Joint Learning Initiative on Children and HIV/AIDS JLICA

Learning Group 1 – Strengthening Families

Co-Chairs: Linda Richter and Lorraine Sherr

DREAMS AND DISAPPOINTMENTS: MIGRATION AND FAMILIES IN THE CONTEXT OF HIV AND AIDS

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Mary Haour-Knipe
Independent Advisor
Geneva, Switzerland

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The Joint Learning Initiative on Children and HIV/AIDS (JLICA) is an independent, interdisciplinary network of policy-makers, practitioners, community leaders, activists, researchers, and people living with HIV, working to improve the well-being of HIV-affected children, their families and communities.

Preface - Learning Group 1: Strengthening Families

The work conducted in Learning Group 1 was based on the fact that families, in all their many forms, are everywhere the primary providers of protection, support and socialization of children and youth, and families exert a very strong influence on children's survival, health, adjustment and educational achievement. This influence tends to be greater under conditions of severe strain, such as is caused by HIV and AIDS, particularly in the context of poverty.

In general, functional families love, rear and protect children and buffer them from negative effects. Functional families are those that have sufficient material and social resources to care for children, the motivation to ensure that children are nurtured and protected, and are part of a community of people who provide one another with mutual assistance. Family environments are especially important for young children. It is well established that multiple risks affect the cognitive, motor and social-emotional development of children and that the quality of parenting, assisted by intervention when needed, can ameliorate such impacts.

From the start of the epidemic, families have absorbed, in better or worse ways, children and other dependents left vulnerable by AIDS-induced deaths, illness, household and livelihood changes, and migration. Similarly, families have contributed, more or less successfully, to the protection of young people from HIV infection. Under the devastating effects of the epidemic, families need to be strengthened – economically, socially and with improved access to services – to enable them to continue, and to improve, their protection and support of children and youth. Families that neglect and abuse children need to be identified and social welfare services must be provided to them.

Families, extended kin, clan and near community are the mainstay of children's protection in the face of the AIDS epidemic - as they have been in poor countries under other severely debilitating social conditions, including war, famine and natural disaster. Only a very small proportion of AIDS-affected children are currently reached by any assistance additional to support they receive from kith and kin. The most scalable strategy for children is to strengthen the capacity of families to provide better care for more children.

The co-chairs, secretariat, lead authors and stakeholders of Learning Group 1 were guided in the work undertaken in the Learning Group by the following key questions. By and large, these are the critical research, policy and programme questions currently being debated in the field.

1. On which children and families should we focus?

2. What evidence is available on which children are vulnerable and what can be done to help them, and how good is the research?

3. What aspects of the HIV/AIDS epidemic impact on children, how and why?

4. How are families changing as a result of adult illness and death associated with HIV and AIDS?

5. In what ways are children's health, education and development affected by the HIV/AIDS epidemic?

6. What does knowledge and experience of other crises teach us about the AIDS response for children and families?

7. What can we learn from carefully evaluated family strengthening efforts in fields other than HIV and AIDS that can be usefully applied in hard hit countries in southern Africa?

8. What programmatic experience has been gained in strengthening families in the HIV/AIDS field?

9. What promising directions are there for the future and what do they suggest?

10. What mistakes have been made and what now needs to be done?

These questions form the structure of the integrated report. As indicated in the Preface, detailed data and references are to be found in the respective LG1 papers.

Twelve detailed review papers constitute the primary evidence base for the conclusions drawn and the recommendations made by Learning Group 1. The papers, their authors in alphabetical order, and their affiliations are listed below.

List of authors, affiliations and paper titles

Authors	**Affiliation**	**Title**
Adato, M Bassett, L	International Food Policy Research Institute (IFPRI) – United States of America	What is the potential of cash transfers to strengthen families affected by HIV and AIDS? A review of the evidence on impacts and key policy debates
Belsey, M	Consultant – United States of America	The family as the locus of action to protect and support children affected by or vulnerable to the effects of HIV/AIDS: A conundrum at many levels
Chandan, U Richter, L	Human Sciences Research Council (HSRC) – South Africa	Programmes to strengthen families: Reviewing the evidence from high income countries
Desmond, C	Human Sciences Research Council (HSRC) – South Africa	The costs of inaction
Drimie, S Casale, M	International Food Policy Research Institute (IFPRI), Regional Network on AIDS, Food Security and Livelihoods (RENEWAL), Health Economics and AIDS Research Division (HEARD – South Africa	Families' efforts to secure the future of their children in the context of multiple stresses, including HIV and AIDS
Haour-Knipe, M	Consultant – Switzerland	Dreams and disappointments: Migration and families in the context of HIV and AIDS

Hosegood, V	London School of Hygiene and Tropical Medicine (LSHTM), Human Sciences Research Council (HSRC) – South Africa	Demographic evidence of family and household changes in response to the effects of HIV/AIDS in southern Africa: Implications for efforts to strengthen families
Kimou, J Kouakou, C Assi, P	Ivorian Centre for Economic and Social Research (CIRES), Family Health International (FHI) - Côte d'Ivoire	A review of the socioeconomic impact of antiretroviral therapy on family wellbeing
Madhavan, S DeRose, L	University of Maryland – United States of America	Families and crisis in the developing world: Implications for responding to children affected by HIV/AIDS
Mathambo, V Gibbs, A	Human Sciences Research Council (HSRC) – South Africa	Qualitative accounts of family and household changes in response to the effects of HIV and AIDS: A review with pointers to action
Sherr, L	Royal Free and University College Medical School – United Kingdom	Strengthening families through HIV/AIDS prevention, treatment, care and support
Wakhweya, A Dirks, R Yeboah, K	Family Health International (FHI) – United States of America	Children thrive in families: Family-centred models of care and support for orphans and other vulnerable children affected by HIV and AIDS

DREAMS AND DISAPPOINTMENTS: MIGRATION AND FAMILIES IN THE CONTEXT OF HIV AND AIDS

Contents

Introduction

This review is one of some fourteen papers commissioned by the Learning Group on Strengthening Families, as part of the 'Joint Learning Initiative on children and HIV/AIDS' (JLICA)**.** Its purpose is to explore the short- and long-term implications of migration for families and to extrapolate what might be applied to the context of HIV and AIDS, focusing as much as possible on sub-Saharan Africa in line with the other JLICA papers in the same group.

How the document is organized: The first half of the document sets the scene for the most important part, an analysis of the main themes that emerge when the key words, 'HIV' or 'AIDS', 'migration' and 'families' are put together. Some of the major trends in migration and population mobility are outlined, then the way in which women, children and families fit into the broad picture of migration is described. The document then turns to a partial review of the effects of migration on children and on families, for some lateral thinking later in the document. HIV and AIDS are then factored into the equation. The main vulnerability factors linked to migration and to population mobility are described, particularly as they affect women and families.

After this long background section, which takes up half of the document but is necessary to set the stage for the rest, the review then turns to a question that has received less attention than the subject of vulnerability, that of migration as a result of HIV and AIDS, and the implication of families in such population movement. The existing literature on the subject is reviewed, organized around the two main themes that emerged: migration to families for care and support (including migration of children when their parents can no longer care for them) and migrant families living with HIV. As mentioned, the document concentrates mainly on the literature from sub-Saharan Africa and Europe, following one stream of migration in an otherwise very complex pattern, but examples from elsewhere are used when pertinent. The final section sums up and identifies gaps and priorities for further research. Some of the factors that help children and families cope with – and grow from – migration are listed, as they may suggest some observations applicable to strengthening families in the context of HIV and AIDS.

Methodology: The review brings together literature from a number of different sources. The section on migration is based on documents produced by the International Organization for Migration (IOM), such as the 'World Migration Report', and on

publications by the Global Commission on International Migration - all of which appeared in 2005 – then is updated with more recent reviews. For the section on HIV, AIDS and families, the review started with a set of basic background documents on HIV/AIDS and children that was distributed to the JLICA working group and that contained a number of references on migration. Literature on the links between population mobility or migration and HIV as an *effect* of AIDS - and as the way such movement pertains to families - was then identified with the help of iterative searches in the major search engines: PubMed; Reference Manager searches using selected Z39.50 sites; Google scholar; FRANCIS; GEOBASE; International Bibliography of the Social Sciences ; Sociological Abstracts; Worldwide Political Science Abstracts, and PsycINFO. One of the most fruitful ways of identifying new literature after the first rounds of search engine consultation was by tracing documents cited in the most relevant articles, using Google and especially Google scholar. Relevant net sites (e.g. AIDS & mobility, NAM, UNAIDS, IOM) were also consulted. Some additional sources emerged during discussions with other JLICA authors in January 2008, especially from documents less likely to appear in the major search engines. Saturation was eventually reached: repeat consultations revealed only publications that had already been identified. The section on migration of families, finally, relies heavily on sources from the library at the International Organization of Migration in the first instance, then on the search engines mentioned above[i].

This, to the author's knowledge, is the first tem the three literatures (migration, HIV, families) have been put together. The review is intended to serve as a starting point, to precipitate further thinking and research.

1. World migration and population mobility

Before discussing migration as a result of HIV or AIDS it is important to set out some basic concepts about migration in general. Some basic numbers and definitions are sketched, as are the major reasons for migration. Subsequent sections discuss migration of women, then of children and young people, then finally of families, in particular discussing the way in which migration may be not an individual matter, but a family affair. The concepts of circular migration and of transnational families, which will be especially important for discussions in later sections, are presented.

1.1 Some numbers and basic concepts

Migration has always been an important part of human endeavour. Westin (Westin 1996) describes the way in which, ever since the first humanoids left their East African homelands in search of food, people have left their communities: to explore, in search of adventure, to flee, to join family members, or to seek what they thought might be a better life elsewhere. Homo Sapiens originally spread across Europe, then from the Indonesian archipelago to Australia, then across the Bering strait into the Americas. In the following centuries the Polynesians crossed the central Pacific; Israelites, Phoenicians, Greeks and Romans colonized the Mediterranean basin; Slavic peoples expanded their territories in Eastern Europe; and the Islamic expansion extended its influence from Spain to the Indus valley. Europeans emigrated to the Americas, later bringing millions of slaves from Africa. Other massive population shifts were precipitated by the Second World War and by the decolonization of countries such as Pakistan and India. In Africa, in Asia, in the Caribbean and also throughout the Americas, movement of individuals and of families between countries, sometimes across great distances, has in fact long been an inherent part of life.

Although the numbers of international migrants have more than doubled since 1960, and one occasionally reads of a ‘migration crisis’, migration experts point out that the *proportion* of people living outside their country of origin today is really not much different from parts of the last century, or earlier eras when population movements peaked[ii]. What has changed, however, is that migration flows are much more complex than they were 30 years ago: the magnitude, density, velocity, and diversity of global connections have increased greatly (Nyberg-Sorensen, Hear, & Engberg-Pedersen 2002). These have been significantly affected by globalization, which has strengthened economic linkages between actors in different regions, but also increased the gaps

between the richer and the poorer countries (Stiglitz 2002). Combined with changing demographics, such gaps create strong pressures for people to move from region to region. Globalization has affected migration in other ways as well: global communications networks now provide people with detailed information to help them in moving from one place to another, global transportation networks have made it much faster and cheaper to do so, and the growth of global social networks and diasporas have made it easier for people to adapt to a new society (Global Commission on International Migration 2005).

In 2005, some 191 million individuals, or approximately 3% of the world population, was an **international migrant**. This number is likely to exceed 200 million in 2008 (International Organization for Migration 2008). Each year between 5 and 10 million people cross an international border to take up residence in a different country (United Nations Department of Economic and Social Affairs 2006). Only 40% of global migration takes place into industrialized countries, the other 60% taking place between developing countries (International Organization for Migration 2005). Significant population mobility also takes place within countries, most commonly from rural to urban areas, but also from poorer rural areas to more prosperous ones. Internal and external migrations are often interconnected, for example when people move internally from a rural to an urban area then later organize to move on to another country, or when people from rural areas move to take up the jobs of workers who have gone abroad. Approximately half of the international migrants world wide have migrated to join family members or to study. The other half, more than 86 million people, are thought to be labour migrants (International Labour Office 2004). About half of today's labour migrants are women, and more women now migrate independently and as main income-earners instead of following male relatives as they had in previous generations (Martin 2005;United Nations Population Fund 2006b). Independently of gender, the highly skilled, such as health workers, now comprise a numerically important segment of those migrating for professional reasons.

In a phenomenon known as 'the migration hump', migration tends to be highest in middle-income situations. Except when war or natural catastrophes lead to destitution and hence to 'survival migration' under the worst conditions, absolute poverty is a barrier to migration, as the very poorest are simply unable to gather the necessary resources (Castles 1999). As Davidson and Farrow put it: 'Migration – especially international migration – is not normally an automatic or unthinking response to a hopeless and desperate situation'. Incipient development raises incomes, providing

families with the financial resources to buy transport, and also the social resources and skills that are needed to migrate to areas where jobs may be more available and where incomes are higher. Such resources and information are not evenly divided amongst or between populations, but instead are structured along lines of class, gender, age, race, ethnicity and/or caste. Massive asymmetries in fact exist between the migration opportunities open to those from poorer countries - even those who are relatively privileged in such countries - and those from more affluent nations. Indeed, people who hold passports from countries with a history of violent political conflict, countries with a strictly autocratic regime, very poor countries or countries with some combination of these (in other words those who most need to migrate) will find it the most difficult to legally enter other countries (Davidson & Farrow 2007).

Migration patterns are not purely economically driven, however: they tend to follow inter-country networks based on family, culture and history. People may move between countries to find work, but they do so more easily between countries with historical links, where they know they will find compatriots, or to which family or friends have already migrated and become established enough to help them (Boyd 1989). As one theorist has put it: 'The majority of movers move along well-trodden paths which, even if they have not travelled them before themselves, have been traversed earlier by family members and friends' (Hugo 1994, p11). Once established, international migration flows thus tend to develop their own momentum.

World-wide, the United States has long been, and still is, the major migration receiving country, receiving migrants mainly from developing countries in the Americas. Canada and Australia have also long been important countries of permanent settlement (Zlotnik 2001) and they also send migrants to live in other countries. International labour mobility has become increasingly important in Asia over the past three decades, a considerable proportion of which takes place within the region (International Organization for Migration 2008). European countries are increasingly becoming migration destination countries, receiving, among others, migrants from former colonies (from Zimbabwe, South Africa or Nigeria to the United Kingdom, for example, or from Algeria or Morocco to France). Although the European Union has introduced extensive controls in recent years, southern European countries, especially, still see substantial clandestine migration. Well-established routes for such migration transit northern and western Africa, but the would-be migrants who use them come from everywhere, including Asia and Latin America (International Organization for Migration 2008).

Africa is the continent with the lowest growth rate in international migrants during the first five years of the 21st century, and, at two percent, also the continent that registers the lowest proportion of migrants as a share of the total population. The large western and Southern African countries (Côte d'Ivoire, Ghana, South Africa) are most affected in absolute terms, although the smallest countries receive more migrants relative to the size of their population. South Africa is a major destination country, with temporary legal cross-border movements from other African countries (particularly the Southern African Development Community) having increased significantly in recent years (International Organization for Migration 2008), as has overseas migration, including to Western Europe (Wanner 2002). Indeed, during the 1990s African countries witnessed the emigration of many of their most educated and enterprising, who 'together fuelled a worldwide diaspora, not as yet reliable quantifiable, but probably as significant in scale as the forced migrations of the pre-colonial slave trade' (Oliver 1999 cited in Preston-Whyte et al. 2006 p. 349). To take just one increasingly cited example, of such 'brain drain', that of health professionals, physicians trained in sub-Saharan Africa but working in OECD countries represent close to a quarter of the current physician workforce in the source countries (World Health Organization 2006) and sub-Saharan African trained nurses and midwives working in OECD countries represent some 5% of the total nurse workforce in the source countries. In 2000, over half of the nurses from Liberia, Mauritius, and Sierra Leone were working abroad (Dumont & Zurn 2007). Most of the recorded migration in Africa occurs within the region and within countries, however, and such migration is substantial: indeed, in the early 1990s one in five Africans no longer lived in his or her birthplace (Findley 1997). As in the rest of the developing world, urban growth is rapid, but comparatively fewer of the urban populations live in the largest cities. Smaller cities predominate, attracting more and more migrants seeking alternatives to 'oversized metropolitan areas with undersized job opportunities' (Findley 1997 p. 110).

In addition to economically-driven 'voluntary' migration, other and quite different forms of population mobility also take place.

Box 1: Definitions

Formal definitions of the major of **migrant terminologies** (asylum seeker, displaced person, family reunification, forced migration, immigration, internally displaced person, irregular migrant, labour migration, migrant, refugee, traveller) can be found in Appendix.

The definition of **'family'** used in this review is a broad one shared by JLICA learning group 1: 'social groups connected by kinship, marriage or adoption that have clearly defined relationships, long term commitment, mutual obligations and responsibilities, and share a sense of togetherness... family groups generally share universal functions, such as reproduction, production, love and protection.'
The term 'household', in contrast, refers to all individuals who live in the same dwelling. The term family as used here is clearly far more encompassing than the term household, especially where transnational families are involved.

As of January 2007, the United Nations High Commissioner for Refugees lists some 32.9 million **refugees, asylum seekers, internally displaced**, and 'others of concern' who have fled political instability, conflict, environmental degradation and natural disasters. Almost half of these are in Asia, and another 10 million in Africa. Four out of ten of the world's ten million persons specifically recognized as refugees at the end of 2006 were in Central Asia, South West Asia, North Africa and Middle East, with another 2.4 million in Africa (almost half of the latter in Central Africa and the Great Lakes region) (UNHCR 2007). Africa also has the world's largest concentration of internally displaced persons, who in fact now largely outnumber the refugee population (Internal Displacement Monitoring Centre of the Norwegian Refugee Council, and UNHCR, cited in International Organization for Migration 2008). Other people have been displaced by infrastructural projects such as dams, deliberately moved in the name of 'eminent domain' law, which allows private property to be expropriated for the sake of a wider public good. Similarly to refugees and internally displaced persons, such forced resettlers have no choice about leaving their homes. In addition, however, they can have no hope of returning to them (Turton 2003).

Other categories are increasingly important today, such as **transit migration**, by which people enter one state in order to travel to another. Many are unable to do so, however, and their presence has turned such countries as Poland, Hungary and other countries in Eastern Europe 'from corridors into vestibules' (Salt 2001, p. 87). **Undocumented migrants** also continue to be in considerable demand: despite relatively high unemployment in a number of developed countries, foreign workers – including particularly unauthorized migrants – are able to find jobs easily. Indeed, industries have emerged to facilitate such flows: a plethora of public and private agencies in both developing and developed countries have materialized to recruit workers for employment abroad (Salt 2001). In addition, the status of numerous **other people who regularly cross international borders**, such as cross-border

commuters, labour tourists, and petty traders – all of whom derive most of their livelihood from frequent short-term visits to other countries - easily blends into that of migrant. In sum, and as the above implies, the terms 'migration' and 'population mobility' cover a wide variety of different motivations, degrees of choice, distances travelled, amounts of time spent away from the community of origin, and legal statuses.

Some final comments on overall migration patterns are in order before turning to families: migration is less and less being seen as a one-way and permanent process. The question of **return migration** is receiving more attention, as it is becoming apparent that migrants frequently go back to their home countries, both for visits and to return permanently after they have lived and worked in other countries (Cassarino 2004;Ghosh 2000;Oxfeld & Long 2004). **Circular migration** (also known as 'shuttle migration' or 'commuter migration') is receiving considerable attention in particular. Circular seasonal migration between rural and urban areas, especially, has long been part of life in, for example, West Africa (Adepoju 2005), South Africa (Dodson & Crush 2006) and also Thailand, where the development of modern transportation systems allows members of farming families to commute to urban centres for regular employment, and also often for part-time or irregular work such as that of petty trader or construction worker (Jones & Pardthaisong 2000). Vastly increased circular mobility between rural and urban areas, in fact, helps blur the distinction between 'urban' and 'rural', since many people who have their permanent place of residence in rural areas actually work for considerable periods of the year in urban areas, in Asia (Hugo 1994) as in Africa (Tienda et al. 2008). Such migration may take place in a stepwise fashion, as people move from smaller to larger places, then from urban place to urban place, rather than in a single leap from village to metropolis (Collinson, Tollman, & Kahn 2007).

For some of today's migrant workers, such as Asians working in the Gulf States or Filipinos working in the Americas or Europe, temporary international migration is becoming a permanent way of life: they return home only to migrate again. In another variant migrants are based in destination countries but run businesses in their native countries, to which they return regularly. Examples include Chinese, Indians, Salvadorans and Dominicans resident in the United States, and people from Ghana or Ivory Coast living in the United Kingdom (Tiemoko 2003). Rather than returning to the cultures from which they came, or integrating into the one in which they are living, such migrants develop 'transnational' lifestyles and perspectives, from which they live 'between' or 'across' two countries, economies and cultures. Scholars are increasingly

recognizing that many contemporary migrants maintain active ties across borders: economically as they send money home or run businesses in two different places; politically as migrants may vote or even run for office in more than one state; socially as they maintain ties with friends and family, sometimes across great distances; culturally; and in religious communities that transcend space (Levitt & Jaworsky 2007).

1.2 Migration of women, of children, and of families

Although there have, of course, always been variants, it has long been assumed that the typical pattern of migration was for a young single man to go abroad to work, later marrying a woman from home and bringing her to the destination country, where couple would settle, have their children, and possibly bring other family members to join them as the family settled in the destination country for future generations. The permanency of today's migration was put into question in the previous section. The next section discusses what is known about today's migration of women, of families, and of children.

1.2.1 Migration of women

As already mentioned women now make up nearly half of all international migrants across the various categories of migrant already discussed. About half of the world's **refugees** are women (United Nations High Commissioner for Refugees 2006). The majority of women migrating to the major receiving countries (Australia, New Zealand, Europe and North America) do so for **family reunification**: they have received permits to join family members who had been migrant workers or been granted refuge in these countries (United Nations Population Fund 2006b). Women are also increasingly **labour migrants**. At the higher end of the skill spectrum migrant women run multinational corporations, teach in universities, supply research and development expertise, and design and programme computers, and a good many women migrate to work in the health sector, particularly as nurses and physical therapists. At the lower end of the skills spectrum, migrant women pick fruits and vegetables, manufacture garments and toys, process meat and poultry, work as aides in nursing homes and hospitals, clean restaurants and hotels and provide a myriad of other services (Martin 2005).

A few studies are beginning to explore women's motivations for migrating. A first reason is economic, but recent reviews have pointed out that while poverty may push

women to migrate, migrant women usually do not come from amongst the poorest members of their societies: in fact women who chose to migrate have been shown to be typically more affluent and better educated than men who do so (Martin 2005;United Nations Population Fund 2006b), as well as more reliable in sending remittances home to their families (Marin 2005). Some women also migrate to 'become modern': to be able to purchase consumer goods, to live in the city, and to be independent (Hew 2003). Others may migrate to escape discrimination and oppression by family members (Commission on Human Rights 2002a;INSTRAW & IOM 2000). These women are enterprising and adventurous enough to resist gender stereotypes and social pressures to stay home: migration may allow them to escape expectations that they will care for elderly family members, relinquish pay checks to husbands or fathers, or defer to abusive husbands[iii]. Migration may also be a practical response to a failed marriage, and to the need to provide for children[iv] (Ehrenreich & Hochschild 2003). Or women - whose circular migration has allowed them to become increasingly less dependent on men for livelihood and life-long support - may decide to skip marriage altogether and migrate alone, relying on social networks based on kinship, friendship groups, churches, and neighbours for child care and support (Hunter 2007;Preston-Whyte, Tollman, Landau, & Findley 2006).

Specifically female forms of migration have emerged in recent years (Carling 2005;Martin 2005;United Nations Population Fund 2006b). One trend is an increase in migrant women who work as **maids or domestics** in almost all parts of the globe, and who come from a wide range of countries. As women have increasingly taken up paid work in developed countries they need others to replace them in taking care of children and the elderly. Domestic work, often rejected by local labour in richer countries, is compatible with traditional female roles (Momsen 1999;Verghis, Fernandez, & Penafort 2003), and may provide socially acceptable jobs for women whose limited education and skills provide them few other employment opportunities (Peberdy & Dinat 2005). But not only: there are strong economic incentives to migrate when, for example, a woman from the Philippines working as a domestic in Hong Kong can earn about 15 times the amount she could make as a school teacher at home (Ehrenreich & Hochschild 2003). Global care chains are thus being created, as women who have gone abroad - to take care of children and for other jobs - hire other women from rural areas in their own countries to care for the children they very often leave at home. The rural women, in turn, need someone to care for their own children, a task that will be taken on by an elder daughter or by the migrant's mother if the woman cannot afford to pay a domestic worker while she is away (Carling 2005). The mothers,

in the meantime, may worry about the care their own children are receiving as they care for those of other people (le Roux 1999).

Female undocumented workers can be found in a range of jobs and industries, with agricultural, food processing, light manufacturing and service jobs being the most common types of employment (Martin 2005). Women are also smuggled into countries by professional traffickers: they may be led to believe that they will work in legitimate occupations, but may find themselves trapped into forced prostitution or marriage, or into sweatshops or exploitive domestic work and other jobs (Laczko, Gozdziak, & International Organization for Migration 2005;Martin 2005). Unknown numbers of women, especially from countries with few good economic opportunities for women, also migrate each year to find spouses through international matchmaking services (Martin 2005). Finally, some female migrants may find sex work the quickest and most lucrative way to earn money (Anarfi 1993;Findley 1997). Families may turn a blind eye to the profession of their daughters engaging in sex work if their earnings contribute significantly to the family's subsistence, or provide the family's sole source of support (Pittin 1984).

1.2.2 Migration of children and young people

Children are affected by migration in a number of ways: when they migrate with their families, or when they are left in their home communities to be cared for by someone else when one or the other parent migrates, or when both parents do. Some children, in addition, migrate on their own. Estimating the **numbers** of children that have migrated and/or are affected by migration is extremely difficult, for several reasons. First, countries differ widely in the extent to which they document migration at all. When data *is* collected this is not done in a standardised way, migration data is often not broken down by age, and data is extremely difficult or impossible compare between sources since different categories are used[v]. In addition, a certain amount of movement concerning children or young people is illegal, so that any numbers are by definition estimates. Studies must thus rely on indirect data, which has its own distinct limitations[vi]. Experts nevertheless agree that young people have always represented a large share of the world's migrants, and still do. An UNFPA special report on migration of young people, relying on a variety of sources, estimates that the proportion of youth from developing countries who cross borders represents about a third of the overall migration flow, and about a quarter of the total number of immigrants worldwide (United Nations Population Fund 2006a).

The reasons children migrate reflect those for which adults do so. Natural disasters and armed conflict may serve as triggers for **seeking refuge**, during which children may migrate independently, or they may become separated from their parents during flight. In the case of Africa, roughly half of the refugee population is comprised of children and adolescents, and roughly a quarter of the continent's refugees are girls under the age of 18 (Carling 2005;United Nations High Commissioner for Refugees 2006). Child migration may also be precipitated by domestic violence (Davidson & Farrow 2007) or the desire to avoid forced labour or loss of liberty (Vungsiriphisal, Auasalung, & Chantavanich 1999). Children may also migrate for **family reunification** (United Nations Population Fund 2006a;Vungsiriphisal, Auasalung, & Chantavanich 1999), as discussed in the next section.

Children also migrate alone. Although parents may encourage their children to go abroad independently, in their excellent background paper on children and migration Whitehead and Hashim (2005) point out that children may well make independent decisions to migrate, to improve their own situation or that of their family. They rarely travel and seek work entirely alone, however. Child migrants come from districts with high rates of adult migration: they usually travel with family or friends, and stay with family or friends in the communities to which they migrate. In another outstanding discussion of child migration, Davidson and Farrow (2007) point out that the main simple and basic reason children migrate is for **income:** children and young people may migrate to seek employment because opportunities for earning money at home are limited, for example, or because their parents are ill or have died. Along with other authors, they also point out that young people who migrate from difficult circumstances are often the least disadvantaged, at least in relative terms: the poorest of the poor are simply unable to migrate.

As with that of adults, migration of young people is usually differentiated by gender, with young men going to such physical labour as construction work at one end of the skills continuum, and to jobs in information and communications technologies at the other (United Nations Population Fund 2006a). Young women migrate to factories, to domestic service and to the jobs discussed above, such as health care. In countries of Asia, Africa and Latin America, where large numbers of young women have migrated from rural to urban areas, their incomes can raise their status within the family and grant them a greater say in such decisions as when to marry and to bear children. For many young people, the experience and skills they acquire in the jobs to which they

have migrated can serve as a step to further migration for better-paid jobs (United Nations Population Fund 2006a).

The experience can also prove to be disastrous, however. One example, documented by Human Rights Watch, concerns unaccompanied children in transit centres in Spain, some of whom had paid smugglers to help them travel to Europe. Many came from poor neighbourhoods in Morocco, where they had left school early with few job skills. They said they had migrated because they saw no future for themselves at home. Some made the move with the express or indirect encouragement of their families, for whom many reported being the only source of support, while others said they were fleeing broken or abusive homes (Human Rights Watch 2002). A different study exploring the motivations and conditions under which young people migrate alone to Western European countries (International Organization for Migration 2001) found that most had set off filled with a sense of adventure. Some were lured by promises of better job opportunities, better income and sometimes marriage to someone from a 'wealthy' country, and few were aware of any danger involved. Both studies documented wretched conditions for many such young people in transit or destination countries, including police abuse, detention in unsafe and unhygienic centres, lack of adequate medical care, extortion and theft, and physical abuse by older and larger children (Haour-Knipe, Eriksson, & Grondin 2006).

On the other hand, and possibly quite differently, for both young men and young women travel to another community can be a **rite of passage**. In some parts of West Africa, for example, it is customary for a young woman to migrate for a period of time to do domestic work, either in her own country or abroad, to earn money in preparation for marriage (Adjei, 2006 cited in United Nations Population Fund 2006a). Another, related, reason for which children migrate is for **education**, a goal that often overlaps with labour migration, as well as with migration to live with kin. Family members to whose home a child has migrated may expect or require that s/he carry out domestic work, or take another job to contribute to her or his keep. Some children and young people, possibly influenced by the stories of others who have migrated or by the media, migrate for reasons of simply **curiosity:** they want to see what life is like in another location (Anarfi et al. 2005; Vungsiriphisal, Auasalung, & Chantavanich 1999). Distinctly opposite is the situation of young people who become involved in arranged or **forced marriages, or in trafficking**. Such abusive child migration involves both genders and jobs ranging from sex work and camel jockeying to fishing, mining and domestic employment (Laczko, Gozdziak, & International Organization for Migration

2005; Martin 2005). Other children prefer to take to the streets – sometimes after multiple migrations - rather than stay with families that are abusive or unwilling to support them (Evans 2005).

In a nutshell, migration of children reflects both the worst and the best of what may be involved in migration. The United Nations Special Rapporteur on the human rights of migrants has pointed out that unaccompanied minors, especially, are at great risk of violence, exploitation, child trafficking, discrimination and other abuses, and that they are also more vulnerable to sexual abuse and being coerced into begging, drug dealing or prostitution (Commission on Human Rights 2004). On the other hand, in a volume that simply lets migrant children from West Africa and South Asia tell their stories, children show that they are very often far from being just passive victims. They very often proactively seek a better life abroad. Some may find themselves exploited, but they also keep trying to do something about it. Some may become resentful, but those who have successfully migrated to help support families in difficult circumstances may tell of their achievements with glorious pride (Anarfi, Gent, Hashim, Iversen, Khair, Kwankye, Tagoe, Thorsen, & Whitehead 2005).

1.2.3 Migration of families

This section defines the principal administrative, or legal, forms of family migration, then the way in which migration may be a matter not of individuals, but of families. Two subthemes that will become important later in the document are discussed, transnational families and – to illustrate the all-important cultural factors in family migration - migration and families in Africa. The subsequent section then discusses the way families may be affected by migration. It is only much later that the review will add HIV and AIDS to the equation.

Family-related migration is the predominant mode of entry into the classical migration receiving countries (United States, Canada, Australia), as well as into the states of the European Union. Several formal types of family migration are important:

Family reunification: migrants who have obtained residence status in a new country are permitted to bring in immediate family members such as children, spouses, parents and others)[vii];

Family formation or marriage migration: children of migrant origin receive permits to bring in fiancé(e)s or spouses from their parents' homeland or diaspora,

or permanent residents or citizens are allowed to bring in a partner they have met while abroad, for example while working, studying or on holiday;

Family migration in which an entire family migrates: this form of migration used to be encouraged by receiving states on the assumption that it would facilitate integration, but has become much less common in recent years except for some categories of refugees, and for highly skilled migrants (Kofman & Meeton 2008).

Two contradictory tendencies can be noted concerning family reunification, in particular. On one hand, the universalization of human rights – including the right to choose a spouse and to live in a family household - has drastically decreased the legal base for restrictions to family migration (Nauck & Settles 2001). On the other hand enhanced border controls and strict migration policies limit entry of accompanying family members to many countries[viii]. It is difficult to estimate the number of families involved world wide since, although migration data now more often includes information about gender and age, data about family units entering or leaving countries is rarely recorded as such. Although numerous scattered studies of family migration have been carried out, neither academics nor policy makers have given the field the research or theoretical attention it deserves (Kofman & Meeton 2008).

Although the literature tends to be dominated by studies from the developed countries that receive migrants, where the point of view of the individual predominates, a number of theorists have stressed the way in which migration is very often the result of decisions that are made not by individuals, but by families (Booysen 2006). In developing countries, especially, economic theorists have suggested that families send members abroad in order to increase the economic wellbeing of the entire family group (Stark & Taylor 1989). The migration is a 'family project', for which resources are pooled: the expected outcomes are not for the individual migrant, but for other family members, including descendents (Nauck & Settles 2001). The wealth migrants generate comes from the remittances they send home, but also in less tangible forms such as increasing the family's exposure to such social resources as culture, education and health services (Collinson et al. 2006). Decisions about which specific family member is to move are made on the basis of age, birth order and gender, in ways that are highly determined by cultural norms[ix]. Box 2 discusses the way in which the family plays an extremely important role in sanctioning - or even completely controlling - decisions about who should migrate, where and for how long in African families, for example (Adepoju 1997).

Box 2: African families and migration

In a book chapter on migrations and family interactions in Africa, Findley (1997) presents several aspects of African families that facilitate migration, noting, first, that people throughout the continent have a long history of migration, and that the transformations caused by migrations reach into numerous aspects of African family life, including work, marriage and childrearing. A first feature of African family structure that conditions migration patterns is that extended households prevail, making it easy for parents to leave their children in another household while they are working elsewhere. Findley notes that networks of obligations arise in such situations, one of the most common forms being financial. Migrants are expected to send money home to their families in exchange for care. She also notes that such obligations may become burdensome, especially if the member working abroad is unable to earn as much as the extended family expects to receive.

Two other characteristics of African families that facilitate migration are that male and female worlds are largely separated, and that lineage controls tend to be stronger than conjugal. Migration decisions thus tend to be made by the head of the household or clan, and it is unremarkable for men and women to migrate and establish separate residences - a high proportion of spouses are separated by migration. The strong affiliation with lineage favours alternative childrearing patterns, and also reinforces the pull on migrants to return to their village of origin. Patterns of circular migration are reinforced, of seasonal, irregular or working-life duration. At the same time, dominance by elders means that some men and women migrate simply to become more independent, to break away from a family felt to be too restrictive.

Yet another characteristic of African families stressed by Findley is that production and reproduction are integrated: family members share responsibilities for child education, and children become productive members of the household at an early age. This means that families who need extra help for one reason or another may take in extended family members or absorb foster children to assist. Indeed, large numbers of people start their migration careers as very young children, being cared for by aunts, grandmothers or other foster carers. There are several reasons why mothers working in urban areas, especially, may leave their children for foster care in rural villages, including because they cannot look after small children while they are working, because it is too expensive to have someone else care for them in the city, or because they prefer to have their children receive a traditional upbringing[x]. Extensive exchanges thus take place between villages and urban areas, in both directions, with food and money sent back and forth between households. Findley further points out that when villagers fall

ill they often go to the city to stay with migrant kin while obtaining health care (Findley 1997).

Migration decisions within families are also made on the basis of particular skills and attributes - households deliberately choose those who are to migrate from among the family members most likely to provide net income gains. In some instances, in fact, specific children may be deliberately educated with migration in mind (Connell et al 1976 cited in Hugo 1994)[xi].

Other theorists postulate that families may also use migration of selected members as a sort of insurance, as a way of diversifying their activities in order to minimize risk. In the case of conflict or of political instability, for example, a family may send members abroad to countries supporting different sides, just in case. In rural areas migration of one or more family members allows households to secure themselves against crop failure or other unanticipated drops in income: a single calamitous event is less likely to wipe out a family's efforts if their sources of income are diversified across different locations and sectors of the economy (Findley 1997; Zourkaléini & Piché 2007). Temporary deployment of family members to distant locations also allows a family to make maximum use of labour, taking advantage of periodic lulls in the home area, or of needs at the destination (Hugo 1994;Massey 2006). Another form of risk insurance is driven by labour market insecurity: this - combined with rising levels of crime in large cities - encourages many families to maintain households in communities of origin as well as in communities of destination. To take just some of many possible examples, in places as widely separated as South Africa (Posel 2006), Barbados (Chamberlain 1998), Jamaica (Thomas-Hope 1999) and Thailand (Hugo 1998; Rende Taylor 2005) migrants working in other countries consider their migration to be temporarily: they fully intend to return to their home communities, where they have left children to be safely cared for by grandmothers or other family members. Many families are thus split between two – or more – countries or even continents, maintaining relationships that span both. Box 3 discusses a study of transnational families with at least one branch in the United States, and other branches in Yemen, Mexico, Central America, and Korea, and the role of children in connecting different branches of the family.

Box 3: Transnational families and children

A series of studies carried out by Orellana and colleagues in the United States among Mexican and Central American migrants, among Yemeni families, and among 'parachute kids' who have migrated from Korea without their families in order to attend school, show how the children in the family may serve as 'pivotal points' or 'linchpins' for households that span transnational borders (Orellana et al. 2001). Children may aid and encourage the settlement and assimilation of immigrant families, but - when an immediate family is split between two or more countries - they may also play an important role in keeping parents connected to their homelands, in helping maintain historical and cultural continuity. Orellana et al describe the bases on which families make decisions about whether or not children left in the home country will later be sent for, including: whether or not money is available to pay for their journey; the needs and circumstances of family members in home and destination countries; the expressed desires of the children themselves; and parents' views of what is safe, appropriate, possible, or good for children of different ages and genders. When they do send for their children, and when possible, Central American and Mexican parents, especially, follow the networks described above, arranging for young children to make the journey in the company of other kin. In the case of the Korean families studied it is the children who take the lead in family migration: young children are sent to live with other Korean families to attend school in the United States, in the aim of improving their chances of being admitted to a top American University.

As have other recent authors, Orellana et al point out that it is now much easier for families to keep in contact between home and destination countries. Families stay in touch through letters, telephone, e-mail, and videos. Parents are well aware of the risks of growing distant, but consider that by working abroad and sending money home they are providing for their children's futures. In many instances children in the same family are split between different countries, and parents must sometimes pit the welfare of children back home against that of children in the destination country. They must decide whether to send money home or to invest in getting ahead in the United States, and some parents expressed frustration that their children in the United States did not appreciate the things their children back home would never have. They sometimes considered sending children back to the home country to give them another perspective on life, or for schooling or other opportunities, or so the children would appreciate where the family came from, or as a potential disciplinary measure when they felt a child was 'going off track' (Orellana, Thorne, Chee, & Lam 2001).

In still other instances social and family structures may enable and encourage migration. In many families, as in many societies, migration is the norm, not a departure from it – the process of migration carries potent symbolic value. Chamberlain's detailed exploration of family histories in the Caribbean, for example, shows that under what may appear to be an economic motive in migration there may well be a family history of social and geographic mobility. An individual's migration is a part of the family history, and becomes an important element of his or her identity: identity, family, professional success, and migration goals are all inter-linked. Within a culture that prizes migration *per se*, the individual who migrates to maintain the family livelihood may gain not only experience, but also status (Chamberlain 1998).

This long introduction on recent migration patterns, especially as they affect women, children and families, gives background necessary to understand migration when HIV and AIDS are factored in. The next section turns to some of the literature discussing the effects of migration on children and families.

1.3 Effects of migration on children and families

This section dips into the literature to pull out aspects that might be used for lateral thinking to apply to the context of families affected by HIV and AIDS. It discusses the inter-relation between health and migration, then between economic wellbeing and migration; the importance of the extended family, and of the child's understanding of what is happening in the family, then finally the importance of structural and community factors. Much of the literature related to the effects on migration on families comes from the major migration-receiving countries in the developed world, especially from the United States, but at least one developing country, the Philippines, has put significant effort into examining such effects. Research from that country is used below as a case study, to give some substance to observations that would otherwise remain at a high level of generalization.

The 'healthy migrant effect' – the observation that, all other things being equal, it is generally the healthiest as well as the most ambitious who migrate - has been mentioned in previous sections of this review, and will come back again in the section on HIV and families. The good level of health of recent immigrants has been established in, for example, studies of immigrants in the United States (Singh & Siahpush 2001) and Canada (McDonald & Kennedy 2004), of Turkish immigrants

living in Germany (Razum et al. 1998), and, more recently, of Nicaraguan migrants living in Costa Rica (Herring et al. 2008). The effect seems to extend to their children: studies in the major migration receiving countries increasingly report good physical and mental health among immigrant youth. A major review in the United States, for example (Hernandez et al. 1998) concluded that in several significant ways - such as in rates of low birth weight and of infant mortality, numbers of specific acute and chronic health problems, and prevalence of accidents and injuries - immigrant children appear to experience better health and adjustment than do children in US-born families. Immigrant adolescents, similarly, were less likely than second-generation or US-born adolescents to consider themselves in poor health, or to report absence from school because of health or emotional problems. In differences that remained after controlling for family income, family composition, or neighbourhood factors, immigrant adolescents were also less likely to report early first sexual intercourse, delinquent or violent behaviours, cigarette smoking, or substance abuse (Hernandez, Charney, National Research Council, & Committee on the Health and Adjustment of Immigrant Children and Families 1998), at least for the first generation, although this changes, as discussed in Section 2.3.3 on the importance of community and social factors for influencing the health of migrant children.

Studies concerning children who have remained in home countries while their parents go abroad to work tend to concur. In the Maghreb, for example, the physical health of children of migrants was reported to be better than that of children of more sedentary parents (Charbit & Bertrand 1985). In the Philippines, Indonesia and Thailand, similarly, a major UNICEF review of the literature comparing children of migrants and of non-migrants found either essentially no differences between the two, or better scores for the children of migrants, in social anxiety; loneliness; reports of verbal, physical, or sexual abuse; children's ratings of their parents marriages; relationship problems or psychological problems; or premarital sex, drinking alcohol, or smoking (Bryant 2005). In both of these studies the authors note the role of increased economic resources in the children's wellbeing: as Bryant remarks, poverty is a potent source of family problems, and migration is usually an effective way of alleviating poverty. As already discussed, parents from numerous countries may feel that the best way they can care for their children is from afar, by working abroad to increase the family's economic wellbeing (Ehrenreich & Hochschild 2003;Hew 2003;Jolly & Reeves 2005)[xii], and when the project is successful increased resources are in fact found to be one of the most consistent and pervasive positive aspects of family migration

(Chamberlain 1998;Rajan 2007;Sorensen & Guarnizo 2007). What about effects on family relations?

1.3.1 Effects of migration on family relations

Migration may profoundly modify family relations. Even under favourable circumstances - when an international move is voluntarily, social and economic difficulties are minor, cultural differences are subtle rather than flagrant, and when racism not particularly an issue – migration causes strains and hassles within a family that, in the worst of cases, can destroy the family unit. In the best of cases, however, surmounting the difficulties caused by migration gives rise to growth that can foster resilience in the entire family unit (Haour-Knipe 2001). Male roles may change drastically after migration, for example, or migration to a different culture can give rise to intergenerational tensions, particularly when children adapt to a new language and culture more quickly than their parents. Migration may enhance the autonomy and power of women, by giving access to financial resources, or permitting women from traditional societies of origin to discover new norms regarding women's rights and opportunities at destination. Migration may equally well lead to decreased autonomy for other women, especially if they cannot speak the new language and have difficulty in adapting to the new society (Martin 2005).

Roles within families shift after migration, especially when only one parent migrates. While husbands and fathers who migrate alone maintain their role as breadwinners in their families, although at a distance, the women and children who have remained behind take over the tasks traditionally done by the absent family members, including becoming de facto heads of nuclear families (for Africa c.f. Adepoju 1997;Gwaunza 1998) or (Asis 2003;Hugo 1994 for Asia). The women remaining at home may face a variety of difficulties such as raising children as a single parent; dealing with their own emotional, psychological and sexual needs; conflicts with in-laws concerning management of resources; avoiding sexual violence; and abandonment of husbands who establish new families in other countries (CARAM Asia 2004).

As discussed in section 2.2.1, labour migration of women has increased significantly in recent years, and the subsequent redistribution of family roles and responsibilities that occurs in families urgently needs to be explored. In the opposite situation studies have rather consistently found that women who remain at home while their spouses migrate to work abroad usually adjust rapidly, even in precarious social and economic

situations. In her world survey of the literature on the role of women in development Martin (2005) found that migrant women see the new roles and responsibilities they have taken on in the absence of their spouses as a learning experience. A study of wives of migrant workers from the Maghreb (Mélika 1997) also reports growth and learning, as does a chapter on families of migrants in Asia (Asis 2003).

Concerning families in general, in a large study of former migrants from seven Asian countries who had returned home after working in the Middle East, Gunatilleke (1991) found that most thought that migration had had a positive effect on their families. Economic wellbeing was improved, but this was not the only positive effect: awareness of the value of family relationships was heightened, the need for closer communication was felt, attitudes regarding the role of women had changed, and international awareness was wider. Interestingly, the study of returnees to one of the countries (India) found that the benefits of migration were not evenly distributed, with the social costs being highest for unskilled migrants: the poorer households were the least able to maximize the benefits of migration, especially as they had difficulty effectively managing suddenly larger flows of income (Gunatilleke 1991).

On the other hand, several authors have argued that migration causes problems for families, and especially for the children left behind. In Asia, for example, an NGO working with families of migrants reports cases of children of overseas workers becoming estranged from their parents. They see their parents only as sources of gifts and money, and blame their absence for problems such as delinquency, drugs, and premarital sex. Others find that children of migrant workers abroad have difficulty making decisions since they are used to having two layers of authority in the family (their caregivers and the absent parent), or that such children are spoiled and wasteful, or lonely and resentful (all described in Bryant 2005). One of the most negative pictures is that painted by the UN Special Rapporteur on the situation of migrants who, after a visit to the Philippines to enquire into the situation of migrant workers, expressed serious concerns about the social costs of such migration. Noting that the rate of divorce and separation among migrant women was 4.4 times higher than the national average, and that migrant women are 15 times more likely to be separated or divorced than their male counterparts[xiii], she went on to list some of the difficulties, for spouses then for children:

> The pressure to provide the family with money sometimes causes migrants to avoid visiting home. Husbands left behind are not often prepared to take over

> their wives' responsibilities. Distance and poor communications weaken relationships. The difficulty - often leading to failure - to maintain their relationships makes both the OFW [overseas Filipino worker] and the spouse left behind emotionally vulnerable. Often, in case of family break-ups, the in-laws of OFWs argue with them over guardianship of children and control and use of the migrant's property or remittances, with the children usually suffering as a result. Reportedly, children of OFWs are more likely to become involved in delinquency or early marriage. Many children become quarrelsome and have difficulties developing healthy friendships with other children. In some cases, their grades in school decline... Most of the parents intentionally do not keep their spouses regularly informed about the situation at home in order not to make them worry. The lack of effective and regular communications leads to the family's growing apart (Commission on Human Rights 2002b paras 17 and 18)

Concerning the same migrant workers, the Special Rapporteur goes on to discuss significant difficulties of reintegration:

> 'not infrequently spouses/partners have begun new relationships and children have suffered psychological problems because of absence of the parent. Dependency on migrant workers' incomes has grown and families often do not engage in alternative income-generating activities. If the returnee finds a job, the wages are usually not enough to provide for the needs of his/her family. The few OFWs who manage to save money and attempt to set up a business upon return often fail because of lack of planning, training and information on business conditions in the Philippines. All these circumstances frequently leave returning OFWs with no choice other than to migrate again.' (Commission on Human Rights 2002b para 63).

This extremely negative picture may have its origins in the fact that the aim or the Special Rapporteur's journey was specifically to make detailed enquiries concerning problems. These might happen in a minority of cases, but they are extremely striking when they do happen. To go a bit more thoroughly into the question as it concerns developing countries we now turn to a review that examines children international migrants by comparing three countries in South East Asia.

1.3.2 Children of international migrants: case study from South East Asia

Some necessarily crude calculations suggest that 3-6 million Filipino children remain in their home country while their parents work overseas. The equivalent figure for Indonesia is something like one million children, and for Thailand half a million. These numbers imply that roughly 10-20 per cent of Filipino children - and 2-3 per cent of Indonesian and Thai children - have a parent overseas (Bryant 2005). In the Philippines about 45% of such children have their mother working abroad, 49% their father, and 6% both parents. The children are generally cared for by their mothers when the father is working overseas, but usually by other members of the nuclear family if it is the mother who has migrated, or if both parents have. Overseas contracts are generally for two or three years, though workers may take several successive contracts. Parents tend to visit regularly, except for those whose legal status abroad is irregular, and for whom it is too much of a risk to cross borders.

A number of studies carried out in the Philippines have examined the effects of family migration on children. A 1996 survey of 700 children carried out by the Scalabrini Migration Center in Manila had found that, compared to their classmates of the same age, children of migrants fell ill more frequently, were more likely to express anger, confusion and apathy, and performed poorly in school. A 2003 survey among 1443 ten-to-twelve year olds with one or both parents working abroad was much more positive, however. Self-reports indicated slightly fewer common ailments (cough, cold, stomach ache etc), and less abuse or violence. Children of migrants were taller and heavier than those of non-migrants, and more were able to attend private schools. The migrant children performed well in school, especially at the elementary level, although those whose mothers were working abroad did somewhat less well than those whose fathers were abroad, or those with both parents abroad. Those whose mothers were abroad also reported more anxiety and loneliness. There were some indirect indications that mothers may have migrated because of marriage problems, but the children saw the main reason for migration as being economic. Most of the children had not been consulted about their parents' migration (many had been babies when the parents went abroad) but, asked to compare before and after migration, most reported changes for the better, including improved economic status, and a happier and closer family. They were in frequent communication with their parent(s) abroad by telephone and text message. Overseas parents were consulted by telephone on important decisions, including discipline.

The authors conclude that although the departure of a parent leaves an emotional mark on the young children, the fact that such children are cared for by family members means that the children of migrants are not disadvantaged in well-being when compared with children of non-migrants. Indeed, the fact that the children of migrants are better off economically leads to other advantages which broaden their learning and may contribute to academic performance. Thus, the authors conclude, when the family is stable it can withstand the separation imposed by migration. They also note that religion and spirituality were important to all the children studied. They caution that the positive findings reported concern children – things may be different when the children reach adolescence. It seems, in any case, that the migration will continue: many of the children studied were already thinking about migrating and working abroad, and were shaping their career plans by what would be marketable (for example they were planning to study medicine and nursing, professions with which it is relatively easy to obtain a job abroad) (Scalabrini Migration Center 2003).

Another study went into a little more depth along the same lines. Sixty nine young adults who had grown up in households in which one or both parents were working abroad reported that if they had indeed endured emotional hardships because of the separation, these were lessened by support from extended families and communities. Difficulties were also lessened when communication with the migrant parents was open, and when the children clearly understood the limited financial options that had led their parents to migrate (see also Labib 1997 , who found that Tunisian adolescents thought the same thing). They felt that their mothers, in particular, had been able to provide emotional guidance from afar. They saw migration as a survival strategy for the good of the family, one that requires sacrifices from both children and parents, and can even provide good training for later in life. Some imagined their mothers as martyrs, and, perhaps somewhat melodramatically, found comfort in their mothers' grief over not being able to nurture them directly. Children who believed that their mothers were struggling for the sake of the family's collective well-being (rather than having left their families to live the 'good life') were less likely to feel abandoned and more likely to accept their efforts to sustain close relationships from a distance (Parrenas 2003).

If these studies of Filipino children of migrant workers abroad were relatively positive, the UNICEF review describes the situation of other migrant children that contrast starkly. These are children whose families receive far less support. Bryant points out that there are over 100,000 children of undocumented migrants from Myanmar,

Cambodia, and Laos living in Thailand[xiv], and perhaps hundreds of thousands of children of Indonesian migrants in Malaysia. Scattered evidence suggests that these children face much greater difficulties than the children left at home by Filipino, Indonesian, and Thai workers abroad on regular contracts. The children brought along clandestinely to Thailand and Malaysia appear to be significantly poorer than other children in their host countries, and have limited access to social services[xv]. Among other problems parents who are very poor are unable to pay for childcare, and they are too far from their home villages to be able to rely on relatives as caregivers. Young children thus sometimes spend their days at their parents' workplaces, receiving little stimulation and facing environmental hazards (Amarapibal, Beesey et al. 2003 cited in Bryant 2005). Older migrant children are often employed themselves: their families need the income, and their irregular legal status means that they are unable to attend school in any case. Besides being decidedly unhealthy in and of itself, the extreme poverty of many of these migrants, and their lack of options, can increase the risks of trafficking or entry into the sex industry (Bryant 2005).

1.3.3 The importance of legal, community and social factors

The studies just presented from South East Asia join other studies showing how external factors - especially a migrant family's legal status and regulations about family reunification - strongly determine the way in which families will be affected by migration. A flagrant example is that of apartheid in South Africa (Heap & Ramphele 1991;Massey 2006;Posel 2006) where formal restrictions made it impossible for migrant families to live together. In other instances, and in numerous places today, low wages, poor employment conditions, and limited space may limit migrant workers ability to live with their families. Farm workers in Zimbabwe (Gwaunza 1998) and in the United States (Holmes 2007) are two of many examples, and others are discussed in the section below on HIV risk. Another example of negative community factors is the situation of refugees, where the environment may be particularly destructive for families. Families who have lost everything when they fled are completely dependent on either local hospitality if they have settled spontaneously among family members or others, or on food aid if they are in camps. Family life is severely disrupted, with constant insecurity and gender imbalances (Adepoju 1997): in particular men in such situations of dependency are unable to fulfil their traditional productive roles in agricultural or other employment, and enforced idleness contributes to loss of self-esteem, anxiety and depression, substance abuse, domestic violence and family breakdown (Harrell-Bond 2000;Turner 1999).

Pernicious effects of social factors are apparent in far less dramatic situations, however. This section began with a review showing good health for first generation immigrant children in the United States (Hernandez, Charney, National Research Council, & Committee on the Health and Adjustment of Immigrant Children and Families 1998). The American review goes on to find that immigrant children's advantages faded, though. Immigrant young people living in the US for longer periods tended to be less healthy and to report increases in risk behaviours, and by the third and later generations rates of most behaviours approached or exceeded those of US born majority adolescents. Other studies have similarly reported that health advantages for immigrant young people tend to disappear with time in the destination country (c.f. Brindis et al. 1995;Gfroerer & Tan 2003;McKay, Macintyre, & Ellaway 2003). Structural factors help explain the slippage, as demonstrated by results of the third wave of the 'Children of Immigrants Longitudinal Study', which has been following a large sample of second-generation youths from their early adolescence. The authors of the study had previously noted that children of immigrants encounter social contexts in host country schools and neighbourhoods that may lead to 'downward assimilation', such as dropping out of school, joining youth gangs, and using and selling drugs (Portes and Zhou 1993 cited in Portes, Fernandez-Kelly, & Haller 2005). By the age of about 24 the majority of second-generation youth being followed in the study were moving ahead educationally and occupationally. But a significant minority was being left behind. These were not distributed randomly: they were children of immigrants with lower levels of education and income, whose families were less likely to be intact, and also less likely to be closely integrated into ethnic networks and to have dense ties to their communities. The divergence between the young people who are doing well and those who slipping behind thus follows predictable channels: for some, intellectual, material, and social resources build on each other and lead to ever greater advantages within and across generations. For others, lack of skills, poverty, and a hostile context of reception accumulate into frequently insurmountable difficulties. The authors observe that the results from their study are 'almost frightening' in revealing the power of structural factors such as family human capital, family composition, and attachment to the community in shaping the lives of the young immigrants (Portes, Fernandez-Kelly, & Haller 2005).

1.3.4 Discussion: Effects of migration on families

A thorough, cross-national comparative review of the effects of migration on children or on families has not, to the author's knowledge, been done. Such a review would be an ambitious endeavour. It would require examining the short- and long-term psychological and economic effects of such migration, taking into account the levels of development of countries of origin and of destination, the family's socioeconomic and other resources, the reasons for the migration and its duration, cultural factors, and the various configurations in which families may migrate (together, or when one or more of the children is left in the care of someone in the home country while the parents migrate together, or while the father goes abroad, or while the mother does). It would also require looking not only downward, at effects on children, but also upward, at effects on the parents whose children have migrated[xvi]. Ideally, the review should also take into account the highly pertinent literature on families and resilience.

The studies sketched in this section have only been able to touch on some of the above. They show decidedly mixed, even contradictory, results. Family relations may be profoundly modified by migration. In the best of cases, capacities are built and independence is increased for the family members left behind. In the worst of cases migration leads to destitution, leaving family members in need with little means for survival. Partners and families may grow apart and/or establish new relationships in the absence of the worker abroad, children may experience a range of behavioural and emotional problems, that - rightly or not - they blame on their parents' abandonment. In the best of cases migration brings improvement in the family's economic wellbeing, an improvement that affects schooling and health among other factors. As seen in previous sections, a certain level of resources is necessary to let this happen, and external conditions far outside the control of the family may prevent it from doing so, and/or undermine the family.

It is interesting to speculate on what might be behind the difference between the best and the worst of cases. The importance of external factors has just been mentioned. The importance of legal status, mentioned in the introductory section of this document, appears again in this section, as it gives the right to health care and education, as well as to some protection from exploitation. The importance of support for families and children is stressed in practically all the studies reviewed. The research on migration in the Philippines, or example, shows how the migration is a family project: the extended

family plays a major role in the decision to migrate, in the preparations for doing so, and in the spending of remittance money. Grandparents, uncles, aunts, and god-parents all help fill the gap left by the absent parent. In fact parents are much more likely to migrate in the first place when the household already contains members of the extended family. In addition to support from the extended family, the studies from the Philippines also demonstrate the importance of support from more official sources such as the Government and NGOs. These can provide a wide range of services to international migrants and their children, including advocacy, counselling, help with reintegration, workshops for children and their caregivers, a magazine for children of migrants, and even a service that allows an absent parent to choose a child's bedtime story - even if the absent parent cannot read the story, the child still feels that the parent has participated (Bryant 2005).

Another factor stressed in this section is the importance of keeping in regular contact: e-mails and text messages can in no way substitute for the physical presence of a parent, but they can help a child feel connected with family members who are away. Finally, there is the importance of the family's relations and communication before the migration. Many parents presumably do not migrate unless they think their children can cope in the first place. A factor found to be extremely important is the child's understanding of, and support for, the family goal. The notion of sacrifice is a leitmotif in the studies from the Philippines, especially: children coped better with absence if they thought their parents were doing something that may perhaps be difficult in working abroad, but that was for the good of the entire family. In fact, an individual's migration can be highly valued within a family: it can give status, not only for the material objects the migration may bring, but in more symbolic form of being the family member who gives for others. Some of these observations might be extrapolated to the situation of children affected by HIV and AIDS, as listed in the final section.

The next section leaves families temporarily to turn to HIV and migration. Section 3.1.1 describes the factors that increase migrants' vulnerability to HIV, vulnerability that is important to document here, as it is what eventually creates the need to return to families for care and support (section 4.1). Section 3 first describes migrants' vulnerability in general, then discusses how gender and family factors may be related to it.

2. Migration and HIV

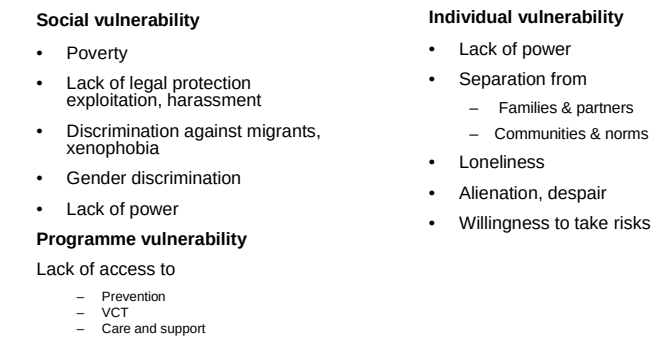
A link between migration and/or population mobility and HIV has been discussed since the beginning of the AIDS epidemic (Amat-Roze 1993;Hunt 1989;International Migration 1998;UNAIDS 2001). One of the initial concerns was that population mobility might be responsible for the spread of HIV, as travellers and migrants carried the virus from one place to another. In most countries, however, the focus later shifted from an individual and in fact somewhat blaming approach - considering the migrant as a possible 'vector' - to a far less stigmatizing one of examining the way in which the conditions and structure of the migration process may increase HIV vulnerability for migrants (Decosas & Adrien 1997) – and trying to do something about these conditions. These conditions and approaches have been discussed in reviews covering practically all regions of the world[xvii].

2.1 Vulnerability factors

Figure 1 sketches the social, individual, and programme vulnerability factors most often discussed in relation to migration:

Figure 1

HIV vulnerability factors for migrants



Social vulnerability factors[xviii] increase the likelihood that risk behaviours will take place. Inter-related issues of poverty, lack of legal protection, exploitation, discrimination, xenophobia, and lack of power reduce migrants' possibilities for making choices where risks are concerned – sometimes to zero (c.f. CARAM Asia 2004;Mishra, Conner, & Magaäna 1996). Migrant workers, especially those who have low levels of education and of skills, are easily replaced. As one business owner put it:

> If [a worker] falls away, he is easily replaceable. It is not a good statement to make but that's life, that's the fact. AIDS has had little effect on us due to the fact that it is not a specialized work, easily replaceable, people are easily trained in what they need to do (International Organization for Migration 2004).

Another of numerous possible examples comes from sugar estates in the Dominican Republic, where female migrant workers who cross the border without a husband and who cannot immediately establish contact with friends or family to help them have been shown to have little choice but to exchange sex for money or goods (Brewer et al. 1998). A similar example, also concerning migrant farm workers, comes from the South African Mozambican border:

As the temporary women begin to arrive at the start of the picking season, "there is overcrowding in the rooms...and the permanent men come scouting, choosing the beautiful ones. [They] take them and stay with them in their own houses. Some may take two or three." Although a woman's refusal to grant sexual favours to the foreman can mean losing her job on the farm, not all the young women are passive in the process: some specifically seek out men who have well paying jobs on the farm, knowing that becoming their girlfriends will guarantee food, money and "nice things." ... Some look for new relationships with men in order to provide for their children:
"We need porridge, that is what brought us to these men. I came to the farm with babies. I earn R200. I have three children...My man ...ran away after giving me children...That is why I want another man, to help maintain my babies" (International Organization for Migration 2004, p 28).

In both of these examples poverty, gender discrimination and lack of protection reduce choices, but the migrant nevertheless has some control over her situation. In extreme cases, such as those of women and men who have been trafficked for sex work, individuals may be highly vulnerable to encountering HIV, but have little or no possibility of protecting themselves (c.f. Beyrer 2001;Global Alliance Against Traffic In Women 2007;Silverman et al. 2007 for Asia) and (International Organization for Migration 2006 for Southern and Eastern Africa). Other extreme cases, such as that of displacement created by longstanding conflict were mentioned in the previous section: in circumstances such as that of Northern Uganda, to take just one example, family relationships may be severely undermined or break down, in the worst of cases giving

rise to behaviours that were previously unknown, such as child prostitution (Olaa 2001).

Lack of power appears on both sides of Figure 1, and permeates the examples just given. Child migrants such as domestic workers may be particularly powerless. An example is that of children as young as ten years old sent to work in urban households by rural families in Ethiopia, who often depend on the remittances they send home. Exploitation, when it occurs, goes hand in hand with isolation for such children: once they are in the city they may have no alternative but to accept their working conditions, or find alternative sources of income that put them at even further risk, such as working in bars or on the streets (Mabala 2006).

Poverty influences HIV vulnerability in most of the examples just discussed, sometimes flagrantly, but the relation is complex. As discussed above, economic resources allow people to travel, including to areas where HIV prevalence is higher and where the risk of HIV transmission is greater. Some authors have suggested, in fact, that a certain level of wealth is needed before one's risk of HIV infection becomes significant: the destitute may be less at risk than the merely poor (Williams & Tumwekwase 2001)[xix].

Individual vulnerability is partly driven by the fact that peoples' behaviour is often different when they are away from home, and from the social norms that guide and control the way they act in stable communities. Separation from their families has been shown to be a risk factor for HIV in the southern African region, for example, for such disparate populations as military personnel, transport workers, mine workers, construction workers, agricultural and farm workers, informal traders, domestic workers, and refugees and the internally displaced (UNAIDS & IOM 2003).

Certain professions may facilitate risk behaviours. Long haul truckers throughout the world (Synergy project 2000), for example, spend long periods of time on the road, live in an environment in which macho behaviour and risk-taking are not only accepted but often encouraged, and also have more disposable income than the residents of the communities through which they pass. They thus attract a number of services at the places where they stop, including those of sex workers (c.f. IOM & UNAIDS 2005 for West Africa;Lippman et al. 2007 for Brazil;Stratford et al. 2000 for the United States). For traders, somewhat similarly, long-term mobile women with mobile partners reported more sexual risk behaviour, and also had higher HIV prevalence among Tanzanian couples (Kishamawe et al. 2006). Female itinerant traders are separated

from partners, may be more willing than their more sedentary sisters to undertake risks, and may exchange sex with drivers for transport as they travel, or enter into relationships with local men for protection for security at market places (Anarfi 2005). Some stigmatized professions, such as sex work, may be more comfortably exercised away from home (van Blerk 2007).

Alienation, and a sense of despair, sometimes precipitated by doubts about the wisdom of one's migration project, may also drive risk behaviours. Marginal social status, relative poverty, and feelings of alienation may make young migrant workers - as well as the children of migrants who have grown up on the margins of the societies to which they have moved - more vulnerable to drug use, and appealing targets for drug suppliers (Rachlis 2007) (see also above, especially section 2.3.3). Another example can be drawn from a study of HIV patients in Tunisia, among whom a significant proportion came from very poor rural-urban migrant families, with whom they had broken by emigrating to European countries as adolescents. Having migrated clandestinely, with little education and no professional training, socially immature, and willing to take risks, they became good targets for drug traffickers. The young HIV patients often returned home involuntarily, expelled from a destination country after several prison stays (Tiouiri et al. 1999)[xx].

Finally **programme-related vulnerability** – lack of access to HIV prevention, counselling and testing, and to care and support for migrants – may have several roots: services may not exist in the first place; or they may exist but migrants may not have access to them, because of formal barriers such as legal restrictions, because of cost - or cost of transport; or simply because foreigners do not know about the services. Other barriers are services that are not adapted to the needs of migrants, or not perceived to be trustworthy. These are referred to again in the section on migrants living with HIV.

2.2 Gender, family and HIV vulnerability

Many of the risk and vulnerability factors discussed above influence, or are influenced by, family. These include a family's sending off one of its members to become a migrant worker in the first place – or an individual using migration to flee his or her family. They also include social and economic conditions in destination communities that may damage – or even destroy – family relationships. And, as just discussed, they include the effects of being away from stable partners and from community and family norms, a distance that may change the way an individual behaves. This section touches on some

further family-related aspects linking HIV and migration, starting with the way gender aspects are factored in, then listing some further subjects for which further exploration is needed.

Gender-related HIV vulnerability factors have been receiving increasing attention in recent years (UNAIDS, UNFPA, & UNIFEM 2004), and many of these vulnerability factors may apply to women who migrate to support their families (Anarfi 2005;Jones & Pardthaisong 2000;Mabala 2006), to those who may migrate because of the threat of marriage (INSTRAW & IOM 2000;United Nations Population Fund 2006b), and also to women who remain in home communities while their partners migrate. One example of the latter that is well analyzed in the literature concerns the partners of migrant mine workers in South Africa. Several authors have described the way in which male mine workers were brought in from other areas, lived under crowded conditions in single sex dormitories, doing dirty and dangerous work, with little opportunity for leisure activity apart from the drinking places and sex work scenes that grew up near the mine gates, especially on pay day. What was in effect partner sharing among the men who patronized the same sex worker in rapid succession efficiently spread HIV, infecting the sex workers, the miners, then possibly the partners when each of these returned home (c.f. Campbell 1997;Decosas & Adrien 1997;Lurie 2006a;Williams et al. 2003).

A few studies have examined the situation from the point of view of the women who remain at home while their male partners work elsewhere. Salgado et al (1996) found that although wives of migrant agricultural workers in rural Mexico may have been aware of and concerned about STIs and HIV, they were reluctant to discuss sexual matters when their partner returned, or to use condoms. Raising such issues would be a breach of norms of trust, silence and discretion, and could be interpreted as an accusation or as a confession of infidelity. Ten years later Hughes et al (2006) reported an identical pattern among partners of oscillating male migrant workers in South Africa. Another risk factor for such women may be that they are left destitute when husbands who have migrated fail to send money home. In rural Nepal, for example, almost half of over 600 migrants' wives, reported receiving no money during their husband's migration, and another quarter reported receiving funds only once a year (Smith-Estelle & Gruskin 2003). For South Africa, Lurie and colleagues have suggested that being left without support while her partner is working abroad may explain the relatively high HIV prevalence found among female partners of male migrant workers (Lurie 2006a). In a series of studies carried out over several years among migrant couples, these researchers suggest that migration is a risk factor not only because men

return home to infect their rural partners, as previously assumed, but also because their rural female partners are likely to become infected from outside their primary relationships[xxi]. The women described needs for social, sexual, financial and emotional support, all of which were frequently lacking in long-term 'stable' relationships, particularly when the partner spends the vast majority of his time far away from home (Dladla et al 2000, cited in Lurie 2006b).

A related factor of HIV vulnerability, which has been examined to some extent from the point of view of migration receiving countries, concerns migrants' infection while making visits home to higher prevalence areas. Among other risk factors, people visiting family may well go for longer periods than do tourists, perceive less personal risk, and have sexual contact with local residents (Angell & Cetron 2005). The possibility of HIV infection while travelling home for visits has been raised concerning migrants living in the United Kingdom, the Netherlands, and Australia for example (respectively Fenton et al. 2001;Kramer et al. 2005;O'Connor et al. 2007).

Finally, an issue that can only be mentioned here is the effect of migration on vertical transmission of HIV within families who are mobile or have migrated. A first line of data concerns sub-Saharan Africa, where early in the epidemic, in Uganda, the occupation of their parents was found to influence the death of children from AIDS and AIDS-related illness. By 1995, children with fathers in business or trading were at a very high risk (Ntozi 1997a): HIV was being acquired by men who had the economic resources to travel to other regions, then transmitted back to partners, then from mother to child. Absence of prevention programmes, and of programmes for reduction of maternal-child transmission, were partly responsible early in the epidemic, but something similar could happen in other regions today: the proportion of children born to immigrant mothers with HIV from high prevalence countries is increasing in Europe (Hankin et al. 2004), as potentially in Canada (MacPherson, Zencovich, & Gushulak 2006) and other countries that receive immigrants. In France the clinical, virological and immunological status of HIV-infected children born abroad has been found to be poorer than that of the children born in France (Macassa et al. 2006), demonstrating a need for appropriate access to prevention, testing and treatment for migrant families (see also section 4.3 on migrant families living with HIV).

Following the extensive introductions on migration in general, especially as it is related to families, and on vulnerability factors, the review now turns to a subject much less well covered in the literature, migration as a result of HIV and AIDS as this is related to

families. Two overarching themes emerge. The first is migration to families for care and support – including going home to die, and migration of children as a result of AIDS, when their parents can no longer care for them. The second is migrant families living with HIV. Each of these is now discussed.

3. Migration, families, HIV and AIDS

The concern that population mobility might be responsible the spread of HIV was mentioned in the previous section. A second concern driving initial interest in migration, HIV and AIDS was about resources. There was fear that HIV may spread to areas with previously low rates of infection, in particular to rural areas, causing worries not only that insufficient attention had been given to prevention in these areas, but also that funding for treatment would be inadequate. This was especially the case when resources for care and treatment were allocated on the basis of residence at the time of diagnosis, giving preference to the urban areas and other centres where testing and treatment facilities tended to be concentrated. In one of the key early studies of the question, Ellis (1996) helped put some conceptual order in an often very delicate issue by proposing a stage model of migration of people with AIDS:

- People infected with HIV but unaware of their infection will move in the same way as anyone else of their age, gender, ethnic group, and educational status;
- Knowledge of HIV infection and awareness of changes in health – or diagnosis with AIDS and deteriorating health – may trigger migration to gain better access to health care, institutional support and preferred living arrangements, at least among people who have the resources necessary to make such moves;
- As health further deteriorates and the individual becomes aware that he or she has only a short time to live, the desire or need to move closer to family or friends increases. In the final stages of the disease persons may migrate back to areas from which they originally came for care and support from their families.

What interests us here are the family aspects, in particular the question of returning to family for care and support, and at the end of life. Temporarily putting aside the first stage, before people know they have HIV (which will come back in section 4.3), the discussion follows the model proposed above, talking first about migration for care and support, then migration home to die, and finally about the effects of such migration on families.

3.1 Migration for care and support

Concerning low prevalence developed countries with relatively adequate medical care - and where moving from one place to another is very common - studies from the United States and Canada, especially, show that, in patterns that have not fundamentally

changed since HAART became available, people living with HIV may indeed migrate for a number of reasons directly or indirectly linked to their HIV status (Berk et al. 2003). People who changed their place of residence between AIDS diagnosis and death moved in patterns that suggested that their migration is for access to health care or tertiary facilities perceived to be of high quality, but also for social support, or to be near family and friends who can provide informal care, especially at the end of life (Buehler, Frey, & Chu 1995;Harris, Dean, & Fleming 2005;Hogg et al. 1997). One direction of movement is towards urban areas, to find physicians and medical centres experienced in treating HIV, to participate in clinical trials, for support services, and to get away from stigma and discrimination in smaller communities. Another current goes in the opposite direction, from urban to rural areas, for family support, to change lifestyles, and to avoid HIV risk behaviours (Cohn et al. 1994;Verghese et al. 1995). In particular almost all of the studies cited have noted that the ability to migrate is correlated with higher income, education, and socioeconomic status.

Specific sub-groups may migrate differently. Injecting drug users may be less liable to migrate because the areas where they are diagnosed offer specific support services for them, or because they depend on social and needle-sharing networks (Harris, Dean, & Fleming 2005). Injecting drug users who do move often cite the need to get away from areas where they had engaged in risk activities, and also to be near their families (c.f. Elmore 2006;Wood et al. 2000). Men who have sex with men may move from rural to urban areas to be near gay subcultures and also to be near high quality HIV treatment[xxii].

The authors who had proposed the stage model of migration of people with AIDS sketched above confirmed that, at least for one state (Florida), and before HAART became available, at least some Americans with AIDS were moving to be with elderly parents in the places to which they had retired rather than to communities that would have been better equipped to provide them formal care. The highest in-migration rates were in counties with the greatest proportion of elderly retirees from other states. Ellis and Muschkin pointed out that since funds were distributed on the basis of locally diagnosed cases, rural communities with high in-migrant AIDS caseloads would be receiving inadequate funding. In addition, the elderly caregivers in these communities were likely to be shouldering a higher burden of care than were caregivers in larger urban communities (Ellis & Muschkin 1996). A more recent study carried out in the same state has confirmed that HIV care facilities continue to see high numbers of

patients who have migrated from elsewhere (Lieb et al. 2006) as do those in nearby states (Agee et al. 2006).

What about international moves for care? An extremely sensitive issue common to countries that receive migrants is whether or not people may be leaving countries where treatment is not available to seek it in countries where it is. This became particularly pertinent in relation to HIV treatment after the mid-1990s, when HAART became generally available in most developed countries but when its availability lagged considerably behind in most of the rest of the world. In countries with established migration patterns, and especially in those with national health systems providing health care to all, policies of universal access to ART pose challenges to the definitions of 'universal', and in particular raise concerns that migrants entering and in need of ART might pose excessive demands on national health systems (Klein 2001;UNAIDS & IOM 2004). The question of - as it is sometimes put - 'health tourism' or 'treatment tourism' has been examined in reviews from the UK, especially (c.f. Barton 2004;Forsyth, Burns, & French 2005;Terrence Higgins Trust 2003). It is of relevance for the discussion below of migrants living with HIV (section 4.3) since it influences attitudes towards incoming migrants in a receiving country, but beyond the scope of the present document. The question merits a detailed review of its own, particularly as the picture shifts and advanced HIV treatment becomes increasingly available in countries from which would-be migrants originate.

The next section turns to migration to families for HIV and AIDS care and support in developing countries. In the impossibility of covering the whole world, thus leaving aside other regions, the discussion focuses mainly on sub-Saharan Africa, with some additional material brought in from Asia where pertinent. The section discusses migration to families for care and support, including the question of returning home to die, then turns to studies of the repercussions of such migration on households and on families.

3.1.1 Focus on sub-Sahara Africa

The issue of migration to families for care and support for HIV disease, and also after the death of a family member, has been discussed concerning several countries in sub-Saharan Africa. Ntozi and Nakayiwa, for example, examining studies carried out in six districts in Uganda between 1992 and 1995, note that while men with AIDS would be cared for by their wives, women would typically return to their parents home, although

their spouses and children remained in the matrimonial home (Ntozi & Nakayiwa 1999). Women who are ill usually return to be cared for by their relatives in Namibia, similarly (Thomas 2006). In Zimbabwe, even very ill patients may move to stay with supportive kin, or relocate to the rural home area (Gregson, Mushati, & Nyamukapa 2007;Heap & Ramphele 1991;Robson et al. 2006). And in Malawi, Munthali (2002) has pointed out that even in the light of rapid social change the extended family remains the primary social safety net. In times of illness the next of kin are responsible for providing care, if necessary sending someone to live with an ill relative, or inviting the sick person to join a household in which care can be received.

A number of studies have examined the question of migration home at the end of life, where research from high prevalence countries brings the issue into stark relief:

> With the onset of serious illness, many urban residents return to their rural villages, fulfilling a wish to go home to die. This decision is based on hard economic reality as much as cultural preference. It is considerably cheaper to be buried in rural areas and the costs of transporting the deceased can be fifty times higher than a bus fare and five times higher than private vehicle hire for a living person (Foster 2005).

A series of longitudinal studies carried out in South Africa, in particular, has examined the hypothesis that migrants who become seriously ill while they are living away from home return to their rural homes - where social networks and support systems may be stronger - to convalesce and possibly to die[xxiii]. The studies focus on the Agincourt district in rural north-eastern South Africa, which - enabled by the development of transport and infrastructure since the late 1990s – is seeing longer periods of circular migration, but with more frequent returns home. Roughly 60% of the men and 20% of the women aged 20-60 in the district are considered circular labour migrants, adults who spend six months or more of the year working away from home, but who return regularly, and continue to view their rural home as the centre of their social and economic lives. Approximately 70,000 individuals (or roughly 11,500 households in 21 villages) were monitored starting in 1992. Annual visits were made to households to collect demographic, socioeconomic and health-related information, including all vital and migration events that had occurred during the previous year. A separate team followed up on each reported death, conducting an in-depth verbal autopsy interview to assign a probable cause to each death. The likelihood of dying was estimated for

residents, short-term returning migrants, and long-term returning migrants, controlling for sex, age, and historical period.

The study confirms that increasing numbers of circular migrants who become ill with AIDS while in urban settings are returning to their rural homes to be cared for before they eventually die: in differences that are generally highly statistically significant, and depending on period, sex, and age, the annual odds of dying were found to be some 1.1 to 1.9 times higher for short-term returning migrants than for residents who had not migrated, or for those who had migrated in the past but returned home more than five years ago. The proportion of HIV/TB deaths among short-term returning migrants has increased dramatically over time in the communities studied. The fraction of HIV-related deaths among short-term returning migrants goes from nearly zero between 1992 and 1997 to between 10% and 25% from 1998 to 2004, with the largest increase in the 40–59 year age group (Clark et al. 2007).

The authors of the Agincourt study point out that those who migrate usually have higher levels of education, health, and access to resources. A different study in the same communities, for example, had shown that better educated women were more likely to become temporary migrants, and also that their children experienced lower mortality risks (Collinson 2007, cited in Clark et al 2007). Another study in the same communities showed that temporary migration was positively correlated with ownership of modern assets in the rural household (Collinson, Tollman, Kahn, Clark, & Garenne 2006). They observe that such findings bear out the 'healthy migrant effect' ... 'but with a new and tragic twist': as in the United States (see above) migrants returning to their families when they are sick or dying do create a healthcare burden in the areas to which they return, in this case increasing demand on already strained rural health systems and posing a significant challenges to health information systems. But the loss is far greater than that: the dying family members in these rural South African households are likely to have been those with the most human capital, and also the bread-winners. Their returning home to die entails not only the increased expenditure for healthcare and funerals experienced by any household caring for a severely ill person, but also permanent loss of household income through cessation of remittances (Clark, Collinson, Kahn, Drullinger, & Tollman 2007;Collinson, Tollman, & Kahn 2007). Those are the economic costs. The next section discusses family costs. First, however, boxes 4 and 5 present studies of return migration of people with AIDS to their families for terminal care in Thailand and in Uganda. Both studies show findings strikingly similar to the study carried out in South Africa.

Box 4: Return migration with AIDS in Thailand

In Thailand, Knodel and VanLandingham used both quantitative and qualitative methods to show a consistent pattern suggestive of extensive return migration to parents during the final stages of AIDS. Key informants reported that people return home at the late stages of illness, an observation supported by examination of applications for assistance, which showed that AIDS cases were more likely than others of the same age to live in the same household as an older person or with a parent. Records also showed that two thirds of the adults who died of AIDS lived either with their parents or next door, and that more than three quarters of the people with AIDS who had a parent alive at the time of illness received some care from the parent. For well over half a parent was a main caregiver. The parents often lived in rural areas, from whence their children had migrated to a city to work, and two fifths of those who were living with their parents when they died of AIDS had returned from living elsewhere. They had returned after they became ill. A third died just a few months after returning.

The decision to move to a parent's home at a terminal stage may be prompted by circumstances that are difficult to anticipate, or that are difficult to accept in advance: the members of groups of people living with HIV and AIDS who had filled out questionnaires for the study and who were still healthy anticipated less return than in fact takes place. Patients who returned to their parent's homes said they did so because of the need for care and for support, and also because they needed help with child care. Many postponed return as long as possible, so that it was likely to occur suddenly, with little advance warning, when the illness was very advanced and the patient had pronounced care needs. Among those who returned after the onset of symptoms only 45% came back alone. A third returned with a spouse, and 22% returned with their own children, thus adding to the economic and care burden.

The authors note that co-residence between generations is common in Thailand, as is migration of young adults away from the parental home for work and education, and also circular migration. At the time the study was carried out Thai hospitals tended to shy away from long-term care of AIDS cases, and hospices had limited capacities, so - unless were married and their spouse remained with them to provide care and financial support – migrant workers often had no alternative than to return back to their parents when they become ill. They also note that one of the consequences of such return migration will be alteration of the geographical location of AIDS cases, and call for funds to be allocated to train local health staff to care for AIDS patients and support their families (Knodel & VanLandingham 2003).

Box 5: Elderly parents giving AIDS care in Uganda

Ssengonzi carried out focus group discussions and in-depth interviews among parents or other relatives over the age of 50 who were caring for persons with HIV and their children in ten rural and urban communities in Uganda. He found that, as in the Thai study just described, children who had been away tended to return to their parents for care only at a late stage of the disease - one to 12 months before their death - when care needs were significant and when they had used up most or all of their financial resources. The transfer of the patients often included the transfer of their dependents as well, placing a significant burden on the caregivers. The economic implications were threefold: loss of remittances from the sick relative, loss of income and/or of time to work, and loss of the savings or personal belongings that were spent or sold to meet care expenses. Their care responsibilities also limited parents' ability to grow food, and to travel out of the community. The latter was in contrast to their grandchildren: many of the older children being cared for were reportedly not interested in 'village life' and tended to run away to other relatives in town, or to want to start to live on their own. In this very poor setting most of the elderly interviewed were not optimistic about the future. They felt they would probably die sooner than they would have without AIDS, not only because of poor health, but also because of the stresses brought by the disease (Ssengonzi 2007).

3.1.2 Migration and AIDS deaths: repercussions on households and families

Several authors have discussed migration after the death of a family member in Africa, a complex picture in which movement is determined by cultural factors such as linearity rules, as well as by the economic and social circumstances of the affected household. One of the basic and often cited studies is that of Ntozi, a survey carried out in six districts in east, south and western Uganda in 1992 and 1993 among 1797 households that had experienced a death. Patterns of migration after the death of a spouse were different for men and for women. Widowers migrated less, as would be expected since they were living in their ancestral homes. Among those men who did migrate, the young predominated - perhaps because they were migrating in search of work, and perhaps because child care prevented the older widowers from migrating. Amongst women, also, younger widows were more liable than older to migrate from the homes of their late spouses[xxiv]. Overall, men and women with children were less liable to move than those without children. Those who were not in good health were more liable to migrate than were the healthy - perhaps because those who were ill were

seeking medical treatment. Men and women who had lost a partner to AIDS were less likely to migrate than those whose spouse had died of other causes (Ntozi 1997b).

Foster's review of community supports for children affected by HIV and AIDS in extremely poor households in sub-Saharan Africa (Foster 2005) raises other important points about migration after the death of a family member: in Zambia, the majority of urban HIV/AIDS-affected families moved out of their original home, which had been provided by the employers of the deceased, into cheaper housing on the outskirts of Lusaka (Nampanya-Serpell 2000, cited in Foster 2005)[xxv]; selective migration of orphans from rural to urban areas can lead to clustering of orphan households in poor slum areas (McKerrow 1996 cited in Foster 2005); and mobility is common among adolescents affected by HIV/AIDS (Foster et al. 1997). Foster cites several sources showing that households experiencing income stress due to HIV/AIDS frequently send their children to live with relatives who then become responsible for their food and education (Sauerborn et al. 1996; Barnett and Blaikie 1992; Lwihula 1999; Rugalema 1999; Drinkwater 1993; Mutangadura and Webb 1999 all cited in Foster 2005), noting that such migration is causing reversal of the normal urban-rural support networks, and that communal lands are increasingly acting as safety nets for urban households in distress (Marongwe 1999 cited in Foster 2005). Rural-urban and urban-rural migration have occured to varying degrees in different countries however: the prevalence of orphans shifted significantly from cities to rural areas in Kenya, Namibia and Zimbabwe, whereas it shifted from rural areas to cities in Central African Republic, Malawi and Zambia (Monasch and Boerma 2004 cited in Foster 2005).

The growing literature on the consequences of HIV and AIDS for the households affected suggests a drastic alteration in household organization, as well as in household capacity to cope with the disease (Madhavan & Schatz 2007). Within this, migration has been noted to be an important coping strategy, both for economic survival and to obtain support from the extended family (Booysen 2006). In a comparison of affected households and their non-affected neighbours in one urban and one rural community of a high-prevalence region of South Africa, for example, Booysen et al showed that migration took place more frequently in the affected households. It occurred when the ill moved to be closer to health care or to family members (usually parents or grandparents), when people moved to take care of ill family members, when parents died and relatives moved in to take care of their children, or when children moved to other homes when a parent died. In the latter case most children moved to locations close to their previous place of residence, i.e. to the same or a nearby town or village, to

be cared for by grandparents, especially, but also by the other parent or other relatives or friends. Some cited conflict in the home and the death of their mother as the main reason for leaving (Booysen et al. 2004). (See also section 4.2 of this review on migration of children after the death of a parent). In a follow-up publication the same author found that in both urban and rural communities in Free State province an adult death in the household increased the probability of out-migration[xxvi], but that the probability of out-migration declined as the number of orphaned children sheltered by the household increased. Booysen concludes that increasing numbers of orphans in the community may obstruct households' normal migratory responses to crises (Booysen 2006).

The effect of adult death on household migration and dissolution has also been studied in a neighbouring area of South Africa, rural KwaZulu Natal, where over a three year observation period starting in 2000, 21% of the households experienced at least one adult death, and 8% experienced an adult AIDS death. By three years later two percent of the households had dissolved and eight percent had migrated out of the area. When factors such as household size and economic status were controlled for, the death of adult members of the household was strongly associated with household dissolution, especially when there had been multiple deaths. Interestingly, after other household risk factors were controlled for, adult mortality had no effect on household migration, however. The authors speculate that a more likely response to crisis is for some members of the family to migrate rather than the whole household: families may cope by sending dependents to be cared for in other households, or by sending adults to find work to replace lost income. While households do migrate in negative circumstances (e.g. defaulting on rent), at this point in the epidemic household migration is more often a response to such 'pull' factors as employment, marriage or a better house. Households unable to cope in situ may be unable to migrate successfully on the other hand, and go on to dissolve instead (Hosegood et al. 2004). Subsequent qualitative research in the same communities explains some of the strains, demonstrating the way in which, in an area with reported adult HIV prevalence of over 20%, households may face multiple episodes of HIV-related illness and AIDS deaths. They also face other causes of illness and death, compounding the impact of AIDS, particularly when the deceased was the main income earner and/or primary carer for young children. Illness and deaths of household members are only part of the households' cumulative experience of HIV and AIDS however: the illness and death of people who lived elsewhere but were connected to the household also had repercussions. For example financial or material support given by former partners who are parents of children

living in the household typically ceased when the donor became ill or died. Somewhat similarly, adult deaths in one household may change the composition and dependency ratio in others, when people move for care or financial assistance as a result of illnesses or deaths. While households may be able to respond effectively to a single death, second or third deaths often follow in quick succession: support from relatives and neighbours diminishes, financial resources are exhausted, and a very bleak period ensues, during which, until financial assistance starts coming, families are unable to buy food or pay school fees (Hosegood et al. 2007b).

In other publications the same authors have noted that the burden of care in AIDS-affected households in rural South Africa is falling largely on older people, who, even before the HIV epidemic, had a well-established role as carers of children whose parents were working elsewhere under apartheid, with its restrictive labour and settlement laws. Older people who were living with children in the absence of other adults were found to be living in the poorest households, and also coping with an increasing burden of young adult deaths, the majority of which were attributable to AIDS. Such households were larger, had poorer quality infrastructure (no sanitation or electricity for example) and their members were less likely to migrate (Hosegood & Timaeus 2005). Box 6 below describes a study of the conditions under which older people may give care to family members with AIDS in South Africa (see also boxes 4 and 5).

Box 6: Elderly women giving AIDS care in South Africa

Schatz uses both quantitative and qualitative data to explore the financial, emotional, and physical responsibilities elderly women are being asked to take on in the light of high levels of both circular migration of adults, and of prime-aged adult morbidity and mortality. Census data from the South African Agincourt district health and demographic surveillance system (see also section 4.1.1) shows that 86% of elders live with non-elders. Households containing a woman over the age of 60 are twice as likely as those without to also include a fostered child, and three times as likely to include an orphaned child.

Interviews with 30 of the women explored the subject of caring for the ill. One-third had taken care of an ill husband, and two-thirds had helped care for other kin such as grandchildren, daughters-in law, siblings, and parents. Over two-thirds had cared for an ill adult child. The respondents' adult children, those with HIV/AIDS in particular, had not been living in the household when they became ill, but had been brought 'home' for care. Care duties included feeding, bathing, fetching and preparing treatments, washing soiled clothing and blankets, and helping the ill person to the pit latrine. Care giving also included accompanying the sick person to visits with a traditional healer, clinic, private doctor, or hospital. Some of the respondents who were caring for their ill sons denigrated their daughters-in-law for not properly caring for their husbands, but many simply considered such care-giving a mother's responsibility: tasks of caring were not 'burdens' because they are simply 'taking care of their own blood' (Schatz 2007).

Overall, the women received significant support from their children, in the form of remittances from children who had migrated outside the area, in-kind assistance with food and other needs such as home improvements, and also physical support with chores such as cooking, cleaning, and collecting firewood and water. Government pensions also played a very important role in maintaining multi-generational households both during 'regular' and 'crisis' times. Pensions were thus spread far beyond the individual subsistence support for elderly individuals for which they had been intended (Schatz & Ogunmefun 2007). The authors conclude, however, that as the HIV/AIDS epidemic escalates, and the numbers of ill adult children and orphaned children of other family members increases, the older women who feel "bound" to take on increasing responsibilities caring for them will need further physical, emotional, and financial support (Schatz 2007).

In sum, studies have shown that in developed countries people with HIV who have the ability to do so may migrate for reasons related to their HIV status. One direction of movement is towards urban areas where appropriate advanced care is available, another is towards rural areas, possibly to change lifestyle, and also to return to families and communities of origin. Even in these countries, some studies express concern that care resources, and also families, may be overburdened in rural areas. Based on similar concerns, several studies have examined the migration of migration of people with AIDS in sub-Saharan Africa, and also in Asia, where the extended family may well serve as the primary social safety net. Particularly well carried out studies in north-eastern South Africa and in rural Thailand are strikingly similar in their findings: families tend to send their most talented members (the 'best and the brightest') to migrate to urban areas in search of employment. Many encounter the vulnerability factors described in section 3.1.1, and some become infected with HIV. As they need care for AIDS-related ill health, and especially at the end of life, they may have no alternative but to return to their families. The return often happens under the most difficult of circumstances: suddenly; at the very end of life when HIV disease is advanced and care needs are pronounced; and when other resources have been exhausted. Children who return to their parents for care often bring their own children with them.

The long-term emotional and economic repercussions on households are worrying, in particular if parents have traditionally relied on their children for support as they reach old age: the cumulative burdens of seeing children become ill and of caring for them as they die - as well as of losing the possibility of their support in old age - leaves older adults with 'a burden of sadness which today pervades [their] lives' (Williams & Tumwekwase 2001).

Demographic analyses, in South Africa in particular, have been examining the effects of AIDS on households, a story that is evolving as the JLICA reviews are being written. The studies described above have shown migration to be a way of coping with the effects of HIV, for example when families move members to take care of the ill, and also when AIDS-affected children are moved to other households. The next section of this literature review turns to the migration of children whose parents can no longer care for them.

3.2 Migration of children affected by AIDS

As with migration after the death of a spouse, who in a family will take care of children whose parent(s) can no longer do so is regulated by complex cultural rules protecting lineage (c.f. Ntozi 1997b for Uganda), or (Rende Taylor 2005 for Thailand). Who will take care of children is also regulated by affective relations (c.f. Adato et al. 2005;Safman 2004): in the best of cases children of deceased family members will play a key role not only in continuing the family line, but also in maintaining reciprocal support networks. Indeed, caring for children of lost family members may serve as an emotional connection to the person who has died, thus help families cope with their loss (Thomas 2006). Such a link may have little to do with space – it may be transported over great distances when children are sent to be cared for by family members living in other countries or on other continents. Who will take care of children is also very much a matter of economic resources, demographic factors, mortality profiles, migration patterns, and patterns of child care (Hosegood et al. 2007a). This section sketches the literature on migration of AIDS-affected children in sub-Saharan Africa, relying heavily on a previous review and on a series of studies carried out in the southern part of the continent.

3.2.1 Studies in Africa

Africa is by far the continent on which the issue of migration of children affected by HIV and AIDS has been the most thoroughly examined. This must be placed in a context in which – as discussed in previous sections of this document - migration has long been widespread[xxvii], in which it is usually more of a family than of an individual matter, and also in which migration of children is usual. In a review of the issue of foster care in Africa, Madhavan (2004) points out that sending children to live in other households has been a feature of black family life in many African countries since well before the onset of HIV/AIDS. Voluntary fostering of children is common in West Africa, for example, 'where the importance of social over biological parenting resonates through the literature'. Other examples can be found in Ethiopia, where it is not uncommon for children to be sent to live with urban relatives, particularly in times of economic difficulty, and where 'contributing children' actively participate in household economies through such activities as caring for other children or for ailing relatives, cooking, fetching water, or cleaning. These are part of socially accepted responsibilities and form an integral part of family livelihood strategies (Abebe & Aase 2007). In rural

Tanzania, to take another example, in a ward with about 20,000 people, about one in three children did not live with at least one of their biological parents, and almost half of all households sheltered at least one foster child or orphan. The authors of the study point out that in such a society, a child living in another household because s/he has lost a parent is likely to be less special than in a society in which virtually all children live with their biological parents[xxviii] (Urassa et al. 1997). And families may absorb new members relatively easily: a study carried out in South Africa, for example, found that families were strikingly willing to consider taking in children in case of need, and that a significant proportion had already done so (Freeman & Nkomo 2006).

A great deal has been written about the care of African children whose parents are ill or who have died - of AIDS or of other causes - and it is frequently mentioned that migration of one sort or another is often involved, as children whose parents are no longer able to care for them move to other households. Some of such moves involve long distances, following migration patterns that had been established for far different reasons. Where families are dispersed as a result of labour migration, for example, the family member best placed to care for a child in need may well reside at a considerable distance. Foster and Williamson (2000) covered migration issues in an extensive review of the literature on the impact of HIV/AIDS on children in sub-Saharan Africa, published in the year 2000. Among the specific points they cited from a wide range of studies are that:

- Children affected by HIV/AIDS are particularly likely to be relocated before or following parental death;
- Mobility is especially common in adolescents affected by HIV/AIDS;
- Children from child-headed households were more likely than their neighbours to have moved in the preceding two years;
- Few households found the idea of separating orphaned siblings from one another acceptable, yet children under five, especially, are likely to be sent away for foster care, leaving siblings living by themselves;
- Dispersion of siblings was a significant independent variable predicting emotional distress in urban orphans;
- Adolescent girls may be sent to a relative or neighbour to work in return for money;
- Non-resident young relatives may be sent to become carers in urban households, thereby forfeiting their education;
- Children of migrant workers are particularly vulnerable since they have limited access to extended family and community safety nets. Children who

> belong to families with little regular contact with relatives are at risk of being abandoned if they are orphaned. (Foster & Williamson 2000).

A study from Manicaland, Zimbabwe, picks up on the latter point, and also demonstrates the importance of community conditions and supports in the experience of migrant children whose parents have died. Interviews with child- and adolescent-headed households showed that one reason households may become child headed is simply because relatives do not know about the children's situation. The authors note that when families are separated by large distances, regular communication may be difficult, and ties are thus weakened. Migrant families and foreigners who have infrequent contact with their extended families were especially vulnerable in this regard (SafAIDS 1996 cited in Foster et al. 1997). The same authors also note that barriers such as national borders make it especially difficult for extended families to fill their traditional roles of providing social support in times of difficulty (Foster, Makufa, Drew, & Kralovec 1997). Other studies touching on orphaned children of farm workers (most of whom are migrant) have pointed out that commercial farm communities are different from traditional rural communities: they have high levels of mobility, little sense of permanency or belonging, and lack the community safety nets usually found in more stable communities (Ansell & van Blerk 2005). In such instances families may be dependent on the farm owners, some of whom in fact have been shown to be supportive of children of their workers who have died (Parry 2000;Walker 2003).

A few studies have looked specifically at migration of children as a result of the death of a parent. Ford and Hosegood, especially, have examined the effect of parental death on the mobility of over 39,000 children aged 0–17 in rural KwaZulu Natal. Parental mortality from all causes increased the risk of a child moving by nearly two times after the age and gender of the child and household characteristics were controlled for. Older children, boys, and children with strong kinship ties to the household (both paternal and maternal) were less likely to move, as were children living in households with more assets. In some instances migrations were undertaken with a surviving parent, while in other cases children moved alone or with siblings. Although some migrations were directly prompted by AIDS, in many instances the causal chain between the illness or death of a relative and a child's migration was not straightforward: families in which a parent has AIDS have time to make arrangements for the children, thus a move to another household may take place quite some time before the parent dies (Ford & Hosegood 2005). Adato et al's study of households in three different provinces of South Africa in which a parent was living with or had already died of HIV disease confirmed

that children may move out to live with relatives when the HIV-positive mother is ill. They do so to ease the care giving burden. Difficult as it might be, Adato et al found that ill mothers unquestionably think about making arrangements for the future of their children. Families told moving stories about their plans and backup plans in case of death of a parent (Adato, Kadiyala, Roopnaraine, Biermayr-Jenzano, & Norman 2005). One further study needs to be mentioned here since it evokes themes to be covered in the next section on migration of AIDS-affected children. A study commissioned by the Save the Children Alliance in Malawi examined the reasons parentless children are - or are not - taken in by their relatives. Mann (2003) found a remarkable discrepancy in the views of adults and of children. Adults tended to believe that children should play no part in decision-making about their care. They emphasized the material capacity of a family to care for an orphaned child, and were highly critical of children who complained of discrimination, because they believed an orphaned child should appreciate the financial challenges posed by their arrival in the household, and should be grateful for this act of generosity. Adult guardians also believed that orphaned children have many behavioural problems and are, therefore, difficult to look after. Children also expressed clear and well-considered opinions about the most suitable care arrangements, and these – it should not be surprising - varied significantly from those just discussed of adults. Children were much more concerned about being cared for by adults who would love them and respect the honour of their deceased parents. They thus strongly preferred to be cared for by grandparents, even if this meant living in extremely poor material and economic circumstances. Orphaned children also revealed abuse and discrimination in the households where they were staying, and some gross examples were cited. As the author points out, such discussions with guardians and children highlighted a vicious circle of misunderstanding that was often difficult to break. She also remarks that the children brought high levels of distress into their new families, stemming from the loss one or both parents, and complicated by the stigma that surrounds both HIV and orphanhood (Mann 2003).

The bleak picture above concerns foster care which does not necessarily involve migration. The next section describes a study, also partly carried out in Malawi, that has specifically examined migration of children after the death of their parents.

3.2.2 Child migration resulting from AIDS: case study from Malawi and Lesotho

Ansell and colleagues' study of children's migration in Southern Africa (Ansell & van Blerk 2004;Young & Ansell 2003b) is one of the rare studies anywhere in the world to

focus specifically on migration of children as a result of HIV and AIDS. It was carried out in 2001 in urban and rural communities in Malawi and Lesotho, countries with respectively a long and a more recent experience with the epidemic. Children aged 10 to 17, thus old enough to have well-informed views regarding migration, and who had moved at least once, were reached through schools. Out-of-school children were reached through local leaders and organizations. In a first phase of the study questionnaires and thematic drawing exercises were used simply to identify young migrants: because of the possibility of stigmatization no effort was made to specifically identify children whose parents had died of AIDS. Subsequent phases of the study used focus groups; story boards with which to tell migration stories; and key informant interviews with guardians, government officials, NGO workers, teachers, and local leaders.

The study found that children leave their households for four main reasons, which may be exacerbated by AIDS:

- To care for sick relatives;
- Because of the death of one or both parents;
- Because of increased poverty due to illness or death in the family;
- Because of remarriage of widowed parents (van Blerk 2007;Young & Ansell 2003a).

Children were commonly sent long distances, often between urban and rural areas. Decisions as to where AIDS-affected children should live were based on:

- Who is responsible for them: This is usually a relative, often female. Some maternal grandmothers said they were caring for children because their daughter would have wanted them to, or because of affection or sympathy for the child. In other cases care was given out of obligation.
- Who can provide for their needs: Often this includes ability to pay school fees. Not all of those who could meet material needs could also meet emotional needs, however. Guardians often failed to acknowledge children's psychosocial needs, were reluctant to believe that children may suffer emotional problems, and found it difficult to understand children's grief.
- Who might usefully employ their capacities: This may be for a variety of tasks, including assisting relatives when household members are ill or die.

One of the striking findings of the study was that the children were generally not aware of the reasons for sickness and death among family members. Nor were they consulted about their subsequent migration. Relatives often made migration decisions after the parent's funeral, and children were simply told where they were to live. They felt they had no choice but to accept what their relatives had decided.

Most children were apprehensive about moving to an unfamiliar environment, and most found migration traumatic. They faced a number of difficulties: learning new ways of life and places; missing old friends and needing to make new ones; and changes at school (bureaucratic difficulties transferring from one system to another, changes in curriculum and teaching methods, and perhaps of language). These are changes experienced by many children who move to a new place, but the children who moved because of the death of a parent had to deal with a host of other difficulties. At the base there was the trauma of losing a parent. Newcomers were said to be often withdrawn, finding it difficult to engage with other children. Families try to spread the burden of caring for children, thus many were separated from their former siblings, and relations were not necessarily easy with their new ones. Rivalry, jealousy and tensions were not uncommon, and the new siblings were sometimes reluctant to share either material resources or the emotional attention required when a child is coming to terms with the death of a parent.

AIDS complicated the adaptation of migrant children in several other ways. Stigma - or fear of stigma - often made their integration more difficult, and poverty created by extended AIDS care meant that the children often did not have resources to share with potential new friends. Repeated illnesses and multiple deaths in their families meant that some children moved several times as they were sent to one caregiver after another. Finally, as also discussed in section 4.1.1 concerning adults, children's AIDS-related migration could take forms that made it particularly problematic: it is more likely to be unaccompanied; it may happen suddenly, with children unprepared and education disrupted; and it is more likely to move children from urban to rural environments where they are ill-prepared for the tasks that will be required of them (van Blerk & Ansell 2006;Young & Ansell 2003a;Young & Ansell 2003b).

Children who moved to take full-time care of a relative were often especially isolated: their care-giving duties limited their movement, and they were removed from their former networks (Robson 2004). There were particular difficulties for children adopted through obligation rather than because of someone's desire for more children: they

were frequently treated differently from the other children in the household, or from the way they had been treated at home. Many felt discriminated against within the new family, particularly if resources were scarce. Some were expected to undertake more and different work than they had been used to, for example when urban children had to learn how to do farm work. Some children, in fact, had been taken in explicitly as workers, to care for ill relatives, to do chores, to send remittances home, or to be sent out to work elsewhere. This changed their relationship within the household: they were specifically not a member of the new family, at least in an equal way.

Some of the migrations failed, giving rise to renewed migration and trauma. Failures happened because orphans felt ill-treated in their new families, or because of changes in a guardian's circumstances (illness or death; remarriage; unemployment; another relative whose needs had increased) or simply because a relative thought that the child's needs would be better met elsewhere. Some of the children were unhappy with the decisions made, for instance because they were separated from their siblings, or because of difficulties with the new guardians. In extreme cases they left the extended family altogether to form alternative families on the streets, making it difficult to maintain links with relatives or to return home as time passed: 'I don't know anybody to visit [any more at home]' (Young & Ansell 2003b).

The authors of this study formulate a set of recommendations for assisting AIDS-affected children, taken up in Box 7.

Box 7: Recommendations for assisting AIDS-affected children in relation to migration

1) Poverty reduction strategies – enabling communities to be self-sustaining despite the burden of increasing numbers of orphans, so that children can continue to be cared for within local communities[xxix]. If appropriate caregivers are available, then staying in the community is undoubtedly the least disruptive of solutions. Reducing the economic costs of caring for children, particularly school-related costs, would allow children to stay with those relatives (such as grandparents) who are best able to meet their nonmaterial needs, reduce resentment of foster children in impoverished households, and also diminish the need for multiple migrations.

2) Building children's capacities to enable them to support themselves. This includes assisting children to stay in school, reducing labour demands, and protecting children from exploitation.

3) Networking and information sharing to avoid unnecessary overlap, for advocacy and government lobbying.

4) Raising awareness among children and communities – giving children information to help them understand the problems their families are facing. This includes promoting understanding and reducing stigma in communities (Young & Ansell 2003b).

The same authors point out, indeed, that orphaned children who have moved to live with other families are newcomers to their communities, and feel no attachment to it. Nor do community members feel responsible for the children: from their point of view the family is responsible, not the community (Ansell & Young 2004).

Thus measures are necessary to increase understanding and support not only of the immediate family caring for the children, but also of the surrounding communities.

In sum, with a long tradition of foster care for a wide variety of reasons - and when the extended family is a major source of social support in very practical ways - it should not be surprising that a certain number of children change houses in countries of sub-Sahara Africa when their biological parents can no longer take care of them. Children's migration under such circumstances follows complex rules of linearity, and, among other factors, depends on the social and economic conditions of the extended family, as well as on affective relations and sheer opportunity. Children's migration also follows previously established migration patterns. As discussed in the introductory sections of this document, one such migration flow involves people from sub-Saharan Africa moving to European countries. They do so for a number of reasons: as health workers

and employees in international organizations, as informal traders, as students, or to seek asylum, join family members already established abroad, and for a host of other reasons.

The final section turns to the last theme in the literature, families and children who have migrated internationally, from developing to developed countries. The discussion focuses on research carried out in Europe, especially in the UK, partly because, as mentioned, that is how the migration streams flow, and partly simply because that is where most of the published studies have been carried out.

3.3 Migrant families living with HIV

A number of studies of migration in relation to HIV or AIDS have been carried out in Europe. Such studies often mention that migrants with AIDS have children, but very few then go on to specifically focus on migrant families. Those that do are reviewed here.

HIV was originally concentrated amongst men who have sex with men and injecting drug users in European countries, but patterns have been shifting over recent years, with increasing proportions of people newly diagnosed with AIDS coming from high prevalence countries. In 2005, migrants from countries with generalised epidemics accounted for about half of the heterosexually acquired HIV infections reported in most countries of the European Union (del Amo J., Broring, & Fenton 2003;Jakab 2007). The European Centers for Disease Control believes that although most of the infections were probably acquired in the country of origin, most migrants were unaware of it: they were diagnosed after arrival, when they become symptomatic or during pregnancy (Hamers et al. 2006;Hamers & Downs 2004).

Migrants are accounting for an increasing proportion of HIV infections in European countries for which immigration is a relatively new phenomenon, such as Italy (Saracino et al. 2005), Greece (Nikolopoulos et al. 2005), Portugal and Spain (AIDS & Mobility Europe 2006), but it is in countries with a long history of migration that the HIV or AIDS epidemiology among migrants has been especially examined in a number of studies. In the **United Kingdom,** for example, about a fifth of all reported HIV infections diagnosed by the end of 2001 were probably acquired in Africa. The proportion of migrants diagnosed late was rising, including among children of migrants (Sinka et al. 2003). Seventy nine percent of HIV-positive children infected either in

utero or postnatally in the UK were of 'black African ethnicity' (Green & Smith 2004). Proportions of people from the Caribbean newly diagnosed with HIV are also rising in the UK (Dougan et al. 2004). **France** has also seen an increase in AIDS cases amongst people from sub-Saharan Africa, especially women, the vast majority of whom had migrated to join family members, to study or for work (Lot et al. 2004). Migrants were less likely than French patients to seek medical care on their own initiative, more likely to have had their HIV test instigated by health professionals (Chee et al. 2005). In **Switzerland**, the relative proportion of AIDS patients from sub-Saharan Africa (and also from South East Asia) has been increasing. Nearly 1/5 of the migrant patients were admitted to an HIV treatment centre during pregnancy or shortly after having given birth (Staehelin et al. 2003). One of the rare studies to touch upon migrants with HIV leaving a destination country found that some patients with indications for ARV had to leave Switzerland when they were denied asylum status (Staehelin et al. 2004).

3.3.1 Studies of migrants living with HIV in Europe

A number of European studies have examined the difficulties of living with HIV disease in a foreign country. Many of these have been brought together in two excellent reviews covering the needs and difficulties of migrants living with HIV in the UK especially, and also more widely in Europe (Green & Smith 2004;Prost 2005). Underlying everything is concern about immigration status. The right to remain in a country, and especially to legal access to employment and to social benefits (and often also to health care and to housing) depends on having a permit. Migrants whose immigration status is irregular, or whose application for asylum status has been denied, may fear deportation, a serious concern when they are on ARV treatment that is not available in the country to which they are to return (Ahmad 2006;Klein 2006). In their 2004 review, Green and Smith noted that many migrants had experienced AIDS in countries of origin where HAART was not available, and where HIV disease was seen as a terminal illness. For these, positive test results were often perceived as a death sentence: patients viewed their ability to remain in the country to which they had migrated as a matter of life and death (Flowers et al., cited Green & Smith 2004).

Studies consistently find that for migrants living with HIV their infection is only one problem among many, and very often not the most immediately pertinent. In addition to their immigration status, many are more concerned about the severe social and economic difficulties they experience. High levels of education but low levels of employment - and the resulting economic difficulties - are major themes (Doyal &

Anderson 2005;Green & Smith 2004;Prost 2005). Weatherburn and colleagues, for example, found that black Africans living with HIV in England were ten times more likely than white British with HIV to report that getting enough money to live on was problematic. Economic difficulties give rise to a series of other difficulties, such as problems with housing and living conditions (7 times more likely to be reported by Africans than by British with HIV), and also anxiety and depression, difficulty sleeping, and lack of self-confidence. Problems in other areas of life were also more common, including experience of discrimination, difficulties with relationships and friendships, mobility problems, and access to training and jobs (Weatherburn et al. 2003).

As reflected in the epidemiological studies sketched above, several European studies show that migrants experience barriers in reaching treatment services, although once they do reach such services no differences have been noted in uptake of HAART, in progression to AIDS, or in survival (del Amo J., Broring, & Fenton 2003). Barriers in access to care include the migration issues already mentioned (health is only perceived to be a priority when one is unwell, otherwise issues around immigration, housing, employment and childcare take precedence) and also poor understanding of the benefits of early intervention, fear of the consequences of testing positive in relation to immigration, uncertainty about entitlement to care, unfamiliarity with the local health system, stigma, and concerns about confidentiality (Burns et al. 2007). A review concerning the UK notes that for many Africans in that country the perception of being able to modify either risk or outcome may be extremely low[xxx], contributing to poor accessing of HIV care and adding to limitations imposed by such structural forces as poverty, gender and economic inequality, political violence, and racism. These are combined with concerns about entitlement to care, discrimination and confidentiality, and fears concerning disclosure to immigration services. When these factors are combined with mistrust of the local medical professionals they mean that - when they do seek help - people may turn to the folk sector for alternative treatments (Burns & Fenton 2006).

Stigma, an important theme to emerge in almost all the studies discussed here, as well as in the United States (Foley 2005), can represent a serious impediment to care. Fear of HIV stigma and discrimination, and worry that they may encounter someone they know at the HIV clinic, were the main reasons for delay in seeking HIV care amongst black Africans in London, for example (Erwin et al. 2002). Stigma within the community can precipitate the worsening of economic problems, for example when people pay to stay in hotels because they are afraid to stay in relatives homes for fear

that their HIV medications will be discovered (Erwin, Morgan, Britten, Gray, & Peters 2002). In the UK (Green & Smith 2004;Prost 2005), Switzerland (Tonwe-Gold et al. 2002) and Sweden, HIV positive Africans have been found to be reluctant to disclose their status to family members. In the Swedish study, for example, five out of 47 African parents with HIV had not informed anyone who was important to them. Eleven of the parents were single women who had no one, or only one person, important to them in Sweden (Åsander et al. 2004).

3.3.2 African parents and children in Europe

The previous section discussed some of the difficulties of living with HIV in a foreign country, where serious problems are complicated by stigma and isolation. This section reviews the literature on migrant parents with HIV, and their children. It starts with a study of migrant women in the United Kingdom, described in Box 8, then goes on to discuss parenting as a migrant and the little that is known about migrant children in relation to HIV.

Box 8: Migrant women living with HIV in London

One of the most helpful studies for illustrating the difficulties of migrant families living with HIV is a qualitative study carried out amongst 62 women receiving HIV treatment in London (Doyal & Anderson 2005). The women came from eleven different African countries. They were highly educated, but only 12 were able to work. Four were students. When asked why they had moved to the UK, 25 of the women mentioned political pressures: more than half of these had feared for their safety because of their own political activities, the others because of those of family members, usually husbands or fathers. Other reasons to migrate included poverty at home, or the pursuit of business opportunities. Only three cited need for medical care as a reason for migrating. The majority of the women had experienced at least one profoundly traumatic life event, including rape, murder of partners and family members, and various other forms of persecution. Twenty seven of the women spoke of direct experience with HIV-related ill health and death amongst close relatives or friends, and eight had experienced the death of at least one child from HIV disease (Doyal & Anderson 2003).

By sampling definition, all of the women were receiving HIV treatment. Although just under half had physical limitations imposed by ill health – and also sick partners or children, or occasionally both - many of the women nevertheless coped with resilience. Most were highly committed to their ARV regimes, for which they felt they had given

up a great deal, including leaving children and significant others in home countries (Anderson & Doyal 2004). They reported that religious faith was an important source of support, as were medical services when nobody else knew of their HIV (Doyal & Anderson 2005). One of the main themes the women discussed when talking about how they coped was stigma, fear of stigma, and the management of information related to such fear. Ten of the women had told no one at all about their diagnosis outside the health care team. Telling parents was seen as especially difficult since most were in the home country: imparting the news on the telephone was often said to be impossible, yet travel constraints made it difficult to do face-to-face[xxxi]. Anxiety about parents finding out also limited who could be told in the UK: 'If it's people from my country, and maybe they know my family, you have to make it a secret. Because they tell them. They won't keep quiet. It would go straight to Africa.' (Doyal & Anderson 2003).

Fifty five of the 62 were mothers, but only 39 had children living with them. Those who lived with their children in the UK were almost all primary caregivers. Many were living in considerable poverty, and without support from extended family: 'I'm the mum, the dad, the auntie – I'm everything.' Eleven had children known to have HIV infection.

The other women had left at least some of their children in Africa. They said they would like to be with the children they had left behind, but that return would cut off their supply of life-saving drugs, and 'what use would I be to him dead?' Many, in fact, felt trapped by the very services that keep them alive. They often reported feelings of debilitating guilt. Changing circumstances meant that their children often had to be passed between carers, and attempts to bring them to the UK were usually difficult and often unsuccessful. Many women were trying to support their children by sending money home, but their resources were very limited, and most found this failure to fulfil what they and others saw as their maternal role deeply distressing: '...that is the thing that is really eating me up ... I am here and my children are on their own' (Doyal & Anderson 2003).

Two of the most delicate questions within such families concern disclosure, and planning for care. Studies have shown that, given support, families can discuss and make plans for the future of children when the parents have AIDS (c.f. Rotheram-Borus, Stein, & Lester 2006 for the United States) and also section 4.2.1 about families in Africa, but migration complicates a process that is already difficult. In an European collaborative study of HIV-affected families in paediatric AIDS centres, migrant parents may have been equally likely as European parents to disclose to their children, but they were less likely to have made long term care plans. Although parents often assumed that in case of their death family members would take care of their children,

many refugees and asylum seekers, especially, are geographically isolated, and have no family on whom to rely (Thorne, Newell, & Peckham 2000). Other studies carried out amongst African parents with HIV living in Europe have also found low rates of disclosure to children concerning their parent's HIV status, in Sweden (Åsander, Belfrage, Pehrson, Lindstein, & Björkman 2004), in the United Kingdom (Weatherburn, Ssanyu-Sseruma, Hickson, McLean, & Reid 2003) and also in Belgium, where parents rationalized that the news would be emotionally disturbing for the child, and they also feared stigma. Other reasons parents gave for not disclosing were that they thought their child was too young, or that they perceived no benefits for the child to know, or simply that they did not feel able to disclose (Nostlinger et al. 2004). Miller and Murray, similarly, noted that parents often postpone telling a child about a parent's - or about its own – HIV postitive status, sometimes until a crisis occurred (see also section 4.1.1). Succession planning is especially difficult: migrant families are cut off from well-recognized family structures, so it may not be obvious who should care for a child if the parent dies. What is in any case an extremely difficult question is made more complicated by the fact that continuing residence and education in the host country may be jeopardized for the children if the parents die, and also by the fact that the home country may be an alien culture for children who have been raised abroad (Miller & Murray 1999). A study that examines the complexities of being a migrant parent with HIV is described in Box 9 below.

Box 9: Migrant parents and HIV

Chinouya (2006) has explored the tensions of disclosing information about HIV amongst families living between continents. Interviews were carried out with 60 HIV positive migrant African parents in London and in home countries (mainly Zimbabwe and Uganda). Three quarters of the respondents reported that they were 'single mothers'[xxxii]. Together, the parents had 164 children, most of whom were less than 18 years old. Seventy three percent were their biological children, the others were children who had lost a parent and for whom the respondents had taken on parental responsibility. Almost half of the children had been left in the country of origin: 70% of these were cared for by grandparents, 26% by uncles and aunts, and 4% by the child's other parent.

Most of the parents reported that they had found out about their HIV status in England, after an illness or in the course of childbirth. A third of the children, most of whom were over the age of 18, knew about their parents HIV status. Children living with the interviewee were more likely to know about the parent's status, at least partly ('something wrong with their blood') but some said they had told their children in the home country so that decisions could be made about how their property should be distributed should they die in England. Some said they had not told their children because they were on HAART, and assumed that everything would be ok - telling children in home countries where HAART was not available that the parent was infected would just make them worry, needlessly, that the parent was going to die soon. Others said they had not told their children in order to protect them from stigma (younger children, especially might not be able to handle the information properly) or since the children had already seen too many family members die, such as the other parent. Some had simply not had the opportunity to tell their children living in other countries: sensitive information needs to be disclosed face to face, not by telephone (see also above).

Concerning their children's own HIV status, worry about child's status had prompted the parents, especially uterine mothers, to take 34 of the children between ages 3 and 15 for HIV tests, all of which turned out to be negative. Not all had told the children concerned since they were worried about the questions the children would then ask. Overall, the parents reported that 4% of their children under the age 18 were HIV positive, and that more than half of these were not aware of their status. Children living in the home country were less likely to know that they themselves were HIV positive. Ascertaining the HIV status of children in the home country was especially complicated: since the parents found out about their HIV in England the children had

not been tested before they left. The parents had rarely disclosed to the caregivers at home, and asking a caregiver to take the child for an HIV test would mean disclosing that the parent was positive, so some had simply let the matter slide. They also rationalized that in any case it would make little sense to disclose if the child would have no access to medical care in the home country... (Chinouya 2006).

As for specific studies of **migrant children affected by HIV**, although a number of the studies cited above mention that the migrants they are discussing are parents, and although the mothers of just over a quarter of the children of HIV-infected parents in Europe come from a high prevalence country (van Empelen 2005) there is a critical lack of studies and interventions focusing on the needs of migrant children and youth affected, because they themselves have HIV or because their parents do (Prost 2005). One thing that is clear is that a high proportion of HIV-affected migrant children live in one-parent families, usually without the support of extended family. Those most likely to help in case of need - the grandparents in particular - are unlikely to have migrated. At times such migrant children may thus care for siblings or parents affected by HIV (Chinouya-Mudari MC & O'Brien M 1999). The only study found related to HIV-affected migrant children in Europe discusses the care given by such children. It helps tie the sections of this review dealing with Africa with those dealing with Europe by comparing the care children give in Tanzania and the United Kingdom, and is described in Box 10.

Box 10: Children and young people giving care for relatives with HIV

There have been a number of studies of care-giving by children in African countries (see other JLICA papers) but one study, of particular interest here, compares the experiences, needs and resilience of young people as they care for parents and relatives with HIV/AIDS in Tanzania and in the UK (Evans & Becker 2007). Twenty four of those interviewed were between the ages of 9 and 17, and nine aged 18 to 24. Most were caring for their mother, and sometimes also for siblings. In the UK most of the families with young carers were African migrants, some of whom had insecure immigration status. The majority of the young carers were girls, and two were living with HIV themselves. In Tanzania, some had lost both parents to AIDS.

The household chores performed by the young carers were broadly similar in the two countries, but the intensity of the household chores, and the time taken to perform them, as well as the care work, differed considerably. Care work took longer in Tanzania, and was more physically demanding. In addition, the absence of sufficient home-based and palliative care programmes in Tanzania meant that some provided

intensive nursing and personal care for parents or relatives with HIV. Young people in the UK were less likely to be directly involved in intensive nursing care, but some played important roles in responding to emergencies, and also in assisting parents with mobility and personal care following periods of hospitalisation and serious illness. The main difference between the two countries was that in Tanzania young people were more likely to be involved in income-generation activities.

Many said that they liked their care-giving duties, because they felt they were helping make life easier for their parent. Some of those in the UK thought that their responsibilities had helped them to become 'stronger' emotionally. However, several in both countries worried about the life-limiting nature of their parent's illness: many were afraid of what would happen when their mother died. Parents, for their part, were concerned about the emotional impact of their illness on their children. In the UK some young people were worried about how their parent would manage on their own when they moved away from home to attend university.

The authors note that loving, supportive family relationships between children, parents, siblings and other relatives helped mitigate the children's vulnerability. Extended family relationships were an important source of social support in Tanzania, where formal welfare support is virtually non-existent. However the resources of extended family members were severely limited, and poverty and discrimination made some relatives unable, or sometimes unwilling, to meet the needs of children and parents in HIV/AIDS-affected households. In the UK only a few of the young people received practical support from extended family members: migration, geographical distance, or parents' fear of disclosing their HIV status limited the families' access.

The authors conclude that while informal safety nets and supportive relationships within the family, school and wider community play a significant role in building resilience in children and in families - as well as in mitigating the negative impacts of care-giving by young people - these informal safety nets are overstretched in severely affected communities in Tanzania, and the capacity of families and communities to support households affected by HIV/AIDS has been seriously diminished. In the UK, as other high income countries, families affected by HIV may not have access to extended family networks or social networks in the community. NGOs and other formal safety nets have stepped in to provide much-needed material and emotional resources for children and families, but their capacity to meet the specific needs of young carers and parents with HIV is currently very limited (Evans & Becker 2007).

In sum, if living with HIV as a migrant brings a series of difficulties, doing so as a parent very often brings even further difficulties, not the least of which is isolation. Stigma once again emerges strongly from the review of the literature, as do economic problems. A very complex set of issues concerns disclosure of one's HIV status, in the country in which one is living (unthinkable, at least to members of one's own community), to one's family in the country of origin (equally unthinkable, at least by telephone – these things must be done face-to-face, something that may be difficult indeed), and to one's children. Planning for the care of children in case of the death of a parent, reading between the lines, may be dealt with mainly by denial. What can never be an easy undertaking is even more complicated in the case of migrant parents, since they may well be far away from the family supports that would normally be relied upon, and since the children's legal right to stay in the country may disappear when the parent does.

One of the most striking findings to emerge from the published literature, though, concerns what might be called living across the treatment divide. Many migrant parents and their children living in developed countries have access to highly effective treatment for HIV disease. Many of the parents had left children behind in their home country, biological children or children of others for whom they are responsible. Mothers, especially, spoke of feeling 'trapped' by the treatment that was keeping them alive: they were unable to bring their children, and treatment was unavailable in their home country. They were put in the guilt-generating dilemma of choosing between their own life-saving treatment and being with their children. A certain number of the children were HIV positive, in addition, and here the situation is even more difficult. It may be complicated to arrange for HIV testing of children in the home country who may have been infected during birth. Treatment may be available to some of the children who need it, but not to others. It is easy to imagine parents splitting pills in such a situation, sending some of the medication to family members they know need it. The evidence is anecdotal only, however: the was not raised in the published literature reviewed. In a nutshell, such parents are living world-wide imbalances in treatment access in the most direct of ways: for themselves and for the children with them HIV has become a chronic manageable condition. For the children they left behind it is still a deadly disease, for which it may not even be kind to tell them treatment exists elsewhere... A point was raised in Box 3, which discussed transnational families and children, about parents wondering to whom to give resources – children in the country or origin or children in the country in which they are living. The questions described above raise these dilemmas to new heights.

This completes this first review of the themes that emerge when the literatures on migration, AIDS, and families are put together. The next section summarises and points out some of the gaps.

4. Summary and discussion

Migration has always been a part of human endeavour, and shows every sign of continuing to be. HIV and AIDS, also, will be with us for generations to come, even if progress is being made in prevention and treatment. This review, carried out for the Joint Learning Initiative on Children and AIDS, factors families in, reviewing the literature on 'migration', 'AIDS' and 'families'. Some extremely powerful themes emerge when the three words are put together:

⇒ migration may be a very positive quest, especially at the outset;

⇒ it is often a family project. Families often send their best and brightest members to find employment elsewhere, in hopes of improving the wellbeing of the entire group;

⇒ at destination, migrants live under conditions that are all too often disappointing, and that may include vulnerability to HIV infection;

⇒ some sub-groups of migrants or of people who are mobile are disproportionately affected by HIV because of these vulnerabilities;

⇒ in case of HIV and AIDS:

- migrants may return to their families for care and support, especially at the end of life;
- children whose parents can no longer care for them may have to migrate in order to live with the guardians that can;
- transnational families may live on both sides of the treatment divide: some members of the same family may have access to highly effective HIV treatment, while others do not. In some instances parents needing treatment will be able to receive it, while other family members, including their own children, cannot.

This final section reviews each of these themes.

Concerning **migration**, several observations are important to the subject at hand. Globalization, along with the development of transport and communication technologies, has brought significant changes in migration over recent years, including an increase in circular (or temporary) migration, and also increased labour migration of women. These in turn have led to the emergence of 'transnational' or – to invent a term – 'transregional' families, in which some individuals simultaneously belong to two households. Members of such families live in two or more different communities, countries, or even continents, but keep in frequent contact, exchanging visits, telephone

calls, e-mails and videos. The individuals concerned feel they belong to two different places simultaneously. Such migration has effects on children and on families. The increase in labour migration of women, especially, has meant that increasing numbers of children (although nobody knows how many) are left at home to be looked after by relatives, often grandmothers – the so-called skipped generation families. The literature on the possible effects of such migration on children and on families gives decidedly mixed results: some of the literature cited describes a host of serious problems for children whose parents are abroad, while other studies find rather positive effects, not the least of which is improved economic wellbeing. The factors that seem to make the difference are listed below.

Some other observations concerning migration are relevant. One is the role of networks in facilitating migration, a role that can scarcely be exaggerated: family members and people from the same communities facilitate the migration of others, helping potential migrants find jobs in a new place and settle in when they arrive. Where they are well established, these networks are potent, and they operate almost totally independently of the formal institutions normally subject to policy interventions (Hugo 1994). In other words, migrants who wish to do so will continue to find ways to migrate. Another observation discussed at some length in this review is that migration is often a deliberate family strategy: if possible families choose their members most likely to succeed to send off to work in another community. This review has focused largely on migration and African families: the continent has a long history of migration, and sending family members to other places is extremely common, part of growing up in many African societies. But a similar analysis could – and should – be carried out concerning other places where migration is a long-standing tradition (Asia, the Caribbean, Latin America, Oceania, the Americas, many European countries...). Finally, if migration has many positive aspects there are also dark sides. The expectations of some migrants may be highly unrealistic, for example, their projects doomed to failure from the outset. Migrants often live in conditions less adequate than those of the host society, and those who are easily replaced (such as the unskilled), especially, are easily exploited.

Concerning **HIV and AIDS**, the HIV vulnerability factors linked to migration are discussed in the review: the process of migration - and the conditions under which migrants live - may increase the risk of HIV infection (other possible ill health consequences of migration are beyond the scope of the present document). This means that a certain number of people who have been working away from their homes will

become infected with HIV. The possibility that such migrants will infect other partners during the years they carry the virus has received a certain amount of attention in the literature (c.f. list in footnote 17): this review then goes on to discuss a topic that has been less examined, migration as a result of HIV and AIDS.

A certain number of people will discover their HIV infection when they are living away from their home communities. Studies consistently find that migrants usually find out about their HIV status later than the natives of the country in which they are living, partly because they usually have other priorities than their own health (in fact illness is a serious hindrance to the migration project, a possibility it may be best not to even think about...) partly because of barriers to testing (formal barriers to access, or informal barriers such as lack of knowledge of where to go, or of trust in the institutions that might carry out the test, or of fear of stigma).

The question **return to family for support** when migrants are ill or near the end of life was then examined. In a mirror image of the migration of elderly parents to be near their children, a process commonly found in the United States, Canada and Australia, for example, adult children who are ill may migrate to be near their parents for support and care. The literature contains accounts of seriously ill adult children returning to be near their families of origin in both developed and developing countries. In both, experts have expressed concerns about the distribution of resources and of appropriate treatment facilities, about the ability of health information systems to capture the movement, and about potential lack of health personnel trained to meet the needs, both for care of the patients and for support of their families. Although as HAART becomes more generally available fewer people should have to return home to their families to die, some will continue to do so, and one of the most effective measures to support them will thus be measures to support their families (see other JLICA papers).

The potential burden on elderly caregivers is particularly worrying. In developing countries, especially, where the family may be by far the main resource in case of illness, the literature consistently finds that migrants usually wait until their disease is very advanced to return, at which point they have significant needs for care. Those who have children very often take the children with them when they return. This causes emotional and financial burdens on the families, which accumulate. The losses when the returning adult child dies are multiple, especially since the family members now being lost may well have been the most talented and ambitious. The effect of the

cumulative loss - and the subsequent burden on families - is, in fact, perhaps the most significant long term implication of the issue of migration, AIDS and families.

Children whose parents can no longer care for them may also go to live with family members in other communities, including in other countries, following complex rules and patterns defined by culture and by opportunity. The conditions under which this happens often leave to be desired. Possibly since neither the ill parents themselves nor other family members may wish to discuss plans with the child, the studies reviewed find that such moves are often made late, and often in a situation of crisis. Children are rarely consulted about where they will move. And, if they were to be, their ideas might be quite different from those of the adults in the family.

Moving to a different community brings challenges for any child - and even more so if the move is to a different culture and language. Additional difficulties are added when a child moves because of AIDS-related illness in the family: dealing with the loss of one or of both parents, stigma, and possibly discrimination in the new home, among others. The move often also brings new responsibilities, such as when the children are asked to care for other family members with HIV disease. Dealing with such new responsibilities can lead to feelings of satisfaction and pride on one hand – or to exploitation and short-changing of other opportunities on the other, such as when care duties prevent the child from going to school. These are referred to here, and discussed more thoroughly in other JLICA papers.

On occasion the most appropriate family member to take in a child who needs a new home may be in another country. An international move under such circumstances may pose significant additional difficulties. One difficulty is that the destination country's definition of 'family' may have little to do with the definition of the family in question. Specifically, the genetic links stressed by some immigration-receiving countries may not be as pertinent as the wider kinship links stressed by the family members. Other difficulties, referred to only briefly in this review since no literature was found on the subject, may stem from the child's potential marginality and vulnerability with his or her new family: when the arrangement is an informal one, especially, the child may be isolated, and cut off from potential support and protection. International placement for care need not be negative, however: in the best of cases the family in another country will welcome the child(ren), and the children thus cared for will help maintain family relations between different places and cultures, as discussed in this review concerning transnational families.

Concerning **migrant families living with HIV**, very few studies were found to examine the situation of such families in Africa, especially in the published literature: studies may have been distributed as grey literature, but are unobtainable beyond the place where they were carried out. The section on living with HIV away from home is thus based on literature from Europe, and especially from the United Kingdom. For many migrants living away from their home communities, living with HIV implies lack of support from extended family and community, loneliness, stigma, and worry about immigration status. It should be noted that the studies reviewed concern migrants receiving treatment, so the picture is necessarily incomplete: no studies were found of the migrant parents or children in developed countries who do not have access to treatment, whose difficulties must be even greater.

One of the striking findings from the literature review concerned what might be called transnational families living across the treatment divide: since access to HIV treatment is not yet universal, in some families certain members will have access to treatment, while others do not. The studies reviewed concerned women, and/or parents in treatment in Europe, who, in the vast majority of cases, had discovered their HIV infection after they migrated (often during pregnancy, thus perhaps helping explain the predominance of women in the studies). They all had family members – some of whom also needed treatment - in home countries where such treatment was not available, and many also had children in that situation. Two extremely potent themes thus emerged. The first concerned being able to receive treatment in the country to which the individual had migrated, but at the same time feeling trapped in the destination country by the very treatment that is keeping one alive. The second theme concerned disclosure: what and how to tell family members in the home country about one's HIV status? How to arrange, at a distance, for testing of uterine children who may have been infected during childbirth without necessarily disclosing one's own HIV status? What to tell family members (including possibly one's own children) for whom treatment may not be available?

4.1 Conclusions

The review briefly sketched several studies of the effect of migration of families, both in developed countries and in developing. A recurrent theme in that section, as indeed throughout the document, was that a certain level of wealth and social capital is necessary to migrate in the first place, and to benefit from it when one does. Thus

studies carried out in developed countries not infrequently find that migrant children are in relatively good health: the poorest households simply cannot migrate, those heavily affected by illness either - especially internationally (but not only: studies carried out in southern Africa also found that the poorest of households were more likely to dissolve than to migrate within the region as a result of illness). An American longitudinal study of immigrant youth showed up another striking pattern: both family capital and community conditions are critically important in orienting the course of the lives of immigrant young people. Migration may then start a virtuous or a vicious spiral for families and for children: it can have disastrous consequences - emotional distancing, undesired destruction of the family unit, physical and mental health problems, dropping out of school, alienation, drug use and prison stays - a whole series of problems that may or may not be directly due to the migration but that are certainly interlinked with it. Or migration may have positive consequences for families and for children, positively changing roles and responsibilities within families, bringing increased economic wellbeing, educational opportunities and social capital; increased autonomy, learning, and pride in achievements. In sum migration can bring the potential strength of transnational identities (Cassarino 2004) [xxxiii], and build resilience. Factors that emerge from the literature review as making the difference include:

- family capital in the first place: a certain minimum level of economic and physical resources, and also emotional resources;
- social and community conditions at destination;
- social safety nets to protect the most vulnerable (including secure legal status to remain in a country, access to services, protection from abuse and exploitation, and someone to whom to go in case of trouble);
- for children who have migrated alone: feeling someone cares about them, relationships with helpful, understanding adults from the extended family or from outside the family;
- family cohesiveness (note that this can be virtual, for example connection to a family myth of migration, or to family members at great physical distance);
- simple measures to help children and adults remain in contact with distant family members and friends (e.g. telephone time), as well as with others in similar situations in order to reduce isolation and break stigma (e.g. newsletters and magazines);
- good understanding of the conditions that caused the migration in the first place, and also clear understanding of the conditions at the destination;
- a feeling of a modicum of control over, or agency in, what is happening to one;

- the feeling that demands can be managed, not feeling (chronically) overwhelmed – or, on the contrary, having enough to do to maintain productivity and self esteem (complete dependency on external assistance is extremely destructive);
- the feeling that there is a meaning, a sense, to the experience, in spite of - or more important than - possible hardships: a sense of working for something that is more important than oneself (e.g. children's education, improvement of family wellbeing).

This first review will not go further than making a preliminary list of these factors. Further attention will need to be paid to adding to the list, and especially to drawing out policy and programme implications, including good practice examples, as they may be applied to the situation of families and children living with HIV and AIDS.

4.2 Gaps, needs and lacks

Limits and gaps in this document: This document turned out to be vastly different from that planned at the outset[xxxiv]. The review has covered neglected subjects in their respective academic fields (families in the migration literature, and migrant families in the HIV/AIDS literature) which means that in some instances the research was simply not available 'out there'. Especially, however, the three main themes (migration to families for care and support, migration of children when their parents can no longer care for them, and migrant families living with HIV) emerged more and more strongly over numerous iterations, and took over.

The document is long, but there are nevertheless gaps. One concerns the HIV vulnerabilities and trajectories of children who migrate unaccompanied. Another concerns those of students. At the other end of the life cycle, some of the repercussions of parents' caring for migrant children were discussed, but the overall effects of children's migration on elderly parents could not be included here. Each of these, and certainly other subjects yet to be identified, could be the subject of a review on its own.
One of the main gaps, however, is geographical. It has not been possible to extend the geographical focus of the review beyond sub-Saharan Africa and Europe, with a little lateral thinking from Asia and elsewhere. Wherever it was possible examples were put side by side in attempt to show similarities in basic patterns concerning HIV and migration across cultures and between levels of development (for instance research shows that vulnerability factors for migrant farm workers, domestic employees, and

other easily replaceable workers are similar across the world; that women whose husbands or stable partners are migrant workers may well know about HIV risk, but find it impossible to ask their partners to use condoms when the latter return for visits in Mexico and South Africa; or that people at the end stages of HIV disease wait until the last minute to return to their parents for care in Thailand, Uganda and South Africa). But a similar analysis of the literature should be done for other regions.

In general: Numerous needs and lacks emerge from this review. To start with, care is needed in definitions when 'migration' is referred to. Just as there has been a call for clarity in definitions when the term 'orphan' is used (see JLICA paper by Sherr et al) there is also a need for specificity about what one means by 'migration'. One author may use the word to indicate a move to a different country, whereas for another author 'migration' may simply indicate movement to another house in the same community.

Research is needed concerning practically all of the themes discussed in this review. Migration data needs to be improved, including by using the family as a unit of data registration and analysis. More generally, the family is remarkably absent from migration research, and also from HIV research. For example, as has been noted several times here, studies of migrants very often mention that they have children, and very often that they have left children at home while working abroad, but surprisingly few then elaborate, even simply to count the number of children thus affected. This is especially regrettable when the migrants are women who may have left children at home: the family effects, especially the long-term effects, of the new trends towards labour migration of women, in particular, need to be examined.

In relation to HIV and AIDS, there has not been much progress since Foster and Williamson's 2000 review of children and HIV/AIDS concluded that little is known about the nature and extent of morbidity- and mortality-related mobility, and its impact on affected children (Foster & Williamson 2000). Several other key questions that remain unanswered have been evoked, such as the circumstances in which female rural partners of migrant labourers take on additional relationships, and the ways in which these relationships increase risk for HIV infection (Lurie 2006b). Others have barely been touched upon, such as how to best factor mobility into treatment for HIV disease, an issue that will become increasingly pertinent as ART becomes more universally available, and as work activities in resource-poor settings requires mobility (Dahab et al. 2008;Russell et al. 2007). Within this, the factors that create vulnerability and resilience when children migrate to live with other families when their parents can

no longer care for them – especially when the move is an international one – need to be examined: under what circumstances is it a good thing to send children abroad, and when should everything possible be done to permit them to stay in their communities of origin?

More generally, in today's world there is pressing need for studies of how families adapt to migration, and of the changes – positive and negative – induced. There is need to look at cultural factors, and also to carry out the fine and detailed analysis required to unpack the sometimes complicated layers of what is said - and not said - and to whom - about important family decisions, and about the degree of consensus involved. Then, there is need to look at how HIV and AIDS are factored in, going beyond the purely descriptive to put analysis into the context of literatures on family stress and coping, looking especially at salutogenesis (Antonovsky 1987) and at family resilience (Boss 2006;Fergus & Zimmerman 2005;Walsh 2006). There is much more lateral thinking to be done, drawing on from what can be learned from family coping with migration and applied to a recent and growing literature on families, coping, AIDS and resilience (Cook & Du Toit 2005;Daniel et al. 2007;Killian 2004;Richter & Rama 2006;Snider & Dawes 2006).

This review is intended to be a start, a first attempt to shine some light on bits of a very large and complex picture, and one that is moving in addition. We end by coming back to the 'dreams and disappointments' of migration: migration can imply following a dream that - under the worst of circumstances, experiences, or conditions - can cause severe disappointments and illness. Or that - under the best of circumstances - can lead to increased wellbeing for entire families, and foster resilience. One of main points of doing such a review is to begin to highlight not only difficulties, but circumstances and conditions can be influenced to reduce the difficulties. The other is the hope that subsequent researchers, theoreticians and activists will be stimulated to take up the story, and carry it further.

5. Appendix

Selected migration definitions

Asylum seekers: Persons seeking to be admitted into a country as refugees and awaiting decision on their application for refugee status under relevant international and national instruments. In case of a negative decision, they must leave the country and may be expelled, as may any alien in an irregular situation, unless permission to stay is provided on humanitarian or other related grounds

Displaced person: A person who flees his/her State or community due to fear or dangers other than those which would make him/her a refugee. A displaced person is often forced to flee because of internal conflict or natural or manmade disasters.

Family reunification/reunion: Process whereby family members already separated through forced or voluntary migration regroup in a country other than the one of their origin. It implies certain degree of State discretion over admission.

Forced migration: General term used to describe a migratory movement n which an element of coercion exists, including threats to life and livelihood, whether arising from natural or man-made causes (e.g. movements of refugees and internally displaced persons as well as people displaced by natural or environmental disasters, chemical or nuclear disasters, famine, or development projects).

Immigration: A process by which non-nationals move into a country for the purpose of settlement.

Internally displaced persons/IDPs: Persons or groups of persons who have been forced or obliged to flee or to leave their homes or places of habitual residence, in particular as a result of or in order to avoid the effects of armed conflict, situations of generalized violence, violations of human rights or natural or human-made disasters, and who have not crossed an internationally recognized State border (*Guiding Principles on Internal Displacement, UN Doc E/CN.4/1998/53/Add.2*.).

Irregular migrant: Someone who, owing to illegal entry or the expiry of his or her visa, lacks legal status in a transit or host country. The term applies to migrants who infringe a country's admission rules and any other person not authorized to remain in the host country (also called clandestine/ illegal/undocumented migrant or migrant in an irregular situation).

Labour migration: Movement of persons from their home State to another State for the purpose of employment. Labour migration is addressed by most States in their migration laws. In addition, some States take an active role in regulating outward labour migration and seeking opportunities for their nationals abroad.

Migrant: At the international level, no universally accepted definition of migrant exists. The term migrant is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of "personal convenience" and without intervention of an external compelling factor. This term therefore applies to persons, and family members, moving to another country or region to better their material or social conditions and improve the prospect for themselves or their family.

Refugee (recognized): A person, who "owing to well-founded fear of persecution for reasons of race, religion, nationality, membership of a particular social group or political opinions, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country" (*Convention relating to the Status of Refugees, Art. 1A(2), 1951* as modified by *the 1967 Protocol*).

Traveller: A person who passes from place to place, for any reason.

Source: IOM. Glossary on Migration, International Migration Law Series no 1, 2004

Family: Families are generally agreed to be social groups connected by kinship, marriage or adoption that have clearly defined relationships, long term commitment, mutual obligations and responsibilities, and share a sense of togetherness. While the structure of families differs widely, family groups generally share universal functions, such as reproduction, production, love and protection.

Source: Richter L, Sherr L, Desmond, C. JLICA Learning Group 1: Strengthening Families, Integrated Report, May 2008 Draft.

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Social and Economic Sciences. Each went far out of her way to help the author find sources.

[ii] World population is estimated to have risen from 1.6 to 5.3 billion between 1910 and 1990, an increase of 3.25. The number of international migrants is estimated to have increased by a factor of 3.6 during the same period (Zlotnik 2001). Stated somewhat differently, it took from the beginning of time until about 1927 to put the first 2 billion people on the planet; less than 50 years to add the next 2 billion people (by 1974); and just 25 years to add the next 2 billion (Cohen 2003).

[iii] The Special Rapporteur on the human rights of migrants has pointed out that migrating to marry or to rejoin family members can create real or perceived relations of dependency, which in turn make women vulnerable to abuse. Since their status is often linked to that of their spouses, migrant women who are victims of domestic violence often feel they must stay with the abuser or face deportation (Commission on Human Rights document E/CN.4/2003/85/Add.2 cited in Martin 2005). Sorensen and Guarnizo have used case histories of women from Colombia and the Dominican Republic living in Europe to document both of these aspects. They show that migration may serve as an escape from violent and abusive families: fractured family relations tend to precede rather than result from female migration. In this study, in fact, and attesting to the power of the social networks just discussed, some of the women even chose to migrate to a different continent rather than to places to which most of their compatriots had migrated in order to escape a violent partner's wider social networks in a destination community (Sorensen & Guarnizo 2007).

[iv] One of the extremely rare publications to specifically discuss *children and families* in relation to increases in female labour migration, carried out in South Africa, points out that women may migrate to nearby towns rather than to more distant metropoles partly so that they can maintain links with home areas. Having young children resident in the household (aged six years or less) reduced the probability that women would migrate, but they were more likely to do so as the number of older children in the household increased. The costs of childcare rise as children get older, partly because of school fees, and these costs may force women to look for employment, leaving their children in the care of their grandmothers or other female relatives in the household. Indeed, the probability of female labour migration increased as the number of female pensioners in the household increased, possibly signalling, among other things, both the contribution of older women in childcare and the role of pension income in facilitating and supporting the migration of women (Posel & Casale 2003).

[v] For example one of the sources cited in this section uses the Commission on the Rights of the Child definition of 18 years. Another uses ages 0 to 17 for children. Another causes an overlap by using ages 15 to 30 for young people. And another does not formally define the age limits used.

[vi] As just one example, in a listing of studies of children migrating alone, Whitehead and Hashim (2005) use the proportion of households in West Africa in which children under the age of 15 are living without their parents. The problem is that the children may have moved internationally, or simply moved from another household in the same community. The data is thus difficult to compare, especially since such foster care may be culturally normal in one place, but quite exceptional in another.

[vii] Family reunification is supported by international human rights law: Article 16 (3) of the Universal Declaration of Human Rights states that "the family is the natural and fundamental group unit of society and is entitled to protection by the society and the State".

[viii] Definitions of family vary for the purposes of immigration admission. In the United States, parents and siblings are eligible, as well as spouses and children of citizens and of legal permanent residents. The European Union directive on family reunification covers spouses and minor children, allowing member States to set policies individually on other family members. The directive permits States to restrict the admission of minor children over the age of twelve. Many States also restrict the admission of more than one spouse in a polygamous marriage. State policies vary with regard to the admissibility of non-married partners and spouses in same-sex unions (Martin 2005).

[ix] Concerning Asia, for example, several authors have noted that strong family obligations prevail for both women and men: the son or daughter who migrates is expected to assist his or her parents and other family members, and most do so, sending home substantial portions of their income as remittances. Work abroad is often considered to be a 'sacrifice' undertaken in the interest of the family, and appreciated as such by family members (Asis 2003;Hugo 1994). Daughters are seen as being more willing and faithful than sons in this regard – by migrating young single women are able to help other family members in ways that would not be possible if they stayed in the rural home where few job opportunities exist. Migration of young women and their subsequent assistance is thus part of a strategy which in the long run helps to maintain the family as a unit (Trager 1984).

[x] For a discussion of fostering in African families see (Madhavan 2004).

[xi] Redfoot & Houser (2005) have pointed out, for example, that in the Philippines and in India family expectations of migration may be built into the decision to send a

daughter to nursing school. Families know that it is easy for nurses to find employment abroad, thus that investment in a daughter's nursing education will be repaid by the remittances she will be able to send back.

[xii] At least some of the children may agree: a study carried out in Tunisia among 200 twelve to twenty year old children of unskilled long-term migrant labourers working in Europe, for example, found that three quarters thought their fathers were making a sacrifice for the family, but that there was no choice. In imaginary letters they were asked to write, 40% of the children told their fathers that they should stay abroad since 'there's no work here'. Perhaps reflecting the upward mobility for which their parents were working, few of the children said they would like to become migrant workers themselves, but that they might like to study abroad, or simply travel to discover another country (Labib 1997).

[xiii] This may well be a selection bias. In a country in which divorce is extremely difficult, and in which migration is common, migration may be the best option for a woman whose marriage is in trouble.

[xiv] Most published research dealing with children of undocumented migrants in Thailand consists of small-scale studies of highly disadvantaged groups such as sex workers. There have been few studies looking at mainstream migrants, or comparing migrants with the surrounding population. In his review, Bryant underlines the need for research on how immigration regulations affect family migration strategies and the well-being of the children.

[xv] At the time the report was being written Thailand was attempting to register foreign workers and their dependants, a situation which should improve access, at least in the short term.

[xvi] A good starting point is a study by Knodel and Saengtienchai (2007) who, citing similar relatively recent studies from Mexico, Turkey, Bangladesh, Brazil, Korea, have examined the matter for rural Thailand. Interviewing older age parents with migrant children in rural communities they had studied ten years earlier, these authors argue that, contrary to previous assumptions (Hugo 1998), the ageing parents are not at all abandoned in rural areas, but, on the contrary, that family relations are tightly maintained - by mobile telephones and because transportation is easier than previously. Social support is given and received even though the children are away. Remittances and other gifts, sometimes substantial, make most parents much better off than if the children had not migrated. Parents also help children, especially when there are special problems, or by taking care of the grandchildren. Many of the elderly

parents had travelled to visit their children after the latter migrated, to check up on them, and most families reported visiting at least once a year.

[xvii] For Southern Africa see for example: (Campbell 1997;Dodson & Crush 2006;International Organization for Migration & Southern African Migration Project 2005;Lurie 2006b;Lurie 2004;UNAIDS & IOM 2003),
Northern Africa and Middle East: (Jenkins & Robalino 2003;Soskolne & Shtarkshall 2002),
Central Africa: (Smallman-Raynor & Cliff 1991),
West Africa (Lalou & Piché 2004),
The Americas (Bronfman 1998;Magis-Rodriguez et al. 2004;Shedlin et al. 2006),
Asia: (CARAM Asia 2004;Chandrasekaran et al. 2006;Fung 2004;Hesketh et al. 2006;Simonet 2004;Skeldon 2000;Smith-Estelle & Gruskin 2003;Tucker et al. 2005;UNDP & APMRN 2004),
Europe: (del Amo J. et al. 2004;Hamers & Downs 2004;Haour-Knipe & Rector 1996).

[xviii] Smith-Estelle and Gruskin (2003) make the useful distinction between social, individual and programme vulnerability, which helps move beyond discussions of individual risk.

[xix] Indeed, migration may allow some households in a community to climb out of poverty, while others unable to send out a labour migrant are unable to do so. The research team studying a sub-district in northeastern South Africa where temporary circular migration is extremely frequent (see also section 4.1.1) have observed that a minimum level of social networking and/or of financial resources is needed to start circular migration, so that households with migrant members were already better off before the migrants departed. In addition, the more circular migrants there are in households the greater the assets. Circular migration is thus strongly related to the socio-economic status of the household, both before and after migration (Collinson, Tollman, Kahn, Clark, & Garenne 2006).

[xx] The family story continues in this example: some of the families tried to 'straighten out' a son in difficulty by arranging for him to marry a young woman from a traditional family. Another subgroup of the Tunisian HIV patients were women infected by spouses who had worked abroad.

[xxi] Indeed, in Lurie's study migration reduced the risk of infection from inside the relationship, while it increased the risk from outside the relationship, both for men and for women. The authors speculate that since men who migrate relatively far to work in mines spend relatively little time at home each year, the likelihood of them infecting their rural partners is correspondingly low, presumably as a result of infrequent

exposure. Interestingly, regarding the same country but a different group, women who had migrated to work as domestics in Johannesburg said something similar: living in employer's homes, where they were not allowed to bring partners to their rooms, limited the sexual relationships they might be able to establish, thus protected them from risk (Peberdy & Dinat 2005).

[xxii] A study from another developed country, Australia, serves as a good reminder that alternative forms of family may emerge. Burnley (1999) has suggested that, in the early 1990s, before HAART was available, many gay men with AIDS, who had originally migrated to be near a gay subculture and institutional structure, may not have migrated back to places of origin to be cared for by their families at the end of their lives. Instead, in a region where a strong gay subculture had given rise to philanthropic and institutional structures to support them, many stayed in their own homes to be cared for by the friends who had become like family.

[xxiii] See special issue of Scandanavian Journal of Public Health, Suppl, vol. 69, 2007 and also Madhavan et al (2007) for a discussion of these studies and how they were carried out.

[xxiv] The same author has commented that although it is easier and more acceptable for widowers to do so, strong taboos in Ugandan societies prevent widows from inviting a potential new partner into the homes of their deceased husbands. Thus a woman may have to migrate if she is considering remarriage (Ntozi & Nakayiwa 1999).

[xxv] All references in this paragraph appear in Foster 2005, available at http://aidsalliance.3cdn.net/452cceba0c5b20b0e9_kam6ba902.doc. See especially the extremely helpful schema depicting the factors that influence final household status of children after parental death, such as which parent dies, whether or not the other parent remarries, who cares for the child, whether or not they stay in the same household, and with whom. These are discussed in other JLICA papers.

[xxvi] Note that 'migration' in this instance can refer to movement within the same state, or even to another household within the same community.

[xxvii] In a study of children in a settlement in the Northern Province (now Limpopo), South Africa, for example, 41 per cent of children changed their place of residence at least once in a single year (Van der Waal 1996 cited in Hosegood, Benzler, & Solarsh 2006)

[xxviii] In a region where circulatory migration is common, children may oscillate between two households, and be a recognised member of both, a condition that can either moderate or exacerbate the impact of parental illness or death (Hosegood, Benzler, & Solarsh 2006). One effect may be that children who have been residing with other

relatives have to return to live with parents when the former can no longer care for them (Ansell & Young 2004). Another is that the impact of the loss of a relative with whom a child had been living may be as great as the loss of a natal parent (Foster & Williamson 2000).

[xxix] Sending a child to another country for care by a family member may be particularly risky: a working paper prepared by International Social Service and UNICEF points out that kinship care in another country is usually an informal arrangement, often involving sending a child from a developing or a transition country to stay with relatives in an industrialised country. The paper points out that sending a child to live with relatives in another country holds fewer of the advantages normally associated with kinship care: the child does not remain in his or her community; direct links with parents will likely be at least temporarily severed; and the relatives may be unfamiliar to the child if they have been abroad for some time. Vulnerability is enhanced by the very fact that the child is outside the country of origin: the child will likely have no one else to turn to in case of difficulties, may not speak the language in the country of destination, may be confused by cultural differences and - according to his or her legal status and that of the caregivers in that country - may not have access to health and education services or be known to the child protection services (UNICEF & ISS 2004).

[xxx] One of the rare studies to examine the needs and experiences of migrants with HIV disease in the United States also notes that, particularly when they come from countries in which HAART was not available when they left, migrants may not know about its existence. Or they are unaware of their rights and of how to obtain access to treatment in the country to which they have migrated (Foley 2005).

[xxxi] If telling family members important news must be done face to face, this may be difficult to arrange. People sometimes go to considerable effort and expense to make visits to do so. Those in irregular status may not be able to make such visits: leaving a country in which one is living as an irregular migrant entails the risk of not being able to return (Miller & Murray 1999).

[xxxii] Some of the women who said they were single mothers had lost husbands to HIV. They said they preferred to describe themselves as ‘single mothers’ rather than as widows because of stigma associated with being a young widow: the community construes being a widow at a young age as indicative that there is HIV in one’s life.

[xxxiii] While migration experts may previously have postulated that splits between two different cultures would give rise to conflicting identities and even psychiatric disturbance, more recent thinking is to consider the development of ‘double identities’ as a source of potential strength (Cassarino 2004).

[xxxiv] Discussions with other members of the JLICA Learning Group in Pretoria in January 2008 were extremely helpful for clarifying the main messages and for seeing where background information was needed: what may seem obvious to one expert may in fact not be at all so to another. Much later in the process, reviewers provided valuable comments, and especially extremely helpful suggestions for tightening up a document that must have strained the patience of even the most committed.