Labour Migration and HIV/AIDS in Southern Africa

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Contents

1 Introduction

By far the worst affected region, sub-Saharan Africa is now home to 29.4 million people living with HIV/AIDS, 70% of the total 42.9 million people living with HIV/AIDS globally. Approximately 3.5 million new infections occurred there in 2002, while the epidemic claimed the lives of an estimated 2.4 million Africans in the past year. Ten million young people (aged 15–24) and almost 3 million children under 15 are living with HIV. Countries like Lesotho, Botswana, South Africa, Swaziland and Zimbabwe have the highest HIV prevalence rates in the world. What the exact impact of the HIV/AIDS epidemic will be is still unknown, but the epidemic is likely to have an impact on nearly every aspect of life in southern Africa. The region will be faced by great personal emotional suffering, a major decline in life expectancy, a great loss of both skilled and unskilled labour, rising costs of health care, social and economic disruption at the family and community level and a reduction of human and financial resources available for civil society organisations and the government. Some even consider HIV/AIDS a threat to social and political stability.

The epidemiology of HIV/AIDS is closely linked to the process of migration. Migrants – and mobile populations in general – have played a significant role in the initial spread of HIV in the southern African region. The largely seasonal or temporary character of migration in southern Africa, with migrants returning home to their families on a regular basis, has facilitated the rapid spread of the virus. However, the fact that population movement distributes HIV has becomes less relevant in the current stage of the AIDS epidemic in southern Africa (with extremely high HIV prevalence levels in the population in general). Migrants are no longer agents that help to spread HIV, but have become individuals at high risk. Several studies have shown that migrants are more vulnerable to HIV infection than their non-migrant counterparts.

Because a vaccine or cure for HIV/AIDS is not expected to be available in the near future, efforts to reduce the spread and the impact of HIV/AIDS should be geared towards changing high-risk sexual behaviour, especially in environments facilitating high-risk sexual behaviour. This can only be done successfully if these efforts are supported by a contextual analysis of sexual behaviour. Insight in the environments (context) that are conducive to high-risk sexual behaviour is extremely important.

This paper investigates the interrelatedness of labour migration and the HIV/AIDS epidemic from the point of view of the migrant (the individual). In this paper I have tried to find an answer to the question why migrants are vulnerable to HIV/AIDS (or how mobility and migration increase vulnerability to HIV/AIDS). The paper is the result of a research project conducted during my internship at the regional office of the International Organization for Migration (IOM) in Pretoria, South Africa from 1 April until 1 September 2002. This project involved an extensive literature review and fieldwork in the form of interviews with migrant mineworkers from Lesotho. Both are discussed here in what must be seen as only a short and preliminary summary of my findings.[2] A comprehensive discussion of a matter of this complexity would exceed the scope of this paper, but within these limitations I have tried to deal with the matter as inclusive as possible.

The first section of this paper deals with the background and framework in which my research took place. It discusses both HIV/AIDS and the role that labour migration has played in the spread of HIV/AIDS in southern Africa.[3] Additionally it gives an overview of existing theories, ideas and research that have tried to link HIV/AIDS and labour migration with a focus on migrants as individuals at risk. The second section gives a more thorough vulnerability analysis of a specific group of migrant labourers: Basotho mineworkers. It is in this section that findings from my interviews with

[2] See my MA thesis for a more extensive presentation of the findings.

[3] Southern Africa is defined in various ways. For the purpose of this report, southern Africa comprises Angola, Botswana, DRC, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe.

mineworkers are introduced and discussed. The paper concludes with a number of suggestions that might help to reduce migrant labourers' vulnerability.

2 Labour migration and HIV/AIDS in southern Africa

2.1 HIV/AIDS in southern Africa

Southern Africa is the epicentre of the global HIV/AIDS epidemic. Of the estimated 40 million people living with HIV/AIDS worldwide at the end of 2001, sub-Saharan Africa accounts for 28.5 million people[4] (UNAIDS, 2002). In some southern African countries more than one in three adults is currently living with HIV/AIDS (see table 1).

Table 1 clearly shows the regional differences in HIV prevalence levels in southern Africa. In Botswana, Zimbabwe, Swaziland and Lesotho roughly one in three adults is currently living with HIV/AIDS, while HIV prevalence figures in Angola and DRC do not exceed six per cent. Besides these national differences, HIV prevalence rates may vary within the different countries.

Table 1 *HIV/AIDS in southern Africa*

Country	HIV prevalence (%) adult population (15-49) end 2001
Angola	5,5
Botswana	38,8
DRC	4,9
Lesotho	31,0
Malawi	15,0
Mozambique	13,0
Namibia	22,5
South Africa	20,1
Swaziland	33,4
Tanzania	7,8
Zambia	21,5
Zimbabwe	33.7

Source: UNAIDS, 2002.

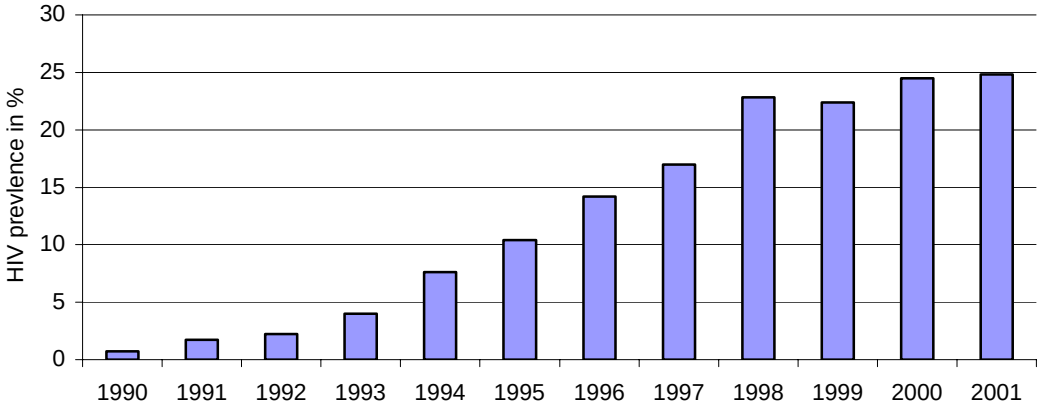
The first AIDS cases in the region were reported in the early 1980s. Because accurate statistics are not always available, it is difficult to get a good picture of the progression the HIV/AIDS epidemic in southern Africa. Some countries have reliable monitoring systems in place, like South Africa where, since 1990 the HIV/AIDS epidemic is monitored with an annual national survey among public antenatal clinic attendees.[5] Figure 1 clearly shows the rapid spread of HIV throughout the South African population. Since 1991 the estimated HIV prevalence among pregnant women in South Africa has increased from 1.7 per cent to 24.8 per cent in 2001 (Department of Health, 2002). Although the

[4] These 28.5 million people living with HIV/AIDS (PLWA) in sub-Saharan Africa make up more than 70 per cent of all PLWA. Sub-Saharan Africa houses only 10 per cent of the global population (UNAIDS, 2002).

[5] In countries were the epidemic is predominantly heterosexually driven, HIV prevalence among pregnant women is believed to be a reliable estimate for HIV prevalence among the population of reproductive age (aged 15-49) in general (UNAIDS, 2000: 117).

epidemics in southern Africa did not start simultaneously, the South African picture does give an idea of the development of the HIV/AIDS epidemic in southern Africa in general.

Figure 1 *National HIV prevalence levels of women attending public antenatal clinics in South Africa 1990-2001*



Source: DoH, 2002.

2.2 Epidemiology: what drives the HIV/AIDS epidemic?

The epidemiology of HIV/AIDS is concerned with the rapid spread of HIV.[6] Infectious diseases like HIV/AIDS are transmitted from one person to another. The main mode of transmission of HIV in southern Africa is (hetero) sexual intercourse (so-called pattern II transmission). Although HIV/AIDS is a medical condition restricted to only a few modes of transmission, the political economy creates an environment that induces transmission. HIV/AIDS is a *consequence of place* (Webb, 1997).

The spread of HIV through sexual intercourse is determined by a complex interplay of different factors. Scientists have come up with different theories or explanations for the rapid spread of HIV/AIDS in (southern) Africa. But as Hunt (1996) concludes in his analysis of theories on the transmission of HIV/AIDS in Africa, 'the AIDS epidemic in Africa is not definitely explained by any means' (p. 1296). Nonetheless, incomplete and imperfect explanations can assist us when we try to comprehend the HIV/AIDS epidemic in southern Africa.

2.2.1 Theories and explanations

Many theorists have tried to find an explanation for the rapid spread of HIV/AIDS in (southern) Africa. Hunt (1996) distinguishes between theories that are based upon *biological explanations* and theories that are based upon *social explanations*. The first category emphasizes the biological determination of the HIV/AIDS epidemic[7], while the theories in the second category have a historical-materialist or cultural nature.

Webb (1997) further distinguishes different approaches within social epidemiology. There is a structuralist approach, which emphasizes the importance of structures or macro issues. Economic and political processes (e.g. the debt crisis, poverty, urbanisation and government policy) influence the AIDS epidemic (Webb, 1997: 31). This approach situates epidemiology in a historical, economical and political context and has a strong focus on power relations within societies. The structuralist approach emphasizes that individual human behaviour is partially determined by global economic and political structures that act on an international and national level, but also locally (Lurie, 2001; Webb, 1997).

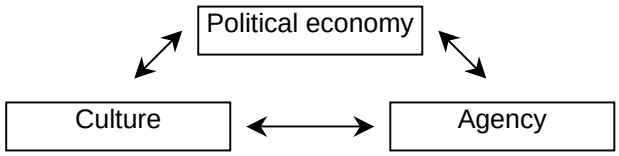
[6] Epidemiology is the study of epidemics, i.e. the study of rapidly spreading infectious diseases.
[7] Biological based theories include a natural history explanation and an explanation that uses race as a significant variable (Hunt, 1996).

On the opposite side of the structuralist approach is the *anthropological approach*, which examines the heterosexual spread of HIV from a bio-anthropological point of view. Cultural variables are the main study object of this approach (Webb, 1997: 29) and the focus is on sexuality and the psychology of individual (sexual) behaviour. It is in this context that some theorists speak of the promiscuity of African men and the tolerance of African societies towards multiple sexual partners.

There are certain dangers inherent to both approaches. Both the structuralist and anthropological approach have the same deterministic nature. The former implicates that in any given area with the same structures, people should develop the same behaviour patterns. The latter can easily lead to ethnocentrism and universalism that will lead to the simplification of the real life situation or the denial of the heterogeneity of African societies. Moreover, the biased focus on cultural and psychological elements of societies ignores the importance of political and economic structures and their impact on the spread of HIV/AIDS. Both approaches are individually not capable of explaining local and regional diversity in sexual behaviour (Webb, 1997: 30-32).

It is thus not only psychological factors that determine the spread of HIV, but also sociological, economical, political and historical factors. Webb conceptualises the social epidemiology of HIV as the study of the constantly changing interrelationship between culture, individual action and socio-political factors (see figure 2). Instead of a narrow focus on one aspect of HIV/AIDS epidemiology, epidemiologists have to look at the interplay of different factors that facilitate the spread of HIV.

Figure 2 *Interrelated themes within the social epidemiology of HIV/AIDS*



Source: Webb, 1997: 32.

2.2.2 The epidemiology of HIV/AIDS in southern Africa

The spread of infectious diseases such as HIV/AIDS and other STDs is not only the result of individual actions. It is also influenced by the political, social and economic organisation of a society (Lurie, 2000: 343). The epidemiology of HIV/AIDS is thus multi-causal. In the southern African context a large number of relevant variables are mentioned in the literature on the social epidemiology of HIV/AIDS. The role of poverty, conflict and gender inequity is reviewed in this paragraph. Paragraph 2.3 deals with the impact of migration and population mobility.

(Under)development and poverty

Decosas (1996) has identified a relation between developmental status and HIV prevalence on the national level. He has linked global patterns of distribution of HIV with national indicators of social development and found a strong correlation between countries' Human Development Index (HDI) values[8] and HIV prevalence rates: the countries with high HDI values were countries with a low HIV prevalence. Nonetheless, the question remains whether the epidemic is caused by development delays or merely is the result of development delays.

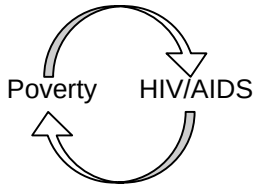
The links between poverty and HIV/AIDS are complex and not fully understood. On the one hand, poverty has played -and continues to play- an important role in the spread of HIV (Whiteside, 2001).

[8] The HDI is a development index used by the United Nations Development Programme (UNDP) based on four variables: life expectancy at birth, adult literacy rate, combined gross primary, secondary, and tertiary enrolment ratio and an adjusted measure of per capita economic production.

This role may not be very explicit but, as Colvin *et al.* (2001) argue, 'whilst there is little direct proof that there is a strong relationship between poverty and HIV/AIDS, it can be concluded from data on the changing distribution of HIV/AIDS that poorer people are more vulnerable to becoming infected'. In situations of dire poverty, the risk of HIV infection will not be the main concern of people. Poverty can drive women and young girls into prostitution or selling sex for food, money or services. Additionally, poor people may have less access to health care (including facilities to treat STDs) and condoms (Ateka, 2001; Buvé *et al*., 2002; Evian, 1993).

On the other hand, HIV/AIDS is likely to sustain and even increase poverty. This is very clear on the household level, for instance. Illness and taking care of sick family members forces productive members of the household to give up their job and households may lose their income and labour. At the same time, the household will have to spend more on health care, medicines and funeral services (Booysen *et al*., 2002). So basically the relationship between poverty and HIV/AIDS is a cyclic one (see figure 3).

Figure 3 *The relation between poverty and HIV/AIDS*



Conflict and war
Conflict and (political) instability contribute to the spread of HIV/AIDS in various ways. 'Countries experiencing political and/or economic instability have been more vulnerable to the spread of diseases such as HIV/AIDS' (Kalipeni, 2000: 966). During conflict or war, people become extremely vulnerable to HIV infection. Soldiers are living in a stressful environment, separated from their family, while civilians might get exposed to sexual violence and have to survive in situations of extreme poverty, which may force them to sell sex to survive (so-called survival sex) (Ateka, 2001; Buvé *et al*., 2002). Moreover, conflicts disrupt social institutions and family life, largely because wars and conflicts often lead to forced migration (Carballo *et al*., 2001) (see paragraph 2.3 and 2.4).

Gender inequity and the position of women
The subordinate social and economic position of women in many southern African countries leaves them particularly vulnerable to HIV/AIDS. Gender inequalities are acute in many southern African (mostly patriarchal) societies. Cultural and social systems have strict rules concerning female sexuality. Women in these societies have little control over their sexual lives and the sexual lives of their husbands/partners outside marriage (Buvé *et al*., 2002; Evian, 1993). While both traditional and modern definitions of masculinity usually prescribe early sexual initiation and accept (or even encourage) many different sexual contacts, women are often expected to be monogamous. 'This culturally prescribed lack of control on their sexual relationships has made women (…) highly vulnerable to HIV infection'[9] (Buvé *et al*., 2002: 2014). This picture of gender inequity is also apparent in the economic sphere. Women are often dependent on men for financial support and consequently find it difficult to enforce condom use or refuse sex (LeBeau *et al*., 2001).

2.3 Migration and the epidemiology of HIV/AIDS

Migration has been a catalyst in the rapid spread of HIV. The spread of infectious diseases that are transmitted from person to person will follow the movement of people (Decosas *et al*., 1995: 826). The spread of HIV/AIDS is thus likely to be accelerated in a situation of large-scale migration (Anarfi,

[9] It is obvious that these cultural systems do not only increase women's vulnerability, but also leave men at high risk.

1993: 46). This paragraph briefly examines the impact of migration on the spread of HIV/AIDS. The effect of migration on the individual and the reasons why mobility leaves individuals extremely vulnerable to HIV infection will be under discussion in paragraph 2.4.

2.3.1 Migration

Migration is usually defined as the movement of people from one place to another temporarily, seasonally or permanently, for a host of voluntary or involuntary reasons. This definition includes refugees and internally displaced persons. To distinguish among categories of migrants, the word *migrant* is usually restricted to those who move for voluntary reasons (internally or internationally), while *refugees* and *internally displaced persons* (IDPs) are those who move involuntarily (usually because of wars or other violent conflicts, but also because of human rights abuse). 'The issues for refugees [and IDPs] are similar to those for all migrants, but the basic problems are usually exacerbated' (UNAIDS, 2001a: 1).

In southern Africa, migration flows are mainly related to large-scale non-voluntary migration in Angola as a result of civil war, to economic migration towards South Africa and to (internal) rural-urban migration in all countries (Girdler-Brown, 1998). Mobile populations are extremely heterogeneous. While Angolan refugees are mostly internally displaced women, children and the elderly, economic migrants are more likely to be young men or women seeking (seasonal or temporarily) work in urban and industrial areas in South Africa.

2.3.2 Population mobility and HIV/AIDS

Migration can play a significant role in transmitting infectious diseases. The level of migration can explain the dissimilarity in HIV prevalence figures in different parts of Africa (Decosas, 1999). In the case of southern Africa, the largely seasonal or temporary character of migration (especially labour migration), with migrants returning home to their families on a regular basis, has facilitated the rapid spread of HIV/AIDS (Fages, 1999: 40). However, this relation between population mobility and the spread of HIV/AIDS is not undisputed. There may not be a causal relation between migration *per se* and the transmission of HIV.

This unclear relation between migration and the spread of HIV/AIDS influences the public opinion in various ways. For instance, governments become concerned that immigrants might bring HIV/AIDS with them. Today, however, there is increasing recognition that mobile populations may be more vulnerable to HIV infection than non-mobile populations. Migration thus not only facilitates the rapid spread of the virus along so-called *corridors of migration*, but also causes behaviours and situations, which facilitate transmission from one person to another (Caldwell *et al*., 1997: 51). This shift in the thinking about migration and HIV/AIDS has led to numerous studies that focus on migrant's vulnerability.

2.4 Migrants' vulnerability to HIV/AIDS

> If one were to design a social experiment in an attempt to create the conditions conducive to the spread of HIV and other sexually transmitted diseases, you would remove several hundred thousand rural men from their families, house them in single-sex hostels, provide them with cheap alcohol and easy access to commercial sex workers and allow them to return home periodically. These conditions roughly describe the situation for more than eight hundred thousand gold miners and countless other migrant labourers working throughout South Africa today (Lurie, 2001: 23).

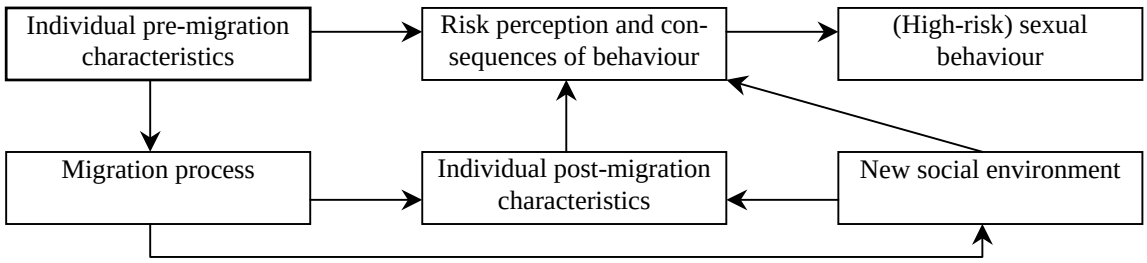
Vulnerability refers to the social, cultural, economic and political environment of individuals, families, communities and societies, and occurs in situations where people are limited in their ability to make free and informed decisions. In the context of the southern African HIV/AIDS epidemic, vulnerability is related to environmental factors that leave individuals or groups at risk of HIV infection. Webb (1997) defines these risk situations as 'socially and geographically defined zones where the capacity of the individual to respond effectively to a health threat is reduced' (Webb, 1997: 80). It is in these situations that people are vulnerable to HIV/AIDS.

Migrants are more vulnerable to HIV infection than are people who do not move, both in southern Africa (Abdool Karim, 1992; Decosas, 1995; Gilgen *et al*., 2001; Lurie, 2001) as in other African countries (Kane *et al*., 1993; Nunn *et al.*, 1995; Pison *et al*., 1993). This vulnerability is not the direct result of mobility. It is via circumstances and events related to the migration process that high risk of HIV infection is caused (Decosas *et al*., 1997). In other words: 'being mobile in and of itself is not a risk factor for HIV/AIDS; it is the situations encountered and the behaviours possibly engaged in during mobility or migration that increase vulnerability and risk regarding HIV/AIDS' (UNAIDS, 2001b: 5).

2.4.1 Determinants of sexual behaviour

Migrants' risk to HIV infection is largely determined by their sexual behaviour. High-risk sexual behaviour among migrants is usually attributed to changes as a result of migration. There are three factors related to migrants' sexual behaviour: pre-migration individual characteristics, changes in individual characteristics due to migration, and exposure to a new physical and social environment (Brockerhoff *et al*., 1999). These factors play a part in the construction of certain perceptions of risk, and eventually have an effect on the actual sexual behaviour of migrants (see the model in figure 4).

Figure 4 *The influence of migration on sexual behaviour*



Source: Brockerhoff *et al*., 1999: 836.

The pre-migration individual characteristics include sex, age, marital status, educational level, ethnicity, social status, and economic prospects. These characteristics influence the decision to migrate and migrants' perceptions of risk of HIV infection. The migration process itself changes some of these individual characteristics into post-migration individual characteristics. The most commonly cited post-migration characteristic is separation from a regular sexual partner and family. Furthermore, migrants' incomes are likely to increase in the case of labour migration and decrease in the case of involuntary migration. The third mechanism that links migration with sexual behaviour is the change of environment. The milieu in which migrants are living is likely to differ from the social and cultural environment at home and migrants may not have access to good (sexual) health services. Migration is very much gendered, which can result in a gender imbalance in both the sending and receiving areas (Brockerhoff *et al*., 1999; Decosas, 1999). Moreover, a new social environment can result in a lack of social support, which has been linked to risk-taking behaviour (Campbell, 2001: 284).

2.4.2 High-risk situations and sexual behaviour

The situations encountered and behaviours possibly engaged in during the migration process that increase vulnerability are numerous. They vary from person to person and from place to place. Undocumented migrants, for example, are faced by other problems than truck drivers, and the high-risk situations encountered by truck drivers are not comparable to the position in which many migrant farm workers find themselves. However, there are some common determinants of migrants' increased vulnerability and risk regarding HIV/AIDS.

First of all, HIV/AIDS education, health services including STD treatment, and condoms are not always available to migrant populations (Decosas *et al*., 1997; Girdler-Brown, 1998; Tarantola, 1999). This lack of access to public services may be due to cultural, social and language barriers that make communication problematic (Tarantola, 1999), a lack of money to buy the available services or, in the case of undocumented migrants, their illegal status.

Moreover, migrants experience many problems living in a new environment. This may influence their mental and physical health. High-risk behaviour such as sex with multiple partners is not solely the result of migration. It is also the result of alienation, of loneliness, of being separated from family and regular partners, and the breakdown of traditional family units. Women and men leave their familiar environment with traditional norms and values and the anonymity of being a foreigner can increase (risky) sexual activities (Decosas *et al*., 1997; Evian, 1993; Girdler-Brown, 1998).

Migration in southern Africa is to a large extent segregated by gender. Men follow different routes and have different destinations than women, which results in a gender disequilibrium in both the destination and sending areas (Decosas, 1997; 1999). This gender disequilibrium and the fact that most migrants are young create a fertile ground for high rates of partner change and commercial sex. For both migrant and local women selling sex may become a means to obtain desperately needed money. Sex is exchanged for money, goods, physical security, jobs, transport, *et cetera* (Evian, 1993; Tarantola, 1999).

Refugees and IDPs have to cope with a number of specific high-risk situations. Large refugee camps are often unhealthy environments where HIV/AIDS is not one of the main priorities. Services for family planning, women's health and the prevention and treatment of STDs are not always readily available, while HIV/AIDS is not foremost on the minds of refugees. Another major problem is sexual violence and exploitation. During conflicts many families and communities are disrupted, and women and children become extremely vulnerable to sexual violence and exploitation (Carballo *et al*., 2001; Decosas *et al*., 1997; Tarantola, 1999).

3 Basotho mineworkers in South Africa

3.1 Methodology

This study is largely based on 40 semi-structured in-depth interviews with Basotho mineworkers (see appendix 1 for the questionnaire/interview guide used in this study) at field offices of The Employment Bureau of Africa (TEBA) in Leribe and Maseru, Lesotho. The interviews were conducted in a three-week period in August 2002. On average, the interviews were 2 hours long, varying from one to three hours. Respondents with a good understanding of English were interviewed in English. The interviews in Sesotho were translated into English by a translator (TEBA fieldworkers). The interviews in English were tape-recorded only with the explicit permission from the respondents.

The TEBA fieldworkers at the TEBA offices recruited the respondents, mostly mineworkers on leave and retrenched mineworkers. Of the 40 respondents, 8 were recently retrenched mineworkers; the other 32 were still employed by a mining company or subcontractor. Only a small number of potential respondents refused to participate, mainly because the interviews took too long and they were in a hurry. One person indicated he did not want to discuss the issue of HIV/AIDS.

3.2 Basotho mineworkers

The migrant labour system on South African mines has always been dependent on foreign labour. Since the 1980s the proportion of foreign workers on the mines has more or less stabilised around 50 per cent. (Crush, 1995: 18). There are different reasons for mining companies to employ large numbers of foreign workers. According to the mining companies themselves, the sector cannot do without the skills, experience and work discipline of foreign miners. Another questionable argument has always been that some ethnic groups were better equipped (psychologically) for work on the mines. Additionally, the mining industry did not want to become overly reliant on any one source of labour (Crush, 1995: 20).

Starting from the second half of the nineteenth century, Basotho men have always been a large proportion of the foreign workforce on the South African mines. Lesotho has been dependent on the remittances of migrant labour ever since. Remittances from mineworkers in South Africa make up a large proportion of the country's gross national product. However, migrant labour by Basotho men to the mines in South Africa has halved in the 1990s. The downscaling South African mining sector has retrenched many workers and is trying to maintain its prominent international position with a mechanised production process and a smaller and more productive labour force (Sechaba Consultants, 1997; Turner *et al*., 2001).

Mineworkers are highly mobile populations. The majority of the respondents returned home once a month for two or three days, while at the same time almost half of the respondents indicated that their wives/regular partners sometimes travelled to South Africa to visit them. Mobile populations like mineworkers are vulnerable to HIV infection (see paragraph 2.4), because they often engage in high-risk relationships with women near the mines and in commercial sex (Jochelson *et al*., 1991). The precise impact of HIV/AIDS on mineworkers is difficult to estimate, since there are hardly any HIV prevalence figures available for the mining industry in southern Africa (Elias, 2001). A study in the Carletonville region (one of the major gold mining areas in southern Africa) in 1998 found that 28.5 per cent of all mineworkers was infected with HIV (Williams *et al*., 2000). Of mineworkers attending a STD clinic in the same region, 49 per cent tested HIV positive (Williams *et al*., 1998).

3.3 Interview findings

In my interviews I have focussed on three (often interrelated) themes related to mineworkers' vulnerability to HIV/AIDS: being a migrant mineworker, gender identity, and sexual behaviour and HIV/AIDS. The following paragraphs give a summary of the main findings.

3.3.1 Being a migrant mineworker

Working underground in South Africa
Lack of jobs in their own country was the reason for most of the respondents to look for employment in South Africa. Unemployment rates in Lesotho are extremely high and work on the mines in South Africa is a welcome opportunity for many men in Lesotho: 'You know…there is a life on that side [in South Africa]…there is no life in Lesotho.' More than 64 000 Basotho men were employed on South African mines in 2000 (Turner *et al*., 2001).

Work on the mines is hard and dangerous. The working conditions are unhealthy: 'Many people get sick and we lose a lot of colleagues…many have TB *[tuberculosis]*.' The miners complained about the heat underground and the long working hours, usually eight continuous hours a day, five or six days a week. They have to work in a stressful environment where the pressure is high:

> **Respondent**: The work on the mines is difficult…to spend eight hours underground. It is too hot. Sometimes you have to work in a small room…a small place and you have to bend over all the time. And the air is not good, it is not natural.

> **Respondent**: The work on the mines is hard. Now there is a lot of work and people are few. They [the mining companies] are not recruiting other people and one person now works for four persons. It is harder than before.

Family
When asked what they thought was the most difficult part of being a migrant mineworker, most respondents mentioned their family. They missed their wives, parents and/or children. Some felt they were not being a good husband/father because they could not see the children growing up or because they could not always assist the family in case of illness:

> **Interviewer**: What is the most difficult part of being a mineworker in South Africa?
> **Respondent**: The main problem is to be in the mines without you wife. You only see her after 2 months.

> **Respondent**: At home everything is all right. I am working at the mines just for work and to make money, not because I like it there.

> **Respondent**: I feel happy at home.
> **Interviewer**: Yes? In what way?
> **Respondent**: To see my family…is the most important thing. To see their prospering, their conditions, their sufferings. Because now, when I am still there [in South Africa] I'm worried. Are they…how are they coping? Even though I have got communication, telephones…but it is still much better to see somebody.

Housing
Almost all the respondents lived in large single-sex hostels, with up to 20 people sharing a room. The conditions in these hostels are far from perfect, above all respondents complained about a lack of privacy and the fact that they have to share almost everything: 'We don't like sharing a room. You can not read or something, you can not relax.' These single-sex housing facilities create an artificial situation where men are separated from their families and/or regular partner. These living conditions can lead to increased sexual activity outside the traditional family structures (Elias *et al*., 2001) and it is important to end this practice.

Some respondents did stress the need for better housing facilities and additionally, for better housing facilities for visiting family members. However, the solution is not as easy as providing family housing at the mines in South Africa. More than half of the respondents did not want their wife/regular

partner to stay with them in South Africa, even if housing was arranged. 'Somebody has to take care of the cows and sheep and other things' and 'I want to work there [in South Africa] only. Then I come home and there I have my house,' were typical answers to the question why they did not want their wife/regular partner to stay with them in South Africa. The respondents often indicated that they did not like South Africa for various reasons and that they preferred their family to stay in Lesotho:

Interviewer: Would you like your wife to stay with you in South Africa?
Respondent: No. There is no discipline on that side.
Interviewer: What do you mean?
Respondent: South Africa is no place for a woman. She will stay with other men.

For many mineworkers the work in South Africa was only a means to get enough money to start a business or small farm in Lesotho and many of them did not seem to support the idea of creating family housing facilities at the mines.

Living in South Africa
Many respondents complained about the fact that there was hardly any entertainment accessible in the mining compound. Usually there was a television set available and people could play soccer, darts or pool:

Interviewer: What do you usually do when your shift is over, after work?
Respondent: We watch TV in the TV room until late.
Interviewer: Are there other things you can do?
Respondent: No, not much. There is no entertainment in the compound.

Because inside the compound there is not much entertainment available, many mineworkers go outside the compound to look for distraction in the surrounding townships. Within the informal sector around these mining sites, activities such as *shebeens* (bars), brothels and gambling flourish, which creates environment conducive to risky sexual behaviour.

3.3.2 Gender identity

Responsibility
When they were asked what it means to be a real man, most of the respondents mentioned responsibility and faithfulness as the two most important aspect of masculinity. Responsibility usually refers to financial responsibility for family members in Lesotho. Almost all the respondents indicated they sent (or brought) money home, usually to their wives. Entire families are dependent on the income of mineworkers, not only wife and children but also parents, brother and sisters:

Respondent: I feel responsible for my wife, my child, my parents and my brothers and sister.
Interviewer: What does this responsibility mean, what do you do for them?
Respondent: I buy the things they need, I send the children to school, these kinds of things.

Respondent: A real man respects himself…respects his family. He must share his money with his wife and don't use the money on bad things on the mines…on prostitutes and drinks. He must share it.
Interviewer: Are people at the mines different, are they always being real man?
Respondent: Some people change when they arrive at the mine, some stay the same. Some drink too much, they don't send money home, they don't visit their family, they don t think about home. Some people like their family but others don't like them. They are not faithful so they can spend their money poorly.

Being faithful
The concept of being faithful is explained in different ways. First of all, it means to take care of the family, to be responsible even when you are not at home: 'A real man must be faithful to his family…must make a future for his own family and not start other families. But only few people are faithful at the mines. Once they are in South Africa they say: "My wife is too far so I have to go outside [sleep with other women]."' Being faithful is also explained in the sense of not sleeping with

other women. Men sleeping outside (with girlfriends or prostitutes) were often accused of not being good men.

Interviewer: What does it mean to be a real man?
Respondent: You've got to be strong and be faithful.
Interviewer: Is there a difference between being a man here [in Lesotho] and in South Africa?
Respondent: It can be at the mines and at home…responsibility is the answer.
Interviewer: The answer to what?
Respondent: You have to be strong not to go outside [sleep with other women] when you only see your wife once a month. If you are not responsible you will go with other women.

Respondent: Some men at the mines are not good men.
Interviewer: Why not?
Respondent: At the mines, some are not serious. They stay with other people...women. They are forgetting about their family at home. Some men stay with prostitutes.

Sometimes there was some confusion about what being faithful exactly meant. Often men, who admitted that they were seeing other women, still classified themselves as good men. The notion of being faithful was surrounded by a lot of hypocrisy. Although every respondent indicated that men and women in principal should be faithful to their partner (faithful in the sense of not sleeping with other men/women), some of them did not apply this standard to their own situation. This double standard was explained in various ways:

Respondent: I have sex with other girls. I have a friend in South Africa.
Interviewer: But you just told me that men should be faithful to their partner.
Respondent: Yes…but I send her money every week…to my wife.

Interviewer: You tell me you are faithful to your wife, yet you also tell me you have other girlfriends.
Respondent: When I'm sleeping outside [sleeping with other women] I always use a condom, so I am faithful to my wife. I can't give here the disease [HIV/AIDS], so she doesn't know.
Interviewer: So as long as you use condoms, you are being faithful?
Respondent: Yes, it is safe.

The practice of having multiple partners came up in different interviews. It was repeatedly justified with referral to the nature of men.

Respondent: AIDS at the mines…it is because of the hostels. Men live there alone and the government of South Africa allows the women to go there and sell themselves. Men live alone there and women arrive and they need money. There is no way…the man must follow.
Interviewer: The man must follow?
Respondent: They are living alone without their wives.
Interviewer: But men can refuse.
Respondent: Men are weak in that...especially when they [women/prostitutes] are near them when people drink. Some men stay without their woman for four weeks!

Respondent: You see, now I am back [in Lesotho] for only a day, so I have only one night with my wife. That is our problem, you see. That's why people…why I have a girlfriend. Because it can't be like this.
Interviewer: It can't be like what?
Respondent: That you have only one night with a girl.

Respondent: Men…they like to taste everything.
Interviewer: All men?
Respondent: All men like to taste. Men always go to different women.

This somewhat deterministic approach of sexuality can result in high-risk sexual behaviour. When people feel they don't have control over their lives and their sexual desire and when people have a sense of powerlessness, they are not likely to respond to HIV/AIDS education messages and engage in health promoting behaviours (Campbell, 1997).

3.3.3 Sexual behaviour and HIV/AIDS

Knowledge of HIV/AIDS
Mining companies, especially in South Africa, have started with HIV/AIDS education and awareness programs more than a decade ago. As a result, the general knowledge of HIV/AIDS among mineworkers is good. Although HIV/AIDS education programmes alone have not been effective[10], HIV/AIDS education remains extremely important. To change their sexual behaviours, people need to be aware of their risk and have some basic HIV/AIDS knowledge.

Questions about HIV/AIDS, modes of transmission of the virus, prevention methods, *et cetera* resulted in typical answers, clearly suggesting that respondents have undergone intensive HIV/AIDS training. However, in accordance with earlier findings of Macheke *et al*. (1998), the knowledge of HIV/AIDS was not complete and some answers indicated doubts and competing beliefs among the respondents. All 40 responded positive to the question whether they had heard of HIV/AIDS, but five informants told me they were not sure whether HIV/AIDS really existed: 'I have heard about it, but I am not sure if it exists.' There were also some doubts about a possible cure:

Interviewer: Do you think that HIV/AIDS can be cured?
Respondent: The traditional healers tell us that it can be cured.
Interviewer: But what do you think?
Respondent: I don't know…I don't know.

Condom usage
While condom usage was mentioned as a means of protecting oneself against HIV/AIDS by more than half of the respondents, 27 of 38 respondents did not use a condom during their most recent sexual contact and 12 respondents indicated they usually did not use a condom. Some respondents did not like condoms: 'Sometimes I just don't like it. I like it flesh-to-flesh sometimes.' Furthermore, condoms were seen as 'not natural' or people did not trust the safety of condoms:

Interviewer: So you don't use condoms?
Respondent: No. It was not created by God. Naturally sex can't be so…with plastic on your penis. It is made to touch one another, you see. Not to fuck something there…no, no, no!

Interviewer: Why do you not use condoms?
Respondent: They are poison.
Interviewer: Condoms are poisonous?
Respondent: I am afraid of the fluid inside condoms. It is poison.

There was a remarkable difference in condom usage with their wives/regular partners and casual partners. A majority (22 out of 35) of the respondents never used a condom when they were sleeping with their wife/regular partner, while at the same time 15 out of 21 respondents always used a condom with a casual partner. Respondents made a clear distinction between their wives, who they trusted, and their casual partners, who they distrusted:

Interviewer: Why do you always use a condom with a girlfriend and not always with your wife?
Respondent: I don't trust my girlfriends…I don't know them. But I trust my wife.

Interviewer: Why do you not use a condom when you are with your wife?

[10] Discussing the South African context Campbell *et al*. (1998) note that 'while [health education programmes] have succeeded in raising peoples' levels of factual knowledge of the risk of HIV infection, levels of HIV continue to rise and unprotected sex is still common in casual or commercial sexual encounters' (p.50). Simbayi (1999) makes a similar point: 'In view of the high levels of knowledge about AIDS and mostly positive attitudes towards AIDS and/or AIDS victims observed in South African [knowledge, attitude, behaviour and practice] studies, one would have predicted more prevalent safer-sex practices than was found to be the case' (p.161).

Respondent: She is a type of a lady that cannot be changed easily. You cannot change her much, even if you talk to her. She is saying: 'Why? Because you are my husband and I know you. Why are you preferring to use this [condom] with me?' So it is a very difficult question.

However, not all respondents trusted their partner while they were away. There was some suspicion among mineworkers:

Interviewer: Why do you think you are at risk of HIV infection?
Respondent: I might be infected by my wife. Women are never satisfied…financially.
Interviewer: Never satisfied?
Respondent: They always want more money, so they do things.
Interviewer: Do what?
Respondent: Sleep with men for money.

HIV/AIDS testing

Voluntary counselling and HIV/AIDS testing (VCT) services play an important role in the fight against HIV/AIDS. Since it is only through HIV positive people that the virus can be transmitted, it is important that people know their HIV status. People who test positive can be treated (if treatment is available) and educated about the dangers of transmitting the virus. If people test HIV negative, they can be trained with skills to stay negative.

The attitude of the respondents towards the issue of HIV/AIDS testing was characterised by a lot of ambiguity. Most of them acknowledged the necessity of knowing their HIV status, but at the same time there was a lot of fear. Only 10 out of 39 respondents knew their HIV status (had recently been tested), all of them were tested in South Africa.

Interviewer: Do you want to know if you are infected [with HIV] or not?
Respondent: No, I am afraid. If you know that you have AIDS you die. It is better not to know and live your life.

Behaviour change

Although there was not always a clear understanding of every aspect of HIV/AIDS, most respondents did appear to be aware of their risk of HIV infection. Mineworkers (along with prostitutes and young people) were often mentioned as one of the groups at high risk of HIV infection. As a result, many mineworkers tried to protect themselves against HIV/AIDS. When asked how they were protecting themselves, the most frequently mentioned prevention methods were condom usage and sleeping with one partner only.

Respondent: Now, since all that talking about AIDS…I am no longer greedy.
Interviewer: You are no longer greedy. What does that mean?
Respondent: It means…I don't just get attracted to anybody I see. I love my partner. It happens…it happens, but not so often. It happens to me…to get involved with somebody else. But I always make sure I carry a condom, even though I still don't trust them [condoms].

Sexual behaviour and life on the mines

'People change once they are in South Africa and on the mines.' This idea that people behave differently once they have left Lesotho was a recurring topic in many interviews. Although they were always talking about 'other men' or 'colleagues' and not about themselves, almost all respondents told me about people whose behaviour in South Africa would not be accepted and tolerated in Lesotho:

Interviewer: Are your colleagues at the mine always being faithful to their partners?
Respondent: Not all of them are faithful. Some see girls…they are really unfaithful. Their wives are here [in Lesotho] and then they can do their own things.
Interviewer: Do you think that people act different when they are in South Africa?
Respondent: Some people change. They start drinking beers and things, they start smoking, jollying around. People from outside South Africa, when they are in South Africa, they start doing their own things.

Interviewer: Why is it, do you think, that people are sleeping with other women at the mines?
Respondent: I don't know. It is just that people on the mines are…are just men living together. They are talking together and their minds are the same. And they are…you know, to be away from the family for a long time changes your mind. If you go to the mines and when you come back, you have changed! People here will say: 'This man has changed.' You are going to say to him that he has changed. It is that life at the hostel that changes. Yes.
Interviewer: How does it change people?
Respondent: It changes you because you meet so many different men from different countries, from Mozambique or… You start forgetting the way you have been brought up. No women, nothing. You talk about women late at night. You talk about it and someone will say: 'Tomorrow I will have to go to see a lady here.' and you will say: 'Let me go with you, I feel like it.'

There is clearly some relation between the system of labour migration and migrants' risky sexual behaviour. The interviews painted a picture in which mineworkers see themselves as powerless and insignificant. They recognize their own high-risk sexual behaviour, but don't think it is something that they can change. This understanding of their own problems should be kept in mind in the design of HIV/AIDS interventions aimed at mineworkers. It could also serve as a reason to focus more on environmental factors contributing to mineworkers' vulnerability to HIV/AIDS.

4 Conclusion

'Addressing the economic, political, social and cultural factors that render individuals and communities vulnerable to HIV/AIDS is crucial to a sustainable and expanded international response' (UNAIDS, 2002: 16). In the fight against HIV/AIDS in southern Africa, it is important to pay attention to specific groups, communities or locations. Migrants or mobile populations are one of these groups at high risk. In this paper I have tried to give an overview of the current debate around the vulnerability of migrants to HIV/AIDS in the southern African context. The factors or processes that contribute to this vulnerability are diverse, complex and not fully understood. Interventions aimed at mineworkers, and mobile populations and their communities in general, must take into consideration their unique pressures, constraints and living environments in order to address their vulnerability effectively. Rather than condemn individual behaviour, these interventions must situate sexual behaviour in its social context (Jochelson *et al.*, 1991: 170).

Certainly, the traditional interventions are extremely important. People must be encouraged to practice safe sex through education and the distribution of condoms. But this is not sufficient. These interventions must be combined with care initiatives, with the prevention and treatment of STDs[11] *et cetera*. Of more importance may be a discussion of social, political and economic factors that contribute to migrants' vulnerability. Issues such as poverty, the social status of women and even the migrant labour system itself should be given attention and may need to be questioned.

[11] The presence of STDs increases the transmission of HIV. Persons with an STD infection are more susceptible to HIV infection and are more likely than uninfected persons to spread HIV to their sexual partners. (Lamptey, 2002: 209). This clearly indicates the need for surveillance and early treatment of STDs and the relevance of STD prevention and treatment for reducing vulnerability. Successful interventions have been reported, for example in a South African mining community, where provision of STD treatment services to a core group of high-risk women eventually reduced the prevalence of STDs, not only in the target group, but also in the wider community (Steen *et al.*, 2000).

Appendix 1: Questionnaire/interview guide[12]

August 2002

My name is Daan Brummer. I am working on a research project for IOM (International Organization for Migration) and I am interviewing people here in ……… in order to find out more about the experiences of migrant mineworkers and about their knowledge, attitudes and behaviours related to HIV/AIDS. I want to collect information that can help to understand better the situation of HIV/AIDS in South Africa and Lesotho.

If you agree to participate in the survey, I will ask you some questions. Your honest answers are very important for the research project. Anything you say is completely confidential. Your name will not be written on this form, and will never be used in connection with any of the information you give me. You don't have to answer any question you don't want to answer (I will skip that question and continue with the following questions), and you can end this interview any time you want. I would greatly appreciate your help in responding to this survey. The survey will take about 60 minutes. Would you be willing to participate?

Do you mind if I record parts of the interview on tape? The tape will be used if I have problems recollecting parts of the interview at a later stage. Again, your name will not be connected with the tape and I will be the only person to have access to the tape.

Questionnaire identification number:……..
Date (dd-mm-yyyy):……..……..……..
Site:…….
Language:……
Recording:……...
Remarks:…….…….
…….……...

Section 1: Background information

No.	***Question***	***Answering categories***	***Skip to***
Q01	How old are you? *(age in years)*	……..……...	
Q02	What is your nationality?	……..……...	
Q03	Where were you born? *(district)*	…….	
Q04	Where do you live at the moment? *(district)*	…….	
Q05	For how long have you been living in … ? *(number of years living in district Q04)*	…….	
Q06	What is your marital status? Have you got a regular partner? Are you living together with your wife/regular partner?	Married, living with partner O Married, not living with partner O Unmarried, living with regular partner O Unmarried, not living with regular partner O No steady partner O No partner O Other……..……. O	
Q07	How many children do you have? *(number of (alive) children)*	……..……...	
Q08	What is your home language?	Sesotho (South Sotho) O Other……..…….. O	
Q09	Can you read easily in your home language?	Yes O No O	

[12] This questionnaire is partly based on the HIV/AIDS Prevention Indicator Survey (UNAIDS/MEASURE Evaluation) and the HIV/AIDS Behavioral Surveillance Survey (Family Health International).

No.	*Question*	*Answering categories*	*Skip to*
Q10	Can you read easily in English?	Yes O No O	
Q11	How many years have you been in school? *(number of years)*	……..……...	
Q12	At what age did you leave school? *(age in years)*	……..……..……..	
Q13	At what grade did you leave school? *(highest grade completed)*	……..……..……..	
Q14	What kind of work do you do at the moment?	Mineworker O Unemployed O Other……..……. O	Q16
Q15	Where do you work at the moment? *(nearest city/town/village)*	……..……...	
Q16	How would you describe your economic position at the moment?	Very good O Good O Reasonable O Bad O Very bad O	

Section 2: Being a migrant mineworker

No.	*Question*	*Answering categories*	*Skip to*
Q17	At what age did you go to the mines for the 1st time? *(age in years)*	…….	
Q18	For how long have you been a mineworker? *(number of years)*	…….	
Q19	Why did you leave for the mines (instead of staying in Lesotho)? *(more than one answer possible)*	No job opportunities at home O Better salary than at home O Other……... O	
i	*Additional questions migration history*		
Q20	At what mine were/are you employed? *(nearest city/town/village)*	…….	
Q21	On average, how many hours a week did/do you work there? *(number of hours, estimate if not sure)*	…….	
ii	*Additional questions working on the mines (working hours, physical workload, mental workload location, colleagues, compare situation at the mine with situation at home)*		
Q22	What was your average monthly salary before deduction? *(salary in rands, estimate if not sure)*	…….	
Q23	What was your average monthly salary before deduction? *(salary in rands, estimate if not sure)*	…….	
Q24	Is anyone except yourself dependent on your salary?	Yes O No O	iii
Q25	How many people are dependent on your income? *(number of people)*	……..…..	
iii	*Additional questions salary spending (basic needs, entertainment, sending money home, savings)*		
Q26	Was/is your wife or regular partner with you at the mines?	Yes O No O	Q29
Q27	Would you like your wife or regular partner to be with you?	Yes O No O	
Q28	When you were/are at the mines, what type of accommodation did/do you have?	A bed in hostel/compound (mine housing) O A single room (mine housing) O A house (mine housing) O A place outside compound O Other…… O	
Q29	When you were/are at the mines, did/do you have a room for yourself?	Yes O No O	iv

No.	*Question*	*Answering categories*	*Skip to*
Q30	With how many persons did/do you share the room?	…….	
iv	*Additional questions living in the compound (accommodation, privacy, additional services, entertainment)*		
v	*Additional questions being a migrant worker in South Africa (work, separation from loved ones, being away from home)*		
vi	*Additional questions contact with home (visits, how often)*		
Q31	Have you got a (rural) homestead?	Yes O No O	 viii
Q32	When you were/are at the mines, who was/is taking care of the homestead?	Wife/regular partner O Relative O Other…… O	
vii	*Additional questions responsibility (partner, children, family, friends, what kind of responsibility, financial, is it something that is expected from you, (possible contradiction between responsibility and being a migrant worker)*		

Section 3: Identity and gender

No.	*Question*	*Answering categories*	*Skip to*
viii	*Additional questions decision making (decision to migrate, work/unemployment, economic position, influence of other people, in Lesotho, in South Africa)*		
Q33	Are you feeling different being at home (on leave) compared to living in South Africa?	Yes O No O	
ix	*Additional questions difference between Lesotho and South Africa*		
x	*Additional questions being a real man (characteristics, behaviours, tasks, responsibilities, culture, difference between Lesotho and South Africa)*		
xi	*Additional questions being a real woman (characteristics, behaviours, tasks, responsibilities, culture)*		
xii	*Additional questions effect of migration on relation (separation, stress, financial situation) (if applicable, see Q06)*		

Section 4: HIV/AIDS and sexual behaviour

The last section of the interview is about HIV and AIDS. Please try to answer these questions as detailed as possible. If you feel uncomfortable answering one of the questions, we will skip that question and continue with the following question.

No.	*Question*	*Answering categories*	*Skip to*
Q34	Have you ever heard of HIV or AIDS?	Yes O No O	 Q37
Q35	In the past 4 weeks/month, have you heard or seen any information about HIV/AIDS?	Yes O No O	 Q37
Q36	In the past 4 weeks/month, from what source did you receive information about HIV/AIDS? Any other source? *(more than one answer possible)*	Television/radio O Newspaper/magazine O Wife/regular partner O Girlfriend/casual partner O Friend or colleague O Doctor or nurse O HIV/AIDS educator O Don't know O Other…… O	
Q37	Do you think HIV/AIDS exists?	Yes O No O Don't know O	

No.	*Question*	*Answering categories*	*Skip to*
Q38	How can a person get infected with HIV? Any other way? *(more than one answer possible)*	Have sex O Have sex without a condom O Have sex with many partners O Touch a person who has HIV/AIDS O Kiss a person who has HIV/AIDS O Injection with a used needle/sharing needles O Blood contact O Breast feeding (child) O During pregnancy or delivery (child) O Don't know O Other…… O	
Q39	Is there anything a person can do to avoid infection with HIV?	Yes O No O	 Q41
Q40	How can you prevent HIV infection? Any other way? *(more than one answer possible)*	Use condoms O Reduce the number of partners O Have sex with only one partner O Have sex with healthy looking partners O No commercial sex (sex with prostitute) O Have no sex at all O Don't use used needles/don't share needles O Avoid blood contact O Don't know O Other…… O	
Q41	Do you think HIV/AIDS can be cured?	Yes O No O	 Q43
Q42	How can HIV/AIDS be cured? Any other way? *(more than one answer possible)*	Using condoms from now on O Living and eating healthy O Go to a hospital/clinic/doctor O Taking medicines O Don't know O Other…… O	
Q43	Do you know people personally who are living with HIV/AIDS?	Yes O No O	
Q44	Did you know people personally who have died of AIDS?	Yes O No O	
Q45	Do you know whether you are infected with HIV or not?	Yes O No O	
Q46	Have you ever been tested for HIV?	Yes O No O	
Q47	Do you want to know whether you are infected with HIV or not?	Yes O No O Don't know O	
xiii	*Additional questions testing (why (not), experiences with previous tests, do it again)*		
Q48	Who are, according to you, at high risk of HIV infection? Any other people? *(more than one answer possible)*	People who don't use condoms O People who are unfaithful to their partner O People who have many girl/boyfriends O Commercial sex workers (prostitutes) O Migrant workers/people who travel O Other…… O	
Q49	What are, according to you, the chances that you could be infected with HIV?	No chance O Small chance O Good chance O Don't know O Already infected O	
xiv	*Additional question being at risk (why (not)) (see Q48 and Q49)*		

No.	*Question*	*Answering categories*	*Skip to*
Q50	If you were worried that you are infected with HIV, where would you go? Any other place or person? *(more than one answer possible)*	Hospital/clinic/doctor O Pharmacy O Wife or regular partner O Girlfriend or casual partner O Family O Friend or colleague O HIV/AIDS educator O Other…… O	
Q51	Have you changed your sexual behaviour because of HIV/AIDS?	Yes O No O	
Q52	How are you protecting yourself from HIV infection by means of sexual intercourse? Any other way? *(more than one answer possible)*	Use condoms O Never use condoms O Reduce number of partners O Have sex with only one partner O No commercial sex (sex with prostitute) O Have no sex at all O Not protecting myself O Other…… O	
Q53	At what age did you have sex for the 1st time? *(age in years)*	……	
Q54	Have you ever paid money for sex?	Yes O No O	
Q55	Have you ever offered gifts, food or drinks for sex?	Yes O No O	
Q56	Have you ever used a condom?	Yes O No O	Q62
Q57	How often do you use a condom?	Use condoms every time O Use condoms most times O Use condoms sometimes O Never use condoms O	
Q58	Last time you had sex, did you use a condom?	Yes O No O	
Q59	In the last 6 months, did you have sex with your wife/regular partner? *(if applicable, see Q06)*	Yes O No O	
Q60	Last time you had sex with your wife/regular partner, did you use a condom? *(if applicable, see Q06)*	Yes O No O	
Q61	How often do you use a condom with your wife/regular partner? *(if applicable, see Q06)*	Use condoms every time O Use condoms most times O Use condoms sometimes O Never use condoms O	Q63
Q62	Why do you not use a condom every time you have sex with your wife/regular partner? Any other reason? *(more than one answer possible)*	I trust my wife O Prefer skin-to-skin O She may think I am HIV positive O She may think I am unfaithful O Condoms are too expensive O Condoms are not available O Other…… O	
Q63	Did you ever have sex outside your marriage/relationship with regular partner? In the last 6 months?	Yes, in the last 6 months O Yes, but not in the last 6 months O No O	xvi
Q64	With whom did you have sex other than your wife/regular partner?	Commercial sex worker O Girlfriend/casual partner O Other……..... O	
xv	*Additional questions other partner(s) (regular partner, casual partner(s), CSWs, difference between Lesotho and South Africa)*		
Q65	Last time you had sex with a person other than your wife/regular partner, did you use a condom?	Yes O No O	

No.	*Question*	*Answering categories*	*Skip to*
Q66	How often do you use a condom with a person other than your wife/regular partner?	Use condoms every time O Use condoms most times O Use condoms sometimes O Never use condoms O	xvi
Q67	Why do you not use a condom every time you have sex with a person other than your regular partner? Any other reason? *(more than one answer possible)*	I trust her O Prefer skin-to-skin O She may think I am HIV positive O She may think I am unfaithful O Condoms are too expensive O Condoms are not available O Other…… O	
xvi	*Additional questions condoms (when (not) use a condom, why (not), with whom (not))*		
Q68	Is it difficult to get condoms at home?	Yes O No O	
Q69	Is it difficult to get condoms at the mines?	Yes O No O	
Q70	Do you discuss HIV/AIDS with your wife/regular partner?	Yes O No O	Q
Q71	Why do you not discuss sex and sexual relations with your wife/regular partner	Uncomfortable/difficult subject to discuss O It is not something you discuss O Other…….. O	
Q72	Do you think a woman should be faithful to her partner?	Yes O No O	
Q73	Do you think a man should be faithful to his partner?	Yes O No O	
xvii	Additional questions being faithful *(when (marriage, regular partner, girlfriend), why (not), differences between men and women, 'double standard')*		

This is the end of the interview. If you have got any questions about the research you can always contact me later on the following number:……. Thank you very much for taking time to answer these questions.

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