments below show, these measures merely drive more people to follow irregular migration patterns and undertake greater risks (Mbiyoza, 2018: 28). These risks have significant impact on the health and wellbeing of migrants, particularly women and children who can face increased levels of violence, abuse, exploitation and subsequently, trauma.

7.4.1 Camps

Much reference was made to the proposed changes by the South African government to the Immigration Act (2002), set out in the White Paper on International Migration (2017), which indicates a clear shift in migration policy. Dhana working for a Government Department in South Africa for example, described her concerns around what she referred to as,

"increasing environment of securitisation and securitisation of migration specifically." (Dhana, Government Department, SA).

Of the proposed changes from self-settlement to "processing centres" Dhana noted,

"The selling point for the government is that it is seen to protect the vulnerable because there are no longer women wandering around in rape-prone South Africa." (Dhana, Government Department, SA)



While the above comment was made with a level of skepticism and sarcasm there was also a clear point being made about how the vulnerability of migrant women – or a focus on a particular type of vulnerability including the risk of GBV and rape – provides a justification for stronger and harsher migration laws. As we have shown earlier in this report, migrant women face very clear heightened risks in terms of GBV and rape, in which the state can be directly implicated due to the marginalisation of migrant women as well as the lack of protection and support and access to documentation. Therefore, to use the vulnerability of migrant women in this way is clearly an attempt to not only deflect from responsibility but also taking advantage of an emotive and contentious issue in South Africa to justify migration policy shifts.

However, the claim of "keeping women safe" was supported by a few individuals working for organisations working with migrants in South Africa. Elena of an International organisation working with migrants for example responded to a question about the proposed immigration changes in the White Paper and how this might impact on women with the rhetorical question,

*"Are you safer in a camp or are you safer on the street?"
(Elena, International Organisation, SA)*

She went onto explain her thoughts,

"[S]ometimes I think these camps might be a good idea. Because I come across so many women and now they want to go back home. I hear their stories and abuse they go through I think maybe it's better and they go back home and are not allowed to come here. But if they come here maybe a camp is better?"


(Elena, International Organisation, SA)

Similarly, Bryan, of the City of Johannesburg (CoJ) argued,

"[T]he women are not safe here...our women here they know that if they face violence or abuse...they know to go to a social worker and how to get help...these women [referring to migrant women] they don't know...so maybe its better to keep them in that place where they can be safer." (Bryan, CoJ, SA)


A number of individuals echoed this view that to "keep them at the borders" (Elena, International Organisation, SA) could be a way to keep migrants safe.

However, as much as there was some support for this idea of camps in response to the risks women faced, there was also a clear view from others that the proposed amendments and shift to camps was negative and would actually lead to greater harms against migrants and especially women and children. As Joan described,




"I'm not sure if the basis for camps works – need people to be free to move in the country while their application is being processed. Based on what is happening in SADC – people have grown up in the camps, kids grow up in the camp and people have applied for recognition on basis of their claim but it goes on and on, cases go on and on – so their initial request has been rejected – appeal again, and again – ultimately in process for many years. For that to happen – to mean they are stuck in a camp.... the perception maybe that this [a camp-based policy] is a good thing for South Africa. The initial perceptions are at least let's be in the camp while application going – but then we'll move. But it's not like that. Many people stay in camps, kids born in the camps – not what you want for your family...If you ask applicants they say I'd rather be out." (Joan, International Organisation, SA)

Abigail and Frida from South African NGOs were also very clear about camps.



"They cannot work and there is no way that suddenly everyone and everything will work together to ensure needs are met and that migrants get the documents they need...it's a joke" (Frida, Legal and Advocacy Officer NGO, SA)



Meanwhile Abigail from a HIV/ Aids NGO highlighted the risks already faced by women and especially by even more marginalised groups like LGBTIQ+ communities in South Africa. She argued that in camps these risks would only get worse and that people would start taking greater risks to cross the border in clandestine ways.

These are crucial reflections as they highlight some of the key challenges of camp-based policies which are found across SADC. Until now South Africa is the only member state that enables migrants to move freely and to self-settle. Other member states, including Zambia have a camp-based policy in which migrants entering the country must be processed through a camp before receiving their documentation and being able to resettle in the country.

When the issue of camps was raised in interviews with stakeholders in Zambia there was also a mixed response. While some argued that the camps worked as a place to keep migrants safe and to allow the processing of documentation, others claimed that such a restriction on movement had negative consequences. Thomas of a

legal organisation in Lusaka for example, noted that “the camps are not a solution” and went onto describe the challenges of statelessness and life in a camp. However, he also highlighted the differences in Zambia in which he argued that processing was faster and more efficient. Zambia he argued,

“worked with the realities of migration... when we know there are more refugees coming we open up another camp and make sure we can accommodate them.”

(Thomas, Legal Organisation, Zambia).

Meanwhile Nina in Zambia also commented that while the camps at the borders of Zambia provided for the migrants who were placed there that,

“...camps are an easy way to run from your responsibilities...easier to monitor but not for safety.” (Nina, International Organisation, Zambia)

There were many questions in fact, that respondents had themselves about how the proposed “processing centres” in South Africa would function, particularly given the fact that Home Affairs is already over-stretched, under resourced and faces high levels of corruption (Vigneswaran, 2011). Joan for example noted that,

“[The] official response is that it’s a service and that will make it easier for the applicants to get their visa done quickly...but we can’t say this can be the case.”

(Joan, International Organisation, SA)

In Zambia, respondents drew a very clear line between migrants who were in camps and the mobile populations who crossed the borders on a regular basis for trade, employment and other reasons. In fact, when asked about migration issues in the country, rarely were the refugees in the camps talked about unless probed by a direct question. Otherwise the focus was on the migrants who regularly crossed in and out of Zambia for trade and employment:

“[T]hey have always crossed here, always traded here, we share the same languages...here we do not have refugees just daily migrants.”

(Leigh Ann, UN Agency, Zambia)

“[N]ot everyone is classed as a migrant, there are those who trade here and some who cross one day and they go back the next...then come again.”

(Thomas, Legal Organisation, Zambia).

However, while these groups who regular crossed the border were not seen as migrants it was recognised that they were increasingly facing challenges around documentation and access to healthcare and some suggested this was increasing due to the change in policies. Nina also commented,

“The Government tends to hover between two opinions: they know they need migration but they also have the securitisation issue and the threat of problems coming from other countries.” (Nina, International Organisation, Zambia).

Katya, working for an NGO in Zambia presented an argument within the context of Zambia’s historical and contemporary role in the SADC. She explained that Zambia was initially a “front line state” in the SADC “influencing policies for the whole region” but added,

“but now we are more about “good governance” – it’s about security and migration and an increased intolerance.” (Katya, NGO, Zambia).

Zambia’s role in the SADC and the country’s experience in dealing with migrants was highlighted by all of the Zambian respondents. A number drew a direct comparison to South Africa’s approach.

"We [Zambia] have played a pivotal role. We are the most experienced in the region for dealing with migrants...as a conduit country many people pass through...whether it is from the Great Lakes region or our neighbours. There is a lot of movement...but we do not generally deal with our brothers from other countries with anger and disdain." (Gladwell, HIV/AIDS NGO, Zambia)

"We are land-locked. In terms of technical expertise, we stand out in the sub-region...South Africa has not had that experience...the issue must not be about making the act tougher for migrants...your people [referring to South Africans] must be educated to live with each other and with our brothers."
(Thomas, Legal Organisation, Zambia)

Nina also noted Zambia's "pivotal role" in dealing with migrants in the region and claimed that "in terms of technical expertise Zambia stands out in the region" (Nina, International Organisation, Zambia).

7.5 LIMITED REGIONAL COORDINATION, COOPERATION, AND POLICY COHERENCE in the development of responses to migration and health, including for women and girls.

"It takes time to come up with a [regional] framework that everyone agrees...but the other issue is that once approved we don't have any enforcement power to say you didn't apply this." (Pierre, SADC)

In response to a question about the role of SADC and SADC policies in relation to member states, Pierre described the challenges faced in terms of getting member states to implement policies. Noting that although SADC could not enforce policies and demand that member states implemented them, Pierre explained that where the influence lay was in the reports and updates that were written on how policies were being implemented and where there were successes and failures,

"when the heads of state meet and read those...they don't want to see that their state is failing...so that is some way of getting them to make sure they implement." (Pierre, SADC)

This was also made clear in interviews with the other individuals working for SADC who described a limited level of success in working with member states. In response to questions about how progressive frameworks such as the Policy Framework for Population Mobility and Communicable Diseases in the SADC Region (2009) and the SADC HIV and AIDS Cross Border Initiative (2010) could work when member states such as South Africa were proposing policies that would reduce the rights and access of migrants and refugees to healthcare, the responses were mixed and sometimes, contradictory. Mpho, from SADC for example described the SADC Scorecard as a part of the SRHR strategy as a "game changer". She argued that this was a way that work could cut across the region and create targets that could hold countries accountable for the ways in which they were addressing key migration, health and SRHR issues. However, she also noted,

"Strategies are regionally based...but each member state has its own issues." (Mpho, SADC)

Of how gender issues were addressed in policy she noted,

"when the heads of state meet and read those...they don't want to see that their state is failing...so that is some way of getting them to make sure they implement."
(Pierre, SADC)

Pierre from SADC however, also pointed out that this policy remained in draft form because “some member states had some concern with some issues”. Pierre also spoke of the importance of the SADC HIV and AIDS cross-border initiative (2010) initially funded by the Global Fund. He described the success of the project in terms of the numbers of migrants “reached” and the number of clinics worked with. However, he also noted that now the first phase of implementation had ended, the initiative had been handed over to member states, leading to “challenges from all sides” with funding and commitment. Moreover, he noted,

“[S]ome countries are still discussing whether foreigners can have access to ARV treatment you know.” (Pierre, SADC)

This comment here succinctly captures the key issues regarding progressive policies and their effective implementation in relation to the narrower political agendas of individual member states.

“In terms of policies we still have a long way to go. In terms of harmonising international and local laws also [...] Coherency of policy is the biggest challenge.” (Mpho, SADC)

While these findings reflect what we also found in the policy review in terms of the lack of power to implement and effect change at a continental and regional level and many sticking points at a national level, they also direct us to consider why certain policies are engaged with and others are not – and why such a disconnection between the two exists.

The findings show that many of the respondents recognised the disconnect between policy and practice. This was reflected in many of the comments made about the challenges of working on the ground and the limitations of what the policies could actually do. This disconnect however, cannot just be explained by the fact that policies, “need to set ideals and standards to which our practices must try and reach” (Thoko, International Organisation, SA), but suggests that there is a need to look at what else is going on here. In particular, what we see in South Africa at the national level is that progressive and responsive initiatives at a regional level are undermined and rendered ineffective while a discourse of blaming migrants and thus justifying restricted access and rights gains currency. Meanwhile at the regional level of SADC, there appeared to be almost a fatalistic acceptance that change could only be pushed so far and that there was no solution to certain obstacles such as unwillingness to commit to certain policies or the countering of initiatives through national policies.

Abigail from an HIV/AIDS organisation argued,

“For the most part, we are unable to deal with the most vulnerable migrants. We have no suitable shelters, ways of integrating people economically and politicians use the issue to gain political points, exploiting the fears of the poor who perceive migrants as the source of the scarcity of resources and housing threatening their survival.” (Abigail, NGO, SA)

Many of the respondents when questioned about how policies dealt with migration and gender and specifically their understanding of gendered vulnerabilities, spoke about the lack of coherence between policy and practice as well as the inability of policies to have an impact on the ground. David for example noted,

“The Initiatives from global to local are there – but don’t filter down.” (David, Government Department, SA)

Meanwhile, although Thoko based with a International organisation and working with migrants was quick to highlight some of the progress that South Africa had made in addressing health challenges with key populations, she was also clear that one of the greatest challenges was that policy-makers from different departments and that “policy-makers need to be informed by the practices on the ground” (Thoko, International Organisation, SA).

At the same time, David, also stated that, “policies must be aspirational – even if you don’t realise them now” suggesting that policies play a visionary role. However, where policies may have an “aspirational” approach the challenge is that the immediate realities, and especially challenges faced by migrants on the ground, are not only ignored but are actually being heightened as Nina commented in regards to policies affecting migrant’s access to healthcare,

“Statements are just mechanisms instead of statements that we can rely on.”
(Nina, International Organisation, Zambia)

This final quote captures much of what has emerged through all of the five key findings in this report. While we have shown that the findings match the policy review in terms of the overall trends from continental down to national, we have also shown that policy-makers and individuals working with policy both defend and question the challenges being faced. Where some respondents are clear that the complex challenges for migrant women on the ground are being addressed and that shifts in policy to further restrict migration and introduce “processing centres” (camps) in South Africa will offer a safer option for women, others recognise another agenda at play. They note that while on the one hand the state is using the vulnerability of female migrants to justify shifts in policy, on the other weaknesses in state systems are being blamed on migrants. What is also clear is that the very limited lens through which gender is viewed – despite progressive gender policies that strive to meet SDG targets – ensures that “invisible” groups such as LGBTIQ+ populations remain hidden and vulnerable while “visible” groups such as women who are victims of trafficking take centre stage. Again, this plays back into a broader agenda in which women are considered to be safer if prevented from moving.



8.CONCLUSION

“To realise the Sustainable Development Agenda 2030 vision, including the achievement of Universal Health Coverage, governments and health actors need to uphold migrants and mobile populations’ health through multi-sectoral responses and develop migration-sensitive health systems that ‘leave no one behind’. (IOM, 2017a: 1)

This report began from the recognition that mobility is a reality, which needs to be acknowledged. People move and will move and increasingly women are moving. Women move in diverse ways and for diverse reasons and research shows that the vulnerabilities they face are specific. This means that approaches and planning need to be based on the “multi-sited lives of Southern Africa’s populations” (Freemantle & Landau, 2017: 11). As Freemantle and Landau argue:

“While mobility is by nature dynamic, there are identifiable patterns and trends to how people move: understanding patterns and complexities empowers authorities at all levels to respond and anticipate to related challenges rather than being overwhelmed by them. From local to continental level, planning without considering mobility is not planning at all” (Freemantle & Landau, 2017: 11)

While the intersections between gender, migration and health, resulting in clear gendered vulnerabilities for women and girls as well as other vulnerable groups such as LGBTIQ+ individuals on the move have been highlighted in this report, the review of policies show that the integration of a gender perspective into health and migration policies is, at best, patchy. Where gender is included, this often fails to translate into practice, or is done in superficial ways that on the one hand fail to engage with the complexity of female migrants' experiences and, on the other completely exclude an understanding of gender beyond women and girls – thus ignoring LGBTIQ+ migrants.

In some cases, policy and practice directly contradict one another. The findings from the interviews with policy-makers and key stakeholders show that whilst there is often recognition of gendered vulnerabilities and key gender issues in relation to migration and health, guiding policies and frameworks are limited and current knowledge appears to be shaped by policy content rather than evidence.

This report also shows that overall, current limitations to policies at all levels not only fail to engage and respond to the realities of migration, but also do so for specific reasons. This can have strong implications for women and other vulnerable groups crossing borders and can heighten the multiple risks already faced both while on the move and once in their host country.

Based on the identified five key themes which we capture again below, the report shows that there is evidence that things are moving in the right direction i.e. increased attention to gender vulnerabilities in health and better awareness of the risks and forms of GBV faced by women who migrate. However, this is limited due to the simplistic understanding of gender and equaling women and girls and thus excluding the experiences of LGBTIQ+ persons. Furthermore, the increased emphasis on security and the restriction of mobility undermines approaches to address the gender vulnerabilities faced when on the move and in some cases directly heighten risks.

TEXT BOX 3: KEY FINDINGS:

- 1. Insufficient policy engagement with migration and health. Where responses do exist, the gendered dimensions are lacking.** Existing responses are also driven by non-governmental and international organisations.
- 2. Political agendas and popular perceptions are driving policy making processes,** including the scapegoating of migrants for the poor performance of public healthcare systems. Insufficient use of existing evidence in the development of policy responses to migration and health.
- 3. Poor understanding of gender** which is often equated as referring to 'women and girls' with no consideration of the needs of male and LGBTIQ+ migrants. Engagement with sexuality is notably absent. Heteronormative assumptions about gender, sexuality and family structures persist, including the framing of migrant 'women and girls' as vulnerable, lacking agency and therefore in need of 'protection'.
- 4. Increasingly restrictive and securitised approaches to international migration** may negatively affect the health and wellbeing of people on the move, including women and girls.
- 5. Limited regional coordination, cooperation, and policy coherence** in the development of responses to migration and health, including for women and girls.

8.1 STRATEGIC OPPORTUNITIES FOR RESPONDING TO MIGRATION AND HEALTH

Several strategic opportunities exist for ensuring healthy migration at local, regional and global levels, including: The Sustainable Development Goals; Universal Healthcare Coverage; World Health Assembly processes; the 'Global Compact on Safe and Orderly Migration'; and the 'Global Compact on Refugees'. These initiatives should be designed to 'leave no-one behind', reflecting a commitment to equity, non-discrimination, and a human rights based approach to health and migration.

8.1.1 The Sustainable Development Goals

The SDG agenda provides multiple opportunities to bring the migration, development and health sectors together to develop and implement unified and coordinated responses. Calls have been made elsewhere for migration-aware and mobility-competent responses to health; these should be considered and actioned within the migration and development terrain. Such responses require intersectoral and multilevel engagement to develop effective governance strategies between sectors in ways that place public health approaches to migration and mobility at the centre.

8.1.2 Universal Healthcare Coverage

Target 3.8 of the SDGs calls for Universal Healthcare Coverage (UHC) – a key SDG target (United Nations, 2015b), providing a strategic opportunity to improve responses to migration and health, indirectly benefiting social and economic development.

8.1.3 World Health Assembly

The World Health Assembly (WHA) is the decision making forum of the World Health Organisation (WHO). Meeting annually, the WHA hears concerns from member states and supports the development of Resolutions that aim to guide global responses to health. Two of these Resolutions – 61.18 (2008) and 70.15 (2017) – focus on migration and health, with subsequent consequences for development – particularly in establishing healthy migration. These Resolutions have been proposed, reviewed and revisited in various platforms and processes, including during the second Global Consultation on Migration and Health, held in February 2017 in Colombo, Sri Lanka (the first was held in Madrid, Spain, in 2010). Convened by the IOM, the WHO and the Government of Sri Lanka, the Consultation aimed to “re-set” the global agenda on migration and health. Taking the 2008 World Health Assembly (WHA) Resolution 61.17 on the Health of Migrants as a starting point, the Consultation provided an opportunity to explore progress made, and challenges encountered, in efforts to improve responses to migration and health. Discussions and lessons shared during the Consultation indicate that – with some notable exceptions – progress is limited and the increasing focus on the securitisation of (im)migration presents challenges internationally to the development and implementation of appropriate public health responses to migration and mobility. The discussions held in Colombo reflect the challenges that continue to limit the development of appropriate policy and programming on migration and health. Following the Colombo meeting, the WHA Resolution 70.15 – Promoting the health of Refugees and Migrants – was released in 2017. This latest Resolution presents opportunities for improving the health and wellbeing of migrant and mobile populations and – as a result – support both social and economic development.

The 72nd WHA will take place in 2019 and sustained efforts to support the development of an evidence-informed (draft) global action plan on the health of refugees and migrants are a global public health priority. Key here is the need for developing and implementing migration-aware and mobility-competent health system responses; such responses are necessary to support realisation of the social and economic developmental benefits of migration.

8.1.4 Global Compacts

However, these possible gains are, in many ways, dependent on the implementation of two recent Global Compacts – for ‘Refugees’ and ‘Safe, Regular, and Orderly Migration’. Current international political fears and moral panics relating to the movement of people – in particular concerns from northern Europe relating to migration from the

African continent – drove the development of these Compacts. Concerns have been raised about the potential for the Global Compacts to support increasingly securitised immigration management that will have impacts not only for individuals on the move, but also for social and economic development, and public health.

8.2 STICKING POINTS IN POLICY IMPLEMENTATION

In particular, the review of SADC policies revealed that there are key ‘sticking points’ which concern member states and prevent draft policies from being signed and ratified. Migration is one of these sticking points and as Dodson and Crush (2015) point out although officially SADC has committed to harmonising migration policy and facilitating intra-regional migration, ‘state and public attitudes towards migration are at best ambivalent and at worst strongly hostile, including serious violations of migrants’ rights’. We have shown that this is particularly the case in South Africa where an array of progressive laws are steadily being peeled away, while also contradicted in practices on the ground.

A growing body of research documents the complexity of migration experiences amongst female migrants: evading any rigid social or policy categorisations, womens’ experiences of agency, empowerment and opportunities typically exist alongside those of victimhood, risks and challenges. When applying a gender lens to policy and practice, it is evident that in the same way that migration is seen through a particular perspective – that of threat – so too, is gender. Gender is generally taken to refer to women, and women on the move are generally seen as vulnerable and as victims of sexual exploitation and other crimes such as human trafficking. While a number of women do face these risks, and issues such as trafficking and exploitation demand attention and careful consideration in relevant policies, it is also clear that the experiences of migration for women often go far beyond simple ideas of forced or voluntary and victim or agent. While women can be victims, they can also make choices, and where choices are made, vulnerabilities are also faced.

Such experiences thus demand a more nuanced and complex understanding and importantly, should be reflected in policy and guidelines that seek to engage with migration and gender. Furthermore, while this report focuses specifically on women when exploring gender, migration and health, it is clear that a consideration of gender should also move beyond heteronormative binaries and recognise the fluid nature of gender and differences in sexualities and gender-orientation. As the report shows LGBTIQ+ migrants are often the most visible in their differences, yet hidden in terms of the heightened vulnerabilities that they face and that they are largely ignored in policy and practice.

We can also conclude that planning for mobility is not well entrenched in Southern African policies. Instead, mobility is either ignored or countered – and from a perspective of migration is as seen a threat to security and to the lives of citizens.

‘SADC remains poorly equipped to initiate and manage the political discussions within and between member states that are required to develop appropriate regional responses to migration, mobility, and HIV’ (Vearey, 2018: 96).

‘There is an urgent need to implement a regional strategy for the development of contextually appropriate migration-aware responses to HIV in SADC, particularly in the UTT [Universal test and treat] era. Efforts must be made to ensure that local-level health programming—including HIV programming in SADC—is not undermined by current global moral panics, and resultant policy discourses’ (Vearey, 2018: 96).

Therefore, there is a need to not only find realistic solutions of improving coordination within SADC and the AU that must include enforcement and financing, but also creative interim solutions that bypass dysfunctional institutions.

Finally, it must also be considered that, while analysis of policy ‘on paper’ is important, it is insufficient on its own in determining actual political objectives. This is because policies that are seemingly ‘failing’ to achieve certain objectives are not necessarily a genuine failure but often simply reflect more hidden agendas and actual priorities (Czaika & de Haas, 2013) as has been highlighted in the findings of the research for this report. Accordingly, changing policy does not always reflect a real desire (or ability) to change practices, and where practices do change this is often with recognition of the limitations and shortcomings of policies themselves.

Therefore, while an analysis of policy can provide insight in understanding the meaning and emphasis given to specific political issues, this report shows the importance of empirical primary research to provide a more comprehensive picture. This is research that can work through the layers to reveal the complexities and competing issues that frame policy approaches and engagement with policy including attitudes, intentions and the influence of dominant issues and perspectives.



9. RECOMMENDATIONS

9.1 AT NATIONAL LEVEL – FOR THE SOUTH AFRICAN GOVERNMENT AND OTHER SADC MEMBER STATES:

TEXT BOX 4: GUIDING PRINCIPLES FOR ACTION ON MIGRATION, HEALTH AND GENDER IN SADC

- Recognise that **migration is a global reality and a key determinant of health**
- Acknowledge that **migration, health and gender are politically and socially sensitive issues** – they are unpopular, associated with moral panics and negative assumptions
- Partner with relevant organisations to implement a **targeted awareness campaign** aimed at key decision makers demonstrating that a migration-aware approach is required to achieve the SDGs, with a focus on UHC
- Identify a **national focal point** to coordinate **alliance building**²⁷ in order to support the development of a national migration and health plan that mainstreams gender
- Implement a **‘Migration and Health in All Health policies (MHiAP)’**²⁸ approach across government departments
- Identify and use **strategic opportunities** for action, including in the development of National Strategic Plans for HIV (NSPHIV), a National Strategic Plan on Gender-Based Violence (NSPGBV), gender programmes, immigration management
- Generate **quality evidence and strengthen evidence-informed policy processes**, including the development of a national migration and health score card that includes a gender component
- Learn from **good practice examples** on the continent and beyond
- Support **postgraduate training, continued professional development and capacity-building** amongst key actors: providers, policy makers, politicians
- Develop a **community of practice**, leading to the creation of a SADC region migration, health and gender network drawing on the **Migration Health and Development Research Initiative (MHADRI)**²⁹

²⁷ A (Vearey et al., 2019)

²⁸ (Vearey et al., 2019, Forthcoming)

²⁹ www.mhadri.org

Drawing on the key principles outlined above, a series of recommendations targeted to key actors are outlined below. Critically, these recommendations should be considered in relation to those from the drafted 2018 SADC Migration Policy Framework.

9.2 AT REGIONAL LEVEL – FOR SADC AND SADC MEMBER STATES:

TEXT BOX 5: RECOMMENDATIONS IN THE 2008 DRAFTED MIGRATION POLICY FRAMEWORK FOR THE SADC REGION

- Conduct robust gender-responsive research and enhance data collection, acquisition, analysis and accountability and highlight situation and realities of migrant women in every phase of the migration process.
- Address violations of migrant women's rights, exploitation and trafficking, with enhanced gender-responsive and evidence based policies to inform advocacy, challenge negative perceptions and prevent abuses and exploitation.
- Develop migration policies that allow equal opportunities for women and men to migrate for employment through safe and regular channels.
- All research on irregular migration in the region should be informed by gender analysis and implemented in a gender – responsive manner.
- Data should always be sex and age-disaggregated to facilitate gender-responsive evidence-based analysis on current mixed migratory trends in the SADC region.
- Migrant women's voices in policy dialogue processes at national and regional level should be encouraged.

9.3 POLITICAL LEADERS AT THE REGIONAL AND NATIONAL LEVEL

- Political champions are needed to take on the cause
- Engagement with parliamentary researchers
- Build on momentum associated with the 2018 drafted SADC Policy Framework

9.4 POLICY-MAKERS

9.4.1 Global

- Clearer calls for local needs assessments to develop context specific responses to migration, gender and health.
- Recognise the migration realities in Southern Africa and across the continent, particularly the movements taking place within and between countries in SADC – and work to rectify the moral panic surrounding “African migrants” trying to reach Europe that fuel securitisation agendas.
- Engage with World Health Organisation & IOM processes, including:
 - 144th WHO Executive Board session
 - 72nd World health Assembly
- Contribution to/engagement with the WHO Draft Global Action Plan on the Health of Refugees and Migrants to be submitted for consideration .³⁰

9.4.2 African Union

- Identify trends and divergences in migration patterns across the AU that can inform continental discussions and subsequent frameworks.
- Identify ways in which policies can be moved beyond ideals to impacting regionally and at a national level.

²⁷ Prof. Jo Vearey is a part of this process.

- Work with WHO-AFRO (Regional Office for Africa) on the development and implementation of the Global Action Plan on the Health of Refugees and Migrants.

9.4.3 SADC

- Recognition of key regional issues and specific disconnects between policy and practices on the ground in order to direct future research.
- Clearer calls for evidence-based research to inform understanding on key immigration/security issues such as human trafficking – with a view to building a regional database and challenging unsubstantiated claims and assumptions.
- Focal person to lead a regional response that works with SDGs and in particular identifies where these may be currently failing, including engagement with SADC Parliamentary Forum and SADC Civil Society Forum.

9.4.4 National

- Identify a focal person to lead a national response to migration and health that mainstreams gender, including coordination of the different sectors
- Learn from good practice examples e.g. Sri Lanka (Wickramage et al., 2017)
- Focal person should map strategic opportunities for action at the national level and have the mandate to drive intersectoral and Whole of Government (WoG) responses
 - Responses to the Global Compacts
 - SDGs – health and gender targets; migration is a strategic opportunity for action
 - Work with National AIDS Councils to support action on UNAIDS 90:90:90 targets and the need to establish migration-aware and gender-sensitive responses to increase uptake of testing and ART as part of Universal Test and Treat (UTT) / Treatment as Prevention (TasP) initiatives including Pre-exposure Prophylaxis (PrEP)

9.4.5 Ministries of Gender/equivalent

- Work with national focal person to support development of a national response to migration and health to ensure and lead gender mainstreaming processes.
- Work with Ministry of Justice/Police/equivalent to mainstream gender and immigration issues into policing responses.

9.4.6 Ministries of Health, including National AIDS Councils

- Work to develop a Migration and Health in All Health policies (MHiAP) (Vearey et al., 2019, Forthcoming) approach that will mainstream (im)migration into health responses, and immigration into health responses, including in the development of the South African National Health Insurance.
- Prioritise responses to communicable diseases (e.g. HIV, Tuberculosis).
- Work with national focal person, Ministry of Gender/equivalent, and Ministry of International Affairs/equivalent to ensure health is mainstreamed into responses to migration.

9.4.7 Ministries of Foreign Affairs / border control

- Work to develop a Migration and Health in All Health policies (MHiAP) (Vearey et al., Forthcoming) approach that will mainstream health into (im)migration responses.
- Recognise key issues which shape the vulnerabilities that women face notably lack of documentation and access to easy, transparent and supportive processes whereby they can obtain the correct documentation.

9.4.8 Security / Police / Justice

- Address violations of migrant women's rights, with enhanced gender-responsive and evidence-based policies to inform advocacy, challenge negative perceptions and prevent abuses and exploitation. This may include trafficking and exploitation but should not be limited to it.

9.4.9 Local level

- Explore the development of local Migrant Health Forums to connect actors at the local level, including migrant women (Vearey et al., 2017)

9.5 CIVIL SOCIETY/INGOS

- Develop accountability measures regarding SDGs, Equal Measures, ombudsman.
- Support the building of alliances across sectors, including through Migrant Health Forums and women's rights coalitions.
- Develop targeted issue briefs/fact sheets for key policy stakeholders and migrant groups.

9.6 PRIVATE SECTOR

- Focal person at national level should engage with private sector stakeholders including those who utilise formal migrant worker schemes.

9.7 ACADEMIA/RESEARCHERS

- Draw and build on the substantial body of research that highlights the complex realities of migrant women and the "gendered vulnerabilities" of migrants moving across borders and internally.
- Based on the identified gaps in this report also invest more time and resources in research that explores why existing research and empirical data is not engaged with – and how it can be in future, i.e. how to engage with women more in policy dialogues, how to interrogate the disconnect between policy and practice and how to engage with the broader political agendas while working with a member states, needs and concerns.
- Support building capacity of postgraduate students and early career researchers who can work across sectors to support the development of evidence-informed responses to migration, health and gender.
- Engage with existing communities of practice e.g. the Migration, Health, and Development Research Initiative (MHADRI) www.mhadri.org
- Establish a regional arm of MHADRI to support sharing of good practice.
- Work with The Lancet Commission in the development of a SADC Regional Migration and Health hub www.migrationandhealth.org



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11. APPENDIX A: LIST OF KEY INFORMANTS

	NAME (PSEUDONYM)	ORGANISATION/POSITION	TYPE OF INTERVIEW
SOUTH AFRICA INTERVIEWS			
1	Dhana	Government Department	In Person – CT
2	Gerard	Government Department	In Person – CT
3	Joan and Elena	International Organisation	In person – Pretoria
4	Thoko	International Organisation	Skype
5	Naledi	Social Justice NGO	In person – JHB
6	Andrew	City of Johannesburg	Phone
7	Bryan	City of Johannesburg	In person – JHB
8	David	Government Department	In person – Pretoria
9	Abigail	AIDS/HIV Organisation	Skype/written response
10	Frida	Legal and advocacy officer NGO	Written response
ZAMBIA INTERVIEWS			
11	Katya	NGO	In person – Lusaka
12	Nina	UN Organisation – Zambia	In person – Lusaka
13	Leigh Ann	UN Agency	Skype
14	Gladwell	HIV/AIDS NGO	Skype

	NAME (PSEUDONYM)	ORGANISATION/POSITION	TYPE OF INTERVIEW
ZAMBIA INTERVIEWS			
15	Margaret	UN Agency	In person – Lusaka
16	Thomas	Legal Organisation	In person – Lusaka
SADC LEVEL INTERVIEWS			
17	Timo	SADC Secretariat	Skype
18	Pierre	SADC Secretariat	Skype
19	Mpho	SADC Secretariat	Skype
ADDITIONAL INFORMAL INTERVIEWS/DISCUSSIONS			
20	James	Researcher	Skype

NB:

- All names have been changed in order to protect the anonymity of the respondents who chose not to be identified. Places of work/affiliations have also been made deliberately vague to protect identities.
- The key informants were all adults (individuals over the age of 18) and agreed to be interviewed in their own capacity, i.e. rather than representing an organisation.
- Written consent was given when interviews were carried out in person and otherwise verbal consent was sought.

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