

---

# Health vulnerabilities of mobile and migrant populations in and around the **Port of Durban**, South Africa

---



---

International Organization for Migration (IOM)  
Organisation internationale pour les migrations (OIM)  
Organización Internacional para las Migraciones (OIM)



A study on health vulnerabilities of mobile and migrant populations in and around the Port of Durban, Durban, South Africa



©2014 COPYRIGHT 2012 3S MEDIA PTY LTD.

Prepared for  
INTERNATIONAL ORGANIZATION FOR MIGRATION (IOM)

Prepared by  
Health Economics and HIV/AIDS Research Division (HEARD)  
10 October 2014

## **ACKNOWLEDGMENTS**

---

This study was carried out with the support of International Organisation for Migration (IOM) Southern Africa Regional Office and IOM Mozambique Office as part of a SADC funded initiative to identify HIV risk profiles for four Southern African ports using the concept of 'Spaces of Vulnerability' where the interaction of all groups in the space are discussed and key programming issues identified to reduce vulnerability to HIV transmission. The research was carried out in Durban, South Africa.

We would like to thank the people of Durban who participated and gave freely of their time to provide us with valuable insights into the interactions between residents and mobile populations in the environs of the Walvis Bay in both the quantitative and qualitative surveys.

A special thank you is hereby given to the Chair and members of the country technical steering committee which assisted immensely in ensuring that the study was successfully implemented in South Africa.

Finally and most importantly, IOM would like to acknowledge SADC through its MS Fund for funding this project.

## TABLE OF CONTENTS

<b>ACKNOWLEDGMENTS</b> .....	3
<b>LIST OF TABLES</b> .....	7
<b>LIST OF FIGURES</b> .....	8
<b>EXECUTIVE SUMMARY</b> .....	11
<b>CHAPTER 1</b>	
<b>HEALTH VULNERABILITIES OF MIGRANT AND MOBILE POPULATIONS LINKED TO THE PORT OF DURBAN</b> .....	13
1.1 Introduction.....	13
1.2 Background.....	15
1.3 Spaces of vulnerability.....	21
<b>CHAPTER 2</b>	
<b>STUDY METHODS</b> .....	22
2.1 Introduction.....	22
2.2 Study procedures.....	22
2.2.1 Stage 1: Development of survey instrument and study procedures.....	22
2.2.2 Stage 2: Scoping exercise.....	23
2.2.3 Stage 3: Gatekeeper meetings.....	23
2.2.4 Stage 4: Sampling.....	24
2.2.5 Stage 5: Field research.....	26
2.2.6 Stage 6: Data analysis and reporting.....	26
2.3 Study limitations.....	26
2.4 Report content and foci.....	28
<b>CHAPTER 3</b>	
<b>RESULTS: DEMOGRAPHIC CHARACTERISTICS OF THE STEVEDORE, TRUCK DRIVER AND SEAFARER STUDY POPULATIONS</b> .....	29
3.1 Introduction.....	29
3.2 General demographic profiles.....	29
3.3 Social profiles of the study populations.....	34
3.4 Summary.....	38

## TABLE OF CONTENTS

---

<b>CHAPTER 4</b>	
<b>RESULTS: SEXUAL BEHAVIOUR AMONGST STEVEDORES, TRUCK DRIVERS AND SEAFARERS</b>	
.....	39
4.1 Introduction.....	39
4.2 Sexual history.....	39
4.3 Marital status and sexual history.....	45
4.4 Gender and sexual history.....	48
4.5 Age and sexual history.....	49
4.6 Condom use amongst stevedores and truck drivers.....	51
4.7 Summary.....	56
<b>CHAPTER 5</b>	
<b>INCIDENCE OF SEXUALLY TRANSMITTED ILLNESS</b> .....	58
5.1 Introduction.....	58
5.2 Stevedores and truck drivers STIs.....	58
5.3 Summary.....	61
<b>CHAPTER 6</b>	
<b>HEALTH SEEKING BEHAVIOUR</b> .....	62
6.1 Introduction.....	62
6.2 HIV testing.....	62
6.3 Summary.....	68
<b>CHAPTER 7</b>	
<b>KNOWLEDGE AND ATTITUDES</b> .....	69
7.1 Introduction.....	69
7.2 Stevedores, truck drivers and seafarers' attitudes towards HIV.....	69
7.3 Summary.....	75
<b>CHAPTER 8</b>	
<b>COMMERCIAL SEX WORKERS</b> .....	76
8.1 Introduction.....	76
8.2 CSW Demographic characteristics.....	76

8.3 Reasons for engaging in sex work.....	76
8.4 Sex work operational area.....	78
8.5 Clients of sex workers.....	79
8.6 Paying for sex.....	80
8.7 CSW health status and sexual behaviour.....	80
8.8 CSW health seeking behaviour.....	81
8.9 CSW Knowledge of HIV/AIDS.....	82
8.10 Summary.....	82
<b>CHAPTER 9</b>	
<b>HEALTH WORKERS.....</b>	<b>83</b>
9.1 Introduction.....	83
9.2 Facility services.....	83
9.3 Health staff perspectives.....	84
<b>CHAPTER 10</b>	
<b>HEALTH VULNERABILITIES OF THE SAMPLE POPULATIONS.....</b>	<b>88</b>
10.1 Introduction.....	88
10.2 The nature of sexual networking.....	89
10.3 Health vulnerabilities: the incidence of disease.....	92
10.4 Health vulnerabilities: knowledge, prevention and treatment of disease.....	94
10.5 Spaces of vulnerability.....	96
10.6 Summary.....	98
<b>CHAPTER 11</b>	
<b>CONCLUSION.....</b>	<b>100</b>
<b>REFERENCES.....</b>	<b>102</b>
<b>ANNEXURE.....</b>	<b>104</b>

## LIST OF TABLES

---

<b>Table 1:</b>	Demographic characteristics of stevedores, truck drivers and seafarers.....	31
<b>Table 2:</b>	Age categories of stevedores, seafarers and truck drivers.....	35
<b>Table 3:</b>	Descriptive statistics on sexual history of stevedores truck drivers and seafarers.....	39
<b>Table 4:</b>	Stevedores, truck drivers and seafarers reported frequency of sexual intercourse with casual acquaintance(s) in preceding 30 days.....	42
<b>Table 5:</b>	STI-infected stevedores and truck drivers reported elapsed time (days) between awareness of STI symptom and seeking treatment.....	67
<b>Table 6:</b>	Reasons for engaging in sex work.....	78

## LIST OF FIGURES

---

<b>Figure 1:</b> Migrancy among stevedore, seafarer and truck driver samples .....	32
<b>Figure 2:</b> Stevedores' perceptions on difficulty of finding work (n=187) .....	33
<b>Figure 3:</b> Stevedores' perceptions on discrimination in securing work (n=200) .....	33
<b>Figure 4:</b> Age categories of stevedores, seafarers and truck drivers .....	34
<b>Figure 5:</b> History of school attendance of stevedore, seafarer and truck driver samples .....	36
<b>Figure 6:</b> Highest level of education attained by stevedores, seafarers and truck drivers .....	36
<b>Figure 7:</b> Marital history of stevedores, seafarers and truck drivers .....	37
<b>Figure 8:</b> Current marital status of stevedores, seafarers and truck drivers .....	38
<b>Figure 9:</b> Number of sexual partners in preceding 12 months reported by stevedores, truck drivers and seafarers .....	40
<b>Figure 10:</b> Stevedores, truck drivers and seafarers reported sexual incidence with someone who is not their regular partner/spouse in previous 12 months .....	41
<b>Figure 11:</b> Number of sexual partners in preceding 12 months, reported by stevedores, truck drivers and seafarers to be casual acquaintances .....	42
<b>Figure 12:</b> Stevedores, truck drivers and seafarers reported frequency of sexual acts with casual acquaintances in the last 30 days .....	43
<b>Figure 13:</b> Stevedores, truck drivers and seafarers reported incidence of sexual intercourse with commercial sex workers in preceding 12 months .....	44
<b>Figure 14:</b> Stevedores, truck drivers and seafarers reported number of liaisons with commercial sex workers in preceding 30 days .....	44
<b>Figure 15:</b> Stevedores current marital status and number of sexual partners in past 12 months (n=181) .....	46
<b>Figure 16:</b> Truck drivers current marital status and number of sexual partners in the past 12 months (n=173) .....	46
<b>Figure 17:</b> Seafarers current marital status and number of sexual partners in the past 12 months (n=37) .....	47
<b>Figure 18:</b> Reported incidence of sexual intercourse with person who is not spouse/regular partner within preceding 12 months cross-tabulated with gender of stevedores... ..	48
<b>Figure 19:</b> Stevedores' reported incidence of sexual intercourse with casual acquaintance(s) in preceding 12 months cross tabulated with gender of informants (n=172) .....	49



<b>Figure 20:</b> Comparison of stevedores, truck drivers and seafarers who had sexual intercourse with someone other than their regular partner or spouse in the previous 12 months....	50
<b>Figure 21:</b> Comparison of stevedores, truck drivers and seafarers who had more than one sexual partner during the previous 12 months.....	51
<b>Figure 22:</b> Percentage of stevedores and truck drivers who reported use of condom in last occasion of sexual intercourse .....	52
<b>Figure 23:</b> Stevedores and truck drivers who reported always using condoms with sexual partner in the preceding 12 months .....	53
<b>Figure 24:</b> Stevedores reported use of condom during previous year of sexual intercourse with most recent regular partner (husband, wife, cohabitee) according to gender (n=93) ....	54
<b>Figure 25:</b> Percentage of stevedores and truck drivers who did not use condoms on last occasion of sexual intercourse with most recent boy/ girlfriend according to age ....	55
<b>Figure 26:</b> Frequency of use of female condom with most recent boy/girl during the preceding 12 months according to gender of stevedores (n=53) .....	56
<b>Figure 27:</b> Stevedores and truck drivers' incidence of genital discharge in preceding 12 months .....	58
<b>Figure 28:</b> Stevedores and truck drivers' incidence of genital sore/ulcer in preceding 12 months .....	59
<b>Figure 29:</b> Prevalence of genital sore/ulcer amongst infected stevedores (n=16) .....	60
<b>Figure 30:</b> Prevalence of genital sore/ulcer amongst infected truck drivers (n=15).....	61
<b>Figure 31:</b> Stevedores, truck drivers and seafarers' percentage tested for HIV .....	62
<b>Figure 32:</b> Stevedores, truck drivers and seafarers: knowledge of HIV test results.....	63
<b>Figure 33:</b> Stevedores tested for HIV cross-tabulated with gender of informants (n=189).....	63
<b>Figure 34:</b> Stevedores, truck drivers and seafaresr knowledge on utility of condoms for HIV protection .....	64
<b>Figure 35:</b> STI-infected stevedores and truck drivers reported ceasing sexual activity upon awareness of symptoms .....	65
<b>Figure 36:</b> STI-infected stevedores and truck drivers reported first source for treatment.....	66
<b>Figure 37:</b> STI-infected stevedores reported sources for treatment for most recent STI infection.....	67

<b>Figure 38:</b> Stevedores, truck drivers and seafarers rating of health services in the port environs.....	68
<b>Figure 39:</b> Stevedores, truck drivers and seafarers who have knowledge of HIV infection/death of anyone, close relative/or friend.....	70
<b>Figure 40:</b> Stevedores' knowledge of HIV infection/death of anyone, close relative or close friend according to age .....	71
<b>Figure 41:</b> Truck drivers' knowledge of HIV infection/death of anyone, close relative or friend according to age .....	71
<b>Figure 42:</b> Stevedores, truck drivers and seafarers' correct knowledge of standard HIV/AIDS information.....	72
<b>Figure 43:</b> Stevedores, truck drivers and seafarers who displayed the correct knowledge about HIV/AIDS misconceptions.....	74
<b>Figure 44:</b> Percentage of stevedores, truck drivers and seafarers who did not show prejudiced views about HIV-infected persons .....	75
<b>Figure 45:</b> Map of Port of Durban with hotspots .....	79

## EXECUTIVE SUMMARY

---

This report assesses findings of the Durban study commissioned by the IOM with particular reference to the socio-geographical concept of ‘spaces of vulnerability’ amongst stevedores, truck drivers, seafarers and commercial sex workers. The concept refers to the social and economic conditions of existence and the personal circumstances of individuals, which can affect negatively their welfare and behavioural decisions.

The report draws attention to the marginalisation of the study populations in Durban as being due in part to urban development programmes and transformation of the maritime industry. Together, these processes are creating more rigid boundaries between the port and the city and pushing away, whilst also reducing the spaces where sexual interactions between mobile and migrant populations occur. Geographically, the effect is to create fragmented ‘pockets’ in the port environs and increasingly, further afield within the Durban metropole, where the mobile and migrant populations are vulnerable in terms of the risks to health arising from the nature of the sexual relationships amongst and between them. Socio-geographically, the report highlights that the spaces of vulnerability are transient, virtual spaces in reference to the psycho-social dimensions of vulnerability; for example ‘risky’ sexual behaviour despite sound knowledge and awareness of the threat to personal health and subliminal fears and prejudices - stemming from conditions of existence and personal circumstances - which contribute to taking sexual risks. In addition, this abstract notion of space refers to contextual factors such as the coercive nature of sexual interactions between commercial sex workers (CSWs) and policemen and influence of alcohol and drugs on sexual behavioural decision-making amongst all the study populations.

Overall, the results reiterate knowledge of mobile and migrant populations being significant channels for the transmission of HIV/AIDS and STIs. The findings revealed generally sound knowledge of HIV/AIDS and the risk to health of HIV and STI infection amongst the study populations but this is ignored by substantive minorities in the stevedore and truck driver samples (and the majority in the case of CSWs) as evidenced by the relatively high incidence of STI infections, risky sexual liaisons and inconsistent condom use. The exception was the seafarer sample where the evidence pointed to sound knowledge and limited sexual risk taking due, it seems, largely to regular health checks of ships crews, access to medical services and restrictions on gaining shore leave. The findings also did not indicate education level and marital status as significant social factors influencing sexual behaviour and vulnerability but, in some instances age was a pertinent factor. However, the study could not determine statistical significance in these sub-analyses due to low sub-sample sizes. More generally, the findings affirm a long standing thesis on the epidemiology of STIs, which also applies to HIV/AIDS; namely that societal factors determine the evident high levels of HIV and STI infection and risk of infection amongst mobile and migrant populations.

Particular findings include the indication that stevedores in Durban no longer constitute a mobile or migrant population and, in contrast, that policemen do constitute a relevant (intra-city) mobile population which is vulnerable due to the nature of the sexual interactions between them and CSWs. More generally, the study findings suggest that the challenges of improving health services for these mobile and migrant populations are due in part to their increasing 'invisibility' in terms of their diminishing numbers in the case of stevedores and, for all study populations, their diminishing social and economic presence and significance within and around the port.

## CHAPTER 1

---

### HEALTH VULNERABILITIES OF MIGRANT AND MOBILE POPULATIONS LINKED TO THE PORT OF DURBAN

#### 1.1 Introduction

This report presents the findings from the research conducted at the Port of Durban, South Africa. The report constitutes one component of a regional project of the International Organization for Migration (IOM). The overall aim of the regional project, as stated in the IOM's terms of reference (2013), is:

*“to contribute to the reduction of HIV incidence and impact of AIDS among migrant and mobile workers and their families, and the communities with which they interact in selected port communities in southern Africa”*

The purpose of this project is to serve the IOM's objectives for eastern and Southern Africa which are:

- “Strengthen knowledge and increase the pool of evidence relating to health vulnerabilities and challenges faced among migrants and migration-affected communities in order to contribute to evidence-based, effective programming and policy development;
- Advocate for migrant inclusive health policies and programmes at national, regional and sectoral levels, and assist in the development of policies to promote and protect the health of migrants;
- Facilitate, provide and promote equitable access to migrant-friendly and comprehensive health care services, information and referrals, in order to improve health outcomes for migrants, migration-affected communities, and crisis-affected population;
- Develop and strengthen regional institutional infrastructure, multi-sectoral partnerships and coordination among governments, stakeholders and migrants in order to support implementation of programmes and policies addressing health vulnerabilities of migrants and migration-affected communities.”

The general rationale for the IOM project is to fill a gap in research evidence and, in turn, enable informed practical interventions. On the one hand, there is a large body of evidence which shows that population mobility and migration are significant drivers of the HIV epidemic in southern Africa (as well as other sexually transmitted illnesses [STIs]). On the other hand, there is a lack of information on the dynamics of HIV and STI transmission in, and through seaports and their environs where there are large concentrations of mobile and migrant populations; notably, seafarers, truck drivers, stevedores and sex workers.

Accordingly, research on these populations is necessary to inform the design of policies and programmes to curtail the HIV pandemic in the region, other STIs and other diseases such as tuberculosis (TB).

The IOM formulated this project according to its objectives for eastern and southern Africa. The conceptual premises (IOM, 2013) are:

- “Spaces of vulnerability’ within a regional context which considers migration as a social determinant of health;
- Regional response and programming;
- Bottom-up approach to promote the voice of the migrants and migration-affected communities;
- Commitment to gender equity; and
- Promotion of partnerships at various levels”

‘Spaces of vulnerability’ is the core premise. It is a socio-geographical concept. It refers to:

- the social and economic conditions of existence within a locality which can affect negatively the welfare of the resident population, and
- the personal circumstances of individuals in those conditions, which can influence their behaviour to the detriment of their own welfare.

In this instance, the concept refers to seaports as geographical areas where there are populations:

- who work in or pass through them, and who by the nature of their work (e.g. as poorly paid, temporary workers) or transient presence occupy the margins of that space;
- who include a significant proportion of individuals whose social, specifically sexual, behaviour can be influenced negatively by their marginal existence or presence in these areas and, consequently; and
- who are likely to face a high risk of STI and HIV infection.

In seaports, seafarers, truck drivers, contract and casual (as opposed to permanently employed) stevedores and sex workers constitute these populations. However, as noted, there is a lack of information on the actual HIV-associated health risks and vulnerability within these populations even though there is broader evidence that they constitute high risk and vulnerable populations for being migrant and mobile populations. Accordingly, the specific aims of the IOM project (*op cit*) are to:

“...build more detailed knowledge and understanding of:

- health vulnerabilities, specifically HIV and TB, within these spaces of vulnerability;
- current responses to those vulnerabilities;
- the nature of sexual networking including concurrent sexual partnerships that exist among sea-going personnel, truck drivers, sex workers and other sedentary populations around ports;
- assist stakeholders in developing relevant policies and programmes that address health vulnerabilities of mobile populations and affected communities in the selected ports.”

The expected outcomes of the project (*op cit*), to which the Durban port study is one contribution are:

- “Strengthened evidence base for future interventions in HIV prevention, treatment, care, and support addressing the specific needs of sea-going personnel, sex workers, and other vulnerable groups they interact with in selected ports in southern Africa; and
- Strengthened information-sharing, networks and partnerships in order to better coordinate the health and HIV response in port settings.”

## 1.2 Background

Durban has the largest and busiest port in South Africa in terms of number of ships passing through it and tonnage of cargo handled. To illustrate, it hosts an average of 4000-4500 ships each year; nearly double the number of ships docking at Cape Town, South Africa’s second largest port (PSMN, 2014; TNPA, 2014). The port is managed by Transnet, a parastatal company which operates all ports in the country (TNPA, 2014). There are no reliable current figures of the size of the population that works in the port; 2009 estimates (Nkosia & Colvin, 2009; Dekker, 2010) of over 6000 people employed at the port and 30000 people dependent in some manner on the port’s activities are still commonly cited.

Amongst the many people who depend economically upon the port are mobile and migrant workers; notably, stevedores, truck drivers, and sex workers. In addition there are seafarers who, while not economically dependent on the port, contribute to the port’s economy. The majority of stevedores who work at the Durban port are employed either as casual labour or as temporary contract employees. There are, reportedly, about 2000 stevedores employed by several companies of whom a minority (30%) are permanent employees. A large but unknown number of truck drivers enter and leave the port every

day; our rough estimate on the basis of observations is that there are 400-500 trucks daily at the port. There is also an unknown number of sex workers whose clients include truck drivers and seafarers. A project conducted in 2012 estimates a total of 4000 sex workers in Durban (TB/HIV Care Association, 2013) but there is no recorded information on the number of sex workers who work in and around the port. Research in the mid-2000s, which included sex workers in Durban night clubs frequented by seafarers, records that the latter tended to congregate at one club near the port and that there were about 80 sex workers who served those seafarers via this venue (Trotter, 2008). An interview for this study with one sex worker in 2013 who had worked at this club affirmed that it was the principal venue for seafarers. However, interviews with staff at the Mission to Seafarers facility revealed that seafarers now also frequent brothels in suburbs adjacent to the port (this is in accord with regular Durban press media reporting in recent years the establishment of brothels in these suburbs). With regard to seafarers, Mission to Seafarers staff stated that about 900 of them visit their facility every month and they estimated that this was the majority of seafarers who enter the city. The Home Affairs Department in Durban has accurate records of the population of seafarers in the city at any one time but we were unable to obtain that information (despite using several different channels).

Several exploratory HIV/AIDS-linked health assessment studies have been conducted in the last decade in Durban, which directly and indirectly cover the health of stevedores, truck drivers, sex workers and seafarers. To our knowledge there are two published studies (Tansey et al., 2010; Trotter, 2008), two available research reports (Dekker, 2010; Nkosia & Colvin, 2009)<sup>1</sup>, and one unidentifiable epidemiological research report from 2006 that was noted by Nkosia and Colvin (2009). There are more recent studies, currently still in progress, with an explicit focus on sex workers but the data and analysis has yet to be disseminated. There are two older studies from the early 2000s (cf. Nkosia & Colvin, 2009). Nkosia and Colvin (2009) noted the lack of a knowledge base to inform their research and analysis and this was still the case for this study.

The continued lack of a knowledge base is matched by a relative lack of substantive investment in programmes to reduce the high risk of HIV infection in these mobile and migrant populations and to address their general vulnerability to impaired health as a result of the social and economic conditions of their existence. To be clear, this is not to say that there are few services nor that there have been no improvements to the services for these populations. The issue is that limitations of these services identified in 2009/2010 (Nkosia & Colvin, 2009) were reiterated by informants during this study (e.g. restricted access to workplace HIV programme services for casual and contract stevedores; clinic

---

<sup>1</sup> Tansey et al. (2010) is based in part on Nkosia and Colvin (2009).



services for sex workers being closed at weekends; lack of systemic evaluation of efficacy and effectiveness of services). Furthermore, as is illustrated later, the results of this study in comparison to those of previous studies show that there are still high levels of risk of HIV and STI infection amongst these populations as well as intimations of high disease prevalence rates. These are indicators of uneven development of services and, hence, of constraints on development of state policies and systemic broadening and deepening of programmes in ways that reduce significantly the high risk, and incidence of HIV and STI infection amongst members of these populations. Put another way, this study, like those that have preceded it, is limited to drawing attention to the need for further investment in health programmes and it supports the ongoing initiatives of private sector and civil society organisation initiatives.

Nonetheless, identifying the limitations of current knowledge, of existing services and of the scope of this study is a first step to understanding the situation and, hence, in due course, to using research to inform changes in approaches (for research as well as policy-level and practical initiatives) to curbing the disease risks and vulnerabilities of migrant and mobile populations in the environs of Durban's port. A starting point indicates that there is uneven development of services which points to constraints on the development of policies and programmes. There is a complex set of factors which lie behind this indicator which can be summarised in terms of changing composition and location of these populations and the political and economic forces which push them onto the margins of the city's economy.

First, designing and implementing public health interventions is difficult because the composition and location of the populations which live and/or work in and around the port is changing as a result of the rapidly changing conditions for residence and livelihoods. The Port of Durban and adjacent areas are very different today to what they were 10 years, even 5 years ago; indeed, the urban landscape is likely to be very different in the next five years. The reason is that there is an ongoing process of urban and port development, which begun 17-18 years ago. The process includes expansion of the port and restructuring of operations within and around it as well as urban renewal projects in areas adjacent to the port. In the first instance, public access into and through the port is severely restricted following interventions of government and port authorities in the early 1990s to make the port a secure area. Furthermore, since 1994 there has been marked shifts in the composition of the population resident and working in the inner city next to the port as a result of removal of racially-based controls on residential and business locations, following the collapse of the apartheid regime, and the associated dramatic increase in urbanisation of South Africa's national population.

There is the possibility of an inland port being created, reaching towards the now defunct (since 2010) international airport 8kms to the south with massive ramifications for the urban landscape in the affected localities. This area is a relatively run down area with a mix of industries, businesses and longstanding working class residential areas. Even if the inland port vision is not realised, infrastructural developments are proceeding to link the port and the old airport to support industrial development at the latter site and the automobile manufacturing industry adjacent to the old airport.<sup>2</sup> There is already a truck staging/rest area in this area to the south; that is, a place where trucks can be parked away from the port prior to collecting cargo. There are plans to build a container depot 30kms inland from Durban at Cato Ridge. The intention is to reduce traffic congestion at the container terminal in the port; in brief, containers would be transferred by rail to the new depot for collection by trucks.

Associated urban renewal projects include 'gentrification' of one 'red light' area next to the port, the Point, beginning in 2001. There is longstanding consideration amongst city planners to promote recreational and tourism development along the east-side of the harbour. This side includes yacht marinas and tourist venues; and it is flanked by up-market flat complexes, hotels and businesses amidst degrading buildings and streets. Currently, such development is restricted by a railway line which separates the wharves from the streets. This line serves bulk cargo and car freight terminals at the ocean end of this side of the harbour. However, this urban renewal agenda could occur if the port is expanded to the south.

These past, current and future developments lie behind the changing composition of the populations that live or work in the port environs. For example, since 1994, there has been a marked influx of immigrants from African countries and attendant growth of formal and informal trading businesses throughout the city. Expansion of container traffic at the south end of the harbour has not only led to congestion in this area and, in turn, planning to alleviate the congestion but also to the growth of informal businesses that serve truck drivers waiting to enter the container terminal. Gentrification of the Point area led to an exodus of sex workers to other suburbs near to the port (e.g. Umbilo) and this is probably a reason for the growth of, and media reporting on, brothels in these areas in the last 6-8 years. It also coincided with the growth of a substantive illegal drug trade due to marked increase in freight movement through the port in one locality of the Point area coupled with relocation of commercial sex trade to this location.

---

<sup>2</sup> Infrastructural developments to support the automobile industry have occurred erratically since the mid-2000s due to conflicting development interests of the port and the automobile industry (Hall and Robbins, 2006).

As is intimated above, port development and urban renewal in Durban are a cause of the marginalisation of the mobile and migrant populations. This is a function of the changing relationship between the city and the port which we summarise below. Since the late 1990s and early 2000s, the city authorities have been actively seeking to consolidate the industrial foundations of the metropolitan economy and to re-fashion the city itself to attract capital inflows (Moffet & Freund, nd). This agenda entails seeking new land for industries (e.g. the old airport) and urban renewal projects such as construction of an International Convention Centre and creation of a 'waterfront(s)' (i.e. the Point area and, potentially, the east side of the harbour). The port authorities have been seeking to develop the port in accord with contemporary business demands (Duvuet & Lee, 2006; Hall, 2008); notably, expansion of container terminal capacity and efficient distribution routes into the hinterland and, potentially in due course, removal of bulk cargo away from the city (i.e. relocation of the bulk cargo and car freight terminal). Both agenda serve local and national political elites (Moffet & Freund, nd) as well as those of large-scale businesses and, hence, inevitably such urban renewal and development is at the cost of the poor and small-scale business interests: the latter are simply pushed away from the development areas.

A notable recent example was an attempt in 2009 by the city authorities to re-develop Warwick Junction, a very large market in the city centre through which over 400000 commuters pass every day and which supports over 900 formal and informal traders. This market had previously been re-developed to improve conditions for traders and customers in the late 1990s and had won several international awards for sustainable and innovative development. In 2009, the city authorities sought to build a shopping mall on two thirds of the area justifying the development on the grounds of achieving 'a wider retail choice and improved traffic flow and security'. The authorities asserted that the development would not drive traders out of the Warwick area on the basis of an absurd claim that the new market would still accommodate 270 traders. The attempt by the city authorities and market developers was thwarted by strong public opposition.

Literature on the subject of contemporary city-port developments recognises this displacement (Ravetz, 2013; Hall, 2008); for example Hall (2008) uses the concept of 'edges' in reference to how port development expand their boundaries and in ways that literally push large sections of people who depend on the port for their livelihoods to the peripheries of the ports. This is evident in Durban. International security concerns led to restricted access of people into the port whilst the planning to ease container truck traffic congestion relocates container transfer and truck rest areas well away from the port. Redevelopment of "obsolescent" areas (i.e. business areas that served the port

economy in the past and now often degraded; residential areas of the poor) (Ravetz, 2013), removes the residents; for example, sex workers and working class residents in the Point area and, probably in due course, working class residents at the south end of the harbour.

From a public health perspective, urban development has transformed, and continues to transform the environment for management of residents' health and welfare. Inevitably, health authorities face difficulties with designing and implementing city-wide public health interventions, because the burden of disease and health care demands within the city population has changed relatively rapidly.<sup>3</sup> In the case of targeted interventions such as HIV prevention and treatment amongst mobile and migrant populations, there are additional difficulties which can be described in terms of their 'invisibility' in the city in the sense of their limited presence and diminishing significance socially and economically in the port environs. In the case of sex workers, urban development around the port is pushing them into 'pockets' within the spaces around and beyond port environs where they work surreptitiously. In the case of truck drivers, urban development is gradually relocating them to places well beyond the port boundaries. As for stevedores, the majority constitute an irregular workforce in a declining sector of the port economy. As casual and contract workers, they have limited access to the services of workplace programmes; indeed, companies that employ them may legitimately claim that these workers should be served primarily by government health services. Furthermore, these stevedores are represented by a trade union which can do little more than act as a labour broker in the context of diminishing demand for stevedoring services. Regarding seafarers, port development and changes to the nature of the global maritime economy restrict their presence in the port environs. Access into the city is limited by both entry permit controls of the immigration authorities and ship operations which are generally geared to rapid loading and offloading of cargoes in order to minimise costs of ship stays in harbours and use of smaller crews than in the past. In sum, there are relatively few seafarers in the city at any one time; they are present for very short periods of time; and, most pertinently, they are largely foreigners whose health is the responsibility of their employers who, via ship agents, secure medical care for ship crewmen and women when necessary from private health facilities.

This is not a conducive environment for investment in public health programmes for these migrant and mobile populations. Put bluntly, market economic forces are overriding the human rights foundations of South Africa's public health policies and, as is presented

---

<sup>3</sup> Indicators of these challenges include the closure of some public hospitals in the city and, according to health officials, plans to build new facilities in different areas in response to the demographic shifts in the city population.

later in the report, private sector and NGO-funded and implemented health interventions are still principal sources of assistance for the migrant and mobile populations.

### 1.3 Spaces of vulnerability

This report is structured to explain and illustrate the ‘spaces of vulnerability’ that exist for the study populations in and around Durban’s port. It may be noted here that the study revealed a process of transience and fragmentation of these spaces, which is due in part to the city and port developments outlined above.

## CHAPTER 2

---

### STUDY METHODS

#### 2.1 Introduction

The project was commissioned by the International Organisation for Migration (IOM) with support from the KZN provincial departments of Health and Social Development and with funding from the Southern African Development Community (SADC). This study is one part of a larger project that includes parallel research at ports in Namibia, Mozambique and Tanzania. HEARD conducted the South African component of the larger study amongst mobile and migrant populations linked to the Port of Durban.

HEARD designed a study proposal that, in essence, sought to identify and investigate the principal channels, directional flow, 'hotspots' and spatial 'footprint' of HIV, TB and STI transmission in and around the port, to provide practical illustration of the spaces of vulnerability'. The focus on stevedores, truck drivers, seafarers and commercial sex workers (CSWs) was designated by the project's terms of reference and governed by a generic behavioural survey instrument which was devised and refined at a workshop involving all the country research teams and IOM representatives. In addition, it was anticipated that all the country teams would construct maps to illustrate the 'spaces of vulnerability, using the services of a consultant, EduAction.

#### 2.2 Study procedures

The Durban study was conducted in stages as is outlined below.

##### *2.2.1 Stage 1: Development of survey instrument and study procedures*

The bulk of the study consisted of a behavioural survey using a generic questionnaire which, as was mentioned earlier, created and refined at a workshop involving all the country study teams. The instrument was a structured questionnaire for use with stevedores, truck drivers and seafarers (with minor question phrasing changes as necessary in the case of some questions depending on the informants' work categorisation). A generic semi-structured interview schedule was also devised for interviews with CSWs and another schedule for key informants; namely health workers and any persons identified during each study as a key informant. It should be noted that some questions in the structured questionnaire were subsequently modified slightly by the Durban team following a pilot study and, later, in response to queries from the University of KwaZulu-Natal's Ethics Committee. The modifications included changes in the phrasing of some questions to ensure clarity of meaning of the question and inclusion of appropriate terminology

(interviews were conducted in English and/or Zulu in the case of the stevedores and truck drivers and in English in the case of the seafarers).

The structured questionnaire (see Appendix) had 155 questions divided into eleven sections as they are listed below:

Section 1: Background characteristics

Section 2: Migration and mobility dynamics, and employment

Section 3: Marriage and live-in partnerships

Section 4: Sexual history - regular partners

Section 5: Sexual history - boyfriends

Section 6: Sexual history - commercial sex

Section 7: Sexual history - casual acquaintances

Section 8: Condoms use and attitudes towards safe sex

Section 9: STIs and health seeking behaviour

Section 10: Knowledge, opinions and attitudes

Section 11: Exposure

### *2.2.2 Stage 2: Scoping exercise*

This involved multiple visits to the port and surrounding areas to enable the research team to identify relevant conditions for the research; and also to identify health facilities, brothels and entertainment clubs adjacent to the port. Repeated trips around the port included GIS mapping and data was compiled on a map of the harbour by EduAction.

### *2.2.3 Stage 3: Gatekeeper meetings*

This stage involved gaining permission for the study from the Durban Port Manager alongside meetings with representatives of relevant companies, and public and non-government organisations to gain an understanding of other relevant research and health interventions directed at the designated study populations. These meetings

provide a network of contacts for devising how to conduct the field research, taking into account ethical standards and logistical feasibility. Specifically, the team worked with representatives from Lifeline, Bidfreight Port Operations, Truckers Against AIDS Wellness Clinics, and Mission for Seafarers, to work out practical means to do the field research, respectively amongst CSWs, stevedores, truck drivers and seafarers. These were organisations which were involved in programmes with each of the designated study populations.

#### *2.2.4 Stage 4: Sampling*

Sampling of each study population was guided by the knowledge of the organisations's team worked with. The principle was to identify a time-based population size in the cases of stevedores, truck drivers and seafarers, in the sense of how large each population was during a specific period. Regarding CSWs, the South African National Aids Council (SANAC) has conducted a sex worker population size estimation study. In this study they estimate that eThekweni Metropolitan (Durban) has roughly 6300 sex workers (SANAC, 2013). This estimate is based on mapping exercises and focus group discussions with sex workers in Durban. Once the number of sex workers has been calculated it is adjusted for whether the district includes mining and trucking activities. For Durban 10% is added to the total, from the mapping and focus group exercises, to account for the port as a hotspot of sex work activity and finally the number is adjusted for an undercount. In addition to this study, the Anova Health Institute and Lifeline estimates are roughly 4000 sex workers in the Durban metropolitan area. Regarding CSWs who specifically cater to seafarers or the latter constitute a large proportion of their clients; there is an estimate of 80 individuals provided by Trotter (2008). These CSWs worked largely from one night club near the port. The ethical protocol prevented research being conducted at this club. It should be noted that Trotter's estimate is from six years ago and he emphasised that the numbers were declining in the face of the transformation of the maritime industry. This assertion by Trotter differs from the numbers provided by the SANAC and Anova Health Institute estimates. In addition, the research with CSWs did not need to know the actual population size as the study protocol sought only qualitative interviews to gain insight into their work in and around the port.

In the case of the stevedores, a time-based population was not defined as the team was informed that Bidfreight employs the majority of the casual and contract stevedores who work at the port and that company estimated there were about 2000 such stevedores. In addition, an early finding was that the vast majority of the stevedores are city residents, not migrants, and hence the rationale for time-based population sampling fell away.



Regarding truck drivers, the intention was to identify the average number of drivers that enter or leave the port each day. However, it proved impossible to obtain accurate figures on the daily number of trucks and drivers. Eventually, the team relied on its observations and an assessment that approximately 400-500 drivers were at the port on average each day of the week. Regarding seafarers, the intention was to obtain the actual number of seafarers who enter the city from the harbour each month; these figures exist as any ship crew has to obtain an entry permit into South Africa from their ships in harbour from the department of Home Affairs. The team sought to obtain figures for the preceding year and then use an average daily number for determining the population size. However, despite using several contacts, the team was not able to obtain the figures from government officials. Ultimately, the team used an estimate provided by a Mission to Seafarers representative of 900 seafarers per month visiting the city.

Sample sizes were determined by these assessments. Bearing in mind time limitations for the study, the decision was taken to sample 200 stevedores (150 casual or contract workers and 50 permanent workers), 250 truck drivers and 50 seafarers. It should be noted that these were not random samples because of constraints for conducting the behavioural survey within a short time frame, the need to access informants via representatives of the organisations which collaborated with the research team, and ethical considerations – notably security for informants and researchers alike. In the case of the stevedores, access was facilitated by Bidfreight and representatives of the trade union which represents casual, contract and permanent workers. Interviews were conducted with stevedores who were working in the harbour during a period of two weeks. Informants were individuals who were brought by the union representatives to the primary interview venue (in the Bidfreight premises) and at the union offices. In the case of the truck drivers, there are numerous areas in and around the port and further afield, where there are daily concentrations of drivers on their way to or from the port, few of which are practical places for interviews. The feasible option was to conduct interviews at the Marianhill truck stop which is one regular stopping point for trucks entering and leaving the port and where access to drivers was initially facilitated by staff of the clinic at this site which serves truck drivers. The team interviewed truckers going to and coming from the port at this truck stop over a period of four weeks during the day. In the case of the seafarers, security and practical factors prevented consideration of interviewing seafarers at port entrances as they entered or left the city or in the clubs they visited; hence, interviews were conducted with seafarers who visited the Mission to Seafarers facility in the port over a period of two weeks. Interviews at this site were conducted at night time as this was the time in the day when seafarers congregated at the facility. Regarding CSWs, the approved ethical protocol dictated identification, accessing and

interviewing of potential informants at a secure venue where there was no possibility of harm. This meant in practice that the team used the Lifeline clinic in Warwick Junction, which also has a programme to assist CSWs to arrange interviews with at this site with the assistance of clinic staff.

Finally, open-ended interviews were conducted with four clinic workers (at the Lifeline, Bidfreight and Marianhill clinics) and with the Bidfreight manager. No interviews were conducted with health workers who serve seafarers; the team did not gain access to ships which have on-board facilities nor to the private hospitals which assist seafarers who need tertiary-level medical attention (arranged as necessary by ships' agents).

### *2.2.5 Stage 5: Field research*

A pilot study was conducted amongst stevedores and truck drivers to test the structured questionnaire. The first testing was conducted at the Bidfreight premises with stevedores. In this instance, two fieldworkers were assigned to each interview to enable all to gain experience with the questionnaire. The following day, the fieldworkers individually tested the questionnaire amongst truck drivers at the Marianhill truck stop; initially, with the assistance of one of the clinic staff (to introduce the study and the field workers to drivers). Questionnaire review and modification followed immediately after this pilot study under the guidance of the two research supervisors. The supervisors monitored the subsequent field research. They visited the research sites along with the field workers on occasion, they checked completed questionnaires at random to ensure quality control, and they were responsible for ensuring completion of the required number of interviews and of the field work generally within a given time frame.

### *2.2.6 Stage 6: Data analysis and reporting*

Data from the questionnaire was analysed via the SPSS programme. Qualitative interviews were analysed manually. Chi-square tests were conducted to test whether there was a statistically significant difference between the expected frequencies and observed frequencies in one or more categories of this study. The bulk of this report refers to the findings from the behavioural survey.

## **2.3 Study limitations**

The team experienced several challenges with implementing the study as has been inferred above.

In the first instance, the draft structured questionnaire was shortened considerably during the initial workshop, to make it feasible to use. It was on this occasion that the study removed the projected focus on TB and concentrated on HIV/AIDS and STIs.

Sampling was a significant challenge in view of the challenges to obtain reliable estimates of the study populations' sizes and, coupled with logistical challenges for fieldwork and ethical considerations, the result was that the study could not obtain random samples.

As is indicated in later chapters, few informants in some samples (notably truck drivers and seafarers) answered questions related to incidence of STIs such which reduced the value of the results on some of these questions. An underlying, associated challenge was that some informants did not seem to understand the questions, despite previous modifications and, where applicable during some interviews, translation of the questions and use of vernacular terms by the fieldworkers. In the case of the seafarer interviews, the principal limitation was the restriction to interviewing individuals who could speak English amongst a wide range of nationalities (the study could not afford the cost of interpreters). Furthermore, securing interview time with an individual was frequently difficult because they were often in the company of colleagues and hence, were sometimes reticent to participate in a relatively lengthy interview. In addition, many seafarers simply refused to be interviewed (particularly Russian seafarers).

Analytical consequences of the above limitation was inability to measure statistical significance of some results (as the observations on certain items were too few) and some doubt regarding the validity of cross-tabulated analysis. In the latter instance, marriage, age and education level were the primary means to disaggregate overall patterns and trends where appropriate. However, in instances where less than 90% of a sample answered a question, the validity of the indicated trends and patterns in relation to marital status, age or education level was compromised.

Regarding cross-tabulation of data, initial analysis did not reveal statistically significant differences in relation to marital status and education level whereas age proved to be pertinent, in a very few instances. A confounding factor for use of education level was that the questionnaire used a general term 'higher education' (above secondary education). While the insinuation of the term was tertiary education, it seemed that informants, particularly in the truck driver and seafarer sample interpreted the term as meaning additional technical skills training.

Finally, the data from the behavioural survey consists predominantly of informants' self-reported behaviour, knowledge and attitudes. There inherent limitations with this method

include some doubt about the reliability of the information provided, lack of adequate data on occasion due to reticence of informants to answer some questions and, as with all quantitative methods, exclusion of context.

## 2.4 Report content and foci

This report presents the behavioural survey findings, the qualitative insights provided via interviews with CSWs, health workers, others and relevant contextual information. The report does not present every finding from the survey. As was noted earlier, the survey tool included 155 questions; hence, an exhaustive analysis that included all possible cross-tabulations was not feasible. Instead the report focuses on the key results. This focus is based on a preliminary assessment of the statistical results which indicated the most pertinent results for the purpose and aims of this study. Subsequent analysis investigated those results in depth; for example, adding cross-tabulated analyses to see if there were trends and patterns hidden within the data. The general approach was to focus on results that provided a platform to define ‘spaces of vulnerability’ at the port and amongst the study populations. The chapter headings indicate the direction taken for this purpose.

## CHAPTER 3

### RESULTS: DEMOGRAPHIC CHARACTERISTICS OF THE STEVEDORE, TRUCK DRIVER AND SEAFARER STUDY POPULATIONS

#### 3.1 Introduction

This chapter provides an introduction to the results of the surveys of the stevedore, truck driver and seafarer samples by presenting their demographic profiles. The chapter first presents economic features (including nationality) to illustrate the characteristics of migration and mobility in the study populations. Thereafter, it presents results regarding education level, marital status and age of the informants as these are key variables for analysis in later chapters on the health vulnerabilities of the study populations.

#### 3.2 General demographic profiles

Notable common characteristics are that each sample includes workers who do not have permanent posts, a majority in the case of stevedores and seafarers and a minority in the case of truck drivers, and, across all samples, the majority was familiar with Durban having worked in or visited it on occasion for more than a year.

The stevedore sample reflected changes that have occurred in this field of employment. Notably, the sample included a sizable proportion of women (36%) as indicated in Table 1. General discussions with key informants and some survey informants revealed that 'traditionally' stevedores were male migrant workers from rural areas of KwaZulu-Natal province who would have temporary contracted work for a period and return to their rural homes in between contracts. This is no longer the case but that norm was reflected in the profiles of the permanent stevedores. These stevedores were generally older men who had been rural migrant contract workers when they started this work but now had homes in both their rural areas of origin and in the city. In contrast, the vast majority of the contract and casual workers were residents of Durban townships. A few casual stevedores reported that they were homeless and that they lived on the streets in the vicinity of the port.

The truck driver sample contained a sizable percentage (approximately 24%) of drivers who did not have permanent jobs as is indicated in Table 1. This was unexpected in view of the responsibilities upon drivers and the value of the cargoes and vehicles that are entrusted to them. However, the finding indicates the variability of haulage contracts for transport companies and associated job insecurity within this business sector. The cosmopolitan nature of the sample indicates the flow of cargoes via Durban's port throughout southern Africa. The preponderance of South African drivers probably reflects

a common bias in purposive sampling: the South African research assistants would have found it easier to establish rapport with South African drivers. The presence of a relatively large minority of drivers (38%) who have been travelling to and from the port for less than 2 years indicates regular addition of new members to this mobile population.

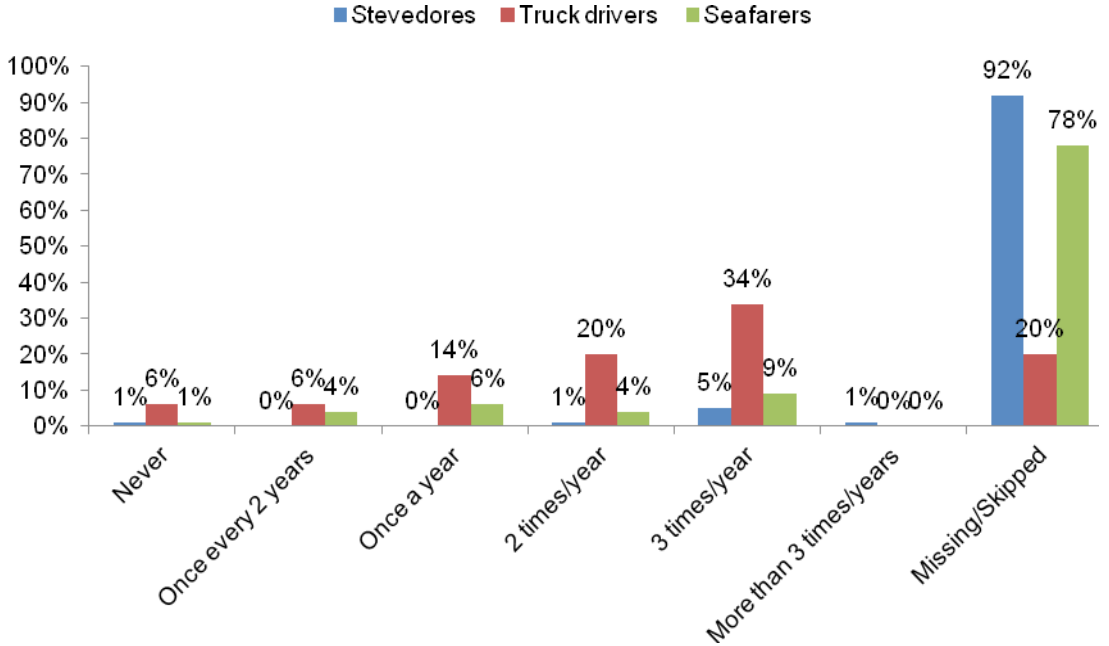
The seafarer population expectedly included a majority (96%) of foreigners as is indicated in Table 1 below. The majority of Asian seafarers in the sample and a minority of seafarers with permanent jobs reflects changes, since the late 1990s, in the composition of the seafarer population that visits South African ports, which itself reflects changes in labour recruitment practices in the global maritime industry to reduce operating costs (Trotter, 2008). There has been a marked increase in employment of Asian crews and fixed period employment contracts to labour costs. Figure 1 provides some indication of these conditions in showing that 13% of the total number of seafarers reported frequent returns (2 or more times per year) to their homes. The presence of a few 'temporary/casual' seafarers reflects the continuation of ad hoc opportunities for short term employment (e.g. men who may secure work for 1-2 voyages on a ship).

Comparatively, truck drivers are far more likely to have permanent employment at the port than their seafarer and stevedore counterparts (77% vs 20% for seafarers and 21% for stevedores and seafarers). Truck drivers have also worked at the port for a shorter time period than their equivalents, as almost a quarter (24%) indicated they have worked for less than a year at the port. Whereas 93% of stevedores indicated they have worked in the Durban port for longer than two years. The comparisons below show that these three types of workers show significant variation in their form of employment and the duration they have worked in the port environment.

Table 1: Demographic characteristics of stevedores, truck drivers and seafarers

Demographic characteristic		Stevedore % (n)	Truck drivers % (n)	Seafarers % (n)
Sex	Female	19 (36)	0 (0)	0 (0)
	Male	81 (128)	100 (200)	100 (50)
	Total	100 (190)	100 (200)	100 (50)
Nationality	South African	99 (197)	78 (155)	4 (2)
	Non-South African	1 (3)	23 (45)	96 (48)
	Total	100 (200)	100 (200)	100 (50)
Form of employment	Permanent	21 (41)	77 (153)	20 (10)
	Contract	22 (43)	11 (21)	74 (37)
	Temp/Casual	58 (116)	13 (25)	6 (3)
	Total	100 (200)	100 (199)	100 (50)
Duration worked at port	<1Year	5 (10)	24 (48)	16 (8)
	1-2 Years	3 (5)	14 (28)	22 (11)
	2+ Years	93 (185)	62 (124)	62 (31)
	Total	100 (200)	100 (200)	100 (50)
How are you paid	Fixed salary	4 (7)	63 (117)	96 (48)
	Per hour	23 (46)	13 (25)	0 (0)
	Per day	1 (1)	3 (6)	2 (1)
	Other (not specified)	73 (146)	20 (38)	2 (1)
	Total	100 (200)	100 (186)	100 (50)

Figure 1: Migrancy among stevedore, seafarer and truck driver samples



Many of the casual and contract stevedores resided in the same townships as work was usually obtained via personal contacts amongst stevedores. The presence of three Zimbabweans indicates that some foreigners had managed to establish social contacts to secure work but their very small number also indicates that access to jobs is informally and tightly controlled amongst stevedores. Figure 2 shows that almost three-quarters (74%) of stevedores indicated that it was difficult to find work. While Figure 3 shows that almost a fifth (17%) of stevedores felt there was discrimination against migrants in their sector.



Figure 2: Stevedores' perceptions on difficulty of finding work (n=187)

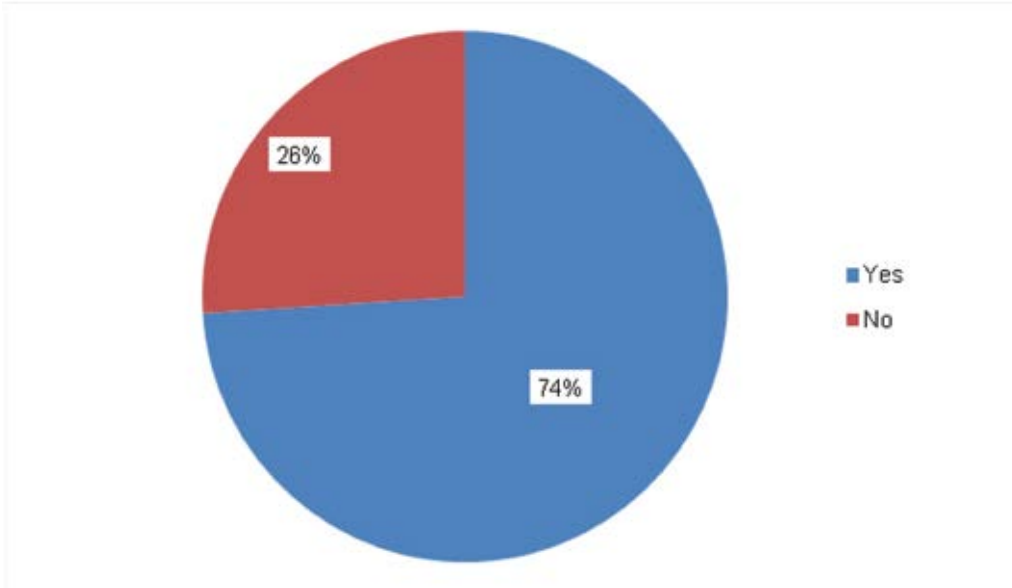
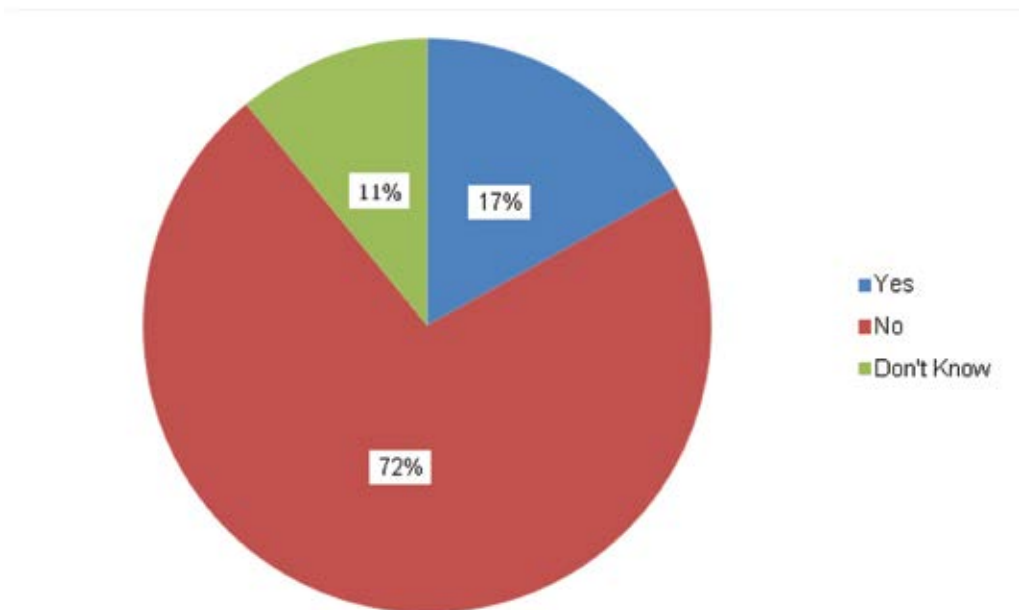


Figure 3: Stevedores' perceptions on discrimination in securing work (n=200)



### 3.3 Social profiles of the study populations

Below we outline the social profiles of the samples. As was noted in the introduction, the expectation at the start of analysis was that education level, marital status and age would probably be pertinent factors for explaining some results. The level of education, for example, can correlate (subject to context) with health risk and vulnerability; in short, higher education can mean lower risks to health. Accordingly, education level was one key variable that was cross tabulated with knowledge about HIV/AIDS and STIs, attitudes regarding these diseases, sexual behaviour and health seeking behaviour. The section goes on to summarise results regarding the marital profile for the same reasons. Furthermore, it is expected that age and behaviour surrounding health may also be correlated in certain instances.

The seafarers sample is the youngest with a mean of 35 years and a standard deviation of 9. This is highlighted in Figure 4 and Table 2 where more than a quarter of seafarers fall between the ages of 35 and 39 years. Stevedores have the eldest sample with a mean of 40 years and a standard deviation of 10. Stevedores' have the highest percentage of people in the older age categories, such as the 60-64 years of age and 50-54 years of age categories.

Figure 4: Age categories of stevedores, seafarers and truck drivers

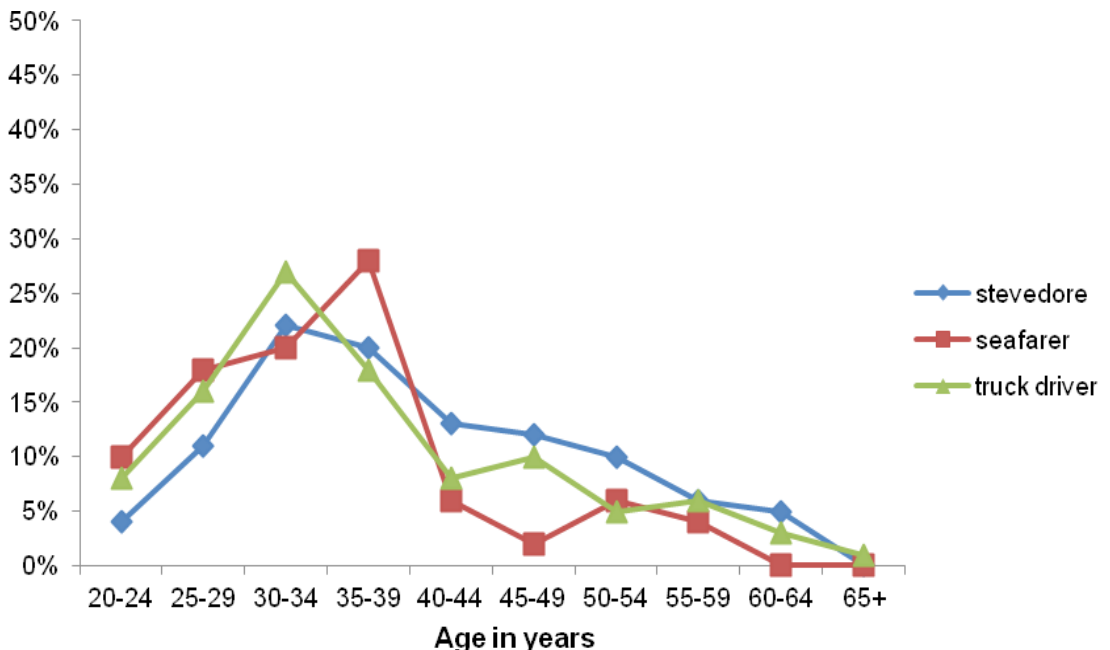


Table 2: Age categories of stevedores, seafarers and truck driver

Age	stevedores %	seafarers %	truck drivers %
20-24	4	10	8
25-29	11	18	16
30-34	22	20	27
35-39	20	28	18
40-44	13	6	8
45-49	12	2	10
50-54	10	6	5
55-59	6	4	6
60-64	5	0	3
65+	0	0	1
Total (n)	100 (200)	100 (50)	100 (199)

A vast majority of truck drivers, stevedores and seafarers attended school, only 10% of stevedores did not attend school as seen in Figure 5. There were evident differences in educational attainment of stevedores, seafarers and truck drivers. Stevedores appear to be the least educated and seafarers appear to be the most educated, as seen in Figure 6. Ten percent of stevedores had no formal education and almost a quarter (23%) had only primary school education. The majority of truck drivers had secondary schooling or higher education (87%). All seafarers reported at least having received secondary education. Sizable numbers of informants in all three samples reported receiving 'higher education' (i.e. above secondary level), indeed a majority of the seafarer sample. However, it must be noted that this result seems to reflect primarily informants' understanding of higher education as additional skills training rather than tertiary level academic education. It was not possible to determine exactly the types of higher education as the survey did not seek such detail. In the case of seafarers, the majority reported receiving higher education, which the research team believes; it refers to technical skills training on the grounds that most of the men within this category were experienced seafarers between the ages of 25 and 35 years old.

Figure 5: History of school attendance of stevedore, seafarer and truck driver samples

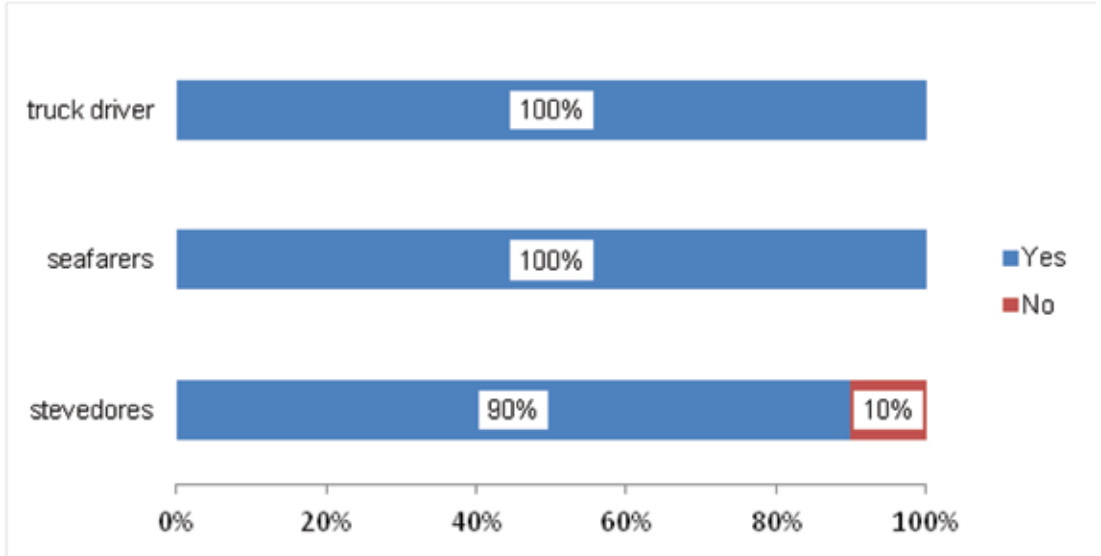
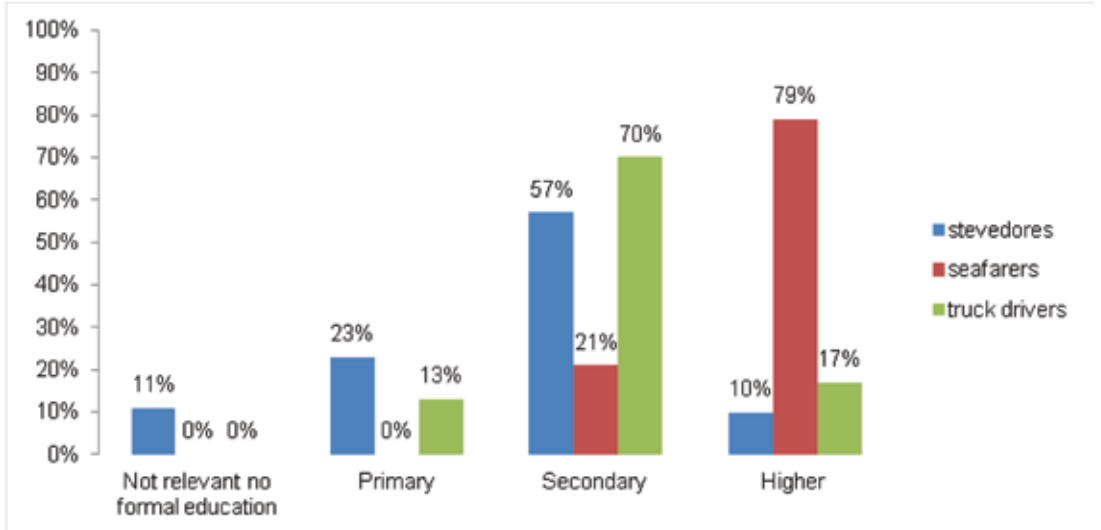


Figure 6: Highest level of education attained by stevedores, seafarers and truck drivers



There were marked differences in the marital profiles of the samples (see Figure 7 & Figure 8). Most notably, steady relationships, through marriage or cohabiting, were reported more frequently amongst the most mobile populations, the truck drivers and seafarers, and the least amongst the most sedentary population, the stevedores. In the case of stevedores, the majority (72%) had never been married, whilst the data suggested that only 30% were in a steady relationship - either through marriage or living with a partner. In contrast, a slight majority (52%) of truck drivers reported that they had never been married. However, half of the truck drivers indicated they are either married or cohabi In the case of seafarers, a small majority reported that they had been, and still were married (56%).

Figure 7: Marital history of stevedores, seafarers and truck drivers

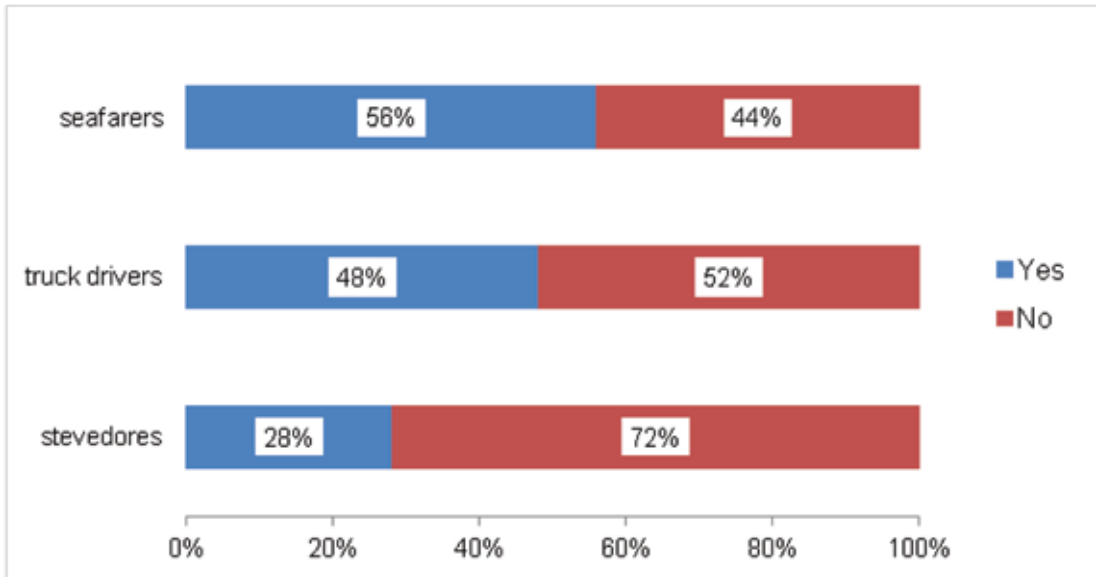
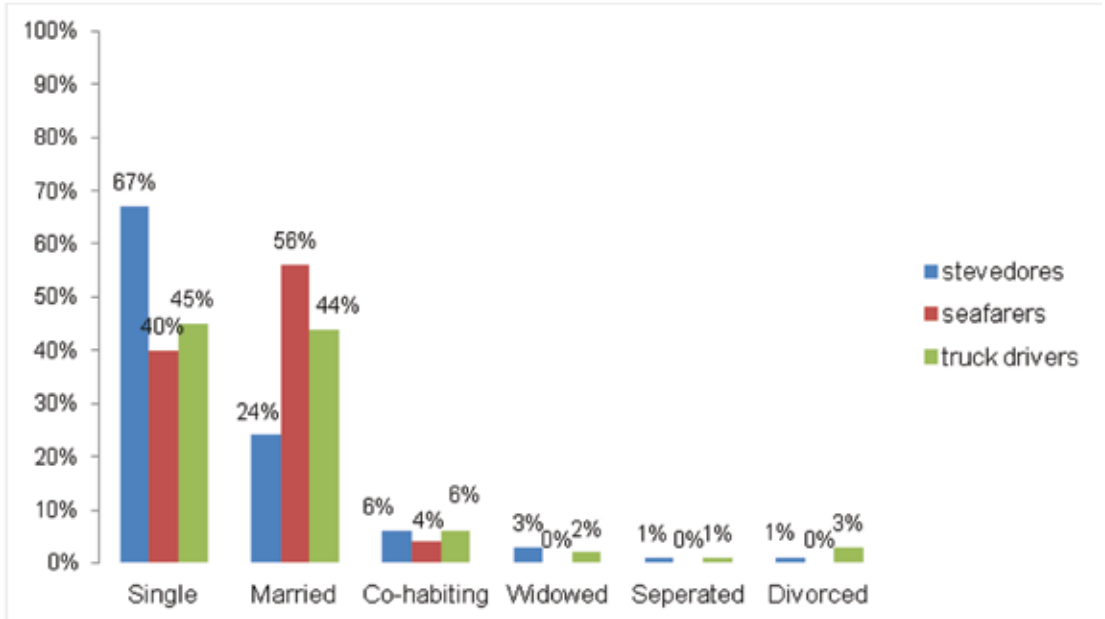


Figure 8: Current marital status of stevedores, seafarers and truck drivers



### 3.4 Summary

The demographic profiles of these study populations provide indicators of material and social vulnerability. Principally, the majority had temporary employment contracts thereby indicating material insecurity. The truck driver sample was the only group within which the majority had permanent jobs. Similarly, the majority of informants were not in steady relationships whilst the groups which reported the highest frequency of marriage, the truck drivers and seafarers, were the most mobile populations in the study and away from their homes for extended periods of time. The educational profiles of the populations are difficult to assess. The impression from the data is that the majority do not have high levels of education. Many informants reported having received secondary education but this does not necessarily mean completion of secondary education. The research did not delve into details of informants' education. It is probable that the majority of truck drivers completed secondary education in view of the job demands, which requires literacy and numeracy skills. It is possible that the majority of stevedores did not complete secondary education.

## CHAPTER 4

### RESULTS - SEXUAL BEHAVIOUR AMONGST STEVEDORES, TRUCK DRIVERS AND SEAFARERS

#### 4.1 Introduction

This chapter presents results on informants' reported sexual behaviour in the stevedore, truck driver and seafarer sample populations. The survey instrument included questions on individuals' sexual relationships, which were the means to assess qualitatively the risk of HIV and STI infection within these populations. The findings in turn provide one foundation for a descriptive epidemiological assessment of HIV and STI transmission within these populations. It should be noted that the quality of the results was very mixed. Informants in all three samples did not answer all the relevant questions. Notably, a majority of seafarer informants refused to answer some questions, which limited use of some data.

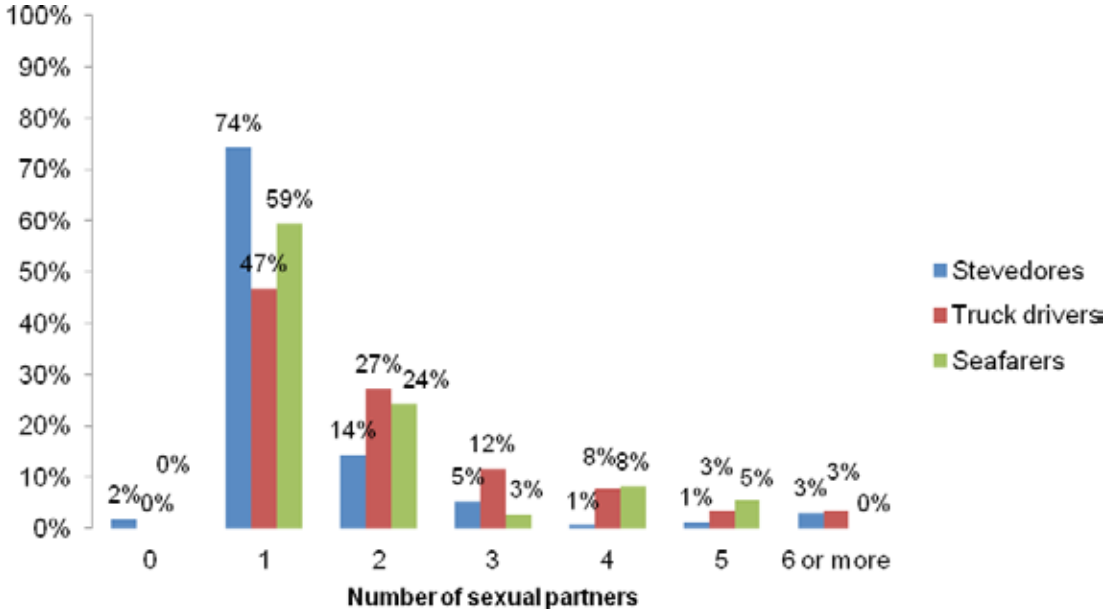
#### 4.2 Sexual history

This section will highlight the sexual history of stevedores, truck drivers and seafarers. Truck drivers had the highest median number (2) of partners in the previous 12 months and also had the lowest mean age (17 years) at sexual debut (see Table 3). Seafarers were generally older at sexual debut than their stevedore and truck driver colleagues. Figure 9 shows that truck drivers were more likely to have two or three partners than their seafarer and stevedore counterparts. This may point to truck drivers being more susceptible to STIs and HIV and AIDS than seafarers or stevedores.

Table 3: Descriptive statistics on sexual history of stevedores truck drivers and seafarers

Sexual history	Stevedores	Truck drivers	Seafarers
Mean number of partners in previous 12 months (Standard deviation)	2 (5.4)	2 (1.6)	2 (1.2)
Median number of partners in last 12 months	1	2	1
Mean age at time of first sexual intercourse (Standard deviation)	18 (4.2)	17 (3.9)	20 (4.8)
Median age at time of first sexual intercourse	18	17	19

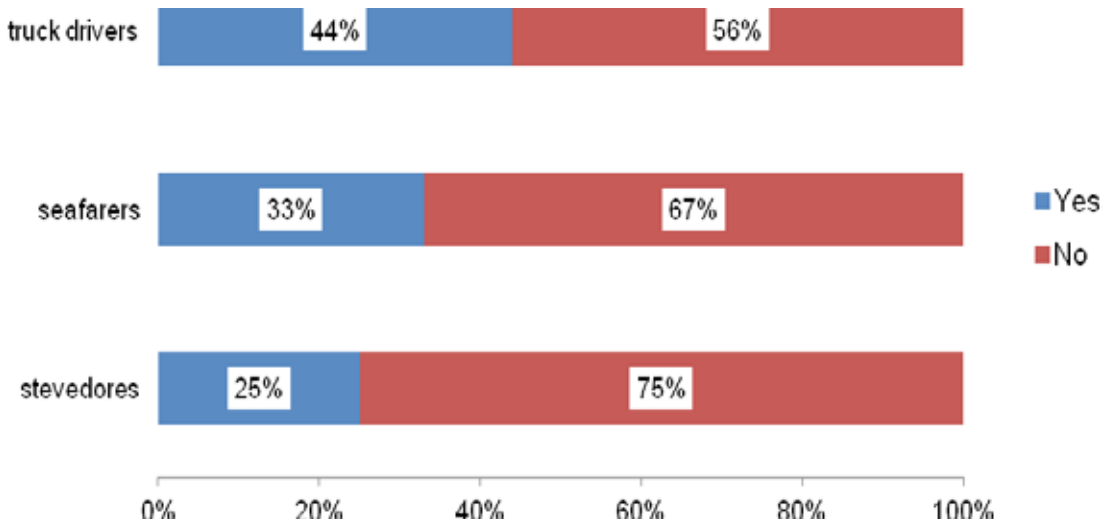
Figure 9: Number of sexual partners in preceding 12 months reported by stevedores, truck drivers and seafarers



As was noted in the previous chapter, the stevedore sample included 58 men and women who stated that they were living with a partner, the latter being either a spouse or person with whom they were cohabiting. Hundred and forty-two men and women stated they were not living with a spouse or partner. Responses to a range of questions on sexual activity revealed that 44 percent of truck drivers reported having sex with someone who is not their regular partner or spouse, comparatively a quarter of stevedores indicated having sex with someone who is not their regular partner or spouse in the previous 12 months (see Figure 10). This indicates that truck drivers are far more likely to have sex with someone who is not their regular partner or spouse than stevedores or seafarers.



Figure 10: Stevedores, truck drivers and seafarers reported sexual incidence with someone who is not their regular partner/spouse in previous 12 months



The majority of stevedores (93%), truck drivers (86%) and seafarers (84%) indicated that they had no sexual partners in the preceding 12 months who were casual acquaintances (see Figure 11). However, of those who indicated they had sexual intercourse with casual acquaintances in the previous 12 months, it appears that seafarers were more likely than the other two types of workers to have sex with a casual acquaintance. Furthermore, the data on the number of acts of sexual intercourse with these casual acquaintances show that truck drivers are more likely to have a higher number of sexual acts (Figure 11 and Table 4). These figures are based on a very small sample size and thus need to be interpreted carefully.

Figure 11: Number of sexual partners in preceding 12 months, reported by stevedores, truck drivers and seafarers to be casual acquaintances

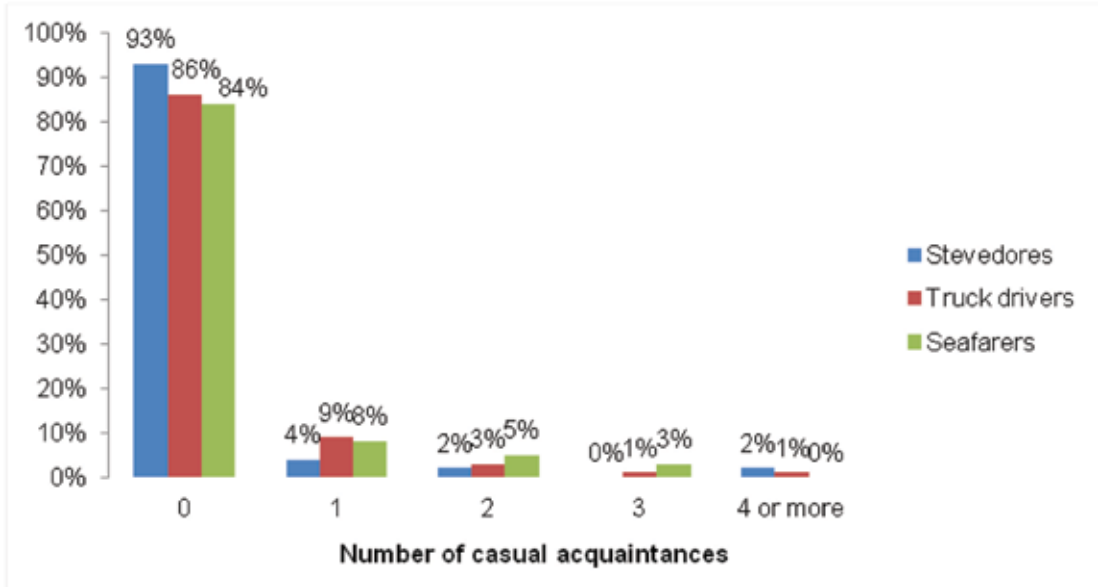


Table 4: Stevedores, truck drivers and seafarers reported frequency of sexual intercourse with casual acquaintance(s) in preceding 30 days

Number of acts of sexual intercourse	Stevedores % (n)	Truck drivers % (n)	Seafarers % (n)
1	55 (6)	29 (7)	67 (4)
2	18 (2)	33 (8)	17 (1)
4	9 (1)	13 (3)	0 (0)
5	9 (1)	4 (1)	17 (1)
6	9 (1)	0 (0)	0 (0)
7	0 (0)	4 (1)	0 (0)
9	0 (0)	4 (1)	0 (0)
Total	100 (11)	100 (24)	100 (6)

Figure 12: Stevedores, truck drivers and seafarers reported frequency of sexual acts with casual acquaintances in the last 30 days

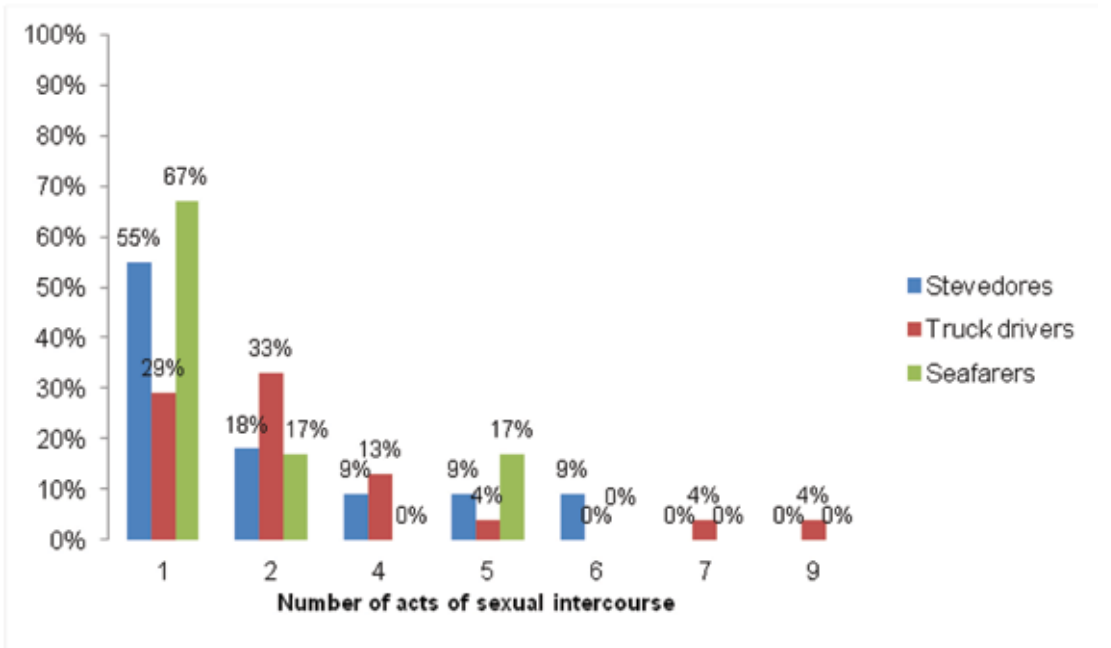


Figure 13 highlights whether the different type of workers have ever had sex on a commercial basis very few respondents indicated they have had sex on a commercial basis. Seafarers had the largest proportion of respondents who indicated they have had sex on a commercial basis; unfortunately this sample is based on eight individuals and thus may not be very reliable. Keeping this limitation in mind, Figure 14 shows that seafarers visit commercial sex workers more frequently than their truck driver and seafarer equivalents.

Figure 13: Stevedores, truck drivers and seafarers reported incidence of sexual intercourse with commercial sex workers in preceding 12 months

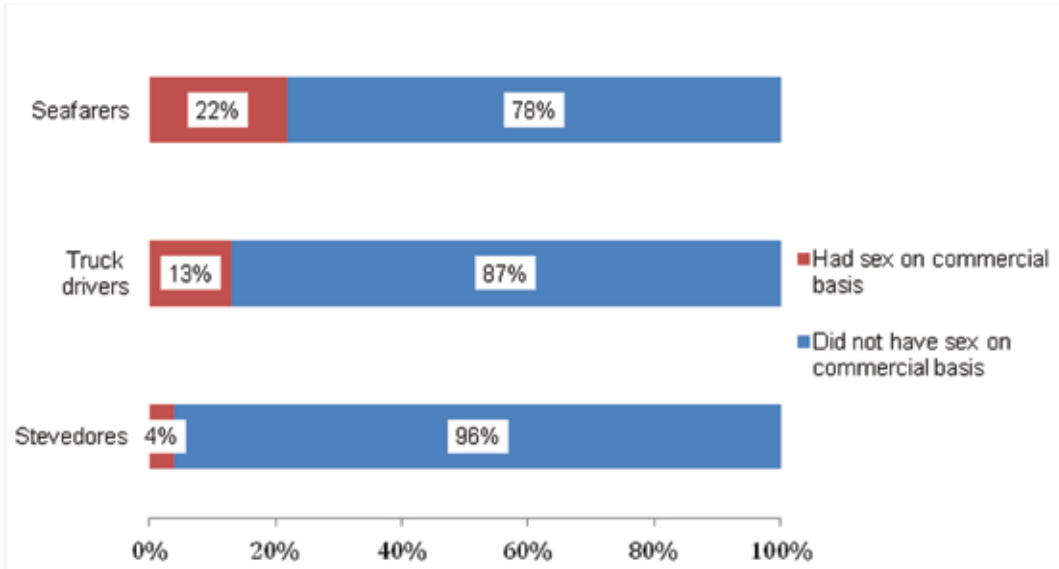
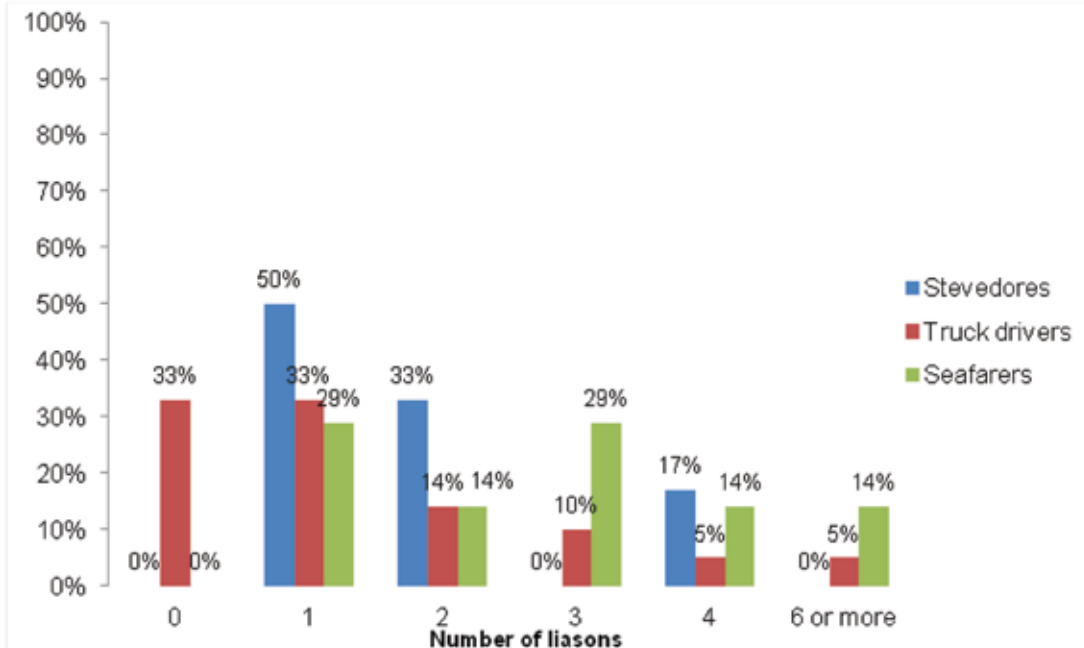


Figure 14: Stevedores, truck drivers and seafarers reported number of liaisons with commercial sex workers in preceding 30 days



### 4.3 Marital status and sexual history

This section investigates the marital status and sexual history of stevedores, truck drivers and seafarers. According to findings from the South African national HIV survey unmarried or cohabiting couples have a higher HIV prevalence than in the married population in South Africa (HSRC, 2014). It is hypothesised that unmarried persons have higher rates of multiple sexual partners.

Figure 15 shows that 38% of married stevedores had more than one sexual partner in the previous 12 months and more than 36% of cohabiting stevedores had more than one partner in the previous 12 months. Thirty-four percent of married truck drivers have had more than one partner in the previous 12 months, while 63% of single truck drivers had more than one partner in the previous 12 months (see Figure 16). In the seafarer sample 36% of married seafarers had more than one partner in the previous 12 months, while 55% of single seafarers had more than one partner in the previous 12 months (see Figure 17).

The hypothesis that being married will lead to fewer sexual partners than those who are single holds true for the seafarer and truck driver sample. In these samples, the mean number of sexual partners in the previous year for the married group is lower than the mean number of sexual partners for those who are single. Yet the stevedore sample shows that the married stevedores generally had more sexual partners, in the previous 12 months, than those stevedores who indicated they are single. This measure is not sensitive to those respondents who got married in the previous 12 months, so their partners might not have been concurrent, but this shows that interventions attempting to implement a sexual risk reduction plan in stevedores should focus on married stevedores as well as single stevedores. The results below indicate that married stevedores may be even more at risk of contracting STIs than their single colleagues.

Figure 15: Stevedores current marital status and number of sexual partners in past 12 months (n=181)

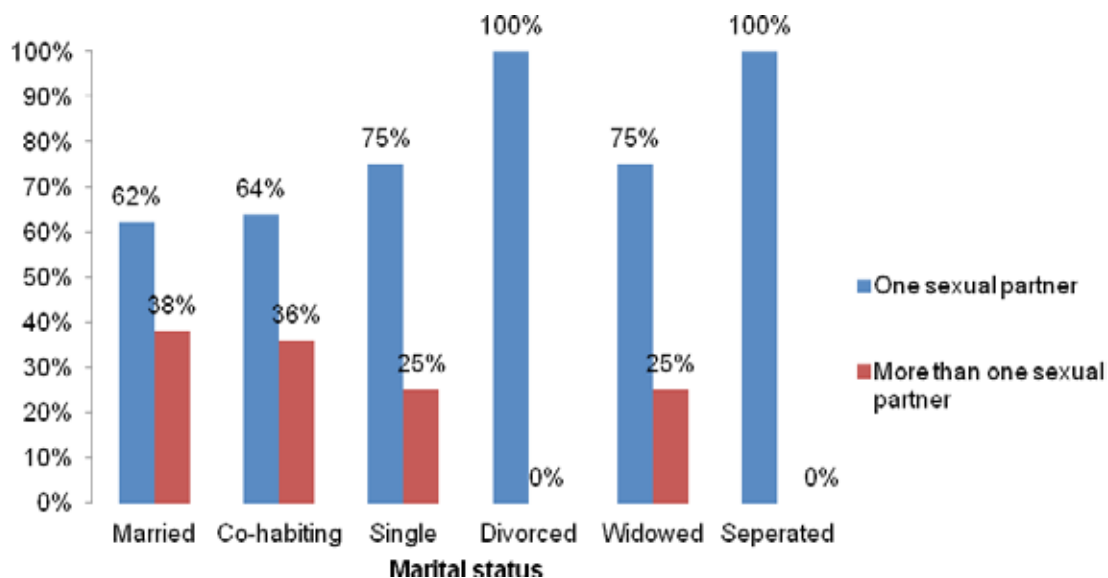


Figure 16: Truck drivers current marital status and number of sexual partners in the past 12 months (n=173)

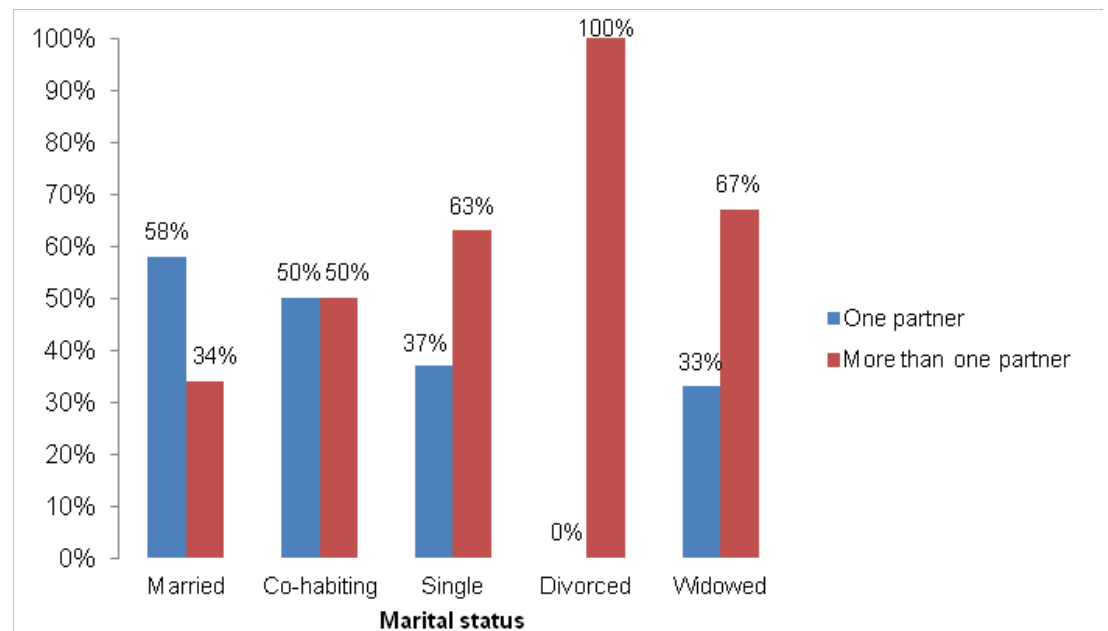
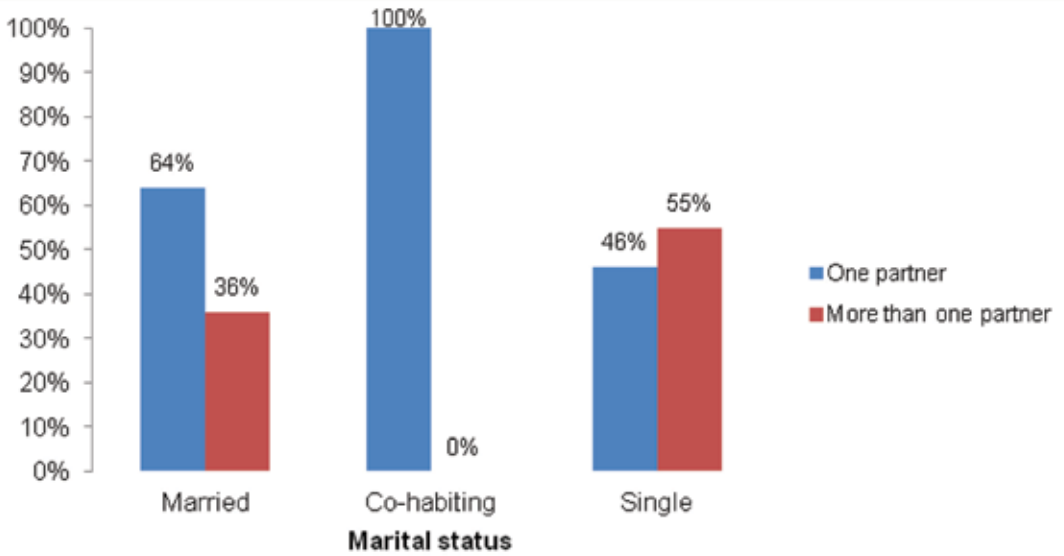


Figure 17: Seafarers current marital status and number of sexual partners in the past 12 months (n=37)



#### 4.4 Gender and sexual history

This section can only present results from the stevedore sample as this was the only sample where men and women were interviewed. Very few women stevedores (5%) reported having such sexual relations with someone who is not their regular spouse or partner as indicated in Figure 18. Figure 19 shows that a higher percentage of stevedore males had sex with a casual acquaintance than female stevedores in the previous 12 months.

Figure 18: Reported incidence of sexual intercourse with a person who is not spouse/regular partner within preceding 12 months cross-tabulated with gender of stevedores

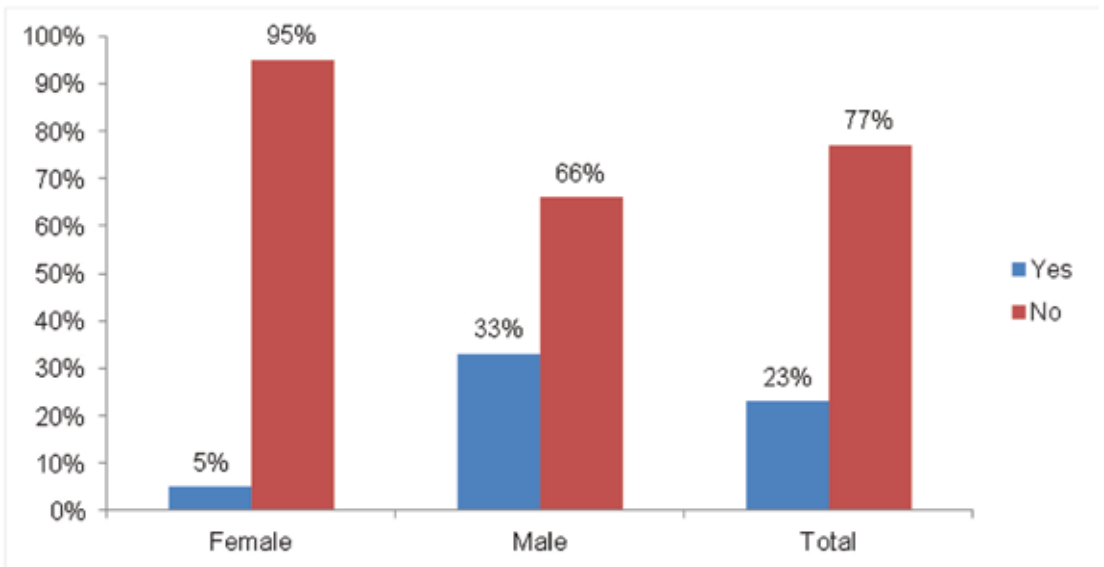
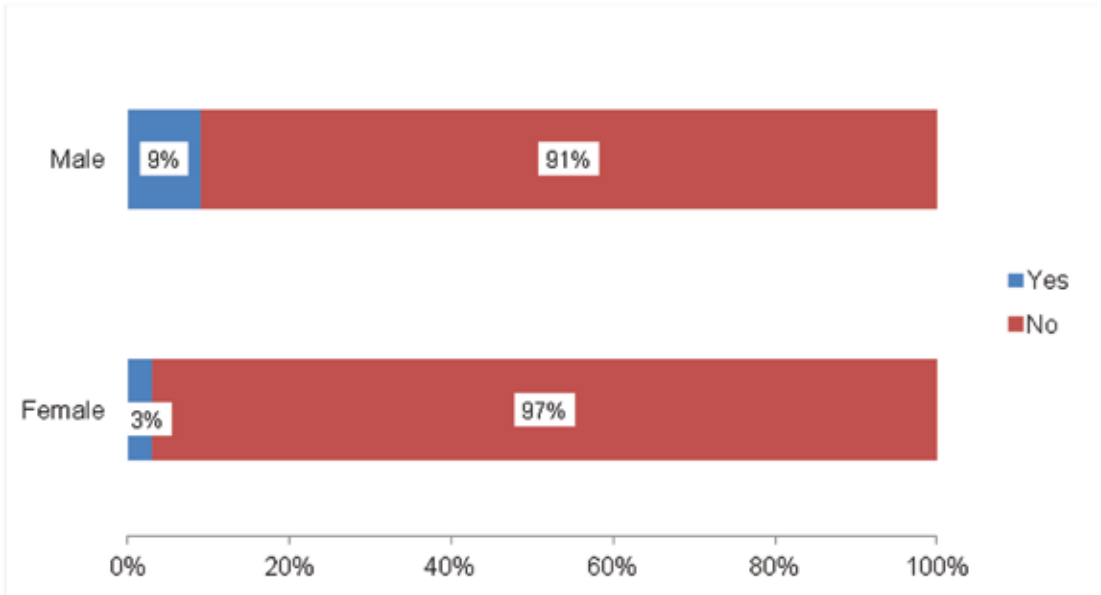




Figure 19: Stevedores' reported incidence of sexual intercourse with casual acquaintance(s) in preceding 12 months cross tabulated with gender of informants (n=172)



#### 4.5 Age and sexual history

This section focuses on the stevedore, truck drivers and seafarers' age and their sexual history. The seafarer sample is problematic in that the different age groups have very few cases and thus should be interpreted with caution. While there aren't differences within the truck drivers and stevedore samples, there appear to be differences between these groups (see Figure 20). There are a larger percentage of truck drivers (between 39% and 48% per age group), than any other workers at the port, that have had sexual intercourse with someone other than their regular partner in the previous 12 months. This shows once again that truck drivers are more at risk, than stevedores, of STIs and HIV and AIDS in the older age groups.

Figure 20: Comparison of stevedores, truck drivers and seafarers who had sexual intercourse with someone other than their regular partner or spouse in the previous 12 months.

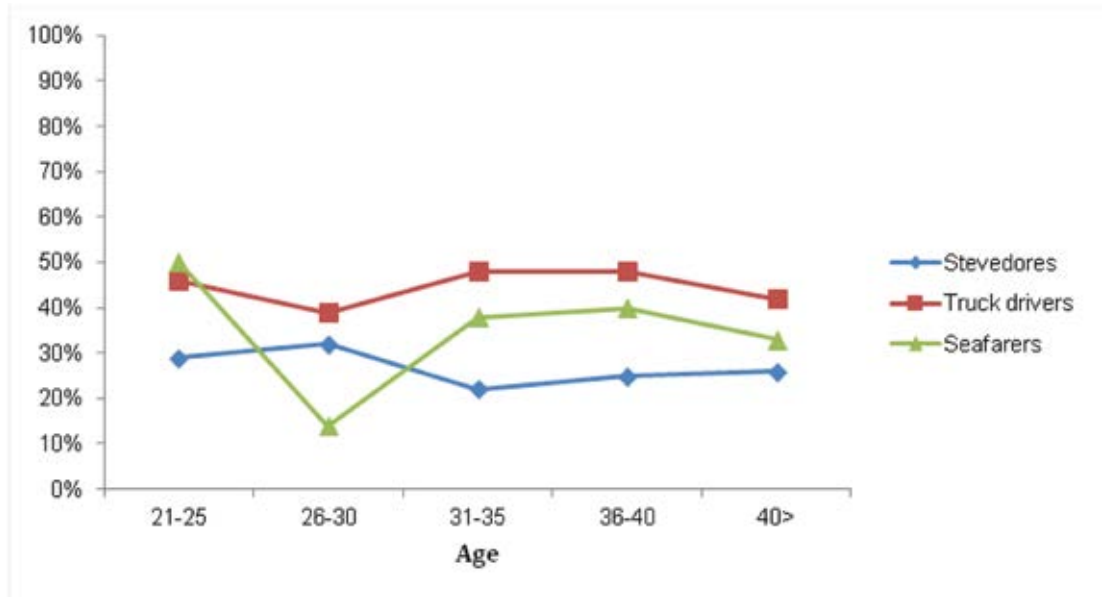
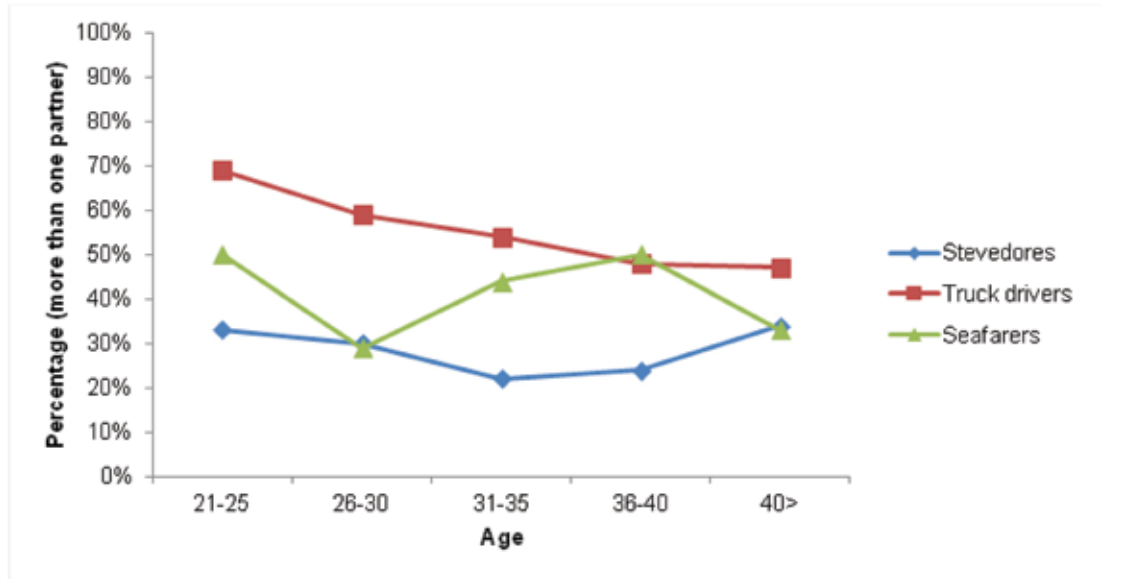


Figure 21 shows the percentage of truck drivers, stevedores and seafarers that have had more than one sexual partner in the previous 12 months. The truck driver sample shows a gradual decline, in those that have had more than one partner in the previous 12 months, as they become older. However the same cannot be said for the stevedore sample. Stevedores seem to be more likely to have more than one partner the older they become, as can be seen by the slight upward trend in the older age categories. These results show that the relationship between age and sexual history differ according to the different type of workers at the Durban port.

Figure 21: Comparison of stevedores, truck drivers and seafarers who had more than one sexual partner during the previous 12 months



#### 4.6 Condom use amongst stevedores and truck drivers

This section focuses on condom use of stevedores and truck drivers working at the Durban port. Furthermore, possible comparisons will be drawn between stevedores and truck drivers to highlight the difference in condom use as well as trying to use age and gender as a factor to explain the difference in condom use. The data for condom use by seafarers was not able to be analysed due to the very low number of observations.

Figure 22 provides a summary of those stevedores and truck drivers who indicated that they used a condom in the most recent occasion of sexual intercourse. As may be expected the lowest percentage of workers indicated they used a condom with their regular partner (husband, wife or cohabitee). Of importance is that stevedores were less to use a condom with a boyfriend/girlfriend (63% vs 75% respectively) or a casual acquaintance (67% vs 87% respectively) than their truck driver counterparts. All the truck drivers and stevedores indicated they used a condom the last time they had sex with a CSW. However, these results are based on only a handful of cases and should by no means be generalised to the larger population.

Figure 23 provides a summary of condom usage in the last 12 months among stevedores and truck drivers and their different sexual partners. The percentages indicate whether the stevedores and truck drivers always use condoms with their sexual partners. As may be expected a minority of stevedores and truck drivers indicated they always use condoms with their regular partners. There is a vast difference in condom usage between truck drivers and stevedores when engaged in sexual intercourse with boyfriend/girlfriend (36% vs 58% respectively) and casual acquaintance (46% vs 83% respectively) in the previous 12 months.

Figure 22: Percentage of stevedores and truck drivers who reported use of condom in last occasion of sexual intercourse

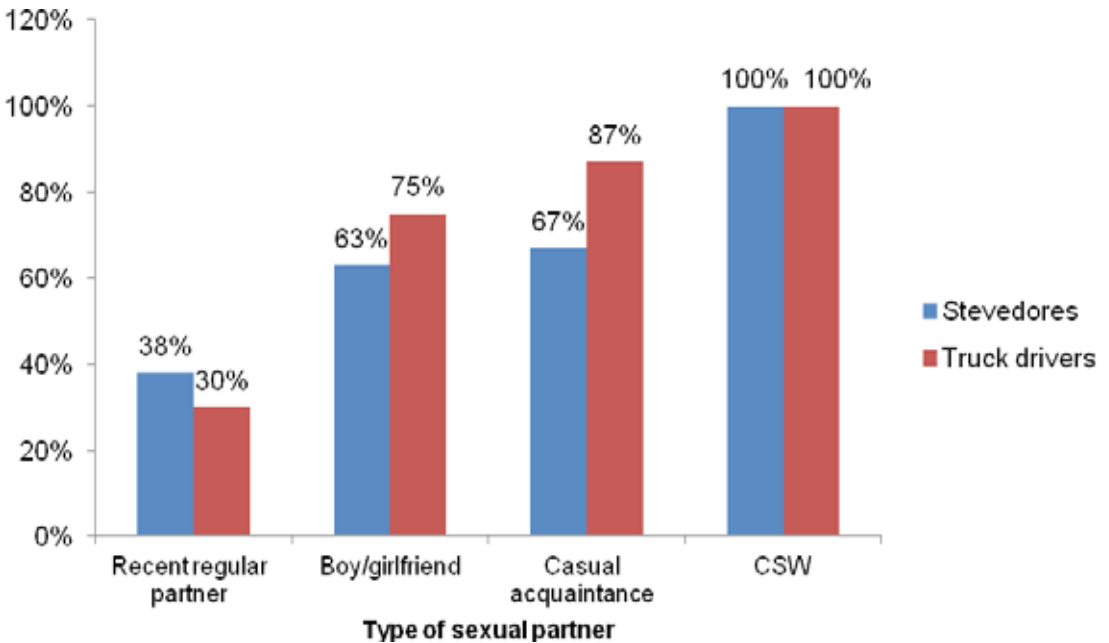


Figure 23: Stevedores and truck drivers who reported always using condoms with sexual partner in the preceding 12 months

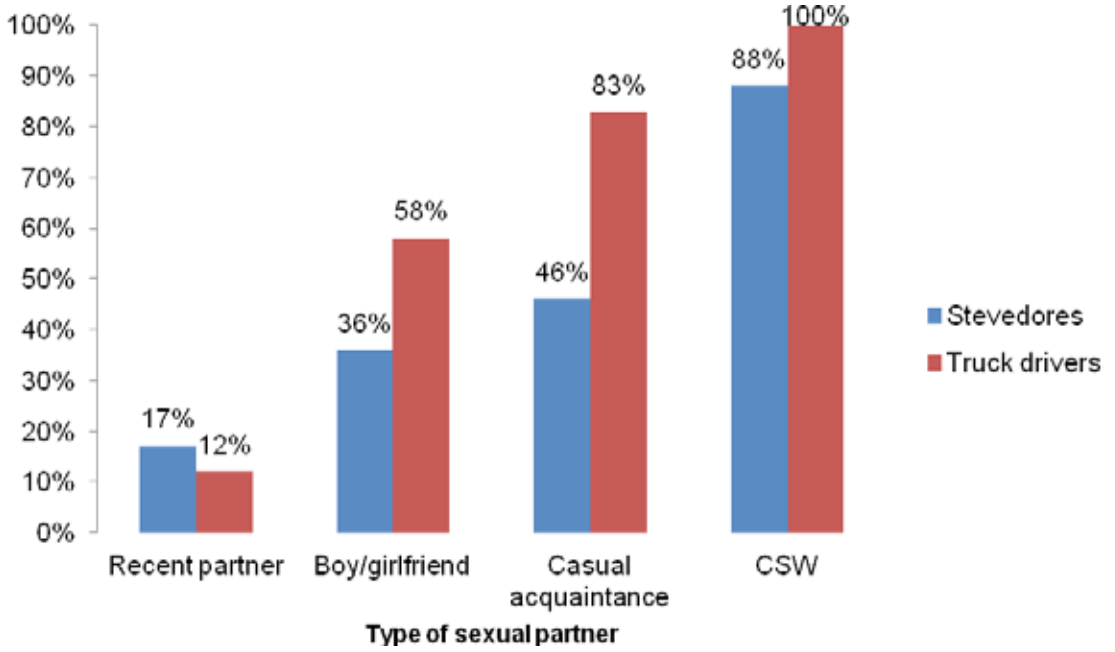
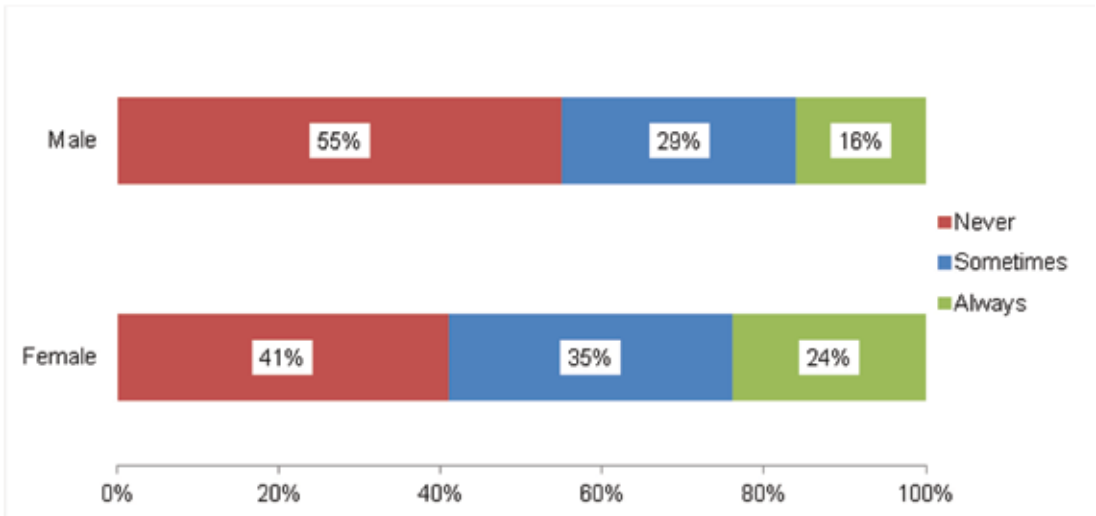


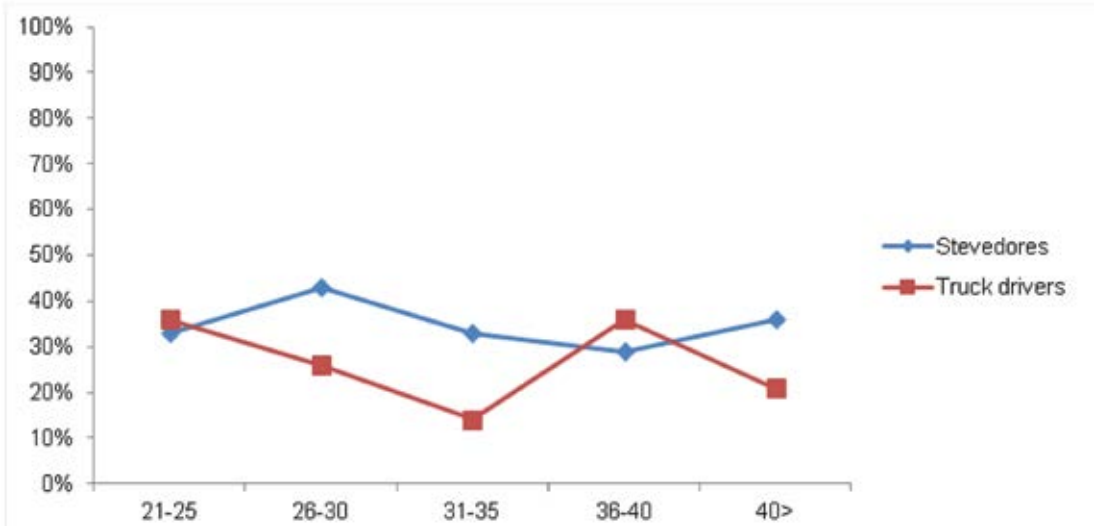
Figure 24 shows that females were more likely to always use condoms with their regular partners than their male counterparts (24% vs 16% respectively).

Figure 24: Stevedores reported use of condom during previous year of sexual intercourse with most recent regular partner (husband, wife, cohabitee) according to gender (n=93)



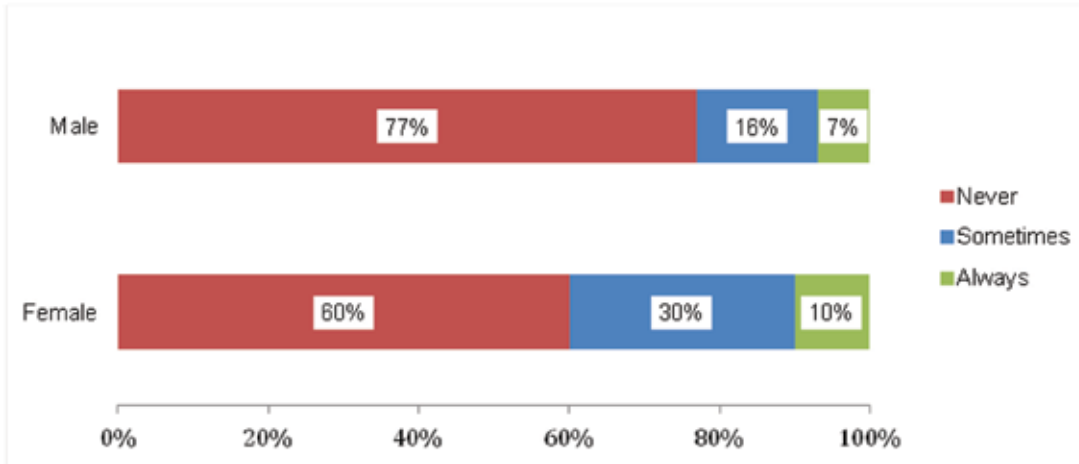
The data for condom use on last occasion of sexual intercourse with most recent boyfriend or girlfriend; shows that stevedores have a higher percentage of individuals who reported not using a condom than truck drivers (see Figure 25). Once again this graph illustrates the inconsistent use of condoms by truck drivers and stevedores, as between 45% and 15% of workers indicated they don't use condoms. Unfortunately, there is no clear trend in condom usage according to age.

Figure 25: Percentage of stevedores and truck drivers who did not use condoms on last occasion of sexual intercourse with most recent boyfriend/girlfriend according to age



The survey included questions on use of female condoms. The data indicated little use of these condoms in terms of the number of stevedores and truck drivers answering the question (see Figure 26). The females were more likely to always (10%) or sometimes (30%) use a female condom during sex than their male counterparts (7% and 16% respectively).

Figure 26: Frequency of use of female condom with most recent boyfriend/girlfriend during the preceding 12 months according to gender of stevedores (n=53)



These results indicate potentially high risk of HIV and STI infection amongst the stevedore and truck driver population. Again, many informants did not answer, but, overall, the data showed irregular and a low use of condoms by stevedores and truck drivers.

#### 4.7 Summary

The results from this chapter suggest truck drivers have the highest number of sexual partners and the highest incidence of sexual intercourse with someone who is not their regular spouse or partner. In addition to this the analysis by age suggests that younger truck drivers are also more likely to have more partners than their older counterparts putting them at extra risk.

The results suggest that the majority of stevedores do not have multiple sexual relationships but that a substantive minority of 23-25% does, though perhaps infrequently. The results also suggest that the stevedores are not frequently clients of commercial sex workers. It seems that the majority of stevedores' sexual relationships are with individuals in the areas where they live and not in the port environs. The results revealed little about the sexual behaviour of women stevedores, but women stevedores were more likely than their male counterparts to use condoms. During the survey, women stevedores frequently mentioned in passing to the research team that they were forced into transactional sex with union representatives and managers at the labour pool offices to secure work.



Generally, the data was problematic regarding sexual liaisons with casual acquaintances and/or CSWs due to reticence of a substantive number of informants to answer the relevant questions. Likewise, answers in relation to condom use were inconsistent. However, the other data on sexual behaviour indicated that a moderate proportion of respondents in the stevedore and truck driver samples engage in risky sexual behaviour in terms of both the number of their sexual partnerships and inconsistent use of condoms.

## CHAPTER 5

### INCIDENCE OF SEXUALLY TRANSMITTED ILLNESS

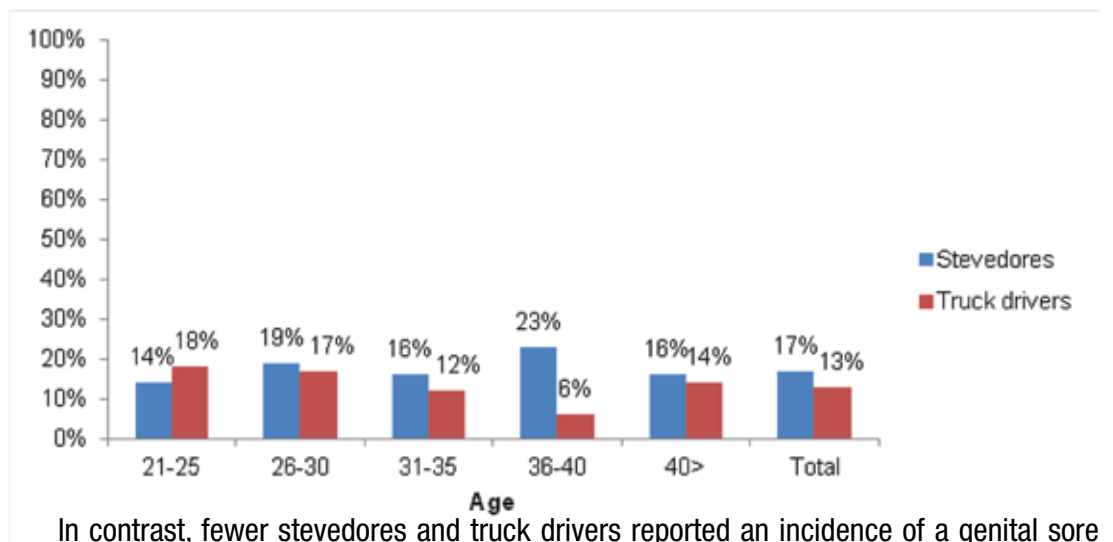
#### 5.1 Introduction

The survey included questions to assess the incidence of gonorrhoea (reported genital discharge) and syphilis (reported genital sore/ulcer). The purpose was to assist analysis of the risk of STI infection amongst the sample populations and, in turn, to use STI incidence as an indicator of risk of HIV infection. In the latter instance, the rationale is that a sexually active individual (with more than one partner) who has an STI has a higher biological risk of HIV infection than if he/she did not have an STI. This is due to having compromised genital or anal membranes. The surveys revealed relatively high incidence of reported STIs amongst the stevedore and truck driver samples.

#### 5.2 Stevedores and truck drivers STIs

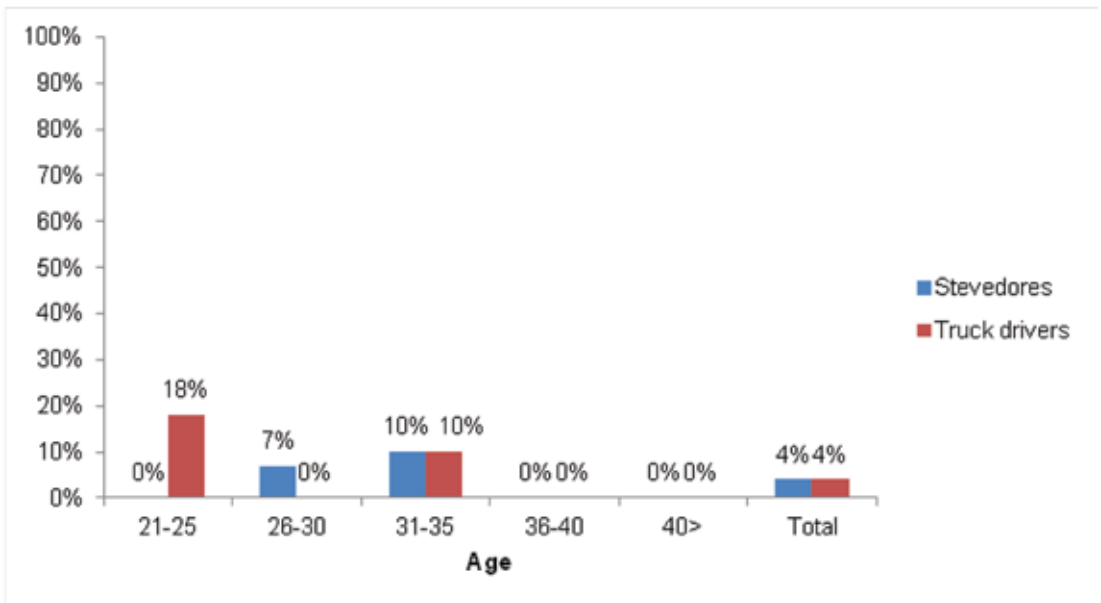
Thirty-three stevedores (17%) and 26 truck drivers (13%) reported having an incident of a genital discharge in the preceding 12 months. Comparison of these results with ages of the stevedores and truck drivers shows that truck drivers have their highest incidence in the younger age groups and stevedores have their highest incidence in the older age groups. Figure 27 summarises these findings.

Figure 27: Stevedores and truck drivers' incidence of genital discharge in preceding 12 months



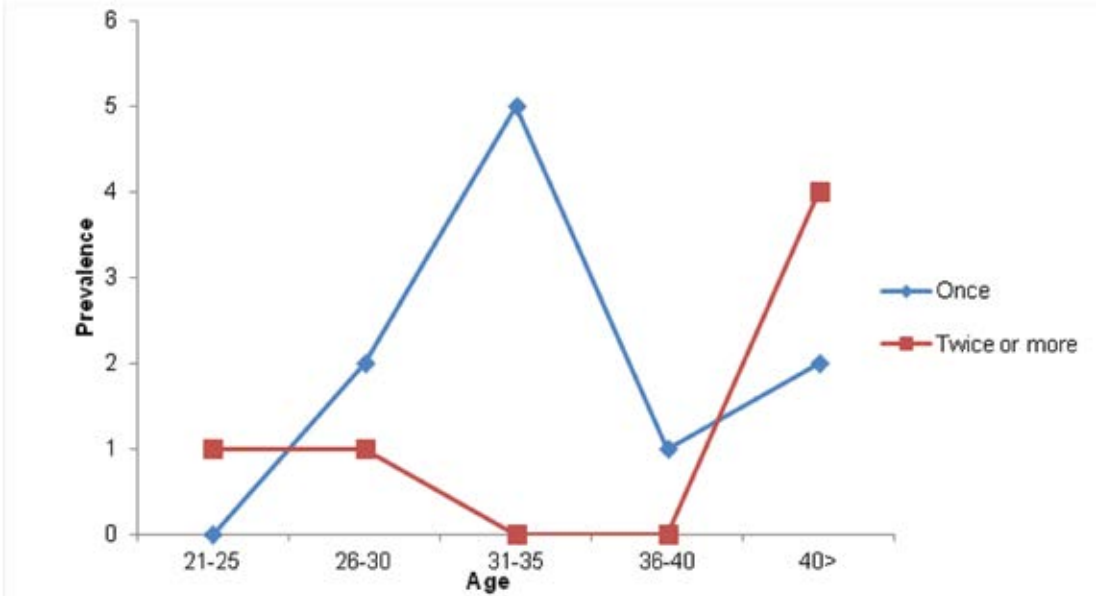
or ulcer in the preceding 12 months (see Figure 28): seven (4%) stevedores and eight (4%) truck drivers. In this instance, all of the cases were in younger stevedores and truck drivers (younger than 35 years).

Figure 28: Stevedores and truck drivers' incidence of genital sore/ulcer in preceding 12 months



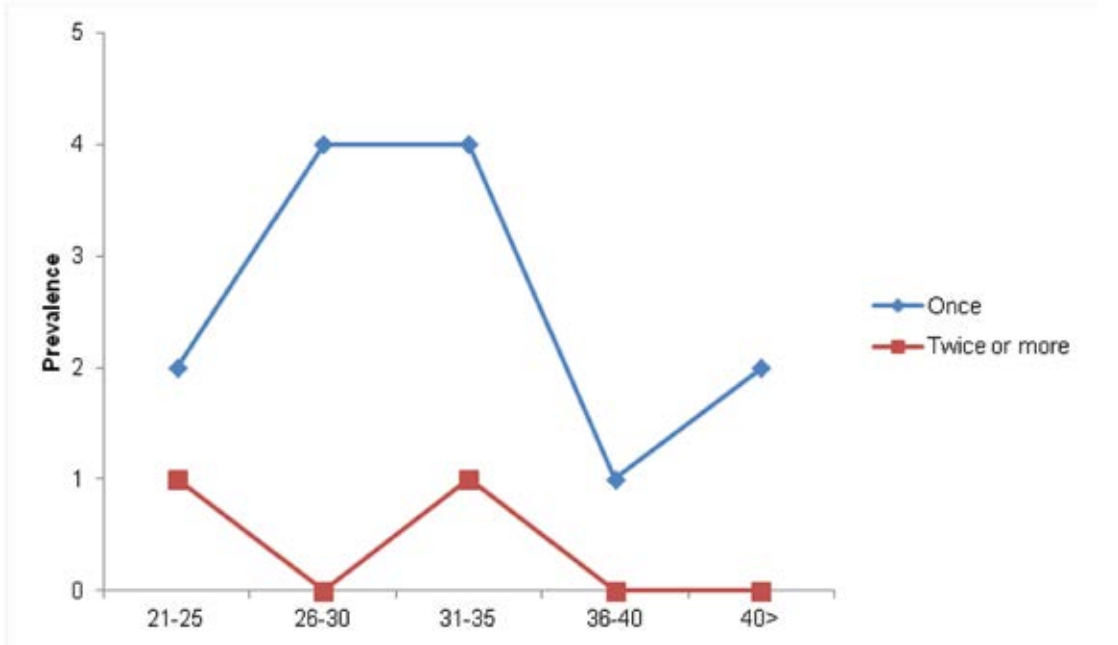
However, it should be noted that the survey yielded confounding data regarding prevalence of genital sores/ulcers amongst the stevedores. Additional analysis was conducted with this indication of syphilis incidence to assess the prevalence and, indirectly, both duration of the illness and whether it was treated. In response to a question on number of separate incidents of sores/ulcers, 16 (not 7) stevedores indicated that they had the symptoms. Figure 29 illustrates the results. It is possible that a number of stevedores who had symptoms of gonorrhoea as opposed to syphilis mistakenly answered this question.

Figure 29: Prevalence of genital sore/ulcer amongst infected stevedores (n=16)



The truck drivers sample have more individuals who only had one episode of genital sores/ulcers in the previous 12 months than stevedores, as seen in the graph below (see Figure 30).

Figure 30: Prevalence of genital sore/ulcer amongst infected truck drivers (n=15)



Additional analysis was conducted to see if the general results were obscuring any differences in reported incidence by cross tabulating the data with the age and education levels of the drivers. The additional analysis did not reveal any significant pattern. The data from the seafarer sample revealed only one reported incident of a genital discharge and one reported incident of a genital sore/ulcer during the preceding 12 months. In this instance, the vast majority of seafarers answered the relevant questions. In both cases, the individuals were in the 41 year old and older category, were permanent employees and had received a higher education.

### 5.3 Summary

The data revealed a remarkably high incidence of STIs amongst the stevedore and truck driver samples. The incidence rates in these samples are an indicator of substantive risk to HIV infection.

# CHAPTER 6

## HEALTH SEEKING BEHAVIOUR

### 6.1 Introduction

Where, whether and how individuals seek medical assistance are important issues for assessing their vulnerability. The survey included a number of questions for this purpose and the results are discussed here. In addition, this chapter presents results related informants own actions to protect their health; specifically, their knowledge on the utility of condoms to prevent HIV and STI transmission in relation to their sexual behaviour.

### 6.2 HIV testing

The vast majority of stevedores, truck drivers and seafarers had tested for HIV and knew the results of their tests as is indicated in Figures 31 and 32. Figure 33 shows that women stevedores had a higher percentage of testing for HIV than their male counterparts. Amongst the 173 individuals who had tested for HIV, the vast majority (82%) had done so voluntarily.

Figure 31: Stevedores, truck drivers and seafarers' percentage tested for HIV

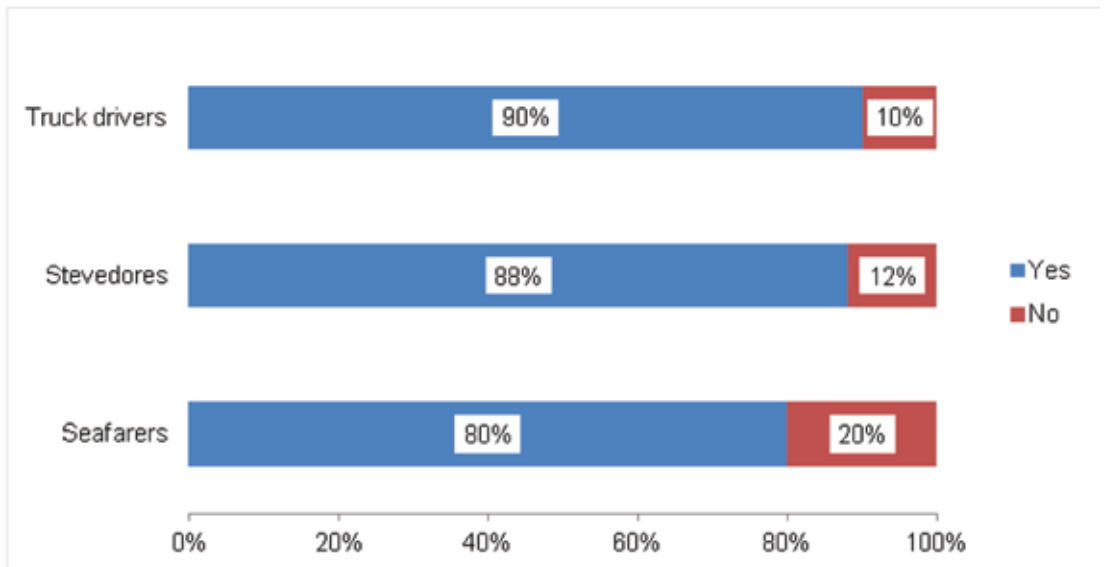


Figure 32: Stevedores, truck drivers and seafarers: knowledge of HIV test results

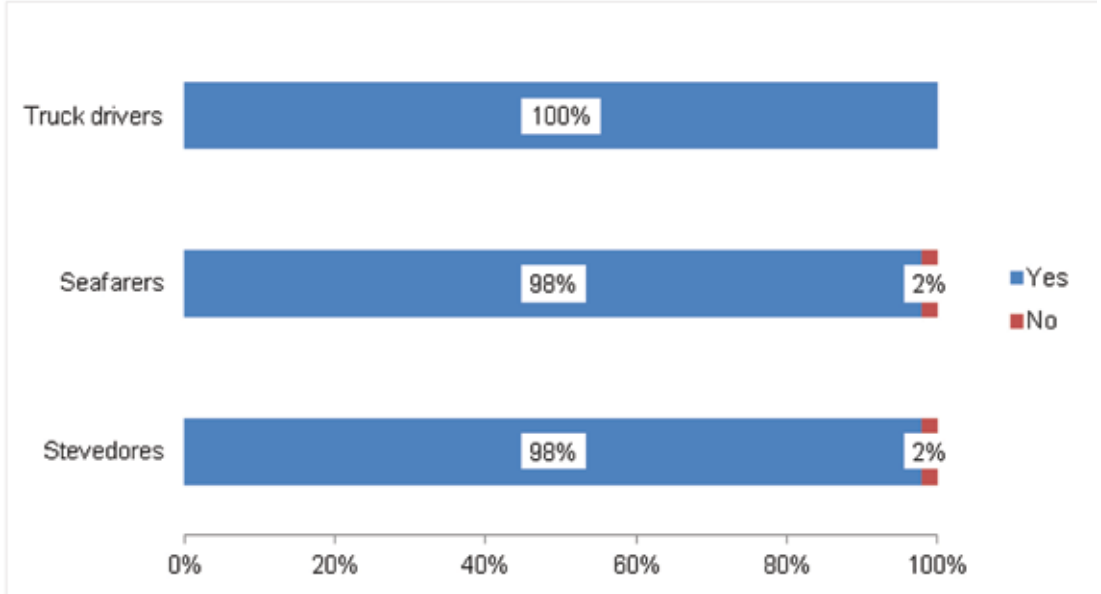
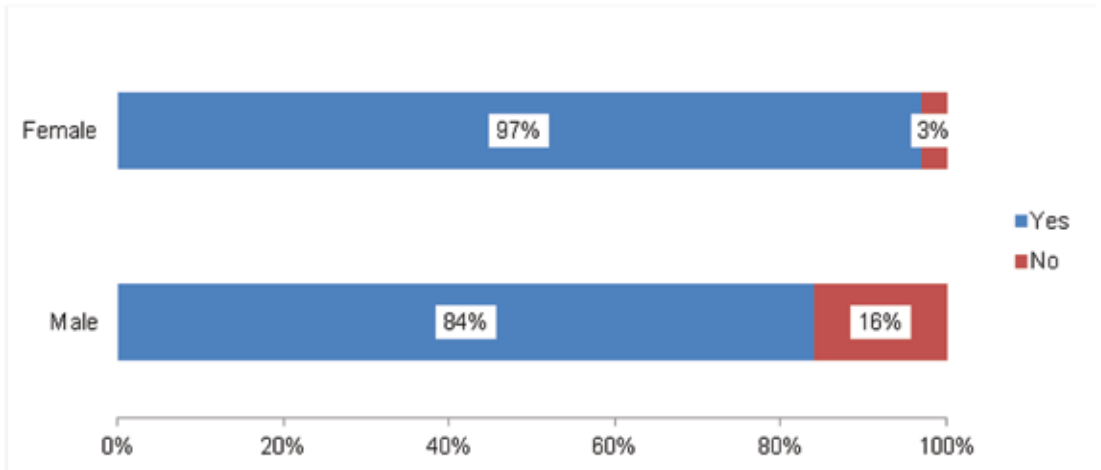
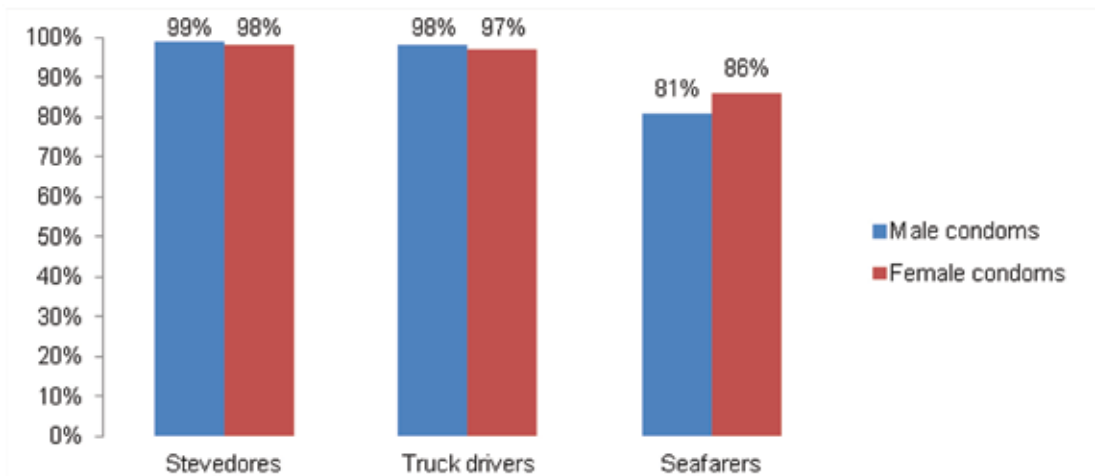


Figure 33: Stevedores tested for HIV cross-tabulated with gender of informants (n=189)



Regarding protection of health in relation to sexual behaviour, the data revealed that the majority were knowledgeable of means to do so. The survey instrument included questions on whether use of male or female condoms on every occasion of sexual intercourse was useful for protecting against HIV transmission. The majority of the stevedores, truck drivers and seafarers who answered these questions knew the utility of condoms as is indicated in Figure 34. However, that knowledge was not always applied in view of the findings on sexual behaviour presented in Chapter 4.

Figure 34: Stevedores, truck drivers and seafarers knowledge on utility of condoms for HIV protection



The survey tool included a question asking respondents, ‘Does use of male condoms allow you to have more sexual partners?’ to elicit informants’ understanding of ‘safe sex’. The data suggested that substantial numbers of informants (32% of stevedores; 15% of drivers) felt that condom use negated admonitions against multiple sexual relationships. However, in addition to the inadequate response rates, an assessment of the results is problematic because of ambiguities in the question. It could be misunderstood as a variation on the question about the utility of condoms to prevent HIV infection; that is, if one has more than one partner, it is still a protective device (e.g. as is inferred in ‘ABC’ messaging). It could also be interpreted as a ‘trick’ question which elicited answers on the basis of informants’ knowledge from HIV education campaigns that multiple and concurrent sexual relationships is ‘risky’ sexual behaviour. It could be interpreted, of course, as it was intended in the sense that condom use does not guarantee prevention of HIV infection if one has multiple sexual relationships.



The data revealed inconsistent behaviour regarding STI infections. Amongst stevedores who stated they had an STI in the preceding 12 months (34: genital discharge; 7 genital sore /ulcer), the majority reported that they did not cease sexual activity when they became aware of the symptoms but they also sought professional medical treatment (i.e. they would have received advice about the need to cease sexual activity). Only 13% of infected stevedores and 8% of truck drivers reported they had ceased sexual activity as is indicated in Figure 35 below yet most of the stevedores sought treatment from a medical professional as is indicated in Figure 36. It seems that a lower percentage (42% vs 77% respectively) of truck drivers use government hospitals or clinics than their stevedore colleagues. Unfortunately, many of the STI-infected truck drivers did not answer these questions and thus they need to be interpreted with caution.

Figure 35: STI-infected stevedores and truck drivers reported ceasing sexual activity upon awareness of symptoms

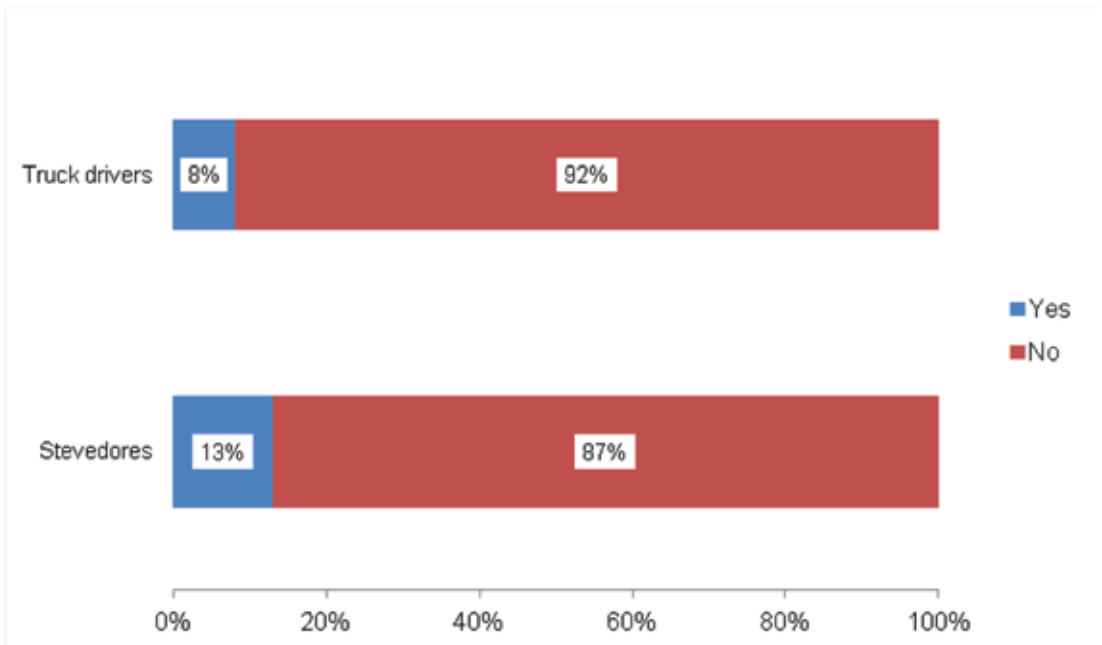


Figure 36: STI-infected stevedores and truck drivers reported first source for treatment

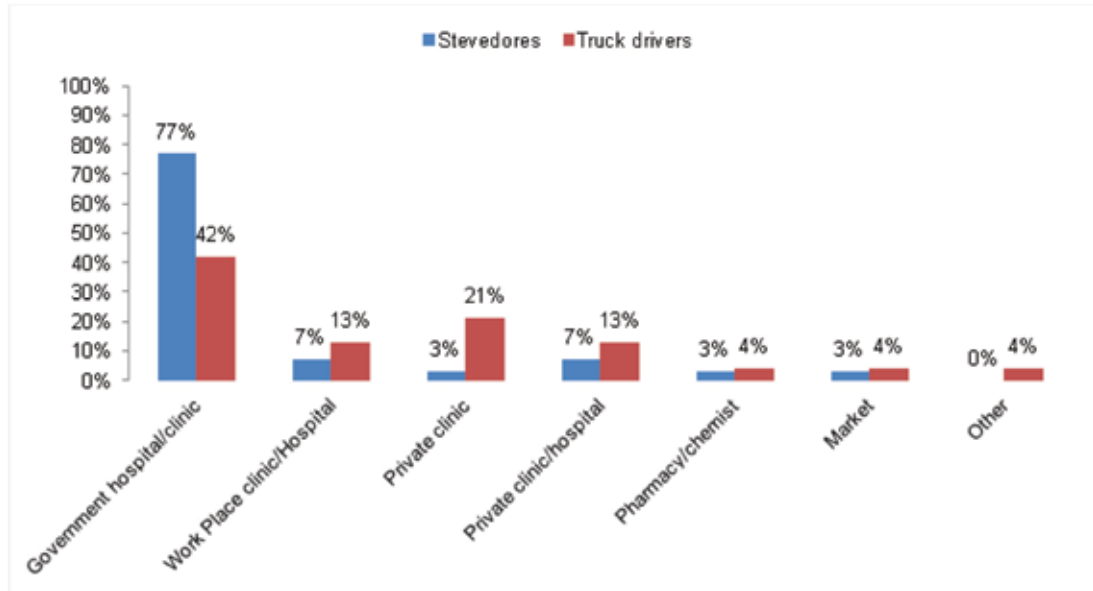
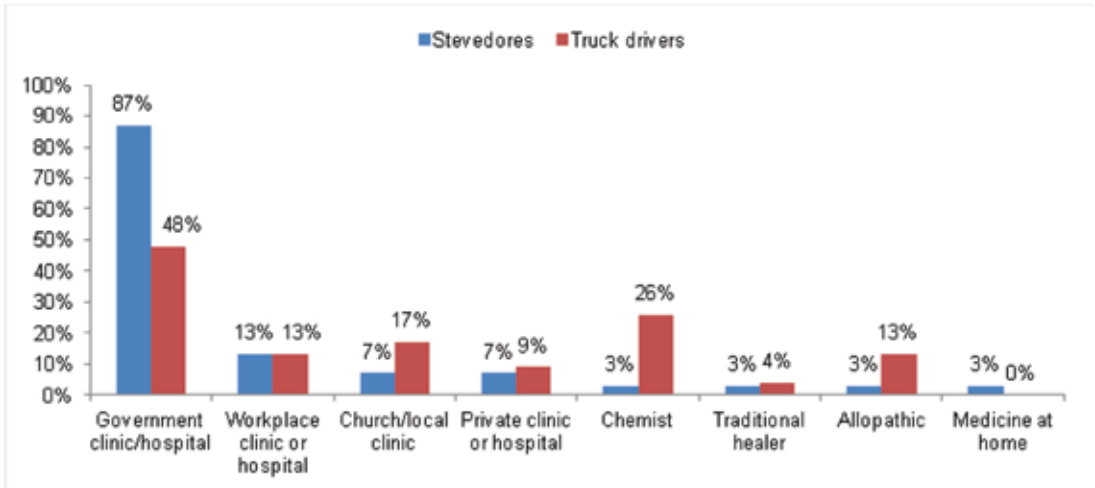


Figure 37 below summarises the different sources of STI treatment used by stevedores and truck drivers. The findings affirm the indication from the data that stevedores generally are well aware of, and rely on professional health services for STI treatment. The figures reflect the emphasis in the sampling of stevedores; the majority (150) being casual or contract workers. Amongst stevedores who reported having had an STI, few were permanent employees which is reflected in the few who stated they sought treatment from the workplace clinic (Bidfreight has a clinic on its port premises). Just more than a quarter (26%) of truck drivers uses a chemist as a source for treatment of STIs. Truck drivers are also more likely to use allopathic care than stevedores to treat STIs.

Figure 37: STI-infected stevedores reported sources for treatment for most recent STI infection



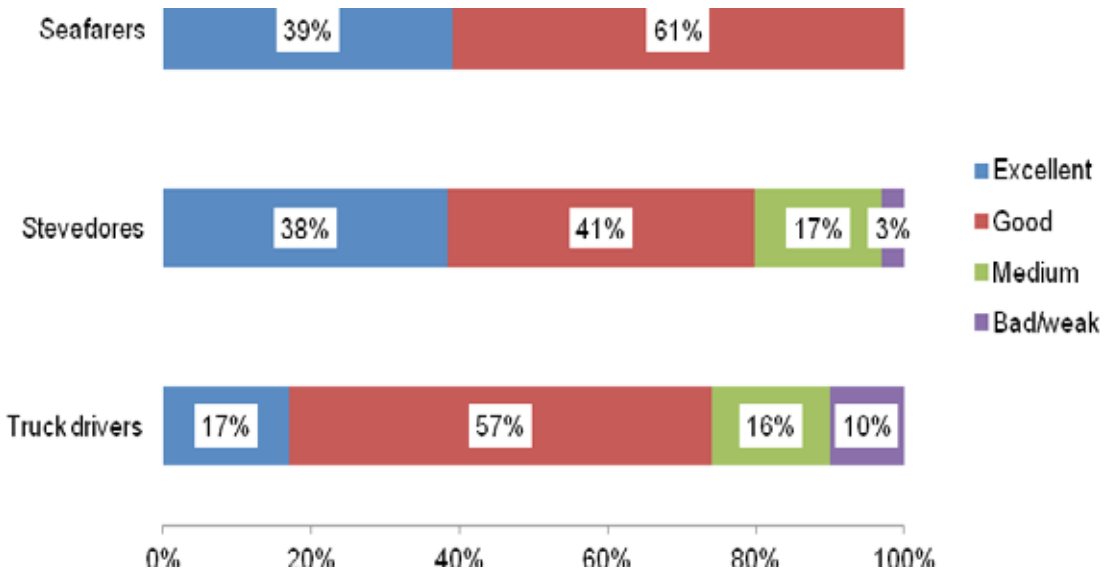
The survey also showed that generally, the informants sought treatment for their STIs relatively quickly; the majority doing so in roughly a week of becoming aware of the symptoms as is illustrated in Table 5. However, truck drivers appear to take longer - as seen by the mean and median number of days - to seek treatment than stevedores. This may be due to the nature of their work being migratory.

Table 5: STI-infected stevedores and truck drivers reported elapsed time (days) between awareness of STI symptom and seeking treatment.

Descriptive statistics	Stevedores	Truck drivers
Mean (Standard Deviation)	7 (8)	8 (12)
Median	3	4
Minimum	0	0
Maximum	31	60

In summary, the survey findings suggest that generally stevedores were knowledgeable of the risks of HIV and STIs to their health and, if actions in relation to STI infection are an indicator, they were also knowledgeable of, and used professional medical services when necessary. Broad affirmation of these findings was indicated in the generally high rating they attached to health services in the port environs as is illustrated in Figure 38. Stevedores and seafarers were more likely to rate the port health services as excellent than their truck driver counterparts (39% and 38% vs 17% respectively).

Figure 38: Stevedores, truck drivers and seafarers rating of health services in the port environs



The finding that very few stevedores and truck drivers reportedly curtail their sexual activity when they have an STI is significant when seen in context. It is one indicator amongst several (relatively high incidence of STIs amongst stevedores and truck drivers; inconsistent condom use; indications that some workers, though relatively few, have sexual relations with casual acquaintances and commercial sex workers) which infer that this is a 'high risk' population regarding sexually transmitted diseases including HIV/AIDS.

### 6.3 Summary

The data indicated that informants in all three samples were generally knowledgeable of the risks to health of HIV and STI infection and individuals sought professional medical treatment when necessary. However, the data from the stevedore and truck driver samples suggested that those who had STI infections did not fully appreciate the risks to themselves and others in view of the relatively few who reported they ceased sexual activity when they had an STI.

## CHAPTER 7

### KNOWLEDGE AND ATTITUDES

#### 7.1 Introduction

The survey instrument included a wide range of questions to enable assessment of informants' knowledge about, and attitudes regarding HIV/AIDS. This chapter draws on much of the data but not all to highlight a key finding; that is, general inconsistency in informants' knowledge and attitudes on HIV and STIs. On the one hand, the informants were generally knowledgeable about the threat to health posed by HIV, how infection can occur and how to prevent infection, and they expressed a lack of prejudice towards HIV-infected people. On the other hand, there were sizable numbers of informants in each sample, whose views suggest denial of the HIV's threat to health; for example claiming not to know any person who was sick or had died of HIV/AIDS and that condom use 'allowed one to have more sexual partners'. The contradiction is not significant in itself. The results simply show that the informants are well informed about HIV/AIDS and STIs and also harbour contrary personal views and beliefs. The pertinent issue is the presence of personal views and beliefs which can override formal knowledge in decision-making about sexual practice.

#### 7.2 Stevedores, truck drivers and seafarers' attitudes towards HIV

The majority (70%) of stevedores and truck drivers acknowledged that they knew of a person who was HIV infected or who had died of HIV/AIDS and, the majority (82% for stevedores and truck drivers) within that group indicated the person was a close relative or friend (see Figure 39). The percentage (approximately 30%) of workers who don't know of anyone who has died of Aids is surprising in the context of KwaZulu-Natal where approximately 1-in-6 people are HIV infected. In this instance, we have cross tabulated the data with informant ages only because of one pertinent piece of data: the relatively high number of 40 year old and over stevedores who reported they did not know of anyone who was sick due to HIV infection or had died of HIV/AIDS. This may be seen in the downward slope of the blue line in the line graph in Figure 40; approximately 40% of stevedores in this age category indicated they know no one who has been infected or died of AIDS. In the context of the longstanding hyper-HIV epidemic in KwaZulu-Natal, it is highly unlikely that people 40 years old and older would not know of anyone afflicted by the virus. Accordingly, the data probably indicates the phenomenon of denial of the epidemic and its effects outlined earlier.

This is the opposite for the truck driver sample (see Figure 40) as there is a not much variation by age group in the percent of truck drivers than know someone who has been

infected or died of Aids. This can be observed in the fairly flat blue line in Figure 41. Only 35% of seafarers indicated they know someone who has been infected or died of AIDS. These results could be expected in view of the demographic composition of the sample and their conditions of employment. The sample included individuals from countries with very low HIV prevalence and the majority were, together, from Sri Lanka and the Philippines where there are not HIV hyper-epidemics as in southern Africa. Medical testing of recruits to crews would tend to exclude HIV-infected individuals; as was noted in Chapter 6, seemingly, the majority was required to take HIV tests.

Figure 39: Stevedores, truck drivers and seafarers who have knowledge of HIV infection/death of anyone, close relative/or friend

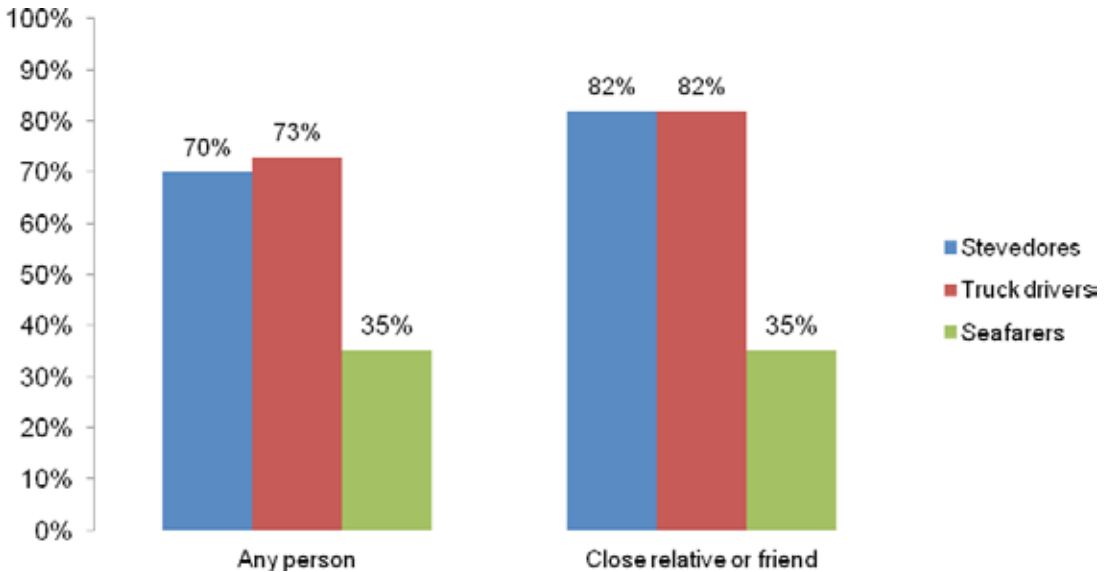


Figure 40: Stevedores' knowledge of HIV infection/death of anyone, close relative or close friend according to age

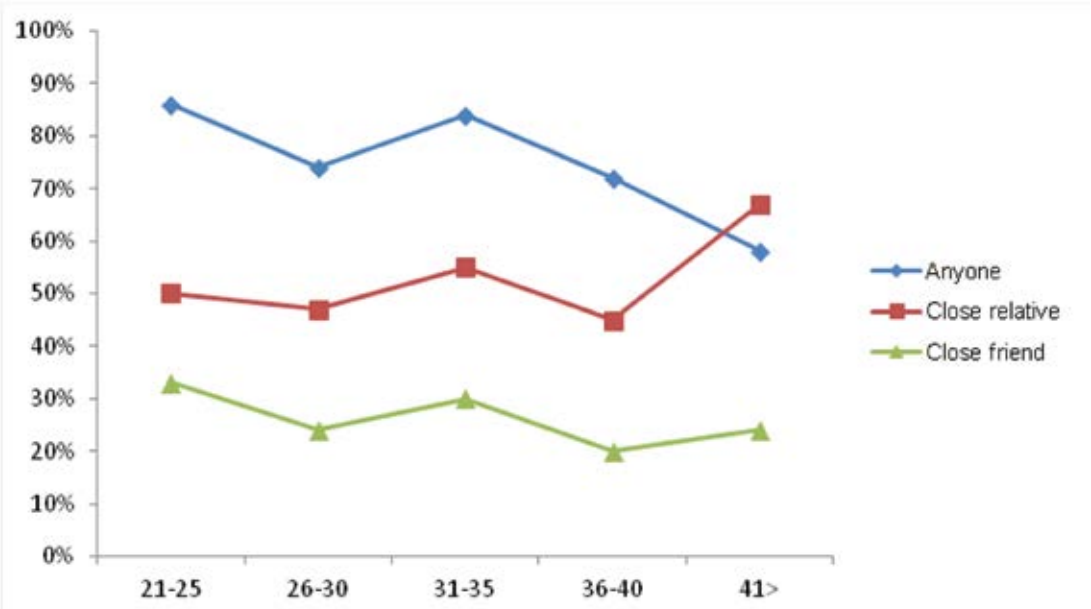
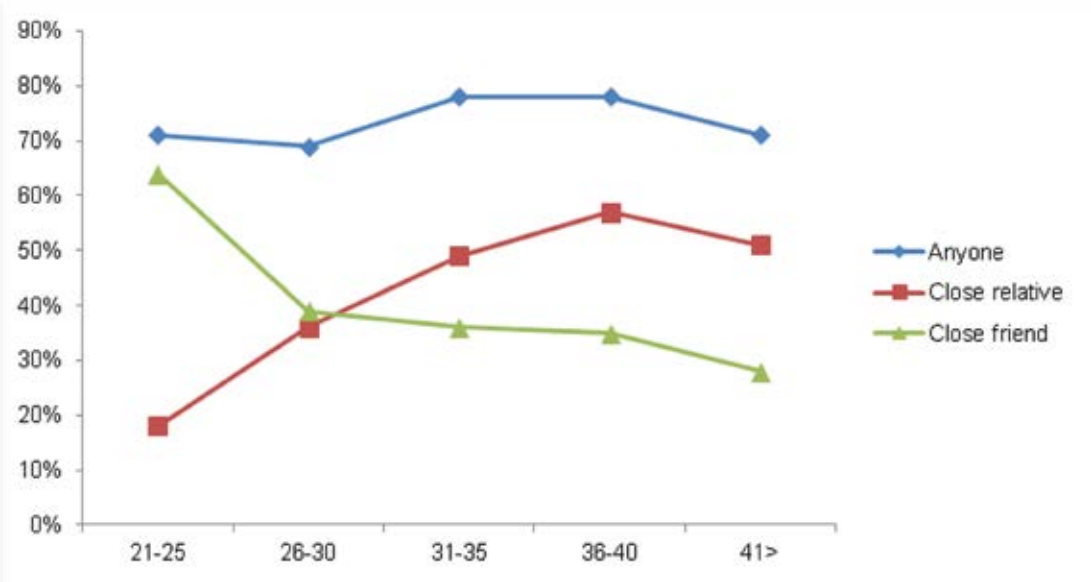
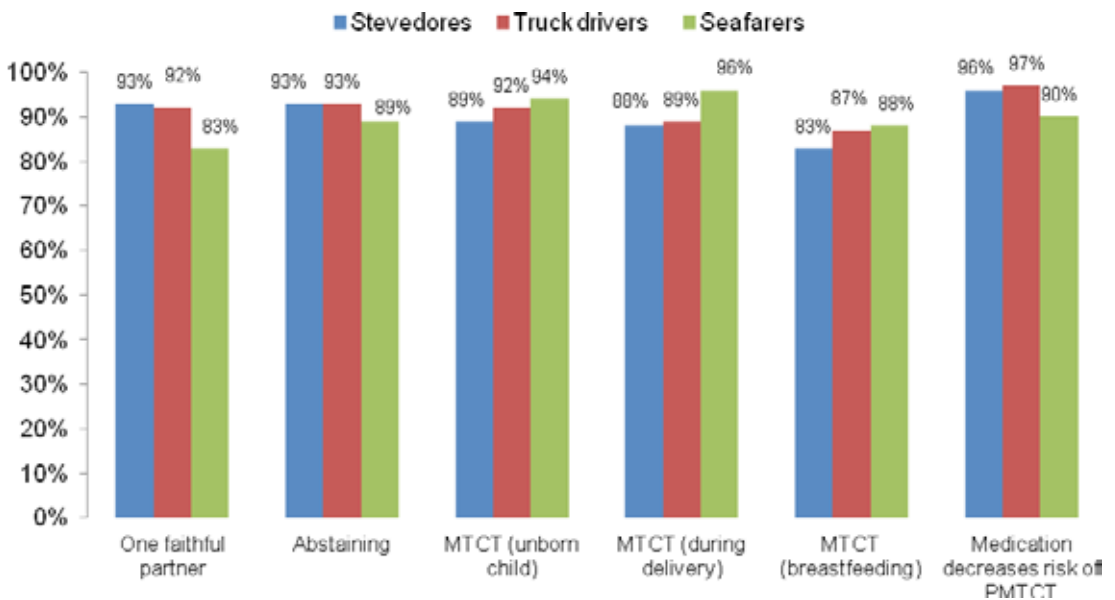


Figure 41: Truck drivers' knowledge of HIV infection/death of anyone, close relative or friend according to age



Nonetheless, the stevedores were generally well informed about HIV/AIDS in terms of knowing the correct answer to standard information that is regularly disseminated in public awareness campaigns. As is indicated in Figure 42 below, very few did not know the correct answers. There was no significant variation between stevedores of different ages. Likewise, the vast majority knew of the threat of mother-to-child-transmission though, in comparison to knowledge on ABC, there were a slightly higher percentage of individuals who did not know the correct answers (10-15%). It may be noted that the numbers in the Figure 42 below refer to percent who answered correctly. There is not much variation between the scores when comparing the three types of workers.

Figure 42: Stevedores, truck drivers and seafarers' correct knowledge of standard HIV/AIDS information



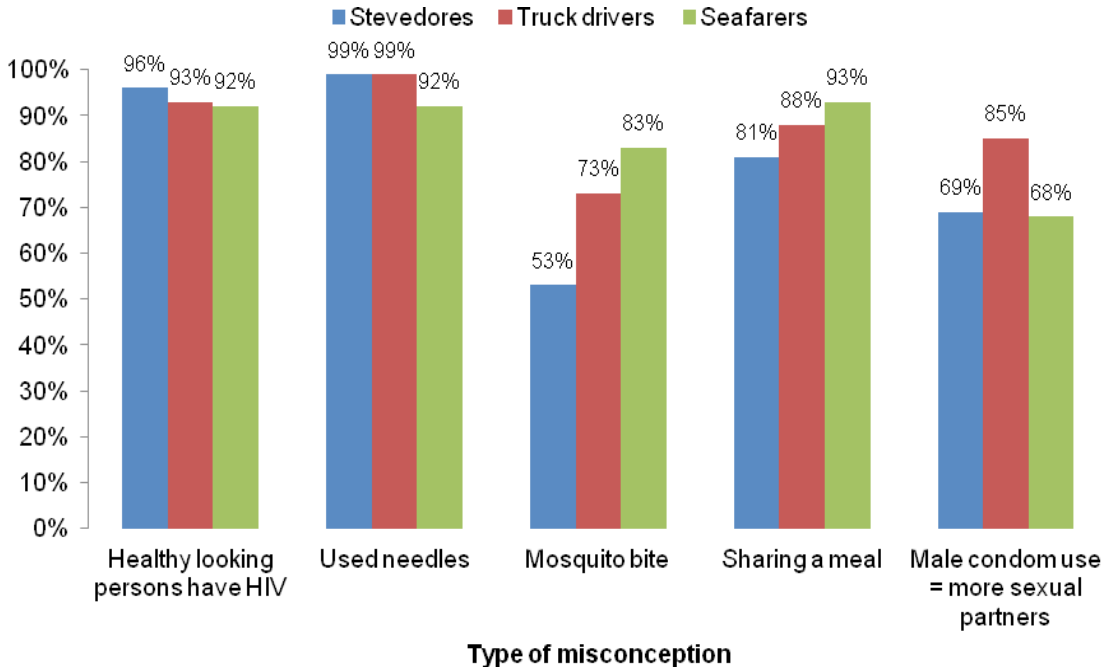
The results from the survey questions on HIV 'truths and myths' and the tests on standard information distributed in public awareness campaigns, revealed variable knowledge amongst truck drivers, stevedores and seafarers. As is indicated in Figure 43, the vast majority knew the correct answer to truths such as anyone can be infected and improper injections can infect. Yet a relatively large proportion of stevedores believed common misconceptions about HIV transmission and a smaller proportion of truck drivers believed these misconceptions as well. Not all stevedores answered every question but in this instance, the figures provide a reasonable indicator of the prevalence of misconceptions



in the sample; indeed, they are possibly an underestimate because the absent data covers those who did not know the answer or who, possibly for the same reason chose not to answer the relevant question.

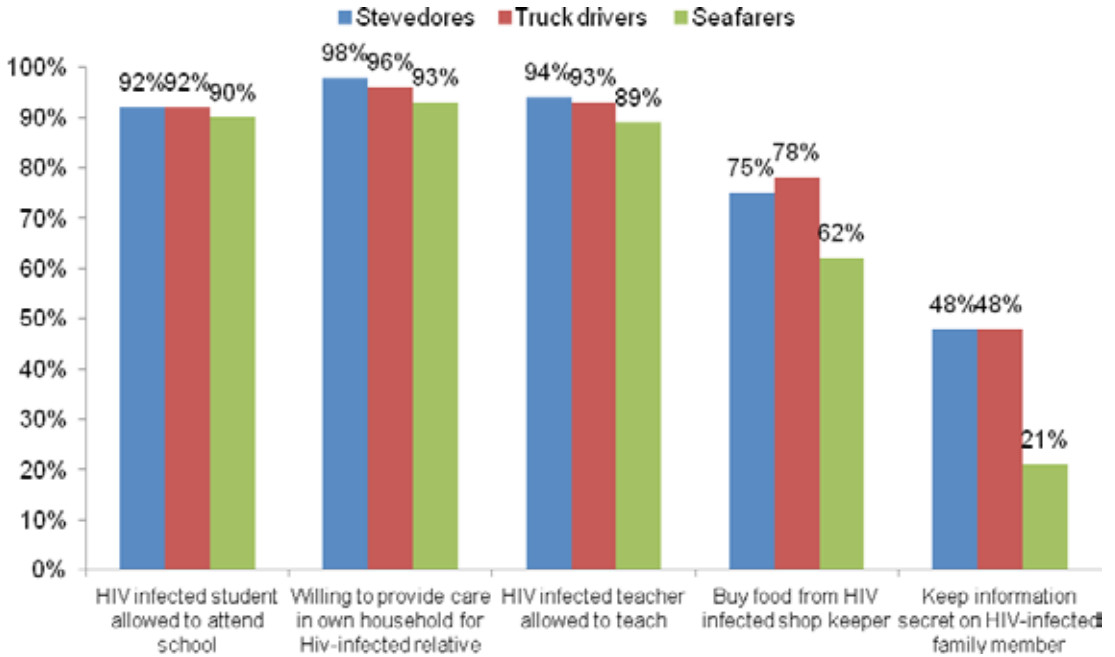
The percentage of stevedores (47%) who believe that mosquito bites can transmit HIV reflects a common misconception. More significant are the relatively large percentages of informants who held misconceptions regarding sharing a meal with an HIV-infected person. The proportion (19% for stevedores and 12% for truck drivers) who reported that it is possible to be infected by sharing a meal with an HIV-infected person is pertinent for it subliminally challenges the general lack of prejudice voiced by stevedores as we outline shortly. The percentage (31%) who believes that use of male condoms allows one to have more sexual partners highlights a misconception that can occur from public awareness campaigns which emphasise condoms as a means for 'safe sex'. Such publicity can be read as meaning that it is not necessary to be cautious in sexual matters if they use male condoms. It may be noted, that there was not a large difference among men and women stevedores who held this misconception.

Figure 43: Stevedores, truck drivers and seafarers who displayed the correct knowledge about HIV/AIDS misconceptions



The vast majority of stevedores did not voice prejudiced views about HIV-infected persons. Figure 44 summarises the results of those stevedore, truck drivers and seafarers who indicated they were not prejudiced against people who are infected with HIV. In other words this is the percentage of workers who were not prejudiced and indicated they would support someone even though they are infected with HIV. However, an indicator that there is popular prejudice was revealed in the answers to the questions on whether the informant would buy food from an HIV-infected seller and on keeping secret that a family member who was ill with the virus. This highlights the subliminal popular concern about the possibility of ingesting the HIV through ‘contaminated’ food prepared by someone who may be HIV infected. In turn, it is not surprising that a relatively large number of informants (52% for stevedores and 52% of truck drivers) stated they would keep secret information that a member of their family was ill with an HIV-linked illness. Whether this is a misconception or a personal preference for allowing the person suffering from the virus to choose whether they want their status known is debatable.

Figure 44: Percentage of stevedores, truck drivers and seafarers who did not show prejudiced views about HIV-infected persons



### 7.3 Summary

The data revealed that informants were generally knowledgeable about HIV/AIDS and, outwardly, held few prejudices. However, the data also indicated internal fears, including denial of HIV/AIDS as a significant public and personal health threat amongst the stevedore and truck driver sample. There are some concerns about misconceptions around condom use and an increase in sexual partners. Furthermore, truck drivers and stevedores were hesitant to share food with someone who may be infected with HIV.

## CHAPTER 8

---

### COMMERCIAL SEX WORKERS

#### 8.1 Introduction

The study included interviews with 16 commercial sex workers (CSWs). As was noted in Chapter 2, ethical approval for this component of the study required the research to be conducted in a secure environment for would-be informants. Consequently, this research was conducted at the Lifeline clinic which assists CSWs and hence, there was inherent sampling bias for this component of the study. One practical limitation was that the interviews were conducted with CSWs who work in the city and whose clients are generally city residents, rather than specifically in harbour locales amongst seafarers. However, truck drivers were named as one common category of clients by all the interviewed CSWs and, therefore, this research provides some qualitative insights into the vulnerability of both CSWs and truck drivers involved in their interactions. The research conducted here was qualitative in nature, with limited interaction amongst a small number of CSWs working near the Port of Durban. The results produced from this research, rather than identifying the total number of sex workers operating in Durban and large-scale quantitative information, reveal trends regarding characteristics of CSWs and their health vulnerabilities.

#### 8.2 CSW Demographic characteristics

Fifteen CSWs were interviewed at the Lifeline clinic and one was interviewed at a night club during the scoping phase of the study. All of the informants were South African, Zulu-speaking women with the exception of one white, English and Afrikaans-speaking woman. Most of these women were in their early to late-twenties within a group whose ages ranged from 18-39 years old. According to the South African AIDS Council (2013), 60% of female sex workers in South Africa are infected with HIV. A study entitled “Operationalizing Peer-Linked Mobile Wellness Services” by Andrew Lambert of the TB/HIV Care Association in 2013 also determined that prevalence of HIV amongst sex workers is at 61%, amongst an estimated 4,000 total CSWs in the Durban Metropolitan Area.

#### 8.3 Reasons for engaging in sex work

Most had also come from homes elsewhere in the KwaZulu-Natal province to Durban to study or to seek work. The common narrative amongst these women was that they had become CSWs when they had run out of money or could not afford to live in the city on their job incomes. The comments below from two informants illustrate the point.

*“I got a child at a very young age. I was living with granny who worked as a domestic worker. The father of my child wasn’t an active supporter of his child. I then came to Durban for work. I left my child with granny. I got a job that paid me very little—with that money I had to pay rent and send some money home. I decided to leave that job. That’s when I met some friends who told me about a quicker way of making money.”*

*“It was in December 2009 and I didn’t have money to go home, therefore I started sex work. When you study in DUT, after completing your exam, they ask you to leave immediately even if you don’t have money.”*

Amongst both the city-born and immigrant women, a related common narrative was that the path towards commercial sex work for many women (as opposed to themselves specifically) began with transactional sexual relationships amongst girls as young as 13 years old and as a result of life challenges such as death of a parent and ‘family problems’ (e.g. family dysfunction; household poverty).

There were three inter-linked themes within these narratives. One theme was that they were doing a job which earned them enough money to live in the city and to support dependents (all stated they had dependents, either parents or children). To illustrate, one informant stated:

*“There are difficult times, but it is an easy way of making money. You don’t get broke. Your money doesn’t run out, if you know how to use it. It is the kind of work that you can continue doing.”*

The second theme was that commercial sex work was temporary work with a range of defined and undefined time horizons. To illustrate, commentaries include:

*“It’s not something I plan to do for my whole life. I would like to have my own business or get a good job. I do it because I don’t have any other work to generate my income.”*

*“I’ll give up after two years or if I get any other job that can give me at least R5000.”*

*“I would like to be a cleaner, counsel people about what I’ve been through, or become a social worker.”*

*“I would like to stop. I can even become a trader. I would like something that will not make me want to go back to sex work.”*

The third theme was equivocation about the nature of their work. Perspectives fluctuated between:

- Acknowledgement of the work being a commercial contract (sexual intercourse for an agreed cash payment);
- Viewing their commercial sexual liaisons not as prostitution but as sexual relations which bring material reward (and all cited other sources of income such as baking, hairdressing and government grants);
- Moral concerns about being categorised as prostitutes (views included disgust with the work, denial in the sense of assertions that the informant ‘did not think’ about the nature of the work, and tacit anger with clients’ hypocritical judgements).

To illustrate the last point, one informant stated:

*“They critic (sic) what we do. After you have finished performing your work, some clients would encourage you to look for other kinds of work. They even quote a script from the Bible—that our body is a temple of God, but they do that after finishing what they came for.”*

Table 6: Reasons for engaging in sex work

Family problems that led to woman fleeing home
Needed income to supplant family support
Financial problems faced by students
Employment in other sectors not enough for sustainable livelihood

#### 8.4 Sex work operational area

Cited work locations covered the city centre (e.g. The Point; Russell Street), inner city suburbs (e.g. Umbilo) and metropolitan areas further afield (e.g. Pinetown; Clairwood). The general impression was that most of these women worked primarily ‘on the street’ (as opposed to brothels) because cited venues for sexual liaisons were cars, parks, hotels, flats and trucks and meeting places included bars, parking lots and, in the case of truck driver clients, the inner city Maydon Wharf harbour area.

Figure 45: Map of Port of Durban with hotspots



### 8.5 Clients of sex workers

Informants' general categorisation of their clients were that they were all men, many of whom were married, and included truck drivers, army and navy personnel, policemen, lawyers, doctors, seafarers and Transnet employees (i.e. port authority personnel). In popular racial terminology, the clients were predominantly South African 'Indians', young and old 'black' men (20-50 years old) and 'older white' men. However, they also mentioned that truck drivers and policemen constituted the bulk of their clients. Here, it may be noted that these findings suggest that seafarer population was not a principal source of clients, in view of statements that most clients were South African and emphasis on truck drivers and policemen. Likewise, possibly, stevedores were one though not significant source, in view of statements referring to Transnet employees, which covers a wide range of people who work in the harbour such as security guards, warehousemen and professional port authority staff.

## 8.6 Paying for sex

All clients pay cash for the sexual relationship though informants cited different rates (R100 for “a round”; R400 for an hour). Cited daily incomes ranged from R650 to R1500 per day. Work times varied with informants citing their busiest periods which, for some, were weekend nights and, for others, weekday lunchtimes. A number of informants said they worked as many hours as necessary. The informants described their work as “hustling”; a term, which, in their context, alludes to the stress and dangers, involved in earning cash from sexual liaisons.

*“When I was working in the street, some truck drivers would not want to pay what you agreed on. They will tell you that you were not up to the standard they were expecting. You’ll end up fighting, arguing, getting assaulted or insulted because he doesn’t want to pay. If the police catch you they ask what you are doing in the street at night even though they know why you are there. The police beat you up or take your money. Some police will pretend as if they are arresting you, and if you reach a spot where no one is looking, that police[m]en will ask you to have sex with him.”*

## 8.7 CSW health status and sexual behaviour

The interviews revealed that the women were not simply part of a ‘high risk’ population regarding HIV and STI infection; most had had an STI and stated that they were HIV positive having had HIV tests. They also cited that generally, CSWs also suffered ill health due to TB infection and drug abuse. There was acknowledgement (by most informants) that drugs and alcohol were used on a regular basis in their work.

*“At times you end up working for drugs. You do everything you are told, so that you are able to get your next fix or a beer. You even sleep without a condom. You can’t just have sex with someone you are not in a relationship with if you are in your right state of mind. It’s better to drug yourself, so that you are able to perform your work.”*

Furthermore, they were by definition involved in multiple and concurrent sexual relationships and in circumstances where there was a very high probability of repeated HIV and STI infections (as well as transmitting disease) because all the women stated that they did not regularly use condoms. In all instances, the women were referring to male condoms; none attested to ever using a female condom. It may be noted that there were allusions to familiar contractual relationships and, beyond their work, to intimate



partnerships in that a number of the women stated that some of the men they slept with did not pay them.

The comments below from three different informants illustrate the point:

*“They come to us because their partners can’t perform oral or anal sex with them. I wish people (clients) can be informed that most sex workers are sick. You can’t force them to use condoms just because you are scared that might infect them. All you think about at the time is money. You don’t think about anything else, because you are there to work.”*

*“You can’t disclose about your status to every client you get; you might not end up getting clients. Some don’t even care if you tell them about your status.”*

*“Some clients promise to increase the payment if you don’t use condoms. And people don’t care about using protection if they know they already have HIV.”*

## 8.8 CSW health seeking behaviour

This study’s sample consisted entirely of women who knew of and used health services pertinent to their work by virtue of the research being conducted with women at the Lifeline clinic that provides STI and HIV testing and counselling. The women stated that they secured treatment for STIs and HIV/AIDS from government clinics and hospitals and also for preventative health services such as contraception (many stated they used) and pap smears.

*“It would be better if they can visit us where we are working.”*

Nonetheless, the interviews revealed limitations on opportunities for many CSWs in the city to access services that were important to them and when they needed them.

In the first instance, these constraints were indicated via informants’ complaints about clinics being closed at weekends (all cited this constraint), prejudice from health workers at clinics and hospitals, and the lack of mobile clinics. Amidst these complaints, there were references to specific constraints; for example that condoms were not readily and widely available in places such as bars, public toilets, and taxi/bus ranks. One constraint, raised indirectly, was not always being able to obtain contraception. The impression given by the informants was that they generally used ‘morning-after’ pills as a means of contraception but a number reported they had had unplanned pregnancies. In this

instant, the inference was that they needed to be able to obtain the pills at any time but could not and/or did not because clinics were closed at weekends and there were few mobile clinics.

Regarding mobile clinics, it may be noted that the complaint appears to be one of heightened expectations due to the inception of an experimental project within the last two years to improve the reach, and efficacy of health services amongst CSWs via mobile clinics. From the informants' perspective, mobile clinics were valuable (and interim results from the project indicate that mobile clinics would be efficacious; Lambert, 2013) but not accessible enough (the innovation has yet to be adopted as a standard service). In addition, another constraint raised indirectly, was that there are mobile services (e.g. Lifeline) in the form of health worker visits to brothels in the city but, in the case of this study, none of the CSWs work in brothels.

## 8.9 CSW knowledge of HIV/AIDS

As was the case with the study's other sample populations, the CSW informants were well informed about the dangers to health of HIV/AIDS. There was a general awareness of the HIV/AIDS campaigns run by various NGO health services such as the Thembalabantu Clinic, Lifeline and Sisonke. All the women knew that HIV and AIDS can lead to death if not treated.

*“I know that it's a dangerous disease, but can be managed and still have a good life. However, you can die if you don't take care of yourself.”*

They all acknowledged that unprotected sex contributed to the HIV and STI transmission. Some acknowledged that anal sex was risky sexual behaviour. Some informants stated that they were taking ART medicines. However, as has been shown in the experiences recounted by different informants, this knowledge is academic in the context of their lives. The probability of preventing HIV infection is minimal and they are very likely to regularly be re-infected with HIV and infect their clients.

## 8.10 Summary

The data revealed that CSWs in Durban are an evident 'high risk' 'key' population; informants' knowledge of the risks to health of HIV/AIDS was overridden by the demands of their work and their personal circumstances.

## CHAPTER 9

---

### HEALTH WORKERS

#### 9.1 Introduction

Semi-structured and informal interviews were conducted with nurses and clinicians who provide health and welfare services to stevedores, truck drivers and CSWs at clinics which were also the research sites. The focus of this component of the study was on the services that the Bidfreight company clinic provides for its stevedores, The Marianhill Truck Stop clinic that serves truck drivers, the Lifeline clinic which serves CSWs. In the case of seafarers, interviews were conducted with staff at the Seafarers Mission which is a recreational facility. The staff are Christian clerics and lay persons who not provide health services but who offer ecumenical support for those desire it.

The clinics are very different facilities. The Bidfreight clinic is fundamentally a company occupational health clinic. The Marianhill clinic is a transport industry funded initiative to counter the effects of HIV/AIDS in that industry. The Lifeline clinic is an extension of this NGO's core activity of phone-call based counselling and assistance; it serves any person who comes to the clinic but it has defined CSW assistance as a specific activity. The Seafarers Mission is designed to provide a secure place for seafarers to relax on-shore, offers spiritual counselling and can provide referrals for HIV testing and other health assistance requested by an individual; hence, in this sense, it caters for their health and welfare. In addition, there was limited informal correspondence with researchers who have been conducting a long term study of CSWs in Durban.

The purpose was to gain contextual insights to the health of these groups and the scope and limitations of health services provided to them. This component was useful in providing information that helps to explain some of the results from the behavioural survey and interviews with CSWs. The information includes that which is both at odds and consistent with some of the survey results. Assessment of these findings is held over to the following chapter.

#### 9.2 Facility services

The three clinics provide deal with HIV and other STI infections amongst their clients but provide different ranges of services. The Bidfreight clinic provides HIV and other STI testing, counselling and treatment only to its permanent employees. The contract and casual stevedores benefit only from workplace injury treatment and condoms that are available in the clinic and in the toilets on the company premises. The Marianhill clinic does not provide HIV treatment for truck drivers but does provide testing for HIV, other

STIs, TB and diabetes, CD 4 counts, and referrals for truck drivers to other NGOs that do provide ART (e.g. Care Wax) and STI treatment. The health staff at this clinic actively broadcast their services daily and advocate with truck drivers to use their services. A practical and substantive part of this daily effort is condom distribution and ensuring the supply and replenishment of condoms in the truck stop cafeteria and toilets. In addition, the clinic will also conduct HIV and other STI tests upon request for the CSWs who work on the perimeter of the truck stop (there are security guards at the truck stop who prevent the women entering for any purpose other than visiting the clinic). The Lifeline clinic is a general clinic for any person who comes in. It also provides HIV and other STI testing and counselling and, as was mentioned in Chapter 8, it specifically offers this assistance to CSWs.

The core services of the Seafarers Mission were aptly described by a cleric:

*“We provide home base for seafarers. It is a holistic home base where it is a safe environment where they come to contact their families on the internet, sit and relax, watch TV, play games and table tennis. There is somebody available if they need to speak with a Chaplain. We are ecumenical, which means we cater for all Christian groups, but we don’t turn anybody away.”*

However, it also provides referrals for HIV and STI testing upon request.

### 9.3 Health staff perspectives

The staff at the four facilities provides different insights on the health and welfare of their clients. The Bidfreight staff mentioned that the general health status of the employees (including contract and casual stevedores) reflected prevailing economic conditions. Specifically, they referred to the current depressed state of the industry as is illustrated in the following comment of one informant:

*“..... basically their morale has gone down and obviously the salaries have gone down, retrenchments have come.... the first thing you will find in any area where there is poverty or anything like that, you’ll find that rates of sexual related incidences increases. So you will find that there is an increase in STI’.... You’ll find that your incidences will increase; your HIV and AIDS infected patients as well as TB because now you’ll find that as opposed to your employees living in, like, your satellite areas or locations, they now move closer to work because of transport costs so they are living in hostels. Living in hostels, to me, is the number one spread where these guys are getting sick and contracting these diseases.*

*Also, visiting prostitutes and stuff because they are living in close proximity to each other, sometimes two people per room. They are sharing toilets, they're sharing utensils. So if one person's got TB, then you know it's going to spread amongst those people. And, also, regarding prostitutes; the closer they are to the harbour area the city area, the more access they have to prostitution. It is higher because they are not visiting their wives as often as they used to."*

However, a clinician who worked at the clinic highlighted indications of improved health seeking behaviour amongst the permanent stevedores:

*"I've been here for two years, but looking back most people were in denial when you give them information. I noticed that while giving them information about STIs. They believed more in traditional treatment, but now; we have people who know they have to come at the clinic for every disease they might have, and that is because of the information we provide them with; more especially HIV but we still have those who doesn't want to test at all; whereas the majority of them do test and they are on antiretrovirals."*

Nonetheless, the general tenor of their commentaries was equivocal. For example, one staff member, though talking about permanent employees, indicated why survey results showed some variation according to age amongst the stevedore sample regarding STI incidence and awareness of the threat of HIV/AIDS:

*"The popular group of workers here are men and few women. Women don't have a problem regarding coming to the clinic. They test and follow guidelines of being on antiretroviral, whereas old men don't attend issues about HIV. They only respond well in other illnesses such as diabetics and so on. The middle age group between 35 [...] does visit the clinic, but we still have those in denial."*

Another staff member referred back to the economic conditions and, in this instance, how it was reflected in the health status of both permanent and casual stevedores:

*"....for any of our specific employees to say they don't understand what HIV and AIDS is, they are lying. For the past 10 years, all we have preached is, around the port area, is HIV and AIDS and how important it is to get tested. They know what the disease is.....Ignorance, I wouldn't say comes more with our guys, it's more maybe your labour brokers. Unfortunately the way that the economy is going, it is more cost-effective and a lot of companies are using labour brokers. And a lot of the labour brokers, unfortunately, do not have access to clinics such as ours...."*

*So a lot of the females that are in these labour broker organisations are sleeping with our guys and they are sharing women. There are incidences that I can tell you for a fact where one woman has infected 4 guys. One woman.”*

In addition, the clinic staff highlighted a concern about the prevalence of drug abuse amongst stevedores and CSWs generally, as well as suggesting that the latter were clients of stevedores, as the following comments illustrate:

*“...the drug culture is massive in and around the port area. And I think when you add alcohol or drugs to any equation, you are gonna get people who let things slip. Maybe initially they were cautious and they cared, but when you add drugs in the mix, they become braver. They don’t care; they just want their next fix kind of thing. And that’s, unfortunately, what a lot of these prostitutes are into. And the sad thing about the reality of the situation, is that they’re not partaking in healthy practices.*

*Because a lot of the time the guys tell you, ‘this is my city girlfriend and my wife doesn’t know about her.’ Or, ‘my wives don’t know about her and she’s the chick that’s bringing all the problems in the relationship’. Because then he’ll come with STDs.... To me, it’s more like they’re using kind of thing. Using their services, like sex workers – it’s just that they’re calling them a relationship, just to hide the whole embarrassment.”*

The Marianhill clinic staff highlighted their perceived success of their condom distribution efforts as is illustrated in the following two comments from different staff members.

*“There is an effect. If you can look closely, most people think that truck drivers are testing positive. Well that’s not the case. The majority of them are HIV negative. Some who tested positive, lost weight and have started (treatment and gained weight). This means we’re helping a lot.”*

*“I’ve been working here for more than five years. I can say it proudly that the number of people with STIs has decreased. It shows that people are protecting themselves. We even dispense condoms in their shower rooms. People have these misperceptions that truck drivers behave badly, not all are like that. I work closely with truck drivers. Some of them are wild but others are gentle. It differs with the times they are away from home. Some are absent from their homes for six and three months. Some are only away for a week.”*

One staff member also emphasised that work-related health problems amongst truck drivers constituted the bulk of the clinic's daily services.

*“People’s problems differ. Sometimes they complain about a headache, when season changes its flu, high blood pressure and diabetics. Those are things that worry people, since they are not close to their families. They’ll have headache which can lead to stress, sometimes an increase in high blood. In some instances, they don’t get enough food to supplement their bodies as they are always on the road. The food they get from truck stop is oily. So, it is not good for digestion. Some get STIs from not protecting themselves. Their illnesses differ. Some have gout from eating lot of meat, others have rash and some only come for testing BP and HIV.”*

More generally, it should be noted that the staff commentaries alluded to the fact that the Marianhill truck stop and its incumbent clinic are unusual entities. The staff mentioned that not all truck stops have strong security control to prevent sexual liaisons between drivers and CSWs (and few truck stops have clinics dedicated to serving truck drivers). A comment by one clinic worker aptly highlighted this point:

As I have pointed out that; truck stops are not the same. Some are open to everyone. Prostitutes even have their place to stay that is organised at the stop, where they have to pay for rent.

The Seafarer Mission staff provided oblique views on the utility of the facility. One of the key services at the facility is free internet access to enable visiting seafarers to contact their families and this was mentioned as having a positive effect on the well-being of the seafarers and, in turn, helped to counter possible sexual forays into the city. A pertinent related point made was that the mission chaplain visits the boats and provides ‘airtime’ to seafarers who are not permitted to go ashore. This service was mentioned in the context of the frequent practice of ships’ captains not permitting their crews off the ships when docked.

## CHAPTER 10

### HEALTH VULNERABILITIES OF THE SAMPLE POPULATIONS

#### 10.1 Introduction

The practical purpose of this study is to assess the health vulnerabilities of designated mobile and migrant populations within the environs of Durban's port. A broad aim is to describe these vulnerabilities in terms of a socio-geographical concept, 'spaces of vulnerability'. To re-iterate from Chapter 1, this concept refers to:

- the social and economic conditions of existence within a locality which can affect negatively the welfare of the resident population; and
- the personal circumstances of individuals in those conditions, which can influence their behaviour to the detriment of their own welfare.

The behavioural survey and interviews with CSWs were the means to research these conditions and circumstances amongst the CSWs themselves, stevedores, truck drivers and seafarers. The surveys and interviews sought to achieve specific empirical objectives, which were the foundation for achieving the broader aim of defining the vulnerability of the designated mobile and migrant populations. Again, to re-iterate from Chapter 1, the empirical objectives are to build more detailed knowledge and understanding of:

- the health vulnerabilities, specifically HIV and TB, within these spaces of vulnerability;
- current responses to those vulnerabilities;
- the nature of sexual networking including concurrent sexual partnerships that exist among sea-going personnel, truck drivers, sex workers and other sedentary populations around ports; and
- assist stakeholders in developing relevant policies and programmes that address health vulnerabilities of mobile populations and affected communities in the selected ports."

This chapter is structured to describe the relative vulnerability of the different sample populations. Our rationale is that the research findings suggest variable levels of risk and vulnerability regarding HIV and other STI infection within and between the sample populations, and also significance in terms of determining priorities for the design of interventions by government and civil society agencies. We refer here to the research evidence which showed clearly that the truck driver and CSW populations constitute 'high risk' and 'key' populations, respectively in terms of high probability of HIV and other STI infection and as significant channels for the transmission of these diseases. In contrast, reasonable inferences from data indicate that seafarers do not constitute such



a population but with the caveat that this is a qualified assessment for reasons discussed later. In addition, the research findings support an equivocal assessment regarding the stevedore sample. One factor guiding this assessment is that the research revealed conditions and circumstances (e.g. drug culture; depressed economic conditions) that influence sexual relationships and networks in the port environs. However, these conditions were not covered in detail and did not seem to be particularly significant in the case of casual and contract stevedores. Accordingly, the text below is organised on this basis. We start by assessing the findings in relation to the nature of sexual networking.

## 10.2 The nature of sexual networking

The CSWs are, in the context of Durban and South Africa, a ‘high risk’ and ‘key’ population. The circumstantial evidence is strong: by definition of their work, their multiple and concurrent sexual relationships, infrequent use of condoms, sexual liaisons fuelled with alcohol and drugs, acknowledgement of HIV and other STI infections, Lifeline’s dedicated commitment to assisting CSWs in the clinic and in brothels, the current experimental intervention of mobile clinics to reach CSWs and, by inference, the relative lack of health care via government facilities that serve their specific needs. The extent of CSWs networks in terms of the varied clientele indicates that this is a key population in terms of being a significant channel for the transmission of HIV and STIs into the general populace and into the CSW population.

The findings from the CSW interviews, though qualitative and via a small sample, suggest that truck drivers are a substantive part of their sexual networks. Superficially, the truck driver data did not confirm this finding; the vast majority of drivers (88%) denied sexual relations with CSWs. However, data on the number of drivers’ sexual relationships and on reported sexual liaisons with ‘casual acquaintances’ and CSWs suggest that the informants were being circumspect with the researchers regarding their interactions with CSWs. A majority of drivers (53%) reported more than one sexual relationships in the preceding 12 months; amongst this group 45 drivers (49%) reported three or more relationships; a majority of the few drivers who reported sexual relationships with casual acquaintances and/or CSWs stated that the relationships had occurred within the preceding thirty days. These reports were made in the context of many drivers also stating that they were intimate relationships. Forty-nine percent stated that they were married or cohabiting but many (44%) reported having had sex with a person other than a spouse or regular partner in the preceding twelve months. Interviews with staff at the Marianhill clinic revealed that sexual relationships between drivers and CSWs, at and beyond truck stops, were common practice. This particular site was unusual only in the restrictions on

access of CSWs to drivers and, possibly, the presence of health workers who encouraged the drivers to practice 'safe sex' in terms of using condoms more frequently than they might otherwise do.

Stevedores were not a specifically named category of clients and the stevedore survey findings do not support the same inferences as in the case of truck drivers. Stevedores, like truck drivers, may have been reticent to disclose the nature of their sexual relationships but, comparatively, there was little evidence to infer the same degree of risk to health. A minority (29%) reported that they were married or cohabiting yet few stevedores (23%) stated that they had sexual intercourse with a person other than a spouse or regular partner. Very few (17) stated they had three or more partners in the last year. Even fewer (11-15) stated they had a sexual relationship with a 'casual acquaintance' in the preceding 12 months or thirty days. Only seven stated they had had sexual intercourse with a CSW. However, in this case, there was some indication in the survey data to support claims by health workers and, indirectly, by CSWs (reported clients including 'young and old 'black men') that older stevedores (40 years and older) tended to be the most at risk age group for HIV and STI infection. Numerically, the older stevedores were the age group in which the most informants (19) reported sex with a person other than their spouse or regular partner.

As was noted in Chapter 4, the study findings did not provide unequivocal evidence of relatively high sexual risk in terms of sexual behaviour amongst the stevedores (permanent and casual). The low number of reported sexual relationships, particularly with CSWs, affirmed the impression from CSW interviews that stevedores were not a substantive proportion of their clients and did not support health workers assertions of frequent interactions with CSWs and, generally, risky sexual behaviour due to liaisons fuelled with drugs and alcohol. However, as was noted in Chapter 5, there was relatively high incidence of STIs (17% for symptoms of gonorrhoea) and yet, evidence from health workers that STI rates rise and fall according to prevailing economic conditions. These findings beg more questions than answers about whether port environs really are the predominant locus of stevedores' sexual networks as opposed to their home neighbourhoods in the townships and slums of Durban. For instance, in the absence of work, stevedores would not be in the port environs and have little or no money to pay CSWs.

At best, we can discern that the stevedores constitute an increasingly marginal working population in Durban's port due to re-structuring of the maritime industry and in view of the report from a senior Bidfreight manager that the bulk of this workforce are casual and contract workers. In addition, the union which represents these workers seems

to really operate largely as labour broker. In essence, the inference is that stevedoring work is becoming harder to get and individuals' incomes may vary widely during any time period due to variable demand for their labour; hence, most stevedores are in all likelihood enmeshed in cycles of poverty and occasional relative wealth. This is a condition of existence which engenders vulnerability as is indicated, for example, in women stevedores' reports of transactional sex with trade union officials to secure work. However, it is not possible on the basis of the results of this study to assert that stevedores' risk and vulnerability stems from sexual networks and behaviour in the port environs as suggested by the Bidfreight clinic health workers.

The findings from the research on seafarers suggested that this population is not a particularly vulnerable population and, possibly, a relatively 'low risk' population. The survey was not very informative due to poor response rate generally from seafarers. The one finding indicating the relatively low risk and vulnerability of seafarers was that it seems that health checks for employment and renewal of contracts includes compulsory HIV testing; hence, there was an incentive against risky sexual behaviour. As was noted in Chapter 6, the vast majority had done HIV tests and knew the results, and a majority (78%) had indicated they were required to undergo such tests. However, it must be noted that limitations of the research included lack of interviews with CSWs whose clients are primarily seafarers, and general reticence of informants to answer questions. Furthermore, background research for the study indicated that the nature of sexual networks of seafarers who do come ashore in Durban was not within the purview of the survey tool. Apart from the ethical protocol restrictions for research with CSWs, we refer here to media reports, noted in Chapter 1, indicating the establishment of many brothels in Durban's suburbs in the last 5-8 years which are possibly frequented by seafarers (as a 'safer' option in Durban) and to anecdotal reports that taxi drivers collect seafarers from the Seafarer Mission in the evenings to go to various venues (not just the 1-2 clubs known to be frequented by seafarers). In other words, it is possible, in view of the reported decline of clubs servicing seafarers and restrictions on crews coming ashore, that the nature of seafarers' sexual networking in Durban has changed fundamentally in recent years. In turn, this study has to recognise that it was not able to identify properly the nature of seafarers' sexual networks in Durban.

Regarding the above, there was circumstantial evidence that sexual networks and sexual activity in particular, in the environs of Durban's port is influenced by a 'drug culture'. In this instance, the study protocol and tools did not include a specific focus on recreational drug use and abuse in and around the port; hence, it omitted a potentially significant factor for assessing the health risk and vulnerability of stevedores and truck drivers.

### 10.3 Health vulnerabilities: the incidence of disease

STI incidence was the study's principal indicator of risky sexual behaviour and for vulnerability; in the latter instance, in terms of threats to health and associated difficult personal circumstances that can influence in turn the level of risk of HIV and STI infection. The relatively high incident rates of STIs amongst the stevedore and truck driver samples (10-20%) and the inferential findings of frequent STI infection amongst CSWs, are clear indicators of health risk and vulnerability in any population. These indicators justify the design and implementation of particular interventions in view of the threat of sustained HIV transmission into the general populace.

However, the surveys produced some seemingly confusing results; notably, a lower incidence of STIs amongst the truck drivers than amongst the stevedores and minimal incidence amongst seafarers. As has been mentioned previously, it is probable that the lower STI incidence amongst the truck drivers is due to the sample being one that is influenced by the health interventions of the Marianhill truck stop clinic health workers and, conversely, the majority of the stevedore sample lacking such levels of health support. Regarding the seafarers, we doubt the results in view of poor response rates to certain questions but, like the truck driver sample, they seem to have regular access to health services (on board their ships and via ships' agents when in harbour) and they undergo regular health checks.

Nonetheless, despite the sampling biases, the different STI incidence rates between truck drivers and stevedores is intriguing for intimating that, in the case of this study, a largely sedentary population (stevedores) were more likely to get an STI than a very mobile population (truck drivers). The difference can be explained, we contend, on the basis of the very different economic conditions of existence of stevedores and truck drivers. To recap, the study revealed very high rates of STIs amongst older stevedores compared to younger stevedores: 45% in the 30-39 year old category and 37% in the 40 years and older category reporting symptoms of gonorrhoea. No such evident differentiation was evident in the truck driver sample in addition to there being lower rates of STI infection in the latter sample (13% for gonorrhoea symptoms; 4% for syphilis symptoms). Secondly, similar age-related ratios were not found regarding reported incidences of syphilis symptoms amongst the stevedore sample (nor in the truck driver sample). These are factors which affirm an old, yet seminal epidemiological analysis of syphilis rates in South Africa (Kark, 1949), which is still a foundation for contemporary views about why migrant and mobile populations exhibit a high risk of HIV infections. Kark's argument was that the pathology of high syphilis rates in South Africa were, at root a societal pathology in the

sense that the migrant labour system created very poor conditions of existence for most Africans (e.g. poor accommodation; low wages) and also conditions which promoted the spread of venereal disease (e.g. single-sex hostels; shebeens, brothels in workplace environs).

The differences in STI incidence rates between the stevedore and truck driver samples and the specific patterns within the former sample, reflect the tenor of Kark's argument. First, the age-related rates for symptoms of gonorrhoea in the stevedore sample reflect differences in the residential status of individuals in that sample. The Bidfreight manager reported that the majority of stevedores were permanent residents in Durban and that the few who did migrate from rural homes were largely 'older men'. As was noted in Chapter 3, the survey affirmed the manager's report: the bulk of the stevedores were not migrant workers. Accordingly, the manager's report suggests that the incidence of gonorrhoea is concentrated amongst the migrant stevedores. Secondly, the lack of any age-related pattern in the syphilis rates in both the stevedores and truck driver samples reflects two sets of influences. In the case of truck drivers, it reflects the well-known health risks associated with mobile populations. In the case of the stevedores, it reflects the particular poor conditions of existence of most stevedores (their marginal employment status; general poverty; residence in Durban's slums and townships) coupled with the indication from the survey that the majority were single men and women. The higher STI rates amongst the stevedores compared to the truck drivers reflects the pathology inherent in the former's conditions of existence in contrast to the normality of the latter's conditions of existence. Truck drivers may be mobile but they are comparatively wealthy via relative secure jobs and, in this instance, the informants were benefitting from a dedicated health service that was knowledgeable of their health challenges.

It is difficult to compare these results with those of Nkozia and Colvin's (2009) study because this study did not include HIV testing whereas the latter study did. That study recorded a general prevalence rate of 15% amongst all Durban port employees with marked variations between different workforces in different companies (in part due to different levels of commitment to HIV health services for employees), lower HIV rates amongst married personnel, and that education level was not a significant indicator of HIV infection risk. Our study's findings regarding the incidence of STIs in the sample populations and associated contextual factors suggest that HIV prevalence rates are unlikely to have decreased.

## 10.4 Health vulnerabilities: knowledge, prevention and treatment of disease

The study revealed a few inconsistencies between informants' knowledge of disease (HIV and STIs) and actions to seek treatment when necessary, on the one hand and, on the other, their behaviour in preventing infection and their attitudes about HIV infection. The vast majority of informants in all the samples, including the CSWs, was well aware of, and knowledgeable about HIV, had done HIV tests, and knew the results. Furthermore, seeking professional medical treatment when necessary was common practice. However, in the stevedore and truck driver samples there were substantive numbers (30% and 27% respectively) who stated they did not know any person who had died of HIV/AIDS. Furthermore, the majority of informants reported that they did not use condoms regularly or consistently. Regarding attitudes, informants in the survey samples generally displayed a lack of prejudices expecting in the matter of buying food from a person known to be HIV positive and about disclosing publicly that a relative had HIV/AIDS.

As was mentioned in Chapter 7, overall, the results allude to the presence of subliminal personal beliefs, indeed latent fears, which can override formal knowledge in decision-making about sexual practice. On this point, one pertinent finding was the indication that 'denial' of the presence and threat of HIV/AIDS was more common amongst older stevedores (41 years and older) than their younger colleagues. We refer here to the surprisingly large number of these older stevedores (44%) who stated that they did not know of any person who had died of HIV/AIDS though they live in a South African province which is the centre of the country's HIV hyper-epidemic. In contrast, as one might generally expect, amongst seafarers (many of whom do not come from countries as ravaged by HIV/AIDS as South Africa), more older (35%) than younger seafarers knew of a person who had died of HIV/AIDS. The age-related result in the case of the stevedore sample is pertinent in view of other age-related findings mentioned earlier which point to older stevedores being, perhaps, those who are most at risk of HIV and STI infection amongst stevedores. Furthermore, as was noted also in Chapter 7, the indication from the data that the older, rather than the younger STI-infected stevedores are more likely not to cease sexual activity points to the former as a source for STI transmission into the general populace.

Regarding truck drivers, the findings reiterate why this population is known to be a 'high risk, key' population. High levels of knowledge about the dangers of HIV/AIDS and STIs and, for this study sample, access to dedicated health services, were evident in tandem with sexual behaviour patterns that included multiple sexual partnerships, inconsistent use of condoms, relatively low (yet cause for concern) incidence of STIs, and 'denial' of

the HIV/AIDS threat amongst a substantial minority of drivers. Here, it is appropriate to explain the findings by referring again to Kark's (1949) argument but to elaborate upon it. The findings support his general argument that such phenomena are the function of a societal pathology: the drivers' conditions of existence as mobile workers promote ill-health and, in particular, STI infections. However, in this instance, the societal pathology is not that the work routine of truck drivers is 'abnormal' in the sense that Kark argued (i.e. creation of deliberately oppressive and constraining living and working conditions). Truck drivers are generally well educated, relatively highly paid workers (increasingly so in countries with HIV epidemics due to supply/demand imbalances for drivers), and have chosen freely their occupation. The societal pathology is the lack of public health services which are structured to address critical health and disease conditions. This is indicated by the nature of current interventions in Durban: they are initiatives of civil society organisations (the Marianhill clinic, Lifeline's CSW services; the scientific research project on mobile clinics for CSWs), not the provincial or national governments. The pathology lies in the absence of government initiatives in the face of longstanding evidence on the health threats for the general populace if no attention is paid to 'high risk, key' populations.

Regarding seafarers, the study did not reveal substantive threats to their health and welfare. They were generally very knowledgeable about HIV and STIs. The majority seem to have regular health checks. Seemingly, they could access professional medical services as and when needed. The number of seafarers in the city is limited due to restrictions on shore access. However, limitations in the implementation of the survey mean that the study did not gather adequate data. Furthermore, as was mentioned in Chapter 1, it seems seafarers may be using brothels in Durban's suburbs, the latter being a relatively recent development in the city due to urban renewal projects in the areas adjacent to the harbour. Covering this development was beyond the scope of this study.

A pertinent finding from the CSW component of the research was the harassment of CSWs by policemen combined with sexual relations between them. This is a micro-level expression of health risks facing mobile populations in the sense that both CSWs and policemen constitute intra-city mobile populations. To define policemen as a mobile population may be stretching the common meaning of the concept but, we contend, not to do so restricts any analysis that seeks to understand 'spaces of vulnerability'. It may be noted that policemen in South Africa are often deployed for periods of time away from their home areas. The mobility of both populations, in this instance, is defined by the fact that they move regularly to different places within the city. They confront each other regularly due to the illegality of commercial sex work. Although the health vulnerability of

CSWs is well known due to the generally coercive nature of the interactions, policemen are also vulnerable for engaging in risky sexual behaviour and with a population known to have high HIV and STI prevalence rates.

The notable difference between these results and those of Nkozia and Colvin (2009) is that our study showed much higher levels of knowledge and awareness of HIV/AIDS and its threats to people's health. However, this improvement does not translate into clear indication of commensurate changes in sexual behaviour that lead to substantive evidence of reduction of HIV and STI infection. We contend that the different levels of knowledge are not particularly significant in view of the persistent presence of conditions of existence for many who work in and around the port, which promote relatively high levels of risk of HIV and STI infection and vulnerability to ill-health. What is pertinent is that both the 2009 and the present study direct attention to differentiation of health risks and vulnerabilities in the port populations. The 2009 study alluded to, but was not designed to address, this differentiation (e.g. noting the relevance of marital status as a measure for differentiating risk and vulnerability; noting the variable HIV prevalence rates between different companies). This study, despite various limitations with the data was able to differentiate some risk and vulnerabilities within and between the sample populations. In our case, it was evident during initial analysis of data that education and marital status were not pertinent measures for differentiating risk and vulnerability but, in some instances, age was pertinent. Furthermore, this study has highlighted contextual factors (e.g. economic hardship influenced by restructuring of the maritime industry) which perpetuate conditions of existence that facilitate the transmission of disease.

### 10.5 Spaces of vulnerability

The researchers for this study expected to find clearly delineated channels of HIV and STI transmission in and around Durban's port, which would help define spaces of vulnerability. In the event, it became apparent that these channels change in concert with urban development initiatives, restructuring of the maritime industry, and general economic conditions. Localities which used to be known as 'red light' areas and which housed venues that catered for the 'sex trade' no longer exist, are 'disappearing' or are becoming small 'pockets' that are likely to disappear in time as a result of urban and port renewal programmes. The process was outlined in Chapter 1 in terms of how these programmes have redefined the port and its environs in ways that push away the sex trade. Put differently, the boundaries of the port have been expanded and tightened to exclude the sex trade. It is an ongoing process.



Much of area along and beyond the seaward side of the port has been upgraded such that the traditional port-focused 'red light' area (the Point) is no more. However, a small area closer to the beachfront has become a notorious locality for drug dealing and sex trade; in essence, an inner city-focused industry. Urban renewal and industrial projects along the port's eastern boundary towards the south (reaching towards Maydon Wharf) are restricting the presence of venues such as the night clubs that used to be frequented by seafarers. The still relatively 'open' area of the port is the perimeter from Maydon Wharf through to the container terminal on the port's south side. This is the location of many warehouses that are the nexus for stevedoring operations (offloading and loading goods to and from the warehouses) and also for truck transport operations (offloading and loading goods at the warehouses and at the container terminal). There is also a small area that is currently the location for concentrations of homeless people and drug addicts. This stretch of the port perimeter is a known locality for street-based sex trade. In addition, there are intermittent sexual interactions between CSWs and truck drivers on the Bluff, south-east side of the harbour. The pertinent factor here is that there are large truck parking areas immediately outside the 'closed' port piers which occasionally are sites of intensive transport operations and concentrations of trucks.

The current, evident 'space of vulnerability' regarding CSWs and truck drivers is the stretch of the port from Maydon Wharf through to the container terminal. However, a question mark must be raised about stevedores even though they regularly pass through this area. On the one hand, doubt arises for the various reasons outlined earlier. On the other hand, accepting that some stevedores do reside as close to the port as possible, the actual 'space of vulnerability' is an area on the port side of a suburb (Umbilo/Gale Street) where there are still some men's hostels originally built for migrant workers. In other words, this is a depressed pocket of the inner city which has yet to be subject to urban renewal interventions. Regarding seafarers, the study findings also indicate that their 'spaces of vulnerability' have become dispersed throughout the city following the establishment of brothels in different suburbs which may now be frequented by members of this population.

It must be emphasised that these 'spaces of vulnerability' are likely to shift again within the next few years. Already, there is a large truck transport parking area (Clairwood) 5 kilometres south of the port. No research could be conducted in that area but anecdotal reports suggested that this was one location of CSW and truck driver interactions. In addition, redesign of port operations includes the plans mentioned in Chapter 1, to construct a large container terminal 30 kms inland from the city (at Cato Ridge). Truck transport operations will be focused on this terminal with containers being shipped by rail to, and from the harbour itself.

## 10.6 Summary

The discussion above focuses on the spatial aspects of vulnerability. Considering ‘spaces of vulnerability’ from the more nuanced socio-geographical perspective leads us to emphasise the following:

- Urban renewal and port development programmes are creating more clearly defined urban spaces, including increasingly rigid boundaries between the port and the city, which create in turn what we have called ‘pockets’ of urban space that constitute the ‘spaces of vulnerability’ for particular populations. In other words, the locations where conditions facilitate ‘risky’ sexual interactions are becoming fragmented within the inner city as opposed to being within and immediately adjacent to the port as was the case in the days when the boundaries between the city and the port were more porous;
- The term ‘pockets’ signifies a restrictive process in the sense that those involved in illicit activities, be it the sex or drug trade, are being forced to find new locations; and one evident trend is movement away from the port into the city and the broader metropole. This is not to say that the process has reached the point where the port itself is no longer significant as a space where there are conditions that facilitate the transmission of disease. As discussed, some of the port perimeters are still relatively porous and these are the areas which facilitate sexual interactions between CSWs and truck drivers and, possibly, between the former and stevedores. Nonetheless, the overall indication from the study findings is that the port is becoming less relevant as an entity deserving particular attention for HIV and STI transmission-oriented research and interventions.

To be clear on both points above (the notion of ‘pockets’ and declining relevance of the port), we are suggesting that the ‘spaces of vulnerability’ need to be seen as:

1. Physical spaces (the areas in and along the port perimeters) but recognising the decreasing size and relevance of these spaces in and adjacent to the port for purposes of designing appropriate interventions. Conversely, physical spaces further away from the port are becoming more relevant, particularly regarding the vulnerability of truck drivers (i.e. the truck ‘rest’/parking areas such as at Marianhill, Clairwood) and the projected container terminal at Cato Ridge;
2. Transient virtual spaces in the sense that, currently, the ‘pockets’ where CSWs work are relatively temporary venues (e.g. bars, streets, flats, brothels) rather than clearly defined, established and entrenched locations, for urban renewal and ongoing official efforts to control prostitution alongside unofficial police harassment force occasional

relocation of CSWs within the city. Likewise, the establishment, closure and re-establishment of brothels in different city suburbs represent the shifting nature of the spaces where seafarers are vulnerable (in view of the intimation from the findings that seafarers are possibly frequenting these brothels more than venues adjacent to the port). Findings about stevedores suggest that the spaces of vulnerability are their residential areas, specifically the poor social conditions in those areas which, for some but possibly not the majority of stevedores are the old hostels in Umbilo near to the port but for the majority are the slums in different parts of the city.

Underlying the above, we contend that the 'spaces of vulnerability' in Durban need to be seen in an abstract sense as a function of the limited reach of health services for CSWs, stevedores and truck drivers. Here we emphasise the continued relevance of Kark's thesis about the root source of the pathology of STIs in South Africa. In reality these limitations were revealed in CSW comments on these limitations, the existence of experimental mobile service for them to overcome the limitations, the limited benefit of workplace wellness programmes for casual and contract stevedores, and the Marianhill clinic being one of very few service sites in the vicinity of Durban that serve truck drivers even though the latter constitute a well-known major 'high risk', 'key' population. The societal pathology is further exemplified in the fact that the bulk of the services that do exist for these mobile and migrant populations are provided by NGOs and the private sector. Additionally, it should not be forgotten that such spaces also have a psycho-social dimension. We refer here to the evidence on informants' generally sound knowledge and awareness of HIV/AIDS and STIs and their recourse to professional medical services when necessary but also subsumed personal views, fears and prejudices which did not prevent relatively high incidence of 'risky' sexual behaviour.

## CHAPTER 11

### CONCLUSION

This study on ‘spaces of vulnerability’ has produced results which question the relevance of continuing to view Durban’s port as a location of such spaces. Specifically, the study results show that concept is still pertinent for some areas in and adjacent to the port as long as one acknowledges that such spaces are diminishing in that location and are becoming dispersed throughout the city. We have used the notion of ‘pockets’ to describe this process whilst also emphasising that, at root, these ‘spaces of vulnerability’ are increasingly transient and, in an abstract sense, they are a reflection of the limited scale and reach of health services for CSWs, stevedores and truck drivers. Seafarers did not emerge as a particularly vulnerable population on this basis because, generally, they have regular access to health services and, in particular, are subject to regular health checks for HIV/AIDS and STIs.

This is not to deny that the populations covered by this study have significant health vulnerabilities. The study has largely reiterated known evidence on the health vulnerabilities of these populations, and that CSWs and truck drivers in particular constitute ‘high risk, ‘key’ populations. Rather, analysis of the survey, interviews and contextual data first directed us to assess the relative vulnerability of these populations. That approach led us to recognise that, from a geographical perspective, the spaces of vulnerability are moving away from the port and, from, a socio-geographical perspective, the virtual nature of these spaces in view of the limited reach of health services and the psycho-social dimensions of vulnerability that lie within individuals’ knowledge, attitudes and sexual practices.

These findings suggest that interventions in the case of mobile and migrant populations linked to Durban’s port need to be directed beyond the port. The current experiment with mobile clinics for CSWs and the Mariannahill clinic for truck drivers represent practical interventions that acknowledge, even if not consciously, the virtual and transient nature of the spaces of vulnerability amongst these populations. In short, health services have to go to the would-be patients. These interventions, however, also have limited potential for being NGO and private sector initiatives which are not complemented by appropriate support and innovations from the city health and national government health services. This is not simply to criticise the failings of the public health services; the study results show that civil society and government programmes have yet to dramatically curtail the transmission of HIV/AIDS in the city via CSWs and truck drivers. We leave aside stevedores in this instance due to the equivocal nature of the findings on this population category and, unlike the other population categories, they are largely now a sedentary population in the city.

The finding that stevedores are largely part of the city's sedentary population, and also a diminishing work group reflects the transformation of the port's operations. Regarding the IOM's strategic agenda, stevedores in Durban no longer fit into the categories of a mobile and/or migrant population. In contrast, it is perhaps appropriate for the IOM to consider including policemen within its strategic purview, in contexts such as Durban where there are sexual interactions between them and CSWs that is due in part to the mobility of both populations within the city.

The report has summarised the findings on health vulnerabilities in terms such as fragmented 'pockets', 'transient spaces' and marginalisation of the study populations. Perhaps, the key point to emerge from the Durban study is that the study populations and their health vulnerabilities are becoming less visible in the domain of public health due to their decreasing numbers and diminishing social and economic significance within and around the port.

## REFERENCES

---

Abdool-Karim, Q., Abdool-Karim, S., Soldan, K., & Zondi, M. (1995). Reducing the risk of HIV infection among South African sex-workers: socioeconomic and gender barriers. *American Journal of Public Health*, 85(11), 1511-1525.

Blanchard, J., O'Neil, J., Ramesh, B.M., Bhattacharjee, P, Orchard, T., & Moses, S (2005). Understanding the social and cultural context of female sex workers in Karnataka, India: Implications for Prevention of HIV Infection. *Journal of Infectious Disease*, 191(1), S139-S146.

Cabieses, B., Pickett, K., E., & Tunstall, H. (2012). What are the living conditions and health status of those who don't report their migration status? A population-based study in Chile. *BMC Public Health*, 12, 1013.

Colvin, M., & Lemmon, G. (2008). CMRA/eThekweni Municipality Trucking Sector HIV/AIDS Pilot Project. Report.

Dekker, M. (2010). Assessment Port of Durban South Africa. Pharm-Access Foundation.

Ducruet, C., & Lee, S-W. (2006). Frontline soldiers of globalisation: Port-city evolution and regional competition. *GeoJournal*, 67(2): 107-122.

Gysels, M., Pool, R., & Bwanika, K. (2001). Truck drivers, middlemen and commercial sex workers: AIDS and the mediation of sex in south west Uganda. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV*, 13(3): 373-385.

Hall, P. (2008). Global Logistics and Local Dilemmas. Paper, Urban Studies program, Stephen Fraser University, Vancouver.

Hall, P., & Robbins, G. (2006). Which link, in which chain? Inserting Durban into global automotive supply chains. Working Paper No. 46. School of Development Studies, University of KwaZulu-Natal.

HSRC. (2014). South African national HIV prevalence, incidence and behavioural survey, 2012. Cape Town. Human Science Research Council Press.

International Organization for Migration. (2010). Report on the assessment of health vulnerabilities among migrant and non-migrant workers in the port of Maputo, Beira and Nacala Mozambique. IOM

Kark, S. (1949). The pathology of syphilis in Africans. *South African Journal of Medicine*, 23: 77-84. (Reprinted in *International Journal of Epidemiology*, 2003, 32: 181-186.)

Lambert, A. Operationalising peer-linked mobile wellness services: Mapping and outreach database. Presentation: MSM Symposium, 23rd April 2013. CDC, PEPFAR, SWEAT, Lifeline

project.

Moffet, S., & Freund, B. nd (circa 2002). Elite formation and elite bonding: social structure and development in Durban. School of Development Studies, University of KwaZulu-Natal.

Nzioka, C., & Colvin, M.A. (nd). Report on the Assessment of HIV and AIDS in the Port of Durban, South Africa. International Organization for Migration.

PSMN. (2013) Ports and Ships Maritime News. From <http://www.ports.co.za/news/> (Accessed 21/2/2014 and 28/5/2014).

Ravetz, J. (2013). New futures for Old Ports: Synergistic development in a Global Urban System. *Sustainability*, 5: 51000-5118.

Ritter, T.T. (2000). Commercial sex workers and truck drivers: Background for a core transmitter Intervention. Uganda, DISH II Project.

South African National Aids Council. (2013). Estimating the size of the sex worker population in South Africa. From <http://sanac.org.za/publications/reports> (Accessed 24/9/2014).

Tansey, E., Theyise, N., Borland, R., & West, H. (2010). Southern Africa ports as spaces of HIV vulnerability: case studies from South Africa and Namibia. *International Maritime Health*, 61(4): 233-240.

TB and HIV Care Association. (2013). Operationalising peer-linked mobile wellness services: Mapping and outreach database. Presentation by A. Lambert at MSM symposium.

TNPA. (2014). Transnet National Ports Authority. From [www.transnetnationalportsauthority.net](http://www.transnetnationalportsauthority.net) (Accessed 21/2/2014).

Trotter, H. (2008). Sugar girls and seamen: A journey in the world of dockside prostitution in South Africa. Johannesburg: Jacanda Media.

UNAIDS. (2006). "HIV/AIDS epidemic update, December 2006," [http://data.unaids.org/pub/GlobalReport/2006/2006\\_GR\\_CH02\\_en.pdf](http://data.unaids.org/pub/GlobalReport/2006/2006_GR_CH02_en.pdf).

Varga, C.A. (2001). Coping with HIV/AIDS in Durban's commercial sex industry. *AIDS Care*, 13(3), 351-365.

Wojcicki, J.M., & Malala, J. (2001). Condom use, power and HIV/AIDS risk: sex-workers bargain for survival in Hillbrow/Joubert Park/Berea, Johannesburg. *Soc Sci Med*, 53(1), 99-121.

# ANNEXURE





