



IOM International Organization for Migration



AN ASSESSMENT OF HEALTH VULNERABILITIES AMONG INTERNAL LABOUR MIGRANTS IN NORTHERN MOZAMBIQUE'S CASHEW INDUSTRY

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FOREWORD

This study identifies a compelling but under-researched area of the HIV epidemic in Mozambique. The economic, social and cultural implications of the epidemic need to be thoroughly analyzed so that appropriate measures can be devised to prevent new infections, scale up treatment, and provide care and support to those most in need. The 2009 population-based survey on prevalence and behaviour on HIV and AIDS depicts an extremely complex and heterogeneous epidemic, with higher prevalence rates in urban settings and in areas of high mobility.

IOM's focus on the migrant population working in the re-emerging cashew industry in Northern Mozambique is crucial in understanding the increased vulnerability to HIV of a particularly key population. The study also offers invaluable insights into the challenges faced by mobile populations in accessing necessary health care – whether for HIV prevention, care or treatment or for other illnesses such as TB and malaria.

The results of the assessment of HIV and AIDS-related knowledge, attitudes and behaviours among employees in cashew-processing factories in northern Mozambique, as well as the level of access to health care in the communities where those factories are located define appropriate measures to reduce new infections, scale up treatment, and care and support services to vulnerable migrant workers.

In complement to other studies in Mozambique (Assessment of Health Vulnerabilities Among Migrant and Non-Migrant Workers in the Ports of Maputo, Beira and Nacala, IOM, October 2010), IOM's focus on mobile populations in "spaces of vulnerability" address structural and workplace issues that further increase the vulnerability of cashew factory workers to HIV. It is worth noting that although migrant cashew workers in this study exhibited a better understanding of HIV and AIDS treatment than non-migrants and had a higher rate of HIV testing, both migrant and non-migrant workers participated in risky sexual behaviour such as low condom use, multiple and concurrent partners and transactional sex.

The United Nations family in Mozambique and its Technical Team on AIDS fully subscribes to and supports the implementation of the recommendations of this study. First, we must promote health and HIV prevention measures at the cashew factories and in the communities where they are located. Secondly, access to health products and services, including workplace HIV testing and condoms must be promoted. Finally, through coordinated and common messaging, activities must focus on the promotion of a supportive environment for industry workers that promote a healthy lifestyle and that connect the factories and community at large.

IOM is a crucial partner for an effective national HIV response. Together, we must use the evidence highlighted in this study to lead the implementation of our bold vision for reaching zero new infections, zero discrimination, and zero AIDS-related deaths in Mozambique.



Mauricio Cysne
UNAIDS Country Coordinator
Mozambique

1. EXECUTIVE SUMMARY

1.1 Background

1.1.1 Migration

Internal and cross-border migration in southern Africa, whether driven by a search for safety or better economic opportunities, impacts the health of migrants as well as members of their host communities and countries (IOM, 2008a). As such, human mobility is a public health issue in southern Africa, both as an epidemiological matter and in terms of physical access to health services (Weiss & McMichael, 2004). In the case of migrants, and the communities they migrate to, communicable diseases such as HIV and tuberculosis are of particular concern, as are mental health and reproductive health problems (Carballo, 2007; Grondin, 2004).

Many of the factors that drive mobility, such as poverty, unemployment and

political instability, also put migrants and their families at an increased risk of health problems even before they leave their homes (IOM, 2008c; Grondin, 2004; Carballo, 2007). Migrants in southern Africa are considered to be at an increased risk of contracting HIV for a variety of reasons. They are often separated from their spouses, or regular partners, and may in the face of poverty, discrimination and exploitation turn to risky sexual practices. Moreover, mobility not only increases the vulnerability of migrants to HIV and AIDS but can also, owing to their transient state, limit migrants' access to necessary health care – whether for HIV prevention, care or treatment or for other illnesses such as TB and malaria.



Figure1: Factors that can affect the health and well-being of migrants during migration



In this context, IOM Mozambique, as part of its regional Migration Health programme, conducted an assessment of HIV and AIDS-related knowledge, attitudes and behaviours among employees in three cashew-processing factories in northern Mozambique, as well as an evaluation of access to health care in the communities where those factories are located. The cashew industry in Mozambique is appropriate for study because it is a growing and important industry that is characterized by a high percentage of migrant workers – a recent study estimates that approximately 35 per cent of the roughly 6,000 workers in northern Mozambique’s cashew processing factories are internal labour migrants.¹

1.1.2 Health vulnerabilities among migrants in Mozambique

According to UNAIDS, it is estimated that there are 1.3-1.7 million Mozambicans living with HIV and AIDS.² The most recent Inquiry on National Prevalence, Behaviour Risk and Information (Knowledge) of HIV/AIDS commissioned by the Ministry of Health (INSIDA 2009) estimated a countrywide prevalence of 11.5 per cent among the adult population aged 15 to 49. Women are at a higher risk and have an estimated HIV prevalence of 13.1 per cent, while men have an estimated prevalence of 9.5 per cent.³ AIDS is responsible for an estimated 37 per cent of deaths of people over

five years of age.⁴ Studies show that over 90 per cent of HIV infections in Mozambique occur through sexual contact with multiple concurrent sexual partners and the failure to use condoms is generally understood to be a principal driver involved in HIV transmission.⁵

High population mobility, including cross-border travel, has been identified as a key driver of the AIDS epidemic in Mozambique.⁶ As transport and communications systems have been rehabilitated following Mozambique’s long civil war, workers have increasingly moved in search of work within and without the country, thereby contributing to the spread of the epidemic. HIV prevalence also varies by region within Mozambique, with the southern part of the country, a region historically associated with labour migration, having the fastest growing rate. Southern provinces that are particularly hard hit include Maputo, Sofala and Gaza.⁷

Mozambique has historically experienced a significant amount of

1 TechnoServe Comprehensive Survey of Cashew Factory Workers in Nampula, 2007

2 <http://www.unaids.org/en/CountryResponses/Countries/mozambique.asp>

3 Inquérito Nacional de Prevalência, Riscos Comportamentais, e Informação sobre HIV/SIDA em Moçambique: INSIDA 2009; Ministry of Health; Prevalence Section of Report released in preliminary and summary form in June, 2010.

4 Instituto Nacional de Estatísticas, *Relatório Preliminar do Inquérito sobre Mortalidade em Moçambique*, March 2010. In the overall population (including children under 5 years of age), malaria is the leading cause of death (29%), followed by HIV/AIDS (27%).

5 Plano Operacional da Estratégia de Aceleração da Prevenção da Infecção pelo HIV, *Conselho Nacional de Combate Ao HIV/SIDA*, January 2009; Dodson, B. and Crush, J., *Mobile Deathlihoods: Migration and HIV/AIDS in Africa*, Paper for the UNAIDS Project ‘AIDS in Africa: Scenarios for the Future,’ 2003.

6 República de Moçambique Conselho Nacional de Combate ao SIDA, *O Plano Estratégico Nacional de Resposta ao HIV/SIDA 2010-201*, 6

7 IOM Briefing Note on HIV and Labour Migration in Mozambique (Pretoria 2007).

internal and cross-border migration.⁸ During the civil war that occurred after Mozambique's independence from Portugal in 1975, 1.7 million Mozambicans took refuge in neighbouring countries and several million more were internally displaced. Following a peace agreement in 1992, Mozambican refugees constituted the largest repatriation ever witnessed in sub-Saharan Africa, and a further estimated four million internally displaced people within Mozambique returned to their areas of origin.⁹

Migration patterns in Mozambique have shifted since the end of the civil war and its related processes of resettlement. Migration in Mozambique over the last decade appears to be driven principally by economic factors and includes the following trends:

- internal migration due to disparities in development, standards of living and employment opportunities among different regions in Mozambique;
- the increasing feminization of migration as more women become labour migrants, often in the less skilled sectors of the economy such as agriculture, domestic work and informal trade;¹⁰
- higher internal and external mobility as long-distance travel both

within and outside Mozambique is facilitated by improvements in infrastructure, including roads, ports and railways;

- traditional/longstanding patterns of cross border mobility to South Africa for work in the mining, agriculture and informal sectors; and,
- an influx of Zimbabwean migrants due to the economic and political crisis in Zimbabwe, which borders Mozambique and is linked to it by important trade routes.¹¹

1.1.3 IOM's Migration Health approach

Within southern Africa, IOM has a Migration Health approach that provides a framework for its health activities in the region, especially those that relate to health promotion and support to migrants. IOM's Migration Health programmes address the health needs of individual migrants as well as the public health needs of host and sending communities by assisting governmental and non-governmental partners in the development and implementation of relevant policies and programmes. In May 2008, the IOM Standing Committee on Programme and Finance approved IOM's strategy paper: *Migration and Health: IOM's Programmes and Perspectives: towards a multi-sectoral approach*. This highlights an IOM focus on three strategic programme areas (IOM, 2008c) in the field of migration health:

1. Service Delivery and Capacity Building: Providing access to health services for migrants, especially the most vulnerable. Services cover: prevention and health promotion;

8 Labour migration in Mozambique dates back to the late-nineteenth century, when an average of over 100,000 Mozambicans annually migrated to work in the gold mines and sugar cane fields of South Africa. *Migration in Southern Africa*, Jonathan Crush, Vincent Williams, Sally Peberdy, for Global Commission on International Migration, September 2005; Helena Dolny, "The Challenge of Agriculture," in John Saul, ed., *A Difficult Road: The Transition to Socialism in Mozambique*, (New York, 1985), 214-223.

9 *Repatriation as peacebuilding and reconstruction: the case of northern Mozambique, 1992-1995*, Olaf Tataryn Juergensen, International Development Research Centre, October 2000.

10 *Migration in Southern Africa*, Jonathan Crush, Vincent Williams, Sally Peberdy, for Global Commission on International Migration, September 2005.

11 According to the 2005 Mozambique UNGASS report, there is clear evidence that the AIDS epidemic is spreading fastest in provinces that contain transport links to countries bordering Mozambique. Southern Mozambique has the fastest growing rate of infection, with Maputo, Sofala and Gaza provinces being particularly hard hit by the spread of HIV/AIDS.

control and management of infectious diseases, chronic diseases, mental health, reproductive health, and social health needs; and environmental hygiene and control.

2. Advocacy and Policy Development: Advises partners and governments on best practices in the management of migration health issues and related strategies and policy options.
3. Research and Information Dissemination: Responds to the needs of governments, partner agencies and civil society for evidence-based, disaggregated information on migrant health.

IOM's migration health framework includes mainstreaming health into other IOM service areas such as counter trafficking, using a human rights-based and public health approach, ensuring gender is proactively mainstreamed in all activities, promoting a partnership approach that brings together relevant stakeholders to address the issue in a harmonized and multi-sectoral approach. IOM's migration health approach considers the different health and HIV vulnerabilities associated with the migration process rather than considering the migrant as the health vulnerability. This approach identifies "spaces of vulnerability" – these are often places where migrant workers live, work or pass through that are areas of high-risk HIV vulnerability (see box below).

Spaces of vulnerability

Often the places in which migrant workers live, work or pass through are high-risk spaces of HIV vulnerability. The presence of many different migrant and mobile populations and interaction with local communities at places such as land border posts, ports, construction sites, informal settlements, farm compounds and mines creates a fluid social environment where social norms regulating behaviour are usually not followed and migrants may feel a sense of anonymity and limited accountability that can lead to high-risk sexual behaviour. Poverty and lack of job opportunities in the communities surrounding such places also induces many women (both migrants and locals) to engage in transactional and commercial sex with those who have resources or disposable income.¹²

¹² IOM, *Regional Assessment on HIV-prevention needs of Migrants and Mobile Populations in Southern Africa* (Pretoria, 2010), 20.

1.2 Methodology

This assessment consisted of two parts:

- 1) A total of 89 interviews with employees at cashew factories were conducted through the use of an in-depth, interviewer-led questionnaire that sought to elicit information on socio-demographic indicators and patterns of mobility; perceptions of local health problems and health services; knowledge and beliefs regarding HIV transmission, prevention and treatment; sexual behaviour and condom use; and HIV testing.
- 2) A total of four key informant interviews were held in order to understand the health care resources and challenges in the communities where the cashew factories are located. Key informants included health care professionals at the local hospitals.

1.3 Findings and conclusions

The assessment findings confirm that the cashew industry in Mozambique consists of a semi-permanent labour force composed of significant numbers of internal migrants. Since cashew processing is a year-round job, these migrants tend to settle in their new communities for most of the year, and thus represent a labour force caught somewhere between more traditional labour migration and a permanent “industrial” workforce.

The findings also reveal that labour migrants in the cashew industry tend to be precarious wage earners due to the economics of the cashew industry that make factory interruptions or closures common. Moreover, an industry-wide

wage structure that pays most workers according to quotas means that some cashew workers do not earn the minimum agricultural wage of 57.50 meticals per day (approximately \$1.70).

The communities in which these labour migrants have settled are highly rural and exhibit low economic diversification, with the majority of working-age adults subsisting from small family farms. The majority of non-migrant cashew workers surveyed in this assessment had not previously engaged in wage labour.

Although migrant cashew workers in this study exhibited a better understanding of HIV and AIDS treatment than non-migrants and had a higher rate of HIV testing, both migrant and non-migrant workers participated in risky sexual behaviour such as low condom use, multiple concurrent partners and transactional sex.

With respect to health care resources available to the cashew workers, none of the factories in this study provided health services or regular HIV education to their employees.

Interviews with health care professionals revealed a series of challenges in addressing HIV and AIDS in these communities. In particular, these professionals cited the low rate of initiation and compliance with ARV treatment by HIV-positive patients. They attributed this to various factors including stigma and denial; fear and misperceptions about ARVs; and side effects owing to a poor diet. Health professionals also pointed to particularly low rates of ARV treatment among HIV-positive females due to the dominance by men of household health care decisions.

2. CASHEW PROCESSING IN MOZAMBIQUE

2.1 A re-emergent industry

Cashew production has long constituted a significant part of Mozambique's economy, providing income to several million individuals across the country, from formal and informal growers and traders to factory workers to vendors in the country's street markets.¹³ In the 1960s, Mozambique produced as much as half of the world's total raw cashew nuts and, following independence in 1975, it became the first African country to process cashews on a large scale.¹⁴ The devastating impact of Mozambique's civil war and economic policy miscalculations, however, pushed the industry into sharp decline in the 1980s and 1990s.

In recent years, the cashew industry in Mozambique has experienced something of a renaissance. The emergence of a new labour-intensive model of factory organization and widespread technical assistance to farmers have helped Mozambique recover from being a negligible cashew processor (as recently as 20 years ago) to being the fourth largest processor in the world today, after Vietnam, India and Brazil.¹⁵ Moreover, Mozambique

now ranks sixth in the world for raw cashew nut production.¹⁶

2.2 New opportunities for wage labour

Cashew processing in Mozambique is concentrated in the northern province of Nampula, where there are currently thirteen cashew processing factories employing between 4,500 and 6,000 workers.¹⁷ Processing is extremely labour intensive, such that the rebirth of the industry has sparked a mini-revolution in the regional job market. In the rural communities where cashew factories have opened, which are generally agricultural areas with little economic diversification, the new factories have provided opportunities for wage labour as an alternative or complement to subsistence farming and informal trading.¹⁸ Indeed, in districts of Nampula province where cashew factories are located, between five and eight percent of residents perform wage labour, as compared to an average of two percent in districts with no cashew processing factories¹⁹

2.2.1 Labour migration to the cashew factories

A significant number of these new jobs in the cashew factories of northern Mozambique are being filled by what cashew worker Momade Abakar characterizes as an influx of "people coming from other places" rather than from the communities in which the

13 Nearly one million households grow cashew nuts in Mozambique, of which 95% are smallholder farmers. Brad Paul, *Value on the Margins: Wealth and Poverty in the Cashew Commonwealth*, (TechnoServe, 2009), 18; "Labor Costs within Mozambique's Cashew Processing Factories: Statutory Minimums and Requirements for Competitiveness, Summary Report (December 2006)," slide 24; Olutayo Akingbe et al, "Cashew Nuts in Mozambique: Recommendations for Developing a Viable Sector," May 2005, 14; Melissa Hall et al., "Benchmarking the Global Cashew Industry," 22.

14 Margaret McMillan, Karen Horn, and Dani Rodrik, "When Economic Reform Goes Wrong: Cashews in Mozambique," (May 2003)

15 Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ), *Competitive African Cashew Value Chains for Pro-Poor Growth* (August 2008). 19; *FAO Cashew Production Data, 1965-2007*; Schwanenflugel and Pinto, "Miranda Expansion Project: Building a World Class Cashew Industry in Mozambique," 47-48; Horus Enterprises, *Long-Term Trends in the International Cashew Market and Strategic Implications for Sub-Saharan African Exporters: Final Report* (June 2005), 26

16 Cashew Handbook 2008: A Global Perspective.

17 TechnoServe Comprehensive Survey of Cashew Factory Workers in Nampula, 2007.

18 In Nampula province, cashew nut farming accounts for nearly one-fifth of total household income and approximately two-thirds of total cash income. Olutayo Akingbe et al, "Cashew Nuts in Mozambique: Recommendations for Developing a Viable Sector," May 2005, 14.

19 Brad Paul, *Factories in the Field: Rural Transformation and the Organization of Work in Mozambique's Cashew Triangle*, (Techno Serve, Maputo, 2008), 23; Save the Children-US, Nampula Province Details, District Characteristics.

new factories are located.²⁰ A 2007 study by TechnoServe, an American NGO, found that an estimated 35 per cent of workers in Nampula's cashew processing factories are internal labour migrants.²¹

A labour recruitment strategy that targets migrants has become one of the defining features of northern Mozambique's new cashew processing model. Many factories rely, especially in the start-up phase, on employees who have previously worked in the industry. Therefore, factories recruit experienced labourers in towns with existing factories or factories that have shut down. Even to the extent that they may have no prior cashew factory experience, migrant workers remain a preferred target for cashew labour recruitment because seasonal harvest and machamba²² requirements cause high rates of absenteeism among locally-hired workers. In fact, research indicates that the most productive full-time cashew factory workers are internal labour migrants from Nampula and Cabo Delgado provinces²³

Internal migrants also arrive at the gates of Mozambican cashew factories due to "push" factors. The lack of access to fertile land and viable markets, and the impact of drought, natural disasters, and disease often drive agricultural households to factory work.²⁴ This may be particularly true in the northern coastal stretches of Nampula province. This is one of the most food insecure areas of the region and here poor households have a tradition of seeking

outside employment in both "normal" and "bad" harvest years.²⁵

2.2.2 A unique type of labour migrant

Labour migrants in the cashew industry present unusual characteristics that allow us to consider internal labour migration in new ways. For example:

- They are a product of a recruitment strategy that seeks to recruit, in many cases, experienced workers from areas where other cashew factories operate or have operated. The arrival of these more experienced, non-local workers at the factory and in the community can lead to conflict with the local population, in particular because locals perceive the recruited migrants as taking jobs that would otherwise be available to them.
- These internal migrants generally travel without their families or spouses and establish a semi-permanent presence in their new communities. Year-round work at the factories means that migrants in this industry seldom return home for any significant period of time other than for a few weeks during the holidays. In this way, labour migrants in the cashew industry occupy something of a middle ground between more traditional labour migrants and a permanent "industrial" workforce and their experience challenges the prevailing cyclical view of labour migrants as people who work for short periods of time – often seasonally – and then return to their areas of origin.
- They tend to be precarious wage earners due to an industry-wide wage structure that pays most workers by weight rather than per day. Cashew

20 Paul, *Factories in the Field*, 24.

21 TechnoServe Comprehensive Survey of Cashew Factory Workers in Nampula, 2007

22 A "machamba" is a garden or small plot of land used for subsistence agriculture.

23 TechnoServe Comprehensive Survey of Cashew Factory Workers in Nampula, 2007; *Factories in the Field*, 24

24 Paul, *Factories in the Field*, 14.

25 FEWS NET and Ministry of Agriculture and Rural Development, "Food Economy Profile Baseline and Current Year: Coastal Nampula and Southern Cabo Delgado (2002)," 2-5

workers paid “by weight” – shellers, roasters, classifiers and peelers, among others – cannot earn the daily minimum agricultural wage of 57.50 meticals (the equivalent of approximately \$1.70) if they do not meet certain weight quotas.

- They are dependent on an economically uncertain industry where the demand for migrants is not entirely linear or predictable. In fact, in the last year, nine cashew factories have closed down in Mozambique – four in Nampula Province, three in Inhambane Province, one in Cabo Delgado Province, and one in Gaza Province.²⁶ The temporary suspension of production at a factory or an outright closure can spell severe hardship for such an insecure workforce. Moreover, technological advances in cashew processing, experimental forms of factory reorganization and harvest size may also play a role in influencing demand for labour, and thus labour migration in this industry.²⁷

These features often mean that labour

migrants in the cashew industry are not experiencing significant improvements in their material conditions. They continue to have to balance their absence from home with remittance obligations, labour-intensive work, little pay and an uncertain future.

2.2.3 *Health-related challenges for a semi-permanent labour force*

In this context, studying the HIV and health-related gaps and needs of cashew workers in Mozambique provides important insights into the particular health-related challenges of a semi-permanent but unstable migrant labour force. Findings from this study may have implications not only for the cashew industry, but also for the health needs of other, similarly situated workers in emerging Mozambican industries such as cotton, banana and sugar processing. For example Mantanuska Africa Limited’s new 3,000 hectare banana plantation in the Nacala Corridor (Namialo and Monapo districts) promises to add up to 4,000 new jobs by 2012, many of these sourced from surrounding districts. Given the high percentage of contingent and migrant labour in these growth industries, their location within or near important transport corridors in Mozambique and the link between HIV and mobility, there is a critical need for private sector engagement and immediate donor support for accessible and sustainable interventions in migration health.

26 “Fabricas Encerram Portas e Milhares de Trabalhadores na Rua,” *Zambeze*, April 22, 2010. Note that these figures do not capture the overall net loss/gain for Mozambican cashew factories during this time period, since, as is the nature of this unpredictable industry, new factories may also have opened as well.

27 “Fabricas,” *Zambeze*, April 22, 2010.

3. SURVEY SITE DESCRIPTION AND METHODOLOGY

3.1 Survey site description

This study was conducted in three towns in northern Mozambique where privately-owned cashew processing factories are located: Anchilo and Murrupula, both in the Province of Nampula, and Alto Molócuè, in the Province of Zambezia.

3.1.1 Anchilo

The cashew factory in the town of Anchilo opened in 2008. As of March 2010, the factory employed 770 people (440 men and 330 women).

Anchilo is located approximately 20 kilometres east of the city of Nampula, along the major highway that runs between Nampula and the port city of Nacala. Anchilo has a population of 54,572, comprising approximately one-third of the total population of the Administrative District of Nampula.²⁸ According to its 2005 district profile, Anchilo:²⁹

- Has an illiteracy rate of 77.6 per cent
- Of the working-age population in the District, 98 per cent are self-employed, the vast majority in subsistence farming (an estimated 95% of jobs in the District are in agriculture)
- Only 2 per cent of working-age residents in the District are wage earners

28 Within Mozambique, the “district” is an administrative subgroup of the “province”. Within each district, there are “administrative posts,” which are essentially towns. The administrative posts of Anchilo, Rapale, Mutivaze and Namaita comprise the District of Nampula.

29 Ministry of State Administration, 2005 District Profile: District of Nampula, available at: http://www.undp.org/mz/en/districts/provincia_de_nampula

- None of the homes in the area have electricity or running water and approximately 99 per cent of houses are made of straw or mud.

3.1.2 Murrupula

The cashew factory in the town of Murrupula opened in 2003. Until recently, it had approximately 250 employees. The factory suspended production in April 2010, at least for the remaining calendar year, due a lack of available raw cashew nuts for processing.

Murrupula is located approximately 90 kilometres west of the city of Nampula, along the major highway that connects Nampula and the city of Quelimane, the capital of Zambezia Province. Murrupula has a population of 83,763, comprising approximately two-thirds of the total population of the District of Murrupula.³⁰ According to its 2005 District Profile, Murrupula:³¹

- has an illiteracy rate of 83 per cent.
- Of the working-age population in the District, 98 per cent are self-employed, the vast majority of whom in subsistence farming (an estimated 95 per cent of jobs in the District are in agriculture).
- Only 2 per cent of working-age residents in the District are wage earners.
- None of the houses in the District have running water or electricity, and between 98-99 per cent of houses are made of straw or mud.

30 The administrative posts of Murrupula, Chinga and Nehessine comprise the District of Murrupula.

31 Ministry of State Administration, 2005 District Profile: District of Murrupula, available at: http://www.undp.org/mz/en/districts/provincia_de_nampula

3.1.3 *Alto Molócuè*

The cashew factory in the town of Alto Molócuè opened in January 2009. It currently has approximately 275 employees (130 men and 145 women).

Alto Molócuè is located in Zambezia Province, approximately 200 kilometres west of the city of Nampula, along the major highway that connects Nampula and the city of Quelimane. Alto Molócuè has a population of 162,236, comprising approximately two-thirds of the total population of the District of Alto Molócuè.³² Similar to Murrupula, according to its 2005 District Profile, Alto Molócuè:³³

- has an illiteracy rate of 69.9 per cent.
- Of the working-age population in the District, 97 per cent are self-employed, the vast majority of whom in subsistence farming (an estimated 92 per cent of jobs in the District are in agriculture).
- Only 3 per cent of working-age residents in the District are wage earners.
- None of the houses in the District have running water, 2 per cent have electricity and the vast majority of houses are made with mud walls (89%) and/or straw roofs (96%).

3.2 Methodology

Interviews for this assessment were conducted with both health care professionals and employees of the cashew factories (“the cashew workers”) located in each of the three towns.

In order to gather structural information about health services in the area, interviewers made site visits to the local public health care facility in each town and met with the Hospital Director in Anchilo, the District Health Director in Murrupula and the District Health Director in Alto Molócuè to discuss health issues and access to health care in their respective communities. Interviewers also met with two representatives from International Centre for AIDS Care and Treatment Programmes (ICAP) – an NGO that works with national and provincial health authorities, including those in Anchilo and Murrupula, to provide HIV and AIDS-related clinical mentoring, training and infrastructure support.

With respect to the cashew workers, a team of four interviewers from IOM visited each cashew factory to conduct one-on-one, standardized survey interviews. Interviewees were selected at random with the assistance of factory management, with an effort being made to interview a selection of cashew workers that was consistent with job categories and gender distribution in the factory.

A total of 89 survey interviews were conducted in the three factories (34 in Anchilo, 26 in Murrupula, and 29 in Alto Molócuè). Each survey interview lasted approximately 30-45 minutes. Surveys were conducted primarily in Portuguese, the official language of Mozambique, although in some cases in Macua, a local language spoken in Nampula and Zambezia provinces.

The in-depth, interviewer-led questionnaire designed for the study sought to elicit information from cashew workers on the following categories:

32 The administrative posts of Alto Molócuè and Nauela comprise the District of Alto Molócuè.

33 Ministry of State Administration, 2005 District Profile: District of Alto Molócuè, available at: http://www.undp.org/mz/en/districts/provincia_de_zambezia

- Socio-demographic information
- Migrant status, patterns of mobility and work history
- Perceptions of health problems and health services in the area
- Knowledge about HIV transmission, prevention and treatment
- Sexual behaviour and condom use
- HIV testing.

Survey respondents were also given the opportunity for open-ended discussion about their opinions or concerns regarding health care in the area.

The introductory section of the questionnaire included an opening statement providing background on the survey, statements assuring the interviewee of anonymity and a request for

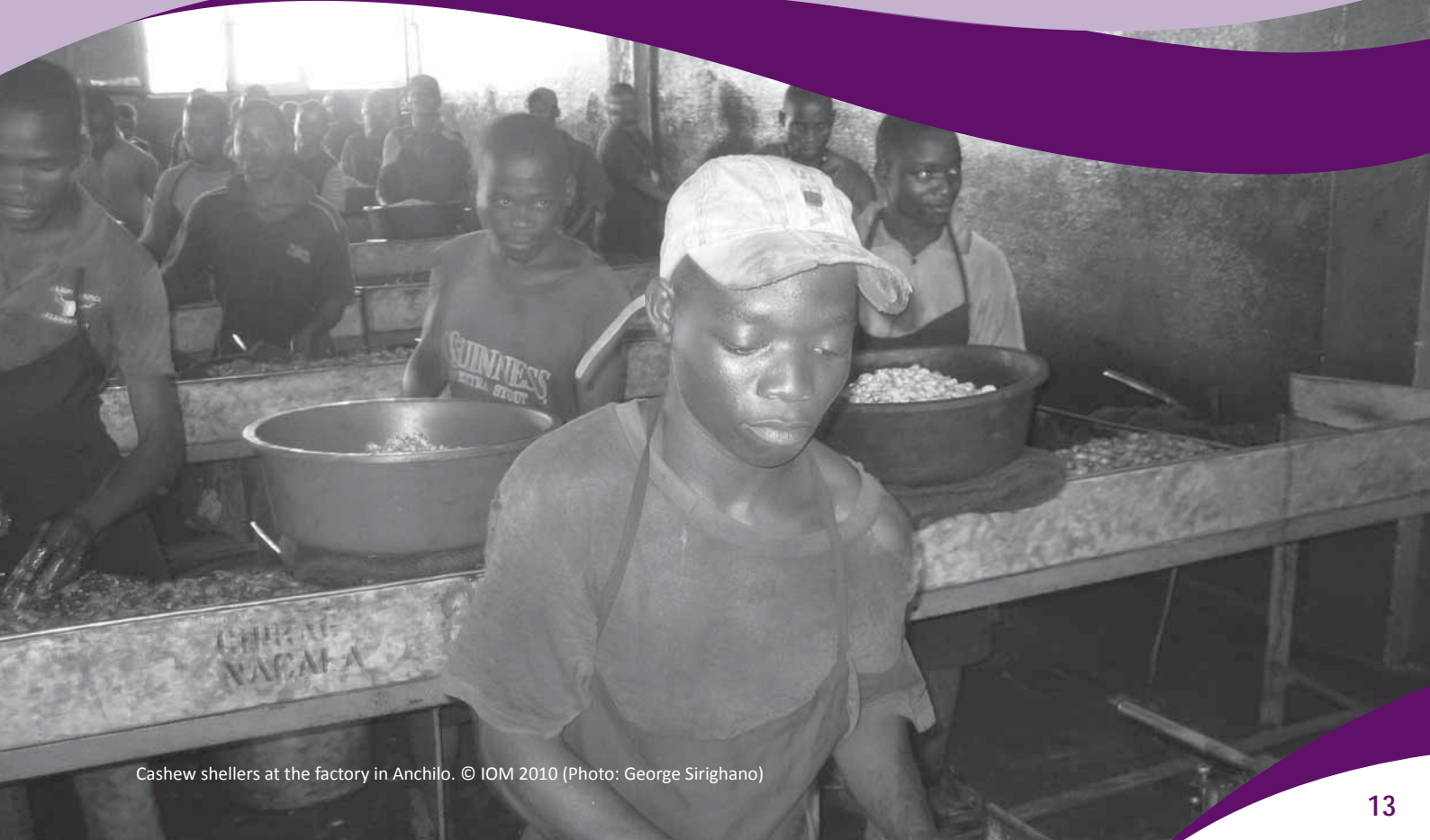
oral consent by the interviewee to participate in the study. A copy of the questionnaire is included in the Annex to this document.

3.3.1 *Limitations*

It is important to note that this was a qualitative assessment with a limited sample size and sampling strategy. Consequently, the findings from this study may not be representative of all knowledge and viewpoints across cashew worker populations.

In addition, due to the sensitivity of the topic under investigation, bias and/or inaccurate responses are possible.

However, given the intended use of the findings from this assessment — programmatic design and areas for implementation within these specific communities — the general trends and tendencies that have been identified can be considered useful.



4. ASSESSMENT FINDINGS

4.1 Results of survey interviews with cashew workers

During the data analysis cashew workers were categorized as “migrants” and “non-migrants”. Cashew workers were considered to be migrants if they were not born and raised in the area where the factory at which they worked was located. This is consistent with IOM’s definition of “migrants and mobile populations” for its work on HIV and AIDS that includes “people who move from one place to another temporarily, seasonally or permanently for a host of voluntarily and/or involuntarily reasons.”³⁴ Migrants made up 66.3 per cent of the survey respondents in this assessment.

4.2 Demographic characteristics

Gender: Of the 89 cashew workers interviewed, 28.0 per cent were women and 72.0 per cent were men. Of this total, a similar gender distribution was reflected within the subgroup of migrant workers (23.7% women and 76.3% men) and the non-migrant subgroup (36.7% women and 63.3% men).

Age: The survey population was distributed across a broad range of ages. For purposes of this assessment, respondents’ actual ages were organized according to ranges, with the following results: 18-24 (40.4%); 26-30 (25.4%); 31-35 (20.2%); 36-45 (15.7%); Over 46 (4.5%); Do Not Know (2.2%). Respondents’ ages were generally consistent between migrants and non-migrants.

Schooling: Of the respondents, 38.2 per cent had no schooling or only some primary-level schooling; 47.2 per cent completed primary school (7th grade); and the remaining 14.6 per

cent completed junior-secondary education (10th grade) or higher. When education levels were broken down by migration status, migrants exhibited significantly higher levels of junior-secondary education. Indeed, 20.4 per cent of migrants completed junior-secondary education (10th grade) or higher, as compared with only 3.3 per cent of non-migrants. Migrants and non-migrants completed primary school (7th grade) at roughly the same rates – 47.5 per cent of migrants and 46.7 per cent of non-migrants – while a higher proportion of non-migrants had no schooling or only some primary school (50.0% of non-migrants as compared to 32.2% of migrants).

Relationship status: Of the respondents, 76.4 per cent were married or in a long-term relationship. Marriage rates were consistent between migrants and non-migrants – 78.0 per cent of migrants were married as compared to 73.3 per cent of non-migrants. However, of the married migrants, 17.4 per cent did not live full-time with their spouses, as compared with 3.3 per cent of married non-migrants.

4.3 Work experience

Experience: Migrants tended to have higher levels of work experience than non-migrants, including higher levels of experience in the cashew industry itself. Of migrants, 69.5 per cent had previously been employed, compared with only 40.0 per cent of non-migrants. Further, 42.3 per cent of migrants had previously worked at another cashew factory, while only 3.3 per cent of non-migrants had done so. The discrepancy in work history, especially with regard to the cashew industry, appears to be related to the factories’ practice of recruiting workers in towns where cashew factories have operated in the past.

Work contracts: A higher number of migrants than non-migrants reported having a work contract (81.4% of migrants, as compared with 66.7% of non-migrants). Moreover, of the respondents who indicated that they had

³⁴ IOM, *Regional Assessment on HIV-prevention Needs of Migrants and Mobile Populations in Southern Africa* (Pretoria, 2010), 7-8; Danielle Grondin, “From Migration Towards Mobility: Needs for a New Model of Migration Health Policy,” (International Organization for Migration, ed).

work contracts, more than twice as many non-migrants as migrants (33.3% versus 14.6%) did not know what the contract guaranteed. Several workers attributed their lack of knowledge about their contracts to the fact that they were not given enough time to review them or permitted to keep copies.

Job category: The distribution of jobs among interviewees (for example, shellers, peelers, classifiers) was generally consistent between migrants and non-migrants. It should be noted, however, that a significant discrepancy existed with respect to supervisors – all of the seven supervisors interviewed for this assessment were migrants. Anecdotally, several non-migrant workers complained during interviews about the lack of non-migrant supervisors and noted that migrants were disproportionately given other types of coveted jobs within the factory, for example security guards and janitorial staff, that required less physical labour and paid a daily, rather than by-weight, wage.

Perceptions of discrimination: Migrants (72.9%) and non-migrants (90.0%) stated that no discrimination against migrants existed at the factory. Several respondents clarified that if it was more difficult for migrants to secure jobs at the factory this was not due to discrimination but rather to migrants' lack of contacts within the community.

4.4 Social environment

Mobility: As previously described, cashew workers are not seasonal labourers, but rather labour migrants who tend to be based in their new communities for the duration of the work year. In the three factories surveyed for this assessment, the work year tended to run from January to November. Nevertheless, migrants tended to visit their areas of origin with some frequency during the work year. Of the migrants interviewed for this assessment, 32.2 per cent returned home at least once per month; another 8.5 per cent returned home between three and four times per year; and 42.4 per cent returned home between once and twice per year. Depending on the frequency of their home visits, migrants remained in their home

areas from one day to the entire two-month period during which the factories closed for the holidays. The frequency with which migrants returned to their areas of origin appeared to be a function of the distance between those areas and the factory. For example, 92.9 per cent of respondents who had migrated from an area located 100 kilometres or less from the factory returned to their homes at least once per month. By contrast, only 26.3 per cent of migrants whose place of origin was located between 101 and 299 kilometres from the factory visited home at least once per month (the most common frequency of visits for this group was once per year – 42.3%). For those migrants who had migrated from an area located over 300 kilometres from the factory, only 5.3 per cent visited at least once per month (again, the most common frequency of visits for this group was once per year – 57.9%).

Home ownership: Approximately half the migrants interviewed rented their homes in the area (47.5%);³⁵ in contrast, all of the non-migrants either owned their homes (90.0%) or lived with family (10.0%). In addition, only 54.2 per cent of migrants cultivated a “machamba”³⁶ in the town where their cashew factory was located, as compared to 80.0 per cent of non-migrants.

Remittances: Migrant households retain less of their earnings than non-migrant households given the expectation that migrants will remit money to relatives in their home areas. Despite multiple complaints by migrants that they barely earned enough to cover the expenses of their workplace household, 61.0 per cent sent money home. Of those, 48.6 per cent sent money home at least once per month;³⁷ 25.7 per cent sent money home between three and four times per year and 25.7 per cent sent money home between once and twice per year.

35 35.6 per cent of migrants owned homes in their areas of origin.

36 Small plot of land.

37 Payment in the cashew industry is made on a monthly basis.

4.5 General health environment

Common illnesses: Respondents were asked what they considered to be the most common illnesses in the area. Migrants and non-migrants exhibited no appreciable differences in the types of diseases that they considered to be most widespread in the towns where they worked. The vast majority of respondents (77.5%) named malaria as the major health concern in their community. Other common responses were respiratory illnesses (32.6%), diarrhoea (28.1%) and HIV/AIDS (21.3%). Respondents also named cholera (11.2%), tuberculosis (7.9%), and malnutrition (5.6%) as among the major diseases in the area. Notably, migrants cited these diseases in similar proportions when asked to identify the most common illnesses in their areas of origin. For example, a nearly identical percentage of migrants identified HIV as a problem in their current area as they did for their area of origin (15.3% vs. 16.9%).

Local health care resources: In order to better understand respondents' attitudes about local health care resources, the cashew workers were asked where they would seek care if they felt ill. A strong majority of both migrants (76.3%) and non-migrants (63.3%) said that they would go to the local public hospital, which in each of Anchilo, Murrupula and Alto Molócuè was the only health care facility available in the area. Among respondents who did not indicate that they would seek care at the local public hospital, non-migrants were nearly four times as likely to say that they would consult a traditional healer in the case of illness than were migrants (20.0% vs. 5.8%).

Of the 93.3 per cent of respondents who had used their local hospital, 64.3 per cent rated the overall services as "good", 25.0 per cent as "average", and 10.7 per cent as "weak". Notably, though, almost all (96.4%) of these respondents reported that they were "satisfied" with the health care they had received at the local hospital. These respondents largely indicated that their satisfaction resulted from having had their particular ailment cured and not necessarily from the standard of care and range of services provided by hospital.

When asked what they would change about the local health system, if anything, 32.6 per cent of respondents said that they would improve the range of services provided by the hospitals, including X-rays, operations and blood transfusions, since the hospitals in Anchilo, Murrupula and Alto Molócuè are community hospitals that are not equipped to handle complex procedures.³⁸ Respondents also complained about long waits at the hospitals (21.3%) and about the need for more doctors and/or nurses (9.0%). Another commonly expressed desire (13.5%) was for the hospital pharmacies to experience fewer shortages of medication. Respondents also suggested that the cashew factories themselves should have health clinics with basic services so that, among other things, workers could have more immediate access to health care. Notably, 28.1 per cent of respondents said that they would either not change anything about the health system in the community where they worked or could not make any suggestion at that time.

4.6 HIV and AIDS

All the cashew workers interviewed had heard of HIV and AIDS and respondents displayed a fair level of knowledge about the disease, including the modes of HIV transmission, prevention and treatment. However, many respondents reported engaging in risky sexual behaviour such as limited condom use and multiple concurrent partners.

Transmission: Most respondents (89.9%) knew that HIV can be transmitted through risky sexual behaviour (86.4% of migrants and 96.7% of non-migrants). Three-fifths of the respondents who mentioned sex as a method of transmission were also able to identify an additional HIV transmission method such as blood transfusions or the sharing of sharp

³⁸ Alto Molócuè is a "rural hospital," a designation in the Mozambican health system that denotes a greater capacity and range of medical services. Indeed, the hospital provides x-ray services and is equipped to perform small operations. The Anchilo and Murrupula hospitals are both considered Level I health care facilities, which means that they offer fewer services and are not equipped to perform operations or x-rays.

objects. This proportion did not significantly differ between migrants and non-migrants. However, migrants were almost three times more likely than non-migrants (10.2% vs. 3.3%) to say they did not know how HIV is transmitted.

Condoms: A majority of respondents (66.3%) mentioned condom use as an HIV prevention method. Migrants appeared to be more likely to understand the role of condom use in reducing HIV infections than non-migrants (71.2% vs. 56.6%). Conversely, proportionally

fewer migrants than non-migrants mentioned limiting the number of sexual partners as a method of protecting themselves against HIV (39.0% vs. 56.6%). Overall, 10.1 per cent of respondents were unable to identify any method of limiting HIV risk (11.9% of migrants vs. 6.7% of non-migrants).

Despite generally high levels of understanding regarding the importance of condom use in HIV prevention, 47.5 per cent of migrants and 50.0 per cent of non-migrants reported “rarely” or “never” using them during sex.

Reported number of partners in last 12 months for respondents with low reported condom usage	Migrants rarely or never using condoms (47.5%)	Non-migrants rarely or never using condoms (50.0%)
One sexual partner	60.7%	80.0%
Two sexual partners	21.4%	6.7%
More than two sexual partners	17.8%	13.4%

Apart from the nearly half of all respondents who reported “never” or “rarely” using condoms during sex, 14.6 per cent said they “always” used them, 6.7 per cent said they “usually” used them while 29.2 per cent said they “sometimes” did. These responses were generally consistent between migrants and non-migrants, except in the case of respondents who reported “always” using condoms – 18.6 per cent of migrants reported doing so while only 6.7 per cent of non-migrants did.

Almost half (48.7%) of the respondents who indicated that there are instances in which they do not use condoms (namely, those who responded “usually,” “sometimes,” “rarely” or “never”) said it was because they were not concerned with contracting disease from their partner. (Of these respondents, 70.3% reported having only one sexual partner in the last 12 months.) Other common responses included that condoms reduce sensation (18.4%) and that they are not readily available (11.8%). An additional 11.8 per cent of respondents could not or did not explain why there were instances in which they did not use condoms during intercourse.

Sexual behaviour: Respondents who reported being sexually active (100.0%) were asked about the number of sexual partners they had in the past 12 months. Over half of respondents (53.9%) reported having one sexual partner in that time period while 3.4 per cent reported having no sexual partners, 16.9 per cent had two partners, 13.5 per cent had between three and five partners, 10.1 per cent had between six and ten partners and 2.2 per cent had over ten sexual partners in the last year. There was little variation in responses given by migrants and non-migrants, except with respect to those with two sexual partners (20.3% of migrants vs. 10.0% of non-migrants).

Variations were observed between men and women with respect to the number of sexual partners in the last year. Of the respondents, 76.0 per cent of women reported having only one sexual partner as compared to 45.3 per cent of men. Moreover, no woman reported having more than two sexual partners in that time period whereas 36.0 per cent of men did.

Respondents were also asked about transactional sex. Respondents (36.0%)

reported having given or received money in exchange for sex and 18.0 per cent reported having given or received clothing, food or accommodation in exchange for sex. There were no appreciable differences in responses given by migrants and non-migrants to these questions although some overall gender differences existed with 29.2 per cent of all female respondents having given or received money, clothing, food or accommodation in exchange for sex, compared with 45.3 per cent of all male respondents.

Testing: Survey respondents were asked several questions with respect to HIV testing. Overall, nearly half the respondents (48.3%) indicated they had taken an HIV test and 90.7 per cent of those who had been tested had collected their results. HIV testing rates appeared to be somewhat higher among migrants (52.5%) compared to non-migrants (40.0%). This discrepancy in testing was even more pronounced between female migrants (57.1%) and female non-migrants (36.4%). Migrants also reported having been tested for HIV more recently than their non-migrant counterparts – 61.3 per cent of migrants who reported having been tested for HIV had been tested within the last six months compared to only 8.3 per cent of non-migrants. With respect to testing at the workplace, 93.9 per cent of migrants and 83.3 per cent of non-migrants said that they would take an HIV test if it were offered at the cashew factory.

Treatment: Migrants exhibited a greater awareness than non-migrants concerning treatment of AIDS. When asked if they knew how AIDS can be treated, 61.0 per cent of migrants stated that medication exists to treat the illness, compared with 40.0 per cent of non-migrants. Other responses to this question included good hygiene and a proper diet. High percentages of respondents in both groups, however, did not know how AIDS could be treated (28.8% of migrants and 40.0% of non-migrants).

When asked specifically about anti-retroviral medications (ARVs), migrants demonstrated both greater awareness and confidence in their use for the treatment of HIV and AIDS – 79.7 per cent of migrants as compared with 66.7

per cent of non-migrants had heard of ARVs. Among those who had heard of ARVs, 72.3 per cent of migrants compared with 65.0 per cent of non-migrants considered them to be effective; 46.9 per cent of migrants compared with 35.0 per cent of non-migrants knew somebody who was taking ARVs and 78.1 per cent of migrants compared with 57.1 per cent of non-migrants knew that ARVs could be obtained free-of-charge at their local hospital.

Moreover, of those respondents who had heard of ARVs, 31.9 per cent of migrants compared to 5.0 per cent of non-migrants reported knowing somebody who had abandoned his or her ARV treatment at some point. Over one-third of these respondents did not know why ARV treatment had been stopped (37.5%) while 31.2 per cent believed that treatment was suspended because the person had been cured. Other reasons that were cited were shame (6.3%), side effects (6.3%) and the distance from the person's home to the health facility (6.3%).

Outreach: Respondents perceived some outreach efforts in the community related to HIV education – 64.0 per cent of cashew workers stated that outreach efforts existed in their communities, although 31.6 per cent of these respondents could not name any groups or organizations that engaged in these efforts. Respondents' perception of HIV outreach at the cashew factories themselves was lower, as only 33.7 per cent of cashew workers reported that outreach efforts had been made there. Of these respondents, 63.3 per cent could not name any groups or organizations that engaged in these efforts.

4.7 Results of interviews with health officials in Anchilo, Murrupula and Alto Molócuè

The information below is based, in part, upon interviews with the Hospital Director at Anchilo, the District Director for Health in Murrupula and the District Director for Health in Alto Molócuè.

4.7.1 Anchilo

The Anchilo Hospital is the only health

care facility in the town of Anchilo and its surrounding areas.³⁹ It is located approximately two kilometres from the Condor cashew factory and 88.2 per cent of the cashew factory workers interviewed in Anchilo reported using the hospital at some point. This community-based hospital has approximately 80 beds and receives between 100-150 patients per day. As is the case throughout the Mozambican health system, the hospital charges one metical (approximately \$0.03) for each medical visit and five meticals (approximately \$0.15) for most medications. All paediatric and maternal care visits are free, as are post-diagnosis malaria treatment and HIV and AIDS-related services (testing, treatment and counselling).

The Hospital Director is the only medical doctor in the District of Nampula. She works principally at the hospital and visits the other health facilities in the District on a rotating basis.⁴⁰ The hospital also employs 11 nurses, four medical technicians and one psychologist.

According to the Hospital Director, the most common diseases in the community are malaria, tuberculosis, pneumonia, diarrhoea, malnutrition and HIV. The hospital also sees a fair number of cashew workers with job-related injuries, in particular lesions and burns to the hands. There are low levels of diabetes and hypertension in the community and cholera appears to be on the wane after an outbreak in 2009.

With respect to HIV the hospital provides testing and both pre- and

post-testing counselling, as well as ARVs for HIV-positive patients. All services related to HIV testing, treatment and counselling are free-of-charge. The hospital also provides male condoms during consultations and at the pharmacy for no charge.⁴¹ Over 125 HIV-positive patients are currently under the hospital's care.

The Hospital Director notes that one of the main health care challenges working in Anchilo is the pervasive lack of understanding by local residents about the severity of HIV and AIDS. Residents often do not come to the hospital until they are in advanced stages of the disease. Moreover, patients who test positive for HIV may not initiate or may abandon ARV treatment due to a variety of factors, including stigma, distance of travel to the hospital, fear or lack of understanding about ARVs, insufficient diet, feelings of denial and/or the perception that they are healthy and therefore do not need medication. The Hospital Director noted that patients who abandon ARV therapy typically do not live near the hospital but rather in the more rural areas in the District.

In terms of HIV outreach, the hospital trains and supports a group of volunteers (*activistas*) who are charged with disseminating information in the community about HIV prevention and treatment. Volunteers also deliver medications to HIV-positive patients who are too ill to go to the hospital. With the help of the International Centre for AIDS Care and Treatment Programmes (ICAP), an NGO, the hospital also facilitates a "Mothers' Group" (*Grupo de Mães*) of HIV-positive women who serve as community leaders on HIV issues. The hospital itself runs education seminars for local residents on HIV although it does not have the resources to do so in the community itself.

39 The Anchilo Hospital is the only Level I health care facility in the District of Nampula. The District also has two Level II/III health facilities and 14 health posts, for a District-wide total of 135 beds. The Anchilo Hospital runs mobile clinics in some of the rural areas of the District.

40 Visits by the medical doctor to the Level II/III health care facilities and health posts are often dependent on the availability of funds for petrol.

41 The hospital does not provide female condoms.

The hospital also attempts to improve knowledge about and adherence to treatments for common diseases in the community, including HIV, by meeting monthly with local leaders to discuss ways to influence residents' attitudes about health care. Issues that hospital workers have discussed with community leaders include adherence to ARV treatment, anti-malaria strategies, the importance of blood donations and greater use by pregnant women of the hospital's pre-natal services.⁴² Hospital workers have also sought help from community leaders in countering the perception by residents that a referral by the hospital to the larger Central Hospital in Nampula city is not a sign of "rejection" by hospital staff but rather an attempt to provide better care to that particular patient.

4.7.2 Murrupula

The Murrupula Hospital is the only health care facility in the town of Murrupula and its surrounding areas.⁴³ It is located approximately two kilometres from the town's cashew factory and all of the cashew factory workers interviewed in Murrupula reported using the hospital at some point. The community-based hospital has approximately 42 beds and receives more than 100 patients per day. As is the case throughout the Mozambican health system, the hospital charges one metical (approximately \$0.03) for each medical visit and five meticals (approximately \$0.15) for most medications. All paediatric and maternal care visits are free, as is post-diagnosis malaria treatment and HIV-related services (testing, treatment and counselling).

The District of Murrupula has one medical doctor who works principally

at the hospital and visits other health facilities in the District on a rotating basis. The hospital also employs 17 nurses, four medical technicians and one psychologist.

According to the District Health Director for Murrupula, the principal diseases in the community are malaria, tuberculosis, leprosy, malnutrition and HIV. Although there have been cholera outbreaks in the past the disease has been under control in 2010 – in part due to clean water and waste management outreach efforts by the hospital. The District Health Director did not report any illnesses or injuries specific to the local cashew workers.

With respect to HIV, the hospital provides testing and pre- and post-testing counselling as well as ARVs. All services related to HIV testing, treatment and counselling are free. The hospital also provides free male condoms during consultations and at any time at the pharmacy.⁴⁴

The District Health Director noted that one of the main health care challenges in Murrupula is encouraging women to be responsible for their own health care and family planning choices. According to the District Health Director, decisions such as whether to have more children or whether to use a condom during intercourse – with a regular or occasional partner – are often viewed as belonging solely to the man. This unbalanced power relationship between local men and women reportedly also leads some women to refuse HIV testing and ARVs for fear that they will be abandoned by their partners if their HIV status is discovered.

The hospital as part of its HIV outreach, in conjunction with ICAP, trains and supports a group of HIV-positive volunteers who are charged with disseminating information in the community about HIV prevention and treatment. Volunteers also deliver medications to HIV-positive patients who are too ill to go to the hospital. The hospital also recently received permission from the provincial health authority

42 Local pregnant women often go to the hospital for the first time late in their pregnancies, thus forgoing pre-natal care and testing.

43 The Murrupula Hospital is the only Level I health care facility in the District. The District also has three Level II/III health facilities and two health posts, with a District-wide total of 56 beds.

44 The hospital does not provide female condoms.

to work with ICAP to create a “Mothers’ Group” (*Grupo de Mães*) of HIV-positive women who serve as community leaders on HIV issues. The District Health Director observed that there are currently no grassroots organizations in the community that work on HIV issues.⁴⁵

4.7.4 Alto Molócuè

The Alto Molócuè Hospital is the only health care facility in the town of Alto Molócuè⁴⁶ It is located approximately two kilometres from the Miranda cashew factory and 93.1 per cent of the cashew factory workers interviewed in Alto Molócuè reported using the hospital at some point. The community-based hospital has approximately 44 beds and receives an average of 310 patients per day. As is the case throughout the Mozambican health system, the hospital charges one metical (approximately \$0.03) for each medical visit and five meticals (approximately \$0.15) for most medications. All paediatric and maternal care visits are free as are post-diagnosis malaria treatment and HIV-related services (testing, treatment and counselling).

The hospital employs two medical doctors, one surgical technician and one nurse who specializes in obstetrics and gynaecology. The hospital further employs 14 general nurses, four medical technicians and one technician specialized in psychiatry. The medical doctors, who are the only two physicians in the District of Alto Molócuè, work principally at the hospital and visit the other health facilities in the District on a rotating basis. Unlike the hospitals in Anchilo and Murrupula, the hospital in Alto Molócuè is equipped for small surgeries such as hernias, caesarean

sections and some amputations. The hospital also has an X-ray machine.

According to the District Health Director for Alto Molócuè, the principal diseases in the community are malaria, respiratory ailments, malnutrition and HIV. There have been no cases of cholera in 2010. The District Health Director did not report any illnesses or injuries specific to the local cashew workers.

With respect to HIV, the hospital provides testing and both pre- and post-test counselling, as well as ARVs. All services related to HIV testing, treatment and counselling are free. The hospital also provides free male and female condoms during consultations and at the pharmacy.⁴⁷

The District Health Director noted several challenges faced by the health care workers at the hospital. In particular, he observed that male control of household health care decisions has had a significant negative impact on HIV-positive women in the community. For example, the District Health Director noted the high rates of refusal by HIV-positive pregnant women for ARV treatment. In 2008, of the 310 pregnant women who tested positive for the virus (out of 3,813 pregnant women who agreed to be tested) only 25 women – less than 10 per cent – began ARV treatment. In 2009, of the 275 pregnant women who tested positive for HIV (out of 7,742 pregnant women who agreed to be tested) only 30 women – just over 10 per cent – agreed to begin the therapy. The most common reason cited by the women for not initiating ARV therapy was that their husbands would not allow them to, as the presence of medication in their homes would constitute an acknowledgement by the men that their wives – and likely the men themselves – were HIV positive.

45 ICAP works directly with government entities such as the Ministry of Health and Ministry of the Interior.

46 The Alto Molócuè Hospital is considered to be a “Rural Hospital,” which is above a Level I health care facility. Apart from the Alto Molócuè Hospital, the District has six Level II/III health facilities and three health posts, for a District-wide total of 69 beds. The Alto Molócuè Hospital runs mobile clinics in some of the rural areas of the District.

47 The hospital’s supply of female condoms is limited.

The District Health Director explained that this gender dynamic also extends to family planning choices, with men often prohibiting their wives from taking contraceptives (the hospital provides these for free). The District Health Director emphasized the need for constant education campaigns aimed at encouraging women to make their own health care and family planning decisions.

The District Health Director also cited as a major challenge the difficulty of changing sexual behaviour among HIV-positive men in the community. He explained that many HIV-positive men did not use condoms because they were not concerned about the fortunes of the person that they might infect.

In terms of HIV and AIDS outreach, the hospital trains, supports and provides bicycles to over 200 volunteers from the community who make individual house calls to educate local residents about malaria, tuberculosis, HIV and AIDS and leprosy prevention. These volunteers also deliver medication to HIV-positive patients with opportunistic infections such as tuberculosis who are too ill to go to the hospital. The hospital also liaises with two NGOs that provide

community-based services to residents in Alto Molócuè – Population Services International (PSI), which provides HIV testing in the community as well as nutrition-related education and Friends of Global Health (FGH), which employs social workers to deliver medications to HIV-positive patients who are too ill to go to the hospital. FGH also supports the hospital by financing the purchase of re-agents for CD4 testing.

The District Health Director noted that the outreach efforts provided by the NGOs to HIV-positive patients could reach a greater number of ill and absentee patients if the vehicles they used did not bear the agencies' logos. He noted the agencies are widely recognized in the community as providing support to HIV-infected residents. This leads some HIV-positive residents to refuse to be seen in their homes by agency representatives for fear of the stigma they will face among their neighbours. The District Health Director suggested that unmarked cars and/or social workers who provide a range of health care education and support – not only for HIV – could be a more effective strategy for reaching the greatest number of sick patients in the community.



The cashew factory at Murrupula. © IOM 2010 (Photo: George Sirighano)

5. DISCUSSION AND CONCLUSIONS

5.1 The cashew workers and their communities

This assessment confirms that the cashew industry in Mozambique consists of a semi-permanent labour force composed largely of internal migrants and that many of these migrant workers are recruited by factories looking for an experienced labour force and/or a labour force unhindered by the demands of subsistence farming.

The existence of a labour force in the cashew industry that is caught somewhere between more traditional labour migration – often seasonal labourers who work for short periods of time – and a more permanent “industrial” workforce is evidenced by several findings of this study. Firstly, almost half the migrants own their homes in the communities where they have migrated for work. Secondly, many migrants – especially those who lived in areas far from the factories – reported returning to their homes only a few times per year or during periods in which the factory was closed for holidays. Many of these respondents indicated they did not return home more often because they lacked sufficient funds to do so. Finally, about half the migrants interviewed reported cultivating “machambas” (small family farms) – a significantly lower proportion than the norm among local workers (80.0%).

This assessment also revealed that migrating for work in the cashew industry is not a guarantee of improved material circumstances for Mozambicans. As an initial matter, the economics of the cashew industry, which makes factory interruptions or closures common, means that the supply of jobs is not always certain. Indeed, one of the factories studied in this assessment suspended production in April 2010, at least for the remainder of the calendar year, due to a lack of raw material for processing. In addition, the industry’s payment structure means that many cashew workers cannot earn the minimum agricultural wage if they do not meet certain weight quotas. Anecdotally, cashew workers reported during interviews

that they were often paid significantly less than the 57.50 meticals (about \$1.70) that is the agricultural minimum wage because they were unable to work fast enough to complete their quotas. Finally, a majority of migrants sent a portion of their scant wages to relatives in their home areas. This places a further financial burden on migrant households.

In evaluating the migrant cashew worker experience, it is worth noting that the communities in which the cashew factories are located in many cases are less developed than migrants’ areas of origin; these communities are highly rural and exhibit low economic diversification, with the majority of working-age adults subsisting off small family farms (“machambas”) for their livelihood. In fact, 60.0 per cent of non-migrant cashew workers had not previously engaged in wage labour, as compared with 30.5 per cent of migrants for whom the cashew factory was their first place of work. Moreover, a majority of non-migrant cashew workers have lower levels of education and awareness of HIV and AIDS risk than migrants.

5.1.1 *HIV and AIDS: Risk behaviours, knowledge and misconceptions*

While migrant cashew workers in this study exhibited a better understanding of treatment for HIV and AIDS than non-migrants and had been tested for HIV at higher rates and more recently, this assessment reveals that migrant and non-migrant workers alike participated in risky sexual behaviour such as low condom use, multiple concurrent partners and transactional sex.

Both migrant and non-migrant cashew workers in the communities surveyed, especially those with multiple and concurrent sexual partners, do not adequately use condoms to protect themselves from HIV and AIDS. Of the respondents who reported “never” or “rarely” using a condom during sexual intercourse, 32.6 per cent indicated that

they had two or more sexual partners in the last 12 months (16.3% had two sexual partners; 7.0% had three to five partners; and 9.3% had six to ten partners). In addition, both migrant and non-migrants exhibited dangerous misconceptions about condom use – for example, interviewees in several cases reported the belief that condoms contained bugs that spread the disease or that condoms had to be boiled before being used in order to be effective.

Multiple sexual partners were common among male respondents in both migrant and non-migrant groups, while a large majority of both migrant and non-migrant female respondents reported having only one sexual partner in the last year. Moreover, both groups engaged in transactional sex – whether for goods for money – in similar proportions (54.2% of migrants and 53.4% of non-migrants).

5.1.2 Health care, outreach and cultural/behavioural barriers to care

Migrants and non-migrants did not exhibit appreciable differences in their perceptions of the most common health problems in their communities nor in the level of care and services provided by the local health facility. In fact, a significant majority of respondents reported being satisfied with their local hospital, although they saw room for improvement in the long waits, shortages of medication and lack of comprehensive medical services. Several respondents also indicated that the factories themselves should provide at least some health care services to their employees.

Respondents indicated middling levels of awareness of HIV outreach efforts in the community and even lower levels at the factories themselves. These responses are supported by interviews with health professionals in the area who stated that their efforts to educate

community members about HIV risk and treatment are limited by a lack of resources and cultural barriers.

One of the main barriers in the fight against HIV and AIDS cited by health care professionals in their communities was the low rate of initiation and compliance with ARV treatment by HIV-positive patients. Efforts to convince these patients to begin treatment – or to not abandon treatment – were hindered by factors such as stigma, distance of travel to the hospital, fear or lack of understanding about ARVs, insufficient diet, feelings of denial and/or the perception that they are healthy and therefore do not need medication. In fact, over 31 per cent of the cashew workers surveyed in this study who reported knowing somebody who had abandoned ARV treatment said that the treatment had been stopped because the HIV-positive person had been “cured”.

According to the health care professionals interviewed for this study, low rates of ARV treatment were particularly acute in HIV-positive females due to the dominance of men in household health care decisions. For example, in Alto Molócuè, only approximately ten per cent of HIV-positive pregnant women agreed to start ARV treatment. The health care professionals attributed this low rate of ARV use to the fact that men often prohibit their wives from taking the medication.

Another significant cultural barrier to controlling the spread of HIV in these communities related to the sexual behaviour of HIV-positive men. In Alto Molócuè, for example, the District Health Director noted that many HIV-positive men did not use condoms because they were not concerned about the fortunes of the person that they might infect.

6. RECOMMENDATIONS

Many of the cashew workers who were interviewed for this assessment demonstrated a basic understanding of issues related to HIV and of the health services available in their communities, but this knowledge could be significantly enhanced through implementing a comprehensive migration-sensitive programme. In particular, this assessment reveals that cashew workers, both migrants and non-migrants, continue to participate in risky sexual behaviours such as unprotected sex, multiple and concurrent sexual partners as well as transactional sex. In addition, cashew workers demonstrated misconceptions about the modes of HIV transmission and treatment including the efficacy and availability of ARVs.

With the aim of improving worker knowledge about HIV and other common illnesses, limiting risky sexual behaviours, increasing HIV and AIDS testing and reducing stigma associated with the disease and misconceptions about its treatment, IOM should sponsor programming related to STIs, including HIV and sexual and reproductive health, at the factories.

Regarding public health, factory workers (migrant and non-migrant) do not live in isolation from the local community. Therefore, any intervention should consider the cashew factories as part of the local community.

Main Recommendations

At the Policy-level:

Because migration is relevant to the three main pillars in PARPA (Action Plan for the Reduction of Absolute Poverty), the Government of Mozambique should include migrants in its strategy for the reduction of poverty, and in line with 'The International

Convention on the Protection of the Rights of All Migrants Workers and Members of Their Families' codify the basic rights of migrants to ensure access to the country's health and education facilities.

At the Programmatic-level:

Develop a social and behavioural change HIV prevention and health promotion programme that tackles the underlying HIV vulnerabilities identified in the study. The programme could include:

- working with factory management to establish a recurring wellness programme for their employees and helping to establish an enabling workplace environment where HIV and health can be openly discussed;
- hiring and training an on-site coordinator to ensure the consistency and quality of these discussions.
- supporting the recruitment and training of peer facilitators to moderate the peer-group discussions and to serve as "leaders" who would promote and facilitate dialogue within the factories on issues related to HIV and health care;
- developing partnerships with local stakeholders to support access to health services and products such as counselling and testing, condoms and ARVs and working with the local hospitals and/or NGOs to provide workplace HIV testing;
- partnering with local NGOs to promote messaging on HIV prevention and treatment through community-wide sporting and cultural activities.

6.1 Recommendation 1: Health promotion should be implemented at the cashew factories and in the communities where they are located

6.1.1 *Creating an enabling environment*

In order to ensure support and buy-in, and to promote and facilitate a supportive and enabling workplace environment, the capacity of factory owners, managers and supervisors should be enhanced, especially on the following issues:

- the impact of HIV on productivity, and therefore the positive effect an HIV programme could have on production;
- key facts on HIV, to dispel misconceptions and address stigma and discrimination;
- wellness policies in the workplace and how these can benefit the company and the employees.

By utilising the findings from this assessment, management and supervisors should be made aware that developing an HIV programme is an effective means of limiting the serious economic and social consequences of HIV for companies. In particular, the high level of absenteeism at cashew factories could be reduced if workers are encouraged to engage in healthier sexual behaviours, to seek medical attention early for health problems including HIV, STIs, malaria and tuberculosis and to comply with medication regimens such as ARVs, anti-malarial treatment and antibiotics.

The issue of leadership within the factories also should be addressed. Senior management should be more active and vocal in their support of workplace strategies.

Building institutional capacity

To ensure stability and value-added local knowledge, an on-site programme representative should be recruited to serve as the coordinator for factory health programming. The on-site programme representative should be trained to implement a comprehensive migration-sensitive response to health needs at the factories.

Peer-led communication

Create and facilitate HIV and AIDS and health education programming, including peer-group discussions.

Relevant stakeholders, in coordination with the on-site programme representative, should organize and facilitate HIV and AIDS and health education programming at the factories, including peer-group discussions regarding HIV and AIDS prevention and treatment, STIs and gender-related issues such as empowering women to make their own health care decisions. Specifically, some of the topics covered in the peer-group discussions should include:

- a dialogue to clarify and correct misconceptions about HIV transmission and treatment;
- facts about HIV risks and vulnerability, with a focus on opportunistic infections such as TB;
- discussions about the importance of consistent condom use and demonstrations on how to correctly use them;
- information about HIV prevention methods and treatment services in the community;
- peer education of community members by factory workers.

These peer-group discussions should occur on a consistent basis (for example monthly) and sessions should

be planned at a time that is suitable for the cashew workers. Factory management should facilitate and encourage such gatherings. Peer leaders should be identified by their peers, should be individuals who are trusted and respected and should serve as points of contact to address questions and concerns relating to HIV and other health issues.

6.2 Recommendation 2: Promote and support access to health products and services, including workplace HIV testing and condoms

By working with and through local partners, a network of health services and products, as well as referral systems, could be made available to cashew factory workers.

The overall reported testing rate of the factory workers (48.3%) likely could be increased if regular HIV testing were performed on-site at the factories. Partnerships with local and/or NGOs to provide HIV testing at the factories at least once every three months should be explored. An added benefit of HIV testing at the factories is that the visits from health care professionals can be leveraged as an

opportunity to educate workers about other services available in the community, such as treatment and counselling for HIV, malaria, TB and other illnesses.

The assessment highlighted the need to provide free condoms at the factories. Despite generally high levels of understanding regarding the importance of condom use in preventing HIV transmission, 47.5 per cent of migrants and 50.0 per cent of non-migrants surveyed at the factories reported “rarely” or “never” using them. The availability of free condoms at the cashew factories, rather than at a hospital located over two kilometres away, might encourage more workers to use them.

6.3 Recommendation 3: Promote sporting and cultural activities

It is recommended that community-wide sporting and cultural activities should be developed as way to promote a healthy lifestyle. These should be done in consultation with local partners in a health promotion programme approach that connects the factories and community at large through coordinated and common messaging. This can create a supportive environment for local partners and health promotion in general.



7. IOM'S FRAMEWORK FOR TAKING THE RECOMMENDATIONS FORWARD

IOM's Migration Health Framework, described above in section 1.4.2, can provide several tools and project designs that will fit squarely with the recommendations and provide a clear path forward towards project design and development in the agro-processing sector of Mozambique:

- A partnership approach and a focus on service delivery and capacity building is recommended. Given the number of possible public-private initiatives, along with IOM's commitment to a multi-sectoral approach to migrant health, including both governmental and non-governmental partners, IOM is positioned well to link the various partners into a holistic programme that addresses the structure and environment that create risks for labour migrants, along with individual behaviour change for each participant.
- IOM Mozambique has developed a strong social change communications capacity, including radio programming documentaries and soap operas. A social change communication project focused on agro-processing could use these established links for increased media attention and increased discussion amongst workers. It is possible to influence long-term behaviour change through interesting and quality social media development.
- The PHAMSA project model, with its focus on peer education and referral, gender-specific tools (e.g. "One Man Can"), recreation and life-skills, and the importance of health care services and product access, can be applied directly to the needs of factory workers. In particular, the model is specifically designed to address the recommendations for behaviour change within "spaces of vulnerability", empowering workers to tackle HIV in their work-places and to use the health care systems available in their areas.

Specific recommendations are listed below:

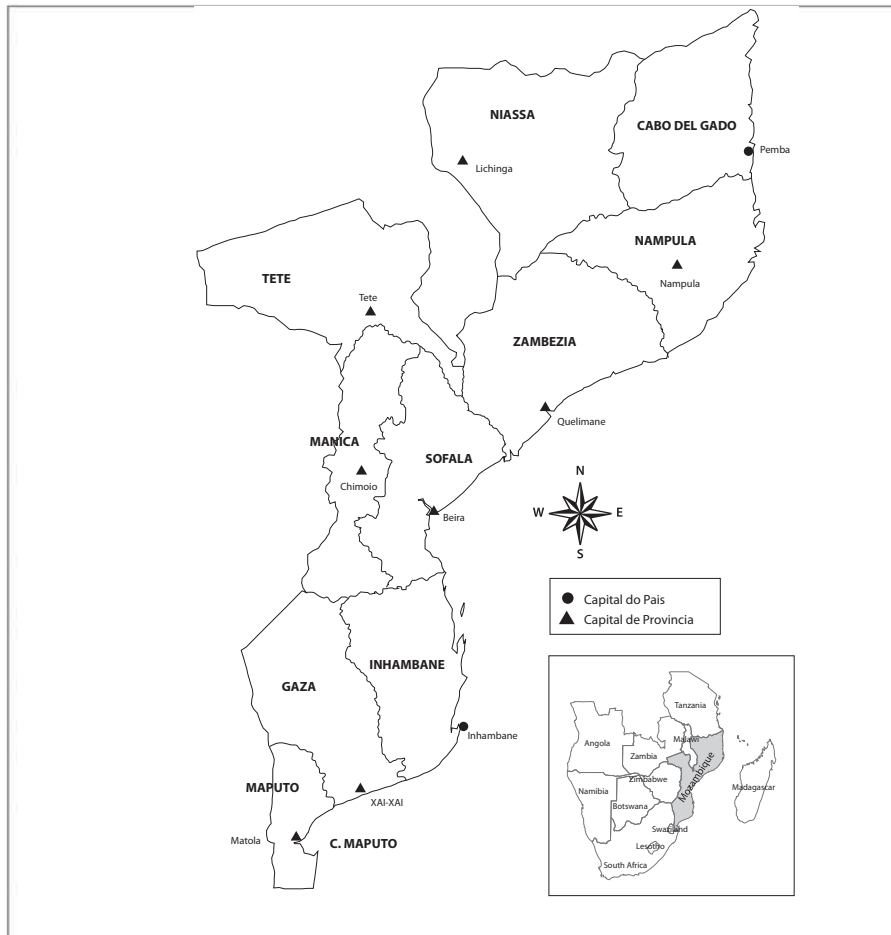
- 1) IOM has developed a curriculum that could be used to build capacity and knowledge. Peer facilitators can promote a two-way process of dialogue in which they develop messages and dialogues that respond to local level needs. This "bottom up" approach to peer education helps to ensure the programme is locally owned and is responsive to local needs as identified directly by the beneficiaries.
- 2) Develop targeted and relevant information and awareness material: IOM's work within the mining sector is illustrative of a model that might be replicated in the cashew factories. In 2007, IOM and TEBA Limited, a service organization primarily responsible for the recruitment of mineworkers for the South African mining industry, partnered to implement a community-based programme to reduce HIV vulnerability of mine workers, their families and the areas of Mozambique from which workers are recruited. Current activities include public education through radio programming and community theatre and the distribution of condoms.⁴⁸ As the result of TEBA-IOM programming, stigma around HIV and condom use has been significantly reduced and women have emerged as leading voices in community activism.
- 3) A gender programme might be established within the project that specifically addresses the negative gender dynamics that impact on HIV vulnerability.

⁴⁸ TEBA Limited, company overview, <http://www.teba.co.za/index.asp>; IOM-Mozambique, "IOM's Collaboration with TEBA Development on Mine Workers and Their Families," issue brief, 2009; TEBA Development, "TEBA Home-Based Care (HBC) Programme," n.d

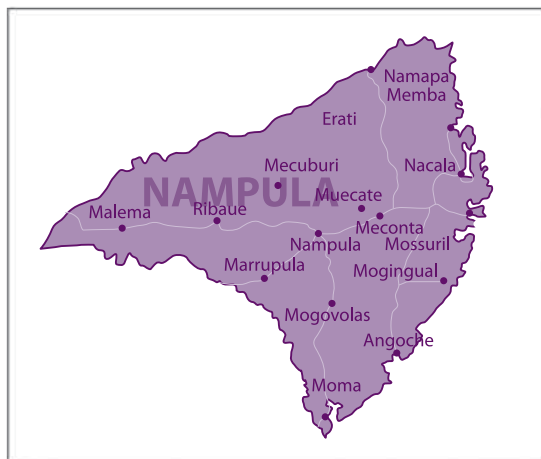
8. ANNEXES

8.1 Maps

8.1.1 Map of Mozambique



8.1.2 Map of Nampula Province



8.2 National policies and commitments

There do not appear to be health-related policies or programmes specifically aimed at migrant populations in Mozambique. However, existing national laws, policies and strategies bear on migrants' access to HIV and AIDS prevention and treatment services.

8.2.1 Public sector response

The Government of Mozambique has implemented a series of legal mandates, policy guidelines and national strategies to combat HIV and AIDS, including several with direct implications for the private sector.⁴⁹ For example, in 2002, it established the Conselho Nacional de Combate ao SIDA (CNCS) to lead and coordinate the Mozambican government's response to HIV and AIDS. The CNCS is responsible for implementing the Plano Operacional da Estratégia de Aceleração da Prevenção da Infecção pelo HIV (PEN). PEN outlines seven priority areas of intervention: Prevention, Advocacy, Stigma & Discrimination, Treatment, Mitigation, Research and Coordination. It also identifies the following groups as especially vulnerable to HIV infection: sex workers, long-distance truck drivers, miners and other migrant workers, brigades of workers away from home, certain military personnel, and informal traders.

The United States Agency for International Development (USAID), through the President's Emergency Plan for AIDS Relief (PEPFAR), supports a full range of prevention, care and treatment programmes in Mozambique. PEPFAR-funded technical assistance and training relies on an extensive network of implementing NGO partners as well

as the Government of Mozambique. In 2008, PEPFAR funds supported the private sector's efforts to combat HIV and AIDS through an initiative to develop a national workforce policy regarding the disease. Other major international donors supporting HIV and AIDS efforts in Mozambique include the United Kingdom, Ireland, Sweden, Denmark, the Netherlands, Norway, Canada, the European Union, the World Bank, various UN agencies and The Global Fund to Fight AIDS, Tuberculosis and Malaria.

8.2.2 Non-governmental organizations

In the two provinces in which the study took place, Nampula and Zambezia, PEPFAR funds are channelled through USAID and the Center for Disease Control (CDC) to specific technical and programmatic lead partners. Technical assistance for HIV and AIDS treatment is directed by ICAP (Columbia University) in Nampula and Friends in Global Health (Vanderbilt University) in Zambezia. In addition, the "Strengthening Communities through Integrated Programming" (SCIP) projects, funded by PEPFAR, are led by Pathfinder and World Vision International in Nampula. Each project is led by the above large-scale NGOs but is implemented by a coalition of smaller NGOs including, but not limited to, International Relief and Development (IRD), Africare, CARE, Population Services International (PSI), the Cooperative League of the USA (CLUSA), World Relief and ACDI/VOCA.

8.2.3 Private sector response

Some effort has been undertaken by the private sector in promoting HIV and AIDS workplace policies. An umbrella organization called the Association of

⁴⁹ CHG study; Government of Mozambique - Ministry of Health and the National AIDS Council Mozambique, *Report of the Mozambique Triangulation Project: Synthesis of Data on Trends in the National and Local HIV Epidemics and the Reach and Intensity of Prevention Efforts*, 2008.

Entrepreneurs Against SIDA (EcoSida) coordinates HIV/AIDS activities among private enterprises and has developed a roadmap for implementing workplace-based HIV/AIDS programmes. EcoSida, which was founded by 23 companies and business associations and currently counts over 40 member businesses, provides programming and HIV and AIDS-related services to the workplace and the larger Mozambican community. EcoSida's principal tool for responding to AIDS in the workplace and in broader community contexts is derived from a blend of existing programmes and strategies utilized by companies like Unilever, British American Tobacco, Coca-Cola, British Petrol and Mozal. These model programmes, which are governed by the principles of the International Labour Organisation (ILO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), have been adapted to the specific conditions of Mozambican workplaces.⁵⁰

Another private sector programme is the SEDE (Health and Development in the Workplace), a Mozambican non-profit initiative that provides education concerning HIV and AIDS prevention to organizations of all sizes in both the public and private sectors. In 2008, over 50 per cent of SEDE's private sector requests for services came from the construction industry or from related industries with mobile workforces and a high percentage of temporary labourers. SEDE provides an integrated set of prevention activities, rather than focusing on one area of HIV and AIDS prevention. For instance, it offers workplace situation analysis and assessment; development of workplace policies and support concerning HIV and AIDS; HIV and AIDS-related training for managers and peer educators; information, education and communication (IEC) activities; HIV and AIDS counselling, testing, condom distribution, care and support.

50 World Economic Forum, "Mozambique: ECOSIDA Profile" (December 2007); EcoSida, *Profile, Framework and Code of Conduct*; EcoSida, *Estatutos da EcoSida*, Maputo, Mozambique, August 30, 2004.



The maternity ward at Murrupula Hospital. © IOM 2010 (Photo: George Sirighano)

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