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DETERMINANTS OF HIV IN KEY HOTSPOTS ON THE SOUTHERN TRANSPORT CORRIDOR:
MAPUTO TO SWAZILAND

STUDY FINANCED BY **UNDP** AND **IOM**
RESEARCH CARRIED OUT BY **ANSA**

APRIL 2012

"HIV has come to take away the one pleasure that poor people have."
Lorry driver, southern transport corridor

This study was financed by the United Nations Development Programme (UNDP) and
The International Organization for Migration (IOM)

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A large quantity of maps were designed for this study, but not all of them are featured in this report. Please search for the title of this report on **www.iom.org.za** in order to get an overview of all these maps and view them online.

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Kerry Selvester

28 November 2011
Maputo

02 ACRONYMS

AIDS	acquired immunodeficiency syndrome
AMODEFA	Associação Moçambicana para Desenvolvimento da Família
ANSA	Associação de Nutrição e Segurança Alimentar
ASWA	Pan African Sex Workers Alliance
AU	African Union
CNCS	Conselho Nacionale de Combate ao HIV/SIDA
FLAS	Family Life Association of Swaziland
GDP	gross domestic product
GIS	geographic information system
GNP	gross national product
GPS	global positioning system
HIV	human immunodeficiency virus
IEC	information, education and communication
INSIDA	National Survey on Prevalence, Behavioural Risks, and Information About HIV and AIDS
IOF	Inquerito do Orçamento Familiar – Household Budget Survey (Mozambique)
IOM	International Organization for Migration
MoH	Ministry of Health
MSF	Medicine Sans Frontiers
Mt	meticais
NER	The number of pupils in the theoretical age group who are enrolled expressed as a percentage of the same population
NERCHA	National Emergency Response Council on HIV/AIDS
NSF	National Strategic Framework
NGO	non-governmental organization
PPP	purchasing power parity
PSI	Population Services International

RSA	Republic of South Africa
SADC	Southern African Development Community
SBCC	social and behaviour change communication
STI	sexually transmitted infection
SZL/E	Swazi lilangeni
TB	tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
US$/$	United States dollar
VCT	voluntary counselling and testing
WB	World Bank
ZAR/R	South African rand

03 EXECUTIVE SUMMARY

This study aims to explore the key determinants of HIV along Mozambique's southern transport corridor, which runs between Mozambique and Swaziland. The locations through which the corridor runs have amongst the highest HIV prevalence of anywhere in the world. The research team worked in four areas that are considered to be hotspots – areas where mobile populations meet with resident populations and there are high levels of risky sexual behaviour. The areas included two border posts (Goba, Namaacha/ Lomahasha), an industrial area in Swaziland (Matsapha) and an area on the road from Maputo to Swaziland that has become a major stopping-off point for travellers, truckers and people from Maputo (Boane).

The report is divided into the following sections: an explanation of the methodology; a context-setting section exploring the socio-economic situation of the study area and the HIV and AIDS context; presentation of the findings of the research and a discussion of the key issues arising; and finally a conclusions and recommendations section providing concrete ideas for working in the hotspots to build capacity in HIV prevention, treatment, care and support.

The report concludes that the situation along the corridor should be considered an emergency, and the hotspots should be saturated with combination HIV prevention programmes, as well as intensified access to treatment and care services. This should to be done holistically, and through addressing the local gender and culture dynamics, as well as the involvement of key populations – particularly sex workers and their clients.

Specific recommendations are:

- Both governments should attain long-term HIV financing and investment in NGO services including Private-sector engagement
- Both governments must address the vulnerabilities of mobile workers in the public-sector
- National partners should support the Zero Tolerance Campaign launched by the Ministry of Education
- Local partners should saturate the hotspots with intensified combination prevention programmes
- Intensify migrant-sensitive health and outreach services targeted at the hotspots
- Patient confidentiality and professional codes of conduct:
- Local partners should conduct male-oriented sensitization programmes on the use of available health services and health-seeking behaviour:
- Increase accessibility of health facilities for mobile populations
- Local implementing partners should conduct robust youth-targeted programming

04 INTRODUCTION

4.1 Background

Mozambique and Swaziland are two of the highest-burden countries in the world in relation to HIV, and the highest prevalence in Mozambique is in the southern region of the country. This is linked to the high levels of (mostly male) migration, and corresponding vulnerability of young women living in migration-affected communities. An IOM study in 2010 showed that among Mozambican migrants working on South African farms in Malelane (just across the border from Ressano Garcia) there is an HIV prevalence of 41.5%.[1] Swaziland has the highest adult HIV prevalence of any country in the world (25.9%), closely linked to the southern region of Mozambique by the southern transport corridors.

4.2 Methodology

The assessment focuses on the dynamics of HIV vulnerability along the corridor, including:

1. Infrastructural factors such as location, number and accessibility of hospitals, health facilities, access to voluntary counselling and testing (VCT) and sexually transmitted infection (STI) treatment, condoms, HIV programmes, and police and social services;

2. Truck stops, bars and lodging, liquor outlets, accommodation, nightclubs;

3. The number of trucks passing through specific truck-stops, interaction between the truck drivers, their helpers and sex workers, knowledge of HIV in these places, condom distribution;

4. Transportation routes, border control and behaviour between border officials and mobile (passing) populations.

4.2.1 Sampling

Sampling was based on an analysis of the main areas where mobile populations have prolonged contact with host communities, namely at truck stops and border posts. The following areas were identified as fulfilling the criteria: Namaacha, Goba and Boane (with additional interviews at the clearing station of Frigo) in Mozambique; Lomahasha and Matsapha in Swaziland.

In each of the areas a mapping exercise was undertaken to identify social amenities (bars, restaurants), accommodation, social infrastructures and estimates of the concentration of people in each of the areas.

Social researchers worked in order to interview a cross section of people in each of the localities, to represent the opinions from both a range of people in the host communities and from mobile populations. Typically the researchers interviewed truck drivers and assistants; public-sector workers posted in the area; health workers; NGO representatives and workers; sex workers; traders; and guest-house, bar and restaurant workers. The entry point for the sequence of interviews was different in each of the areas and was dependant

1 IOM, Integrated Biological and Behavioural Surveillance Survey in the Commercial Agriculture Sector in South Africa, November 2010

on the willingness of people to participate in the investigation as well as referrals from one person to another.

The time spent in each of the areas in Mozambique was approximately five days. The first day would typically be spent introducing the researchers to the local authorities (including community leaders and police authorities), identifying key informants in the area (NGO staff, health staff and key community figures), and investigating potential avenues to begin the in-depth interviews. Days one to three were interviewing days with de-briefing sessions between the researchers at regular intervals. The final day was spent cross checking and following up on information received during the preceding days.

In Swaziland a total of ten working days were spent in the field conducting research. Training for the researcher from Swaziland had taken place beforehand, following which he had then trained the interpreters using key topic interview guides (see below for further information). Seven days were spent in Matsapha with three researchers carrying out interviews. Three days were dedicated to the work in Lomahasha. The timing division reflects the complexity of the situation in Matsapha and the need to spend more time capturing information from a wide variety of people in the area.

In Mozambique two social researchers carried out the in-depth interviews. They had had experience of working with the key topic sheets in the Nacala corridor research, and had worked on a previous piece of research on sex workers in the southern region in 2009. In Swaziland, the team was increased to include a researcher from Swaziland who had experience of qualitative research in the country and had a strong public health and HIV background. In addition, two interpreters were hired to facilitate the interviews between the Mozambican researchers and the respondents. The key topic guides had been translated into SiSwati to facilitate the smooth running of the interviews.

4.2.2 Research techniques

Key topic interview guides

A series of key topic interview guides (see Annex 1) were prepared with the research team based on previous research carried out in the area and the principle objectives of study. Interview guides were prepared for the following groups: mobile populations (truck drivers and assistants, customs and police officers, commercial traders); sex workers; clients (truck drivers and assistants, customs and police officers, commercial traders); health workers; and NGO workers. The topics to be explored in the interviews were: sexual relations and sexual behaviour; knowledge and attitudes towards HIV and AIDS; health services provision and use of health services. In addition, people were asked to give their opinions about the general environment in the hotspots, both positive and negative aspects. A total of 120 interviews were conducted over the period of the study, 65 with women and 55 with men.

Traffic survey

A traffic survey was conducted to track the number of trucks and passenger transport vehicles that passed through and remained stationary in Matsapha. A team of three carried out a 24-hour survey working in pairs on a four-hour shift to tall the vehicles. ANSA requested official figures for the traffic that passed through the Namaacha-Lomahasha border and the Goba border (there are no trucking stops on either border). This information was not provided by the border authorities and ANSA was unable to obtain the information from official sources.

Mapping

Mapping was carried out using global positioning system (GPS) technology. The team of four technicians worked in pairs to map the following: social amenities (bars, restaurants, guesthouses); social services (health facilities and schools); and population concentration. A variety of maps were produced including representational maps and satellites images. A number of these maps can be found in Annex 2 of this report, and all of them can be viewed by accessing the IOM regional website (www.iom.org.za).

4.2.3 Limitations of the study

There were a number of general limitations to the study:

1. The nature of the subject matter covered under the study required extensive periods of time spent in an area to find the people to interview and triangulate the information received from different sources. In the case of Matsapha this meant that seven rather than five days were spent in the field.

2. As the information from the interviews accumulated, additional issues begin to arise, and it was not always possible to investigate these as thoroughly as needed during the study period. One is left with the unsatisfactory recommendation of "more study needed". We have tried to avoid this in the study by following up on issues as they arose but it was not always possible.

3. The researchers were unable to find respondents willing to participate in a diary exercise that involved the researchers returning once a day to discuss the events of the day and record them.[2] This exercise was not concluded.

4. The issue of sexual abuse of children: children involved in sex work is a reality that was made clear to the researchers. However, as there are ethical issues relating to speaking to children involved in the sex trade, children were not interviewed as part of the research. The findings presented in the report about children involved in sex work were gathered through interviews with adult sex workers and their clients. This important gap in the literature and in current research would require a specific study with researchers trained in participatory research with abused children and related legal and ethical concerns.

5. In Namaacha and Lomahasha it was extremely difficult to find any sex workers to interview as many have left the area due to a downturn in the economic situation at the border crossing. Interviews were carried out with women who frequent bars in the two areas, and it was possible to discuss transactional sex rather than self-identified sex work.

6. In both Lomahasha (Swaziland) and Goba (Mozambique), border officials were reluctant to provide information to the researchers on the key topics. The material gathered from these sources was extremely weak. There was a level of "survey fatigue" with these officials who said that they had answered similar questions many times and nothing ever changed for them.

7. In general, truck driver and assistants did not have time or the patience to answer extensive and probing questions. Considerable tenacity was needed to obtain information from these key informants.

2 Previous attempts in other research projects (IOM mobile populations, 2006, and UNFPA Sex Worker vulnerability to HIV and AIDS) to ask sex workers to keep diaries themselves also proved unsatisfactory.

8. In Matsapha there was a section of the recreational area (bar, restaurants and rooms to let) to which the researchers could not obtain access. This section was controlled by "leaders"[3]who oversee the comings and goings of people and goods. Although the researchers tried to get permission to carry out interviews in the locale this was not granted. The researchers had a good relationship with the community police, which helped gain access to the other areas in Matsapha.

9. Much of the research had to be conducted at night, in situations that were potentially unsafe (areas where there is a considerable amount of drunkenness and possible drug abuse). The areas where the research took place are largely unregulated. Although this is not necessarily a limitation in terms of the data collection, it added a layer of complexity to the fieldwork exercise, and required that researchers were aware of their own safety at all times.

4.3 Terminology

Hotspots: Locations where alcohol is consumed and where sex is negotiated or takes place. This includes border crossings, bars, lodgings, restaurants, seaports, fish landings and parking lots. The environment in such locations and mobility of populations is conducive to both men and women engaging in multiple concurrent sexual partnerships.

Sex workers: This term is used for people who self-identify as having sex for money.

Transactional sex: This term is used for people who are engaged in sexual activity in exchange for money or goods (food, drink, etc.) but do not self-identify as sex workers.

3 The implication was that they are gang leaders.

05 BACKGROUND

5.1 Mozambique

Table 1. Basic economic indicators in Mozambique

INDICATOR	ESTIMATE	UNIT	REFERENCE PERIOD	SOURCE
Gross domestic product (GDP) per capita	802	PPP US$	2007	UNDP
GDP annual growth	6.8	%	2008	World Bank (WB)
Gross national income per capita	380	$	2008	WB
Industry as % of GDP	24	%	2008	WB
Agriculture as % of GDP	29	%	2008	WB
Services as % of GDP	47	%	2008	WB
Paved roads as % of total roads	19	%	2001	WB

Table 2. Key poverty statistics for Mozambique (Source: National Institute of Statistics – INE: IAF 2005 and IOF,2010)

	2003	2008
Poverty headcount (% below poverty line)	54.1	54.7
Inequality (Gini, 0–1)	0.42	0.41
Child malnutrition (Stunting, %)	47.1	46.4
Access to services:		
Primary education (NER, %)	66.8	76.5
Secondary education (NER, %)	8.2	22.0
Health post less than 45 minutes distant (%)	54.4	65.2

5.1.1 The economic situation

Mozambique has shown steady growth in GDP during the last decade (an average of 5%). This has not translated into a reduction in poverty, which now stands at 55 per cent; approximately half of the population is living below the poverty line. Agriculture contributes an estimated quarter of GDP but is the main livelihood option for approximately 80 per cent of the population. The main exports are aluminium (61% share in 2007), electricity, natural gas, prawns and agricultural commodities (cashew nuts, cotton, sugar, tobacco). In addition, returns from extractive industries will increase substantially in the next five years as the coalmines in Tete province move into full production. Food imports from South Africa feed the southern markets where there are production deficits. In the provinces of Inhambane, Gaza and Maputo, poor farmers buy food for between six and nine months per

year to supplement their own production.[4] Internal marketing from the productive central region and north of the country to the south is low due to the costs of transportation and an underdeveloped formal commercial trading network. The majority of food crops from the centre and north are traded, informally, to neighbouring countries.

Rural poverty has decreased at a faster rate than urban poverty, and there are deep pockets of poverty found in all urban centres. Urban poverty is linked to the high levels of unemployment and lack of income-earning opportunities in larger cities. Urban households become more reliant on the cash economy (without the back-up of a small holding), are obliged to pay for basic services such as water, domestic fuel (charcoal, gas or electricity) and often live in rented accommodation. In addition, the informal charges[5] made for services in the cities are often higher than in rural areas. The competition for school places is increasing, along with schooling costs. Similarly, with the proliferation of private pharmacies, the cost of medicine is increasing for all as hospital dispensaries do not stock even the most basic medicines that are state-subsidized,[6]and people are forced to buy medicine on the informal market or at expensive retail outlets. All these costs impact on the low, unstable incomes of the urban poor.

HIV has severely hit the southern provinces of Mozambique, with an estimated quarter (25.1%) of the adult population infected with the virus in Gaza province, and a fifth (19.8%) in Maputo province. At a national level, all sectors are facing increased costs in terms of training and decreased productivity due to ill health, mortality and the burden of care deriving from HIV and AIDS. Previous studies carried out by economists suggest similar impacts on the overall economy, namely a reduced (healthy) labour force, with government and household resources diverted from investment to health and social protection. The Arndt model indicates a slow-down in growth of between 0.3 per cent to 1 per cent per annum due to HIV, while the Jones model shows that with zero HIV prevalence the economy would grow by a further 0.8 per cent per annum (World Bank, 2007).

5.1.2 Migration in Mozambique

Mozambique experiences both cross-border and internal labour migration. In the south of the country, traditionally there have been high levels of male labour migration to South Africa, to work on mineral mines in Gauteng province. Although there has been a reduction in the number of miners officially recruited, Mozambicans still make up a high proportion of the foreign workforce in the gold mines outside of Johannesburg and there is a strong pull to South Africa – the economic hub of the region – to seek work. Young men and women are drawn to South Africa for both formal and informal work, especially in the mining and agribusiness sectors, domestic work, and work in informal workshops (e.g. mechanics assistants). A recent study carried out in March 2010 by IOM (IOM, 2010) with farm workers in the Malelane area of Mpumalanga province (24% of the sample was Mozambican) had the highest recorded level(49.1%)of HIV-positive testing within any workforce in South Africa; a prevalence higher than the district rates of 34.9 per cent in the Ehlanzeni District (IOM, 2010). A report released by Human Rights Watch (2007) states, “records of the Mozambique Labour Department’s sub-delegate office in Nelspruit (Mpumalanga) show

4 Food price rises hit these communities harder due to the reliance on external markets.

5 Illegal fines charged to street traders; illegal payments for official papers needed to live in the urban areas, etc.

6 In rural areas and small towns there are few private pharmacies and the drugs supplied through the health facilities are significantly subsidized. A course of antibiotics in Maputo city can cost between 300 and 600 Mt in a state-run pharmacy, though the cost is between 15 and 50 Mt. The disadvantage is that in the rural areas there are drug shortages and a limited choice of treatment.

that there are 25,000–27,000 Mozambicans who are registered as working legally on farms in Limpopo and Mpumalanga provinces" (Human Rights Watch, 2007).

This is a significant number of migrant workers, and only represents the number of formal, registered workers, which likely make up the minority.

The major cities of Maputo, Beira and Nampula are magnets for job seekers. In the last five years the port city of Nacala and the mining city of Tete have also seen considerable rural-to-urban migration. There are no formal statistics of the number of people moving to these areas seeking job opportunities.[7] Both internal trading and cross-border trading account for considerable population movements in the country (IOM, 2006). It is important to understanding fully the potential additional risks of HIV and STIs among mobile populations and host communities in order to develop mitigation programmes.

5.1.3 HIV in Mozambique

Overall HIV adult prevalence was 11.5 per cent in 2009 (INSIDA, 2009). Among young women aged 15–24, HIV prevalence was estimated at 13.1 per cent (INSIDA, 2009). There are considerable regional differences, with the highest prevalence in the south of the country (up to 25% in Gaza province) and much lower in the northern provinces of Nampula (9.4%) and Niassa (3.7%).

Southern provinces of Gaza, Inhambane and Maputo (high HIV prevalence)

There are a number of drivers of HIV in the southern provinces, including the long-standing tradition of male migration to South Africa, high concentrations of people in urban centres and large wealth disparities. The factors that heighten migrant workers' vulnerability to HIV include: lengthy absences from home (up to twelve months at a time) resulting in multiple concurrent sexual relationships; high-risk sexual behaviour, including unprotected sex with sex workers; and high HIV prevalence in destination areas. In addition, the lengthy absences from home mean partners are more likely to have extra-marital sexual relations.

The geographical areas most severely affected by HIV in Mozambique also correspond to the areas disrupted during the war that led to hundreds of thousands of people taking refuge in the neighbouring countries of South Africa, Zimbabwe and Swaziland – all of these countries had high HIV prevalence during the late 1980s and early 1990s. In Maputo province there are a number of hotspots that are characterized by areas where there is a considerable amount of informal trade, transport stops, bars, restaurants, rooms for hire and guesthouses, similar to the dynamics in border areas and along the transport corridor that runs from Maputo to Swaziland and Maputo to South Africa.

A study carried out to examine the impact of the 2007–2008 food crisis[8] clearly identified the importance of access to healthcare (and use of HIV- and AIDS-related services) in keeping people living with HIV healthy and in the labour force (De Walque et al., 2010).

In generational terms, the highest rates of increase are in the age group 15–24-year-olds, where girls are particularly susceptible. There are, however, some signs that prevalence rates for girls attending pre-natal clinics peaked in 2004 at 15.6 per cent and have now dropped to 11.3 per cent.

7 There are no statistics available to support this statement but the pull of burgeoning mining industry in Tete and the development of Nacala port has led to people moving to the areas seeking work opportunities.

8 Food and fuel-price rises in 2007–2008 had a significant impact on the welfare of people in Mozambique.

The HIV epidemic impacts more critically on women. A World Bank study states that: "projections of AIDS deaths suggest that two current demographic characteristics of the pandemic will continue: an increasing number of adult deaths and a widening gender gap, with more women dying from AIDS than men every year" (World Bank, 2007). The reasons for the unequal patterns of infection are various, including:

- patterns of sexual relations, that include early sexual debut and relations with older men;
- physiological vulnerability in which penetrative vaginal sex puts the female partner at greater risk than the male;
- low usage of condoms, especially in the context of high levels of sexually transmitted infections;
- women's powerlessness to negotiate safe sex, linked to low levels of girls' education and lack of value for girls' literacy (which often leads to early sexual debut);
- widespread culture of male domination, and acceptance of multiple concurrent partners, even within stable relationships.

All of the above reasons are intensified when we speak about the high levels of risk of the mobile populations and their interactions with host communities.

5.2 Swaziland

Table 3. Basic statistics for Swaziland

INDICATOR	ESTIMATE	REFERENCE PERIOD	SOURCE
Population	1,018,449	2007	Population Census
Per capita gross national product (GNP)	US$1,390	2009	World Bank
Poverty headcount (% below poverty line)	69.2%	2009	World Bank
Female poverty	63%	2009	UNDP
Male poverty	37%	2009	UNDP
Rural poverty	84%	2009	UNDP
Life expectancy at birth	46%	2009	World Bank
Prevention of mother-to-child transmission services offered by health facilities	79%	2008	Ministry of Health (MoH)

5.2.1 The economic situation in Swaziland

Swaziland is currently 140 in the UNDP development index – down two places from 2010. The economy of Swaziland is largely dependent on the economy of South Africa for both exports and imports. The main exports are sugar and wood pulp, with smaller industries, such as textiles and agro-processing, playing an important part in the absorption of local

labour. Poverty is estimated at 69 per cent of the population, with female poverty almost double the estimated percentages for male poverty. Unemployment is estimated at around 40 per cent of the active adult population. South Africa absorbs the majority of the migrant labour force, mainly in the mining and agricultural sector, while two thirds of the Government of Swaziland revenue comes from customs duties from the Southern African Customs Union (SACU). With the global economic downturn, both the customs duties and the demand for migrant labour have fallen.

Unlike the situation described above for Mozambique, economic growth in Swaziland was low between 2004 and 2008, averaging 2.9 per cent, and dropped significantly in 2009 to 1.2 per cent.[9] This is mainly attributed to the impact of the global economic downturn for exports, especially textiles and wood pulp. In addition, Swaziland suffered from a long period of drought in the last four years.

The impact of HIV and AIDS continues to be felt in the economy, and it is thought that it will continue to hamper economic growth in the foreseeable future. Models for estimating the impact of HIV and AIDS on economic growth for Swaziland predict that the percentage annual loss in GDP growth due to HIV and AIDS ranges from1 per cent to 2.8 per cent (Whiteside et al., 2006).

5.2.2 *Mobile populations*

Although there has been a drop in official figures for male migration to work in South African mines, the Southern African Migration Project (SAMP) estimates that there are still approximately 5,000 Swazi miners working in South Africa. See Table 4 for external migrants to the South African mining sector. Other sectors that employ migrant workers from Swaziland are the South African manufacturing sector, agribusiness and tourism in Mpumalanga, and domestic service in Mpumalanga and Gauteng provinces. Swaziland is characterized by high levels of internal migration, with the main sectors employing migrant workers identified as the manufacturing sector (particularly the textile industry) and agribusiness (IOM Swaziland).

Table 4. Number of external migrants employed in the South African mining sector from 2008 to 2010

YEAR	SWAZILAND	MOZAMBIQUE	LESOTHO	BOTSWANA	NON-RSA TOTAL (%)	RSA TOTAL
2008	6,397	43,004	42,851	2,654	94,906 (50%)	187,516
2009	5,855	39,090	38,559	2,357	85,861 (34%)	168,109
2010	5,009	35,782	35,179	2,042	78,012 (34%)	152,486

Source: The Employment Bureau of Africa Limited (TEBA)

The high levels of male migrant labour to South Africa present one of the HIV drivers of the epidemic in Swaziland. However, there have been changes in the patterns of migration in recent years. Previously the main migrants were men working in the mines of South Africa in formal-sector employment) or farm workers, also in South Africa. However, in recent years

9 www.indexmuni.com

there has been extensive movement of people trading across the borders to both South Africa and Mozambique, thereby increasing the number of informal temporary migration. The IOM Briefing Note (IOM Swaziland) indicates that this increase is mainly among female traders. In addition, this study highlights the situation of internal female migrant workers in Swaziland (from the rural areas to the Matsapha textile factories) – a phenomenon which appears to be growing in the country.

Statistics relating to migrant workers are less clear than in the past as many of the recent migrants are now working in the informal sector. Thus, there are no reliable estimates for other key populations at higher risk (UNAIDS, 2011) in Swaziland. The Swaziland UNGASS report (2010) states that one of the key challenges in preventing HIV transmission is the non-recognition of sub-populations at high risk and, as a result, there are no programmes that are tailor-made for the groups. This is partially due to the illegal nature of the activities carried out by some of the groups (i.e. sex work and illegal cross-border trading) (UNGASS, 2010).

5.2.3 HIV and AIDS

Table 5. HIV statistics for Swaziland

			SOURCE
HIV prevalence	25.9%	2009	UNAIDS
People living with HIV	180,000	2009	UNAIDS
HIV prevalence among pregnant women at antenatal clinics	42%	2008	MoH, Swaziland
Prevalence rates for women aged 30–34	49.1%	2008	UNAIDS
% of HIV-positive pregnant women receiving antiretroviral treatment	88%	2009	UNAIDS

The impact of HIV and AIDS is making it more difficult for individuals in Swaziland to access good-quality health, education and social-welfare services. This in turn impacts negatively on the socio-economic status of people in the country. With the declining economy and the high levels of HIV infection, the conditions for increasing risk-taking behaviour in sexual relationships are heightened. This is particularly evident in the hotspots examined in this piece of research. The disparity between the wealthier members of society and the poorly paid or unemployed men and women in the areas is clear, and is a precursor for risk-taking behaviour.

5.2.4 Mobile-population and sex-worker studies (Swaziland)

The Ministry of Health and Social Welfare, together with the United Nations Population Fund (UNFPA), National Emergency Response Council on HIV/AIDS (NERCHA) and Population Services International (PSI) presented the situation analysis of sex workers in Swaziland in a 2008 regional conference (UNFPA, 2008, Maputo).The information presented shows that the age of the majority of sex workers ranges from 12 to 60 years and that they are Swazi nationals. Sex work is prevalent in the transport corridors from Ngwenya border post via Manzini to Lomahasha and Lavumisa. Hotspots have also been identified in Manzini and Matsapha, both of which are fast-growing industrial centres (street-based). There is a high demand for sex as a commodity in exchange for goods. There is considerable

stigma attached to sex work in Swaziland and it is illegal in the country. Very little specific or dedicated funding for sex-worker education programmes exists due to the clandestine nature of the work and the stigma attached to it.

The National Strategic Framework for HIV and AIDS (NSF 2009) identifies commercial sex as one of the key drivers of HIV and AIDS in Swaziland. However, there are few reliable statistics or data about sex work. A modes of transmission survey in 2009 (Mngadi, 2009) estimated that the total population size of sex workers was approximately 2,298, both male and female; In the 2010 UNGASS report 87.4 per cent responded that in the last sexual act a condom was used while 12.6 per cent did not use a condom (UNGASS, 2010)

Although poverty is one of the drivers for women to enter into the sex trade, it is not the only cause. Other factors included pleasure-seeking or sensation-seeking, and freedom from the burden of marriage. Motivation for non-use of condoms was similar to those found in the Mozambican studies, namely intention to earn more money, pleasure and not having enough time (linked to alcohol use). It was also found that penile–vaginal sex was not universal in male–female sexual relations (and other more risky sexual practices, such as anal sex, are common). The study recommends that programmes aimed at reducing the vulnerability of these groups need to be tailored to the specific needs of the sub groups within each key population at higher risk, and that general information, education and communication (IEC) and behaviour change programmes are not sufficient to address the issues raised within the most-at-risk population groups.

A study carried out by Whiteside et al. (2002) affirms that people in Swaziland are highly mobile and states that: “People’s mobility is known to give both the opportunity, and increase the likelihood of having non-regular sexual partners”.

Swaziland is characterized by both internal migration from the rural areas to the industrial areas and towns, and strong cross-border migration, principally to South Africa. The report further states that evidence shows: “If you put people in circumstances where they cannot maintain stable relationships, where they are mobile, where life is risky and pleasures few and necessarily cheap, then sexually transmitted diseases will be rampant. If, further, there are inadequate medical services and little is available in the way of immediate, accessible and effective treatment for STIs, then HIV will spread rapidly” (Whiteside et al.,2002).

5.3 Transport sector

There are a number of relevant studies that have been undertaken on the risks for people working and interacting with the transport sector (IOM, 2009; IOM, 2010). The studies reviewed stress that greater and easier access in the region due to the road networks and economic growth has lead to greater mobility and opportunities, but also higher risks in terms of sexually transmitted diseases. The concentration of mobile populations at trucking spots, loading and unloading areas, ports and border crossings are all hotspots for sexual activity and potentially high-risk sexual behaviour.

The IOM report on the transport sector states that: “Hotspots can be generally defined as locations where alcohol is served and where sex is negotiated or takes place. This includes bars, lodgings, restaurants, seaports, fish landings and parking lots” (IOM, 2010).The report goes on to state that: “The environment in such locations and mobility of populations is conducive to both men and women engaging in multiple concurrent sexual partnerships” (IOM, 2010).

Due to the frequency of sexual relations in the hotspots between the mobile populations and members of the resident population, there is increased probability of STIs including HIV. The impact of the heightened possibility of STIs reaches beyond the primary interaction between the mobile population and members of the resident population. There is a high probability that both members of the resident population and members of the mobile population have partners in their home communities, thus increasing the spread of STIs and HIV beyond the hotspots.

The influx of people to areas with limited health services can lead to stress on health services. Many of the migrant populations studied have difficulties in accessing health services due to their working patterns. Hotspots are often poorly served by general health services and HIV-prevention services in particular, thus compounding the problem of the spread of STIs. Generally, health services do not have specific programmes to reach out to the mobile populations or other key populations at high risk in the hotspots, and therefore remain effectively inaccessible to these groups.[10]

These issues are analysed in this report, following discussions with both mobile-population and host-community informants about their attitude to and use of the existing health services.

The IOM assessment makes the following specific recommendations:

- Develop policies and regional coordination mechanisms (for example, improve customs clearance to reduce waiting time at the border);
- Emphasize awareness-raising and information dissemination on high-risk behaviour;
- Improve HIV and AIDS programmes and services (health services, entertainment centres that encourage "wellness" above high-risk behaviour);
- Undertake more research specifically in the areas of social networks and concurrent partners.

5.4 Female migration

There is reference in the literature to the possibility that women are increasingly migrating in search of work and new experiences. This trend is clear in both southern Mozambique and Swaziland where traditionally women were left on farms while men migrated to the South African mines. Women are increasingly becoming traders, setting up small-scale businesses and migrating to South Africa to become domestic or farm workers (IOM Swaziland). In Swaziland the internal migration of women to the textile industries clustered in the industrial zone on the outskirts of Manzini will be examined in this report as part of the mobile groups found in this "hotspot". This trend in migration represents increased economic opportunities for women but there is some evidence that women are becoming more vulnerable to trafficking and/or abuse –leading to higher risk of HIV and STIs. People in vulnerable social and economic situations, particularly children, are unlikely to be able to negotiate condom use; they may be forced to endure sexual practices most associated with HIV transmission; and may be forced to have sex with multiple partners (IOM Swaziland).

10 For example, the health units do not work outside of normal working hours, there are no mobile services offered and there are few outreach programmes aimed at servicing the needs of mobile populations.

5.5 Mobile-population and sex-worker studies in southern Mozambique and Swaziland

Presentations from PSI[11] (working with sex workers in Maputo city and province) emphasized the need to understand the dynamics of the cross-border movement of the population. They identified the following categories of people as potentially at risk of HIV infection: cross-border sex workers, people seeking employment in South Africa, girls who are trafficked, cross-border traders, truckers and their assistants, building workers, uniformed personnel, border officials, people in transit, police and tourists. PSI recommended the harmonization of the treatment and care protocols across the borders, including access to treatment in neighbouring countries, as well as initial discussions on the legalization of sex work to afford more protection to women.

From a study carried out in 2008/2009 (Selvester, 2009) in the border crossings of Ressano Garcia (Mozambique and South Africa) and Namaacha (Mozambique and Swaziland), the following findings were presented as reasons why women and girls become involved in sex work:

- economic necessity;
- other sources of income insufficient to cover basic needs;
- abandonment by partner or death of partner, leaving the women with children to support;
- single mothers who have friends who are sex workers and encourage them to join;
- need to earn a living after moving to a new area;
- curiosity and a belief that it may be possible to meet a partner through sex work to marry and create a home;
- need to satisfy sexual desires.

The study also highlighted the complex rationale for condom use, including;

- money (the variation in the price paid for sex with or without condoms);
- classification of relationships (partner, client, regular client) and risk assessment (there is less perceived "risk" with regular clients);
- misinformation (there is a widespread view that condoms cause HIV by being impregnated with the virus and a belief by female sex workers that condoms cause gynaecological problems);
- pleasure (both men and women interviewed stated that condoms reduce the pleasure in the sexual act);
- the desire to fall pregnant;
- impaired function due to intoxication.

The recommendations from the study were to:

- allocate increased resources to HIV-prevention programmes tailored to the needs of sex workers and their clients;

11 "Sex workers in Maputo", PSI PowerPoint presentation, UNFPA Regional Conference on HIV and AIDS Vulnerability for Sex Workers, 2009.

- develop specific IEC and behaviour change programmes for sex workers that address the specific needs of the various sub groups of sex workers;
- review posting policy in the public service to encourage family life;
- sanction inappropriate sexual behaviour formally by public-service employees;
- intensify campaigns about the danger of concurrent sexual relationships.

It was recommended that all condom-education programmes should take into account the reasons for the non-use of condoms identified in the research as a starting point for counselling discussions and advocacy material. Further recommendations were made to encourage proactive health-seeking behaviour, including the opening of night clinics and mobile clinics. Finally, recommendations were made to enforce the laws against sexual abuse of children, including prosecution of men who sexually abuse children, protection measures for children in educational institutions and the development of public information campaigns on child sex abuse and the implications for children and society.

A study was carried out in 2006 on the vulnerabilities of mobile populations to HIV and AIDS on the Nacala corridor and the southern corridor of Maputo to Inhambane (IOM, 2006). It mapped the hotspots along the corridors and the movements of a wide variety of mobile populations (refugees, traders, truck drivers, public-sector workers) and sex workers. The recommendations of the study were as follows:

- The complexity of the lives of mobile populations should be reflected in nuanced programmes aimed at the groups;
- The habitual stopping-off places should be saturated with HIV information and condoms;
- Institutions catering to transient populations should develop strong positive policies that protect their inmates (boarding schools, training colleges);
- Peer education should target active leaders (even if they do not fit the stereotype of trainers or teachers) in the different groups;
- Strong advocacy positions must be taken on sexual predators (older men having sexual relations with school children);
- Flexible health services should be developed to cater to the needs of both isolated sedentary populations and mobile populations.

5.6 Legal and policy frameworks

There are numerous legal and policy frameworks in place in both countries. However, a study carried out in Mozambique (and Malawi) (Kalanda et al.) found that there is a gap between signing the treaties or passing the laws, and action on the ground. The recommendations of the study were to: disseminate information on obligations, link national instruments to conventions and declarations, and define processes and mechanisms for operationalizing the conventions and declarations.

Table 6. Summary of international and regional treaties adhered to by the governments of Mozambique and Swaziland

INTERNATIONAL AND REGIONAL TREATIES		
Declarations	Swaziland	Mozambique
The UN International Convention on the Protection of the Rights of all Migrant Workers and Members and Their Families	Not signed	Not signed
The UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)	Acceded to on 26 March 2004	Acceded to on 21 April 1997
The UN International Covenant on Economic, Social and Cultural Rights (ICESCR)	Acceded to on 26 March 2004	Not signed
The AU Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa	Signed on 7 December 2004	Signed on 15 December 2003 and ratified on 9 December 2005
UN Millennium Declaration (2000)	Signed	Signed
The Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001)	Signed	Signed
The SADC Protocol on Health (1999)	Signed	Signed
The Maseru Declaration and Commitment to AIDS in the SADC region (2003)	Signed	Signed
The Brazzaville Declaration on Commitment on Scaling up towards Universal Access to AIDS Prevention, Treatment, Care and Support in Africa by 2010 (2006)	Signed	Signed
The Declaration of Human Rights and the African Charter for Human and People's Rights	No information	Ratified resolution 9/88 on 25 August 1988
The Convention of the Rights of the Child	No information	Ratified resolution 19/90 on 23 October 1990
The African Charter on the Rights and Welfare of the Child	No information	Ratified on 29 November 1999
National charters, laws and policies		
Swaziland	**Mozambique**	
The Second National Multi-sectoral HIV/AIDS Strategic Plan (2006–2008) acknowledges that high population mobility in Swaziland is one of the key drivers of the AIDS epidemic.	The National Strategic Plan on HIV and AIDS (PEN IV) recognizes the importance of services and programmes aimed at highly at-risk populations	
The National Strategic Framework (2009–2014)	The National Action Plan for Vulnerable Children (minimum care standards) 2010 takes into consideration child trafficking, sexual and physical abuse of children and child labour	

National charters, laws and policies	
Swaziland	**Mozambique**
The National Strategic Framework (2009–2014) has a section on migration and mobility in the country and how it is a significant factor in sexual behaviour	The National Strategy for Basic Social Security (April 2010) provides the framework for supporting HIV-positive people and households affected by HIV and AIDS (the operational plan for the strategy is being finalized for budgeting in 2012)*
The Umbutfo Swaziland Defence Force, through the United States Department of Defence on HIV/AIDS Program (DHAPP)	Family law – strengthens women's legal position within the family
Agro-industries such as Royal Swaziland Sugar Corporation, Swazi Peak Timber, Dalcrue Agricultural Holdings, and Swazi Fruit Canners have developed HIV and AIDS policies and programmes	The law against domestic violence of 2009protects women in cases of domestic violence
Sex work is illegal in Swaziland	The anti-trafficking law of2008 includes specific provision for the protection of children
	An anti-discrimination article in the labour law, Act No.5 of February 2003,provides for non-discrimination against HIV-positive employees with regards to their work, training and promotion rights

* National Strategy for Basic Social Security coordinated by the Ministry of Women and Social Action (MMAS), with Health, Education and Labour as key cooperating Ministries. Cooperation partners supporting the Basic Social Security Strategy are the International Labour Organization (ILO), the Department for International Development (DFID), the Dutch Embassy and the United Nations Children's Fund (UNICEF), with additional collaboration from NGOs and civil-society organizations

5.6.1 Sex workers and their legal position

Sex work is not clearly legislated within the Mozambican legal framework, and therefore can neither be punished nor protected under the law. Punishment under the law for sex workers takes the form of using the existing loitering and indecency laws.[12] There are articles in a 1962 law that make "facilitating the practice of prostitution illegal" – Article 2(1) – and maintaining houses of prostitution is also illegal – Article 3. Forced sex work or forced sexual acts, sexual violence and violence against another person are all illegal under the Mozambican penal code. Other relevant articles in the penal code include articles against third parties profiting from prostitution (article 405) and the law on the corruption of minors (article 406) from the law enacted in 2002, Law 8/2002.

The newly formed Mozambique chapter of the Pan African Sex Workers Alliance (ASWA) is pressing parliament to recognize the rights of sex workers, especially to ensure their health and security (ASWA is a Cape-Town-based group fighting for sex-worker rights). Currently ASWA is collaborating with organizations such as Pathfinder International, PSI, UNFPA, Mozambican Human Rights Organization (known as Liga Moçambicana Dos Direitos Humanos) and the Lurdes Mutola Foundation (Gender Links) to strategize about how to work towards a safer environment in which sex work can take place.

Sex work is illegal in Swaziland and sex workers can be punished under the law. Although a number of studies have highlighted the drawbacks to the law, such as driving the practice

12 US State Department report on Human Rights in Mozambique, 2007. Also the point of view of Deolinda Moiane (lawyer and researcher for this paper).

under-ground, the inability to create a healthier environment for the women to work and the possibility of more targeted programming, there is little political will to discuss the de-criminalization of sex workers in the country.

5.6.2 *Sexual abuse of minors*

In article 19 of the Convention of the Rights of the Child, children are protected against obscene acts and violence (with criminal punishment). However, forced (commercial) sex is not specifically cited. Infant prostitution is therefore not a specific crime within the existing legal framework. In 2003, Mozambique opted to sign an additional clause of the Convention for the Rights of the Child pertaining to the prohibition of the sale of children, infant prostitution and infant pornography.

In Mozambique, the family law, the law for the protection of children, the basic laws for the protection of children and adolescents, and the people trafficking law pay special attention to minors and provide protection. It should be noted that these frameworks have not been tested thoroughly in the courts in Mozambique.

Although there are some laws for the protection of the child against sexual abuse (both through international law that Mozambique has ratified and national law – 8/2002, articles 405 and 406) there is no specific legislation against child prostitution (either for those who abuse children or for those who make profits from children). Child prostitution is not criminalized at present in Mozambique.

5.6.3 *Concluding remarks on the socio-political and economic situation in Mozambique and Swaziland*

From the brief summary above of the situation in both countries it is clear that they are struggling with difficult economic situations and high levels of poverty. In Swaziland, although the GDP per capita is higher than in Mozambique, the levels of poverty are extremely high (69% of the population living below the poverty line). There are high levels of inequality in terms of income distribution in Swaziland. In contrast to the economy of Mozambique, which has shown steady growth over the last decade, the economy in Swaziland is stagnant, and highly affected by the world economic downturn. Both countries are battling with unacceptably high levels of HIV and AIDS, which further strain the economy and social spending, and have a devastating impact on the lives of hundreds of thousands people. The juxtaposition of wealth disparity, poverty and high levels of HIV prevalence create a pessimistic scenario, not only in terms of the resources necessary to fight for change in terms of HIV but also on the attitudes of people to engage in the fight. As was said by one interviewee during the research, “HIV has come to take away the one pleasure that poor people have”. A lorry driver in Matsapha also spoke passionately about the difficult economic situation in his country, and why this reduces his willingness to think about HIV prevention:

“HIV/AIDS is spoken about too much, but no-one speaks about how to resolve the problem of poverty. The population in this country are suffering with a lack of employment, our children don’t have clothes because we don’t have money to buy them, and then people talk about AIDS and say we have to prevent it. What difference does it make to die from AIDS or die of hunger? Death is death the same. The government needs to solve the problems that affect the population. There are many illnesses, they will never finish, but solutions to finish with poverty and hunger the government can arrange.” (Lorry driver, Matsapha)

06 PRINCIPAL FINDINGS FROM THE FIELD WORK

6.1 Description of the hotspots

Hotspots are defined as areas where there is a concentration of people, bars, restaurants and entertainment halls (e.g. video clubs, billiards rooms), and high opportunities for multiple concurrent sexual relationships.

The IOM 2010 report on the Transport Sector states that: "Hotspots can be generally defined as locations where alcohol is served and where sex is negotiated or takes place. This includes bars, lodgings, restaurants, seaports, fish landings and parking lots ….The environment in such locations and mobility of populations is conducive to both men and women engaging in multiple concurrent sexual partnerships" (IOM, 2010).

The hotspots studied during the research were Namaacha, Boane and Goba in Mozambique. In addition a limited number of interviews were carried out in the customs clearing area known as "Frigo", 18 km from Maputo city, with truck drivers and sex workers, as they were difficult to access at the Namaacha border crossing. In Swaziland interviews were carried out in the border post of Lomahasha and in the industrial area of Matsapha approximately 100 km from the Mozambique–Swaziland border.

6.1.1 Characteristics of mobile populations in the hotspots

In Mozambique the mobile populations are principally from Mozambique, although some of the drivers and assistants are from South Africa or Swaziland. The traders are mainly female and Mozambican; the informal currency-exchange traders are Mozambican, both male and female. In Swaziland, it was found that mobile populations were a more heterogeneous mix of nationalities, with drivers and traders from Swaziland, South Africa and Mozambique. All of the textile workers in Matsapha were female and Swazi.

Namaacha

Namaacha is the main town of a district by the same name, which is approximately 70 km from the capital city of Maputo, on the border of the Kingdom of Swaziland. The transport corridor is used by petty traders – mukheristas – trucking companies and tourists. In the past the Namaacha border crossing was the main point of exit and entry between the two countries. However, the Goba border-crossing (which is open 24 hours a day) has divided the through-traffic. The Namaacha crossing closes officially at 8 pm. This has had an impact on the economy in Namaacha town, as the flow of people and goods has slowed down considerably over recent years. The town has one boarding school as well as primary and secondary day schools; there is also a teacher training college in the town. There are two hotels[13] and numerous boarding houses and rooms to let. The town has a thriving informal market comprising bars, roadside restaurants and rooms that are hired by the hour.

People interviewed over the course of the research stated that the flow of trade has slowed considerably, which has affected the traders, bars and restaurants. It has also affected the transactional sex trade, and many of the girls now work in the town of Boane or Maputo at the weekends. One of the cigarette sellers in the town said that you do not see as many women on the street any more, and that you had to go to the bars and drink with the men if you wanted to talk to girls involved in transactional sex. The researchers found it difficult

13 One of the hotels has a casino attached.

to identify women involved in sex work, and even though the researchers tried to follow up with women interviewed in a previous research project specifically working with sex workers, they were not able to identify the women. When they inquired after them they were told that they had moved to Maputo, or people did not have any information on their whereabouts. One of the main reasons for the reduction in visible sex work in the town is the early closing of the border (8 pm) and the 24-hour opening of the Goba border. Truck drivers no longer sleep on the Mozambican or Swaziland side of the border; they would rather pass through Goba and go onto Maputo or Manzini.

Please see the map with social amenities in Namaacha in Annex 2 (Map 2.1).

Boane

The town of Boane is in the district of Boane that lies on the transport corridor leading to Swaziland, approximately 50 km from Maputo. The town is small with only one hotel and one bank. There are, however, numerous bars and roadside restaurants. There is a particular areas referred to as "Island" (*Ilha*), where there is a vibrant trade in alcohol and food. Although the women involved in transactional sex are not found in designated areas of the town (as in Maputo city or Matsapha), they more easily identified than the women in Namaacha (who were reluctant to talk to the interviewers). In Boane, the women were happy to discuss their work, both the advantages and disadvantages. Truck drivers, bar owners and staff from an NGO working in the area were also interviewed in the town. The general opinion was that Boane was a town that was growing due to the urban sprawl of Maputo, with large houses and condominiums being built between Maputo and the town. This was leading to a small boom in the construction trade and associated services. However, it did mean that much of the land that was formerly small-holder farming plots has now been taken over by the construction of houses. With more through-traffic, meaning more money in the economy, the business in the bars and roadside restaurants has improved. One of the main industries that employs women in the area is Bananalandia – a banana farm and distribution centre just outside of Boane town.

Please see the map with social amenities in Boane in Annex 2 (Map 2.2).

Goba[14]

The district of Goba borders Swaziland and, as mentioned above, the border is open for 24 hours. The border post is relatively small, with approximately 50–60 houses, including the housing for the border staff (police, customs and migration officers). There is also an insurance company that works on the border post. There are no social facilities in the area of the border post. The nearest schools and health facilities are in the village of Goba that lies approximately 15 km from the border crossing. The border is used by informal traders, who trade food and clothing from Swaziland to Mozambique, and the trucking companies. In addition, Goba is often used by tourists who travel to Swaziland (or Durban in South Africa) for leisure. There is no truck stop at the border; the truck drivers may stop to eat and process their loads but they do not generally sleep on the border. There are a number of small bars and roadside restaurants that are frequented by the public-sector staff who are working on border control.

Lomahasha

This small border town has suffered a similar fate to Namaacha on the other side of the border. With the opening of the Goba crossing much of the through-trade has moved away from the area. The petrol station in the town closed down and there are a few remaining shops and bars, where residents and the border staff drink and eat.

14 The frontier post of Goba was added to the research in the course of the field work and after the mapping component had been completed. Therefore there are no maps for the Goba area

Please see the map with social amenities in Lomahasha in Annex 2 (Map 2.3).

Matsapha

The Matsapha hotspot was included at the request of NERCHA (Swaziland National AIDS Council) as an area frequented by truck drivers and rural in-country migrants due to the mushrooming textile industry and subsequent services that had grown up in the area. It is seen as a largely unregulated area. One of the respondents in the research said: "Whatever that happens in Matsapha will be practiced in the extremes. If you sell mealies in Matsapha you will sell a lot; likewise if you sell your body you will have a lot of customers. If the water of Matsapha were to be contaminated it will infect a number of people."

There is a strong feeling that the vibrancy of the area is also matched by disparate wealth levels, unregulated accommodation that caters for the migrant populations and high levels of sexual transactions. In Matsapha the researchers were able to talk to self-identified sex workers, as well as a wide range of clients, textile workers and community members.

One of the interviewees described the area in the following way. "We have a business section next to the road, then the residential areas. The residential areas are now filled with single rooms for renting mainly to the people working at the factories A large number of women come from rural areas to the textile industry. Many small businesses are attracted by the factories – people from all over the country and region. There are yards where there are rooms that women hire by the day or the month. In the same place others are renting rooms and not involved in the (sex) trade."

Please see the map with social amenities in Matsapha in Annex 2 (Map 2.4).

6.2 Sexual networks

Sexual networks in the hotspots are characterized by multiple concurrent sexual relationships and inconsistent condom use. This is similar to behaviour in the general population. However, in the hotspots there is more opportunity, significant amounts of available money, less social or family constraints and the extent of the web of relationships is much wider than in purely settled communities.

This is in spite of the fact that knowledge and understanding of HIV is high. Across the board people were able to explain the basic concepts about HIV as a disease and how it is transmitted. Everybody had heard of HIV, and the vast majority of people knew someone who was HIV positive, someone who was in treatment or someone who had died of AIDS.

"Knowledge about HIV changed my life. I now take tests and use condoms with my lover (but not with my husband)."(29-year-old worker on the Goba border post)

Reported testing for HIV was also high. The majority of people interviewed said that they had been tested for HIV. However, very few of the respondents went for regular testing. Given the high levels of unprotected sex taking place, the sporadic testing by the respondents was not an effective way of tracking HIV status. The women in Swaziland who were in touch with the Family Life Association of Swaziland (FLAS)[15] services were more likely to go for regular testing. In Mozambique people reported patchy testing. Typical responses were:

"I had a (HIV) test a year ago and I was negative." (Lorry driver who is still not using condoms, Goba)

15 An NGO offering counselling, treatment and support to women in reproductive health and sexual matters in Swaziland. More information available in section 9.3.3 of the report.

"I had a test six months ago and they said to come back, but I was negative so I don't think I will go again."(Girl in a bar, Boane)

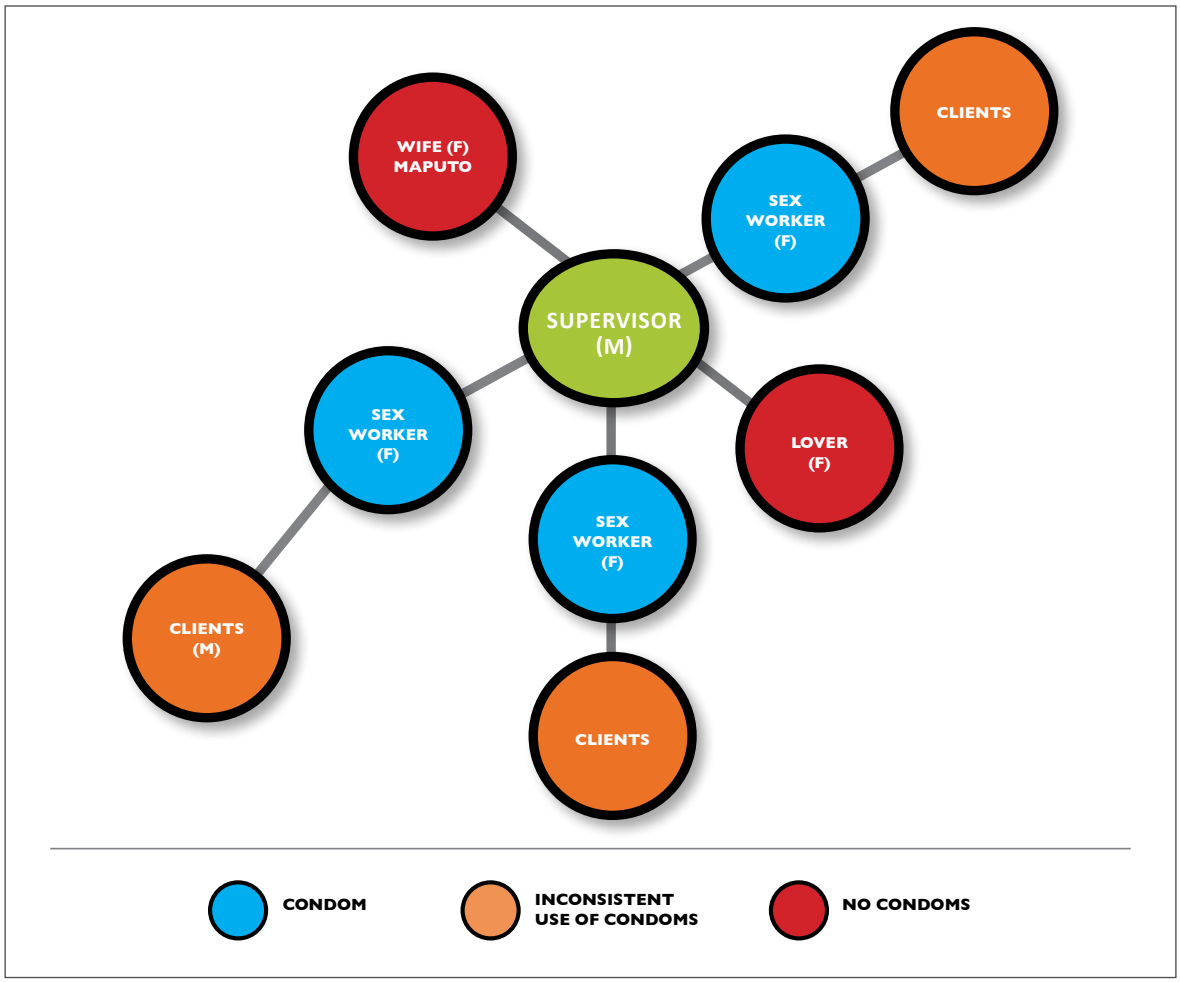
Some of the respondents stated that they had changed behaviour due to their HIV status, or due to knowledge of HIV and AIDS. One sex worker in Swaziland said that she was HIV positive and now always used condoms:

"My life changed. Before, I didn't protect myself. Unfortunately I only started to use condoms after I knew I was positive (HIV positive); if I had listened to the advice I was given before I would be healthy now. All of this started because of poverty. I wanted to earn easy money, and though the disease was something that happened to others …. Now I always insist on clients using condoms. I have four children to look after and I have to stay healthy. Imagine if I died, what would happen to them." (Sex worker, Matsapha)

The following figures illustrate a series of multiple concurrent sexual relationships that were explored during the research.

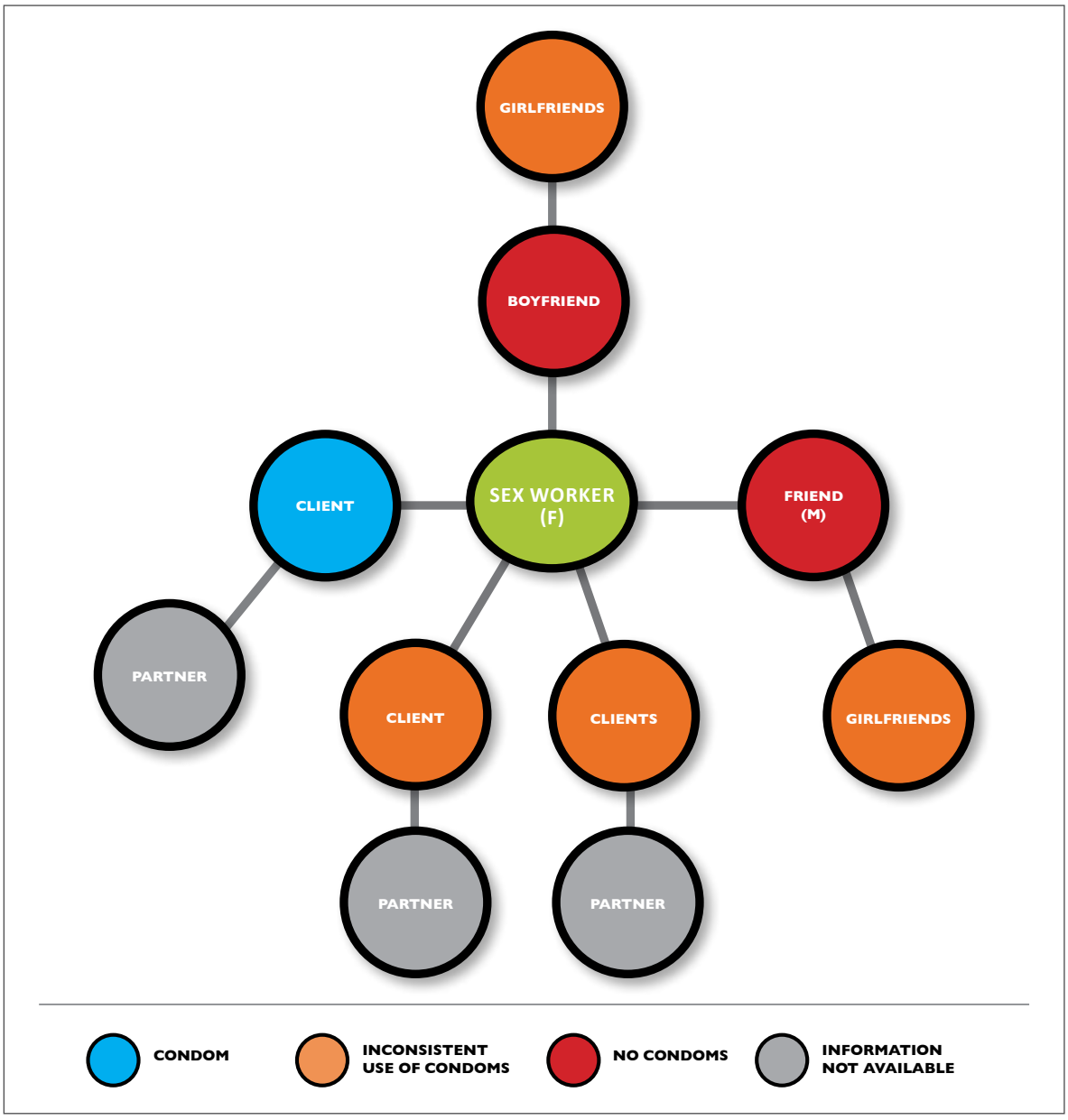
Figure (a) – a supervisor for a trucking company based on the Swaziland border explained his relationships. He has a wife in Mozambique and a regular lover. With these partners he does not use condoms. He regularly pays sex workers (he spoke about three sex workers in particular). With the sex workers he always uses condoms. He stated that he started using condoms with sex workers when he became aware of the dangers of HIV. However, he felt that it was not appropriate to use condoms with his wife or his girlfriend (even though he was unsure if his girlfriend was faithful to him).

Figure (a): Supervisor with a trucking company (Swaziland border)



The case study illustrated in Figure (b) shows the multiple relationships described by a sex worker (who is HIV positive). She has both a steady boyfriend and a regular lover. She does not use condoms with either of these partners. They do not know her HIV status (and she does not know theirs). She said that she inconsistently uses condoms with her clients. Although she would prefer to use condoms with all her clients, if they are willing to pay more for not using condoms then she complies. She is in treatment and receives counselling from FLAS.

Figure (b): Network of multiple concurrent sexual relationships (sex worker)



Figure(c) illustrates the multiple concurrent relationships of a single mother, who maintains an irregular relationship with the father of her children. He is married to another woman. She also has a boyfriend. With both the father of her children and her boyfriend she does not use a condom. As she does not live with either of her regular partners she also has casual partners who help her "put food on the table" for the children, and give her money for clothes, going to the hairdresser or take

her out for meals. With her casual partners she uses condoms. She knows that both of her regular partners are married and believes that they probably have additional girlfriends.

Figure (c): Network of multiple concurrent sexual relationships

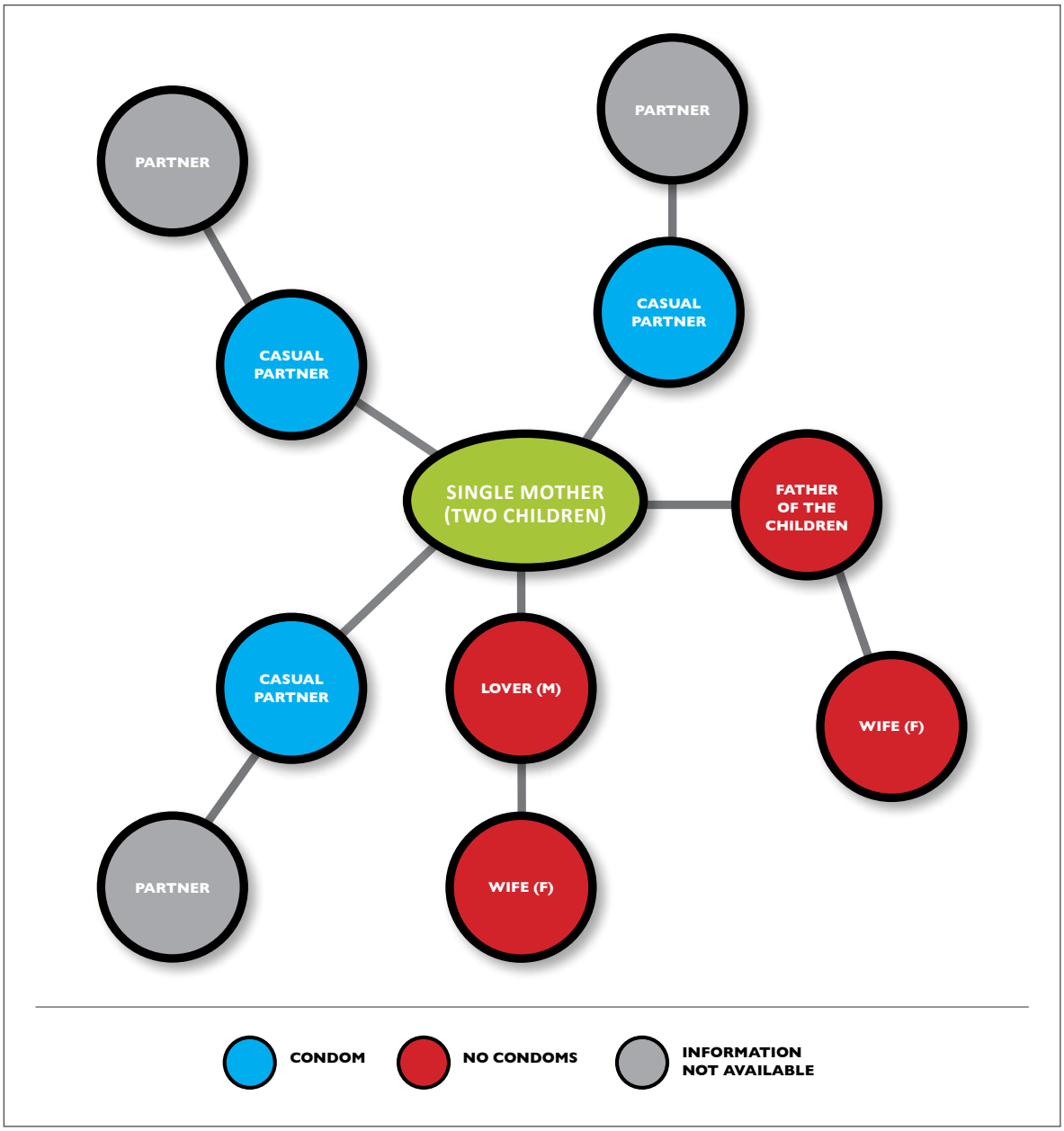
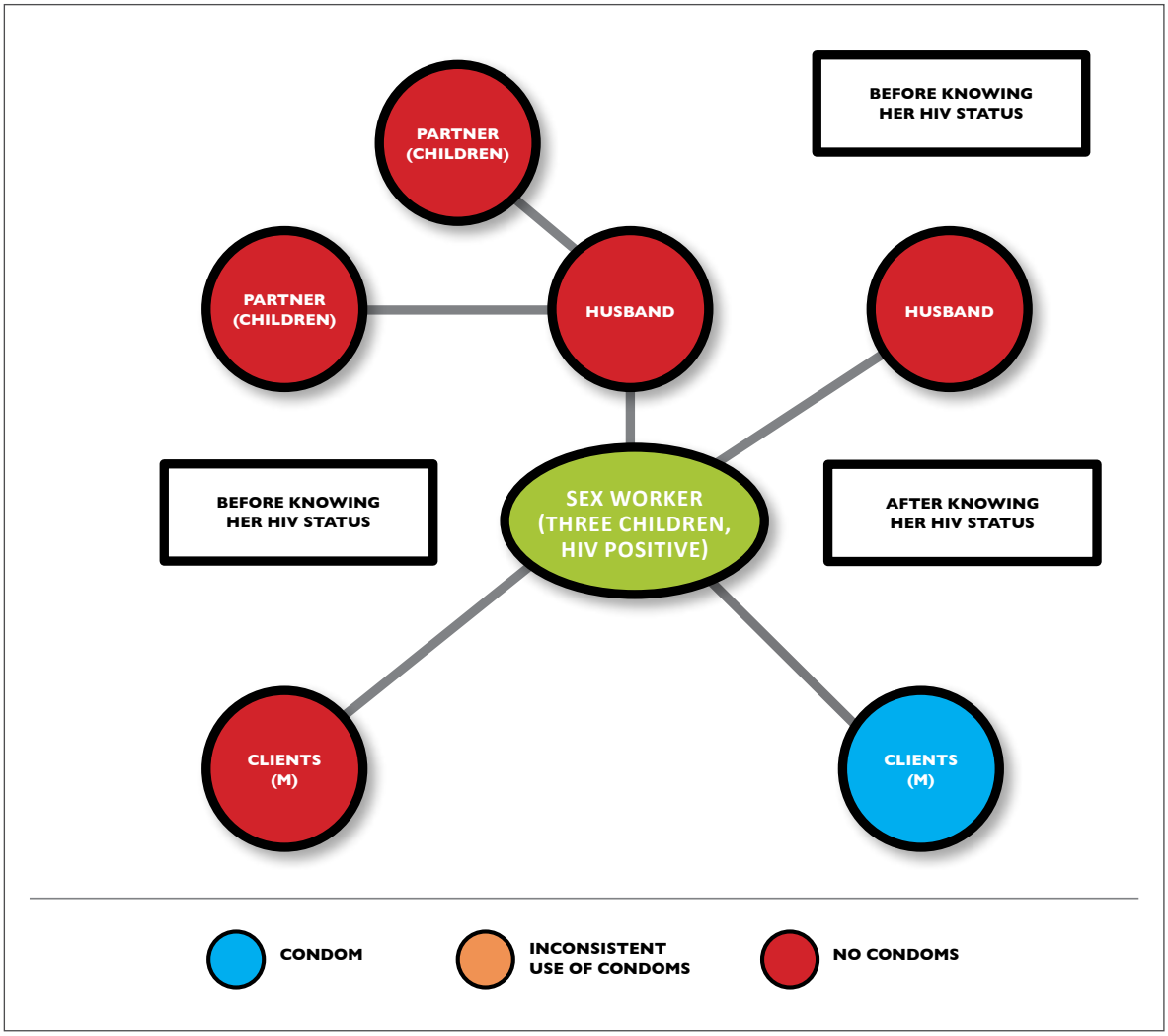


Figure (d) illustrates the relationships of a sex worker who began to work in the sex trade when her husband was in prison and she needed to support her children. She was unaware that her husband was HIV positive and always practiced unprotected sex with clients. She also became sexually involved with her brother-in-law who helped her with the children when her husband was in prison. She discovered that she was HIV positive while pregnant with her third child and, subsequently, discovered her husband's status. When he was released from prison their relationship broke down (although she does occasionally have sex with him when they meet). She knows that her husband has children with at least two other women, and that he does not use condoms. He has always refused to use condoms even when he knew his HIV status. She continues to work on weekends as a sex worker, but states that she always uses condoms with her clients.

Figure (d): Sex worker, Boane



These case studies offer some interesting insights into multiple concurrent sexual relationships. With the exception of the second case study on the sex worker in Matsapha, there is a tendency to use condoms with clients (in the case of sex workers) and sex workers (in the case of clients); and an extremely worrying tendency not to use condoms with regular partners (wives, husbands, regular lovers etc.).The case studies also clearly show that knowledge of HIV status does not automatically lead to safe sex practices. It was also clear that among the people interviewed there is an acceptance of the inevitability of non-exclusive relationships by both men and women. The case studies also clearly indicate that women are spreading their economic and social risk through increasing the number of partnerships, but at the same time increasing their physiological risk of contracting HIV.

6.3 Condom use

The majority of respondents stated that before the AIDS epidemic they had never used condoms in any of their relationships. The use (even inconsistent use) of condoms is largely due to fear of contracting HIV. Many of the women state that they use condoms to prevent disease and the contraceptive pill to prevent pregnancy.

6.3.1 *Trust relationships and safe sex*

Many of the interviewees explained that they did not use condoms when there was a "trust relationship". However, as seen in the case studies above, a trust relationship does not mean an exclusive relationship. People refer to trust relationships when they are talking about longer-term lovers and not just their permanent partners. Trust is linked to the length of the relationship, the level of commitment and the quality of the relationship, but not necessarily to sexual exclusivity. Some of the reasons for non-use of condoms by type of relationship are shown in Table 7below.

Table 7. Factors linked to the non-use of condoms by type of relationship

MARITAL RELATIONSHIPS	EXTRA-MARITAL RELATIONSHIPS	CASUAL RELATIONSHIPS
Wanting children	Length of time of the relationship	Terms and conditions of the relationship: For example, men will pay more money for sex without condoms.
Habit	Mutual testing for HIV	Motive for the sexual encounter: For example, women may accept having sex without condoms for their own pleasure or because they are offered more money.
Obligation – non-negotiable within a "trust" relationship	Commitment (regular visits, support with household costs)	
Inability to re-negotiate terms of the relationship (even after trust has been broken)	Inability to negotiate the terms of the relationship	

In addition to the above-mentioned situations there are a myriad of reasons why people choose to use or not to use condoms in any given sexual encounter. Some of the reasons evoked have a clear gender bias, while others are common between both men and women. As one can see from Table 8, there are many more compelling reasons for both men and women for not using condoms than for using condoms.

Table 8. Reasons for use and non-use of condoms from a male and a female perspective

MALE PERSPECTIVE		FEMALE PERSPECTIVE	
Use of condoms	Non-use of condoms	Use of condoms	Non use of condoms
Prevention of disease		Prevention of disease	Powerlessness (unable to refuse)
	Pleasure		Pleasure
Prevention of pregnancy*			Having children
	Trust (see above discussion of trust)		Trust (see above discussion of trust)
	Ethnic (African) customs		
	Faith (against church dictates) and fate		Faith (against church dictates) and fate
			Fear of reprisals from men (violence or that men will leave them)
			Obtaining additional resources (money, support for the household)
	Alcohol (reducing inhibitions)		Alcohol (reducing inhibitions)

* Women do not trust condoms as a way of preventing pregnancy. The majority of the women interviewed were taking the contraceptive pill, had an intrauterine device (IUD) or were getting hormone injections from the health centres.

Source: Research interview transcripts, 2010

The following quotes from respondents support the summary in Table 8.

- "Using condoms takes away the pride of men."(Truck driver assistant, Goba)
- "African men don't use condoms; it is not our way." (Mini-cab driver, Swaziland)
- "I don't use condoms because I don't like them. If it is God's will that we die because of AIDS then we will die. Having sex with a beautiful woman and using a condom – this is an insult to that women." (Truck driver, Matsapha)
- "Women are frightened to ask men to use condoms. They are frightened of taking a beating; some men beat women when she asks them to use a condom." (Lorry driver, Goba)
- "(Men say) ... you are unique, and then they give you a lot of caresses, they hold you very nicely, really nicely, and you yourself don't want to use a condom, because it is so good without a condom." (Young woman, Goba)

- "I always ask men to use a condom, but if they say they will give me more money for sex without a condom, I usually say yes. Mainly it is the older men that don't want to use condoms and they are the ones with more money." (Sex worker, Matsapha)

- "Many of the sex workers are young; they can't tell the men to use condoms. They are frightened and powerless." (35-year-old sex worker, Matsapha)

- "It is difficult to go home, where you already have two children, and say that from now on we are going to use condoms." (Border guard, Goba)

Patterns are emerging about how people perceive their behaviour in relation to condom use and relationships. The stated behaviour is that condoms are used with causal partners in order to prevent disease transmission and pregnancy. However, even over the course of the interviews it became clear that the stated behaviour and actual practice are not always the same; drinking alcoholic, pleasure, and carelessness, can all mean that condoms are not used.

What is particularly striking about the findings on the use and non-use of condoms is that availability and access to condoms, knowledge about the importance of condoms, and how to use condoms, are no longer barriers to use. There was some evidence that the young women from the rural area of Goba had less information about condom use, but when interviews were conducted with the girls themselves they did in fact know about prevention of STIs through condom use. This is a triumph for the tireless programmes that have strived to take away the stigma of condom use and make them widely available. Staff from one of the first associations of people living with HIV and AIDS – Kindlimuka, in Mozambique –stated that when they first talked about condoms more than ten years ago, many of the condoms were thrown away after the sessions. Now people use the condoms that are distributed and buy them from the outlets. One of the truck drivers said that the strong policy from his company on HIV sensitization and the provision of condoms had really reduced the number of STIs among the drivers.

PSI was widely recognized as one of the most important agencies in both countries in terms of increasing access to and availability of condoms. Condoms were widely available in all of the hotspots, both freely distributed through the NGOs and health services and for sale in bars, restaurants, chemists and markets. In Swaziland there was a clear preference for buying condoms over receiving the ones distributed freely because of the perceived quality of the free condoms (people suggested that they were out of date or that they were of an inferior quality).All of the respondents in the research knew about condoms and the vast majority had used condoms in some of their sexual relationships. Unfortunately, they had not been used consistently, and therefore did not prevent transmission of STIs.

Perspectives on the concept of safe sex

The idea of safe sex is not confined to the use of condoms. During the research, questions were asked about what constitutes safe sex, and how feasible safe sex is given the lifestyle of people in the hotspots.

As mentioned previously, sexual behaviour in the hotspots does not have a fundamentally different character(multiple concurrent relationships and inconsistent use of condoms) to sexual behaviour in other areas, but there is increased intensity and velocity of sexual activity that, in turn, increases the risk of contracting HIV and other STIs.

Perceptions of what constitutes safe sex

Interviewees were asked what constituted safe sex, and how this could be encouraged. The vast majority of the respondents were fully aware of safe sex practices, including abstinence, faithfulness, consistent use of condoms (although it was recognized that this was not completely safe as condoms could break or come off during the sexual act) and non-penetrative sex. Information on HIV and AIDS, on safe sex, treatment and care for people with HIV and AIDS was largely obtained through:

- Information campaigns on radio and TV;
- NGO community-based work (this was a more common response in Swaziland than in Mozambique, with the exception of Boane where Kindlimuka was well known for their campaigns and sensitization work);
- Health services, both public and NGO-run(this was a common response for women but not for men);
- Workplace policies (this was a common response for public-sector workers on both sides of the border and for one of the truck drivers who stated that his company had strong campaigns on condom-use).

There are some persistent myths that provide men with an excuse for not practicing safe sex. One of the myths was perpetrated by the now President of South Africa, Jacob Zuma, that thorough washing of the penis after sex protected men from catching STIs. This was repeated on a number of occasions by men in the study.

Another of the myths is that you can judge by the appearance of your partner whether they are HIV positive or not. This was less prevalent in the southern region of Mozambique than on the northern Nacala Corridor.[16]

"People do not use condoms because they judge people by their appearance. They see someone who is well built, with a good appearance and they think they are healthy."(Lorry driver, Matsapha)

6.4 Changing behaviour

6.4.1 Safe sex practices

A number of respondents showed some optimism about the potential for changing sexual behaviour in the younger generation:

"Safe sex is a paradox for the older generation who started to have sex without condoms. They felt the real pleasure of having sex without condoms, and it is inconceivable that they will use condoms. But you can't say the same thing about this generation, "Generation Biz",[17] they need to be made aware about using condoms. Now people use the condoms that are distributed and buy them from the outlets, practicing safe sex, but you must also reduce the number of partners."(Respondent, Boane)

16 A similar study was undertaken by the team of researchers on the Nacala corridor, funded by IOM.

17 Geração Biz is an NGO that works with young people on sexual and reproductive health services, including treatment, care and counselling.

"Adolescents and young people just starting out (having sex) – before they have sex, they should be taught better about protection. That way they will start their sex life knowing that it is normal to have sex with protection. It will be easy to get used to it."(Respondent, Namaacha)

This optimism was, however, not confirmed in terms of the reported sexual behaviour among the younger generation interviewed during the research. A number of older male respondents in both Swaziland and Mozambique saw themselves as "victims" of young girls, and blamed the children who were involved in sexual relationships with older men, rather than viewing the situation as one of sexual abuse of minors:

"Look at these girls: they are the same age as my daughters and they are in relationships with men of my age. It is not possible to have safe sex in this situation. This young girl that is having sex with that old man – it is not for love but because she wants something from him. It is these girls that give our sons diseases. They (the sons) think that the girls are their girlfriends when in fact they are players. Do you think that if one of these old men says to the girl that they cannot use condoms that she will refuse? No. Of course not – she will not say 'No'. It is more important to her that she is able to spoil herself (by buying things) than the risk of getting sick."(40-year-old lorry driver, Swaziland)

The young people themselves indicated that contracting STIs, including HIV, was not something that concerned them. One young driver assistant (22 years old) in Matsapha wanted to tell his story, which illustrates in an extreme way how some young men are more interested in imposing their will on their partners than reducing risk.

He explained that he has five girlfriends and stated that he "controls" all of them, in that he does not allow them to have any other relationships.[18] He does not use condoms with any of his girlfriends. In the last year he has had a STI four times. Each time he goes to the clinic to treat the infection, and uses condoms for a week during treatment. He was not willing to discuss changing his sexual behaviour even after the numerous STIs. He intimated to the researcher that using condoms would be an admission that he was not able to "control" his girlfriends, that is if he used condoms with them this would be an admission that his girlfriends had other lovers.

The young women interviewed during the research were generally involved in transactional sex[19] and were practicing high-risk sexual behaviour, including unprotected sex, anal sex, group sex (a number of men with one woman). As these young women were sought after by older men, their powers of negotiation (particularly if they were offered large amounts of money) were unequal to the fear of having unprotected sex, and the majority agreed to the non-use of condoms.

Some of the older community members in Matsapha also described the link between unsafe sex, alcohol and drugs, and the rapidly burgeoning informal infrastructures and wealth inequalities in the Matsapha area, as being conducive to the accelerated spread of HIV. In the opinion of this group, the use of alcohol led to violent confrontations between men and women who were drinking together, and led to a higher probability of unprotected sex.

18 He freely admitted to using both threats and material bribes to keep his girlfriends.

19 This was due to the nature of the research and not indicative of all the young women living in the districts. As the work was carried out in the hotspots, the young women interviewed were bar staff, clients in the bars, sex workers, textile workers and traders.

A number of the respondents said that the key to increasing safe sex practices was to empower the young girls to insist on condom use. However, the same respondents were not optimistic about this happening and unclear how this could be done, given that the girls were involved in the sex trade to earn money, and the money was better when they accepted risky sexual acts.

Other respondents referred to both social and economic empowerment of women that would help them to take better decisions in terms of safe sex practices. One person (female) stated that the strongest motive would be "economic freedom" for women that would allow them to control their own lives.

It was interesting to note that on a number of different occasions (on both sides of the border) the following sentiment was reiterated: "It is not only illiterate people who do not negotiate safe sex. Often people with more education are more complicated – the majority of people who are HIV positive know how to read" (Kindlimuka, Mozambique).

People also stated on a number of occasions that it was time for the messages about HIV and AIDS to be more positive and not as "aggressive" – giving people hope rather than saying that HIV would kill people. "If you continue to say that AIDS kills then people will not do the tests" (Male respondent, Swaziland).

An NGO worker in Swaziland said that it is important to convey that there is treatment for HIV, to transmit a message of hope, so that people who have HIV do not feel that it is the end of the world. He further stated that this was the way attitudes had changed to diabetes and cancer.

6.4.2 Non-penetrative sex

Non-penetrative sex was also discussed. However, once again this was rejected by the majority of the interviewees as impractical. The following response was typical of the general sentiment from men interviewed: "There is no such thing as safe sex and there are no ways we can get people to practice non-penetrative sex because of our nature. We are Africans, and for us, sexual relations mean penetration" (Male respondent, Matsapha).

Another respondent exclaimed: "Imagine if a man has a lot of women and he practices penetration with some and not with the others! That is impossible! You can only prove that you are man if there is penetration" (Male respondent, Namaacha).

There are also misconceptions about safe sex. For example, some men felt that oral sex was safe sex in terms of transmission of HIV, and were unaware of the risks involved in oral sex.

Some of the women interviewed said that they felt "cheated" if the man did not ejaculate in their vaginas. These comments were usually made by women when referring to relationships with their partners. They felt that this was part of the pleasurable experience of sex. Sex workers or women involved in transactional sex did not generally refer to this as being important.

In Swaziland, one of the older community members interviewed in Matsapha spoke about the practice of "thigh sex". This is something that youth do in pre-sexual relationships. However, this was not seen as a potential substitute for penetrative sex for adults, and would be unacceptable behaviour for adults.

6.4.3 *Abstinence*

People recognized that abstinence was the only real safe situation in terms of non transmission of STIs. However, this was not seen as an option by 99 per cent of the respondents. Only one of the 120 interviewees stated that she was abstaining from sex completely. She was an HIV-positive woman who had become extremely religious after nearly dying from AIDS-related symptoms. She was a trader in Swaziland, had children and felt she wanted to live without a partner in order to remain healthy for her children. No other interviewees stated that they were interested in abstinence as the ultimate risk reduction.

6.4.3 *Faithfulness*

Two of the 120 interviewees stated that they were faithful to their partners. One of the interviewees had changed his behaviour due to knowledge of the impact of HIV on people's lives.

"Women are a headache. I already have trouble with one – imagine if I had more! Today it is expensive to keep your wife and children, and then there is the problem of HIV and AIDS that people are constantly exposed to. It is better to stick to one woman." (Male respondent, Boane)

The other interviewee stated that he was faithful to his three wives and that each of them was under his control and did not have relationships outside of the polygamous circle. It was not possible to verify if this was true as his wives lived in another province.[20]

As stated previously, the majority of women who were interviewed for this piece of research were involved in the sex trade and frequenting bars and restaurants in the hotspots. They do not represent a cross-section of women living in the areas. For these women faithfulness, or even long-term partnerships, is not currently part of their lexicon.

6.5 Profile of women receiving payment for sex

In Swaziland sex work is known as DEAL or PG (People of Gobondela). In Mozambique there was no specific name for this type of work.

The ages of the women interviewed ranged from 18 to 35. Although there were clearly many underage girls working in the same areas, we did not knowingly approach them for interviews as they were legally children. When asked about the ages of women involved in sex work, the majority of respondents (male and female) said that girls started at around 15 years of age, while the older women were near to 35.

All those interviewed who were involved in sex work were women, with the exception of one young man who provided sexual services to an older women market trader on a regular basis (in Mozambique). None of the women admitted to having same-sex sexual encounters, and further stated that they were not aware of same-sex sexual relationships in the hotspots.

In Matsapha women self-identified as sex workers, while in the other areas women did not identify as sex workers but were engaged in transactional sex, usually receiving money in payment for sex.

20 Given the researchers' experience of sexual behaviour in general, it is highly unlikely that either the male partner or the three wives are completely faithful within the relationship.

In Matsapha a number of female textile workers were interviewed (as rural-to-urban migrant workers). In some cases it was clear from the interview that the women were involved in transactional sex in order to pay all of their bills, send money home to their children in the rural areas and maintain their accommodation.

6.5.1 *Rates of pay: Swaziland*

A reasonable living can be made from sex in relation to other types of jobs in the area. Traders of food or fruit make between ZAR1,200 and ZAR2,000 (US$170–280) per month, textile workers between R880 and R1,200 ($120–170), while sex workers charge a minimum of R70 ($10) for a "short one", and usually make a minimum of R2,000 ($280) a month. They normally earn more than this as they are paid more if the client wants to stay longer, if they want oral sex, or anal sex. They can typically earn between R2,500 and R4,000 ($360–570) a month. The men will pay considerably more for group sex. In addition, if any of these acts are carried out without condoms the price can be ten times as much.

"We charge SZL70 ($10) for a round. We use a condom. If there is no condom we do not engage in sex. Some of the girls would risk and not use a condom if the client puts a lot of money on the table, e.g. E700 ($100) or E1,000 ($140). But one needs to know that whosoever give E1,000 and do not want to use a condom …you need to ask yourself 'What is this E1,000 coming with?' Obviously, it is coming with death." (Sex worker, Matsapha)

One of the sex workers claimed: "In a bad month I make about E1,700 ($240), but for my needs and obligations I need about E2,500 ($360 a month)."

Another sex worker in Matsapha provided the following information:

"A 'short-time' in a busy day costs R100 ($14); on a quiet day it costs R70 ($10). I prefer to be paid in money. I don't have time to go out and eat with clients. When I want to eat I buy it myself. Each month I earn about R2,500. Just in the last week I have made R1,000."

The women working out of the "yards" in Matsapha are usually charged R70(US$10) a day for the rooms which they rent although they may share the rooms with one or more women.

Another sex worker in Swaziland said that the prices varied according to the amount the men could pay. She said that generally a "short-time" was R70 for black men and R150 for white men. She also said that she used to work in South Africa and there she would charge R350 for half an hour. In South Africa she would wait in a room and contact the men through the Internet. She said she was earning between R1,500 and R2,000 a week.

6.5.2 *Rates of pay: Mozambique*

The rates for sex are more difficult to ascertain in the hotspots in Mozambique, as the nature of the transaction will often decide the price. One of the key informants in Boane said: "Ilha is a place where we have fun in Boane. There are lots of bars and lots of things happen there. Many of the young girls will sell their bodies for a glass of beer; in one of the bars you will see the girls having sex for a skewer of chicken or meat".

One of the community workers from AMODEFA[21] in Namaacha said that she had seen a young girl going into the cab of a lorry driver, so she waited for her to come out of the cab.

21 AMODEFA is the Mozambican Association for Reproductive Health and has a branch in Namaacha.

After an hour the girl appeared. When the community worker spoke to her, the girl said she had unprotected sex in exchange for a 1kg bag of sugar given to her by the driver.

One of the women explained how she makes ends meet each month (through transactional sex):

"My married boyfriend usually gives me between 1,000Mt and 1,500 Mt each month ($40–60) and he buys me clothes. My other friends (men) buy me beer and food, and sometimes give me 100 or 200Mt ($4–8). If I add all this up it comes to about 3,000 Mt a month ($120 a month)."

The rates for sexual acts range widely –from a low 50 Mt ($2) to variable rates between 150 Mt ($6), 300 Mt ($18) to 500 Mt ($20). Generally rates are lower in Mozambique than in Swaziland (declared sex workers).

6.5.3 Organizations of people working in the sex trade

The women working in the sex trade who were interviewed in the hotspots in Mozambique did not have any formal organizations. They worked from bars and roadside restaurants, or in clubs in the small district towns. Each woman was responsible for her own earnings and there were no intermediaries. The women did not live together and sex took place either in the cabs of trucks, in small rooms at the back of bars, in the bush, or occasionally men pay for a hotel room. Generally the women did not self-identify as sex workers, but as having different partners who help with their expenses (by giving them money), and buy drinks and meals for them.

In Swaziland in Matsapha there were a number of self-identifying sex workers who worked either on the streets, in the bars or from their "yards" – where a number of women live together in rented rooms.[22] In one of the yards visited during the research there was a considerable level of organization, with a spokeswomen for the group – she was also a peer educator trained by PSI/FLAS. However, she was keen to point out that she did not manage the other women or their earnings. She saw herself as a resource for the women for the "vouchers for treatment" programme[23] and for any advice she could give them. She is an active sex worker herself. During one of the interviews with women in the yards, an older sex worker (35 years old) made a statement which demonstrated the level of organization in the yard, where decisions have to be made in consensus on issues pertaining to the "group".[24]

"Last week we had a 15-year-old girl who was trying to join us. As much as the other girls were willing to welcome her to stay with us, I refused because she was too young. She did not know what was involved and I told my colleagues that we have children also and we would not like them to join this business. The others then agreed with me. I did not understand what need she had at her age that she could want to be a sex worker. Hence, I asked for her mother's phone number. I called her and I told her that I found her daughter and I was bringing her home. I took the girl home."(Sex worker, Matsapha)

22 It should be noted that the "yards" are not exclusively used by sex workers, and there may be rooms let in the compound to other people not in the same trade.

23 This programme will be described in the section concerning availability of health services.

24 This is not a formal association, but a loose grouping of women who live together and generally look out for one another.

She went on to say: “As much as we do what we are doing, we are still human beings and we care. I did not want to see that girl getting abused by men. She had only had sex once. So she did not even know what is involved in making sex.”

6.5.4 *Transactional sex*

In all of the hotspots there was a significant amount of transactional sex taking place.

One of the NGO workers in Swaziland gave this advice about speaking to women involved in transactional sex: “When you look at sex workers do not just focus on those who you find in “that place” (referring to one of the yards where rooms are rented). Even university girls go to the highway once they have finished their allowances to sell sex for their survival. You also have other women who get favours in Matsapha in exchange of sex, including those women who are failing to find work or not getting enough to make ends meet.“

The researchers spoke to female traders on both sides of the border, textile workers in Swaziland and women in the bars and roadside restaurants in the hotspots. Many of the women involved in transactional sex have other sources of income; these are often precarious or do not provide enough money to survive. All of the women interviewed (ranging from 18 to 40 years old) had children. In the majority of cases the women were solely responsible for the children, although they often lived with their mothers or grandmothers. This was common on both sides of the border, although in some cases in Mozambique the children still lived with their mothers.

6.5.5 *Tax relief*

For the informal traders (*mukheristas*) crossing the Mozambique–Swaziland border, many of them see transactional sex as part of the “costs” of doing business. They tend to trade sex for non-payment of customs duties or the rapid processing of their transit through the border. It should be noted that with more and more goods becoming legally tariff free between the two countries, the women are feeling less pressure to have sexual relations with border officials. One of the *mukheristas* said that many of the traders have “special” relationships with one or two customs officers or border officials. This protects them from having to have sex with different officials (as she is seen as having a relationship with the officials’ colleagues). If she is involved with one of the customs officers she does not have to pay the informal taxes, and the customs officer may even pay some of her expenses.

6.5.6 *High-risk traders*

One of the trading activities that is carried out between Mozambique and South Africa, but using the Mozambique–Swaziland border at Namaacha, is smuggling cigarettes. There are high profits for this business but also high levels of risk. The women cross the border illegally and sell cigarettes in Mbuzini (South Africa). They stated that they could come home with R1,000–R2,000 profit from one trip. When they are in Mbuzini they often engage in transactional sex to increase their earnings. However, the risks are high and many of the women are caught by the South African police and have their goods confiscated. The women also reported sexual abuse by the border guards and police. One of the female cigarette traders said she had been raped, and had gone to the health clinics in Mozambique to be checked out for STIs as her rapist had not used a condom. They generally do not report the incidents to the police on either side of the border as they are aware that they are carrying on an illegal trade and worry that they will be arrested.

6.5.7 *Age of people involved in the sex trade*

As mentioned previously, the interviews in the hotspots highlighted the fact that many of the sex workers were underage (as young as 15 years old). The researchers did not

knowingly interview underage girls as this was not part of the protocol. All information about underage sex workers was obtained by the clients who had sex with them or older sex workers.

Reported information showed that young girls (either in or out of school) were heavily involved in transactional sex, particularly over weekends, and their presence in the bars, clubs and roadside restaurants was witnessed by the researchers. Clients reported preferring young girls as they were attractive and willing to engage in experimental sexual practices. Clients stated that if they did not want to use condoms they generally picked a younger girl as she was more likely to accept the non-use of condoms. There was some evidence that the girls had less information about the importance of condom use (as well as less ability to negotiate safe sex).

One client in Goba (Mozambique) stated that he had a met a girl at the bar on the border, that she came from the village close to the border. He did not think she was 18 years old. When he produced a condom she asked him why he wanted to use a condom and said she did not want to use them. He said he decided not to have sex with her.

6.5.8 *Textile workers*

A series of interviews were carried out with female textile workers in the Matsapha area. None of those interviewed identified as sex workers or spoke openly, in the first person, about transactional sex. They did talk about fellow workers and their sexual behaviour.

The following tables show the earnings of women in the industry and their expenses. The tables clearly show that it is difficult for women to meet all of their monthly expenses.

Table 9. Expenses and earnings of a female textile worker (1) in Matsapha

EXPENSES	RANDS
Gas	100
Rent	220
10 kg rice	60
10 kg maize	48
750 ml oil	10
1 kg sugar	7
Laundry soap	10
Soap	7
Colgate (toothpaste)	10
Potatoes	10
Vegetables	20
Rotational savings (informal)	200
Money sent to mother who looks after her children	300
Total expenses	1,002
Debt	1,500
Total earnings	**1,000**

Earnings for this woman are generally weekly (R250). This may reduce or increase depending on the number of hours she works.

The woman explained that when she was not able to make ends meet, she asked the landlady to wait for the rent or she borrowed money from money lenders (at an interest rate of 10% a week). She also said that when she did not have enough money to eat she would eat at her boyfriend's house. She stated that she would like to have an additional boyfriend as it would help with the expenses. She is looking for a mature man, with money, she said: "I am still looking because all of the men around here are as poor as I am!"

Table 10 shows a similar picture. For this textile worker wages are barely enough to cover her expenses in Matsapha and send money home to care for her children.

Table 10. Expenses and earnings of a textile worker (2) in Matsapha

EXPENSES	RANDS
5 kg rice	30
5 kg maize	15
2 kg sugar	15
750 oil	10
5 kg beans	45
2 kg chicken pieces	35
10 kg potatoes	30
Onions	20
Eggs	20
1 kg soup	15
Coffee	7
Gas	36
Vegetables	10
500 ml milk	4
Juice	7
Fruit	120
Rent	140
Money sent to grandmother to look after her children	250
TOTAL	**809**

Table 10 illustrates the textile worker's expenses. She earns between R1,500 and R1,800 a month depending on the extra hours she does at the factory. She does not have any savings. She has a number of boyfriends in Matsapha who buy clothes for her and she sometimes stays overnight with one of them (the others are married) who buys food for her.

Work in the textile factories is casual and women are rarely contracted for more than three months at a time. They work a minimum of eight hours a day for six days a week. When the contract finishes, many of the women stay in the area, going to the factory gate in the morning, trying to get hired again by the factory. In the meantime they have to pay rent and feed themselves, as well as sending money home for their children. This level of vulnerability, coupled with the opportunities for transactional sex in Matsapha, creates ideal conditions for women to move into sex work – even if only on a part-time or temporary basis.

6.5.9 Reasons for transactional sex

The reasons for transactional sex are not merely economic, but are complex, including:

- Pleasure (sex without the burden of a steady relationship);
- Pleasure and companionship (many of the women are single mothers who have reduced expectations in terms of having exclusive marital relationships);
- Protection (in the case of informal traders, their lovers protect them from other colleagues and provide services to expedite their goods);
- Belief that one of the relationships will lead to marriage or a stable relationship;
- Alcohol abuse.

6.5.10 Abuse and physical violence

There was much more reported violence in Matsapha than in the other areas. The information came directly from the sex workers, who report rape, abuse and non-payment. Some of the men interviewed admitted using violence to control their girlfriends. Once again this admission was more common on the Swaziland side of the border than the Mozambican side.

Incidents were not generally reported to the police in Swaziland (or the community police) as sex work is illegal and sex workers feel they do not have any rights to protection under the law.

Less violence was reported in Mozambique. This may be due to the lower concentration of people in the Mozambican hotspots as compared to Matsapha, for example. Matsapha is a densely populated area close to one of the two main towns in Swaziland. There was some suggestion during the research that some areas of the settled parts of Matsapha are controlled by gangs. In Boane (Mozambique) some the clients and bar workers said that things could get violent in the area as people began to get drunk. This was not specifically between sex workers and clients, but between any of the people who had been drinking.

6.5.11 Clients

In the current study all the clients interviewed were men. The men were generally employed or had an income and were in the age bracket 22 to 55 years old. Younger (unemployed) men do not generally have the money to engage in transactional sex or have sex with sex workers. In Mozambique most of the clients were Mozambican and came from Maputo. In Swaziland the clients were Mozambican, Mswazi or South African (white and black). The women stated that men came in cars, were mini-bus or truck drivers, and that they had money and the overwhelming majority were married.

Interviews were carried out with men from the mobile population, and not all the categories of clients that frequented the hotspots. A number of women stated that their clients were men from Manzini or Maputo who had good jobs and nice cars. Unless these men were mini-bus drivers, truck drivers or their assistants, migrant workers, or public service workers, they were not identified for interview.

The following brief descriptions characterize key groups of clients among the mobile population identified in the hotspots.

Public-sector workers (Mozambican border posts)

Border guards on the Mozambican border have 15-day shifts. The other migration and customs workers have only three-day shifts (three days at the post and three days at home). According to one of the interviewees, it is more likely that the border guards will have other sexual partners due to the length of time they spend away from home. Respondents on the border posts (Mozambican side of the border), stated that sex between colleagues was frequent. Information from both Goba and Namaacha stated that the border guards were most likely to maintain sexual relations with women from the resident community. However, this was not exclusively their domain, as customs officers also admitted to having sex with the informal traders or women they met in the bars and roadside restaurants. The researchers were unable to obtain information from border officials in Lomahasha about their sexual activities while on post. They refused to answer questions about their own behaviour and limited their observations to the behaviour of the female traders and the women who frequented the bars and roadside restaurants. The women interviewed in Namaacha, Goba and Lomahasha said that all of the border officials had sexual relations with women in bars and roadside restaurants.

Truck drivers and assistants

Namaacha, Lomahasha and Goba are no longer stopover places for truck drivers. A few drivers will stop to eat chicken on the Namaacha border but they do not generally overnight there. The drivers either park their trucks in Simunya (approximately 30 km from the Lomahasha border on the Swaziland side) or drive through to Matsapha or the South African border.

Truck drivers who were interviewed in the hotspots (including Boane and Matsapha) said that they had relationships with women when they were travelling. Either they brought their girlfriends with them in the truck or they had regular girlfriends along the road in their stopover spots. In Matsapha truck drivers would stay for an evening or sometimes longer depending on the cargo they were carrying.

A number of the truck drivers said that their companies had good HIV and AIDS policies; condoms were distributed to them and they were given pamphlets about safe sex and treatment for STIs, including HIV. As mentioned previously in the section concerning condom use, the majority of the truck drivers said that they did use condoms in some of their relationships. However, this did not include relationships with girlfriends (even if they were not exclusive) or their wives.

Other clients

Other people interviewed included mini-bus drivers and men who traded (informally) in foreign exchange (*cambistas*). Mini-bus drivers ply their trade to the borders and generally do not stay overnight in the hotspots. They do, however, stay for long periods of time on the border waiting for clients. Many of the mini-bus drivers and their assistants engage in transactional sex with the informal traders (*mukheristas*): sex in exchange for reduced

tariffs for transporting their goods. They also frequent the bars and may have sex with women who are drinking in the bars. The *cambistas* also work on or near the borders and are there for long periods of time. A number of them admitted to becoming involved with woman in the bars close to the border.

6.6 HIV and AIDS health-service provision and health-seeking behaviour

In each of the hotspots mapping was undertaken of the available health facilities. See Annex 2 (Map 2.5) for an overview of health facilities and schools along the southern transport corridor

The situation between Mozambique and Swaziland is different in terms of the type of health services that are offered in and around the hotspots. The hotspots in each of the countries will be described separately.

6.6.1 Mozambique

Health services in the hotspots in Mozambique are provided through the government-run clinics. There are no private clinics offering services in these areas. Government clinics offer the full range of services linked to STIs and HIV. Testing for HIV is now offered in all clinics and not confined to a specific, specialized service. The government-run clinics offer a free service for all antenatal and post-natal consultations; well-child clinics; STI treatment and HIV testing, counselling, treatment and care. Other outpatient clinics have a symbolic cost.

In Namaacha, the sexual and reproductive health NGO, AMODEFA, provides family-planning services, counselling and outreach services, in coordination with government health clinics in the town. AMODEFA works in the community on testing and treatment of STIs through information campaigns and referrals to the health facilities. Young volunteers work with the health centre to carry out theatre presentations and “shows” to encourage people to come to the clinics.

In Boane, the Maputo-based association of people living with HIV and AIDS – Kindlimuka – works in close coordination with the health facilities to follow up on patients who are on antiretroviral treatment to ensure adherence and minimum home-based care.

In both of the areas, PSI works with the NGOs to provide condoms, training and support.

Pharmacies are used by people to treat common ailments such as malaria, headaches, fever and upper-respiratory tract infections. Generally people stated that they used the government health clinics for treatment of STIs.

Although these services are available, the quality of service varies and there were many complaints about the professional ethics of the health staff (not keeping information confidential about HIV status, for example), long waiting times before being attended, and the cost of medicines (excluding antiretroviral drugs and other drugs used in AIDS-related illnesses that are free). The clinics in Namaacha and Boane said that they had not had any problems with drug shortages for people on antiretroviral treatment in the last six months. Staff stated that women were much more likely to use the health services than men, and that many of the HIV-positive cases were detected through the antenatal services, where HIV testing is offered to women (and their partners). However, they said that it was very rare that partners would follow up and come for testing. Most of the patients treated in the clinics for STIs were also women.

The Goba border post is very under-developed and there is no town on the border (on either side). The nearest health facilities on the Mozambican side of the border are in the small town of Goba[25]. The health facility is small and does not provide all services. Women generally go to Boane to have their babies as there is no maternity facility in Goba. The border staff stated that it would be useful to have a clinic with basic curative and preventive services (with longer working hours)on the border, particularly during the weekend (from Friday to Sunday) when there was more traffic coming through the border. People felt that if there was a clinic that offered testing and STI treatment (not exclusively) that some of the truck drivers and the women working in the sex trade may avail themselves of the services. Although the truck drivers do not overnight in the area they do have to process their papers and sometimes take time to eat something. This would be an ideal time to encourage use of the health facilities.

Please see Annex 2 (Map 2.5), (Map 2.6), and (Map 2.7) to view schools and health facilities in Boane, Matola and Namaacha districts.

With the exception of Goba, there are no problems with physical access to basic healthcare in the hotspots. The main issues are around use of the health services and the quality of the services offered. As mentioned above, in addition to government-run health services there are a small number of NGOs that work in coordination with the health services, namely Kindlimuka and PSI in Boane, and PSI and AMODEFA in Namaacha. Geração Biz, working with youth groups, is also active in both areas. The reach of the NGOs is extremely limited due to the insubstantial, patchy and short-term nature of the funding they receive.

6.6.2 Swaziland[26]

Swaziland has more a complex health system with a number of service providers. There are government clinics where treatment is largely subsidized, and preventive healthcare is free. HIV testing and antiretroviral treatment services are free in all of the health facilities.

The main service providers in the area of Matsapha are the government clinics and hospitals (in Manzini), the mission hospitals and health facilities (Nazarene) and the NGO clinics. Payment is required at both the mission-led clinics and the NGO clinics for general medical services.

A significant proportion of the people interviewed, both men and women, said that they had been treated for STIs in the last twelve months. The majority of these people had chosen to be treated in private clinics. The reasons given were:

- Higher levels of confidentiality. People did not trust the government health staff not to divulge their HIV status or discuss the STI for which they were being treated.
- Less time spent waiting in queues. One of the most common complaints about the government clinics was the length of time spent in the clinics waiting to be seen by a doctor or a nurse.
- More respect was afforded to the person. People explained that in the government clinics the nurses, when they were organizing the people before being seen by the

25 The frontier post of Goba was added to the research in the course of the field work and after the mapping component had been completed. Therefore there are no maps for the Goba area.

26 No health facilities were found within a 5 kilometre radius of the main road in Lomahasha, which is why there is no map available of health facilities in this area. The area of study of the Swaziland part of the corridor went up until Manzini, which is why there is no map of health facilities and schools in Mbabane district.

doctor, would shout out, “People with HIV in this queue, people with an STI in this queue, people with malaria in this queue”, etc. This was felt to be humiliating.

- High levels of confidence in the treatment. A very common comment was that the private clinics provided effective treatment for STIs (injections), and even though you had to pay you could trust the treatment. Interestingly there were similar comments about the free condoms that were distributed. These were felt to be of a lower quality than the ones you could buy.

Once again in the Swaziland case there were no problems with physical access to the health facilities, and all of the health facilities offered a wide range of services. The problem was with people, particularly men, not using health services.

There were a number of innovative healthcare solutions in Swaziland that are working to reduce the burden of HIV and AIDS and guarantee a humane, caring environment for treatment and care. FLAS is an NGO that works mainly with female clients on all health issues, including sexual and reproductive health. They run clinics and also have outreach services. One of the innovative schemes that is currently talked about by many of the people interviewed in the hotspot of Matsapha, is the “coupon scheme” that is run by PSI in collaboration with FLAS. PSI identifies women who may be at risk of STIs, HIV or would like sexual and reproductive health advice. They are referred to FLAS, and use coupons that are distributed by the peer educators. One of the peer educators (a sex worker) explained the scheme:

“PSI trained me to discuss HIV and other STIs with fellow sex workers. I give talks and advise them. Sometimes I don’t have all of the information so I can contact PSI or FLAS and they help. I give the girls coupons so they can go to be tested and treated for STIs. Many of them have to go on AIDS treatment. I encourage them to keep going even when it is difficult.”(Sex worker and peer educator, Matsapha)

PSI also stated that the coupon system is working, and is not only confined to FLAS. A staff member at PSI commented:

“We do know that the coupon programme is working as sex workers are able to access reproductive health services and get HIV testing. They do not only go to FLAS but to other facilities, including New Start and Litsemba Letfu where circumcision is carried out on males.” (PSI staff member, Swaziland)

The women in the Matsapha area are extremely pleased with the services offered by FLAS. They find it a caring and compassionate service. Some of the women go there after having suffered rape or physical abuse; they go for treatment for STIs and the morning-after pill if a client has refused to use a condom.

In addition to the above-mentioned health services, Medicine Sans Frontiers (MSF) have opened a clinic at the Matsapha industrial site. The facility has been operating for not more than four months. Matsapha MSF clinic provides a wide range of outpatient clinical services. These include antenatal care, family planning, HIV testing and counselling, treatment of

ailments, a laboratory, tuberculosis (TB) treatment, antiretroviral treatment and social-work services. They have plans to start operating a community service that would address issues of sexual violence, TB and HIV. The clinic director said that at present the majority of the clients are women (but these are still early stages). The staff members have also noticed that people often come from outside the area as they do not want to go to clinics close to home, due to stigma and the lack of confidentiality.

A discussion with the STI coordinator for the Swaziland National AIDS Programme in the Matsapha area detailed the programme of peer education with the sex workers, bus conductors, and taxi, kombi and bus drivers in the area. The current focus is to have peer educators among these groups that propagate the use of condoms, promote circumcision, promote health-seeking behaviour particularly to treat STIs at the early stage and encouraging people to know their HIV status. The funding for this initiative will run out in six months' time. The coordinator stated that: "The dream of the Transport Association was to have a pilot clinic service at the Manzini Bus rank" (STI coordinator, NERCHA, Manzini). The STI coordinator felt that there was a lot of focus on sex workers and never on the demand side. "I believe that there will be no sex work if there was no demand" (ibid.).

"Yes there is some impact – as much as I can't say how much.[27] But look, almost all of our sex workers do know their HIV status; there is a general use of condoms; they call PSI when these are finished. Their health-seeking behaviour primarily for treating STIs is improving, as reflected by the coupons that come back to FLAS." (STI coordinator for the Swaziland National AIDS Programme)

In addition to the peer education programme the STI coordinator believes that there should be concentrated work carried out at the household level to discuss family relations, and reduce the possibility of multiple concurrent sexual relationships.

In order to reduce the stigma attached to going to clinics for STI treatment and testing, NERCHA is starting to consult and meet with local pharmacies, as they come into contact with many people, particularly those who do not come to the health facilities. They have established formal collaboration and will introduce a treatment protocol.

The STI coordinator felt that it was important that the data from the pharmacies be captured in order to help understand how many and which STIs were treated through this type of outlet.

Another of the services offered in Swaziland is called "Hospice at Home". It was originally set up to provide palliative care services to its clients. However, due to government policy, and the overwhelming need for HIV and AIDS services, they are now providing other treatments and prevention. These services include VCT (pre- and post-counselling), collecting CD4-count specimens, outpatient terminal care, STI treatment, and education of clients and their families.

Please see annex 2 (Maps 2.9 and 2.10) to view schools and health facilities in Manzini district, and Matsapha village.

27 There has been no formal evaluation of the effectiveness of the peer education programme.

6.6.3 Note on prevention messaging

Many people who took part in the study – health professionals, NGO staff members, sex workers and clients, had strong opinions about "messaging" on HIV and AIDS. There follows a summary of the opinions:

- Messages and information should give hope to people that they can live a full life even if they are HIV positive.
- Clear and detailed information should be provided to different groups of people. A one-message-fits-all solution is no longer viable.
- The best sort of information comes from someone who can talk knowledgeably, or someone who can help people to access the right information.
- Peer education is a good route if there is support for the peer educator.

07 CONCLUSION AND RECOMMENDATIONS

7.1 Key issues arising from the research

1. Multiple and concurrent sexual relationships are the norm in hotspots: As with previous studies, this research shows clearly that for the sub-set of the population that live, work and interact in the geographic areas denominated "hotspots", multiple concurrent sexual relationships are the norm. The majority of these relationship networks are unsafe in terms of HIV transmission.

2. Condom use is not rational, and is dictated by a complex set of trust factors. People consistently report that their decision to use a condom is linked to whether a partner is considered trusted or casual. More consistent condom use is displayed with casual partners than with those who are considered trusted. However, trust is not based on exclusivity in a relationship.

3. Women choose to enter into the sex trade for various reasons: The local job market is one of these but there are others. Hotspots are a magnet for people, who often do not find permanent jobs but are reluctant to leave the possibility of work to return to rural areas. In Swaziland this is especially the case in Matsapha where women are attracted to work in the factories, and in Boane where many women no longer practice agriculture and are drawn to the possibilities of trading in the small towns. Many refer to economic stress as a driving force for entering into the sex trade, though this research has shown that this is not the only motivator. Pleasure, excitement and a dream of finding a well-off partner are all driving factors. There are no shortages of clients in the hotspots. Many of the relationships established in the hotspots are characterized by unequal power relations, with both age and gender at play. Many of the women in the sex trade are young (reportedly as young as 15 years old) and the men are mainly older. Multiple concurrent sexual relationships are the norm, and the wide network of unsafe sexual relationships sets up a shocking scenario for the spread of HIV.

4. Good knowledge of HIV does not necessarily lead to behaviour change: The battle to inform people about the dangers of HIV and AIDS has largely been won; we did not interview anyone who did not know about HIV or how to prevent it. However, the findings from the research also show that knowledge about HIV and how to stay healthy is not a sufficient motive for practicing safe sex, and other motivations result in the majority of people in the hotspots taking high-risk decisions regarding their sexual practices. Inconsistent condom use coupled with multiple concurrent sexual relationships will continue to fuel the HIV epidemic in the foreseeable future.

5. HIV remains a workplace issue: Both public-sector and private-sector employers have a responsibility to implement functional HIV and AIDS workplace policies that can provide workers with a strong foundation in terms of information and rights regarding HIV. Supporting workers to take decisions for lowering the risk of HIV infection should be a key concern of all employers since HIV impacts on productivity.

6. HIV-prevention and treatment programmes are complex, and there can be no one-size-fits-all response at the community level: As stated in the body of the report, this complex problem requires nuanced programming, the targeting of a variety of different people and accepting the various perspectives in order to bring about change. It is important to build on the momentum for testing and treating, and proactively pursue people involved in sexual relationships emanating from the hotspots to use and adhere to treatment programmes.

7. Health services – where available – need to be more client-friendly, migrant-sensitive and attractive to men if more people are to access them: Although there is healthcare provision close to the hotspots there are issues around the quality of the services in terms of confidentiality, care and the inability, due to lack of resources, to cater for the needs of the mobile populations. In Swaziland there are a number of innovative experiences that could be replicated and used to extend healthcare and provide services suited to the needs of these difficult-to-reach populations. The services provided by FLAS to the sex workers and women in the Matsapha area were highly appreciated and appear to provide a safe place for women to discuss their health issues and receive non-judgemental support. MSF have opened a clinic in the heart of a hotspot that aims to provide a comprehensive service for residents and visitors to the area. Both of these services are uniquely suited to address the local challenges related to accessibility and use of services. As yet there are no services that could cater specifically for the male mobile populations, and this continues to be a significant gap.

8. Lack of consistent and reliable civil-society funding is a barrier to HIV programming: There are a number of NGOs that specifically target people living and working in the hotspots. All of the NGOs are struggling with short-term funding cycles and in some cases an absolute lack of resources. Without significant long-term commitments to the local NGO sector it is difficult to see how consistent, predictable programming can take place. The NGOs are uniquely placed to contribute to proactive programming in the hotspots. There has been little attention from governments and cooperating partners to the essential role that NGOs play in liaising with the public services and the communities – providing a possible bridge between the real needs of the people and development of adequate services.

08 RECOMMENDATIONS

The locations through which the Maputo–Swazi corridor runs have amongst the highest HIV prevalence of anywhere in the world. All the evidence from this study points to the fact that the hotspots along the corridor are areas that require specific, urgent attention in terms of good HIV and AIDS programming: prevention, treatment and care. These must address both the symptoms of the problem and the underlying structural and environmental issues. For this reason we recommend:

8.1 National recommendations

8.1.1 Attain long-term HIV financing and investment in NGO services

1. The National AIDS councils in Mozambique (CNCS) and Swaziland (NERCHA) should design – with the donor community and the national governments – strategies for securing long-term predictable funding for key local NGOs, thereby allowing investment in human resources and continuity of services in areas of high risk of HIV transmission.

2. Both governments and cooperating partners engage the private sector in long-term investment funding for NGOs. Developing a ten-year investment plan would allow the NGOs not only to provide community-based services to the populations in the hotspots but carry out pre-emptive programming as new problems begin to emerge.

> ***The role of NGOs in health-service provision:***
>
> *NGOs on both sides of the border play an important role in community liaison and mobilization. In Swaziland they also play a key role in service provision. They are the only groups that have a permanent on-the-ground presence and can work comprehensively in the hotspots. The response to the crisis in the hotspots requires an organic approach to programming, including flexibility to respond and develop with the context. However, at present the breadth of their programming is severely limited due to resource constraints and the short-term nature of much of their funding. This goes against all good-practice guidelines in terms of both service provision and behaviour change potential, which recognizes that long-term predictable funding is the most effective form of support.*

8.1.2 Governments must address the vulnerabilities of mobile workers in the public-sector

Public-sector workers in Mozambique are highly mobile and often spend considerable amounts of time away from their homes and stable emotional ties. This creates a volatile situation in terms of sexual relationships, as seen in this research. It was noted that there has been a change in the shift patterns of customs officers, who now only spend three days away from home. This contrasts to the border guards who have 15-day shifts. Recommendations for these groups of public-sector workers are:

1. Carry out a **brief review of how the three-day shift rather than the 15-day shift has affected workers' behaviour (particularly sexual behaviour)** and based on the findings make recommendations for all public-sector workers who are posted away from their homes.

2. Compile a **review for the Ministry of the Public Sector, of workplace HIV and AIDS policies in the public service, including targeted prevention programmes**. The review should take into consideration the findings of this study and promote a frank discussion about: concurrent sexual relationships, inconsistent use of condoms, the illegality of having sexual relations with underage children (including child sex workers and girls involved in transactional sex). The review should have clear policy and programme recommendations to tackle these issues, including potential punitive action against public-service workers found to be in breach of the law and/or the code of professional conduct.

3. **Support to the Zero Tolerance Campaign launched by the Ministry of Education: Create mechanisms for non-state actors to provide support** to the Ministry of Education campaign "Zero Tolerance for Sexual Abuse of School Age Children" targeting resources to the schools on the Maputo corridor and the interior areas that draw children to the hotspots.

4. Discuss with UNICEF and Child Rights Organizations the possibilities of engaging with the legal profession (associations such as MULEIDE, the Association for Women in the Legal Profession and equivalent organizations in Swaziland) to **target and prosecute sex offenders** who engage in sexual acts with children in the hotspots on the transport corridor.

Private-sector engagement

Good workplace policies on HIV prevention, treatment and care have been seen to make a major difference in employees' health and well-being in some of the major industries in South Africa. There was some evidence in the research that investment in workplace policies had made a difference in a number of transport firms. These lessons should be shared and encouraged in all workplaces. For this particular study it is recommended that the Swaziland Business Coalition on HIV and AIDS targets the industries in the Matsapha area to ensure that they have good HIV and AIDS workplace policies in place and are functional (particular reference to the textile factories that employ a large number of female migrant workers).

8.2 Maputo-Swazi Corridor Recommendations

8.2.1 Government and partners should saturate the hotspots with intensified combination prevention at all hotspots

This report recommends taking a "Spaces of vulnerability" approach to prevention and care programmes in hotspots along the corridor. This includes using communications for change, evidence-based approaches, building partnerships, local active participation, and capacity-building of service providers ***in each hotspot*** to:

1. Create an enabling local environment

2. Address gender dynamics within the specific context of migration

3. Address contextual barriers to health

4. Facilitate access to health services and products

5. Promote peer-led health communication, information and education

6. Strengthen local implementing partners

8.2.2 Recommendations for health service providers

As the hotspots represent significant concentrations of the population and are often close to cities or towns, overall healthcare provision was found to be reasonable. However, there were major issues with the quality of care and use of the health services, particularly by men. In terms of specific services for HIV and AIDS, we recommend the following.

1. Provide migrant-sensitive health and outreach services targeted at the hotspots (following the example of the MSF clinic in Matsapha).

2. Patient confidentiality and professional codes of conduct:

    a) Reinforce training of health personnel on professional Codes of Conduct and ethics, regarding issues of confidentiality (with special reference to STIs and HIV status).

    b) Discuss the possibility of introducing a **"**Patient Charter**"** indicating key professional ethics in the health sector, linked to publicity campaigns to educate the public about the Charter.

    c) Ensure that there are adequate systems that manage confidentiality issues (for example, record keeping, private counselling space) in particular in the light of integrated consultations.

    d) Introduce the concept of "humane" care (take the example of FLAS where the women feel cared for when going for treatment) into all health facilities to encourage greater adherence to treatment regimes and early presentation of symptoms.

3. Male-oriented sensitization programmes on the use of available health services and health-seeking behaviour:

    a) Promote male health and health-seeking behaviour through an annual campaign week with the aim of: increasing the familiarity of men with the health facilities and the services offered; increasing early treatment of STIs; and delivering key IEC activities effectively to men in the workplace, at home and on the road.

4. Increase accessibility of health facilities for mobile populations:

    a) Extend working hours of health facilities in the hotspots, carry out a cost-effectiveness analysis and a budgeted plan for implementation in key health facilities.

a) Discuss the provision by pharmacies of limited diagnostic and treatment facilities, including STIs (this plan is already underway in Swaziland and should be followed carefully to gauge the success of the initiative).

b) Place healthcare facilities in the centre of the hotspots (following the MSF example in Matsapha) and extend services to include counselling and community-outreach services.

8.2.3 Local implementing partners should conduct robust youth programming:

1. Counselling of boys and girls in relationship negotiation and sexuality. For future healthy generations it is necessary to equip adolescents with as many tools as possible to be able both to understand the dangers of unsafe sex and the need to negotiate safe sex and mutually acceptable relationship patterns.

2. Build parent skills for keeping their children safe. Examine how to broach sexuality and how to reach negotiation skills[28] in schools through school counsellors and peer-education programmes.

3. Geração Biz-type initiatives should be implemented, through which social media and drop-in centres are used to discuss key sexual and reproductive-health issues.

4. Build community consensus with elders about the need for youth to pursue healthy sexual relationships. Confront cultural norms that perpetuate unsafe practices and gender inequality in sexual relationships. In Swaziland this is an extremely important point. Presently children in school are not exposed to discussions on sex, safe or otherwise, yet in the field we found girls as young as 14 years of age working in the sex trade in Matsapha. The debate on sexual education and counselling needs to be had at national level.

5. Governments must put a stop to the practice of older men having sex with underage girls. The practice of older men having sex with underage girls is unacceptable and the government must put a stop to this. In other societies these men are considered paedophiles and are prosecuted when caught. Campaigns should concentrate on the unacceptability of this practice and prosecutions should be undertaken.

28 Many of the women will not themselves have had the possibility to negotiate safe sex within their own relationships, so successful programming will have a multiplier effect.

09 REFERENCES

De Walque, D., Kazianga, H., Over, M. and Vaillant, J.

2010 *Food Crisis, Household Welfare and HIV/AIDS Treatment: Evidence from Mozambique*.

Human Rights Watch

2007 *"Keep your Head Down": Unprotected Migrants in South Africa*, Human Rights Watch, New York.

Selvester, K. et al.

2009 *Vulnerability to HIV and AIDS: Sex Workers and Clients: Border Crossings of Namaacha and Ressano Garcia*, UNFPA, Maputo.

UNGASS

2010 *Monitoring the Declaration of the Commitments on HIV and AIDS: Mozambique Country Report*, UNGASS.

UNICEF

2009 The State of the World's Children. United Nations Children's Fund. New York. USA. (available at http://www.unicef.org/sowc09/report/report.php).

US State Department

2009 *Trafficking in Persons Report*, June 2009, US State Department.

Whiteside, A., Andrade, C., Arrehag, L., Dlamini, S., Ginindza, T., Parikh, A.

2006 *The Socio-economic Impact of HIV/AIDS in Swaziland*

Whiteside, M.

2002 Neighbours in Development: Livelihood Interactions between Northern Mozambique and Southern Malawi, a report for DFID by Martin Whiteside, with case studies by Donata Saiti, Guilherme Chaliane and the Women's Border Area Development Programme.

World Bank

2007 Beating the Odds, World Bank.

10 BIBLIOGRAPHY

ADF

2005 *Project completion report, transport programme, Republic of Mozambique*, Transport Division (ONIN 3) Infrastructure Department – North, South and East regions. African Development Fund.

INE

2008b *Multiple Indicator Cluster Survey (MICS) 2008 – Summary*. Instituto Nacional de Estatistica, Maputo, with support from UNICEF (available at http://www.unicef.org/mozambique/MICS_Summary_English_201009.pdf).

INE.

2009b *Apresentaçao dos resultados definitivos do censo 2007*, Instituto Nacional de Estatistica, Maputo (available at http://www.ine.gov.mz/censo2007/censo2007).

IOM

2007 *Regional Guidelines on HIV and AIDS for the Commercial Agriculture, Construction, and Informal Cross Border Trade Sectors in the SADC Region*, Version 1, April, IOM Pretoria,

IOM

2009a *Mozambique – Facts and Figures (August 2009)*, International Organization for Migration, Geneva (available at http://www.newwebsite.iom.int/jahia/Jahia/activities/africa-and-middle-east/southern-africa/mozambique).

IOM

2009b *Transport sector report.* February 2009 IOM and Transport against HIV/AIDS: Synthesis of Experience and Best Practice Guidelines. TP-25TRANSPORT PAPERS 2009INE.

IOM

2007 Briefing Note on HIV and Labour Migration in Mozambique.

MMCAS

1999 *Relatório inicial sobre a implementação da Convenção sobre os direitos da Criança*.

National AIDS Council, Mozambique

2004 *National AIDS Strategic Plan to Fight HIV AND AIDS 2005–2009, Book I – Situation Analysis*, Maputo.

Sloth-Nielson, J. and Gallinetti

2004 Reforma Legal para a Protecção da Criança em Moçambique, Maputo.

UNICEF

2006 *A pobreza na infância em Moçambique, uma analise da situação e das tendências*, UNICEF, Maputo.

UNAIDS

2008 *Report on the Global AIDS Epidemic*. Joint United Nations Programme on HIV/AIDS.

(available at http://www.unaids.org/en/KnowledgeCentre/HIVData/GlobalReport/2008/2008).

UNDP

2009 *Human Development Report*, United Nations Development Programme, New York (available at http://hdr.undp.org/en/reports/global/hdr2009/chapters/).

UNESCO

2006 "Human trafficking in Mozambique: Root causes and recommendations", Policy Paper, *Poverty Series*, 14(1) (E) Paris.

UNHCR

2009 *Mozambique Sub-regional Operations Profile – Southern Africa*, UNHCR, Geneva (available at http://www.unhcr.org/cgi-bin/texis/vtx/page?page=49e485806).

UNICEF

2003 *Trafficking in Human Beings, Especially Women and Children, in Africa*, Innocenti Research Centre, Italy, UNICEF.

UN Mozambique

2009 *Annual Report*. United Nations, Mozambique.

US State Department

2007 *Report on Human Development.* US State Department.

11 ANNEX 1

11.1 Interview guides

11.1.1 Guide for social researchers

The separate interview guides were used as "key topic guides" and not as questionnaires. The researchers had extensive, in-depth conversations with all of the groups identified. It was recognized that it was not possible to obtain all the information from all of the interviewees.

Key pointers for the social researchers:

1. Use iterative questioning – build on knowledge obtained in previous interviews.
2. Use in-depth interviews – obtain as much detail as possible about the issues in the guides.
3. Use triangulation – confirm information through asking the same questions from a wide variety of people.
4. Be creative – do not necessarily limit your investigation to the topics in the interview guides.
5. Keep in mind potential recommendations for the report.

The research team spent a day discussing the guides and ways of obtaining information from the various groups. The researchers had experience of working with sex workers and clients.

The researchers provided written notes on each of the interviews and context (how the information was obtained – where, when) and any difficulties they found in talking to any of the groups.

11.1.2 Guide for sexual network exercise

Objective:
Understand concurrent sexual relationships and risk factors (sex workers and mobile populations)

Methodology:

Work with sex workers/mobile populations – clients
Ask the interviewee to describe the number of sexual partners they currently have. Plot this on a chart. Ask if they use condoms with any of the partners and mark these on the chart. Ask the interviewee if they know whether any of their partners have other partners – and if they know whether they use condoms with those partners.

Ask for as many details as possible about the partners (number of times they have sex with those partners, whether they are regular partners, occasional partners etc.)

If possible to work with a group of sex workers
Plot the sexual partners and identify any "cross-over" partners – plot condom use.

Ask for as many details as possible about the partners (number of times they have sex with those partners, whether they are regular partners, occasional partners etc.)

11.1.3 Traffic tally

Instructions for use:
Observe the area for a period of 24 hours.

Tally the vehicle movement in the boxes provided below.

Fill in page two of the form with a description of the area.

Objective:
Monitor the movement of transporters of people and goods in the areas where there are large concentrations of mobile populations.

Date: **Area:** **Time period:**		
Vehicles		
Passenger transport	Lorries (small)	Lorries (large)

Vehicles that are stationary for more than 5 hours		
Passenger transport	Lorries (small)	Lorries (large)

Observations in the area:

1. Description of the area (name, why is it a busy area, are there bars, guesthouses, rooms to rent etc.)

_____

_____

_____

_____

2. Description of the traffic (when is the place busy, when is it quiet etc.)

_____

_____

_____

_____

3. Type of goods that are transported:

_____

_____

_____

_____

4. Parking: patterns of parking in the area; how long do the transporters stay?

_____

_____

_____

_____

5. Other observations about the mobile populations in the area:

_____

_____

_____

_____

11.1.4 Sex workers

Questions to be selected for individual interviews and focus-group discussions.

Data on individual sex workers interviewed

Age: _____

Sex: _____

Level of education: _____

Marital status: _____

Any children (ages of the children): _____

The children live with the interviewee: _____

Where was the interviewee born? Where did she grow up? _____

Does she live at her place of work? For how long has she lived there? _____

If not, where does she live? _____

(Add any other pertinent information.) _____

We need to find out what they think about the situation in the area (social and economic) – have there been changes in the area (in the last year, for example)? Ask for details about the social changes and their opinion about them and whether they think that the changes will have an impact on high-risk sexual behaviour in the future.

1. Characteristics of sex workers

- Is there much transactional sex in the area?
- Who are the sex workers and where do they work?
- Who are the clients?
- Where are the places that people procure sex?
- Where are the places where sex takes place?
- What are the types of sexual relations that contribute to the transmission of STIs/HIV in this area? Why are these practices more risky?
- Do young people (below 18 years of age) practice transactional sex?
    f) If yes, what age?
    g) Who are their sexual partners? What are the reasons that young people enter into sex work?
- Are there any sexual practices that are untaken by young people who are particularly risky? Why are they risky?

2. Health-seeking behaviour

- What are the main health problems that sex workers suffer from?
- How can you prevent STIs/HIV?
- Is there anything you would like to do to protect yourself better against but you don't always do? If yes, why do you not always use safe practices?
- Why do you sometimes use safe practices and sometimes not?
- Do you take measures to prevent unwanted pregnancy?
  If yes, what do you do, and how often?
- Have you had a planed or unplanned pregnancy this year?
    h) If yes, what did you do?
- Do you regularly go for family planning at the health clinic?
- Do you have to pay for family planning?
- What contraceptive methods are available at the health facilities?
- Are there times when you don't use contraceptives for the prevention of pregnancy or STIs?

- Have you ever had an STI?
    i) If yes, which one? What did you do?
    j) Did you receive treatment? Where were you treated? How were you treated by the health workers or traditional doctors?
    k) Did you pay for your treatment?
    l) If no, what would you do if you suspected that you had an STI?

- Where is the best place to receive treatment for an STI?

- What would be the best way to offer treatment to groups such as sex workers or young people?

- Do people know about condoms?
    m) If yes, where do they get them?
    n) How much do you pay for the condoms?
    o) Where would be the best places to put condoms so people could have access?
    p) What could be done to make access to condoms easier?

- Do you use condoms with all of your sexual partners? Explain the logic for condom use.

- When do you use condoms? What are the main reasons for using condoms?

- When do you not use condoms? Why do you not use condoms?

- What are the main obstacles to condom use?

- What help could be given to people to encourage regular condom use?

- How often do you use male condoms during sexual acts? If you do not use them every time, why not?

- Have you ever used a female condom? If yes, with what frequency? If you don't always use the female condom, why don't you use them regularly?

3. Knowledge of HIV and AIDS

- What do you know about HIV and AIDS?

- What is the gravity of the situation in your opinion?

- Why do you think that?

- Has your life changed due to HIV? Why and how?

- Have you had the opportunity to take an HIV test? Did you do the test?
(if possible, ask the result, and about treatment)

- What would help people to go and get tested for HIV?

- What can be done to make HIV testing as easy as possible?

- What do you think that health workers could do to teach people to avoid HIV?

4. Health services

- Which health services would you like to have?
- What don't you like about the existing health services?
- What do you think about the family planning services, the MCH, antenatal, STI clinics, HIV and AIDS services?
- Where would you prefer to be treated if you had an STI or HIV?
- Where would you prefer to receive family planning?
- What days/opening hours are there at the health clinics in the area?

5. Services linked to HIV and AIDS care and treatment

- In this area do you know any organizations that are working with aspects linked to HIV and AIDS (counselling, distribution of condoms, testing etc.)?
- Is there any information/publicity/IEC campaigns in the area about HIV and AIDS? Are they effective? How could they be improved?
- What type of services do you know?
- Do you think there are services (in addition to the health services) that could be useful?

6. Client characteristics

- Are there any types of men that are known to have multiple sexual partners?
- Who are they? For example, officials, miners, sailors, foreigners, married men etc.
- Who do they have sex with and why?
- Are there men who are at more risk of STIs or HIV? Why?
- Who are your regular clients?
- Why do you think your clients look for your services?
- Where do you meet the majority of your clients?
- What age are your clients?
- What is the most common occupation of your clients?
- What is the most common nationality of your clients?
- What is the sex of your clients?
- Have you ever had sex with clients that are the same gender as you? If yes, with what frequency?

7. Transactions

- Which days and at what time does sex work happen? (For example, are weekends, end of month busier?)
- What do you charge for sexual relations?
- In the majority of cases how do clients pay? What form does payment take? Types of payment? Tips or presents?
- On average how much would you earn in a month? Week? How much did you earn last week?
- Do you have any sexual partners that do not pay? If yes, who are they?
- Do you have any other work or income sources?
- On average how much do you earn from other income sources?
- On average how much do you earn from all your income sources, including sex work?
- Is your income important to your family?
- How many dependants do you have?
- Do you have any debts?
- Are you paying any debts for your family members?
- Have you managed to make any savings in the last three months?

8. Nature of sex work in the area

- What is your sort of work called in the area?
- What do you think of your work?
- What are the implications of your work – economically and/or socially?
- Do you like your work? Why (for yes or no answers)?
- How did you begin sex work? What made you start in sex work?
- What challenges do you face in your work?
- Would you like to stop doing sex work? If yes, what would you like to do? If no, why do you think you will continue with the work?

9. Physical or sexual abuse

- In the last three months have you been insulted while working?
- Have you ever been physically abused by any of your clients? If yes, how many times in the last three months?
- Why do you think the aggression occurs?

- What did you do when you were physically abused?

- Have you ever been forced to have sex against your will?
  q) Why did it happen?
  r) What did you do?
  s) Did you notify the police?

- What do other sex workers do when they are abused or forced to have sex against their will?

- What are the main challenges in your work (legal, violence, discrimination etc.)?

10. Use of drugs and alcohol

- Have you ever used drugs?
  t) If yes, which ones ?
  u) If no, why?

- Do you drink?
  v) What do you drink? How much do you drink? When do you drink (day or night)?
  w) Do you drink at home?
  x) Do you drink at work?
  y) Were you drunk at any time last week?
  z) Do you like to drink or take drugs. Is use related to your job?

11. Legal aspects

- What would you like changed in the legal situation of your type of work?

- Do you see that you have any role in making these changes?

12. Perception

- How do you see sex work?

- Do you think other people see sex work in the same way? How do you think other people see your work?

- What do you think about yourself as a sex worker?

- What aspects of your work do you like?

- What aspects do you like least about your work?

- How much longer do you think you will work as a sex worker?
  What would you like to do if you were not involved in sex work?

13. Social networks

- Do you have a close friend(s), in the area or work place?

- Do you have any family in the area?
  aa) If yes, who? Brother, sister, mother, father, husband, wife, children?
  ab) If not, do you have contact with your family? How often do you see your family?

- Are your work colleagues also your friends?
  ac) Who would you count on for help in the following circumstance?
    - When you need money
    - When you need somewhere to stay
    - When you need food
    - When you need to go to the hospital
    - When you have a problem with the police
    - When you are sad or unhappy
    - When you have been involved in any abuse situation.

- Who normally comes to you to ask for help?

- Could you give any examples of when you have helped someone?

14. Stigma and discrimination

- Do your family and friends know about your work?
  ad) If yes, how do they treat you?
  ae) If no, why haven't you told them?

- Within the last year have you had any contact with the police?
  af) If yes, did they know you were a sex worker. Did this affect the way they treated you or your relationship with them?

- Within the last year have you used the health services? Or contacted a health worker?
  ag) If yes, do you think they know you are a sex worker? How were you treated? Did they treat you differently because of your work?

- Could you describe any incident in the last year where you feel you have been stigmatized or discriminated against because of your work?

11.1.5 NGOs that work with sex workers or offer services to mobile populations

Mobile populations: Transporters, traders, construction worker, travellers

Name of the organization:

Describe the programmes that your organization has in the area. (How long have you worked in the area, what sort of programmes, activities, coverage?)

Why did the organization decide to work in the area and on the chosen issues?

We need to find out what they think about the situation in the area (social and economic) – have there been changes in the area (in the last year, for example)? Ask for details about the social changes and their opinion about them and whether they think that the changes will have an impact on high-risk sexual behaviour in the future.

Name and position of the people interviewed

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

The following questions should be part of the individual interviews or group interviews with the staff of the NGO. The topics should be selected in accordance with the work carried out by the NGO.

1. Characteristics of mobile populations:

Transporters, traders, sailors, miners, construction workers, public-service workers (customs officers, police), visitors (specify the type of visitors)

- Which are the groups of people that leave the area (men, youth etc.)?
- How long, in general, are they absent?
- Number of female-headed households?
- Describe the people who are arriving in the area or are frequent visitors.
- Do these people generally stay in the area or pass through?
- What are the impacts of these movements in the area, both positive and negative?

2. Details about the mobile populations

- Sex:
- Nationalities:
- Frequency of visits to the area:
- Average length of time they stay in the area:

3. Characteristics of the sex workers in the area

- Is there transactional sex in the area?
- What are the different types of transactional sex in the area?
- Who are the sex workers in the area?
- Who are the clients? Where do they work?
- Which types of sexual practices increase the risk of STI transmission? Why?
- Are young people are involved in transactional sex (sex where money or "in kind" payment is made)?

- Who are the sexual partners for these young people? Why do the youth become involved in transactional sex?

- Which are the sexual practices that put young people at most risk? Why?

4. Health-seeking behaviour

- What are the main health problems that people suffer from in the area – especially the mobile populations (do they use the health services) and the sex workers?

- Do the mobile populations know how to prevent STIs (including HIV)?

- Do the sex workers know how to prevent STIs (including HIV)?

- Any opinions about why sometimes people practice safe sex and sometimes do not?

- Do people know how to prevent unwanted pregnancies?

- Do you know many people who have unwanted pregnancies? Do you know if any of these women were sex workers?

- Are there contraceptives available in the health centre? If yes, which are now available – pills, condoms? In this year have there being any stock-outs of the contraceptives – if yes, which?

- Which are the main STIs treated at the health facility?

- Do people pay for the treatment?

- How are they treated (drugs, counselling, health worker attitudes)?

- In your opinion what are the best ways to provide care in the area of STI prevention – in particular for transient populations, sex workers and young people?

- Do people know about condoms?
    g) If yes, where do they get them from?
    h) How much do people pay?
    i) Where are the best places for people to access condoms?

- What can be done to improve access to condoms?

- What can be done to improve use of condoms?

- What are the main obstacles for the use of condoms?

- Is the female condom available? Are women asking for the female condom?

5. Knowledge about HIV and AIDS

- What do people know about HIV and AIDS?

- In your opinion what is the seriousness of HIV and AIDS in the area?

- If the answer is that there is no problem ask the health worker to explain why he/she has that opinion.

- What would help to get people to test for HIV?
- What would help to improve adherence to testing for HIV?
- What do you think health workers should do to improve information flows about STIs and HIV?

6. Health services

- Are the health services accessible? Are they available to everyone, including the mobile populations and sex workers? What could be done to improve accessibility for these at-risk groups?
- In your opinion should these services be more accessible?

7. Client characteristics

- Are there any types of men that are known to have multiple sexual partners?
- Who are they? For example, officials, miners, sailors, foreigners, married men etc.
- Who do they have sex with and why?
- Are there men who are at more risk of STIs or HIV? Why?
- Where do sex workers meet the majority of their clients?
- What age are the clients?
- What is the most common occupation of your clients?
- What is the most common nationality of your clients?
- What is the gender of your clients?
- Do you know of sex workers having sex with people of the same gender?

8. Transactions

- Which days and at what time does sex work happen? (For example, are weekends, end of month busier?)
- What is the rate for sexual relations?

9. Nature of sex work in the area

- What is your sort of work called in the area?
- What do people think about sex workers?
- What are the implications of sex work – economically and/or socially in the area
- What challenges do sex workers face in the area?

10. Physical and sexual abuse

- Have you heard of any incidents where sex workers have been insulted or suffered from physical abuse (in the last three months)?

- Is this a regular occurrence? Is your organization working with these sorts of cases?

11. Use of drugs and alcohol

- Do drugs and alcohol play a part in the lives of the mobile populations and sex workers? Could you describe any incident that substantiates your opinion?

12. Social networks

- Who are the main people who support the sex workers?
    j) Other sex workers
    k) Clients
    l) Partners (non-clients)
    m) Family
    n) Friends
    o) Other

- Please explain your response (we would like to know who they turn to for advice and support, emotional and financial)

13. Stigma and discrimination

- Do you think there is discrimination against sex workers in the community by:
    p) Family?
    q) Friends?
    r) Partners?
    s) Police?
    t) Health workers?
    u) Religious leaders?
    v) Others? Specify.

- Could you give any examples of behaviour or discriminatory attitude.

- Does the NGO work in any programmes to reduce stigma and discrimination?

11.1.6 Hotspot mapping

Cartographers will plot the following information using handheld GPS devices at pre-identified hotspots on the Maputo–Swaziland corridor. Working along the corridors they will map infrastructures within 3.5 km on either side of the road:

1. Social infrastructures (health posts, schools)
2. Bars, restaurants, rooms for hire, guesthouses
3. Markets, commercial centres
4. Truck stops
5. Border posts

Further information from the traffic monitoring and the social research will be plotted on the maps:

6. Hotspots for sex workers

7. Traffic concentration

8. NGO activity

After the analysis of all the information the team will discuss if additional information can be represented on the maps.

11.1.7 Guide for people working in high-risk occupations (residents)

Waiters, bar workers etc.

Age:

Time of service:

Sex:

Nationality:

Working hours:

Average salary (with tips):

What aspects you like about your work:

What aspects you do not like about your work:

We need to find out what they think about the situation in the area (social and economic) – have there been changes in the area (in the last year, for example)? Ask for details about the social changes and their opinion about them and whether they think that the changes will have an impact on high-risk sexual behaviour in the future.

1. Clients

- Who are the clients (at the bar, restaurant, guesthouse)? Are they the mobile populations and/or the residents?
- (sex, age, nationality)
- Do the clients look for sexual relations?
- If the answer is yes, use the questions in the Sex Worker Guide to ask about the clients – where, when, how many times, with whom, use of condoms etc.

2. Perception of risk

- Does your work have risks?
- What are the risks?
- Explain.

- How can you reduce the risk?
- If you believe that your work is high risk, why do you continue to work at the place?

11.1.8 Health workers

1. Type of health facility

Specify the type of health worker (nurse, medical officer, preventive medical officer etc.)

Ask the health worker to describe the health services offered at the health facility, in particular treatment of STI, HIV testing and ARV.

Ask the health workers about how they feel the socio-economic situation in the area is changing – in the last year, for example. Request details of the changes and the opinion of the health worker about the future impact of the changes. In particular, will this change (sexual) risk behaviour?

2. Characteristics of mobile populations

Transporters, traders, sailors, miners, construction workers, public service workers (customs officers, police), visitors (specify the type of visitors)

- Which are the groups of people who leave the area (men, youth etc.)?
- How long, in general, are they absent?
- Number of female-headed households?
- Describe the people who are arriving in the area or are frequent visitors.
- Do these people generally stay in the area or are they passing through?
- What are the impacts of these movements in the area, both positive and negative?

3. Details about the mobile populations

- Sex:
- Nationalities:
- Frequency of visits to the area:
- Average length of time they stay in the area:

4. Characteristics of the sex workers in the area

- Is there transactional sex in the area?
- What are the different types of transactional sex in the area?
- Who are the sex workers in the area?
- Who are the clients? Where do they work?

- Which types of sexual practices increase the risk of STI transmission? Why?

- Are young people involved in transactional sex (sex where money or "in kind" payment is made)?

- Who are the sexual partners for these young people? Why do the youth become involved in transactional sex?

- Which are the sexual practices that put young people at most risk? Why?

5. Health-seeking behaviour

- What are the main health problems that people suffer from in the area – especially the mobile populations (do they use the health services) and the sex workers?

- Do the mobile populations know how to prevent STIs (including HIV)?

- Do the sex workers know how to prevent STIs (including HIV)?

- Any opinions about why sometimes people practice safe sex and sometimes do not?

- Do people know how to prevent unwanted pregnancy?

- Do you know many women who have unwanted pregnancies? Do you know if any of these women were sex workers?

- Are there contraceptives available in the health centre? If yes, which are now available – pills, condoms? In this year have there being any stock-outs of the contraceptives – if yes, which?

- Which are the main STIs treated at the health facility?

- Do people pay for the treatment?

- How are they treated (drugs, counselling, health worker attitudes)?

- In your opinion what are the best ways to provide care in the area of STI prevention – in particular for transient populations, sex workers, and young people?

- Do people know about condoms?
    i) If yes, where do they get them from?
    j) How much do people pay?
    k) Where are the best places for people to access condoms?

- What can be done to improve access to condoms?

- What can be done to improve use of condoms?

- What are the main obstacles for the use of condoms?

- Is the female condom available? Are women asking for the female condom?

6. Knowledge about HIV and AIDS

- What do people know about HIV and AIDS?
- In your opinion what is the seriousness of HIV and AIDS in the area?
- If the answer is that there is no problem, ask the health worker to explain why they have that opinion.
- What would help to get people to test for HIV?
- What would help to improve adherence to testing for HIV?
- What do you think health workers should do to improve information flows about STIs and HIV?

7. Health services

- Are the health services accessible? Are they available to everyone, including the mobile populations and sex workers? What could be done to improve accessibility for these at risk groups?
- In your opinion should these services be more accessible?

8. Other services offered linked to HIV and AIDS

- In this area do you know any organizations that are working with aspects linked to HIV and AIDS (counselling, distribution of condoms, testing etc.)?
- Is there any information/publicity/IEC campaigns in the area about HIV and AIDS? If so, are they effective? How could they be improved?
- What type of services are offered?
- Do you think there are services (in addition to the health services) that could be useful?

9. Characteristics of the clients

- Do you know if any of the clients of sex workers have sought treatment in the health centre?
    l) If yes, what type of treatment?

10. Sexual and physical abuse

- Have you ever treated sex workers for physical or sexual abuse? Do sex workers receive abuse from clients, family, the police?
- Does abuse occur frequently? How many times in the last month have you treated cases of abuse? Has the number of abuse cases increased in the last six months?

11. Use of drugs and alcohol

- Have you treated people who have abused drugs or alcohol?
- If yes, explain the treatment and the frequency that this occurs.

12. Legal aspects

- What do you think, legally, could be done about the sex trade in the area?

- Do you think the activity should be legalized?

13. Perception

- In your opinion what is the sexual behaviour that is prevalent in the area – especially among the mobile populations and the resident population?

14. Stigma and discrimination

- Do you know any sex workers?
  - m) If yes, how do you treat them?
  - n) Do you know of any cases where sex workers have been discriminated against? For example, in health facilities, police stations, public places etc.
  - o) If yes, give details.

11.1.9 Mobile populations

Drivers, assistants, construction workers, traders, public-service workers

The following questions are the basis of interviews with mobile populations.

Data about the interviewee

Age: _____

Nationality: _____

Sex: _____

Occupation: _____

How long are you in the area (each time you vist): _____

How many times have you passed by this area in the last six months? _____

We need to find out what they think about the situation in the area (social and economic). Have there been changes in the area (in the last year, for example)? Ask for details about the social changes and their opinion about them and whether they think that the changes will have an impact on high-risk sexual behaviour in the future.

1. Sexual behaviour

- When you are travelling do you have sexual relations?
  - p) With whom?
  - q) How many times?
  - r) Do you use condoms?

- Ask for details about sexual behaviour.
    s) When?
    t) Where?

- Have you used the services of sex workers? (You may want to ask: In the last month, or week, how many times have you had sex with a sex worker? Where? At what time? Was the sex worker female? What age was s/he? What nationality? How much did you pay? Do you always go to the same sex worker? etc.) Obtain as many details as possible.
    u) How much do you generally pay for sexual relations?
    v) What do you usually pay – money, supper, other presents?

- Do you have any sexual partners that you don't pay to have sexual relations? If yes, who are they?

2. Characteristics of sex work in the area

- Is there much sex work in the area?

- What types of sex workers are there in the area?

- Where can you find sex workers? Where do they work? Where are the most common places where you can find sex workers?

- Who are the clients of the sex workers? (It is possible that the interviewee will rather talk in the third person about experiences with sex workers.)

- Where do people have sexual relations?

- What types of sexual relations are most risky for the transmission of STIs/HIV? Why?

- Are young people practicing transactional sex?
    w) If yes, at what age?
    x) Who are their partners? What are the reasons for the young people practicing transactional sex?
    y) Are any of the sexual practices particularly dangerous for the young people? Why?

3. Health-seeking behaviour

- How do you prevent STIs/HIV?

- Is there anything more you could do, but are not managing to do?
    z) If yes, what? And why are you not doing it?

- Why do people sometimes practice safe sex and at other times not?

- Have you ever had an STI?
    aa) If yes, what did you do?
    ab) If no, what would you do if you suspected that you had an STI?

- If yes, where did you get treatment? What treatment did you get?

- Did you pay for the treatment? How was the quality of the treatment in your opinion?

- What type of services would be ideal for offering testing and treatment for STIs and HIV? If the response is a health facility, what would be the ideal opening hours – in the interest of the mobile populations? Ask their opinions about mobile clinics – late night services etc.

- Do people know about condoms?
  ac) If yes, do people use them?
  ad) Where do they get them from?
  ae) How much do people pay for the condoms?
  af) What are the best places to access condoms?
  ag) What could be done to make condoms more available?

- Do you use condoms with your different sexual partners? If yes, explain.

- When you use condoms what are the main reasons for using them?

- When you don't use them, what are the main reasons for not using them?

- What are the main reasons for not using condoms?

4. Knowledge about HIV and AIDS

- What do you know about HIV and AIDS?

- In your opinion is HIV a serious problem?

- On what do you base your opinion?

- Has your life changed due to HIV? If yes, why? What? If no, why not?

- Have you ever had an HIV test? (If the person is willing, ask what was the result of the test.)

- What would help people to test more regularly?

- What can be done to make the test more accessible?

- What do you think that health workers or other community workers could do to improve AIDS awareness?

5. Health services

- What health services would you like to have (most useful to you given your work/ life style)?

- What don't you like about the health services that are currently available?

- What do you think of the health services at the moment – in particular the services for HIV and STI treatment?

- Where would you prefer to have treatment if you had an STI or HIV?

- What days and times would you prefer to access health services?

6. Other services linked to HIV and AIDS

- In this area do you know any organizations that are working with aspects linked to HIV and AIDS (counselling, distribution of condoms, testing etc.)?

- Is there any information/publicity/IEC campaigns in the area about HIV and AIDS? Are they effective? How could they be improved?

- What type of services?

- Do you think there are services (in addition to the health services) that could be useful?

7. Sexual or physical abuse

- Have you shouted at or insulted your sexual partner (either permanent partner or occasional partner) (in the last three months)? If yes, why? If no, do you know other people who do insult their partners? If yes, could you tell me about the incident?

- Have you ever physically hurt your sexual partner (permanent or occasional). If yes, how many times, why? If no, do you know of any cases of physical abuse against sex workers? Could you talk about it?

- If there was a problem, what happened? Were the police called? How was the situation resolved?

8. Use of drugs and alcohol

- Have you ever used any drugs?
  ah) If yes, what and when?
  ai) If no, why not?

- Do you drink alcohol frequently?
  aj) What would you normally drink (Monday to Friday)? What do you drink at the weekend? What do you drink when you are on the road? (You could ask when was the last time they had a drink, where and how much they drank.)

- Do you drink when you are travelling?

- Do you drink at home?

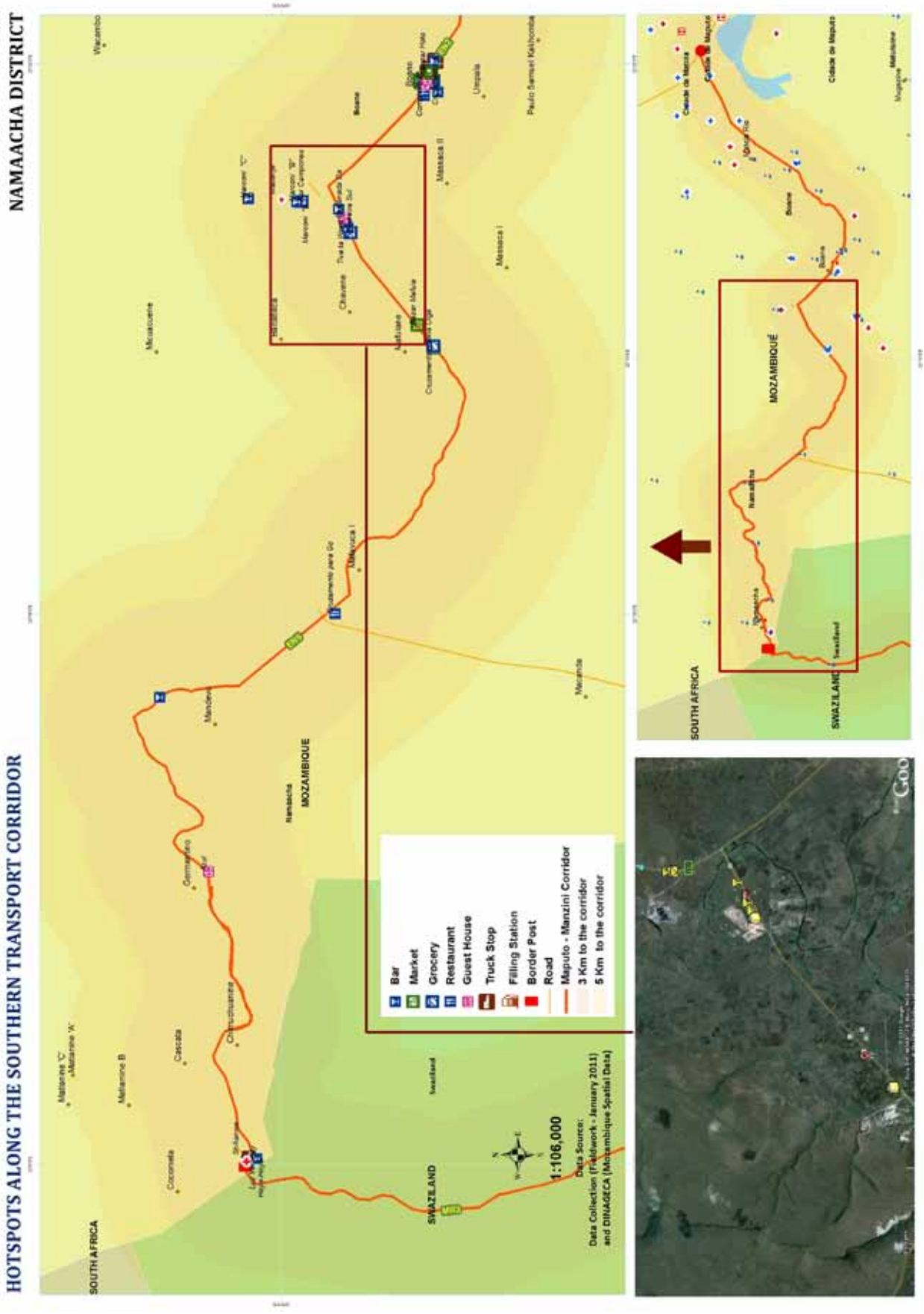
- Do you drink at work?

- In the last week have you been drunk?

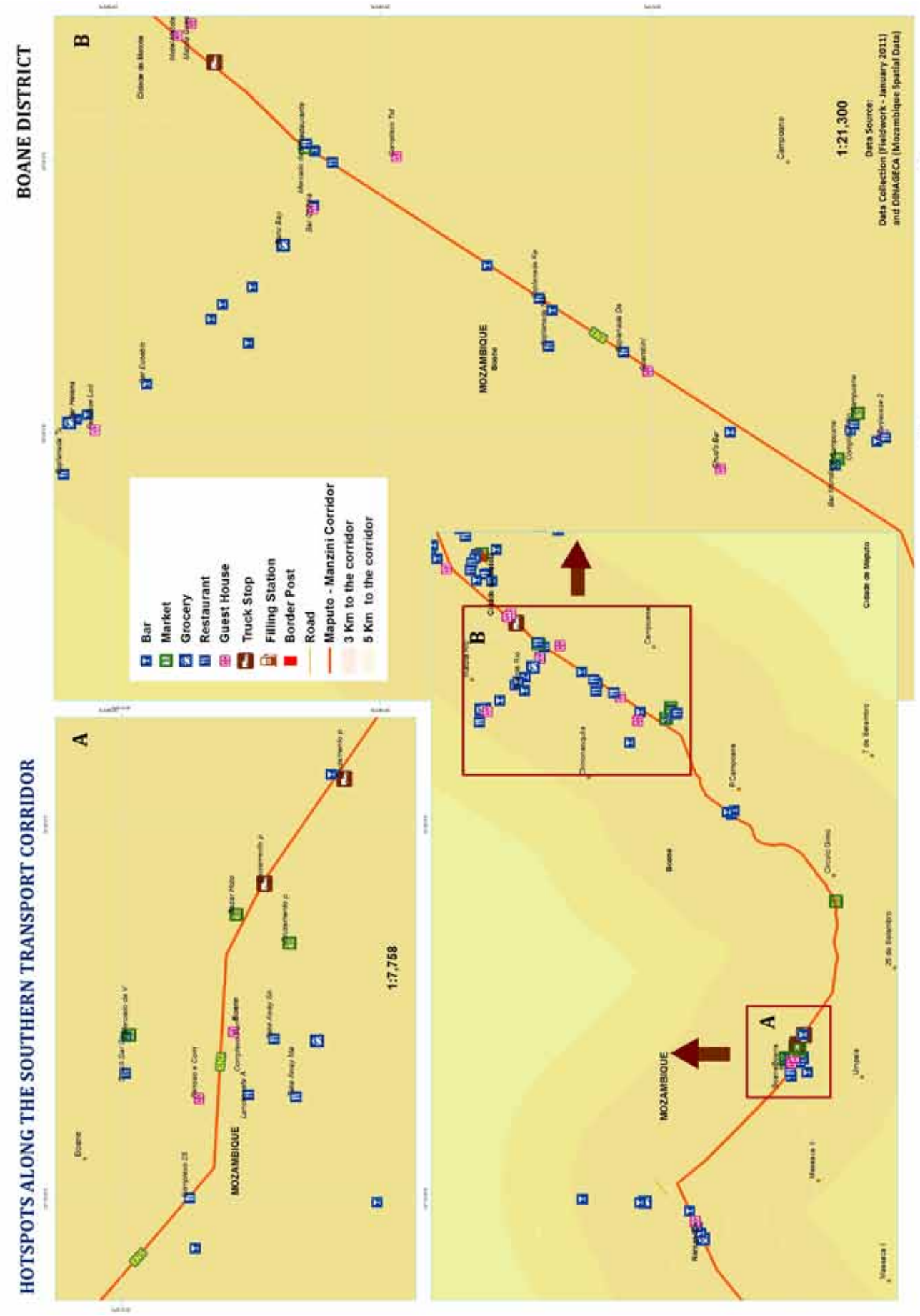
- Why do you like to drink or use drugs? Is there any relationship between drink/drugs and sex?

12 ANNEX 2

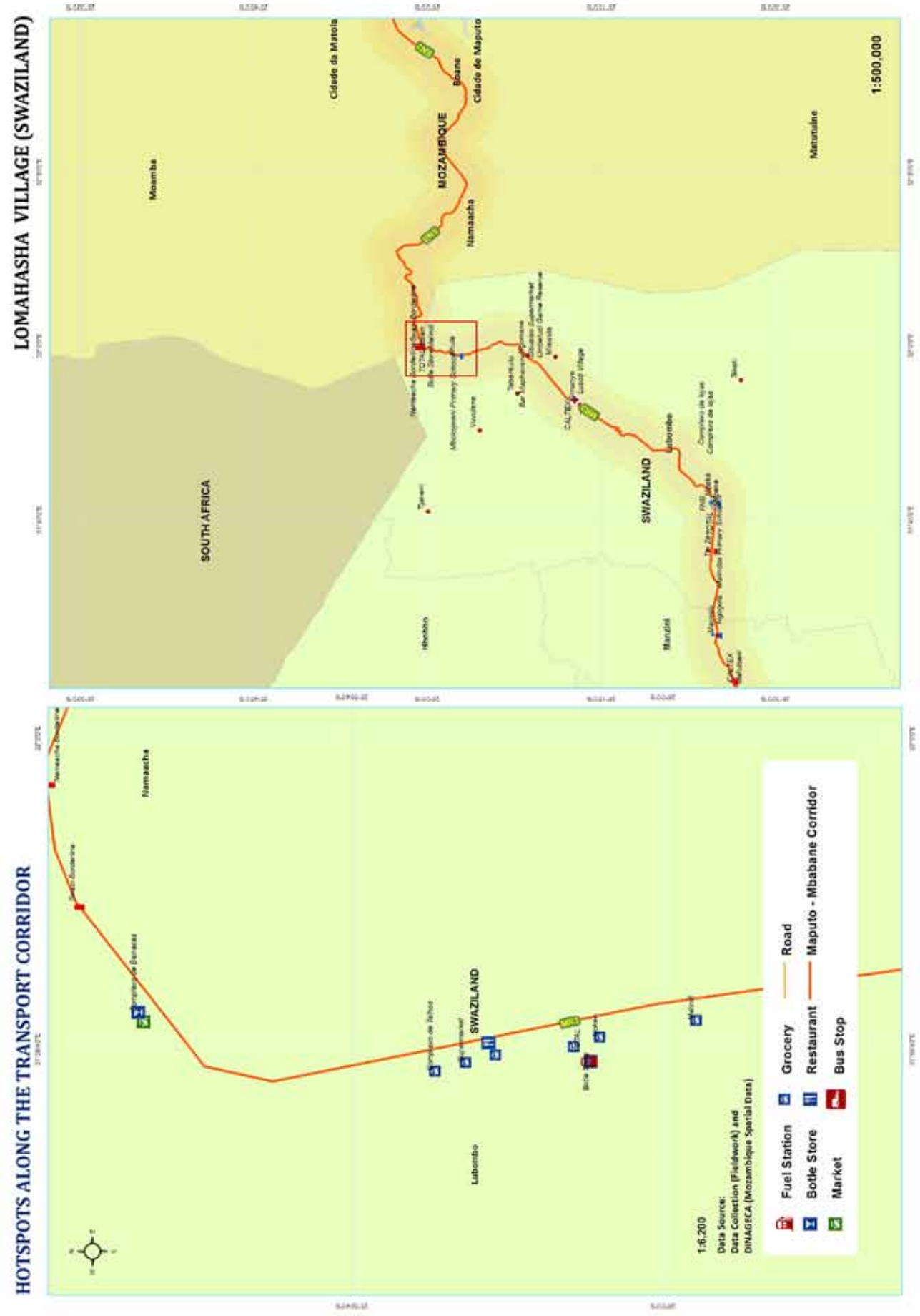
Map 2.1



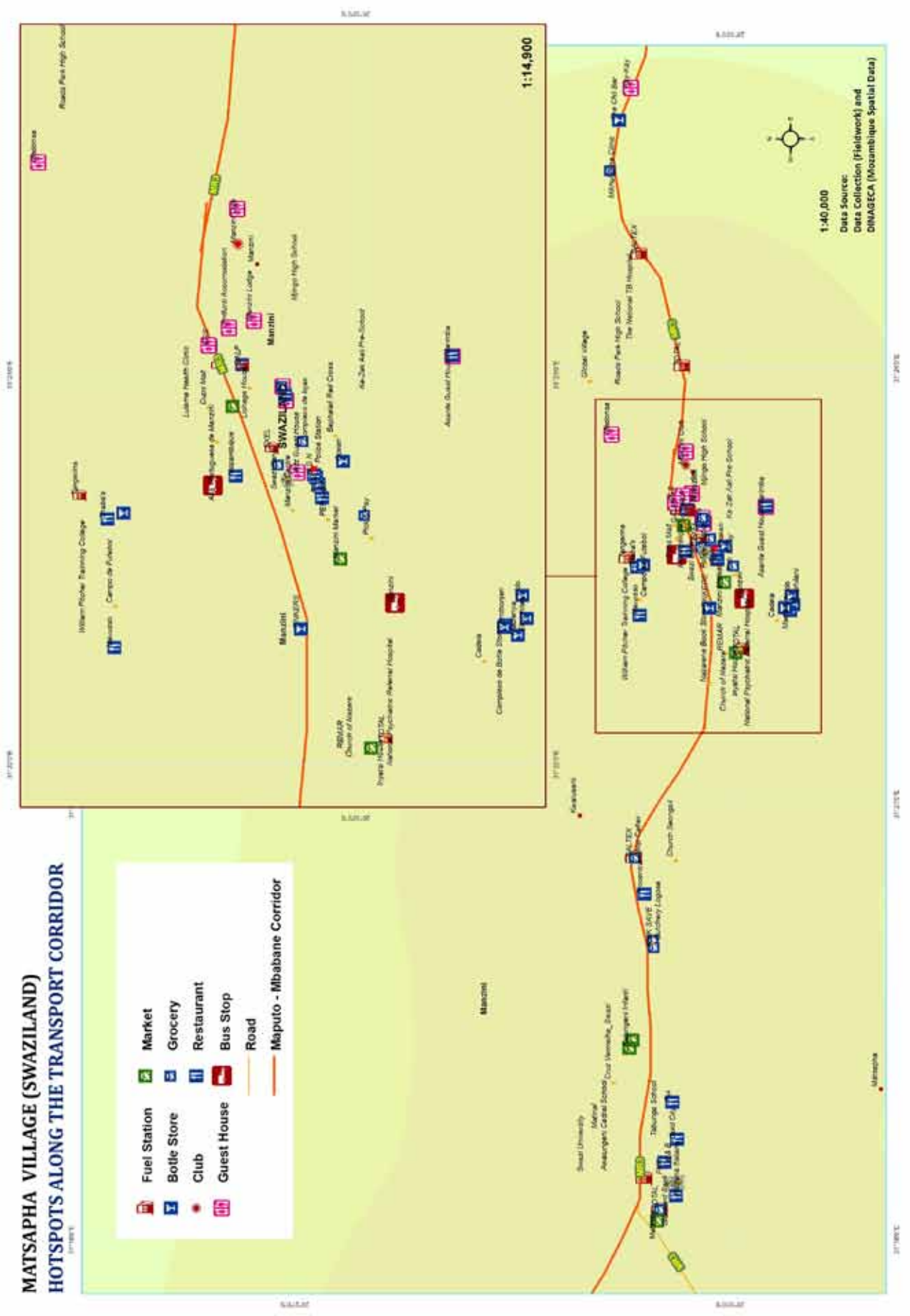
Map 2.2


HOTSPOTS ALONG THE SOUTHERN TRANSPORT CORRIDOR
BOANE DISTRICT
A
B
1:7,758
1:21,300
Data Source:
Data Collection (Fieldwork - January 2011)
and DINAGECA (Mozambique Spatial Data)
MOZAMBIQUE
Boane
Bar
Market
Grocery
Restaurant
Guest House
Truck Stop
Filling Station
Border Post
Road
Maputo - Manzini Corridor
3 Km to the corridor
5 Km to the corridor

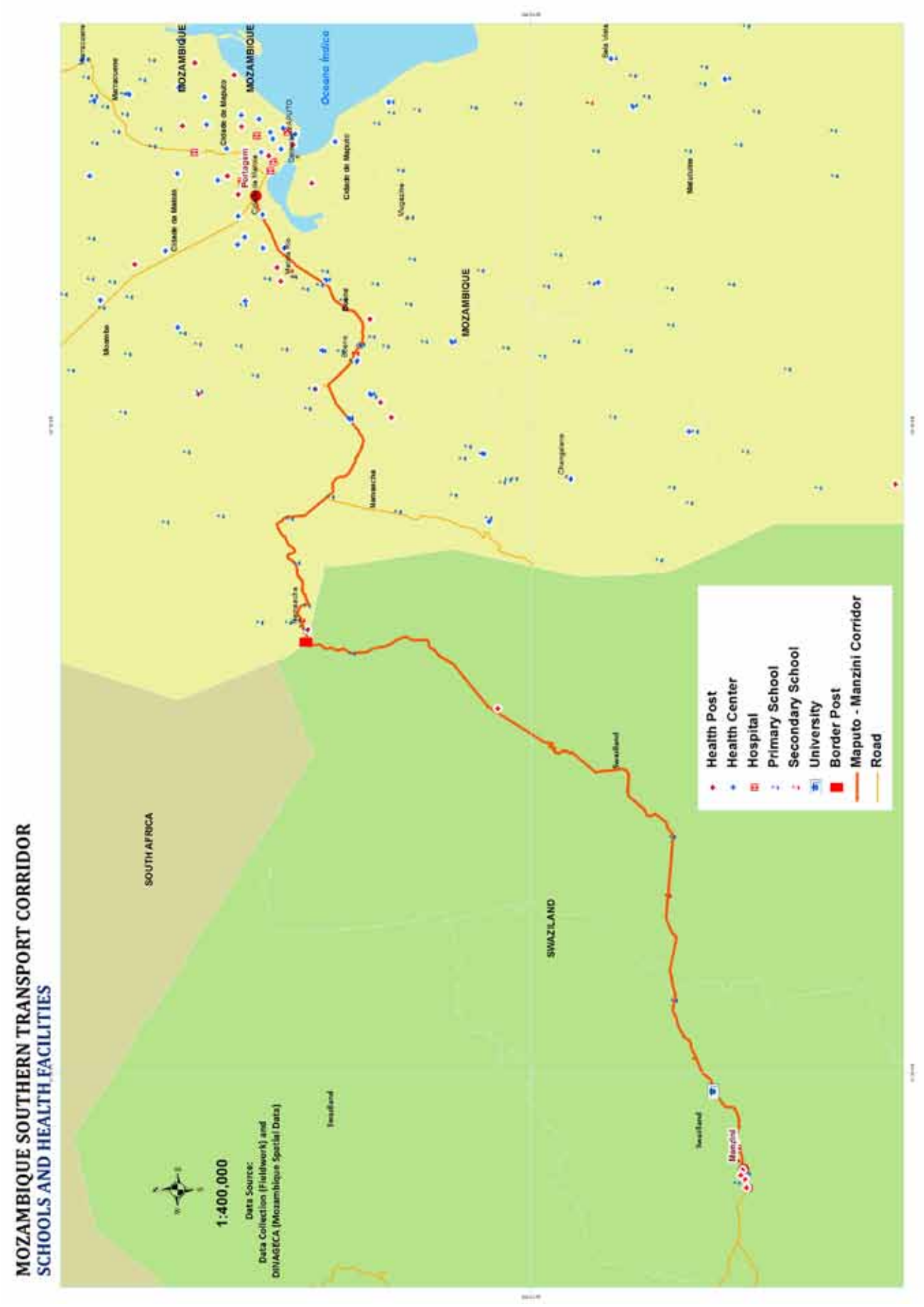
Map 2.3


LOMAHASHA VILLAGE (SWAZILAND)
HOTSPOTS ALONG THE TRANSPORT CORRIDOR
1:500,000
1:6,200
MOZAMBIQUE
SOUTH AFRICA
SWAZILAND
Cidade da Matola
Cidade de Maputo
Boane
Moamba
Namaacha
Matutuine
Lubombo
Manzini
Hhohho
Fuel Station
Grocery
Road
Bottle Store
Restaurant
Maputo - Mbabane Corridor
Market
Bus Stop
Data Source:
Data Collection (Fieldwork) and
DINAGECA (Mozambique Spatial Data)

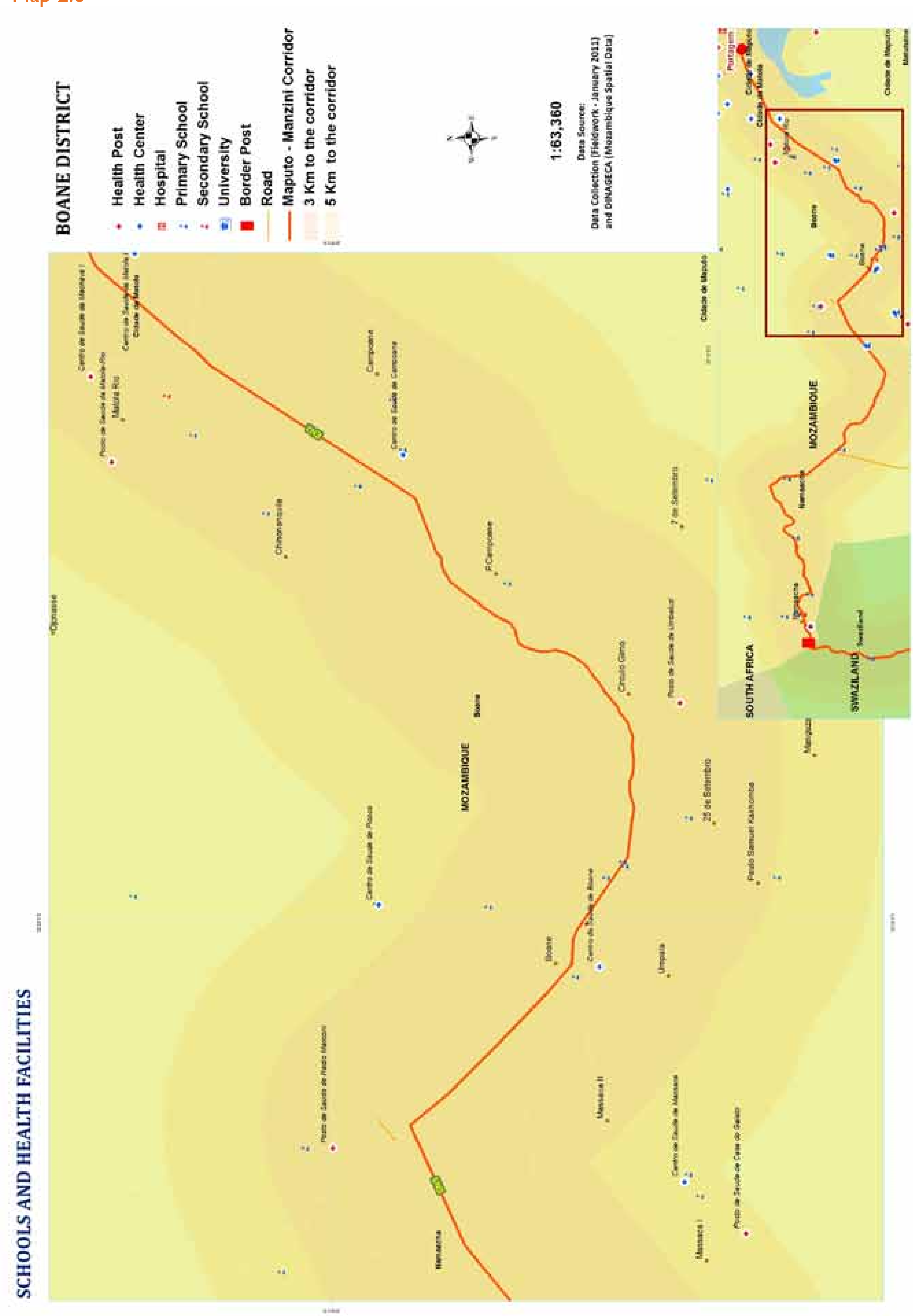
Map 2.4


MATSAPHA VILLAGE (SWAZILAND)
HOTSPOTS ALONG THE TRANSPORT CORRIDOR
Fuel Station
Bottle Store
Club
Guest House
Market
Grocery
Restaurant
Bus Stop
Road
Maputo - Mbabane Corridor
1:14,900
1:40,000
Data Source:
Data Collection (Fieldwork) and
DINAGECA (Mozambique Spatial Data)
Manzini

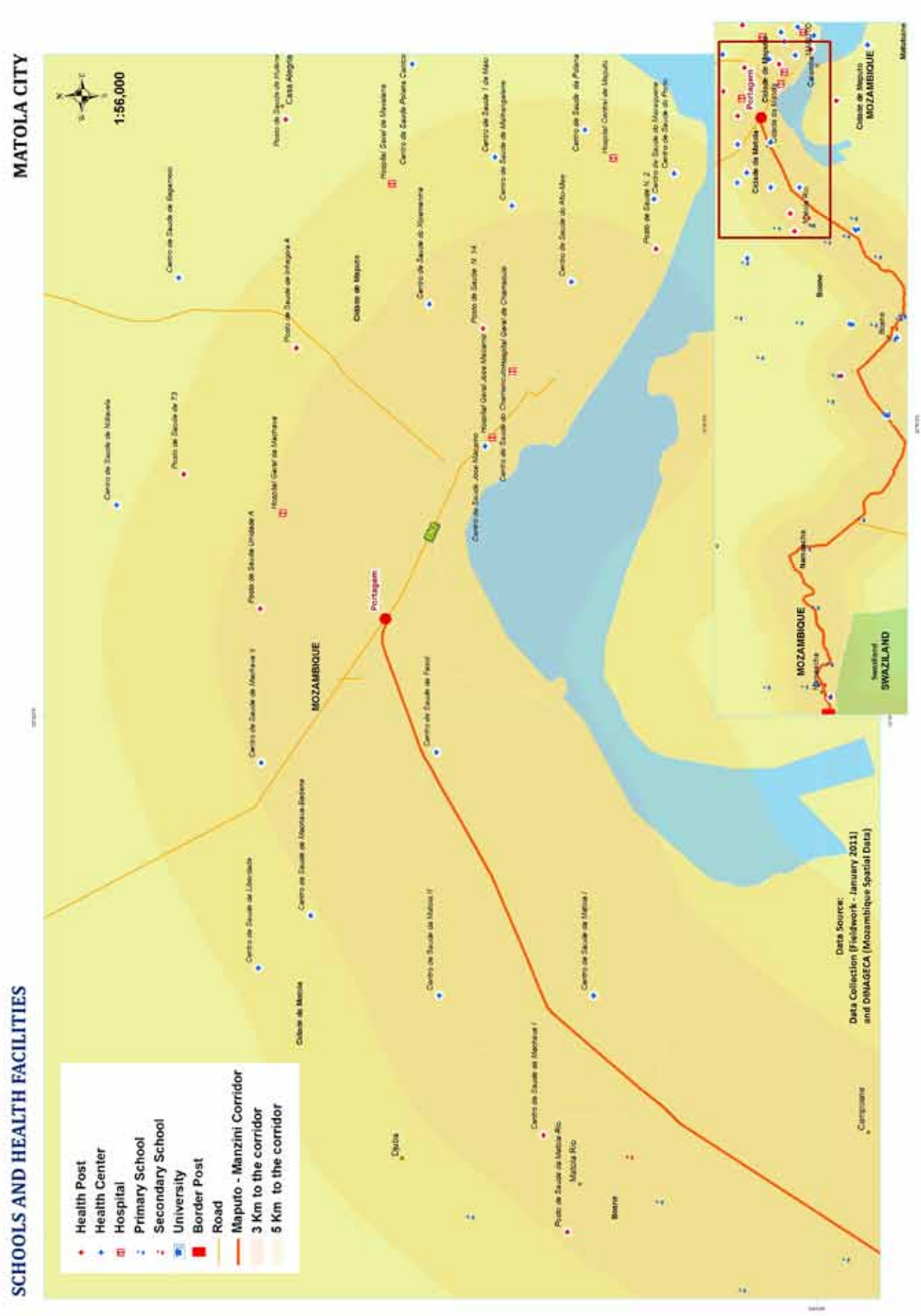
Map 2.5


MOZAMBIQUE SOUTHERN TRANSPORT CORRIDOR
SCHOOLS AND HEALTH FACILITIES
1:400,000
Data Source:
Data Collection (Fieldwork) and
DNYAGECA (Mozambique Spatial Data)
Health Post
Health Center
Hospital
Primary School
Secondary School
University
Border Post
Maputo - Manzini Corridor
Road
MOZAMBIQUE
SOUTH AFRICA
SWAZILAND
Oceano Índico

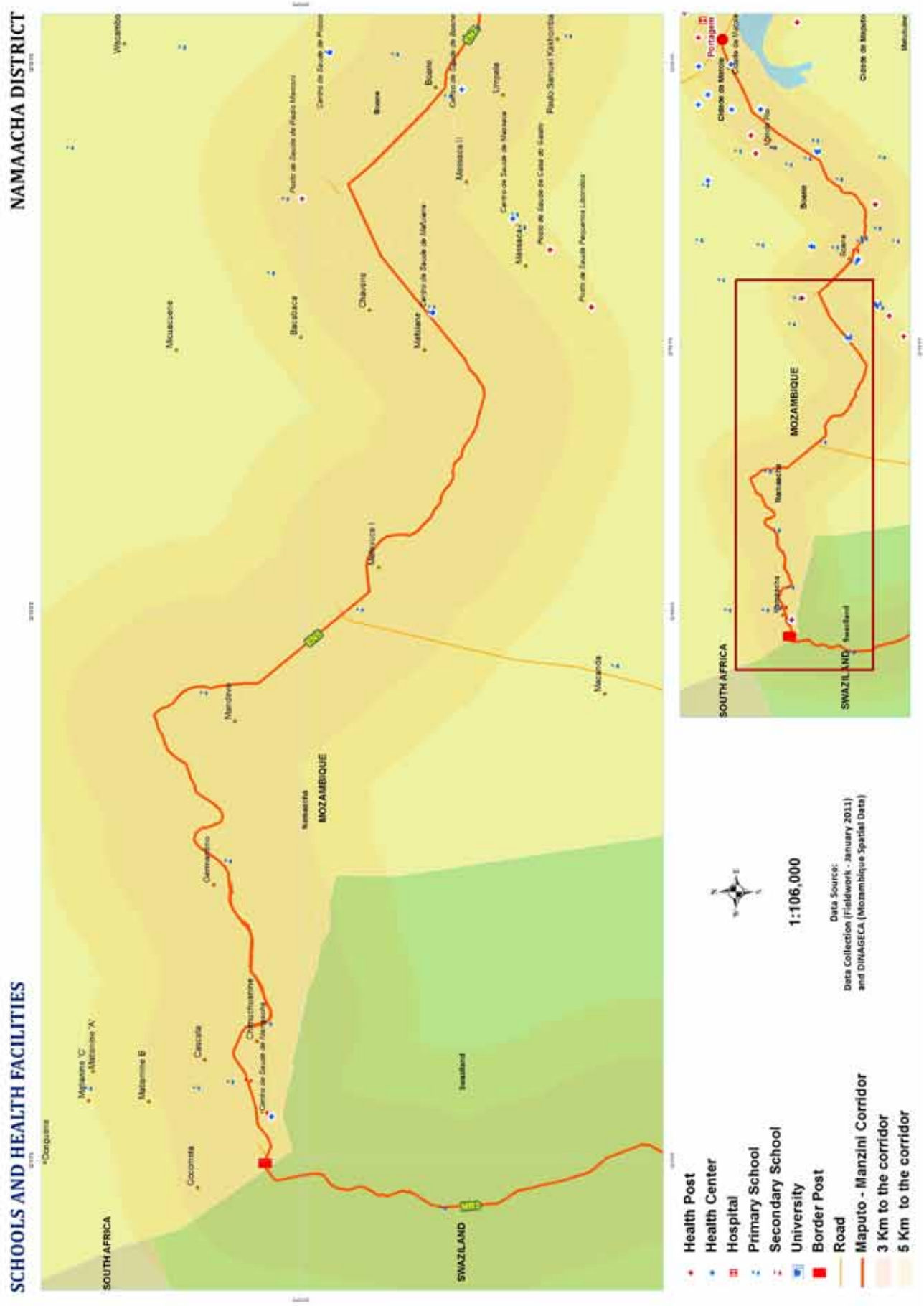
Map 2.6


SCHOOLS AND HEALTH FACILITIES
BOANE DISTRICT
Health Post
Health Center
Hospital
Primary School
Secondary School
University
Border Post
Road
Maputo - Manzini Corridor
3 Km to the corridor
5 Km to the corridor
1:63,360
Data Source:
Data Collection (Fieldwork - January 2011)
and DINAGECA (Mozambique Spatial Data)
MOZAMBIQUE
SOUTH AFRICA
SWAZILAND

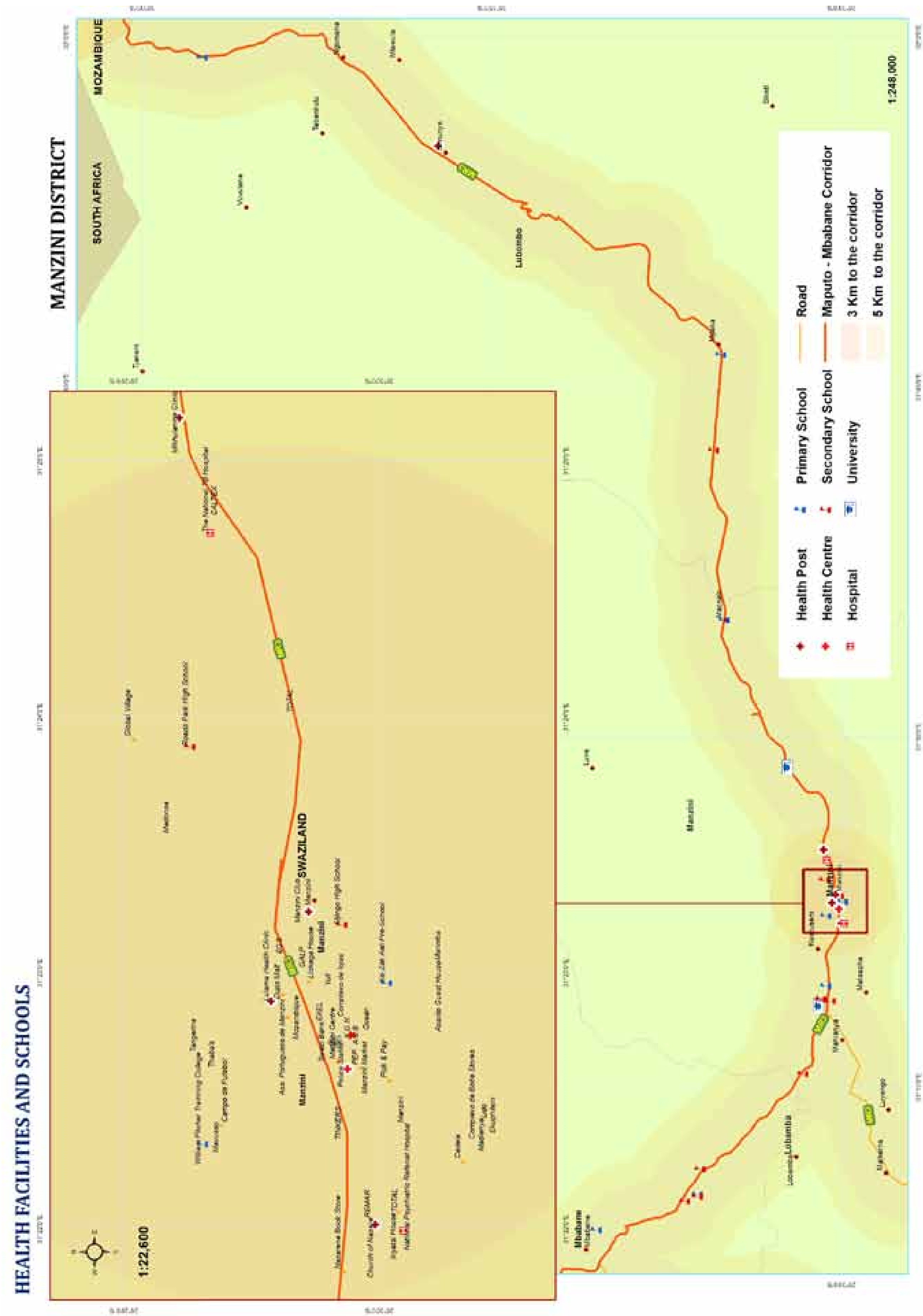
Map 2.7


MATOLA CITY
SCHOOLS AND HEALTH FACILITIES
1:56,000
Health Post
Health Center
Hospital
Primary School
Secondary School
University
Border Post
Road
Maputo - Manzini Corridor
3 Km to the corridor
5 Km to the corridor
Data Source:
Data Collection (Fieldwork - January 2011)
and DINAGECA (Mozambique Spatial Data)
MOZAMBIQUE
SWAZILAND
Portagem
Matola Rio
Boane
Catembe
Maputo

Map 2.8

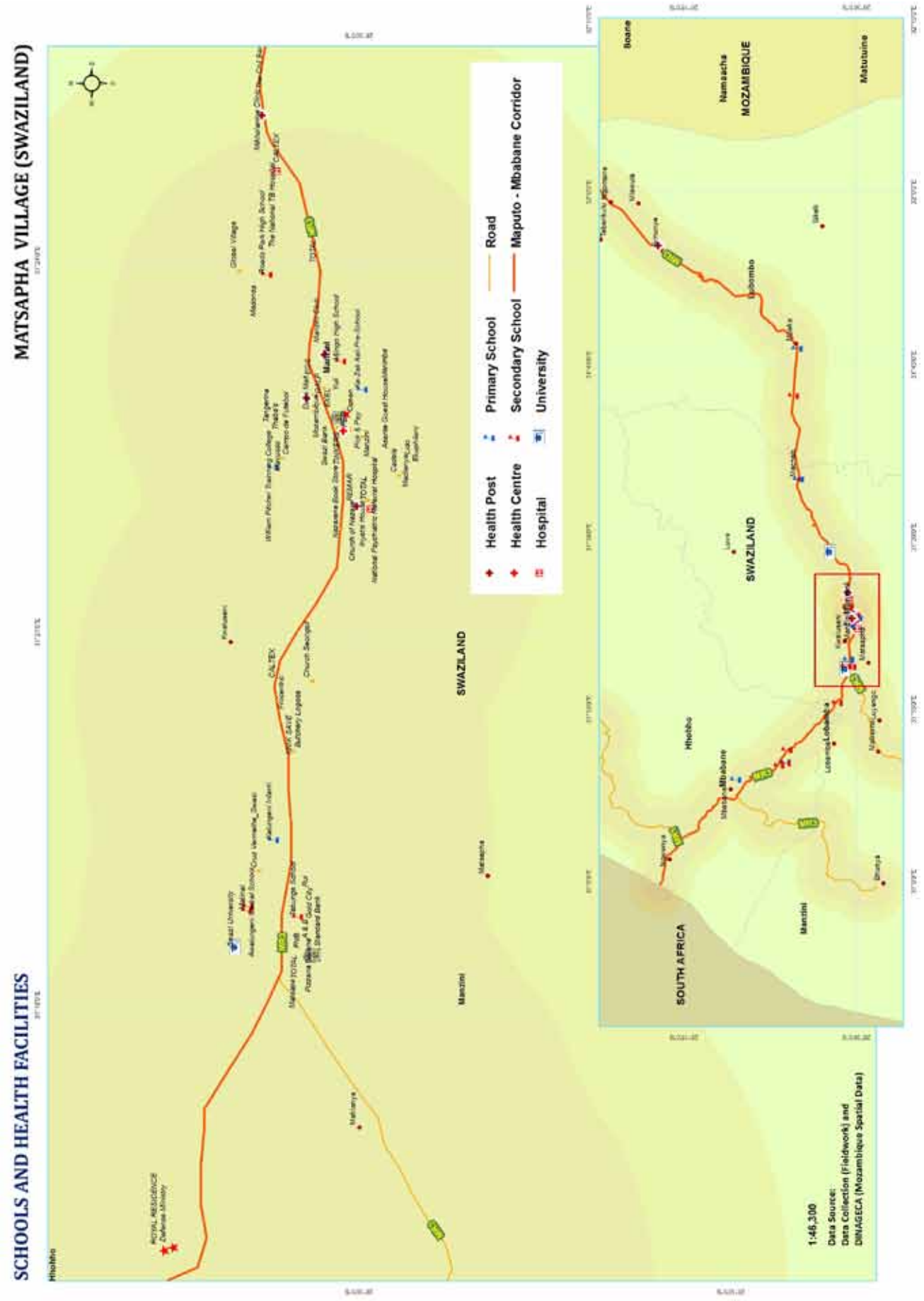

SCHOOLS AND HEALTH FACILITIES
NAMAACHA DISTRICT
SOUTH AFRICA
MOZAMBIQUE
SWAZILAND
Health Post
Health Center
Hospital
Primary School
Secondary School
University
Border Post
Road
Maputo - Manzini Corridor
3 Km to the corridor
5 Km to the corridor
1:106,000
Data Source:
Data Collection (Fieldwork - January 2011)
and DINAGECA (Mozambique Spatial Data)

Map 2.9



HEALTH FACILITIES AND SCHOOLS
MANZINI DISTRICT
SOUTH AFRICA
MOZAMBIQUE
SWAZILAND
Manzini
Mbabane
Matsapha
Lobamba
Lubombo
Maputo
1:22,600
1:248,000
Health Post
Health Centre
Hospital
Primary School
Secondary School
University
Road
Maputo - Mbabane Corridor
3 Km to the corridor
5 Km to the corridor

Map 2.10


SCHOOLS AND HEALTH FACILITIES
MATSAPHA VILLAGE (SWAZILAND)
Health Post
Health Centre
Hospital
Primary School
Secondary School
University
Road
Maputo - Mbabane Corridor
SWAZILAND
MOZAMBIQUE
SOUTH AFRICA
Manzini
Hhohho
Matsapha
Malkerns
Boane
Namaacha
Matutuine
Lobamba
Mbabane
Manzini
1:46,300
Data Source:
Data Collection (Fieldwork) and
DINAGECA (Mozambique Spatial Data)

NOTES

NOTES

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