IOM International Organization for Migration

AN ASSESSMENT OF HEALTH VULNERABILITIES AMONG MIGRANT AND NON-MIGRANT WORKERS IN THE PORTS OF MAPUTO, BEIRA AND NACALA, MOZAMBIQUE

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PREFACE

The HIV epidemic in Mozambique constitutes a major development challenge for the country. Over 1.3 million Mozambicans are estimated to be infected, and around 400,000 need treatment. The economic, social and cultural implications of the epidemic need to be thoroughly analyzed so that appropriate measures can be devised to prevent new infections, scale up treatment, and provide care and support to those most in need. The 2009 population-based survey on prevalence and behaviour on HIV and AIDS depicts an extremely complex and heterogeneous epidemic, with higher prevalence rates in urban settings and in areas of high mobility.

IOM's definition of 'spaces of vulnerability' when describing places in which migrant workers live, work, pass through and interact with the local community, and its use in the design of long-term programmes to address health and HIV vulnerability issues in "hot spots" fills in an important knowledge gap of the HIV epidemic in Mozambique. It identifies appropriate measures to mitigate the impact of the HIV epidemic in key populations, such as port-users.

The study findings corroborate available evidence that port areas are "hot spots" for HIV transmission. The study also identifies significant structural and workplace issues of concern that further exacerbate the vulnerability of port-users to HIV. It is comforting to verify that the study does not show great differences in results between migrant and non-migrant workers, which points to port-users having equal access to information and services related to HIV and AIDS.

The United Nations family in Mozambique and its Technical Team on AIDS fully subscribes to and supports the implementation of the recommendations of this study. First, we must promote structural measures to address job security, contracts and income generation for port-users. Secondly, we must support risk behaviour-change activities that include life skills and recreational activities for port-users and their families, as well as targeted campaigns to address specific risk points for port-users, sex workers and families. Furthermore, it is paramount that HIV testing and counselling should be made widely available, as well as the promotion of consistent use of condoms and the reduction of sexual partners as priority measures to reduce new infections. Finally, it is worth highlighting the effective Public-Private Partnership (PPP) campaign that has been documented in the port of Beira. This joint effort has led to tangible results in knowledge, attitudes and practices and must be replicated as best practice for other port areas.

We congratulate IOM for this initiative and we join the call to use the evidence highlighted in this study as part of the implementation of our bold vision for reaching zero new infections, zero discrimination, and zero AIDS-related deaths in Mozambique.

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- The port-users of Mozambique who contributed heavily their thoughts and life stories to help the IOM assessment team gather information and understand their individual working situation to better serve their needs in the future.

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1. EXECUTIVE SUMMARY

The ports of Mozambique, located in Maputo, Beira and Nacala, are "spaces of vulnerability," both for migrants and for the populations who live and work around the ports. IOM commissioned this assessment to identify specific issues and problems presented by the people working in the ports (port-users) to consider long-term programme design and project development for interventions in the port areas. In parallel, IOM is currently studying the Mozambican (and cross-border) transport corridor "hot spots": spaces of vulnerability located along transport routes, terminating in the ports.

A total of 165 port-users were interviewed individually. Health, human resources and safety and security staff were interviewed in groups to gather greater detail about port operations, health and workers' protections. Further interviews with the local union and health project staff were conducted if and where applicable.

The findings point to structural and work environment problems for a large number of port-users as well as evidence that port-users as a whole, engage in higher risk behaviour than their urban counterparts. The assessment findings show limited differences between migrant and non-migrant workers, demonstrating that vulnerability, knowledge and behaviour is dependent primarily on the geographic space in which the worker finds him or herself. The ports are easily identifiable as "migrant spaces" or "spaces of mobility" based on evidence that over 50% of the port-users are highly mobile or urban migrants. The risk behaviour differences between provincial statistics for each port city and the port-users – 31% more likely to have two or more partners and 22.5% more likely to pay for sex – further demonstrates that the ports can be viewed as "spaces of vulnerability," as defined by IOM's Migration Health Unit.

As the majority of port-users work for private companies, public-private partnerships are a useful project model and recommended for future interventions. Specifically, the assessment uses the case-study of Cornelder's Health Port project throughout the findings to demonstrate a viable model, and the success of a strong public-private partnership project. Cornelder managed to leverage its funds, and its 446 contracted employees, to successfully test and counsel for HIV status with 5,038 port-users, family members and others linked to the port operations and economic activities (in 2009). The best-practices of Cornelder and possible partnerships are similarly linked to the IOM project model that focuses on partnership and capacity building.

Finally, due to the risky sexual behaviours and practices amongst port-users evidenced in the findings, the promotion of behaviour change activities is highly recommended. Specifically, use of interventions that focus on gender, life-skills development, peer-education and recreation should be emphasized to begin to change the environment of risk that surround the port-users and their families. Projects focused on behaviour change should similarly address social change through communications that include local radio, and recreation to spur debate and build upon change media already available in Mozambique.

2. HEALTH VULNERABILITIES AMONGST MIGRANTS IN MOZAMBIQUE: CONTEXT AND PHAMSA BACKGROUND

According to UNAIDS, there are currently an estimated 1.3-1.7 million Mozambicans living with HIV and AIDS.[1] The most recent Inquiry on National Prevalence, Behaviour Risk and Information [Knowledge] of HIV/AIDS commissioned by the Ministry of Health (INSIDA 2009), estimated a countrywide prevalence of 11.5 per cent among the adult population aged from 15 to 49. Women are at a higher risk and have an estimated HIV prevalence of 13.1 per cent, while men have an estimated prevalence of 9.5 per cent.[2] AIDS is responsible for an estimated 37 per cent of deaths of people over five years of age.[3] Studies show that over 90 per cent of HIV infections in Mozambique result from sexual contact with multiple concurrent sexual partners and low rates of condom use. These are generally understood as the principal risk behaviours of HIV transmission.[4]

High population mobility, including cross border travel, has been identified as one of the key drivers of the AIDS epidemic in Africa.[5] The post-war rehabilitation of the transport and communications systems in Mozambique has led to increased movement of workers within and without the country. HIV prevalence also varies by region with the southern region, a region historically associated with labour migration, having the fastest growing prevalence. Provinces that are particularly hard hit include Maputo, Maputo City, and Gaza.[6] (See map of Mozambique on page 44) Gaza currently has the highest prevalence rate for 15 to 49 year olds – 25.1 per cent - while Maputo Province and Maputo City are the next highest – 19.8 per cent and 16.8 per cent respectively.[7]

With increased population mobility either in search of better opportunities or safety, human mobility in southern Africa impacts on the health of migrants and the public health of the host communities and countries (IOM, 2008a). Human mobility is a significant public health issue in terms of both the epidemiological aspects of disease and physical access to health services (Weiss & McMichael, 2004). Particular concerns are communicable diseases such as HIV and tuberculosis, adverse mental health and sexual and reproductive health outcomes (Carballo, 2007; Grondin, 2004). Many of the underlying factors sustaining mobility such as an unbalanced distribution of resources, unemployment, socio economic instability and political unrest are also determinants of the increased risk of migrants and their families to ill health (IOM, 2008c; Grondin, 2004; Carballo, 2007).

In normal circumstances migration itself is not a risk to health, but conditions surrounding the migration process can increase the vulnerability to ill health (DRC online, 2008). Social disruption caused by migration, overcrowded living conditions, discrimination in accessing health services, and a lack of social capital increase migrants' exposure to diseases and poor health outcomes (Purcell, 2004). Further, port-user migrants move constantly to Mozambique's urban zones, which puts the migrants at a greater risk for HIV infection. Currently, national urban HIV prevalence is estimated to be 15.9 per cent, in relation to 9.2 per cent in the rural areas.[8]

1 http://www.unaids.org/en/CountryResponses/Countries/mozambique.asp

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

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

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

5 UNAIDS: 2004 Report on the Global AIDS Epidemic; pp. 33

6 IOM Briefing Note on HIV and Labour Migration in Mozambique.

7 INSIDA, 2009: See annexed map for geographic distribution throughout the country.

8 INSIDA 2009

Historically, Mozambique has experienced a significant amount of internal and cross-border migration.[9] During the civil war after Mozambique's independence from Portugal in 1975, 1.7 million Mozambicans took refuge in neighbouring countries and several million more were internally displaced. Following a peace agreement in 1992, Mozambican refugees constituted the largest repatriation ever witnessed in Sub-Saharan Africa, and a further estimated four million internally displaced people within Mozambique returned to their areas of origin.[10]

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

- internal migration due to disparities in development, standards of living and employment opportunities among different regions in Mozambique;
- the increasing feminization of migration as more women became labour migrants, often in the less skilled sectors of the economy such as agriculture, domestic work and informal trade;[11]
- higher internal and external mobility as long-distance travel both within and outside Mozambique is facilitated by improvements in infrastructure, including roads, ports and railways;
- traditional/longstanding patterns of cross border mobility to South Africa for work in the mining, agriculture and informal sectors;
- an influx of Zimbabwean migrants due to the economic and political crisis in Zimbabwe, which borders Mozambique and is linked to it by important trade routes.[12]

2.1 IOM's Migration Health Approach

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

1. Service Delivery and Capacity Building: Providing access to health services for migrants, especially the most vulnerable. Services cover: prevention and health promotion; control and management of infectious diseases, chronic diseases, mental health, reproductive health, and social health needs; and environmental hygiene and control.
2. Advocacy and Policy Development: Advises partners and governments on best practices in the management of migration health issues and related strategies and policy options.

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

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

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

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

3. Research and Information Dissemination: Responds to the needs of governments, partner agencies and civil society for evidence-based, disaggregated information on migrant health.

IOM's migration health framework includes mainstreaming health in other IOM service areas such as counter trafficking, using a human rights-based and public health approach, ensuring gender is proactively mainstreamed in all activities, and promoting a partnership approach that brings together relevant stakeholders to address the issue in a harmonized and multi-sectoral approach.

IOM's approach to migration health considers the different health and HIV vulnerabilities associated with the migration process rather than considering the migrant as the health vulnerability. By identifying spaces of vulnerability, which are often places where migrant workers live, work or pass through as areas of high-risk HIV vulnerability (see box below).

Spaces of vulnerability: Often the places in which migrant workers live, work or pass through are high-risk spaces of HIV vulnerability. The presence of many different migrant and mobile populations and interaction with local communities at such places as land border posts, ports, construction sites, informal settlements, farm compounds and mines creates a fluid social environment where social norms regulating behaviour are usually not followed and migrants may feel a sense of anonymity and limited accountability, which can lead to high-risk sexual behaviour. Poverty and lack of job opportunities in the communities surrounding such places also induces many women (both migrants and locals) to engage in transactional and commercial sex with those who have resources or disposable incomes[13].

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

3. RATIONALE FOR THE STUDY

Currently there is very limited information on migrant and mobile populations in Mozambique. IOM is currently carrying out comprehensive assessments, focusing on the maritime sector, the agriculture sector (specifically the cashew processing centres) and the transport sector (including border communities and major transport corridors) to facilitate more effectively tailored HIV and general health interventions targeting these groups, and to increase awareness about factors affecting these populations,.

The ports of Mozambique are "spaces of vulnerability," both for migrants and for the populations who live and work around the ports. IOM commissioned this assessment to identify specific issues and problems presented by the people working in and around the ports (port-users) to consider long-term programme design and project development for interventions in the port areas. In parallel, IOM is currently studying the Mozambican (and cross-border) transport corridor "hot spots": spaces of vulnerability located along transport routes, terminating in the ports. The "hot spots" studies will provide more detailed information about the sex workers, truckers en route to terminal locations and vendors who service the ports and the corridors linked to the ports.

Mozambique's private sector response to HIV/AIDS has been significant and well organized. In addition to large-scale workforce efforts at Unilever, MOZAL, CETA and Coca-Cola there are promising unified private sector and Public Private Partnerships (PPP) initiatives in EcoSida and SEDE. However, the private sector response tends to be somewhat workplace specific and while migrant workers are eligible and on occasion receive company-sponsored HIV education and health services, this can be incidental to their work status and not as part of systematic effort or targeting. As such, mobile populations and labour migrants often escape the reach of generalized workplace HIV programming when they return to their home communities. This also implies that families and sending communities do not reap the benefits of these programmes.

Vulnerability to HIV is greatest in conditions of poverty, inadequate financial resources, social instability, and unequal gender relations. It is these dimensions of migration that are frequently overlooked when designing and implementing HIV responses within the context of mobility. This assessment aims to target not only the migrants as the focus of HIV interventions but also the broader environment and his/her community of origin.

The assessment includes:

- an assessment of HIV related knowledge, attitude and practises,
- map existing health and HIV related services so as to estimate the health needs and service delivery gaps for migration affected communities;
- the identification of relevant stakeholders active in the identified geographical areas (including govt. civil society and private sector);
- the identification of potential partners with whom IOM could collaborate;
- recommendations for future projects, assessments and programmatic tools;
- the identification of current and existing Migrant Health Framework tools and practices that apply to the recommendations as well as areas of future tools development.

4. BACKGROUND AND CONTEXT FOR PORTS AND PORT-USERS IN MOZAMBIQUE

4.1 The Ports and Port Management

Mozambique has three primary cargo ports in the south, centre and north of the country. The ports serve trade along corridors that run west to east delivering goods for international export from South Africa, Zimbabwe, Zambia and Malawi. The ports were originally controlled by the public (government owned) company, Mozambique Ports and Railways (CFM). In the late 1990s and early 2000s, CFM privatized various port and rail companies and leased concessions to private companies that now manage the bulk of port operational activities.[14]

4.1.1 Maputo

Maputo is the largest port in Mozambique, currently handling over 6 million tonnes of cargo per year. It must be consistently dredged to keep its channel depth at between 7.5 and 9.1 metres. Located on the western side of the bay at the mouth of the Tembe River, the port includes a containerized and general cargo section and a bulk cargo section (near Matola – Mozal). Maputo City, originally named Lourenço Marques by the Portuguese, is linked directly by road and rail (currently being rehabilitated) to major industrial and agricultural areas in South Africa and Zimbabwe.

Maputo port is managed by the Maputo Port Development Company (MPDC)[15] after a concession was granted in 2003. CFM still controls 49 per cent of the company shares. MPDC controls all the port operations and all terminals. A sub-concession was granted to Maputo International Port Services (MIPS) in 1995 to control the container terminal which remains with MIPS although MPDC now oversees all port operations. MIPS is partially owned by CFM (40%) along with DP World (60%), one of the largest international terminal operators.

Like the port, Maputo City is on the western side of the Maputo Bay, to the north of the port area. The city is divided into seven municipal districts (Districts 1 - 5, Inhaca Island and Catembe). The port is in Municipal District 1. Officially the city has an estimated population of 1.35 million. Though estimates vary with regards to the periphery of the city, when an urban population using the city is included, the figure rises to about 2 million persons. People who live in the Matola and Marracuene districts often work in Maputo City daily as well. The districts are divided into 63 bairros (neighbourhoods). Many languages are spoken in Maputo but the primary local language (after Portuguese) is Ronga. Current HIV prevalence statistics for Maputo are 16.8 per cent of the population aged from 15 to 49 years.[16]

4.1.2 Beira

Beira is the second largest port in Mozambique and handles over 1.5 million tonnes of cargo per year. Like Maputo, it must be constantly dredged to keep its depth at between 12 and 8 metres. Located in Sofala Province, the centre of the country, where the Pungue River meets the Indian Ocean, the port and city of Beira serve as a primary transportation point for export items coming from Zimbabwe, Malawi and Zambia. The Sena Railway line,

14 For detailed public documentation of the rationalization of labour and privatization of port and railroad activities, read Xitamela Magazine, published by CFM on its website: http://www.cfm.co.mz/xitimela.htm.

15 http://www.portmaputo.com/home/

16 INSIDA, 2009

currently in rehabilitation, links the coal fields of Moatize in Tete Province, a convenient transport stop near Zambia and Malawi, directly to the port.

The port came under management by Cornelder of Moçambique in 1999. Cornelder controls the concession for the multi-purpose container terminal. CFM retains control of the petroleum and chemicals terminal. Cornelder de Moçambique is a privately owned, Dutch port-management company although CFM retains 30 per cent of the shares in country. When CFM privatized and began the process of concessions for control of the ports, the workforce was rationalized and CFM retained only port authority and basic security control. Cornelder employs 446 personnel within its concession, controls additional security, and partners with many companies for basic stevedoring and transportations tasks.

Beira City is the second largest urban centre in Mozambique, located in Sofala Province, on a peninsula south of Dondo, with the Indian Ocean surrounding its eastern, southern and northern limits. The city is at an elevation slightly below sea-level, which creates problems for drainage and long-term growth capacity. Beira's population is estimated at 445 thousand in 26 bairros (neighbourhoods). After Portuguese, the majority of the local population speak either Ndao or Sena. Although there are no HIV prevalence statistics for Beira City, the province of Sofala (Beira is the capital) has a 15.5 per cent prevalence rate amongst those aged from 15 to 49 years. More drastically, the urban zones of the central provinces (Sofala, Manica, Tete and Zambezia) have an average HIV prevalence rate of 19.7per cent.[17]

4.1.3 Nacala

Nacala Port boasts the deepest natural port on the east coast of Africa and is in Nampula Province, on the south side of Bengo Bay. Bengo Bay has a natural port with an 800 metre width and 60 metres in depth. The Nacala port serves the northern development corridor, including a rail line linking land-locked Malawi and the Malawian Central East African Railway to Mozambican railroads that arrive at the Indian Ocean. The population of Nacala is approximately 200 thousand residents. Along with the port, Nacala's Bengo Bay is a prime location for tourism, particularly scuba diving and fishing.

A port concession was granted to the Northern Development Corridor (CDN) in 2005. CDN directly manages the container sectors and manages sub-concessions for the petro-chemical and general cargo areas. Currently the port only receives about 200 ships per year but CDN is planning to continue renovating and upgrading the port to grow its capacity over the current 1 million tonne estimated annual capacity. The Nacala-Malawi-Moatize railroad line will greatly benefit Nacala port as it has the growth capacity for much larger operations than Beira or Maputo in the long run. U.S. companies are also in talks with Mozambique concerning a possible oil refinery to be built on the northern coast of the Bengo Bay at Nacala Velha.

Nacala Port (the municipal designation of the city) is a city located on a peninsula approximately 210 kilometres to the north-east of Nampula City, the capital of Nampula Province. Its 200,000 occupants live in 23 separate bairros (neighbourhoods). The city is divided into an upper bloc and a lower bloc divided by a steep hillside that falls into the downtown port area.

17 INSIDA, 2009

After Portuguese, the majority of the population speak Macua. Similar to Beira, there are no Nacala City statistics for HIV prevalence. Nampula Province has an overall HIV prevalence rate of 4.6 per cent but within urban zones of the Northern Provinces (Nampula, Niassa and Cabo Delgado) the prevalence rate rises to 9.9 per cent.[18]

Further INSIDA 2009 statistics on HIV and behaviour will be referenced in the section on data analysis as it allows us to compare the urban and general population behaviours with those of the port-users.

4.2 General overview of the port-user labour force

Although each port has its own management structure, the labour forces are similar and can be described in the following broad categories:

4.2.1 Contracted employees of the primary port operators

MPDC, Cornelder and CDN all hire between 300 and 800 employees and the bulk of each company's effective staff focus directly on daily operations and management. Jobs often include pilots, machinists, machine operators, mariners, internal transport, security, human resources and company administration managers. All three companies had comprehensive health care packages and legal contracts for their workers. Workers are skilled employees, often with specific long-term training acquired while working in the ports. In relation to their counterparts in the port, contracted employees are better educated, know more about HIV and other health issues and have the capacity to respond and seek treatment with ease.

4.2.2 Transport and dispatch personnel

Transporters and their dispatchers work as port-users, delivering and receiving containerized and general cargo for transport to local cities as well as long-distances. Specific companies have contracts with ports for access. Some local truck drivers also deliver and receive goods on one-time contracts for local businesses. The "Despachante" controls the paperwork with the cargo transit authority and controls the truck movement in and out of the port for his/her specific company. Truckers and despachantes earn a decent wage, though only some are on legal work contract.

Most long-haul truck drivers travel 5-7 days a week. Outside the ports, there is also a large group of "local transporters" that work only to deliver and receive containers destined for businesses in the port city. The majority of the "highly mobile" population in the port consists of truck drivers. Truck drivers often see their wives and family once a week, usually en route to a terminal destination. Distances to family homes vary depending on the port. Maputo's local truck drivers live near their place of operation, while corridor drivers – Maputo to South Africa – rarely stay in the country and generally do not stop for more than an hour or two at the port. Nacala truck drivers are either from Nacala or live in Nacala during the week, leaving their families in Nampula City or another town along the corridor roads. Beira truck drivers consistently described family bases 300-700 km away along the Beira corridor between the port and Zimbabwe or Malawi (Manica and Tete Provinces). In general, most South African (Maputo) long-haul drivers return home to South Africa each day while Beira and Nacala long-haul drivers rarely see their families.

18 INSIDA, 2009

4.2.3 *Temporary hires employed by licensed sub-operators*

Sometimes called "stevedores", although technically all port workers are stevedores, the bulk of the port employees are on temporary (day-labour) contracts with "stevedoring companies". These companies keep a roster of unemployed semi-skilled and unskilled workers. The workers arrive daily at specified locations and await the possibility that they will be given work, usually earning USD 3-4 per day. If they are selected, they receive material and uniforms. When they are not selected, they return home or await possible non-port day labour at another location. In Maputo and Beira there are several stevedoring companies. In Nacala, there is only one company licensed for stevedoring. "Stevedores" pay no taxes – often salaries fall below the legal tax minimum – they have no contracts and almost no job security. Although stevedores are covered in case of an accident, they are not considered effective hires (they describe themselves as "eventual") and thus receive no salary for days of work missed. Many are holdovers from retrenchment during the CFM privatization that occurred in the late 1990s and early 2000s.[19] Some private security guards may be in a similar position.

Roughly 50 per cent of the day labourers (stevedores) are migrants, but the majority are urban migrants. In most cases, they described coming to the city – sometimes 10-20 years before – in search of work and a better life. In Beira, there were also foreign Zimbabwean migrants that participated in the interviews, many of whom were only in the country for a few months before heading home. Considering that these workers operate in a serious "space of vulnerability" – both in their work conditions, job insecurity and the constant increase in new outsiders coming for jobs – the total population is in an extremely risky position, regardless of migrant status.

4.2.4 *Seafarers (sailors)*

Seafarers do not generally interact with the working port populations interviewed, except for landing and loading. Each shipping company has a shipping agent in the commercial district around the ports and takes care of transport, medical care and the needs of its seafaring employees. Human Resources and Safety and Security personnel at the ports explained that international shipping companies have established contacts with private hospitals and service providers (hotel, transport etc.) for the use of their employees. Further, as the shipping companies generally do not linger in the port and their employees are occupied when on the boats, no interviews were conducted directly with international seafarers.

4.2.5 *Commercial vendors and sex workers*

Although this study limited its scope to personnel and migrants working for companies directly involved in port operations, interviews illustrated a thriving market of various trades occurring amongst the populations located around the ports. As in all major port cities, the port is the primary commercial area and serves the needs of imports and exports. Around each port are small shops selling various food and non-food items. Wherever truckers congregate, there are often women and young men selling food and drinks from coolers in the parking area. During the daytime, sex workers

19 CFM publishes Xitimela Magazine to elaborate on privatization and company policies and actions. Publication no. 10 describes the "Rationalization of Labour" that occurred in 2001: http://www.cfm.co.mz/XITIMELA10.pdf

are not easily identifiable but truckers explained that when large numbers are forced to wait overnight outside the ports, sex workers will arrive to service the truckers. Also, many sex workers are linked specifically to the long-haul drivers, who often arrive with one or two sex workers in their cab. Several trucking companies also have truck parking areas outside the port area that the interviewers did not access. In most cases, though, these truckers talked about girlfriends (second wives, partners etc.) with whom they would stay after parking their vehicles.

IOM is currently conducting in-depth "hot spot" mapping of all three major transport corridors. The Beira Corridor mapping has shown the many sex workers link to truckers through phones, catch rides and/or stay with truckers as they pass through towns. Beira's hot spots include truck driver parking areas that fill up during the weekend and include sex workers arriving in town to service the drivers while they wait for ports to open and work to begin. The sex worker population includes a large number of Zimbabwean migrants who come to the cities to make general sales during the day and trade in sex by night.[20]

4.3 Migration and mobility in and around the ports:

As explained in detail below in section 6.1.1, there are several types of migrants in and around the ports. The largest group of migrants are "urban migrants". Large numbers of (mostly) men come to the port as economic migrants in search of "a better life".[21] Some retain their original family home, farming land and regularly visit.

Often these migrants are coming from within 200-300 kilometers (rural areas that feed into the closest urban zone). Other migrants have come to the urban zone and built homes and started families, leading to the assumption that they are unlikely to leave unless forced to through economic difficulties. Truckers and stevedores include the largest migrant populations. Stevedores tend to be among the most precarious of workers (that is no contracts, no minimum wage) therefore often can include foreign migrants from de-stabilized countries like Zimbabwe.

Truckers are more highly skilled labourers and thus often include people who live in foreign cities or neighbouring urban zones, passing to and from home during their weekly travels (particularly Malawians and Zambians). Port officials involved with human resources and health projects specifically mentioned the difficulty in reaching truckers as well as stevedores when working on health and HIV interventions because of their constant mobility and turnover in the ports. The ports, then, should be considered "spaces of vulnerability", where migrants, mobile workers and those with whom they interact should be targeted together rather than attempting to focus only on one sub-group. Further evidence of the importance of the workers' geographic location in a particular "vulnerable space" will be discussed in the analysis section.

4.4 Health-related challenges for port-users

Studying the HIV and health-related gaps and needs of port-users in Mozambique provides important insights into the particular health-related challenges of a semi-permanent but precarious and, often, migrant labour force. Findings from this study may have implications not only for the ports of Mozambique, but also for the health needs of other, similarly-situated

20 IOM Beira Corridor/Tete Corridor hot spot mapping. Taken from preliminary reports received by IOM Mozambique from KULA, the consulting agency in charge of the assessment.

21 This was a common quote from workers when asked why they came to the port.

workers in the three primary port cities – as the ports are an integral hub of economic activity affecting all sections of the commercial workforce. In fact, many of the results point to specific *geographic* differences in knowledge about health risks and opportunities available to workers. They do not point to specific differences between the migrant precarious workforce and the non-migrant, but just as precarious, workforce. Taken within the context of "spaces of vulnerability", as defined above, it is clear that the space/area of work around the port, in the highly movement-oriented urban port setting, exists in an environment prone to health and behaviour risks that may generate more vulnerability for a given labourer, regardless of his or her migrant status.

Further, this study can be used to understand the general urban migrant population in the three port cities. In Mozambique, current estimates show a 50 per cent urban population growth over five year periods (4% annual growth).[22] In this context, large numbers of persons moving into cities from rural areas should be considered internal migrants and could be included in projects focusing on migrant populations, health and HIV. Approximately 39 per cent of the migrants interviewed in this assessment could be categorized within the context of urban migration (see section 6.1.1 for a more detailed discussion of assessment definitions of migrants).

22 Case Study: Southern Africa – Population Dynamics and the Emerging Competition for Water Use in the Zambezi River Basin: http://www.aaas.org/international/ehn/waterpop/southaf.htm.

5. METHODOLOGY

As the section on Rationale indicates, this assessment was designed to target the migrants and workers that are considered "port-users". The scope was limited in order to design standardized material and questionnaires that could serve for all economic migrants that work in the ports while gathering information and perspectives from the people that serve and employ these workers.

5.1 One-on-one interviews

With respect to the port-users assessed, a team of three to five interviewers from IOM visited each port to conduct one-on-one, standardized survey interviews. Interviewees were selected at random with the assistance of the port authority and company management, while an effort was made to interview a selection of port-users that was consistent with job categories and gender distribution in the ports.

Because ports are constantly in motion, with ships and workers entering and leaving different areas and working on different shifts, the team focused on individual interviews rather than focus groups. Some small groups were interviewed to gain a better understanding of the work conditions – much of which appears in the section that describes the general job categories. But as the team worked with the close cooperation of the port operators it determined that individual interviews would take priority as they caused the least disruption to port functions.

A total of 165 individual survey interviews were conducted in the three ports (49 in Maputo Port, 60 in Beira Port and 56 in Nacala Port). Each survey interview lasted approximately 30-45 minutes. Surveys were conducted primarily in Portuguese, the official language of Mozambique, although in some cases English

was required for Zimbabwean and Malawian workers, particularly in the port of Beira. A minimum of two interviewers at all port locations were fluent in both Portuguese and English to facilitate the translation process.

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

- socio-demographic information
- migrant status, patterns of mobility and work history
- perceptions of health problems and health services in the area
- knowledge about HIV transmission, prevention and treatment
- sexual behaviour and condom use
- HIV testing.

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

The introductory section of the questionnaire included an opening statement providing background on the survey, statements assuring the interviewee of anonymity and a request for oral consent by the interviewee to participate in the study. A copy of the questionnaire is included in the annexures to this document.

5.2 Focus groups and focused group and organizational interviews

General interviews for this assessment were conducted with health care professionals, human resources managers, project staff (where possible) and port-users that work for various companies in, around and outside the port area.

In order to gather structural information about health services in the area, interviewers held directed conversations with health staff working in the ports. All three ports have an on-site emergency clinic with trained Ministry of Health staff. Clinical staff at the ports consult patients and direct them to proper care. Because they only work with port-users, they are in the best position to describe the overall effectiveness of different methods and issues they see amongst workers. The assessment occurred in large municipal areas and local clinic personnel were considered a better alternative to attempting to speak to staff at large hospitals that would not be able to give specific responses to questions about port-users.

At each site, the lead interviewer also made rapid assessments of further interview and discussion possibilities that could aid the overall information-gathering process. For instance, in Beira, as many workers explicitly discussed the impact of the local union, the lead interviewer met with union representatives in that city. Similarly, in Nacala, discrepancies in interviews and the local clinic take on health care provisions led the lead-interviewer to discuss directly with the Human Resources and Safety and Security managers to better understand the position of the operator and its role and capacity in regards to various worker benefits. Interview notes are provided where useful in annex documents, or in summary in the findings section.

5.3 A note on data intake and the limited size and scope of the study

It is important to note that in light of the numbers of port-users interviewed (165), the findings from this study may not in all cases be representative of information that would have been obtained about these issues from other port-users interviewed at different times in Mozambique. Moreover, questions regarding health issues and sexual behaviour in some cases are uncomfortable for interviewees and therefore may have led to inaccurate responses. However, given the intended use of the findings from this assessment — programmatic design and areas for implementation within these specific communities — the general trends and tendencies are considered to be useful and

represent the perspectives of the port-users that participated and will be participating in future projects.

INSIDA 2009 was published in early 2010 with statistics representing a larger sampling size in the general population for each province. Similarly, recent INSIDA statistics on prevalence were published that point to trends in risky behaviour in urban zones and the correlation between that risky behaviour and higher prevalence rates. Many of the results in this study demonstrate similar trends and, although the risk factors are greater within the ports, the geographic differences between the ports closely parallel those that appear in the INSIDA report, giving the consultants greater confidence in the final results. INSIDA 2009 is available online and at the Ministry of Health.

6. ASSESSMENT FINDINGS

6.1 Results of survey interviews with port-users

6.1.1 *Migrant demographics: definition*

The definition of "migrant": For the purposes of the assessment on migrants in the ports, the demographic results of those interviewed were divided into four categories:

Status	Definition
Status 0 Non-migrant	Born, raised and living in the port's local area or raised and living in the local area
Status 1 Migrant	Born and raised in another area of Mozambique but currently living in the port's local area (urban migrant)
Status 2 Migrant	Primary residence outside the port's local area but within Mozambique (domestic migratory port-user)
Status 3 Migrant	Primary residence outside the port's local area in a foreign country (foreign migratory port-user)

This process definition of "migrant" is consistent with IOM's definition of "migrants and mobile populations" for its work on HIV that includes "people who move from one place to another temporarily, seasonally or permanently for a host of voluntarily and/or involuntarily reasons".[23] Migrants made up 55 per cent of the survey respondents in this assessment.

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

For the general analysis of data captured during interviews, Status 0 represents the non-migrants and Status 1-3 represents the migrants. Each specific port has a difference in types of migrants. Below is a breakdown of the types of migrants in order to better understand migrant typology in the local geographic areas. For instance, Beira had the largest number of Status 2 and 3 migrants while Maputo and Nacala had almost no foreign-living port-users (interviewed).

6.1.2 *General migration demographics for the three ports*

Interviews	Maputo	Beira	Nacala	Total	%
Total interviews	49	60	56	165	100%
Status 1	21	15	29	65	39%
Status 2	05	07	05	17	10%
Status 3	00	08	00	8	5%
Total migrants	26	30	34	90	55%
Total non-migrants	23	30	22	75	45%

Beira has the most mobile population with 50 per cent of its migrant port-users living outside the Beira area, mostly at locations along the Beira corridor – specifically Chimoio and Tete cities in Mozambique, as well as Malawi and Zimbabwe. The majority of the mobile population in all three ports consists of truck drivers, but some unskilled day-labourers come from Zimbabwe and work for the stevedoring companies.

6.2 Various tables of port-user characteristics and narrative analysis

6.2.1 Demographic characteristics

Gender, education and family		Migrants	Non-migrants	All port-users
Gender	Male	98%	99%	98%
	Female	2%	1%	2%
Schooling*	None	0%	0%	0%
	<5th Grade	17%	5%	12%
	5th Grade	22%	19%	21%
	7th Grade	30%	33%	32%
	10th Grade	16%	31%	22%
	12th Grade	10%	7%	8%
	University	2%	5%	4%
	No response	1%	0%	1%
Marital status	Married	88%	89%	88%
	Single	12%	11%	12%
Do you live with your husband or wife?	Yes – here	76%	84%	79%
	Part-time	6%	3%	4%
	No	7%	5%	6%
	N/A	12%	8%	10%

* Please see http://www.sacmeq.org/education-mozambique.htm for a detailed explanation of the Mozambican education system.

Very few women work in the ports of Mozambique. Evidently, migrants are fairly similar demographically with non-migrants, although they are more likely to have a lower education level than their non-migrant counterparts and a slightly higher percentage do not live with their wives. Most migrants that do not live with their wives make up the Status 2 and 3 migrant categories.

6.2.2 *Work experience*

Time in the port, work conditions and discrimination		Migrants	Non-migrants	All port-users
How long have you worked here	< 1 year	19%	16%	18%
	1-2 years	18%	16%	17%
	2+ years	61%	68%	64%
Is this your first job?	Yes	21%	27%	24%
	No	79%	73%	76%

Time in the port, work conditions and discrimination		Migrants	Non-migrants	All port-users
Current Job Description	General Stevedore (loading)	33%	36%	35%
	Cargo Specialist	9%	13%	11%
	Verification (supervision)	7%	13%	10%
	Security	1%	3%	2%
	Trucking	40%	32%	36%
	Mariner	7%	1%	4%
	Other (Pilot/Diver/Mechanic)	3%	1%	2%
Do you have a contract?	Yes	29%	21%	25%
	No	71%	79%	75%
How are you paid (method of payment)?	Fixed Salary	58%	56%	57%
	Per Hour	1%	1%	1%
	Per Day	18%	12%	15%
	Per Trip (truckers) + Salary	3%	1%	2%
	Per Item (truck)	18%	29%	23%
	DNK	2%	0%	1%
Is it more difficult for migrants to find work here?	Yes	57%	49%	53%
	No	37%	43%	39%
	DNK / No answer	7%	8%	7%
Is there discrimination against migrants here?	Yes	18%	13%	16%
	No	72%	81%	76%
	DNK / No answer	10%	5%	8%

The bulk of all port-users have worked in the port area for over two years, although the majority of those interviewed do not have an official work contract. Truckers make up the largest migrant population and a slightly smaller percentage of migrants manage to find specialist positions within the port labour pool. During interviews, it became evident that any projects conducted within the port zone would need to take into account the obvious problems of contracts, or lack of contracts, as workers were quite verbal in their complaints about their treatment by various companies.

Although many workers described difficulties obtaining jobs, discrimination was not an obvious reason but most workers stated that finding work required a "patron" or a connection. In some cases, workers directly described the need to pay for a job posting – although most of these were the general stevedoring population describing the reason behind their lack of contracted positions.

The ports of Mozambique are currently undergoing a growth phase. Stevedoring companies can go days without labour for their workers, then reach a peak and require many labourers. This ebb and flow of labour requirements in the ports obviously contributes to the lack of permanent contracting from these sub-contracting companies. Migrants and non-migrants appear to have the same problems with finding contracted jobs and, likely, most urban migrants would fall into a category of semi-permanent labour without job security, benefits or a strong union to protect them. A short interview in Beira with the most active Stevedore Syndicate (union) is described below the health post and services summary.

6.2.3 *Mobility and the socio-economic environment*

While the definition of migrant sufficed, during the course of interviewing some port-users classified themselves slightly differently. The table below shows that about 21 per cent of migrants never return home, while 15 per cent of non-migrants do return to a home location. Often, the non-migrants are returning to a family or birth location or they have a family farm they tend away from the city. The migrants that do not return often have settled completely in the city and no longer have family to visit at their original home.

Migrant mobility, remittances and housing		Migrants	Non-migrants	All port-users
If migrant, how often return home?	Never / N/A	21%	84%	50%
	0.5x/year	8%	1%	5%
	1x/year	39%	8%	25%
	2x/year	2%	1%	2%
	3x/year	3%	0%	2%
	4x/year	9%	1%	5%
	12x/year (monthly)	9%	4%	7%
	48-52x/year (weekly)	9%	0%	5%
Do you send money home? Remittances? (Non-migrants also send to family in country.)	Yes	52%	33%	44%
	No	48%	67%	56%
If yes, how often send money?	Never	0%	0%	0%
	1x/year	8%	4%	6%
	2x/year	4%	1%	3%
	3x/year	1%	0%	1%
	4x/year	10%	3%	7%
	12x/year (monthly)	18%	23%	20%
	52x/year (weekly)	6%	0%	3%
	Upon request only	4%	1%	3%

Migrant mobility, remittances and housing		Migrants	Non-migrants	All port-users
Do you own or rent your housing in the local port location?	Own	48%	60%	54%
	Rent	40%	31%	36%
	Family/Friend	6%	9%	7%
	Sleep in truck (truckers)	6%	0%	3%
	Other	0%	0%	0%

The question of remittances was a touchy subject for many migrants. Often they looked sadly back at the interviewer and stated that they did not make enough money to return home or send money home. Some workers, particularly in Nacala and Beira, complained of making less than USD 12 per month on a regular basis. Most only return home on a yearly basis although they try to send funds home more often.

Almost 50 per cent of migrants have built or bought their own homes but they remain below their non-migrant counterparts in home-ownership. Similarly, although non-migrants live in family homes, their families are often their parents – an option for young workers. Migrants most often are living with cousins, uncles and family members in shared living quarters rather than with parents or direct siblings.

Although questions were asked about farming and excess income activities, over 60 per cent of all those that responded did not have a farm or any other income-generating activity. Likely, the urban nature of the port work limited farming possibilities. Similarly, the demands of daily industrial labour did not allow for workers to create businesses on the side that would generate additional income. Most truckers and contracted port employees earned USD 90 or more per month and therefore did not necessarily require additional income. The general day-labour stevedoring population earns very little and almost all would be described as living below the poverty line. In the context of Mozambique as a whole, this fits closely with the reality that over 50 per cent of the population currently lives below the poverty line.[24]

24 Report on Millenium Development Goals: Mozambique, 2005; http://planipolis.iiep.unesco.org/upload/Mozambique/Mozambique_Second_MDG_Report.pdf.

6.2.4 *General health environment perceptions*

Health concerns and services		Migrants	Non-migrants	All port-users
What are the major health concerns in this area? - all responses counted and added to category to show the incidence of repetition. Thus % will be the % of respondents to mention specific health problems in the community.	Malaria	64%	71%	67%
	Diarrhoea	2%	4%	3%
	Respiratory/asthma	10%	5%	8%
	HIV/AIDS	24%	25%	24%
	STD	3%	7%	5%
	TB	29%	32%	30%
	Cholera	3%	5%	4%
	Malnutrition	1%	5%	3%
	Job injuries	2%	9%	5%
	Sanitation/work hygiene	4%	4%	4%
	Headaches	2%	1%	2%
	Gen weakness	1%	7%	4%
	Other (hernia specific to Nacala)	8%	11%	9%
	DNK	3%	1%	2%
Where would you go in this area if you were feeling ill? (Some were multiple answers - thus over 100%)	Health post	28%	34%	31%
	Public hospital	54%	54%	54%
	Private clinic (work)	10%	8%	9%
	Traditional healer	0%	1%	1%
	Wait to return home	0%	1%	1%
	Purchase medicine	3%	1%	2%
	DNK or Never Used (N/A)	4%	3%	4%
	NR	0%	0%	0%

Port-users are fairly aware of the primary health issues of Mozambique (in the general population) and use the public hospitals and clinics as their primary care. Private services are often available within public hospitals and the workers for the major port operators had access to these services as a benefit provided by the employer.

In the general context of health access, the Mozambique free health system provides a basic level of care and treatment for most common diseases and the port-users, situated in an urban setting, have a variety of choices for levels of care at hospitals. Maputo has the largest selection of hospital options, but all port-users described their own health care options and preferences with ease. We can see that projects aimed at health care access would require training regarding options and an emphasis on personal responsibility to seek care and treatment, as all three locations have some of the best care available in Mozambique due to their urban settings.

Perceptions of care, quality and needs		Migrants	Non-migrants	All port-users
How would you rate the health services in this area?	Excellent	4%	3%	4%
	Good	26%	35%	30%
	Medium	19%	20%	20%
	Bad/weak	36%	32%	34%
	DNK/NR or N/A	15%	11%	13%
What would you change about the health system in this area?	Increase capacity/effectiveness	8%	15%	11%
	Better patient services (speed/care)	26%	34%	29%
	More medicine (shortage)	28%	16%	23%
	Provide health (more) facilities	9%	16%	12%
	More doctors/nurses	3%	9%	6%
	NR/DNK	29%	14%	22%
	Other	4%	11%	7%

Very few workers described the local health services as good or excellent. In Nacala, a large percentage of workers described a serious shortage of medicine. Many went to local nurses living in their neighbourhoods and purchased medicine directly. In Beira, the stevedore union supplied the day-labourers with a union card that allowed them to access up to USD 3 in medicine available at participating pharmacies through their membership benefits programme. (That was the only benefit.)

Many workers also pointed to corruption and lack of quality patient treatment in the hospitals. The most precarious of the stevedores constantly mentioned a lack of respect for the poor (themselves) and long lines in the hospital. They needed to pay money to the nurses in order to be seen and often the richer or more connected received care immediately while sick patients waited. Some even described watching people die in the waiting room as nurses dealt with less urgent patients who paid to be seen.

Companies that help workers have differing levels of success – usually determined by the size and power of the company. In general, the three port operators provide both urgent treatment and quality follow-up and transfer options for their contracted employees, often including private clinic access (Cornelder and MPDC) or dedicated medical staff (CDN). Some trucking companies have arrangements with hospitals to help their staff, though the best benefits were held by foreign, mostly Malawian, truckers. Although stevedoring companies sometimes claim to offer specific medical benefits, no stevedore considered their benefits useful and all protested that, even in the case of an accident, they would receive little follow-up, poor medical compensation and likely no longer have work with the company and no compensation for days missed.

6.2.5 *HIV/AIDS prevention, risk, behaviour and testing*

HIV prevention and risk perceptions		Migrants	Non-migrants	All port-users
How is HIV transmitted? (inaccurate responses mixed with correct appear twice)	Sex + 1 other method	80%	85%	82%
	Sex only	15%	14%	14%
	Sex not mentioned	1%	0%	1%
	Response includes false information (kissing etc. included in the response).	24%	26%	25%
	DNK	0%	0%	0%
How can people reduce their chances of contracting HIV?	Condoms only	43%	51%	47%
	Limit partners only	12%	9%	11%
	Condoms + lim part	31%	26%	29%
	Condoms + others	9%	11%	10%
	Abstinence only	0%	1%	1%
	DNK	6%	1%	4%
How often do you use condoms?	Always	30%	26%	28%
	Usually	1%	3%	2%
	Sometimes	17%	20%	18%
	Rarely/never	34%	26%	30%
	Always w GF; never w wife	18%	26%	21%
Reasons for not using condoms? (multiple answers are included)	Not concerned with partner/trust	51%	43%	47%
	Condoms not available	4%	4%	4%
	Reduces sensation	4%	9%	7%
	Desire children	12%	19%	15%
	Distrust condoms (give HIV)	3%	4%	4%
	NR/DNK or N/A	34%	34%	34%

Evidently, most port-users are aware of HIV and transmission prevention. But, at least 25 per cent of all the port-users hold inaccurate beliefs about transmission. Some ports had varying understandings but the differences between Migrants and Non-Migrants regarding perceptions were not statistically significant. On the other hand, as we can see below, the use of condoms was very different between port locations, with Maputo showing very little condom use in relation to Beira and Nacala.

Condom use divided by port location		Maputo	Beira	Nacala	All port-users
How often do you use condoms?	Always	11%	40%	30%	28%
	Usually	6%	0%	0%	2%
	Sometimes	28%	20%	9%	18%
	Rarely/never	30%	20%	41%	30%
	Always w GF; never w wife	26%	20%	20%	21%

Similarly, although migrant status did not seem to determine knowledge about HIV treatment options, those that came from Maputo were far more likely to know about treatment options.

Treatment knowledge by port location		Maputo	Beira	Nacala	All port-users
Have you heard of ARVs?	Yes	68%	43%	32%	47%
	No	32%	57%	68%	53%
Do you think ARVs are effective?	Yes	40%	28%	18%	28%
	No	13%	7%	9%	9%
	DNK	20%	7%	5%	12%
Do you know anybody on ARVs?	Yes	38%	18%	18%	24%
	No	45%	23%	23%	29%
Are ARVs available in this area?	Yes	43%	25%	21%	29%
	No	17%	8%	21%	15%
	DNK	21%	8%	11%	13%
Are ARVs free in this area?	Yes	30%	18%	18%	21%
	No	4%	3%	4%	4%
	DNK	28%	7%	5%	12%

Likely, the number of hospital options and media campaigns that occur in Maputo help disseminate information about HIV treatment. Being a large metropolitan city, Maputo may also have reduced stigma attached to HIV status and treatment and open discussion thereof.

The most interesting results for migrant status and location were seen in HIV testing. Below are the results of HIV testing and when it occurred, first by status and then by port location. Migrants were less likely to have taken an HIV test.

HIV testing divided by migrant status		Migrants	Non-migrants	All port-users
Have you taken an HIV test?	Yes	56%	70%	63%
	No	43%	30%	37%
	No Answer	1%	0%	1%
If yes, when was your last test?	< One month	2%	1%	2%
	1-3 months	11%	16%	13%
	3-6 months	15%	15%	15%
	6-12 months	16%	14%	15%
	> 12 months	12%	23%	17%

Cornelder has an aggressive HIV-testing project that works with port-users and, considering the treatment knowledge gap between Beira and Maputo, we can see that their programme is working to push port-users to test. The Cornelder

"Health Port" project, described as a case-study in Section 8, included mobile testing in the port and at the offices of port-user sub-contracting companies, including trucking and stevedoring companies.

HIV testing divided by port location		Maputo	Beira	Nacala	All port-users
Have you taken an HIV test?	Yes	62%	75%	50%	63%
	No	38%	23%	50%	37%
	No answer	0%	2%	0%	1%
If yes, did you collect the results of the test yourself?	Yes	60%	73%	48%	61%
	No	2%	2%	2%	2%
If yes, when was your last test?	< One month	0%	3%	2%	2%
	1-3 months	10%	13%	14%	13%
	3-6 months	18%	13%	9%	15%
	6-12 months	10%	20%	11%	15%
	> 12 months	8%	25%	14%	17%

Unfortunately, the actual gap between migrants and non-migrants in Beira is similar to the gap shown throughout the ports in the previous table (67% to 83% respectively). On the other hand, the testing gap does not appear in Maputo, where migrants are even more likely to be tested than non-migrants (64% to 59% respectively). These discrepancies in the data show that any project should take into account the location and geography of the migrant population and not assume that migrants will need the same programming options in all three ports. That is, each "space of vulnerability" should be analyzed separately and all port-users integrated into the interventions and project designs.

Looking at the general population surveys in the recent INSIDA report published by the Ministry of Health, it shows that port-users are more likely to have tested for HIV. According to the report, approximately 27.7 per cent of urban respondents claimed to have been tested before and about 15.9 per cent had been tested in the last twelve months.[25] In contrast, amongst the port-users, 63 per cent claimed to have been tested before and 45 per cent within the last twelve months.

Similarly, the sexual behaviour differences were far more pronounced through regional differences than through migrant status differences.

We can see a 21 per cent difference in reported multiple sexual partners amongst the port-users of Maputo in relation to those of Nacala. The religion (Islam), and fairly recent urbanizing of the population of Nacala, likely accounts for the difference. On the other hand, we see very little variation in the behaviour responses between migrants and non-migrants. In fact, a larger percentage of migrants claim to have only 1 sexual partner (48% to 41% of non-migrants).

25 Inquerito Nacional de Prevalência, Riscos Comportamentais e Inforamação sobre HIV e SIDA em Moçambique – INSIDA 2009: Relatório Preliminar Sem Dados de Prevalência, Ministry of Health: National Institute for Health, http://www.misau.gov.mz/pt/hiv_sida, Page 43.

Interestingly, in all cases, port-users show relatively higher rates of multiple partners than the provincial average. The recent INSIDA report, published in draft form in 2010, shows the following data for the provinces of Maputo City, Sofala and Nampula (the provinces in which this assessment occured):

Two or more sexual partners in last 12 months		Maputo	Sofala	Nampula	General urban population
% of men responding affirmatively to having 2 or more partners in the last 12 months	INSIDA Report*	35.9%	9.5%	25.1%	22.4%
	IOM Port-User Assessment	61%	54%	46%	54%
	Variance Port-users to general Population	+ 25.1%	+ 44.5%	+ 20.9%	+ 31.6%

* Ibid, Page 39.

The general data above shows a pronounced difference between the port user behaviour risk and the general population. This shows that the "spaces of vulnerability" understanding of increased risk to both migrants and non-migrants is a very important factor in understanding the epidemic.

One obvious cause of the above results, is the money and transactions occurring daily at the ports. Several truck drivers in Maputo actually complained of the frequency with which female sex workers arrived at night to service the truck drivers, attempting to put the blame on the sex workers.

IOM plans to complete "Hot Spot" mapping of the transport corridors terminating in the three major ports. The study and resulting reports will include more detailed and specific questions oriented towards the commercial sex workers, not included in this assessment. Preliminary progress on the 2009-2010 Beira Corridor study, show that about 50 per cent of sex workers in Beira are from Zimbabwe, with the majority of transactions occurring on the weekends including travel to and from the ports.

If we do a similar analysis as above, concerning payment for sex in the port population and within the general population (INSIDA), we again find very different results between the general population and the port-users.

Payment for sex		Maputo	Sofala	Nampula	General urban population
% of men responding affirmatively to paying for sex	INSIDA report[3] *(in the last 12 months)*	7.9%	1.6%	12.6%	8.5%
	IOM port-user assessment	21%	30%	39%	31%
	Variance port-users to general population	+ 13.1%	+ 28.4%	+ 26.4%	+ 22.5%

As indicated above, there is a slight discrepancy in the questions asked. The current assessment did not focus on the last 12 months and that may account for some of the differences in responses. Still, we can see a clear increase in risky behaviour when looking at the port-user population in relation to their provincial and urban counterparts.

Overall, knowledge and testing amongst port-users seems to be relatively high in relation to the national average while behaviour tends to be more risky. This data is extremely important in the context of the generalized epidemic in Mozambique. Elizabeth Pisani, one of the world's leading HIV epidemiologists, points out that "eventually, risk will always translate into HIV infection". Namely, "we know:

- Where a significant proportion of men buy sex from professional sex workers and condom use is low, a heterosexual epidemic will eventually begin. HIV will initially be concentrated among professional sex workers with high client turnover and the men that buy sex from them.

- Infection will be passed on to the regular partners of clients of sex workers, with whom condom use is very low. This puts infants at risk, too."[26]

In the context of Mozambique, it is accepted that a generalized epidemic is underway. Judging by the risk variance between the port-user population and the general urban population data shown above, we can estimate that the port-user population is likely to have a much higher prevalence of HIV than the general population, even the general urban population. Any project designed to address HIV amongst port-users will require a strong focus on behaviour change in sexual practices.

6.3 Summary of health context for port-users

IOM believes that migration health goes beyond the traditional management of diseases among mobile populations and looks at the broader social determinants of health, such as legal status, housing, education, occupational health, nutrition and food security, environmental conditions and water and sanitation. Consequently this assessment looked not only at the access to medical services but also at some of the social determinants of health.

6.3.1 Summary of health services available to port-users:

The ports are located in major urban centres and thus port-users have access to general hospitals and the best care the public health system has to offer. In Maputo and Beira, port-users often mentioned the Central Hospitals and the Military Hospital (Maputo only) as their primary care locations. In Nacala, which is not the provincial capital of Nampula, port-users described decent, but limited, care that sometimes required transfers to the Nampula Central Hospital in Nampula City. No specific hospitals could be singled out as primary port clinics as the port-users generally go to the local hospital nearest their home when seeking long-term treatment.

Each port has an urgent and first-aid clinic and all ports had ambulances for urgent transfers to the central or general hospital. Stevedores and contracted port employees have access to the first aid clinics, while the truck drivers are covered (or not) by their transport company employers. Seafarers can receive immediate urgent care if necessary, but all are covered directly by agents that control their accommodation, transport and medical needs when in the port.

The urgent and first-aid clinics provide consultations for diseases and transfer documentation to the appropriate hospitals and clinics. All had Ministry of Health approved staff and Nacala had a doctor that visited three times a week for consults. Truck drivers are not contracted and stay a very short time in

26 Pisani, Elizabeth, *The Epidemiology of HIV at the start of the 21st Century: Reviewing the Evidence*, Unicef, September 2003, page 25-26.

the port. For this reason, few had any health care access at the port and the majority received their care on their own time in the public hospitals.

Although the first-aid clinics do not provide medication other than paracetemol and aspirin, they provide a necessary service through consultation. Clinics can identify problems (Sexually Transmitted Infections (STIs), respiratory diseases etc.) and send them to appropriate medical staff in the central/city hospitals thus skipping the need to see a nurse at the hospital first. Many workers described going to the clinics and a transfer process for care in the general hospital that allowed them to seek care. The primary port operators (MPDC, Cornelder and CDN) provide excellent care for their staff including transfer and coverage at private or privatized clinics. Health options offered to direct hires depend on the capacity of the health system in the area – Nacala being the weakest. Cornelder, for instance, offers 100 per cent health coverage to its staff and 85 per cent coverage for all immediate family members at a private clinic attached to the Beira Central Hospital. Lacking a private clinic in Nacala, CDN pays the salary of a doctor who works at the Nacala General Hospital and treats all CDN employees immediately and charges the services to CDN.

In discussion with the health staff, many felt that workers were treated well although concern was expressed about safety and hygiene for day labourers in both Beira and Nacala. Some health professionals identified statistics concerning sexually transmitted diseases but the trend in knowledge and data collection was limited and different at each port making it difficult to give comparative information. The health professionals do not distinguish between migrants or non-migrants and most of their case-load consists of urgent treatment and basic headaches and pains. Most workers deal with their long-term health care at various different hospitals and on their own time.

The health system of Mozambique provides comprehensive care for the majority of health issues mentioned. Specifically, HIV testing, care and treatment is free in Mozambique although it requires travel to a hospital every 15 days at the start of treatment. In urban settings, like the ports, this requirement is not a problem. The few port-users that knew about treatment, or admitted openly to being on treatment themselves, described good relationships with their doctors and found they received transfer documentation easily or larger dosages of their medicines when travelling long distances.[27]

6.3.2 Access to housing:

Migrant workers are about 10 per cent less likely to own their homes. As stated in the above analysis section, urban migrants often described moving to the city to live with family members (e.g. cousins, aunts, uncles) in the process of finding work and "a better life". Further, these same migrants, even as they move into rented or self-built homes, often take on further family members from their sending community who move in with them for similar reasons. This study did not delve into housing typologies or specific ownership issues (for example, land rights) but we can presume that many "owned" homes, of migrants and non-migrants alike, are not built to an urban code or with conventional materials. Based on the

27 WHO publishes a country profile assessment on Mozambique's Health System that gives further details about policies and guidelines in development and existent: http://www.who.int/countries/moz/areas/health_system/en/index.html.

low salaries of about 50 per cent of port-users, most likely live in housing made from local materials.

Although Mozambique does have specific urban codes and urban policies, it lacks a national housing plan. Further, urban codes distinguish only between "conventional housing" – cement block and tin, or apartments – and "precarious housing" – traditional adobe, reed and/or thatch constructions. Housing terms such as "transitional housing" are not developed in the Mozambican code. Due to the nationalization of land in Mozambique, very few Mozambicans in general own land. Although the nationalization of apartment buildings in urban zones helped supply housing to current urban dwellers in the 1970s and 1980s, the urban migrants arrived too recently to have been beneficiaries of these policies. Thus few, if any, migrants covered by this study lived in conventional urban housing and apartment buildings.

If, and when, a housing policy begins development in earnest, IOM should take an interest in increasing definitions and options for urban migrants and persons in transition and mobile situations.

6.3.3 *Education levels:*

The average migrant port-user is about two grades behind his or her non-migrant counterpart. Presumably, migrants come from the more rural zones to the urban zone and some even mentioned education as a reason for their move. In Mozambique, secondary schools exist in some urban zones, but often 8-12th grades are relegated to urbanizing areas with larger populations. Mozambique has night school classes available in secondary schools for adults' continuing education. The fees are reasonable but still may not be accessible to the general stevedore population (enrolment costs are above the average stevedore monthly earnings). Considering their familial responsibilities, few would choose to go back to school in favour of their children. Truck drivers, on the other hand, cannot take advantage of night school due to their constant movement in and out of cities.

Contracted workers in the ports had the highest education levels. Similarly, contracted port employees received on-the-job training and regular re-training. Although the general education opportunities could be extended to help the general stevedoring and day-labouring population, they would benefit even more from port-oriented training that increased their value to the ports.

A day-labourer (non-contracted) in Nacala described a training he received from the employer that allowed him to become a "conferente" (verification of containers) and led to his being employed regularly for six days a week. He thus received approximately USD 80 a month, a salary equivalent to a teacher in Mozambique. Clearly, increased value through education could benefit many of the current day-labourers. Further, as the Mozambican ports are undertaking a growth phase, directed education for the current port employees could benefit the port operators as well.

6.3.4 *Occupational health issues:*

Each port has different standards for occupational safety. Maputo port kept the highest standard, in which no port-users (including the interviewers) could be present without boots, reflective jackets and hard-hats. Most port-users in the three ports kept to this standard. But in Beira and Nacala the team noticed day-labourers in sandals and without some basic safety gear. The general stevedores also described loading activities with cement and fertilizers

where they did not receive and/or use masks to protect themselves. Often, respiratory illnesses were highlighted in the health sections of the interviews, and the medical staff mentioned similar concerns. Port operators could, and should, be pressured to ensure that their sub-concessions and sub-contracted employees are all covered and required to keep to the same safety standards as their direct hires. A further discussion of the differences in health care between direct hires and non-contracted hires, as well as truckers' health care, is discussed above in section 6.3.1.

Non-contracted stevedores described similar concerns with post-accident follow-up in terms of health care. Although the port operators fund capable first-aid care and provide ambulances to the hospitals, their sub-contracted companies do not provide the same follow-up with their employees after the initial care occurs. Stevedores also do not receive payment for days lost due to injury, increasing the likelihood of their working while injured and/or not reporting injury to a supervisor. Further occupational health and safety issues are described below in the case study of the stevedore union in Beira (Section 6.4).

6.3.5 Access to water and sanitation:

The Mozambican government has made great strides towards providing water and sanitation over the past few years. FIPAG, a privatized water company, is currently increasing water access throughout the country, in particular to urban and urbanizing zones that include Maputo and Beira. Nacala has not yet been reached. Currently 76 per cent of urban dwellers have access to clean drinking water while 47 per cent have access to sewer or closed-defecation systems.[28] This study did not include direct questions regarding each individual's access to water or sanitation.

6.4 Case study: Stevedore union – Beira City

Few workers mentioned the stevedore union (SINPEOC-Sindicato Nacional dos professionais de estiva e oficios correlativos) in relation to their work conditions and salaries. But, in Beira, the general stevedores (those working for Xigolo) that worked on a day-labour contract all specifically pointed to the limited but real benefits the union provided. Thus the team conducted a short interview with the provincial director of SINPEOC, working under the Mozambican Workers' Organization (OTM). OTM is a FRELIMO-sponsored (ruling political party) umbrella organization with specific labour unions participating under its sponsorship.

SINPEOC is headed by a national secretary, Alexandre Ibrahim, and made up of a national board of directors. Each province is headed by a provincial secretary elected by an assembly of workers paying dues and participating in the union. In Beira the team interviewed the provincial secretary, Pascaol Heriques Lourenço, to specifically discuss the union functions, difficulties and long-term plans in relation to the workers.

It is interesting to note that although we talk about "stevedores" in the context of day-labourers in this assessment, all persons working in the port – be they machinists, mariners[29], internal drivers or day labourers – are considered stevedores. But SINPEOC is not the only option as workers are also allowed to form internal unions. We discovered the work of SINPEOC through the workers of Xigolo that requires all its employees to pay 1 per cent of their salaries per month. Xigolo could thus

28 WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation: March 2010; wssinfo.org.

29 Marine operators that guide and work with ships at the docks.

be considered a “closed shop”. The majority of stevedoring companies are “open shops” with no union requirement. Xigolo was started with the support of SINPEOC and so retains a permanent affiliation.

The majority of day-labourers make USD 9-20 per month. This means USD 0.09-0.20 monthly payments to fund the union. SINPEOC is thus an extremely weak organization. The union itself lacks a telephone and any of the modern resources needed to fight legal battles. But, according to the provincial secretary, they continue to deal with specific cases (the bulk of their work) and attempt to grow their workers’ base.

The stated mission/objectives of the union are as follows: (1) Defend the interests of workers; (2) Promote the interests of the worker; (3) Defend workers’ rights; (4) Defend specific cases for workers and (5) Negotiate salaries and correct payment of salaries for workers. Participating companies have an internal union committee that refers cases and negotiations to SINPEOC.

SINPEOC mentioned the following as its (and its members) primary concerns in the ports [translated]:

1) Work accident protection (occupational safety and post-accident and injury care)

2) Work security (contracts and long-term security)

3) Payment of salary

4) Hours of work without compensation.

In discussing success in addressing the above concerns, the tone was pessimistic. Although laws protect workers and their safety, few companies have complied and negotiations often led to promises that were never fulfilled. As witnessed by the interviewers, port companies followed different standards of safety regulations depending on the port operators’ regulations and each company’s individual compliance standards. In Maputo, for instance, safety standards were the strictest but in Beira there were day-labourers working without boots or gloves when loading and unloading materials. The issue of payment for day-labourers was primarily defined by lack of work and waiting, as few workers received enough days of labour to concern themselves with overtime.

Although SINPEOC had very few successes, and explained their financial and legal difficulties in winning battles for workers, they had focused on providing a health care option for the day-labourers that showed creativity and a desire to succeed. SINPEOC created a union card and signed contracts with local pharmacies that allowed union member day-labourers, not covered under any company health plan, to receive up to USD 3.00 worth of medicine per month when in need. This was obviously a prized benefit to the workers as each mentioned it specifically when discussing their health care options. Although imperfect – many workers mentioned the limitations of the amount – considering the reality of salaries and dues paid to the union, this insurance-like medicine scheme was one of the few successes the interviewers discovered in relation to workers’ rights for the lowest level of port workers. Future projects could follow similar possibilities and look to help SINPEOC grow and succeed in workers’ rights and protection.

7. CONCLUSIONS AND RECOMMENDATIONS

The analysis above gives us a broad picture of the port-user experience, knowledge and access to health care facilities, risk-behaviour and other social determinants of health. Although project design for health and HIV interventions in the ports should take into account specific geographic areas and the specific ports and their needs, there are several general issues that come up amongst all the port-users that should be included in future projects in the ports.

7.1 Conclusion 1: Lack of contracts and job security lead to real risk for port-users

Although the large operators provide comprehensive benefits and contracts to their direct-hires, 75 per cent of all port-users do not have any form of contract agreement with their employers. This leads to two very important structural problems that put port-users at risk.

Firstly, truck drivers that do not have contracts often will live in the port area but do not bring their families with them to the port. Many of the Nacala truck drivers, for instance, described moving to Nacala port to live during the weekdays while leaving their wives and children at home in Nampula city. The same drivers often openly lived with girlfriends in Nacala and admitted to using condoms only when straying away from both their girlfriend and their wife. Further, living with a girlfriend reduces the need for renting a house and allows the driver to save money. Without a contract that ensures a permanent place at a company, it is unlikely these workers will ever move their families with them to Nacala.

Secondly, the stevedores are often living in a worse situation, receiving an extremely low income without any job security. Not only does the absolute poverty of the stevedores create risks for their health – through malnutrition, willingness to disregard safety rules and other factors – but it also puts their entire family at risk for participating in transactional sex in order to survive. Although this assessment did not address the wives and children of the port-users, we can assume that families attempting to live on less than USD 12 a month are more likely to engage in transactional sex in order to provide food for the family. The problem is exacerbated by families not knowing if their breadwinner will even be working and receiving any income in the future.

The migrant as well as the spouse back home are vulnerable to HIV infection

Research undertaken in migrant-sending areas in the KwaZulu Natal province of South Africa and rural Tanzania has compared "*migrant couples"* in which one of the partners migrates for work, with "*non-migrant couples*". The results indicate that it is not always the returning migrant men who are infecting their rural spouse. Migrant couples were more likely than non-migrant couples to have one or both partners infected with HIV (35% versus 19%) and to be HIV discordant (27% versus 15%) – meaning that one partner is infected and the other is not. It has long been assumed that it is returning migrant men who are infecting their rural partners. This research found that among HIV discordant couples, 30 per cent of the time it is the woman who is HIV-positive and her migrant partner who is negative. Clearly, an HIV-positive woman whose migrant husband is not infected must have been infected by someone else.

From: Lurie, M. Who Infects Whom? HIV-1 Concordance and Discordance among Migrant and non-Migrant Couples in South Africa, 2003.

7.1.1 *Recommendation 1: Address job security, contracts and income generation/augmentation in projects targeting port populations.*

Possible options for addressing job security would be the following:

- Partnership with the International Labour Organization in port projects.
- Direct assistance and capacity building for the stevedore union (SINPEOC: Sindicato Nacional dos professionais de estiva e oficios correlativos) – currently SINPEOC only manages to help the more fortunate workers of the major port operators.
- Partnership and capacity building for the provincial directorates of the Ministry of Labour and the responsible personnel in each city and port area.
- Innovative insurance and financial savings and loan options for non-contracted stevedores to provide increased financial safety nets in case of injury and/or job loss.
- Partnership with income-generation-focused NGOs to help workers organize for increased non-port income options during low seasons where few vessels are arriving at the ports.
- Capacity building and advocacy with stevedore contracting companies to increase transparency and information access for day-labourers to enable them to predict monthly incomes and know when, and if, they will be working – allowing them to better assess their needs and find other work during low periods.

7.2 Conclusion 2: Public-Private Partnership (PPP) campaigns work and should be continued

Looking at the variance between Beira and the other two ports, we can see a striking increase in the testing numbers for Beira. As described in Section 8, Cornelder and GTZ formed a public-private partnership to address HIV in the port areas. Although the general statistics by province show that Maputo city has the strongest HIV testing culture, 39 per cent against Sofala's 24.7 per cent, the port-users of Beira were 13 per cent more likely to have been tested than their counterparts in Maputo and 25 per cent more likely than their counterparts in Nacala. This shows that when companies take initiative and focus on a specific problem they can achieve success.

Further, the workers of MPDC, Cornelder and CDN represent a viable volunteer/activist force for change in the ports. Being the highest educated and well paid, they can and do take an interest in changing the environment around them. The Cornelder Healthy Port project organically grew out of a worker-built coalition that was supported by the Cornelder human resources department. Projects should take advantage of the educated and stable workers in the ports to help address issues for their counterparts, with whom they are in daily contact.

7.2.1 *Recommendation 2a: Continue and increase PPP HIV and health campaigns in the port areas to use the workforce and capacity of the companies to reach their workers*

Several activities should begin immediately to directly increase the PPP campaigns and their effectiveness in the ports:

- Hold a countrywide conference on PPP projects with representatives

from port-user companies and their workers to discuss project options and learn from the experiences of the past PPP projects conducted by the large-port operators (Cornelder and CDN).

- Establish clear guidelines and agreement letters between IOM and the various companies to agree to objectives and funding capabilities of each organization.

- Take immediate action to establish future project options with Cornelder's Healthy Port project including funding and project expansion for the year 2011 (project funds will terminate in 2010).

- Meet with Ministry of Health officials and technical NGO partners in each city to ensure that PPP projects include them as partners and address each agency's long-term goals in the city.

- Increase publicity to PPP projects through radio and newspapers to help companies earn respect and good publicity for the projects they are undertaking currently and stimulate the interests of non-participating companies to seek out partnerships.

7.2.2 Recommendation 2b: Take a direct interest in training and capacity building for the workers of the large port operators to help them build projects that address their health needs and the needs of their colleagues

- Seek out and directly support organic associations of workers already addressing HIV, health and any other activities in the workplace.

- Study and understand workers' limits and capacities to provide training and design projects that do not overburden the volunteer workforce.

- Create agreements with the companies that allow for limited compensation when workers spend large quantities of time volunteering for PPP projects.

- Develop and promote a social and behavioural change programme that addresses local concerns and vulnerabilities.

- Train workers with new tools on social and behavioural change activities and life skills (with specific tools on gender and internal family units) to enable them to use these tools amongst their colleagues and the community to attain higher levels of success.

- Celebrate and publicize successes of projects with workers at the fore to create positive feedback and increased interest in worker-run projects.

7.3 Conclusion 3: Port-users practice risky sexual behaviour

Specific ports have different risk patterns but all port-users practice risky sexual behaviour in far greater numbers than the general population. This is extremely important for Nacala, in particular, that operates in a low-prevalence are of Mozambique (about 8%) but will see increases in movement and a rise in HIV prevalence if the risky behaviour is not reversed. In all cases, a change in behaviour – specifically to reduce the number of partners and increase condom use – will cause a reduction in the HIV prevalence amongst port-users.

Behaviour change is a difficult subject as the views on how to change behaviour are varied. As the first recommendation points out, there are definite structural problems to reducing risky

behaviour. UNAIDS and others consider that in order to promote behaviour change contextual and other factors have to be considered and included.[30] The Declaration of Shared Principles at the recent high level dialogue on universal access in southern and eastern Africa included:

> Champion a movement for social change by engaging with communities and challenging social exclusion, inequality and other factors that currently increase people's vulnerability to infection.

Specifically, any project must integrate HIV/AIDS knowledge and life skills (attitudes, decision-making and planning skills).[31] The recent INSIDA 2009 report shows that neither information access nor economic position will suffice to reduce risk. In fact, amongst the Mozambican population, the higher one's income, the likelier one is to be HIV positive. The richest fifth of the Mozambican population has an estimated prevalence of 17.4 per cent amongst those between 15-49 years of age. The lowest fifth of the population has a corresponding estimated prevalence of only 6.0 per cent.[32]

30 UNAIDS high level dialogue on universal access in southern and eastern Africa (London 9 March 2010). A Declaration of Shared Principles

31 "Life skills" is defined as training courses (there are various that already exist) that focus on decision-making, role-play and long-term life planning that allow for participants to hold a clearer picture of their goals, the ways to achieve those goals and the pitfalls to avoid. They integrate information and attitude and skills building to more effectively address behaviour change amongst participants. For a non-IOM example of HIV and AIDS life skills training, see http://www.unicef.org/lifeskills/index_hiv_aids.html. IOM has published a similar life skills training manual focused on gender and HIV amongst migrants: iom.org/za.

32 INSIDA 2009

7.3.1 Recommendation 3a: Increase availability of capacity building and recreational activities for port-users and their families

Although Cornelder recently began training with families and social groups, most projects have focused on knowledge and testing as the primary activities for HIV prevention, care and treatment. The following options should be considered in port-user oriented projects:

- Life skills training courses for port-users (oriented towards male head of household);
- Life skills training courses for families of port-users, specifically focusing on women and children (families of workers);
- Increase recreational activities linked to HIV and health training (e.g. football clubs, children and family theatre clubs, group events and music events);
- Partner with port companies to provide job skills courses focused on port needs that will increase the value of non-contracted labourers and give them a better chance to find permanent port jobs as the ports grow over the next decade – similarly it will give them a positive activity on which to focus their time and efforts;
- Partner with NGOs to provide savings and loan programmes as well as non-port job training activities for families and workers with little constant labour at the ports – this will support constructive uses for workers' incomes;
- Partner with the government and/or NGOs to provide literacy programmes to families and uneducated workers as well as

additional schooling for those with less than 7th grade education.

In general, workers and their families, particularly the day-labourers, would benefit greatly from an increase in positive activities that give them options and more control over their labour situation and after-hours recreation.

7.3.2 *Recommendation 3b: Design targeted campaigns to address specific risk points for port-users, sex workers and families*

Project designers and company representatives should acknowledge openly the high-risk activities going on amongst the port-users and begin discussing ways to curb the risks and change port-user behaviour. Campaigns to consider include:

- Campaigns that target sex-workers at the site where most truck drivers meet them on a nightly basis – preferably with trained truck drivers and sex workers that initiate trainings and follow-up activities with their colleagues;

- Increase the free access to condoms and identify specific locations around the port and port serving commercial areas where condoms should be easily accessible and promote consistent and correct condom usage (and address myths around condoms);

- Campaigns that focus on the partners of port-users to increase women's understanding of their rights and the importance of limiting risky behaviour for their households;

- Promote improved health-seeking behaviour amongst men through capacity building and social change through:

  – Capacity building and action that focuses on coalitions of workers to change or curb the risky behaviour amongst themselves and their colleagues;

  – Partnerships with churches and other organic institutes that naturally focus on behaviour change and may have greater success than NGOs or INGOs in convincing workers to change (many of those that claimed they only had one partner gave religion as a primary reason for not "playing around").

7.4 Current IOM Migration Health Framework tools for recommended interventions

IOM's Migration Health Framework, described above in section 2.1, can provide several tools and project designs that will fit squarely with the recommendations and provide a clear path forward towards project design and development in the ports of Mozambique:

- Partnership approach and a focus on service delivery and capacity building: given the number of possible public-private initiatives, along with IOM's commitment to a multi-sectoral approach to migrant health, including both governmental and non-governmental partners, IOM is positioned well to link the various partners into a holistic programme that addresses the structure and environment that creates risks for port-users, along with individual behaviour change for each participant.

- IOM has developed a strong social change communications capacity, building capacity of local peer educators and facilitating regular dialogue on issues directly relevant to the target group. Supporting this

"bottom up" approach to social change could include engagement with multi-media approaches including radio. A port-focused social change communication project could use IOMs established links with radio programming for increased media attention on good partner practices (e.g. Cornelder) as well as being a tool for reinforcing the locally driven and developed messages related to behaviour change.

- The PHAMSA project model, with its focus on peer education and referral, gender-specific tools (e.g. "One Man Can"), recreation and life-skills and the importance of health care services and product access, can be applied directly to the needs of the ports. In particular, the model is specifically designed to address the recommendations for behaviour change amongst port-users within the ports' "spaces of vulnerability", empowering them to tackle HIV in their workplaces and increasing port-users access to, and stimulus to use, the health care systems available in their urban zones.

8. CORNELDER "HEALTHY PORT" PUBLIC PRIVATE PARTNERSHIP – A CASE STUDY

Twenty Cornelder employees formed a volunteer association in 2005 to increase awareness about HIV/AIDS and to fight stigma against HIV-positive colleagues in the workplace. With no funds or specific training, the workers sought out training manuals and videos focused on HIV stigma, and started holding informal discussions and film events. The human resources department agreed to give them space in their training rooms and soon the group increased activities, starting a theatre group and formal discussions at various port locations.

Over the course of two years, the programme gained strength and the direct support of Cornelder's management. Noticing that many port-users, not employed by the organization, were joining discussions and requesting opportunities to participate, the association and the human resources department began planning an expansion of project activities. In 2007, Cornelder formed the "Healthy Port" project management team, including a project manager to directly oversee project outputs and began negotiations to receive partial funding for a three-year project with Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)[33] to address HIV globally in the port of Beira. The company attempted to acquire donations from partnering businesses in the ports, but in the end, funded 60 per cent of the project (GTZ funded the other 40%).

Healthy Port[34] focuses on training port-users about HIV and increasing volunteer testing. In 2008, 1 200 port-users tested for HIV, including workers from 12 companies outside Cornelder. Although participating companies did not directly fund the programme, they appointed "focal points" to communicate directly with the Healthy Ports committee that leads the project implementation. With the initial success, another 14 companies participated in 2009, bringing the total participation to 26 port-user companies

33 GTZ is a German, federally owned, development organization. Its mandate is to support the German government in achieving its development objectives. Official website: http://www.gtz.de/en/index.htm

34 Healthy Port website: http://www.portosaudavelbeira.org/

alongside Cornelder. That year, over 5 000 port-users and port-user family members were tested for HIV. Additionally, 116 young men were circumcised by the local hospital, and hundreds of Cornelder family members participated in women's health training that occurred in various training centres around the city. The project is funded until the end of 2010.

"We started the project five years ago, in 2005, during a time when the government started talking about HIV and the need for workers of companies to take an interest in activism and social responsibility," Diogo, one of the founding members, said. "Our nucleo [committee] began by giving talks to other workers about stigma. We asked for videos about workplace stigma and showed them. Then we created a theatre group to show people about HIV risks and how HIV-positive workers were not a risk to us."

In interviews with the project manager and one of the founding members of the association, the vibrancy and pride of Healthy Port's success shines forth. To begin with, the organization started through the activism of local volunteers, all Cornelder employees. Cornelder provides private, quality health care services to its workers and their families. The Cornelder workforce also receives decent wages and job security – very different from the bulk of the port-users. Having those benefits actually gave the workers the energy to (1) address HIV in their workplace and (2) look around them and take an interest in improving the health conditions of their colleagues working in less than ideal situations. The organic growth of the Healthy Ports project – from volunteer activism to company sponsorship to fully fledged project management and donor funding – gives the project life and sustainable energy.

The project received funding in order to reach out to port-users from other companies. "We began to include workers in machinery, stevedores, transporters ... about 16 companies. Each company identified a focal point. Our nucleo gave speeches at the companies to talk to their workers," Diogo explained. "Then the government began to notice and they were very impressed."

In 2007, Healthy Port became a fully-funded project with project manager Moisés Mavaringana leading project design and management. The commitment of Cornelder management is evident in the learning and project design elements. In order to reach over 5 000 port-users and their families, the project staff and volunteers directly addressed four social groups linked to the port: (1) workers' wives, (2) workers' sons, (3) workers' daughters and (4) transporters and those that serve the transport sector (sex workers, bar owners, etc.).

Although the project activists are still learning and developing, Moisés was particularly happy with the experience involving workers' wives. "Many workers didn't give their wives the invitations sent out to invite the women to health sessions. They were afraid to involve their wives. But some did. Then the women began talking to each other. The women (port-users' partners) really liked the health sessions. We had hospital doctors and nurses come and talk about women's health issues with the women. Many wives had never known about women's health and services. They were very pleased." Moisés plans to expand the breadth of training on health in future project plans. He thinks it's time to move beyond HIV and discuss many more health issues. He also sees the project addressing the gender gap: "I think the next time, the Cornelder men will invite their wives to go to the sessions. Those that did not invite their wives this time know that they heard about the training from their neighbours."

There is no denying the success of the Cornelder project. Moisés can reel off the statistics – 26 participating companies, 14 000 hours of training, 1 000 family members participating – but obvious success comes from the outreach numbers. Last year, Cornelder, which employs only 446 workers in Beira, managed to counsel and test for HIV with 5 038 people.

9. ANNEXES

9.1 National policies and commitments

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

9.2 Public sector response

The Government of Mozambique has implemented a series of legal mandates, policy guidelines and national strategies to combat HIV/AIDS, including several with direct implications for the private sector.[35] For example, in 2002, it established the Conselho Nacional de Combate ao SIDA (CNCS) to lead and coordinate the Mozambican government's response to HIV/AIDS. The CNCS is responsible for implementing the Plano Operacional da Estratégia de Aceleração da Prevenção da Infecção pelo HIV (PEN). PEN outlines seven priority areas of intervention: Prevention, Advocacy, Stigma & Discrimination, Treatment, Mitigation, Research and Coordination. It also identifies the following groups as especially vulnerable to HIV infection: sex workers, long-distance truck drivers, miners and other migrant workers, brigades of workers away from home, certain military personnel and informal traders.

The United States Agency for International Development (USAID), through the President's Emergency Plan for AIDS Relief (PEPFAR), supports a full range of prevention, care and treatment programmes in Mozambique. PEPFAR-funded technical assistance and training relies on an extensive network of implementing NGO partners as well as the Government of Mozambique. In 2008, PEPFAR funds supported the private sector's efforts to combat HIV/AIDS through an initiative to develop a national workforce policy regarding the disease. Other major international donors supporting HIV/AIDS efforts in Mozambique include the United Kingdom, Ireland, Sweden, Denmark, the Netherlands, Norway, Canada, the European Union, the World Bank, various UN agencies and The Global Fund to Fight AIDS, Tuberculosis and Malaria.

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

9.3 Non-governmental organizations

Non-governmental organizations focused on health vary widely depending on the specific provinces and cities. The following is an incomplete list of the organizations working in each port city and nationally.

National

HIV Prevention and Mitigation: Population Services International (PSI), Foundation for Community Development (FDC)

Maputo

Technical HIV/AIDS Care and Treatment: Medecins Sans Fronteiras (MSF), International Centre for AIDS care and treatment Programmes (ICAP)

Beira

Technical HIV/AIDS Care and Treatment: Health Alliance International (HAI)

Nacala

Nampula Province is currently receiving massive funding (approximately USD 30-million) from PEPFAR for a project entitled "Strengthening Communities through Integrated Programming" (SCIP) that is controlled by Pathfinder International. The project elements include technical support, prevention as well as care and treatment (alleviation for affected populations). As the prime partner with USAID and CDC in

the province, Pathfinder is the ideal source for links and future partnership opportunities in Nacala Porto.

9.4 Private sector response

Some effort has been undertaken by the private sector in promoting HIV/AIDS workplace policies. An umbrella organization called the Association of Entrepreneurs Against SIDA (EcoSida) coordinates HIV/AIDS activities among private enterprises and has developed a roadmap for implementing workplace-based HIV/AIDS programmes. EcoSida, which was founded by 23 companies and business associations and currently counts over 40 member businesses, provides programming and HIV/AIDS-related services to the workplace and the larger Mozambican community. EcoSida's principal tool for responding to AIDS in the workplace and in broader community contexts is derived from a blend of existing programmes and strategies utilized by companies like Unilever, British American Tobacco, Coca-Cola, British Petrol and Mozal. These model programmes, which are governed by the principles of the International Labour Organisation (ILO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), have been adapted to the specific conditions of Mozambican workplaces[36]

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

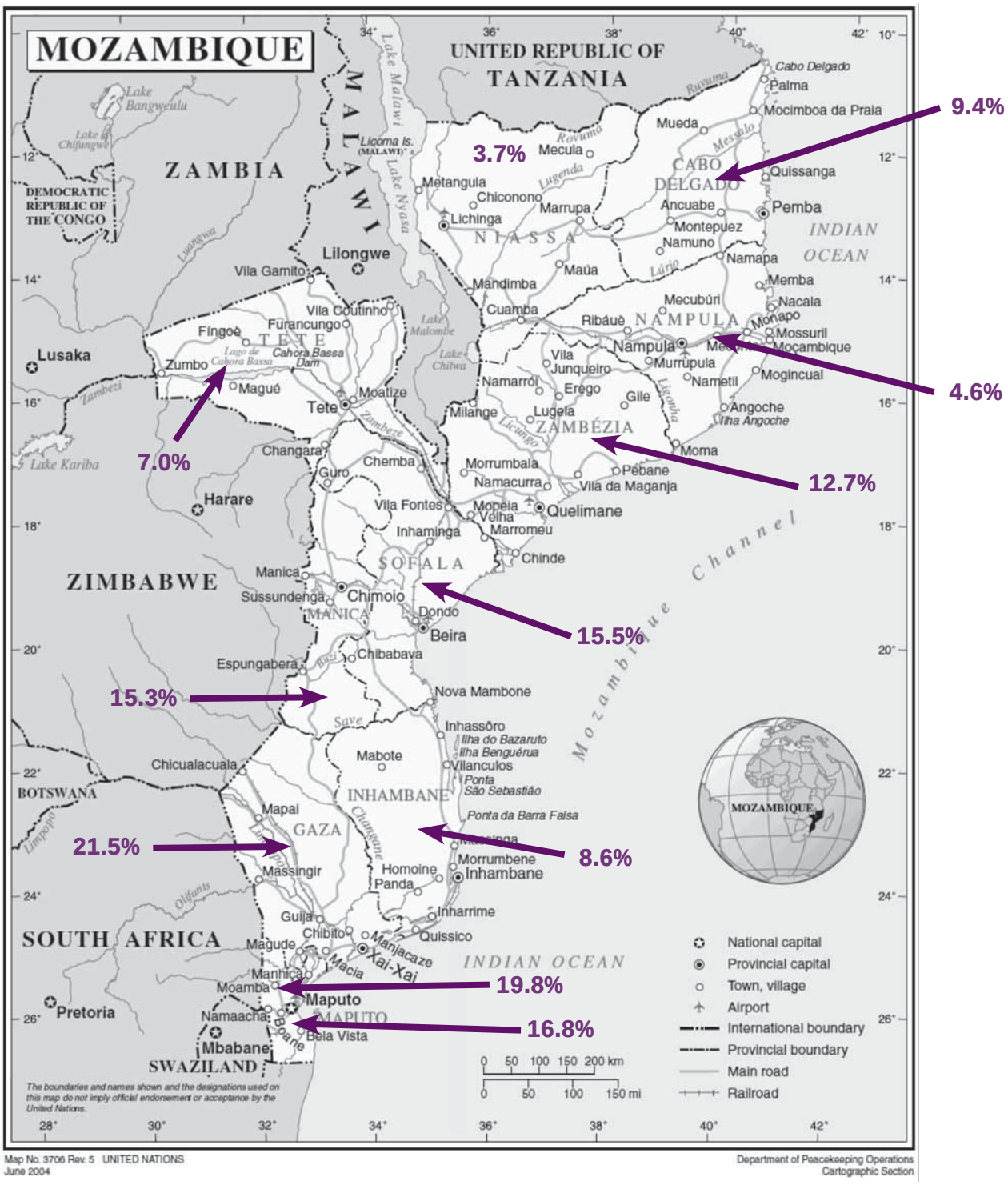
The USAID Health Policy Initiative works with private companies and created a Workplace Policy Builder software designed to help companies create comprehensive policies. Several companies have worked with the software, including Cornelder. Cornelder currently works with partner companies to contribute to the spread of the software and ensure that partner companies have a health policy in place.[37] Cornelder's other responses are discussed in detail in Section 8.

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

37 http://www.healthpolicyinitiative.com/index.cfm?id=wherewework&regionCode=AFR&countryCode=MZ

9.5 Map of Mozambique

Map showing most recent INSIDA 2009 HIV-prevalence estimates by province for adults 15-49 years of age



9.6 Charts on risk behaviour amongst port-users in relation the general population

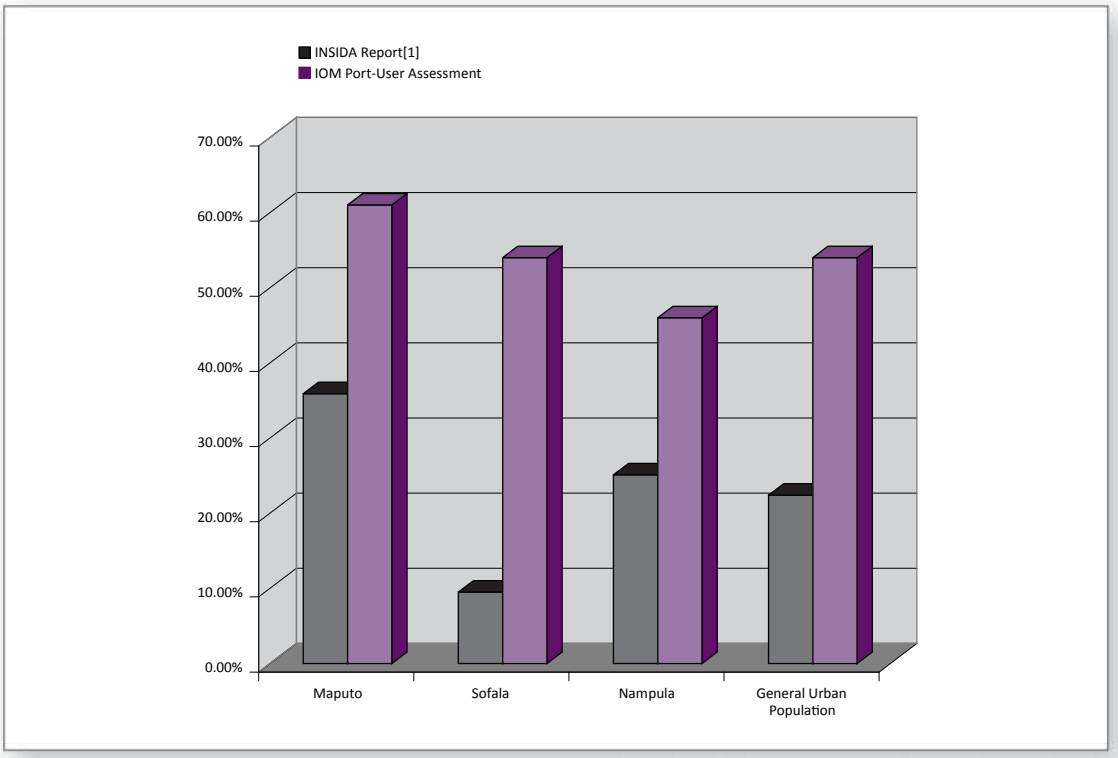


Figure 1: Differences by geographic area and general urban population in terms of respondents having two or more sexual partners during the last year.

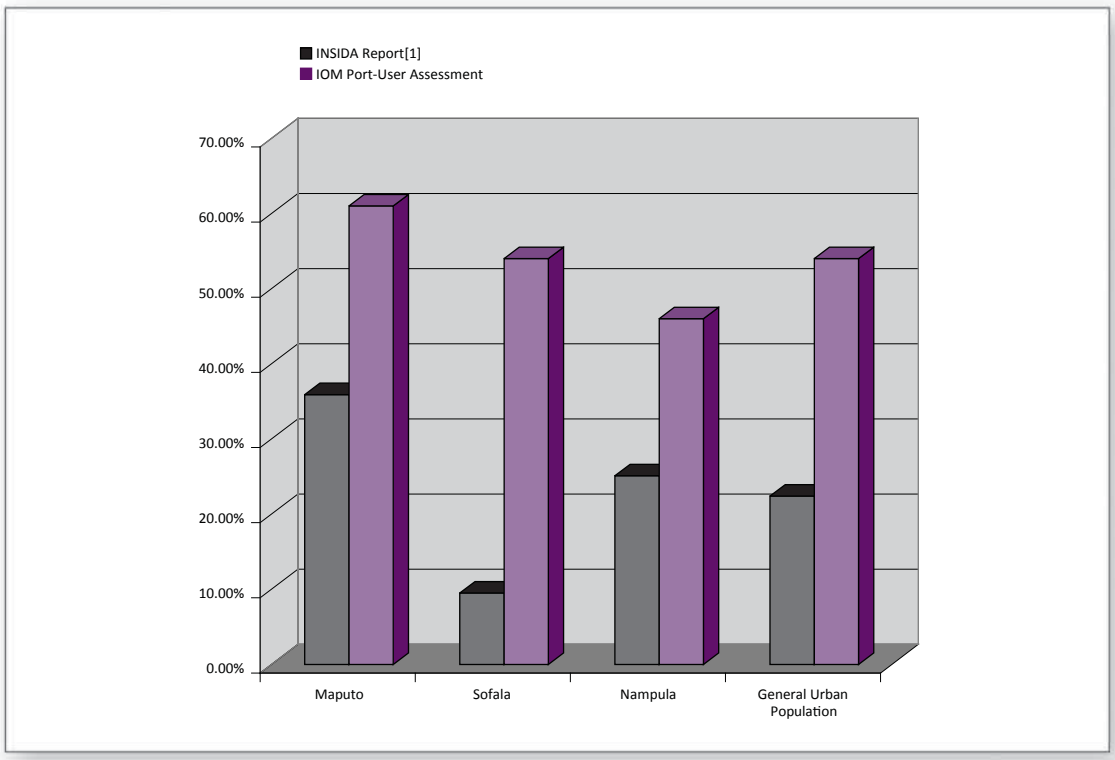


Figure 2: Affirmative responses to having paid for sex amongst port-users in relation to the general population.

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