



**MINeworkers AND
THEIR FAMILIES**



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

Mining Sector Report

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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
WB MPC	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 five countries: Lesotho, Namibia, South Africa, Swaziland, and Zambia. This report investigates the specific challenges the migrants in the mining and minerals sector in these countries face 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 within which they interact. Some of the factors influencing the HIV vulnerabilities of mineworkers and the people with whom they interact are: dangerous working conditions and masculine identities, living away from families, limited access to healthcare, mine locations/settlements in isolated and often desolate and inhospitable places, and impoverished mineworker-sending communities.

In summary, the assessment makes the following specific recommendations:

Policies and Regional Coordination:

- 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.

- 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.
- National Departments/Ministries of Mining/ Natural Resources and employers should facilitate policies that address HIV prevention for miners, and offer HIV-prevention services to miners, their families and the communities with whom they interact.
- Together with unions, government and civil society should develop workplace-based policies and programs based on the ILO, SADC and national laws and guidelines for workplace HIV interventions.
- Public-private partnerships to develop workplace/wellness programs should be established and stimulated.

Awareness Raising and Information Dissemination:

- An evidence-based behavior and social change communication (BCC/SCC) strategy with appropriate communication messages and materials that are linguistically and culturally appropriate should be developed and implemented.
- Awareness-raising meetings on HIV and STI prevention, gender-related issues and prevention of Sexual and Gender Based Violence should be organized at the work sites or after working hours.
- Health personnel in areas where migrant miners are found should undergo basic

training on migrants' rights, including issues on countering xenophobic attitudes.

- Cultural activities at mining sites should be promoted in order to reduce xenophobia and increase social cohesion.

Programs and Services:

- Employers and NGOs need to support governments in reaching isolated mining settlements to offer them: adequate basic healthcare, including HIV-prevention services; alternative recreational activities and programs to encourage social change and wellness. Condom distribution should be strengthened around mining sites.
- Healthcare service providers in mining sites should facilitate mineworker-friendly services, open after conventional working hours.
- Mining companies should provide periodical medical checkups which include voluntary STI/HIV screening.
- Government should enforce greater regulation over small/less formal employers or provide incentives for them to implement workplace policies and/or provide regular access for all their employees to other HIV-prevention services. NGOs need to support smaller mining contractors in developing workplace/wellness programs including contract and/or casual labor.
- NGOs and mine companies need to include specific HIV-prevention interventions that target irregular and informal workers on mining sites.
- Government, the private sector and NGOs should provide recreational facilities in and around

mining settlements, and implement programs to encourage social change and wellness.

- Government, the private sector and NGOs should also target mineworker-sending areas with program interventions such as HIV and STI awareness, access to testing and treatment of STIs and Behavior Change Communication.

Research:

- More research should be conducted on the nature of sexual networks and the level of concurrent sexual partnerships that exist among mineworkers, their families and the communities with whom 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 migrants and mobile populations and the communities within which they interact.
- Additional research is needed on the barriers of accessing healthcare by migrant workers.

Others:

- Government should improve and expand statistical data collection on migration, disaggregated by age, sex and country of origin, as well as on the nature of mobility of construction workers.
- Donors should strive to harmonize their funding strategies in the area of migration and HIV.
- Non-traditional funding sources (e.g. private sector) should be explored.

2. HIV Vulnerability in the Mining Sector in Southern Africa

2.1 The Mining and Minerals Sector in Southern Africa

In southern Africa, mining is a major economic contributor, not only in terms of the number of people employed but also the foreign exchange its exports earn. Countries which have large reserves of oil and natural gas are largely dependent upon a combination of foreign experts and labor migrants. Historically, there have also been periods of centrally organized mine migration in the region. However, the scaling down of this system in the 1990s created dilemmas for both the supplying and receiving countries of migrant laborers (Chirwa, 1997).

Studies of the mining sector show a high HIV prevalence among miners. In Namibia, Rosh Pinah Zinc Mine had an HIV prevalence of 24.98% among its workers in 2007, 5% above the national average. In South Africa, HIV prevalence rates among miners vary from 25% to almost 50% in some areas (IFC, 2004). In Zambia 18% of the copper miners are estimated to be HIV positive (IFC, 2004).

Lesotho is a net labor exporter to South Africa. The number of Basotho employed in South African mines fell from a high of 127,000 in 1989 to a low of 47,000 in 2005, mainly because of the declining profitability of gold mines, which absorbed about 80% of Basotho migrants (FAO and WFP, 2007). Lesotho's economy continues to depend quite significantly on migrant remittances from the mines, which by some estimates account for almost 60% of Lesotho's GDP. Most mineworkers from Lesotho are recruited through TEBA Limited to work in

South Africa on a one-year renewable contract. TEBA Limited is a service organization primarily responsible for the recruitment of mineworkers for the South African mining industry. The mining industries employing Basotho miners are mainly in the Free State, Mpumalanga, North West, Limpopo and the Gauteng provinces, South Africa (IOM, 2007).

In **Namibia**, mining is the traditional backbone and main driver of the economy; it accounted for 12.4% of the GDP in 2007. Namibia currently has 11 large mining operations producing diamonds, gold, uranium, zinc, salt and fluor spar, as well as a gemstone sector in which many small/informal miners operate. In 2008, there were 8,000 permanent workers employed in the mining sector (Chamber of Mines, 2008) and 2,300 employed by service providers. The skills shortage in the mining sector also means that a high proportion of expatriate workers are attracted to fill skilled positions (Afrol News, 2008).

The migrant laborers are primarily from the north, working in the uranium and gold mines in central Namibia, or the diamond and zinc mines in the south. Mines which have been in operation for a long time, for example Rosh Pinah Zinc Corporation, have long-standing arrangements with workers from the north who were recruited under the old migrant labor system. Mines which have opened more recently, since independence in 1990, for example Skorpion Zinc Mine, are more likely to have a younger workforce employed locally. However, many of these 'locally recruited' workers are in fact migrants themselves who come from

other areas in search of jobs. In recent years, a growing informal and/or small-scale mining sector emerged in the mountainous regions where gemstones are found. In Erongo region alone, it is estimated that there are more than 6,000 workers living in the mountains, most from outside the region. They typically stay in the mountains for several weeks until they have found enough gemstones, whereupon they go into nearby towns to sell their stones and spend their newfound riches.

The mining industry in **South Africa** is one of the main contributors to the economy. The Department of Minerals and Energy estimates that until 2007 gold contributed to 5.4% of the country's GDP, and South Africa produces nearly 90% of the platinum metals on earth, 80% of the manganese, 73% of the chrome, 45% of the vanadium and 41% of the gold (Department of Minerals and Energy, 2009). The industry attracts migrants from various parts of the country and from other countries in the region. It is estimated that about 60% of workers in the mining sector in South Africa are from neighboring countries, mainly from Lesotho, Mozambique and Swaziland.

Swaziland is a migrant-sending country, with an estimated 8,000 Swazi workers in South African mines (Rees et al., 2009). Mineworkers who come from all parts of Swaziland are formally employed through TEBA offices in Hhohho, Manzini and Shiselweni regions to work in South African mines on a one-year renewable contract. The mining industries employing Swazi miners are mainly in Gauteng and North West provinces under mine houses such as Anglo Gold Ashanti, Goldfields,

Harmony, DRD, Anglo Platinum and Implats. Traditionally there were only male Swazi miners, but from around 2001, women also started to work in the mines.

In **Zambia**, copper accounts for 75% of the country's export earnings, and 18% of the copper miners (a skilled workforce) are estimated to be HIV positive (IFC, 2004). In Zambia, most mining companies have been adversely affected by the HIV and AIDS pandemic. Companies have experienced low productivity and loss of profit, and have witnessed an increase in the loss of skilled personnel through AIDS-related deaths.

HIV and AIDS may undermine the profitability of the mining sector, particularly small-scale mines, owing to HIV and AIDS related increased costs, both direct and indirect. The direct costs include increased contributions to medical, death and disability benefits and pension schemes. The indirect costs are those related to increased absenteeism, sick leave, a reduction in staff morale owing to a loss of colleagues, increased workloads, training and the need to replace labor that has been lost, perceived and actual stigma and discrimination, all of which may contribute to reduced productivity (SADC, 2004).

2.2 HIV Vulnerabilities in the Mining Sector

Health is an important factor as the nature of mining requires peak physical fitness yet it is also associated with the risk of severe occupational illnesses such as pneumoconiosis, asbestosis, silicosis and tuberculosis (TB). Silicosis is a substantial risk factor for TB, as is HIV infection, and research describes a multiplicative, rather than an additive effect of these three conditions (IFC, 2004). STIs are an important cofactor for

HIV transmission, and rates of other STIs have, in many instances, been found to be higher amongst mineworkers than in the general population.

There are a number of factors that contribute to mineworkers' vulnerability to HIV, which have been identified through site visits, focus group discussions, key informant and in-depth interviews, and a desk review. These specific vulnerability factors include the following:

Dangerous working conditions and masculine identities: Most mineworkers are young men who risk their lives daily by going deep underground to look for metals. Many work 12-hour shifts per day with only short breaks for 10 days in a row. Exposed to hazardous working conditions and the risk of physical injury, mineworkers tend to preoccupy themselves with other immediate challenges and may regard HIV as a distant threat. In such conditions, there exists a strong form of masculine identity which encourages high levels of sexual activity and alcohol and drug use, as a way of dealing with the stressful lifestyle. Such risk-taking mentality is further aggravated by mineworkers' sense of lack of control over their life circumstances, absence of social constraints that prevail at home, and poor living conditions.

'It seems that when people come here they lose their fear for AIDS and are willing to even engage in unsafe sex. Someone may see that his friend just left a sex worker's house and he also goes there to have sex with her and he is not even scared...' (Focus group discussion, Solwezi, Zambia)

Living away from families: Most mineworkers live in single-sex hostels with limited home leave. Some workers at the copper mine in Solwezi, Zambia share one large room with as many as 16 colleagues, sleeping on bunk beds. Even in cases where family accommodation is available, either on-site or in nearby communities, family members prefer to remain in their rural home areas since mining sites are often located in isolated places with limited infrastructure. Overall, mineworkers thus tend to live away from their families, and many end up having relationships with local girlfriends or sex workers.

The way in which mines organize shift work and sharing of accommodation creates further HIV vulnerabilities in some places. For example, shift workers at mines in Namibia (such as Skorpion Zinc) work around the clock for two weeks and then get two weeks off. Because of an accommodation shortage, they have to vacate their quarters during this time, are transported to Windhoek and are expected to make their own way back home from there. However, most of these workers reportedly do not proceed on to their homes in the rural north, preferring to find closer lodgings in townships around Windhoek for the duration of their leave with 'girlfriends' who are most likely to have other partners while these miners are at work. (Key informant interviews in Namibia)

Basotho Miners who hardly get leave days claim that after what could be weeks of dangerous and difficult work in the mines and a long, uncomfortable journey from the mining areas of South Africa, they need to relax and enjoy themselves before reaching home, which means either lodging in town or sleeping at a sex worker's place (FHI, 2001).

Limited Access to Healthcare: Mining communities tend to have less developed health infrastructures and available facilities are often under-utilized due to workers' lack of familiarity with the area (Campbell, 2003). There are also disparities in accessing health services: workers employed directly by the mine company have access to healthcare, but those who are casually employed by contractors are less likely to have these benefits. Furthermore, referral systems, particularly cross-border, and follow-up mechanisms for care are extremely poor in many instances. Different mining companies implement state-of-the-art prevention and care programs including anti-retroviral treatment in the workplace, however there is little or no continuity or linkages of these programs with the labor-sending communities. Furthermore, residents of communities surrounding the mines have very limited access to HIV-prevention services.

One employee explained that *'there is an emergency clinic for mine employees ... but us who are from the other [contractors], we are not allowed to go there. We are referred to go to the General Hospital or to the other clinics outside but we are still performing duties inside*

... it's not easy to find the chance to go.' (Focus group discussion, Solwezi, Zambia)

Mine location and settlements: Many mines in southern Africa are located in isolated and often desolate and inhospitable places. These locations offer few recreational facilities, limited social support and little opportunities for intimacy. Thus drinking and sex with casual partners are often the only recreational activities that are available (Campbell, 2003).

Furthermore, it is typical in southern Africa for informal settlements to spring up near mines to accommodate an influx of sub-contractors and other people looking for work at the mine or hoping to provide services to those working at the mine. Such settlements are overcrowded and dirty with a highly fluid social environment. Many young women who arrive at these settlements find no employment or livelihood opportunities available to them other than sex work, transactional sex or opening an informal drinking establishment. Furthermore, sex workers may travel from other areas looking to capitalize on the disposable income of mineworkers.

Box 1: HIV and Human trafficking within the mining sector

A practice termed *'ngoanatsela'* has been reported to take place among Basotho mineworkers coming to work in South Africa. The practice entails bringing a young girl from home as a 'girlfriend', but in effect making her available to a group of mineworkers coming from the same region. Frequently these young girls are unaware of what lies in wait for them once they reach the mine, but have no recourse for escape in a foreign country where they may not know the language or how to seek help. (Interviews with former mineworkers in Lesotho, 2006).

Mine Labor-sending Communities: Many rural communities in southern Africa send large numbers of men to the mines and rely on remittances for survival. These impoverished communities are often in isolated and inaccessible places, with low levels of education, poor health facilities and little or no social support, making the family members, along with their migrant partners, vulnerable to HIV. For example, women whose migrant spouse might be infected with HIV may find it difficult to negotiate condom use as they are frequently in socially and economically weaker positions. Also, women who stay behind in the rural areas may have unprotected

sex with other sexual partners in the absence of their migrant spouse for a host of different reasons, such as sexual pleasure, wanting to bare children, or in return for money or other favors (IOM, 2007).

Although mines may provide STI treatment services for their workers, few provide treatment for their sexual partners back home. Mineworkers who become disabled as a result of advanced HIV disease are medically retired and frequently return home to remote rural areas where resources and care are limited. With their return, the flow of income to their household ceases, resulting in increased impoverishment.

Box 2: Both the migrant and spouse back home are vulnerable to HIV infection

Research undertaken in migrant-sending areas in the KwaZulu-Natal province of South Africa compared migrant couples (where one partner is a migrant) and non-migrant couples, and found that migrant couples are more likely than non-migrant couples to have one or both partners infected with HIV (35% vs 19%) and to be HIV discordant (27% vs 15%), meaning that only one partner is infected. It was further found that it is not always the returning migrant men who are infecting their rural partners – among 30% of the HIV discordant couples, it is the woman who is HIV-positive and not the migrant partner. (Lurie et al., 2003).

3. Policies Relevant to HIV in the Mining Sector in Southern Africa

In addition to the regional and national policies and legislation pertaining to migrant workers in general, mentioned in the Regional Report, this section reviews some of the policies relevant to mineworkers.

At the regional level, the SADC Protocol on Mining (1997) was adopted to promote the integration and interdependence of mining sectors across the region and identify ways in which SADC countries could collaborate on various issues such as: community outreach programs in partnership with civil society and governments targeting miners and other vulnerable populations, development of community capacity for HIV prevention and care and support services, and income-generating activities and services to assist needy families in mineworker-sending communities.

At the national level, most SADC countries do not have specific HIV policies for the mining sector. However, there are various policies that address migration, under which mineworkers and their families may be included.

- **Lesotho's** National Policy on HIV/AIDS (2006) commits to identifying, addressing and reducing the vulnerability of mobile populations to HIV, including vulnerabilities caused by their living and working conditions. The policy provides a guiding framework for the development of strategies aimed at ensuring that mobile populations, including marginalized segments of the mobile population, gain access to HIV and AIDS related services. In terms of mineworkers' rights, the Inter-Government Labor Agreement of 1973,

a bilateral treaty, governs the recruitment of temporary labor in Lesotho on legal contract by South African employers, while the Labor Code of 2006 prohibits pre-employment and during-employment HIV testing, ensures confidentiality and non-disclosure, and prohibits discrimination in employment.

- The **Namibian** National HIV/AIDS Policy (2007) commits to identify, address and reduce the vulnerability of all mobile populations to HIV, including their living and working conditions. The policy also commits Government to the establishment of transnational and joint regional interventions with governments and regional institutions such as SADC and IOM in order to facilitate access to VCT and appropriate treatment, care and support services for mobile populations and to develop human rights based regional responses to HIV that address the vulnerability of mobile populations.
- Although **South Africa** does not have a specific HIV policy for the mining sector, in 1991 the Chamber of Mines signed an agreement with the National Union of Mineworkers on HIV/AIDS. The agreement contains the fundamental principles that guide HIV programs in the mining sector, including: pre-employment testing, confidentiality, training and benefits. The Chamber of Mines also signed an agreement with Government and Labor in 2001 to establish a Tripartite HIV/AIDS Committee for the mining sector, and also organized the first Summit on HIV and AIDS in the mining industry (2003) where a number of commitments were made including the development of HIV and AIDS

policies and programs in all workplaces and implementation of measures to improve the standard of housing for mineworkers.

The South African HIV and AIDS and STI Strategic Plan (2007–2011) identifies population mobility and labor migration as one 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.

- **Swaziland's** National Multi-sectoral HIV/AIDS Strategic Plan (2006–2008) acknowledges that high mobility in Swaziland is one of the key drivers of the AIDS pandemic. One of the strategies is to strengthen and promote programs that address both HIV vulnerability and risk factors among special groups

including migrant workers and their sexual partners. Similar to the one in Lesotho, the Inter-Government Labour Agreement of 1973 with South Africa governs the recruitment of Swazi laborers to South African mines.

- Issued by the **Zambian** Ministry of Health in 2005, the National AIDS Policy mentions migrants and mobile workers. Mobility of groups is mentioned as one of the factors that perpetuate the transmission of HIV. Mobile populations such as migrant workers, refugees, etc are mentioned specifically.
- **Zimbabwe** has an HIV and AIDS Policy for the mining sector (2006). The policy encourages stakeholders and partners to develop workplace policies and programs based on key principles that include: recognition that HIV and AIDS is a workplace issue, prevention of HIV and other sexually transmitted infections, transparency and dialogue among partners and stakeholders, non discrimination, confidentiality, gender, equality and care and support.

4. Assessment Findings

4.1 Sector-specific Vulnerabilities

Based on the field findings, the following factors make workers vulnerable to HIV in the mining sector:

Dangerous working conditions

Faced daily with difficult and dangerous working conditions, occupational hazards and risk of physical injury, mineworkers tend to be preoccupied with other immediate challenges, which can result in them not taking the risk of HIV seriously (De la Torre et al., 2009: 29).

<p><i>Time spent away from families</i></p>	<p>Many miners in southern Africa live in single-sex hostels, separated from families. Even if there are facilities at or near mines to accommodate family members, miners or family members do not utilize these as they are often located in isolated and harsh environments. For example, although senior permanent workers in some of the Namibian mines are provided with family accommodations, they often do not choose to do so as the desert environment around the mines are not conducive to family life.</p> <p>In addition, they may have limited home-leave which further distances them from their partners. Some are even vulnerable during their travel back home for home leave. On their way home, many miners pass through the capital before they get to their rural homes, where they often engage with sex workers. Research outlines that they usually do not use condoms during these encounters.</p>
<p><i>Boredom, loneliness and social exclusion</i></p>	<p>There is limited availability of recreational activities such as sports or entertainment facilities at or around mines, resulting in significant boredom among mineworkers. Also, being away from families, traditional norms and support systems that regulate behavior in stable communities produces a feeling of loneliness as well as social exclusion. All of this may lead to risky sexual behavior among workers who may use sex and alcohol as coping mechanisms.</p>
<p><i>Masculine identity and gender inequality</i></p>	<p>Among the mineworkers there exists an exaggerated form of masculine identity which advocates for high levels of sexual activity and subsistence abuse.</p> <p>Furthermore, traditional gender norms which relegate females to a lower status heighten vulnerability, particularly for partners of mineworkers. For instance, most Swazi miners are from polygamous communities where women are expected to be subordinate and submissive. It is considered acceptable for men to have multiple sexual partners, and women cannot negotiate for safe sex.</p>
<p><i>Limited access to healthcare</i></p>	<p>Workers employed directly by the mine company have in theory access to healthcare while those who are employed by contractors are less likely to have these benefits. The health facilities in the vicinity of the mining sites are not necessary adequately equipped; logistical difficulties may be encountered in implementing interventions due to the geographical remoteness of the mining sites.</p> <p>Access to healthcare is also limited in many rural mineworker-sending communities. In Leribe district, home to many Basotho miners, limited health and HIV-prevention services are provided. Also, it was found that some Basotho mineworkers on ART encounter adherence problems as they cannot access ART in South Africa due to different treatment regimes. They are allowed to collect up to three months treatment when traveling out of Lesotho, but that is usually not enough to last them until their home leave.</p>
<p><i>Availability of sex and alcohol</i></p>	<p>Typically informal settlements emerge near mines to accommodate the influx of sub-contracted workers and those seeking opportunities to service the mineworkers. Such settlements are overcrowded and dirty with a highly fluid social environment. Many young women find no opportunities available to them other than sex work, transactional sex or opening an informal drinking establishment. The ready availability of sex workers in and/or around mining sites, coupled with the availability of disposable cash, which they can use to pay for sex and buy alcohol, places mineworkers at risk of contracting STIs/HIV.</p>

<p>Partners of mineworkers</p>	<p>While husbands are away, their wives can also engage in extra-marital sexual relationships or resort to transactional sex if they are not being provided for by their husbands. The spouses of miners who were interviewed revealed that ‘these husbands do not return home and we are deprived of our conjugal rights for long periods of time, which in some cases translate to a full year. We have no option except to look for other men’ (Interview, 29 August 2009).</p>
<p>Poor education and HIV knowledge</p>	<p>It was found that mineworkers (both permanent and sub-contractors) and their spouses tend to be poorly educated, with only a basic knowledge of HIV and STIs. Moreover, many misconceptions and myths exist, resulting in denial and reluctance to access VCT and ART.</p>
<p>Low/inconsistent condom use</p>	<p>Condom use by mineworkers was found to be low because of the stigma attached to condoms in rural communities, from whence they come. Gender inequality also hinders spouses of miners from accessing and negotiating condom use. Even where education and information is relatively available, there seem to be various misconceptions about condom use.</p>

Box 3: Access to healthcare in mineworker-sending communities

Migrants and their spouses in the rural communities of Hhohho region, west of Swaziland, lack access to healthcare facilities. Jubukweni, one of the labor-sending communities about 40 kilometers out of Mbabane, is not easily accessible. Migrants and their spouses can only access a mobile clinic in Jubukweni which provides VCT, family planning and general healthcare services on a monthly basis. Although miners can access HIV-prevention services through the Salvation Army Hospital, most migrants and spouses cannot afford it because it is a private center. Miners who are on medical aid schemes at work in South Africa cannot access such private facilities as they still have to pay in Swaziland. This leaves migrants with limited options apart from accessing government hospitals. Most of them prefer visiting Motshane Clinic, 26 kilometers southeast of Mbabane. The clinic has no in-patient facilities but has an adequate supply of frontline STI drugs. Although consultation fees are low at government clinics and hospitals, long queues and transport costs often makes access difficult.

(Interviews in Swaziland, August–September 2009)

4.2 HIV-prevention Services and Programs

Apart from IOM, its partners and some large mining corporations, the field research did not

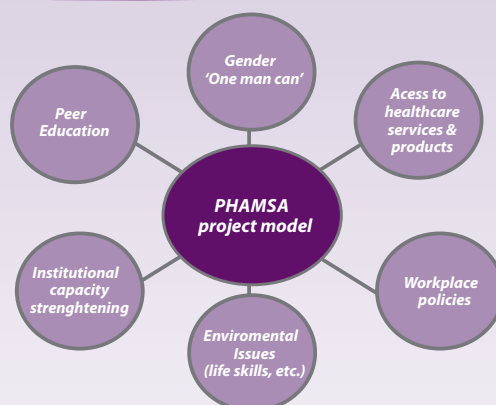
find many organizations on the ground which specifically provide migrant miners with HIV-prevention services.¹

¹ A mapping of workplace policies and activities at the various mines were not included in this assessment; however, the assessment is based on a literature review which found some examples of projects and employers that target miners.

The mining industry has been proactive in adopting the role of concerned employer while simultaneously developing a business case for addressing HIV and AIDS (IFC, 2004). A group organized by the International Council on Mining and Metals (ICMM)² have produced an improved strategy on how to halt the

spread of AIDS. Most large mining corporations have an HIV strategy in place, but small and medium-sized companies have fewer policies. Worldwide policies include the International Finance Corporation's (IFC) HIV/AIDS resource guide for the Mining Sector, which provides briefing notes and case studies.

International Organisation for Migration (IOM): Partnership on HIV and Mobility in Southern Africa (PHAMSA)



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.

In implementing on-the-ground projects, IOM utilizes the PHAMSA project model (see diagram above), which brings together workplace and community practices and interventions to create a more holistic approach to tackling the epidemic.

Specifically in the mining sector, PHAMSA has actively supported two NGOs: TEBA Development (specifically for their activities in Lesotho and Mozambique; see above box) and CHAMP (Zambia) who target mineworkers (see below for details). Furthermore, PHAMSA has been active in advocacy, information dissemination and research in the mining sector.

² ICMM is a CEO-led organization representing many of the world's leading mining and metals companies as well as regional, national and commodity associations.

4.2.1 Regional Programs and Services

The assessment found only three regional programs addressing HIV vulnerability in the mining sector in southern Africa:

Soul City 'One Love Campaign'

Soul City, a regional social change communication organization, embarked on a three-year prevention campaign focusing on multiple concurrent partnerships in 2008. 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 focuses on 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 migrant mineworkers, they can access the information/campaign provided by Soul City.

4.2.2 National Programs and Services

At the national level, the assessment reviewed programs and services in the mining sector in

five countries: Lesotho, Namibia, Swaziland, South Africa and Zambia.

Lesotho

Government:

The **Ministry of Labor and Employment** facilitates a pre-departure HIV-prevention program for mineworkers, to increase migrants' knowledge on issues concerning HIV and AIDS. The ministry holds sessions on HIV prevention and AIDS-related issues before miners leave for South Africa and conducts follow-up visits at the mines. The program also focuses on the spouses of migrants. The **Ministry of Home Affairs** conducts community education programs on a monthly basis where families of migrants are informed about the risks associated with migration in relation to HIV. The **Ministry of Health and Social Welfare** conducts outreach, peer education, condom distribution, VCT and treatment in mineworker-sending communities.

Non-governmental Organizations:

- **USAID-Lesotho**, through Elisabeth Glaser Pediatric AIDS Foundation (EGPAF) and International center for AIDS Care and Treatment Programs (ICAP), targets miners working in South Africa when they come back home on weekends. Mineworkers are provided with information and training on HIV and ART. Additionally, they are trained to support partners who are going through PMTCT.
- **TEBA Development** (see box above).
- **PSI New Start Centre** at **Maputsoe Filter Clinic**, **Maputsoe Seventh Day Adventist private clinic** and **CARE** conduct outreach, peer education, condom distribution and VCT. **Medicines Sans Frontiers/Doctors without Borders- Lesotho** provides ART to an estimated 35 mineworkers.

Namibia

Government:

At a district level, the **Ministry of Health** conducts Behavior Change Communication (BCC) activities, PMTCT, HIV Testing and Counseling, distributes condoms, provides PEP, and facilitates workplace policies.

Most staff of the mines together with their families access services at the small and understaffed Rosh Pinah government clinic. It offers services free of charge but lacks capacity to reach most of the township residents and is located far from the settlements.

Non-governmental Organizations:

The following organizations do not specifically target migrants and mobile populations but focus on HIV prevention, treatment and care for the whole community: **Social Marketing Association, New Start Centre, Catholic AIDS Action, NAWA Life Trust, National Social Marketing Program** and **Change of Lifestyle**.

Private sector:

Namdeb's Oranjemund Diamond Mine Health Education Project is a proactive response to the HIV pandemic. It has expanded to other mines and is now run by the Chamber of Mines' Occupational Health Education and Awareness Program (OHEAP). The program targets mining communities and also extends services to other non-mining organizations. The components of the program include the development of workplace HIV policies and programs, counseling and education on HIV and AIDS. All permanent workers in the formal mining sector have access to very good HIV-prevention services, including free VCT, condoms, education materials and training sessions with health workers and peer educators. Mine clinics also provide high-quality treatment and care, including ART for all workers on medical aid and others who can afford to use their services. While sub-contractors, who can form up to half of a mine's workforce (IFC, 2004), are often included in VCT, education, training and condom distribution if they are present when such activities happen, they are not the primary beneficiaries and do not receive medical aid from mining companies. The company for whom such contractors work do not run workplace HIV programs or provide medical aid since most of their employees work on contract.

Pinah Zinc Mine and **Skorpion Zinc Mine** provide wellness programs to permanent workers and sub-contractors, including VCT, condom distribution, training, peer education and information dissemination.

Permanent workers, their families and others who can afford it make use of the **Sidadi private clinic** for their health needs, including ARVs.

In addition to the services highlighted above, a detailed mapping of services was conducted, which can be found in section 6 of this report.

Swaziland

Government:

The **Swaziland Action Group Against Abuse (SWAGAA)** and the **Ministry of Health** disseminate IEC materials. The **Swaziland Government Regional office** provides technical guidance on issues of policy development, training and peer education. Government hospitals and clinics in either Mbabane or at Ngwenya border post provide for most HIV-related services such as PMTCT, PEP, ART, VCT, condoms and IEC materials. Motshane Clinic and Ngwenya's are the only health facilities 26 kilometers southeast of Mbabane, with an adequate supply of frontline STI drugs, although they encounter shortages when drugs are not delivered from the Swaziland Ministry of Health medical stores. Staff members have all been trained in STI management.

Non-governmental Organizations:

HIV-prevention programs that benefit migrants and the community include: **Siphephile Outreach program**, **Siphilanje, Inhlolo Campaigns** (which include discussions with men on gender equality), **Soul City's 'One Love Campaign'** in partnership with **Lusweti and Swaziland Red Cross Society**.

Private sector:

TEBA Limited runs HIV programs every morning from its offices, targeting miners who have come home for contract renewal. TEBA Ltd also conducts community visits to all mineworker-sending communities in Swaziland through its Home-Based Care unit and teaches the communities about HIV prevention, treatment and care, family planning, condom use, PMTCT and STIs. To prevent infection and re-infection TEBA tries to provide communities with condoms supplied by the government. However, these visits and training sessions are limited as they are provided through one healthcare worker for all mineworker-sending communities in Swaziland.

ILO and Swaziland Business Coalition on HIV and AIDS (SWABCHA) provides technical guidance on issues of policy development, training and peer education.

Zambia

Public-private Partnerships:

The mining industry has established a public-private partnership: the **Global Development Alliance**. This is a partnership between the mining sector and Governments of Zambia and the United States. It is geared towards alleviating the impact of HIV and AIDS in Zambia's mining industries and surrounding communities by supporting mobile, door-to-door and clinic-based counseling and testing; care and support for orphans and vulnerable children, and people living with HIV in workplace programs; and strengthening of ART services and laboratories.

Intergovernmental Organizations:

In Zambia, **IOM** works with Government, CHAMP and a wide range of NGOs in its HIV program activities and projects, through its Partnership on HIV and Mobility in Southern Africa (PHAMSA).

Non-governmental Organisations:

Comprehensive HIV and AIDS Management Program (CHAMP) is a private, non-profit Zambian organization dedicated to combating the HIV epidemic in Zambia. Since its establishment in 2002, CHAMP has earned a reputation as a leading organization in HIV responses, particularly in workplace and community programs. It currently conducts initiatives with some of the largest companies in Zambia, such as Dunavant Zambia Limited, FQML PLC, Equinox Mining and Zambia Sugar. CHAMP undertakes activities in 39 districts in all nine provinces, and reaches an employee base of over 80,000 as well as these employee's dependents and their surrounding communities. Examples of activities are: on-site counseling and testing services to the client community; ongoing provision of recreational activities; focus group discussions on various issues raised during the day-to-day interaction with the client community; integration of gender approaches in all project activities; identification of life skills themes through focus group discussions.

Since 2004, CHAMP has entered into a partnership with IOM through its PHAMSA program. CHAMP implements the PHAMSA project model in the mining sector. For instance, they assist mining companies in developing workplace policies; train change agents to work at the mining sites; conduct social change communication activities.

Private Sector:

The **Zambia Business Coalition on AIDS (ZBCA)** is the official voice for the private sector in Zambia on HIV and AIDS. Launched in 2000, it is made up of large and small companies, including mining companies. It assists companies to implement workplace policies through its implementing partners, and has advocated for companies to recognize and appreciate the importance of workplace policies and programs on HIV (IOM, 2007).

The mining industry uses an HIV/AIDS policy developed for them by the **Copperbelt Health Education Project (CHEP)**, which was officially launched in 2004. Based on CHEP's HIV/AIDS policy, many large mining companies like Konkola and Kansanshi mines have developed HIV and AIDS workplace policies. CHEP has also provided capacity-building training to small and medium-sized enterprises in HIV prevention and awareness-raising and in peer education.

In addition to the services highlighted above, a detailed mapping of services was conducted in Solwezi. This can be found in section 6 of this report.

5. Gaps, Challenges and Corresponding Recommendations

The following table summarizes the gaps and challenges identified during the assessment, and makes corresponding recommendations for future activities.

Gaps/Challenges	Recommendations
Policies and Regional Coordination	
<p>There is limited legal protection for migrant and mobile workers, including undocumented workers.</p> <p>Cross-border mineworkers who are initiated for ART encounter adherence problems as they cannot access ART in other countries due to different treatment regimes.</p>	<ul style="list-style-type: none"> Greater coordination is needed at the regional level between 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 (SADC) HIV/AIDS 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 sustainability. 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. Implementation of the World Health Assembly Resolution 61.17 on Migrants Health should be promoted (see Section 8 of the Regional Assessment Report).
<p>There is a lack of HIV policy that targets migrants at national level. This makes it difficult to advocate for pro-migrant mine workplace programs.</p>	<ul style="list-style-type: none"> National Departments/Ministries of Mining/Natural Resources and employers should facilitate policies that address HIV prevention for miners, and offer HIV prevention services to miners, their families and the communities with whom they interact.

Gaps/Challenges	Recommendations
<p>Limited or inadequate workplace policies, particularly among smaller sized mining companies</p>	<ul style="list-style-type: none"> • Together with unions, government and civil society should develop workplace-based policies and programs based on the ILO, SADC and national laws and guidelines for workplace HIV interventions. This includes undertaking HIV-prevention programs, putting in place policies that combat stigma and discrimination in the workplace, and providing care and support including counseling and treatment for workers and their partners. This should also be accessible for seasonal, temporary workers and sub-contractors. • Government should establish and stimulate public-private partnerships to develop workplace/wellness programs. NGOs can provide technical support to mines/employers to develop comprehensive workplace/wellness policies.
Advocacy and Awareness Raising	
<p>There are gaps in knowledge on HIV and STIs among mineworkers as well as misconceptions about transmission, which can lead individuals to engage in unsafe sexual practices.</p> <p>Certain cultural backgrounds and norms make it difficult for people to talk about issues relating to sexuality, STIs and HIV.</p>	<ul style="list-style-type: none"> • An evidence-based behavior and social change communication (BCC/SCC) strategy with appropriate communication messages and materials that are linguistically and culturally appropriate should be developed and implemented. • Awareness-raising meetings on HIV and STI prevention, gender-related issues and prevention of Sexual and Gender Based Violence should be organized at the work sites or after working hours. • Health personnel in areas where migrant miners are found should undergo basic training on migrants' rights, including issues on countering xenophobic attitudes. • Cultural activities at mining sites should be promoted in order to reduce xenophobia and increase social cohesion.

Gaps/Challenges	Recommendations
Programs and Services	
<p>The remote areas in which many mines are found do not have sufficient HIV-prevention services from either the public or the NGO sector. When services are available, they are often not accessible due to their hours of operation, during which mineworkers are usually underground.</p>	<ul style="list-style-type: none"> Employers and NGOs need to support governments in reaching isolated mining settlements to offer them: adequate basic healthcare, including HIV-prevention services; alternative recreational activities and programs to encourage social change and wellness. Condom distribution should be strengthened around mining sites. Healthcare service providers in mining sites should facilitate mineworker-friendly services, open after conventional working hours. Mining companies can support these service providers under their wellness programs. Mining companies should provide periodical (e.g. after three months) medical checkups which include voluntary STI/HIV screening. This will buttress the fear of stigma that many employees have when they consider going for STI/HIV testing and will assist management to plan activities and services for the workforce. For ethical reasons, this information should remain confidential.
<p>Smaller mining contractors which do not have money to invest in their staff and use mostly contract or casual labor also do not provide any health benefits for employees. In addition, many of these companies will often not release their employees for VCT or other services offered by NGOs.</p>	<ul style="list-style-type: none"> Government should enforce greater regulation over small/less formal employers or provide incentives for them to implement workplace policies and/or provide regular access for all their employees to other HIV-prevention services. NGOs need to support smaller mining contractors in developing workplace/wellness programs including contract and/or casual labor.
<p>Where workplace HIV programs exist for this sector they tend to provide solely for employees while employees' families, casual workers and others living in the vicinity often do not have proper access to VCT, IEC materials, medical aid or good-quality services.</p>	<ul style="list-style-type: none"> NGOs and Mine Companies need to include specific HIV-prevention interventions that target irregular and informal workers on mining sites.
<p>Many HIV-prevention programs available to migrants are not intended nor tailored for migrants, either culturally or linguistically. Migrants become secondary recipients of services that were not originally intended for them. Often migrants are not aware of the services that are available for them.</p>	<ul style="list-style-type: none"> Government, the private sector and NGOs should provide recreational facilities in and around mining settlements, and implement programs to encourage social change and wellness.

Gaps/Challenges	Recommendations
<p>Generally, there is a lack of healthcare and HIV/AIDS services in mineworker-sending communities.</p>	<ul style="list-style-type: none"> Government, the private sector and NGOs should also target mineworker-sending areas with program interventions such as HIV and STI awareness, access to testing and treatment of STIs and BCC.
Research and Strategic Information	
<p>Although some research has been conducted among migrant mineworkers, there is still a general lack of adequate data on HIV and STIs in the mining sector.</p> <p>Better information needs to be collected on health-seeking behavior of both miners and the people with whom they interact.</p>	<p>More research should be conducted on the nature of sexual networks and the level of concurrent sexual partnerships that exist among mineworkers, their families and the communities with whom they interact.</p> <p>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 migrants and mobile populations and the communities within which they interact.</p> <p>Additional research is needed on the barriers of accessing healthcare by migrant workers.</p>
Others	
<p>Lack of statistical data: There is limited data on the dynamics of labor migration in the mining sector, particularly of casual workers.</p>	<p>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 mineworkers.</p>
<p>Funding is identified by most role players as a challenge in reaching migrants. Most programs are funded year by year so there is no certainty or continuity of effort.</p>	<p>Donors should strive to harmonize their funding strategies in the area of migration and HIV.</p> <p>Non-traditional funding sources (e.g. private sector) should be explored.</p>

6. Localized, Detailed Mapping of Services

A localized, detailed mapping of health services was conducted in Rosh Pinah, Southern Karas Region, Namibia and Solwezi, North-Western Province, Zambia.

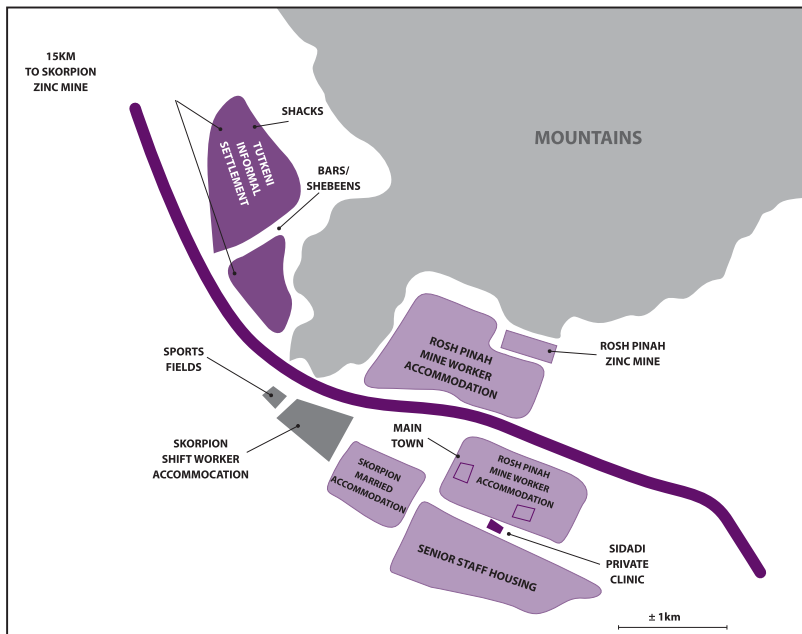
Although there are several public and NGO-led services available, migrant mineworkers in this area face challenges in accessing these services, including a lack of money for transport to the city where these services are provided and no time off given to miners by their employers during regular work hours.

6.1 Rosh Pinah, Southern Karas Region, Namibia

The site chosen for mapping of health services in Namibia was Rosh Pinah in the southern Karas region. The town was established in 1969 when Rosh Pinah Zinc Mine became operational. It is still maintained and serviced by a private company called Roshcor. There are two large

zinc mines in the area (Rosh Pinah Zinc, Skorpion Zinc), which house their workers in the town. It is estimated that more than 11,000 people live at Rosh Pinah, which has grown rapidly since the second mine, Skorpion Zinc, was opened in 2001. While most permanent workers live in formal mine accommodation, many of the sub-contractors stay in a growing informal settlement (known as Tutukeni/'Sand Hotel') on the north-western outskirts of the town. Both mines have an employee wellness program through which they organize regular VCT, distribute condoms and IEC materials, hold training workshops and use peer educators to pass HIV-related messages to other workers. They are part of the Chamber of Mines' Occupational Health Education and Awareness Program (OHEAP), which provides them with training and materials.

Sketch map of Rosh Pinah town



There are two health facilities available to the residents of Rosh Pinah. The first is the *Sidadi Clinic*, which was established by the two mining companies and is a private operation for which users pay. All permanent mine employees are on medical aid and can therefore access their treatment at this clinic. If workers need VCT or treatment of any kind, they are referred there. Most of those workers who have brought their families to live in Rosh Pinah have included them on their medical aid policies or earn enough to make use of Sidadi clinic. While the clinic does distribute condoms and HIV-awareness materials in the wider community from time to time, its services are mostly inaccessible to those living in Tutukeni as they cannot afford to take treatment there.

The only other available facility is the Rosh Pinah Clinic, located amongst the housing provided for Rosh Pinah mineworkers. This is a small government clinic with limited facilities and staff. A doctor consults once a month from the nearest big centre (more than 300 km away) but it is usually staffed by two nurses. A Red Cross counselor works at the clinic to provide VCT and other needs but there is no dedicated office in the small building for counseling patients. Despite being more than 2 km away, most residents of Tutukeni have no choice but to make use of this clinic for all their health needs. The clinic does provide VCT, condoms, multi-language IEC materials, ARVs, PMTCT and PEP to everyone for free, but given the lack of staff and facilities, it cannot provide much of an HIV-prevention outreach service to the residents of Tutukeni. The clinic does not have its own vehicle to fetch drugs and equipment, which are often sporadically available as a result.

There are no other NGO or CSO-run HIV-prevention services available to people living in Rosh Pinah. Thus, the area of greatest risk in this mining settlement (Tutukeni) has no HIV-prevention services of any kind located there and the residents of this area are unable to access adequate services at the facilities which are available in the town.

6.2 Solwezi, North-Western Province, Zambia

The mine site included in this assessment is located in Zambia's North-Western Province and is approximately 8 km from the town of Solwezi. Until 2001, Solwezi was an isolated and sparsely populated town, despite being the provincial capital for North-Western Province. With the establishment of the mining company and the subsequent opening of an additional mine, Lumwana (the largest mine in Africa), located 70 km from Solwezi town, the town witnessed an influx of migrants from within Zambia, the region and overseas, leading to a rapid increase in population. Because Solwezi is the nearest town to both mines, it has become the hub of the province and indeed of much of Zambia, with numerous activities taking place. With insufficient accommodation to cater for the large numbers of residents and migrants, accommodation is a major issue in Solwezi.

The mine has an employee wellness program run by the Comprehensive HIV/AIDS Management Program (CHAMP) through which regular VCT services are provided, condoms are distributed, and IEC materials are disseminated. CHAMP also holds training/sensitization workshops and uses peer educators to share HIV-related messages with their colleagues.

Mineworkers are accommodated at the mine site, and they reside in Solwezi town, often sharing houses with colleagues. The majority of the workforce at the mine sites is male. In Solwezi there are five health facilities available to the residents, namely Solwezi General Hospital, Solwezi Urban Clinic, Hilltop Hospital, St Jones Clinic and Solwezi Medical Centre. Residents can access general medical services from these centers, such as HIV-related services like VCT, STI screening and treatment and ART. Apart from the general hospital and the urban clinic, access to the other centers has to be paid for by patients. The mine refers its employees to Hilltop Hospital for medical services. Non-residents are required to pay for medical services in Solwezi.

A number of NGOs in Solwezi conduct HIV-prevention activities, providing information and referrals to other services, including clinics and hospitals:

- New Start Centre, which offers VCT and referral services to its clients;
- Corridors of Hope/Zambia Health Education and Communication Trust which offers VCT, STI screening and treatment, HIV and AIDS sensitization campaigns, BCC, referral and local capacity building;
- Health Communication Partnership which offers information dissemination of IEC materials;
- Zambia Prevention, Care and Treatment Partnership which currently offers capacity building of health personnel, PMTCT, ART (including pediatrics) and infrastructure development.

These facilities are well spread across the town, and are accessible to Zambians and non-Zambians alike. With the exception of Corridors of Hope, however, these programs are not specifically designed to target migrant and mobile populations.

7. Migrant Stories

Below are two stories of migrants working in the mining and minerals sector:

Migrant Story: Teboho Tau, Miner from Lesotho at Carltonville, South Africa

Teboho Tau is originally from Amatswete Village in Leribe, Lesotho. Like his father he migrated to Carltonville, South Africa. He left behind his wife and two-week-old son. Teboho stayed in a hostel with other mineworkers. The hostel was a dangerous place and a group of fellow miners attempted to sodomize him. These hostels are like a prison and nobody is safe. Teboho witnessed young and weak hostel mates being sodomized by older mineworkers. Having worked as a miner for 13 years, Teboho is now living at the safer quarters. At the mine, Teboho works with many migrant mineworkers. Since 2001, female miners started to join the mine.

For Teboho, the major challenge of working as a miner is being away from his family. Home is far away and he hardly gets leave days, visiting them fortnightly. Teboho states that most miners have sexual partners to 'quench their thirst'. Teboho feels that the separation from his wife pushed him to look for a partner at the mine. He has had the same girlfriend for six years and uses condoms. Teboho is aware of HIV and how it is spread and how it can be prevented. He noted that most miners are not aware of the risk of unsafe sex as they hardly attend the programs on HIV awareness that are organized by his employer. It is also evident that mineworkers engage in high-risk behavior. Teboho says that his friends regularly hire sex workers and do not use condoms. Recreational facilities are not accessible to low-ranking workers, which produces a bad situation because the type of work requires much rest and relaxation after work.

(One-on-one interview, South Africa, September 2009)

Migrant Story: João, Miner from Mozambique, working at Rustenburg, South Africa

João (44), was born in Mozambique, and has been working for a mining company in Rustenburg for the past 19 years. His journey as a migrant started in 1986 when he went to work for a textile industry in Germany. When the contract ended in 1990 he went back home to Mozambique. He eventually found work in the South African mines and migrated to Rustenburg, first as a sub-contractor for three months. Thereafter, he was recruited by TEBA on a 12-month contract and became a permanent staff.

‘At first I was very worried; it is not easy to work five days of the week without seeing the sun, and the work underground is dangerous. I was in a new environment with people that I did not know. I felt very lonely but had to be strong because I am a man and I have to be able to adapt to any situation. Many times I feel sad because I am missing on the chance of being a father to my children. When I go home I see they have grown and this breaks my heart because they are growing without me. But, mining is the only way I can sustain myself and my family. I have no other choice.’

When he first started in 1991, he stayed for a year without visiting family because he first wanted to make sure that he had his work permit and the job was secure. In 1992 he took 74-days leave to go visit family, which was the norm then (now it is 35 days). Then in 1997 his wife came to visit for the first time. He applied for a leave-out of hostel allowance so that he could have his own space where his wife and kids now stay when they come to visit. They do not live at the mine since he wants to build a small house back home where he can go when he retires, ‘If my wife comes to live with me, I will not have anyone to supervise the building of the house.’

‘In May 1998 I had an occupational injury and I was advised to go test for HIV. During that time people didn’t really talk about HIV, there was more stigma than now. But I decided to get tested and the result was positive. It was not easy but I decided to tell my wife and she also went to test but she was negative and since then we have been using a condom.’

‘I became a peer educator here at this company and now I talk to the women and more especially men that work as miners here in the company about HIV. We have an induction program for all new employees and those coming from holidays. During the induction session focus is on how to prevent HIV infection and how to deal with people living with HIV; condoms are made available in toilets and hostels corridors. Many of the men still do not want to use condoms. Some of my fellow Mozambicans mineworkers say that back home they were not informed about condom use. They stress that they are grown ups and cannot be told how to engage sexually with a woman. In some cases, even though they have been told that HIV cannot be cured they refuse to believe because some traditional healers tell them that they can cure it. Many times when I arrive home after work, I have to cook for myself and it feels as if I do not have a family. I think that this is one of the reasons why people engage with other woman.’

(One-on-one interview, South Africa, September 2009)

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