IOM International Organization for Migration
OIM Organisation Internationale pur les Migrations
OIM Organización Internacional para las Migraciones

Regional Workshop

on HIV responses among seafarers and port-based communities in southern Africa

4 – 6 November 2009

Durban, South Africa

UNAIDS
JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS

UNHCR
UNICEF
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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
CBO	Community-based Organisation
CdM	Cornelder de Mozambique
CSO	Civil Society Organisation
FHI	Family Health International
HAART	Highly Active Antiretroviral Therapy
HCT	HIV Counselling and Testing
HIV	Human Immuno-deficiency Virus
HR	Human Resources
ICFTTU	International Confederation of Free Trade Unions
ICSW	International Committee On Seafarers' Welfare
ILC	International Labour Convention
IEC	Information, Education and Communication
ILO	International Labour Organization
IMHA	International Maritime Health Association
IMO	International Maritime Organization
IOE	International Organisation of Employers
IOM	International Organization for Migration
ISF	International Shipping Federation
ITF	International Transport Workers' Federation
ITUC	International Trade Union Confederation
KZN	Kwazulu Natal
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
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
NAMFI	Namibian Maritime Fisheries Institute
NCFAWU	National Certificated Fishing and Allied Workers' Union
NGO	Non-governmental Organisation
NSF	North Star Foundation
NSP	National Strategic Plan
PEP	Post-exposure prophylaxis
PHC	Primary Health Care
PLHIV	People living with HIV
PMAESA	Port Management Association of East and Southern Africa
PMTCT	Prevention of mother-to-child Transmission
PPE	Personal Protective Equipment
PPP	Public-Private Partnership
PSI	Population Services International
ROADS	Regional Outreach Addressing AIDS through Development Strategies
SADC	Southern African Development Community
SAMP	Southern African Migration Project
SAMSA	South African Maritime Safety Authority
SANAC	South African National AIDS Council
SCC	Social Change Communication
STI	Sexually Transmitted Infection
SWEAT	Sex Workers' Education and Advocacy Taskforce
TB	Tuberculosis
TPA	Tanzania Port Authority
TW	Trucking Wellness
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
VCT	Voluntary Counselling and Testing
WBCG	Walvis Bay Corridor Group
WHA	World Health Assembly
WHO	World Health Organization
XDR TB	Extremely Drug-Resistant TB

Introduction

In response to the vulnerabilities faced by seafarers and port-based communities in the ports of southern Africa, the International Organization for Migration (IOM), in partnership with Southern African Development Community (SADC), United Nations Joint Programme on HIV/AIDS (UNAIDS), International Labour Organization (ILO) and Trucking Wellness, organised a **Regional Workshop on HIV Responses Among Seafarers and Port-based Communities in Southern Africa**, which took place in Durban, South Africa, between 4 and 6 November 2009. The ports that were included in this workshop were:

- Durban (South Africa)
- Dar-es-salaam (Tanzania)
- Maputo and Beira (Mozambique)
- Walvis Bay (Namibia)[1]

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

1. Raise awareness on the issue of HIV and mobility as it relates to seafarers and port-based communities in southern Africa.
2. Increase understanding of IOM's role in HIV and mobility in the southern African region.
3. Share lessons learned, experiences and good practices of HIV responses, research, policies and programmes, as they relate to seafarers and port-based communities.
4. Identify existing gaps and challenges in terms of responses, programmes, policies and research.
5. Facilitate networking and increased coordination among partners and stakeholders, and among different agencies implementing HIV responses.
6. Outline the way forward in terms of key components of an effective and comprehensive regional HIV and AIDS programme.

The expected outcomes were:

1. Increased understanding of migration dynamics and related HIV vulnerability around the ports of southern Africa.
2. Strengthened networks for future coordination and collaboration among participating organisations.
3. Draft framework for a comprehensive programme on HIV prevention, treatment, care, and support addressing the specific needs of seafarers and port-based communities in southern Africa.
4. Agreed short and medium term action plan for taking forward the above draft framework, identifying key activities and role players.

For the purposes of this workshop, "seafarer" is defined as a person who makes his or her living in the navigation, conduct, maintenance or service of ships or other vessels.

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1 Unfortunately Angola was not represented at the workshop, although it is a target port. To this end, background research for the workshop did include Angola.

Background

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 a 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 in the ports of southern Africa

Southern Africa has an immense coastline, with fishing and sea-based industries contributing greatly to the region's economy. The major ports along the southern African coast are the main entry and exit points of most of Africa's transport corridors and facilitate trade and economic growth. The ports also link the transport corridors and port communities with seafarers coming from all over the world, working on fishing and cargo vessels and who dock in southern Africa ports for short periods. At the same time, port communities have unique dynamics that impact on the HIV vulnerability of community members including sex workers and the mobile workers who stay at the ports for relatively short periods of time. The sexual web between seafarers, truck drivers and sex workers create a triangle of high-risk sexual behaviour. With the mobility of truck drivers and foreign seafarers, ports are an important node in a regional and international web of risk behaviour.

Seafarers and HIV vulnerability

The presence of foreign seafarers provides additional incentives for commercial sex work based at the ports, which creates a potentially high HIV risk environment. The implications and consequences of unsafe sexual practices do not only have potentially devastating consequences for the mobile workers such as seafarers but also for the port communities and for the families of seafarers thousands of miles away. The vulnerabilities of seafarers are discussed extensively in this report (see below).

Sex workers and HIV vulnerability

Sex work is illegal in all of the workshop's target countries. Research conducted by the IOM has shown that around ports sex work can take various forms: high-end, full time commercial sex work; low-end, part-time commercial sex work, and transactional sex. Frequently many sex workers are young (between 18 and 30 years), poor and with dependents.

Truck drivers and HIV vulnerability

The ports in southern Africa are the first or last port of call for the region's main transport corridors. Depending on the port and the cargo truck drivers often stay in town for only short periods of time (at most a couple of days at a time) whilst freight is loaded or off-loaded and it is during this time that they frequent the shebeens and meet sex workers.

Like fishermen, truck drivers often prefer sex with sex workers because of the difficulties of maintaining monogamous relationships due to their frequent and prolonged periods of absence. Although some truck drivers would have regular girlfriends in various places along the routes they travel, most see this as too expensive in the long run, and hence, revert to using sex workers again.

These are some of the health vulnerabilities facing seafarers and port-based communities which form a backdrop to this regional workshop. Many of them were contemplated at length during presentations and discussion at the workshop.

Welcome and opening remarks

Welcome

Nono Simelela
Chief Executive Officer
South African National AIDS Council (SANAC)

Simelela welcomed participants to the workshop. She spoke about the newly constituted SANAC secretariat in Midrand, Gauteng, which has been set up to coordinate the South African national response to HIV. She mentioned that it is a special time in South Africa in terms of leadership around HIV – the country has a leader who is vocal and honest about HIV. South Africa faces the challenge of being a country with a high prevalence of HIV. In terms of antiretroviral (ARV) treatment, demand outstrips supply, thus in the coming months there will be a big scale up of ARV roll out. SANAC's key activity for World AIDS Day is to have a Voluntary Counselling and Testing (VCT) day and the key message is that South Africans must know their status. Furthermore, SANAC is also going to make a policy announcement on this day. Simelela concluded by saying that she was excited about this workshop, as the issue of HIV among seafarers and port-based communities is one that is hidden from campaigns. She congratulated the IOM on focusing on this area. She promised to report back to the Deputy President about the workshop and mentioned that SANAC looked forward to ongoing collaboration with IOM and partners on the issue.

Opening remarks

Petra Neumann
IOM

Neumann mentioned the importance of migration in Africa. In southern and east Africa as well as globally, migration has become significant in meeting economic and social challenges of globalisation, with the search for employment at the heart of most movements. With more than 200 million international migrants in the world today there is a need to ensure that the physical, mental and social needs of migrants as well as the public health needs of host and home communities are addressed. Migrant health needs can only be fully met when migrants' rights are respected and protected.

Neumann outlined the issue of HIV and mobility and the HIV vulnerabilities of seafarers and port-based communities for participants (as discussed in the "Introduction" section of this report). Because of these vulnerabilities, the IOM has convened a regional workshop to provide a forum whereby stakeholders may share information, identify gaps and challenges, strengthen networks and collaboration, and agree on a way forward.

After these opening remarks, Simelela took the opportunity to present on the current state of the HIV epidemic in South Africa.

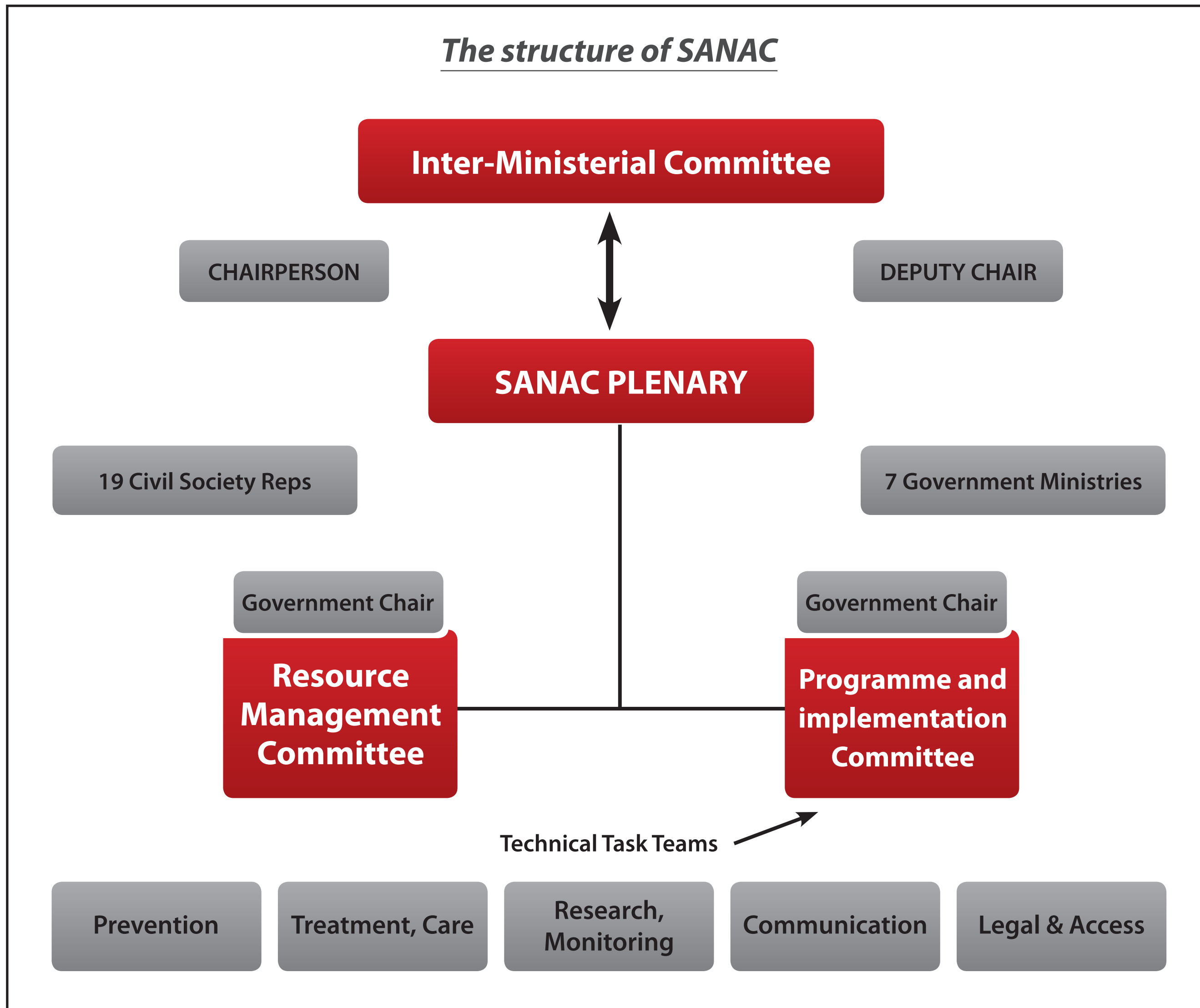
Business as usual?

Nono Simelela

Simelela gave a presentation on the HIV epidemic in South Africa, which shows how the epidemic is increasingly "out of control" since the 1990s:

- **HIV Prevalence:** Data from antenatal clinic surveys show an increase of HIV prevalence from 0.7% in 1990 to 29.3% in 2008. According to 2008 data, there is particularly high HIV prevalence among the sexually active population (15-49 year olds) in certain provinces, for example Kwazulu Natal (KZN) (25.8%) and Mpumalanga (23.1%).
- **Life Expectancy:** Life expectancy in is 56 for females and 51 for males – according to the Actuarial Society of South Africa; this is 13 years below what it would be without HIV.
- **Deaths:** In 2006, 59.3% of deaths were of those younger than 50 years. The number of deaths peaked in the age group between 35 and 39. In most developed countries people in the age group of about 70 are dying at higher rates than those between 30 and 50.
- **Health and Disease Burden:** With a population of 48 million (equal to 0.7% of the world's population), South Africa has twice the global average per capita burden of ill health and the highest health burden per capita of any middle-income country. It has 17% of the global HIV burden (23 times the global average) and 5% of the global Tuberculosis (TB) burden (7 times the global average). TB is the main cause of death of people with HIV and South Africa has 28% of the world population with HIV and TB.
- **Maternal and Child Mortality:** 75,000 of children under the age of five die every year. 57% of deaths of children under the age of five during 2007 were as a result of HIV.

After this account of the HIV epidemic in South Africa, Simelela gave an overview of the purpose and structure of SANAC. It is a hybrid structure located at the interface of government and civil society. The follwing diagram explains the structure of SANAC:



The following sectors of civil society are represented in SANAC: Disability, People living with HIV (PLHIV), women, men, children, legal and human rights, NGO and CBO sector, religions, traditional healers, youth, higher education labour, business, academic and research organisations working in health, health professionals, sport and entertainment, Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) and sex workers.

The following government ministries are represented: Health (the lead government department), education, transport, minerals and energy, social development, public service and administration and correctional services.

SANAC is charged with overall responsibility for coordination, oversight and review of the implementation of the National Strategic Plan for HIV and AIDS and STIs, 2007–2011 (NSP), which has two primary objectives:

1. Reduce the rate of infections by 50% by 2011
2. Cover 80% of the people who need to be on ARVs by 2011

The SANAC mandate is as follows:

1. To advise government on HIV, AIDS and STI policy and strategy, and related matters

2. To create and strengthen partnerships for an expanded national response to HIV and AIDS in South Africa
3. To receive and disseminate all sectoral interventions to HIV and AIDS and consider challenges
4. To oversee continual monitoring and evaluation (M&E) of all aspects of the NSP

SANAC's vision is to have a well-coordinated national response that has people at the heart of it and to achieve an AIDS-free society. Accountability will be ensured through a mid-term review of the NSP; a UN agencies review of the health system; the HIV Counselling and Testing (HCT) task team state of readiness report; an approach of "know your epidemic, know your response" and a National AIDS Spending Assessment. SANAC is currently finalising and aligning a number of polices and scaling up financial and human resources. Review and action of SANAC's response will prepare a comprehensive picture of the health system and our ability to respond, be used to identify gaps and devise creative strategies to bridge gaps and frame the needs, focus areas and target populations of a national HIV counselling and testing campaign to be conducted 21 to 24 March 2010.

Discussion

After Simelela's presentation, participants posed questions about **SANAC's structure and budget**. A participant asked about under which ministry SANAC falls, as HIV is a multi-sectoral issue and therefore SANAC needs to be able to coordinate all these sectors. Simelela responded that SANAC does not fall under a ministry; instead the Deputy President of South Africa is the chairperson.

Another participant wanted to know more about where SANAC obtains its budget and how much is allocated to prevention, treatment and research. As SANAC is a coordinating agency, it does not have a budget as such. It is an advisory body and not a legal agency – furthermore, its structure is currently under review. The plenary is SANAC's highest structure, which decides on which issues to advise government. South Africa is fortunate in that it has a vibrant civil society and in terms of SANAC decisions, government and civil society representatives have an equal say.

In response to a question about **HIV among adolescents and pregnant women**, Simelela said that the challenge is to get young people to understand risk of HIV infection so that they can make alternative choices. In KZN, where prevalence is highest, there are several interventions and all levels of government are involved. The current national guidelines for Prevention of mother-to-child Transmission (PMTCT) recommend dual therapy for pregnant women, but in KZN patients have access to highly active antiretroviral therapy (HAART or triple therapy). They also have guidelines about exclusive breastfeeding and replacement feeding. Nationally, the government are looking at moving to HAART for pregnant women. Simelela added that prevention services are key and behavioural issues are the challenge. We need to have more than simply a biomedical response to the HIV epidemic.

Simelela concluded by saying that it is imperative that people come to the table – participants have gathered at this workshop to discuss HIV among seafarers and port-based communities and it is up to us to come up with recommendations and ultimately prevent new infections.

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 seafarers and port-based communities. This helped to raise awareness on the issue of HIV and mobility as it relates to seafarers and port-based communities in southern Africa; and increase understanding of IOM's role in HIV and mobility in the southern African region.

The presentations in this session were:

- Kalpesh Rahevar, World Health Organization (WHO): "WHA resolution on migrants' health"
- Evelyn Serima, ILO: "Working with employers"
- Rosilyne Borland, IOM: "Global partnership on HIV and mobile workers in the maritime sector pilot programme"
- Doreen Sanje, SADC: "SADC draft policy framework for population mobility and communicable diseases"
- Reiko Matsuyama, IOM: "Addressing HIV vulnerability in the maritime sector in southern Africa: Case study Walvis Bay, Namibia"

WHA resolution on migrants' health

Kalpesh Rahevar
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. At the 61st session of the WHA (Geneva, May 2008), ***Resolution 61.17 on Migrants' Health*** was adopted to promote migrant-sensitive health policies, equitable access to health and to promote equitable access to health.

The WHA 61.17 resolution calls upon Member States to, among others:

- Establish health information systems in order to assess and analyse trends in migrants' health, disaggregating health information by relevant categories
- Devise mechanisms for improving the health of all populations, including migrants
- Gather, document and share information and best practices for meeting migrants' health needs among countries involved
- Raise health service providers' and professionals' cultural and gender sensitivity to migrants' health issues
- Train health professionals to deal with the health issues associated with population movements
- Promote bilateral and multilateral cooperation on migrants' health among countries involved
- Contribute to the reduction of the global deficit of health professionals

Member countries are required to report back on the implementation status of this resolution at the 2010 WHA.

IOM, in partnership with the Southern Africa Migration Project (SAMP) and WHO, organised the Migration Dialogue for Southern Africa (MIDSA) workshop on Migration Health from 10 to 12 June 2009 in Dar es Salaam, Tanzania, with the objective of discussing implementation of the Resolution[2]. The conclusion of the MIDSA was that health is a basic human right and that addressing the health needs of migrants benefits migrants and host communities alike. The Resolution recommendations are relevant and applicable within the SADC context. The development of the Draft SADC Policy Framework on Population Mobility and Communicable Diseases should be commended and sustained and SADC Member States need to take steps to implement the WHA Resolution.

MIDSA recommended that SADC member states should:

- Explicitly state migrants' access to health in national health policies and implementation plans
- Ministries responsible for immigration should undertake a policy review to ensure that immigration policies explicitly re" ect the rights of migrants to access health care and services
- Promote the inclusion of migrant health into primary health care reform principles and ongoing health systems strengthening efforts
- Implement existing SADC policies and protocols as well as bilateral agreements that facilitate migrants' access to health
- Adopt the Draft Policy Framework on Population Mobility and Communicable Diseases and then implement it to ensure policy coherence in the region
- Designate focal points responsible for establishing mechanisms to facilitate multi-sectoral dialogue and promote partnerships

2 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

- Recommend the inclusion of the WHA 61.17 Resolution on "Health of Migrants" into the agenda of the WHO Africa Regional Committee Meeting and other appropriate forums, in order for Member States to adapt and adopt
- Partner with expert organisations and academic institutions to conduct research and strengthen health information systems
- The African Union should facilitate and the SADC Secretariat should engage in dialogue among African Regional Economic Communities
- Advocate for migrant health issues to be more prominent at multilateral forums such as the Global Forum for Migration and Development
- SADC Member States and SADC Secretariat, in collaboration with partners, should address the financial constraints of migrant host, transit and source communities
- SADC Secretariat, in collaboration with the MIDSA organisers and other partners, should take the lead in establishing and maintaining a forum to review and discuss the implementation of the above recommendations, and share information and knowledge on good practices

Working with employers

Evelyn Serima
ILO

Serima started her presentation by saying that the ILO is the UN agency responsible for the world of work and it is the only UN agency that has a unique tripartite structure, working with employers, labour and government. Specifically, the ILO works with employers to strengthen the response to HIV among mobile and migrant workers. The ILO's approach is encapsulated in the following quote:

"Working with the employers on issues related to mobile workers involves listening and understanding needs and priorities of the business world and looking for ways in which they can be utilized to put in place effective responses to HIV/AIDS, in harmony with the workers' rights and needs".

Serima explained that all men and women have aspirations for decent work and to have their rights recognised. HIV infection can threaten these aspirations, but it also can create an opportunity for people to advocate for their rights and ensure that they do have access to decent work.

Why does the ILO work with employers around the issue of HIV and migrant workers? Firstly, HIV poses a serious threat to productivity, enterprise performance and profits. Secondly, employers have a key role to play in issues around stigma and discrimination in relation to HIV, which are more widespread when dealing with migrant workers, who are often screened for HIV before being employed. Finally, employers have a major role to play addressing the HIV-related needs of migrant and mobile workers.

The frameworks that the ILO uses to work with employers are:

- ILO Code of Practice on HIV/AIDS and the world of work
- International Organisation of Employers and International Confederation of Free Trade Unions (IOE/ICFTU) Joint Declaration, Geneva, May 2003
- Joint IOE/International Trade Union Confederation (ITUC) statement during G8 Summit, July 2009

Furthermore, the proposed "Recommendation on HIV/AIDS and the world of work", as discussed in International Labour Convention (ILC) 2009, states that: "Members should ensure that migrant workers, or those seeking to migrate for employment, are not excluded from migration on the basis of their HIV status, whether real or perceived."

The ILO has a multi-pronged approach to working with employers, which operates on a national, institutional and enterprise level. On one level, it creates a conducive policy framework. Then it builds the capacity of employer organisations and partners. It also reaches mobile or migrant workers directly. This approach guides implementation and links employers and workers.

The entry points for a comprehensive migrant workers HIV programme in sending countries, transit routes and receiving countries are:

- Overseas agencies
- Recruitment agencies
- Maritime schools
- Vocational schools
- Transport corridors
- Migrant workers' associations
- Government agencies

Some examples of ILO good practice in working with migrant and mobile workers are the multi-country transport sector project in southern Africa and work done in South East Asia. The transport sector project consists of:

- Education and awareness programmes with unions and employers' organisations (for example, Ministries of Labour and Transport)
- Policy and programme development and capacity building
- Strengthening private sector response, resource leveraging, non-discrimination approaches, and advocacy

Serima concluded by outlining the ILO programmes in South East Asia. In Indonesia ILO has worked with the Association of Migrant Workers' Employment Agencies, the Indonesian Migrant Workers' Service and placement centres on education and non-discriminatory practices. In the Philippines the ILO has supported capacity building and work plans development for the Department of Labour and Employment, Overseas Workers Welfare Administration and Occupational Safety and Health Center.

Global Partnership on HIV and Mobile Workers in the Maritime Sector pilot programme

Rosilyne Borland
IOM

Borland spoke about the newly formed Global Partnership on HIV and Mobile Workers in the Maritime Sector. The key messages of her presentation were that characteristics of the migration process can lead to increased health vulnerabilities and that mobile workers in the maritime sector face specific HIV risks and vulnerabilities. Though many programmes and lessons learned exist, we still need to improve HIV prevention with seafarers. HIV prevention must take place along the migration route, across sectors, across countries and with seafarers. Migration is not a health risk but the conditions surrounding the migration process can lead to increased vulnerability. The Global Partnership has designed a model to address HIV among seafarers; the pilot phase of the global programme will develop and test that model in the Philippines and the Port of Durban. The definition of "seafarers" is taken from the in the Maritime Labour Convention and therefore excludes military and fisherman.

In terms of migration health, migrants may face health risks and vulnerabilities at all stages of migration – pre-departure, travel, destination and return. In all stages there are crosscutting factors that contribute to vulnerability. The Global Partnership works on the rationale that there are vulnerable places (such as ports), as opposed to vulnerable groups – hence the work in Africa.

Seafarers constitute a large amount of the mobile workers in the world. A 2000 report by the International Commission on Shipping estimated that there are over 1,227,000 seafarers worldwide. The supply of seafarers is concentrated in several countries, and the Philippines is by far the largest source, supplying nearly 20% of all seafarers. However, data from the Philippines HIV/AIDS Registry suggest that HIV infection among Filipino seafarers is increasing. Furthermore, basic knowledge on HIV is low among these seafarers (PRIMEX/ADB, 2008) and there are still many misconceptions and misunderstandings around HIV. Thus, we need more data. Despite what we know about mobile workers in general (for example, truckers) there are still gaps in the published literature about seafarers.

Many aspects of transportation workers' demographic profile and working conditions contribute to making them more vulnerable to HIV/AIDS. Mariners spend a great deal of time away from their homes and isolated from their spouses and families. This makes them more likely to engage in high-risk activities such as unprotected sex with multiple partners and drug use. The increased risk that transport workers face also makes their families and home communities more vulnerable to HIV and STIs.

We should base our responses on the knowledge we already have about seafarers. We need to increase their HIV knowledge through the use of audiovisual materials and community volunteers. We need to decrease high-risk behaviour by improving seafarers' communication with their family, facilitating ways of saving money while abroad and providing access to healthcare in source and destination countries. In terms of the latter we need referral systems to track treatment, programmes that target entire port-based communities, and improved awareness to available resources (health, social and legal services).

We also know there are areas that must be improved. There are low levels of HIV knowledge among seafarers despite pre-departure orientation, information campaigns, ship visits, and so on. Given the high mobility of seafarers, responses need to take place along the migration route and they need to be composed of consistent messages and seafarers need consistent access to them. This requires multi-stakeholder commitment and cooperation, also across countries, between sending countries, on ships, and in ports.

The Global Partnership is an initiative among international organisations and global networks dedicated to reducing the vulnerability of seafarers to HIV. The partnership has seed money from the Seafarers' Trust, from the public-private partnership (PPP) unit of the UNAIDS Secretariat and in-kind support from all members. The members of the Global Partnership are:

- IOM
- ILO
- UNAIDS
- International Transport Workers' Federation (ITF)
- International Shipping Federation (ISF)
- International Maritime Health Association (IMHA)
- International Committee On Seafarers' Welfare (ICSW)

These are all global organisations and international agencies working on migration, labour and HIV and AIDS, with a very broad reach to employers, unions, ship owners, maritime health professionals, and maritime welfare stakeholders. Over the past year members have met to design a global programme based on their collective experience, including strategy sessions and ongoing coordination with the support of an external consultancy firm. The overall objective of the Global Partnership is to contribute to a reduction in the number of new HIV cases among seafarers.

The Global Partnership has designed a model and the pilot phase of the global project will develop and test that model in the Philippines and the Port of Durban. There are four interrelated project components:

1. Change HIV risk behaviours among seafarers

The changes that the project organisers would like to see as a result of component one are:

- Seafarers have measurably changed their attitudes towards high risk behaviours
- Seafarers report less high-risk behaviours
- Condoms are easily accessible and available for seafarers
- Seafarers make more regular contact with families (including communicating while on board ship)
- Seafarers have increased access to recreational activities on board ship and in ports

2. Increase access to HIV-related services for seafarers

The changes that the project organisers would like to see as a result of component two are:

- A higher proportion of seafarers are aware of available HIV information and services
- Front-line service providers (medical staff on board ship, ship visitors, counsellors) are referring seafarers within the target group to these services in a confidential manner
- The quality of HIV information and services available (pre-departure, on board ship, and in ports) is improved and barriers to access are reduced

3 Increase sense of ownership of HIV prevention strategies by key stakeholders

The changes that the project organisers would like to see as a result of component three are that key stakeholders:

- Are aware of the benefits of supporting HIV prevention programmes for seafarers
- Have made organisational commitments to providing HIV education to seafarers; encourage the referral of seafarers to HIV-related service providers; and encourage a rights-based approach to HIV testing and counselling
- Have committed to supporting HIV prevention initiatives among seafarers (and have implemented relevant legislative, policy and regulatory changes)
- Have started new joint initiatives that address the issue of HIV among seafarers

4 Promote best practices in HIV voluntary counselling and testing (VCT) in the context of seafarer recruitment

The changes that the project organisers would like to see as a result of component four are:

- An increased number of health providers in the maritime sector are aware of minimum standards around HIV testing and counselling (consent, confidentiality, and counselling)
- An increased number of health providers are using best practice guidelines on VCT in the context of medical screening

In the overarching project component, project organisers would like to see the following changes:

- Global decision-making mechanisms
- Coordination
- M&E
- Donor reporting and fund-raising

- Financial administration and reporting
- Communications and external relations on behalf of the Global Partnership

As seen above, each component aims to contribute to a tangible change. Taken together, these four components will be the most effective way to contribute to the overall objective of the partnership. The Philippines has been chosen as part of the pilot project because it is a significant sending country of seafarers and there are ongoing efforts to protect foreign workers, including improving conditions of employment. Durban has been chosen because of its significance as a transport hub, the presence of the Global Partnership (through existing projects in the region), and the nature of southern Africa's HIV epidemic, which requires a different response than that of the Philippines.

Activities will target Filipino seafarers throughout all stages of their mobility: pre-departure; on-board ships; in ports; and upon return. The pilot project will take place over three years and will undergo ongoing M&E.

Borland concluded by giving an update of the current status of the Global Partnership:

- One year of planning and development
- National Stakeholders Consultation, Manila
- Informal discussions with Durban partners (during this workshop)
- Ongoing internal meetings of the Partnership
- Revisions to the project proposal
- Submission to donors (early 2010)
- Some activities likely to begin in early 2010

SADC Draft Policy Framework for Population Mobility and Communicable Diseases

Doreen Sanje
SADC

Sanje started her presentation by giving a number of useful definitions that are used in the 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.

Sanje then went on to describe SADC. It 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 also has 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, port 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 Peoples 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. M&E will involve the production of annual reports, with the input from member states and coordination by the SADC secretariat.

Sanje concluded her presentation by outlining the way forward in terms of finalising and implementing the draft framework. This involves sensitising all critical partners at national and regional level for buy in, ensuring that the private sector is involved, elaborating on the funding mechanisms and the costs, and presenting the framework to Ministers of Health for adoption.

Addressing HIV vulnerability in the maritime sector in southern Africa: Case study Walvis Bay, Namibia

Reiko Matsuyama
IOM

Matsuyama started her presentation by giving a background to the HIV epidemic in southern African and the link to mobility.
As mentioned previously, MCP by men and women, coupled with low consistent condom use, and in the context of low levels of male circumcision, have been identified as key drivers of the epidemic. Contributing drivers include male attitudes and behaviours, intergenerational sex, gender and sexual violence, stigma, lack of openness and untreated STIs. Related to some of these causes and perhaps explaining the rapid spread of HIV over the last decade, is population mobility. Population mobility and migration especially contribute to the phenomenon MCP – as migrants and mobile workers are regularly separated from their permanent partners, they are more inclined to engage in short or long-term sexual relations with other partners. Evidence confirms that migrants and migrant households are particularly at risk to HIV infection. There is a higher rate of HIV infection in "communities of the mobile", which often include socially, economically and politically marginalised people.

There are at least three key ways in which mobility is tied to the spread of HIV:

1. Mobility per se can encourage or make people vulnerable to high-risk sexual behaviour;
2. Mobility makes people more di cult to reach, whether for prevention education, condom provision, HIV testing, or post-infection treatment and care; and
3. Migrants' multi-local social networks create opportunities for sexual networking.

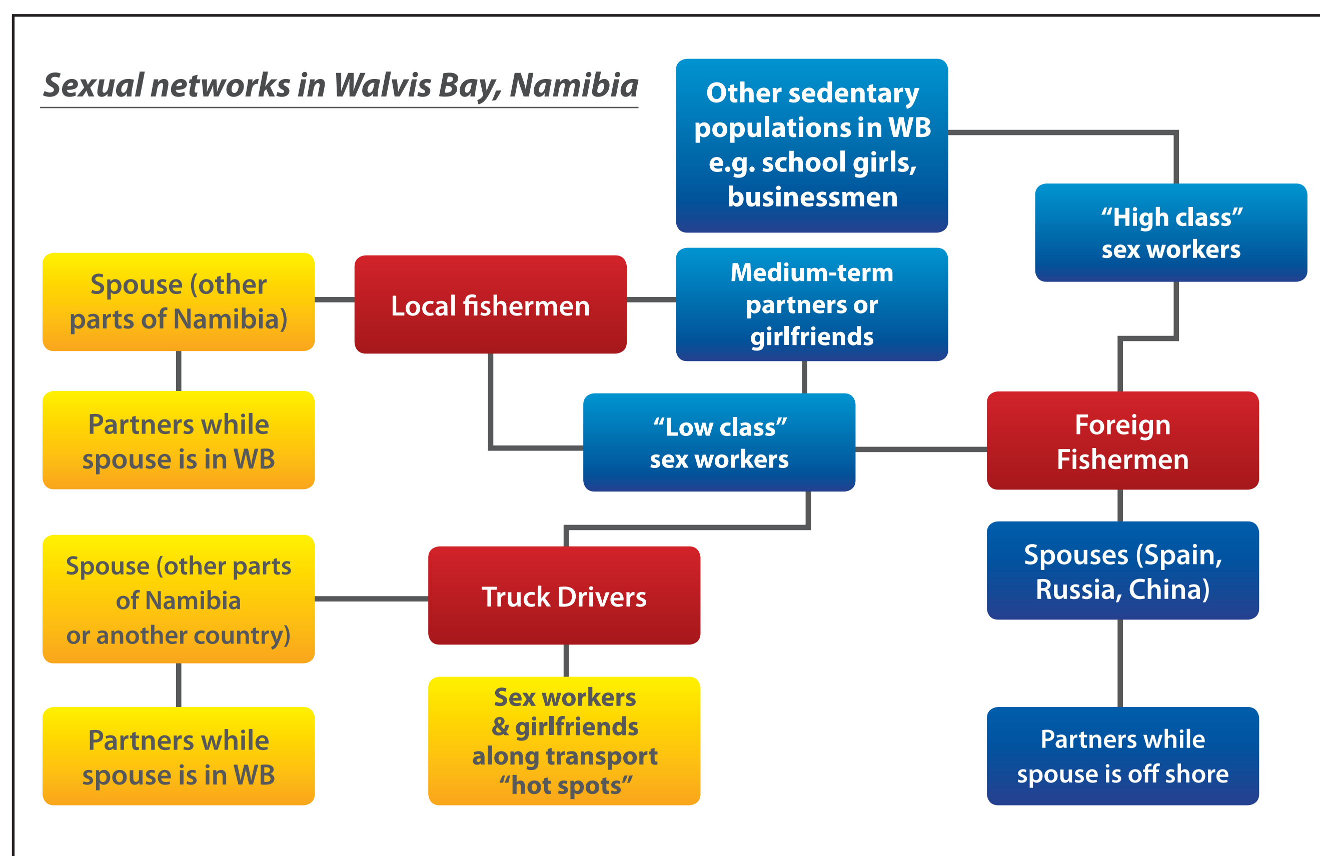
"Mobility" in itself is not key factor for HIV vulnerability and HIV infection among mobile populations but is one of many factors related to the migration process. There is no automatic link between risk, vulnerability and HIV prevalence among mobile populations. In a region which has a generalised epidemic there shouldn't be a separate focus on mobile populations but rather focus on migrant sites or "vulnerable places" that includes targeting the whole sexual network.

Matsuyama then turned to the case study of Walvis Bay, which illustrates some of the above points on HIV and mobility. Walvis Bay is Namibia's only deep-water port and is the focus point of a very large commercial fishing industry, which attracts job seekers from other parts of Namibia as well as other southern African countries. In addition to being the commercial hub of the commercial fishing sector, Walvis Bay is a key node on the two major highways – the Trans-Caprivi Highway, and the Trans-Kalahari Highway that link Namibia directly with Angola, Zambia, Botswana and South Africa. Indirectly these highways link the town of Walvis Bay with destinations well beyond its immediate neighbouring states.

The lucrative fishing industry means that Walvis Bay is frequented by large number of foreign fishermen fishing for international vessels. These foreign fishermen arrive on a regular basis mainly

from Europe (Spain, Russia) and Asia (China). The presence of these foreign fishermen and truck drivers provide additional incentives for commercial sex work. These mobile workers, through their contact with local sex workers, put their regular partners and many others at risk of infection, thereby providing new impetus to the ever-increasing pandemic.

Research conducted by the IOM in 2006 shows the intricate sexual network at work in Walvis Bay:



Truck drivers often stay in Walvis Bay for only short periods of time (at most a couple of days at a time) while freight is loaded or off-loaded. During this time they frequent shebeens (bars) and meet sex workers. There are also high levels of alcohol consumption and abuse. Depending on where they are from they have had some HIV education (for example, Namibians often have but Angolans not), but there is often an unwillingness to internalise HIV messages and change sexual behaviour. In terms of commercial sex workers, there are additional incentives to be based at the port, which creates a potentially high HIV risk environment.

There are different types of sex workers who work at the port ("high-end" full time commercial sex to "low-end" part time commercial sex, or transactional sex). High-end sex workers have more regular clients, mainly foreign fishermen and businessmen, who remain in contact by means of cell phones, and often refer their (visiting) friends. Some sex workers become attached as "temporary" girlfriends and given accommodation, receive higher compensation and luxury items as gifts. Club owners often inform them when foreign fishermen arrive in town. "Low-end" sex workers operate mostly in shebeens, bars or on the street, and have local fishermen and truck drivers as clients. Their remuneration is low and sometimes they are even paid in alcohol. Often, sex workers are aware of the risks associated with sex work. However, due to cultural and gender practices that reduce their ability to negotiate safe sex, exposure to violence, alcohol and drug abuse, and possibly due to language barriers, sex workers often remain vulnerable.

Foreign sea-going personnel are often on 3-6 months employment contracts in Walvis Bay with short-term shore leave. While on short-term shore leave they may engage in once-off unprotected sex and high risk sexual activities with sex workers, or may engage in medium-term relationships with partners who may have other sexual partners (sex workers as "girlfriends"). They are unlikely to receive HIV education prior to arrival in southern Africa as they typically come from countries with low prevalence where there is little attention to HIV education. Once at the ports, not only do their short periods of stay make them difficult to target, but also language and cultural barriers make it difficult for them to access information and services. Mostly these men engage in once-off unprotected sex/high risk sexual activities with sex workers:

"The Chinese do no like condoms and do not want to pay so they have high-risk sex with low level prostitutes, other foreigners have high end girls but also do not want to use condoms, while the local guys have girlfriends in Kuisebmund so they are not using the prostitutes as much, but they go out and look for other women." – SMA Educator

The alternative is that these men engage in medium-term relationships with women who may have other partners (sex workers as "girlfriends"):

"High end prostitutes get foreign fishermen to rent houses for them. The fishermen live with the women when in port and when they are at sea the women 'have a good old time' going to the nightclubs and having other men. They know when the boats come back and clean up for them. The foreigners think all is well and that they have a woman and a place to stay. For the men it is about having a place like home, while for the women it is all about security and using men for a place to stay. These are most foreigners, Spanish not Chinese." – Real estate agent

Among local seafarers the following attitudes towards HIV were expressed. Firstly, there is distrust in vessel owners and management:

"You know those who are supposed to give us that [HIV] information are our bosses, the boat operators. They are all foreigners, so they don't really care about us. Their concern is just work and their fish. As you know, those foreigners are still having that wish that we should suffer so that they can come back in our country." – Oshiwambo Fisherman

Secondly, many engage in unprotected sex with low-end sex workers and transactional sex:

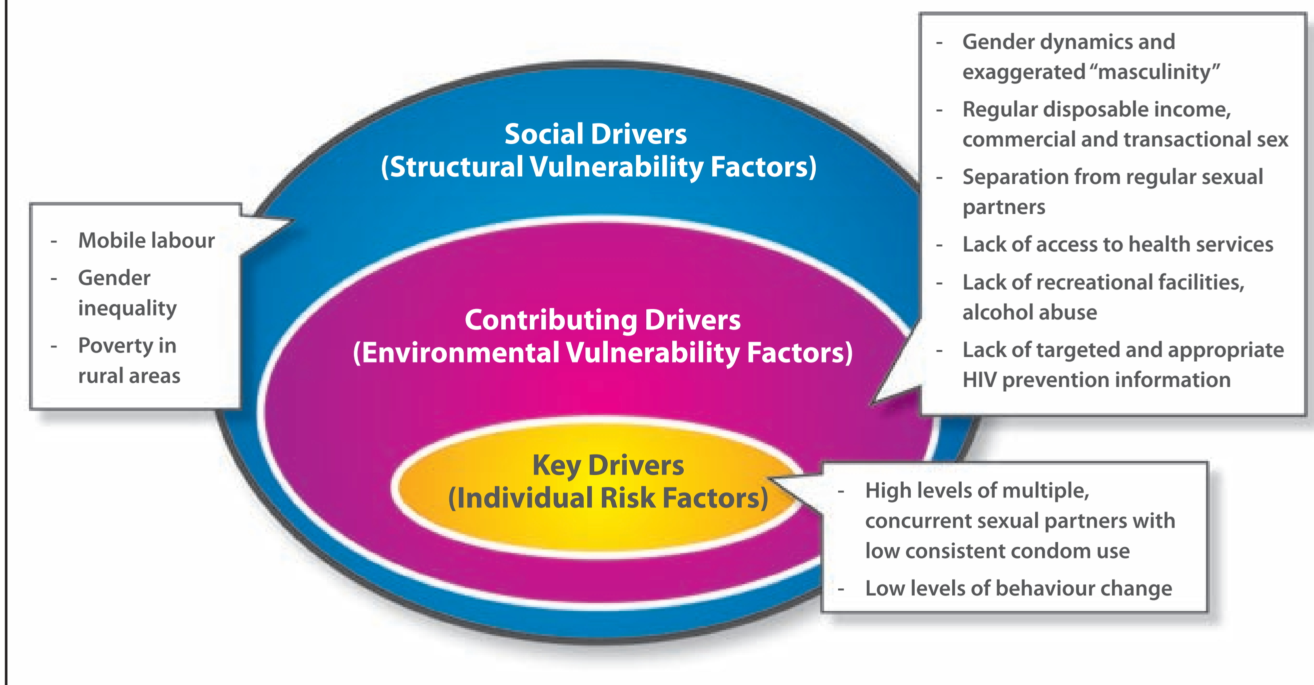
"Why do you want me to use a condom if I am paying you? … No, I cannot have sex with you using a condom. I pay you or I can add some more money, so that we cannot use a condom." – Namibian Fisherman

"These girls, I think they are helping the fishermen. … Because, one thing is that we fishermen do not have enough time to find a girl that is not paid for sex. Sometimes we come in here in the morning and then you will go back in the sea in the afternoon the same day. … You don't really have time to struggle for a normal girl. That is the only option you have to be able to be with a woman." – Namibian Fisherman

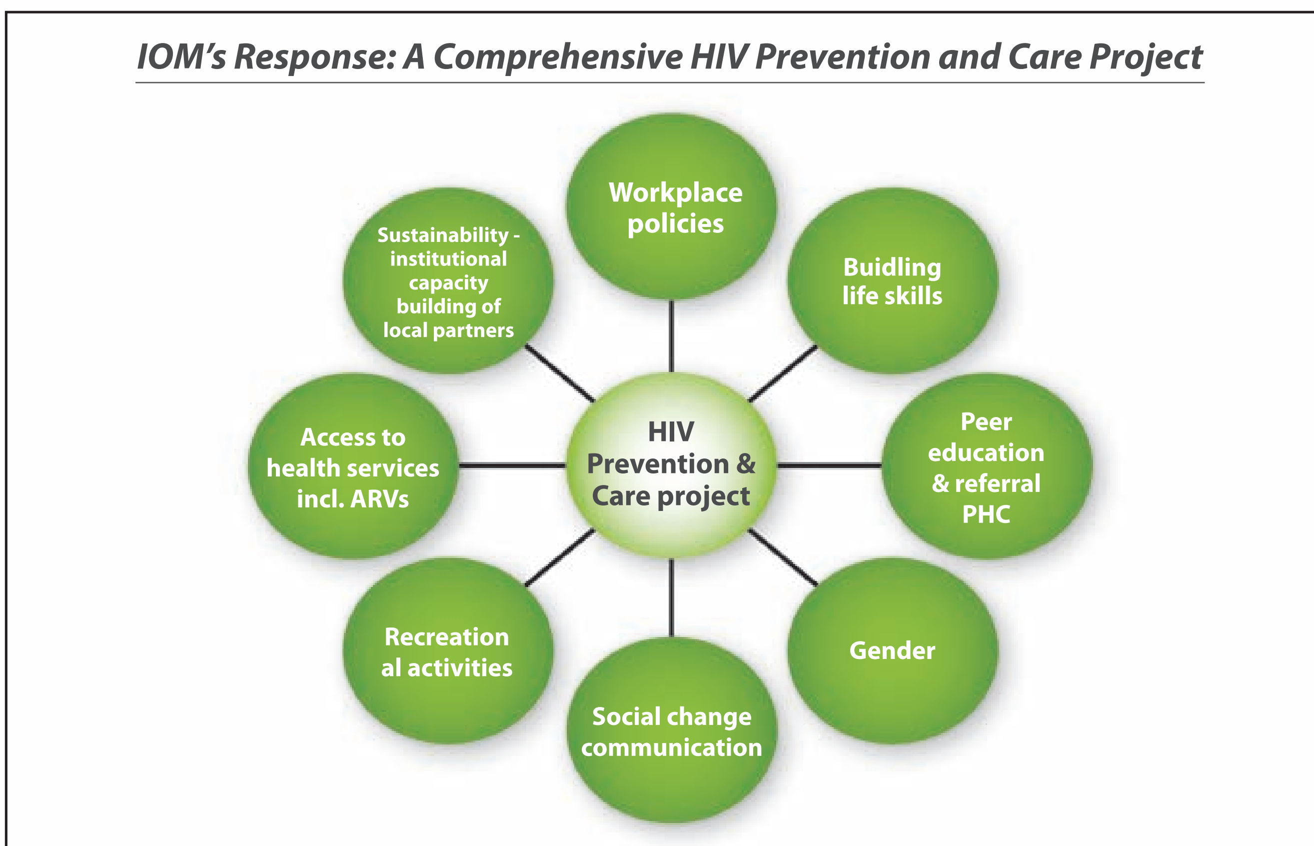
Like foreign fishermen, there is widespread alcohol abuse among local seafarers compounded by a lack of recreational activities while on shore leave, separation from family, and inability to communicate while on the ships.

Thus, the above quotes show the dynamics of risk behaviour around the port of Walvis Bay. Commercial sex work ties truck drivers, fishermen and sex workers in a triangle of risk. Transactional and commercial sex further links sedentary populations (local girlfriends, other clients of sex workers) with the above triangle of risk. Mobile sub-populations at risk ties Walvis Bay to other locations in southern Africa and also in other parts of the world. Infections picked up along any of the main transport routes in southern Africa could potentially be carried all the way around the globe to cause new infections, with new strands of the virus. Conversely, infections picked up elsewhere in the world would be brought to southern Africa. In this way, the port becomes a hub linking mobile and sedentary populations, as well as high and low prevalence areas. This is why we should concentrate prevention efforts at "vulnerable places", not "vulnerable people".

The drivers of HIV infection in the maritime sector in southern Africa can thus be described by use of the following diagram:



The IOM's response to the above was to develop a model that outlines components of an HIV prevention and care project among mobile workers.



The model incorporates the following components:

1) Workplace policies to create a conducive work environment
2) Building life skills (e.g. financial literacy)
3) Peer education and referral to Primary Health Care (PHC)
4) Gender interventions, particularly around male role models, addressing discriminatory gender dynamics and prejudices through the training of male role models
5) Sustainability – institutional capacity, building of local partners
6) Facilitating access to health care and services including VCT, ARVs and condoms
7) Recreational activities – addressing the issue of loneliness and boredom and other contextual factors that impact on HIV vulnerability
8) Integrated and locally tailored Social Change Communication (SCC) programmes, which link all components

Currently, the IOM HIV interventions in Walvis Bay are:

- Working with a local implementing partner to target local and foreign seafarers, particularly in the fishing sector
- Working with five fishing companies as a pilot to target their seafarers
- Working with the Namibian Maritime Fisheries Institute (NAMFI) to mainstream HIV within seafarers vocational training
- Producing advocacy/training material (e.g. the comic book *Chasing Dreams)*

Discussion

During this session, many points from the presentations were revisited for clarification or further discussion. One participant wanted to know more about **illegal immigrants and sex workers** and what is being done to **address migrant health among these groups**. In both of these cases, people's activities are "criminalised" which makes it harder for organisations to work with them. Rahevar responded that the WHA resolution covers all kinds of migrants, regardless of their status. Borland added that migrant health work usually is carried out with undocumented migrants, as they are the most vulnerable to HIV infection. But documentation is a barrier that needs to be addressed.

Another participant questioned the **WHA process of reporting back on the resolution** and what objectives had been achieved. Rahevar responded that this question should be addressed to the WHO focal person who deals with the WHA resolution. However, he could report that the issue of migrant health has been raised at many global and regional meetings, for example, the WHO 7th Global Meeting on Health Promotion, held in Nairobi, Kenya, in the last week of October 2009. The IOM and WHO worked together on a sub-plenary on the health of migrants, which brought together the experience of Thailand, Mexico and Spain. The Nairobi Call for Action also does make mention of the support of health promotion for migrants.

A participant drew attention to the **issue of TB**, especially multi-drug resistant (MDR) and extremely drug-resistant (XDR) TB and asked how these were being addressed among migrant workers. Rahevar agreed that HIV is driving the TB epidemic. South Africa has the second highest prevalence of TB in the world and prevalence is increasing every year. The country also has the largest MDR treatment programme in the world. However, the data system to understand and track prevalence is weak and needs to be improved. The problem with the treatment of MDR and XDR TB is that patients are admitted for six to nine months and are treated with very complex with expensive and toxic drugs. It is a long regimen and once people are feeling better they stop treatment and go home. This is highly problematic as it causes drug-resistant strains of TB.

In terms of the **Global Partnership**, a participant wanted to know about **what it was doing to address HIV among host communities** – in this case those in and around the ports. Participants were reminded to think of the many kinds of people who interact with seafarers, for example, the significant population of women who are involved in transactional sex, but those who do not identify their behaviour as sex work.

Furthermore, the **exclusion of fisherman from the Global Partnership's programming** could be seen as a problem, as it makes them more vulnerable to HIV. Borland said that behaviour change material is available to port-based communities. Thus, there is a benefit beyond the target group as all groups ultimately gather in the same place. But fishermen are formally excluded

because they work under different conditions and therefore have different vulnerabilities to transport workers.

There is a question about whether staff on **cruise ships** should be included in the Global Partnership and it was felt that they should.

Participants were very interested in the **multi-sectoral approach of the Global Partnership in the Philippines**. Borland explained that this is because the labour and maritime sectors in the Philippines are quite advanced in terms of their response but they are still quite separate from the National AIDS Council. One of the goals of the partnership is to bring them together. There was a question about why the **Global Partnership** pilot project cannot be started in **other ports** as well. This is because members chose one port to run the pilot and Durban was picked because of the nature of the epidemic in this region. But there is a need to scale up in the future.

The **low level of knowledge around HIV** was reiterated. Most Filipinos that come into Cape Town harbour know very little about HIV and critically need education.

On the subject of **working with employers**, a participant wanted to know who takes responsibility within a company to liaise with the ILO. Is it the Human Resources (HR) representative in the company or another dedicated staff member? Serima responded by saying that each case is different and the company decides who the focal person is. Leaving it open is a problem, because then the HIV policy and programme may not get implemented. Other participants added that the company usually designates a high level manager to carry out the HIV programme and policy. But all decision-making is consultative. Borland mentioned that part of the task at hand is to identify different levels at which the Global Partnership can work for example, with doctors and first aid people on ships.

The **SADC draft policy framework** drew a number of questions and comments. One participant remarked that **TB and HIV require long-term treatment**. Mobility is a major challenge to this so a good referral system is needed. However, feedback is a major problem – SADC is not getting feedback from receiving countries. This needs to be in place and it needs to happen at these kinds of forums.

Another concern was **how to harmonise SADC protocols**. There has been a delay and now there is going to be a further delay until April 2010. Participants wanted an understanding of how best to make these ideas come to fruition – is it funding, political will or a combination of both? If we know where the blockages are then it would be easier for us to change it. SADC responded by saying that the framework was developed some time ago but has budgetary implications, so it needs buy-in from ministers in member states. Harmonisation is ongoing work and is not something that can happen in one quarter. There are fifteen countries that need to agree on it and then implement the framework. Wide consultation needs to occur with stakeholders so that everyone has endorsed it when it is implemented. There are other frameworks that are being developed (for example, on HIV and PMTCT) and aspects of these will impact on the framework. SADC reminded participants that member states determine what the secretariat should push. The secretariat is simply the executing arm of member states. Thus, the secretariat can be held accountable – people can write to it and request accountability. SADC partners with organisations and stakeholders at a regional level, such as NACs and Ministries of Health. The partnership forum meets in April and October and at these forums member states can advocate for an issue to be put on the agenda. The draft framework has economic implications, thus it is important to have the buy-in of the private sector in terms of the framework. Therefore, the secretariat is in an ongoing process of engaging and consulting with the private sector.

Another participant added that it must be remembered that **many mobile workers are casual workers**, and when we engage with companies we need to take this into account. Mobile workers still contribute to company's bottom line. Furthermore, the private sector's disease surveillance of mobile workers is poor and should be improved.

One participant wanted to know **what the SADC secretariat is planning for the World Cup**. SADC is going to work with other initiatives – such as organising a SADC artist's festival in the first week of December. The 50 by 15 campaign message is one that will be taken to 2010. SADC also has a meeting with the Southern African Editors' Forum planned to ask it to take into account issues of HIV and the 50 by 15 campaign.

Plenary Two: Evidence from the ground

The purpose of this session was to give a number of presentations that shared lessons learned, experiences and good practices of HIV responses and research as they relate to seafarers and port-based communities. The presentations in this session were:

- Isaac Omoke, Port Management Association of Eastern and Southern Africa (PMAESA): " Impact assessment study of HIV/AIDS in the PMAESA port of Dar Es Salaam"
- Erin Tansey, IOM: "Migrants' vulnerabilities to HIV and their access to prevention services at the Port of Durban, South Africa"
- Rev. Des Vaubell, Mission to Seafarers (MTS): "The Mission to Seafarers and the health vulnerabilities of seafarers"

Impact assessment study of HIV/AIDS in the PMAESA port of Dar Es Salaam

Isaac Omoke
PMAESA

PMAESA is a non-profit, non-governmental and non-political organisation of port authorities in the Eastern and Southern Africa region. The secretariat is in Mombassa, Kenya, and it has 20 member countries. Recently, PMAESA, in partnership with the IMO, undertook studies in ports to assess HIV vulnerability in the ports of Durban, Mombassa, and Dar Es Salaam. Omoke presented the findings from the Dar Es Salaam arm of the study.

The objectives of the study were:

- To collect and analyse all available data on HIV and AIDS for the port.
- To review existing HIV and AIDS policies and programmes within the port.
- To determine the level of HIV and AIDS knowledge, awareness and behaviour among port employees.
- To understand gaps and best practices.
- To provide technical support and guidance on how to formulate sustainable action plans for dealing more effectively with HIV in the port.

Three methods of data collection were used in this study: document review/analysis, key informant interviews, and observations.

The key findings were as follows:

Level of HIV Infection and AIDS Related Sickness

Tanzania Ports Authority (TPA) has been collecting data on the impact of HIV on its personnel, which demonstrates that HIV is impacting negatively on the port through increased morbidity and mortality among port workers. Most affected port workers are mainly those aged less than 49 years, and most infections occurring between 45 and 49 years. Presently, some 136 workers are on ARV treatment in the TPA clinics.

Risk Factors

- Lack of enough money, especially among women, and excess cash on the part of some workers, especially men
- Multiple sexual partnerships
- Transactional sex
- Crowded housing
- Idleness and loneliness
- Inadequate HIV knowledge
- Drug and substance abuse
- Incapacity to access condoms
- Inability of poor women to negotiate safer sex due to gender power relations

Port Responses to HIV

The TPA has developed a draft HIV policy. TPA has also appointed an HIV Steering Committee to manage the organizational response to HIV. Other responses have included the provision of comprehensive medical services to all TPA employees, identification and training of peer educators and recruitment of counsellors. TPA has also made HIV information available to its employees.

Key Challenges

Despite efforts by TPA to reduce the impact of HIV within the port, a number of factors still impede progress. These include the lack of:

- Explicit institutional policies to address HIV in the workplace.
- Budgets for HIV programmes and activities.
- Skills on the part of staff charged with HIV activities and lack of systematic training programmes for these staff.
- Customised HIV IEC materials, since current ones are fairly generic.
- Condoms in port facilities.

Lessons Learned

- HIV-related stigma and discrimination can be significantly reduced through effective, engaging and meaningful workplace programmes.
- Peer education can be a very effective tool in promoting HIV education and in reducing stigma and discrimination.
- If well sensitised on the benefits, most employees would be willing to take up VCT.
- The provision of ARVs to workers living with HIV can significantly increase their productivity and reduce levels of absenteeism from work, as well as AIDS related deaths.

Recommendations

I. Build Appropriate Policies and Institutional Responses

TPA should:

- Adopt and implement the draft HIV workplace policy (which has been done since the study was conducted – see below).
- Develop the capacity of its HIV Steering Committee through training and skills development.
- Set aside a budget for HIV activities.
- Strengthen its systems for gathering information on levels of HIV and AIDS-related absenteeism, sickness and deaths.

II. Prevention of HIV Infection

TPA should:

- Introduce Provider Initiated Counselling and Testing at the TPA health centre and make available appropriate equipment for rapid tests and all service providers trained in its use.
- Place condom dispensers in all offices and washrooms within TPA.
- Augment current generic IEC materials with customised IEC materials.
- Engage in outreach behavioural change programmes targeting port workers' spouses and family members in the residential areas.
- Develop continuous and systematic HIV awareness campaigns through entertainment, drama, workshops, seminars, video shows and rallies.
- Have an internal AIDS Day within its calendar where workers would be involved in HIV-related activities.

III. Treatment Care and Support

- Support groups for PLWHA within the port and in port workers residential areas are needed.
- Strategies for empowering women economically need to be devised and promoted to counter current gender inequalities that make women more vulnerable to HIV and AIDS within the port.
- There is a need to scale up the ARV programme within the port area.

IV. Provision of Care and Support

TPA should:

- Encourage the formation of support groups for people living with HIV.
- Establish more user-friendly centres for counselling at the work place.
- Develop educational materials that emphasise positive living.
- Promote education on insurance and encourage employees to take appropriate policies.
- Make available telecommunications infrastructure (AIDS toll free hotline) to link various HIV-related issues at the port.

Migrants' vulnerabilities to HIV and their access to prevention services at the port of Durban, South Africa

Erin Tansey
IOM

This research was part of an assessment that was conducted for the United States Agency for Development (USAID). It covers eight countries in the SADC region and looks at access to HIV prevention services for migrants. It gives an overview of what is happening on the ground in selected sectors in different countries.

Tansey began her presentation by giving a short background to the port of Durban. For the past century, Durban Port has been southern Africa's major port and trade gateway. It is the busiest and biggest port in Africa. The port and its associated activities (such as shipping, stevedoring, and marine engineering) now employ some 25,000–30,000 people, at least a quarter of whom are casual labourers. In addition, it is host to several other large migrant populations: truck drivers, construction workers, commercial sex workers, crews of vessels using the port and uniformed customs, immigration and security officials.

Most workers at the port in non-management positions are migrants from rural KZN. They mainly reside in townships such as Umlazi and KwaMashu, or in various former same-sex hostels closer to the harbour. Since the 1990s the port has attracted more foreign workers, particularly from Mozambique, Zimbabwe and even Tanzania.

Significant mobile populations at the port are:

- **Seafarers** who make up the crews, particularly of cargo or container vessels, but also of fishing, ocean liner or navy vessels.
- **Sailors** of many different nationalities – Filipinos, Koreans, Chinese, Indonesians, Japanese, Indians, Pakistanis, Russians, Ukrainians, Croatians, Montenegrins, Lithuanians, Poles, Germans, Brits, Spaniards, Senegalese and Americans.
- **Truck drivers**: thousands of trucks visit the port every week from all over southern Africa. They often spend nights sleeping in their trucks along Maydon Road or on the Bayhead side of the harbour.
- **Commercial sex workers** frequent the areas where trucks are parked.

The study showed that migrant's levels of knowledge about HIV varied but were generally poor. Respondents believed that having multiple partners or using commercial sex workers was acceptable behaviour for men. Most claimed to use condoms, but did not use them with longer-term relationships, as they "trusted" their partners. Less than half of the informants were able to comment on what makes migrant workers vulnerable to HIV, but those who did named factors such as economic desperation by migrant women, leading to sex work, being away from families, and alcohol abuse.

The vulnerabilities of migrants around the port include:

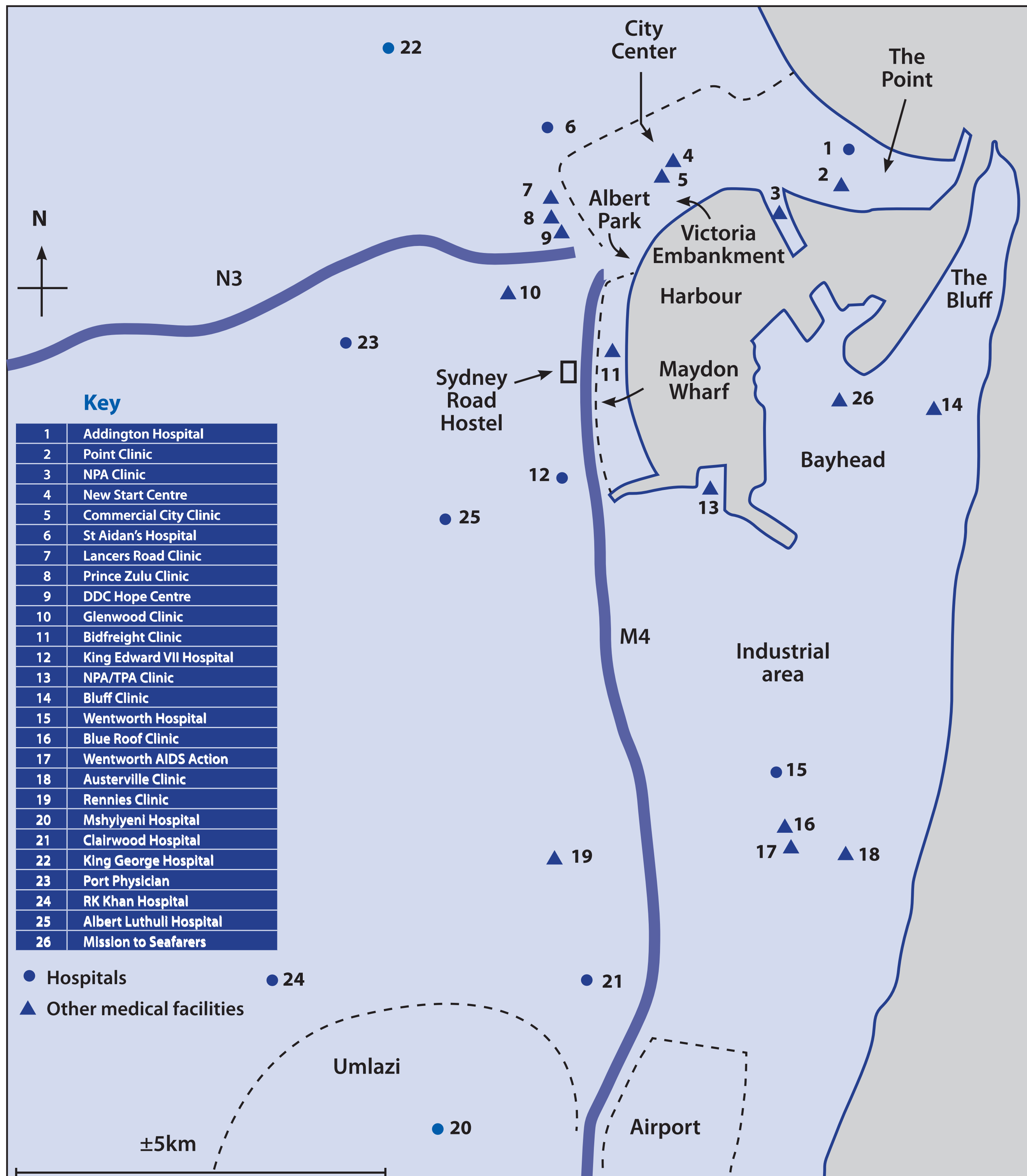
- Long periods of time away from their families, especially seafarers, truck drivers, construction workers and foreign dockworkers.
- The separation of regular partners encourages the use of sex workers and the formation of multiple partnerships.
- Cultural beliefs around gender relations also augment this tendency.
- The dangerous nature of work: workers attach a low risk to HIV since they are too preoccupied with everyday survival matters and perceive HIV as a distant threat.
- A " uid social environment in which social norms regulating behaviour are not followed. Migrants may feel a sense of anonymity and limited accountability, leading to high-risk behaviour.
- Increasing numbers of woman migrants to Durban – they often have little choice other than to resort to sex work or transactional sex to support themselves.
- Lack of education in general and HIV awareness in particular.

There are HIV prevention services at or near the port. An example is the workplace HIV programme at the Transnet National Ports Authority and the Port Terminal Authority. It has a "Lifestyle Management Programme" which covers 4,000 workers. The 2,000 casual workers Transnet employs are excluded from this programme, except for access to condoms and IEC materials on ad hoc basis. Peer educators are also trained to pass on knowledge to their colleagues. Workers who test positive are put onto Antiretroviral Therapy (ART), which is paid for by Transnet. If they leave the company, they are kept on the programme for a year to give them time to transfer to the state's ART programme.

Access to HIV prevention services is generally quite poor. Of the 30,000 workers associated with the port, an estimated 10,000 or more are not accessing HIV prevention through workplace programmes. There are few HIV prevention services specifically targeting workers or mobile populations associated with the port. Casual workers, in particular, are left out because they are not given access to company clinics, HIV education sessions or medical aid. This is a major challenge for casual workers, who are often foreign migrants. For those not covered by workplace policies, government health clinics and hospitals are the most accessible.

The following map shows some of the services that are available, in the form of government hospitals and clinics, as well as those run by NGOs:

Health services available to migrants near the Durban port



Other challenges to accessing health care services include:

- Poor service, anti-foreigner attitudes and long queues at government institutions discourage migrant workers from using services.
- Accessing ART is very difficult and complicated because of the bureaucratic nature of ART programmes.
- The ARV budgets of local hospitals often do not make allowance for an influx of patients from outside, limiting the extent to which patients can be referred to other facilities of they are mobile.
- Families of migrant workers do not have access to VCT, or other HIV prevention services.
- Language is a problem, as foreign migrants/seafarers may not speak local languages or English.
- Limited NGO HIV services, especially programmes specifically targeting migrant port workers. Migrants have little choice but to use state facilities.
- Lack of education, HIV awareness and enduring stigma and misconceptions about HIV means that even if HIV prevention facilities are available some migrants or seafarers will not want to make use of them.

Mission to Seafarers and the health vulnerabilities of seafarers

Rev. Des Vaubell
Mission to Seafarers

Rev. Vaubell began his presentation by stating that if we want to understand seafarers and the HIV epidemic we need to know something about the way they live. Seafarers study at a Maritime Academy and then use a Crewing Agent to sign a contract to go to sea. They usually have six- to nine-month contracts and often engage in dangerous work. In 2003 five seafarers died and three ships sank every week worldwide. Although these are outdated statistics, they probably give a good indication of what is happening in 2009.

Seafarers have the following vulnerabilities, which were not yet mentioned in previous presentations:

- Very little personal space
- Fear of hijacking and piracy
- A small percentage of unscrupulous shipping companies
- They miss most family celebrations and tragedies
- When they get home, they have changed and feel remote from their spouses and children

Thus, when they do have shore leave they want to have fun and this often means female company. They visit places like the Seafarer Centres, pubs and restaurants, Gateway, the Pavilion (shopping malls) and Ushaka (a water park). The Seafarer Centres have a TV, games room, library and so on.

Mission to Seafarers is in over 300 ports all over the world and its mission is to care for seafarers worldwide. It is an outreach of the Anglican Church. The organisation sees itself as promoting justice and welfare within the maritime industry. There are eight centres in southern Africa (Richards Bay, Durban, East London, Port Elizabeth, Cape Town, Saldhana Bay and Mossel Bay). With ITF funding, new centres in Maputo and Luanda will open next year. The centres are open to everyone regardless of race, gender, or religion, although sex workers are not permitted to visit the centres. Sixty six nationalities of seafarers have visited the centre in Durban.

In terms of its HIV response, Mission to Seafarers believes that it is not its place to judge anyone. The system the organisation has in place in terms of HIV prevention is, firstly, ship visits, in which they speak to both the captain and crew. Chaplains who visit the ships offer information on the local HIV prevalence and use the "ABC" (Abstain, Be Faithful, use a Condom) approach to prevention. The Mission to Seafarers also hands out literature on HIV to the seafarers, which, although outdated, is available in many different foreign languages such as Korean, Tagalok, Arabic, Thai, Chinese, Japanese, Spanish, and Russian.

The second place the organisation meets seafarers is at the Seafarers Centre at Durban Port. It is never closed and a chaplain is always on duty and available for spiritual guidance. Sometimes the chaplain is asked by a visitor to organise an HIV test. In this case, the chaplain facilitates a visit to the local clinic for the seafarer to be counselled and tested for HIV. The seafarer would sign a release form which allows the chaplain to receive the result of the test and once this is done, the chaplain emails it to the seafarer, who is usually back at sea at this stage.

Discussion

The presentations stimulated an interesting discussion. One participant wanted to clarify the **Mission to Seafarers position of discouraging seafarers from visiting sex workers**. It was felt that such a statement blames sex workers as vectors of HIV, when this is often not the case and clients may infect sex workers. Instead of blaming sex workers perhaps it is also fair to educate clients as well. Rev. Vaubell responded by saying that the organisation tries hard not to be judgemental. The issue is not about sex workers, it is about having the desire to stop new HIV infections. In their work, chaplains meet a lot of sex workers on the ships, talk to them, and learn a lot about their lives and the challenges that they face.

The issue of the **VCT procedure that Mission to Seafarers offer its clients** was raised. Participants felt that it would be better for the seafarer to receive a rapid test (the result of which is given in 15 minutes) and in this way, he/she can have access to post-test counselling. Furthermore, the issue of confidentiality is then respected and the seafarer can leave the port already knowing the result. Mission to Seafarers responded that the point was taken and that this would be looked into. The group agreed that this was a good illustration of how we can learn from each other's expertise in a range of different areas, such as VCT.

In terms of the **PMAESA report**, TPA wanted to add that the workplace policy has been adopted and that employees and their families now have access to TPA health care services.

There was a question about **why there is no wellness centre in the actual port**. Apparently there have been numerous attempts by different organisations but they have not come to fruition. "Hotspots" are actually just outside the port, and it has been proven at other locations (like Mombassa port, for instance) that wellness centres work better if located just outside the port.

Other populations besides seafarers seem to be underserved. One participant wanted to know if NGOs working in the area (such as Trucking Wellness) are seeing **other clients besides truck drivers**. Participants from these organisations confirmed that other workers, such as construction workers, stevedores and so on, are accessing the clinics.

Another participant was concerned about the **new labour law in Tanzania**, which makes it possible for women to be out on the street after dark. He wanted to know if this would impact on HIV infections. His colleague from the Port of Beira reassured him that women have always worked at night there and that things were not going to change considerably especially in terms of HIV infections.

Plenary Three: Programmes and policies

This session had the objective of sharing lessons learned, experiences and good practice of HIV responses, policies and programmes, as they relate to seafarers and port-based communities, with the view to identifying existing gaps and challenges in current policy and programming. The presentations in this session were:

- Moises Mavaringana, Cornelder de Mozambique: "Porto Saudavel: HIV/AIDS workplace programmes"
- David Dungan, Port Health Officer, Port of Durban: "Port workers' vulnerability to disease"
- Dorothy Muroki, Family Health International (FHI): "Extending HIV services to the port-based community in Dar es Salaam"

Porto Saudavel: HIV/AIDS workplace programmes

Moises Mavaringana
Cornelder de Mozambique (CdM)
Mavaringana talked about the PPP between the German Technical Agency (GTZ) and Cornelder de Mozambique (CdM). CdM is the management company of Beira Port and has 446 employees. The PPP has worked together on developing and implementing an HIV workplace programme for CdM entitled "Porto Saudável" ("Healthy Port"). The general objectives of the project are to create awareness on HIV at the Port of Beira and provide ongoing counselling, testing, prevention and treatment for HIV at the port.

The province of Sofala has the highest HIV prevalence in Mozambique – about 23% - and its capital, Beira, has a HIV prevalence rate of 34%. This is owing to its proximity to the Beira transport corridor and the borders of Zimbabwe, Malawi, and Zambia.

The specific objectives of the project are to:

- Develop workplace policies in the companies operating at Beira port
- Engage with other HIV structures
- Implement programmes at workplaces
- Sensitise the workers and their families, and other mobile populations (truck drivers, seafarers and so on)

IEC material is distributed to workers and their family members, namely children between 14 and 18 years and spouses. A Medical Male Circumcision (MMC) campaign ("Operation Takes Off Hat") is run with workers and their sons. So far fewer than 100 circumcisions have been carried out. Just over 5,000 people have been tested for HIV – 4,400 men and 600 women. Over 800 have tested HIV positive – more women than men.

The challenges and lessons learned from the project are:

- The project required a 3% contribution from participating companies. The companies do not pay, but rather contribute in giving time and venues for workers to attend sensitisation workshops.
- At the start of the project, companies were reluctant to join. Project organisers had to convince them.
- Some companies have not yet included the wives of workers into the project. They are being educated on the importance of women participating and encourage workers to include their family.
- Low attendance of family members – they have been motivated to join by low fees.

Mavaringana ended his presentation by saying that these kinds of projects are important. They depend on the commitment of senior level management at the companies. If there is a joint effort, these kinds of projects have a better chance of succeeding. It requires a great sacrifice of time and effort to keep these kinds of projects running.

Port workers' vulnerability to disease

David Dungan
Port Health Officer, Port of Durban
Dungan is the Port Health Officer for Durban Port, as well as being a South African Maritime Safety Association (SAMSA) Medical Advisor, a specialist in travel medicine, an immigration practitioner, and part of the IMHA Working Group, to name a few of his roles.

As previously mentioned, Durban is the largest, busiest port in Africa. It deals with multiple cargoes. It has 4,500 vessel visits per year and 120,000 international crew visit every year. There

are approximately 30,000 workers in the port daily, of whom approximately 40% are casual day labour. Port workers are all exposed to a large variety of health risk issues from occupational hazards, environmental conditions and disease hazards of migration (particularly HIV, TB and epidemics).

In terms of health facilities, port workers have access to the following:

- Three NPA clinics
- 3-5 company based clinics
- Two private clinics off Maydon Rd
- Addington Hospital
- Shipmed Facility

Dungan spoke about the vulnerabilities of international crews visiting the port of Durban. Many were similar to those mentioned by Rev. Vaubell in his presentation. He then spoke about the conditions of other port workers.

SAMSA has recently developed new regulations in terms of safe working conditions for stevedores and the ship repair and building industry. These were introduced to help protect people working in the industry. They set out specific work practices and methods, codes of practice, basic minimum personal protective equipment (PPE) and health standards. Each worker must have an annual medical examination and VCT is strongly promoted in the process. The sector is still awaiting the promulgation of these regulations.

Dungan highlighted the working conditions and health vulnerabilities of a range of port workers. Stevedores work the cargo on the vessels. They are part of the formal sector, are regulated, have access to health care, feeding programmes, annual medical examinations, and structured shift work. However, informal sector stevedores work under very different conditions. They are known as the "bakkie brigade" (after the van they are transported in) and are often foreign workers or illegal immigrants They are usually casual workers and are very vulnerable to alcohol abuse, environmental exposure, malnutrition, drug abuse, long working hours, and have no access to health care (including VCT) or education and training generally or on HIV. They have no or ill fitting PPE. They are exposed to multiple environmental hazards during cargo handling, such as dust, fumes, noise, radiation and trauma. Security officers and those working in the ship building and repair industry face a very similar situation.

Comparatively speaking, the vulnerabilities of truck drivers are well known and there are active health care programmes in place for them. Sex workers are exposed to multiple crews and often face re-infection with different strains of HIV and are exposed to other epidemics, like SARS. Thus, the health vulnerabilities of all these different communities who use and are based at the port are as follows:

- Lack of education
- Environmental exposures
- High-risk work
- Erratic work
- Malnutrition
- Drug and alcohol abuse.
- High-risk sexual practices
- Lack of access to information, health care and VCT
- Exposure to multiple diseases

The solutions to these vulnerabilities are:

- Regulation and legislation
- Identifying those at most risk
- Access for the most vulnerable to:
    - Education
    - Information and Communication
    - Religious facilities
    - Healthcare facilities
    - Feeding programmes
    - Alcohol and drug education
    - Promotion of safe sex practices (knowledge of risk)
    - Inter-professional health promotion

Extending HIV services to the port-based community in Dar es Salaam

Dorothy Muroki
FHI

The Regional Outreach Addressing AIDS through Development Strategies (ROADS II Project) has expanded to 36 sites in 10 countries in East and Central Africa, and Zambia will be added in this fiscal year. The objectives of the ROADS project are to:

- Extend HIV and broader health and related services for high-risk mobile and community populations along regional transport corridors, including major ports
- Increase African regional institutional capacity for rapid scale up of state-of-the-art practices and sustainable models
- Identify, test and diffuse innovations

The ROADS vision is to reach most-at-risk populations (MARPs), foster community driven programming, and to address root causes of vulnerability.

Muroki gave a background to the port of Dar Es Salaam. HIV prevalence in Temeke district is 10%. The national prevalence is around 15%. The port sees more than 2,300 port workers per day, many of whom are away from home for extended periods. There are high levels of sexual interaction between port workers, including seafarers and transport workers, and vulnerable community members. MCP and commercial or transactional sexual relationships, idleness among youth, cross-generational sex, alcohol and drug use drive HIV infection. There is high stigma at community and family levels, resulting in low disclosure of HIV status by many PLHIV. Despite port authority workplace programmes, there are low levels of condom use and women lack condom negotiation skills.

As part of the ROADS project, "SafeTStop" Recreation and HIV Resource and Wellness Centres have been established along the main transport corridors. A centre is currently being established at the port of Dar Es Salaam. The centre will offer the following to visitors:

- Alcohol-free setting as alternative to bars and lodges
- HIV education, condom distribution, HCT, STI diagnosis and treatment, alcohol counselling, and men's discussions
- Satellite TV, pool, other games
- Internet access to help transport workers stay connected with their families
- Referral to facility- and community-based outlets, including private sector pharmacies
- Joint prevention, care and support programming with community "clusters"

"Cluster" programming is community driven. Conventional projects contract a few larger NGOs to implement, disempowering local responses and limiting sustainability. The "cluster" model fosters collective action of small, sustainable, indigenous volunteer groups with similar focus and interests. In the 10 countries, there are 57 clusters representing 916 community groups with more than 65,000 individual members. 90% of them are participating in a donor-funded development programme for the first time.

For example, a typical SafeTStop community might include: low-income women's groups, support groups, youth groups and orphans and vulnerable children (OVC) support providers who form clusters to conduct HIV activities in a coordinated fashion. They will be supported by, and link with, the indigenous service providers – the local health clinic for counseling and testing outreach, pharmacy owners who have been trained to provide information to customers on ART adherence or sexually-transmitted infections, churches that offer alcoholic anonymous services, business leaders who might be coordinating a food drive for PLHA or OVC and so on.

Thus, SafeTStops have multiple meanings in communities:

- **Safe**guard health through increased use of HIV and health services
- People are **safe** and have skills to talk about and take action to address HIV
- Reduction in un**safe** use of substances such as alcohol
- Women and children are **safe** from violence and sexual exploitation
- Improved access to **safe**ty nets for most vulnerable families and children
- Increased ability to secure **safe** income

Key achievements of the ROADS project at Dar Es Salaam in the first six months have been:

- 35,000 people reached with relevant HIV prevention messages
- Working with Temeke district Ministry of Health, over 3,000 people have been provided HIV counselling, testing and results
- HIV-positive clients were referred to community- and facility-based services, including ART
- Close collaboration with Port Authorities; dialogue meetings with TPA and PMAESA, regular updates to the Port Manager; and a community partnership pact
- "Wrap-around" programming including community-based alcohol counselling

In light of the challenges faced by port workers, as outlined above, the following recommendations have emerged from the ROADS project:

- Establish attractive "safe" spaces to draw port workers away from bars at times when they are the most vulnerable
- Help workers away from home stay connected with their families
- Do not focus on one target audience in isolation; reach transient workers and vulnerable audiences together
- Involve port authorities and local ministry of health in planning from the beginning to ensure project services complement those that exist ("drive uptake")

Discussion

There was a discussion around the **issue of MMC**. A concern was raised about "risk compensation" – that men who have been circumcised do not use condoms because they think they are "safe". It was agreed that there is a lot of debate and controversy around the issue of MMC and it needs to be handled with a great deal of care. CdM added that it is very important that the process of sensitisation is carried out during the process of MMC, and they counsel the men to use a condom and be faithful to their partners and the men accept this.

One participant questioned the **decision of the FHI not to serve alcohol at the SafeTStops**. FHI responded that this approach does work and that mobile populations specifically expressed a need for a place where they are not exposed to alcohol because there are few, if any, places like this. Sometimes clients are struggling with alcohol abuse and need help, thus they turn to the centre. In Kigali, the resource centre has over 100 people coming in every day, and they find that the facility is meeting their needs. The centre actually becomes an attraction as it offers a whole package of services – on-site health services, a wellness centre, and VCT.

Another participant wanted to know **how many SafeTStops are located at ports**. At this stage, there is only one at a seaport – Dar Es Salaam - but there are also ones at Mwanza (Malawi) and Bukavu (Democratic Republic of Congo), which are inland ports.

An issue that is important to address is **tracking of clients between sites**. One participant wanted to know if FHI has a system in place to do so. FHI responded that this is a work in progress and the organisation is working on this with IT support. The sites are fully branded so that mobile populations able to identify outlets as places where they can get similar services, and this is part of the messaging. But there is definitely a need for record keeping, in order to address issues like harmonisation of drug regimens. The organisation is working with North Star Foundation (NSF) on this and following its model.

In terms of **medical certification**, a participant was worried about VCT being incorporated into medical certification. He was concerned that a TB or HIV diagnosis can mean the end of work for that person. There is discrimination on part of owners to allow that seafarer to work. Dungan agreed, adding that HIV is nothing more than a chronic illness that can be treated, but employers sometimes do not see it like this. But a health certificate is just to see that worker is healthy enough to work. VCT is offered only for the person's individual knowledge and it would not go into any documentation. Compulsory testing is illegal. Dungan added that if a person is sick they are not able to do this kind of physically demanding work, whether with an AIDS-related or any other kind of illness. VCT is simply offered so that the patient knows his status. The representative from Transnet clarified that there are only two Transnet National Ports Authority clinics in the port – the other belongs to Transnet Port Terminals.

Plenary Three continued: Programmes and policies

The second day of the workshop continued with more plenary presentations on HIV programmes and policies for seafarers and port-based communities. The presentations in this session were:

- Diane Massawe and Severine Deng, SWEAT: "Sex Workers' Education and Advocacy Taskforce"
- Envor Barros, National Certificated Fishing and Allied Workers' Union (NCFAWU): "The trade union response to HIV/AIDS among seafarers and port-based communities"
- Alice Pedro Magaia, Provincial Health Directorate for Maputo City: "100% Vida": port health centres at Maputo and Nacala ports, Mozambique
- Edward Shivute, Walvis Bay Corridor Group (WBCG): "HIV/AIDS response in the transport sector of Namibia: Sectoral experience"

Sex Workers' Education and Advocacy Taskforce

Diane Massawe and Severine Deng
SWEAT
Massawe gave a short background to SWEAT. The organisation has been working with adult sex workers in Cape Town since 1994.It has three programmes:

- Outreach and Development: direct work with sex workers, including outreach (condom distribution), peer education and workshops
- Advocacy and Networking: work around law reform (creating an enabling environment, advocacy and network)
- Research: research to inform programmatic work and produce credible information on sex work.

The organisation regards sex work as work and advocates for the rights of sex workers to be recognised. It does not have exit strategies for sex workers, but will assist when someone wants to leave the industry. It only works with adult sex workers and people who are already in industry, and does not encourage people to enter the industry. It does not work with children. SWEAT works in both rural and urban areas, although it has a stronger presence in Cape Town (where the head office is based) and Johannesburg, where Sisonke (South African sex worker led movement started in 2003) is based.

The sex work industry is divided into the indoor and outdoor sector. Indoors sex workers see their clients at agencies, brothels, private rooms or flats. Outdoor sector sex workers solicit their clients on the street and see them in a rented room, the client's car or home, or at an outdoor venue. Very few of the women SWEAT works with have pimps. Some work with their boyfriends or partner for some protection. The indoor sector is larger than the outdoor sector. In a SWEAT/ISS research survey conducted in 2008, 964 sex workers worked indoors, compared to 245 outdoors. However, the outdoor sector is more visible and gets more police and public attention. The majority of sex workers are women; about 11% are males and just less than 1% are transgender. The research suggests that transgender sex workers mostly work outdoors. Only 5% of sex workers are foreign. The reason for entry into sex work is mostly financial – either from lack of opportunities and or a higher earning potential. The average age for all sex workers was 29 years. The average earning for outdoor sex workers was R2,700, compared to indoor sex workers, who earned R10,186. The industry is very fluid, people move in and out of it depending on need. Very few sex workers work continuously. Sex workers exit and re-enter the industry when they fail to find other work.

Sex workers face multiple realities. The reasons for entry into sex work are primarily economic, due to lack of employment and to earn more to provide for families. Rape makes it more difficult to negotiate safe sex and often clients who do not want to use condoms offer to pay more. Not many sex workers use condoms with their partners, which is a reflection of society at large. Due to stigma and discrimination sex workers do not go to clinics or test for HIV very often. Accessing post-exposure prophylaxis (PEP) for rape is also difficult as the police do not take them seriously and so they do not report rape to the police.

Outdoor sex workers fear constant police harassment, abuse and arrest, especially if they are found with condoms, so few sex workers choose to carry them. Indoor sex workers also fear the police and are often entrapped. Often outdoor sex workers store condoms outside in the areas they work so sometimes condoms not stored safely or properly. The use of drugs and/or alcohol as a coping mechanism increases their vulnerability and engagement in risky sexual behaviour. Some owners and clients offer sex workers drugs, sometimes as a form of payment.

As a result of these realities, SWEAT organises safer sex workshops with SWEAT sex workers (indoors and outdoors) and some clients (after sex workers have asked for intervention with some of their clients). SWEAT encourages sex workers to test for HIV but not to disclose, so there are no statistics of HIV prevalence among the sex workers it works with. Access to condoms is a problem, especially female condoms.

SWEAT distributes condoms to sex workers, at rent-a-rooms and garages (male and female). SWEAT has also begun to work with clients, like truck drivers, at the request of sex workers. Sex workers have also been trained as peer educators to engage with other sex workers in the areas they work. It also creates good relationships with clinics to support sex workers and encourage VCT and follow up visits. SWEAT works closely with organisations like the Tutu Testers.

Severine Deng from SWEAT then spoke about sex work and working with sex workers as a peer educator. She remarked that a lot of sex workers are responsible for educating foreign fishermen about HIV and using condoms. These fishermen are in desperate need of education, as they often come from countries with low HIV prevalence and know very little about it. They are also in a lot of emotional pain, because of being separated from families and loneliness from long periods at sea. Sex workers are often quite skilled in that they work with these men first hand, and can often speak many different languages. They have experience that can be utilised and should be involved in any HIV prevention efforts. This is also true for the clubs in which sex workers work. Deng also spoke about the lives of sex workers and the abuse, sexual assault, rape and police harassment that they face. This is especially true for sex workers on the street. They need assistance, and they need to be understood. They are not "bad people" – they are simply trying to survive and put food on the table for their families.

Discussion

During the discussion, the question about **male sex work** was raised. SWEAT does deal with male sex workers but male sex work is also an issue of sexuality. Health4Men, which offers medical and psychosocial services especially aimed at men and is also based in Cape Town, deals with issues around men who have sex with men (MSM). SWEAT offers workshops with male sex workers and has separate programmes for them. One participant had a question around the **profile of male sex workers and their clients**. Male sex workers are usually younger men, around the age of 20 or 21, although some are as old of 40. They usually have a primary school education and have been displaced by job loss. SWEAT does not work with clients as such, but many clients of male sex workers are married men who engage in MSM.

The **profile of female sex workers** is as suggested in the research presented above – it shows that the average age is 29, although SWEAT works with all adults over the age of 18 and does not ask for ID. There are also sex workers as old of 50.

The **female condom** was discussed at length. SWEAT promotes male and female condoms. More women prefer the female condom, as well as MSM. But there are more funds invested in male condoms and often there is a shortage of female condoms. Lubrication is also an issue. It needs to be part of the package but it is expensive and organisations need to work on partnerships with government in this regard.

One participant remarked that this was a useful presentation in that it brought **concrete practical experience from the ground**. The particular issues which were important and should be highlighted are the availability of lubricant and condoms; the use of the female condom for MSM, targeting and sensitising service providers and health workers who provide VCT; transforming attitudes towards sex work; the need to ensure that IEC materials are available in all of the different foreign languages; and exploring the possibility of female sex workers as a peer educators for men. Participants agreed that IEC materials are vital. But perhaps even more important are resources and strategic partnerships. These will ensure access to ports and port-based communities.

There was a need for **clarification around the methodology of the SWEAT research**. Massawe responded that researchers did not use the capture/recapture method. Instead it had a sex worker consultation group and used the snowball method. Researchers went to the research site at different times of the day. For the indoor sector they looked at newspapers, called the people advertised in the classifieds and surveyed them. They did not survey women who engage in sex work but do not identify as sex workers.

SWEAT was asked **how sex workers are organised socially**. Massawe responded by saying that indoor and outdoor sex workers work very differently. Outdoor sex workers are naturally easier to organise. Indoor sex workers do not visit SWEAT offices and do not participate in SWEAT events. For them to come to SWEAT offices is to "out" themselves. In terms of social organisations, *stokvels* are quite popular and sex workers know each other well. Some have a funeral system and they also monitor each other's health.

SWEAT's involvement with children and pimps is limited. The organisation contacts the police if they ever encounter children involved in sex work. Often child sex work is linked with human trafficking. SWEAT may use pimps to access to sex workers but there are issues of control. Often women work with their boyfriends for safety purposes, but they are not pimps as such.

The trade union response to HIV/AIDS among seafarers and port-based communities

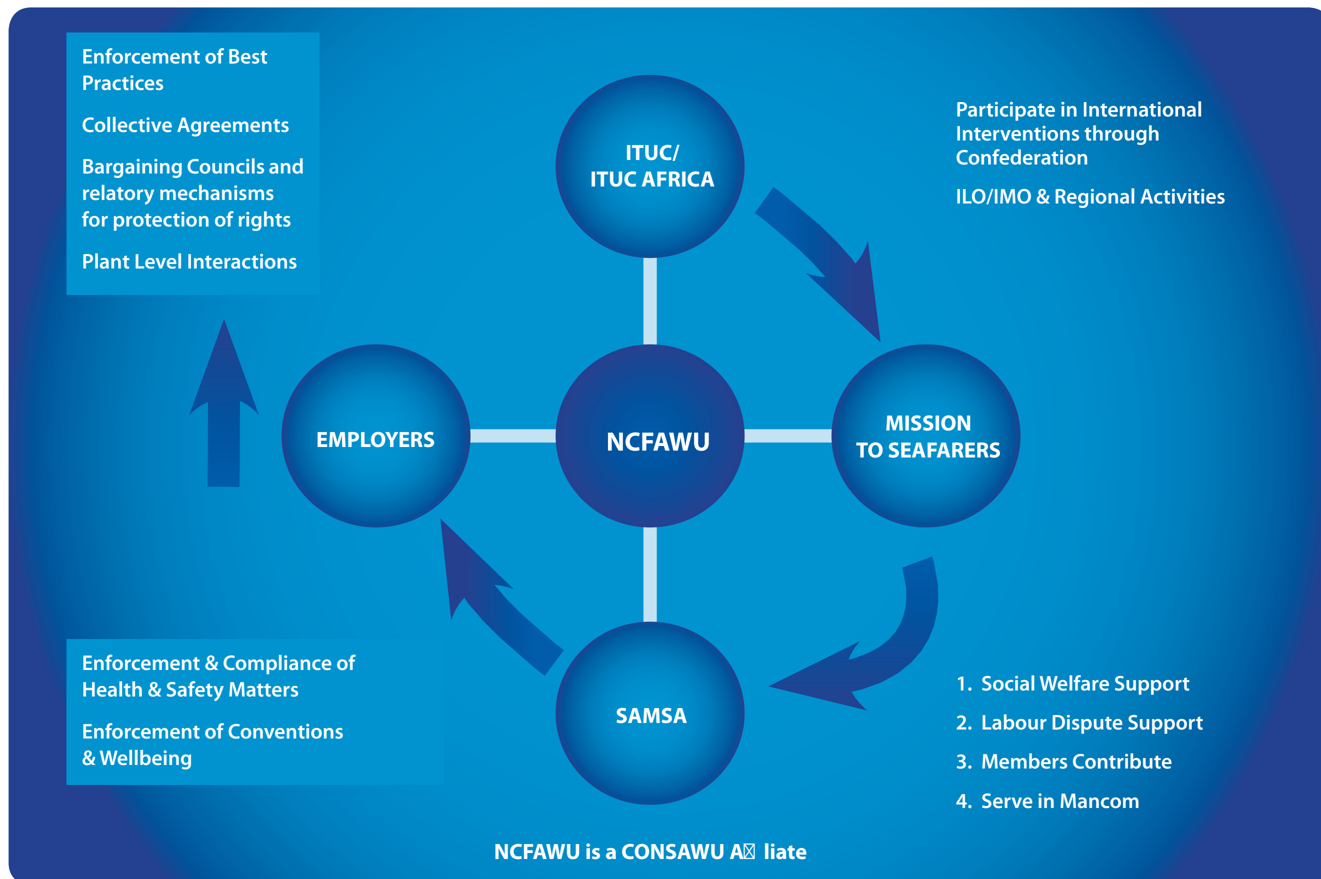
Envor Barros
NCFAWU

NCFAWU was established 1947 and is based in Cape Town. It specialises in the fishing sector and has all nationalities as a member base. It participates in broader forums on migration (for example, ITUC AFRICA on migration) and serves on a variety of forums, for example, the TETA/Bargaining Council on Fishing and is affiliated to CONSAWU. NCFAWU is developing training opportunities on capacity and human development in conjunction with People Plus and supports Mission to Seafarers in case management and interventions. It reaches out to vulnerable workers, especially seafarers.

The mission of NCFAWU is:

- The protection of the rights of its membership to fair and secure workplaces
- Equity and inclusive access to trade union rights
- Development of its membership for leadership and skills
- Advance the inclusion of women in leadership
- Enhance skills through training

Barros remarked that the trade union movement has been pivotal in the fight against the HIV pandemic. It has participated in the development of policies and programmes on prevention and treatment and facilitated workplace programmes on safe sex practices and HIV awareness. It has ensured workplace protection in terms of collective bargaining around health and safety, encouraging disclosure and confidentiality, training of officials and shop stewards, capacity building, and roll out of treatment and prevention programmes. The following diagram shows the different organisations in the maritime and fishing sector with which NCFAWU works:



NCFAWU has been involved in issues around HIV. For example, it was the first respondent in a labour court action in 2002 on the issue of VCT among a fishing company's employees. It engages in the implementation of legislation through the tripartite alliance of government, labour and business. This sees the adoption of conventions, implementation of collective agreements and social dialogue. It has a network of social partners and developing strategic support.

"100% Vida": port health centres at Maputo and Nacala ports, Mozambique

Alice Pedro Magaia
Provincial Health Directorate for Maputo City
Magaia started her presentation by giving a background to Mozambique and mentioned that the HIV prevalence rate in the country is 14%. There is an estimated 30,000 sex workers in the country and sex work is concentrated in peripheral and urban areas, borders, commercial and port corridors and tourist zones. According to a 2009 survey, sex work is responsible for 19% of new HIV infections. 13.2% of men (15-49 years) pay for sex and only 21% of men used condoms in commercial sex (DHS, 2003). The vulnerabilities of sex workers in Mozambique are very similar to that of South Africa, as outlined in the SWEAT presentation earlier in the day.

In the light of this context, the "100% Vida" project was developed. It is a partnership between the Ministry of Health, United Nations Population Fund (UNFPA), Pathfinder and Population Services International (PSI). It is implemented in seven major cities and five provinces. Its focus is on prevention and care activities. It is based on peer educators and mobilisation community strategies. The project is designed in three components:

1 Health Prevention and Education

- Training of sex workers as peers educators and health promoters
- Distribution of prevention supplies – male and female condoms, water-based lubricants, and IEC materials
- Outreach activities: peer educators disseminate information about sexual reproductive health, HIV, violence and human rights
- Referrals of sex workers and clients to the night clinic through an invitation card
- Peer educators participate in a monthly technical update session on issues like reproductive health, violence, living with HIV, and STIs
- Monthly supervision meetings
- Field support provided by technical supervisors

4 Medical Health Care

- Night clinic opens twice a week at night hours
- Multi-professional health team (doctor, nurses, counselors, medical technician, lab specialist)
- Provides health services such as diagnostic, treatment, testing and counselling for HIV/STIs, ART, family planning, and primary health care (PHC)
- All services and medicines free of charge. The costs of this are supported by partners
- Health professional team participate in monthly technical update and sensitisation sessions to qualify their attention and address specific needs
- Monthly supervision meetings to analyse data and discuss specific cases

3 Human Rights Promotion and Legal Assistance

- Outreach activities on human rights education and promotion
- Paralegal professional offers counselling and advise on violence and any legal issue twice a week at the Health Centre and on outreach activities
- Partnership with Mozambican Human Rights League for referrals on cases needing legal support
- Referrals to the "Unit for Attention of Women and Children Victims of Violence"
- Advocacy with police authorities to reduce violence against sex workers

The achievements of the 100% Vida project are:

- Tailored intervention to address sex workers' special needs
- Comprehensive package of HIV prevention and care, reproductive health and human rights promotion
- Increased coverage through expansion of the project
- Full involvement of sex workers in designing and implementation of all activities

- Access and availability of prevention materials
- Access to health care and services
- Family planning promotion
- Focus on community mobilisation processes
- Advocacy to reduce violence
- M&E system
- Government support to design and implement the National Strategy for the Acceleration of HIV Prevention

The challenges and lessons learned are:

- There should be an integrated approach to HIV prevention and sexual and reproductive health
- Work must be based on partnership and coordinated action towards prevention efforts for sex workers
- Support participation and involvement of males on HIV prevention and health promotion strategies
- Partnership and coordination with Mozambican Human Rights League to promote legal protection for sex workers against violence
- Extend efforts to reduce stigma, prejudice and discrimination against sex workers
- Enhance community mobilisation strategies to bring around all the stakeholders for programming and intervention of prevention strategies
- Expansion of interventions to all areas, specifically on borders, corridors and tourist zones
- Support sex workers in the organisation of associations

The recommendations of project organisers are:

- Peer education for HIV prevention and health promotion
- Ensure continuous access to prevention supplies
- Access to nocturnal comprehensive friendly health services
- Ensure a good interaction among peer educators and health providers
- Ensure continuous training and technical update for both peer educators and health providers
- Human rights must be a pillar of any programme focused on sex workers or other marginalised communities
- Community mobilisation is the meaningful involvement of sex workers, clients, police, health professionals, and community leaders.
- Support sex worker voluntary association as a main mechanism to reinforce prevention strategies on HIV and human rights

HIV/AIDS response in the transport sector of Namibia: Sectoral experience

Edward Shivute
WBCG

WBCG is a joint PPP of logistics providers. Its core business is business development, cross border facilitation and infrastructure development. The WBCG HIV/AIDS helpdesk was established in 2003 and was hosted by an external HIV agency. It was reintegrated into WBCG as social responsibility to specifically address the issue of HIV amongst mobile populations, for example, truck drivers, seafarers and train drivers.

The vision of the helpdesk is to create a complete HIV awareness and response capacity within the WBCG member companies. Its mission is to mitigate the impact of HIV within the WBCG member companies by facilitating the development and implementation of comprehensive workplace programmes. Its membership has doubled since 2003, to 15 members.

The structure and forums of communication and support are as follows:

- Focal persons – gatekeepers
- Senior management
- Peer educators/peer coordinators
- Peer educator support group forums
- On site clinics
- Help desk steering committee
- HIV wellness committees

The following are services offered by the helpdesk:

- Facilitate the design of appropriate HIV prevention, treatment, care and support programmes for transport companies
- Facilitate the development of HIV wellness policies
- Training and re-training of peer educators
- Distribution of IEC materials and male and female condoms
- Promote and facilitate access to VCT
- Promote home-based care services for employees

- Provide information and promote services on treatment and care options, for example medical aid schemes
- Promote impact assessment studies
- Monitor and supervise workplace interventions for quality assurance
- Conduct HIV awareness sessions within member companies

The help desk has also helped establish roadside wellness centres in Walvis Bay (near the entrance of the port) and Katima Mulilo (Wenela Border Post). Target groups are truck drivers, seafarers and commercial sex workers. The services they offer are PHC, treatment for STIs, condom distribution, HIV behaviour change communication information and materials, VCT services, referrals for TB and ARV therapies.

The outcomes of the project have been:

- Lower prevalence rates amongst transport workers (according to reports from six transport companies)
- Increased awareness and knowledge amongst employees (at all levels)
- Increased preventive and health seeking behaviour
- Increased commitment and involvement of management in HIV events (signed agreements with companies)
- Formulation of a five-year strategic plan for the help desk (2008-2012)
- WBCG HIV/AIDS HD Steering committee established
- Over 150 peer educators trained to date, plus ongoing refresher courses (seafarers also trained)
- Six peer educator support group forums established in the region
- Development and distribution of 400 truck drivers health information toolkits (KAPB study conducted)
- Hosting of leadership seminars on policy implementation and addressing the impact of HIV on the transport sector
- Joint initiative to spearhead World AIDS Day events for the transport sector
- Transport sector IEC materials committee established
- "Peer educators training manual" developed for mobile workers
- Regular morning awareness sessions conducted with truck drivers in collaboration with trained peer educators
- Increased demand for male and female condoms
- Group workplace policy and guide developed and is currently being implemented

The challenges/lessons learned are:

- HIV policy implementation is not an issue or a priority for some transport companies – their main focus is profits
- Interventions in transport companies are sometimes sporadic
- Clear strategies and defined responsibilities for peer educators are needed
- Lack of proper and accurate reporting mechanisms
- Lack of awareness programmes beyond the workplace
- Lack of incentives to motivate peer educators
- The highest level of management is the critical focal point
- Establish HIV/AIDS Steering Committees that consists of top-level management within the workplace
- M&E strategies need to be put in place as to measure programme efficiency
- The involvement of PLHIV is vital in workplace programme strategy designs
- Sustainability depends on promoting a healthy life style without creating room for stigma and discrimination
- Unions can play a vital role

Recommendations are:

- Continuous advocacy for senior management involvement and secure their commitment
- Best practices around effective advocacy efforts should be shared
- Establishing a Sectoral Steering Committee
- Development of a Sectoral HIV/AIDS Wellness Policy
- Establishing a sub-committee for materials development and a sectoral M&E framework
- Effective implementation of the Strategic Development Plan and Workplace Policies (ILO Code of Practice)
- Target group tailored activities should be a priority
- More ground needs to be covered in the area of advocacy at national and regional levels
- Establishment of Wellness Centres at "hot spots"
- Promote and facilitate more on-site prevalence and VCT testing campaigns
- Promote medical aid insurance for all mobile workers
- Develop materials that discourage MCP

Discussion

The presentations were followed by a rich discussion. The **WBCG toolkits** have budgetary implications – as such, how sustainable are they? Shivute responded by saying that by law companies must have first aid kits as part of their Occupational Health and Safety Policy but most of them do not have them. Thus, WBCG comes to an agreement with them that WBCG will provide them with first aid kits and the company will be responsible for replenishment and therefore ensure that this project is sustained.

There was a question around **Namibia's current policy on HIV** – although they do mention mobile populations, are they using a blanket approach to migrants? The current national policy is under review and the revised policy (MTP4 – National Strategic Framework on HIV/AIDS) for Namibia is being developed. In this policy the issue of mobile populations will be addressed more effectively.

A participant wanted to know if **WBCG provides its services to smaller companies**, which often do not have policies. WBCG responded by saying that member companies pay an annual fee, which smaller companies were reluctant to pay, and due to the size of their workforce, some felt that the company was not ready for a comprehensive workplace programme. There are some nominal services that are provided to these smaller companies, though, such as the training of peer educators. Furthermore, if they do need assistance they can approach WBCG and it tries to assist.

The **age group and gender breakdown of the sex workers in the 100% Vida project** was questioned. Magaia responded that the sex workers are usually between 18 and 20. There are more women, as men often do not have the courage to say that they are sex workers (because of cultural and gender norms). Some of the visitors to the health centre are male clients of sex workers. The peer educators are female sex workers. They carry out peer education during the time that they are waiting for the next client; they hand out invitation cards and carry out sensitisation work. Peer educators work on a voluntary basis so they do not receive monetary payment, but they are not forced to doing the peer work. There are certain advantages – they learn a lot and have access to the services at the clinic. The invitation is given to another sex worker but it does not reveal any information about the peer educator or divulge that they are a sex worker. It is simply an invitation card to visit the clinic.

A participant wanted to know about the **role of government** in the 100% Vida project. The project relies heavily on the participation on the Ministry of Health – in fact, it is one of the partners on the project. The Ministry of Health provides human resources in the form of personnel. Other partners provide test kits. UNFPA and Pathfinder do project coordination and future steps. These partners also provide the funding for the project.

Participants were impressed with the idea of **invitation cards** and said that this is a very good way of facilitating access to the clinics. One participant wanted to know if the 100% Vida project organisers **tracked their data** in any kind of a systematic way and whether they can see any trends. Magaia replied that the project organisers hold monthly meetings which peer educators attend, and there they present data concerning coupons that are handed out and redeemed. There are also regular meetings with the medical team, including doctors and nurses. They prepare a report indicating the number of HIV tests carried out, how many are positive and negative and so on. The same is done with STIs. Project organisers also evaluate the performance of the peer educators and medical teams when they see patients.

In terms of **payment of peer educators**, WBCG also do not pay them but there are incentives in terms of certificates, t-shirts, and food. Occasionally they also bring the peer educators together and take them out. In response to a question about working with unions, WBCG responded that it definitely works with unions – for example, testing in companies must be done with the buy-in of unions. Revisiting the question of **policy in Namibia**, WBCG commented that workplace policies and programmes are developed during a consultative process and WBCG policy is very much aligned with the National Policy on HIV/AIDS and the policy of the company in question. The government does participate in this process, as it needs to regulate policy. The trade unions also play an integral role.

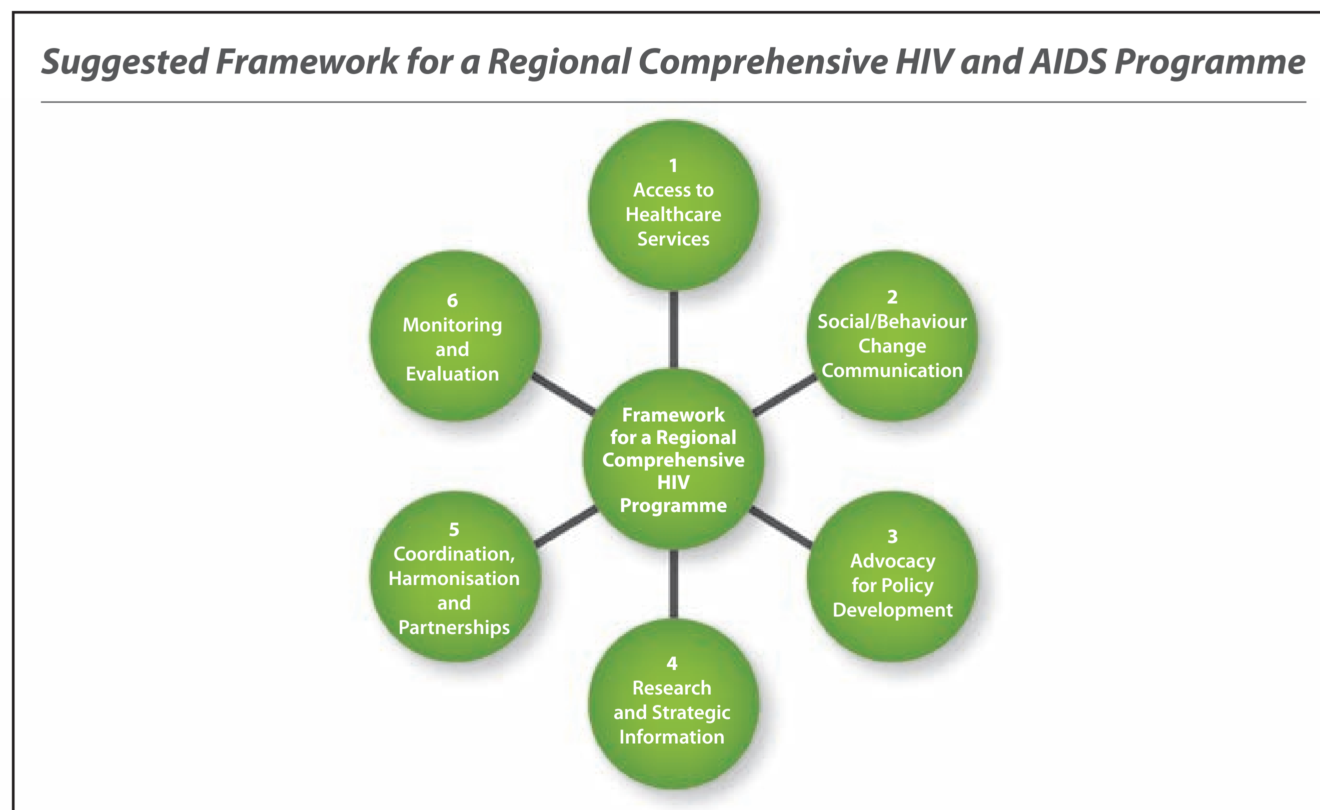
Another participant wanted to know if **wellness centres in southern Africa are linked with those in South Africa**. The TW and NSF wellness centres will be linked soon, so that data that is captured in South Africa will be linked with centres in the SADC region – so if a client visits one wellness centre the data will be available at the other. There was also a question about whether wellness centres should be located inside or outside port. NSF stated that it was better if they are located outside ports, so that all members of the port-based community have access to them. Then they can also be close to residences, bars and clubs, which are frequented by seafarers and port-based communities.

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 seafarers and port-based 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 sector[3]. 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 seafarers and port-based communities in southern Africa.

The suggested framework is as follows:



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 on the following pages outlines the group work and plenary discussion.

3 Please see the IOM's website for a full copy of this report: http://iom.org.za/site/index.php?option=com_docman&task=cat_view&gid=22&limit=5&limitstart=5&order=date&dir=DESC

Key Component	Description	What interventions need to be implemented?	How will they be done?	By whom and who takes the lead?
1) Access to Health Services	• *Access to health services, including HIV prevention, care and treatment* • *Target group: Seafarers, their families and port communities*	Access to Primary Health Services, including nutritional support and ARVs, at ports, on route and on vessels	Map services that already exist and identify gaps	Coordination: National AIDS Council Implementation: Relevant line ministries with a multi-sectoral mandate: Health, Transport, Maritime Private Sector International Organisations NGOs (PPPs)
		Wellness centres based outside of ports that serve all port-based communities (truck drivers, sex workers, seafarers, casual workers etc.)	Based on models that already work – Trucking Wellness, NSF, SafeTStop, 100% Vida etc.	
		Affordable and accessible services, open to all migrants, regardless of status (i.e. no documentation required)		
		Adequate marketing of services, including proper branding		
		Tracking of clients between different countries in SADC	Regional IT system	
		Standardise medicine across countries and service drug regimes	Regional protocols and training	
		Obtain buy-in from management (owners, captains etc.)	Regional consultations and social dialogues	
		Train health care workers	Training	
2) Social/Behaviour Change Communication	• *Targeted social/behaviour change communication interventions* • *Relevant information to foreign seafarers prior to and upon arrival in southern Africa*	Train peer educators with standardised curriculum	Training and curriculum development	Soul City and other partners with SCC expertise UNAIDS IOM Unions
		Make available IEC materials in all languages	Production, promotion and distribution of IEC materials	
		Branding of services	Regional marketing and branding strategy	
		Provide HIV training for port health o cers	Training	IMHA, global networks in maritime and maritime health and port authorities

Key Component	Description	What interventions need to be implemented?	How will they be done?	By whom and who takes the lead?
3) Advocacy for Policy Development	• *Awareness among policy makers* • *Capacity of governments, employers, unions to develop relevant policies* • *Conducive environment for policy development*	Inclusive consultations at all levels		IOM Relevant line ministries
		Review and redesign existing guidelines and policies		
		Document reviews and share with policy maker		
		Participants must engage in advocacy with management and peers		
		Develop and harmonise guidelines on ARVs and TB DOTS		
4) Research and Strategic Information	• *Evidence and research* • *Sharing of strategic information*	IBBS on port-based communities	Recognise that some data already exists and build on that	
		"Barriers to adherence" study		
		Investigate sexual networks	Use common framework with particular set of indicators	
		Conduct prevalence survey		
5) Coordination, Harmonisation and Partnerships	• *Strengthen networks and partnerships in order to better coordinate the health and HIV response in port settings* • *Coordination and harmonisation among SADC Member States, as well as with other regions (Asia, Europe) from where seafarers originate.*	Standard guidelines for ARVs		High-level representatives from relevant line ministries. Structures at a regional, national and community level
		Branding		
		Ongoing services in ports		

Key Component	Description	What interventions need to be implemented?	How will they be done?	By whom and who takes the lead?
6) Monitoring and Evaluation	• *Holistic and standardised system for monitoring health dynamics within port communities in the region*	Conduct impact analysis of programmes Standardised M&E framework	Regular meetings with local and regional stakeholders Shared M&E agenda	National AIDS Councils Relevant line ministries Private sector Academic institutions
CROSS-CUTTING ISSUES				
a) Gender	• *Mainstream gender concerns throughout programming*			
b) Capacity Building	• *Build capacity of stakeholders*			
c) Quality Assurance	• *How to ensure quality*			
d) Resource Mobilisation	• *Traditional and creative resource mobilisation initiatives*			

Conclusion

The workshop concluded with a discussion on the way forward. Participants agreed that the specifics of the framework had been decided upon but that there was still work to be done on future action. It was agreed that a smaller group comprised of the co-organisers would refine the regional framework and this would be shared in the workshop report. The way for participants to take this forward was to advocate on a country or sector level for what had been agreed upon.

SADC reminded participants that if there were any additions or comments for the draft policy framework that they would be welcome to email SADC with these. IOM added that the draft literature review on seafarers would be distributed to participants and that any input into this literature review would be welcome. ILO stated that the ILO Code of Practice and other relevant documents were available on the ILO website.

IOM thanked everyone for their active participation and mentioned that it was a very fruitful two days. It was felt that the proceedings met the workshop objectives and that there was a productive way forward to develop and implement appropriate HIV responses among seafarers and port-based communities in southern Africa.

Appendix One: Workshop Programme

DAY 1: Wednesday 4 November 2009			
REGISTRATION: 08h00–08h30			
08h30–09h00	30 min	Welcome	Dr. Nono Simelela CEO South African National AIDS Council
09h00–09h30	30 min	Opening remarks	Petra Neumann IOM
09h30–10h00	30 min	Introduction to the workshop: objectives, expectations, programme	Natalie Ridgard IOM
10h00–10h20	20 min	Tea	
PLENARY 1: SETTING THE SCENE **Facilitator: Sikhulile Ngqase, IOM**			
10h20–10h40	20 min	World Health Assembly Resolution on the Health of Migrants	Dr. Kalpesh Rahevar WHO
10h40–11h00	20 min	Working with Employers	Evelyn Serima ILO
11h00–11h20	20 min	Global partnership on HIV and Mobile Workers in the Maritime Sector	Rosilyne Borland IOM
11h20–11h40	20 min	Q&A	
11h40–12h00	20 min	SADC Draft Policy Framework on Population Mobility and Communicable Diseases	Doreen Sanje SADC HIV Unit
12h00–12h20	20 min	Addressing HIV Vulnerability in the Maritime Sector in South Africa: Case Study, Walvis Bay	Reiko Matsuyama IOM
12h20–12h40	20 min	Q&A	
12h40–13h40	1 hour	LUNCH	
PLENARY 2: EVIDENCE FROM THE GROUND **Facilitator: Evelyn Serima, ILO**			
13h40–14h00	20 min	Impact Assessment Study of HIV/AIDS in the PMAESA Port of Dar Es Salaam	Isaac Omoke PMAESA
14h00–14h20	20 min	Migrants' Vulnerabilities to HIV and Their Access to Prevention Services at the Port of Durban, South Africa	Erin Tansey IOM
14h20–14h40	20 min	Mission to Seafarers and the Health Vulnerabilities of Seafarers	Rev. Des Vaubell Mission to Seafarers
14h40–15h00	20 min	Q&A	
15h00–15h20	20 min	Tea	

PLENARY 3: PROGRAMMES AND POLICIES Facilitator: Evelyn Serima, ILO			
15h20–15h40	20 min	"Porto Saudàvel": GTZ/Cornelder Public-Private Partnership at Beira Port, Mozambique	Moises Mavaringana Cornelder
15h40–16h00	20 min	The Health Vulnerabilities of Port Workers at the Port of Durban	David Dungan IMHA
16h00–16h20	20 min	"SafeTStop" Recreation and HIV Resource Centre at the Port of Dar Es Salaam	Dorothy Muroki FHI
16h20–17h00	40 min	Q&A	
End of Day 1			

DAY 2: Thursday 5 November 2009			
08h00–08h30	ARRIVAL		
08h30–09h00	30 min	Recap of Day One	Natalie Ridgard IOM
PLENARY 3 continued: PROGRAMMES AND POLICIES **Facilitator: Tertius Wessels, Trucking Wellness**			
09h00– 09h20	20 min	Sex Work and Sailors in Cape Town	Severine Deng SWEAT
09h20– 09h40	20 min	Abroma Fishing Company's Workplace Policy and Programme	Thomas Harris Abroma Fishing Company
09h40– 10h00	20 min	Q&A	
10h00–10h20	20 min	Tea	
10h20–10h40	20 min	Unions' Response to HIV	Envor Barros NCFAWU
10h40–11h00	20 min	"100% Vida": Port Health Centres at Maputo and Nacala Ports, Mozambique	Alice Pedro Magaia Provincial Health Directorate for Maputo City
11h00–11h20	20 min	HIV/AIDS Responses in the Transport Sector of Namibia: Sectoral Experience	Edward Shivute, Walvis Bay Corridor Group
11h20–12h00	40 min	Q&A	
12h00–13h00	1 hour	Lunch	

DAY 2: Thursday 5 November 2009			
BREAKAWAY SESSIONS AND DISCUSSION **Facilitator: Doreen Sanje, SADC**			
13h00–14h30	1.5 hours	Breakaway sessions: Group work	
14h30–15h15	45 min	Plenary: Report back on group work	
15h15-15h30	15 min	Tea	
15h30–16h00	30 min	Agreement on the way forward	
16h00–16h30	30 min	Workshop closure and evaluation	
End of Day 2			

DAY 3: Friday 6 November 2009			
FIELD TRIP			
PARTICIPANTS TO CONVENE IN HOTEL LOBBY AT 08H30			
09h00–11h00	2 hours	Field trip to area around Port of Durban and Blue Roof Clinic	Rhona Buckley Blue Roof Clinic
11h00–12h00	1 hour	Lunch and Departure	

Appendix Two: Participants List

Name	Surname	Designation	Organisation	Country	Email
International Organisations					
David	Dungan	Port Health Officer - Durban Port	International Maritime Health Association (IMHA)	RSA	docdavid@shipmed.co.za
Kalpesh	Rahevar	Medical Officer - Tuberculosis	World Health Organization	RSA	rahevark@za.afro.who.int
Doreen	Sanje	Technical Advisor: Partnership Coordination	SADC HIV/AIDS Unit	Botswana	dsanje@sadc.int
Evelyn	Serima	HIV/AIDS Technical Specialist	ILO Sub-Regional Office	Zimbabwe	serima@ilo.org
Government					
Bonakele	Dlamini	Director: Partnerships and SANAC Secretariat, Department of Health	South African National AIDS Council (SANAC)	RSA	DlamiM@health.gov.za
Alfred	du Plessis	Port Health Officer	Ministry of Health and Social Services	Namibia	porthealthwalvisbay@gmail.com
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Alice	Magaia	Chief Co-ordinator of Community Health	Provincial Health Directorate for Maputo City	Mozambique	bmaia69@yahoo.com.br
Khalid	Massa	Port Health Officer	Ministry of Health and Social Wefare	Tanzania	kmkmassa@yahoo.com
Moses	Maswanganye	Director OD, Employee Wellness and Change Management	Department of Transport	RSA	maswangm@dot.gov.za

Name	Surname	Designation	Organisation	Country	Email
Albertina	Maxanguana	Tecnica Profissional	Ministerio das Pescas	Mozambique	omicane@mozpesca.gov.mz
Nono	Simelela	CEO	SANAC	RSA	
Rustica	Tembele	Director: National Response	Tanzania Commission for AIDS	Tanzania	tembele@tacaids.go.tz
Ivory	Uirab	Sectoral Focal Person	Ministry of Fisheries and Marine Resources	Namibia	huirab@mfmr.gov.na
Port organisations/authorities					
Nelia	Gomes	Corporate Social Responsibility	Maputo Port Development Company (SARL)	Mozambique	nelia.gomes@portmaputo.com
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Angelo	Massache	Port Health Officer	Maputo Port Development Company (SARL)	Mozambique	angelo.massache@portmaputo.com
Ombeni	Mbwambo	Chief Medical Officer	Tanzania Ports Authority	Tanzania	ombwambo@gmail.com
Nonhlanhla	Mbokazi	Manager: Employee Assistance Programme	Transnet National Ports Authority	RSA	nonhlanhla.mbokazi@transnet.net
Isaac Onyango	Omoke	Statistics/Programme Officer	Port Management Association of Eastern and Southern Africa (PMAESA)	Kenya	iomoke@pmaesa.org

Name	Surname	Designation	Organisation	Country	Email
NGOs					
Rhona	Buckley	Director	Blue Roof Clinic	RSA	rhona@keepachildalive.org
Severine	Deng	Peer Educator	Sex Worker Education and Advocacy Taskforce (SWEAT)	RSA	summerleedeng@yahoo.com
Diane	Massawe	Researcher	SWEAT	RSA	dianne.massawe@sweat.org.za
Paul	Matthew	Operations Director: Africa	North Star Foundation	RSA	paul@northstarfoundation.org
Dorothy	Muroki	Deputy Director, ROADS Project	Family Health International	Kenya	dmuroki@fhi.org
Des	Vaubell	Principal chaplain	Mission to Seafarers	RSA/Nam	mtsdbnchap@iafrica.com
Tertius	Wessels	Director	Trucking Wellness	RSA	tertuis@corridorempowerment.co.za
Unions					
Envor	Barros	General Secretary	National Certificated Fishing and Allied Workers' Union (NCFAWU)	RSA	ncfawu@eject.co.za; efbcapri@vodamail.co.za
Private Sector					
Edward	Shivute	Project Coordinator: WBCG HIV/AIDS Help Desk	Walvis Bay Corridor Group	Namibia	edward@wbcg.com.na
Moises	Mavaringana		Cornelder	Mozambique	Moises.Mavaringana@cornelder.co.mz

Name	Surname	Designation	Organisation	Country	Email
International Organization for Migration					
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Markus	Larsson	Programme Development Officer	IOM Tanzania	Tanzania	mlarsson@iom.int
Natalie	Ridgard	Consultant	IOM MRF Pretoria	RSA	nridgard@iom.int
Petra	Neumann	Regional Project Support Officer	IOM MRF Pretoria	RSA	pneumann@iom.int
Reiko	Matsuyama	Migration Health Officer	IOM MRF Pretoria	RSA	rmatsuyama@iom.int
Rosilyne	Borland	HIV and Health Promotion Coordinator	IOM HQ Geneva	Switzerland	rborland@iom.int
Sikhulile	Ngqase	Migration Health Project Officer	IOM MRF Pretoria	RSA	sngqase@iom.int
Interpreters					
Manuel	de Freitas	Interpreters	Eurolinga Interpreters	RSA	
Maria	Teixeira	Interpreters	Eurolinga Interpreters	RSA	

Appendix Three: WHA Resolution

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[4]

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 in" uenced 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;

4 Document A61/12.

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;

(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

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