Partnership on HIV and Mobility in southern Africa

BRIEFING NOTE
ON HIV AND LABOUR MIGRATION IN SOUTH AFRICA

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In Annexure 1: National Composite Policy Index (NCPI), the Government affirmed:

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

While the definition of “vulnerable groups” was not outlined in the previous National Strategic Plan or the UNGASS Progress Report, according to the World Health Organization, South Africa has recognized sex workers, migrant labourers, truck drivers, men who have sex with men, and people with sexually transmitted infections as vulnerable groups. This being the case, other sections of the NCPI which South Africa answered positively and which may be relevant for migrant and mobile workers, include the following:

- “The country has a policy or strategy to promote information, education and communication and other preventive health interventions for most-at-risk populations” (NCPI-A-III-3).
- “The country has a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities. (These commodities include, but are not limited to, access to confidential voluntary counselling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections)” (NCPI-A-III-4).
- “The country has non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination” (NCPI-B-I-2).
- “The country has a policy to ensure equitable access to prevention and care for most-at-risk populations” (NCPI-B-I-7).

Finally, the Government acknowledged that the following was not achieved: “The Government has, through political and financial support, involved vulnerable populations in governmental HIV-policy design and programme implementation” (NCPI-B-I-5).

RECOMMENDATIONS FOR FUTURE POLICIES/INTERVENTIONS

It is suggested that the Government of South Africa 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 harmonisation of existing legislation, especially labour and immigration legislation, which has a potential impact on migrants and mobile populations. This should include a review of various immigration and work visas.
- Initiate a programme specifically addressing xenophobia and stigmatisation of foreigners in South Africa, such as the previous ‘Roll-back Xenophobia’ campaign.
- 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.

Cover photographs: Tsvangirayi Mukwazhi

47 The Roll Back Xenophobia Campaign was coordinated from the office of the South African Human Rights Commission and comprised of various organisations such as Lawyers for Human Rights, OHCHR and others. For further information, refer to the Plan of Action at http://www.the.org.za/human_rights/plan_of_action
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, South Africa 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 South Africa, 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 South Africa can better fulfil its UNGASS, and other, commitments to migrants and mobile populations.

MIGRATION: AN OVERVIEW

In 2005 there were approximately 191 million migrants globally, a figure that has more than doubled since 1960. Migrants now constitute almost 3% of the world population. 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.

South Africa is a net importer of labour. Historically there has always been movement of migrants from most SADC countries to South Africa, as well as from South Africa to other countries in the region. Since the end of apartheid in 1994, there has been a steady increase of both documented and undocumented migrants in the country from countries in Africa as well as from South and East Asia. In recent years, there has been a marked increase of Zimbabwean migrants coming into South Africa due to the economic difficulties experienced in Zimbabwe.

South Africa has had a long history of internal migration. During the apartheid era, population movements were largely characterised by migratory patterns that oscillated between the underdeveloped Bantustans/homelands and black townships, and the industrial/urban centres of employment. The abolition of segregationist policies and influx control measures in the post apartheid era has resulted in a significant change in the configuration of internal migratory patterns as migrants have come to establish more permanent settlements in urban and peri-urban areas. However, migrants continue to keep strong ties with their rural roots.

Population mobility and migrant labour in South Africa has been identified as one of the key drivers of the AIDS epidemic. South Africa has an estimated 18.3% prevalence within the adult population of 15-49 years, with a higher prevalence amongst women than men. According to recent surveillance data, women in South Africa account for 55% of all people living with HIV. Mobile populations are also highly vulnerable to the epidemic, and key populations at higher risk include sex workers, cross border migrants, informal traders, seasonal agricultural workers, miners, construction workers and uniformed personnel.

HIV prevalence in South Africa varies by province, sub-province and by geo-type of residence, with the level of HIV prevalence in informal urban areas being nearly twice as high as in formal urban areas. Similarly, there are variations between the informal rural areas and formal rural areas showing 11.6% and 9.9% prevalence respectively. A survey conducted in 2005 showed that persons aged 15-49 years living in informal settlements had by far the highest HIV prevalence at 25.8%. Individuals at high risk of HIV infection in informal settlements tend to include work-seekers, temporary workers, and labour migrants.

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

**MINING**

A study conducted by Crush et al in 2000 estimated that about 60% of workers in the mining sector in South Africa were from neighbouring countries, mainly Lesotho, Mozambique and Swaziland. Table 1 shows the number of cross border migrants working on the mines - by sending country - in previous years.

<table>
<thead>
<tr>
<th>YEAR</th>
<th>RSA</th>
<th>BOTSWANA</th>
<th>LESOTHO</th>
<th>MOZAMBIQUE</th>
<th>SWAZILAND</th>
<th>TOTAL</th>
<th>% RSA</th>
<th>% FOREIGN</th>
</tr>
</thead>
<tbody>
<tr>
<td>1920</td>
<td>74,452</td>
<td>2,2112</td>
<td>10,439</td>
<td>77,921</td>
<td>3,449</td>
<td>174,402</td>
<td>43</td>
<td>57</td>
</tr>
<tr>
<td>1940</td>
<td>178,708</td>
<td>14,427</td>
<td>52,044</td>
<td>74,883</td>
<td>7,152</td>
<td>347,054</td>
<td>51</td>
<td>49</td>
</tr>
</tbody>
</table>

7 Ibid.
8 Ibid
9 Ibid, pg2
11 Ibid, p26
During the 1990s, South African mines experienced major downsizing with retrenchments creating considerable social disruption and increased poverty in migrant-supply areas. Interestingly, the mines laid off local workers at a much faster rate than foreign workers. As a result, the proportion of foreign workers rose from 40% in the late 1980s to close to 60% in 2000. This “externalisation” of the workforce was particularly beneficial to Mozambicans, who now make up 25% of the mine workforce, up from 10% a decade ago.13

The mining industry in South Africa, which relies heavily on migrant labour, has been adversely affected by the AIDS epidemic. An in-depth survey commissioned by the South African Business Coalition on HIV/AIDS (SABCOHA) to assess the impact of AIDS in business revealed that HIV and AIDS related illnesses and deaths are clearly taking their toll on the mining sector.14 Over 60% of the mines in the survey reported having lower profits due to HIV and AIDS. Further, over 75% of mining companies surveyed expected HIV and AIDS to have an adverse impact on profits in five years time. At the time of the study two of South Africa's mining giants, Harmony and Anglo-Gold, each estimated that approximately one in three of their employees was infected with HIV.

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

- **Dangerous working conditions:** Faced daily with difficult and dangerous working conditions and risk of physical injury, mine workers tend to be preoccupied with other immediate challenges and may regard HIV as a distant threat.

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

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

Although commercial agriculture in South Africa accounts for less than 5% of gross domestic product, it accounts for almost 11 percent of formal sector employment, and nearly 10% of South Africa's total exports. Continuing a long-term trend, the number of agricultural workers in South Africa decreased by 152,445 (13.9%) from just over one million in 1993 to 940,820 in 2002. Employment opportunities in commercial agriculture in South Africa have been largely limited to unskilled workers earning low wages, and a large share of total employment in commercial agriculture is of a seasonal and temporary nature.

While the number of people employed in regular and seasonal employment on commercial farms has declined, there has been an increase in the employment of foreign migrants since 1990. Farms in border areas in particular, tend to employ foreign migrants who are concentrated in border areas, or where major migration routes cross commercial farming districts. Foreign farm workers are concentrated on the commercial farms in the border areas of provinces like Mpumalanga, Limpopo and the Eastern Free State.

It is estimated that there are between 10,000 and 80,000 Mozambicans working on South African farms in Mpumalanga Province, while in Limpopo Province the number of Zimbabweans working on farms seasonally ranges between 70,000 and 80,000. Further, it is estimated that more than 7,000 migrants from Lesotho work on asparagus farms seasonally in the Free State Province.

A study conducted on HIV vulnerability with 183 South African and Mozambican farm workers on 12 commercial farms in Hoedspruit (Limpopo) and Burgersfort (Mpumalanga) found high levels of migration and mobility on commercial farms, with fluctuations corresponding to harvesting seasons. Factors that were found to lead to HIV vulnerability included: a lack of access to information on HIV; belief in HIV myths and misconceptions; very few interventions from government and non-governmental organisations targeting the farm workers; lack of incentive or facilities to test for HIV; lack of appropriate information, education and communication (IEC) materials (for example, there were no materials in languages spoken by the workers and/or materials for lower literacy levels); and lack of access to condoms.

Other 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.

- **Lack of access to health care facilities**: In general, there is a dearth of health care and HIV and AIDS services in commercial farming areas. This is exacerbated by the few rights and legal protection accorded to agricultural workers – with limited protection, especially if they are undocumented, farm workers may be unable or unwilling to access existing clinics for health related matters. In other words, the need to remain far from any type of “officialdom” may result in less access to health care facilities, impacting on health information and access to condoms, treatment for STIs etc.

- **Boredom and loneliness**: There is limited availability of recreational activities such as sports or entertainment at or around farms. Workers are often distanced from traditional norms and support systems that regulate behaviour in

16 ibid
19 Ibid.
stable communities, and coupled with feelings of boredom, loneliness, and isolation, this can result in a disregard for health. In addition, the proximity and availability of commercial and/or casual sex may fill the workers’ (temporary) emotional and sexual needs.

**TRANSPORT**

The transport sector generally does not employ foreign workers, but the nature of work makes those involved, for example truckers and taxi drivers, mobile. Research in South Africa has shown that an estimated 71% of long distance truck drivers spent 15 or fewer days at home in the prior six months of the study.\(^{21}\) Delays in border crossing are commonplace; for example, drivers travelling to Zimbabwe, Mozambique and Malawi can wait days before all the formalities are completed and they are allowed to cross the borders.\(^{22}\)

Workers operating within the transport sector are highly vulnerable to HIV due to the mobile nature of their occupations, which increases their likelihood to engage in multiple sexual partnerships. Sex work and trucking are interwoven in border sites. Informal “brothels” are often situated near truck routes and truck stops, and their inhabitants acknowledge that their clients are largely drivers. A study conducted by Family Health International in the northern borders of South Africa with Zimbabwe revealed that there is a large sex work industry in the town of Messina that targets thousands of truckers who cross and sleep at the border each month.\(^{23}\) The sex work industry in Messina attracts sex workers from the Northern Province in South Africa, and adjacent areas of Mozambique and Zimbabwe.

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 condition:** 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.

**CONSTRUCTION**

In 2003, approximately 5.4% of total employment in South Africa was accounted for by the construction industry.\(^{24}\) While formal employment in the construction sector has dropped from 255,000 workers in 1990 to about 214,333 in 2002, there has been a continuing shift to informal employment and the Census 2001 indicated that as many as 520,000 people are employed within the construction industry.\(^{25}\)

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 taken in 1997/8...

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23 Corridors of Hope in Southern Africa: HIV Prevention Needs and Opportunities in four border towns (source: http://www.fhi.org)
among South African construction companies, the vast majority these workers are male, young, single, and have low levels of formal education.\(^{26}\)

The South African construction industry has a very high incidence of HIV. Labour camps of construction workers have been described as breeding grounds for the spread of Sexually Transmitted Diseases (STDs) including HIV, this being compounded by the situation whereby migrant workers on contract generally ignore or are ignorant of the consequences of casual sexual relationships.

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 sex and/or sex work with construction workers who have disposable income. Further, the isolated work sites lead 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 sex workers may fill the workers’ (temporary) emotional and sexual needs.

- **Dangerous working conditions:** Faced daily with difficult 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 South African National Defence Force (SANDF) embraces the Army, Navy, Air Force, Military Health Division, Joint Support Division and Intelligence Division as well as the Secretariat for Defence Division.

The SANDF is currently actively involved in peacekeeping in Africa, with the largest peacekeeping troop in Africa and the ninth largest peacekeeping troop in the United Nations. South African troops are deployed under United Nations and/or African Union auspices in Africa in:

- Democratic Republic of the Congo, where approximately 1,330 troops have been posted since 2002;
- Burundi, where approximately 1,290 troops have been posted since 2001; and
- Liberia, Ethiopia, Eritrea and Sudan, where 270 troops have been posted since 2000.

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Further, missions have assisted in election monitoring in Mozambique in December 2004; provided assistance in election readiness in Comoros; and provided humanitarian relief in Madagascar. SANDF has also been involved in border control, and the control of organised drugs and crime in South Africa. Thus, troops are moving either within the country or across borders for varying lengths of time.

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

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

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

- **Dangerous working conditions:** Faced daily with the prospect of danger and death, military personnel may be preoccupied with other immediate challenges and may regard HIV as a distant threat.

- **Lack of social cohesion:** The social exclusion that mobile workers often feel in their new environment and the lack of community cohesiveness may lead to risky sexual behaviour among workers and members of the surrounding community. The social structures and norms in these environments may create feelings of anonymity, which could result in feelings of limited accountability and responsibility. These feelings could also be due to shifting social norms and lack of community sanction for errant individual behaviour.

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

### INFORMAL CROSS BORDER TRADE

Informal trade is a vibrant sector in South Africa, for both informal traders within South Africa and also for cross-border traders from various neighbouring countries and beyond. A study examining 541 female informal traders from Malawi, Botswana, Mozambique, and Zimbabwe and from within South Africa found that South Africa was the country of choice for all traders. Goods purchased in South Africa ranged in type and cost. The majority of informal cross border traders were women, usually the sole providers for their families travelling from days to months.

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. 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.30

- **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.31 As STIs are a major contributory factor for HIV, such delays in treatment are a major contributory factor leading to increased HIV vulnerability.32

- **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.33 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.34

**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.

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. Because it is criminalized in southern Africa, it is difficult to find statistics on commercial sex or initiatives targeting sex workers. However, 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.

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

32 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.)
34 Op cit.
35 Op cit.
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 SOUTH AFRICA

The importance of migration in SADC, as well as the impact of migration on 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. Most States including South Africa follow a dualist approach to treaty ratification, whereby an international or regional treaty must be domesticated officially to be relied on domestically. Thus the most important policy document is the national strategic plan.

This section will examine selected relevant international and regional treaties that impact on HIV and migration. It will then examine South Africa’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 South Africa 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 South Africa, 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 South Africa acceded to on 06 May 2002, 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 signed by South Africa on 03 October 1994, 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,

36 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 its 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.
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 16 March 2004 and ratified on 17 December 2004 by South Africa, 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 on 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. South Africa is a signatory of all of these declarations, which illustrates a willingness to engage with the issues relating to HIV and AIDS.

NATIONAL POLICIES AND COMMITMENTS

The National Policy on HIV/AIDS provides a framework for a reduction in the transmission of STDs and HIV infection. It also provides a framework for the provision of appropriate care, treatment and support for those affected.

The HIV & AIDS and STI Strategic Plan for South Africa 2007-2011
The HIV & AIDS and STI Strategic Plan for South Africa 2007-2011 (NSP) provides a guiding framework to the national multi-sectoral response to the AIDS epidemic. The primary aim of the NSP is to reduce the number of new infections by 50% by 2011, and to mitigate the impact of the AIDS epidemic by expanding, among others, access to treatment, care and support to 80% of all people diagnosed with HIV by 2011.

The NSP identifies population mobility and labour migration as one of the drivers of the AIDS epidemic and recognises the vulnerability of mobile populations to HIV. It acknowledges that individuals who engage in work-seeking, mobile forms of work or migrant labour are at increased risk to HIV. Mobile populations described as vulnerable to HIV in the NSP include informal traders, long-distance truck drivers, sex workers, cross border migrants, seasonal agricultural workers, and migrant workers (mine workers, construction worker and uniformed personnel).37

The NSP provides an HIV prevention framework that seeks to promote the adoption of behaviour change curricula for different target groups including higher risk groups. It also provides a framework for the increased roll-out of comprehensive customized prevention packages to higher risk occupational groups including access to VCT and provision of male and female condoms, STI symptom recognition and STI services. Another objective outlined in the NSP for prevention is to increase rollout of workplace prevention programmes. One of the interventions outlined under this objective includes assisting SMEs to implement workplace policies.

The NSP also provides a guiding framework for the protection of rights of casual, contract and or poorly organised workers. It also seeks to ensure non-discrimination in access to HIV prevention, treatment, and support by marginalised groups including sex workers, refugees, and undocumented migrants and immigrants.

The NSP does not provide a framework for interventions that address mobile populations’ access to treatment, care and support.

38 http://www.buanews.gov.za
Lastly, Goal 17 of the Strategic Plan seeks to enhance an enabling policy and legal for effective HIV prevention, treatment and support. This includes amending the Sexual Offences Act to decriminalise sex work.

Other Policies for Vulnerable Groups
There are a number of policies that have been developed to protect vulnerable groups in South Africa. These include the National Policy Framework for Women’s Empowerment & Gender Equality (1995), the National Youth Policy (1997) and Youth Development Policy Framework 2002-2007, Policy Framework for Orphans and other Children Affected by HIV&AIDS (2005), Employment Equity Act, Social Assistance Act (2004), Welfare Amendment Act (1997), and the Domestic Violence Act (1998) among others.

SECTOR POLICIES, PLANS AND PROGRAMMES

South African Business Coalition on HIV&AIDS (SABCOHA)
The South African Business Coalition on HIV and AIDS (SABCOHA) was established in 2000 by the South African Foundation. One of the key aims of SABCOHA is to mobilize the private sector around the AIDS pandemic. SABCOHA has developed partnerships with government and civil society in dealing with the pandemic.

In 2005, SABCOHA conducted a survey of various companies in the private sector to measure progress in the implementation of workplace HIV and AIDS programmes. Included in the sample that was surveyed were companies in the following sectors: mining, transport, building and construction, manufacturing, and retail. The surveyed showed that 60% of the mines and around 50% of the manufacturing and transport companies surveyed had an HIV policy in place. The survey, however, revealed poor implementation of HIV and AIDS workplace policies in the labour intensive sectors in particular transport, building and construction.

Public Sector
All government departments have focal points on HIV and AIDS as well as workplace policies and strategies on HIV and AIDS. The public sector has a comprehensive legislative and policy framework for HIV and AIDS workplace programmes. The legislative and policy framework for HIV and AIDS workplace programmes comprise the following among others; the Public Service Regulations (2002), the Code of Good Practice on Key Aspects of HIV, AIDS and Employment (2000), and the Employment Equity Act (1998).

Transport
The Department of Transport has developed a Transport Sector HIV/AIDS Strategic Plan, which was launched at the Transport Sector Conference on HIV and AIDS in November 2001. The overall goal of the Plan is to “…establish and maintain a healthy community and a stable and comparative transportation sector by effectively preventing and managing HIV/AIDS”.

The Plan focuses on five priority areas: promotion which includes promoting safe and healthy sexual behaviour; treatment, care and support which includes providing care and support in transport communities; research, monitoring and evaluation which includes conducting regular surveillance and conducting policy research; human and legal rights

39 The Public Service Regulations was first published in 2001 and amended in 2002 to include minimum stds for departmental HIV&AIDS programmes. The Regulation stipulates that working conditions should take into account employees’ personal circumstances including HIV&AIDS. And it also prescribes specific measures, procedures and services with regard to non-discrimination, HIV testing, confidentiality, disclosure and health promotion programmes among others.
40 Ibid.
which includes creating a supporting and caring transport environment and complying with appropriate legal and policy provisions; and training and development which includes training of peer educators.

The Corridors of Hope initiative that is an integral part of South Africa’s transport sector response to the AIDS epidemic has also played an instrumental role in assisting the country to reach various segments of workers in the transport sector including truck drivers, and other mobile populations such as sex workers along the major borders areas, roads and main urban centres in the country.

The “Trucking Against Aids” initiative is a national programme for the prevention of HIV in the road freight industry. The launch was the culmination of a pilot project pioneered by the Department of Health, the National Bargaining Council and the Road Freight Association which saw six roadside clinics set up on major truck routes around the country: near Beaufort West in the Western Cape, Harrismith en route to Durban, Beitbridge on the border between SA and Zimbabwe, Ventersburg in the Free State, the Tugela Toll Plaza in KwaZulu-Natal, and on the Port Elizabeth N2 route in the Eastern Cape. Staff at each roadside clinic - a qualified nurse, a health educator and about 10 trained peer educators - provide truck drivers and their partners with after-hours primary healthcare, condom distribution, and education and treatment for HIV, AIDS, tuberculosis and sexually transmitted diseases.

Construction
The Department of Public Works has developed a strategy to mitigate the impact of HIV and AIDS on the construction industry. As part of this strategy, the Department enforces the implementation of HIV programmes in the construction work it commissions; contracts exceeding ZAR two million are obliged to incorporate HIV awareness programmes, and once contracts are granted there are penalties for non-compliance. An HIV/AIDS Specification for Civil Contracts has been developed which outlines the processes to be followed and includes requirements for the HIV programmes, recommended practices, checklists, and reports.

Uniformed Services
The Department of Defense has a comprehensive policy in place for national uniformed personnel focused on: education and prevention; prevention of discrimination and victimisation; care and support of those affected and infected; monitoring, surveillance and research; and coordination and inter-sectoral cooperation. The aim of the policy is to reduce the transmission of HIV and to provide appropriate treatment, care and support for those infected and affected through sound management, cooperation and coordination within the SANDF as well as collaboration with other government departments and organisations like the Civil Military Alliance to Combat HIV and AIDS, and non-governmental organizations.

THE UNGASS PROGRESS REPORT

Mobile populations and migrants are not specifically mentioned in South Africa’s 2006 UNGASS Progress Report. However, the Government outlines collaboration and harmonization in the region in line with the SADC HIV and AIDS Strategic Framework and Programme of Action 2003-2007 as an important initiative in order to address HIV in the region.

42 Department of Defence, Instruction on HIV/AIDS: SG1/99
43 Ibid, p. 15.
44 Ibid. The National Composite Policy Index (NCPI) is Annexure 1, pages 42-44.
45 While UNAIDS developed in July 2005 Guidelines on Construction of Core Indicators: Monitoring the Declaration of Commitment to HIV/AIDS (available at: http://data.unaids.org/Publications/IRC-pub06/JC1126-ConstrCoreindic-UNGASS_en.pdf), the Guidelines leave it to the country to determine what are “most at risk populations” and “certain groups identified as especially vulnerable”. The examples provided in the Guidelines are men who have sex with men, injecting drug users and sex workers. The Guidelines stress that “The term ‘most-at-risk populations’ … should be replaced with a defined segment of the population (e.g. sex workers, injecting drug users, men who have sex with men), which are being measured. In countries where there are multiple most-at-risk populations, the indicators should be reported for each population” (page 10). Further, it appears that this indicator is stressed for countries with low-prevalence/highly concentrated epidemics.
In Annexure 1: National Composite Policy Index (NCPI), the Government affirmed:

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

While the definition of “vulnerable groups” was not outlined in the previous National Strategic Plan or the UNGASS Progress Report, according to the World Health Organization, South Africa has recognized sex workers, migrant labourers, truck drivers, men who have sex with men, and people with sexually transmitted infections as vulnerable groups. This being the case, other sections of the NCPI which South Africa answered positively and which may be relevant for migrant and mobile workers, include the following:

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

- “The country has a policy or strategy to expand access, including among most-at-risk populations, to essential preventative commodities. (These commodities include, but are not limited to, access to confidential voluntary counselling and testing, condoms, sterile needles and drugs to treat sexually transmitted infections)” (NCPI-A-III-4).

- “The country has non-discrimination laws or regulations which specify protections for certain groups of people identified as being especially vulnerable to HIV and AIDS discrimination” (NCPI-B-I-2).

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

Finally, the Government acknowledged that the following was not achieved: “The Government has, through political and financial support, involved vulnerable populations in governmental HIV-policy design and programme implementation” (NCPI-B-I-5).

**RECOMMENDATIONS FOR FUTURE POLICIES/INTERVENTIONS**

It is suggested that the Government of South Africa 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 harmonisation of existing legislation, especially labour and immigration legislation, which has a potential impact on migrants and mobile populations. This should include a review of various immigration and work visas.

- Initiate a programme specifically addressing xenophobia and stigmatisation of foreigners in South Africa, such as the previous ‘Roll-back Xenophobia’ campaign.

- 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 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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46 World Health Organization, 2005, Summary Country Profile for HIV/AIDs Treatment Scale-up. Available at: http://www.who.int/3by5/support/june2005_zaf.pdf#search=%22summary%20country%20profile%20south%20africa%20who%22

47 The Roll Back Xenophobia Campaign was coordinated from the office of the South African Human Rights Commission and comprised of various organizations such as Lawyers for Human Rights, UNHCR and others. For further information, refer to the Plan of Action at http://www.lhr.org.za/refugee/policy/xenonat
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BRIEFING NOTE
ON HIV AND LABOUR MIGRATION IN SOUTH AFRICA

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