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# Vol. 7, No. 1: Deadly Links Between Mobility and HIV/AIDS

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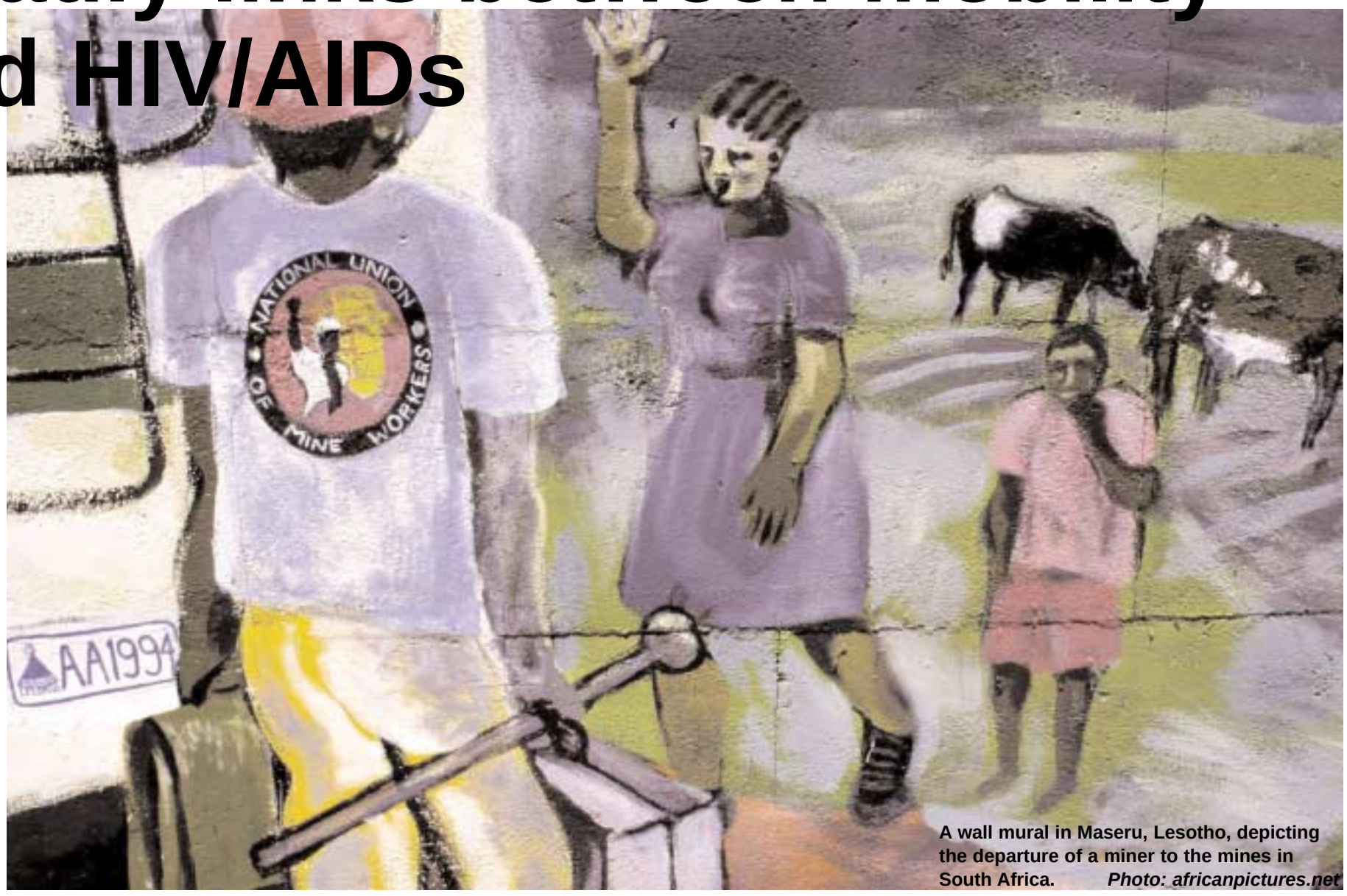
# CrossingS

# Deadly links between mobility and HIV/AIDs




A wall mural in Maseru, Lesotho, depicting the departure of a miner to the mines in South Africa. *Photo: africanpictures.net*

**BELINDA DODSON** AND **JONATHAN CRUSH**

EXAMINE THE RELATIONSHIP BETWEEN HIV/AIDS AND MIGRATION IN SOUTHERN AFRICA, AND FIND THAT IT WORKS BOTH WAYS.

The geography of the HIV/AIDS epidemic is a clue to its link with mobility. The highest incidence is in Southern African countries such as Swaziland, South Africa and Botswana, which have good transport infrastructure and high levels of internal and cross-border migration. In this region, as elsewhere, the incidence of HIV has been found to be higher near roads and amongst people who either have personal migration experience or have sexual partners who are migrants. Itinerant traders display high infection rates, and the rate is spectacularly high amongst truck drivers – over 90% in one South African study. Border towns have high rates of HIV prevalence, being places where transients such as truck drivers encounter a more stable local population, and which are by definition remote from nationally centralised HIV/AIDS intervention programmes. Refugees and internally displaced persons have also been found to be especially vulnerable to HIV infection, often resulting from the same disruption that caused them to migrate (eg soldiers using rape as a weapon of war).

What is it about people moving that makes them vulnerable? While the specific explanation will vary from migrant to migrant and place to place, there are four key ways in which migration is tied to the rapid spread and high prevalence of HIV/AIDS:

- Migrants' multi-local social networks create opportunities for wider sexual networking.
- Mobility and transience can encourage, or make people vulnerable to, high-risk sexual behaviour.
- Mobility makes people more difficult to reach through interventions, whether for preventive education, condom provision, HIV testing and counselling, or post-infection treatment and care.
- Migrant communities are often socially, economically and politically marginalised, both officially, in terms of legal rights and protection, and unofficially, through discrimination and xenophobia.

These deadly intersections between mobility and HIV/AIDS mean that mobile populations are more likely to be exposed to infection, less likely to have access to formal health care and treatment, and less likely to have family and community support when sick or dying.

Looking at the relationship from the other direction, it is also apparent that HIV/AIDS is becoming an increasingly important factor driving migration and mobility in Southern Africa. High rates of death or disability in particular labour sectors, such as the mining industry, create a need for new migrant workers. Loss of household income though the death or disability of a former migrant worker encourages migration by remaining household members to seek income-earning opportunities. People with HIV/AIDS, especially those with AIDS-related infectious diseases, migrate to obtain medical care, or to be cared for by family members. This might entail moving from an urban back to a rural area or from one country back to another (eg from South Africa to Lesotho or Mozambique). Others move to care for family members living elsewhere. New widows or widowers, themselves often HIV-positive, may migrate upon the death of their partners, either to seek support from family members

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# Cause or effect: HIV/AIDS and migration intersections explored

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or to search for new sources of livelihood. AIDS orphans, who may also themselves be HIV-positive, commonly migrate to live with relatives or to seek their own income-earning opportunities. And people living with HIV/AIDS move to escape the stigma and ostracism they experience in their communities.

In drawing attention to these two-way connections between HIV/AIDS and human mobility, it is essential not to characterise migrants as bearers of disease, people to be "kept out" with stricter migration controls. Stigmatising or marginalising migrants further, or even simply ignoring their particular HIV/AIDS intervention needs, will serve only to strengthen the dangerous synergy between HIV/AIDS and migration. Attempting to limit mobility by imposing legal restrictions on migration simply creates clandestine flows of people, who are thus further excluded from access to social and medical services. Instead of futile attempts to prevent people from moving, there needs to be HIV/AIDS interventions, from education and prevention through testing and counselling to treatment and care, which are designed for and targeted at particular migrant populations.

Different forms of migration demand different policy responses. In Southern Africa there are at least four broad categories of migrant populations, and each demands a specific intervention strategy:

- Migrant or immigrant communities who have left one place to settle in another, either long-term or permanently. These people require focused interventions in their new location, ideally in their own language, until they become fully integrated into their new host societies.
- Trans-migrants, such as migrant workers, who have "homes" in more than one location. They require interventions at both "homes", as well as en route between them, and interventions for their partners.
- Itinerant or mobile populations, such as truckers and traders, who either have no fixed home or spend most of their time away from home. Perhaps the most difficult to reach, as they do not constitute a spatially fixed community, these people require interventions that mirror their movements – for example, condoms at truck stops, education material on buses and clinics at markets.
- Temporarily dislocated communities such as refugees and internally displaced persons. Intervention here requires rapid response in a highly mobile form, especially where the very circumstances forcing people to move, such as war, simultaneously expose them to the threat of HIV infection.

Providing migrant communities with appropriately targeted HIV/AIDS interventions is the only realistic means of dealing with the current HIV/AIDS epidemic and containing its spread. Mobility is the means by which many African individuals and households seek security of income and livelihood. Yet surely the very means by which a migrant seeks to secure a living should not also have to be a virtual guarantee of death?

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## Editorial A dangerous synergy

Across Southern Africa, people engage in diverse forms of migration. Their mobility varies in motive and purpose, as well as in its spatial, temporal and social characteristics. Some, seeking to escape poverty and unemployment, move to find better economic opportunities. Many people's livelihoods are based directly on mobility: traders move between sources and markets; truckers travel long distances transporting goods; migrant workers go to the mines, factories, towns and farms where they earn their living. In addition to economic reasons, migration is also driven by social, political and personal motives. People move in order to get away from situations of political oppression or to escape social discrimination. Others are forced from their homes by war or violence. Voluntary or forced, long-term or short-term, internal or international – migration is as much part of the region's present as it is characteristic of its past.

Yet if mobility today forms part of many people's lifestyles and livelihoods, it also makes them vulnerable to increased risks and dangers, both on their journeys and at their destinations. Evidence from a number of studies, some described in this issue of *Crossings*, demonstrates the close and deadly links between migration and HIV/AIDS. We are reminded, for example, that the system of migrant labour from rural areas of Southern Africa continues and has a significant effect on HIV infection rates among migrant men and their partners.

Also, we learn about the circumstances of domestic workers in Johannesburg, most of whom are migrant workers living away from their homes and families. Separated from their social support networks and enduring isolation and loneliness, these women reveal alarmingly low levels of knowledge about HIV/AIDS issues or how to protect themselves from the disease.

The links between gender, mobility, livelihood, household dynamics and vulnerability to HIV/AIDS are highlighted through the experience of female traders at Durban's Warwick Junction. The very mobility that is essential to securing these women's individual and household livelihoods increases their vulnerability to HIV/AIDS, not just through infection, but also in terms of their exposure to the broader impacts of the epidemic. The women of Warwick Junction identified lack of information as one of the main factors making them more vulnerable, echoing the findings about Johannesburg domestic workers and highlighting the need for HIV/AIDS education initiatives targeted at specific migrant communities.

HIV/AIDS is creating new forms of migration and vulnerability, and prominent here is the experience of the young people called AIDS orphans. We highlight the lives of children in Lesotho and Malawi who have migrated in response to the sickness or death of parents or guardians. For AIDS orphans, moving to live with kin is often the only available option, but relocation brings its own challenges and hardships.

Although the role of migration in exposing people to HIV infection is well documented, HIV/AIDS as a *cause* of migration has been relatively under-researched. These two-way interactions suggest a "dangerous synergy" between AIDS and mobility. Contributors to this issue of *Crossings* recommend appropriately targeted interventions for particular migrant populations, while warning of the dangers of further stigmatising migrants as "bearers of disease".

Policy interventions for people in the latter stages of HIV/AIDS are the focus of the piece on migrant mineworkers, in which the concept of a "good death" is interrogated. Recommendations are made for reducing the stigma attached to people with HIV/AIDS, improving their material conditions, and removing gender stereotypes. These are broad and ambitious – necessarily so in the face of this deadly and deeply entrenched epidemic.

Some of the policy challenges for AIDS education, prevention and care for migrant communities are being taken up by the Partnership on HIV/AIDS and Mobile Populations in Southern Africa (PHAMSA) programme, but much remains to be done.

Combining insights from the various articles in this issue of *Crossings* further elucidates connections between HIV/AIDS and migration. Some of the female traders and domestic workers who were interviewed may well be partners of men who have become sick or died because of AIDS, with women resorting to migration as a response to lost livelihoods or the costs of caring for sick or dying family members. Migration exposes people to HIV/AIDS; HIV/AIDS and its impacts make people migrate.

The third point of the triangle is, of course, poverty, itself both cause and consequence of the disease and certainly a leading cause of migration. HIV/AIDS is one of the major factors undermining regional poverty reduction and development initiatives. Addressing the particular vulnerabilities of migrant populations to HIV/AIDS is thus not simply an act of compassion, but an appropriate entry point into national and regional poverty reduction initiatives.

*Belinda Dodson, Guest Editor*

# Uprooted by AIDS, children migrate in search of new homes

AS HOUSEHOLDS BUCKLE UNDER HIV/AIDS, CHILDREN ARE FORCED TO BECOME MIGRANTS IN THEIR OWN COUNTRIES OR ACROSS BORDERS. BUT THEIR DESTINATIONS DON'T ALWAYS OFFER MUCH COMFORT. **NICOLA ANSELL AND LORRAINE VAN BLERK** INVESTIGATE THE LINK BETWEEN HIV/AIDS AND CHILD MIGRATION IN SOUTHERN AFRICA.

Southern African countries have very high levels of migrancy, and also the highest HIV/AIDS prevalence rates in the world. The role of human mobility in spreading HIV is well known, and the particular vulnerability of migrants to HIV infection is increasingly recognised. But there is a third, less well-documented phenomenon that links migration to HIV/AIDS: the migration that occurs as a consequence of the pandemic. AIDS imposes heavy costs at many levels – not only for those infected, but also for their families and communities. So coping strategies have to be employed, and these sometimes involve the relocation of individuals or entire households.

Many of those migrating are children, who are affected by AIDS in a number of ways. Some have contracted HIV through their mothers, and as many as 20% of children in Southern Africa are orphans.

However, children are affected by HIV/AIDS long before they become orphans. Adults with AIDS suffer debilitating illness over months or years, which often reduces household income, increases medical expenses and diminishes the capacity of the household to care for children. Children may have to take on additional work, including tasks usually performed by adults – domestic and agricultural work, wage-earning and caring for the sick – while also having to endure AIDS-related stigma.

Those experiencing the impact of HIV/AIDS need support, care and an infrastructure to help them cope with their lives. Here, a young patient at an AIDS hospice in Johannesburg sleeps outside as children play. *Photo: PictureNET Africa*

Following the death of a parent or guardian, the difficulties children face often increase, with financial hardship exacerbated by problems of inheritance and the absence of childcare within the household. At this point, or at any other stage in the course of the disease, children may be forced to migrate. Because extended families in Southern Africa are often widely dispersed, many children move considerable distances to live with relatives.

In 2001, we undertook research, funded by the UK's Department for International Development, into AIDS-related migration by children in Lesotho and Malawi. Our purpose was to examine the forms of migration that young people affected by HIV/AIDS engaged in, the difficulties they faced, the coping strategies they employed and the forms of support available to them, and to look at ways in which they might be better supported.

We found that many children were migrating, some over very long distances. Of these, significant numbers were relocating in response to sickness or death that was likely to be HIV/AIDS related. In many cases, migration that was not directly related to AIDS was nonetheless an indirect outcome of the sickness or death of family members. Longer-distance AIDS-related migration was predominantly urban to rural – and, in several cases, international. Many children moved several times. Sometimes these multiple moves were circular, as children moved among the households of different relatives over the course of a week, or between institutions and their extended families. The clustering of AIDS afflictions in families and communities, and the cost of caring for many children, complicates migration strategies, so siblings are often separated.

Most children who relocate because of AIDS go to their maternal grandparents. Others live with paternal grandparents, aunts, uncles, brothers, sisters or sometimes more distant relatives. A minority of AIDS-affected children enter institutions or resort to living on the streets because relatives lack the resources to care for them.

There are three sets of considerations that generally determine where AIDS-affected children go to live: who is believed to be responsible for the children; who can provide for their needs; and who might find their presence useful in some way. Children have needs that include shelter, economic support, schooling, supervision and psychosocial support. However, they can contribute to households by helping with domestic and agricultural work, earning wages and caring for the sick. A child's age and gender significantly influence what are thought to be his or her specific needs and abilities.

The complex issues influencing migration by AIDS-affected children create a range of difficulties when they attempt to fit into new families and new communities. When children are adopted into a household through obligation, as is the case with AIDS orphans, they are often treated differently from other children in the household, particularly if resources are scarce. Migrant children are sometimes given different food to eat, deprived of adequate clothing, beaten and overworked. Even where foster parents are supportive, the biological children may resent having to share resources, financial and emotional, with "new" siblings. This is especially problematic if the migrants are still coming to terms with parental death and need extra attention.

Many children in a new home as a consequence of HIV/AIDS are expected to carry a heavier workload than they are used to, and to perform new and unfamiliar tasks. They may have to do domestic or agricultural work, or care for children or sick adults. Some are explicitly required to work for their keep, making them unequal members of their new families. Others are sent away to earn wages to support younger children. Children migrating from urban to rural environments find it particularly difficult to adapt to agricultural chores.

Children moving over long distances generally miss their friends, and need to develop new social contacts, but the trauma of losing a parent makes integration more difficult. In our research, guardians noted that newcomers were often withdrawn and found it difficult to engage with other children. This was exacerbated for those children who had to learn new skills, as work and play are often interrelated. Furthermore, the stigma attached to orphanhood through AIDS makes integration into community life difficult.

Many migrant children drop out of school, particularly those who go to live with rural grandparents who cannot afford to send them to school. Others enrol at new schools, but struggle with a different curriculum, or even an unfamiliar language.

Ways need to be found to ease the assimilation of migrant children into their new households, new communities and new schools, partly in order to reduce the number of repeated migrations they are forced to undertake. Since young AIDS migrants are maintained largely through their extended families, support needs to be channelled in ways that support not only the children themselves, but also the families that receive them.

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# Women traders deal with

A STUDY OF WOMEN ENGAGED IN INFORMAL CROSS-BORDER TRADE SHEDS LIGHT ON THEIR RELATIONSHIPS AND THEIR VULNERABILITY TO HIV/AIDS. **NTOMBI MSIBI** REPORTS.

Small entrepreneurs are active participants in cross-border trade in Southern Africa, with women prominent among them. In July 2005, SAMP undertook a study of 100 female informal cross-border traders in Johannesburg. The study explored the women's access to, and use of, health care services, as well as their knowledge and experience of, and vulnerability to, HIV/AIDS. Most of the women interviewed were from 25 to 49 years old. Although of an age at which women are generally expected to be in long-term relationships, 37% were single, separated, divorced or widowed. Only 47% were married and living with their partners, and, irrespective of marital status, the majority (73%) were the primary income-earners in their households.

To pursue their business, women traders need to spend time away from home. In theory, this could affect their relationships with their partners and provide opportunities for contact with multiple partners, which, with erratic use of condoms, might increase their vulnerability to HIV. However, a quarter of respondents saw their partner at least once a week, and only five percent had two partners. The rest had one partner or were single.

Interviewees were asked if they knew whether their husbands had another wife or other sexual partners. Eighteen said they knew their husbands had other partners (seven of whom were second wives). Almost a third said they did not think their husbands had any other sexual partners, while 28 were unsure.

The study also hypothesised that the nature of the traders' business would make it difficult for them to access health care. However, reflecting the financial status of some traders, 21 were members of a medical aid scheme which could give them access to private health care when travelling. Overall, it seemed that access to health care was not an insurmountable problem, as half had visited a doctor in the previous year and seven had stayed overnight in hospital. Only nine had visited a traditional healer. They said the biggest obstacles to health care access were time and money.

Perhaps because of their age, the traders interviewed seemed to be knowledgeable about issues of sexual and reproductive health, and 43% had attended a family planning service in the past year. The same proportion were using some form of contraception. Although the women showed relatively high levels of experience of HIV/AIDS in their personal life, and some vulnerability in their relationships, their use of condoms was low and erratic. Half had never used a condom, and only 19 regularly used one in sexual relationships. Furthermore, 22 could not describe how to have sex safely. Disturbingly, over a third of interviewees thought one could tell by looking at someone if they had HIV.

Vulnerability to HIV infection is often related to a lack of power in relationships. The women indicated that they were vulnerable to crime and domestic violence as well as violence from officials.

Fifteen of the traders had been pushed, shoved or slapped, and/or had things thrown at them, and 12 had been threatened with a gun or knife. Five traders said they had been raped and 12 reported forced sex by husbands and partners. (Rape, whoever commits it, increases vulnerability to HIV as negotiated condom use is unlikely.) One common strategy adopted by women was to travel in groups on buses and trains to reduce risks on the road.

# Life and death in Warwick Junction

**MAY CHAZAN** HEARS THE STORIES OF TWO MIGRANT FEMALE TRADERS IN A DURBAN MARKET AND DISCOVERS COMPLEX FAMILY NETWORKS, IMPRESSIVE STRENGTH AND RESILIENCE, AND INCREASING VULNERABILITY TO HIV/AIDS.

Sitting on the sidewalk in Warwick Junction, the largest transport hub and informal trading area in Durban, South Africa, I watch as two women – mother and daughter – mix rat poison into pails of seeds with their bare hands. Rat poison increases the value of the seeds because it keeps pests away from growing plants. The mother, commonly called "Ma", is 52 years old and has been selling seeds in Warwick Junction since 1983. She came to Durban from Umzinto, a rural area on the south coast of the province of KwaZulu-Natal, because she had a growing family to feed, and no one at home was working. For 20 years, she has traded and slept on the streets of Warwick Junction, visiting Umzinto once each month. She supports her six children, six of her grandchildren, her paternal uncle, a boy from the village and, at times, her husband. Her husband works as a temporary labourer in an industrial area north of Durban; they see each other once every two or three months.

Their eldest daughter, Sibongile, is 27. She came to the city in 1997 to work with Ma because she was also unable to find a job in Umzinto. Sibongile stays in a township 20 minutes outside of Durban city centre with her common-law husband, their newborn baby and her husband's three siblings. Like Ma, Sibongile remains closely linked to her rural roots: her elder daughter lives at the family home in Umzinto, where she is cared for by her aunt (Sibongile's sister) and supported by her grandmother (Ma). Sibongile also visits once a month.

I had the privilege of sharing these women's stories as part of an intensive study on HIV/AIDS vulnerability amongst informal street traders in Warwick Triangle. The project involved frequent interviews with 20 traders, as well as focus groups, interviews and key informant meetings with 30 other participants: health care providers, traditional healers, municipal employees and trading committee leaders. The objective was to begin to unravel whether and how street vendors working in a rapidly changing urban environment were vulnerable to HIV/AIDS, defining "vulnerability" as both *exposure* to conditions that increase a person's likelihood of being infected and the *impacts* of the epidemic on that person, regardless of whether he or she is actually infected.

I did not set out to investigate migration, but the links between gender, migration, and HIV/AIDS vulnerability become apparent as Ma and I sit huddled under an umbrella attempting to map out her household in a diagram. As she explains, her husband is head of the household, although he visits home infrequently and does not provide steady financial support. She is the main breadwinner; she sleeps six nights per week on the streets of Warwick Junction, one night per week in a room she rents in Clermont (a Durban township), and one weekend per month in Umzinto. They have had eight children, two of whom are dead. Of the six living, Sibongile is the eldest. Sibongile resides in Clermont, but considers Umzinto her home; that is where her children will be raised. Ma's other children reside at home in Umzinto: three live there with their partners and/or children and two are still at school. Only one child is employed: he works as a security guard in a game park, which requires him to leave his partner and two small children at the family home for extended periods. Ma also includes her uncle and a boy from the village in her household because they live in the Umzinto house. Her diagram includes four generations.

> Even after 20 years in the city, the household revolves around the family home in Umzinto, although members sleep in six different locations.

Ma's "household" ("umdeni" in isiZulu) is defined by a combination of kin relationships, resource-sharing and a symbolic, if not physical, connection to a common place marked by the house structure. Even after 20 years in the city, the household revolves around the family home in Umzinto, although members sleep in six different locations and some travel regularly between several different residences.

The experiences of Ma and Sibongile as migrants offer valuable insights into mobility, informality, gender, changing household structures and vulnerability to HIV/AIDS. For Ma, a key issue is that in Durban, where there are no AIDS education programmes targeted specifically at informal traders, those who reside predominantly on the market's streets or move around frequently may not have adequate access to information; they slip through the cracks of rural and township health promotion campaigns. Ma identifies the lack of access to information as her top concern among factors that make traders vulnerable: "There is a real lack of information because we

# HIV/AIDS and life on the road


Women traders who live at the markets are often denied information, health care and other services that may be provided to women in the townships or rural bases.

*Photo: PictureNET Africa*

don't get it here in the market, we're not at home long enough, we're not in the township." Although it is well understood that information alone does not result in behaviour change, the information gap in this case may at least partly explain why Ma claims that she has never seen a condom and has no idea if they work.

From Sibongile's perspective, a major problem with "not being from Durban" is that she has difficulty accessing services, including the public health clinic directly across the street from their trading site. She tells about going to this clinic with health problems during her pregnancy, and being turned away because she could not prove she had a permanent address in central Durban. Sibongile leaves her flat at 4:30 each morning and does not return until after dark; her waking hours are spent in Warwick Junction. Furthermore, she cannot afford to leave her trading site for any length of time – whether to sit in a clinic queue or to travel to a different health care facility. Although several participants voice similar concerns, the clinic manager insists that it is their policy not to turn anyone away. Nevertheless, not having access to health services – whether because of structural gaps, the inability of health care providers to cope with impossible workloads or miscommunication – makes mobile populations extremely vulnerable to the impacts of the epidemic. This is particularly worrisome because antiretroviral therapies, the most effective known AIDS treatment, require continuous follow-up and dose re-adjustment.

Both women raise concerns around where the burden of care falls when a household member becomes ill, and specifically about the uneven responsibilities borne by women. In their family, the older female siblings take on the roles of care providers: if there were no women available at home, Sibongile would have to give up trading. The women in this family, however, are responsible not only for physical care, but for financial provision as well, so Ma and Sibongile are concerned about the financial burden if they or another family member became ill with AIDS.

Ma worries about how the family would survive without her income: "My children at home count on me and will suffer when I die." Sibongile worries about how they would pay for treatment or funeral costs, and she explains that they do not have access to adequate resources, loans or insurance.

Moreover, both women feel strongly that if they were to get sick, they would return home to Umzinto. Ma explains that she would certainly go home to die because she does not belong in the city. Yet the family at home has no running water, no electricity, and no easy way to transport a sick family member to hospital. In a country that has seen the number of registered adult deaths rise from 272 000 in 1998 to 457 000 in 2003, and where mortality is certain to worsen, further research is clearly needed on the scale and implications of urban-to-rural migration as people fall ill and die, as well as on how this migration affects already underserviced rural communities.

> As much as the stories of Ma and Sibongile provide insights into vulnerability, they also reflect strength and adaptability.

As much as these stories provide insights into vulnerability, they also reflect strength and adaptability. Like many migrants and informal workers, Ma sleeps on the streets in an exposed situation; this could make her susceptible to gender-based violence and increase the likelihood of her being involved in risky sexual behaviour. However, while younger participants speak about "doing favours" in exchange for a night's accommodation, and one older woman painfully told me about her daughter being raped in the market, Ma does not feel that her sleeping arrangements are in any way dangerous. She explains that the women sleep together in large groups and beat up any man who comes near. A strong and dignified woman, she insists that they "are here to sell [their] goods, not [their] bodies".

The stories of Ma and Sibongile demonstrate the central role of female migrants in their fluid and fragmented households. They also expose the complex intersection of mobility, informality, gender, changing household structures and vulnerability to HIV/AIDS. With South Africa's rising unemployment, more women leaving home to find work, and the growth of a predominantly female informal economy, women's vulnerability to HIV/AIDS seems set to increase.

# Challenging Common assumptions

**MARK LURIE** PRESENTS THE FINDINGS OF A STUDY INTO THE ROLE OF MIGRANT LABOUR IN THE SPREAD OF HIV AND SUGGESTS INTERVENTIONS.

It is not hard to see how migrant labour plays a major role in spreading the epidemic of HIV and sexually transmitted infections (STIs) in Southern Africa: take millions of young men, remove them from their rural homes, house them in single-sex hostels, give them easy access to sex workers and alcohol and little or no access to condoms, and pretty soon you will have a major HIV/STI epidemic. Send those men back to visit their rural partners every once in a while and the epidemic will take hold in rural areas as well. This situation roughly describes the conditions for more than 2.5 million official – and many more unofficial – migrants in Southern Africa, and explains, at least in part, why the HIV prevalence in Southern Africa has reached epidemic proportions.

This pattern of circular migration, so prevalent throughout South Africa, did not develop out of chance. On the contrary, its design has been an integral part of government policy for more than a century. The system of apartheid, which was officially established in 1948, in practice existed for decades before that. It prohibited workers from settling permanently in "whites only" areas, and forbade them from bringing their families to live with them. Indeed, the aim of the system was to provide cheap black labour to the country's agricultural, industrial and commercial sectors. Further, by sending workers who were old and sick back to rural "homelands" the system absolved companies of the responsibility of caring for their own personnel. Migrant labour and apartheid were therefore almost inextricably linked and it is unclear what forms labour migration will eventually take in a democratic South Africa.

Against this background, a research project was set up in the province of KwaZulu-Natal, beginning in 1998. Of the nine provinces in South Africa, KwaZulu-Natal has the highest HIV prevalence: 33.5% of antenatal clinic attendees were infected with HIV by 2001. The study aimed at understanding the role that migrant labour plays in the spread of HIV/STIs and exploring interventions for migrants and their partners. Based in the Hlabisa district in northern KwaZulu-Natal, we targeted migrant men from the district who were working at two different locations: Carletonville, a gold-mining community near Johannesburg, about a seven-hour drive from Hlabisa (these men were able to return home on average four times a year), and Richards Bay, considerably closer (men who work there come home at the end of every month). All study participants were screened for HIV and STIs, counselled, and given health education. All symptomatic and lab-diagnosed STIs were treated. We then recruited into the study the partners of these men who were living in the district, as well as a group of non-migrant couples.

Over 600 people were recruited for the study, and followed for up to three years. The overall prevalence of HIV was 20.1%. Among migrant men, HIV prevalence was 25.9%, and migrant men were 2.4 times more likely to be infected with HIV than non-migrant men. HIV infection was more common among partners of migrants than among partners of non-migrants (21.1% versus 16.5%), although this difference was not statistically significant. In a multivariate analysis, the main risk factors for men to be infected with HIV were being a migrant, having two or more current casual partners, never having used a condom, and having lived in four or more places in their lifetime. For women, the main risk factors were having more than one current partner, being under 35 years old, and having STI symptoms in the last four months.

The results were analysed by couple. Migrant couples were more likely than non-migrant couples to have one or both partners infected with HIV (35% versus 19%) and to be HIV-discordant (27% versus 15%), meaning that one partner is infected and the other is not.

The discordance data challenge one of the central assumptions about the role of migration in the spread of the epidemic: it has long been assumed that it is returning migrant men who infect their rural partners. This is far from always the case: among HIV discordant couples, 30% of the time it is the woman who is HIV-positive and her migrant partner who is negative. Clearly, an HIV-positive woman whose migrant husband is not infected must have been infected by someone else. These findings highlight the importance of working not only with migrants at their place of work, but also with their rural partners who stay at home.

Since the epidemic occurs on a number of levels – individual and structural, for example – interventions, if they are to be successful, must be aimed at all levels of the epidemic. Too often organisations have shied away from structural-level interventions for fear that the problems are so systemic that they can have no impact. But South Africa needs to decide whether a system that separates families for extended periods of time is one that should survive in the new democratic era. Alternatives include sustainable rural development programmes that offer local employment opportunities, thus mitigating the need to migrate in the first place. At the same time, mining companies in particular should be making real attempts at providing family-friendly housing – at present only about 2% of miners live in such accommodation.

On the individual level, it is clear that as a highly vulnerable group, migrants and their partners need targeted interventions, including good management of STIs, health education and access to health services. The possibility of presumptive STI treatment (treating people regardless of whether or not they are known to be infected) before men return home is a possibility that needs to be explored. This kind of treatment is currently being tested in Carletonville among sex workers around the mines. But one thing is clear: interventions aimed at migrants must be aimed at their partners as well.

- Mark Lurie was the Principal Investigator of the Migration Research Project, a joint activity of the South African Medical Research Council and the Africa Centre for Population Studies and Reproductive Health, with funding by The Wellcome Trust, UK. This article was originally published in *Aids & Mobility News* No. 4, October 2002, and is reprinted with the author's permission.

# Dying a good death

**PRUDENCE MAKHURA** ASKS HIV-POSITIVE MINEWORKERS WHAT A "GOOD DEATH" MEANS TO THEM, AND FINDS THAT FEW ARE LIKELY TO EXPERIENCE ONE.

Can mineworkers who are dying from AIDS have a "good death"? To answer this question, I developed a case study consisting of 25 HIV-positive mineworkers at Impala Platinum in Rustenburg, three of whom had full-blown AIDS.

Openness and communication are important, but often easier to attain with professional health workers than with family members and loved ones. Mineworkers stress the importance of having family and friends around them before death and say that it would be difficult to cope with the anxieties of impending death without their understanding and support. They also support the idea of a dignified death, and believe that a "good death" requires one to have lived a good life and materially provided for oneself and one's family.

As for choosing the right place for death, some believe that in order to die a "good death" one would have to be hospitalised, while others see themselves dying in the comfort of their own home. Then there are those who think of a "good death" in terms of both locations: freedom from pain and suffering during their last days can more readily be assured at a hospital, but, at the same time, if they want to be surrounded by their loved ones during their final moments, that is more likely to be achieved at home.

Some believe in the efficacy of modern medicine and others choose traditional preparations, while a number plan to use both. Some of the respondents who want to spend their last days at home hope to have easy access to *muti* (traditional medicines). Even those who opt for dying in hospital say that they would like their families and friends to sneak *muti* in for them. A similar duality of opinion emerges regarding spiritual beliefs: they believe that satisfying both God and the ancestors will lead to a "good death". They do not choose between Christianity and ancestor worship, but claim they can follow both approaches. One belief is a back-up plan "just in case the other does not work out".

Mineworkers agree that while there is such a thing as a "good death", such a death is highly unlikely for an HIV-positive person in South Africa. First, the stigma associated with AIDS makes a "good death" impossible. Stigma limits openness about AIDS, as it inhibits the disclosure of one's HIV-positive status. Consequently it prevents

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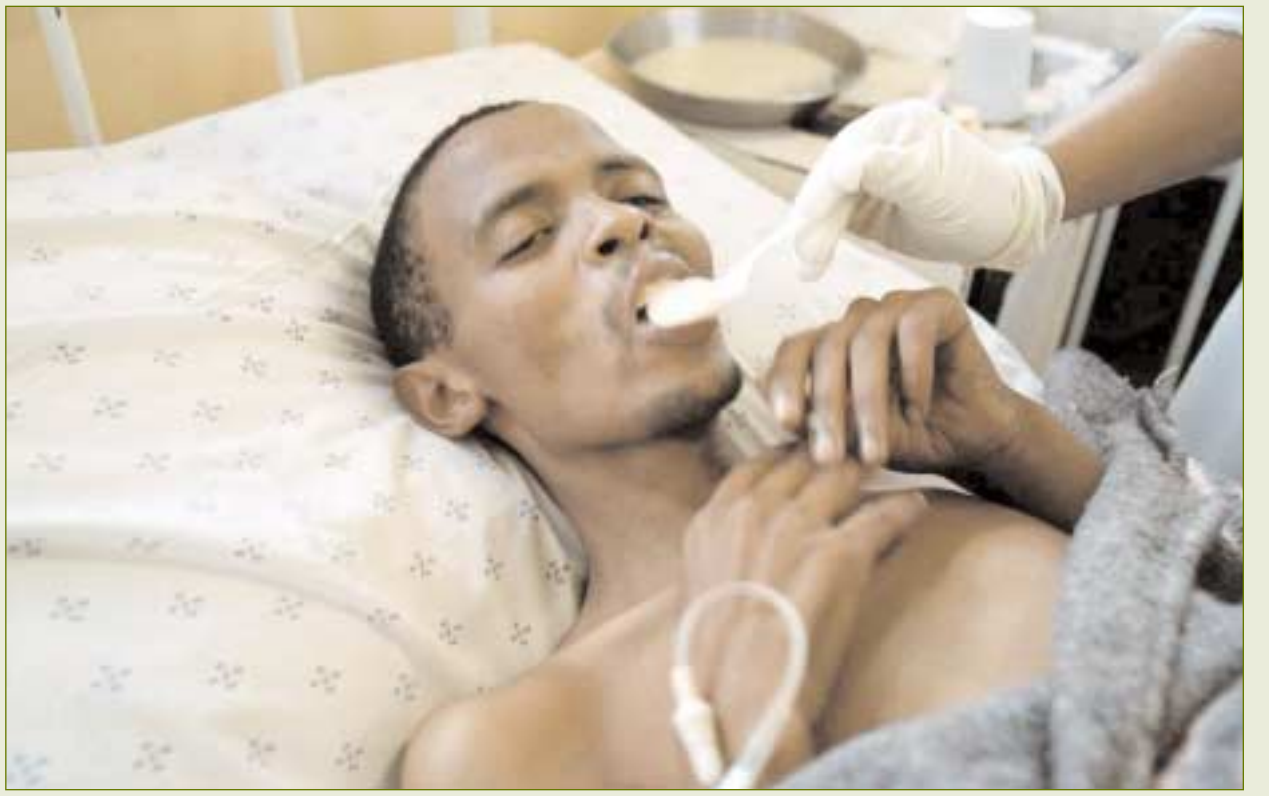
HIV-positive people from being open about the fact that they are dying. Stigma may also limit the emotional support provided by family and friends, as they might reject their dying relatives in order to avoid humiliation.

Stigma also makes an HIV-positive person feel guilty for having contracted the virus. This guilt makes it difficult for those living with HIV to aspire to a high quality of life. Those who are or want to become Christians fear that they might not be spiritually prepared to meet death, as they believe that they might have committed a mortal sin before God. Those who worship ancestors feel that the ancestors might never forgive them for committing such a dreadful sin.

Poverty further diminishes the prospects of a "good death". Lack of money limits an AIDS patient's chances of selecting the medication of his or her choice and also restricts choice in the location of death. Sometimes those respondents who would like to spend their last days in hospital cannot afford to do so. On the other hand, those who want to die at home might not be able to pay doctors and nurses to make house calls.

Mineworkers also agree that gender stereotypes make a "good death" harder to achieve for AIDS patients. When women are sick, they are seen as disrupting the family unit. Women therefore find it difficult to express their dying wishes, as they were not supposed to get sick in the first place. For males, the social gender stereotype is that "men don't cry", meaning that men end up not saying what they really want to at the moment of their death because they fear the shame of not being "man enough". The other problem for men is the perception that their manhood is limited by their inability to have children. The fact that with AIDS they cannot be sure of having healthy babies, and that even if they do, they will not live long enough to see to it that their babies are taken care of properly, further obstructs the attainment of a "good death".



Health care and support were identified by many AIDS patients as an essential factor in reaching a dignified end. *Photo: PictureNET Africa*

In summary, the study identified the following as the three main obstacles to the achievement of a "good death" for the respondents:

- The stigma surrounding AIDS, and the associated fears of dying and death;
- Gender stereotypes; and
- The lack of health and care facilities.

Until these are addressed, a "good death" remains an unattainable ideal for most migrant mineworkers living with HIV/AIDS.

Trucking

# Long-distance truck drivers at high risk

Long hours on the road and weeks away from their families are only two of the reasons long-distance truck drivers are widely regarded as a high-risk group when it comes to contracting HIV/AIDS.

"It's a war out there," said Louis Hollander, chairperson of Trucking against AIDS at the National Bargaining Council (NBC) for the road freight industry. "HIV/AIDS and trucking is like a wave that is still building. When it eventually breaks, it is going to hit the industry extremely hard."

"Truck drivers travelling the national long-haul freight routes in South Africa are away from their homes, families and friends for long periods of time," said Paul Matthews, MD of the Learning Clinic, a local NGO. "Many encounter sex workers and other women who exchange sex for money or presents at truck stops and along major trucking routes and are tempted to start relationships with these women."

A study conducted at five truck stops in the heavily affected region of KwaZulu-Natal in 2000 with men who visited sex workers found high levels of HIV prevalence (56%) among both truck drivers and sex workers. Two-thirds of the men reported having a sexually transmitted infection in the previous six months.

Condom use was not very high; almost a third of the truckers reported never using condoms, while less than half reported always using condoms.

The focus of the Trucking against AIDS project is firmly set on this mostly male-dominated sector of the South African transport industry, said Jerry Thibedi, minister of transport and roads in the North West province.

"Transport remains an economic contributor and as long as goods need to be transported across local and international borders, the prevalence of HIV/AIDS among these truckers will continue to be an issue," he said. "During their time on the roads, of which some spend weeks on end away from their homes, a lot can happen."

According to Thibedi, speaking in Zeerust at the recent launch of the North West's first Roadside Wellness Centre as part of the Trucking against AIDS project, these drivers are seen as an easy market to sex workers who patrol the stopover points along their routes.

Thibedi said the main aim of the programme is to slow down and eventually stop the spread of HIV/AIDS in the freight industry in South Africa.

"The long-distance trucking industry represents a sizeable number of vehicles on the country's roads and is therefore a priority when it comes to prevention and educating communities as to the dangers of this lifestyle," he said.

Ria Schoeman, national programme officer for the Swedish embassy, said HIV/AIDS among truckers is a much larger problem than initially meets the eye.

"Once a trucker becomes infected on the road and heads back to his family, a large number of people are at risk.

"Ignorance is therefore a major obstacle that needs to be addressed and we have to take into account that once the trucker dies or becomes too ill to work,his whole family is affected."

According to Schoeman, drivers are also more likely to become infected with HIV as their jobs are physically demanding and they are more prone to illness.

"The truckers need to understand that once they are away from their wives, they are not invincible and that they can't act irresponsibly," Schoeman said.

Nomonde Rasmeni, minister of health in North West, said that by educating truckers on the effect that HIV/AIDS can have on their families, not only they, but also the women who are at risk, are protected.

Elana Olivier, HIV/AIDS councillor at the Potchefstroom campus of the North West University, said illiteracy is another reason why truckers are in danger of becoming infected.

"Most of these drivers have no or very little formal schooling. They are therefore not fully aware of the dangers of the virus and many believe that certain traditional customs will protect them from getting HIV/AIDS.

"These men travel all over South Africa as well as in neighbouring countries and are a huge risk of spreading the virus to all corners of the continent."

Steve Andrews, doctor of the HIV/AIDS activist Zachie Achmat, said truckers often dictate the terms of sexual contact with commercial sex workers as they are relatively wealthy in comparison with the communities they travel to.

"These truckers often have more than one home base and because most of the people they meet live in relative poverty they can get sex quite easily," he said.

Adds Thibedi: "The best way of getting truckers to acknowledge the seriousness of the situation is by word of mouth. If a single trucker is assisted by these centres, chances are that more will follow suit."

*This article by Eduan Roos first appeared in the Mail & Guardian.*

• See interview on page 8.

# HIV: Truckers express degree of fatalism

RUNNING PRIMARY CLINICS AT KEY REMOTE STOPS ON SOUTH AFRICA'S MAJOR ROADS WOULD BE OF CONSIDERABLE VALUE TO THE HEALTH OF TRUCKERS, SAYS **TESSA MARCUS**, WHO IS INTERVIEWED HERE BY **KATE LEFKO-EVERETT**.

**Q: In your research you have looked at the role of long-distance truck drivers in HIV transmission in Southern Africa. What motivated your studies?**
A: This research was conducted in the second half of the 1990s. Research in East Africa suggested that long-distance truck drivers might be the vectors of HIV, given that in their travels they also came into sexual contact with local populations. There was no research with truckers in South Africa and so I was interested in understanding truck drivers' working conditions and the extent to which these were similar to those of East Africa, on the one hand, and on the other, the extent to which their working conditions created structural conditions that made them vulnerable to HIV infection and whether HIV infection was in fact experienced as an immediate and present risk. This last question was important given truckers' vulnerability to road accidents and robbery.

The studies (1996 and 2000) found that, because of the sophistication of the economy and high quality road infrastructure, conditions in South Africa were not similar to those in the east of the continent. Truckers criss-crossed the entire country in days rather than weeks and months. Demands of timely delivery of goods meant that they worked extraordinarily long hours, with financial incentives to beat deadlines by reducing the number and duration of stops. Also risk of robbery and local by-laws discouraged truckers from stopping at non-designated truck stops on the roads or in small towns.

Generally, given the regional variations in HIV prevalence across the country, the evidence does not seem to suggest that the frequency and reach of their mobility in the normal course of their work has been the driver of the epidemic in South Africa.

That said, it is likely that truck drivers and their assistants contributed to the spread of the disease, not least because they are sexually active young adults who, like many South Africans, have multiple partners and do not use condoms in all these interactions.

**Q: When you conducted your research in 1996 and 2000 how aware were truck drivers about the risks of HIV, and how much do you think this may have changed a decade later?**
A: The research showed that truckers working on the transport artery that links the port of Durban to the Johannesburg conurbation and the rest of the country were aware of HIV as a sexually transmitted disease. Whereas in 1996 the disease seemed somewhat remote, by 2000 it was regarded as a greater risk and of greater concern. By the end of the decade several had been exposed to colleagues who were sick or had died. But whether being witness to illness or death has a demonstrable effect on individual behaviour is a matter for debate. Truckers expressed a degree of fatalism, given that all of them knew colleagues who had been killed in road accidents or hijackings – risks that they felt came with the job – and, at least for some, the risk of HIV infection was a price they paid for the relief that the promise of female company provided. For most drivers, their working conditions prohibited any form of recreation other than transactional sex.

**Q: Do you think migration may have contributed to the spread of HIV in the region? If so, how?**
A: The movement of people – whether it is across borders, between town and countryside, or between towns – will impact on the spread of disease, especially where such disease is sexually transmitted. This is as true for long-term migrants as it is for those who move to study or work or even for vacations. The change of context, and thereby the way that individual interpersonal interaction is regulated, is a major driver influencing disease transmission and individual vulnerability to infection. Research on students suggests that they are migrant-like populations who, in being out of home and out of place, are able to construct interpersonal relations "at will" so to speak, with all the attendant risks of HIV infection that go with their often new-found freedom.

**Q: Based on your own work, would you say that rates of HIV infection are higher among migrants than non-migrants?**
A: Certainly in a generalised AIDS pandemic like that in southern Africa, sexually active young adults especially are all at very high risk of infection. Chances of being infected or infecting others in many localities in the 18 to 30-year-old age group are as high as one in two or even two in three.

**Q: Are migrants more vulnerable than other groups to HIV infection? Why?**
A: This is a question that needs to be studied. I expect that the vulnerability of migrants to HIV infection is likely to vary by age, reason for and nature of migration, the environment they find themselves in and their own and family context. It would be a mistake to lump migrants together as if they and their circumstances were all the same.

**Q: What are the implications of this vulnerability for families and communities in countries of origin?**
A: This question assumes that migrants are the vectors of HIV infection and that they carry it home to their families. Research on discordant couples among migrants in South Africa has found HIV-positive non-migrant women being married to HIV-negative migrant men. These data show that at least some women enjoy intimate relationships in their home localities with men other than their absent marriage partners and that therefore the transmission routes are not unidirectional.

For most long-haul truck drivers in South Africa, working conditions prohibit any form of recreation other than transactional sex. *Photo: PictureNET Africa*

**Q: In your understanding, what inroads need to be made towards reducing HIV vulnerability among migrants?**
A: Other than with truck drivers, mobile populations like taxi drivers, travelling salesmen, holiday makers or migrants more generally are not specifically targeted in terms of prevention or treatment initiatives in South Africa. There is a clear need to engage people who are mobile or migrate to ensure that they understand the risks that their physical movement present and more importantly to ensure that they can have easy and affordable access to advice, treatment and care should they find themselves in need of such treatment. Returning to the study of truckers, one very big change in working conditions for them in the five years between the two studies that I undertook was that they were increasingly under surveillance by their companies, using increasingly sophisticated technology. While intensified surveillance might be protective of them in terms of preventing hijackings, it eats into their own discretionary behaviour – the time they take to rest or sleep; the number of stops they make; whether they could even spend 20 minutes doing an interview; and more importantly whether they could stop or detour to get medical attention. Such controls directly influence health-seeking behaviour, arguably to the detriment of preventative treatment and timely care.

**Q: In what ways could governments and health services providers do more for migrants in the way of prevention and care?**
A: The circumstances of the migrants and mobile populations require that government services do not discriminate against people because of their place of origin or usual place of residence. Effective primary health care services also need to be made accessible to them. For truckers, and indeed all road users, there is likely to be considerable health value in running primary clinics at key remote stops on the major road arteries. While a pilot project was started several years ago, the initiative has not been generalised. Equally, the health and infection control value of making public health care services open to anybody, irrespective of their nationality or residence status, needs to be researched. Lastly, the private sector, especially the freight industry, needs to carefully review conditions of work in light of the health and safety risks – HIV infection, fatigue, visual impairment, risk of heart disease, diabetes and AIDS-related illnesses – associated with long haul road transport.

*Dr Tessa Marcus is the Executive Director of the Knowledge Fields Development programme at the National Research Foundation in Pretoria.*

# Isolation and vulnerability: domestic workers confront AIDS

**SALLY PEBERDY** AND **NATALYA DINAT** REPORT ON THE WORKING AND LIVING CONDITIONS OF MIGRANT DOMESTIC WORKERS IN JOHANNESBURG, AND HOW THESE AFFECT THEIR SUSCEPTIBILITY TO HIV/AIDS.

Across Johannesburg, tens of thousands of workers wake up, many alone, perhaps thinking of their partners and children scattered across South Africa. These are not the male workers in the factories and mines of the city of gold, but women – domestic workers. Domestic work is the second largest sector for employment for black women in South Africa and its economic centre, Johannesburg.

A SAMP survey of domestic workers undertaken in Johannesburg in late 2003 examined their access to health care services, their reproductive health and their vulnerability to HIV/AIDS, as well as their lives as migrant workers. The study interviewed 1 100 individuals to see if their working lives as domestic workers could affect their access to health care and vulnerability to HIV. While the study did not find that the women interviewed had problems accessing health care on the whole, its findings in regard to their vulnerability to HIV/AIDS did raise areas of concern.

A defining feature of the lives of these domestic workers was that they were migrant workers. Over 86% had a second home outside Johannesburg, and more than 70% of those who had other homes said they would live there if they could find work with similar pay and conditions. The overwhelming majority of the migrant workers came from other South African provinces, while 6% said their other home was in another country. None claimed to come from outside Southern Africa.

Another defining characteristic of the lives of many of the domestic workers was separation and isolation. Most were of an age (between 21 and 50) at which women are generally thought of as wives, partners and mothers. Yet over 40% defined themselves as single, widowed, divorced or separated. And the majority of those who did have long-term partners or husbands lived apart from them, because of their or their partner's migrant status. So barely more than a quarter of the women interviewed lived with their long-term partner or husband. Most of the others who had partners saw them only a few times a year.

Separation from partners and children also reflected these women's working conditions. Almost 65% lived in (ie resided on their employers' property), and most of these were not allowed visits from their families and friends. Other aspects of their working lives were hard, and in many cases did not appear to meet the minimum standards of employment set by the Department of Labour, even though the majority had been working for the same employer for more than four years. Some 88% of the sample had only one employer, and almost 45% worked six or seven days a week, most of them for eight to ten hours a day. Their incomes were not commensurate with their long working weeks: although more than half earned between R501 and R1 000 per month, over 20% earned less than R500 per month.

Although almost half were single, only just over 10% of the women interviewed had not had a sexual partner in the preceding five years. As the majority of those with long-term partners lived apart from them, the opportunities for either partner to have other sexual partners were magnified, increasing the likelihood of risky behaviour. Women were also vulnerable to violence within and outside relationships, which could affect their suscepitibility to HIV. Almost a fifth had been pushed, shoved or slapped, or had things thrown at them, in the previous year, and 12% had been raped, including 6% by their own partners.

In this context, their lack of knowledge about HIV/AIDS issues and erratic condom use in sexual relationships were of concern. Although the women interviewed claimed relatively high levels of personal experience of HIV/AIDS, with more than a third reporting that they thought a member of their family had HIV/AIDS or had died of AIDS, and almost 20% that they had supported someone with AIDS, they showed low levels of knowledge of HIV/AIDS issues. Almost one-third of the women were unable to describe how to have sex safely, and only 16% knew about antiretroviral therapy.

Domestic workers are often lonely, leaving them particularly vulnerable to risky sexual behaviour.
*Photo: PictureNET Africa*

As for condom use, over 60% of the women had never used a condom in their lives, even though almost 90% knew where to get free condoms. Most of those who used condoms did so erratically – only sometimes with their sexual partner, or with some partners and not others. Only a fifth of condom users, or 8% of the total sample, said they used condoms all the time with all partners. This lack of condom use may reflect a lack of knowledge, but most did not see themselves as vulnerable to HIV: only 11% said they thought they might have been infected.

Although the vulnerability of domestic workers to HIV/AIDS may be aggravated by their status as migrant workers, it could be argued that the nature of their work also provides some protection. For many domestic workers in Johannesburg, particularly those who live in, their social lives are restricted by their working and living conditions. This social isolation may protect these domestic workers, as it reduces opportunities for starting new, unsafe relationships. On the other hand, their migrant status, the long periods of separation from their partners and the many restrictions on contact with their partners could make them more vulnerable.

Given the circumstances of these women's relationships, and their meagre knowledge of HIV/AIDS-related issues, the low levels of condom use cause concern. The majority depend on television and the radio for information, and most make use of government health services at some point every year. And yet, it seems, health education initiatives and prevention and treatment campaigns relating to HIV/AIDS are not reaching this cohort of women workers in Johannesburg.

## A life in Johannesburg

### At work in other people's homes

Ms A is 33 years old. She came to Johannesburg over five years ago from a farm in the North West province. She now thinks of Johannesburg as home, but would rather live in the North West. She left because she was unemployed, and her family supported her decision to seek work in Johannesburg. She was able to stay with family members when she arrived in Johannesburg to look for a job.

Ms A has a lot of financial responsibilities, as she supports seven dependants: her own child, who is 16, her parents and two siblings, and her two young nieces. All of them live in the North West, and she only gets to see them once or twice a year, as they cannot visit her in Johannesburg.

The long gaps between visits may reflect her working conditions, which seem hard, considering the fact that she has worked for the same employer for more than five years. Ms A lives on her employer's property and says she works about nine hours a day for six days a week. She only earns R750 a month, but does not pay rent. She is not a member of a medical aid scheme, pension fund or *stokvel*.

At the end of her long day, Ms A crosses the yard to go to her room. When she needs water she has to get it from an outside tap. However, there is electricity in her room and she has a cell phone, so she can contact other people.

Ms A has a partner living locally whom she sees more than once a month. She also has friends, her closest being a neighbouring domestic worker who gets together with her more than three times a week. Otherwise, she socialises at church. Ms A has to see her partner and friends away from where she stays, because she is not allowed visitors there.

Ms A says she doesn't feel lonely too often, but she does get homesick, especially in the evenings when she has finished work. After her long working day, Ms A just rests in her room and watches television, her main source of information.

Ms A has at least one family member who is HIV-positive. Although she says she knows where to get an HIV test, and would take one if it was offered in secret and for free, she has not taken a test. She knows where to get free condoms and knows how to protect herself when having sex, but has never used a condom in her life.

• *This profile is a composite of responses by different interviewees and does not describe any one individual.*

# Valuable guide that includes practical lessons

"Letting them Die": Why HIV/AIDS Prevention Programmes Fail
by Catherine Campbell
Oxford: James Currey, 2003

"*Letting them Die*" is the story of a large HIV-prevention programme in a gold-mining community near Johannesburg, South Africa. Concluding with a set of practical lessons, it provides policy-makers and others with a valuable guide that skilfully marries the author's five years of evaluative research on the programme with a meaningful set of ideas drawn from social psychology, sociology and anthropology.

The HIV-prevention programme that is the subject of the book was itself an attempt to improve on previous (failed) projects led by the mining industry. But within three years, this ostensibly "gold-standard" programme, made up of methodologies that are becoming standard practice throughout Africa, had also failed, with rates of sexually transmitted infections (STIs) actually increasing among mineworkers.

Campbell is acutely aware of the ideological pitfalls of "explaining" the failure to curb the spread of HIV/AIDS in Africa. Refusing to give way to victim-blaming or paternalism, avoiding both the reification of African cultural practices and despondency in the face of seemingly insurmountable macroeconomic forces, Campbell's book argues for an understanding of HIV/AIDS prevention as "a social issue located at the interfaces of a range of constituencies with competing actions and interests".

The core chapters focus on the stories of the constituencies that make up the community in which the intervention took place. According to Campbell the community included both what are conventionally thought of as "target groups" (sex workers, miners, youths living in a township near the mines) and also, crucially, the more powerful project managers, donors and researchers who considered themselves agents of change. All these groups were stakeholders in the project and potentially needed to alter behaviours and practices in order to address the problem of the epidemic. Campbell systematically unpacks the relations within and between the groups. In the process, she demonstrates where the obstacles to the programme lay. This qualitative analysis works well, with the unequal distribution of power in the community emerging as a central theme and the key to understanding the failure of the intervention.

The book should be of considerable interest to those concerned with mobility and HIV/AIDS, the focus of this issue of *Crossings*. The chapters on miners and sex workers address the challenges of preventing the spread of HIV/AIDS in migrant populations. Campbell seeks to explain why these groups knowingly engaged in behaviour that carried a serious risk of a slow and painful premature death caused by AIDS. Socially marginalised, miners and sex workers felt they lacked the power to shape their lives in significant ways. They were therefore less likely to engage in health-promoting behaviours.

Choices between health-promoting and health-damaging behaviour are viewed by Campbell not as the product of individual decisions but as a socially negotiated phenomenon strongly influenced by peer identities. For example, Campbell asserts that going after women and "flesh-to-flesh" sexual contact (not using condoms) formed part of a socially constructed masculinity – a mechanism for miners to cope with the danger of their work and the lack of social support characterised by their living conditions. Abstinence or condom-use were therefore at variance with miners' strategies for coping with life-challenges.

The HIV-prevention programme sought to address the root causes of such health-damaging behaviours. Participatory project management by a multi-stakeholder committee aimed to empower marginalised groups, while community-led peer education and condom distribution were intended to aid the collective renegotiation of social identities and sexuality. However, a series of obstacles to collective action in the context of the mines emerged, which Campbell catalogues in detail. For example, broader social forces, notably poverty and unequal gender relations, were not addressed by the programme as planned. A lack of co-operation on the part of the mine houses meant the programme failed to mobilise peer education among miners. Another serious setback was that neither miners, sex workers nor youths, supposedly core stakeholders, were adequately represented on the stakeholder committee.

Several factors accounted for these failures. Among these, Campbell argues, is that the concept of multi-stakeholder project management was naïve. It failed to take account of hierarchies of power among stakeholders and did not create appropriate incentives for participation. Secondly, innovative approaches to HIV-prevention that were core activities set out in the programme proposal, such as peer education, were not taken seriously and were perceived as "vague social science" by the dominant stakeholders. Biomedical approaches, specifically STI control, were given symbolic and real precedence in the programme.

The specific failures of the HIV-prevention programme documented in "Letting them Die" may or may not have been repeated elsewhere, but the broad lessons that can be drawn from the experience are probably relevant for all community projects. Interventions aimed at a community should acknowledge that communities are not homogeneous and that an unequal distribution of power can derail even a well-designed and amply funded project unless appropriate stakeholder incentives and management practices are in place. In this light, there is a need to build on Campbell's penetrating insights into the processes and tools that community projects provide for donors, managers and researchers, groups emerging from Campbell's narrative as important *subjects* (not only agents) of qualitative research seeking to explain the failure of HIV-prevention programmes.

*– Philipa Mladovsky*

Refusing to give way to victim-blaming or paternalism, avoiding despondency in the face of seemingly insurmountable macroeconomic forces, Campbell's book argues for an understanding of HIV/AIDS prevention as "a social issue located at the interfaces of a range of constituencies with competing actions and interests".

## SAMP and HIV/AIDS

SAMP has begun a policy-oriented set of research activities to raise knowledge and awareness of the linkages between migration, HIV/AIDS and the vulnerability of mobile populations.

To date, SAMP has published several policy series papers on migration and HIV/AIDS:

- *Spaces of Vulnerability: Migration and HIV/AIDS in South Africa*, Policy Paper No. 24, 2002.
- *Migration, Sexuality, and the Spread of HIV/AIDS in Rural South Africa*, Policy Paper No. 31, 2004.
- *HIV/AIDS and Children's Migration in Southern Africa*, Policy Paper No. 33, 2004.

With funding from the Partnership on HIV/AIDS and Mobile Populations in Southern Africa (PHAMSA) initiative (see page 12), SAMP has embarked on a series of research projects on the vulnerability of mobile persons to HIV/AIDS:

- HIV/AIDS, Gender and Cross-Border Trade. Research teams have been interviewing women in Francistown, Maputo, Harare, Lilongwe and Johannesburg to gain a better understanding of how they perceive the epidemic and how their economic activities make them more vulnerable to infection and affect their access to health services.
- Migrant Construction Workers and HIV/AIDS. SAMP, in partnership with Progressus, is looking at the perceptions, attitudes and risk behaviours of migrant construction workers. Interviews are in progress with workers at construction sites across Gauteng.
- Agricultural Plantation Workers and HIV/AIDS. SAMP is examining the situation of plantation workers in Swaziland and Malawi who work and live in typical migrant labour accommodation.
- HIV/AIDS in Migrant-Sending Areas. Both Mozambique and Swaziland are major suppliers of migrant miners to the South African gold mines. SAMP is examining the vulnerability to HIV/AIDS of partners and relatives of migrant miners.

Workshop

# HIV/AIDS and mobility in Southern Africa: defining research and policy priorities

STAKEHOLDERS BRAINSTORM RESEARCH AND POLICY ON HIV/AIDS AND MIGRATION, AND SET THE AGENDA FOR THE NEXT FIVE YEARS.

As part of their collaboration, the Southern Africa regional office of the International Organisation for Migration (IOM) and SAMP organised a regional workshop, bringing together researchers and other stakeholders, to brainstorm research and policy on the linkages between HIV/AIDS, population mobility and migration in Southern Africa.

The workshop, held on 22 and 23 November 2004 in Cape Town, South Africa, was attended by 40 participants, including international researchers in the field of migration and HIV/AIDS.

The aims of the workshop were:

- To review past research on HIV/AIDS, population mobility and migration in Southern Africa by defining gaps, critically reviewing past approaches and methodologies, and making an inventory of policy recommendations and actual programmes and policies that have resulted from, or are linked to, research;
- To define future strategies by setting priorities for research on HIV/AIDS, population mobility and migration in Southern Africa, and by strengthening links between the research community and policy-makers so that research outcomes are more effectively translated into action through policies and programmes; and
- To improve communication by providing a platform for discussion and networking – during the workshop and through an e-mail network afterwards – for key stakeholders in research on HIV/AIDS, population mobility and migration in Southern Africa.

The outputs of the workshop were:

- A recommended agenda of priorities for research on HIV/AIDS, population mobility and migration for the next five years; and
- Recommendations on how the research agenda on HIV/AIDS, population mobility and migration should feed into regional and national policies and programmes in Southern Africa.

A background paper co-ordinated and edited by Professor Jonathan Crush focused on:

- Major changes in mobility and migrancy – cross-border and internal – within and to Southern Africa;
- The state of knowledge of reciprocal connections between population mobility and HIV/AIDS;
- The different research methodologies used to address the link between population mobility and HIV; and
- The extent to which population mobility has been accounted for in policy thinking, dialogue and plans about HIV/AIDS.

This background paper, *HIV/AIDS, Population Mobility and Migration in Southern Africa, Defining a Research and Policy Agenda*, was published by the IOM in 2005.

The report summarises the main recommendations for

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## SAMP migration series

1. *Covert Operations: Clandestine Migration, Temporary Work and Immigration Policy in South Africa* (1997) ISBN 1-874864-51-9
2. *Riding the Tiger: Lesotho Miners and Permanent Residence in South Africa* (1997) ISBN 1-874864-52-7
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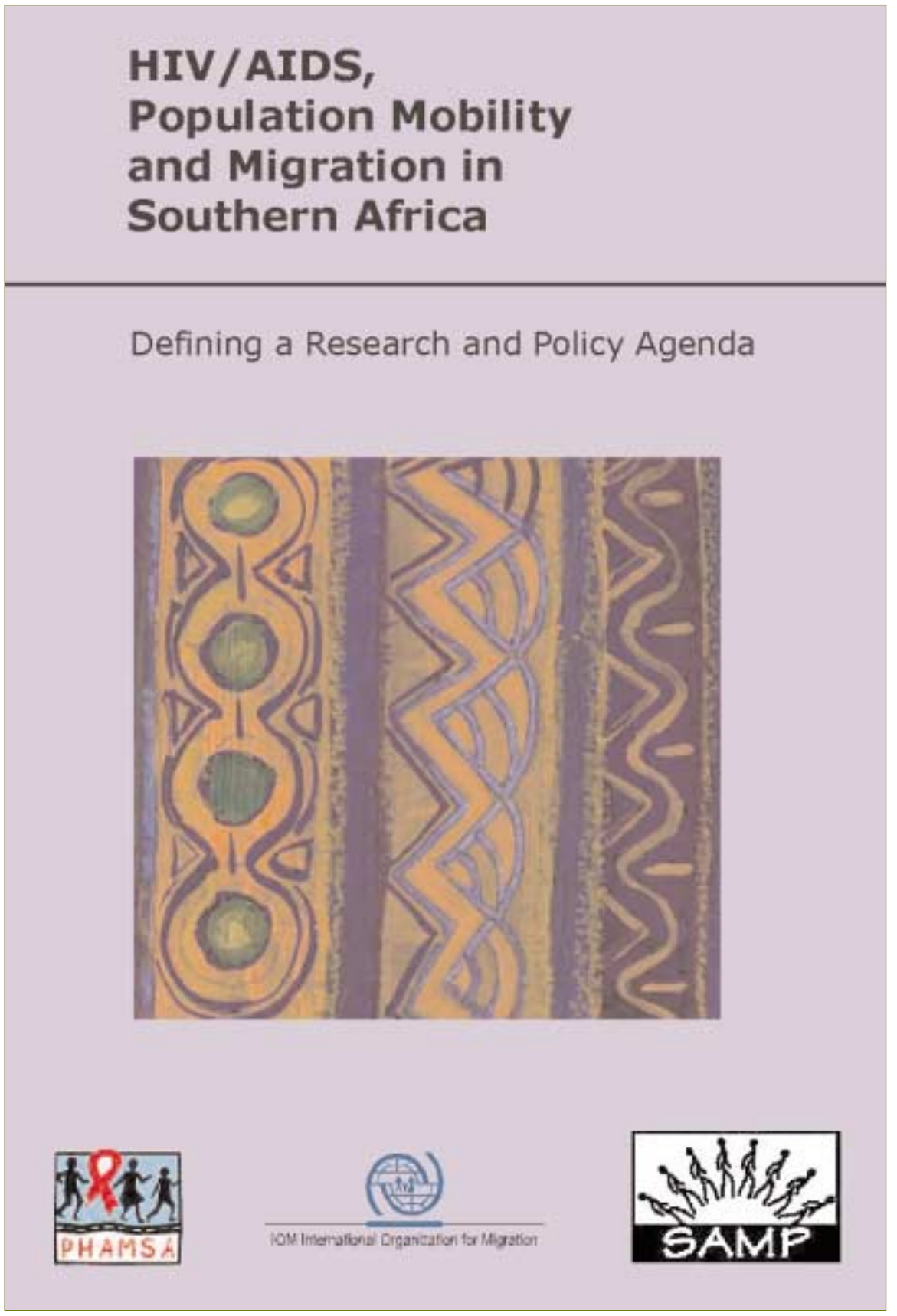


# New partnership on HIV/AIDS and mobile populations

**BARBARA RIJKS** OUTLINES A REGIONAL INITIATIVE AIMED AT REDUCING THE VULNERABILITY OF MIGRANTS TO HIV/AIDS.

Research on the linkages between the various mobile populations and HIV/AIDS in the Southern African region has found that migrant and mobile populations are among the groups most vulnerable to the disease. In response, the International Organisation for Migration (IOM) has initiated a new regional programme: the Partnership on HIV/AIDS and Mobile Populations in Southern Africa (Phamsa).

PHAMSA aims to reduce the vulnerability of mobile populations to HIV/AIDS by establishing partnerships with key organisations working on HIV/AIDS and/or mobile populations in Southern Africa. Phamsa will pull together stakeholders from the secretariat of the Southern African Development Community (SADC), sectors employing mobile workers, civil society, research organisations and international organisations in the SADC region in order to create a more effective response to the specific vulnerabilities of migrant and mobile populations to HIV/AIDS.

This three-year programme will:

- Implement qualitative and quantitative research on linkages between HIV/AIDS and mobile populations in migrant sites and migrant-sending sites (with SAMP as one of the partners);
- Disseminate information on mobile populations and HIV/AIDS to stakeholders through a Phamsa website with an electronic literature database and a regional electronic discussion forum;
- Develop HIV/AIDS prevention and care programmes in migrant sites and migrant-sending sites, with a focus on Swaziland and Lesotho, in partnership with Population Services International (PSI);
- Implement advocacy programmes that use various media channels and lobby national governments in order to increase awareness among policy-makers of the HIV vulnerability of mobile populations in the SADC region; and
- Develop regional guidelines on HIV/AIDS for sectors employing mobile workers (construction, commercial agricultural and informal trading) by organising regional workshops involving stakeholders from the government, unions and the private sector, together with experts.

Phamsa has been developed in line with the overall objectives and strategic areas of focus of the SADC HIV/AIDS Strategic Framework and Programme of Action (2003–2007). It will contribute in particular to two of the strategic areas identified as priorities in the framework: Policy Development and Harmonisation, and Facilitating Resource Networks.

*For more information visit www.iom.org.za/PHAMSA.html or contact Barbara Rijks at brijks@iom.int.*

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research on the linkages between HIV/AIDS, population mobility and migration in Southern Africa as identified by the workshop participants.

The key factors linking HIV/AIDS and population mobility throughout the world, such as poverty, exploitation, separation from families and partners and from the socio-cultural norms that guide social conduct in stable communities, are particularly important in Southern Africa, where social and economic imbalances and political instability drive hundreds of thousands of people to migrate each year.

With this report, it is expected that the significant role of population mobility and migration in driving and sustaining the HIV epidemic will be recognised by policy-makers.

It is hoped that the report will stimulate researchers and policy-makers to address the recommendations that are put forward, which will go a long way in reducing the vulnerabilities of migrants and mobile populations in Southern Africa.

**HIV/AIDS, Population Mobility and Migration in Southern Africa**
**Defining a Research and Policy Agenda**
**can be found at http://www.iom.org.za/Reports/PopulationMobilityReport.pdf**

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