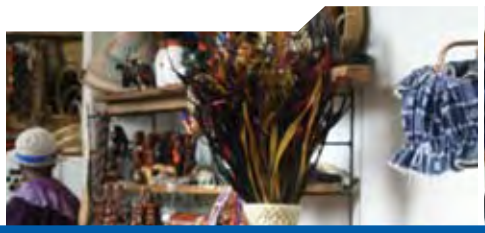
IOM International Organization for Migration
OIM Organisation Internationale pur les Migrations
OIM Organización Internacional para las Migraciones


# BRIEFING NOTE

## ON HIV AND LABOUR MIGRATION IN SWAZILAND

Sida

PHAMSA

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**Cover photographs:** Masimba Sasa

# INTRODUCTION

In the United Nations General Assembly Special Session on HIV and AIDS (UNGASS) Declaration, adopted in 2001, countries committed themselves to: "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".[1] As a Member State, Swaziland has committed to pursuing this goal and is to report on its progress every two years.[2]

In light of this commitment, the purpose of this Briefing Note is to provide an overall picture of labour migration patterns in Swaziland, present the main sectors employing migrant and mobile workers, and highlight the particular vulnerabilities to HIV of these workers. Existing plans and policies related to HIV and migration will then be highlighted and finally recommendations made on how Swaziland can better fulfil its UNGASS, and other, commitments to migrants and mobile populations.

## MIGRATION: AN OVERVIEW

In 2005 there were approximately 191 million migrants globally, a figure that has more than doubled since 1960. Migrants now constitute almost 3% of the world population.[3] The movement of migrants can be for a few days or months, or for many years. Increasingly, women are migrating on their own as primary income earners for their families, and about half of the world's economic migrants are now women. Approximately half of migrants worldwide are economically active, with the other half having migrated to join family members or to study. Migrants contribute an estimated US$2 trillion to the economies of the countries in which they work, and financial remittances to migrants' home countries were expected to reach US$167 billion in 2005. This sum represents more than twice the level of overall development aid.[4]

Historically, some of the major causes of migration in southern Africa include poverty, conflict, war and the apartheid policies of separate development and exclusion. In some cases the end of colonialism resulted in arbitrary boundaries cutting across communities with long standing historical and kinship ties. People living in these areas move across national boundaries for various reasons including to visit family or to search for work.[5] The general decline and uneven development in Southern African Development Community (SADC) economies over the years has, resulted in the need for cheap labour in some countries, and skills shortages in others, set in motion a stream of migrants destined for relatively better performing countries in the region.

Because of the often undocumented nature of many migrants and mobile workers there is has been a lack of research into these groups. However, large, labour-intensive sectors tend to employ both internal mobile workers, - those from other areas within the country - and cross border migrants. Sectors or types of work that generally employ high numbers of mobile and migrant workers in southern Africa are: Mining, Commercial Agriculture, Transport, Construction, Domestic Work, Military and Uniformed Services (such as military personnel and immigration officials), Informal Cross-Border Trade, Fisheries, and Sex Work.



1 United Nations, The Declaration of Commitment on HIV/AIDS (2001), A/Res/S-26/2. Paragraph 50.

2 The latest report of Swaziland, Follow up to the Declaration of Commitment on HIV/AIDS (UNGASS), was published in December 2005 and can be found at: http://data.unaids.org/pub/Report/2006/2006_country_progress_report_swaziland_en.pdf

3 United Nations Department of Economic and Social Affairs, (2005) Trends in Total Migrant Stock: The 2005 Revision POP/DB/MIG/Rev.2005/Doc, February 2006. Available at: http://www.un.org/esa/population/publications/migration/UN_Migrant_Stock_Documentation_2005.pdf.

4 The World Bank, (2006) Global Economic Prospects 2006: Economic Implications of Migration and Remittances. Available at: http://web.worldbank.org/WBSITE/EXTERNAL/EXTDEC/EXTDECPROSPECTS/EXTGBLPROSPECTS/0,,menuPK:615470~pagePK:64218926~piPK:64218953~theSitePK:612501,00.html

## MIGRATION IN SWAZILAND

Swaziland has had a long history of migration, both internal and external. Traditionally, cross border migration was a male preserve with the majority of male migrants headed for the South African mining industries. Women also participated in cross border migration during the colonial years, albeit to a smaller extent. However, because it was generally discouraged by tradition and by the colonial officials, female migration during the colonial period was largely undocumented.[6]

The 1990s to the present have witnessed a steady decline in the number of migrant Swazi mineworkers, owing to massive retrenchments and downsizing of South African mines. According to a study by Crush et al,[7] Swaziland's market share of the foreign migrant labour force fell from 10% in 1990 to 7% in 2000. In the year 2000, an estimated 9360 Swazi men were employed in the mines. Recent figures released by the Southern African Migration Project (SAMP)[8] indicate that Swaziland supplies an estimated 6,878 workers to mines in South Africa.

The post 1990s period witnessed not only a progressive decline in male cross border migrants, but also a dramatic rise in the participation of women as cross border traders. There has been a strong indication that the number of female cross border migrants might soon surpass that of male migrant mineworkers. The significant proportion of female cross border migrants is made up of informal traders who take handicraft goods from Swaziland to sell in different parts of South Africa. Once they have sold their items in South Africa the women use their proceeds to buy goods in Swaziland.

Domestically, the major employers of internal migrants include commercial agriculture, manufacturing and services. Externally, the main employer of Swazi migrants has been the South African manufacturing sector, agribusiness and tourism in Mpumalanga and domestic services in both Mpumalanga and Gauteng, with women participating more noticeably than before.

While a significant proportion of rural households and an increasing number of urban-based informal settlements in Swaziland rely on migrant remittances for their sustenance, high population mobility has been identified as one of the key drivers of the AIDS epidemic. Biennial antenatal surveillance surveys have shown a rapid rise in the infection rate from 4% in 1992 to an alarming 42.6% in 2004, and more recently at 39.9% in 2006. Slight variations in prevalence rates exist between rural and urban areas with infection rates in the urban areas recorded at 44.5% compared to 40.3% in the rural areas in 2004.[9] Similarly, HIV surveillance data collected in 2004 show slight variations in prevalence across the four geographic regions of Swaziland as follows; Hhoho (37.3%), Manzini (42.8%), Shiselweni (38.8%) and Lubombo (38.1%).[10] Uniformity in the distribution of the infection rate is attributed to the country's good roads and communications infrastructure that evens out the differences between regions.

The AIDS epidemic has had an adverse impact on the development gains made in Swaziland during the 1980s. Reversals in some of the key human development indicators have been attributed to the negative impact of the epidemic. The agricultural sector which accounts for a large portion of economic productivity and the bulk of employment in the country has been hard hit. The agricultural subsistence sector on which an estimated 78% of the



5 United States Agency for International Development Regional HIV/AIDS Program for Southern Africa (USAID/RHAP) (2004). HIV/AIDS Strategic Plan Southern Africa, FY 2004-2008. Available at: http://www.rhap.org.za/resources/154.pdf

6 Simelane & Crush , (2004) Swaziland Moves; Perceptions and Patterns of Migration, pg 12

7 Ibid, pg 5.

8 Southern African Migration Project (SAMP), SADC Migration News November 2006 source:http://www.queensu.ca/samp/migrationnews/article)

9 UNGASS Indicators Country Report, 2005: Available at http://data.unaids.org/pub/Report/2006/2006_country_progress_report_Swaziland_en.pdf

10 Ibid, pg

population rely for their livelihood has been particularly affected, with high mortality rates of the productive labour force contributing to severe food shortages and a reduction in the land area under cultivation. The HIV epidemic has also incrementally eroded the capacity of various other structures in both the private and public sectors. High morbidity and mortality as a result of AIDS have significantly reduced productivity, increased production costs and caused disruptions in business operations.

Mobile populations are also highly vulnerable to the epidemic, and key populations at higher risk include sex workers, seasonal and factory workers, long distance truck and taxi (kombi) drivers, migrant miners, uniformed personnel and employees of the public transport sector. Corresponding vulnerable sectors that employ the aforementioned segments of the migrant population include the construction, transport, uniformed services, commercial agriculture, mining and the textile sectors.

Several of the relevant sectors employing migrant workers from and in Swaziland, as well as the particular HIV vulnerabilities faced by these workers are presented below.

## MINING

As mentioned, Swaziland provides labour to mines in South Africa. It is estimated that about 60% of workers in the mining sector in South Africa are from neighbouring countries, mainly from Lesotho, Mozambique and Swaziland. Table 1 shows the number of migrants working on the mines by sending country.

**Table 1: Sources of Mine Labour in South Africa, 1920-2000**[11]

| YEAR | RSA | BOTSWANA | LESOTHO | MOZAMBIQUE | SWAZILAND | TOTAL | % RSA | % FOREIGN |
|---|---|---|---|---|---|---|---|---|
| **1920** | 74,452 | 2,2112 | 10,439 | 77,921 | 3,449 | 174,402 | 43 | 57 |
| **1940** | 178,708 | 14,427 | 52,044 | 74,883 | 7,152 | 347,054 | 51 | 49 |
| **1960** | 141,406 | 21,404 | 48,824 | 101,733 | 6,623 | 375,614 | 38 | 62 |
| **1980** | 233,055 | 17,753 | 96,308 | 39,636 | 5,050 | 415,337 | 56 | 44 |
| **1995** | 122,562 | 10,961 | 87,935 | 55,140 | 15,304 | 291,902 | 42 | 58 |
| **2000** | 99,575 | 6,494 | 58,224 | 57,034 | 9,360 | 230,687 | 43 | 57 |

During the 1990s, South African mines experienced major downsizing and retrenchments creating considerable social disruption and increased poverty in supplier areas. Interestingly, the mines laid off local workers at a much faster rate than foreign workers. As a result, the proportion of foreign workers rose from 40% in the late 1980s to close to 60% in 2000.[12]

The factors that may exacerbate HIV vulnerability of mine workers include the following:

- *Dangerous working conditions:* Faced daily with difficult and dangerous working conditions and risk of physical injury, mine workers tend to be preoccupied with other immediate challenges and may regard HIV as a distant threat.
- Single-sex hostels and limited home-leave: Mine workers often have no choice but to live in single-sex hostels without the option of being accompanied by their partners and families. In addition, they may have limited

11 For the period 1920 – 1989, data for Angola, Malawi, Tanzania, Zambia and Zimbabwe are not shown although the figures are reflected in the totals. International Labour Organization/ Southern African Multidisciplinary Advisory Team (1998) for years 1920 – 1980; Crush J et al. (2002) for years 1995 – 2000

12 J Crush, S A Peberdy and V Williams, (2005) Migration in Southern Africa: A Paper prepared for the Policy Analysis and Research Programme of the Global Commission on International Migration.

home-leave which further distances them from their partners. These circumstances may lead some workers to seek other (multiple) relationships.

- *Boredom and loneliness:* There is limited availability of recreational activities such as sports or entertainment at or around mines. Workers are often distanced from traditional norms and support systems that regulate behaviour in stable communities, and coupled with feelings of boredom, loneliness, and isolation, this can result in a disregard for health. In addition, the proximity and availability of sex may fill the workers' (temporary) emotional and sexual needs.
- *Lack of social cohesion:* The social exclusion that migrants often feel in their new environment and the lack of community cohesiveness may lead to risky sexual behaviour among workers and members of the surrounding community. The social structures and norms in these environments may create feelings of anonymity, which could result in workers feeling less accountability and responsibility. These feelings could also be due to shifting social norms and lack of community sanction for errant individual behaviour.

## COMMERCIAL AGRICULTURE

In Swaziland commercial agriculture revolves largely around the sugar industry with its estates concentrated in the Lowveld, in areas such as Big Bend, Simunye and Mhlume. The sugar industry has played, and continues to play, an important role in the economic growth of Swaziland. In 1999, the industry contributed 24% of the nation's Gross Domestic Product (GDP), 16% to private sector wage employment and 11% to national wage employment.[13] In terms of exports, the industry contributed 13% of total national exports.

A research study undertaken at the Royal Swaziland Sugar Corporation (RSSC)[14] in Mhlume found that, of the 101 workers sampled, the majority were seasonal workers (56.4%), while the rest were permanent (22.8%) or temporary workers (20.6%). Seasonal workers were employed for specific times depending on the stage of growth of sugarcane and their contracts lasted up to eight months. Most of those employed in weeding were employed in the estate for periods of up to six months. Each time they finished their contracts, the majority of workers returned to homes in rural areas. Thus, unlike classic long distance labour migrants, workers were able to go home relatively frequently to see their families and many were also visited at their places at work. Despite this, however, the study found that because the majority of workers did not live with their spouses or partners in the estate, both partners had an increased vulnerability to HIV.[15]

RSSC has recently increased the use of contracted labour for security (mainly men), cleaning (mainly women), cutters/ harvesters (mainly men) and for transportation. These contracted workers who are not directly contracted by Swazi Sugar have partial access to the company's workplace HIV and AIDS programme.

Commercial agriculture includes the citrus and timber industries that have contributed significantly to Swaziland's export earnings. These industries also employ a substantial number of seasonal workers who present an elusive captive audience for HIV and AIDS programmes. In companies where HIV and AIDS policies and programmes have been adopted such as at Swazi Can, Dalcrue Agricultural Holdings, and Peak Timber, the biggest challenge lies in ensuring that seasonal workers are comprehensively targeted to benefit from such programmes.



13 Swaziland Business Year Book 2005: Available at http://www.swazibusiness.com/sbyb2006/index.php?f=10

14 The Royal Swaziland Sugar Corporation is the largest Swazi owned business group controlling about two thirds of the country's sugar product.

15 Southern African Migration Project (SAMP) (2006) There is nothing we can do: HIV/AIDS Vulnerability and Migrant Commercial Farm Workers in Southern Africa, Chapter 2: Mobile Farm Workers' Vulnerability to HIV/AIDS at Swaziland's Mhlume Sugar Estate

Factors that may exacerbate HIV vulnerability of commercial agricultural workers include the following:

- *Poor living conditions and seasonal mobility:* The poor living and working conditions including lack of adequate accommodation, lack of security of tenure and the increasing casualisation of labour preclude workers from bringing their families to the farm sites. These circumstances may lead some workers to seek other (multiple) relationships.
- *Lack of access to health care facilities:* In general, there is a dearth of health care and HIV and AIDS services in commercial farming areas. This is exacerbated by the few rights and legal protection accorded to agricultural workers – with limited protection, especially if they are undocumented, farm workers may be unable or unwilling to access existing clinics for health related matters. In other words, the need to remain far from any type of "officialdom" may result in less access to health care facilities, impacting on health information and access to condoms, treatment for STIs etc. In some companies, contracted seasonal workers are especially disadvantaged by not benefiting from HIV and AIDS programmes to which permanent and other staff members are entitled.
- *Boredom and loneliness:* There is limited availability of recreational activities such as sports or entertainment at or around farms. Workers are often distanced from traditional norms and support systems that regulate behaviour in stable communities, and coupled with feelings of boredom, loneliness, and isolation, this can result in a disregard for health. In addition, the proximity and availability of commercial and /or casual sex may fill the workers' (temporary) emotional and sexual needs.

## TRANSPORT

The transport sector generally does not employ foreign workers, but the nature of work makes those involved, for example truckers and taxi drivers, mobile. Within the trucking industry, truck drivers who are particularly at risk are those who make cross border deliveries, and those who are in transit from other countries.[16] The interaction of the transport sector with other vulnerable sectors heightens their vulnerability to HIV.

A study conducted on four border sites (two between South Africa and Swaziland; one between Swaziland and Mozambique; and one between South Africa and Mozambique) found, for example, that:[17]

- In Ngwenya about 800 trucks cross the border monthly and very few truckers stay overnight at the border but if they do, they generally sleep in their trucks. The length of time away from home is between two and ten days, depending on their destinations.[18]
- An estimated 14 trucking companies use the Lavumisa route and about 1,150 trucks cross the border every month. As Swaziland is part of the South African Customs Union, trucks are rarely delayed at the border for more than 30 minutes. The average length away from home for truckers depends on their destination in South Africa, but the study found truckers stayed away between two and six days.[19]

The factors that may exacerbate HIV vulnerability of workers in the transport industry include:

- *Duration of time spent away from home:* Transport industry workers may be away from their homes for days or months. Lengthy periods away from home can create isolation from families, social structures, and traditional and cultural norms. Isolation may create a sense of boredom and loneliness and a feeling of anonymity with a

16 Sabine Beckmann & Pallavi Rabi (2005) ILO Programme on HIV/AIDS and the World of Work.

17 Family Health International (2001) Lesotho and Swaziland: HIV AND AIDS Risk Assessments at Cross-border and Migrant Sites in Southern Africa. Available at: http://www.fhi.org/NR/rdonlyres/eun6eahbxs7aj7nfmfwivaqoqmd3cgssw6cdaztzkcyiblgmhhqhdgx3now3wxtqykytal36ibsztl/FHIFINAL.pdf. Pages 29-52. The assessment sought to describe the general environment for HIV/STI transmission at the following borders:

- Ngwenya-Oshoek (Swaziland–South Africa), which borders Mpumalanga and is the entry point for people coming into Swaziland from Johannesburg
- Lavumisa-Golela (Swaziland–South Africa), which borders KwaZulu-Natal, a potentially important transit route to and from Durban
- Lomahasha-Namaacha (Swaziland-Mozambique), the entrance to Maputo and Goba, which will open soon
- Komatipoort–Ressano Garcia (South Africa-Mozambique), the gateway between Johannesburg and Maputo and an important trade route for Mozambique. This Briefing Note will not go into detail on the findings from this border site.

18 Ibid, p. 46.

19 Ibid, p. 48.

limited sense of accountability. This may induce a person to behave in a way that she or he otherwise would not under normal circumstances such as engaging in risky sexual interactions.

- *Lack of access to health services:* This may be due to irregular working hours as most clinics are open during business hours and transport workers may be on the road during that time. Further, workers who cross borders may not have access to health services in other countries. Lack of access to health services also often includes lack of information about HIV and a belief in HIV myths, lack of treatment for STIs and lack of access to condoms etc.
- *Dangerous working conditions* Faced daily with the prospect of accidents and dangerous working conditions and risk of physical injury, transport workers tend to be preoccupied with other immediate challenges and may regard HIV as a distant threat.

## UNIFORMED PERSONNEL

Uniformed personnel include those serving in the military services, as well as those working at cross border sites, such as customs officials, immigration officials and customs clearing agents. The nature of work for these uniformed personnel results in the mobility of its workers who are away from their homes for varying time periods.

The uniformed services comprise of the Umbutfo Swaziland Defense Force (USDF), the Royal Swaziland Police Force (RSPF), immigration and customs officials operating along border posts, among others. The USDF includes a Ground Force and Air Wing and the Royal Swaziland Police Force (RSPF) and comprises approximately 3,000 personnel.[20]

A UNAIDS report observes that the USDF is a relatively small group of an estimated 3,500 personnel who are dispersed across the country.[21] The report also indicates that the conditions in the barrack camps where soldiers and their families live are particularly disturbing with a high number of sex workers, vulnerable women and children.

The factors that may exacerbate HIV vulnerability of military and other uniformed personnel are similar for other sectors, including:

- *Single-sex hostels and limited home-leave:* Military personnel have no choice but to live in single-sex hostels without the option of being accompanied by their partners and families. In addition, they may have limited home-leave which further distances them from their partners. These circumstances may lead some workers to seek other (multiple) relationships.
- *Boredom and loneliness:* There is limited availability of recreational activities such as sports or entertainment at military bases or at borders. Personnel are often distanced from traditional norms and support systems that regulate behaviour in stable communities, and coupled with feelings of boredom, loneliness, and isolation, this can result in a disregard for health. In addition, the proximity and availability of sex may fill the workers' (temporary) emotional and sexual needs.
- *Dangerous working conditions:* Faced daily with the prospect of danger and death, military personnel may be preoccupied with other immediate challenges and may regard HIV as a distant threat.
- *Lack of social cohesion:* The social exclusion that mobile workers often feel in their new environment and the lack of community cohesiveness may lead to risky sexual behaviour among workers and members of



20 The Strategy Page, Armed Forces from around the World. Available at: http://www.strategypage.com/fyeo/howtomakewar/databases/armies/default.asp. This was valid as of 2002-2003. The active military manpower is the total uniformed, paid manpower organized into combat and support units. Because of the widely varying systems of organizing military manpower, this figure is at best a good indicator of the personnel devoted to the military. The use of reserve troops varies considerably.

21 http://uniformservices.unaids.org/contacts.asp?region

the surrounding community. The social structures and norms in these environments may create feelings of anonymity, which could result in feelings of limited accountability and responsibility. These feelings could also be due to shifting social norms and lack of community sanction for errant individual behaviour.

- Duration of time spent away from home: Military and immigration personnel may be away from their homes for months. Lengthy periods away from home can create isolation from families, social structures, and traditional and cultural norms. Isolation may create a sense of boredom and loneliness and a feeling of anonymity with a limited sense of accountability. This may induce a person to behave in a way that she or he otherwise would not under normal circumstances such as engaging in risky sexual interactions.

## INFORMAL CROSS BORDER TRADE

As mentioned, since the 1990s, there has been strong indication that the number of female cross border migrants in the informal trade sector is increasing. These traders take handicraft goods from Swaziland to sell in different parts of South Africa, then on their return bring home goods bought in South Africa.

According to a study conducted by Family Health International in 2001, limited cross border trade was found to exist at Lavumisa and Ngwenya, but a significant amount of trade was found at Lomashasha. On three randomly chosen days in April 2000 there were 123/114/119 informal cross border traders either crossing or sleeping at the border respectively. Similarly, cross border trade from Namaacha in Mozambique into Swaziland is significant; the study found between 114 and 164 informal traders crossing the border on the three random days in April 2000.[22]

The factors that may exacerbate HIV vulnerability of informal cross border traders include:

- Extended periods of time spent in high transmission areas: Informal cross border traders pass through and often spend extended periods of time in high transmission areas, in particular cross border areas due to unforeseen delays.[23] Reasons for delays include inadequate infrastructure and/or staff at border posts to handle the volumes of traffic, or "early" closure of border posts, particularly busy ones. There is often limited affordable accommodation, food, transport and recreational facilities at border posts. This environment contributes to the existence of an intricate web of sexual relationships among informal cross border traders, uniformed personnel (customs officials, immigration officials and customs clearing agents), sex workers, truck drivers, money-changers ('touts'), local border-town residents and deportees, which could potentially increase HIV vulnerability for all involved.[24]
- Limited access to healthcare services: Because of their meagre resources, most informal cross border traders do not seek treatment in foreign countries; rather they wait until they get home where they can access subsidized treatment.[25] As STIs are a major contributory factor for HIV, such delays in treatment are a major contributory factor leading to increased HIV vulnerability.[26]

22 Ibid, pp. 49-50.

23 IOM (2003), Mobile Populations and HIV/AIDS in the Southern African Region: Desk Review and Bibliography on HIV/AIDS and Mobile Populations Pretoria: South Africa.

24 IOM (2005) Mission Report on HIV/AIDS among Informal Cross-border Traders in Botswana, Zambia and Zimbabwe, Pretoria: South Africa. Firstly, those who command authority (such as border officials) or who possess economic resources may sexually exploit those in weaker positions. Female informal cross border traders who find themselves in situations of unexpected delays at border posts may engage in transactional sex, or may be coerced into sex by customs officials to facilitate passage. Secondly, in some cases the sexual liaisons are in response to the loneliness arising from being away from families and supportive social support networks or boredom. Such may be the case for truckers who spend long hours on the road and long periods away from their families. Lastly, in many cases the sexual relationships are for economic reasons, such as female informal cross border traders sleeping with truck drivers in exchange for transport or even just for the opportunity to sleep overnight in the trucks.

25 IOM (2005) Mission Report on HIV/AIDS among Informal Cross-border Traders in Botswana, Zambia and Zimbabwe Pretoria: South Africa.

26 Genital ulcers and lesions caused by some STIs increase the risk of HIV infection because they allow easier entry of the virus into the body. Inflammation caused by other STIs may also increase the viral load in the semen or vaginal fluids of those who are HIV positive; this increases the probability of the transmitting the virus. Thus, prompt treatment of STIs greatly reduces the probability of HIV transmission. (Source: Grosskurth H, Mosha F, Todd J, et al. (1995), "Impact of improved treatment of sexually transmitted diseases on HIV infection in rural Tanzania: randomized control trial". Lancet 1995,346:530-536.)

- Lack of HIV and AIDS interventions: In general, there are few HIV and AIDS interventions that target informal cross border traders. For example, informal cross border traders have difficulties in accessing condoms as, in most public areas of customs or immigration buildings at border posts, there are no condoms available; rather, condoms are available at clinics, shops or AIDS service organizations, which are usually far from the border post.[27] Further, difficulties in actually targeting informal cross border traders, who are constantly on the move, preoccupied with survival needs, and may not be receptive to HIV and AIDS education and prevention messages, are experienced by some AIDS service organizations.[28]

## SEX WORK

Sex work is a profession with high levels of mobility because women often move to different areas in response to a perceived market demand for their services, for example towards large construction projects, mining sites, trucking routes or cross border areas. Sex work also contributes to sexual networks linking other mobile or migrant workers such as miners, construction workers and truck drivers. For these reasons, it is necessary to target sex workers, without further stigmatizing or penalizing them, in order to address HIV vulnerability of mobile and migrant workers. The vulnerability of sex workers is exacerbated by the fact that sex work is criminalised in Swaziland and that sex workers interact frequently with other vulnerable workers in sectors such as transport, informal cross border trade, uniformed services, construction and mining.

Sex workers in Swaziland often operate along border areas and in the major towns and industrial sites of the country, as permanent or transient workers. Transient sex workers along the border areas often operate during peak times such as at weekends, month end and during festive seasons where their market demand is perceived to be at its highest. The extent of sex work along border posts varies. Border posts that expedite speedy crossings for truckers and informal cross border traders like the Ngwenya/ Oshoek and Lomahasha borders tend to have limited sex work activity compared to others like the Namaacha and Komatipoort border posts.

Factors that may exacerbate HIV vulnerability of sex workers include:

- *Inadequate HIV and AIDS interventions:* In general, there are few HIV and AIDS interventions that target sex workers. As sex work is criminalized and stigmatized, sex workers may not want to come forward to access HIV interventions. Further, there are difficulties in actually targeting sex workers who are constantly on the move, and who may not be receptive to HIV and AIDS education and prevention messages
- *Poor management of STI infection among sex workers:* The stigmatization of sex work further hinders sex workers' access to health care services for STI management. The transient nature of encounters between sex workers and their clients renders partner notification difficult.
- *Inability to negotiate condom use:* although research in Swaziland shows a positive trend towards condom use among sex workers and their clients, sex workers still confront clients who are unwilling to use condoms. The marginalized status of sex workers often renders them unable to negotiate condom use. In addition, those with regular clients may not feel the need or may be unable to insist on condom use
- *Poverty:* Faced with the daily reality of poverty and survival challenges, sex workers may be unwilling to insist on condom use if unprotected sex comes with higher pay

27 IOM (2005) Mission Report on HIV/AIDS among Informal Cross-border Traders in Botswana, Zambia and Zimbabwe Pretoria: South Africa.
28 Op cit.

## CURRENT LEGAL AND POLICY INTERVENTIONS IN SWAZILAND

The importance of migration in SADC, as well as the impact of migration on HIV vulnerability, requires that States examine HIV and migration in an attempt to make meaningful and relevant legal and policy interventions for HIV mitigation. There are various international and regional treaties and declarations in place that, once signed and ratified/acceded, illustrate a country's commitment to adhering to the spirit and provisions of the treaty, whether they are legally binding or not. These international and regional treaties and declarations seek to reduce the impact of the AIDS epidemic on vulnerable groups and to address socio-legal and structural factors that render certain population groups vulnerable to HIV. Since most States including Swaziland follow a dualist approach to treaty ratification, whereby an international or regional treaty must be officially domesticated to be relied on domestically, the most important policy document is the national strategic plan.

This section will briefly examine selected relevant international and regional treaties that impact on HIV and migration. It will then examine Swaziland's national strategy and relevant sectoral plans in some detail, examining the impact of such plans on migrant and mobile populations. The final section will make recommendations for Swaziland on issues relating to HIV and mobile and migrant populations.

### INTERNATIONAL AND REGIONAL TREATIES

There are various international and regional treaties and declarations in place relating to HIV, that are applicable to all persons, including mobile workers and migrants, refugees and other non-nationals within a Member State. Some of the relevant treaties are as follows:[29]

- The UN International Convention on the Protection of the Rights of all Migrant Workers and Members and their Families, which has not yet been signed by Swaziland, in article 23 states that "migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health".
- The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which Swaziland acceded to on 26 March 2004, calls for the elimination of both intentional discrimination against women and acts that have a discriminatory effect on women including in employment and health care. The NGO sector in partnership with government has embarked on a process of preparing for the implementation of CEDAW and its incorporation into domestic laws.
- The UN International Covenant on Economic, Social and Cultural Rights (ICESCR), which was acceded to on 26 March 2004 by Swaziland, in article 12 recognizes the right of everyone to the enjoyment of the highest attainable standard of mental and physical health, which includes prevention, treatment and control of epidemic, endemic, occupational and other diseases, as well as the creation of conditions which would ensure access to all medical service and medical attention in the event of sickness.
- The AU Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, which was signed on 07 December 2004 by Swaziland, recognizes the equal rights of African women, including the right to health care, sexual and reproductive health and the right to be protected against sexually transmitted infections including HIV.

29 From the United Nations Office of the High Commissioner for Human Rights, valid as of 09 March 2006. Available at: http://www.ohchr.org/english/bodies/docs/status.pdf. The difference between signature, ratification and accession is as follows: "Signature of a treaty is an act by which a state provides a preliminary endorsement of the instrument. Signing does not create a binding legal obligation but does demonstrate the state's intent to examine the treaty domestically and consider ratifying it. While signing does not commit a state to ratification, it does oblige the state to refrain from acts that would defeat or undermine the treaty's objective and purpose. Ratification is an act by which a state signifies an agreement to be legally bound by the terms of a particular treaty. To ratify a treaty, the state first signs it and then fulfils its own national legislative requirements. Accession is an act by which a state signifies its agreement to be legal bound by the terms of a particular treaty. It has the same legal effect as ratification but is not preceded by an act of signature". From The United Nations Children's Fund (UNICEF) (undated).Introduction to the Convention on the Rights of the Child: Definition of Terms. Available at: http://www.unicef.org/crc/files/Definitions.pdf.

Other declarations (not legally binding) have specific provisions relating to migrants and HIV such as the UN Millennium Declaration (2000), the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001), and the SADC Protocol on Health (1999), the Maseru Declaration & Commitment to AIDS in the SADC region (2003) and the Brazzaville Declaration on Commitment on Scaling up Towards Universal Access to AIDS Prevention, Treatment, Care and Support in Africa by 2010 (2006) among others. Swaziland is a signatory of all of these declarations which illustrates a willingness to engage with the issues relating to HIV and AIDS.

## NATIONAL POLICIES AND COMMITMENTS

**The National Multi-Sectoral HIV/AIDS Policy 2006**

The National Multi-Sectoral HIV/AIDS Policy provides broad guidelines for the design, implementation and management of HIV interventions, programmes, and activities at various levels. The overall goal of the policy is to create an enabling policy environment for the national multi-sectoral response to the AIDS epidemic. However, the policy does not address the vulnerability of mobile populations. Only sex workers are included in groups considered vulnerable to HIV infection.

**The Second National Multi-Sectoral HIV/AIDS Strategic Plan (2006-2008)**

The Second National Multi-Sectoral Strategic Plan for HIV/AIDS 2006-2008 acknowledges that high population mobility in Swaziland is one of the key drivers of the AIDS epidemic. Strategies outlined to support Prevention include strengthening and promoting programmes that address both HIV vulnerability and risk factors among special groups such as sex workers, mobile populations including migrant workers, and their sexual partners among others. Another strategy for prevention as outlined in the NSP is to expand HIV and AIDS workplace programmes to include all categories of workplaces inclusive of the informal sector, small to medium scale and big business as well a families and communities of employees. The Plan recognises that there is generally poor targeting for STI prevention and management of high risk populations such sex workers, long distance drivers and their sexual partners. However, no specific strategy is outlined to address the needs of this specific target group for STI prevention and management. The thematic areas of intervention in the Plan that focus on Treatment, Care and Support; Impact Mitigation; and Management of the National Response, do not provide strategies for accessing services to mobile populations.

The Plan tends not to view migrant populations as vulnerable groups but rather prefers to categorise them as high risk populations. As such, vulnerable groups as identified in the Plan include youth, orphans and vulnerable children, widows, bereaved elderly, people living with HIV, and disabled persons. The tendency is thus to exclude vulnerable and often marginalised segments of the mobile population from impact mitigation services, and not to pay adequate attention to enhancing their access to mitigation services.

**Other Policies for Vulnerable Groups**

There are a number of policies that have been developed to protect vulnerable groups but still remain in draft form awaiting approval by Parliament. These draft policies include the draft National Policy on Children, including orphans and vulnerable children, draft Gender Policy, the National Social Welfare Policy, and the draft Land policy, draft Comprehensive Agriculture Sector policy, National Education policy among others



## SECTOR POLICIES, PLANS AND PROGRAMMES

**The Swaziland Business Coalition against HIV and AIDS (BCHA)**

The Swaziland Business Coalition against HIV and AIDS (BCHA) was formed in 2001[30] to respond to the high

30 The Swaziland Business Coalition Against HIV&AIDS, 2006 (source: http://www.weforum.org/pdf/GHI/Swaziland.pdf

prevalence of HIV and AIDS in the workplace. The BCHA is a substructure of the Federation of Swaziland Employers and Chamber of Commerce. The overall objective of BCHA is to provide coordination and facilitation support to the private sector response to the AIDS epidemic. The BCHA has developed a charter to which a number of private sector establishments are signatory. In early 2005, BCHA launched an HIV and AIDS workplace programme. The BCHA has played a pivotal role in influencing businesses to prioritise HIV and AIDS in workplaces. The UNGASS Country report indicates that a workplace survey revealed that about 48% of the companies sampled had workplace policies and programmes.

**Public sector**

The Ministry of Public Service and Information coordinates the public sector response to the HIV and AIDS pandemic. An HIV/AIDS committee for the Public Sector was formed in 2004 to drive the public sector response, and a government wide workplace policy has been adopted.

**Transport**

Information, education and communication and other health interventions for cross border migrants are addressed through the SADC inter-country strategy and the Ministry of Works and Transport. The Transport Sector has an HIV and AIDS policy that was adopted in 2002. The policy provides a framework for the expansion of access to preventative commodities to long distance truck drivers and taxi drivers both within Swaziland and for those engaged in cross border long distance travel.

A draft HIV and AIDS Strategic Plan for the transport sector has also been developed but has not been adopted. There have been numerous challenges encountered in expediting the finalisation and adoption of the strategic plan, including lack of funds for its implementation.

The Corridors of Hope of Southern Africa project has played an instrumental role in assisting the country to reach key populations at higher risk, including those who work in the transport sector, along the major borders and roads in the country. It seeks to address correct and consistent use of condoms as well as encouraging early treatment of sexually transmitted infections

**Uniformed Services**

The military - The Umbutfo Swaziland Defence Force, through the United States Department of Defence on HIV/AIDS Program (DHAPP) - implements an HIV programme providing voluntary counselling and testing services to soldiers and the community. It also has a robust strategic plan with components that are focused on prevention, care and support.[31] Furthermore, at the time when the UNGASS country report (2003-2005) was prepared, the police force and correctional services were in the process of developing HIV and AIDS programmes.

**Commercial Agriculture**

A number of ago-industries such as Royal Swaziland Sugar Corporation, Swazi Peak Timber, Dalcrue Agricultural Holdings, Swazi Fruit Canners have developed HIV and AIDS policies and programmes. Some of these industries have embarked on behaviour change communication strategies spearheaded through peer education programmes and have started initiatives linked with home based care for terminally-ill workers. The biggest challenge faced by these industries however, lies in the extension of programmatic interventions to seasonal workers, as well as contract workers not directly employed by companies.



31 Ibid, p. 15.

32 UNGASS Country report, p. 15.

**Sex Work**

The Corridors of Hope of Southern Africa project has also played an instrumental role in targeting sex workers along the major borders and roads in the country. It project seeks to address correct and consistent use of condoms as well as encouraging early treatment of sexually transmitted infections. Referring to the 2002 Behavioural Surveillance Survey, the UNGASS country report observes that that there has been a high level of reported condom use by sex workers; with condom use at last sex among paying clients at 90% compared to condom use with non-paying partners at 60%. About 75% of sex workers interviewed reported to be consistently using condoms with their clients. The country report also notes that: "With the peer education programs targeting sex workers along the major borders and highways in the country, it is expected that condom use will be on the rise among this group."[32]

### THE UNGASS COUNTRY PROGRESS REPORT

The UNGASS Country Progress Report notes that the most-at-risk groups include: sex workers; seasonal and factory workers; long distance truck drivers; army personnel and the public transport sector.[33]

## RECOMMENDATIONS FOR FUTURE POLICIES/INTERVENTIONS

It is suggested that the Government of Swaziland consider the following:

- Sign, ratify and domesticate the UN International Covenant on the Protection of Migrant Workers and their Families. This would afford migrant and mobile workers with increased legal protection, such as better living and working conditions and access to health. At the same time, domesticate the other international and regional treaties to make them applicable in the country.
- Undertake a review and harmonization of existing legislation, especially labour and immigration legislation, which has a potential impact on migrants and mobile populations. This should include a review of various immigration and work visas.
- Include mobile and migrant workers in any national and sectoral plans, programmes and strategies to address HIV and AIDS including in treatment, care and support and prevention.



33 UNGASS Progress Report, p. 14.

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