IOM International Organization for Migration

# REGIONAL WORKSHOP ON HIV RESPONSES FOR MINE WORKERS, THEIR FAMILIES AND AFFECTED COMMUNITIES IN SOUTHERN AFRICA

**27 and 28 May 2010**

**Maputo, Mozambique**

**REPORT**

## CONTENTS


ACRONYMS AND ABBREVIATIONS 3

INTRODUCTION 5

BACKGROUND 6

HIV and population mobility . . . 6

HIV vulnerability among mine workers, their families and affected communities . . . 6

DAY 1 7

WELCOME AND OPENING REMARKS 7

Welcome . . . 7

Opening remarks . . . 7

PLENARY ONE: SETTING THE SCENE 8

WHA resolution on migrants' health . . . 8

SADC Draft Policy Framework for Population Mobility and Communicable Diseases . . . 11

HIV prevention in Southern Africa . . . 13

Discussion . . . 17

PLENARY TWO: EVIDENCE FROM THE GROUND 19

Health vulnerabilities and HIV-prevention needs of migrants and mobile populations in the mining sector of southern Africa . . . 19

The relationship between alcohol use and HIV among mine workers in a Namibian mining town . . . 26

Lessons learnt from the evaluation of a Community Training Partnership Programme in five diamond mining communities in South Africa . . . 27

Discussion . . . 29

Findings from the Thibela TB project . . . 30

Knowledge, attitudes and perceptions of HIV testing and antiretroviral therapy in a sample of mine workers in South Africa . . . 32

The life of a mine worker: an on-the-ground perspective . . . 33

Discussion . . . 34

GROUP DISCUSSION 35

DAY 2 36

PLENARY THREE: PROGRAMMES AND POLICIES 36

Working with mine worker-sending communities in southern Africa . . . 36

First Quantum Mineral Limited’s health-related corporate social responsibility programme . . . 38

The private sector response to the health vulnerabilities of mine workers, their families and affected communities . . . 38

Discussion . . . 40

Technical Working Group on HIV-positive Mine Workers in Mozambique . . . 41

The response to HIV by trade unions in the mining sector . . . 42

Regional Association of Mine Workers . . . 43

Discussion . . . 45

SUGGESTED FRAMEWORK FOR A REGIONAL COMPREHENSIVE HIV AND AIDS PROGRAMME 47

RECOMMENDATIONS AND CONCLUSIONS 52

APPENDIX ONE: WORKSHOP PROGRAMME 53

APPENDIX TWO: PARTICIPANT’S LIST 56

APPENDIX THREE: WHA RESOLUTION 60

## ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **ART** | Antiretroviral Therapy |
| **ARV** | Antiretroviral |
| **CBO** | Community-based Organisation |
| **CNCS** | Conselho Nacional de Combate ao HIV/SIDA |
| **CoM** | Chamber of Mines |
| **COP** | Code of Practice |
| **CSR** | Corporate Social Responsibility |
| **CSO** | Civil Society Organisation |
| **CTPP** | Community Training Partnership Programme |
| **DRC** | Democratic Republic of Congo |
| **FQML** | First Quantum Minerals Limited |
| **HAART** | Highly Active Antiretroviral Therapy |
| **HBC** | Home-based care |
| **HCT** | HIV Counselling and Testing |
| **HIV** | Human Immuno-deficiency Virus |
| **IEC** | Information, Education and Communication |
| **ILO** | International Labour Organization |
| **IOM** | International Organization for Migration |
| **IPT** | Isoniazid Preventative Therapy |
| **KII** | Key Informant Interviews |
| **KZN** | Kwazulu Natal |
| **M&E** | Monitoring and Evaluation |
| **MARP** | Most at risk population |
| **MCP** | Multiple and Concurrent Partnerships |
| **MDR TB** | Multi Drug-Resistant TB |

| | |
|---|---|
| **MIDSA** | Migration Dialogue for Southern Africa |
| **MMC** | Medical Male Circumcision |
| **MOU** | Memorandum of Understanding |
| **NDOH** | South African National Department of Health |
| **NGO** | Non-governmental Organisation |
| **NIHL** | Noise-induced hearing loss |
| **NSP** | National Strategic Plan |
| **NUM** | National Union of Mine Workers |
| **OHEAP** | Occupational Health Education and Awareness Programme |
| **PEP** | Post-exposure prophylaxis |
| **PHC** | Primary Health Care |
| **PLHIV** | People living with HIV |
| **PMTCT** | Prevention of mother-to-child Transmission |
| **PPP** | Public-Private Partnership |
| **PTB** | Pulmonary Tuberculosis |
| **SADC** | Southern African Development Community |
| **SAMP** | Southern African Migration Project |
| **SCC** | Social Change Communication |
| **SRH** | Sexual and Reproductive Health |
| **STI** | Sexually Transmitted Infection |
| **TB** | Tuberculosis |
| **UNAIDS RST–ESA** | Joint United Nations Programme on HIV/AIDS Regional Support Team for Eastern and Southern Africa |
| **VCT** | Voluntary Counselling and Testing |
| **WHA** | World Health Assembly |
| **WHO** | World Health Organization |
| **XDR TB** | Extremely Drug-Resistant TB |

## INTRODUCTION

In response to the health and HIV vulnerabilities of mine workers, their families and the communities with which they interact, the International Organization for Migration (IOM), in partnership with Southern African Development Community (SADC) HIV/AIDS Unit, United Nations Joint Programme on HIV/AIDS Regional Support Team for Eastern and Southern Africa (UNAIDS RST-ESA), and TEBA Development (Regional Office), organised a **Regional Workshop on HIV Responses for Mine Workers, Their Families and Affected Communities in Southern Africa**, which took place in Mozambique, Maputo, on 27 and 28 May 2010. The countries that were included in this workshop were both mine worker-sending and mine worker-receiving (including internal and cross-border migrants):

- **Mineworker-sending**: Lesotho, Mozambique, and Swaziland
- **Mine worker- receiving**: Botswana, Namibia, South Africa, Tanzania and Zambia

The workshop brought together representatives from National AIDS Councils, relevant line ministries, as well as the private sector, international organisations, non-governmental organisations (NGOs), community-based organisations (CBOs), research organisations, unions, mine workers' associations, and others implementing HIV prevention and care programmes and/or research in the mining sector from the abovementioned countries. The objectives of the workshop were to:

1) Raise awareness on the issue of HIV and mobility as it relates to mine workers, their families and affected communities in southern Africa.
2) Share lessons learned, experiences and good practices of HIV responses, research, policies and programmes, as it relates to mine workers, their families and affected communities.
3) Identify existing gaps and challenges in terms responses, programmes, policies and research.
4) Facilitate networking and increased coordination among partners and stakeholders, and among different agencies implementing HIV responses.
5) Outline the way forward in terms of the key components of an effective and comprehensive regional HIV programme.

The expected outcomes were:

1) Increased understanding of migration dynamics and related HIV vulnerability in the mining sector of southern Africa.
2) Strengthened networks for future coordination and collaboration among participating organisations.
3) Agreed draft framework for a comprehensive HIV response addressing the specific needs of mine workers, their families and affected communities southern Africa.

This workshop report is a summary of the proceedings of the workshop.

## HIV and population mobility

Within southern Africa, livelihoods are increasingly based on mobility, with the search for income opportunities in different locations and sectors seen as sound risk management by many. However poverty and exploitation, separation from regular partners and social norms, and a lack of access to HIV prevention and care services, make labour migrants and mobile workers vulnerable to HIV infection. Mobility, and the loneliness and isolation this generates, especially contributes to the phenomenon of Multiple and Concurrent Partnerships (MCP), which is arguably one of the leading drivers of HIV in the southern African context. In addition, migrant and mobile workers often live and work under difficult circumstances, whereby preventing HIV or Sexually Transmitted Infections (STIs) is not perceived as an immediate priority.

## HIV vulnerability among mine workers, their families and affected communities

It is widely acknowledged that HIV prevalence is higher and vulnerability to HIV infection more acute among mine workers, their families and communities with which they interact than the general population. Although a region-wide HIV prevalence survey has not yet been conducted, many mining companies conduct their own prevalence surveys on a regular basis. For example, AngloGold Ashanti estimated HIV prevalence among employees at 30%1 and in 2008, Goldfields estimated it at 33.5%2. For purposes of comparison, in the same year, HIV prevalence among the general population was 10.9%, according to the Human Sciences Research Council's South African National Household Survey.[3]

There are a number of structural, environmental and individual factors which increase HIV vulnerability for mine workers, their families and affected communities.

Broader structural factors, such as sectoral, national, and regional policies on labour, migration and health have an overall impact on the HIV epidemic, primarily by determining the conditions under which the mining sector operates.

The factors which impact on the immediate socio-economic conditions of mine workers include single sex accommodation, with few recreational activities and easy access to sex workers or other regular sexual partners.

Moreover, given the dangerous and risky nature of the work, preventing STIs or HIV is not often perceived as an immediate priority to many mine workers[4]. It is not only the men who have migrated to the mines that are vulnerable – their wives and the women left behind in the rural areas are as well. Women who stay behind in the rural areas may have unprotected sex with other sexual partners in the absence of their migrant spouse for a host of different reasons, including sexual pleasure, want of children, or economic survival.

Thus, HIV responses in the mining sector in southern Africa should address the broad structural, environmental and individual factors that increase the risk of HIV infection for migrant labourers and mobile populations. The issues outlined briefly in this background form the backdrop to the presentations and in-depth discussion and debate at this regional workshop.

1 AngloGold Ashanti. (2007). AngloGold Ashanti Report to Society 2007 – Regional Health. http://www.anglogold.com/subwebs/InformationForInvestors/Reports07/ReportToSociety07/p/rh/regional_health.htm

2 See http://www.goldfields.co.za/sus_health_safety.php

3 See http://www.avert.org/safricastats.htm

4 Campbell, Catherine. (1997). Migrancy, Masculinity and HIV: The Psycho-Social Context of HIV-Transmission on the South African Gold Mines. *Social Science and Medicine* 45(2): 273-83.

# DAY 1

# WELCOME AND OPENING REMARKS

## Welcome

***Reiko Matsuyama***
***IOM***

Matsuyama welcomed participants to the workshop. She thanked the co-organisers – UNAIDS, SADC, TEBA Development - for their valuable collaboration in realising this workshop.

This workshop is part of IOM's regional coordination work under the Partnership on HIV and Mobility in Southern Africa regional programme, funded by the Swedish International Development Cooperation Agency and the Norwegian Ministry of Foreign Affairs.

The overall objective of IOM's work in regional coordination is to strengthen the institutional infrastructure for supporting the implementation of HIV programmes and policies that affect or are affected by HIV dynamics of labour migration in southern Africa. This includes strengthening regional networks coordinating the HIV response in sectors employing migrant and mobile workers, and a key activity in achieving this is to organise regional workshops on HIV and mobility for specific sectors in selected countries of SADC.

Thus, this workshop is one of a series of regional sector workshops that IOM, with various partners, have been organising in the past few years. For example in 2007 the IOM organised a regional workshop for the road transport sector and in 2009 it organised a similar workshop for the maritime sector and port based communities.

As many people already know, the mining industry is a major contributor to the economies of southern Africa, either in the production of materials or the provision of labour to neighbouring countries. In particular, the sector employs a significant number of internal and cross border labour migrants – a system which has been in place for over a century.

However, due to a host of reasons, mine workers, their families and affected communities, are vulnerable to ill-health, including HIV. What may complicate the matter further is the fact that many mine workers are cross-border migrants – originating from one country, working in another, then going back home to their countries of origin, often after retirement or retrenchment.

Thus, it is imperative that the HIV responses in the mining sector in southern Africa takes this cross-border migration into consideration and approach it from a regional collaborative perspective.

Matsuyama concluded that, through this workshop, we hope to share our experiences in dealing with some of these issues and hope to culminate in an agreed draft framework for a comprehensive HIV response addressing the specific needs of mine workers, their families and affected communities in southern Africa.

## Opening remarks

Dr. Diogo Milagre, Deputy Executive Secretary from Conselho Nacional de Combate ao HIV/SIDA (CNCS), Mozambique, gave the opening remarks at the workshop. He acknowledged the presence of representatives from the IOM, World Health Organization (WHO) and the International Labour Organization (ILO) Mozambique, distinguished guests and delegates from the regional countries. On behalf of CNCS he welcomed these delegations to city of Maputo. He expressed satisfaction for the selection of Mozambique to host this meeting on HIV in the mining sector.

The choice of Mozambique is timely for three main reasons:

1) The country is currently reviewing its National Strategic Plan (NSP), and the workshop is an opportunity to learn from other experiences, share lessons and gather information that will

enable better interventions in these issues in communities.

2) Mozambique has a large population of current and ex-mine workers, especially in the southern region, where HIV prevalence high and growing (whereas it has stabilised in the central and northern regions). This high prevalence can be ascribed to mobility and attendant MCP.

3) The sector experiences high rates of morbidity and death, which places a heavy social burden on children and families of mine workers. At the same time, mining contributes to the development of rural areas and the economy in general. The challenge lies in promoting mining, while also addressing the impact of HIV.

Milagre stated that there were very high expectations of the meeting because it includes sharing of regional experiences and research presentations that will enrich policy making. He thanked the IOM and partners for this effort, and on that note, officially opened the meeting.

## PLENARY ONE: SETTING THE SCENE

The purpose of this session was to contextualise the issue of migrant health and how different organisations have attempted to address HIV among mobile and migrant workers, specifically mine workers, their families and the communities with which they interact. This helped to raise awareness on the issue of HIV and mobility as it relates to mine workers, their families and communities with which they interact in southern Africa.

The presentations in this session were:

- Thebe Pule, WHO: "WHA resolution on migrants' health"
- Reiko Matsuyama, IOM (on behalf of Doreen Sanje, SADC): "SADC Draft Policy Framework for Population Mobility and Communicable Diseases"
- Mumtaz Mia, UNAIDS RST-ESA: "HIV prevention in southern Africa"
- Laetitia Rispel, Centre for Health Policy, University of the Witwatersrand: "Lessons learnt from the evaluation of a Community Training Partnership Programme in five diamond mining communities in South Africa"
- Fazel Randera, Aurum Health Institute: "Findings from the Thibela TB project"
- Gavin George, Health Economics and HIV/AIDS Research Division, University of Kwazulu-Natal: "Knowledge, attitudes and perceptions of HIV testing and antiretroviral therapy in a sample of mine workers in South Africa"

### WHA resolution on migrants' health

***Thebe Pule***
***WHO***

WHO is the directing and coordinating authority for health within the United Nations (UN) system, and it was constituted on 7 April 1948. The World Health Assembly (WHA), which meets every year in Geneva, is the decision-making body of WHO and is composed of delegates of all 193 member states. The WHA determines WHO's policies and approves and reviews its budgets. At the 61st session of the WHA (Geneva, May 2008), *Resolution 61.17 on Migrants' Health* was adopted to promote migrant-sensitive health policies and equitable access to health.

The WHA resolution responds to current migration flows in a globalised world. Population mobility can be forced or voluntary, short or long-term, and across or within borders. Migrants and mobile populations require humanitarian responses, as there can be substantial displacement. Thus, there is a need to deliver effective and culturally-sensitive social and health services to these populations.

Worldwide, the estimated number of internal migrants is 740,000,000 and 214,000,000 cross-border migrants, such as workers, refugees, students, and so on. While their vulnerability levels vary greatly, the collective health needs and implications of a population cohort of this size are considerable.

Population movement render migrants vulnerable to:

- Health risks and potential hazards: stress arising from displacement, insertion into new environments and re-insertion into former environments.
- Recent migrants have to deal with marginality, poverty, limited access to social benefits and health services – in particular low-skilled and seasonal migrants. Families and children are also affected.
- Victims of human trafficking, especially women and children, are likely to suffer from communicable and non-communicable diseases.
- Migration can be triggered by disaster, conflict, food, disease, insecurity, and climate change – these are linked with destruction of livelihoods as well.

Health information for migrants and access to health services are scarce. Skewed surveys lead to negative perceptions of migrants, their health and health-seeking behaviours. Migrants carry certain health risks and this has public health implications. We must pay attention to the epidemiologic profile of migrants and their vulnerability in host or countries of origin. Health assessments for prospective migrants make sense from a public health and a human rights perspective. We need to improve the health surveillance system, early warning and detection and treatment of most at risk populations (MARPs).

We need to reach out to migrants, addressing their vulnerabilities and health care needs and ensuring equitable access to health services. We need to provide sustained health insurance in countries of origin on return. In destination countries, the workplace is an excellent entry point for health service provision. Another issue to consider is that of the migration of health professionals, as this affects the health system.

The following are strategies for improving the health of migrants:

### Advocacy for policy development

- Promote migrant-sensitive policies
- Develop mechanisms for social protection in health and safety
- Collaboration between health, foreign affairs and other concerned parties

### Assessment, research and information dissemination

- Assess health of migrants and trends of migration
- Disaggregate health information by gender, age, origin
- Encourage health and migration knowledge production
- Document and disseminate best practice for migrant health

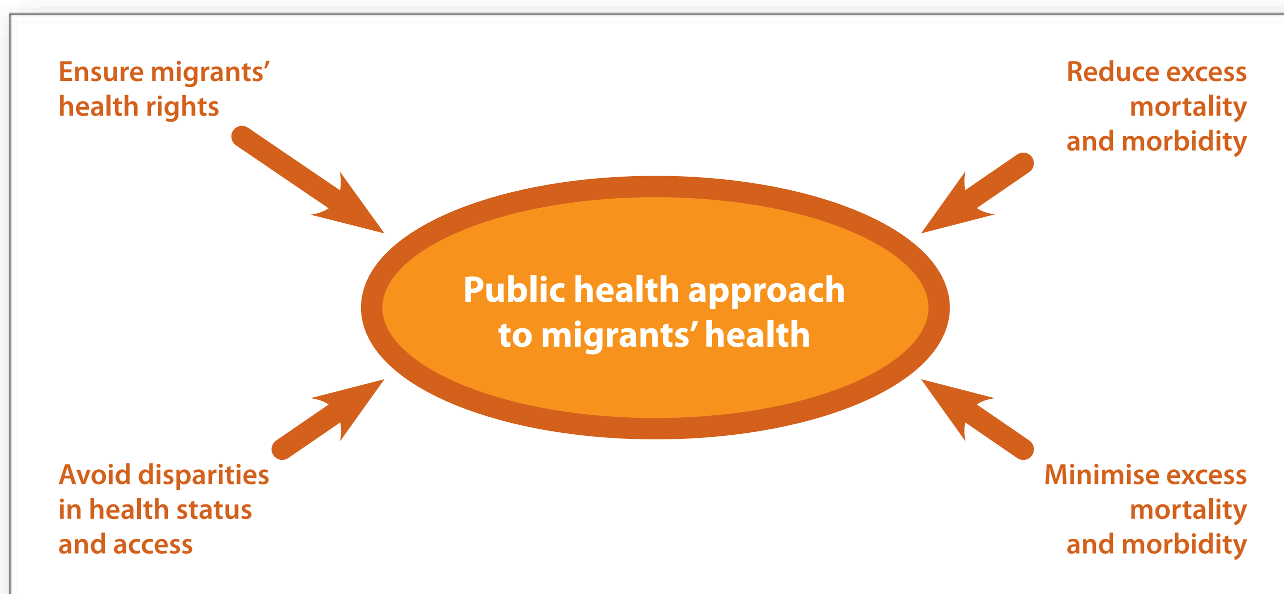
### Capacity building

- Sensitise and train relevant policy makers and stakeholders
- Create a network of collaborating centres

### Service delivery

- Migrant-friendly public health services and health care delivery methods
- Strengthen health promotion and disease prevention
- Establish minimum standards of health care for vulnerable migrants

The basic principles in a public health approach to migration health are:




In response to the public health and rights-based approach to migrants' health, in 2008, the 61st WHA accepted *Resolution 61.17 on Migrants' Health,* which lays out concrete action points for the WHO, its member states and partners.

There have been various challenges in the implementation of the resolution. These have included the global economic crisis, natural disasters, conflict, food insecurity and the H1N1 pandemic. These factors have all influenced the poor health of migrants and the link between population mobility and the spread of disease.

However, there has been some progress in the implementation of the resolution. Among other activities the WHO has mobilised resources for displaced people in Afghanistan, Cameroon, Central African Republic, Chad, Colombia, Democratic Republic of Congo (DRC), Jordan, Pakistan, Sudan, and Syria Arab Republic. There have also been attempts to integrate information for displaced populations into national information systems. The organisation has provided support in generating data on some hard-to-reach migrant groups in Mexico and Thailand. In Europe, WHO has conducted research among women in support of promoting reproductive health; mapped activities undertaken; shared information; and coordinated technical input into relevant processes. It co-authored recommendations on moving towards a migrant-sensitive workforce, and presented them at the "Better health for all" EU consultation in Lisbon in September 2009.

There have also been various meetings and other forums at which the WHO has promoted the resolution:

- Migration Dialogue for Southern Africa (MIDSA) workshop on Migration Health in June 2008[5]
- Ministerial Roundtable Breakfast organised by UNESCO on migrant women's needs
- Seventh Global Conference on Health Promotion, Nairobi, October 2009

5 Please see the IOM's website for a full copy of the MIDSA report at http://iom.org.za/site/index.php?option=com_docman&task=cat_view&gid=23&Itemid=50

- Global Forum on Migration and Development
- WHO and IOM entered into cooperation agreement – secondment of staff member to WHO as Senior Migrant Health Officer
- Twenty-fourth Meeting of the Programme Coordinating Boards of UNAIDS, whose theme was "People on the move – forced displacement and migrant populations"
- International Task Team on HIV-related Travel Restrictions
- Global Forum on Migrants' Health, Madrid, 2010

Pule concluded by outlining planned activities in terms of the WHA resolution. These include conducting of systematic analyses of migrants' health, based on disaggregated data, such as gender and age, fostering multi-country and multi-sectoral cooperation, the development of cohesive policies and the Libreville Declaration on Health and Environment.

## SADC Draft Policy Framework for Population Mobility and Communicable Diseases

***Reiko Matsuyama, IOM***
***(on behalf of Doreen Sanje, SADC)***

The following definitions are useful when discussing the draft policy framework:

- **Population mobility**: movement of people from one place to another, temporarily, seasonally or permanently for either voluntary or involuntary reasons – short or long term.
- **Internal mobility**: movement from homes to other places within the same country.
- **External mobility**: across international borders to a foreign country. These kinds of migrants may have legal status or be undocumented.
- **Migration**: is used to describe mobile populations who take up residence or remain in another place for an extended period.
- **Mobility** can be voluntary or involuntary; as a result of coercion, trafficking, or poverty (this includes most refugees). People who are not mobile may also be vulnerable to the health consequences of population mobility – at source, in transit or at destination.
- **Communicable disease**: an illness due to a specific infectious agent or its toxic products which arises through transmission of the agent or its products from an infected person, animal or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector or inanimate environment.

SADC is comprised of 15 member states. It exists to promote economic integration with eventual free movement of capital, labour, goods and services in the southern African region. This region faces the triple burden of HIV, TB and malaria. SADC recognises that mobile populations are at a high risk of contracting these communicable diseases. They are the major causes of morbidity and mortality in the region and are a health and development priority.

Population mobility is historically linked to labour migration. Recently, labour migration has become increasingly feminised, with more and more women becoming mobile. Current trends in population mobility include:

- Trafficking and involuntary movement for labour and sexual exploitation, especially of girls
- Increased movement of skilled professionals, including health workers
- Circular movement
- High proportion of undocumented migrants
- Prevalence of intra-regional mobility
- North-South Movements

SADC's response thus far is to include article 12 in the SADC Health Protocol. It has also developed strategic plans for all three communicable diseases, advocated for the harmonisation of policies and programmes and standardisation of systems and encouraged member states to develop their own policies and programmes.

Currently, the gaps in the response are as follows:

- Inadequate harmonisation and coordination – disease specific guidelines, health services, referral system and disease control across borders
- Difficulty in accessing health services due to fees, lack of information, reluctance by health care providers, differing treatment protocols, immigration status and weak health systems
- Inadequate disease surveillance and epidemic preparedness in terms of case definition, notification system, and a lack of a plan to deal with emergencies and epidemics
- Inadequate information, education and participation by mobile populations
- Inadequate operations research and sharing of information
- Legal and administrative barriers

Thus, the purpose of the draft framework is to give guidance on the protection of the health of cross-border mobile populations in the face of communicable diseases and also to give guidance on the control of communicable diseases in the face of movement across borders. It is aimed at policy makers and managers, is applicable to all communicable diseases, and complements current SADC work on harmonisation. The beneficiaries of the framework are voluntary and involuntary migrants or those with or without documents, regardless of their duration of stay at their destination.

The following documents form the foundation of the framework:

- Founding Charter of SADC, which under article 6 stresses non-discrimination
- SADC Protocol on Health – articles 9 to 12 prioritise communicable disease control
- Human rights principles as enshrined in the Universal Declaration of Human Rights and reaffirmed in the African Charter of Human and People's Rights
- *Resolution 61.17 of the 61st WHA* of May 2008
- SADC Protocol on Gender and Development, which emphasises gender equality and equity in all development endeavours

In the framework there are policy guidelines for programming for population mobility and communicable diseases. These are:

### Regional Harmonisation and Coordination

- Harmonised treatment regimens and management guidelines
- Cross-border referral services and mechanisms for continuity of care for patients with communicable diseases
- Joint programming; harmonised lists of diseases targeted for surveillance

### Equitable Access to Health Services

- Re-supply of drugs for treatment
- Target diverse nature of mobile populations
- Recognise the special needs of women, children and adolescents
- Formalise use of health facilities; harmonise fee structures

### Coordinated Surveillance and Epidemic Preparedness

- Harmonise case definitions, notification and referrals systems across member states
- Define regional mechanisms and institutional frameworks for monitoring,

managing and reporting health emergencies and communicable disease threats and epidemics

- Update regional health emergency and epidemic preparedness and response plans
- Harmonise collection, analysis and use of disaggregated data

### Information, Education and Health Promotion for Mobile Populations

- Participation and involvement of mobile people
- Information, Education and Communication (IEC) to involve source, transit and destination communities and use of languages appropriate to the target groups

### Operational Research and Strategic Information

- Strengthened data collection and sharing of information on population mobility and communicable diseases, for example on numbers of mobile people entering member states, numbers contracting communicable diseases and numbers accessing treatment and other services to allow better planning for service delivery
- Documentation and sharing of best practices among member states
- Regional mechanisms for information sharing

### Legal, Regulatory and Administrative Reforms

- Align laws, regulations and policies on communicable diseases to international norms and standards
- Protection of foreign workers in high-risk work environments, such as mining and agriculture, by minimising unfair labour practices
- Minimise hurdles to access travel and other documents
- Appropriate fee structures to allow equal access to curative and preventive services
- Establish multi-sectoral mechanisms at national and regional levels to effectively respond to issues of mobile populations

The institutional framework within which to implement the draft framework include SADC Ministers of Health, the SADC Secretariat, Member States, the UN, development partners, and local and international NGOs and civil society organisations (CSOs). The financing mechanism for the draft framework involves exploring the use of the current SADC HIV Trust Fund, and mechanisms for reimbursable funds. Monitoring and Evaluation (M&E) will involve the production of annual reports, with the input from member states and coordination by the SADC Secretariat.

The next steps in terms of the policy framework involve sensitising all critical partners at national and regional level for buy in, ensuring that the private sector is involved, and elaborating on the funding mechanisms and the costs. The framework was presented to Ministers of Health in April 2010 and is awaiting approval.

## HIV prevention in Southern Africa

***Mumtaz Mia***
***UNAIDS RST-ESA***

Mia started her presentation with a graph showing the trends in selected high HIV prevalence countries in southern Africa. The graph shows that national adult HIV prevalence exceeded 12–15% in eight southern African countries in 2005. Globally ESA contributes to 57% of infections.

The epidemic has stabilised in most countries in the region and there is evidence of a significant decline in national prevalence in Zimbabwe. Mozambique has a new, but growing, epidemic with a significant variant between regions (17.9% in the South and 7.2% in the North). Not only are there variations between regions within countries, but also some cities have higher HIV epidemics than countries. For example, HIV incidence in Gauteng (a province in South Africa) is fourth in a list which ranks urban and national epidemics (after South Africa, Nigeria and India):

## Ranking of urban HIV epidemics (ESA) among national epidemics

| | | Est. number Adult PLHA (2007) |
|---|---|---|
| 1 | South Africa | 5,400,000 |
| 2 | Nigeria | 2,400,000 |
| 3 | India | 2,300,000 |
| | Gauteng | 1,550,000 |
| 4 | Mozambique | 1,400,000 |
| 5 | Kenya | 1,400,000 |
| 6 | Tanzania | 1,300,000 |
| 7 | Zimbabwe | 1,200,000 |
| 8 | USA | 1,100,000 |
| 9 | Zambia | 980,000 |
| 10 | Russian Fed | 940,000 |
| 11 | Ethiopia | 890,000 |
| 12 | Malawi | 840,000 |
| 13 | Uganda | 810,000 |
| | Durban | 730,000 |
| 14 | Brazil | 710,000 |
| 15 | China | 690,000 |
| 16 | Thailand | 600,000 |
| 17 | Cameroon | 500,000 |
| 18 | Ukraine | 430,000 |
| 19 | Cote d'Ivoire | 400,000 |
| | Cape Town | 315,000 |
| 21 | Vietnam | 290,000 |
| 22 | Botswana | 280,000 |
| 23 | Indonesie | 270,000 |
| 20 | Lesotho | 260,000 |
| | Harare | 260,000 |

| | | Est. number Adult PLHA (2007) |
|---|---|---|
| 21 | Ghana | 250,000 |
| 22 | Myanmar | 240,000 |
| | Maputo | 220,000 |
| 23 | Carribean | 220,000 |
| 24 | Mexico | 200,000 |
| | Lusaka | 185,000 |
| 25 | Angola | 180,000 |
| 26 | Chad | 180,000 |
| | Nairobi | 180,000 |
| | Dar Es Salaam | 180,000 |
| 27 | Swaziland | 170,000 |
| 28 | Colombia | 160,000 |
| | Port Elizabeth | 155,000 |
| 29 | Italy | 150,000 |
| | Addis Abeba | 150,000 |
| 30 | France | 140,000 |
| 31 | Spain | 140,000 |
| 32 | Central African Republic | 140,000 |
| 33 | Rwanda | 130,000 |
| 34 | Argentina | 120,000 |
| 35 | Burkina Faso | 120,000 |
| 36 | Togo | 120,000 |
| | Kampala | 110,000 |
| | East London | 105,000 |
| | ... | |
| | Pakistan | 94,000 |
| | Buluwayo | 90,000 |
| | UK | 77,000 |
| | Luanda | 70,000 |

Source: UNAIDS

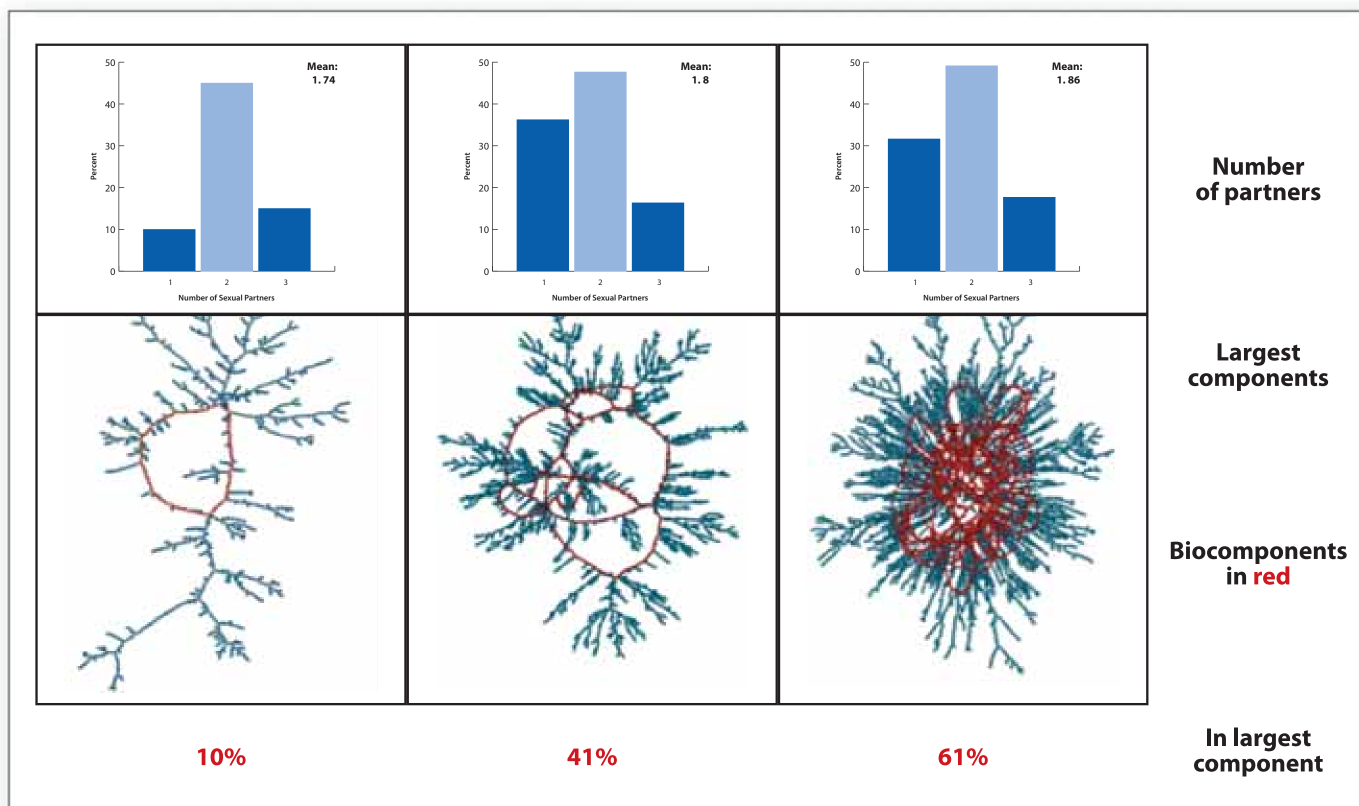
Mia presented a slide which shows that young women continue to be disproportionately affected by HIV, especially young women (25–29-year-olds), whereas older men (above 30 years) have higher rates of infection than younger men. This difference can be explained by phenomena such as intergenerational sex and it is important to explore the gendered "face" of the epidemic for this reason.

According to the 2006 SADC Prevention Think Tank, the key drivers of the HIV epidemic in the region are "multiple and concurrent partnerships by men and women with low consistent condom use and in the context of low levels of male circumcision". Contributing drivers include:

- male attitudes and behaviours
- inter-generational sex
- sexual and gender based violence
- stigma, denial, lack of openness
- untreated viral STIs
- lack of male involvement

Contextual factors such as gender and socio-economic inequalities, mobility and other structural factors need to be taken into account. Furthermore,

behaviours such as MCP become particularly risky in that in the first three weeks of HIV infection, viral load spikes and is undetectable. This makes the possibility of HIV transmission among partners who do not practise safer sex during this "window period" high. The following figure shows the level of risk even among a low degree of networks:




Source: Source: Martina Morris, University of Washington and James Moody, Duke University, used with permission from a presentation given at a meeting on concurrent sexual partnerships and sexually transmitted infections at Princeton University, 6 May 2006.

This figure shows that the number of partners only has to increase slightly in order for risk to increase significantly. For an average of 1.74 partners, the possibility of being in the same sexual network is only 10%, whereas for an average of 1.86 partners this possibility increases to 64%.

Mia emphasised that men and women in southern Africa do not have more partners than people in other regions, but there is a higher frequency of long-term concurrent partners (for example, "small houses", "second office" and so on) by both men and women, combined with low and inconsistent condom use.

In this context, the best 'proven' HIV prevention strategies are:

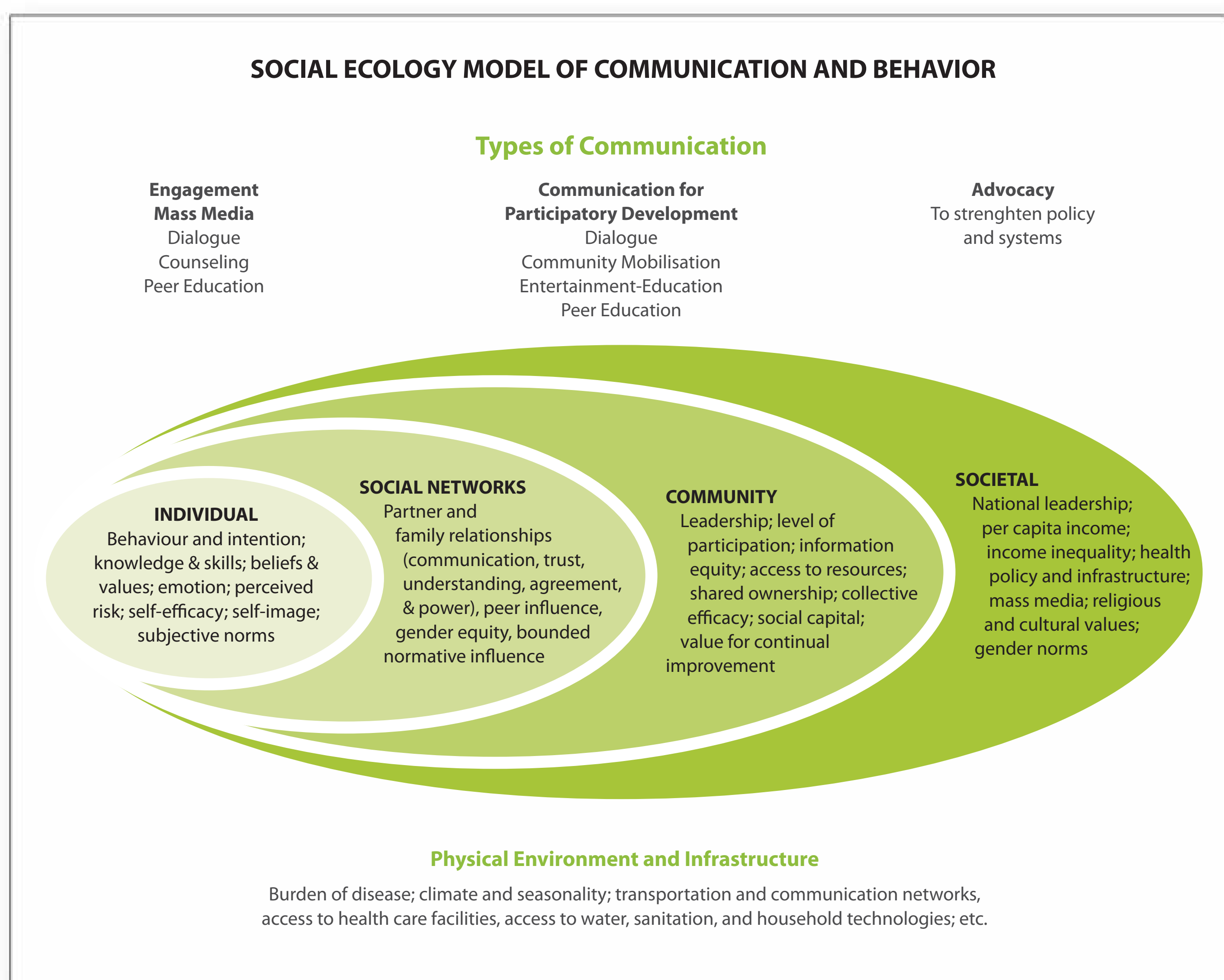
- **Male circumcision** reduces the risk of HIV infection among men who engage in heterosexual sex by 60% (evidence from three randomised controlled trials and 50 ecological, cross-sectional and prospective studies).

- **Prevention of mother-to-child Transmission (PMTCT)**: for example, Botswana has reduced mother-to-child transmission to less than 4% from around 40%. Related strategies

include avoiding unwanted pregnancies and reduction of maternal mortality.

- **Blood safety**
- **Consistent and correct condom use**: this has an over 90% efficacy, but very mixed field effectiveness according to type of sex relationship.
- **Reduced sexual partnerships:** field evidence from three countries
- **Antiretroviral Therapy (ART)**: evidence from WHO modelling shows that ART greatly reduces transmission and delays the onset of AIDS.
- **Social and behaviour change**: reduced sexual partnerships in Uganda, Kenya and Zimbabwe.

The following diagram shows that behaviour change needs to be addressed on different levels and needs to use a combination of different strategies:




Source: Johns Hopkins University Center for Communication Programs

Often there are questions about how male circumcision reduces the risk of HIV infection. Thus, Mia presented a slide which explains this in more detail. Male circumcision offers protection from HIV by removing cells that are vulnerable to HIV infection and reducing the possibility of tearing and injury to the penis during sex. Semen on a circumcised penis also dries more quickly and thus reduces the lifespan of any HIV present after sex. As mentioned above, male circumcision significantly reduces the risk of HIV infection among men. This is evidenced by figures which show that African countries with high levels of male circumcision have low HIV prevalence and visa versa.

Mia concluded by reviewing what we need to do in terms of HIV prevention:

- **Understand the key drivers of the HIV epidemic** and where most new infections occur; measure incidence; expand the evidence base; know the evidence for what works; translate knowledge into quality practice and improve M&E.

- **PMTCT** works and keeps parents alive.

- **Protect young women** by raising risk perception, reducing inter-generational sexual partnerships, encouraging condom use, providing strong life skills education and youth-friendly sexual and reproductive health (SRH) services.

- **Provide testing and counselling**, particularly for couples, together with support services for both treatment and prevention, and routine provider-initiated in health care.

- **Reduce vulnerability**: social, economic, political and other structural factors that increase risk, for example, gender inequality and violence, mobility and partner separation, social and economic insecurity, patterns of alcohol use, inequalities of income and wealth and education (also between men and women), address stigma, discrimination, human rights abuses, and laws that drive people living with HIV (PLHIV) or vulnerable groups at highest risk underground (for example, men who have sex with men, sex workers, etc.)

- **Reduce MCP** through changing social norms and values and individual behaviours, and increase realistic risk perception of HIV.

- **Roll out male circumcision**, particularly for young men.

- **Increase condom use** particularly in casual sex and sex work, in discordant couples, among PLHIV, and for men who have sex with men. Condoms provide over 90% protection if used consistently and correctly.

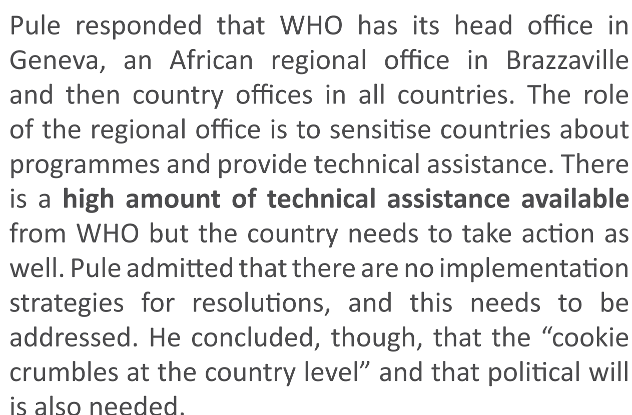
- **Remember key vulnerable groups** and HIV prevention with PLHIV.

Mia concluded by saying that effective prevention is imperative to sustain treatment and care, and to mitigate the impacts of HIV and AIDS.

## Discussion

A participant noted that the statistics presented in the UNAIDS presentation are shocking, especially that so many young people are infected with HIV. The participant wanted to know what could be done about **family breakdown** and **poverty reduction strategies** to try and address these statistics. In terms of the levels of HIV in countries with high levels of **circumcision** – could this also be due to religious reasons?

Another participant commented on the **SADC** and **WHO** presentations. He mentioned that over the years these organisations have developed many protocols, conventions, and policies. But after 25 years of the HIV epidemic, what has been the impact of these policies? He questioned whether WHO and SADC are doing enough, considering the global burden of the epidemic. He also wanted to know why countries have not signed off on these conventions and policies.



Pule responded that WHO has its head office in Geneva, an African regional office in Brazzaville and then country offices in all countries. The role of the regional office is to sensitise countries about programmes and provide technical assistance. There is a **high amount of technical assistance available** from WHO but the country needs to take action as well. Pule admitted that there are no implementation strategies for resolutions, and this needs to be addressed. He concluded, though, that the "cookie crumbles at the country level" and that political will is also needed.

Matsuyama added that it can be frustrating working at the policy level and that a lot of these treaties and conventions are not enforceable, even if they are ratified. But they are **advocacy tools** and provide a framework from which to advocate for migrants' right to health. We need to use a policy or convention from the bottom up (if the member state has ratified it) and ask minister to act upon it. For instance, the SADC secretariat has received funds from the Global Fund to implement cross-border initiatives, with assistance of member states.

A participant wanted to know how we can address **obstacles in the way of mine workers bringing their families** with them when they migrate for work purposes. The participant was concerned that after many years migrant mine workers still live in hostels.

A participant from **Swaziland** remarked that his country has made progress on many of the prevention strategies mentioned in the UNAIDS presentation. However, there are still **no policies or programmes which focus on MCP** and this must be addressed.

Mia responded to questions and comments by saying that when we think about the different levels of HIV infection in age groups, we must also think about **children that have been infected at birth** who are now growing up. How do we address the needs of this group now? Also, older people are an emerging group to whom we must pay attention.

Mia added that **hostel accommodation** does not makes sense to the private sector in the long run as it promotes risk-taking and ultimately it is more expensive to replace workers than to keep them alive. We need to think about not only the risky sexual behaviour of the man that leaves, but also the wife that is left behind. We also need to keep girls in primary, secondary and tertiary education. To do this we must address the issue of **intergenerational sex**. The reduction of partners is a key prevention strategy and also consistent **condom use with casual sexual partners**.

There was more discussion on the issue of **MCP**. A participant wanted to know if there is actual research that proves the link between MCP and HIV. At a recent national conference a presenter indicated MCP is not as big an issue as initially imagined. Mia responded that she would have to see the paper that was presented, but that MCP is not like medical male circumcision, where a clinical trial can be conducted. However, longer-term, concurrent relationships do increase risk – the "modelling diagram" (see Mia's presentation) shows how this happens. In a closed community, it has been proven that being in the same sexual network puts one at a higher risk.

Others wanted to know more about the **drop in HIV prevalence in Zimbabwe**. What were the strategies used here – is it because of a reduction in MCP or perhaps because of economic difficulties? Mia responded that it may have been somewhat due to the economy but that there was research conducted that proves there has been partner reduction in the country.

A follow up question was asked about the **funding mechanism of the SADC HIV Trust Fund**. All that is known about it is that it targets proposals that involve cross-border initiatives. It was only established last year and at this time there was a public call for proposals from the SADC Secretariat.

A participant questioned the sole focus of cross-border migration and reminded others that **internal migration** is equally important, as there are many people that migrate from the rural areas to the urban areas of the mines. Matsuyama agreed that the vulnerabilities that internal migrants face are the same as cross-border migrants and that IOM covers both in its programmes. The SADC framework covers cross-border migrants because of SADC's mandate, but issues are still the same.

## PLENARY TWO: EVIDENCE FROM THE GROUND

The purpose of this session was to provide presentations that shared lessons learned, experiences and good practices of HIV responses and research as they relate to mine workers, their families and communities with which they interact. The presentations in this session were:

- Erin Tansey, IOM: “Health vulnerabilities and HIV-prevention needs of migrants and mobile populations in the mining sector of southern Africa”
- Janetta Ananias: “The relationship between alcohol use and HIV among mine workers in a Namibian mining town”
- Laetitia Rispel: “Lessons learnt from the evaluation of a Community Training Partnership Programme in five diamond mining communities in South Africa”

### Health vulnerabilities and HIV-prevention needs of migrants and mobile populations in the mining sector of southern Africa

***Erin Tansey***
***IOM***

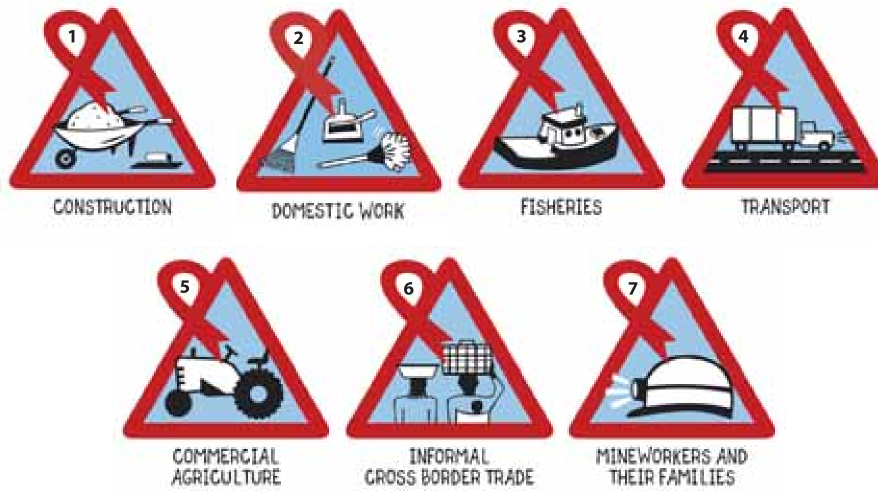
Tansey presented the findings of an IOM regional assessment that reviewed migrants’ vulnerability to HIV and their access to prevention during the different stages of the migration process. She began her presentation by giving a short background to the IOM.

The IOM is a growing inter-governmental organization, with 125 member states. It was established in 1951 and now active in over 290 field locations worldwide. The objectives of the IOM are to:

- Assist in meeting the operational challenges of migration and mobility;
- Advance understanding of migration issues;
- Encourage social and economic development through migration; and
- Uphold the human dignity and well-being of migrants and mobile populations.

The regional assessment was conducted in late 2009 and its purpose is to provide policy makers, donors and civil society with a regional overview of the different forms of migration and associated HIV related vulnerabilities; to identify opportunities and challenges for HIV prevention programming; and to prioritise key HIV prevention activities that should be pursued. Its primary focus is labour and irregular migrants. It used a methodology of a desktop review, key informants interviews (KII), focus group discussions and a mapping of key HIV prevention services.

The following map shows the sectors and countries which were covered in the regional assessment:

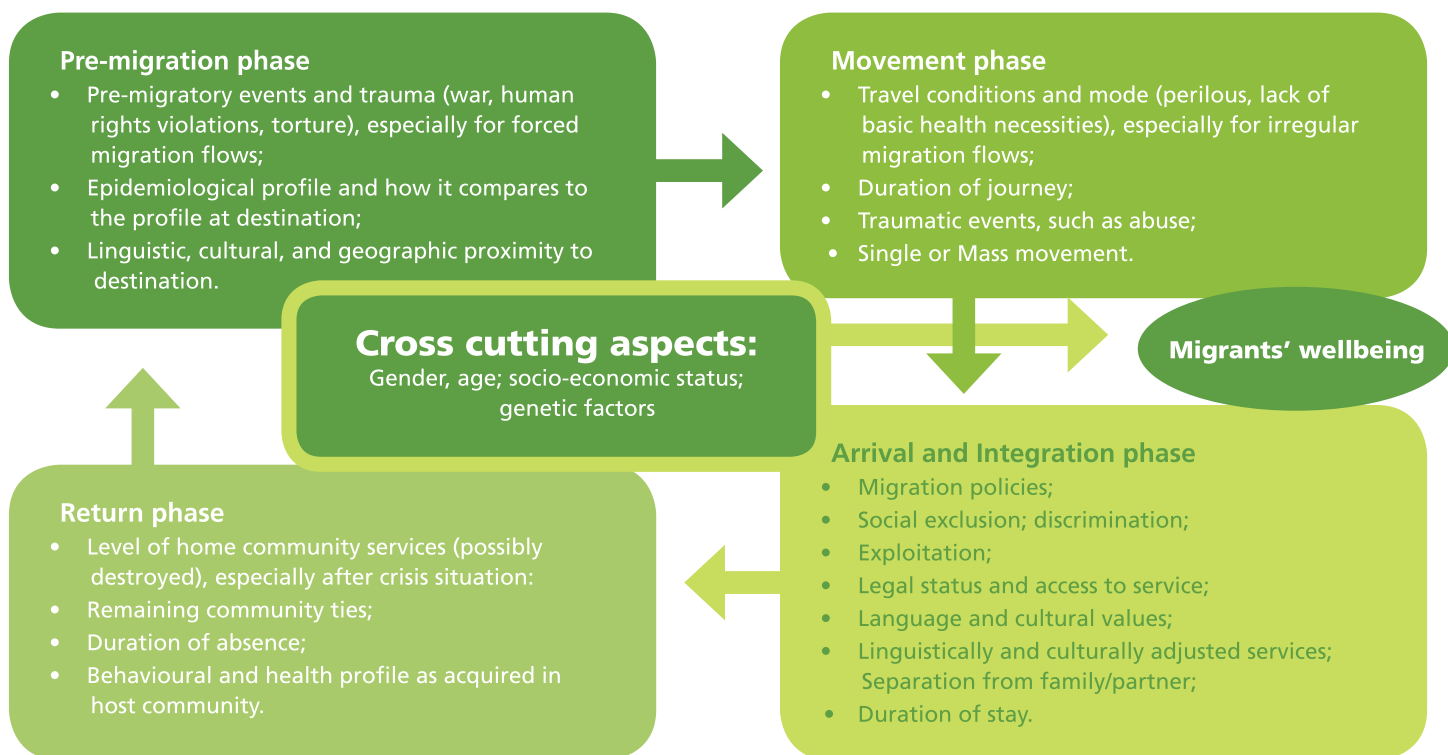



Angola 1 4
Zambia 5 6 7
Malawi 2 5 6
Mozambique 2 7
Zimbabwe
Namibia 3 4 7
Botswana
South Arica 1 2 3 5 6 7
Swaziland 5 6 7
Lesotho 5 6 7

Source: Regional assessment on HIV-prevention needs of migrants and mobile populations in southern Africa (IOM, 2010)

Tansey then presented a diagram which shows a migrants' vulnerability to HIV during the stages of the migration process:

**Factors that can affect the well being of migrants during the migration process (IOM, 2008)**




There is a long history of cross-border migration in southern Africa, especially among organised labour migrants (for example, workers from Mozambique or Lesotho in South African mines) and people seeking employment in the informal sector (commercial farm workers, cross-border traders, and domestic workers). In some areas, borders are arbitrary demarcations, and people move back and forth between them regularly.

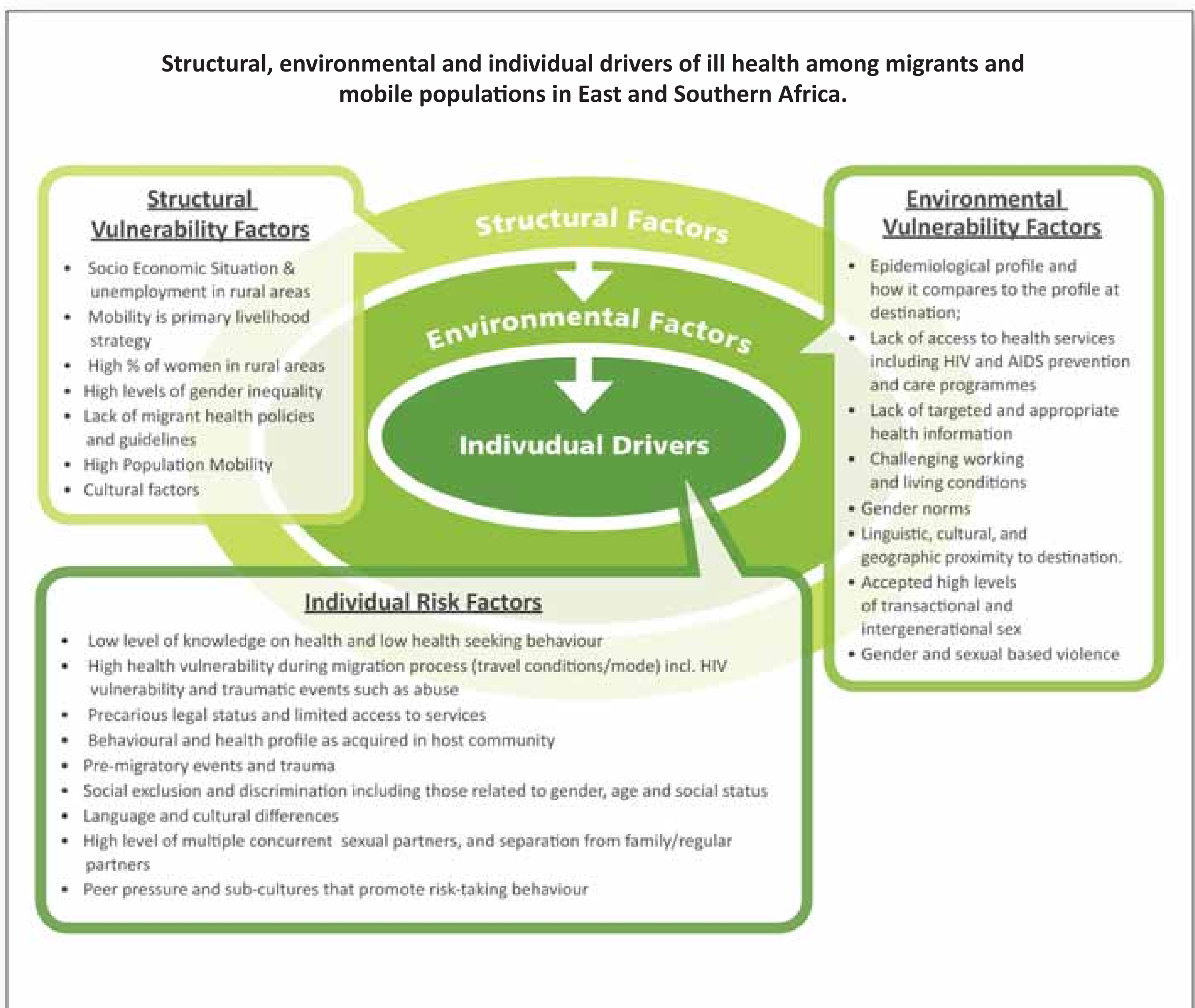
The IOM approaches migrants' right to health from a public health and human rights perspective, guided by the WHO's constitution (mentioned in Pule's presentation).

Tansey then outlined the health vulnerabilities of migrants. Human mobility is a significant public health issue, both in terms of epidemiological aspects and migrants' physical access to health services. Particular concerns are SRH and communicable diseases such as Tuberculosis (TB) and HIV. In normal circumstances, migration is not a risk to health, but the conditions surrounding the migration process can increase vulnerability to ill health. Irregular migrants are even more vulnerable due to poverty, powerlessness, and discrimination.

Migrants often have limited access to social benefits and health services due to legal, economic, linguistic and cultural factors. Evidence suggests that migrants are more vulnerable to contracting HIV than the local population, as they are often subjected to discrimination, xenophobia, exploitation and have little legal or social protection and limited access to HIV prevention services. They are also often occupied with survival.

People in migrant-sending communities (such as the families of mine workers) are also vulnerable to HIV infection. Both migrants and their partners are more inclined to engage in short or long-term sexual relations with other partners. Research in Zambia shows that more frequent stays away from home for short periods increases the risk of HIV infection, especially among women. Research in Kwazulu-Natal (KZN) shows that migrant couples were more likely than non-migrant couples to be HIV discordant. Among these couples, in 30% of the cases it was the woman who was HIV positive and her migrant partner HIV negative.

Tansey demonstrated the discussion around the health vulnerabilities of migrants by the use of a diagram, which shows that inter-related structural, environmental and individual drivers contribute to HIV infection:



The findings from the field work of the regional assessment corroborate many of the drivers mentioned above and reveal the following HIV vulnerabilities in the context of migration:

| Structural | Environmental | Individual |
|---|---|---|
| Lack of jobs | Time spent away from home | Low education & lack of comprehensive HIV knowledge |
| Poverty | Type of accommodation | Multiple & concurrent partnerships |
| Demand for seasonal labour | Dangerous working conditions | Low and/or inconsistent condom use |
| | Impoverished social environments: alcohol and transactional sex only forms of entertainment | Boredom & loneliness |
| | Lack of healthcare facilities | |
| | Lack of relevant IEC materials | |
| | Masculine identity and gender inequality | |

Irregular migrants face even more health vulnerabilities. They generally try to avoid accessing public health services for fear of being deported. They have to pay out of their pockets for medical care, often only when sick, and are most often beyond the reach of prevention health services. Furthermore, service providers may not speak their language, may look down upon them, discriminate against them, or display xenophobic sentiments.

Dangerous working conditions, poverty, and a lack of opportunities are interlinked and foster a sense of fatalism and the daily dangers can make such workers discount the importance of looking after their long-term health.

Researchers have argued that in current social structures, with their multitude of stressors, many people might find it difficult to give meaning to their lives and therefore struggle to see a purpose. Unless they feel that they have a reason to live and work, it cannot be expected that they will care for themselves and others. In such conditions, HIV may be perceived as a distant threat compared to daily survival, while the often "macho'" coping strategies adopted by male workers also feed into high-risk sexual behaviour.

In terms of access to health care services, the regional assessment reveals that migrant workers, their families and those individuals with whom they interact still have inadequate access to HIV-prevention services. This is despite the increasing presence of HIV workplace programmes and HIV prevention services provided by governments, NGOs and private sector companies.

National health services are limited and generally countries in the region have over-stretched health infrastructures. Although legally migrants have access to basic medical care, in practice this does not really happen. As a result, many migrant workers end up at NGO-run health institutions. Most large private companies have workplace programmes, either independently or as part of a Public-Private Partnership (PPPs) but they mostly do not cover casual labour (most of whom are migrants).

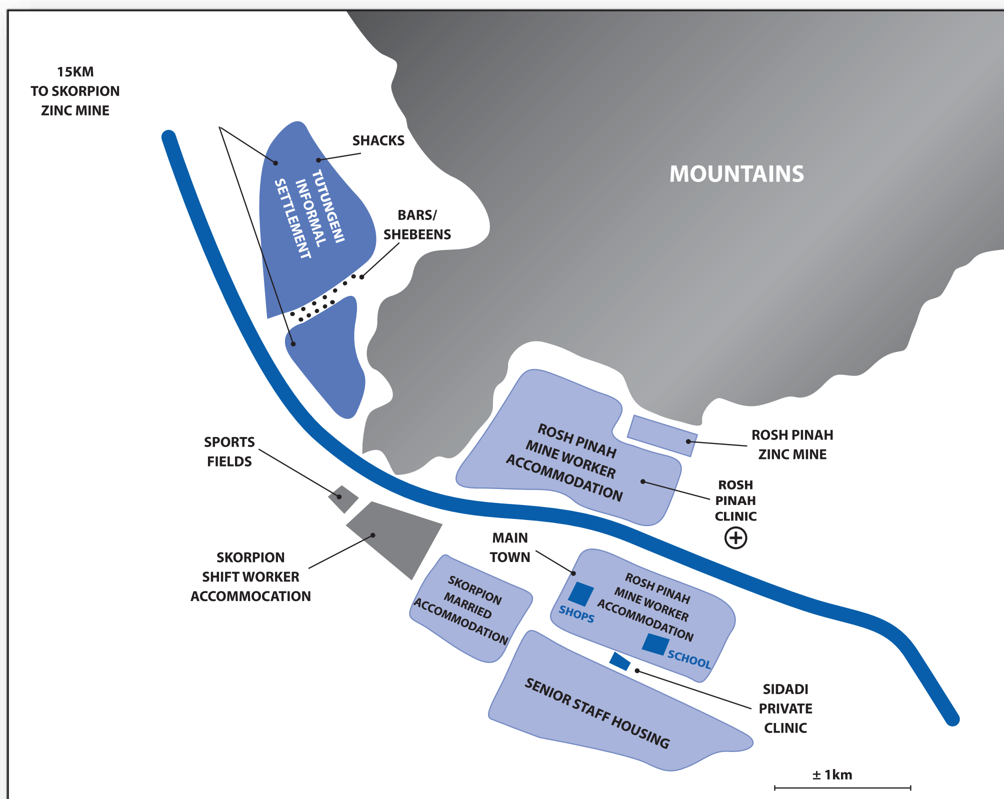
Tansey then presented findings from the localised, detailed mapping of health care services in Rosh Pinah, a small mining town in the southern Karas region of Namibia. The town was established in 1969 when Rosh Pinah Zinc mine began operations. It is still maintained and serviced by a private company called Roshcor. Today, there are two large zinc

mines in the area (Rosh Pinah Zinc and Skorpion Zinc), which house their workers in the town. It is estimated that more than 11,000 people now live at Rosh Pinah, which has grown rapidly since the second mine, Skorpion Zinc, was opened nearby in 2001. While most permanent workers live in formal mine accommodation, many of the sub-contractors and others who live in Rosh Pinah stay in a growing informal settlement (known as Tutungeni or "Sand Hotel") on the north-western outskirts of the town.

Both mines have an employee wellness programme with regular Voluntary Counselling and Testing (VCT), condom distribution and IEC materials, hold training workshops and use peer educators to pass HIV-related messages to other workers. Both are part of the Namibian Chamber of Mines' Occupational Health Education and Awareness Programme (OHEAP), which provides them with training and materials.

There are only two health facilities available to residents of Rosh Pinah: Firstly, Sidadi clinic, which was established by the two mining companies and is a private operation for which users pay. Its services are mostly inaccessible to those living in Tutungeni as they cannot afford treatment there.

Secondly, Rosh Pinah clinic is a small government clinic with limited facilities and staff. A doctor comes once a month from the nearest big centre (more than 300km away) but it is usually staffed by two nurses. Most residents of Tutungeni have no choice but to use this clinic for all their health needs. It provides VCT, condoms, multi-language IEC materials, ARVs, PMTCT and post-exposure prophylaxis (PEP) to everyone for free (or a small nominal fee that is often waived), but given the lack of staff and facilities, it cannot provide much of an HIV-prevention outreach service. Furthermore, the clinic does not have its own vehicle to fetch drugs and equipment. There are no NGOs or other organisations providing HIV-prevention services to people living in Rosh Pinah. The following map provides a visual overview of the abovementioned services:




Source: Country assessment on HIV-prevention needs of migrants and mobile populations: Namibia (IOM, 2010)

The gaps and challenges identified from the findings are:

- **Limited legal protection** for migrants and mobile workers, including undocumented workers.
- Cross-border mine workers who are initiated for ART encounter **adherence** problems, as they can't access ART in other countries (owing to different regimens).
- **Lack of HIV policy** that targets migrants at national level. This makes it difficult to advocate for pro-migrant mine workplace programmes.
- **Limited or inadequate workplace policies**, particularly among smaller sized mining companies.
- **Remote areas** in which many mines are located do not have sufficient HIV-prevention services. Often services only available to permanent employees (not their families or casual workers and communities).
- Generally a **lack of healthcare** and HIV services in **mine-sending** communities.
- Reluctance of companies to allow workers **time off** to attend VCT or HIV education sessions.
- **Sub-contracted and seasonal contract workers lack access** to workplace programmes
- **Lack of education, HIV stigma and illiteracy**, as well as misperceptions about condom use among migrant workers and their families limit the impact of HIV-prevention programmes.
- Health services that exist have incompatible **opening hours** for migrant workers.
- **Fear of victimisation or dismissal** from work discourages some migrant labourers from knowing their HIV status.
- **Lack of data on the dynamics of labour migration** in the mining sector, particularly with regard to casual workers.
- **Lack of data on the epidemiological profile** of migrant workers and mobile populations in southern Africa, as opposed to sedentary populations.
- Migrant workers are **hard to reach**.
- **Lack of behaviour change programmes** targeted at migrant sites.
- **Health care workers** need better understanding of migrants' vulnerabilities.
- **Language and cultural** issues.
- **Lack of data on regular and irregular migration** due to lack of standardised data collection mechanisms at border crossings.
- Inadequate and insecure **funding**.

The key recommendation to emerge from the regional assessment research is that the most effective intervention that will ultimately reduce HIV vulnerability of migrant workers and mobile populations is to develop projects and programmes that target "spaces of vulnerability" as opposed to "persons of vulnerability". This approach is in line with both a human rights and a public health-based approach to the health of migrants and the communities with whom they interact.

Tansey concluded her presentation by pointing to some of the national policy-related recommendations of the research:

- Governments should sign, ratify and domesticate the UN Covenant on the Protection of Migrant Workers and their Families and translate legal obligations into operational policies.
- Governments should enforce greater regulation over smaller companies or provide incentives for them to implement workplace policies and/or provide regular access for all their employees to all HIV-prevention services.

## The relationship between alcohol use and HIV among mine workers in a Namibian mining town

***Jannetta Ananias***
***University of Namibia***

Ananias presented research conducted by a team of researchers from the Universities of Minnesota and Namibia, which looked at the intersection of substance use and HIV in a Namibian mining town.

HIV prevalence is approximately 19.6% in Namibia and at the same time, research shows that 55% of Namibian adults consume more than 10 litres of alcohol per week. A number of studies have found alcohol consumption to be a risk factor for HIV in southern Africa. However, little research has been done in southern Africa on the link between alcohol and sexual risk-taking, especially in settings like mining towns, where it may be even higher than the general population.

In this context, the research questions of this study are:

1) What is the level of knowledge regarding the link between HIV and alcohol use among people living in a remote mining town in southern Africa?

2) What mechanisms affect how alcohol consumption leads to higher-risk sexual behaviours among people living in a remote mining town in southern Africa?

The research was conducted in a remote mining town in southern Namibia, with a population of 10,000. It is a "company town" in a "restricted region" and most mine workers come from the North, as far as 1,500 km away. Most workers live in dormitories and visit home a few weeks per year. The primary form of recreation is the "Sands Hotel", an informal drinking place.

This research is the qualitative aspect of a two-phase study. Seven FGDs, with 56 participants, were conducted with mine workers, supervisors/foremen, clients of the Social Therapy Unit for Addiction, Oshiwambo-speaking mine workers, spouses, primary school children and out-of-school youth. KII were conducted with 16 participants, selected on the basis of his/her job category (including health care professionals, company representatives and community members/leaders).

The following findings emerged from the research, illustrated by excerpts from the KIIs and FGDs:

### *Knowledge*

- **Knowledge of HIV is high among mine workers**

*"There is not a thing about HIV that is not known".*

- **Knowledge of the link between alcohol and HIV is also well-known**

*"I think they have an idea of the dangers, but they use poor judgment and have poor decision-making when they are under the influence. It affects their decisions".*

### *Factors leading to alcohol use among mine workers*

- **Boredom**

*"…nothing to do but party, party and drink, drink".*

- **Spending money**

*"Here we have too much money. In other places they can only buy one or two [drinks]. Here they can buy ten".*

- **Gender imbalance**

*"If their families are around, they don't do that [drink excessively]".*

### *Interactions between alcohol use and living in a remote mining community*

- **Mine workers seek partners in town**

*"Some people like alcohol to meet women".*

- **Gender imbalance leads to sharing partners**

*"There [are] more males than females. People start sharing partners. That's where the spreading [of HIV] comes in".*

*"Then there are only a few ladies in the area... you have to live with the fear that you are not only the person dating that person. I'll wait until the weekend and go drink, and then go find the girl".*

- **Sex work**

*"[Mine workers] look for artificial courage to do those things".*

*"Whenever you are under the influence of alcohol, you do something, you don't do what you want to do. You might regret it later".*

*"After she is drinking, she says if you give me a certain amount of money, I will go with you..."*

### *Alcohol reduces use of condoms*

*"If you are sober, you might be responsible – use a condom – but if you are under the alcohol, you don't even think about using a condom".*

*"If you are drunk, even if you have a condom, you have no idea where your condom went".*

*"When you drink, you don't have control over yourself. The girl is beautiful, so you don't think of using a condom or using it properly".*

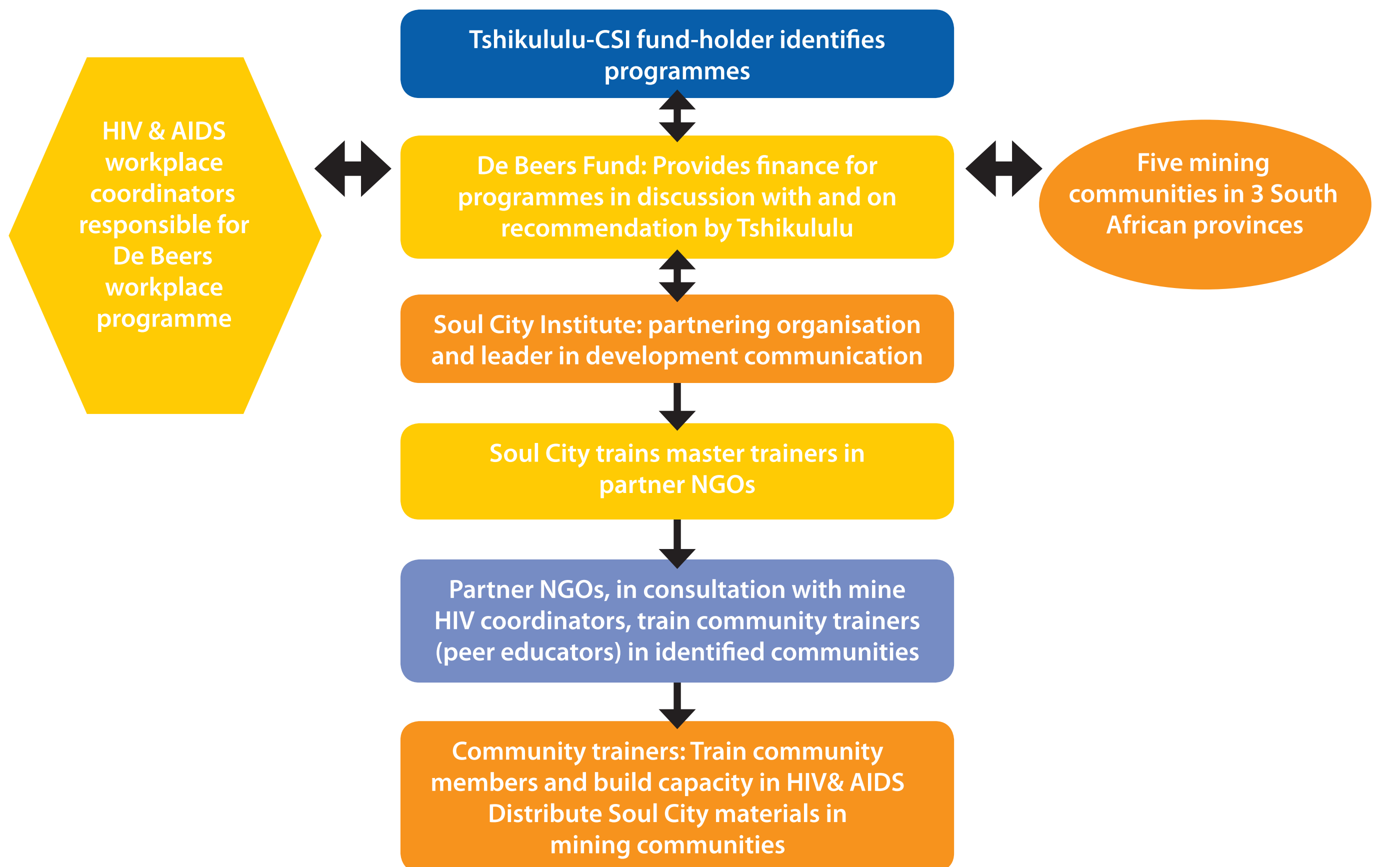
Thus, these findings show that alcohol is used as an accelerant for high-risk sexual behaviour in two ways – firstly, as an excuse for engaging in high-risk sexual behaviours and, secondly, as the cause of high-risk sexual behaviour. In other words, people who intended to avoid high-risk sexual behaviour would forget these intentions after using alcohol. The nature of the mining town creates further risks for high risk sex, in the extremely high use of alcohol and gender imbalance inherent in the town's structure.

Ananias concluded her presentation by stating that the implications of this research are that HIV-prevention efforts must take into account the relationship between alcohol use and risky sexual behaviour, particularly in southern Africa and mining communities. There is a need to revisit the structure of mining communities.

## Lessons learnt from the evaluation of a Community Training Partnership Programme in five diamond mining communities in South Africa

***Laetitia Rispel***
***Centre for Health Policy, University of the Witwatersrand***

Rispel began her presentation by providing a brief background to the Community Training Partnership Programme (CTPP). It is part of De Beers Corporate Social Investment Programme and is an extension of its workplace programme. In 2006, the company announced its first partnership with the Soul City Institute for Health and Development Communications. The following diagram shows the structure of the partnership:




In February 2007, Soul City and De Beers requested a qualitative evaluation of the process and impact that the programme has had in the five mining areas, in order to inform future programmes and/or activities.

Objectives of the evaluation were to determine:

- The impact of the training programme on the trainers in the community
- Community trainers' activities and the barriers to and facilitators of their actions
- The impact that the training has had (if any) on the surrounding community

The study sites were the mining areas of Namaqualand, Finsch, Cullinan, Venetia and The Oaks in South Africa.

Thirteen KIIs and one FGD were held with De Beers, Tshikululu, community leaders and mine HIV coordinators; nine KIIs with community trainers and 142 KIIs with community members.

The findings show that the partnership between de Beers and Soul City succeeded in:

- The introduction of an **innovative approach** to training and assisting people to confront issues of personal significance.
- **Capacity building** of master and community trainers.
- HIV and AIDS **knowledge transfer** to targeted communities in remote diamond mining towns.

The **Soul City edutainment brand** emerged as a major reason for this success.

The findings revealed the following challenges:

- Translation into **behaviour change was limited**. A relatively high proportion of participants reported having multiple sexual partners (27%) and a lack of condom use with non-regular sex partners (23%)
- Insufficient attention to the **contextual factors** in the mining towns
- Insufficient **resources**
- High **turnover** of community trainers (peer educators)
- Low **coverage** of certain target groups (for example, men and youth)
- Absence of an **M&E** framework

Recommendations for programme strengthening included:

- Adjustments to the overall **implementation** framework in line with specific mining town context
- Programme expansion and **improved coverage** of men and youth
- **Standardised, clear,** yet **user-friendly M&E** framework, to enable measurement of inputs, outputs, process and outcomes and to allow for comparisons across the mining areas.

From a methodological point of view, the lessons learnt are that mixed methods work best. It is possible to conduct an evaluation with a small, dedicated budget, but it is best not to underestimate the time it takes. One needs to have a community sample and make the distinction between process and impact.

From a programmatic point of view, the CTPP shows that PPPs work. This research has also shown the value of independent evaluation, as well as the importance of an M&E framework when designing a programme.

Rispel ended her presentation by saying that the programme came to an end during 2009, for various reasons. However, this research is important in terms of documentation of best practices and sharing of experiences.

## Discussion

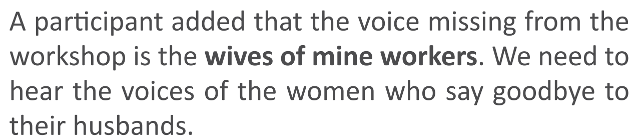
The discussion opened with a comment by a participant that the **health vulnerabilities of migrants** which were mentioned in the first two presentations are similar.

Another participant wanted the meaning of **"spaces of vulnerability"** clarified. Tansey responded that "spaces of vulnerability" are areas where there is high mobility, for example, a border town, where there is a mixture of different people from different places and people in transit. These are places where HIV transmission is higher than others.

A participant felt that there are certain institutions, like TEBA, do not assist mine workers effectively enough. Organisations work with TEBA to reach the ex-mine workers, but the participant felt that this is not an effective approach. He then urged participants to find ways to reach men.

In response, Ananias added that we need to **empower men** in their role, inform them in their local language, use men as peer educators, and have a much more comprehensive approach in our education programmes.

A question was asked about **how the IOM collaborates with UN**, especially in terms of cross-border migrants who flee from conflict. He also wanted to clarify the **meaning of "macho"**. Tansey responded that the IOM has working agreements with many of the UN agencies, and depending on the context, IOM would deal with the physical movement of people from one place to another, for example resettlement to a third country. The IOM plays the role of **"travel agent"**. It also assists with the movement of refugees internally and works with WHO on a policy level. It also works with SADC on cross-border strategies. Macho is a way of describing masculinity or a masculine way of dealing with a problem.



A participant added that the voice missing from the workshop is the **wives of mine workers**. We need to hear the voices of the women who say goodbye to their husbands.

Another participant added that the issue of migration, salaries, alcohol abuse, and poverty revolve around the **family unit**. Often, the nearest home of a mine worker is a pub. How do we deal with the realities that mine workers face?

There was a point of clarification on Tansey's presentation. The participant wanted to contrast the issue of migrants not having access to health care services mentioned in her presentation with other evidence that **95% of the population live within 5km of health facility**. Tansey said that the issue is not simply whether **physical access** to the health service is available. There are other barriers to consider – "no work no pay", language barriers, lack of confidentiality (because of lack of counselling rooms), prohibitive fee structures, transport to health facilities and so on.

In response to the presentations by Ananias and Rispel, a participant argued that **resources and leadership have to come from mining companies** and they have to work with organised labour. The best workplace programmes, where there has been the most impact, are from mining companies who commit resources and show leadership.

Rispel agreed with the abovementioned comments and stated that we need to address the **contextual and structural issues that impact on HIV and risky sexual behaviour**. We must think carefully about the issue of voluntary peer education, as many people see it as an opportunity for employment although it is not. In addition, HIV coordinators at mining sites need better management. Government health services need to be scaled up, because although facilities are available, there are problems around use of these facilities because of structural factors and attitudes.

Ananias added that the primary focus of her research was **substance abuse** and how to develop programmes to address the issue – HIV was only a small aspect of the study. But the findings do provide an understanding of the relationship between HIV and substance abuse.

It was agreed that we need to recognise the wider structural issues which impact on migration and acknowledge that **migration is a reality**. The challenge is to find ways to make it more orderly and less risky.

## Findings from the Thibela TB project

***Fazel Randera***
***Aurum Health Institute***

Randera started his presentation by showing how active pulmonary TB (PTB) in mine workers at autopsy has risen over the last 30 years, from fewer than 50 cases per 10,000 in 1975 to over 350 cases per 10,000 in 2008. TB control is failing in areas of high HIV prevalence – the South African gold mines being a case in point. For example, TB incidence in the mining sector is approximately 2,000 to 6,000 per 100,000 per annum, in comparison to 960 per 100,000 per annum in the general population.

In this context, the aim of the Thibela TB Project is to compare the efficacy of community-wide Isoniazid Preventative Therapy (IPT) with the current standard of care. The study compares the results of standard TB control versus standard TB control plus community-wide IPT.

The end points of the study are:

***Primary endpoint:***

- TB incidence measured over 12 months following the last person enrolled completing therapy

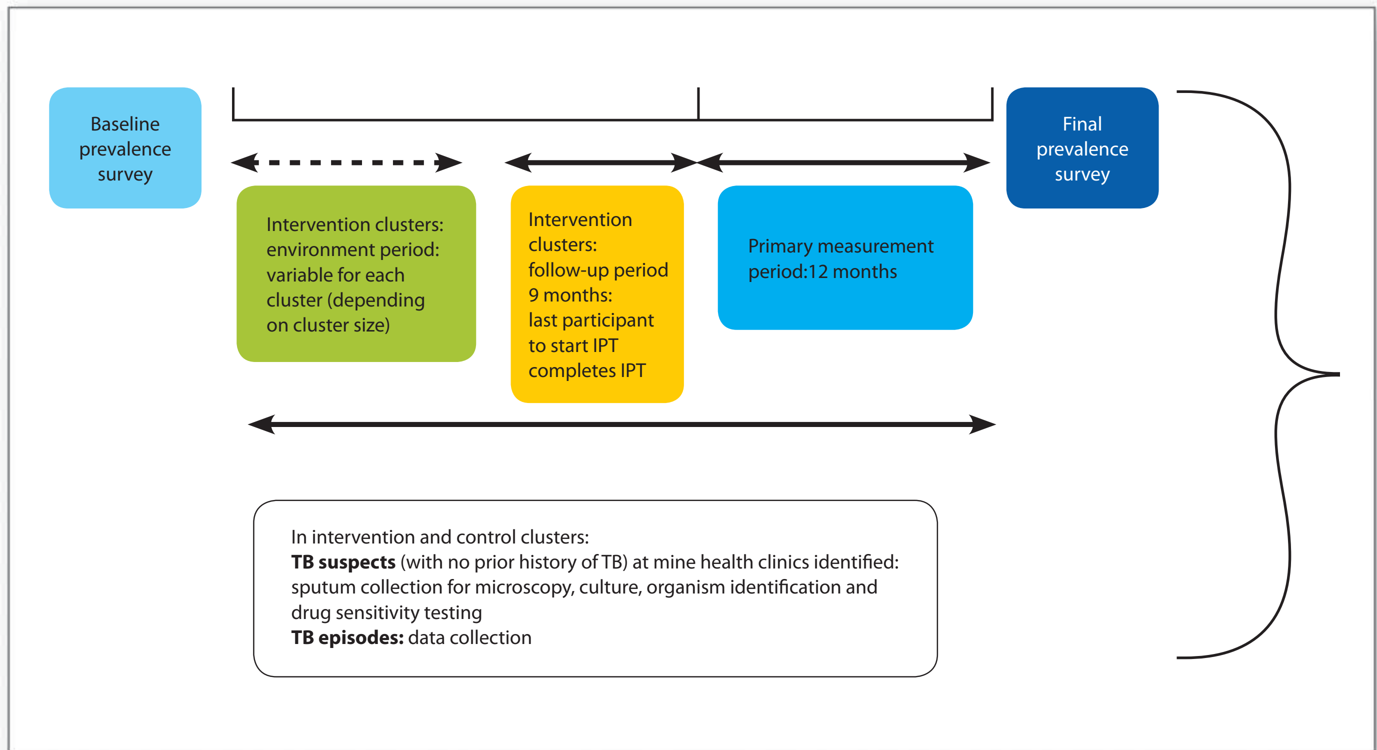
***Secondary endpoints:***

- TB prevalence (sputum culture) at end of follow-up period
- TB case notification rate in follow-up period
- Safety: number of serious adverse events due to IPT
- All-cause mortality rate during the follow-up period

- Incidence of isoniazid-resistant TB

The project is a cluster-randomised invention study. A cluster is defined as all employees at a mine shaft.

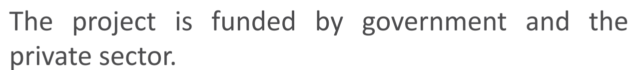
The study has enrolled 20 mine shafts, translating into 15 clusters, and over 70,000 mine workers. The following diagram shows the cluster flow through the study:




The lessons learnt from the study are that:

- **Prevalence** of TB is **high** (89%)
- Despite relatively strong TB control programmes, **TB incidence** remains **high**
- It is **feasible to implement IPT** in the mines – uptake and retention has been positive
- **Community mobilisation** is essential. It has supported rapid and large-scale uptake of IPT, created high awareness of TB and IPT and there has been strong community support for the study
- **TB screening** prior to IPT has worked well
- **Isoniazid is safe** – 126 adverse events, 4 serious adverse events and 33 deaths recorded (31 not related, 1 possibly not related and 1 not recorded)
- Thibela TB project has had a **wide impact**
- **Support of policymakers** is essential

The final culture prevalence survey measures the proportion of mine workers with undiagnosed, active, infectious TB. It provides critical information to determine whether the Thibela TB Project has been successful. It will also provide important information on risk factors for transmission of TB, prevalence of drug resistant TB, and the role of new rapid diagnostics for TB.



The project is funded by government and the private sector.

In conclusion, the progress of the project is on track. It is providing important data for public health policy. But continued stakeholder involvement is essential and supplementary funds are needed to complete the project.

## Knowledge, attitudes and perceptions of HIV testing and antiretroviral therapy in a sample of mine workers in South Africa

***Gavin George***
***Health Economics and HIV/AIDS Research Division***
***University of Kwazulu-Natal***

In this presentation, George shared the findings of the abovementioned study, which was conducted by the Health Economics and HIV/AIDS Research Division and School of Psychology at the University of KwaZulu-Natal and a De Beers mining site in Finsch in the Northern Cape (including the mine management and organised labour). The research was independently funded by Merck.

George first outlined the context of this study. In previous research, George and others have found that there is limited participation of employees in VCT, perceived to be due to persistent fears of discrimination and stigma in the workplace. Furthermore, there is the tendency of individuals to seek treatment once they are sick and incapable of working, thereby confounding programme intentions to maintain worker productivity by enrolling individuals in health care programmes before they fall ill.

The limited numbers of individuals on ART present a very high cost ratio for individual care, high costs in time and resources are expended to enroll employees in programmes and delays/low uptake impact profoundly on individual health outcomes and quality of life.

At the time of data collection, the employee population at the study site comprised approximately 951 permanent employees, 250 temporary employees, and almost 1,600 contract workers. The 2007 VCT campaign at the mining company achieved an exceptional average uptake of 86% (83% of permanent and temporary employees and 90% of contractors had participated); this was in line with the previous year's performance of 84% average VCT uptake, but late ART enrolment.

The primary aim of the study was to investigate cognitive and behavioural constructs (VCT, work place perceptions of the ART programme, HIV risk infection and HIV testing) and their association with general attitudes towards ART amongst a sample of mine workers.

***Findings:***

- Low negative attitudes towards the mine's HIV treatment programme were associated with positive attitudes towards ART.

- Participants who had higher levels of knowledge of ART were more likely to hold positive attitudes towards ART. Participants with positive attitudes towards ART were more likely to have favourable perceptions of their experience of VCT at the mine, to believe that other people they know will support their decision to have a HIV test, and to feel confident in their ability to perform behaviours that will reduce their risk of contracting HIV.

- Stigma, barriers to partner disclosure, barriers to partner HIV testing and fear of HIV testing were significantly associated with a poorer attitude towards ART.

- Being afraid of having an HIV test was significantly related to stigma and to having a negative attitude towards the mine's HIV treatment programme. The results also indicated that individuals who appraised the value and benefit of HIV testing positively were more likely to hold positive attitudes towards ART. Normative beliefs about VCT participation were found to be significantly associated with a favourable experience of VCT, holding stigmatising attitudes towards HIV positive people, fear of HIV testing, and a low negative attitude towards the mine's HIV treatment programme.

- Five variables were identified as significant predictors of attitudes towards ART: knowledge of ART was the highest, followed by negative attitudes towards the mine's treatment programme, self-efficacy for limiting HIV risk behaviours, stigma and barriers to partner HIV testing.

The **recommendations** that emerge from the research are:

- Individuals are inclined to hold similar beliefs and attitudes towards ART as they hold towards HIV testing and PLHIV. Therefore, interventions designed to increase VCT uptake rates should place significant emphasis on **improving individuals' knowledge of ART**.

- Individuals' attitudes towards ART are significantly related to their self efficacy beliefs regarding HIV risk reduction, which may be indicative of a relationship between individuals' attitudes towards ART and their perceived ability to perform behaviours related to the management and adherence of ARV regimens. The primary role of knowledge of ARV medications in influencing individuals' attitudes towards ART underscores the importance of **finding more efficient and effective ways of communicating accurate information about ARV medication** and regimens to HIV patients and their significant others.

- Although a high rate of VCT uptake was identified, significant concerns include evidence of relatively poor knowledge of trust in HIV testing, and the negative stereotypes related to HIV testing that was displayed by a substantial proportion of the sampled mine workers. These issues should be addressed by management and health care workers at the mine through **systematic efforts to educate mine workers about the reliability and accuracy of HIV testing, reduce stigma and increase levels of trust related to HIV testing** in order to foster a positive and supportive attitude towards workplace VCT services. Such efforts may succeed not only in sustaining high rates of VCT participation amongst the mine workers, but may also engender more positive attitudes towards ART and a more successful uptake of treatment services

- At a more general level, individuals' attitudes towards ART in are strongly influenced by their attitude and opinion of their own company's treatment programme, peer norms and behaviour, workplace norms, and the marketing and communication of the VCT service. Interventions need to **consider contextual factors when designing and implementing VCT programmes**. This also includes attention to issues like mobility of workforce, retrenchments, employer-employee relations, and history of VCT work in the organization.

## The life of a mine worker: an on-the-ground perspective

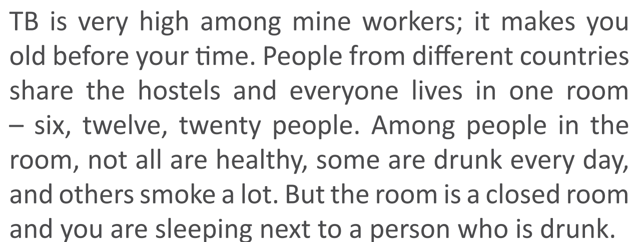
***Ernesto Libombo***

Libombo is an Mozambican ex-mine worker who has worked on the South African mines for almost three decades. He shared his story with the rest of the participants.

"We all look for better conditions for life – this forces us to migrate. The result is that we leave our countries to other countries to look for better conditions.

When a person migrates to another country he finds problems, and this obliges him to change his mindset – the culture, environment, everything is different. Frequently these things will put him away from the realities of his family and obligations. The labour environment influences our lives and the management of our behaviour. Other people lead you to another way of living, different habits.

The work of a miner is very hard work – my twin brother looks like my son because [I look old] from working in the mine where conditions are difficult. It is very hot in mines – I drink five litres of water a day. I have worked for 27 years in these conditions. I have seen many problems – boredom and tiredness causes accidents. We stay for eight hours in these places.



TB is very high among mine workers; it makes you old before your time. People from different countries share the hostels and everyone lives in one room – six, twelve, twenty people. Among people in the room, not all are healthy, some are drunk every day, and others smoke a lot. But the room is a closed room and you are sleeping next to a person who is drunk.

Another issue is that we share the diseases – new policies do not prevent women coming into the hostels and drinking with the men. So those friends, they are really 'friends' [in that they have sex with the same woman].

Treatment in hospitals is not good. We are treated when we are sick, but it is not a good treatment. We go to the hospital and everything is paid for by the mining company, but officials and [those in] lower ranks go to different hospitals. Mine workers have to go home without a diagnostic and go to a doctor at home and treatment starts all over again, which presents problems. If he [the mine worker] had brought a diagnostic the doctor would know.

The children remain with mother, she educates them, and then the father comes back and struggles with educating the children. When the miner has been gone for a long time he leaves the wife pregnant.

People working on these programmes for mine workers need to deal with the leaders of the miners, visit the mines, and work with mine workers' associations."

## Discussion

Participants had a number of follow up questions for Randera. One wanted to know **what the standard of care for TB is** and how **IPT** fits into this. Another wanted to know what the **inclusion criteria for the Thibela TB Project** are and the implications for treatment when the study results are finalised.

Randera responded that in the South African mining industry there are 450,000 workers across all commodities, of which 100 000 are contract workers. Of this total, 75,000 of permanent employees have medical insurance. **TB** is recognised as an **occupational disease** in a mine worker who has worked for one year or more. Once a diagnosis is made he is referred to the public health service. **TB diagnostics** are based on **active case findings**, in other words, regular chest x-rays. IPT is a preventative therapy and Isoniazid is given to a community, not an individual. The inclusion criteria for the project are permanent and contact workers.

Another participant wanted to know **the effect of IPT on the TB epidemic**. Is it a lifelong treatment and if not, how long must it be administered? Randera responded that the aim of IPT is to decrease the number of TB cases. There is a three-year period of protection with Isoneze. But we also need to be looking at improving infection and dust control, silica dust control, VCT, and so on – these issues need to be integrated into a comprehensive approach to reducing the health vulnerabilities of mine workers.

A participant commented that too many mine workers return to surrounding countries without completing their treatment – is this because of the **distinction between permanent and contract employees**? He argued that government, labour and the mining companies have a responsibility to address this.

Another participant responded by saying that **TB treatment is available for all mine employees**, regardless of whether they are contract or permanent employees. A standard guideline used, and this is aligned to South African national Department of Health (NDOH) guidelines, and signed off by government, labour, and the private sector. Everyone receives the same treatment and mining companies don't talk about contractors or workers anymore, they talk about employees. A person who has medical insurance will go to private hospital, but the medication used is the same.

In terms of the **difference in access to health care for Mozambicans in comparison to South Africans**, Randera responded that there is **no discrimination** in mine health hospitals between different nationalities. Workers receive equal access to health care services.

## GROUP DISCUSSION

At the end of Day One, participants broke into three groups to discuss the main issues which emerged from the presentations. The groups addressed the following questions:

1) What are the key health vulnerabilities of mine workers, their families and communities with which they interact, that emerged from the day's presentations?
2) How are these vulnerabilities being addressed?
3) What are the gaps in this response?

| | Key vulnerabilities | How are these vulnerabilities being addressed? | What are the gaps? |
|---|---|---|---|
| GROUP 1 | Migration: internal and external | | Lack of attention to mental health e.g. induction, orientation |
| | New environment: no orientation | | Receiving government or agencies not doing enough in terms of follow up |
| | Spousal and family separation | | Unequal development in health systems among countries |
| | Working conditions | | Address primary problem of economic under-development |
| | Intrinsic job conditions, e.g. dust | | South Africa's role in referrals |
| | Living conditions, e.g. hostels, overcrowding etc. | | |
| | Poverty of surrounding communities | | |
| | Sex work | | |
| | Impact of mining on the environment and health of surrounding communities | | |
| | Family of mine workers: lack of follow-up care | | |
| | Gap between legislation and policies | | |
| GROUP 2 | Being away from home | Hostels – we need to come up with an alternative | Advocacy for mine workers |
| | Loneliness | Family accommodation | Health passport |
| | Living environment | | Mind set change – more openness |
| | Language and cultural barriers | | Speed up implementation of SADC protocol |
| | Gender imbalance | | Less stigma |
| | Lack of HIV information | | Revitalisation of existing policies |
| | Inadequate/lack of treatment | | Harmonisation of treatment within SADC |
| | Disclosure of information to spouses: couples counselling | | |
| | No visas allowed for wives to visit husbands: does the wife have money; is the hostel the right environment? | | |
| GROUP 3 | Communicable diseases, e.g. TB & HIV | Workplace programmes – what about the families: is this responsibility of the state? | Families do not access same treatment as mine workers |
| | Occupational diseases | Public-private partnerships | Little/no involvement of mine workers associations |
| | Social and lifestyle diseases e.g. substance abuse, accommodation-related | NGO responses – e.g. Soul City | Medical referral system |
| | | Mine workers associations | |
| | | Corporate Social Investment | |

## DAY 2

## PLENARY THREE: PROGRAMMES AND POLICIES

The second day of the workshop opened with the third and final plenary. This session had the objective of sharing lessons learned, experiences and good practice of HIV responses, policies and programmes, as they relate to mine workers, their families and communities with which they interact, with the view to identifying existing gaps and challenges in current policy and programming. The presentations in this session were:

- Georgia Mbuga, TEBA Development: "Working with mine worker-sending communities in southern Africa"
- Gertrude Musunku, First Quantum Minerals Limited: "First Quantum Mineral Limited's health-related corporate social responsibility programme"
- Khanyile Baloyi, South African Chamber of Mines: "The private sector response to the health vulnerabilities of mine workers, their families and affected communities"
- Cecilia Martine, CNCS: "Technical working group on HIV-positive mine workers in Mozambique"
- Lennox Mekuto, National Union of Mine Workers: "The response to HIV by unions in the mining sector"
- Moises Uamasse, Associacao de Mineros Mocambicanos: "Regional Association of Mine Workers"

### Working with mine worker-sending communities in southern Africa

***Georgia Mbuga***
***TEBA Development***

TEBA Development was established in 2001 and is the non-profit arm of TEBA Limited. Its focus areas are HIV prevention and home-based care (HBC); agriculture and food security; school assistance; skills development and training; water and sanitation; and social and labour planning.

The objectives of the HIV prevention and HBC component of the programme, run in partnership with the IOM, are:

- To develop gender-responsive programmes within targeted mine worker-sending communities in Mozambique and Lesotho.
- To run HIV programmes and deliver HIV-related services within targeted mine worker-sending communities in Mozambique and Lesotho.
- To improve attitudes towards HIV and SRH education and services within targeted mine-sending communities Mozambique and Lesotho.
- Improved mitigation of impact of AIDS in selected migrant sending communities in Mozambique and Lesotho.
- Increased adoption of positive healthier lifestyles, including safer sexual practices within targeted mine-sending communities in Mozambique and Lesotho.

TEBA uses IOM's Health Promotion & Service Delivery Model in its HIV prevention and HBC programming:

- HIV and/or wellness workplace policy
- Skills building of managers, supervisors

Creating and enabling environment throught workplace policies & programmes

Facilitating access to health services, programmes & products

- Skills building
- Adressing health providers attitudes
- Establishing a referral system
- Health passports

Strengthening of local implementing partners

Social & Behavioural Change Communication

Gender

IOM Health Promotion & Service Delivery Model

Capcity Building

GIPA

Strategic Information

- Institutional Capacity assessment
- Strategic Planning
- M&E
- Profile raising

- Recreational activities
- Life skills i.e. ABET
- Personal development
- Income generation

Addressing contextual barriers to behaviour & social change

Peer-led communication, information and education on health, incl. HIV, TB and STIs

Addressing gender dynamics in the context of HIV & migration

Facilitation of dicussion on:

- Gender socialisation
- Men's health seeking behaviour
- Empowering women & girls

- Dissemination of HIV related information
- One on one
- Focus group discussions

TEBA Development recruits mine workers for its projects in partnership with Associacao de Mineros Mocambicanos (AMIMO)'s "One Man Can" activities. TEBA's community activities include:

- Engaging men in the community
- Bio security workshop
- HIV Testing and Counselling (HCT)
- Income-generating activities in partnership with HOPE
- Drama in partnership with PSI
- Radio partnership with the National Radio Institute in Xai Xai
- Malaria Day
- Distribution of mosquito nets in partnership with Right to Play
- TB Day
- World AIDS Day
- Adult classes
- Condom access for the community
- Gender dialogue about alcohol and HIV
- The challenges that the project faces are:

- Mine workers are not repatriated through the TEBA system, which makes it difficult to trace and provide HBC to patients.
- Transport to take very ill patients to health centres, especially in remote rural areas that are inaccessible to vehicles.
- Limited number of medical services in rural areas is a threat to HBC services, especially when it comes to referrals for HIV-positive patients.
- Low number of men knowing their HIV status.
- Lack of information about TB treatment for mine workers.

## First Quantum Mineral Limited's health-related corporate social responsibility programme

***Gertrude Musunku***
***First Quantum Minerals Limited***

First Quantum Minerals Limited (FQML) is a mining company involved in exploration, development and mining. It has copper and/or gold mining operations in the DRC, Zambia and Mauritania. Its workforce in Africa is approximately 7,000 employees.

FQML's corporate social responsibility (CSR) programme in Zambia has a number of components, including health. The health programme operates within the FQML health/HIV programme framework, while the company partners with the IOM and Comprehensive HIV AIDS Management Programme on the programme. It includes everything from policy documents to programme activities. The following activities have been carried out:

- Baseline KAP survey with migrant workers
- Recruitment of technical support assistants who are responsible for the daily running of the site programme
- Trained 18 change agents
- FGDs
- Sensitisations
- HCT: people who test HIV positive are referred to the mine site clinic or to the mobile ART unit for further management
- Recreation facilities
- Implementation of "One Man Can", which is a call to action for many to take action against HIV
- Health road shows are an education-entertainment forum, which allows active engagement with the communities at a large scale and community members to educate one another in their own language in a controlled environment

In short, CSR gives the company "a license to operate". In its programme areas the company has seen an increased demand for services and more cohesion between communities and employee populations.

## The private sector response to the health vulnerabilities of mine workers, their families and affected communities

***Khanyile Baloyi***
***South African Chamber of Mines***

Baloyi opened his presentation by giving participants a background to the South African Chamber of Mines (CoM) and its roles and responsibilities. The CoM is a private sector employer organisation and membership is voluntary. It exists as the principal advocate of major policy positions endorsed by the mining industry and represents these policy positions to South African national and provincial government organs and other relevant policymaking and opinion-forming entities, both within South Africa and abroad. The CoM also works closely with the various employee organisations in formulating these positions where appropriate.

CoM officer bearers lobby and advocate on behalf

of mining industry but they do not represent any specific company, rather "the chamber". They work in terms of a mandate.

Baloyi then outlined the mining industry's response to HIV:

***Mining Industry HIV Tripartite Committee***

- Drafted the guideline for the compilation of the Code of Practice (COP) for HIV/AIDS for the Industry (includes treatment protocols).
- Hosted the 2003 and 2006 HIV/AIDS Summits.
- Drafted and implemented the HIV Tripartite Action Plan.
- Commissioned an HIV/AIDS Survey in 2006 and 2010.
- 26 May 2010: hosted a workshop with ILO and NDOH to revise the COP and align it to the international standards.
- Second survey planned for July 2010 to review progress.
- Next HIV Summit planned for October 2010.

***Industry commitment***

- Provision of ART
- VCT campaigns at operations
- Provider-initiated HCT

The challenges faced in provision of these services are that there has been low uptake due to stigma, compliance to ART and the fact that VCT is incentive driven.

### *Community projects*

***Government HCT initiative***

In November 2009 a bilateral meeting between government and the business sector resulted in the principle outcome of commitment to improve collaboration between business and the government in dealing with HIV and AIDS.

In terms of occupational diseases, Baloyi argued that without diminishing the gravity of the HIV epidemic, there is no doubt that TB is the most prevalent occupational disease in the mining industry. HIV is the key driver of the TB epidemic. Silicosis is not a major crisis, but we have to ensure that workers who fall ill from it receive compensation. The latency period for silicosis is approximately eight years and so it is hoped that there will be no new cases by 2013. Noise-induced hearing loss (NIHL) has dropped dramatically, to only four cases per 1,000 in 2009.

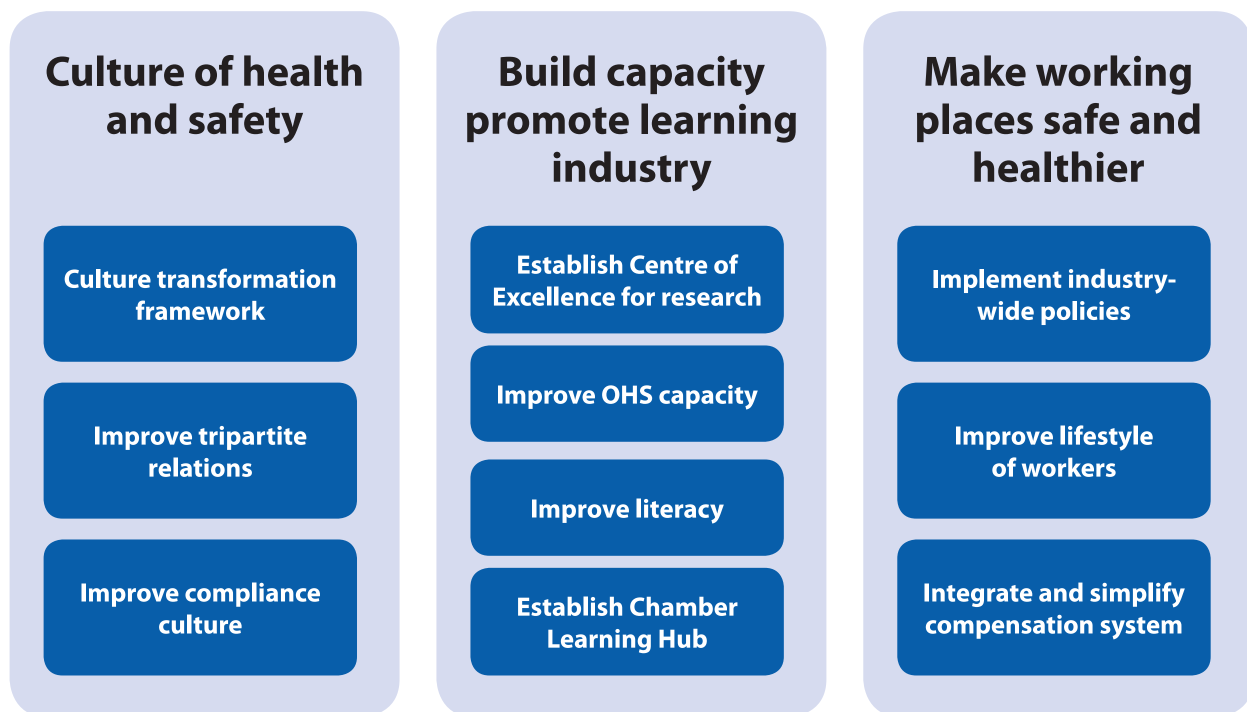
Baloyi mentioned that the key challenges the mining industry face are the current accommodation system for mine workers, the referral system to ensure continuum of care for employees exiting the industry, compensation systems and the low uptake of VCT and ART. Compensation is a government function – the Compensation Fund and compensation process is managed by the state through Medical Bureau of Occupational Diseases and Compensation Commissioner for Occupational Diseases. Industry contributes levies into the fund and the state administers the fund and compensation process. However, there is a need for the industry to assist with process re-engineering.

The following recommendations were made:

- IOM and partners should establish a task team (inclusive of all key stakeholders) for addressing issues.
- Investigate how best to assist the compensation process.
- Investigate and assist with acceleration of hostel conversions to family units.
- Expand Service Level Agreement with TEBA to address patient referral system and assist with ensuring continuum of care.
- Establish a national database on medical information for each SADC member state (a comprehensive referral document) for exiting employees.
- Design target or group-specific HIV prevention strategies and messages.

The work that has been done by the CoM has presented the inescapable conclusion that competitiveness, transformation and sustainability are interlinked. An industry that is not competitive in the global marketplace - no matter how zealous the commitment - will not have the essential capacity to achieve transformation benchmarks.

The mining industry's approach is summarised in the following diagram:




## Discussion

A participant wanted to know how one goes above **"changing men's consciousness"**, as mentioned in Musunka's presentation. Musunka responded that appealing to men's consciousness means how one **packages information** and providing opportunities for men to learn. It is important to have management buy-in so that all employees are given an opportunity to attend meetings, otherwise men will not have the opportunity to engage.

The same participant asked about **occupational diseases** other than those mentioned in Baloyi's presentation: what about those besides silicosis and NIHL? Baloyi replied that the private sector plans to address all occupational diseases in the workplace and that participants could **consult the CoM website** for detailed reports on all of these diseases, as these documents are in the public domain.

Another participant raised the issue of the **photographs that are used in presentations**. He felt that caution must be used in the use of photographs and that organisations must ensure that they are also included in the photographs when carrying out work with communities. This makes the photographs more believable and trustworthy, especially to mine workers. Musunka said that the point was taken and that one of the pictures in her presentation did have a FQML banner in it.

In terms of **CoM membership**, a participant wanted to know how many mining companies in South Africa are members. In addition, are there any group of mines which have **best practices** that could be rolled out in other mining groups in South Africa? Baloyi responded by saying that some companies have the best programmes and other companies have the opportunity to learn from such companies. Unfortunately we cannot "copy and paste" programmes because of limited budgets .

A participant noted that in terms of how the mining industry deals with occupational diseases, there should be better collaboration between **mine worker-sending and receiving countries**.

In terms of better collaboration from the mining industry, Baloyi said that we must investigate what the law says about the **obligations of the employer**, devise an "obligations of employers" document and sign off on it. The mining industry has been criticised for its **response to TB** in the past but this is because there was a lack of data on the disease. The first database has just been developed and the first set of information was available at the in beginning of May and will be looked at in June.

TB is classified as an occupational disease for all **controlled mines**.

A participant wanted to know about what **TEBA** is doing in other areas besides Mozambique, as it is a regional organisation. Clarification was also sought on how to **strengthen local partners** and who these partners are in TEBA's case. Mbuga responded that TEBA is doing similar work in mine worker-sending communities in **Mozambique, Lesotho and Swaziland**. She also mentioned that working with local partners means the greater involvement of people living with HIV, working with community organisations and running campaigns like "One Man Can".

A participant spoke about **MCP in terms of biological imperative** in that there are more women than men in the population and thus it is difficult for men to limit themselves to only one relationship. Musunka responded by saying that this is not an adequate justification for MCP, and that we need to look at the **sociological drivers of risky sexual behaviour**. MCP are also driven by economics and power imbalances between men and women. She suggested that if someone chose to be in a relationship then they should adhere to the responsibilities that the relationship brings.

It was mentioned that it is not sustainable to give **incentives for VCT**. But how do we address the challenge of getting people to test without them? Baloyi responded that it is the company's choice to decide how they are going to run their VCT campaigns. If the company does not have enough funds to provide incentives then they are obligated to provide counselling and testing.

There was a protracted discussion about the issue of **compensation for mine workers**. A participant remarked that it is government's responsibility but the private sector also has a role. Compensation should benefit mine workers and it should not be coordinated by only one organisation.

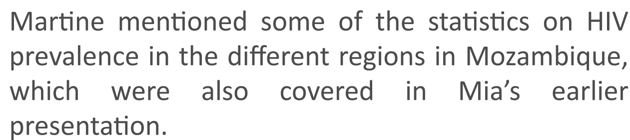
Baloyi responded that it is indeed the government's responsibility to administer compensation. The **Occupational Diseases in Mines and Works Act** (administered by the NDOH, provides a workers' compensation framework for occupational diseases attributable to "risk work" in a mine or works) is inefficient – people were not compensated and levies were not adjusted accordingly. Whereas the **Compensation for Occupational Injuries and Diseases Act** (administered by the Department of Labour and is the workers' compensation safety net which covers all employees and provides for the medical examination, certification and compensation of all employees who are injured on duty or who suffer from an occupational disease) was outsourced to Rand Mutual to improve efficiency in processes and fund administration. The lesson learnt here is to remove the management of the fund from the state and give it to a private company; however, this will have cost implications. However, it would be better to have people compensated than leaving them for years with no compensation.

Baloyi also acknowledged that compulsory **hostel accommodation** needs to be replaced with a system that gives a mine worker the choice about where he wishes to reside.

## Technical Working Group on HIV-positive Mine Workers in Mozambique

***Cecilia Martine***
***CNCS***

The purpose of the presentation was to speak about the Technical Working Group on HIV-positive Mine Workers in Mozambique and to share information on the national response to HIV in Mozambique.



Martine mentioned some of the statistics on HIV prevalence in the different regions in Mozambique, which were also covered in Mia's earlier presentation.

The country's National AIDS Council, CNCS, is chaired by the Prime Minister, and includes ministers (health, foreign affairs, education and so on), civil society, and private sector. The NSP was first developed in 2000 and it will be revised soon. In order to strengthen the existing plan, it was felt that the strategy for HIV prevention needed to be sped up and that high risk groups need to be identified.

In this regard, a working group was created in order to harmonise the response to mine workers working in South Africa. The group had a consultation with NGOs in both countries and visited the South African CoM in 2007. It conducted a detailed mapping of existing health units and HIV services. At that time, the CoM committed to new health services that would be transferred to government after three years.

By 2009 the working group had lost stamina, as some members had changed positions and so on. However, the group is being revitalised and it is preparing a joint mission to review the process and the agreement with the CoM.

The objectives of the technical working group are to:

- Provide a road map of assistance available to Mozambican mine workers and to have a memorandum of understanding (MOU) between the governments of both countries.
- Develop an action plan of providing assistance to migrant mine workers, their children, wives and widows.
- Be a single platform that can ensure monitoring of this group.
- Mobilisation and technical assistance to AMIMO in a decentralised manner.
- Promotion of the development of skills in AMIMO.
- Promote studies which investigate programmes and policies.

## The response to HIV by trade unions in the mining sector

***Lennox Mekuto***
***National Union of Mine Workers***

The National Union of Mine Workers (NUM) organises in the mining, energy and construction industries and has 317,000 members. It is affiliated to the Congress of South African Trade Unions, International Federation of Chemical, Energy, Mine and General Worker's Unions and Building and Wood Workers' International. NUM has been involved in addressing the HIV epidemic since 1986.

NUM has a HIV and AIDS policy, which is currently under review. It also has signed workplace agreements with a number of mining companies, including Anglo Gold Ashanti, Anglo Platinum, Goldfields, Harmony, De Beers and SACEC, among others. Most of these agreements obligate employers to provide ART to mine workers. Some of the agreements allow for the appointment of full-time HIV mine coordinators.

In 2002/3, in the wage agreement, NUM and CoM agreed to hold regular Mining Industry HIV/AIDS summits. Two have been held – one in April 2003 and 2006. NUM has also bee instrumental in forming the Mining Industry HIV/AIDS Forum.

Every year NUM commemorates World AIDS Day. At every activity the organisation conducts HCT. At a recent event on 13 and 14 May, 306 delegates volunteered for HCT. In the last three years, NUM has trained 300 peer educations and 11 lay counsellors. It is working on the action plan of the South African government to have 15 million people tested by June 2011.

NUM has signed a MOU with Aurum Health Institute on the Thibela TB Project and with the Tshepang Trust on the "Stop HIV Stick to One Partner" campaign.

***The challenges the union faces in its HIV response are:***

- Extending treatment to **dependents** of mine workers

- **Repatriation** of sick mine workers and those who are on HIV and/or TB treatment
- Engaging **spouses**

***Recommendations for future work in this area are:***

- Speed up **finalisation of comprehensive health care** so that mine workers can benefit
- Strengthen **relationship with HBC workers** and care givers
- Strengthen **relationship with mine workers associations**
- Develop a **coordinated approach** to campaigns/projects which work with mine workers and their families
- Develop a joint funding model for the **empowerment of spouses** of mine workers

## Regional Association of Mine Workers

***Moises Uamasse***
***AMIMO***

AMIMO took the initiative to coordinate and bring together mine workers from the region (Botswana, Swaziland, Lesotho, South Africa and Mozambique) at the first regional meeting of southern African mine workers associations in 2008. The need for the formation of a regional body was discussed in the meeting and the Ministry of Health in Mozambique recommended a joint regional response to address HIV.

A follow-up meeting of directors of associations in was held in Johannesburg in June 2009. Here a task force was established with Lesotho as chair, Mozambique as secretary and Swaziland as a member. The major task was to develop a constitution to spearhead the formation of a regional body to cater for mine workers. AMIMO also convened a second regional seminar for mine workers associations, which was held in Pretoria on 30 and 31 March 2010).

***The recommendations of the second regional seminar included:***

- Developing a prevention and social mobilisation framework that would strengthen the HIV response for mine workers.
- Strengthen cooperation among governments, associations and NGOs in the region
- Improving care, access to counselling and testing services; treatment and assistance for mine workers in the region.
- Expanding access to VCT for mine workers across the region.
- Intensifying the resource mobilisation framework for joint and coordinated initiatives to mitigate the impact of HIV and AIDS.
- Accelerating development and mitigating the impact of HIV and AIDS.
- Strengthening institutional M&E mechanisms for national mine workers associations.
- Conducting negotiations with governments in order to:
    - Create a basket-fund to support mine workers initiatives in the country of origin.
    - Pay reform and pension funds to mine workers.
    - Be entitled to treatment continuity (for TB, HIV and any other occupational diseases).
    - Strengthen healthy dialogue with SADC Secretariat in the implementation of regional instruments by SADC member states and associations.

- Developing cross border initiatives in the region.
- Improving HIV prevention measures and dissemination mechanisms.
- Improving close relations with operators, employers and partners in the mining industry.
- Creating a regional body of mine workers' associations.

### *Why a regional mine workers' association?*

- Challenges facing mine workers are similar across the southern Africa region.
- There has been little or no involvement of mine workers in the response to HIV.
- Limited support to the mine workers either from CSOs or governments in the region.
- Health and social status of mine workers is seldom addressed comprehensively.
- Individual efforts of mine workers are not effective (loss of rights,payments and benefits).

### *Objectives of the regional mine workers' association:*

- Establish wealth among southern African national active and former mine workers' associations through social reintegration and job creation after retrenchment.
- Provide capacity building to national active and former mine workers' associations to encourage self employment and mobilise funds for promotion of community development projects.
- Support and promote income generating activities for ex-mine workers, widows and orphans.
- Create a database for research, communication and documentation of mine workers.
- Advocate and lobby for full participation and decision-making in regional and international organisations with an interest in mine workers' issues, including ILO.
- Provide technical support to national mine workers' associations to work on occupational health and diseases.
- Strengthen alliances, partnerships, unity and solidarity with relevant bodies and agencies working on HIV and AIDS nationally, regionally and internationally.
- Advocate to African governments to protect the basic human rights of all mine workers, including right to occupational health care insurance and insurance after death.
- Encourage formation of new national organisations and support groups and strengthen existing ones.

### *Main activities*

- Coordination of mine workers to achieve one common goal within the region.
- Lobbying and advocacy (human rights).
- HIV prevention, care and support.
- Care for orphans and widows.
- Community projects for social reintegration of active and mine workers, their families and the communities with which they interact.

### *Main successes*

- Relationship with supporting partners has been established.
- Mine workers are more united and ready to work together.

- First and second regional seminars had high participation and support from all sectors.
- The formation of the regional body has had approval from all sectors.

***Challenges***

- Resource mobilisation (funds for the implementation of recommendations of the second regional seminar).
- Institutional capacity building and systems development.
- Partnerships: no partners yet to assist in the implementation of the recommendations of the regional seminars.
- Communication: flow of information between the national associations has been difficult as there are no operational funds.
- Operations: limited funds to spearhead the process.

***As a call for support, a regional mine workers' association would need:***

- Institutional support.
- Programme and operational support.
- Capacity development.
- Funding for project implementation (for example, community and income generating activities).
- Strong partnerships.

## Discussion

The issue of **accommodation** for mine workers was discussed at length.

NUM argued that the **issue of accommodation is embedded in a long history of struggle**. The organisation believes that there is no reason why mining companies cannot improve housing conditions. There are other examples of best practices, where big companies are addressing this issue adequately, for example, the large construction companies in Doha. Mine workers should also have the opportunity to buy houses in the place that they live.

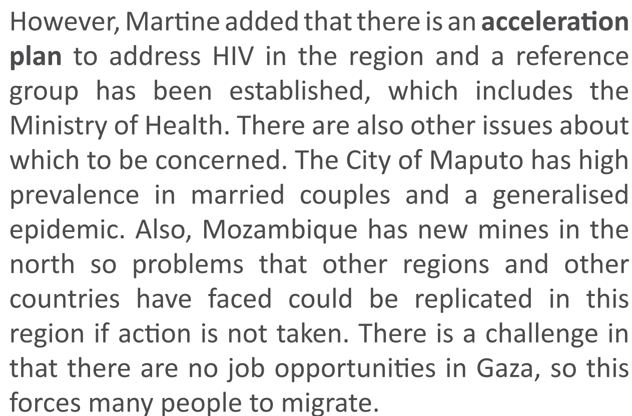
With regards to a **housing allowance**, it is NUM's position that mine workers should receive one. How they use it and how much they receive must be decided between employers and labour. These parties must also ensure that the funds received are spent on accommodation.

Another participant mentioned that the **voice of the mine houses** is missing from the discussion. He argued that, given the choice, mine workers would choose more money over better housing. He also said that family housing may not be feasible for **contract workers**, who are on site between six months and two years and are mobile. They also move from mine to mine. Their needs have been neglected and must be addressed.

Ultimately, it was agreed that all the different kinds of mine workers (permanent, casual and contract workers) must be **given a choice** of the kind of accommodation in which they want to live. This may be single accommodation or a family unit, but the point is that they need to be given an option.

With this said, the group was unsure of whether better accommodation would necessarily **decrease HIV prevalence** among mine workers.

There was a question about the **dynamics of HIV prevalence in Mozambique**. Why is prevalence in the south higher than other regions? Because of this difference there needs to be a specific plan to address it. Martine responded that the prevalence in Gaza province is a concern for all. An assessment which examines HIV transmission in the province has not yet been released, but it can be assumed that the high level of prevalence in Gaza is related to behavioural and cultural aspects: MCP, low levels of condom use, and low levels of circumcision. Gaza is a frontier province with South Africa and there is a lot of cross-border migration in the area.



However, Martine added that there is an **acceleration plan** to address HIV in the region and a reference group has been established, which includes the Ministry of Health. There are also other issues about which to be concerned. The City of Maputo has high prevalence in married couples and a generalised epidemic. Also, Mozambique has new mines in the north so problems that other regions and other countries have faced could be replicated in this region if action is not taken. There is a challenge in that there are no job opportunities in Gaza, so this forces many people to migrate.

A participant had a question about the **low numbers of peer educators** which have been trained by NUM. Mekuto responded by saying that this training is supplementary to the main training that takes place in mining companies. He reminded participants that the responsibility should be among all.

A challenge was issued to all stakeholders to formulate a **more coordinated response** to HIV in the mining sector. The unions and mine workers' associations need to work together more closely and governments need to be lobbied to take action. There needs to be a bigger involvement of the private sector in the issue.

The issue of **human trafficking** needs to be considered in the mining sector as well, especially in illegal mining. There was an incident in the Free State in 2009 where many Sotho people who were working in the illegal mines were killed. The police need to be involved in the issue.

The issue of **compensation** was raised again. Participants felt that consultants who are employed to facilitate the compensation process need to be investigated. There are stories of embezzlement and compensation that is not received, or lower amounts than expected were received. NUM, TEBA and other parties should investigate.

There was a photograph in the AMIMO presentation of women who enter the hostels and drink with the men. A participant wanted to caution against **stigmatising women** as being 'vectors' of infection. It is not a one-way process and we must not think one-directionally. AMIMO responded that they are not saying that it is only women who are infecting men. The issue is that mine workers should be able to bring their families with them.

A participant wanted to clarify the **role of the IOM** and which government departments it works with. IOM responded by saying that it deals with all aspects of migration and so mostly it deals with the Department of Immigration and Home Affairs. However, people migrate for socio-economic reasons and therefore the organisation also has relationships with Ministries of Health, Labour, Social Welfare and so on. When talking about health it is important to involve the Ministries of Immigration and Health.

## SUGGESTED FRAMEWORK FOR A REGIONAL COMPREHENSIVE HIV AND AIDS PROGRAMME

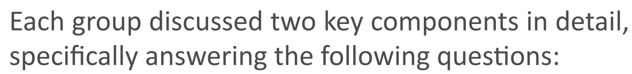
After the presentations, participants broke into groups in order to discuss a suggested regional framework for an HIV and AIDS programme for mine workers, their families and affected communities. The suggested framework was based on the presentations and discussion during the workshop, and a regional framework that had previously been developed for the transport and maritime sectors[6]. Groups discussed the overall suggested “Framework for a Regional HIV and AIDS Programme” (key components, cross-cutting issues) and decide whether there were any aspects that were missing or irrelevant.

The objective of the framework is to scale up an integrated and harmonised programme of HIV prevention, treatment, care, support, and impact mitigation, addressing the specific needs of mine workers, their families and affected communities in southern Africa.

The suggested framework is as follows:

6 Please see the IOM’s website for a full copy of both reports: www.iom.org.za

Framework for a Regional Comprehensive HIV Programme
1a Access to Healthcare Services destination
1b Access to Healthcare Services: sending/return
2 Social/Behaviour Change Communication
3 Advocacy for Policy Development
4 Research and Strategic Information
5 Coordination Harmonisation & Partnerships
6 Monitoring and Evaluation



Each group discussed two key components in detail, specifically answering the following questions:

- What are the interventions that need to be implemented?
- How will they be done?
- By whom and who takes the lead?

Participants also discussed each cross-cutting issue and made recommendations on how they may be addressed, and made recommendations for next steps. Groups prepared a 10-minute report back presentation for the plenary, which was discussed among workshop participants as a whole.

The table below outlines the group work and plenary discussion.

| Key Component | Description | What interventions need to be implemented? | How will they be done? | By whom and who takes the lead? |
|---|---|---|---|---|
| 1a) Access to Health Services – destination | Access to health services, including HIV prevention, care and treatment at the mines<br>Target group: Mine workers and affected communities, including sex workers | Improve referrals | MOUs between ministries; health passport | Ministries of Labour, Health, SADC |
| | | Education for health care professionals | Induction | Employers |
| | | Education on workers' and migrants' rights | Workshops, training | Employers, unions, government, NGOs |
| | | Workplace policies to include contract and casual workers | Legislation/collective agreement | Government, unions and employers |
| | | Universal National Health Insurance | Social dialogue | Ministry of Health |
| 1a) Access to Health Services – Sending/ Return | Access to health services, including HIV prevention, care and treatment in sending/return communities<br>Target group: Ex-mine workers, members of their families, affected communities | Improve referrals | | Ministries of Labour, Health and SADC |
| | | Conduct exit medicals and provide to Ministry of Labour | | TEBA, Ministry of Labour |
| | | Social dialogue | | Ministry of Health |
| | | Regional dialogue | | SADC |
| 2) Social/Behaviour Change Communication | Targeted social/behaviour change communication interventions<br>Relevant information to mine workers prior to and upon arrival in mines | Address male-dominated culture at mining sites | | Companies, NGOs, unions |
| | | Reunite families | | Public and private sector |
| 3) Advocacy for Policy Development | Awareness among policy makers<br>Capacity of governments, employers, unions to develop relevant policies<br>Conducive environment for policy development | Review existing bilateral and tripartite agreements and SADC protocols to identify and close gaps | | Inter-agency task team coordinated by IOM |
| | | Identify best practices with view to creating minimum standards programme | Sharing of workshop report with mining houses | Task team |
| | | Capacity building for implementation of policies – ownership, accountability | | SADC<br>Employers, unions<br>Task team to review processes and identify bottle necks |
| | | Create conducive environment | | Identify key partnerships |

| Key Component | Description | What interventions need to be implemented? | How will they be done? | By whom and who takes the lead? |
|---|---|---|---|---|
| 4) Research and Strategic Information | Evidence and research<br>Sharing of strategic information | Establish collaborative platform between Safety in Mines Research Advisory Committee and research institutions across region | | Task team |
| | | Establish formal process for ensuring/promoting implementation of research outcomes | | |
| | | Identify best practices and advocate for widespread adoption in industry | | |
| | | Regional stakeholder forum for information sharing | | |
| 5) Coordination and Harmonisation | Strengthen networks and partnerships in order to better coordinate the health and HIV response in mine settings<br>Bilateral agreements | Coordination and harmonisation of mine workers' interests<br>Formation of a regional body: create a desk within SADC | | Mine workers<br>Employers<br>Ministry of Health<br>National AIDS Commissions<br>Ministry of Labour<br>International Organisations<br>NGOs, CBOs<br>Networks of PLHIV<br>Recruiting agencies<br>Gender sector |
| | | Mainstream gender issues | | |
| | | Conduct situational analysis to identify gaps and explore cross-cutting issues | | |
| | | Bilateral agreements: short term<br>Agreements between NUM & national mine workers' associations<br>Agreements between mine workers' associations & government<br>Situational analysis | | |
| | | Bilateral agreements: long term<br>Agreements between international organisations and member states | | |
| 6) Monitoring and Evaluation | Holistic and standardised system for monitoring health dynamics within mining communities in the region | Review and incorporation of specific indicators into already-existing M&E systems | | |
| | | Include gender-sensitive indicators | | |

| Key Component | Description | What interventions need to be implemented? | How will they be done? | By whom and who takes the lead? |
|---|---|---|---|---|
| **CROSS-CUTTING ISSUES** | | | | |
| a) Gender | Mainstream gender concerns throughout programming | "One man can" campaign<br>Consider families of mine workers<br>Economic empowerment of women in mine-sending and receiving sites<br>Address gender inequality as a structural driver of HIV<br>Public health and rights-based approach | | Ministry of Gender |
| b) Capacity Building | Build capacity of stakeholders | Led by activities<br>Address spouses and families of mine workers<br>Spouses need to be organised | | |
| c) Quality Assurance | How to ensure quality | M&E built into budgets<br>Use WHA resolution & national protocols as guiding documents for work<br>Feed into national programmes that have QA already built in<br>PPPs | | |
| d) Resource Mobilisation | Traditional and creative resource mobilisation initiatives | SADC HIV Trust Fund<br>Encourage member states to have Workers' Compensation Insurance Fund, National Social Security Funds, National Health Insurance Fund across borders<br>Accessing compensation across borders<br>Unemployment funds for retrenched workers<br>Use resources optimally | | |

## RECOMMENDATIONS AND CONCLUSIONS

In conclusion, the following **key issues** emerged during presentations and discussions at the workshop:

- SADC **treatment protocols** need to be harmonised.
- Workplace policies and programmes should include **contract and temporary workers**.
- **Access to health care services** at mining sites should be improved (including uptake of VCT and ART).
- Government should improve and expand **statistical data on migration**.
- The current **accommodation system** for mine workers needs to be addressed.
- **Referral systems**, to ensure continuum of care for employees exiting the industry, need to be developed.
- The private sector should get involved in improving the **compensation** system.
- **Public-private partnerships** should be strengthened.
- All stakeholders should use **"spaces of vulnerability"** approach in programming (SBCC; health services etc.) – this includes mine worker-sending sites.
- Boredom and loneliness of mine workers need to be addressed through provision of **recreational facilities**.

The following **recommendations** were made:

1) Finalise and share the report – use it as an advocacy tool.
2) Coordination with other agencies.
3) Form a partnership which could take the key issues and recommendations of the workshop forward. This should be coordinated among the following selected organisations: SADC, UNAIDS, TEBA, WHO, ILO, CoM, NUM and national mine workers' associations (represented by AMIMO).
4) Consult further to have an understanding of the roles and responsibilities of different organisations in taking key issues and recommendations forward.

At this stage, the workshop was closed by the IOM. All partners and participants were thanked for their animated and productive participation in the proceedings of the workshop.

## APPENDIX ONE: WORKSHOP PROGRAMME

| DAY 1: Thursday 27 May 2010 | | | |
|---|---|---|---|
| **REGISTRATION: 08h00–08h30** | | | |
| 08h30–09h00 | 30 min | Welcome | Reiko Matsuyama<br>IOM Regional Office |
| 09h00–09h30 | 30 min | Opening remarks | Dr. Diogo Milagre Conselho Nacional de Combate ao HIV/ SIDA (CNCS), Mozambique |
| 09h30–10h00 | 30 min | Introduction to the workshop: objectives, expectations, programme | Natalie Ridgard<br>IOM |
| 10h00–10h20 | | TEA (20 minutes) | |
| **PLENARY 1: SETTING THE SCENE**<br>**Facilitator: Reiko Matsuyama, IOM** | | | |
| 10h20–10h40 | 20 min | World Health Assembly Resolution 61.17 on the Health of Migrants | Thebe Pule<br>World Health Organization Regional Office for Africa |
| 10h40–11h00 | 20 min | SADC Draft Policy Framework on Population Mobility and Communicable Diseases | Doreen Sanje<br>Southern African Development Community HIV/AIDS Unit |
| 11h00–11h20 | 20 min | HIV Prevention in southern Africa | Mumtaz Mia<br>United Nations Joint Programme on HIV/AIDS Regional Support Team for ESA |
| 11h20–11h40 | 20 min | Q&A | |
| **PLENARY 2: EVIDENCE FROM THE GROUND**<br>**Facilitator: David Cooper, TEBA Development** | | | |
| 11h40–12h00 | 20 min | Health vulnerabilities and HIV-prevention needs of migrants and mobile populations in the mining sector of southern Africa | Erin Tansey<br>IOM |
| 12h00–12h20 | 20 min | The relationship between alcohol use and HIV among mine workers in a Namibian mining town | Janetta Ananias<br>University of Namibia |
| 12h20–12h40 | 20 min | Lessons learnt from the evaluation of a Community Training Partnership Programme in five diamond mining communities in South Africa | Professor Laetitia Rispel<br>Centre for Health Policy, Wits University |
| 12h40–13h00 | 20 min | Q&A | |
| 13h00–14h00 | | LUNCH (1 hour) | |

| PLENARY 3 (cntd): EVIDENCE FROM THE GROUND<br>Facilitator: Katy Barwise, IOM | | | |
|---|---|---|---|
| 14h00–14h20 | 20 min | Findings from the Thibela TB project | Dr. Fazel Randera<br>Aurum Health Institute |
| 14h20–14h40 | 20 min | Knowledge, attitudes and perceptions to HIV testing and antiretroviral therapy in a sample of mine workers in South Africa | Gavin George<br>Health Economics & HIV/AIDS Research Division, University of Kwazulu Natal |
| 14h40–15h00 | 20 min | The life of a mine worker: an on-the-ground perspective | Ernesto Libombo |
| 15h00–15h20 | 20 min | Q&A | |
| 15h20–15h40 | | TEA (ten minutes) | |
| 15h40–16h00 | 20 min | Group discussion of main issues emerging from presentations<br>What are the key health vulnerabilities of mine workers, their families and communities with which they interact, that emerged from the day's presentations?<br>How are these vulnerabilities being addressed?<br>What are the gaps in this response? | |
| 16h00–16h30 | 30 min | Plenary: Report back | |
| End of Day 1 | | | |

| DAY 2: Friday 28 May 2010 | | | |
|---|---|---|---|
| 08h00–08h30 | ARRIVAL | | |
| 08h30–09h00 | 30 min | Recap of Day One | Natalie Ridgard<br>IOM |
| **PLENARY 3: PROGRAMMES AND POLICIES**<br>**Facilitator: Sharone Backers, IOM** | | | |
| 09h00– 09h20 | 20 min | Working with mine worker-sending communities in southern Africa | Georgia Mbuga<br>TEBA Development |
| 09h20– 09h40 | 20 min | First Quantum Mining Limited's health-related corporate social responsibility programme | Gertrude Musunku<br>FQML |
| 09h40– 10h00 | 20 min | The private sector response to the health vulnerabilities of mine workers, their families and other communities | Dr. Khanyile Baloyi<br>South African Chamber of Mines |
| 10h00–10h20 | 20 min | Q&A | |
| 10h20–10h40 | | TEA (20 minutes) | |
| 10h40–11h00 | 20 min | Technical Working Group on HIV-positive miners in Mozambique | Cecilia Martine<br>CNCS Mozambique |
| 11h00–11h20 | 20 min | The response to HIV by unions in the mining sector | Lennox Mekuto<br>National Union of Mine Workers |
| 11h20–11h40 | 20 min | Regional Association of Mine Workers | Moises Uamasse<br>Associacao de Mineros Mocambicanos |
| 11h40–12h00 | 30 min | Q&A | |
| 12h00–13h00 | | LUNCH (1 hour) | |
| **BREAKAWAY SESSIONS AND DISCUSSION**<br>**Facilitator: Mumtaz Mia, UNAIDS** | | | |
| 13h00–14h30 | 1.5 hours | Breakaway sessions: Group work | |
| 14h30–15h15 | 45 mins | Plenary: Report back on group work | |
| 15h15-15h30 | TEA (15 mins) | | |
| 15h30–16h00 | 30 mins | Agreement on the way forward | |
| 16h00–16h30 | 30 mins | Workshop closure and evaluation | |
| End of Day 2 | | | |

# APPENDIX TWO: PARTICIPANT’S LIST

| Name | Designation | Name | Country | Email |
|---|---|---|---|---|
| **International and Regional Organisations** | | | | |
| Mr. Ilidio Jorge da Silva | Programme Manager: HIV/AIDS Programme | International Finance Corporation | Mozambique | idasilva1@ifc.org |
| Mr. Thebe Pule | | World Health Organization Regional Office for Africa (WHO AFRO) | Regional | pulet@afro.who.int |
| Mr. David Cooper | Director | TEBA Development | Regional | davidc@teba.co.za |
| Ms. Nobesuthu Mnguni | Project Manager | TEBA Development | Regional | nobesuthum@teba.co.za |
| Ms. Mumtaz Mia | Regional Advisor, Humanitarian Response | UNAIDS RST ESA | Regional | miam@unaids.org |
| **National AIDS Councils** | | | | |
| Ms. Liengoane Kotele | Programme Officer | National AIDS Commission | Lesotho | liengoanekotele@yahoo.com |
| Ms. Cecilia Martine | Focal point - high risk groups | National AIDS Council (CNCS) | Mozambique | cecilia.martine@cncs.org.mz |
| Ms. Cecilia Uamasse | MPE Officer | CNCS | Mozambique | cecilia.uamusse@cncs.org.mz |
| Dr. Diago Milagre | Deputy Executive Secretary | CNCS | Mozambique | |

| Name | Designation | Name | Country | Email |
|---|---|---|---|---|
| Mr. Hashim Kalinga | Director: Civil Society and Private Sector | Tanzania Commission for AIDS | Tanzania | hkalinga@tacaids.go.tz |
| Mr. Innocent Hadebe | National HIV Prevention Coordinator | National Emergency Response Council on HIV/AIDS | Swaziland | imhadebe@nercha.org.sz |
| Ms. Gladys Ngoma Kamanga | Private Sector Specialist | National AIDS Council | Zambia | gngoma@nacsec.org.zm |
| **Line Ministries** | | | | |
| Ms. Mpinane Masupha | Principal Migrant's Liaison Officer | Ministry of Labour and Employment | Lesotho | mpinanemasupha@hotmail.com |
| Mr. Samson Nghiteeka | Inspector of Mines | Ministry of Mines and Energy | Namibia | snghiteeka@mme.gov.na |
| Dr. Cleopas Sibanda | Occupational Health Specialist | Department of Labour | Swaziland | lhpaconsultancy@gmail.com |
| Ms. Sophia Shariff | | Ministry of Energy and Mineral Resources | Tanzania | sophiashariff@yahoo.com |
| Mr. Andrea Habweza | HIV/AIDS Workplace Programme Focal Point | Ministry of Mines and Mineral Development | Zambia | andrehabs@gmail.com |
| **Private Sector** | | | | |
| Ms. Onalethata Johnson | Group Manager: HIV/AIDS Impact Management | Debswana | Botswana | ojohnson@debswana.bw |
| Mr. Ronney Mutjavikua | Assistant OHEAP Coordinator | Chamber of Mines | Namibia | mutjaa@mweb.com.na |
| Dr. Khanyile Baloyi | Assistant Health Advisor | Chamber of Mines | South Africa | kbaloyi@bullion.org.za |

| Name | Designation | Name | Country | Email |
|---|---|---|---|---|
| Ms. Gertrude Musunka | Health Programmes Manager/deputy | First Quantum Minerals Limited | Zambia | gertrude.musunka@fqml.com |
| **Unions and Mine Workers' Associations** | | | | |
| Mr. Rantso Mantsi | Secretary-General | Ex-Mineworker's Association | Lesotho | rantsomantsi@yahoo.com |
| Mr. Moises Uamusse | Chairperson | Associacao de Mineros Mocambicanos (AMIMO) | Mozambique | amimo_sede@tvcabo.co.mz |
| Mr. Ernesto Libombo | Ex-mine worker | | Mozambique | |
| Mr. Lennox Mekuto | Health and Safety Officer | National Union of Mine Workers (NUM) | South Africa | lmekuto@num.org.za |
| Mr. Vama Jele | Secretary-General | Swaziland Migrant Mine Workers' Association | Swaziland | vamajele@yahoo.com |
| **NGOs and other** | | | | |
| Ms. Alzira Ferreira | Regional HBC Coordinator | TEBA Development | Mozambique | alziraf@teba.co.za |
| Ms. Georgia Mbuga | Project Coordinator | TEBA Development | Mozambique | georgiam@teba.co.za |
| Mr. Jose Carimo | Regional Manager: HBC | TEBA Development | Mozambique | josec@teba.co.za |

| Name | Designation | Name | Country | Email |
|---|---|---|---|---|
| Ms. Rosanna Price-Nyendwa | Programme Director | Comprehensive HIV/AIDS Management Service (CHAMP) | Zambia | rosanna.price-nyendwa@champ.org.zm |
| **Universities and research organizations** | | | | |
| Mr. Sozinho Ndima | Investigator | Universidade de Eduardo Mondlane | Mozambique | sozinhondima@gmail.com |
| Ms. Janetta Ananias | Lecturer | University of Namibia | Namibia | mmaree@unam.na |
| Dr. Fazel Randera | Medical Director | Aurum Health Institute | South Africa | frandera@auruminstitute.org |
| Mr. Gavin George | Senior Research Fellow | HEARD, University of Kwazulu Natal | South Africa | georgeg@ukzn.ac.za |
| Prof. Laetitia Rispel | Adjunct Professor | Centre for Health Policy, Wits University | South Africa | laetitia.rispel@wits.ac.za |
| **IOM** | | | | |
| Ms. Sharone Backers | Migration Health Project Officer | IOM Maputo | Mozambique | sbackers@iom.int |
| Ms. Reiko Matsuyama | Migration Health Officer | IOM MRF Pretoria | Regional | rmatsuyama@iom.int |
| Ms. Natalie Ridgard | Consultant | IOM MRF Pretoria | Regional | nridgard@iom.int |
| Ms. Erin Tansey | Migration Health Research Officer | IOM MRF Pretoria | Regional | etansey@iom.int |
| Ms. Katy Barwise | Migration Health Project Officer | IOM Zambia | Zambia | kbarwise@iom.int |

## SIXTY-FIRST WORLD HEALTH ASSEMBLY
## WHA61.17

***Agenda item 11.9 24 May 2008***
***Health of migrants***

The Sixty-first World Health Assembly,

Having considered the report on health of migrants[7]

Recalling the United Nations General Assembly resolution 58/208 underlining the need for a high-level dialogue on the multidimensional aspects of international migration and development (New York, 23 December 2003);

Recalling the first plenary session of the United Nations General Assembly on migration issues and the conclusions of the High-level Dialogue on Migration and Development (New York,14–15 September 2006) with their focus on ways to maximize the development benefits of migration and to minimize its negative impacts;

Recognizing that the revised International Health Regulations (2005) include provisions relating to international passenger transport;

Recalling resolutions WHA57.19 and WHA58.17 on international migration of health personnel: a challenge for health systems in developing countries, calling for support to the strengthening of health systems, in particular human resources for health;

Recognizing the need for WHO to consider the health needs of migrants in the framework of the broader agenda on migration and development;

Recognizing that health outcomes can be influenced by the multiple dimensions of migration;

Noting that some groups of migrants experience increased health risks;

Recognizing the need for additional data on migrants' health and their access to health care in order to substantiate evidence-based policies;

Taking into account the determinants of migrants' health in developing intersectoral policies to protect their health;

Mindful of the role of health in promoting social inclusion;

Acknowledging that the health of migrants is an important public health matter for both

Member States and the work of the Secretariat;

Noting that Member States have a need to formulate and implement strategies for improving the health of migrants;

Noting that policies addressing migrants' health should be sensitive to the specific health needs of women, men and children;

Recognizing that health policies can contribute to development and to achievement of the

Millennium Development Goals,

1. CALLS UPON Member States:

(1) to promote migrant-sensitive health policies;

(2) to promote equitable access to health promotion, disease prevention and care for migrants, subject to national laws and practice, without discrimination on the basis of gender, age, religion, nationality or race;

7 Document A61/12.

(3) to establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories;

(4) to devise mechanisms for improving the health of all populations, including migrants, in particular through identifying and filling gaps in health service delivery;

(5) to gather, document and share information and best practices for meeting migrants' health needs in countries of origin or return, transit and destination;

(6) to raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues;

(7) to train health professionals to deal with the health issues associated with population movements;

(8) to promote bilateral and multilateral cooperation on migrants' health among countries involved in the whole migratory process;

(9) to contribute to the reduction of the global deficit of health professionals and its consequences on the sustainability of health systems and the attainment of the Millennium

Development Goals;

2. REQUESTS the Director-General:

(1) to promote migrants' health on the international health agenda in collaboration with other relevant international organizations;

(2) to explore policy options and approaches for improving the health of migrants;

(3) to analyse the major challenges to health associated with migration;

(4) to support the development of regional and national assessments of migrants' health status and access to health care;

(5) to promote the inclusion of migrants' health in the development of regional and national health strategies where appropriate;

(6) to help to collect and disseminate data and information on migrants' health;

(7) to promote dialogue and cooperation on migrants' health among all Member States involved in the migratory process, within the framework of the implementation of their health strategies, with particular attention to strengthening of health systems in developing countries;

(8) to promote interagency, interregional and international cooperation on migrants' health with an emphasis on developing partnerships with other organizations and considering the impact of other policies;

(9) to encourage the exchange of information through a technical network of collaborating centres, academic institutions, civil society and other key partners in order to further research into migrants' health and to enhance capacity for technical cooperation;

(10) to promote exchange of information on migrants' health, nationally, regionally, and internationally, making use of modern information technology;

(11) to submit to the Sixty-third World Health Assembly, through the Executive Board, a report on the implementation of this resolution.

Eighth plenary meeting, 24 May 2008

A61/VR/8

## NOTES

## NOTES

## NOTES

IOM Regional Office for Southern Africa
PO Box 55391  Arcadia  0007  Pretoria  South Africa
**tel** +27 (0) 12 342 2789   **fax** +27 (0) 12 342 0932
**email** MHUpretoria@iom.int

**www.iom.org.za**