BRIEFING NOTE
ON HIV AND LABOUR MIGRATION IN ZIMBABWE

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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”. As a Member State, Zimbabwe has committed to pursuing this goal and is to report on its progress every two years.

In light of this commitment, the purpose of this Briefing Note is to provide an overall picture of labour migration patterns in Zimbabwe, 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 Zimbabwe 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 % of the world population. 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.

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. 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.

MIGRATION IN ZIMBABWE

Historically, Zimbabwe was a country of immigration. However, since independence in 1980 emigration has outstripped immigration, with three main waves of emigration: (1) Emigration of white Zimbabweans after independence; (2) Emigration after the massacres in Matabeleland in the 1980s; and (3) The most recent wave of emigration occurring among black Zimbabweans for political and economic reasons.6

A study conducted by the Scientific and Industrial Research and Development Centre (SIRDC) among documented Zimbabweans estimated that over half a million Zimbabweans have emigrated abroad since 1990. The majority went to the United Kingdom (36.8%), followed by Botswana (34.5%), the USA (6.9%), South Africa (4.6%) and Canada (3.4%).7 This however is believed to be an underestimation, as the number of undocumented migrants who either over-stay or travel without valid documents, usually to neighbouring countries such as South Africa or Botswana, has increased.

Although there are no reliable data on the number of undocumented Zimbabwean migrants staying in South Africa or Botswana, a recent estimation by the Zimbabwean Central Bank put the number of Zimbabweans staying in South Africa at 1.2 million.8 The increasing number of Zimbabweans migrating to South Africa can also be deduced by the number of those who are deported back to Zimbabwe. According to the IOM’s Beitbridge Reception and Support Centre for returnees, since its opening in May 2006, over 12,000 Zimbabwean returnees have passed through Beitbridge per month. In January 2007, figures rose to more than 21,400 returnees and more than 14,000 for February 2007.9

In addition, many Zimbabweans in the informal and agriculture sectors have become vulnerable due to the 2005 clean-up operation, “Murambatsvina” and the “Fast-Track Land Reform Programme” in 2000-2002.10

High population mobility has been identified as one of the key drivers of the HIV epidemic in Zimbabwe. Recent surveillance data show an estimated 20.1% prevalence in the 15-49 age group, and an estimated 1,610,000 Zimbabweans infected with HIV at the end of 2005.11 Although HIV prevalence is high, the 2005 rate is an improvement from the 24.1% recorded in 2003 indicating that Zimbabwe has made some progress in controlling the spread of the epidemic.

10 IRIN (2005) Zimbabwe: Call for new voters’ roll after cleanup campaign displacement
The AIDS epidemic has impacted strongly not only on families and communities, but also on commerce, industry, education and health and other social services. Capacity in both the private and public sectors has been incrementally eroded owing to high morbidity and mortality due to AIDS. The loss of skilled labour through illness and death has significantly reduced productivity, increased production costs and caused disruptions in business operations.

Although the AIDS epidemic in Zimbabwe is generalised, women and girls are particularly vulnerable to infection. Surveillance survey reports show that women and girls are twice as affected by HIV compared to the general population. The 2005 surveillance data show that HIV prevalence among women 15-49 constitutes more than 56% of the adult prevalence.\(^\text{12}\) HIV prevalence surveys have also shown very high levels of infection in border areas, growth points, mining towns and on commercial farms,\(^\text{13}\) suggesting mobility and spousal separation are major vulnerability factors. 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 Zimbabwe, and the particular HIV vulnerabilities faced by these workers are presented below.

**MINING**

Zimbabwe’s mining industry is focused on a diverse range of small to medium-sized mining operations. The most important minerals produced by Zimbabwe include gold, asbestos, chromite, coal and base metals. The mining industry contributes approximately 8% towards the country’s Gross Domestic Product (GDP).

Due to the general small-scale nature of mining activities in Zimbabwe, there are an estimated 100 000 to 300 000 informal miners active throughout Zimbabwe. The lower commodity prices have had a worse affect on these small operations and as a result several operations have closed down. Thirty five different metals and minerals are produced, with the formal mining industry employing some 57 000 people although there have been significant job losses as a result of low commodity prices.\(^\text{14}\)

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

\(^{12}\) ibid
\(^{13}\) 2003 Zimbabwe Antenatal Surveillance Survey
\(^{14}\) http://www.mbendi.co.za/indy/ming/af/zi/p0005.htm
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

The number of large-scale white and corporate owned farms increased from 545 in 1904 to a peak of 6255 in the mid-1950s, declining to 4 500 in 1990. The large scale commercial farms, the largest employer of formal labour, employed 450 000 full time workers who, together with their families, comprised about two million people or 20% of the country's population. The difficulties encountered in recruiting labour for the commercial farms led to a policy of recruitment from neighbouring Malawi, Zambia and Mozambique. By 1966 an estimated 54% of male labour in the agriculture sector was foreign. A study by the General Agriculture and Plantation Workers’ Union of Zimbabwe (GAPWUZ) in 1999 put the figure of “alien” farm workers at 30% of the total farm worker population.\(^{15}\)

The “fast track” land redistribution policy of the Government has resulted in many commercial farmers leaving or being forced off their land, and has created thousands of mobile farm workers within the country. The attitudes towards farm workers have been described as follows:

> In the fast track programme, farm workers are no longer seen as a specific category to be considered for resettlement, but are viewed with suspicion if not outright hostility, while senior government officials claim that it is not government policy to displace farm workers, and that these would be considered on all fast tracked farms (either for resettlement on that farm or another property) the reality on the ground tends to contradict this. Since the beginning of the Fast Track Land Resettlement Program from July 2000 to February 2001, 347 farms with an estimated 13 800 farm worker households were noted to have been negatively affected while an estimated 738 farms were gazetted which is likely to affect a further 29 520 farm worker households...There seems to be a resurgence of the perception that the majority of farm workers are aliens, who have no rights in Zimbabwe other than those, bestowed by their employers. Although this argument has been used by politicians and the media since the late 1980s to disqualify farm workers from securing land rights in resettlement schemes or even communal areas, this occurred as a new land policy was emerging that emphasized efficient, productive and skilled settlers. This has even been used to explain the “failure” of resettlement policy in terms of farm productivity, by early resettlement policy in terms of farm productivity, and by early resettlement schemes of the 1980s.\(^{16}\)

Factors that may 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.

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16 Ibid, p. 4.
• **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 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’ (temporary) emotional and sexual needs.

**CONSTRUCTION**

Currently, the South African construction sector attracts migrant workers from Mozambique, Zimbabwe, Swaziland and Botswana, with Mozambique and Zimbabwe as the major suppliers of labour. According to a survey undertaken in 1997/8 among South African construction companies, the vast majority of these workers are male, young, single, and have low levels of formal education.\(^\text{17}\)

The factors that may exacerbate HIV vulnerability of construction workers include:

• **Isolated work sites for short periods**: Short term work on sites often located around isolated and impoverished communities, which may lead to members of the local community, especially poor women, to engage in transactional and commercial sex with construction workers who have disposable income. Further, the isolated work sites leads to a lack of social cohesion and social norms governing behaviour of workers, which may lead to engagement in risky sexual behaviour.

• **Single-sex hostels and limited home-leave**: Construction 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 construction sites. 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.

• **Dangerous working conditions**: Faced daily with the prospect of accidents and dangerous working conditions and risk of physical injury, construction 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 Zimbabwean military consists of the Zimbabwe National Army, Air Force of Zimbabwe (AFZ) and Zimbabwe Republic Police, with approximately 41,000 personnel.\(^\text{18}\)

Zimbabwe, as of 31 August 2006, had 98 police and military observers at the following missions: United Nations Interim Administration Mission in Kosovo (UNMIK), United Nations Mission in Liberia (UNMIL) and United Nations Mission in the Sudan (UNMIS).\(^\text{19}\)

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

- **Single-sex hostels and limited home-leave**: Military personnel have no choice but to live in single-sex hostels without the option of being accompanied by their partners and families. In addition, they may have limited home-leave which further distances them from their partners. These circumstances may lead some workers to seek other (multiple) relationships.

- **Boredom and loneliness**: There is limited availability of recreational activities such as sports or entertainment at military bases or at borders. Personnel are often distanced from traditional norms and support systems that regulate behaviour in stable communities, and coupled with feelings of boredom, loneliness, and isolation, this can result in a disregard for health. In addition, the proximity and availability of 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

Informal cross border trade in Zimbabwe has developed against a background of deteriorating economic conditions in Zimbabwe over the past decade. The economic decline in Zimbabwe has forced many low and middle income households to engage in informal trading in order to supplement their families’ income.\(^\text{20}\)

Informal cross border trade in Zimbabwe has become dominated by women. Besides migrating into South
Africa for trade purposes, Zimbabwean women also go to Mozambique, Zambia, Botswana and even as far afield as Tanzania to purchase and bring home second hand clothing and goods for resale at home.\footnote{Ibid, p4}

The factors that may exacerbate HIV vulnerability of informal 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.\footnote{IOM (2003) Mobile Populations and HIV/AIDS in the Southern African Region: Desk Review and Bibliography on HIV/AIDS and Mobile Populations Pretoria: South Africa.} 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.\footnote{IOM (2005) Mission Report on HIV/AIDS among Informal Cross-border Traders in Botswana, Zambia and Zimbabwe Pretoria: South Africa.}

- **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.\footnote{Ibid.} As STIs are a major contributory factor for HIV, such delays in treatment are a major contributory factor leading to increased HIV vulnerability.\footnote{IOM (2005) Mission Report on HIV/AIDS among Informal Cross-border Traders in Botswana, Zambia and Zimbabwe Pretoria: South Africa.}

- **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.\footnote{Op cit.} Further, difficulties in actually targeting informal cross border traders, 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.\footnote{Op cit.}

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**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. Sex work also contributes to sexual networks linking other mobile or migrant workers such as miners, construction workers and truck drivers. For these reasons, it is necessary to target sex workers, without further stigmatizing or penalizing them, in order to address HIV vulnerability of mobile and migrant workers.

Because it is criminalised throughout southern Africa, it is difficult to find statistics and information about sex work or to implement initiatives targeting sex workers. In the Zimbabwe/South Africa border town of Beitbridge, which is an area approximately 500 kilometres away from Harare with about 20 000 residents, there are about 500 resident sex workers, with about 200 part time sex workers coming in from arid rural Masvingo and Matabeleland South at peak periods. In Chirundu, a town of approximately 2700 to 4000 residents, there are approximately 100 resident sex workers, with another 200 part-time sex workers coming in from Kariba, Makuti, Karoi and rural Urungwe and Magunje at peak periods.

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.

- **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.

**CURRENT LEGAL AND POLICY INTERVENTIONS IN ZIMBABWE**

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 AIDS epidemic on vulnerable groups and to address socio-legal and structural factors that render certain population groups vulnerable to HIV. Since most States including Zimbabwe 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 Zimbabwe’s national strategy 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 Zimbabwe on issues relating to HIV and mobile and migrant populations.


30 Op cit.
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 and their Families, which has not yet been signed by Zimbabwe, 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 Zimbabwe acceded to on 13 May 1991, 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 Zimbabwe on 13 May 1991, 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 18 November 2003, 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), Maseru Declaration and Commitment on 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. Zimbabwe is a signatory of all of these declarations which illustrates a willingness to engage with the issues relating to HIV and AIDS.

**NATIONAL POLICIES AND COMMITMENTS**

**National HIV and AIDS Policy (1999)**

The Zimbabwe national policy on AIDS provides a guiding framework for a multi-sectoral national response to the epidemic and a context within which sectoral and other strategic plans are formulated, monitored and coordinated. The national policy is premised upon a number of guiding principles that allow for comprehensive HIV interventions including prevention, care and support, respect for human dignity and human rights, sectoral and workplace responses to the epidemic to mention a few.

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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/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 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.
Guiding principle 31 as outlined in the policy calls for more effective policies and strategies to deal with sex work, while guiding principle 32 indicates a need to ensure that information, education, counselling, male and female condoms and STI care services are accessible and affordable to all sex workers and their clients.

**National HIV and AIDS Strategic Plan 2006-2010**

The Zimbabwe National AIDS Strategic Plan (ZNASP) provides a strategic framework for a multi-sectoral national response to the epidemic. The overall goal of the ZNASP is to reduce the spread of HIV, improve the quality of life of those infected and affected by HIV, and to mitigate the socio-economic impact of the epidemic in the country.

The ZNASP acknowledges high population mobility as one of the key drivers of the AIDS epidemic. It considers mobile populations as a vulnerable group and these include sex workers, cross-border traders, uniformed personnel (soldiers, police, game rangers, the militia, customs and immigration officials), truck drivers, the internally displaced and the farming community. The ZNASP also recognises that the vulnerability and risk factors of mobile populations are caused by long periods of separation from regular partners and social settings, which may result in causal and commercial sex and/or irregular access to HIV prevention and care services.

The ZNASP seeks to address high risk vulnerabilities arising from spousal separation through workplace policies that minimise spousal separation. It also provides a framework for the development of policies/programmes that regulate sex work with particular focus on areas where high commercial sex trade is concentrated and the development a minimum service package (prevention and mitigation) for the commercial sex industry. It also provides a framework for the development of specially tailored programmes for mobile populations that address and mitigate their vulnerability to HIV. Significant to mention also is that the ZNASP calls for AIDS mitigation services to be broadened to the workforce through workplace programmes and policies. The strategic plan also seeks to ensure that all sectors actively engage in national HIV policy making and planning at national level and calls for the further mainstreaming of HIV in sectors such as mining, transport, construction, agriculture, uniformed services, informal cross-border trade and commercial sex.

Some of the strategies in the current ZNASP that were not included or emphasised in previous strategic plans and interventions include the following:

- Lobbying and advocating policies and practices which enable married couples to live in the same locality, for example teachers, uniformed forces and personnel, contract workers (road maintenance, infrastructure development, etc.);
- Information, education, counselling, male and female condoms and STI care services must be made accessible and affordable to all sex workers and their clients; and
- Longer-term regulation of the commercial sex scene.

It is significant to note that there is no specific mention of migrants and mobile populations under the strategy on Treatment and Care in the ZNASP. This becomes critical, particularly for segments of the mobile population who are highly stigmatised and marginalised, and not likely to easily access services.

**Other Policies for Vulnerable Groups**

There are a number of policies that have been developed to protect vulnerable groups in Zimbabwe. These include the National Gender Policy (2004), the Sexual Offences Act (2001), the Children’s Act (2002), and the Social Welfare Assistance Act (1998), and the Disabled Persons Act (1992).
It is significant to note however, that the Gender National Plan of Action is still to be developed and that a fair number of the international instruments of which Zimbabwe is a signatory are still to be domesticated. These include CEDAW, the Women’s Human Rights Protocol and the SADC Gender and Development Declaration together with its addendum on the Eradication of Violence Against Women and Children.

**SECTOR POLICIES, PLANS AND PROGRAMMES**

In the UNGASS Progress Report, the Government notes that while Zimbabwe has made much progress in establishing a good policy framework, there are still gaps that exist, especially in sectoral policies. While Transport, the Uniformed Services, and the Public Service have HIV policies already in place, Education, mining, Agriculture and the private sector are still in the process of developing their sectoral policies, and strategies. The private sector is currently developing a draft strategy for HIV and AIDS that seek to promote effective, high quality prevention, care and treatment interventions at sector and organisational level. It also seeks to ensure improved coordination among private sector organisations in the overall response to the epidemic.

**The Zimbabwe Business Council against AIDS (ZBCA)**

The ZBCA was registered in 2004 and only became fully operational in 2006 when the secretariat was established. The ZBCA’s membership if made up of small, medium and large business companies, and it offers a range of services to members. ZBCA aims to assist business, labour unions, government and non-governmental organisations to establish effective HIV programmes and policies for the workplace.

**Uniformed services**

The Uniformed services comprise of the Zimbabwe National Army, the Zimbabwe Air Force, the Zimbabwe Prison Services and the Zimbabwe Republic Police. Each of these sub-sectors has their own HIV policy due to differences in their operations. Priority programme areas across all sub-sectors focus on prevention, care and treatment and the management of opportunistic infections, ARTs, and home based care. Prevention programmes include voluntary counselling and testing, peer education, condom promotion and distribution, prevention of mother-to-child-transmission of HIV, and information dissemination. Since the uniformed forces each have their own schools that cater for dependants, they also have prevention programmes targeting children and youth. HIV and AIDS programmes in the Uniformed Services started in early 2003.

**Transport**

The Zimbabwe National Transport Sector Policy was launched in 2003. The primary goal of the policy is to guide the process of dealing with HIV and AIDS in the workplace at all levels in the transport sector. Priority areas outlined by the policy include provision of HIV prevention services, reduction of AIDS stigma and discrimination, and care and support. The policy applies to all employers and employees including applicants for work in the public and private sectors, and all aspects of work, formal and informal.

The Corridors of Hope initiative is an integral part of Zimbabwe’s transport sector response to the AIDS epidemic, and has also played an instrumental role in assisting the country to reach various segments of workers in the


33 http://www.weforum.org

transport sector including truck drivers, and other mobile populations along the major border areas, roads and main urban centres in the country.

**Commercial Agriculture**

Zimbabwe has an agricultural sector strategy on HIV/AIDS that was launched in 2006. The primary aim of the strategy is to halt the spread of HIV/AIDS on farms, reduce stigma against people living with HIV, fight gender inequality and domestic violence and to facilitate treatment for infected people. The strategy provides a framework for the provision of HIV prevention services to the workplace and to communities and special care and treatment programmes for vulnerable groups. It also seeks to advance special mitigation programmes and economic empowerment of vulnerable groups.

**THE UNGASS PROGRESS REPORT**

According to the UNGASS Progress Report, there are a few in-depth research initiatives in the country that are examining HIV and mobile groups. The most prominent is the Manicaland Study coordinated through the Biomedical Research and Training Institute (BRTI). It aims to describe and evaluate the temporal dynamics of HIV transmission, impact and control in small towns, large-scale commercial farming estates, roadside trading centres and subsistence farming areas in eastern Zimbabwe. Between 1998 and 2003, a community-randomized controlled trial was used to evaluate the effectiveness of peer education, community condom distribution and intensified syndromic management of sexually transmitted infections – interventions that are widely applied in Zimbabwe. Unfortunately, the study found no effect of the programmes on HIV incidence at the community level over a three-year period.

**RECOMMENDATIONS FOR FUTURE POLICIES/INTERVENTIONS**

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

- Sign, ratify and domesticate the UN International Covenant on the Protection of Migrant Workers and their Families. This would afford migrant and mobile workers with increased legal protection, such as better living and working conditions and access to health. At the same time, domesticate the other international and regional treaties to make them applicable in the country.

- Undertake a review and harmonization of existing legislation, especially labour and immigration legislation, which has a potential impact on migrants and mobile populations. This should include a review of various immigration and work visas.

- Include mobile and migrant workers in any national and sectoral plans, programmes and strategies to address HIV and AIDS including in treatment, care and support and prevention.

- Expand prevention strategies to include all migrant 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.

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

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