IOM Regional Office for southern Africa
PO Box 55391 Arcadia 0007 Pretoria South Africa
tel +27 (0)12 342 2789 fax +27 (0)12 342 0932
e-mail phamsa@iom.int

www.iom.org.za
According to the National Composite Policy Index Questionnaire, the country's strategy to address HIV in national uniformed services is focused on the Corridors of Hope programme, as follows:

The Corridors of Hope (COH) targets high-risk men and women, including sex workers and their clients, truck drivers, mini bus drivers, and uniformed personnel at border and high transit sites to reduce the transmission of HIV. Technical strategies include STI management, Counselling and Testing (CT), referrals for ART, behaviour change interventions that promote partner reduction and condom use, and condom social marketing. Services are provided at 10 service delivery sites and through outreach workers. FHI (Family Health International) provides technical assistance and project management and monitoring, while World Vision manages the drop in centres and provides STI management and CT. Society for Family Health implements behaviour change interventions that promote STI treatment, CT, partner notification, adherence to treatment, and consistent condom use, along with positive living and reduction of stigma for PLWHAs. Proven communication methods are used such as peer education and outreach work, drama, one to one interpersonal counselling, group discussion, mass media and local-based promotional activities.

The Government further notes that the Corridors of Hope project is the strategy used to promote IEC and other health interventions for cross-border migrants and that the United Nations High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM) are also involved in projects targeting cross-border migrants.

**RECOMMENDATIONS FOR FUTURE POLICIES/INTERVENTIONS**

It is suggested that the Government of Zambia 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 all national and sectoral plans, programmes and strategies to address HIV and AIDS including in treatment, care and support and prevention.

- Expand prevention strategies to include all migrants and mobile populations in existing care and support policies such as access to antiretroviral drug treatment; treatment of opportunistic infections; home and community based care; and psychosocial care.

- Develop a Government programme that addresses cross-border migrants, based on the lessons learned from the Corridors of Hope programme.

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53 Ibid, Appendix 2 comprises the National Composite Policy Index Questionnaire and it can be found at pp.36-41

54 Ibid, p. 38.

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, Zambia 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 Zambia, 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 Zambia 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 three percent 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 visiting family or in search of 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.

Zambia has a long history of men migrating to work, for example to large agricultural estates, and mines in the Copperbelt Province. Generally, Zambian men and women have a fairly high level of mobility. Large mobile groups in Zambia include truck drivers, sex workers, fishermen/women and fish traders, seasonal agricultural workers, cross border traders (especially young girls), miners, uniformed services personnel, prisoners, and refugees. The food crisis is also resulting in population movements.  

High population mobility in Zambia has been identified as one of the key drivers of the AIDS epidemic with the result that Zambia is one of the hardest hit countries in the SADC region. Recent surveillance data show an estimated 16% prevalence in the 15-49 age group and an estimated one million Zambians infected with HIV.  

HIV prevalence is twice as high in urban areas as it is in rural areas. The prevalence varies significantly by and within provinces, ranging from 8% in the Northern Province to a high of 22% in Lusaka.  

The AIDS epidemic has incrementally eroded capacity in both the private and public sectors. High morbidity and mortality due to AIDS has 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 agricultural workers, long distance truck drivers, mine workers, cross border traders, uniformed personnel and employees of the transport sector.  

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

**MINING**

Zambia’s economy is heavily dependent on mining copper, cobalt, zinc, silver and gold. Mining constituted 9.1% of GDP in 2006.  

As the price for copper declined, the mining industry in Zambia was hard hit. Formal employment at mines was approximately 32, 103 workers in Zambia in 2005 which is almost half of the 64 500 that were employed in mining in 1985. This amounted to 7.4 percent and 12.4 percent of formal sector employment respectively.  

The privatisation of the big mining company, Zambia Consolidated Copper Mines, in 1995 may have also played a role in this decline.  

In 2001, an anonymous unlinked prevalence survey was carried out in the Konkola Copper Mines, a major mining company in the Zambian Copperbelt region. In total, 9,024 employees were surveyed, representing 55% to 88% of employees in the various company divisions. Findings indicated that HIV prevalence in the various sites ranged from 18.1% to 20.1% among permanent employees and 14.4% to 15.2% among contract employees.

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.

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7 Zambia National HIV/AIDS Strategic Framework 2006-2010  
• **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 commercial 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 2000, agriculture accounted for 85% of total employment (formal and informal). Maize (corn) is the main cash crop. Other important agricultural products include sorghum, rice, cassava, groundnuts, sunflower, vegetables, horticultural products, tobacco, cotton, sugarcane, livestock, coffee, and soybeans.

Zambia has a long history of men migrating to work in large agricultural estates in rural Lusaka Province and sugar estates in the Southern Province. On sugar estates, for example, men leave their families to work as cane cutters from March to November.

Factors that may exacerbate the 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. This leads to 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 sex may fill the workers’ (immediate) 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. Zambia has six major trucking routes. The Chirundu-Lusaka and Lusaka-Copperbelt routes each have 100 trucks daily. Livingstone-Lusaka has over 40 trucks a day. Lusaka-Chipata, Lusaka-Mumbwa and Mongu, and Kapiri Mposhi-Nakonde each host 20 trucks a day. On average, about 300 trucks use

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12 Ibid.
13 Ibid.
Zambia’s main highways each day. There are 1,500 registered commercial trucks. Approximately 3,500 drivers and assistants are away from their families for extended periods.\textsuperscript{15}

Zambia’s place in the regional transportation network is boosted by the existence of the Zambia rail network that comprises of Zambia railways running from the Zimbabwean border in the south to the Congolese border, and the Tanzania-Zambia Railways (TAZARA) - jointly owned by Zambia and Tanzania - which links to the port of Dar es Salaam in Tanzania.

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 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 Zambian National Defense Force (ZNDF) comprises of the Army, Air Force, Police and National Service, approximately 20,000 personnel.\textsuperscript{16}

Zambia, as of 31 August 2006, had 462 police, troops and military observers at the following UN missions: UN Stabilization Mission in Haiti (MINUSTAH), UN Organization in the DRC (MONUC), UN Operation in Burundi (ONUB), UN Mission in Ethiopia and Eritrea (UNMEE), UN Interim Administration Mission in Kosovo (UNMIK), UN Mission in Liberia (UNMIL), UN Operation in the Ivory Coast (UNOCI) and UN Mission in the Sudan (UNMIS).\textsuperscript{17}

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

\textsuperscript{15} Ibid.

\textsuperscript{16} 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 in thousands) 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.

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.

- **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 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.

- **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**

There is evidence of informal cross border trade between Zambia and other SADC countries, for example Mozambique, Tanzania, Zimbabwe, and the Democratic Republic of Congo. This trade occurs among communities residing along the porous border areas, and includes both agricultural and non-agricultural commodities.

Many informal cross-border traders are women, and due to unequal gender dynamics they are vulnerable to sexual violence and likely to participate in transactional sexual relations. In Zambia some female traders exchange sex with truck drivers for transport. Police and customs officials may demand sex from women caught crossing borders illegally or who want to avoid paying customs duties. Children are increasingly entering this trade, and young girls are especially vulnerable to sexual exploitation.

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),

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20 UN Integrated Regional Information Networks Cross border trade an issue for DRC and Malawi Available at: http://www.tralac.org/scripts/content.php?id=2864

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.
sex workers, truck drivers, money-changers (‘touts’), local border-town residents and deportees, which could potentially increase HIV vulnerability for all involved.23

- **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.24 Many informal traders also avoid Zambian government services because they lack the proper documents to operate legally within Zambia and fear arrest and imprisonment. As STIs are a major contributory factor for HIV, such delays in treatment are a major contributory factor leading to increased HIV vulnerability.25

- **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.26 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.27

### FISHERIES

Fisher folk often leave their families in rural areas for several days, weeks or months at a time. Their cash earnings may result in a number of temporary sexual liaisons. Married female fish traders may exchange sexual favours for preferential road and water transport to and from fishing camps. Research findings conducted in the Kafue Flats Wetlands28 revealed the high incidence of ‘fish for sex deals’ between female traders and fishermen. These deals are often a means of survival for the women and occur particularly when fish are scarce and there is intense competition over the fish catch. Consequently female fish traders have become increasingly stigmatized by local communities because they are perceived to be responsible for the spread of AIDS. The study further revealed a growing tendency for female fish traders to hide their sexual activities, thus lessening the likelihood to seek treatment.

HIV interventions in the fisheries sector often pose serious challenges to service providers owing to the highly mobile nature of fisher folk and the transient nature of community structures. There is thus limited access to HIV information and health care in the fishery sector, and reported condom use is low.29 The low visibility of the sick in fishing camps - they move home when they become ill - combined with scarcity of condoms alcohol abuse and high-risk work, contribute to sexual risk taking behaviour among fishermen and fish traders.

The factors that may exacerbate HIV vulnerability of people engaged in fishing may include:

- **Duration of time spent away from home**: Fisher folk 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 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.

- **Limited access to healthcare services**: Because they are based along Zambia’s waterways, in remote regions, far from population centres and government services for extended periods of time, fisher folk do not have access to health care

25 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 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.)
27 Op cit.
services, including information about HIV and AIDS and/or treatment for STIs. As STIs are a major contributory factor for HIV, such delays in treatment are a major contributory factor leading to increased HIV vulnerability.30

- Lack of HIV and AIDS interventions: In general, there are few HIV and AIDS interventions that target fisher folk. Further, difficulties in actually targeting fisher folk, who are constantly on the move, preoccupied with survival needs, and who may not be receptive to HIV and AIDS education and prevention messages, are experienced by some AIDS service organizations even when they do target the traders.31

**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 workers are often motivated to maintain their mobility and work in other areas so they cannot be identified in their own villages or cities. According to the August 2006 issue of the Zambia News, the recent resurgence of the mining industry in Zambia’s Copperbelt Province has triggered a rise in sex work in the region.32 This has created renewed concern over the further spread of HIV and other STIs in the region.33

Sex work constitutes one of the largest sources of urban informal income in some parts of Zambia including towns situated along the major transport routes and at border posts. The vulnerability of sex workers to HIV is heightened by the fact that they interact with mobile or migrant workers such as miners, construction workers and truck drivers. It is necessary to target sex workers in HIV prevention and care campaigns, without further stigmatising or penalising them, in order to address the HIV vulnerability of mobile and migrant workers.

Because it is criminalized in southern Africa, it is difficult to find statistics on sex work or initiatives targeting sex workers. A study done in Chirundu (Zambia), which borders with Zimbabwe, found that every month, several thousand truckers cross the border, and over 1,000 truck drivers sleep at the border on a monthly basis. The area has approximately 300 resident sex workers, with another 200 part-time sex workers coming in from rural Chiawa at peak periods.34 Tasintha, an NGO that works with sex workers, estimates that there are at least 6,000 full-time sex workers in Zambia. Other studies put the figure at 24,000 (7,000 in Lusaka and 17,000 in tourist locations, major highways, and border and trading towns).35

Factors that may exacerbate HIV vulnerability of sex workers include:

- **Lack of HIV and AIDS interventions:** In general, there are few HIV and AIDS interventions that target sex workers. As sex work is criminalized, sex workers may not want to come forward to access HIV interventions. Further, difficulties in actually targeting sex workers, who are constantly on the move, may not be receptive to HIV and AIDS education and prevention messages, are experienced by some AIDS service organizations even when they do target the sex workers.36

- **Inability or unwillingness to negotiate condom use:** Research shows that clients of sex workers are often unwilling to use condoms or will pay for more for unprotected sex. This may result in sex workers being unwilling or unable to negotiate condom use with their clients. In addition, those with regular clients may not feel the need or may be unable to insist on condom use.

30 See Footnote 24.
31 Op cit.
33 See also IRIN, 14/06/2007, ZAMBIA: Mining growth brings increased HIV risk
36 Op cit.
CURRENT LEGAL AND POLICY INTERVENTIONS IN ZAMBIA

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. Since most States including Zambia follow a dualist approach to treaty ratification, whereby an international or regional treaty must be domesticated to be relied on in the country, the most important policy document is the HIV/AIDS national strategic plan.

This section will briefly examine selected relevant international and regional treaties that impact on HIV and migration. It will then examine Zambia’s national strategy or action plan and relevant sectoral plans in some detail, examining the impact of such a plan on migrant and mobile populations. The final section will make recommendations for Zambia 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:

- 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 Zambia, 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 Zambia signed on 17 July 1980 and ratified on 21 June 1985, 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 UN International Covenant on Economic, Social and Cultural Rights (ICESCR), which was acceded to by Zambia on 10 April 1984, 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 03 August 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 Brazzaville Declaration on Commitment on Scaling up Towards Universal

37 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.
Access to AIDS Prevention, Treatment, Care and Support in Africa by 2010 (2006) among others. Zambia is a signatory of all of these declarations, which illustrates a willingness to engage with issues relating to HIV and AIDS.

**NATIONAL POLICIES AND COMMITMENT**


The National policy provides a directive and mandate for a national multi-sectoral response to the AIDS epidemic. It also commits the government of Zambia to provide treatment for AIDS and improved care and support for those affected by the epidemic.

Issued by the Ministry of Health in January 2005, the National AIDS policy mentions migrants and mobile workers. In the situation analysis of the Policy document, mobility of groups is mentioned as one of the factors that perpetuate the transmission of HIV. Mobile populations, such as long distance truckers, migrant workers, cross-border traders, refugees, fish traders and uniformed personnel are mentioned specifically. Furthermore, “high-risk and vulnerable groups” include sex workers. In the policy the Government commits to protect high-risk groups (including sex workers) from infection. It provides a framework for the rehabilitation of sex workers, the targeting of clients of sex workers with appropriate information and education, and encourages sex workers to take responsibility for their partners’ sexual health. The Policy specifically targets sex workers in information, education and communication (IEC) prevention efforts. The policy also provides a framework to enhance migrant populations’ free access to HIV/AIDS/STI/TB interventions including VCT.

The policy also provides a framework for specific sectoral responses to the AIDS epidemic. These sectors include the following: the Agriculture, Communications and Transport, Tourism, Defense and Security, and the Private, Construction and Industry Sectors.

The policy does not provide for special targeting of migrant populations for treatment, care and support.

**The National HIV&AIDS Strategic Framework 2006-2010**

The overall goal of the National HIV&AIDS Strategic Framework (NSF) is to prevent, halt and begin to reverse the spread and impact of the HIV and AIDS epidemic by 2010. Some of the themes for priority action outlined in the NSF include intensification of HIV prevention, expansion of treatment, care and support for people affected by HIV, mitigation of socio-economic impact of AIDS, and strengthening the decentralized response.

The NSF identifies high population mobility as one of the key drivers of the epidemic. It identifies vulnerable mobile populations as comprised of refugees, long distance truckers, and migrant workers, cross border traders, fish mongers and uniformed security personnel.

The NSF provides specific HIV prevention strategies that might be used to target mobile populations. Core strategies outlined in support of the reduction of sexual transmission of HIV among people with high risk behaviours include the following:

- Improve and expand IEC and BCC activities to ensure people have access to clear, accurate information on safer sexual practices and practices that perpetuate HIV transmission including transactional sex; and
- Focus relevant BCC interventions on high-risk behaviours and groups vulnerable to these behaviours, e.g. mobile populations, refugees, truck drivers etc.

The NSF also provides a framework for the mainstreaming of HIV in sector development policies, and the development of comprehensive workplace policies/ programmes that take into account education, awareness, prevention, treatment, and care and support. The NSF does not provide a framework for the development of special programmes geared towards enhancing the access of vulnerable segments of the mobile population to treatment, care and support services.
Other Policies for Vulnerable Groups
There are a number of policies and legislative frameworks that have been developed to protect vulnerable groups in Zambia. These include the National Gender Policy, the National Youth Policy, the Public Welfare Assistance Scheme and a National Programme for Orphans.

SECTOR POLICIES, PLANS AND PROGRAMMES

The Zambia Business Coalition on AIDS (ZBCA)
In early 2004 the total formal employment in Zambia was estimated at 416,228, and the private sector accounted for an estimated 58.5% of the formally employed workforce in Zambia. The Zambia Business Coalition on AIDS (ZBCA) which is the official private sector voice in Zambia on HIV and AIDS was launched in 2000. ZBCA is made up of large and small companies, including those operating in the mining sector. ZBCA assists companies to implement workplace policies through its implementing partners, and has driven companies to recognize and appreciate the importance of workplace policies and programmes on HIV. Today there are more than fifty companies in Zambia that have policies in place, and others have taken the lead to expand their programmes further.

The ZBCA has also catalysed action to include associations of smaller businesses and even community organizations. Through advocacy work, ZBCA has encouraged small business to form associations that can act as members of the coalition and benefit from its services.

Public Sector
The UNGASS Country report shows that the mainstreaming of HIV in the Public Sector is being addressed. Focal points from 30 line ministries and establishments were being trained in HIV mainstreaming in the workplace at the time that the country report was being compiled. A fair number of government ministries have developed HIV and AIDS workplace policies and programmes such as the Ministries of Communications and Transport, Minerals and Energy, Education, Agriculture and Cooperatives.

Uniformed Services
The Ministry of Defense in 1993 established the Zambia Defense Forces HIV/AIDS Prevention, Care and Support Programme to be implemented by the Defense Forces Medical Services (ZDFMS). The programme targets military personnel, their families and populations near military bases. Proposed activities include condom distribution, home based care, training of psychological support, peer educators, and care givers for different targeted groups including youth in the military, women, military dependants and civilian populations.

In March 2003, ZDFMS announced that it will implement mandatory HIV testing of potential recruits and serving personnel. Testing positive for HIV will automatically disqualify one from joining the military. Serving members with HIV will not be discharged but will be placed in lower categories and offered “available medical attention.” In reaction to concerns about the mandatory testing, ZDFMS has responded: “Our discrimination is positive in a way, as we feel it is pointless to subject our young Zambians to rigorous training when it is going to accelerate their progression from HIV to AIDS. We reached at this decision after experiences and scientific studies to support this have been conducted.”

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Mining

Most mining companies have been adversely affected by the pandemic and have experienced low productivity and loss of profit, and have witnessed an increase in the loss of skilled personal through AIDS-related deaths. The Copperbelt Health Education Project (CHEP) developed an HIV/AIDS policy guide for the mining sector, which was officially launched in 2004. CHEP has also provided capacity building training to Small and Medium-sized Enterprises (SMEs) in HIV prevention and awareness-raising and in peer education. SMEs play a critical role as suppliers of goods and services to the mining sector, and are important stakeholders in the prevention of HIV among the surrounding communities.

Most of the largest mining companies have developed HIV and AIDS workplace polices, and established HIV workplace programmes. Examples of such mines include the Konkola copper mine, the Mopani copper mine, Kansanshi copper mine and the Copperbelt Energy Corporation.

Further developments in the mining sector’s response to the AIDS epidemic are evident in the establishment of a public-private partnership – the Global Development Alliance (GDA) - between the mining sector and the Governments of Zambia and the United States. This public-private partnership is geared towards alleviating the impact of AIDS in Zambia’s mining industries as well as surrounding communities and was established in to expand efforts that promote HIV prevention, care and treatment for miners, their families and surrounding communities. The partnership supports mobile, door-to-door and clinic-based counselling and testing, care and support for orphans and vulnerable children, and PLWAs in workplace programmes and the strengthening of ART services and laboratories. The five mining companies involved in this partnership are the Konkola copper mine, the Mopani copper mine, First Quantum Minerals through their operations in Bwana Mkubwa Mining, Kansanshi copper mines and the Copperbelt Energy Corporation.

Commercial Agriculture

As in the mining sector a GDA - public-private partnership between the agribusiness industry and the Governments of Zambia and the United States - was established to alleviate the impact of HIV and AIDS in Zambia’s agribusiness industries and surrounding communities. The industries involved in this initiative are notably Dunavant Zambia limited, Zambia Sugar Company and the Mkushi Farmers Association.

Transport

The Ministry of Communications and Transport in Zambia has a workplace HIV policy in place with a programme that includes peer education training, condom and IEC distribution and VCT services for staff. Various other stakeholders in the transport sector have established a number of HIV and AIDS interventions that include condom distribution, HIV awareness, peer educator programmes, IEC services, and VCT services. Stakeholders in the transport sector include the National Drivers’ Association of Zambia, the Truck Drivers’ Association of Zambia, Tanzania-Zambia Railways, and the Federation of Haulers. One of the most significant achievements in the Transport sector response to the AIDS epidemic has been the establishment of Truck-stop Wellness Centres.

The Corridors of Hope initiative has reached various segments of workers in the transport sector including truck drivers and other mobile populations along the major borders areas, roads and main urban centres in the country.

Commercial Sex

As well as reaching truck divers, Corridors of Hope has been instrumental in reaching sex workers. One of the main objectives of Corridors of Hope is to decrease the transmission of HIV and STIs through increased condom accessibility.
and other preventive health measures among key populations at higher risk. The initiative has targeted high-risk mobile populations in at least ten sites in Zambia, including Chirundu, Lusaka, Ndola and Chipata.

THE UNGASS PROGRESS REPORT

The UNGASS Progress Report reaffirms that Zambia has:

- A policy or strategy that promotes IEC and other health interventions for cross-border migrants.\(^\text{46}\)
- A policy or strategy to ensure or improve access to HIV/AIDS related medicines, with emphasis on vulnerable groups.\(^\text{47}\)
- Laws and regulations that protect against discrimination groups of people identified as being especially vulnerable to HIV/AIDS.\(^\text{48}\)
- A policy to ensure equal access for men and women to prevention and care, with emphasis on vulnerable groups.\(^\text{49}\)

According to the UNGASS Progress Report:

> There are a number of initiatives where consortia of civil society organizations (CSOs) have come together to strengthen outreach to hard to reach and vulnerable groups within a multi-sectoral framework (for example, the Corridors of Hope Programme targets truck drivers and sex workers in cross-border environments, whilst the C-Safe initiative operates regionally and targets farmers, farm workers and the rural poor).\(^\text{50}\)

Key populations at higher risk that have been targeted for interventions include sex workers, cane cutters, fishermen, and drivers. Table 1 shows the number of beneficiaries by focus areas through three major community-supporting institutions, notably; Community Response to HIV/AIDS (CRAIDS), Zambian National AIDS Network (ZNAN), and Church Health Association of Zambia (CHAZ) combined with the Zambian Inter-Faith Networking Group (ZINGO).\(^\text{51}\)

Table 1: Number of Beneficiaries by Focus Areas through three major community-supporting institutions (CRAIDS and ZNAN)\(^\text{52}\)

<table>
<thead>
<tr>
<th>Focus</th>
<th>Male</th>
<th>Female</th>
<th>CRAIDS</th>
<th>ZNAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex Workers</strong></td>
<td>0</td>
<td>90</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td><strong>Prisoners</strong></td>
<td>1,744</td>
<td>14</td>
<td>1,758</td>
<td></td>
</tr>
<tr>
<td><strong>Cane cutters</strong></td>
<td>431</td>
<td>582</td>
<td>1,016</td>
<td></td>
</tr>
<tr>
<td><strong>Police officers</strong></td>
<td>431</td>
<td>539</td>
<td>970</td>
<td></td>
</tr>
<tr>
<td><strong>Fisherfolk</strong></td>
<td>385</td>
<td>133</td>
<td>519</td>
<td></td>
</tr>
<tr>
<td><strong>Drivers</strong></td>
<td>500</td>
<td>0</td>
<td>500</td>
<td></td>
</tr>
<tr>
<td><strong>No. of high risk people receiving training in life skills</strong></td>
<td></td>
<td></td>
<td></td>
<td>4,594</td>
</tr>
</tbody>
</table>

\(^{46}\) The UNGASS Progress Report, p 7.
\(^{47}\) Ibid.
\(^{48}\) Ibid, p. 8.
\(^{49}\) Ibid.
\(^{50}\) Ibid, p. 12.
\(^{52}\) Ibid. This table has been adapted from the original.
According to the National Composite Policy Index Questionnaire, the country's strategy to address HIV in national uniformed services is focused on the Corridors of Hope programme, as follows:

The Corridors of Hope (COH) targets high-risk men and women, including sex workers and their clients, truck drivers, mini bus drivers, and uniformed personnel at border and high transit sites to reduce the transmission of HIV. Technical strategies include STI management, Counselling and Testing (CT), referrals for ART, behaviour change interventions that promote partner reduction and condom use, and condom social marketing. Services are provided at 10 service delivery sites and through outreach workers. FHI (Family Health International) provides technical assistance and project management and monitoring, while World Vision manages the drop in centres and provides STI management and CT. Society for Family Health implements behaviour change interventions that promote STI treatment, CT, partner notification, adherence to treatment, and consistent condom use, along with positive living and reduction of stigma for PLWHAs. Proven communication methods are used such as peer education and outreach work, drama, one to one interpersonal counselling, group discussion, mass media and local-based promotional activities.

The Government further notes that the Corridors of Hope project is the strategy used to promote IEC and other health interventions for cross-border migrants and that the United Nations High Commissioner for Refugees (UNHCR) and the International Organization for Migration (IOM) are also involved in projects targeting cross-border migrants.

RECOMMENDATIONS FOR FUTURE POLICIES/INTERVENTIONS

It is suggested that the Government of Zambia 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 all national and sectoral plans, programmes and strategies to address HIV and AIDS including in treatment, care and support and prevention.

- Expand prevention strategies to include all migrants and mobile populations in existing care and support policies such as access to antiretroviral drug treatment; treatment of opportunistic infections; home and community based care; and psychosocial care.

- Develop a Government programme that addresses cross-border migrants, based on the lessons learned from the Corridors of Hope programme.

53 Ibid, Appendix 2 comprises the National Composite Policy Index Questionnaire and it can be found at pp.36-41
54 Ibid, p. 38.
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BRIEFING NOTE
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