BRIEFING NOTE
ON HIV AND LABOUR MIGRATION IN MALAWI

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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, Malawi 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 Malawi, 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 Malawi 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, to months, or for years. In recent years, women have migrated on their own as the primary income earner for their families and about half of the world’s economic migrants are now women. Approximately half of the migrants world-wide 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 have been 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 whole communities with long standing historical and kinship ties; people living in these areas move across national boundaries for various reasons such as visiting family and for work. The general decline and uneven development in South African Development Community (SADC) economies over the years has, due to the need for cheap labour and/or the skills shortage in receiving countries, 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, the larger sectors of employment in any country are likely to employ both internal mobile workers i.e. those from other areas within the country, as well as cross border migrants. Sectors or types of work that include significant 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.

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Migration in Malawi

Malawi is a net exporter of labour in the region. Further, many people move within the country to look for opportunities and work. This is exacerbated by the drought that has been affecting the country for several years, which has impacted on agricultural production. According to Malawi’s National AIDS Control Program (NACP), male migration is a common phenomenon. The NACP also noted that both men and women (adults and youth) are increasingly mobile as they pursue trading activities.

The Malawi Human Development Report identifies population mobility as one of the drivers behind the AIDS epidemic. Malawi, like its neighbouring countries in the SADC has been severely affected by the AIDS epidemic with HIV prevalence estimated at 14.1%. The impact of the epidemic has been felt by all sectors of Malawian society causing significant reversals to the country’s socio-economic gains since independence. HIV prevalence is higher in urban areas than in the rural areas, with concentration of prevalence in the Southern region (23.7%) followed by the northern (20%) and central (15.5%) regions of country.

Women and girls are particularly vulnerable to HIV with their lower socio-economic status placing them at greater risk of infection than their male counterparts. Poverty frequently leads women and girls to engage in transactional sex as a source of income and subjects them to sexual trafficking and exploitation. The Malawi National HIV/AIDS/STI/TB Policy recognises mobile populations as a vulnerable population whose rights need to be protected to ensure that they gain access to HIV and AIDS services. Such mobile populations in Malawi typically include sex workers, informal cross border traders, long-distance truck drivers, agricultural seasonal workers, uniformed and security personnel, and mine workers.

Several of the relevant sectors involving migrant workers in and outside of Malawi, and the particular HIV vulnerabilities faced by these workers are presented below.

Mining

Mining in Malawi contributed to an estimated 1% of its Gross Domestic Product (GDP) of US$7 million in 2004. In 2003, the mining sector grew by 23.5% and formal employment in the sector amounted to about 2700 workers in 2004, although it is probably higher than the formal figure when taking into account artisanal mining for aggregate, sand and gravel.

There is also a long history of Malawian labour migrants going to South Africa to work on the mines. There was a dramatic rise in the number of Malawian labour migrants to South Africa in the 1960’s, followed by a dramatic decline after 1974, when Malawi withdrew its workers following a WNLA plane crash that killed 73 miners. In 1988, Malawians were thrown out of South Africa due to false accusations that they were responsible for spreading HIV in South Africa.
The factors that may exacerbate the 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 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 workers 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**

Malawi’s economy is highly reliant on agriculture, which accounts for about 90% of its export earnings and 45% of its GDP.\(^\text{13}\) Commercial agriculture is the chief national income earner for Malawi.\(^\text{14}\)

A study by the Southern Africa Migration Project (SAMP)\(^\text{15}\) in Mchinji and Kasungu in Malawi found that in-migration surpassed out-migration because the tobacco and other farms attract workers from various regions of the country; the 111 sampled workers were from 20 different districts in Malawi and almost half of the sample had lived in at least four different places, including their original home, during their working life. The majority of the farm workers were men under the age of 40 years and many migrated with their families. One-third of the farm workers’ spouses worked outside their home as small-scale business operators (30%), fellow farm workers (3%), and sex workers (13%) or in other employment (53%). In cases where there were children, they were often involved in labour on the farms rather than being in school.

The study found that the farm workers’ response to poor working and living conditions was to move and to try and find a farm where circumstances were better. Eighty percent of the sample had worked on more than one farm; 40% had work experience on three or more farms and only 45% of the farm workers had been working at the same farm for more than three years. The study concluded that migrant farm workers were a mobile population, who stayed on a farm where working conditions were relatively better, or if they had no other option.

The study also found, through key informant interviews, that employers preferred workers from other regions over those from their own because migrants were considered more reliable as it was more difficult for them

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14 Southern African Migration Project (2006) There is nothing we can do: HIV/AIDS Vulnerability and Migrant Commercial Farm Workers in Southern Africa, Chapter 1, The Vulnerability of Migrant Farm Workers to HIV/AIDS in Malawi.
15 bid.
to abandon work and return home; and they did not have land of their own outside the estate which made it unlikely they would leave during harvesting times to tend to their own crops.

The study found that farm workers had a very high awareness of HIV but that the belief in HIV myths was also high. HIV vulnerability of the workers was high, whether or not their spouses/partners were with them, for various reasons including the power imbalance existing with older male farm workers with younger spouses, gender disparities in the ability to negotiate condom use and alcohol use.

Another study on male workers from the Nchalo sugar plantation sampled men primarily from 11 residential communities located inside and around the estate.\(^\text{16}\) The study found that men’s rate of HIV decreased as the distance to the Nchola trading centre increased. The trading centre was where most recreational activities and commercial sex occurred. Both HIV and syphilis were highest in communities closest to the trading centre and lowest in communities furthest from it.\(^\text{17}\)

Other factors that have been found to exacerbate HIV vulnerability of commercial agriculture workers include:

- **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.

- **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.

**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 Malawi Armed Forces comprises of the Air Wing, Naval Detachment and Police services, approximately 5000 personnel.\(^\text{18}\)

16 Cane cutters, most often men, usually are seasonal workers, employed on sugar estates between March and November.


18 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.
The Malawi Armed Forces, as of 31 August 2006, had 167 troops and military personnel overseas in various United Nations missions, including: Organization in the DRC (MONUC), Operation in Burundi (ONUB), Interim Administration Mission in Kosovo (UNMIK), Mission in Liberia (UNMIL), and the Mission in the Sudan (UNMIS).\textsuperscript{19}

While official statistics of HIV prevalence in the Armed Forces are not available, in November 2002, the Malawi Armed Forces reported during a workshop that between January and April 2002, the Force lost 48 members, with majority of deaths due to AIDS-related illnesses. It also reported that these 48 AIDS deaths resulted in 169 orphans.\textsuperscript{20}

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

- \textit{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.

- \textit{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 commercial sex may fill the workers’ (temporary) emotional and sexual needs.

- \textit{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.

- \textit{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 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.

- \textit{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.

\textbf{INFORMAL CROSS BORDER TRADE}

There is evidence of informal cross border trade between Malawi and its neighbours - Zambia, Mozambique, and Tanzania.\textsuperscript{21} This trade occurs among communities residing along the porous border areas, and includes both agricultural and non-agricultural commodities.

A study conducted of female informal cross border traders from Botswana, Malawi, Mozambique, South Africa and Zimbabwe found that, of the 182 women surveyed in Blantyre (127 were from Malawi while the

remainder were from other countries), they were found to travel less frequently but for longer durations which was probably due to the distances involved in travelling to South Africa and other countries in the region. Further, the vast majority, 87.9%, crossed the border by bus.

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. 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.

- **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. As STIs are a major contributory factor for HIV, such delays in treatment are a major contributory factor leading to increased HIV vulnerability.

- **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. 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.

**TRANSPORT AND CONSTRUCTION**

The transport sector is one of the most vulnerable sectors to the AIDS epidemic in Malawi due to its highly mobile workforce and inherent working conditions. Migration, short-term or long-term, of the transport sector...
workforce increases opportunities for sexual relationships with multiple partners, transforming transport routes to critical links in the propagation of HIV.

The building and maintenance of transport infrastructure in Malawi often involves sending teams of men away from their families for extended periods of time, thereby increasing their likelihood of having multiple sexual partners. In addition, workers involved in the construction and maintenance of infrastructure constitute a mobile and at risk population. Similarly, people who operate transport services (truck drivers, train crews, sailors) spend many days and nights away from their families. This increases the likelihood of risky sexual behaviour, while their comparative wealth enables them to purchase sex from sex workers.

The trucking industry, with its extensive routes such as the Dar Corridor that links the port of Dar es Salaam and Tanzania with Malawi; the North-South Corridor that links Malawi with neighbouring countries to the south and the port of Durban is one of the most vulnerable transport sub-sectors. Malawi has particularly heavy cross border traffic along the Mwanza border post. The Mwanza border post for instance is a hive of activity, handling 70 percent of all road freight into Malawi, where drivers often spend days waiting for their trucks to be inspected by the Malawi Revenue Authority (MRA) and other officials.

Sex work and trucking are interwoven in border sites. Informal “brothels” are often situated near truck routes and truck stops, and their inhabitants acknowledge that their clients are largely drivers. As a consequence, border posts attract a number of sex workers.

The factors that may exacerbate HIV vulnerability of workers in the transport and construction industries include:

- **Duration of time spent away from home:** Transport industry workers may be away from their homes for days, weeks or months. Lengthy periods away from home can create isolation from families, social structures, and traditional and cultural norms.

- **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 difficult working conditions, transport workers tend to be preoccupied with other immediate challenges and may regard HIV as a distant threat.

**CURRENT LEGAL AND POLICY INTERVENTIONS IN MALAWI**

The importance of migration in SADC, as well as the impact of migration on the vulnerability to HIV, 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 HIV epidemic on vulnerable groups and to address socio-legal and structural factors that render certain population groups vulnerable to HIV. Importantly, since most States
including Malawi 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 Malawi’s national strategy or action plan and relevant sectoral plans in some detail, examining the impact of the plan on migrant and mobile populations. The final section will make recommendations for Malawi 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:31

- The UN International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families, which has not yet been signed by Malawi, 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 Malawi acceded to on 12 March 1987, calls for the elimination of both intentional discrimination against women and acts that have a discriminatory effect on women. It calls for equality in issues such as employment and health care.

- The UN International Covenant on Economic, Social and Cultural Rights (ICESCR), which was acceded to by Malawi on 22 December 1993, 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 ratified by Malawi on 20 May 2005, 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.

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. Malawi is

31 From the United Nations Office of the High Commissioner for Human Rights, valid as of 09 March 2006. Available at: http://www.ohchr.org/eng/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 fulfills 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.
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 Malawi HIV/AIDS policy provides a framework for the strengthening of a coordinated multi-sectoral response to the HIV epidemic. The policy also provides a legal framework for the reduction in vulnerability to HIV, to improve the provision of treatment, care and support for people living with HIV, and to mitigate the socio-economic impact of the epidemic. Significant also is that the policy provides a framework for all public and private sector workplace policies and programmes.

The National HIV/AIDS policy categorises mobile populations and sex workers as a vulnerable group. One of the guiding principles on which the policy is based is the promotion and protection of human rights, particularly those of vulnerable populations. The policy recognises mobile populations, including sex workers, as a group that can be discriminated against, and that may be less able to fully access services for HIV prevention, treatment, care and support. In addressing the vulnerabilities of sex workers, the policy commits Government to ensure that sex workers have access to confidential and respectful health care including sexual reproductive health. In addressing the vulnerability of other mobile populations the policy commits Government and the private sector to identify, address and reduce the vulnerability of all mobile groups to HIV, including their living and working conditions. It also stipulates that Government will collaborate with regional institutions such as SADC and IOM in developing regional responses to HIV.

The policy also stipulates that Government will ensure the protection of the rights of refugees including their rights in respect of HIV prevention, treatment, care and support.

The overall goal of National HIV/AIDS Action Framework (NAAF) is to prevent the spread of HIV infection, to provide access to treatment for people living with HIV, and to mitigate the health, socio-economic and psycho-social impact of HIV and AIDS on individuals, families, communities and the nation at large.

The NAAF does not directly address the vulnerabilities of mobile populations, and no mention is made of mobile populations in the framework. Consequently, none of its objectives and strategies address the need to ensure that migrants specifically and their various segments, access HIV and AIDS related services. Furthermore, strategic interventions geared towards impact mitigation in the NAAF do not mention mobile groups and are limited to youth, widows/widowers and the elderly.

Some aspects of the NAAF do hold significant implications for mobile populations and their various segments;
- Prevention: one of the objectives under prevention is to promote safer sex practices among key populations at higher risk, and to enhance equitable access by Malawians to HIV testing and counselling services through outreach and mobile services.
- Mainstreaming, Partnerships and Capacity building: Some of the key action areas outlined are: to institutionalise the process of mainstreaming HIV and AIDS in all sectors; promote the participation of employees at sector level in HIV and AIDS activities; and to disseminate and implement the national and civil service workplace policy to all sectors.
Other Policies for Vulnerable Groups
There are a number of policies and legislative frameworks that have been developed to protect vulnerable groups in Malawi. These include the National Policy on Orphans and other Vulnerable Children (2003), the National Gender Policy (2000), Domestic violence Act (2006), Employment Act, and the National Policy on Equalization of Opportunity for Persons with Disabilities (2006) among others.

SECTOR POLICIES, PLANS AND PROGRAMMES

Malawi Business Coalition against AIDS (MBCA)
The Malawi Business Coalition on AIDS (MBCA) which has become the private sector voice in Malawi on HIV and AIDS was launched in 2004. MBCA is made up of large and small companies, and assists member companies to implement workplace policies and programmes. In 2006, the MBC supported the development of HIV and AIDS workplace programmes and policies in a number of companies within the tobacco, construction and transport industries.

A UNAIDS country report on Malawi however, observes that the Malawi Business Coalition Against AIDS coordinates private-sector response but is only present in big cities, and its membership is limited to large business enterprises, mainly multinational organisations. Similarly, the existence of HIV and AIDS programmes, policies and activities in private companies are almost exclusively in large, international companies.

Public Sector
The public sector response to the AIDS epidemic in Malawi is guided by the National Public Service HIV/AIDS Policy and the National HIV/AIDS workplace policy. The latter is based on the ILO Code of Practice on HIV/AIDS and Employment. According to the Malawi Human Development Report, fifteen large sectors (including agriculture, defence, community services, education, and health) had full-time HIV and AIDS Coordinators and all 28 districts in the country had recruited and posted full-time District HIV and AIDS Coordinators by 2004.

Transport
The transport sector in Malawi has a Policy and Strategic Framework of Action on HIV/AIDS. The policy seeks to guide the transport sector in dealing with HIV and AIDS in the workplace and provides a framework that can be used by the transport sector employers, workers and their representatives to formulate and design their workplace HIV and AIDS policies and programmes. The policy presents a set of guidelines for HIV prevention, care and support, non-discrimination in the workplace, establishment of a healthy working environment, and for the promotion of gender equality in the workplace.

The Strategic Framework of Action on HIV/AIDS seeks to contribute towards reducing, controlling and preventing the further spread of HIV and to mitigate its impact on the transport sector workforce, their families and communities. Areas of intervention outlined in the strategy include prevention, treatment, care and support, and capacity building for peer education. The strategy targets employers and employees in the transport sector and their families, with particular focus on the mobile workforce.

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33 ibid
35 Malawi Human Development Report, 2005 (UNDP, Malawi)
Uniformed Services
The Malawi Armed Forces has an AIDS policy (1999) whose goal is to reduce the incidence of HIV and other sexually transmitted diseases and to improve the quality of life for those infected and affected by HIV and AIDS in the MDF. One of the key objectives of the policy is to develop and manage HIV/AIDS/STI programmes and to provide high quality management services for STIs and HIV/AIDS; and to maintain a healthy combat ready force.37

An HIV/AIDS Strategy and Action Plan (2007-2011) for the MDF was recently adopted by the MDF with support from the UN team in Malawi. The overall goal of the strategy and action plan is to reduce the impact of HIV and AIDS on the mandate of the defence force. The key objective of the strategy and action plan is to prevent the spread of HIV infection in the defence force and surrounding communities, and to ensure access by the MDF personnel and their families to prevention, and care and treatment. The strategy also seeks to mitigate the psychosocial impact of HIV and AIDS on the MDF personnel and their families including communities that surround the MDF sites.38

Agriculture
Agriculture Malawi’s Rural AIDS Initiative is a major programme to mainstream HIV prevention and mitigation within rural communities. It entails policy and field support, as well as field operations carried out by rural development management teams. It aims to:

- Reduce HIV prevalence among farmers, agricultural workers, and other rural development actors;
- Reduce the adverse effects of HIV/AIDS on the agriculture sector; and
- Effectively integrate HIV/AIDS within poverty reduction and development strategies.39

THE UNGASS PROGRESS REPORT

Besides mentioning various studies that have examined issues relating to HIV prevalence in populations such as sex workers and truck drivers, the UNGASS Progress Report does not mention migrants or mobile populations. While research is necessary in order to plan appropriate interventions, the UNGASS Progress Report and the National HIV/AIDS Action Framework do not elaborate any plans or strategies to address HIV vulnerability in migrant and mobile populations. Government’s identified Recommendations in the Progress Report do not mention mobile populations.40

In Annexure 2: National Composite Policy Index (NCPI)41 the Government affirmed:

- “The country has an action framework/strategy for addressing HIV and AIDS issues among its national uniformed services, military, peacekeepers and police” (NCPI-A-I-4).

Other sections of the NCPI which Malawi answered positively and which may be relevant for migrant and mobile workers include the following:

- “The country has a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations” (NCPI-A-III-3).

40 UNGASS Progress Report, pp. 46-47.
41 Ibid. The National Composite Policy Index (NCPI) is in Annexure 2, pp. 52-56.
• “The country has a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities. (These commodities include, but are not limited to, access to confidential voluntary counselling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections)” (NCPI-A-III-4).

• “The Government has, through political and financial support, involved vulnerable populations in governmental HIV-policy design and programme implementation” (NCPI-B-I-5).

• “The country has a policy to ensure equitable access to prevention and care for most-at-risk populations” (NCPI-B-I-7).

However, Malawi acknowledges that the following are not in place:

• “The country has non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination” (NCPI-B-I-2). However there are also no “laws and regulations that present obstacles to effective HIV prevention and care for most-at-risk populations” (NCPI-B-I-3).

While vulnerable groups have been defined in the Malawi National Policy, the UNGASS Progress Report does not define vulnerable groups or “most-at-risk” groups. It is likely, however, that the definition of vulnerability in the Policy will apply.42

**RECOMMENDATIONS FOR FUTURE POLICIES/INTERVENTIONS**

It is suggested that the Government of Malawi 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.

• Develop and implement a law to protect most-at-risk populations including mobile and migrant workers explicitly.

• Undertake a review and harmonisation 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.

• Although mobile workers are mentioned in the National Policy and in the UNGASS Progress Report, HIV strategies and plans have not yet been developed to target mobile workers and migrants. Thus, it is recommended that Malawi 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.

• Work closely with other SADC countries to address issues related to migrants and mobile workers.

42 While UNAIDS developed in July 2005 Guidelines on Construction of Core Indicators: Monitoring the Declaration of Commitment to HIV/AIDS (available at: http://data.unaids.org/Publications/IRC-pub06/JC1126-ConstrCoreIndic-UNGASS_en.pdf), the Guidelines leave it to the country to determine what are “most at risk populations” and “certain groups identified as especially vulnerable”. The examples provided in the Guidelines are men who have sex with men, injecting drug users and sex workers. The Guidelines stress that “The term ‘most-at-risk populations’ should be replaced with a defined segment of the population (e.g. sex workers, injecting drug users, men who have sex with men), which are being measured. In countries where there are multiple most-at-risk populations, the indicators should be reported for each population” (page 10). Further, it appears that this indicator is stressed for countries with low-prevalence/highly concentrated epidemics.