



DOMESTIC WORK



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

Regional Assessment on HIV-Prevention Needs
of Migrants and Mobile Populations in Southern Africa

Domestic Work Sector Report

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USAID
FROM THE AMERICAN PEOPLE



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List of Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
AU-NEPAD	African Union-New Partnership for Africa's Development
BCC	Behavior Change Communication
CBO	Community Based Organization
CDC	Center for Disease Control
CIDB	Construction Industry Development Board
CoH	Corridors of Hope
CoL	Change of Lifestyle
CRS	Catholic Relief Services
DRC	Democratic Republic of Congo
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EU	European Union
FBO	Faith Based Organization
FGD	Focus-group discussion
FHI	Family Health International
GDP	Gross Domestic Product
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit
HAMSET	HIV/AIDS, Malaria and Tuberculosis Control Project
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counseling
ICBT	Informal Cross-border Trade
ICAP	International Center for AIDS Care and Treatment Programs
ICMM	International Council on Mining and Metals
ICSW	International Committee on Seafarer's Welfare

IEC	Information, Education, Communication
IFC	International Finance Corporation
ILO	International Labor Organization
IMHA	International Maritime Health Authority
INLS	National Institute to Fight HIV and AIDS (Angola)
IOM	International Organization for Migration
ISF	International Shipping Federation
ITWF	International Transport and Workers Federation
JHU	John Hopkins University
KII	Key Informant Interview
MARP	Most-at-risk population
MCP	Multiple and Concurrent Partners
MHSS	Ministry of Health and Social Sciences
MoH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
MOU	Memorandum of Understanding
NAAF	National HIV/AIDS Action Framework
NABCOA	Namibia Business Coalition on AIDS
NAC	National AIDS Commission
Nasoma	National Social Marketing Program
NBCRFI	National Bargaining Council for the Road Freight Industry
NGO	Non-governmental Organization
NSF	North Star Foundation
NSO	National Statistics Office
NSP	National Strategic Plan
OHEAP	Occupational Health Education and Awareness Program

OSBP	One Stop Border Post
OVC	Orphaned and Vulnerable Children
PEP	Post-exposure prophylaxis
PHAMSA	Partnership on HIV and Mobility in Southern Africa
PMTCT	Prevention of mother-to-child transmission
PPP	Public-private Partnership
PSI	Population Services International
RSSC	Royal Swazi Sugar Company
SADC	Southern Africa Development Community
SCC	Social Change Communication
SMA	Social Marketing Association
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
USD	United States Dollar
VCT	Voluntary Counseling and Testing
WBCG	Walvis Bay Corridor Group
WBMPC	Walvis Bay Multi-purpose Center
ZBCA	Zambian Business Coalition on AIDS
ZHECT	Zambia Health Education and Communication Trust

1. Summary

This sector report forms part of a regional assessment commissioned by USAID entitled *Regional Assessment on HIV-prevention Needs of Migrants and Mobile Populations in Southern Africa*, which examines the migration patterns and the HIV vulnerabilities faced by migrants and mobile workers in the southern African region.

The assessment was conducted from August to September 2009 in the following three countries: Malawi, Mozambique and South Africa. This report investigates the specific challenges faced by domestic workers, both male and female, in accessing HIV-prevention services. It identifies opportunities for programming and prioritizes key activities that should be pursued in the region so as to lessen the overall HIV vulnerabilities of migrants, mobile workers and the communities with which they interact.

Some of the factors influencing the HIV vulnerabilities of domestic workers and the people with which they interact are: poor working and living conditions; casual work contracts and unlawful labor practices; duration of time away from home; limited access to health services; low knowledge of sexual and reproductive health (including HIV); low health-seeking behavior and sexual and gender-based violence.

In summary, the assessment makes the following specific recommendations:

Policies and Regional Coordination

- At the national level, all governments should sign, ratify and domesticate the *UN International Covenant on the Protection of Migrant Workers and their Families*.
- Implementation of the *World Health Assembly Resolution 61.17 on Migrants Health* should be promoted.
- Greater coordination is needed at the regional level among SADC countries to provide accessible health facilities and HIV-prevention programs in all countries in the region.
- National Ministries/Departments of Labor should facilitate policy that address HIV prevention for domestic workers, and ensure to offer HIV-prevention services to both domestic workers and the communities with which they interact.
- National Governments should work towards formalization of the domestic work sector, including recognition, facilitation and awareness raising of labor rights for migrant domestic workers.
- Government should enforce greater regulation over private/individual, less formal employers or provide incentives for them to implement/ provide regular access for all their employees to other HIV-prevention services.

Awareness Raising and Information Dissemination

- In addition to the HIV education which all healthcare providers need, health personnel in areas where migrant and mobile populations are found should undergo basic training on migrants rights, in which xenophobic attitudes are countered.
- Radio and possibly television can be used to disseminate specific health and HIV-awareness raising information to domestic workers.
- Effective support systems for migrant domestic workers should be strengthened.

Programs and Services

- NGOs need to include specific HIV-prevention interventions that target migrant domestic workers, such as providing mobile clinic services after hours in areas where many migrant domestic workers live and work.
- Government and NGOs should provide recreational facilities and implement programs to encourage social change and wellness.
- Employers should facilitate healthy lifestyles, and should be held accountable for the wellbeing of their domestic workers.

Research

- More research should be conducted on the nature of sexual networks and the level of concurrent sexual partnerships that exist

among migrant domestic workers and the communities with which they interact.

- Further research is needed, especially on sero-prevalence linked to behavior and other socio-economic indicators, in migrant-sending and receiving areas to further understand the vulnerabilities of migrant domestic workers and the communities with which they interact.

Others

- Government should improve and expand statistical data collection on migration, disaggregated by age, sex and country of origin, as well as the nature of mobility in the domestic work sector.
- Donors should strive to harmonize their funding strategies in the area of migration health.

2. HIV Vulnerability in the Domestic Work Sector in Southern Africa

Domestic work is a large sector of employment mainly for women, but also men and children, in southern Africa (Cockerton, 1997). Available evidence suggests that domestic work has traditionally been, and remains, a significant area of employment for cross-border migrants or internal migrants, often moving from the rural to urban areas for more job opportunities (Cockerton, 1997). Prospective workers usually find employment through advertisement, word of mouth or through family connections. They live away in isolation from their families and support systems for long stretches of time, in basic accommodation with few recreational facilities.

For the sake of this assessment the following definition is used: a domestic worker is any worker or independent contractor who performs domestic work in a private household and who receives, or is entitled to receive pay. It includes: domestic maids and gardeners; a person employed by a household as a driver of a motor vehicle; a person who takes care of children (nannies); the aged; the sick; the frail or the disabled; domestic workers employed or supplied by employment services.

Overall working conditions of domestic workers are hard with long working hours per day and days per week. They usually earn low incomes and often work

under hazardous conditions (Peberdy and Dinant, 2007). Living conditions are usually a barrier to accessing health facilities. If not staying on the property of their employer, migrant domestic workers tend to rent accommodation in impoverished or informal areas where rent is cheap but there are inadequate public amenities, including health services. Their access to health services may be limited, as time away from work often means loss of income.

Domestic workers are vulnerable to HIV as a result of their gender, migration, social isolation, poverty, low levels of education, lack of access to healthcare services and lack of power at work and possibly at home (Peberdy and Dinat, 2005). Domestic workers are especially vulnerable to HIV because they are not well informed about HIV and AIDS. They have no say or control in their sexual relationships (UNIFEM,

2006). While some domestic workers may have full-time, permanent jobs, for many the work is largely casual, part-time or temporary. This insecure and poorly paid livelihood option pushes many women in the sector to supplement what they earn with sex work, or to engage in transactional sex in order to secure shelter and other basic survival needs.

Domestic workers are particularly vulnerable when they are HIV positive, as they sometimes cannot claim the full benefits of the labor and employment laws.

Although migration of domestic workers is acknowledged as an important phenomenon, research on domestic migrant workers and their rights is scarce. The following presents some trends and vulnerabilities found in the domestic work sector in Malawi, Mozambique and South Africa.

Domestic work in Malawi

The domestic work sector in Malawi, which includes many female internal migrants, is little investigated, despite many reports of abusive conditions. A significant proportion of domestic workers travel from their rural-based homes to the urban areas to work as domestic workers. Evidence from focus groups discussions (FGDs) conducted with female domestic workers in Lilongwe suggests that most migrant female domestic workers had been married before but are now divorced or separated. They usually travel to town leaving their children with relatives to take care of them. Male domestic workers are usually young men, predominantly unmarried. Both men and women travel back home at least once a year (FGD, September 2009).

When domestic workers migrate from their homes with or without their spouse in search of employment, they find themselves in an alien place with no acquaintances. At such a time, out of loneliness, boredom or necessity, they may engage in sexual relationships which put them at risk of contracting HIV (One-on-One interview, September 2009).

Sometimes female domestic workers run away from abusive relationships at home in search of a more independent life: 'I know of a woman who runs away from her husband to come and look for work and she got herself two boyfriends. She tells me she is doing it to get money to send home to support her children back home. Her husband is also saying that when she goes back to the village, they will get back together' (One-on-one interview, Mchinji, September 2009).

Domestic work in Mozambique

In Mozambique, significant numbers of internal migrants work as maids, gardeners and guards in the main urban areas of the country. Also, the increase in English-speaking expatriates has expanded the market for English-speaking domestic labor coming from other countries, particularly Zimbabwe. Although there is no data available to verify the number of people working as domestic workers in Mozambique, over the decades there has been a significant increase in female migrants entering the less skilled and informal sectors, including domestic work (Crush et al., 2005). Women migrate from Inhambane Province on the coast to work as domestic staff in the towns of Maputo and Matola (One-on-one interview, Maputo, September 2009).

Whilst both men and women work in domestic service, the majority of domestic workers are women aged between 16 and 45. Women have been migrating to Maputo in search of work for generations. Most are driven by lack of services (particularly education and health), poor returns on subsistence agriculture and the lure of jobs in the cities. A growing number of women have been driven away from their homes in Inhambane Province on the coast, following the death of their partner, thus plunging them into deep poverty. Many of these families had men who had migrated to South Africa for work, and many of the men are assumed to have died of AIDS-related illnesses.

Women either travel with members of their family or with their children and come into either Maputo or Matola. Initially they stay with family or friends who have previously migrated to the city until they find places of their own. Many women migrants have had little or no formal education, because of a lack of opportunity, education for girls not being a priority in their family, or girls being kept too busy with household chores to attend school. Employment for women in domestic service is precarious; women are rarely offered contracts of employment, while long working hours, poor wages (often below the minimum wage), physical or verbal abuse and sexual exploitation are not uncommon. However, domestic work remains a major form of employment due to lack of alternative opportunities (One-on-one interview, Maputo, September 2009).

In the past, domestic service positions such as guards or gardeners were available to the largely uneducated male migrant community. The work was insecure, with no contracts, long hours and poor terms and conditions. However, the Labour Law of 2007 formalized the security sector, and organizations and private households are opting to use security firms rather than hire guards privately. Whilst this creates a more regulated environment, it may also limit migrants' ability to enter this market due to lack of appropriate documentation (One-on-one interview, Maputo, September 2009).

An emerging trend in Maputo is the rise in employment of English-speaking women as domestic workers, particularly as children's nannies and maids. Zimbabwean women are particularly sought after as they speak English, often have teacher or other professional qualifications, and are willing to work long hours for low pay. Since most are undocumented they are extremely vulnerable to exploitation and fear deportation (One-on-one interview, Maputo, September 2009).

Domestic work in Mozambique

Domestic workers form one of the largest labor forces in South Africa. In 2003, the official number of domestic workers was 500,000; however, the real figure is likely to be much higher due to the informal nature of the sector. In South Africa, a high proportion of domestic workers are migrants, predominantly from within South Africa, but increasingly also from other African countries (Peberdy and Dinat, 2005). Given the legacy of apartheid, which prevented black Africans from living and working in urban areas in the Western Cape (Driver and Platzky, 1995), domestic workers in Cape Town historically came mostly from the local Cape Malay/'colored' population. It was not until the 1980s that black migrants, mostly from the Eastern Cape, came to live and work in Cape Town in significant numbers (Poswa and Levy, 2006; Small, 2008). Many of these migrants have sought jobs in the domestic sector and there are currently likely to be nearly as many Xhosa-speaking domestic workers as there are from the local 'colored' population.

According to the organization Activists Networking Against the Exploitation of Child Domestic Workers (Anex-CDW), a significant number of children, some as young as 11 years old, are being employed as domestic workers in South Africa. These children are recruited in poor rural areas, often through trickery or false pretence by agencies, individuals and syndicates, to work in urban areas. They typically work 12 hour days for 7 days a week and endure poor living conditions, humiliation, little pay and abuse, some of which is likely to be sexual.

There are increasingly also many foreign women in the sector, especially in informal or casual positions, as indicated by the numbers of women waiting at pick-up points for casual jobs, or advertising their skills on supermarket notice boards. In addition, many Malawian and Zimbabwean men are offering their services as housekeepers and gardeners. Like other migrants of their gender, many female domestic workers prefer to come to South Africa legally and then apply for asylum papers when their visas expire.

3. Policies Relevant to HIV in the Domestic Work Sector in Southern Africa

The domestic work sector is not a formalized sector in most of the countries in southern Africa and, as a result, there are no specific national policies with regards to the HIV response for domestic workers. South Africa and Mozambique are the only countries that have legislation that recognizes domestic work as a sector.

- In **South Africa** according to the Unemployment Insurance Amendment Act No. 32 of 2003 Domestic workers are legally entitled to claim from the Unemployment Insurance Fund (UIF) for a period of six months if they are unable to work due to illness or have been terminated from their employment by the death of the employer. In the event of death of the domestic worker, relatives of the deceased domestic worker may claim from the fund.

Furthermore, in South Africa, the HIV & AIDS and STI Strategic Plan (2007–2011) identifies population mobility and labor migration as two of the drivers of the AIDS epidemic and recognizes the vulnerability of mobile populations to HIV. It acknowledges that individuals who engage in work-seeking, mobile forms of work or migrant labor are at increased risk to HIV. The Plan also provides a guiding framework for the protection of rights of casual, contract and/or poorly organized workers (e.g. domestic workers).

Under the South Africa's Employment Equity Act of 1998, no person may unfairly discriminate, directly or indirectly, against an employee, in any employment policy or practice, on one or more grounds, including HIV status. The act also prohibits testing of an employee to determine their HIV status unless the Labour Court justifies such testing.

- In **Mozambique**, Law No. 5/2002 (5 February 2002) promotes non-discrimination in the workplace against workers or candidates for employment who are HIV/AIDS carriers. Law No. 23/2007 (1 August 2007) clearly articulates working terms and conditions applicable to all sectors of the economy, including domestic labor and also recognize domestic work as a sector. In practice, the law is often abused by employers and poorly understood by employees, especially migrant women. The Strategy to Accelerate Prevention of HIV Infection (2008) makes no specific mention of migrants, though it does acknowledge population mobility as a significant contributing factor in the transmission of HIV through sexual contact. There is a recommendation to support family integrity among migrant and mobile workers.

4. Assessment Findings

4.1 Sector-specific Vulnerabilities

Based on the field findings, the following factors make domestic workers vulnerable to HIV.

<p>Poor living and working conditions</p>	<p>Among most domestic workers, poverty levels are high and education levels low; their jobs carry a poor status in communities, particularly for women. Their overall working conditions are also hard, with long hours for low pay. They frequently live in isolation, separated from families and support systems for long stretches of time.</p> <p>They are often housed at the residence where they are employed in basic accommodation and with few recreational facilities. If not living in the employers' residence, domestic workers find accommodation in the townships, which may be in dangerous/insecure areas, especially for foreign migrants.</p> <p>As was discovered during FGDs in Maputo, Mozambique, employment for women in domestic service is precarious: women are rarely offered contracts of employment, while long working hours, poor wages (often below the minimum wage), physical or verbal abuse and sexual exploitation are not uncommon.</p>
<p>Casual work contracts and unlawful labor practices</p>	<p>While some domestic workers may have full-time, permanent jobs, for many, the work is largely casual, part-time or temporary – especially for foreign and newly arrived migrants. Most domestic workers are employed on a casual basis, meaning that the terms of employment – including salary, time off and medical insurance – are largely determined by the employer.</p> <p>This insecure and poorly paid livelihood option pushes many women in the sector to supplement what they earn with sex work, or to engage in transactional sex in order to secure shelter and other basic necessities. Several informants spoke of responding to adverts for domestic work, only to find out that those behind such adverts wanted to recruit them as sex workers.</p> <p>Domestic workers may also face irregularity in the means of their recruitment (such as exorbitant fees and contract substitutions), and abuses (such as confiscation of passports, a situation resembling sequestration, non payment of salaries). Labor laws and codes are also often not applicable to domestic workers, and there are often prejudices around their work (Committee on the Protection of the rights of All Migrant Workers and Members of Their Families, 2009).</p>
<p>Duration of time away from home</p>	<p>Being far away from regular partners for extended periods of time increases the chance that domestic workers and/or their partners at home may form other relationships to counter their feelings of loneliness and isolation or to meet their sexual needs. This may be particularly true for the men who leave their families to work as housekeepers and gardeners in urban areas.</p> <p>Informants argued that it is easy for migrants to engage in commercial and transactional sex because, being away from home, they feel anonymous as there is nobody to monitor their behavior and the cultural and behavioral norms they experienced at home do not apply.</p>

<p>Sexual and gender-based violence</p>	<p>Particularly for foreign female domestic workers, coerced sex with the employer is not unheard of. Vulnerability factors may include the particular power relation that exists, which make domestic workers feel powerless to refuse advances or to negotiate condom use, and the ‘privacy’ of the domestic sphere. Since domestic work is carried out in the domestic sphere, where there are often paternalistic and gendered power relations, domestic workers often do not have much power to negotiate or enforce their rights. The isolation, lack of large social networks and effective support systems for migrants makes them particularly vulnerable to abuse by employers.</p> <p>Reporting of rape or sexual harassment is very low amongst domestic workers, particularly amongst undocumented migrants who may not have legal papers to work in the country, and thus may be weary of contacting the police for fear of losing their jobs or deportation.</p>
<p>Limited access to health services and low HIV knowledge</p>	<p>Lack of education is a problem for many domestic workers (Peberdy and Dinat, 2005), who consequently have low levels of knowledge about HIV and a low perception of the risk the disease poses to them. This translates into low-levels of condom use or even mistrust of condoms, which increases their vulnerability to HIV.</p> <p>Furthermore, their scattered and isolated working situations make them difficult to target with HIV-prevention interventions and consequently there are limited HIV interventions (including social support) for domestic workers.</p>
<p>Low health-seeking behavior</p>	<p>Since time away from work often means loss of income, domestic workers may have low health-seeking behavior, including accessing HIV testing or STI follow up. They may also ignore HIV messages or avoid finding out their HIV status for fear that their employers will find out and dismiss them.</p> <p>For foreign domestic workers (e.g. in South Africa), the need to remain far from any type of ‘officialdom’ often results in them having less access to healthcare facilities, impacting on their health information and access to condoms and treatment for STIs (IOM, 2007).</p>

4.2 HIV-prevention Services and Programs

This section, while not a comprehensive list, mentions the most well-known programs and services that specifically target migrants and their families in the domestic work sector. Neither at the regional nor national levels did the assessment find any HIV interventions specifically targeting migrant domestic workers. The following is therefore a summary of general services and programs to which domestic workers may have access.

4.2.1 Regional Programs and Services

At the regional level, there are two organizations with regional programs targeting migrant workers (but not specifically domestic workers), namely Soul City One Love Campaign, and the International Organization for Migration.

Soul City 'One Love Campaign'

In 2008 Soul City, a regional social change communication organization, embarked on a three-year prevention campaign focusing on multiple concurrent partnerships. The One Love Campaign is a multi-media, multi-country HIV-prevention campaign targeted specifically at countries in southern Africa. The central message of the campaign is eliminating secrets and lies in core relationships by communicating effectively and challenging harmful cultural practices that put people at risk of HIV.

Although these interventions do not specifically target domestic workers, they can access the information/campaign provided by Soul City.

International Organisation for Migration (IOM)

In order to reduce the HIV incidence and impact of AIDS among migrant and mobile workers and their families in southern Africa, IOM has been implementing the regional PHAMSA program since 2004. PHAMSA targets six sectors with high levels of migrant and mobile workers (commercial agriculture, construction, cross-border trade, maritime, mining and transport) and has four main program components: (1) advocacy for policy development; (2) research and learning; (3) regional coordination and technical cooperation; and (4) pilot projects.

4.2.2 National Programs and Services

At the national level, the assessment reviewed domestic work in Malawi, Mozambique and South Africa, but did not find organizations on the ground which

specifically provide migrant domestic workers with HIV-prevention services or overall health and social services. There are some NGO initiatives that domestic workers may access.

Malawi

Government:

Public health facilities such as Mchinji and Kasungu District Hospitals provide VCT, ART, PMTCT, information and education through posters, leaflets and brochures usually in English and Chichewa (official language), as well as male and female condoms. Tertiary health centers also provide VCT, PMTCT, information and education through posters, leaflets and brochures, usually in English and Chichewa, as well as male and female condoms.

In addition to the public-health services in the assessment districts (Mchinji and Kasungu), there are district hospitals in almost every district (except Likoma, Neno and Phalombe) and many health centers across the country where mobile and migrant populations can access HIV-prevention services.

Non-governmental Organizations:

USAID in Malawi supports the following partners in providing HIV-prevention services: Management Sciences for Health (MSH), HIV Peer Anonymous Counseling and Testing (PACT), Population Services International (PSI), John Hopkins University (JHU), BASICS, Light House and the National AIDS Commission. These partners implement HIV-prevention programs which focus on VTC, PMTCT, behavior change communications, access to free as well as socially marketed condoms and bio-medical prevention (blood and injection safety). There is at least one USAID-funded NGO partner in each district in Malawi.

World Vision International (WVI), Adventist Relief Agency and Banja La Mtsogolo (BLM) provide HTC and information and education to the general population. Most of the services provided by the NGOs are free. Mchinji District Hospital, WVI in Mchinji and BLM reported that some migrants from Zambia access HIV-prevention services.

Private Clinics:

Private clinics provide a limited number of HIV-prevention services, such as VCT and information and education. At a private clinic, everyone including migrants can access the services as long as they can afford the charges.

Mozambique

Government:

Public healthcare services are available in most suburbs through health posts and district hospitals, which provide basic HIV-prevention services such as VCT and PMTCT as well as generic information. Services are accessible by everyone, no documents need be presented and migrants experienced no problems using health facilities as needed.

Non-governmental Organizations and Faith-based Organisations:

- **The Integrated network for the prevention of HIV and AIDS** programme in Tete runs a clinic providing STI services to high-risk groups, including commercial sex workers and their clients, truck drivers and itinerant traders; it is broadly seen as a successful and replicable program.
- **Medicines Sans Frontier/Doctors without Borders** (Belgium) supports government health centers in Alto Maé health center, the Chamanculo Hospital, Primeiro de Maio health centre in Mavalane district. Activities include AIDS-prevention materials, VCT, PMTCT, ARTs. They also undertake outreach work to sick households along with local NGOs.
- **Health Alliance International** (HAI) works within the District Health Service and have staff in the provincial hospital and four district hospitals in Tete. There are plans to scale up HAI's work in Tete, where the health-system strengthening and treatment role will be expanded to include HIV-prevention activities.
- The **I DREAM (Drugs Resources Enhancement against AIDS and Malnutrition)** program involves HIV positive and affected people in challenging stigma to encourage others to get tested. They are one of the few programs identified that has attempted to reach migrants in suburbs and urban settings. None of the migrants interviewed had specifically been to a DREAM event but many had heard of the work of Sant Edigio and its message of hope.
- **Churches** are seen as the most important providers of HIV-prevention information, partially because they were the only entity consistently present in the suburbs. HIV information provided was generic rather than specifically focused on migrants as a target group and the emphasis was on staying HIV negative.

South Africa

Government:

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5. Gaps, Challenges and Corresponding Recommendations

The following table summarizes the gaps and challenges identified during the assessment, as well as the corresponding recommendations. It should be noted that there are very few programs (government, NGO and private sector) that directly target migrant domestic workers and HIV in the three countries covered in this assessment.

Gaps/Challenges	Recommendations
Policies and Regional Coordination	
<p>Limited legal protection for domestic workers, particularly for migrant undocumented workers.</p>	<ul style="list-style-type: none"> • At the national level, all governments should sign, ratify and domesticate the UN International Covenant on the Protection of Migrant Workers and their Families. This would afford migrant and mobile workers increased legal protection, such as better living and working conditions and access to health. At the same time, governments should domesticate the other relevant international and regional treaties to make them applicable in their country. • National governments should work towards formalization of the domestic work sector, including recognition, facilitation and awareness raising of labor rights for migrant domestic workers. • Implementation of the World Health Assembly Resolution 61.17 on Migrants Health should be promoted (see Section 8 of the Regional Assessment Report).
<p>Lack of regional coordination on matters relating to HIV and mobile populations.</p>	<ul style="list-style-type: none"> • Greater coordination is needed at the regional level among SADC countries to provide accessible health facilities and HIV-prevention programs in all countries in the region. There is a need to create a regional HIV-prevention mechanism, such as a card system that people can use to access ART for free in the region, as well as to standardize treatment regionally to ensure prevention and treatment sustainability.
<p>There is a lack of HIV policy that specifically targets domestic workers at a national level. This makes it difficult to advocate for pro-migrant workplace programs.</p>	<ul style="list-style-type: none"> • National Ministries/Departments of Labor should facilitate policies that address HIV prevention for domestic workers, and offer them HIV-prevention services.

Gaps/Challenges	Recommendations
<p>Absence of workplace policies targeting domestic workers.</p>	<ul style="list-style-type: none"> Government should enforce greater regulation over private individuals/less formal employers and provide incentives for them to facilitate regular access for their employees to HIV-prevention services.
Awareness Raising and Information Dissemination	
<p>Lack of education and HIV knowledge among domestic workers makes it difficult to reach them with HIV-prevention messages and other services. At the same time, domestic workers may ignore the reality of HIV or be reluctant to reveal their HIV status to their employers for fear of dismissal.</p>	<ul style="list-style-type: none"> Radio (and possibly television) messages should be used to disseminate specific health and HIV awareness raising information to domestic workers. Government and NGOs need to include specific HIV-prevention and health interventions that target migrant domestic workers. After hours health services (mobile clinics) should be provided to increase accessibility in areas with a dense migrant and mobile community.
<p>Limited behavior and social change communication targeting domestic workers: Many HIV-prevention programs available to the general public or even to migrants are not intended nor tailored for domestic workers, either culturally or linguistically. They then become secondary recipients of services that were not originally intended for them.</p> <p>HIV-related stigma and discrimination presents a significant challenge in targeting vulnerable groups in general. Domestic workers would be nervous to attend HIV trainings with the knowledge of their employers as they may fear dismissal.</p>	<ul style="list-style-type: none"> An evidence-based behavior and social change communication strategy with appropriate communication messages and materials that are linguistically and culturally appropriate should be developed and implemented.
Programs and Services	
<p>Many foreign domestic workers have no job security and no guarantee they will get work on any given day. They are thus likely to be too preoccupied with everyday survival needs to give much attention to their health needs, especially since a trip to the clinic could cost them a day's income.</p> <p>The long hours and constrictive responsibilities of domestic workers (child-minding, for example) may inhibit their ability to visit health facilities in working hours.</p>	<ul style="list-style-type: none"> Government should enforce greater regulation over private individuals/less formal employers and provide incentives for them to facilitate regular access for their employees to HIV-prevention services. Employers should be held accountable for the wellbeing of their domestic workers. They should facilitate healthy lifestyles of their employees and include in their contracts the right to access healthcare facilities if needed.

Gaps/Challenges	Recommendations
<p>The isolated nature of domestic work in which each worker is employed in a different household, often informally, makes it difficult to identify and reach domestic workers with HIV-prevention services.</p>	<ul style="list-style-type: none"> • Government and NGOs need to include specific HIV-prevention and health interventions that target migrant domestic workers. Available Mobile Clinic services after hours should be provided to provide accessible healthcare in areas with a high migrant and mobile community. • Government, the private sector and NGOs should provide public recreational facilities and implement programs to encourage social change and wellness.
Research	
<p>Little research has been conducted, and there is generally a lack of data on issues related to health and/or HIV in the domestic work sector.</p>	<ul style="list-style-type: none"> • More research should be conducted on the nature of sexual networks and the level of concurrent sexual partnerships that exist among domestic workers and host communities. • Further research is needed, especially on sero-prevalence linked to behavior and other socio-economic indicators, in migrant-sending and receiving areas to further understand the vulnerabilities of migrant domestic workers and the communities within which they interact. • Governments should improve and expand statistical data collection on migration, disaggregated by age, sex and country of origin, as well as the nature of mobility of construction workers.

6. Localized, Detailed Mapping of Services

The localized, detailed mapping of services was undertaken in **Cape Town, South Africa**. Although a number of HIV NGOs are present in Cape Town, there is very limited NGO activity specifically aimed at HIV prevention among migrants and specifically targeting cross-border domestic workers. One of the only available services is the **Refugee HIV Awareness and Management Project**, which is an initiative of the Whole World Women Association. This NGO, in partnership with other refugee-focused NGOs (e.g. Cape Town Refugee Centre and the Scalabrini Centre), provides HIV-education workshops and counseling to migrants and refugees but refers them to public health facilities for HIV testing. Doing very similar work with foreign migrants and refugees is the **Sonke Gender Justice Network**, through its Refugee Health and Rights project. Another service, which does not primarily target migrants but does provide for them along with local beneficiaries, is the **Tutu Tester** of the **Desmond Tutu HIV Foundation**.

It appears that despite fairly low levels of HIV awareness, domestic workers in Cape Town have

acceptable access, at least to government health services. Most of the informants had experienced satisfactory treatment and few problems at the public health facilities they had visited, although a few were not satisfied with the quality of service. The local informants felt that as citizens they had a right to healthcare and that Cape Town had better facilities than the Eastern Cape, from where many internal migrant domestic workers originate.

As indicated by informants, public health facilities are relatively numerous and well known, even to foreign domestic workers in Cape Town. On paper, as clarified in 2007 by the Department of Health, foreigners should be able to access HIV prevention and care freely, without having to present any papers (Breen and Gwyther, 2009). Only one informant indicated that she makes use of health facilities for HIV-related treatment. She has had mostly good, but also a few bad experiences, at government hospitals, less to do with access and more to do with the quality of treatment.

Common advertisement placed in post boxes in Cape Town

Hello, My name is Blessing and I am Malawian.
 I am looking for work on Monday, Tuesday and or Friday.
 I Work at No 18 Theresa Ave Camps Bay and love walking the 3 Big
 dogs on the mountain. I also clean iron and work in the garden if needed .
 I am reliable and honest.
 If you are interested please call me 0784695880..... Thank you

LOOKING FOR EMPLOYMENT
 I AM GERSON MALAWIAN LOOKING THE FOLLOWING
 WORKS, PAINTING, GARDENING, HOUSE KEEPING, MY NUMBER
 IS 0738130919 REFERENCE 0824456140, 0823782155.

MALAWIAN WORKMAN OFFERS TOP SERVICES-GARDENING,
 HOUSEKEEPING, GENERAL CLEANING, WINDOW WASHING,
 PAINTING WORK, GOOD WITH ANIMALS
 PHONE INNOCENT ON 0781698385

7. Migrant Stories

Migrant Story: Male domestic worker from rural Malawi working in Lilongwe

Wages (not his real name) is 34 years old and is a male domestic worker working in the Malawian capital of Lilongwe. 'I have been a domestic worker for 18 years. I live in Ntandire (a slum area). When I left home, I was 15 or 16 years old. I decided to come and work because my parents could not afford to send me to school and I thought finding a job would be a good way of making a living. I dropped out of school in Standard 3. When my uncle picked me up, he took me straight to my new employer. At times I walk for an hour to my place of work or, if my bicycle has not broken down, I cycle. I usually only visit my home village every two to three months.'

'Most domestic workers I know are from the central region and the southern region, particularly Chiradzulu district. Many employers prefer domestic workers from their home areas. Working conditions are usually not good. They are based on verbal agreements and you leave when you feel the place is no longer beneficial for you.'

'All men and women are vulnerable to contracting HIV. Women are more vulnerable because they need money to help them supporting their children. Generally, men have more sexual partners than women because of lust and lack of sexual satisfaction. The danger is to have multiple casual relationships and become vulnerable to HIV.'

'I think the Malawi AIDS Counseling and Resource Organization is the best place to seek HIV and AIDS services. They give you information on HIV and AIDS. The Area 18B health centre (government-run) is another good place. If someone is HIV positive they can go to the Light House at Kamuzu Central Hospital. One can get free condoms there. The only problem is that the condom dispenser is in an open place where everyone can see you taking the condoms and people think you are promiscuous. HIV and AIDS services are available in this area but it is difficult for me to go and get assistance because I am so busy with work and my employer does not allow it.'

(One-on-one interview, Lilongwe, Malawi, September 2009)

Migrant Story: Domestic worker in Mozambique

Yvonia (not her real name) is 25 years old, is married to a domestic guard, and has one son (3) and one stepdaughter (10). She left her home town in Vilanculos with her husband five years ago. She used to live with her father and sisters on a small farm but their life was very difficult since her mother passed away. 'My husband was very kind and asked me to come with him, so I did. We traveled straight to Maputo from Vilanculos by bus and stayed with my uncle in Maputo. I have never been to school and cannot read or write. I did not speak Portuguese but my husband said it was important to learn so now I speak it fluently. My husband knows many people who had already migrated from Quelimane to Maputo and we were able to find a straw hut in the neighborhood where many people from Quelimane live. My husband worked with an NGO as a domestic security guard for expatriates. His contract was for two years and the salary and terms and conditions were good. We were able to access good healthcare during that time.'

In 2006, Yvonia found out she was pregnant and went to the Central Hospital in Maputo where she took an HIV test – she was told she was HIV positive. 'The doctor said my husband must also come for a test but he said he did not want because he was scared he might lose his job. The doctor did many tests on me, but I did not really understand what they were. He told me I must eat good food. I try to but it costs a lot of money to eat well and is not always possible. I have not been back to the hospital since having the baby because I do not feel ill.'

Her husband lost his job at the end of the two years as the NGO no longer employed independent guards. He was offered the chance to join one of the security companies with the help of someone from the NGO but he was scared he might have to take an HIV test, so he did not apply. He got a job with a private person guarding their house at night. 'Unfortunately he fell asleep one night and the car was stolen. His boss believes that he told the thieves to come to that house and had him put in jail. He has now been in jail since December 2008. The boss has paid the police to keep him there until he gets his car back. Since my husband went to jail, life has been very hard. I have never found work as I have no skills even as a maid in a house. I have sold everything we have and some of my husband's friends have tried to help us.'

'I do not really understand how people catch HIV, and I do not know how to use a condom, though I have seen one. My main source of information has been from my church, the Apostolic Church in the centre of Maputo. Our pastor often talks about HIV and says we must not catch it. HIV is my secret; nobody except my husband knows that I am HIV positive. I have not talked to anybody else and do not want anyone to know because I am ashamed. I have not had my son tested because I did not know he could be infected. The hospital had been very helpful and kind, but I would rather learn about HIV from my church because I trust them.'

(One-on-one interview, Lilongwe, Malawi, September 2009)

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