HIV/AIDS VULNERABILITY AND MIGRANT FARMWORKERS IN SOUTHERN AFRICA: THE CASE OF SWAZILAND AND MALAWI

CHARLES CHILIMAMPUNGA AND HAMILTON SIMELANE

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List of abbreviations

ANC .....Ante-natal Clinic
AIDS .....Acquired Immune Deficiency Syndrome
ARV .....Antiretroviral
DFID .....Department for International Development, United Kingdom
FAO.....Food and Agriculture Organization
FGD.....Focus Group Discussions
GNP.....Gross National Product
HIV .....Human Immunodeficiency Virus
IOM.....International Organization for Migration
MK .....Malawian Kwacha
NAC .....National AIDS Commission
NERCHA .....National Emergency Response Council to HIV and AIDS
RSSC.....Royal Swaziland Sugar Corporation
STI.....Sexually Transmitted Infections
TB .....Tuberculosis
UN.....United Nations
UNDP.....United Nations Development Programmme
UNESCO.....United Nations Education, Scientific and Cultural Organization
UNICEF .....United Nations Children Fund
USD.....United States Dollar
VCT.....Voluntary Counseling and Testing

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Executive Summary

Migrant workers on commercial farms are amongst the most exploited, vulnerable and insecure workers anywhere in Southern Africa. In country after country, employers in search of cheap and disposable labour have conventionally turned to migrants to fulfil their labour needs. Human rights investigators and labour researchers have continually pointed out that migrant farmworkers are under-paid and outside the protection of labour laws and standards. Many migrant farmworkers are also in an irregular situation which makes them vulnerable to the attentions of corrupt law-enforcers and reluctant to avail themselves of services, such as health and education. Previous research by SAMP has demonstrated that the working and living conditions on many farms, particularly in South African border areas, remain dire.

There is now growing evidence that the HIV/AIDS pandemic sweeping Southern Africa has been fuelled by migration and that migrants are especially vulnerable to HIV/AIDS. Most of the work on migrant vulnerability has been conducted on mineworkers and truck-drivers with much less attention paid to the particular circumstances of migrants in sectors such as construction and commercial agriculture. Notable exceptions to this rule include work in Zimbabwe in the 1990s and, more recently, by Sechaba Consultants in Lesotho and the IOM in South Africa. As the IOM concluded in its study of migrant farmworkers along the South African-Mozambique border:

The present study aimed to build on this new body of research by focusing on farming sectors and forms of migration that have so far not been given a great deal of attention. First, most work to date (including that by the IOM) has focused on international migration. This report looks instead at the situation of internal migrants working on commercial farms. Second, explaining the reason for the choice of Malawi, in contrast to much farmworker migration, there is a well-established pattern in Malawi of family migration for farmwork. Given the common assertion in the literature that family separation is a key factor in increasing migrant vulnerability, the choice of a study area of migration without separation seemed particularly interesting and relevant. Third, not all

employees in the commercial farming sector have taken a laissez-faire attitude towards the HIV and AIDS epidemic, though many have. In Swaziland, the sugar etstates have been particularly pro-active in HIV and AIDS education programmes and in raising awareness of the dangers of unprotected sex. The question posed by the Swazi case study is whether such efforts have had an impact in raising knowledge and reducing vulnerability among migrant farmworkers. Finally, the Swaziland case is also interesting because, as internal seasonal migrants, sugar estate workers can, and do, return home very frequently and can much more easily be visited by their spouses and partners (who do not have to cross international borders to see them).

The contrasting case studies of commercial farmworkers in Malawi and Swaziland is based on research conducted by the SAMP partners in each country: the Centre for Social Research at the University of Malawi and the management and Consultancy Centre at the University of Swaziland. In Malawi, the two Central Region tobacco-growing districts of Mchinji and Kasungu were selected for study. The Central Region was chosen because most of the larger tobacco estates in Malawi are in this region, while Mchinji and Kasungu contain many of the estates that employ significant numbers of migrant tenants and other migrant farmworkers. In Swaziland, sugar is the primary commercial agricultural crop. Research was conducted in the Swaziland lowveld at one of the major sugar-growing areas, Mhlume. The Mhlume Estate of the Royal Swaziland Sugar Corporation was the chosen research site.

In Malawi, interviews were conducted with 111 migrant farmworkers who were

employed on four sampled estates, and 81 spouses or partners of these workers.

In Swaziland, all of the interviews were conducted with 101 migrant farmworkers on the working for the Mhlume estate of the Royal Swaziland Sugar Corporation. The two studies revealed several important differences in the migration patterns and circumstances of internal farmworkers in the two countries.

The geographical separation of migrants from their partners and spouses is often held to be a primary source of migrant vulnerability to HIV. In the case of the Malawian districts studied here, patterns of migrancy do not follow this general pattern. Most farmworkers migrate with their families. Although a migrant may leave first on their own, the spouse or partner soon follows. In theory this should lead to decreased vulnerability. In Swaziland, the more traditional pattern of migration predominates with migrants leaving their rural homes and partners to work on the estate for extended periods of time. Although migrants come from all over the country, they do return home far mre often than their counterparts who go to South Africa. It is also far easier for their partners to visit them at the estate. In other words, separation per se is not necessarily a major risk factor in Swaziland either.

In practice, farmworkers and their partners in both countries remain at high risk of infection for other reasons including power imbalances in gender relationships between older men and younger women. In Malawi, migrant farmworkers and their spouses are theoretically as much as risk as people in any other rural community in the country. However, the conditions of farmwork do tend to make farmworkers and their partners more vulnerable. These households are highly dependent on farmwork income and do not have any other major sources of income. They also do not have the same access to land as they would in their home communities. Farm wages are poor and conditions onerous. Farmworkers and their households live in endemic poverty. Poverty encourages risk-taking. Partners trade sex for money and income for their families. Farmworkers themselves, with what little income they have, find it easier to engage in casual sex.

In Swaziland, farmworkers are slightly better off. They are paid more and their living conditions on the estate are better than those in Malawi. However, they are also the major wage-earners in a sea of rural poverty outside the estate. They too find that causal relationships are easier to engage in; probably more so than in Malawi since regular partners are absent. In addition, some of the farmworkers are single women. They live

in the same quarters as men and some swop sex for work. In other words, male workers undertake their farm tasks in exchange for sex.

Amongst farmworkers in both countries, awareness levels of HIV and AIDS are generally high. They are aware of the disease, its major means of transmission and the devastating impact it can have on families and communities. Those who hold popular misconceptions, such as an association with witchcraft or that there is a cure, are definitely in the minority. In Malawi,k this "book knowledge" comes primarily from the radio. In Malawi, over 80% mentioned radio as their main source of information about the disease, followed by mobile clinics (5%). Less than 1% mentioned the workplace as a source of information. Educational campaigns or community meetings were almost never mentioned as sources of AIDS-related information. This is not to say that community initiatives are absent but rather that farmworkers are poorly integrated into local communities.

In Swaziland, by contrast, the Mhlume estate clearly puts a premium on educating its workforce about HIV and AIDS and in providing access to appropriate testing and healthcare. Programmes included condom distribution, pamphlets, TV, workplace peer education counseling and free testing. These programmes are operated by a specialized HIV and AIDS unit established by the company. The establishment of this unit was part of the national agenda of creating sectoral structures to address HIV and AIDS issues. RSSC was one of the first companies to run an HIV and AIDS unit. Virtually all of the workers indicated that they have full and easy access to all of the clinic's programmes. Free ART has been available since 2004. In Malawi, nearly 40% of the workers had never even heard of ART, much less had access to the medication.

In Malawi, although virtually all the workers know about unsafe sex, few actually use condoms. They are certainly more likely to use a condom when they have sex with transactional/favours or non-regular non-commercial sex partners than with regular partners. In part this reflects the workers' perception of the risk of contracting the HIV and other STIs associated with each type of partner. But usage is far from consistent.

In Swaziland, too, condom use (despite availability and promotion by the company) is sporadic and inconsistent. For example, as many as 43% of the workers did not use a condom during sex with regular partners in the previous month. In both countries, those who did not use condoms indicated that they did not like them or think it was necessary.

Yet, in Malawi, 42% of the respondents said they did not personally feel at risk of becoming infected with HIV/AIDS. Only 13% saying they were at high risk of becoming infected. When asked why they might be at risk most cited the unfaithfulness of partners not their own behaviour. Among those who felt that they were at low or no risk, the most common response given for feeling that way was that they abstain from sex. A few said that they use a condom or that they have frequent blood tests. Perceptions of risk are higher in Swaziland, with only 16% feeling they were at no risk and 27% that they were at high risk. The differences in risk perception are probably attributable to the educational programmes and messages in Swaziland.

What is striking is that even with a higher perception of risk, there is no evidence that Swazi workers are actually at greater risk or are less inclined to take protective measures than Malawian. Both are at risk, yet neither shows any greater proclivity than the other to avoid unsafe sex. The aversion to condoms and condom use still appears to be very strong at this late stage of the epidemic in both countries.

In terms of recommendations, the studies proposes the following:

- In Malawi, HIV/AIDS programmes should be expanded on farms and within migrant-sending communities to include the provision of VCT services as part of a broad-based health care system, and be organized in a way to target both migrant and non-migrant workers to avoid stigmatizing migrants. The Ministry of Health should design the programmes with assistance from NAC and with the cooperation of farm owners. For workers to have a sense of ownership over the programmes, input from the workers has to be sought and incorporated in a consistent manner. VCT services should also be made accessible to members of the surrounding communities since migrant workers have sexual relations with partners from those communities. The

Swaziland case is something of a model for workplace education for farmworkers. Yet it is clear that educational programmes are not sufficient on their own.

- The Malawian study notes that since not all migrant farmworkers have full knowledge of how HIV can be transmitted, there is a need for better educational programming. As indicated by the workers, the providers of this service should be hospital personnel from the Ministry of Health (District Hospital) who would periodically visit the workers at home (the compounds) during off hours. These medical personnel must be committed and well-trained individuals who understand the vulnerabilities of migrant workers. Again, in Swaziland, the estate appears to have such programmes in place. In Malawi, workers depend almost exclusively on radio for information. In Swaziland, information is provided on site.

- The Malawian study notes the need for encouragement for migrant workers to establish social relationships and networks among themselves and with the local community to reduce feelings of alienation and marginalization. Such networks can provide social support to the migrants and can act as a disincentive to risky sexual behaviour. Formation of migrant workers' associations would serve at least two purposes: first, they would act as a social support network for the migrant workers and, second, they would represent migrant workers in negotiations with farm management on matters affecting the migrant workers. Meaningful social interaction among and between the migrant workers, non-migrant workers, and the community can be enhanced through participation in events of common interest. Through participation in community activities would learn about important matters relating to HIV/AIDS and health in general.

- The main problem in both countries, which becomes a crucial issue of vulnerability, is that these respondents indicate that knowledge is still not reflected in practice or prompted comprehensive behavioural change. For instance, while the workers indicated that condom use was critical to preventing infection, the majority still said they do not use a condom during sexual intercourse. The mobile farm workers at

RSSC rarely practice safe sex even though they are aware that HIV and AIDS is a serious health problem within the estate. The survey also revealed that although testing facilities are available at Mhlume estate, and easily accessible to the workers, the majority have not taken the test to find out their HIV status. The results of the research indicate a resistance to HIV testing too mainly, it appears, out of fear or aversion to stigmatization. Voluntary testing needs to be encouraged and the continuing aversion to condom use needs to be addressed.

- In both countries, poverty is the underlying cause of migration of most of the workers. It is therefore important that the governments strengthen their efforts to reduce poverty through poverty alleviation programmes. As long as there is absolute poverty in the country, poor people will migrate and work in environments that worsen their situation and make them even more vulnerable to HIV/AIDS.

CHAPTER 1

THE VULNERABILITY OF MIGRANT FARM WORKERS TO HIV/AIDS IN MALAWI

CHARLES CHILIMAMPUNGA

1.1 Introduction

Malawi is a small Southern African country that covers a geographical area of about 119,140 square kilometers. The total population is estimated to be about 11 million people of whom about 85% live in rural areas (Malawi Government, 2002). Agriculture is the economic mainstay of the country. In the 1997-2001 period, agriculture accounted for 37% of GDP, over 90% of exports and 83% of employment (Sharma et al, 2002). In 2000, the agricultural sector accounted for about 74% of export earnings (National Economic Council, 2001) of which tobacco contributed approximately 61% (Mataya et al, 2002: 6). The majority of the population are smallholder farmers whose productivity is very low. In the smallholder sector, income per farmer is just over half of that in the commercial agriculture sector (Kalemba, 1997). Commercial agriculture is the chief national income earner for Malawi.

In Malawi, poverty is widespread. The World Bank (2003) reports that Malawi's GNP per capita for 2002 was only US$160. This placed Malawi among the 10 poorest countries in the world. According to a number of studies, about 65% of the Malawian population is poor (Bloom et al, 2004; Malawi Government, Sharma et al, 2002; NSO, 2002a and b; UNDP and Government of Malawi, 2003).[1] The poorest of the population include wage labourers, tenant smallholder farmers and female-headed households with less than 0.5 Ha of land. Farmworkers in the commercial agriculture sub-sector are also vulnerable to poverty, poor health and HIV/AIDS. Not only do their living and working conditions put them at risk, but they are accorded few rights and little labour protection.

There is a growing consensus and recognition in the research literature that highly mobile populations are vulnerable to HIV/AIDS (Boerma et al, 1999; Chirwa, 1995 and 1997;

[1] Most of these studies define the poor as those who live below the poverty line of US$1 per day, that is, people who are unable to meet their basic daily requirements.

Orubuloye et al, 1994). In Malawi, an estimated 14.4% of the population aged 15-49 years were living with HIV/AIDS in 2003 (NAC, 2003). The majority of farmworkers are in this age category and are at high risk of being infected with HIV. A recent study by Lurie (2004) justifies this concern. Undertaken in rural South Africa, Lurie's study found that the prevalence of HIV among migrants and their partners was significantly higher than among non-migrants and their partners. Due to the transient nature of the labour market and seasonality of farmwork, farmworkers are highly mobile people. The seasonal nature of farm work increases the mobility of farmworkers who often live in compound accommodation, tents or shacks that are unhygienic, overcrowded and lack privacy. Recreational facilities are almost non-existent. The availability of casual and commercial sex on or near the farms is a significant risk factor.

As highly mobile people, spending time on different farms or estates, migrant farmworkers may find it difficult to access HIV/AIDS education and prevention programmes, or to act on information they have received. Where do they get information about HIV/AIDS? Are they informed about HIV/AIDS and how to protect themselves? And, what do they do to protect themselves? Have the estates or farms facilitated access to information and services for workers? Migrant farmworkers spend a large amount of time traveling and working, especially at peak harvest times, and are often away from their homes and in areas where access to health care services may be problematic. Do migrant farmworkers find time to get appropriate health care advice and treatment if they are infected with HIV/AIDS or are experiencing other health problems?

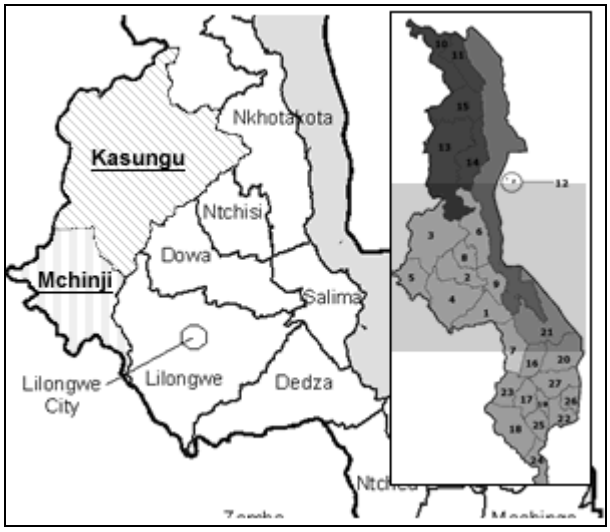
1.2 Objectives of the study

The main objective of this study is to assess the vulnerability of Malawian migrant farmworkers and their families to HIV/AIDS and to gauge their access to health education, prevention and treatment services. It is well recognized that migration increases the risk of becoming infected with HIV as traveling exposes migrants to new situations, environments and pressures to engage in risky behaviour. With such a high percentage of Malawians migrating for work it was deemed an ideal environment to

document the extent of these risks and the impact or knowledge of mitigation efforts and programmes.

Two Central Region districts were selected for the study; Mchinji and Kasungu. The Central Region was chosen because most (about 82%) of the tobacco estates of at least 10 Ha in Malawi are in this region (Chilimampunga et al; 1998), while Mchinji and Kasungu districts were selected because they contain many of the estates that employ significant numbers of migrant tenants and other migrant farmworkers. The selection of individual estates was made with the assistance of key informants, including the Chief Executives for the District Assemblies of the two districts, who identified estates where many migrants worked.

Figure 1: The Kasungu and Mchinji Districts of Malawi



The study utilized four main methods to gain data. First, the author carried out a literature review of studies on migration and migrant labour, commercial farming and migration, and migration and HIV/AIDS. Second, interviews were conducted with key informants, including two assistant estate managers, one female nurse and one male senior health surveillance assistant who were working at a nearby health centre and district hospital and two compound supervisors.

Third, interviews were conducted with a sample of migrant farmworkers and their spouses/partners. Using a structured questionnaire with largely close-ended questions, interviews were conducted with 111 migrant farmworkers who were employed on four sampled estates, and 81 spouses or partners of these workers. Spouses were included to better understand the impact of migration on the families that stay behind. They also provided insight into general family dynamics and allowed researchers to assess the extent of communication within families on issues related to health and HIV/AIDS.

The selection of farmworker respondents was carried out in the following manner: assistant estate managers helped identify an initial group of migrant farmworkers (defined as workers whose home of origin was outside the district where the farm was located). Using a snowball sampling technique, each of the interviewed migrants was requested to identify at least one other migrant worker who was subsequently interviewed. The sample was male-dominated with only 31.5% of the respondents being female. An assistant farm manager noted that 80% of migrant farmworkers are male, partly because farm work is male-oriented and also because long distance migration is selective in favour of males.

Finally, four focus group discussions (FGDs) were conducted, one with female migrant farmworkers, two with male migrant farmworkers and one with community leaders, health workers and church leaders. The FGDs were open-themed, centering on topics such as perceptions of health care services, knowledge of, and perceived vulnerability to, HIV/AIDS, experiences as migrant farmworkers, community risk and problems in the community. Each focus group had between 6 and 15 participants.

The farmworkers for the FDGs were randomly selected from among the interview sample. Community leaders were selected purposively with the assistance of key informants. Of these 9 participants, 4 were female. The FGDs were conducted in the local language and were held on or near the estates. On average, each focus group lasted 2 hours and 45 minutes.

Throughout the fieldwork the research team made observations on such matters as the type and condition of the workers' houses, their general socio-economic status, their openness or reluctance to discuss issues related to HIV/AIDS and sexual behaviour and their non-verbal behaviour during interviews and FGDs. These observations were important to ensuring sensitive issues were dealt with properly and in a respectful manner and also so that the research team maintained the trust of participants.

As the study progressed researchers confronted four main challenges to the collection of data. First, some estate owners were reluctant to allow their workers to participate in the study arguing that productivity would decrease. Second, because of the sensitivity of many of the issues addressed, there may be under-reporting on some questions even when adequate probing was done. This may also be the case during FGDs, even though they provided an opportunity for people to discuss sensitive issues in ways which did not necessarily identify their own behaviour and vulnerabilities. Third, some male migrant workers interviewed during the first day refused to allow their wives/partners to be interviewed. Fourth, almost all the respondents did not identify sexual partners who they were not married to. Although pre-marital and extra-marital relationships are common, these are not openly sanctioned.

1.3 Migration for Farmwork in Malawi

Over 80% of the population of Malawi is directly dependent on agriculture (Kaluwa (1994). The agricultural sector of Malawi is bimodal, divided between the smallholder sub-sector which produces mainly food crops and some low-value cash crops such as cotton and sun-dried tobacco, and the commercial sub-sector which is export-orientated and produces high-value cash crops such as burley and flue-cured tobacco, tea, sugar and coffee. About 80% of Malawi's exports are made up of tobacco, sugar, tea and coffee (Malawi Government, 1997). Each crop is confined to a general geographic area dependent upon soil and climatic conditions. This means that certain regions of Malawi are more likely to grow specific crops that would not flourish in other areas.

Tea estates are found mostly in Mulanje and Thyolo districts in the southern region. Tobacco estates are found mostly in the central region districts of Kasungu, Mchinji, Ntchisi, and Dowa, and Mzimba in the northern region. Sugar estates are found in Chikwawa in the southern region and in Nkhota Kota in the central region. There are a few coffee estates mostly in Thyolo and Zomba districts in the south and Mzimba district in the north. Most (about 95%) of the commercial farms grow tobacco which is the main foreign exchange earner for Malawi (Malawi Government, 1997). From 2000 to 2003, tobacco accounted for 55% of all exports from Malawi (NSO, 2004) and for 13% of GDP. This translates into a staggering 23% of Malawi's tax base (Jaffee, 2003).

The first agricultural estates in Malawi, which grew mainly tobacco, were established in the 1920s in Blantyre in the southern region. Gradually, more estates were established in the central region (Nyanda, 1989). Most of the country's large estates (of at least 400 Ha) were established in the 1970s (Chilimampunga et al, 1998). Between 1985 and 1994, the number of estates grew from about 3500 to about 30000 (Malawi Government, 1997).

The majority of the estates in Malawi utilize labour-intensive modes of production and many of them employ tenant farmers. The majority of the tenants work on the farm together with their families, including children. It is estimated that about 13% of the population of Malawi is directly supported by the estate farming sub-sector (Malawi Government, 1997). The increase in agricultural employment over the years has taken place in the face of gradually declining real wages for estate workers, including migrants (Nyanda, 1989).

Migration is extremely important in the area studied. During the colonial period and early years of political independence, many people, but especially men, used to migrate to neighbouring countries to seek employment (Boeder, 1984; van Velsen, 1969). Later, migration for work within Malawi became more prominent (Chilimampunga, 1992; Tsoka, 2005). In Mchinji and Kasungu, in-migration surpasses out-migration because the tobacco and other farms attract workers from outside the districts.

Of the 111 migrant workers sampled, 52% were interviewed in Kasungu district and 48% in Mchinji. As Table 1.1 shows, the sampled migrant workers originally came from 20 different districts. The Southern Region sent a higher percentage (51%) of the workers than the Central Region (41%) where the two districts sampled are located. The Northern Region sent the lowest percentage (5%) of the sample. At district level, the majority of the sample came from Lilongwe (14%), Thyolo (11%), and Mangochi (8%). As only migrant farmworkers were surveyed, it is not entirely surprising that very few migrants working in Kasungu and Mchinji were from Mchinji (2%) and Kasungu (3%), as those from within these districts would be more likely to commute to work from their permanent residence.

As the key informants noted, employers prefer migrant to non-migrant workers. The former are considered more reliable because it is more difficult for them to abandon work and return home. In addition, as migrants, these people have no land of their own outside the estate and therefore are unlikely to absent themselves at busy times to tend their own crops (Malawi Government, 1997).

Table 1.1: Region and district of origin of migrant farmworkers

Northern Region Districts of Origin	%	Central Region Districts of Origin	%	Southern Region Districts of Origin	%
Mzimba	5.4	Lilongwe	14.4	Thyolo	10.8
Rumphi	0.9	Dowa	7.2	Mangochi	8.1
Total	6.3	Dedza	6.3	Machinga	7.2
		Ntchisi	4.5	Mulanje	7.2
		Kasungu	2.7	Phalombe	7.2
		Ntcheu	2.7	Balaka	4.5
		Mchinji	1.8	Chiradzulu	2.7
		Salima	1.8	Zomba	1.8
		Total	41.4	Chikwawa	0.9
				Nsanje	0.9
				Total	51.3
				Outside Malawi	0.9

Focus group discussions and key informant interviews suggested that lack of access to adequate land and limited employment were the main factors pushing workers and their families to migrate. Lack of employment opportunities was cited as particularly important. In fact, in a study in the Southern Region of Malawi, where the majority of the migrant farmworkers in Mchinji and Kasungu come from, Chilimampunga (1997) found that migration in search of work opportunities was a strategy that individuals, not entire families, use to cope with deprivation.

For almost 30% of those interviewed violence had forced them to move from one residence to another at some point in time in the past. Often this was a result of conflict over land which is one of the main causes of family migration. Witchcraft accusations and marital problems tend to cause individual migration. Some migrants are "fugitives," having committed some offence in their home of origin, such as theft or impregnating a school girl. The individual makes the decision and migrates alone. Once in the new community such migrants maintain a low profile

Focus group participants noted that generally the poorest do not migrate because of poor health, or a lack of transport money, knowledge, or skills that would help them adapt to a new environment. Consequently, when the poor do migrate, they typically make short moves. However, because some estate owners prefer workers from afar, they make deliberate efforts to recruit and transport such workers with them to their farms in trucks. Such workers are desperate for work and are unlikely to quit even where work conditions are very poor. The majority of the migrants interviewed moved with their immediate family members. Virtually all of those who migrated as individuals were males.

According to the FGD participants and key informants, migration has a major impact on the community that is left behind. First, the extended family may be shattered, particularly when a whole family or household migrates. Given that most of the migrants are married men with child and adult dependents, the impact of their absence is felt by the whole community. Second, when a married individual or part of the family migrates,

this often creates dual or stretched families. The migrant worker or his family are never completely uprooted or separated from their community of origin, while at the same time constructing new families and relationships at the place of work. Migration results in households being reshuffled in size and composition, and household and community life is fundamentally changed as a result. Third, when large numbers of the middle-aged move out, young children, including orphans, are left in the hands of the elderly (Ansell and van Blerk, 2004). Some live in child-headed households. The social and economic support they receive under these conditions is often inadequate.

Receiving communities have been affected by migration in four main ways. The social fabric of the host community is disturbed because of differences in language or dialects between the hosts and the migrants. Also, the influx of large numbers of adult males is a potential threat to existing social and gender relations. As a result there tends to be mutual mistrust between migrants and local residents. As one FGD participant put it, "migrants bring bad behaviour like theft." Comments from key informants suggested that although they have lived in the area for many years, the migrant workers have not integrated into the local communities. They are seen as a potential threat to the stability of the communities they live in or nearby. Often, they are discriminated against and stigmatised as very poor people.

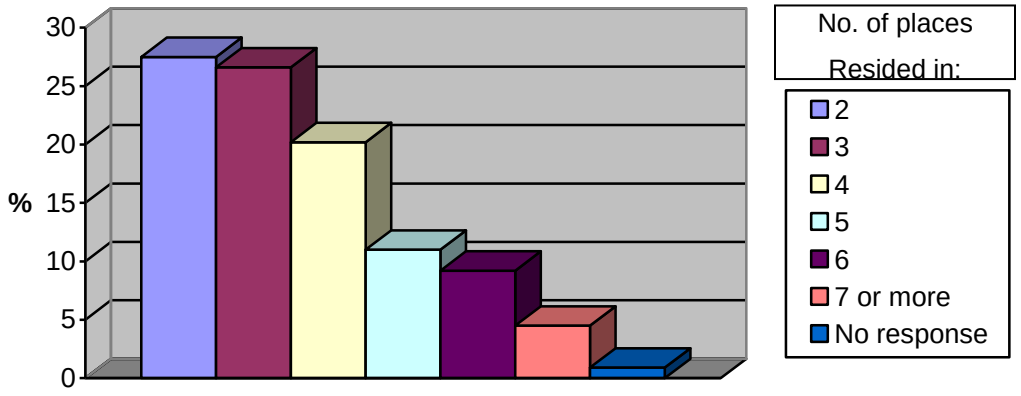
Also, with the influx of large numbers of individuals and families, resources and facilities such as land, water, health facilities and schools become overstretched. However, it must also be noted that migrants expand the market and bring new skills and knowledge that benefit their adoptive communities. Thirdly, host communities tend to blame migrants for spreading HIV/AIDS in the communities through their sexual liaisons with locals.

Finally, migrants often send money back to their home communities to support their families and ensure they have a legacy to return to when they have finished working. However, as Chilimampunga (1997) notes, these remittances usually fail to compensate for the migrants' absence. As a result family members left behind suffer. Further, as migration increases the health risks faced by workers this threatens their ability to

financially support their families. When a migrant becomes ill with HIV/AIDS the family loses the remitted funds altogether and often has to care for the affected individual which can put a financial and emotional strain on families and the greater community.

FGD participants and key informants agreed that migration will increase in the future because of the shortage of cultivable land, especially in the southern region and as a result of increasing poverty and the scarcity of job opportunities. Much of this movement will be rural-rural migration of individuals and families or households. Today migration patterns are also not unidirectional. In other words, migrant farmworkers do not simply have a home in one location from which they migrate to a single destination. Nearly half of the sample had lived in at least 4 different places, including their original home, during their working life (Figure 1). This is significant given that most (77%) of the migrant workers were under 40 years old, and that there are serious transportation and accommodation problems in rural Malawi. A highly mobile population is very likely to be exposed to HIV/AIDS.

Figure 1.1: Residence Patterns of Migrant Farmworkers

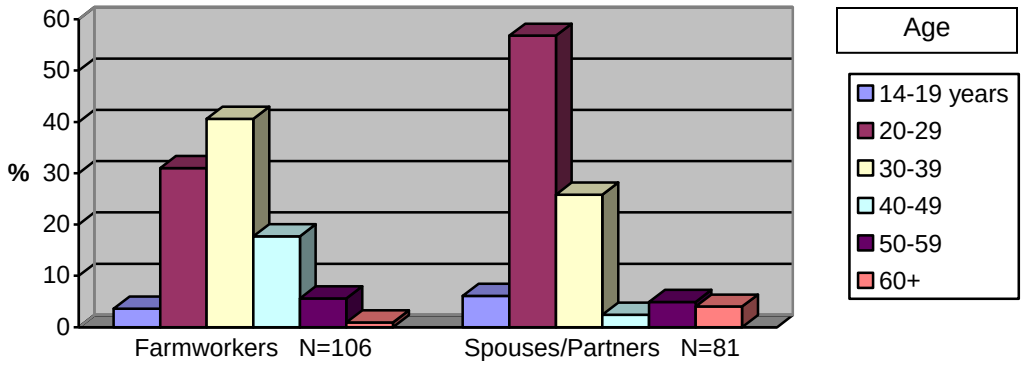


1.4 Migrant Livelihoods

The first series of questions posed to the farming migrants was meant to provide a better idea of the overall demographic and make-up of the migrant population. It was revealed that migrant workers tend to be young to middle-aged men (Figure 2). The ages of the respondents ranged from 15 to 62 years, with the largest percentage (40.6%) of them in the 30-39 year age-category. As expected, the spouses, most of whom were female, were

younger, with a mean age of 27.9 years. Their ages ranged from 14 to 57 years. Most (82.6%) were in the 20-29 year age-category.

Figure 1.2: Age of Migrant Workers and Spouses/Partners



As many as 87% of the respondents, when asked their current marital status, said that they were married. Only 7% had never married, 2% were divorced, 2% were widowed and 1% were separated (due to rounding percentages do not equal 100%). About 70% of the married workers had been married for more than 5 years. As pointed out earlier, most farmworkers migrate with their families. However, a significant proportion of male migrants initially leave their spouses at home with the intention of having them move later after settling into the new place.

Only 12% of the respondents had no children. The number of children ranged from 1 to 11, with most (55%) having between 2 and 4 children. A significant number of the migrants had 5 or more children. The mean number of children per migrant farm worker was 3. Most of the migrants and their spouses are still in their child-rearing years so family size could well increase.

Almost all of the migrants had dependents. Most (67%) had between one and four dependents, but as many as 21% had five or more dependents. As Table 1.2 shows, most of the workers provide for at least one child and at least one adult.

Table 1.2: Number of Dependents of Migrant Farmworkers

No. of Dependents	Child Dependents % of Migrants+	Adult Dependents % of Migrants+
0	2.8	1.0
1	8.3	25.7
2	18.3	27.7
3	21.1	14.9
4	19.3	8.9
5	10.1	7.9
More than 5	20.2	13.0
N*	109	100

+ Due to rounding %s may not add up exactly to 100%.

** The number responding is less than the total number of farmworkers surveyed (111) as refusals and "don't know" responses have been excluded.*

Part of the reason for the high numbers of child dependents is that HIV/AIDS deaths amongst adults are leaving orphans (Ansell and van Blerk, 2004:6). Some are cared for by other migrants in the area, others are sent home to be taken care of by relatives, while still others are left to fend for themselves through child labour, begging and theft. A high number of dependents places a large burden on the migrant worker whose socio-economic status is already very low. Consequently, many children are forced to seek employment on the farm or outside it to supplement low household income. In their study, Matemba and Dzilankhulani (2002) found that many children are employed on tobacco estates in Kasungu. They observed that more than 90% of the children engaged in child labour came from poor families. This is common on many other estates, especially among tenants. A UNICEF study (2001) observed that Kasungu and Mchinji are two of the districts in which child labour on tobacco estates is a significant problem.

The education status of the migrant workers is low. Three quarters had completed only the first year of primary education while only 6% had completed at least 5 years of schooling. None had completed more than 6 years. It is important to note that 8% had either no formal education or did not even complete one year of schooling. Given the lack of schooling amongst migrant workers it is not surprising that their illiteracy rate is about double (94.1%) the national rate in Malawi (46.2%) (NSO, 2002c:9).

The education status of spouses/ primary partners of migrant workers is equally low, with most (66%) having had some primary education and 26% having had no formal education at all. Only 64% of workers'school-aged children were in school (Table 1.3). Many of the children of school-going age who were not in school had dropped out because of the pressure from their parents to work as tenants or child labourers. A survey by the Malawi Human Rights Commission (2002) of child labour in Nkhota-kota and Dedza districts sheds light on the situation in the neighbouring districts of Kasungu and Mchinji. The Commission observed that in the tenant system, children are used as part of family labour to work in the fields, and in most cases this is at the expense of school since working in the fields receives priority. The Commission found that it is common for tenants to have big families to provide a large labour force. At one estate in Nkhota-Kota district only 13% of the children of tenant farmers were at school, compared with about 30% among the migrant farmworkers interviewed in this study.

Table 1.3: Number of Children in School

No. of children in school	% of Workers
0	35.6
1	21.2
2	20.2
3	11.5
4	6.7
5 or more	4.8
Total	100
N	104

Farm work is the main source of income for all the families of migrant farmworkers, and given that over 80% of Malawians draw their income from agriculture it is not surprising that income levels were consistent with national averages. Most of the respondents are labourers doing general duties, and 87% earn between MK1000 and MK2500 (US$8-20) per month. Seven percent earn more than MK2500 and 6% less than MK1000 per

month.[2] When the worker receives food (usually a 50 kilogram bag of maize per month which costs about US$8) on loan from the employer, the wages at the end of the month are reduced to as little as MK400. Most of the workers live below the poverty line. Only 20% have other sources of income such as pensions, small-scale business or casual labour. A third of the farmworkers' spouses work outside their home as small-scale business operators (30%), fellow farmworkers (3%), commercial sex workers (13%) or in other employment (53%).

The poverty of migrant farmworkers begins in their home areas and is hardly relieved by working on the farms. Key informants pointed out that many migrant workers are unable to take with them their bulky possessions, such as bicycles or furniture, when they leave their places of origin. The possessions they leave behind are lost forever, which sometimes includes their land. They are unable to buy new possessions and when they are fortunate enough to own land at their destination, it is often small and of marginal quality. When times are extremely hard, migrant workers are sometimes forced to sell their possessions.

Migrant and non-migrant workers doing the same job generally receive the same wages. However, non-migrant workers have greater bargaining power because employers or supervisors know them and their families better. In addition, their socio-economic status is higher because they have other sources of income at their disposal. As one male migrant worker said in an FGD, "The employer and people from here do not allow us to engage in business ventures. They say that we did not come here to do business." In addition, migration results in a loss of social and business networks, putting migrants at a disadvantage when seeking assistance or securing loans. As Cernea (1996) observes, the contribution of informal networks among households is vital to the daily economic life of the poor and their destruction is a net economic and social loss. Household networks help individuals cope with poverty through informal loans, exchanges of food, clothing and

[2] Malawi's Gross National Income (GNI) per capita for 2004 was US$160, according to the World Bank.

durable goods. It is difficult and takes time for the migrants to construct such social networks.

Most migrant farmworkers in the study area are engaged primarily in manual labour. They cultivate, plant, weed, harvest, sort/grade, package and load tobacco or paprika, provide other general assistance on the farm as demanded by the employer. Very few migrant workers do clerical work or use machinery. Three quarters claimed to be on permanent work contract; fewer said they were on temporary (17%) and seasonal (8%) work contracts. Irrespective of the nature of the contract, a worker can be laid off at any time if the amount of work declines. Most (57%) have one full day off every week, but when there is a heavy workload, they are sometimes forced to work seven days a week. Focus group participants said that they were ill-treated by employers and supervisors who sometimes force them to work more than 12 hours a day, 7 days a week, even when they are sick.

Migrants rarely return home temporarily, for example during off-seasons, because of a lack of money or transport. When they do return it is often to visit a sick close relative, to marry, or, where the distance is not prohibitive, to collect foodstuffs. Many of the migrant farmworkers plan to return home at some point in their life. The majority want to leave as soon as they can because of the low wages and harsh working conditions but they do not have enough transport money to take them back home. The employer does not provide transport home for workers. At the same time, the idea of returning home can also be troubling as many do not know what changes await them in their home communities.

Case Study

Mrs Zunzika (not her real name) was walking towards estate number 88 in Kasungu district to ask for *ganyu* (casual labour). She hoped the researchers were from some organization that could give money for transport to migrant farmworkers who want to "flee" from estates. She was at pains to explain why she wanted to go back to her home village in Thyolo district, over 350 kilometres away.

She said that she migrated to the estate together with her husband and their two sons about four years ago. For two years her husband worked as a general labourer while she stayed at home doing chores in their home in the compound provided by his employer. Her husband began having an affair with a woman from a neighbouring village. After the birth of their third child, he abandoned her for his mistress. Mrs Zunzika feels that he abandoned her because, with his low wages, he could not cope with the burden of looking after two women and three children. She does not know where he is and he has not tried to contact her since.

Living alone and without any relative to depend on, Mrs Zunzika lived on food donations from her estranged husband's employer. Soon men began taking advantage of her vulnerability and she bore two more children from different men who do not assist her in any way. Currently she is pregnant. Like her three youngest children aged about 9, 7, and 2 years who were with her during the interview, she looked unkempt, malnourished, and much older than her age.

The reasons why migrants return home before the expiry of their work contract include: harsh working conditions on the farm, a lack of better alternatives near the farm, chronic illness of the worker or his/her live-in family members or their deaths, and the illness or death of family members or relatives living in home communities. When witchcraft is associated with the illness or death of relatives at home, the migrant is less likely to return home permanently for fear of the consequences.

One response to poor working and living conditions is to try and find a farm where circumstances are better. Eighty percent of the sample had worked on more than one farm (Figure 1.3). Forty percent had work experience on three or more farms. Only 45% of the farmworkers had been working at the same farm for more than 3 years. At the same time, there were some who had worked on the same farm for much longer periods (Figure 1.4). Almost 40% of the migrants have lived on or near the farm for at least 5

years. Some 15% had more than 10 years experience working on the same farm. Although these figures confirm that migrant farmworkers are a mobile population, it is clear than when working conditions are better (or migrants have no other option), they will stay on the same farm for a longer period.

Figure 1.3: Number of Different Farms Worked On

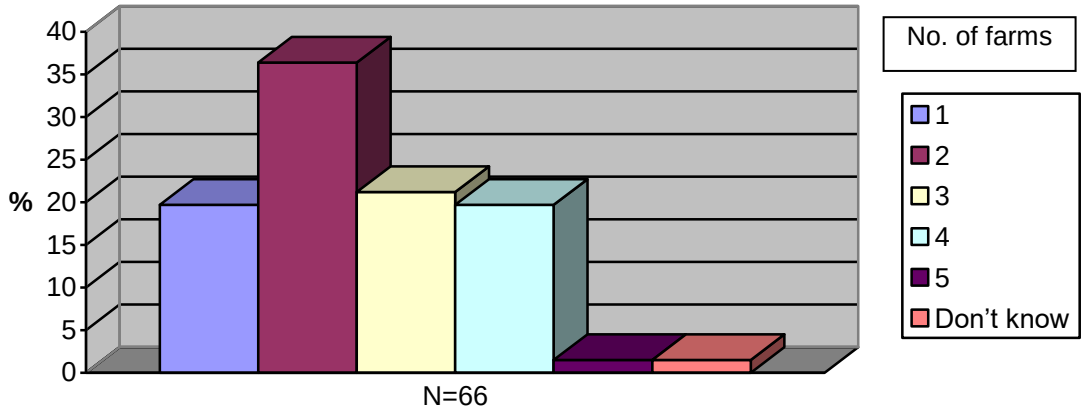
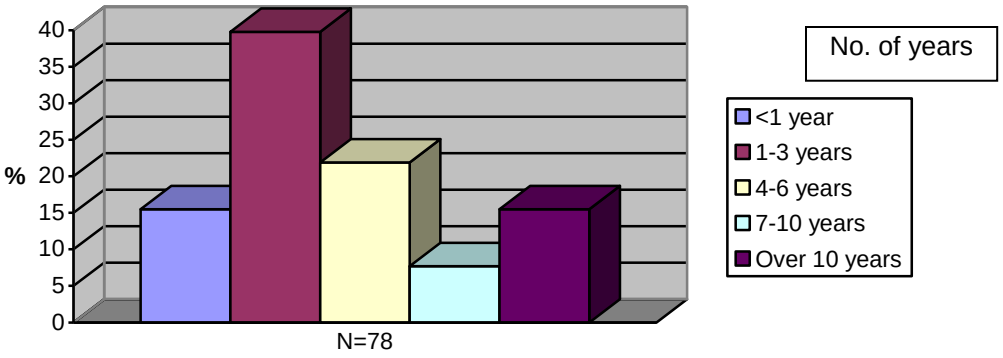


Figure 1.4: Number of Years of Work at Current Farm



Most (almost 80%) of the migrant farmworkers live in traditional houses of which about 18% are compound houses provided by the employer.[3] Twelve percent live in what the respondents themselves described as "shacks" and only 8% live in brick houses. None of the houses have electricity and only 3% have indoor tap water. Sanitary facilities are rudimentary. The houses are very small; many of them smaller than an average Malawian hut. Most of them have only a small bedroom and a tiny living room which also serves as

[3] According to the 1998 Malawi Census, traditional houses are identified as having grass thatched roofs and mud brick or mud and wattle walls.

a children's bedroom. Yet, on average, 5 people live in each house. Only 7% of the respondents said they live alone. The rest live with their spouses and/or children, and often with some young dependents.

1.5 Migrant Vulnerability to HIV/AIDS

Migrant labour systems in Southern Africa generally separate workers from their families for long periods of time. This, in turn, tends to riskier sexual behaviours and heightened risk-taking (Lurie, 2004:23). Indeed, it is the geographical separation of migrants from their partners and spouses that is often held to be a primary source of migrant vulnerability. In the case of the farming districts studied here, patterns of migrancy do not follow this general pattern. As discussed above, although a migrant may leave first on his or her own, the spouse or partner soon follows. Alternatively, husbands and wives often migrate together for work. In theory this should lead to decreased vulnerability. In practice, farmworkers, male and female, remain at high risk of infection. There are a number of general reasons for this state of affairs which are discussed below.

First, there is the issue of power imbalance in relationships. The partnership profile of farmworkers tends to show that the female partner is usually younger than the male. Studies have shown that in Malawi the HIV prevalence rate is particularly high among persons in the 20 to 49 age category. HIV/AIDS prevalence among females aged 15-49 years is four to six times higher than that amongst males (NAC, 2003). As Makwiza (2005) et al note, this reflects gender disparities in abilities to negotiate safe sex, which in turn reflects unequal access to resources and asymmetrical gender roles and relations. Adolescent female migrant workers are most at risk because of their limited negotiating power with sexual partners who are almost always older than they are.

Second, the abject poverty of many farmworkers encourages risk-taking. Focus group discussions and key informant interviews confirmed Zulu et al's (2000) observation that separation from spouses and an abundance of economically-desperate women increase the potential for extra-marital relations. Many of the divorced or widowed respondents were female. It is typical for men not to wait for many years after they are divorced or

widowed before re-marrying or securing a sexual partner. As Boerma et al (2000) suggest, there tends to be more risky sexual behaviour among persons in less stable relationships. However, even among migrant workers who have been married for many years, such behaviour is not uncommon.

Third, because two thirds of the spouses do not work outside their homes, most are particularly vulnerable to poverty as they almost totally depend on the income of their husbands. In the midst of this dependency, sex has become a survival strategy for female migrant workers and the spouses of male migrant workers (see also Bryceson et al, 2004). Women's vulnerability to HIV infection is augmented by economic hardship. As one FGD participant put it: "the problem of HIV/AIDS will always be with us because of poverty." This echoes Kishindo's (1995:159) observation about commercial sex workers in Malawi:

> As long as poverty remains at present levels and the female, for whatever reason, cannot get a job or profitable self-employment, commercial sex will remain an attractive option. And in the context of current male attitudes where penetrative, unprotected sex is regarded as the only 'normal sex,' the high rate of AIDS infection in the Malawian population will continue.

Unlike in the villages, where husbands and wives work together on their family farms, almost all of the spouses who work outside the home work on different farms. In addition, the farmworkers rest only one day a week which many of them (the males in particular) spend drinking beer for recreation without the company of their spouses. Protracted separation of the spouses tends to facilitate the initiation of extra-marital sexual activities.

Fourth, the over-crowded living conditions and lack of privacy for couples means that children are not insulated from early knowledge about sex. As Zulu et al (2000:23) suggest, such housing "contributes to predisposing people to indulge in risky sexual behaviour, particularly early initiation of sex … children are socialized into sex by being exposed to sexual intercourse even in their houses at very early ages." Zulu et al (2000) note that strategies devised by the parents to avoid exposing the children to sex are

usually unsuccessful. They make two important points here. First, having sex in such an environment makes it difficult for parents to have any discussions about sex and how to protect each other from contracting sexually transmitted infections, including HIV/AIDS. Second, often the emphasis on the sexual act alone and not sexuality prevents a better understanding of protective behaviour and more caring attitudes toward sex.

1.6 HIV/AIDS Awareness Amongst Farmworkers

The survey of farmworkers provided further insights into their and their partners' knowledge of and vulnerability to HIV/AIDS. Among migrant farmworkers, awareness levels of HIV/AIDS are very high. As many as 95% of the migrants, when asked, responded that they had heard about the pandemic. Radio (82%) was the overwhelming main source of information about the disease, followed by mobile clinics (5%). Just two percent cited friends as a source while a further ten percent were split amongst a number of different sources including television, educational campaigns, community meetings pamphlets and newspapers. Surprisingly, less than 1% mentioned the workplace as a source of information. As noted, educational campaigns or community meetings were almost never mentioned as sources of AIDS-related information. A significant proportion of the migrant farmworkers are not well-integrated into the local community. Feeling alienated, they rarely, if ever, attend meetings.

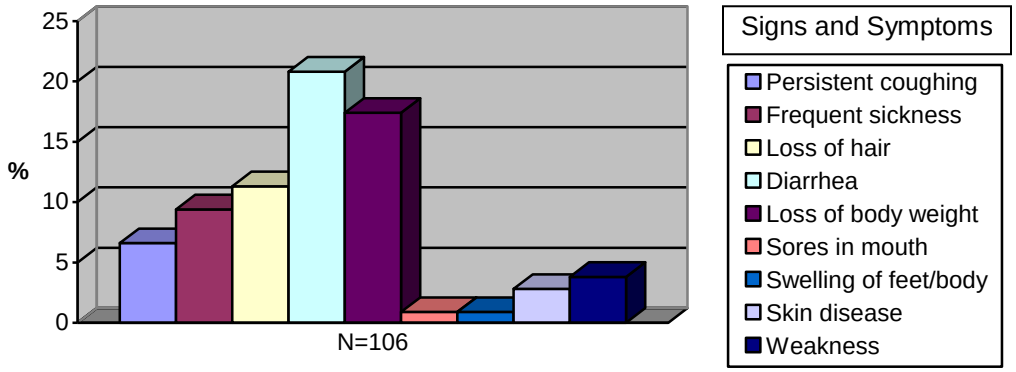
Given how few farmworkers mentioned friends and family as a primary source of information about HIV/AIDS, it is apparent that discussion among migrant farmworkers at work or outside the workplace about health-related matters is minimal. As Munthali and Chimbiri (2003) observe, education about sex or HIV/AIDS is considered taboo in many Malawian communities. Parents rarely talk to their children about sex; traditional birth attendants, traditional initiators, aunts, and grandparents are designated to discuss sex and related issues. For most adolescent children of migrant workers this is a great disadvantage because they are isolated from such people.

Discussion of HIV/AIDS among migrant workers is also rare because many of them are new to the area and therefore do not feel comfortable discussing sensitive topics around

strangers. As a result, there is little trust amongst workers. Over half (54%) do not belong to church, sports, or youth groups, trade unions, or associations/clubs where they could discuss issues including those related to prevention of HIV/AIDS. Of those who are members of associations/clubs, three quarters are members of church/religious groups. Such groups tend to meet only once a week, and HIV/AIDS is often a taboo subject at such meetings as well.

Almost all respondents said they are aware of HIV/AIDS. They, as well as FGD participants, observed that HIV/AIDS is a serious problem in their community. Frequent illnesses, deaths, and the rising number of orphans were identified in FGDs as indicators of the magnitude of the problem. However, analysis of the results shows that a significant proportion of them have inadequate knowledge about the pandemic. For example, as Figure 1.5 shows, that of the nine signs and symptoms of AIDS mentioned by respondents individually, none were listed by more than 21%. According to the National Statistics Organization of Malawi, knowledge of HIV/AIDS is almost universal amongst Malawians (NSO, 2001), so it is significant that 10.4% of this sample said that they do not know any of the signs and symptoms of this disease.

Figure 1.5: Percentage of Migrant Workers Listing Signs and Symptoms of AIDS



Other answers confirmed that knowledge of HIV/AIDS is limited amongst the workers. For example, 37% of the respondents said that they have never heard of antiretroviral therapies. Of those who had, 22% said that HIV/AIDS can be controlled or stabilized with antiretroviral medication, while 12% said they did not know if it could be or not. More seriously, 8% said that HIV/AIDS can be cured with antiretroviral medication.

There is a potential, therefore, for workers to avoid seeking treatment in the event that they test HIV positive. Those who believe that antiretroviral medication cures HIV/AIDS are at risk of contracting HIV from partners on this medication, or spreading the disease to others.

While knowledge about HIV/AIDS is limited, Table 1.4 shows that many migrant workers have a good working knowledge of how the disease is transmitted. For example, almost all migrants were aware that sharing needles and having unprotected sex could lead to the transmission of HIV/AIDS. Also, significantly few of the farmworkers believe the disease can be spread by incidental contact. It appears that many farmworkers hold conflicting opinions on the influence of witchcraft. For instance, while only 17% said that HIV is transmitted by witchcraft, 38% said they had heard of someone who had been bewitched so that they have AIDS. Two key informants pointed out that witchcraft accusations are common amongst migrant and non-migrant workers, especially when the former appear to be prospering, or when they seem to be favoured by the employer. It was argued that the symptoms associated with bewitchment are similar to some of those associated with AIDS, such as sudden illness, loss of body weight, and persistent and severe headaches. This suggests that farmworkers have a weaker grasp of the connections between HIV and AIDS and of the influence of witchcraft than the statistics would imply and that more research should be done on this issue.

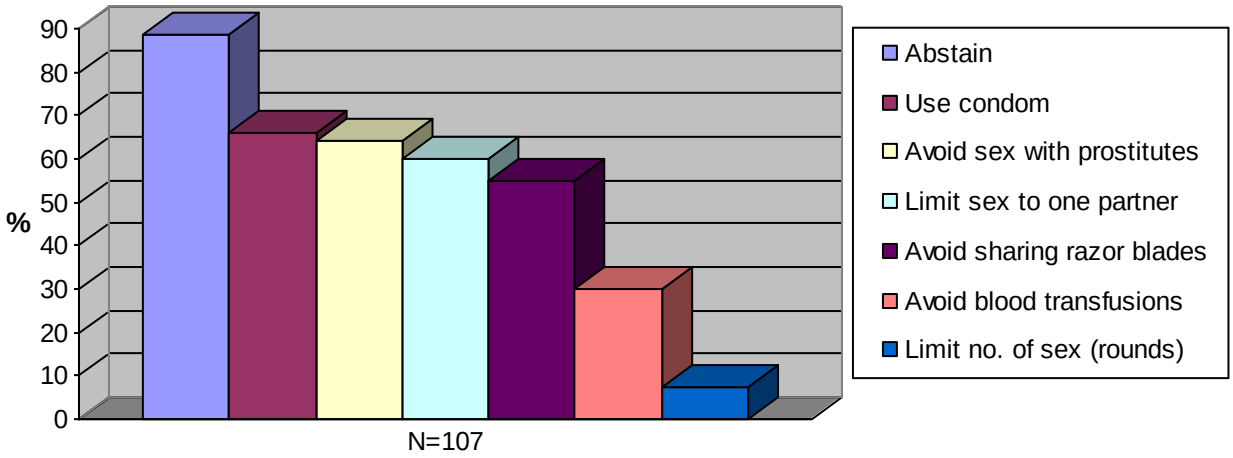
Table 1.4: Knowledge of How HIV is Transmitted

Mode of HIV Transmission	Yes %	No %	DK %+	N
Sharing meal with HIV infected person	5.1	88.9	6.1	99
Sharing tools at work	11.2	85.7	3.1	98
Injections with a needle used by someone else	98.0	2.0	0.0	98
Having sexual intercourse	92.9	7.1	0	98
Touching someone's blood	58.8	33.0	8.2	97
Having Sex without using a condom	99.0	1.0	0	96
Sharing a bed with HIV infected person	8.6	84.9	6.5	93
Sharing clothes with HIV infected person	10.8	78.5	10.8	93
Shaking hands with HIV infected person	6.5	91.4	2.2	93

Transmission from pregnant mother to unborn child	80.4	14.0	5.6	107
Mother to baby transmission through breast-feeding	87.9	7.5	4.6	107
Through witchcraft	16.7	75.0	8.3	96
Note: due to rounding row percentages may not add to 100%. *+ DK refers to "Do not Know"*				

When asked an open-ended question on how a person can protect themselves from contracting the HIV, most responded by citing the standard precautions of abstinence and the use of condoms. Fewer farmworkers mentioned practices such as not sharing razor blades (55%) or limiting sex to one partner (60%) (Figure 1.6). It should be noted that this question did not ask if the farmworkers followed these protection methods. On a separate question, about 30% said that a healthy-looking person cannot be HIV positive. This belief puts these people at higher risk of contracting and transmitting HIV.

Figure 1.6: Knowledge of Protection Methods



Key informants and FDG participants claimed that abstinence among migrant farmworkers, and the Malawian adult population in general, is hardly practiced. When the unemployed wife of the migrant worker periodically leaves the farm, returns home and stays there for months, especially during cultivation and harvesting time, the husband fails to abstain from sex.

Most of the respondents (70%) said that they did not know anyone infected with HIV, yet a similar number (66%) reported that they knew someone with AIDS. Only 17% said they have a close relative or friend respectively who is infected with HIV while 21.5% have a relative or friend suffering from AIDS. This suggests that those who are HIV positive do not exhibit visible symptoms of the disease, do not know their status or are keeping their status secret. Although key informant interviews were inconclusive, there was some suggestion that workers who test HIV positive do not disclose their status for fear of being stigmatized and dismissed from work. This tends to support the view that secrecy is a common tactic used to protect the names of those affected. In turn, such people are unlikely to warn others who may become infected by their HIV positive friends. Some do not disclose because they feel that having a relative or friend who tested HIV positive, or who is suffering from AIDS-related illnesses, is a shameful thing.

As Table 1.5 shows, secrecy is also important within families as over half the respondents said they would want to keep a family member' status secret if that individual tested positive for HIV. Generally speaking, however, levels of stigmatization by migrants are not as high as anticipated. The vast majority would have no difficulty sharing a meal with a person with HIV/AIDS, caring for a relative who is ill, or working with someone who is HIV positive. Slightly fewer, but still the majority, felt that a teacher who is HIV positive should be allowed to continue teaching.

Table 1.5: Attitudes Towards HIV Positive Persons

Attitude	Yes %	No %	N
Would share meal with person with HIV/AIDS	88.8	11.2	107
Would care for male relative who is ill with HIV, in my household	95.3	4.7	106
Would care for female relative who is ill with HIV, in my household	91.6	7.5	107
HIV+ teacher who isn't visibly sick should continue teaching	78.3	21.7	106
HIV+ co-worker who isn't visibly sick should work with others	82.7	17.3	104
HIV illness of family member should be kept secret	51.4	47.7	107

When asked about the impact of AIDS in their home communities, 93% of the migrant farmworkers admitted that HIV/AIDS is a problem in their community. Sixty-four

percent said that more people are dying in their community than a few years ago and nearly 60% claim that AIDS is the main cause of death. It can be expected, therefore that most (90%) also said they worry a lot about HIV/AIDS. Yet, 42% feel that they are not personally at risk of becoming infected with HIV/AIDS, with only 13% saying they were at high risk of becoming infected. When asked why they might be at risk most claimed the unfaithfulness of their partner. What is interesting is that almost all the respondents put the blame on their partner's risky behaviour rather than on their own behaviour.

Among those who felt that they were at low or no risk, the most common response given for feeling that way was that they abstain from sex. A few said that they use a condom or that they have frequent blood tests. This category of workers is vulnerable to HIV infection because they are not likely to protect themselves. In fact, FGD participants suggested that the majority of migrant workers, irrespective of marital status, do not abstain from sex. As will be demonstrated in a section below, use of condoms is low.

Farmworkers were then asked about the potential fallout that would occur if they became ill with HIV/AIDS. Virtually all (98%) of the respondents said that there are people in their life who would be affected if they were to fall sick. Spouses (wives) were by far the most frequently mentioned followed by children and parents/grand parents, other relatives and workmates.

When a migrant becomes sick, dependents are affected in many ways. A sick worker cannot work or earn income which leads to a shortage of food in the home, a shortage of money for health care, and school fees and poor attention to the field. Being the breadwinner in most of the homes, the migrant farm worker's illness results in reduced access to income. Key informants observed that in such circumstances, wives are sometimes forced to indulge in petty trading to raise income for the household. But women who indulge in petty trading are at risk of contracting HIV. They interact with many men and many of their male trading counterparts demand sexual favours in exchange for business transactions. A key informant in Mchinji pointed out that on pay day and a couple of days after, when a migrant farm worker buys lots of *kachasu* (a

locally-brewed kind of gin) from a woman, she feels obliged to accept his sexual advances to her since he has promoted her business.

Spouses would also be affected by the imposed necessity to care for the sick. Culturally, it is women who nurse ill family members. It was therefore not surprising that spouses (wives) were said to be most likely to nurse the workers if they fell sick at home (71%), followed by parents/grandparents (16%), other relatives (7%), children (3%) and workmates or others (2% each). If the husband falls sick at a time when the wife has gone to her original home for various reasons, he must rely on others to take care of him.

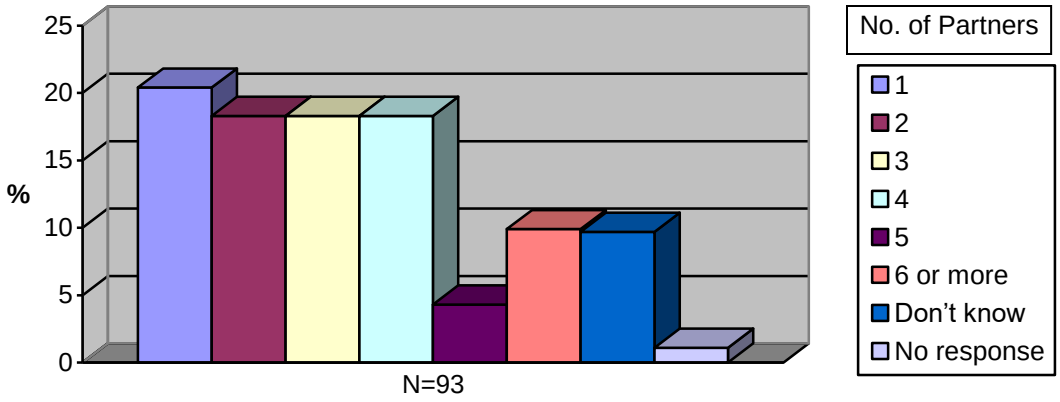
Most (56%) of the respondents have experienced the problem of looking after a terminally sick person but only 26% said they had physically or financially cared for someone who was sick with AIDS. Looking after a terminally sick person disturbs a person from their normal, routine day to day activities such as working on the farm. Providing financial assistance makes the worker even more vulnerable to poverty as it takes away money desperately needed to make ends meet. Particularly when their partner falls sick, migrant farmworkers have to spend many hours looking after the partner since relatives are far away. The worker has to weigh the risks involved; that is, whether to spend more time at work and be accused of abandoning the sick wife (sometimes people begin to suspect that one is a witch when they do that) or to spend more time with them and jeopardize their employment.

1.7 Sexual Activity Amongst Farmworkers

Farmworkers were also asked about their sexual history, attitudes and practices to better understand their vulnerability to disease and HIV/AIDS. Virtually all of the respondents have had sexual intercourse with the mean age of first penetrative sexual intercourse being 18 years, with a range of 9 to 26 years. As many as 46% had their first experience before the age of 18 which means that the majority of the workers have been exposed to the risk of contracting HIV for many years.

Sexual activity among the migrant workers is also frequent, with 88% having had sex in the 12 months before the study. The mean number of lifetime sexual partners was 4, with a low of 1 and a high of 25. The number of those who had had sex with more than one partner was extremely high (80%) (Figure 1.7).

Figure 1.7: Estimated Number of Sexual Partners



The majority of the sexual partners were committed partners or spouses. Among the casual partners, most were people who the workers were not married to and had never lived with, followed by transactional/favours partners with whom the farmworkers exchanged a good or service for sex and, lastly, one-time partners.

Most (73%) of the spouses/regular partners live on the farm the majority of the time. The rest live in villages or towns near the farm. Because of this proximity, even if the worker does not live with his/her spouse/partner, they do not have to walk a long distance to meet each other for sexual encounters. It is common, therefore, for them to meet either daily or weekly. Over 40% of the workers reported that they had last seen their partner within days before the interview. Only 20% said they had last seen their partner months or years ago. When couples rarely meet the chances are higher that each partner could be involved in extra-marital relations.

Almost all (97%) of the migrant workers interviewed had a regular partner; that is, a spouse or live-in sexual partner. Most (68%) had one regular partner, and 28% had at least two regular partners. The highest number of regular partners reported was 11 and

the mean was 1.5. By having more than one regular partner, the workers obviously increase their risk of contracting, or spreading HIV/AIDS and other STIs.

Many male workers have casual sexual partners in addition to their regular partners. Most (73%) of the respondents have had sexual partners who they were not married to and had never lived with. The most reported was 9 partners but the majority (40%) had had only one or two other partners. Key informants observed that married men are among those that have these partners. Such men are more likely to become infected with HIV and infect their wives.

The study also found that nearly 20% of the migrant farmworkers had had non-regular, non-commercial sex partners in the last 12 months. The most common reasons given for having such partners were that the sex is more fun, less inhibited and makes the worker feel more loved.

Case Study

At the age of 24, Joseph (not his real name) had slept with 8 or so women in addition to his wife of 5 years. Before migrating to the farm with his wife 2 years ago, he had already slept with 3 girls in his village. While 2 of these encounters happened before Joseph got married, the third time occurred afterwards, this time with a transactional partner. In his own words, "I wanted to experience how sex outside marriage tastes. It was also adventurous and to be able to have sex with a prostitute without being discovered by your wife and relatives was like playing hide and seek. After all, everyone was doing it, including elderly married people!"

Only six months after arriving at the farm Joseph had sex with two transactional partners. He said life was boring; he had no friends and his wife was pregnant. He went drinking with friends and met the women. As both groups were drunk it was easy for them to talk about sex freely. Joseph had never talked about sex and the different ways of performing sex with his wife. "I made wonderful discoveries. These Chewa women know how to

entertain men. I was able to do it more than three times to one woman in one night. It is impossible to do it that way with my wife. She is like my sister now. I don't find her as attractive as a strange woman. After all, how can you be free to do it the way you want when there are children in the house?" Joseph has three children aged 3 years, 2 years, and 7 months.

Although the majority who have casual partners did not disclose why, the main reasons given by those who had were sexual satisfaction, emotional support (particularly when they have marital problems) and, for female workers, financial support. Where multiple partners are involved, the migrant worker showed little concern about the sexual behaviour of the other party who might actually be unknown to him.

About a third of the workers admitted to having had transactional partners, partners with whom they traded goods or money for sex. The number of such partners per worker ranged from 1 to 23. Although only 14% of the workers said they had had sexual intercourse in exchange for money or goods in the last 12 months, frequent sexual intercourse with these partners takes place. This is evidenced by the fact that 46% of the workers who had transactional partners, had engaged in sexual intercourse with them at least twice in the previous 30 days in exchange for money or goods. The highest number of times was 30.

A significant number (30%) of migrant workers have had once-off sexual partners. The most frequently mentioned reasons for these relationships were drunkenness and lust, both of which have to do with lack of self control. A study by Bisika et al (2004) revealed that in Malawi, a third of those interviewed were more likely to engage in casual sex when under the influence of drugs and alcohol.

The study therefore showed that migrant farmworkers are sexually active. Virtually all of them have had sex and were currently having sexual relations with their spouse and or other partners. Although most respondents did not admit that they had multiple partners, key informants reported that there is an impression, either real or imagined, that migrant

workers tend to have more partners than non-migrants. Being away from the surveillance of kith and kin, and having come to the area with the status-granting label of 'foreigner,' the migrant farm worker has access to more sexual partners than would be the case if he or she was living at home.

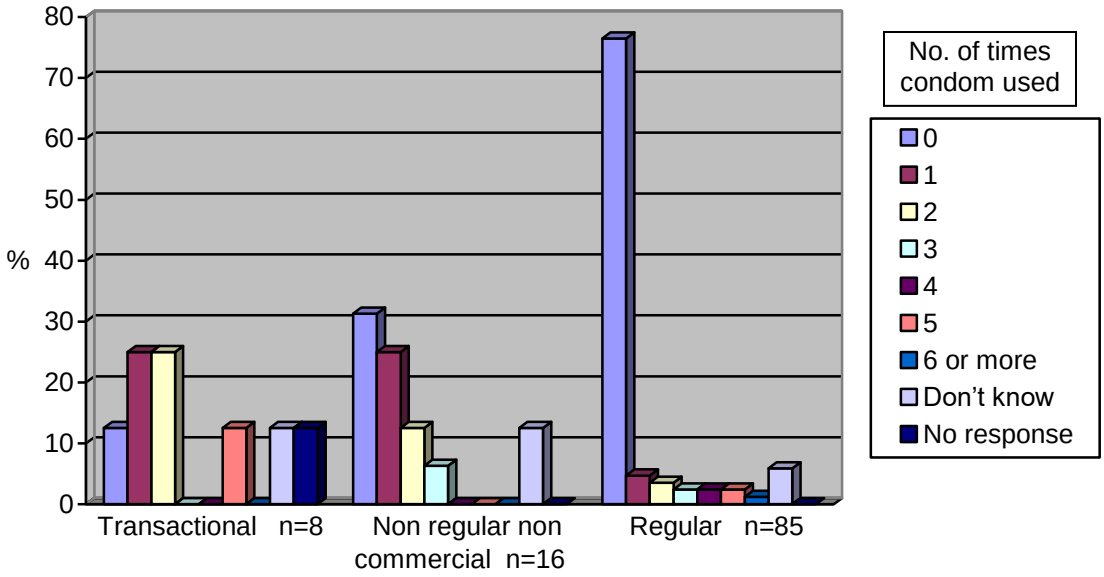
1.8 Condom Use

Although virtually all the workers know that HIV can be transmitted through sex without a condom, few actually use them when they have sex, whether as a protection against contracting the HIV or to prevent pregnancy. As Table 1.6 and Figure 1.8 show, workers are more likely to use a condom when they have sex with transactional/favours or non-regular non-commercial sex partners than with regular partners. In part this reflects the workers' perception of the risk of contracting the HIV and other STIs associated with each type of partner.

Table 1.6: Frequency of Condom Use by type of partner

Type of Partner	Every time	Almost every time	Sometimes	Never	No response	N
Transactional	50.0%	0%	8.3%	33.3%	8.3%	12
Non-regular non-commercial	75.0%	0%	6.3%	18.8%	0	16
Regular	14.0%	5.8%	12.8%	65.1%	2.3%	86

Figure 1.8: Condom Use in Last 30 days, by Type of Partner



The sexual behaviour of regular partners can be more easily monitored and is better known than that with other partners. Migrant workers noted that transactional partners do not pressure them to use protection during sex. While a greater percentage of migrants used condoms with non-regular partners than transactional ones, this discrepancy is likely due to the small size sample size. Focus groups argued that non-regular non-commercial partners are viewed by the workers as less likely to be infected with HIV and other STIs than transactional partners. One key informant articulated the differences among the three categories of partners as follows:

> A spouse is in a stable relationship and she has sex because it is an obligation. The male partner has sexual rights over her which no other man has. A non-regular non-commercial partner has sex when and because she wants to. A transactional partner is in a very unstable relationship if there is a relationship at all. All she wants is sell her body to the highest bidder.

Table 1.7 shows the reasons why workers did not use a condom when they had sex with their regular partner in the previous 30 days. The majority (83%) said they did not think it was necessary or did not think of it at all. While this demonstrates a high level of trust in committed relationships, such action is highly risky to each partner. Nearly 70% said they used other contraceptives, 57% that they did not like condoms and 53% that the

partner objected to their use. None of these answers suggest an environment in which the use of condoms is habitual or normalized.

Table 1.7: Reasons for Not Using Condom with Regular Partner		
Reason	**%**	**N**
Didn't think of it	73.3	96
Partner objected	52.6	92
Condom too expensive	4.8	90
Don't like them	57.1	90
Partner might think I am HIV positive	27.3	89
Use other contraceptive(s)	68.0	86
Condom not available	28.6	83
Didn't think it was necessary	82.9	76
Note: more than one answer permitted.		

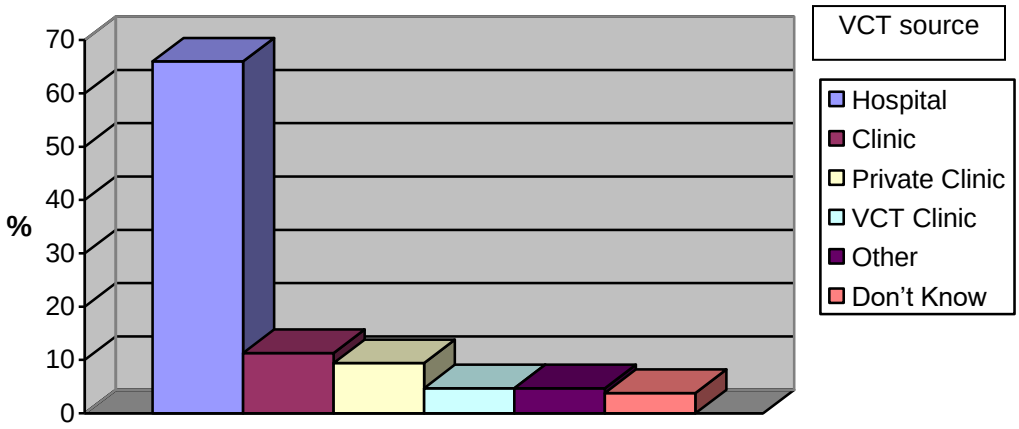
As many as 53% of the workers who used a condom with their regular partner said that the decision to use condoms was a joint one. Twenty-four percent said they made the decision while 18% said their partner suggested the condom use. The picture is different when the partner is transactional; 67% of the respondents reported that they made the decision themselves and only 17% said the decision was made jointly.

Negotiation of condom use is thus more common when the partner is regular than when s/he is non-regular. Husbands generally feel that it is their wife's/regular partner's responsibility to ask for condom use. The couple negotiates but the man often makes the final decision. It is difficult for the wife/partner to demand that a condom be used. Married women have little say on condom use unless they doubt their husband's fidelity. As Zulu et al (2005) note, if young women accept gifts or money from men, they lose the power to negotiate and have to give in to sex without condoms, even if it is against their will.

1.9 Access to HIV/AIDS Services, Treatment and Health Care

Participants were also asked about their access to sexual health services to get a better understanding of the environment in which migrants live and face vulnerability to disease. A majority of respondents (56%) reported that it was not possible in their community for someone to get a confidential HIV test. From FGDs, it was evident that there are two main reasons for this. Only 18% of the respondents said that they had ever had an HIV test, of whom 80% had tested voluntarily, 10% as part of an ante natal clinic programme, and 5% as part of another programme. First, there are no Voluntary Counseling and Testing (VCT) sites at or near the farms. In fact, according to NAC (2005), only 48% of counseling and testing sites in Malawi are in rural areas where most of the population lives. Mchinji district, with a population of 324,941 in 1998, had only 3 such sites while Kasungu, with a population of 480,659, had 6 sites. As Figure 1.9 shows, two-thirds of the respondents said that they must travel to hospitals to receive VCT services.

Figure 1.9: Sources of VCT Services as Identified by Sample



Secondly, many workers avoid being tested because they feel that they cannot trust health officials to keep the test results a secret. The workers believe that they are not able to get a confidential test, and many share common misconceptions about the testing process, such as that once one tests HIV positive one's life is drastically shortened.

On a related confidentiality issue respondents were almost equally divided on whether, if they were HIV positive there should be a law that clinics should tell close relatives. This

suggests that many workers would not want a relative, let alone a non-relative, to know that they are infected with HIV. Again, such secrecy obviously facilitates the spread of HIV/AIDS and limits the opportunity to seek help.

Focus group participants and key informants said that some workers fear that if they test positive, their employer and spouses would come to know about it and they would lose their jobs and marriage. Over 80% of those who had gone for testing had been counseled either before or after testing. A full 94% had found out the results of the test. In 2005, as many as 17% in Mchinji and 16% in Kasungu who accessed HIV counseling and testing services tested positive (NAC, 2005). The migrants are therefore living in communities where HIV prevalence is high though not necessary higher than the rates in the communities they came from.

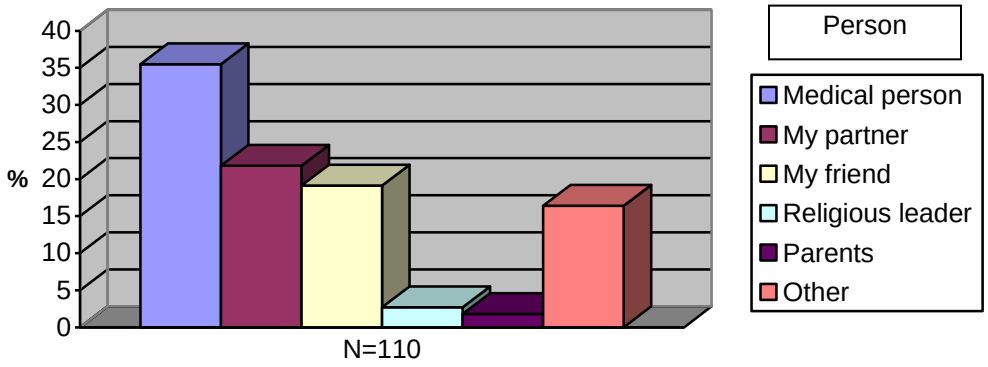
Virtually all the respondents observed that currently there are no programmes in the communities or the farms which address HIV/AIDS. Key informants confirmed this finding. The respondents who said that such programmes do exist were referring to single occasion visits by personnel from the Ministry of Health or NGOs to the community or the farm to distribute condoms or pamphlets on HIV/AIDS, to counsel and test workers or community members or to train people how to manage STIs. Those who attended said that they had free access to these "programmes" which they found to be beneficial. They further noted that to make the programmes more beneficial there was a need to implement condom-distribution programmes at farms, present AIDS-related information in entertaining ways such as through theatrical performances, and maintain the activities on a consistent and frequent basis on the farm or at the compound where the migrants spend much of their time.

The key informants from the health centre and hospital reported that there are few, if any, specific and established programmes in the communities either. Instead, health surveillance assistants who live in the communities are supposed to conduct regular community meetings to discuss various health issues including HIV/AIDS, but many of them do not. Village health committees were also said to be inactive. When such

meetings are held, migrant farmworkers rarely attend because they would rather rest at home or engage in other social activities. Being "strangers" they are rarely elected into village or community committees such as the village health committee.

Despite the fact that workers said health officials cannot keep secrets, medical officials were said to be the best people to talk to about HIV/AIDS and sexual matters (Figure 1.10). Such personnel are not only trusted with regard to confidentiality but they are also believed to have adequate information on these matters. Although partners were the second most frequently mentioned, very few migrant workers actually discuss HIV/AIDS and sexual matters with their partners. In any case, most of the partners were females whose access to information on these matters is very limited. HIV/AIDS and sexual matters are also often regarded as taboo subjects in churches in Malawi. Religious leaders tend to avoid discussion of sexual matters with their followers, as parents do with their children.

Figure 1.10: Person Best Placed to Talk About HIV/AIDS



Farmworkers gave some indication of how they would like these programmes implemented in the future. Most respondents (83%) said radio was their preferred method for them to hear about HIV/AIDS. Pamphlets (3%) came a distant second, followed by peer education (2%), and television (1%). Other modes with similarly low support included community meetings and newspapers. Most of these modes are unidirectional and do not provide the workers with the opportunity to ask questions or to seek clarification. The location chosen as being the most effective for such programming efforts is the home (40%), although a third selected the work site (Table 1.8).

Table 1.8: Best Place to Receive Messages About HIV/AIDS	
Place	**%**
At home	39.8
At work	33.3
At political rallies	5.6
At entertainment places	4.6
At mobile clinics	3.7
Don't know	13.0
N = ???	108

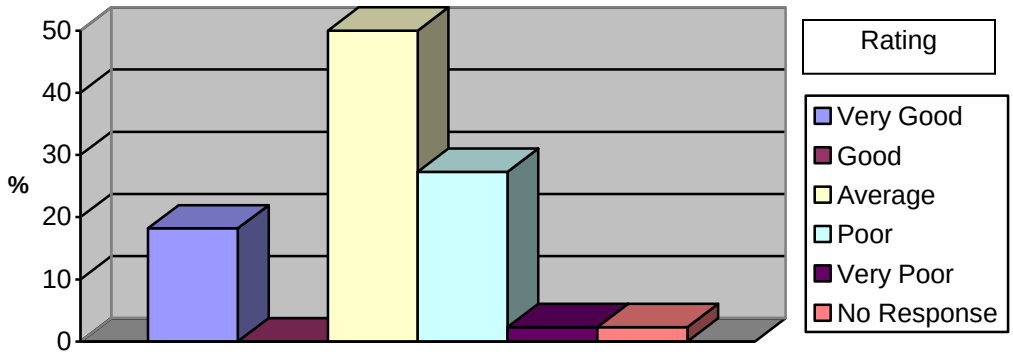
Given that workers spend the majority of their time on the farm it is unknown whether they would be allowed or able to access radio programming during working hours. It is also questionable whether farm owners would allow medical personnel to visit farms during working hours to discuss HIV/AIDS matters with the workers

The study clearly shows that existing health services on or near the farm are currently limited. Although 60% of the respondents reported that there is a clinic or hospital in the community, it was usually located more than 5 kilometres away, either at a district headquarters or in a separate village. None of the farms visited provided even basic health services to their workers. Two-thirds of the respondents reported that mobile clinics do not go to their community.

Lack of transport and lack of money for transport were the main reasons respondents said they are normally unable to get to the hospital or clinic. In fact, very few migrant farmworkers own a bicycle which further limits transportation options. Walking the distance when one is sick is very taxing for the workers. Unlike non-migrant workers, migrant workers cannot easily draw upon a local support network when they fall ill. Key informants noted that farm owners will provide transport to the clinic or hospital only when the worker is very sick.

Access to medical services is critical, especially consideration that most of the respondents have been sick while living in the community. When asked where they normally go for medical advice or medicine, the majority (59%) said a hospital, 30% said a clinic or health post, and 6% said a private clinic. A key informant who is a nurse at a clinic near one of the farms observed that migrant farmworkers come to the clinic for help more often than non-migrant workers. This is probably a reflection of the poor health conditions that migrants suffer. She noted that the migrants do not attend the STI clinics with their sexual partners because they do not want anyone else to know about it. It is discouraging to note that migrants do not rate the quality of medical service particularly highly with half of respondents saying it is average and close to 30% saying it is poor or very poor (Figure 1.11).

Figure 1.11: Rating of Medical Help



Despite the lackluster impression most migrants have of health care facilities, most of the workers (70%) said that if they get sick in the future, they will go to a hospital, while a further 13% said a clinic or health post. The remainder listed private clinics (4%), traditional healers (4%) or family or relatives (2%) as their preferred source of assistance. Focus group participants said that sometimes migrant workers are denied services at the clinic. A key informant argued that some traditional leaders influence the health providers to give priority to local residents because the clinic was built for them. The migrants then choose to go to a hospital which is far away, where their migrant status is not known.

1.10 Conclusion

Migrant farmworkers in Malawi are vulnerable to HIV/AIDS infection for a number of key reasons. First, migrant farmworkers are highly mobile. This is the consequence of the poor working conditions at the farms and the nature of their work contract. They move from one farm to another, sometimes even before the end of their contract, only to find that conditions at other farms are no better. As a result they are likely to meet many potential sex partners whose sex history they do not know since they (the migrant farmworkers) are not integrated into the host communities.

Second, they have poor access to health care services. The farms that they work at do not provide health care and do not have programmes that address HIV/AIDS. Clinics and hospitals where VCT services are offered are not very close to where the workers live. Often, the migrant workers are provided "average" or poor quality health services.

Third, lack of social support and "surveillance" from marriage counselors and other extended family relations provides migrants with an environment conducive to pre- and extra-marital sexual activities. Significant numbers of them have multiple sexual partners and many have sexual relations with transactional and non-regular, non-commercial partners on or near the farms.

Fourth, significant numbers of the migrant farmworkers do not have adequate knowledge about HIV/AIDS, how HIV is transmitted and how they can protect themselves from contracting the virus. Even more troubling, amongst those who expressed some knowledge and understanding of HIV/AIDS the use of preventative measures is far from routine. This is mostly because the farms do not have HIV/AIDS programmes. In addition, because they are not integrated into the host community, migrants rarely attend community meetings, and are not members of village AIDS or orphan care committees at which issues related to HIV/AIDS are discussed. This lack of adequate knowledge about HIV/AIDS results in many migrant farmworkers not using condoms when they have sex with their partners.

Fifth, the status of "foreigner" gives the male migrant farm worker access to many women including transactional and non-commercial sexual partners. In *Chichewa* (language spoken throughout Malawi), there is a saying that "*mlendo ndiamene amayenda ndikalumo kakuthwa*" (a visitor comes with a sharper tool, idea, skill, etc), a belief that imbues foreigners with an almost mythical quality. In addition, in poor communities, the mere fact that a person was able to travel a long distance by vehicle implies that he/she has cash to spend. Moreover, even if he does not have cash, he can pretend, at least during the first few weeks or months of his arrival, that he is not poor. This status is attractive to women, particularly those who want to exchange sex for money.

Sixth, because of very low wages and poverty, the threat exists for many migrant workers to vent their frustration in risky behaviour which could lead to unsafe sex. Because of high levels of poverty, female migrant workers and wives/partners of migrant workers sometimes exchange sex for cash or food in order to make ends meet, thereby putting themselves and their sexual husbands/partners at high risk of contracting the HIV.

Migrant farmworkers in Malawi are poor, they lack adequate knowledge about HIV/AIDS, and they have poor access to health services. This study has shown that all these factors increase the vulnerability of the migrants to HIV/AIDS. There is need to address all three factors if the migrants' level of vulnerability is to decline significantly. As Murphy argues, human behaviour is a key factor in determining health. The behaviour of migrant farmworkers in Malawi is characterized by unsafe sex which is the second-highest risk factor for preventable death and disease in the poorest countries of the world (WHO). It can lead to HIV/AIDS and other sexually transmitted infections, cervical cancer, unintended pregnancies, and unsafe abortions. There is need to address the risk behaviour of the migrant workers if their health is to improve.

The migration of individuals and families in search of work on farms is likely to continue for the foreseeable future as poverty, food insecurity and unemployment continue at high levels and alternative sources of income outside farm work are out of the reach of a large

percentage of the population. Based on the findings of this study, five major recommendations can be made on how the vulnerability of migrant farmworkers to HIV/AIDS can be reduced.

First, HIV/AIDS programmes should be expanded on farms and within migrant-sending communities to include the provision of VCT services as part of a broad-based health care system, and be organized in a way to target both migrant and non-migrant workers to avoid stigmatizing migrants. The Ministry of Health should design the programmes with assistance from NAC and with the cooperation of farm owners. For workers to have a sense of ownership over the programmes, input from the workers has to be sought and incorporated in a consistent manner. VCT services should also be made accessible to members of the surrounding communities since migrant workers have sexual relations with partners from those communities.

Second, since many of the migrant farmworkers do not have full knowledge of how HIV can be transmitted, there is a need for better educational programming. As indicated by the workers, the providers of this service should be hospital personnel from the Ministry of Health (District Hospital) who would periodically visit the workers at home (the compounds) during off hours. These medical personnel must be committed and well-trained individuals who understand the vulnerabilities of migrant workers.

Third, migrant workers must establish social relationships and networks among themselves and with the local community to replace those they left behind to reduce feelings of alienation and marginalization. Such networks can provide social support to the migrants and can act as a disincentive to risky sexual behaviour. Formation of migrant workers' associations would serve at least two purposes: first, they would act as a social support network for the migrant workers and, second, they would represent migrant workers in negotiations with farm management on matters affecting the migrant workers. Meaningful social interaction among and between the migrant workers, non-migrant workers, and the community can be enhanced through participation in events of common interest, for example, sporting activities, cultural dances, adult literacy classes,

and religious discussions, that would help to keep the workers away from drink, drugs, and sex. Through participation in community activities and already existing committees such as Village Aids Committees and Village Health Committees, the migrant farmworkers would learn about important matters relating to HIV/AIDS and health in general. The local traditional and religious leaders, the farm owners, and the migrant workers' representatives can play a major role in the establishment of such events.

Fourth, the Ministry of Labour and Vocational Training should advise individuals and families seeking work on farms far away from home on the risks involved in long distance migration. The ministry must also discourage farm owners from uprooting individuals and families from their homes to work in unfamiliar environments far away from their homes. In addition, it should establish mechanisms to protect the rights of the migrant workers to ensure that they are not exploited. Farm owners must be convinced that if they improve both the conditions of the work (including providing migrant workers with permanent rather than temporary or seasonal contracts) and the welfare (including housing) of the migrant workers they will reap dividends as the workers will become more productive.

Fifth, poverty is the underlying cause of migration of most of the workers. It is therefore important that the government strengthens its efforts to reduce poverty through, for example, its poverty alleviation programme. As long as there is absolute poverty in the country, poor people will migrate and work in environments that worsen their situation and make them even more vulnerable to HIV/AIDS.

For any of these recommendations to be effectively implemented, migrant farmworkers must be regarded as a very important category of the population who contribute to the development of the country through their hard work on the farms. Unless this is recognized by the government, farm owners and other stakeholders, migrant farmworkers will continue to be marginalized and ignored.

CHAPTER 2

MIGRANT FARM WORKERS' VULNERABILITY TO HIV AND AIDS AT THE MHLUME SUGAR ESTATE, SWAZILAND

HAMILTON SIPHO SIMELANE

2.1 Introduction

Only a limited amount of research has been conducted on commercial farmworkers in Southern Africa and their vulnerability to HIV and AIDS (Chikovore and Mbizvo 1999; Morris et al 2000, IOM 244, Sechaba Consultants 2004). In Swaziland, there is a death of information on the living and working conditions of farmworkers and their knowledge, attitudes and practices with regard to HIV and AIDS (Coutinho 2001). .Farmworkers in the commercial agriculture sector are vulnerable to HIV in much the same way as mobile workers in the mine and construction sectors (Crush et al 2007, Peberdy et al 2007). Farmworkers are often very mobile and highly mobile populations have been identified as being particularly vulnerable to HIV AND AIDS (Crush et al 2005). Previous research shows that the living and working conditions of farmworkers put them at risk, but they are accorded few rights and little labour protection. They live in over-crowded compounds, tents or shacks that are unhygienic and lacking in privacy. Casual and commercial sex is common on or near the farms. HIV AND AIDS programs or STI services and access to health care services is limited. Many farmworkers have seasonal contracts which increase their mobility; recreation facilities are often lacking; and income-earning opportunities are unequal for men and women

Migrant farmworkers spend a large amount of time travelling and working, especially during peak harvest times. Often they are away from their homes and in places where access to health care services may be problematic. One question this study sought to answer, therefore, is do migrant farmworkers find the time to get appropriate health care and advice and access treatment programmes if they become infected with HIV and AIDS or are experiencing other health problems. As highly mobile people, spending time on one or different farms or estates, migrant farmworkers may find it difficult to

access HIV and AIDS education and prevention programmes, or to act on information they have received.

The commercial agricultural sector in Southern Africa is varied and complex. Many different categories of worker can be identified; resident farmworkers, tenant labourers, commuter labourers and migrant labourers. In some areas, all categories can be found working together. At the Royal Swaziland Sugar Corporation's (RSSC) Mhlume estate there are no tenant labourers and migrants predominate. In order to better understand the risk factors and vulnerability of migrant workers in Swaziland's commercial sugar industry, SAMP undertook a research project with the University of Swaziland at the Mhlume estate of the Royal Swaziland Sugar Estate in October 2005. The research methodology was similar to that developed for a companion study in Malawi.

2.2 The Sugar Industry

The research in Swaziland focused on the Swazi sugar industry since this sector has the largest concentration of farmworkers. The report is based on research conducted at Mhlume sugar estate in Swaziland. Mhlume is located in the north-eastern part of the country (see Figure 2.1) and was established in the late 1950s on land owned by the Commonwealth Development Corporation (Simelane, 2003: 132). In 2003 its business was merged with that of Simunye Estate under single management and these estates are now collectively called the Royal Swaziland Sugar Corporation (RSSC).

Labour migration has been pivotal to the sugar industry from its inception. The industry dates back to the immediate post-World War II period when the country experienced intensive capital investment for development purposes (Booth, 1983). During this period, sugar cane production was undertaken in the Lowveld. Later, sugar mills were established at Big Bend and Mhlume, while a third mill was established at Simunye in 1980 (Figure 2.1). Recently, sugar production has expanded as small-scale sugar cane producers have been empowered to undertake production of the crop on Swazi Nation Land.

Figure 2.1: Map of Swaziland with Study Area Highlighted

The sugar industry has played, and continues to play, an important role in the economy of Swaziland. In 1999, the industry contributed 24% to the nation's GDP, 15% to private sector wage employment and 11% to national wage employment. In terms of exports, the industry contributed 13% of total national exports. The sugar industry earns about E900m for the Swazi treasury per annum (Nevin, 1999). Because of its contribution to the Swazi economy, the sugar industry has been referred to as "the real Swazi gold" (a reference to a well-known type of marijuana known as Swazi Gold) (IRIN, 2005).

In spite of past success, the future of the Swazi sugar industry is uncertain. As a result of changes in the European Union sugar regime, quotas and prices will be brought in line with efforts to increase sector liberalisation. Over the next three years the minimum price of sugar accepted in the EU will decrease 36% which will have severe consequences on the Swazi economy (European Union Committee 2005). In 2004 the FAO estimated the revenue brought by sugar (both raw and processed) to Swaziland at USD 118,772,000 (E307,000,000). It is predicted that the country will experience a major decline in revenue from sugar earnings. The decline in sugar prices has already affected the

employment capacity of the sugar industry. In 2005 the Mhlume and Simunye estates retrenched about 1,100 workers (IRIN, 2005).

2.3 The HIV AND AIDS Situation in Swaziland

Swaziland, like most sub-Saharan countries, continues to face the challenge of HIV and AIDS. The pandemic has not only inflicted a physical toll on individuals, but has undermined almost all aspects of human existence in Swaziland. Since its advent, human resources have been depleted, state capacity to deliver services has been compromised, communities are continuously under stress to provide prevention and health-related services to those affected, and there is a continued rise in the number of vulnerable children. The Swazi social fabric has been greatly undermined and no economic sector has remained untouched by HIV and AIDS (Swaziland VAC, 2004; Tobias, 2001; Muwanga, 2002; Government of Swaziland, 2000; Gumedze, 2004).

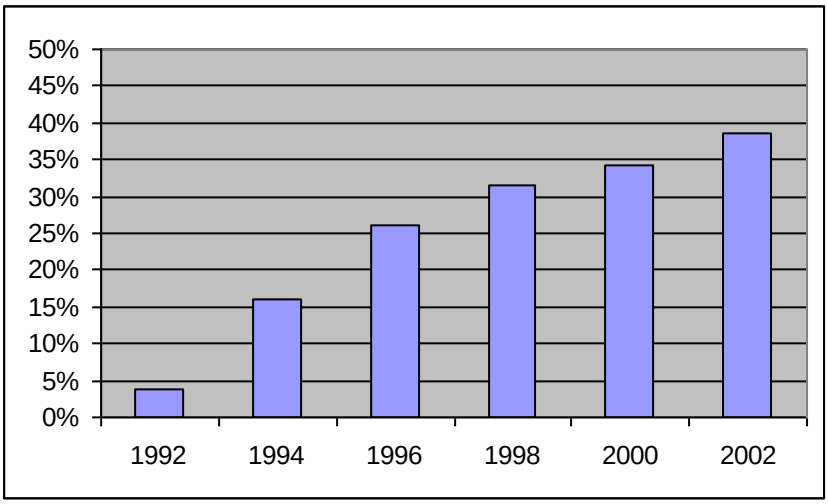
Researchers have yet to understand the extent of the pandemic and its effects on different sectors of Swazi society. A body of literature has emerged addressing some of the research concerns surrounding the havoc caused by HIV and AIDS in Swaziland (Lawson and Gato, 1999; UNAIDS, 2002; Government of Swaziland, 2002; Zwane et al, 2002), yet significant gaps in the research remain.

The first reported case of AIDS in Swaziland was in 1987. Since then the disease has spread very quickly through the population and in 2001 it was estimated that 26% of the population in Swaziland was infected with HIV (Tobia, 2001). Most data on HIV and AIDS prevalence in Swaziland is derived from national sentinel surveillance surveys designed to track the epidemic. The surveys have been conducted on three population groups since 1992: antenatal clinic (ANC) attendants, sexually transmitted infection (STI) patients and TB patients at the survey sites. The 2002 surveillance report focused only on antenatal clinic attendants. In addition to being tested for HIV, the women are also tested for syphilis and hepatitis infections. The HIV and AIDS situation in Swaziland continues to deteriorate as prevalence rates are high and rising, posing a severe threat to the overall development of the country. Swaziland has one of the highest HIV and AIDS

prevalence rates in the whole world (Swaziland Youth United Against HIV and AIDS / UN Theme Group on HIV and AIDS, 2002).

Data from the 8th HIV Sentinel Serosurveillance Report published in 2002 shows that out of 2,787 blood samples tested from the ANC population, 39% were HIV positive (see Table 2.1). This signifies an 890% increase in the 10 years since 1992 when the first Serosurveillance sentinel survey was undertaken (Figure 2.2). The report also indicates that the Shiselweni region recorded the highest increase in HIV infection rates in the country, rising from 27% in 2000 to 37.9% in 2002. Evidence of some degree of stabilization was observed in the Manzini region from 41% in 2000 to 41.2% in 2002 (Ministry of Health and Social Welfare, 2002a: 6).

Figure 2.2: HIV Prevalence Rates among ANC Patients over a Period of 10 Years



In Swaziland, 87% of those infected with HIV in 2002 were 30 years of age or younger. Infection rates among ANC women aged 15 – 19 were found to be 32.5% which means that 3 out of 10 young women are infected with HIV (Ministry of Health and Social Welfare (MOH&SW, 2002:6).

High prevalence rates have become a cause of major concern in the country because the epidemic is recognized to be reversing all developmental gains of the past few years. HIV and AIDS has become the major cause of death in the country. Particularly affected

are the young and economically productive members of the Swazi population, thereby undermining the country's social and economic security. As in some of the other countries in the region, HIV AND AIDS has become "the single most important phenomenon that will shape future demographic, health and development trends" (Centre for Health Systems Research and Development, 2002:19).

According to research, knowledge about HIV and AIDS is very high (Simelane, Sithole, Zindela and Mkhonta, 2005; Tsabedze, 2004; Dlamini, 2000). However, there is also evidence to indicate that knowledge has not translated into behavioural change. The country's National Emergency Response Committee on HIV AND AIDS has been grappling with this issue. Some researchers have argued that labour migration to South Africa, and Swazi culture in general, need to be recognized as the main drivers of the pandemic (Dube, 2004; Whiteside, Ngcobo, Hickey and Tomlinson, 2003). In terms of culture, practices such as polygamy, levirate, wife inheritance, and patriarchy are seen as playing an important role in contributing to the spread of the pandemic.

Like all sectors of the Swazi economy, the sugar industry has been affected by, the spread of HIV and AIDS. The most obvious negative impact is that the disease has caused the depletion of the industry's human resource base, impacting negatively on production. However, at the present moment we do not have well-grounded and authoritative research on the impact of HIV and AIDS on the Swaziland sugar industry. The data that exists strongly indicate that HIV and AIDS is a serious problem in the sugar industry. For instance, in 2003 the infection rate at Simunye and Mhlume was about 38% (Cullinan, 2003).

RSSC has recognized HIV and AIDS as a strategic business issue and has put in place several programmes to reduce its impact. These interventions have been facilitated through the HIV and AIDS Tripartite Committee in which Management, the Union and the Staff Association are represented. After conducting an HIV and AIDS prevalence study in 2002, RSSC became the first company in the country to offer medical assistance to its affected employees. This was initially based on a cost-sharing arrangement,

pending the roll-out of free Anti-Retroviral drugs (ARVs) under the Global Fund scheme. In collaboration with the National Emergency Response Council to HIV and AIDS (NERCHA), two voluntary Counselling and Testing (VCT) centres were established and started operating in 2003, one on each of the company's estates.

There is presently an on-going campaign to encourage workers to test for HIV for early diagnosis. Information on HIV and AIDS is disseminated to all the workers in both Mhlume and Simunye estates. The research reported here shows that the programme has been largely successful. Employees now have access to medical facilities and advice, and they are constantly educated on issues of HIV and AIDS. There is, however, a need for an evaluation exercise to assess the gains made and set-backs suffered, especially as they impact on infection rates.

2.4 Methodology

In order to better understand the risk factors and vulnerability of workers in Swaziland's commercial sugar industry, SAMP undertook research at the Mhlume estate in October 2005. The choice of Mhlume Estate as a research site was determined by both administrative and academic concerns. When RSSC was contacted about research at their operations they agreed to the carrying out of interviews at Mhlume. Mhlume fitted very well with the context of the research because it is an agricultural estate with a large concentration of migrant workers.

The research methodology used was similar to that developed for a companion study in Malawi. First, key interviews were undertaken with the following individuals: Mhlume health clinic officials, union leaders, estate church leaders, and estate managers and supervisors. Second, interviews were conducted with a total of 101 migrant farm workers using a structured questionnaire with closed ended questions. Third, three focus groups were organized comprising migrants, community leaders, health workers, and other groups identified during the survey. Discussions were open-themed and included debate on topics such as perceptions of health care services, perceived risk of HIV and

AIDS, knowledge of HIV and AIDS, experiences as migrant farm workers, community risk and problems or gaps in the health care capacity of the community.

2.5 Conditions at Mhlume Sugar Estate

The migrant farm workers interviewed for this study ranged in age from 18 to 58, and were predominantly male. The majority were in their twenties and thirties. The farmworkers are employed in a variety of jobs, although most work in cultivating and planting crops (46%) or in picking and harvesting (30%) (Table 2.1).

Table 2.1: Type of Job Performed

	No.	Percent
Managerial	1	1
Operating machinery	6	5.9
Picking/harvesting	30	29.7
Sorting/packing	1	1
Cultivating/planting crops	46	45.5
Washing/cleaning	8	7.9
General Assistance on the farm	6	5.9
Other	3	3
Total	101	100

The majority of the workers had been working at Mhlume for the last five years and had not changed farms during this time. Those who had changed farms (17%) did so either because they were not re-employed after the previous contract or because other farms offered better salaries and working conditions. It appears that change of farms may intensify as sugarcane production by farmers on Swazi Nation Land increases. Presently, about 1,400 families are producing sugarcane on a small scale and they are heavily involved in labour recruitment.

The majority of the workers interviewed in the study were seasonal workers, while the rest were either employed on permanent or temporary contracts (Table 2.2). Permanent workers are pensionable and work mainly in the offices. Seasonal workers are employed

for specific seasons depending on the stage of growth of sugar cane. Their contracts sometimes last as long as eight months. Most of those employed in weeding were employed in the estate for periods of up to six months. Each time they finish their contracts the majority of the seasonal and casual workers return to homes in rural areas.

Table 2.2: Type of Contract		
	No.	**Percent**
Permanent worker	23	22.8
Seasonal worker	57	56.4
Temporary	21	20.8
Total	101	100.0

Almost all the interviewed workers are accommodated within the Mhlume Estate and indicated that they spend most of their time in company houses. Accommodation is basic but generally clean and sanitary. There are no shacks on the estate (only one farmworker reported living in a shack off-site) and none of the workers saw overcrowding as a concern. Half the workers live in compounds and the rest in stand-alone houses (26%) or flats (23%) (Table 2.3). Workers are assigned specific fields to work in as their work stations and they are assigned to these fields as groups. Accommodation follows this pattern as compounds are divided into sections accommodating workers according to their field groups.

Table 2.3: Type of Accommodation		
	Frequency	**Percent**
Brick structure on separate stand	26	25.7
Flat	23	22.8
Informal dwelling, shack	1	1
Compound	51	50.5
Total	101	100

The farmworkers are not high earners. The majority earn less than E700 per month. Only one employee earned more than E2000 a month and this person was employed in a

supervisory role coordinating the day to day operations of field workers. Sixteen percent earn only E800 a month and 20% earn about E500 a month. The situation is made worse by the fact that three-quarters of the workers indicated that they have no other source of income beyond their farm salaries.

2.6 Patterns of Migrancy

The classic migrant labour pattern in Southern Africa (and Swaziland) sees married and unmarried male migrants leaving their rural base and migrating to work either inside or outside the country (Booth, 1982; Crush, 1987). A little over a third of those interviewed are married, while another third (36%) said they have regular partners (Table 2.4). The majority of these relationships were well established, with most marriages having lasted at least four years, while most of the relations with partners are of shorter duration. Only 4% of the workers were living with their spouses or partners within the estate, and only 13% said they were single. Most of the respondents indicated that they live alone (35%) or with other workers on the estate (52%).

Table 2.4: Marital Status of Farm workers

	No.	Percent
Married	35	34.7
Single	13	12.9
Separated	4	4
Cohabiting	9	8.9
Widowed	4	4
Has partner	36	35.7
Total	101	100

All workers have homes away from the estate, and regularly visit these homes. The homes are spread throughout Swaziland but are predominantly in rural areas. Most spouses and partners live at the rural homes and are visited on a regular basis. Nearly 40% of the workers see their partner every week (Table 2.5). Another 30% see them once a month. The visits home are generally of very short duration. As many as 94% indicated that they spend only one to two days in their rural homes when they visit

Table 2.5: Frequency of Return Home		
	No.	**Percent**
Daily	7	8.8
Weekly	31	38.8
Once in 2 or 3 weeks	13	16.3
Monthly	23	28.8
Once in 2 to 6 months	6	7.5
Total	80	100

In addition, 54% of the workers who were married or in long-term relationships had been visited at the estate by their partners. Of those, 20% had been visited in the previous week and 35% in the previous month. This does tend to suggest a likely pattern of regular visits. In other words, unlike classic long-distance labour migrants, farm workers within Swaziland get home relatively frequently to see their spouses or partners and many are also visited quite often at the place of work.

In theory, at least, this should decrease the vulnerability of workers to HIV and AIDS. The fact remains, though, that because the majority of them do not live with their spouses or partners in the estate, both partners have an increased vulnerability to HIV and AIDS.

2.7 Knowledge and Behaviour

Workers were first asked a series of general questions about their perceptions of the health of the workforce on the estate. Asked how many people they knew had died in the previous year, nearly 60% said between 1 and 5. A further 14% said between 6 and 10 and 17% said more than 10. There is a widespread perception that the number of deaths has increased recently.

Table 2.6: Deaths in Community in Previous Year		
	No.	**Percent**
1-5	57	56.4
6-10	14	13.9

10-15	12	11.9
15-20	5	5.0
Don't know	13	12.9
Total	101	100.0

Asked what they see as the major causes of death amongst farm workers, 60% said HIV and AIDS, and another 19% said tuberculosis (Table 2.7). No one mentioned malaria despite its prevalence in the area (Packard, 1984). This shows that workers are under no illusion about the deadly nature of HIV and AIDS and the associated risks of contracting the virus.

Table 2.7: Perceptions of Causes of Death of Farm workers

	No. of Workers Mentioning Cause of Death	**% of Workers**
AIDS	60	59.4
TB	19	18.8
Diarrhoea	6	5.9
Old age	5	4.9
Occupational Injury	5	5
Accidents	4	4
Heart attack	2	2
Exhaustion from work	1	1
Other diseases or illnesses	23	22.8
Don't know	12	12
Total	137	
Note: respondents could provide more than one answer		

However, despite the belief that workers are dying of AIDS-related diseases, three quarters said that they did not know anyone infected with either HIV or AIDS. Around 22% said that they have a close relative who is infected with HIV while 17% said that they have a close relative who is suffering from AIDS.

Awareness of the existence of HIV and AIDS also appears to be high. Every respondent had heard of HIV and/or AIDS. One of the participants in the focus group discussions

noted: “Every day we hear about AIDS everywhere, so, yes, we are familiar with HIV and AIDS. I do not think there is anyone who does not know about AIDS.” Sources of information on HIV and AIDS include radio (mentioned by 56% of workers), information in the workplace (50%), mobile clinics (23%), educational campaigns (24%) and friends (19%) (Table 2.8). While curriculum information was not available at the time of publication, the RSSC reports that they offer educational services at six primary schools (two private), and three high schools on the estate.[4]

Table 2.8: Sources of Information About HIV AND AIDS			
		No. of Workers Mentioning Source	**% of Workers**
Radio		57	56.4
Newspaper		9	9.0
Television		6	5.9
Friend		19	18.8
At work		50	49.5
Community meetings		15	14.9
Mobile clinic		23	22.8
Educational campaigns		24	23.8
Other:	School Meetings	4	4
	Clinic	2	2
Total		209	
Note: respondents could provide more than one answer			

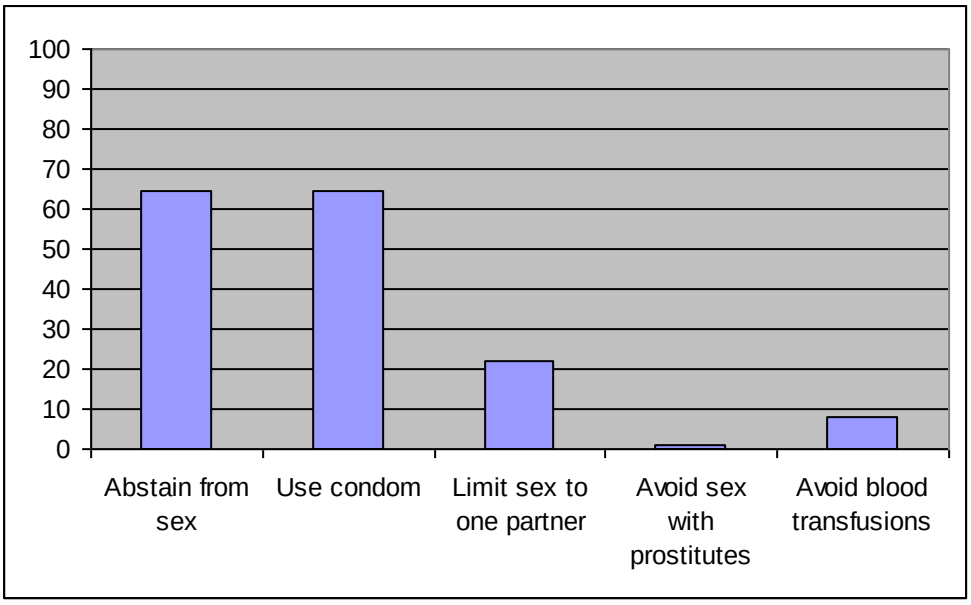
When asked to identify the best methods to communicate information about HIV and AIDS, the majority of workers (63%) mentioned radio, while 34% felt that peer education is most effective. Very few feel that print media (such as pamphlets or newspapers) would be at all effective. Since discussions on sexual matters can be highly sensitive, respondents were also asked who they felt were the people best placed to talk to them about HIV and AIDS. Medical personnel were chosen by 55% of the farmworkers, while 23% said their partners were in the best position to have these discussions. Very

[4] Group Profile, Corporate Affairs Office, Royal Swaziland Sugar Corporation, March 2006. Accessed August 8, 2006. http://www.simunyesugar.co.sz/AboutUs/profile.htm

few think they could discuss sexuality and HIV and AIDS with their friends (6%), parents (4%) or religious leaders (3%).

Knowledge about HIV is high. Most know that a person cannot be infected with HIV by sharing a meal with an infected person, by sharing tools at work, by sharing a bed, or by shaking hands. They are also aware that one can be infected with HIV through sharing needles or by having sex without a condom. Two thirds of the workers said that they could protect themselves by abstinence or condom use (Figure 2.3). Interestingly, very few said that limiting sex to only one partner or avoiding sex with sex-workers would protect them from the virus, despite the large percentage that admitted to having extra-marital relations.

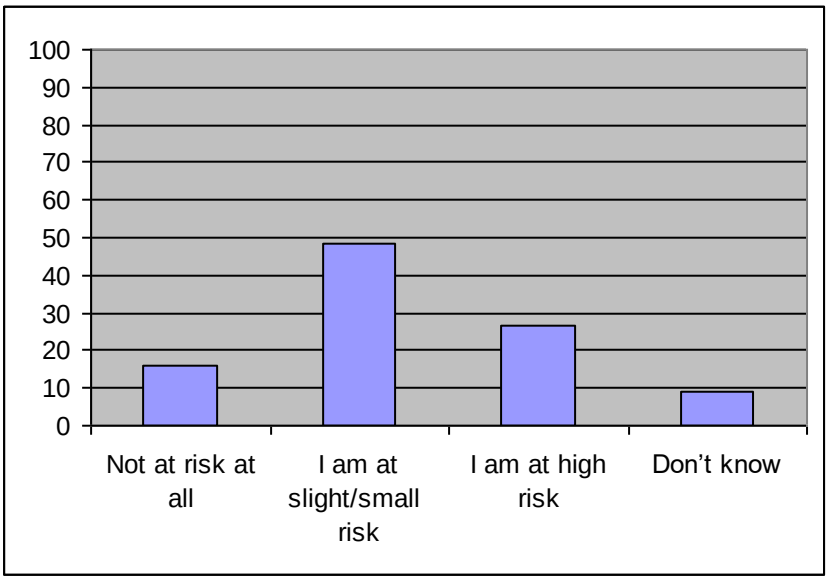
Figure 2.3: Means of Protection Against Infection



Note: Respondents could provide more than one answer

Workers also indicated that they worry a lot about the HIV and AIDS situation in the estate. Some 90% feel that HIV and AIDS is a problem in the district. Only 16% said that that they are at no risk of becoming infected while more than a quarter felt that they were at high risk of infection.

Figure 2.4: Perceived Risk of Being Infected with HIV



Among those who thought they were not at risk, 56% said this was because they are not sexually active. Others said they take the necessary precautions and have only one regular sex partner. Those who said they were at a slight risk stated that they practice safe sex and are faithful to their partners. Prominent reasons for those at high risk are that they do not trust their partners and that they have had unprotected sex.

Some pointed out that they are at high risk because of the myriad ways of contracting HIV and AIDS. Others in this category also indicated that they have multiple sex partners, or that their partners are unfaithful. As one worker said: "There is a high risk of contracting the virus because we exchange partners often and many of us have multiple sex partners." Many workers blamed the unfaithfulness of their partners for exposing them to HIV.

The majority of respondents were aware that pregnant women infected with HIV and AIDS can transmit the virus to the unborn child. They were also aware that the virus can be transmitted to a child through breastfeeding. The majority have heard of antiretroviral (ARV) therapies. They are also aware that AIDS can be controlled or stabilized with antiretroviral medication. The high level of knowledge may indicate that national educational programmes on HIV and AIDS are yielding positive results. It may also

indicate that the programmes put in place by the HIV and AIDS section of Royal Swaziland Sugar Corporation are having a positive effect.

Despite the high level of awareness and knowledge of the threat HIV and AIDS, the majority of farmworkers at Mhlume indicated that they are sexually active. Most started having sexual intercourse between the ages of fifteen and twenty, with a few admitting to having sex before the age of fifteen. Although most had had between two and five sex partners, most (94%) had had only one regular sex partner in the previous year. However, having a regular sex partner does not necessarily eliminate multiple sex partnerships. It transpired, for example, that 79% of the workers had had sex with a non-regular partner, usually from the local area or the small number of female workers on the estate, in the previous thirty days. Some had had sex with up to four non-regular sex partners. For those who had had sex in the last thirty days with their regular partners, the average number of times was only two. As many as 43% of these workers did not use a condom during these encounters. The decision to use a condom was mainly made through joint decision-making (47% of cases) or suggested by the farm workers (43% of cases). Those who did not use a condom indicated that they did not think it was necessary.

The workers said that commercial sex is not common at Mhlume and that they do not often encounter commercial sex workers within the estate. No farm worker admitted that they had had sexual intercourse with partners in exchange for money or goods in the previous twelve months. Research in other parts of Southern Africa indicates that sex for money is widespread in areas where there are large concentrations of migrant workers. However, the focus group discussions revealed that women from outside the estate come on payday explicitly for purposes of selling sex to workers who have money in their pockets. The group discussions also indicated that sex is often exchanged for work. Most of the work at Mlume requires individuals to complete assigned tasks on a daily basis and payment is dependent on the completion of the task. A few women workers pay men with sex to have their tasks completed. There was also an indication that some women have sex with men in return for groceries.

One of the most important problems surrounding HIV and AIDS is that of stigmatization and discrimination which can create a hostile environment making it difficult for the infected to cope with their condition. Such an environment also leads to a breakdown of social support systems that would otherwise play a crucial role in prolonging the lives of infected persons. Workers were asked several questions relating to their behaviour towards HIV-infected persons or those living with AIDS. Nearly 60% said they would share a meal with a person they knew to be HIV positive. An overwhelming majority also said they would care for their relatives if they became ill with HIV and AIDS. They also strongly expressed the view that people who are HIV positive should be allowed to continue working where they are employed even if the nature of their work brings them into daily contact with the general public.

Farmworkers certainly appear to be less prone than many others to stigmatize people living with AIDS. For example, more than two thirds felt that if a member of their family became ill, they would not want the matter to remain a secret. About 56% said that if they were infected, they would discus their status with other people, and advise them on issues such as the risk of contracting HIV and AIDS, the importance of safe sex and the importance of abstinence as a preventive strategy.

2.8 Access to Testing and Care

The availability of health facilities is important for workers in such an isolated environment. In the case of RSSC Mhlume, a health clinic is available within the estate. Nearly half of the workers indicated that they had been sick while working in the estate, and almost all said that when they were sick they receive medical advice and medicine from the estate clinic. The majority were happy with the service they received from the clinic, with only 6.5% saying the service received was poor.

Workers have easy access to the services at the health clinic. As one worker pointed out: "If someone gets sick he or she goes to Mhlume Clinic which is a short distance away. It is easy to get there because when you are sick you get free transport from the company."

About 70% of the workers indicated that when they are very sick, they are allowed to stay on the estate. Indeed, some of the workers said that that even if they have to go home because they are too sick to work, they are still allowed to access the health facilities of the company, and are still accommodated within the estate when they come for medical help. The workers also indicated that mobile clinics also come into the farm area.

The Mhlume estate clearly puts a premium on educating its workforce and in providing access to appropriate testing and healthcare. Over 90% of the workers knew of the existence of the clinic and many of the programmes available (Table 2.9).

Table 2.9: Availability of HIV AND AIDS Programming at Mhlume

	No. of Mentions	% of Workers
Condom distribution	88	87.1
Pamphlets on HIV AND AIDS	13	12.9
TV based programmes	5	5
Workplace peer education	26	25.7
Counselling	42	41.6
Testing	52	51.5
Management of STD/STIs	14	13.9
Total	240	

All the programmes listed in Table 2.13 are based on the estate and are operated by a specialized HIV and AIDS unit established by the company . The establishment of this unit was part of the national agenda of creating sectoral structures to address HIV and AIDS issues. RSSC was one of the first companies to run an HIV and AIDS unit in response to the call for a sectoral approach to combating the epidemic

Virtually all of the workers indicated that they have full and easy access to all of the clinic's programmes. The majority also indicated that they do not pay for these services, while the few that said that they did have to pay may be accessing programmes outside the estate, or are including the costs of certain private educational facilities available on

the estate. Furthermore, the RSSC notes that free Anti-retroviral treatment programmes were introduced in late 2004 thanks to outside funding and support. Beforehand, treatment was provided on a cost-sharing basis between the sugar estate and the employee and this may be the source of those who reported paying for HIV and AIDS-related services.[5]

When asked if the programmes provided by the estate were beneficial, most responded in the affirmative. In fact, 60% of the workers said the programmes are fine as they are and do not need any changes. There was, however, a sizeable minority (22%) who felt that there is need for more open talk about HIV and AIDS. A few of the respondents thought that instructors should practice what they teach, claiming that instructors come to teach workers of the importance of faithfulness and having one sexual partner, but are often seen with numerous sexual partners themselves.

Workers noted that the estate is favourably disposed towards workers undertaking a confidential test to find out if they are infected with HIV. Two thirds said that they can easily get tested for HIV either at the estate's health or VCT clinic. Certainly, company policy is to make it possible for the workers to have easy access to testing facilities. The RSSC has an agreement with The AIDS information and Support Centre (TASC) to operate VCT clinics on the Mhlume and Simunye estates and offers these services to workers and their dependents.[6] Despite the availability of testing, nearly three quarters of the workers (73%) had not had an HIV and AIDS test. This certainly indicates a marked reluctance on the part of farm workers to know their HIV status. This kind of attitude is not unique to the migrant farm workers at RSSC, but is common in Swazi society as a whole (MOH&SW, 2002; UNESCO-Swaziland, 2005).

2.9 Conclusion

[5] Group Profile, Corporate Affairs Office, Royal Swaziland Sugar Corporation, March 2006. Accessed August 8, 2006. http://www.simunyesugar.co.sz/AboutUs/profile.htm
[6] The AIDS information and Support Centre (TASC) website; Accessed August 9, 2006. http://www.tasc.org.sz/projectsandplans.htm

This study of migrant workers at the Royal Swaziland Sugar Corporation at Mhlume reveals some important dynamics concerning the vulnerability of migrant farm workers to HIV and AIDS. These dynamics are crucial to our understanding of the situation in Swaziland, and also suggest possible directions for intervention to improve the situation.

Mobile farm workers at Mhlume estate are predominantly male, the majority of whom are in their twenties and thirties. Such gender bias stems from a recruiting process that predominantly targets males. At the time of the research the main activity for migrant workers was cane cutting, a job that is usually done by males. Although the workers live at the estate, they maintain homes in different parts of the country, an overwhelming majority in rural areas. From time to time they move between the estate and their rural homes. The workers do not live with their spouses in the estate and it is only when they visit their rural homes that they meet their spouses or partners. This certainly makes these mobile workers vulnerable to HIV and AIDS. The extended periods they spend away from their partners create spaces of vulnerability. This vulnerability is extended to their spouses in the rural areas. Under such conditions each partner may enter into extramarital relations and increase the chance of becoming infected with HIV.

The migrant farmworkers at Mhlume estate appear well-informed about basic issues on HIV and AIDS. They are fully aware that the pandemic is widespread in Swaziland, and also that it is a major health problem. Most of the information they have is derived from national radio educational programmes on HIV and AIDS. Another major source of information for the workers comes from the health facilities within the estate. The knowledge level of the workers is high and the majority of them are fully aware of how a person can and cannot be infected with the HIV virus. They were also well informed about issues of prevention.

The research revealed that Mhlume has health facilities within the estate which act as support systems for ill workers. According to the workers, they have easy access to health facilities and medicines. The company, through their agreement with TASC, also provides VCT outreach services within the estate for the benefit of the workers and their

dependents. The availability of these health facilities is fundamental to mobile farm workers who are vulnerable to HIV and numerous sexually transmitted infections. If some of the mobile farm workers are or were to be infected with the HIV virus, it appears that they would be well supported medically through the health facilities available within the Mhlume estate.

The main problem, which becomes a crucial issue of vulnerability, is that knowledge is still not reflected in practice or prompted comprehensive behavioural change. For instance, while the workers indicated that condom use was critical to preventing infection, the majority still said they do not use a condom during sexual intercourse. The mobile farm workers at RSSC rarely practice safe sex even though they are aware that HIV and AIDS is a serious health problem within the estate. The survey also revealed that although testing facilities are available at Mhlume estate, and easily accessible to the workers, the majority have not taken the test to find out their HIV status. The results of the research indicate a resistance to HIV testing, yet the source of this attitude is difficult to identify.

The issue of multiple partners came out prominently when the workers were interviewed. The majority of the workers indicated that they have had multiple sex partners in the past and continue to do so. The pervasiveness of this practice is a reflection of what is happening at the national level. Swazi men have been culturally empowered to have multiple sex partners. The perpetuation of this practice greatly increases the chances of HIV infection, especially, as has been observed, amongst migrant farmworkers.

In the final analysis, the main thing that makes mobile farm workers at Mhlume estate vulnerable to HIV and AIDS is their own behaviour. Certainly migrancy heightens vulnerability. But, the environment in which they work has sensitized them to the dangers of HIV and AIDS, yet they continue to have multiple sex partners, and to practice unsafe sex. Fortunately, the health support system available at Mhlume estate is indicative of the employer's willingness to assist workers to adopt positive preventative

measures, and mitigate the impact of the pandemic amongst those who are already infected.

The issue of behavioural change remains a crucial challenge and it is therefore important that more programmes targeting behavioural change be put in place. There is a strong need for more effort to teach workers about the importance of condom use. It is not enough for workers to be aware of the importance of condoms in the struggle against HIV and AIDS; using them is absolutely crucial. Stressing the importance of mobile farm workers knowing their HIV status is also very important in reducing their vulnerability to the pandemic. Presently, testing facilities at the Mhlume estate are there but the majority of workers refrain from being tested, a situation that urgently needs to be understood and addressed.

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