

# **Mobile Populations and HIV/AIDS in the Southern African Region**

**Recommendations for Action**

**Deskreview and Bibliography on  
HIV/AIDS and Mobile Populations**

**May 2003**



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IOM International Organization for Migration



This document has been financed by the Swedish International Development Cooperation Agency, Sida. Sida does not necessarily share the views expressed in this material. Responsibility for its contents rests entirely with the author.



Joint United Nations Programme on HIV/AIDS

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IOM's Regional Office for Southern Africa would like to thank the following organizations and people:

- Khulisa Management Services and Barbara Rijks (IOM) for the research and writing;
- Daan Brummer (IOM) for collecting the database on mobile populations and HIV/AIDS in the SADC region;
- Mary Haour Knipe (IOM), Helen Jackson (UNFPA), Aurorita Mendoza (UNAIDS) and Danielle Grondin (IOM) for their review and feedback;
- Hein Marais (UNAIDS) for editing;
- Ivan Hermans and Bunmi Makinwa (UNAIDS ICT for Eastern and Southern Africa) for financial support towards the printing and launch of the report, and
- Colleagues in IOM Publications Unit in Geneva for their efforts in producing this report.

And in particular:

- Swedish International Development Cooperation Agency for their financial support for this review.

*The human immunodeficiency virus (HIV) epidemic carries with it forces of destruction and healing. Which prevails will be the measure of ourselves and our societies.*

Reid (1995)



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## ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AIDSCAP	AIDS Control and Prevention (FHI Project)
AZT	Azidothymidine
BCC	Behaviour Change Communication
CFU	Commercial Farmers Union (Zimbabwe)
COSATU	Congress of South African Trade Unions
CSIR	Council for Scientific and Industrial Research
CSM	Condom Social Marketing
CSW	Commercial Sex Worker
DPW	Department of Public Works (South Africa)
DRC	Democratic Republic of Congo
EU	European Union
FAO	Food and Agriculture Organization
FHI	Family Health International
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IDPs	Internally Displaced Persons
IEC	Information, Education and Communication
ILO	International Labour Organization
IOM	International Organization for Migration
ISAPSO	Integrated Services for AIDS Prevention and Support Organization (WFP Project)
MRC	Medical Research Council
MSM	Men Having Sex with Men
MTCT	Mother To Child Transmission
NACL	Network Against Child Labour (South Africa)
NBC	National Bargaining Council
NECTOI	National Employment Council for the Transport Operating Industry (Zimbabwe)
NEPAD	New Partnership for Africa's Development
NGO	Non-Governmental Organization
NUM	National Union of Mineworkers
OVC	Orphans and Vulnerable Children
PWA	Person living With AIDS
RHAP	Regional HIV/AIDS Programme (USAID)

RSA	Republic of South Africa
SAA	South African Airways
SACTWU	Southern African Clothing and Textile Workers Union
SADC	Southern African Development Community
SAMP	Southern African Migration Project
SETA	Sector Education and Training Authority
SIDA	Swedish International Development Cooperation Agency
SMME	Small Medium and Micro-Enterprise
STI	Sexually Transmitted Infection
TB	Tuberculosis
TFGI	The Futures Group International
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNGASS	United Nations General Assembly Special Session
UNHCR	United Nations High Commissioner for Refugees
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
WFP	World Food Programme
WHO	World Health Organization
WSSD	World Summit on Sustainable Development
ZCTU	Zimbabwe Congress of Trade Unions

## FOREWORD

By far the world's worst-affected region, sub-Saharan Africa is now home to 29.4 million people living with HIV/AIDS, 70 per cent of the total 42.9 million people living with HIV/AIDS globally. The eight Southern African Development Community (SADC) countries under review in this study have the highest HIV adult prevalence rates in the world: Botswana (38.8%), Zimbabwe (33.7%), Swaziland (33.4%), Lesotho (31.0%), Namibia (22.5%), South Africa (20.1%), Zambia (21.5%), and Mozambique (13.0%).

Since the start of the HIV/AIDS epidemic, SADC governments have been concerned that the movement of people between countries was a major factor in the spread of HIV. Today there is increasing recognition that mobile populations may be more vulnerable to HIV/AIDS than populations that do not move. They may be subject to discrimination, xenophobia, exploitation and harassment, and enjoy scant legal or social protection in the host community. They may also have little or no access to HIV information, health services and means of AIDS prevention such as condoms or treatment of sexually transmitted infections (STIs). Mobile people may acquire HIV while on the move, and return home with the virus, often unwittingly.

Given the high number of mobile populations in the SADC region, there is an urgent need for responses that address their particular vulnerabilities to HIV/AIDS. Such responses are critical to the effectiveness of national AIDS programmes in the many countries that experience significant migration and population mobility. Such responses must be based on the social and contextual realities faced by mobile populations and should form part of broader empowerment that improves their legal, social, economic and health status.

The Regional Office for Southern Africa of the International Organization for Migration (IOM) is concerned with the vulnerability of mobile populations in the SADC region to HIV/AIDS. In consultation with the Swedish International Development Cooperation Agency (SIDA), IOM initiated this desk review which focuses on eight mobile groups in as many SADC countries.

The following eight mobile groups were reviewed: (1) Military personnel, (2) Transport Workers, (3) Mine workers, (4) Construction Workers, (5) Agricultural Farm Workers, (6) Informal Traders, (7) Domestic Workers, (8) Refugees/IDPs.

The following countries were reviewed: (1) Botswana, (2) Lesotho, (3) Mozambique, (4) Namibia, (5) South Africa, (6) Swaziland, (7) Zambia, (8) Zimbabwe.



The objectives of the study are:

- to document the vulnerability of the different mobile groups to HIV/AIDS;
- to examine existing policies and programmes that address the causes of HIV vulnerability of these groups;
- to identify policy and programmatic gaps, and provide recommendations that could help reduce HIV vulnerability for mobile populations;
- to compile a bibliography on mobile populations and HIV/AIDS.

This study is the first part of a regional project on Mobile Populations and HIV/AIDS, funded by SIDA. The second part of this project entails field research, implemented in partnership with CARE International in Zimbabwe, South Africa and Mozambique. The field research will map different migrant or mobile populations, especially traders, agricultural workers, fishermen/sailors/seafarers, miners' families and domestic workers (mainly internal migration) and offer programming recommendations.

One of the objectives of this study was to create a bibliography on mobile populations and HIV/AIDS in the SADC region.<sup>1</sup> The bibliography is a comprehensive and up-to-date overview of newspaper articles, papers, articles in journals and books covering mobile populations in ten SADC countries. Together with the southern African organization CADRE (the Centre for AIDS Development, Research and Evaluation), IOM is hosting this bibliography on CADRE's website [www.cadre.org.za](http://www.cadre.org.za).

This report is not a complete overview of all the programmes and policies that have been developed in the SADC region, nor is it an in-depth study into the sexual behaviour or root causes of HIV vulnerability of the different mobile populations. Many in-depth studies of this sort have already been carried out, many of which can be found in Annex C of this report.

By searching the Internet, reviewing existing literature and interviewing key experts between July and December 2002, this desk review has tried to analyse how different mobile populations are vulnerable to HIV/AIDS, and what policies and programmes exist to address such vulnerability. The review also formulates some recommendations to address the causes of vulnerability for each stage of the mobility process: source, transit, destination and return. These recommendations are by no means exhaustive.

We hope this desk review will encourage more research and stronger operational policies and programmes that could eventually reduce the HIV vulnerability of mobile populations and of those close to them.

In commending this publication to a wider readership, I would like to thank SIDA – on behalf of IOM – for its generous financial support for this desk review. Our organization is committed to playing a key role in addressing the HIV vulnerability of mobile populations in this region, in cooperation with Governments, appropriate UN Agencies and NGOs.

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## EXECUTIVE SUMMARY

In much of the literature on HIV/AIDS and mobility, mobile populations and/or migrants are described and treated as one, homogenous group. This report examines the different sub-groups of mobile populations, and looks at their commonalities and differences.

Mobile groups are vulnerable to HIV/AIDS in different respects, which complicates prevention and mitigation strategies. Vulnerability to HIV/AIDS is often related to a particular stage of the mobility process. IOM has defined a process framework for HIV/AIDS based on four stages of mobility:

- **Source:** where people come from, why they leave, and the relationships they maintain at home while away;
- **Transit:** the places people pass through, how they travel and their behaviour while they travel;
- **Destination:** where people go, the attitudes they encounter and their new living and working conditions;
- **Return:** the changes that have occurred in people's lives and the conditions they find upon their return.

Some migrants are most vulnerable at their destination – for example, men who work far from home, such as mine workers, farm workers and military personnel who live in men-only camps or barracks. For others, the greatest risk occurs in transit, when female informal traders or farm workers might have to trade sex in order to survive or complete their journeys.<sup>2</sup>

This report highlights the ways in which the different mobile populations are vulnerable to HIV/AIDS, and draws together some of the policies and programmes that governments, employers, unions and NGOs have put in place. Since different mobile populations are vulnerable to HIV infection at different stages of mobility, the report formulates recommendations for each stage of the mobility process. Although Commercial Sex Workers (CSWs) constitute a mobile group in their own right, we have decided not to highlight them in a separate section but rather integrate them in the other sections. A separate section on Commercial Sex Workers can be found in the bibliography in Annex C.

## Findings

It has long been clear that the AIDS epidemic thrives in an environment of social exclusion. Most mobile populations work and live in such an environment. Separated from their familiar social structures and from shared norms and values, language and social support, they are more likely to engage in risky behaviour. Their new environment often lacks strong community cohesiveness, thus increasing the risk of HIV infection.<sup>3</sup>

The optimal context for HIV transmission is one where men have money, have few recreational options, are away from families, and are amid low-income communities where women's limited access to education, employment, credit or income can force resort to commercial or transactional sex. Thus, migrant workers – including (seasonal) plantation workers, truckers, military personnel and mine workers – are especially vulnerable to HIV,<sup>4</sup> and infection rates tend to be highest in peri-urban areas beside major highways, military bases, mines, plantations, timber estates and other migrant centres.

Mobile populations experience a multitude of risks. Preoccupied by more immediate challenges of physical survival and financial need, many people on the move regard HIV as a distant risk.<sup>5</sup>

The transient nature of migrants' lives puts them at risk. The longer they spend away from home, the more likely it is that some will indulge in casual, high-risk sex. Other factors boost the odds of infection even more. Lengthy delays at border crossings can turn those areas hotspots for high-risk sexual activities. The overcrowded shacks of farm workers, the isolation of migrant worker hostels or the anonymity of refugee camps beckons companionship and the possibility of risky sexual conduct.

Gender relations are an important dimension of migration. In Southern Africa most migrants are men who move to urban areas, leaving their partners in rural areas. Areas from which migrants originate often are underdeveloped and impoverished – and women, in the absence of their partners, might have to sell or trade sex in order to survive. Rural women face an even higher risk of HIV infection when their migrant partners return home regularly from areas of high HIV prevalence.

Many migrating women move to urban areas in order to achieve economic and social independence. Lack of education, however, restricts many of them to the informal trading sector, domestic work or sex work. CSWs are often migrant workers themselves, moving from city to city in pursuit of better earning opportunities and

safer working conditions. For example, a study found that 40 per cent of the CSWs in Hillbrow, Johannesburg, were originally from South Africa's Eastern Cape province.<sup>6</sup> At the same time, migrating female farm workers in rural areas (who often outnumber men as seasonal labourers on some border farms in South Africa) have been known to exchange sex for food.<sup>7</sup>

The social constructions of gender and sexuality underpin HIV vulnerability. Working environments, such as that of truckers, soldiers, mineworkers, plantation workers and fishermen, contribute significantly to male notions of masculinity and sexuality. Next to the boredom and loneliness of these jobs, the men endure dangerous and unpleasant working conditions, poor accommodation and estranging environments, to which they may respond with exaggerated "masculinity" and sexual bravado.<sup>8</sup> Male migrants often subscribe to gender norms that prize multiple sexual partnerships. Another significant source of HIV transmission is sex between men, especially those working and living in predominantly male environments.<sup>9</sup>

In summary, the main factors increasing the vulnerability of mobile populations to HIV include:<sup>10</sup>

- work involving mobility, in particular the obligation to travel regularly and live away from spouses;
- separation from socio-cultural norms that regulate behaviour in stable communities;
- work in isolated environments with limited recreation and easy access to CSWs, drugs and alcohol;
- limited access to health facilities, including treatment for sexually transmitted infections (STIs) and HIV/AIDS prevention and care programmes;
- types of accommodation such as single-sex, overcrowded living quarters or having to sleep in trucks;
- difficult and dangerous working conditions, with high risk of physical injury;
- workplaces dominated by men;
- transactional sex, sexual abuse and sexual violence;
- a sense of anonymity which allows for more sexual freedom;
- xenophobia and discrimination;
- lack of legal rights and legal protection.

There are many policies and programmes in place to address the vulnerability of various mobile populations to HIV/AIDS. Many are related to the workplace and address issues such as discrimination, confidentiality, recruitment and employment, testing and treatment. Some government departments have established strategic plans on HIV/AIDS for specific sectors, though their implementation has been slow.

Most workplace programmes cover peer education, condom distribution, dissemination of Information, Education and Communication (IEC) materials, HIV/AIDS awareness programmes and support to Voluntary Counselling and Testing (VCT). Some trade unions have been active in addressing some of the socio-economic factors driving the epidemic like housing and working conditions of migrant workers. Some successful programmes, mostly funded by international donors, have specifically addressed HIV vulnerability of certain mobile workers such as truck drivers, CSWs, traders and miners in mining towns, border areas and other risk-areas along transport routes.

Overall, however, few policies and programmes address the specific socio-economic conditions that increase HIV risk for mobile workers. Conditions that devalue people's dignity signal to individuals that their lives are considered to be of little worth. In such circumstances the fight against HIV/AIDS is unlikely to encounter much success.

Dangerous work environments – the heat and noise of a cramped mine stope, the ferocity of a battlefield, the rush to meet tight transport deadlines – imperil life. Why worry about HIV/AIDS when one may die in a rock fall, a landmine explosion or an accident? And poverty imposes its own imperatives. As one Botswana sex worker once explained, “I can ask clients to use condoms but they pay more for sex without condoms, by the time I die of AIDS I will have been able to educate my children and build a house.”<sup>11</sup>

SADC governments, companies and NGOs need to take such factors into consideration when they develop policies and programmes on HIV/AIDS and mobile populations.

## **The way forward**

To reduce the HIV vulnerability of mobile populations in the long term, the socio-economic and political factors that drive mobility should be addressed, including the uneven distribution of resources, unemployment, socio-economic insecurity, economic instability and political unrest.

Similarly the characteristics and underlying conditions of migration should be addressed. Programmes that train peer educators in the workplace and that distribute IEC materials and condoms are extremely important. But they do not address the root causes of vulnerability. Therefore such programmes need to be implemented in

tandem with efforts that protect basic human rights and improve the living and working conditions of mobile workers. If these workers feel valued and have their basic human rights protected, they would be more likely to value their own lives enough to practice safe sex.

The next section, Agenda for Advocacy, offers recommendations for action on policy, research, programme implementation and advocacy. Heeding and implementing them can address some of the structural causes of HIV vulnerability among mobile populations.

## **AGENDA FOR ADVOCACY**

Policies and programmes aimed at reducing the risk of mobile populations to HIV infection work best when they reflect an understanding of the economic, social and contextual dimensions of AIDS. This entails distinguishing between different mobile populations and their respective characteristics. At the same time, the experiences of various mobile populations can also be quite similar. The common issues should be used to advocate for programmes and policies for all mobile populations and to put their HIV vulnerability on the agendas of governments, international organizations, regional organizations and NGOs. There are many global, regional and national plans, declarations of commitment, and codes of conduct in place that include recommendations and guidelines on mobile populations. These can be used to raise the profile of mobile populations and reduce their vulnerability to HIV/AIDS.

### **Recommendations for action**

The following recommendations address the most urgent needs of mobile populations and their vulnerability to HIV/AIDS:

#### **1. Develop a solid policy framework in each SADC country and within the SADC secretariat to reduce the vulnerability of mobile populations**

The many HIV/AIDS policies in place in the SADC region include strategic plans, codes of conduct, workplace policies and sectoral policies. However, few national strategic plans include mobile populations as a vulnerable group. But research conducted for this desk review also showed that some SADC countries have sectoral policies on HIV/AIDS that are relevant to mobile populations – such as in the agriculture, minerals and energy, transport, public works, and uniformed services and police sectors. The underlying causes of vulnerability of mobile populations are seldom mentioned, however. In addition, there are questions about the extent to which such policies are in fact being implemented. In some cases, Ministry participation is limited to having an AIDS policy for employees while in others, a Ministry might be more actively involved in implementing programmes to address HIV/AIDS for a constituent.

As long as mobile populations are not addressed in national and sector policies, responses to reduce their vulnerability will fall short. One effective and important way of developing more appropriate policies is to increase the representation of mobile populations in decision forums. Key representatives of relevant sectors (transport, mining, agriculture, military, etc) representing mobile populations could be included



in multi-sectoral national AIDS councils. The SADC Secretariat, in particular its Health Sector Coordinating Unit (HSCU), could play a strong facilitating role in developing policy and developing advocacy activities.

There is a need to develop and strengthen policies in the following areas:

- Mobile populations need to be integrated into national strategic plans on HIV/AIDS of SADC countries as a vulnerable group and separate strategies should be developed to address this vulnerability;
- Sectoral policies on HIV/AIDS are needed for sectors that employ mobile workers – especially in Agriculture, Minerals and Energy, Transport and Works, and Uniformed Services and Police – in various SADC countries themselves and in the relevant SADC sector units;
- Laws and policies can be harmonized and systems can be strengthened to speed up customs and immigration formalities. This would reduce delays at borders and reduce the potential sexual abuse and bribery of especially female migrants by border officials. Needed, too, are working visas that cater for informal traders and cross-border farm workers;
- Laws and regulations can be improved to protect the basic rights of mobile populations, especially in the informal sector;
- Reduce the time that mobile populations spend away from families and regular sexual partners by facilitating increased family visits. Employers of mobile populations can review leave schedules and change workplace policies;
- Employers should recognize as co-factors of HIV transmission issues such as job security and working conditions, including comprehensive medical aid schemes that allow for regular HIV testing, treatment of opportunistic infections and STIs, post-exposure prophylaxis (PEP) and provision of antiretroviral (ARV) treatment. Workplace HIV/AIDS policies should include these co-factors.

## **2. Conduct more research to inform policies and programmes on mobile populations**

Among the aspects that require more research and analysis are:

- Sector impact studies. Too little is known about how HIV/AIDS affects the formal and informal sectors in the SADC region, including those that employ mobile workers (such as minerals and energy, transport, uniformed services and public works). Also, in the informal sector, where mobile populations such as informal traders, domestic workers and to some extent informal farm workers are employed, there is very little knowledge of the impact of HIV/AIDS and what the most effective responses to HIV/AIDS would involve.

- Migrant-sending areas. Some mobile populations (such as mineworkers, construction workers, domestic workers and informal traders) leave their places of origin in search of better economic opportunities. Greater efforts are needed to determine how the economic prospects of their places of origins could be boosted. Also requiring further research are the particular types of vulnerability that beset migrants' families, and the sexual networking patterns in which they participate in.
- Men having sex with men (MSM). The research encountered anecdotal evidence of sexual relationships between men, especially in single-sex working and living environments, as well as of male rape. Too little is known about the character of these relationships and what possible role they play in the transmission of HIV/AIDS in the SADC region.
- Mobile populations such as seafarers, fishermen, domestic workers, female migrants, informal traders, students, teachers, and public servants can be presumed to be vulnerable to HIV, but the evidence base needs to be improved.
- The extreme vulnerability of female mobile populations such as refugee women, informal traders, CSWs, farm workers and domestic workers. In 1999, about half of all migrants were female,<sup>12</sup> yet there has been very little research done on female migrants. They receive scant attention at international and regional conferences, in policies or in programmes. Female migrants are subject to sexual abuse and violence, especially those who work in informal occupations where they are easily exploited and where they enjoy few legal rights. Such exploitation makes them even more vulnerable to HIV infection than migrant men.

### **3. Implement programmes that reduce the vulnerability of mobile populations to HIV/AIDS**

Some guiding principles:

- ✓ Programmes should shift from biomedical and behavioural interventions towards “structural interventions” and “enabling approaches”. In addition to trying to *persuade* people to change their behaviour, the latter involve greater emphasis on creating circumstances that *enable* behaviour change. Programmes should therefore focus more on strategic sites through which mobile population groups pass, thereby addressing the needs of multiple target groups. For example, some programmes in the SADC region are targeting border areas that cater to several groups at once – such as truckers, informal traders and commercial sex workers. In some cases, the coverage would extend to other groups around the intervention site who may also be at risk.

- ✓ Involve employers, trade unions, relevant community support organizations and CSWs whenever possible in HIV/AIDS prevention and care programmes. It is not enough to only focus on the workforce if mobile workers socialize in or eventually return to communities where high-risk behaviour is the norm. HIV/AIDS education needs to extend into communities close to the work environment.
- ✓ Programmes should reflect the needs of mobile populations. Some mobile groups may see their social conditions as their main concern, not HIV.

**Programmes that need to be developed or integrated include:**

- Training and sensitizing border officials on the human rights of mobile populations, and steps to prevent sexual abuse and transactional sex between border officials and informal traders and CSWs;
- Implementing prevention and care programmes in the migrant-receiving *and* migrant-sending areas;
- Programmes that mobilize mobile populations to target their own communities, for example using peer education or drama performances. Community or peer theatre groups are often effective in putting across thought provoking messages in a memorable way. Peer educators (if possible PWAs) are often more effective educators on HIV/AIDS and STIs than outside educators;
- The integration of voluntary HIV counselling and testing (VCT) in formal and informal sectors, especially in the uniformed services where typically screening takes place upon recruitment and deployment;
- Especially in all-male work and living environments, programmes need to tackle gender stereotyping, promote women's rights and sensitize men against sexual violence;
- Develop and strengthen care and support programmes for mobile workers, especially at key migrant labour points such as border posts, mines, commercial farms, construction sites, etc. This could include extend to low-cost pre-packaged STI treatment kits, PEP STI treatment and VCT and also other aspects of care such as support groups, spiritual care and information on nutrition to bolster immune systems;
- Set up counselling services and support groups to deal with work-related stress, in particular for those who face danger in their work, whether miners, truckers or soldiers. Stress, particularly when related to alcohol and drug abuse, increases the risk of unsafe sex;

- Provide entertainment and recreation facilities at key migrant routes such as border posts, mines, commercial farms, construction sites, etc. Recreational activities – especially sport – enable workers to use spare time constructively and safely. Fostering a sense of belonging within the broader community (via church groups, youth clubs, etc.) can help build self-esteem and counter risky behaviour;
- Integrate compulsory HIV education in all training manuals and develop IEC/BCC programmes, which include education on sexual and reproductive health issues;
- Develop pilot projects on family housing or alternative housing that respects privacy and reduces vulnerability;
- Ensure condoms are available at every stage along migrants' journey (at places of origin, transit, destination and return).

**4. Alongside advocacy activities aimed at establishing the policies and (research) programmes mentioned above, distinct information, education and communication (IEC) advocacy activities are needed:**

- SADC should facilitate greater sector involvement in HIV/AIDS programmes by popularizing tangible examples of successful sector programmes in and beyond the region;
- Lobby groups, civil society and other relevant players can seek to strengthen workers associations where there are no unions, especially for informal traders, domestic workers and farm workers;
- There is a need for a central independent information dissemination service within SADC that could raise awareness about the vulnerability to HIV/AIDS among key stakeholders. It could use tools such as a central website, email service and other IEC material to regularly update interested parties;
- To reach the broader public and educate members of the media, journalists from SADC countries can be commissioned to write regular articles about the vulnerability of the different mobile populations to HIV/AIDS;
- Community radio programmes could be produced by mobile populations for their peers, or IEC audio tapes on HIV/AIDS could be developed for truck drivers;
- Of special importance is the extreme vulnerability of female mobile populations such as refugee women, informal traders, CSWs, farm workers and domestic workers. Special information, education and communication initiatives should target these groups and help them to reduce their vulnerability to HIV/AIDS.

## What instruments can be used to reduce the vulnerability of mobile populations to HIV/AIDS?

Knowing what needs to be done is one thing; developing strategies and instruments that can get the job done is another.

### National and sector policies

The Policy Project<sup>13</sup> has reviewed national and sectoral HIV/AIDS policies of SADC member states. It found that, of the eight countries under review, only Lesotho and Zambia explicitly include migrants in their national strategic plan on HIV/AIDS (see Table 2A and 2B). Only Lesotho, Namibia, South Africa and Zambia have or are beginning to have a policy that applies to sectors that employ mobile populations (such as agriculture, minerals and energy, transport and public works and uniformed services; see Table 1). As long as mobile populations are not addressed in national and sectoral policies, efforts to reduce their HIV/AIDS vulnerability will falter.

TABLE 1  
RELEVANT SECTOR POLICIES ON HIV/AIDS<sup>a</sup>

Country	Sector			
	Agriculture	Minerals and Energy	Transport and Works	Uniformed Services and Police
Botswana				
Lesotho	X		I	X
Mozambique				
Namibia	I	I	I	I
South Africa	W	W	W	W
Swaziland				
Zambia	I	W	W	I
Zimbabwe				

X = Either partial or comprehensive HIV/AIDS policy or programme in place and being implemented

I = HIV/AIDS policy or programme in initial planning stages

W = Workplace specific HIV/AIDS policy or programme only

Note: (a) The Policy Project, *National and Sector HIV/AIDS Policies in the Member States of the Southern Africa Development Community*, September 2002.

The biggest question around sector initiatives is not so much which sectors are formally involved in the AIDS programme, but what they are doing. In some cases, ministerial participation is limited to having an AIDS policy for ministry employees while in others, the ministry is actively involved in implementing programmes to address HIV/AIDS for its constituencies (e.g. school children, prisoners, military personnel, truck drivers). SADC should facilitate greater sector involvement in HIV/AIDS programmes by promoting dissemination and discussion of concrete examples of successful sector programmes inside and outside the region.

Tables 2A and 2B summarize the main HIV/AIDS policies that were identified in the SADC region.

TABLE 2A  
HIV/AIDS POLICIES IN THE SADC REGION<sup>a</sup>

Policies	SADC Country							
	Botswana	Lesotho	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
Strategic Plan	X	X	X		X	X	X	X
National Crisis/Disaster	X	X				X		X
Multi-sectoral approach	X	X	X	X	X	X	X	X
Human Rights	X	X		X	X	X	X	X
PWA Involvement	X	X	X		X			
Employment	X	X			X	X		X
Travel	X	X				X		X
Wilful Transmission	X	X					X	X
Confidentiality	X	X					X	X
Right to Insurance		X						
Prisons		X					X	X
MSM		X						
Testing	X	X				X	X	X
VCT	X	X	X		X	X	X	X
IEC	X	X	X	X	X	X	X	X

TABLE 2B  
HIV/AIDS POLICIES IN THE SADC REGION<sup>a</sup>

Policies	SADC Country							
	Botswana	Lesotho	Mozambique	Namibia	South Africa	Swaziland	Zambia	Zimbabwe
Condom Promotion	X	X		X	X	X	X	X
STIs	X	X	X		X	X	X	X
Safe Blood	X	X	X	X	X	X	X	X
PMTCT	X	X			X		X	X
Breastfeeding	X	X						X
Care	X	X	X	X	X	X	X	X
Care for Care Givers	X	X			X		X	X
Gender	X	X			X		X	X
Youth	X	X			X	X	X	X
Research/Surveillance	X	X	X		X	X	X	X
HIV/AIDS and poverty	X	X	X		X		X	X
Orphans	X	X		X	X	X	X	
Migrants		X					X	
Culture and HIV/AIDS		X			X			

Note: (a) The Policy Project.

## Regional and global instruments

The SADC Code of Conduct on HIV/AIDS and Employment is an important instrument that can be used to enforce the rights of mobile populations in the SADC region. Relevant paragraphs in the Code of Conduct include:

- (para. 1.1) “information and education programmes should be developed jointly by employers and employees [...] and should incorporate employee families”;

- (para. 3.1) “there should be no compulsory workplace testing for HIV. Voluntary testing [...] should be done [...] with informed consent of the employee [...] with pre- and post-test counselling”;
- (para. 8.3) “under conditions where people move for work, government and organizations should lift restrictions [on family reunification] to enable them to move with their families and dependants”;
- (para. 8.4) “people who are in an occupation that requires routine travel in the course of their duties should be provided with the means to minimize the risk of infection including information, condoms and adequate accommodation”.

Equally valuable is the Declaration of Commitment on HIV/AIDS which was signed by the governments of 189 countries at the United Nations General Assembly (UNGASS) on HIV/AIDS in June 2001. The Declaration established a number of goals for the achievement of specific quantified and time-bound targets. UNAIDS and its partners have developed guidelines for tracking and measuring the implementation of the commitments adopted at UNGASS.<sup>14</sup> In particular, the indicators of national commitment and action could be used as advocacy tools to hold governments accountable on their expressed commitment to protect mobile reduce HIV vulnerability of mobile populations.

**Declaration of Commitment on HIV/AIDS** The Declaration of Commitment on HIV/AIDS signed at the United Nations General Assembly Special Session (UNGASS) in June 2001 maps the actions needed to mount a comprehensive and coordinated global response against the epidemic. Among the commitments: “By 2005, develop and begin to implement national, regional and international strategies that facilitate access to HIV/AIDS prevention programmes for migrants and mobile workers, including the provision of information on health and social services.” [para 50]



The National Composite Policy Index assesses progress in the development of national-level HIV/AIDS policies and strategies and covers four broad areas of policy:

- ✓ Strategic Plan
- ✓ Prevention
- ✓ Human Rights
- ✓ Care and Support

For example, governments are obliged to report on whether they have a strategy that addresses HIV/AIDS issues among its national uniformed services, including armed forces and civil forces. With respect to prevention efforts, governments are required to report whether they have a policy or strategy that promotes IEC and other health interventions for cross-border migrants. Governments also have to report whether they have put in place laws and regulations that protect certain vulnerable groups against discrimination, including sex workers and mobile populations.

With respect to care and support, Governments have to report whether they have a policy or strategy to promote comprehensive care and support, with emphasis on vulnerable groups, including UCT, psychosocial care, access to medicines and community-based care.

## INTRODUCTION

Migration, mobility and HIV/AIDS are major global phenomena at the beginning of the new millennium. The 2002 UNAIDS *Report on the global HIV/AIDS epidemic* highlights relevant and crucial links between HIV/AIDS and Mobile Populations.<sup>15</sup> The United Nations Population Division estimates that approximately 175 million people worldwide are considered migrants in that they live outside their country of birth.<sup>16</sup>

People move for a variety of reasons – some voluntary – some not. The dramatic political, economic, social and demographic changes in Africa over the past few decades have been accompanied by rapid urbanization, significant population displacement, and migration. Improved transport and communication systems, the increased exchange of goods, and the launching of large-scale development projects have prompted millions of young women and men to move within and beyond their countries. Armed conflicts, political instability, economic crises, natural disasters and environmental degradation have forced many millions more to flee their homes and run a gauntlet of dangers which, for many, could include much higher risks of HIV infection. Population mobility facilitates the spread of STIs, including HIV as documented in the UNAIDS Technical Update on population mobility and AIDS. In many countries, areas reporting higher seasonal and long-term mobility also have higher rates of HIV infection, and rates of infection also tend to be higher along main transport routes and in border regions.

Southern Africa has significant levels of migration and the world's highest rates of HIV infection. The latest statistics from UNAIDS indicate that 14.7 million out of the total 42 million adults living with HIV/AIDS are living in southern Africa.<sup>17</sup>

The following sections describe different groups that face increased vulnerability to HIV/AIDS because of their mobility. The first section surveys southern Africa's armed forces, among which HIV prevalence rates are estimated to be about twice as high as among civilian populations. In peacetime, STI rates among armed forces are generally two-to-five times higher than in the general populace. This difference can be much greater in times of conflict, with infection rates increasing as much as 50 times.<sup>18</sup>

The next section highlights truck drivers, whose vulnerability to HIV/AIDS is associated largely with long delays at border crossings, relatively easy access to CSWs and limited access to services for the management of STI. As the section shows, little information on STI clinics along major transport routes is available to truckers, migrants, sex workers and travellers.

Mineworkers in Southern Africa, as the following section shows, endure dangerous working and difficult living conditions. Separated from their families for long periods and often released from the behavioural norms and sanctions associated with their communities, the mineworkers are more likely to engage in high-risk sexual behaviour.

Few policies or programmes address the needs and vulnerabilities of construction workers, agricultural farm workers (Section 5.5), informal cross-border traders and domestic workers. The migrant workers in the informal sector are especially vulnerable as they are not officially employed, do not have trade unions and lack access to medical facilities, awareness initiatives and condoms.

The issues facing refugees, described in the final section, are particularly complex. The second largest population of refugees in the world is in Africa (following Asia)<sup>19</sup> and includes people of all ages and socio-economic backgrounds. Having escaped from the perils of war, civil strife or natural disasters, many of them now find themselves even more vulnerable to HIV/AIDS.

Experiences worldwide underline the fact that action aimed at behaviour change alone is unlikely to yield the necessary results. The missing link has been a solid understanding of social, economic and cultural contexts that engender risk practices and inhibit behaviour change. An appreciation of the social dimensions of HIV vulnerability for mobile populations is an essential building block for effective responses.<sup>20</sup> The recommendations in this report therefore are aimed at facilitating an enabling environment for behaviour change and addressing some of the underlying causes of HIV vulnerability for mobile populations.

## **Limitations of the research**

A desk review of this type faces some limitations, given the extensive number of countries and diverse mobile population groups it sets out to examine. Budgetary constraints did not allow for travel to the eight countries, limiting the review to already-available documentation, especially material available on the Internet. This imposed additional constraints. In several southern African countries, there is a paucity of information available electronically. Besides South Africa, no country in the region has an official government website where legislative and policy documents can be viewed, nor do most trade union and employer organizations have websites. This desk review therefore focuses on countries such as Botswana, South Africa, Zambia and Zimbabwe and, to a lesser extent, on Lesotho, Mozambique, Namibia and Swaziland.

Due to the scarcity of information available on some mobile groups (specifically fishermen/maritime workers and domestic workers), the review focuses mainly on the well-documented mobile population groups (such as the military, mineworkers and truck drivers). In addition, the groups examined are predominantly male, although it is known that women are becoming increasingly mobile, especially as informal traders.

A follow-up study is therefore recommended – using face-to-face interviews as its primary methodology – especially in the countries that yielded insufficient information. Visits to each country would enable interaction with key personnel from trade unions, NGOs, governments, etc. and allow for more effective access to documentation, information and analysis.

## MILITARY PERSONNEL

### Vulnerability to HIV/AIDS

International and national uniformed services, including peacekeepers, peace observers, national defence and civil defence forces, generally rank among the population groups most affected by STIs, including HIV/AIDS.<sup>21 22 23</sup> Risk factors for military personnel include:<sup>24 25</sup>

- living in same-sex quarters;
- age group at greatest risk for HIV infection – the sexually active 15-24 year age group, perceiving themselves invulnerable and trained not to be deterred by risk and danger;
- mostly single, separated for long periods from spouses and partners, or denied marriage during enlistment periods;
- frequently deployed away from their home countries and/or communities, which removes them from the social discipline that might hold sway in their own communities;
- nearby civilian populations often become economically dependent on the military who are relatively well-paid which can create high levels of sexual activity between women from the local communities and members from the military;
- access to commercial sex workers;
- susceptible to peer pressures;
- on active duty, members of the military often live and work in close proximity to refugees and displaced persons who are vulnerable to sexual exploitation;
- trained to regard risk-taking and aggressive behaviour as the norm;
- at risk to physical injury involving loss of blood and need for blood transfusion under possibly non-sterile conditions;
- sharing of razors and skin-piercing instruments in tattooing and scarification;
- long periods on duty without access to sex, alcohol and/or drugs often followed by short breaks of sex, drinking and/or drug binges, including the injection of drugs.

It is estimated that HIV prevalence rates in southern Africa's armed forces average between 20-40 per cent.<sup>26</sup> Soldiers contract HIV in the same ways that civilians do: through unprotected sex, sharing equipment in drug use, receiving infected blood transfusions. However the conditions in which they live and work often mean that they are significantly more likely than civilians to encounter HIV risk. Soldiers live in an enclosed community where masculine values predominate, stress and boredom is commonplace, and alcohol abuse and sexual activity may be rife. Accustomed to taking risks in their profession, they may be more inclined to engage in risky sex.

According to two recent studies, more than 40 per cent of military personnel report having unprotected sex during their deployment.<sup>27</sup> Sex is usually consensual, but in times of war it may include rape, including male rape, sometimes as part of deliberate terror tactics.<sup>28</sup>

Studies have shown that, during peacetime, STI rates among military populations can be between two and five times that found among their civilian counterparts. Indeed, there is some evidence that soldiers might even consider the acquisition of an STI as a symbol of sexual prowess and proof of manhood.<sup>29</sup> Yet, HIV transmission is five to 20 times more likely to occur when other STIs are present. The upshot is considerably enhanced risk for military personnel.

While emotional bonds among soldiers boost morale, in armed forces sex between men is aggressively barred. Like most of their peers, male Zambian soldiers, for example, claim that there is no sexual interaction between them – partly because of the strong taboo, and partly because two men are seldom alone together. Nevertheless, there is evidence that some soldiers around the world do have sex with men, either exclusively or in addition to sex with women.<sup>30</sup>

In the midst of war, attitudes towards death and survival and perceptions of risk change. The increased likelihood of death means that soldiers and civilians may also be more willing to engage in risky sex. Indeed, during war, sex activity increases, prostitution spreads, the age of sex workers tends to decline, rape becomes more commonplace and protection against STIs is seen as less important.<sup>31</sup>

Deployment to military zones and training settings increases the chances of acquiring HIV, as military personnel are exposed not only to socially disrupted settings where STIs may be more prevalent, but also to the possibility of infection through transfusions of contaminated blood, and sharing unsterilized sharp or skin-piercing instruments, such as medical equipment, syringes in drug injection, needles in tattooing, and razors. In comparison with HIV transmission through sex, however, these forms of HIV transmission are reportedly relatively rare.<sup>32</sup>

High rates of HIV infection are often found in civilian populations living near military installations. In navy ports and remote garrisons, soldiers often have a limited choice of partners. Soldiers or sailors are likely to have sex with the same women over a period of time; when their units are replaced, the new soldiers or sailors frequent the same women. For instance, in northern Namibia in the 1990s, HIV prevalence rates in communities close to military bases were significantly higher than the national average.<sup>33</sup> The large military presence in Oshakati, Eenhana and Grootfontein,

where personnel interacted closely with surrounding communities, is believed to have been a significant factor.<sup>34</sup>

Civilians – especially adolescents – are at risk during armed conflict. They are targets for (forced) recruitment into armed forces, as well as for sexual exploitation and abuse – all of which increases their chances of contracting STIs, including HIV.<sup>35</sup> The proliferation of trafficking of women for prostitution is increasingly associated with armed conflict and peacekeeping operations.<sup>36</sup>

The physical and psychological conditions in which soldiers live vary widely. Sleeping, washing and other facilities may be overcrowded and poorly maintained. Common rooms, sport facilities and entertainment facilities (such as television and video) are often absent. In the case of peacekeeping, the duration of deployment differs significantly; Kenyan peacekeepers were deployed for a year in East Timor without home leave, while their Australian colleagues had home leave every three months.<sup>37</sup>

Families and communities of military personnel can become more vulnerable to HIV when armed forces are demobilized and soldiers move back home to reintegrate into civilian life. For instance, the comparative isolation of towns and communities during Angola lengthy civil war probably helped the country to avert the HIV/AIDS epidemic facing other southern African populations. During the war, HIV infection levels rose at a relatively slow rate because the conflict restricted the movement of people, internally and to and from neighbouring countries. The demobilization of soldiers and the emergence of peace in Angola will see an increase in trade, migration and travel – three important factors that facilitate the spread of HIV infection.<sup>38</sup>

HIV/AIDS can also compromise the ability of the military to protect state sovereignty and defend national interests once high infection rates take hold among military personnel.<sup>39</sup> In the worst affected countries, which tend to be poor and have relatively few adults in higher education, the epidemic reduces the pool of potential replacements, particularly for officers. HIV/AIDS could well be so widespread among the military in southern Africa that complete well-trained companies are not immediately available for mobilization. The epidemic therefore also poses a threat to international peacekeeping and to the prospect of significantly reducing or even ending conflicts.

## **Relevant policies and programmes**

It is unclear which SADC countries conduct mandatory testing. The military authorities are often reluctant to reveal their recruitment and strength-related deploy-

ment practices with regard to HIV/AIDS. However, many African militaries are believed to have begun practising mandatory testing, for a variety of reasons. In some cases this might be occurring in apparent violation of countries' legal and/or constitutional human-rights provisions.<sup>40</sup>

An expert panel, convened by the Executive Director of UNAIDS in early 2002, concluded that mandatory testing is not the most effective means for preventing the transmission of HIV in the context of peacekeeping, and that HIV tests do not efficiently stem the spread of HIV/AIDS. UNAIDS argues that mandatory testing has not demonstrated individual or public health benefits. The panel stressed that Voluntary Counselling and Testing (VCT) should be provided to peacekeeping personnel and should be offered as part of a comprehensive range of integrated HIV prevention and care services.<sup>41</sup>

A regional policy seminar held in February 2001<sup>42 43</sup> in Namibia and attended by representatives from the military of eight southern African countries focused on developing a comprehensive approach to HIV/AIDS in the military. There was general agreement to include the following points in national policies: recruitment, incapacity, periodic assessment, surveillance and monitoring the epidemic, prevention, counselling, care, research and resource allocation.<sup>44</sup>

Two months later, the South African Department of Defence (DoD) approved a departmental policy on HIV/AIDS, which outlines measures for controlling the epidemic and the provision of care and support for personnel and their dependants. In addition, the policy provides specific guidelines to ensure a non-discriminatory work environment.<sup>45</sup> In August 2001, DoD launched a campaign, *Masibambisane* (Zulu for working together and supporting each other), which aims to:

- Provide every member of DoD with basic information on HIV/AIDS through a peer education programme;
- Develop workplace policies and programmes in all parts of DoD;
- Inform and sensitize management at all levels;
- Ensure all health care staff have the skills to deal with pre- and post-test counselling;
- Develop the HIV/AIDS management skills of medical staff; and
- Establish specialized HIV/AIDS health management information throughout DoD.

Within DoD, the Surgeon General (the most senior medical professional within the organization) is responsible for the HIV/AIDS programme. *Masibambisane* also commits DoD to combine its HIV/AIDS communication, coordination and cooperation work with that of other stakeholders.<sup>46</sup>



In Zambia, meanwhile, the Ministry of Defence has drafted a comprehensive, five-year HIV/AIDS prevention, care and support programme. Proposed activities include condom distribution, home-based care, training of psychosocial counsellors, peer educators, and care-givers for different target groups, including youth in the military, women, military dependants and civilian populations.<sup>47</sup>

Many other countries in southern Africa have introduced peer education and other prevention programmes in their militaries. Zimbabwe, for example, initiated a peer education programme with the national army and air force that includes military personnel and their spouses.<sup>48</sup>

## Recommendations

- In terms of mandatory testing in the military, it is recommended that the example of the Brazilian Government be followed. There, People Living with HIV/AIDS (PWAs) are allowed to serve in the army, while people who are not HIV-infected are provided with the means to protect themselves against acquiring HIV infection. General cognitive tests are regularly applied to all relevant personnel, thus identifying those who are not capable of fulfilling their tasks, irrespective of the cause. Performance tests are not selectively applied to PWAs.<sup>49</sup>
- Although military personnel are highly susceptible to STI and HIV infections as a group, the military is also a unique opportunity in which HIV/AIDS prevention and care programmes can be provided to a large “captive audience” in a disciplined, highly organized setting. The military could take more advantage of this fact.<sup>50</sup>
- The military should adopt a gender-sensitive approach in training and education on HIV/AIDS and set up codes of conduct that promote respect for women and girls. The duty of protecting people deserves greater emphasis. The aim is to get soldiers and peacekeepers to re-think their role as responsible individuals and as important advocates in preventing the spread of HIV/AIDS.
- Deployments to areas of conflict can be of shorter duration. In non-conflict settings, provision can be made for regular family visits or even family housing.
- HIV prevention services, including STI treatment, should be available to military personnel, their families and the civilian population living nearby deployment areas.<sup>51</sup> Compulsory HIV education and training appears to have worked in countries, such as Cameroon, Uganda, and Viet Nam, where the military stages compulsory

courses in STI prevention, broadcasts weekly radio programmes on STIs and AIDS, and assigns peer educators to conduct further HIV/AIDS education.<sup>52</sup>

- In the case of demobilized soldiers, some could be trained as community educators to organize discussion groups, provide counselling, ensure distribution of condoms and assist in other activities that can promote changes in attitude and behaviour. Therefore, soldiers should receive HIV/AIDS prevention and care education prior to demobilization.
- SADC governments should be encouraged to implement the relevant sections of the UNGASS Declaration of Commitment on HIV/AIDS. National, regional and international stakeholders should hold them accountable to those commitments. Several clauses in the Declaration of Commitment address HIV/AIDS and the uniformed services.<sup>53</sup>

(para. 77) By 2003, have in place national strategies to address the spread of HIV among national uniformed services [...] and consider ways of using personnel from these services who are educated and trained in HIV/AIDS awareness and prevention to assist with HIV/AIDS awareness and prevention activities [...].

(para. 78) By 2003, ensure the inclusion of HIV/AIDS awareness and training, including a gender component, into guidelines designed for use by defence personnel [...] while also continuing with on-going education and prevention efforts, including pre-deployment orientation, for these personnel.

Table 3 lists specific recommendations for each stage of mobility concerning military personnel.

TABLE 3  
RECOMMENDATIONS FOR INTERVENTIONS WITH MILITARY,  
BY STAGE OF MOBILITY

Recommendations	Particular relevance to*			
	Source	Transit	Destination	Return
Create a climate that encourages disclosure and openness about HIV infection	✓	✓	✓	✓
No mandatory HIV testing for military personnel	✓		✓	
Provide compulsory HIV education in training manuals	✓		✓	
Medical aid schemes should provide for VCT and treatment of opportunistic infections and ideally, ARV treatment in the long term	✓	✓	✓	✓
Organize free and easily accessible VCT, support groups and provide counselling for issues ranging from HIV to substance abuse	✓	✓	✓	✓
Provide access to stress counselling and debriefing as part of a mechanism to reduce high-risk sexual conduct	✓		✓	✓
Ensure STI clinics and treatment are accessible in deployment areas	✓	✓	✓	✓
Use peer educators and PWAs from among military personnel for HIV prevention and coping skills	✓		✓	
Ensure accessibility to condoms	✓	✓	✓	✓
Have the military assist with community HIV/AIDS education and care programmes	✓		✓	
Train the military to reduce sexual violence and exploitation in deployment areas and include aspects of human rights education in the military training	✓	✓	✓	✓
Relieve boredom and reduce substance abuse and interaction with CSW by providing recreational and entertainment facilities	✓		✓	
Give the option for spouses/partners to accompany personnel or arrange regular leave for family visits	✓		✓	
Conduct more research into MSM behaviours and into sexual violence among military personnel	✓		✓	✓
Integrate the military into national AIDS plans and include key representatives of the military in multi-sectoral National AIDS Councils	✓		✓	
Use the UNGASS Declaration of Commitment on HIV/AIDS as advocacy tool to ensure compliance with agreed commitments of governments	✓		✓	

Note: A given intervention might well be appropriate throughout several stages of the mobility process, but it is *particularly* relevant at the stage checked.

# TRANSPORT WORKERS

## Vulnerability to HIV/AIDS

The trucking and shipping industries in southern Africa are largely in private hands. South Africa alone has over 200,000 registered commercial vehicles in which more than 40,000 are heavy freight vehicles operated by some 3,000 companies.<sup>54</sup> In contrast, most airlines and railways are largely government-owned and -operated. Although the vast majority of rail operations are focused on moving cargo, passenger travel is increasing in the region and is dominated by South Africa's railway system,<sup>55</sup> which covers 7 million train kilometres and services approximately 4.2 million passengers each year, most of them (85%) commuters and traders. It operates daily long-distance passenger services between urban centres of South Africa, as well as to destinations in Mozambique, Swaziland and Zimbabwe.

Most attention has been directed at the factors that boost the risk of HIV infection among truck drivers.<sup>56</sup> The highly mobile lifestyles and high-risk sexual behaviour of many truck drivers is widely believed to have facilitated the spread of HIV infection along major road transportation routes. Risk factors for truck drivers include:

- **Duration spent away from home.** The extent and nature of truck drivers' vulnerability to HIV/AIDS varies from country to country and depends largely on the distance of truck drivers' routes. Research in South Africa has shown that an estimated 71 per cent of long-distance truck drivers spent 15 or fewer days at home in the six months prior to the study.<sup>57</sup>
- **Poor working conditions.** Many truck drivers prefer to stay at the border gates to avoid paying for boarding. Truck drivers often sleep in their trucks for fear of being robbed or highjacked and because accommodation is expensive. Sleeping at the home of a sex worker is sometimes the only affordable source of accommodation for truckers.<sup>58</sup>
- **Delays at border crossings.** Drivers often spend many hours – even days – waiting to complete customs and other formalities at border crossings. Truck drivers from Durban (RSA) to the mines in Brazzaville (Congo) often spend days waiting to pass through borders.<sup>59</sup> It can take an entire day to cross the Mozambique-South Africa border. Delays of two to three days are commonplace at Beit Bridge (which separates South Africa and Zimbabwe), while crossing into Malawi can take even longer.<sup>60</sup>

- **High-risk behaviours.** Qualitative assessments of extremely high-risk communities along different routes between Durban and Lusaka indicate that men and women often adopt riskier behaviour when in cross-border communities.<sup>61</sup> Another study found that 35 per cent of South African drivers had two or more concurrent partners and that condom use was scant and irregular.<sup>62</sup> Low condom use could not simply be attributed to a lack of access; at the Lesotho border, clients were found to pay M50 (approximately US\$5.00) to spend a night with a CSW if a condom was used and M100 (approximately US\$10.00) without a condom.<sup>63</sup>
- **Low levels of knowledge.** The Cross Border Road Transport Aids Project<sup>64</sup> has found low levels of HIV/AIDS knowledge among truckers from South Africa and Mozambique. One-third believed that AIDS could be cured and one in ten questioned whether the disease existed at all. Knowledge levels appear to be related in part to the presence of HIV/AIDS education programmes. Fifty per cent of transport workplaces in Zimbabwe offer HIV/AIDS information to employees, while only 19 per cent of workplaces in Mozambique, 17 per cent in South Africa and 16 per cent in Zambia have followed suit.
- **Lack of access to health services.** Often transport workers have neither access to health services nor the time to use them. Because of drivers' irregular work hours, clinics are not always open when drivers are able to visit them.
- **Conditions of service, salaries and relations with employers.** Conditions of employment are believed to affect drivers' vulnerability to HIV/AIDS. Most truck drivers are on contract and do not receive medical benefits.<sup>65</sup> This makes it more difficult for truck drivers to access the necessary medical care needed to treat STIs and HIV, even when such treatment is available.

Many efforts have been made to address HIV/AIDS among mobile workers in the transport sector (specifically in road transport) but such efforts have too often been limited to distributing information: they do not address the underlying causes of transport workers' vulnerability, including their working conditions.<sup>66</sup> According to the International Transport Workers Federation, "truck drivers maintain that the daily insecurity, isolation and hostility they experience encourages them to respond counterproductively to the HIV/AIDS prevention message."<sup>67</sup> As a result, prevention efforts often fail to achieve the desired behaviour changes.<sup>68</sup> The costs are likely to keep mounting, as Paul Matthew of the Learning Clinic has pointed out:

If we don't act now, in five or six years time we will be in trouble. To train a new driver is very expensive because of the increasing sophistication of the equipment. Ten years ago there were unemployed

drivers waiting for work hanging around any depot. You don't see that any more, that pool has gone. Absenteeism due to illness has been high during the last three years. We know that many new recruits are already infected. Measures must be taken, not just to save the drivers but also to save the industry.<sup>69</sup>

Transport managers are drawn from a small group of educated and professional people. They are in scarce supply, expensive to train, and take time to replace. Evidence suggests that in Africa HIV prevalence rates among managers and professionals are comparable to those in the general population.<sup>70</sup>

The vulnerability of air/rail/water crew<sup>71</sup> is similar to that experienced by truck drivers. The longer they are away from home and separated from their families, the greater the chance of casual sexual relations and potential exposure to HIV/AIDS. Sailors and fishermen experience long periods of isolation at sea. Their comparatively high incomes (and limited expenses while at sea) can make commercial sex at ports of call a common feature of their working lives.

Since 1992 the South African Medical Research Council (MRC) has conducted research among an estimated 800 CSWs operating at truck stops on the national highway that links Durban and Johannesburg.<sup>72</sup> Between 1996 and 1998, 4,777 women from five truck stops were screened for HIV as part of a microbicides trial. In 1998 ten CSWs were trained as field workers to collect sociodemographic data from their clients and to obtain a saliva sample to determine the HIV status of their clients.<sup>73</sup> A total of 320 truckers were interviewed of whom 60 per cent reported having had an STI in the previous six months. More than one-third of them said they always stopped for sex along the route, while almost 30 per cent reported never using condoms with CSWs. A mere 13 per cent had ever used condoms with their wives. All the truckers had travelled to three or more provinces in South Africa and 65 per cent had been to neighbouring countries in the SADC region. Fully 56 per cent of the truckers were HIV-positive.<sup>74 75</sup>

## Relevant policies and programmes

Pre-employment HIV testing for transport workers is illegal in most countries in southern Africa. There have been cases where such testing has been used however. In 2000, South African Airways (SAA) was found guilty by the country's Constitu-

tional Court of discrimination after it had refused to employ an HIV-positive person as a cabin attendant.<sup>76</sup> SAA argued that HIV-positive individuals could not receive yellow fever vaccinations for travel to endemic areas.

Existing policies/programmes are largely focused on the road transport industry, and thus there are gaps in policies for the air/rail/water sectors. Likewise, while policies are publicly available in South Africa and Zimbabwe, the same cannot be said for most other SADC countries.

## **Governments**

The very nature of transport work requires that policies and programmes be implemented across the region (and not just within individual countries). Most SADC countries are aware of the susceptibility of transport workers to HIV/AIDS, and their Ministries of Transport have begun to develop plans to address the epidemic. However, a number of reasons, including financial and human resources constraints, are holding up full implementation of those plans.<sup>77</sup>

There is a clear need for more forthright action in some countries. According to Barney Curtis,<sup>78</sup> spokesperson for the Federation of East and Southern African Road Transport Associations (FESARTA), there is ample scope for stronger efforts in Zambia and Malawi, for example. The Governments of Botswana and Swaziland were described as “very proactive”, while Namibia was beginning to move towards stepping up its activities.

The South African Department of Transport developed its Transport Sector HIV/AIDS Strategic AIDS Plan in November 2001.<sup>79</sup> The plan contains components on prevention; treatment and care; research, monitoring and evaluation; human and legal rights; and training and development.

Only Lesotho and Zambia make explicit reference to mobile populations and transport workers in their national AIDS plans. In the Zambia National HIV/AIDS/STI/TB Institutional Framework for 2001-2003, truck drivers are categorized as one of the most vulnerable to infection.<sup>80</sup> The framework also mentions non-governmental programmes that address HIV/AIDS within the trucking industry. In the Lesotho National AIDS Strategic Plan for 2001/2002 to 2003/2004, long-distance truck drivers are mentioned as one of the target groups.<sup>81</sup>

The Maputo Corridor Spatial Development Initiative created in the 1990s to strengthen trading links between Mozambique and South Africa has plans to create a

“Borderlands” Initiative. This initiative plans to upgrade the border post and ease the congestion of truckers by creating a 24-hour “one-stop” border post. This would mean that truckers would only have to stop once to clear customs and immigration for both countries.<sup>82</sup>

## **Private sector**

Private sector transport companies are beginning to recognize that HIV/AIDS can drain productivity levels, as increased absenteeism and the time-consuming training of replacement workers takes its toll.<sup>83</sup>

Some South African transport companies have set up rest stops for drivers, primarily to improve security. However, it appears that the stops have also reduced risky sexual encounters.<sup>84</sup> In Namibia, the petroleum company Engen and transport company FleetWatch launched a booklet called *Living on the Road, a Driver's Handbook* which also has a chapter on HIV/AIDS.<sup>85</sup> In Zimbabwe, CLAN Transport (PVT) Ltd. has initiated weekly HIV/AIDS peer education for all workers at its depot. CLAN also has a full-time nurse to provide home-based care for ill workers. Peer educators encourage workers to bring their wives to the training session (though most prefer bringing girlfriends).<sup>86</sup> It is estimated that about two-thirds of the CLAN employees' spouses live in rural areas.

UNIFREIGHT, another Zimbabwean transport company, has developed an HIV/AIDS awareness campaign<sup>87</sup> and an AIDS Policy for the company.<sup>88</sup> The company operates two clinics, one in Harare and one in Bulawayo, and has organized about 100 peer educators and some drama groups to disseminate information among workers. UNIFREIGHT also distributes free condoms from the National Employment Council for the Transport Operating Industry (NECTOI).

Spoornet, the region's largest rail company, has introduced a variety prevention activities for its workers – including access to information and knowledge about HIV/AIDS, promotion of a culture of responsible sexual behaviour, encouraging compassionate attitudes towards people affected by the disease, establishment of HIV/AIDS support groups within the company, and voluntary HIV/AIDS testing with pre- and post-test counselling.<sup>89</sup>

By protecting their workers at all levels (including management), transport companies can limit the steadily mounting costs and setbacks that accompany the epidemic.<sup>90</sup>



## **Trade unions**

In Zimbabwe, the National Employment Council for the Transport Operating Industry (NECTOI) has implemented peer education programmes among truck drivers and border communities and has helped build up the peer education programmes within the transport industry.<sup>91</sup> The Zimbabwe Congress of Trade Unions (ZCTU) has an HIV/AIDS policy and supports union members who offer HIV/AIDS information and training within their industries.<sup>92</sup>

## **Non-governmental and international organizations**

Various NGOs have targeted transport workers for HIV prevention programmes. In South Africa, the Learning Clinic Roadside Containers Project<sup>93</sup> (which receives funding from the transport industry and government) includes initiatives such as:

- Clinics that focus on preventing and treating STIs by providing condoms and medication. The clinics operate from 5 p.m. to midnight in order to be accessible to truck drivers and sex workers. The clinics train truck drivers and sex workers in issues related to HIV/AIDS and to other STIs. They distribute condoms. Each night about 30 to 40 people visit the clinics, which have assisted an estimated 54,000 in the three years since they were set up.
- A Training Unit runs programmes within the workplace.

The Learning Clinic is also involved in a project initiated by the National Bargaining Council (NBC) for the Road Freight Industry called “Trucking Against AIDS in the Road Freight Industry”.<sup>94</sup>

The Regional HIV/AIDS Programme in Southern Africa (RHAPSA) is active in Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe.<sup>95</sup> The programme is funded by the United States Agency for International Development (USAID). The primary aim of the programme is to target high transmission areas at cross-border sites and to implement appropriate interventions. RHAPSA has four activities: (1) policy initiatives, (2) networking initiatives, (3) surveillance, and (4) cross-border initiatives. As part of the cross-border initiatives, assessments have been conducted to identify target groups such as truckers, sex workers, uniformed services and informal traders. Initiatives include: Condom Social Marketing (CSM), IEC for behaviour change, Syndromic Management of STIs, Community Mobilization, Peer Support, and Home Based Care.

The project works on the assumption that there is a direct correlation between the length of time truckers spend at border posts and the number of sexual encounters they have. Therefore, the strategy is to convince governments to improve and speed up procedures for cross-border customs clearance.

World Vision, which is implementing the Cross Border Initiative Project in Zambia<sup>96</sup>, is mainly targeting CSWs and truck drivers. The main objectives of the project are behaviour change through peer education, CSM and STI Management. World Vision has also provided entertainment facilities such as cinema halls, football pitches and other recreational games at some of their border.

The Regional Programme of the International Labour Organization (ILO), “HIV/AIDS Prevention in the Transport Sector in Southern Africa”,<sup>97</sup> has chosen the following objectives in its bid to help reduce the spread of HIV/AIDS among transport workers and mitigate the epidemic’s impact on the sector:

- Develop national policies to prevent the transmission of HIV among employees of the transport sector, including road, rail, water and air transport;
- Develop a regional strategy and a set of inter-country mechanisms for the prevention of HIV transmission in the transport sector; and
- Assist the countries with the implementation of effective national strategies.

This regional project will also address HIV/AIDS in all elements of the transport chain, including the development of policies and strategies that address the underlying cause for the vulnerability of transport workers (such as rules and regulations governing the transport sector, border formalities and the working conditions of transport workers).

The desk review was unable to identify existing policies or programmes that are aimed at reducing the HIV/AIDS vulnerability of sailors and fishermen in southern Africa. Most policies generally pertain to safety at sea. However, the South African National Port Authority has awarded R4 million (approximately US\$400,000) to a programme that includes prevention, treatment, care and support, research, monitoring and surveillance, human and legal rights and joint ventures with NGOs, CBOs, government and private sector. It is establishing peer education programmes, the treatment of opportunistic infections, home-based care and a toll-free line. The programme will employ People Living with HIV/AIDS (PWAs).<sup>98</sup>

There are a wide variety of religious organizations and NGOs that provide psychosocial and social support to seafarers<sup>99</sup> at major ports throughout the world,

including southern Africa. The International Society of Seafarers Welfare has HIV/AIDS-awareness materials available in different languages on their website,<sup>100</sup> although none are specific to southern Africa.

## Recommendations

- Trucking companies could establish rest stops that offer security, meals and rest facilities for drivers. Such rest stops could significantly reduce risky sexual behaviour.
- Governments can be more supportive of transport sector initiatives and take stronger action to speed up border-crossing formalities.<sup>101</sup>
- HIV/AIDS activities should be prioritized in border towns. Yet, national prevention programmes tend to be weaker at border towns/international ports, despite the fact that mobile populations can be reached more effectively at international borders than at other points along their routes.<sup>102</sup> Since men and women show increased risk behaviour in cross-border communities, risk-reduction strategies should adopt a contextual and community response thus going beyond approaches that focus strictly on the individual.<sup>103</sup> This entails targeting entire communities, including the transient groups (such as the truck drivers, commercial sex workers, traders, etc.) that move in and out of areas.
- HIV/AIDS programmes should also be implemented in cities that lie close to borders where high-risk activities occur (as is the case in Lesotho, Mozambique and Swaziland).<sup>104</sup>
- Programmes need to be coordinated regionally, where possible, with consistent and complementary prevention strategies implemented on both sides of a border.<sup>105</sup>
- Low-cost pre-packaged STI treatment kits (that contain antibiotics for men with urethritis, gonococcal or chlamydial infection, condoms and information on HIV and STI prevention) could be distributed. The kits are often subsidized and marketed over-the-counter in settings where antibiotics are being sold without medical prescription. They are ideally suited for the male traveller who may not have time for a clinic visit, but can afford to buy an inexpensive prevention package.<sup>106</sup>
- Establish national and regional (SADC) HIV action plans for the transport sector which include addressing root causes of HIV vulnerability, such as working conditions of transport workers.

- Integrate the transport sector into national AIDS plans and include key representatives of the transport sector in multi-sectoral National AIDS Councils.
- Use SADC Code of Conduct on HIV/AIDS and Employment and UNGASS Declaration of Commitment as advocacy tools to enforce compliance with agreed commitments of governments and employers

**TABLE 4**  
**RECOMMENDATIONS FOR INTERVENTIONS WITH TRANSPORT WORKERS,**  
**BY STAGE OF MOBILITY**

Recommendation	Particular relevance to*			
	Source	Transit	Destination	Return
Create a climate that encourages disclosure and openness about HIV infection	✓	✓	✓	✓
Incorporate HIV/AIDS and STI topics into the general occupational health/safety training or technical training for transport workers	✓			✓
Involve transport workers, unions and employers in HIV programmes	✓	✓	✓	✓
Conduct more in-depth research into sexual behaviour patterns of transport workers	✓	✓	✓	✓
Provide comprehensive medical aid schemes which include VCT, treatment of opportunistic infections and ideally, ARVs in the long term	✓			
Increase interactions with nearby community and include CSW and community stakeholders in programme design		✓	✓	
Develop secure rest stops along major transport routes and enhance security conditions at truck stops to reduce vulnerability to hijacking and crime		✓	✓	✓
Develop policies that provide for safe and clean accommodation along major transport routes		✓	✓	✓
Focus HIV/AIDS activities in border towns and nearby cities		✓	✓	
Consistent and complementary prevention strategies and messages, implemented on both sides of a border	✓	✓	✓	✓
Involve transport workers spouses/partners in prevention and care programmes	✓			
Provide reproductive/sexual health services incl. low-cost or free STI treatment packs along transport routes		✓	✓	✓

Recommendation	Particular relevance to*			
	Source	Transit	Destination	Return
Speed up and harmonize immigration and customs regulations across the SADC region to minimize time spent at borders		✓		
Provide entertainment/recreation at major transport hubs		✓	✓	✓
Reduce the length of time away and allow transport workers to bring along family members for long-haul trips where possible		✓	✓	✓
Provide condoms and information on correct condom use	✓	✓	✓	✓
Develop and implement HIV prevention campaigns for transport workers and CSWs in high-risk areas		✓	✓	✓

Note: A given intervention might well be appropriate throughout several stages of the mobility process, but it is *particularly* relevant at the stage checked.

# MINE WORKERS

## Vulnerability to HIV/AIDS

Mineworkers, like the other mobile population groups surveyed in this report, are characterized by a transient lifestyle and a vulnerability to HIV/AIDS that is exacerbated by their living and working conditions. Mines are often located in remote and inhospitable areas, and often employ workers drawn from distant communities. Typically, the workers are young men from rural areas, who now work in dangerous, stressful conditions, and who live in single-sex hostels with easy access to CSWs and alcohol. Their living and working environment provide ideal conditions for the spread of an infection such as HIV.

Epidemiological surveys among mine workers in southern Africa show very high HIV prevalence. In March 2001, Zambia's Konkola Copper Mines reported that of the 8,523 workers surveyed, 18 per cent were found to be HIV-positive. Konkola accounts for about two-thirds of Zambia's copper output.<sup>107</sup>

In interviews with mine workers in a South African gold mine, issues such as working and living conditions at the mines, the ever-present risk of accidents, and mine workers' perceived lack of control over their health and well-being were consistently highlighted.<sup>108</sup>

In the mines, workers engage in physically taxing and dangerous work for 8-12 hours a day, with infrequent breaks, limited access to food and water, and in sweltering and dusty conditions. Mine workers live with the constant prospect of mutilating or fatal accidents. Indeed, occupational injuries and diseases are more common in mining than in any other sector of industry.<sup>109</sup> The average gold miner faces a one-in-forty chance of being killed on the job and a one-in-three chance of suffering a reportable injury during a 20-year mining career.<sup>110</sup> There are often limited channels for airing grievances or complaints. The upshot is a relative lack of control over one's fate, which shapes the ways in which miners might approach other dangers. The distant risk of AIDS appears faint when compared to the daily odds of being maimed or killed in the mine.<sup>111</sup>

Compounding all this is the fact that most mine workers live some distance from their homes and families, in large single-sex hostels, with up to 18 people sharing a room.<sup>112</sup> These settings offer limited social support and scant opportunities for intimacy. In conditions of loneliness and isolation, sexual intimacy comes to symbolize a

form of emotional intimacy that may be lacking in other areas of their lives.<sup>113</sup> Mine-workers describe compound life as dirty and overcrowded, with no privacy. Opportunities for leisure are few, which makes drinking and sex with girlfriends, CSWs or other mine workers one of the few recreational activities available on a day-to-day basis.

In such ways, the migrant labour system that has serviced the mines of southern Africa has also generated exaggerated forms of masculine identity that now abet the spread of HIV.<sup>114</sup> Lacking power over their own lives, separated from kin and loved ones, and surrounded by the discipline of work and the peer pressure of colleagues, many mine workers adopt a “macho masculinity” in which manhood is equated with prolific sexual prowess.<sup>115</sup>

Mining communities also tend to have a less-developed health infrastructure, and available facilities are often under-utilized due to workers’ lack of familiarity with the area. For foreign mine workers, HIV/AIDS prevention programmes are often not accessible or effective because of cultural and language differences.<sup>116</sup>

Mineworkers are seen as bridging populations in a sexual network that links transient and residential communities. For example, Basotho workers in the South African mining industry provide a valuable monetary lifeline to extended families in Lesotho. If they lose that capacity and return home, the loss of income drives poor communities deeper into poverty. This exacerbates the HIV/AIDS risk, as migrants’ spouses and children may be forced to offer sex in exchange for money and food. Similarly, the tradition of “going-home-to-die”<sup>117</sup> is familiar in the rural communities from which many migrant workers come, and could place even greater economic pressure on the infected individuals’ families and communities.

Generally, men who live away from their families, as well as the spouses of migrants, are more likely to have multiple sex partners and to maintain links to more than one “family”.<sup>118</sup> A study in South Africa’s Limpopo province showed that migrant mineworkers who return home three times or fewer annually, report more concurrent partners than other men.<sup>119</sup> Most migrant mineworkers who return home four or more times a year appear to be at significantly lower risk of HIV infection than other men working in the same area. This indicates that the commonly held assumption that migration itself leads to higher risk behaviour is not always justified, and that high risk behaviour can be as widespread among rural men as their urban counterparts.

In another South African study<sup>120</sup> male migrant mineworkers were found to be 2.4 times more likely to be infected with HIV than non migrant men. Migrant couples were also significantly more likely to be HIV discordant (one partner infected, the other not) than non migrant couples. Significantly, among these discordant couples the woman was the infected partner in nearly 40 per cent of the cases. This seems at odds with the common assumption that it is principally migrant men who become infected while away and who then return home to infect their rural partners. These findings highlight the need to improve the understanding of sexual networking in migrant sending areas. It might be that the socio-economic situation in many migrant sending areas forces women to sell or barter sex for essential goods and services.

## Relevant policies and programmes

Many gold mines are investing in the development of a range of innovative HIV/AIDS awareness and educational interventions. However, many still rely on traditional information-based awareness programmes that are provided to largely passive audiences.<sup>121</sup>

A SADC Protocol on Mining came into effect in September 1997. It has been ratified by 12 member states, including Botswana, Mozambique, Namibia, South Africa, Zambia and Zimbabwe.<sup>122</sup> The protocol, however, does not address HIV/AIDS explicitly but focuses on environmental protection, small-scale mining and occupational health and safety. A SADC HIV/AIDS Strategic Framework and Programme of Action was established in 2000.<sup>123</sup> It outlines plans and strategies for dealing with the epidemic for all SADC sectors. Within this strategic framework, a section relating to mining is enunciated, which includes:

- establishing the extent of HIV/AIDS in the SADC mining sector;
- minimizing the spread of HIV/AIDS in the mining sector; and
- providing adequate care for the infected and affected in the mining sector.

The main thrust of these strategies appear to be aimed at dealing with the economic impact of HIV/AIDS on the sector, rather than the preventing HIV infection.<sup>124</sup> The SADC HIV/AIDS strategic framework has been guided by the SADC Protocol on Health,<sup>125</sup> which recognizes the need for policies and procedures to be devised and carried out by member states. However, it takes little cognizance of the vulnerability of specific groups such as mobile populations.



## Government

South Africa's White Paper on Mining and Minerals (in which dates to October 1998)<sup>126</sup> outlines the need to develop an HIV/AIDS policy, the plight of migrant labour, housing and living conditions and the respective responsibilities of government and employers in addressing these issues. It also emphasizes the need to protect human and labour rights in relation to education, counselling, testing and treatment. The White Paper<sup>127</sup> recommendations include:

- A range of tenure types should be offered to workers, including rental accommodation, home ownership and social housing. Housing options should include single and family accommodation, accommodation in nearby settlements where feasible, and accommodation in mineworkers' home areas. The principle of choice for mineworkers from a wide range of flexible housing options should apply;
- Existing hostels on mines should be converted steadily into family units and into single units for mine workers without families or who choose not to live with their families. The provision of family housing should include community and education services and facilities;
- Each mine should, in conjunction with representative trade unions, be required to draw up a five-year plan for the improvement of living conditions for workers, incorporating specific targets;
- The management of hostels must be democratized so that residents participate jointly with mine management in all areas of decision-making around the running of the hostels.

The White Paper also specifically mentions the need to address migrant labour issues, and deals with other important issues such as the right to citizenship, suitable living conditions, remuneration levels and the disintegration of families.

Namibia's Ministry of Mines and Energy, in partnership with unions and relevant private corporations, is also targeting families of employees and "relevant communities" for HIV/AIDS prevention, condom distribution, and care and support programmes.<sup>128</sup>

In Zambia, the Ministry of Energy and Water Development has recognized the loss of human resources, lower productivity due to illness and funeral attendance, and the costs of recruiting and retraining new staff as high HIV/AIDS mortality rates take their toll among staff. The 2001 work plan included the training of designated "HIV/AIDS focal persons" and health committees, distribution of male and female condoms, establishing counselling centres, and providing support through peer education.

## Private sector

A recent development by Lonmin Platinum in Rustenburg, South Africa, has seen the building of family housing in an effort to stem the spread of HIV and nurture a more stable workforce. The emphasis appears to be on replacing crowded, all-male accommodation with low-cost family housing. This is being done in several ways, including building new houses, converting old hostels into family dwellings and offering financial stipends to miners who live off company property and wish to have their families present.<sup>129</sup>

The Lesedi Project is a model of best practice in the Mining Sector in South Africa's Free State province.<sup>130</sup> This project has reduced the prevalence of STIs among mineworkers and CSWs by using periodic presumptive STI treatment among CSWs. The project demonstrated that STI interventions are a cost-effective means of preventing STIs, including HIV infection at the mines.

AngloGold, a South African mining company, is striving to ensure that STI treatment services, amongst other health care services, are readily available on-site. In an attempt to reduce new HIV infections and mitigate the impact of HIV/AIDS, the company maintains a clinic and wellness centre, and is in the process of providing anti-retrovirals to the workforce.<sup>131</sup> AngloGold has also signed an agreement on HIV/AIDS in the workplace with various trade unions.<sup>132</sup> In many respects a progressive policy, the agreement recognizes the combined role of all stakeholders in combating HIV/AIDS and supports an approach that includes prevention and care. It makes provision for counselling, awareness, education, testing and disclosure, and highlights the need to address housing issues:

In accordance with the NUM/COM 2001 Wage Agreement, AngloGold will, within the parameters of affordability and employee preference, involve its best endeavours to accelerate programmes of making family accommodation available, including the conversion of hostels and utilization of empty houses.<sup>133</sup>

Goldfields mining company established an HIV/AIDS in the Workplace Policy<sup>134</sup> in December 2001 that resembles that of AngloGold. It emphasizes the need for interventions and programmes to focus not only on workers but on their communities and families. Its three-pronged approach includes education, home-based care interventions and counselling.

In Botswana, the Debswana Diamond Company has developed a comprehensive HIV/AIDS policy and strategy. Its Jwaneng Mine AIDS programme is a good exam-

ple of the private sector's growing involvement in the fight against HIV/AIDS. Started in 1992, the programme has a pro-active management committee, an HIV Policy and provides for support groups and services. The HIV/AIDS Programme Coordinator manages the activities of the various support structures and links with national AIDS management structures, including NGOs. The programme addresses mineworkers, their families and the wider community, and has three main components: AIDS awareness (mainly through IEC), Education (peer education programmes, gender workshops) and Care (VCT, Home Based Care and ARVs).<sup>135</sup>

## **Trade unions**

The South African National Union of Mineworkers (NUM) has established an HIV/AIDS policy that addresses the issue of single-sex housing.<sup>136</sup> This policy was created in line with other legislative instruments (such as South African Constitution, Mine Health and Safety Act, Labour Relations Act, Employment Equity Act and the Basic Conditions of Employment Act) and takes the rights of workers into account.

In dealing with the living conditions of mine workers, the NUM Policy<sup>137</sup> calls for management commitment to provide family housing, facilities for visiting wives and other members, and humane hostel management.

## **Recommendations**

- The risky nature of the mining environment makes it difficult to bring about behaviour change among mine workers. Thus, the response to HIV/AIDS in the mining sector should take into account the social, cultural and psychological pressures facing this group and the community contexts that facilitate the spread of HIV infection.<sup>138</sup> A collaborative relationship needs to be established between governments, mining organizations and unions to ensure that the mechanisms for dealing with the epidemic are holistic and involve all stakeholders.
- While many mines made substantial efforts to establish HIV prevention programmes relatively early in the epidemic, these appear to have had little impact. Campbell and Williams argue that the energy devoted to biomedical/behavioural prevention programmes or to individual human rights issues has served to obscure the social and developmental dimensions of HIV transmission.<sup>139</sup> They suggest developing a more holistic approach to HIV management in an industrial setting by conceptualizing HIV as a social and development issue that has to be addressed not only at

the level of specific mines, but also at the level of the communities in which the mines are located.

- It is essential that HIV and STI prevention programmes in mining communities include all sexual partners, including CSWs who are often excluded from such programmes due to the stigma and discrimination that surrounds them. Studies by the Council for Scientific and Industrial Research (CSIR) in South Africa among mineworkers in Carletonville have shown that the inclusion of sex workers in programmes can lead to an increase in visits of their clients to STI clinics.<sup>140</sup>
- Other studies have shown that STI services are cost-effective. However in the context of mobile populations, such as CSWs, it is estimated that the cost-effectiveness would improve two- to threefold by scaling up such services to cover all the major high-risk areas in their social networks. Issues of sexual networks always present a challenge to evaluating STI services, as the effects register not only in the target group but also throughout their sexual networks (which may consist of both high and low-risk populations).<sup>141</sup>
- One study in a mining community in South Africa showed that there is a strong link between sexual health and “social capital”.<sup>142</sup> This relates to the cultivation of community cohesion via the membership of local voluntary associations such as sports clubs and youth groups. Findings of the study show, amongst others, that young men and women who belonged to sports clubs were less likely to be HIV-positive, and young women who belonged to sports clubs were more likely to use condoms with casual partners than non-members. If such initiatives can reduce an individual’s vulnerability to HIV/AIDS, they could be replicated in other countries.
- Recent analyses<sup>143</sup> indicate that family housing could substantially reduce HIV transmission among migrants and their partners in South Africa – by as much as 41 per cent. This policy alternative should be examined closely to assess its viability and use as a prevention method.
- Integrate the mining sector into national AIDS plans and include key representatives of the mining sector in multi-sectoral national AIDS councils.

TABLE 5  
RECOMMENDATIONS FOR INTERVENTIONS WITH MINE WORKERS,  
BY STAGE OF MOBILITY

Recommendations	Particular relevance to*			
	Source	Transit	Destination	Return
Create a climate that encourages disclosure and openness about HIV infection	✓	✓	✓	✓
Remove conditions that cause (unintended) migrancy and develop sustainable rural programmes in mineworker-sending areas	✓			
Improve working conditions (e.g. medical aid, working hours, establish complaint procedures and support groups)			✓	
Improve living conditions (privacy, family-friendly housing, and home ownership or rental)			✓	
Increase interactions with nearby community and include community stakeholders, including CSWs, in programme design			✓	
Increase entertainment and recreation facilities (e.g. sports, youth clubs, video, table tennis, etc.) on mines and in surrounding communities			✓	
Manage STIs (possibly through presumptive treatment), and provide better health education and access to health services	✓		✓	
Facilitate trade union/worker and company partnerships in HIV education and care			✓	
Reach the spouses and regular partners of mine workers with HIV prevention activities	✓			✓
Develop and implement HIV prevention campaigns for mineworkers and CSWs	✓		✓	
Provide condoms and information on correct condom use	✓	✓	✓	✓
Conduct more research on sexual knowledge, attitudes and practices among mineworkers, especially on MSM and sexual violence among mineworkers	✓		✓	

Note: A given intervention might well be appropriate throughout several stages of the mobility process, but it is *particularly* relevant at the stage checked.

## **WORKERS IN THE CONSTRUCTION SECTOR AND OTHER MAJOR INDUSTRIES**

### **Vulnerability to HIV/AIDS**

Like mine workers, construction workers are generally young men. Construction work is characterized by relatively short-term work on a variety of sites. By removing workers from their families and support systems for extended periods of time, this nomadic “on-site” lifestyle increases their vulnerability to HIV infection. Often living in all-male housing in isolated areas that offer little diversion or recreation, workers are more likely to indulge in risk-taking behaviour such as alcohol abuse and unsafe casual sex.<sup>144</sup> In addition, their comparative wealth enables them to purchase sex from sex workers in the community.

The construction sector develops major transport and infrastructure routes that are often HIV risk areas due to the steady flow of people along them. Large construction projects can require opening new transport links (whether road or rail) through isolated and impoverished communities. In Malawi, road construction has been linked to the spread of HIV,<sup>145</sup> while in Lesotho the Highlands Water Project has led to an increase in STIs in the remote mountain areas.<sup>146</sup>

Research conducted by construction industry stakeholders and the South African Department of Public Works (DPW) indicates that the industry has the third highest HIV incidence among economic sectors in that country. If allowed to persist, this situation will negatively affect the South African economy, as productivity decreases and the costs of replacing and retraining workers rise.<sup>147</sup>

The experiences of other industrial workers (e.g. clothing and textile, manufacturing or chemical workers) in relation to the epidemic do not appear to be well-documented. These workers appear not to share specific patterns of recruitment or placement that place them at specific risk to HIV/AIDS. Nevertheless, many industrial workers do work in areas distant from their own communities, even if their living conditions might be less isolating and estranged than those of mine and construction workers. In Lesotho, for example, women are the primary workers in the clothing manufacturing industry. They migrate to the factories from other areas (leaving children in the care of grandparents or other family members). Meanwhile, many of their spouses work in South Africa as migrants.

## Relevant policies and programmes

### Governments

South Africa's Department of Public Works (DPW) has launched a project aimed at building awareness about the HIV/AIDS pandemic in the construction industry.<sup>148</sup> The overall goal is to improve health and safety in the industry by implementing awareness campaigns on DPW projects. The strategy is aimed at addressing issues such as HIV/AIDS training and prevention programmes, encouragement of voluntary HIV/AIDS and STI testing, the creation of a non-discriminatory working environment, the establishment of counselling and referral systems for support and care, and the promotion of respect for the rights and obligations of individuals, as well as employer responsibility.<sup>149</sup> Once the pilot project phase is completed, implementation of the strategy will become mandatory for all contractors tendering for DPW contracts. The Department's procurement process will be amended to ensure enforcement of this requirement.

In Lesotho, the Ministry of Works, Department of Rural Roads plans to supply free condoms to employees. In Namibia, ministries' and unions' respective works, transport, and communication companies will ensure condom social marketing and care and support services.<sup>150</sup> In Zambia, the Ministry of Works and Supply has established a workplace-specific HIV/AIDS work plan for workers and their families. The plan calls for the formation of a health committee, establishment of workplace condom distribution centres, and a travelling theatre group to "sensitize workers on the messages of the HIV/AIDS campaigns".<sup>151</sup>

### Trade unions

In South Africa, the National Union of Mineworkers (NUM) also organizes workers in the construction industry. It has an established HIV/AIDS Policy<sup>152</sup> that pinpoints the vulnerability of employees in the construction sector due to poor housing conditions.<sup>153</sup> However, since the majority of NUM members are mineworkers, the trade union's policy tends to focus more on them than on construction workers.

The Southern African Clothing and Textile Workers Union (SACTWU) has adopted what it regards as a groundbreaking HIV/AIDS Policy.<sup>154</sup> Despite being a progressive and practical policy, it does not address the needs of mobile populations directly. The policy covers testing and counselling, home-based care, education and the provision of anti-retroviral therapy. It also addresses the issue of dependants and proposes

innovative use of collaborations and the education of shop stewards to help ensure that educational messages are conveyed in the workplace.

## **Private Sector**

A framework agreement has been drafted between the South African Federation of Civil Engineering Contractors (SAFCEC), the NUM, and the Building Construction Allied Workers Union (BCAWU) to combat the spread and impact of HIV/AIDS in the industry. The agreement was formally signed in January 2003. Lifeline Southern Africa has been identified as the preferred service provider and employers will pay a monthly fee per worker to finance the HIV/AIDS programmes.

## **Recommendations**

- On-site training programmes can serve as an important vehicle for AIDS education and for encouraging support of HIV-infected and -affected workers. It is suggested that the construction industry enters into collaborative partnerships with surrounding communities to find ways of extending cooperative housing and social services.
- It is vital that the industry takes into account the factors that render individuals susceptible to HIV infection (such as long periods away from families) and make every effort to combat those factors.<sup>155</sup> Regular family visits should be encouraged and work schedules could be revised to enable more contact between construction workers and their spouses. Steps such as these could go a long way towards narrowing the risk of HIV infection.
- As well, governments can encourage the employment of local labour, and require building and maintenance contracts to integrate this. The construction sector can also link up with national HIV/AIDS control programmes to ensure the sector is included in relevant activities.
- Reducing the exposure to HIV during road building and maintenance programmes (for both workers and local communities) would involve several agencies and organizations. Governments and private sector firms using a mobile labour force can, through training, increase awareness of HIV/AIDS and improve the sexual health of workers and CSWs. On-site health services should be available and should include HIV/AIDS education; distribution of condoms and treatment of STIs.



- Integrate the construction sector into national AIDS plans and include key representatives of the construction sector in multi-sectoral National AIDS Councils.

TABLE 6

RECOMMENDATIONS FOR INTERVENTIONS WITH THE CONSTRUCTION SECTOR AND OTHER MAJOR INDUSTRIES, BY STAGE OF MOBILITY

Recommendations	Particular relevance to*			
	Source	Transit	Destination	Return
Develop policies that create an enabling environment and encourage disclosure and openness about HIV infection	✓	✓	✓	✓
Encourage a sense of community on the job-site that includes all workers and involves surrounding communities (incl. CSWs) in HIV/AIDS prevention and care efforts			✓	
Management of STIs (possibly through presumptive treatment), health education and access to health services close to/at the job site			✓	
Encourage businesses, trade unions and governments to form partnerships and address the HIV vulnerability of mobile populations in their HIV/AIDS policies and programmes			✓	
Improve living and working conditions (e.g. family housing, medical aid, working hours, establish complaint procedures and support groups)			✓	
Develop recreational programmes such as sports and entertainment both at the job-site and in surrounding communities			✓	
Reach the spouses and regular partners of mobile workers in this sector with HIV prevention activities	✓			
Develop and implement HIV prevention campaigns for mobile workers and CSWs			✓	
Provide condoms and information on correct condom use	✓	✓	✓	✓

Note: A given intervention might well be appropriate throughout several stages of the mobility process, but it is *particularly* relevant at the stage checked.

# AGRICULTURAL FARM WORKERS

## Vulnerability to HIV/AIDS

The commercial agriculture sector is vitally important to most developing countries. It contributes substantially to the GDP, is often the largest single employer of wage labour, and can be essential for achieving food security in a country.<sup>156</sup> But farm workers in this sector are vulnerable to HIV in much the same way as mobile workers in the mine and construction sector. Not only do their living and working conditions place them at risk,<sup>157</sup> but they are accorded very little rights and labour protection:

- Farm workers often live in compound accommodation, tents or shacks that are unhygienic, overcrowded and lacking in privacy;
- Casual and commercial sex is common on or near commercial farms;
- Commercial farms are characterized by a high incidence of STIs and other common diseases;<sup>158</sup>
- Most farms do not have HIV/AIDS programmes or STI services and workers' access to health care services is often poor;
- The sector employs many undocumented farm workers and border-crossers who are reluctant to access health services for fear of revealing their work status to the authorities and risking deportation. As a result, there is a major burden of untreated STIs among migrants;<sup>158</sup>
- Many farm workers have seasonal contracts which increase their mobility;
- Recreation facilities are sorely lacking often;
- Income-earning opportunities are strikingly unequal for men and women;

In Zimbabwe and South Africa, many farm workers are migrants who enjoy little if any legal protection. A recent farm workers survey in Zimbabwe notes that a large percentage of farm workers in Zimbabwe are from Malawi, Mozambique and Zambia.<sup>159</sup> A study by the Southern African Migration Project (SAMP) in 2000 South African Commercial Agriculture found that most foreign migrants working on South Africa's commercial farms endure extremely poor working and living conditions.<sup>160</sup> The study documents shocking wage levels on many farms, ranging from 2 SAR per day (approximately US\$ 0.20) to 23 SAR per day (approximately US\$ 2.30). The same study found difficult working conditions with long working hours and working weeks of up to seven days. Remuneration is often late, wages are not paid in full and in some cases workers are not paid at all (some farmers would deliberately hire undocumented workers and report them to the police shortly before pay-day).<sup>161</sup>

Temporary workers are the worst-paid and lowest-skilled people on farms. The duration of their work stints ranges from mere days to months. Seasonal workers may be employed for longer periods of time, but the work and conditions are insecure and trying. Permanent workers earn the highest wages and enjoy better conditions of work; on some farms they may belong to medical aid schemes, with their employer contributing to the Unemployment Insurance Fund.<sup>162</sup> The SAMP study found that most farms do not have grievance committees, and those that do exist are of limited value to seasonal migrant farm workers.<sup>163</sup>

South African border farmers appear to be drawing on cross-border migrants to meet their temporary and seasonal labour needs. Farmers hire undocumented migrants, particularly during harvesting, for three reasons. First, the workers are available and accessible. By their own accord, the workers arrive at the right times of the season seeking employment. Second, the official channels for soliciting workers are slow and cumbersome by comparison. And, third, some farmers prefer to hire workers who lack the required documentation because they are cheaper and are more easily exploited. The threat of exposure (coupled with the knowledge that the farmer himself is seldom prosecuted) can, and is used to keep workers in line.<sup>164</sup>

In South Africa, foreign farm workers are virtually “invisible” and lack a “voice”. Most of them are concentrated in border areas or where major migration routes cross commercial farming districts. Many of these areas are relatively remote and difficult to monitor. Those in the country clandestinely have a vested interest remaining as invisible as possible to the authorities – a defensive option which, paradoxically, also renders them more vulnerable to exploitation and abuse.<sup>165</sup>

Estimates of the number of Mozambicans working on farms in Mpumalanga province (South Africa) range from 10-80,000, while between 7,000 and 80,000 Zimbabweans work seasonally on farms in South Africa’s Limpopo province. Upwards of 7,000 Basotho seasonal farm-workers are estimated to be employed on asparagus farms in the Free State province (South Africa).<sup>166</sup>

Considerable confusion and uncertainty surrounds the regulatory mechanisms that govern the hiring of foreign farm workers in South Africa. For instance, no official agreement with Zimbabwe, a major supplier of labour in South Africa, underpins the hiring of Zimbabwean workers. There is also wide, local-level variation in the ways in which Mozambican, Basotho and Zimbabwean migrants are allowed to enter and work. The effective policing of undocumented migration is hampered by these local-level formal and informal “deals” among officials, farmers and labour recruiters.<sup>167</sup>

The many female farm workers who work in this sector are particularly vulnerable to HIV infection because of sexual harassment and abuse. About 15 per cent of the women migrants interviewed in the SAMP study reported having being raped or knowing someone who had been raped or sexually harassed while working on Free State farms, for example. One interviewee described sexual violence and abuse as a very common occurrence, but said most women were too afraid or embarrassed to report the incidents for fear of losing their jobs.<sup>168</sup> Rape and child abuse were also cited as major concerns of Zimbabwean female farm workers interviewed during a recent IOM/CARE study in the Limpopo province. Blame was pointed mainly at male Zimbabwean border-crossers, but further investigation revealed that South African soldiers were also highly feared by female residents.<sup>169</sup>

Female farm workers may also be forced to engage in sexual relations to supplement their meagre wages or food rations or to gain liberties such as being able to slip away from the farm, receive lighter work duties, or work shorter hours.<sup>170</sup>

## **Relevant policies and programmes**

Policy reform in the commercial agriculture sector is urgently needed. Governments in the SADC region need to establish clear and standardized policies that cover foreign farm workers. It is clear that these workers fill an important gap in the labour market in the region. Therefore there is a need for policies that support a system of controlled access that is workable and manageable.<sup>171</sup>

Most policies that deal with HIV/AIDS in the agricultural sector appear to focus on mitigating the epidemic's impact rather than preventing infection. Even then, there are only a few examples of prevention activities, such as the commercial farm worker peer education programmes in Zimbabwe, where the Commercial Farmers Union (CFU) established an intensive peer education and condom supply programme among farm workers.

The sector can serve as a powerful conduit for information and training on HIV prevention, as well as provide opportunities for youth to learn essential life skills and agricultural skills. More commercial farmers can introduce farm worker education and support programmes such as those developed and implemented in Zimbabwe.<sup>172</sup> In addition, commercial farms can organize living arrangements that accommodate family members of migrant workers.

In Lesotho, the HIV/AIDS Strategic Plan of the Ministry of Agriculture and Marketing recognizes the importance of targeted communication channels (for example,

for personnel, youth farmers, herd boys, agriculture association members) and reinforced behaviour change messages via HIV/AIDS radio broadcasts, competitions, public gatherings of extension workers, and district and central agricultural shows.

## Recommendations

- A CARE/IOM Regional Migration Study in South Africa and Zimbabwe, carried out in 2002, found that migrants' rights were systematically violated in ways that increased their HIV vulnerability. It is essential, therefore, that HIV/AIDS programmes for migrants adopt a rights-based approach.<sup>173</sup>
- The commercial agricultural sector is both varied and complex. Distinctions can be drawn between resident farm workers, tenant labour, commuter labour and migrant labour, for example. In some areas (such as South Africa's Mpumalanga province) all four labour categories can be found, while only one or two might be present in other areas. Nevertheless, migration management policies have to reflect and respond to such local dynamics and conditions.<sup>174</sup>
- The commercial farm sector, in collaboration with employee welfare organizations and NGOs, should address the social and economic environments in which behaviours are shaped and perpetuated. This includes improving and expanding workers' access to social facilities, improving sanitation and general hygiene in housing estates, combating violence against discrimination against women, and mounting campaigns to reduce alcohol abuse.<sup>175</sup>
- Foreign migrant workers on commercial farms should be regulated, not arrested and deported. Strictly punitive strategies are not only likely to fail, but they also aggravate the vulnerability of undocumented workers on commercial farms.<sup>176</sup>
- There is disagreement whether the unionization of farm workers would indeed improve the conditions of foreign migrants in the short- to medium-terms.<sup>177</sup> In South Africa, trade unions have been struggling to organize permanent workers on farms, let alone foreign seasonal workers. In addition to opposition from farmers, trade unions wishing to organize farm workers have had to contend with a fragmented workforce that is scattered across vast distances. However, conditions on commercial farms in other countries might be more conducive to effective unionization of farm workers.
- Integrate the commercial agricultural sector into national AIDS plans and include key representatives of the commercial farming sector in multi-sectoral National AIDS Councils.

TABLE 7  
RECOMMENDATIONS FOR INTERVENTIONS WITH AGRICULTURAL FARM  
WORKERS, BY STAGE OF MOBILITY

Recommendations	Particular relevance to*			
	Source	Transit	Destination	Return
Create a climate that encourages disclosure and openness about HIV infection	✓	✓	✓	✓
Remove conditions causing (unintended) migration and develop sustainable rural programmes in migrant-sending areas	✓			
Improve living and working conditions (e.g. family housing, medical aid, working hours, establish complaint procedures and support groups)			✓	
Encourage farmers to provide family-friendly housing that is safe and hygienic with privacy			✓	
Increase HIV, TB and STI campaigns and programmes on farms, especially during harvesting and times of a high influx of seasonal workers			✓	
Increase access to health care services, incl. STI services (possibly through mobile clinics), with possible presumptive treatment of STIs for farm workers and CSWs			✓	
Encourage and strengthen workers organizations/associations and unions for farm workers			✓	
Provide condoms and information on correct condom use		✓	✓	✓
Provide entertainment/recreation facilities on farms			✓	
Improve legal rights and protection of farm workers	✓		✓	
Develop public education programmes that address xenophobia and show foreign migrants are important contributors to economic growth who should be afforded rights and protection	✓	✓	✓	✓
Promote knowledge of human rights among farmers and farm workers			✓	
Reach the spouses and regular partners of farm workers with HIV prevention activities	✓			

Note: A given intervention might well be appropriate throughout several stages of the mobility process, but it is *particularly* relevant at the stage checked.

# INFORMAL TRADERS

## Vulnerability to HIV/AIDS

South Africa is now the seventh-largest trading partner in Africa, catering for its neighbours and “newer” shoppers from Malawi, Mozambique, Zambia, Gabon, Mali and Senegal.<sup>178</sup> According to research by Market Decisions, one in 12 passengers on African flights is a self-employed trader. Traders also travel via taxis or buses, using the major road networks.

Although informal trading often mirrors formal trading,<sup>179</sup> certain aspects of vulnerability to HIV/AIDS may be different, and policies might affect formal and informal traders differently. Several factors affect informal traders’ vulnerability to HIV/AIDS:

- **Length of time away from home.** Many informal traders spend long periods away from home – either because they permanently work in another country or because they travel back and forth with their goods. One study has found traders spend between one week and three months away from home.<sup>180</sup>
- **Poor working conditions.** Since most traders are self-employed or part of a micro or small enterprise, they often survive on minimal expenses and cannot afford quality accommodation. It is reported that sleeping at the home of a sex worker is sometimes the only affordable accommodation.<sup>181</sup>
- **Delays at borders.** Traders often spend many hours, even days, at border crossings where high-risk sexual behaviour is often common. Some cross-border traders supplement their income with sex work or trade sex for customs clearance or to hitch a ride to their destination. Female traders are often coerced into sex by customs officials and policemen.<sup>182</sup> There are widespread and credible reports of sexual harassment of Zimbabwean female informal traders and illegal border-crossers by South African border officials/guards, as well as in South African prisons.<sup>183</sup>
- **Lack of policies facilitating the informal sector.** Informal traders have to contend with a daunting array of government regulations and officialdom. Southern African states do not acknowledge that traders should have a “trading visa”; instead they are forced to seek inappropriate visitor, business, work-seeking or work permits. Traders have problems getting a multiple-entry visa and must nego-

tiate each entry and departure. Sometimes, they are required to travel to a primary city and remain there for several days before being issued with a visa.

- **Lack of access to health services.** Like other mobile workers, traders often lack the time or access to health services, including those that treat STIs or that provide information on HIV/AIDS.

There are many myths about informal traders who come to South Africa that encourage xenophobia, thus isolating further from the communities they temporarily work in. Some include:<sup>184</sup>

**MYTHS AND TRUTHS ABOUT INFORMAL TRADERS IN SOUTH AFRICA**

Myths	Truth
Traders come to South Africa to stay and use benefits meant for South Africans	Actually, most traders travel away from their home for only one to twelve weeks. Most leave their families back home and only come for the purpose of work, returning to their families as often as possible <sup>a</sup>
Traders have little or no education	Informal traders are often educated; one study shows that more than 90% of traders have some secondary education <sup>b</sup>
Migrants traders take jobs away from South Africans	Less than half of all migrants are interested in finding formal employment. 61% are handicraft/curio traders at home and do not intend to switch jobs <sup>c</sup>
Migrant traders are in the country illegally	Most of the migrant traders that come to South Africa enter the country legally. Because of the nature of their work, they are often publicly selling their goods thus it would not be beneficial for them to come into the country illegally. According to one trader, despite the difficulties of remaining legal in South Africa, imost are prepared to suffer the inconvenience and cost in order to remain legal <sup>d</sup>

Notes: (a) Peberdy, S., iMobile entrepreneurship: informal sector cross-border trade and street trade in South Africa, *Development Southern Africa*, 17(2), June 2000; (b) Peberdy, S., and Crush, J., 1998, *Trading Places: Cross-Border Traders and the South African Informal Sector*, Migration Policy Series No. 6, SAMP, IDASA, <http://www.queensu.ca/samp/>; (c) *ibid*; (d) *Ibid*.

### **Relevant policies and programmes**

There are very few policies in place that deal specifically with informal traders.



## **Government**

Because traders work mainly in the informal sector, most national policies do not make specific reference to traders. However, Zambia's National HIV/AIDS/STI/TB Framework refers to cross-border traders as a highly mobile group. The framework also mentions that casual sex often occurs between female traders and truck drivers, and suggests that informal sector trading is closely related to sexual exploitation.<sup>185</sup> The framework suggests that programmes for traders should be closely linked to programmes for truck drivers as they are often situated in the same areas.

Informal traders are not mentioned in the national policies of most countries nor are employment rights extended to them – often leaving them without legal protection in their own countries and in the host countries.

## **Non-governmental organizations**

Most of the HIV/AIDS initiatives that target cross-border informal traders do so under umbrella projects (such as USAID's Regional HIV/AIDS Project) that target truck drivers and CSWs.<sup>186</sup> The USAID project incorporates traders into peer education programmes with truck drivers and commercial sex workers.

## **Recommendations**

- According to the Southern African Migration Project (SAMP)<sup>187</sup> a new, temporary permit category for individual informal cross-border traders should be introduced. This permit would allow multiple entries, reducing administrative costs, alleviating some of the work done by South African Home Affairs officials and removing the ambiguous and vulnerable status of informal traders. It would also reduce delays at borders and limit opportunities for border officials to extort sex or money from traders.
- Another important way to strengthen the legal rights of informal traders is to encourage regional associations of small traders to help empower and protect traders.<sup>188</sup>

TABLE 8  
RECOMMENDATIONS FOR INTERVENTIONS WITH INFORMAL TRADERS,  
BY STAGE OF MOBILITY

Recommendations	Particular relevance to*			
	Source	Transit	Destination	Return
Revise immigration and visa policies to include a category catering for traders, particularly in South Africa		✓	✓	
Develop public education messages that counter myths about informal traders and resulting expressions of xenophobia	✓	✓	✓	✓
Highlight the position and contributions of informal traders and enhance their business rights	✓	✓	✓	✓
Ensure that all traders are provided with some form of legal protection, either from their host or home country	✓	✓	✓	
Encourage regional associations of small traders to empower and protect traders	✓		✓	
Provide safe inexpensive accommodation at borders		✓		
Sensitize border officials about sexual bribery and the health consequences of HIV/AIDS and STIs		✓		
Prosecute officials that exploit traders by demanding sex and bribes		✓		
Provide entertainment and recreational activities at borders		✓		
Increase access to health facilities at borders		✓		
Provide condoms and information on how to use them correctly	✓	✓	✓	✓

Note: A given intervention might well be appropriate throughout several stages of the mobility process, but it is *particularly* relevant at the stage checked.

# DOMESTIC WORKERS

## Vulnerability to HIV/AIDS

Domestic workers are among the most vulnerable mobile populations in southern Africa, given their poor working conditions and lack of labour rights protection.<sup>189 190</sup> They often lack proper contracts, and employers frequently violate the legal procedures for dismissal.<sup>191</sup> Domestic workers living on employers' property can also be subject to sexual harassment,<sup>192</sup> which renders them vulnerable to HIV infection. Domestic workers are often young women with little formal education and who earn low wages, which compels some to supplement their income with transactional sex.<sup>193 194</sup>

## Relevant policies and programmes

None of the countries surveyed in this desk review appear to have direct HIV/AIDS policies for domestic workers – although Botswana, Namibia and South Africa have addressed domestic workers in their general employment legislation.<sup>195</sup>

South Africa's Basic Conditions of Employment Act fixes a minimum monthly wage of R600-800 (approximately US\$60-80) for domestic workers in urban areas and R498-527 (approximately US\$50) for those in rural areas. The legislation also contains regulations and guidelines regarding leave benefits.<sup>196</sup>

Provisions for workers' rights protection in Namibia's Constitution were strengthened by the 1992 Labour Act, which emerged out of tripartite consultations between government, employers and workers. It places domestic and farm workers on an equal footing with other workers – a breakthrough. The Act legislates certain basic minimum standards of employment, introduces the concept of "unfair dismissal" into the law and provides a framework for industrial relations. Unfortunately, the Act does not yet fully reflect the unique nature of domestic work and the need to provide specific protections for this vulnerable sector.<sup>197</sup> Nevertheless, the Act has the potential to improve the lot of domestic workers. Its enforcement in that sector, however, remains weak. For example, inspections in this sector are undertaken only in response to worker complaints. A few domestic workers have brought cases to district labour courts, but the isolated nature of their working environment means that there

are usually no witnesses to support domestic workers in their complaints, thus making it more difficult for them to press their cases successfully.<sup>198</sup>

Some training initiatives for domestic workers have been staged in recent years, thanks mainly to the ad hoc efforts of a few, dedicated individuals. The response to the training confirms that the demand for such courses is high; domestic workers with specialized training are more employable and can often command higher wages.

In Botswana and South Africa, workshops, education sessions and printed materials on labour rights, domestic violence and HIV/AIDS have been prepared for domestic workers.<sup>199</sup> The Services Sector Education and Training Authority (SETA) in South Africa has launched a programme for conducting training and certifying domestic workers so that they are more employable.<sup>200</sup>

Several trade unions and NGOs represent and support domestic workers. In South Africa the Network Against Child Labour (NACL) has produced the *Basic Employment Conditions for Domestic Workers* booklet, which explains the rules and regulations that apply to domestic workers and employers.<sup>201</sup> The HIV/AIDS section notes that domestic workers cannot be forced to undergo any test or medical examination without the full understanding and approval of the worker. As well, the terms of employment cannot be altered or ended if the worker refuses such a test.<sup>202</sup> In Botswana, a booklet called *Rights of Domestic Workers* has been developed, and an informal group Domestic Workers Foundation has been set up to provide a forum for domestic workers to air their concerns.<sup>203</sup>

TABLE 9  
RECOMMENDATIONS FOR INTERVENTIONS WITH DOMESTIC WORKERS,  
BY STAGE OF MOBILITY

Recommendations	Particular relevance to*			
	Source	Transit	Destination	Return
Create a climate that encourages disclosure and openness about HIV infection	✓	✓	✓	✓
Provide HIV/AIDS training for workers and employers through community organizations such as religious groups, NGOs, etc.	✓		✓	
Ensure that domestic workers have legal protection including access to medical care, decent accommodation, leave, a dignified environment and entitlement to family visits			✓	
Encourage domestic workers to know about their rights regarding criminal prosecution of employers who sexually harass or sexually exploit them; their right to fair labour practices, and access to medical and psychological services after abuse as well as general health care	✓		✓	
Provide condoms and information on correct condom use	✓	✓	✓	✓
Strengthen associations of domestic workers unions and organizations			✓	

Note: A given intervention might well be appropriate throughout several stages of the mobility process, but it is *particularly* relevant at the stage checked.

# REFUGEES AND INTERNALLY DISPLACED PERSONS (IDPS)

## Vulnerability to HIV/AIDS

Refugees are people who have fled their countries due to a well-founded fear of persecution (on the basis of race, religion, nationality, political opinion) and who cannot or do not wish to return. Internally Displaced Persons (IDPs), on the other hand, are people who have fled their homes, but who remain within the borders of their country.

Like other mobile populations, refugees and IDPs can be particularly vulnerable to HIV. However, the conditions of war, conflict and human rights abuses can render refugees and IDPs even more vulnerable to HIV infection.<sup>204 205 206</sup> HIV can spread fast amid impoverishment, powerlessness and social incohesion – conditions that are often at their most extreme during emergencies. HIV/AIDS prevention and care services tend to be severely disrupted, even destroyed in wars and civil strife.

Factors that render refugees and IDPs vulnerable to HIV infection include:<sup>207</sup>

- sexual abuse and violence often accompanies the flight of refugees and IDPs. In some conflicts, rape is used as a tool of repression against certain population groups;
- the break-up of stable relationships and the loss of mutual support, as well as loosening of cultural and familial controls on social behaviour;
- youth may become sexually active earlier than they would normally;
- the occurrence of transactional sex – one of the few survival strategies for people cut off from their normal sources of income;
- the displacement of rural populations to heavily-populated areas, where they can find themselves much more at risk;
- the likelihood of injuries that might require blood transfusions in settings where blood supplies are unsafe.

Once refugees and IDPs move outside their original country or region, their abilities to earn a reliable income diminish or disappear, and many suffer from the stigma associated with their refugee status. Overcrowding, boredom and shortages of food and other basic necessities can engender unsafe behaviour (including drug and alcohol abuse, transactional sex and multiple sexual relationships).<sup>208</sup> In most countries, non-nationals such as refugees are generally not covered by national HIV/AIDS

control programmes<sup>209</sup> or lack access to other public health services. Language and cultural practices may also prevent refugees from accessing social or health services.

At the end of 2001, southern Africa hosted some 365,000 refugees, 21,700 asylum seekers, and 202,000 IDPs. Most refugees in the region reside in Zambia (280,000) and in Namibia (about 31,000). All the region's IDPs are in Angola. South Africa hosts half of the asylum seekers in the region.<sup>210</sup>

## Relevant policies and programmes

Comprehensive policies have been designed to help guide the response to HIV/AIDS for refugees in emergency settings. The WHO/UNAIDS/UNHCR *Guidelines for HIV Interventions in Emergency Settings* (1996) describe five stages of an emergency, each of which requires different HIV/AIDS interventions:

- 1. The destabilizing event.** Ensure safe blood supply, mobilizing funds, collect and develop IEC materials in local languages;
- 2. Loss of essential services.** Ensure safe blood transfusion, access to condoms, material and equipment available for universal precautions, basic HIV/AIDS information;
- 3. Restoration of essential services.** More sophisticated and proactive HIV/AIDS interventions, such as conducting situation analyses (baseline data, research, etc.), identify HIV/AIDS coordinator, prepare work plans, establish partnerships with NGOs, leaders in the refugee community as well as in the local community, IEC activities, regular programme for condom supply and distribution, establish programme for STI control including syndromic management and education, clinical care for people with HIV/AIDS;
- 4. Relative stability.** Strengthening programme infrastructure, surveillance, monitoring and evaluation;
- 5. Return to normality.** Focus on sustainability of programmes after relief organizations withdraw.

Other relevant policies and guidelines include:<sup>211</sup>

- *UNHCR Policy and Guidelines regarding Refugee Protection and Assistance and Acquired Immune Deficiency Syndrome (AIDS) – 1992;*
- *UNHCR Sexual Violence against Refugees, Guidelines on Prevention and Response –1995 (updated in 2002);*

- *UNAIDS Refugee and AIDS, Technical Update* – 1997. This contains the guidelines discussed earlier;
- UNHCR's policy regarding Refugees and Acquired Immune Deficiency Syndrome (AIDS) – 1998;
- HIV/AIDS Post Exposure Preventative Treatment Starter Kits for Staff – 1999;
- *UNHCR Emergency Handbook* – 1999;
- *Inter-Agency Field Manual on Reproductive Health in Refugee Situations*, WHO/UNFPA/UNHCR – 1999.

Zambia has an established National HIV/AIDS/STI/TB Institutional Framework<sup>212</sup> that makes specific mention of refugees and displaced people. It is one of the few available policies that recognize many different mobile population groups and their specific issues.

The stigma associated with refugees and their supposed link with the spread of HIV infection needs to be addressed through HIV/AIDS policies that focus on vulnerability. Refugees and IDPs are entitled to the best possible health care that is available to the local host community or that was available in their home country.

A relevant paragraph from the UNGASS Declaration of Commitment to which all SADC governments committed in June 2001, is the following:<sup>213</sup>

(para. 75) By 2003, develop and implement strategies that incorporate HIV/AIDS awareness, prevention, care and treatment into responses to emergencies and into international assistance programmes.



TABLE 10  
RECOMMENDATIONS FOR INTERVENTIONS WITH REFUGEES AND INTERNALLY  
DISPLACED PERSONS, BY STAGE OF MOBILITY

Recommendations	Particular relevance to*			
	Source	Transit	Destination	Return
Create a climate that encourages disclosure and openness about HIV infection	✓	✓	✓	✓
Develop public information programmes to counter myths and xenophobia about refugees and IDPs	✓	✓	✓	✓
Develop income-generating, education, sports and cultural programmes for refugees, especially for youth			✓	✓
Ensure that refugees have access to information and life skills training for protection from HIV infection			✓	✓
Ensure that refugees have means to protect themselves including access to condoms		✓	✓	✓
Develop and implement training that addresses gender relations			✓	
Focus regional and government attention on the need for HIV/AIDS prevention and care programmes for refugees/IDPs		✓	✓	✓
Strengthen the systems to keep refugee/IDP families together	✓	✓	✓	✓
Provide adequate shelter that prevents overcrowding and sexual abuse		✓	✓	✓
Ensure access to reproductive health services, including STI treatment		✓	✓	✓
Screen all donated blood and provide gloves and other precautions to avoid transmission in health care settings			✓	
Provide access to post-traumatic stress counselling as part of a mechanism to reduce high-risk sex conduct	✓	✓	✓	✓

Note: A given intervention might well be appropriate throughout several stages of the mobility process, but it is *particularly* relevant at the stage checked.

## CONCLUSION

Migration and mobility are complex realities with far-reaching consequences. Reasons for mobility range from professional aspirations to life-threatening catastrophes.

The system of migrant labour in southern Africa, which gathers together young men at work sites while leaving their partners and wives behind in typically impoverished rural areas, is a key factor in the pattern of the region's HIV epidemic, with the cyclical nature of labour migration facilitating the spread of HIV infection. To be effective, a response has to address all stages of the migration process.

Awareness about HIV/AIDS and basic prevention knowledge is quite widespread. However, the knowledge is often not put into practice. This is because current approaches to HIV/AIDS prevention are based largely on persuading individuals to change behaviour, without due regard for the social, cultural and economic contexts in which behaviour is shaped and lodged. This highlights the profoundly social – and economic – dimensions of the epidemic. A response that ignores the cultural, economic and sociological aspects of HIV/AIDS is unlikely to meet with success. This poses a major challenge: the challenge facing SADC governments is to develop policies that impact on the cultural, economic, social and normative factors that make so many southern Africans vulnerable to HIV/AIDS.<sup>214</sup>

A thorough analysis is required to map the geographic and social networks of migrants, which could enable the identification of current and potential risk profiles. The key to success at this stage is the involvement of migrant mobile populations, local communities and other stakeholders. One of the main lessons is the importance of working with and empowering target groups, rather than imposing external programmes that are less liable to be effective and that may even alienate the intended beneficiaries.

Reducing HIV prevalence in the Southern African region will require cutting edge solutions that not only reform the world of work and governance, but also create more respectful human relations. Addressing HIV/AIDS demands not only stimulating radical behaviour change, but constructing a new world of work. It will involve renewed political and corporate accountability.

“Knowing is not enough; we must apply. Willing is not enough; we must do.”  
(Goethe)

## ENDNOTES

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# APPENDIX A

## Acknowledgements

We would like to acknowledge the assistance we received from the following individuals during the data gathering phase of this research.

Name	Organization
Louise Robinson	CARE Lesotho
Puleng Letsie	CARE Lesotho
Charity Sisy	CARE Zambia
Thelma Kwaramba	CARE Zimbabwe
Diane Lindsey	CARE Zimbabwe
Mike St. Louis	CDC
Dr. Tom Kenyon	CDC Botswana
Sister E.C. Mlilo	CLAN Transport, NECTOI
E. Tichawangana	CLAN Transport, NECTOI
Jacqueline Mpolokeng	COSATU
Pulane Lefoka	ERNESA
Barney Curtis	Federation of Southern African Transport Operators
Ferial Haffajee	Financial Mail
Kevin Jauffeau	Ikamji Freight – South Africa
Henning Morr	ILO – South Africa
Paul Matthew	Learning Clinic
Mark Lurie	Medical Research Council
S.R. Makoni	NEC Construction
David Howe	NECTOI Zimbabwe
F. Makanda	NECTOI Zimbabwe
T. Kanengoni	NECTOI Zimbabwe
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Lynn Taylor	SACTWU
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Dr. Sunanda Ray	SafAIDS
Ngoni Chibukire	SafAIDS
Sally Peberdy	SAMP
Anselm Tapfumanei	Silveria House – Zimbabwe
Matthew Roberts	SMARTWork
Rene Loewenson	TARSC Zimbabwe
Simon Mphisa	UNICEF
Prof. Sheldon Weeks	University of Botswana
Michele Russell	USAID – South Africa
Patrick Osewe	USAID – Zimbabwe
W. T Chibebe	ZCTU – Zimbabwe
Joyce Nonde	ZUFIAW Zambia

## APPENDIX B

### National and Sector HIV/AIDS Policies in the Member States of the Southern African Development Community (SADC)<sup>1</sup>

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## **Endnote**

1. The same bibliography database is also hosted on [www.cadre.org.za](http://www.cadre.org.za).